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Implementing Best Practices to Improve Veteran's Primary Care: A Pilot Project for Suicide Screening, Assessment & Referral

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Implementing Best Practices to Improve Veteran's Primary Care: A Pilot Project for Suicide
Screening, Assessment & Referral

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Abstract

Problem Description: Suicide is an increasing problem within the United States, but an even greater problem among the veteran population. Veterans are twice as likely to commit suicide than individuals within the civilian population. El Paso County, Colorado has the highest veteran population in the state and the highest number of suicides. Despite numerous military mental health programs available. Studies have found that many veterans will visit a civilian primary care clinic (for various reasons) within a month of taking their own lives but rarely are mental health concerns noted. This can be due to a lack of awareness and training within civilian healthcare clinics, and as a result, a low confidence in addressing veteran's mental health needs. Having confidence in themselves and understanding veteran mental health concerns and military culture is vital if civilian healthcare staff are to intervene when an opportunity presents itself.

Interventions: A pilot project was conducted at a primary care clinic within El Paso County, Colorado. The staff were provided education on military life and its effect on mental health. A process change was initiated that included inquiring about veteran status of all adult patients and screening for stressors occurring in their life. Any at-risk patients were then referred for additional evaluation or intervention as appropriate.

Results: The cumulative post-test results following the education initiative showed a 21% increase in participants' knowledge of veterans and an increase in their perceived self-efficacy in discussing mental health issues. A greater awareness of veteran community support programs was noted along with the recognition that veteran status of all primary care patients should be assessed.

Interpretation: The S.A.V.E educational training was well received and provided participants with the tools necessary to understand and discuss mental health with veteran patients. As

research shows, the more healthcare workers are trained in awareness of veteran issues, the more they will be confident to discuss mental health issues.

Conclusion: The pilot was successful in improving the participants' understanding of veteran mental health and resources available within the community. Although identifying veteran patients is recognized as an important step within the family practice clinic, the process is believed to be better served by electronic means, rather than paper surveys. As research shows, continued efforts within the primary care setting will lead to a better understanding of veterans and a confidence of the staff to intervene, thus bridging the gap between mental health and primary care within the community.

Key Words: veteran suicide, suicide intervention, suicide education, civilian healthcare, mental health.

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Problem Description

Introduction

Suicide is an increasing problem within the United States. The American Foundation for Suicide Prevention (AFSP) reports that in 2016 over 47,000 people were successful in committing suicide and over 1.4 million people made a suicide attempt (AFPC, 2016). Additionally, they reported the national age adjusted suicide rate was 14.0 per 100,000 individuals (AFPC, 2016). In comparison, the Veterans Administration (VA) reported that in 2016 over 6000 veterans committed suicide; at an age adjusted rate of 34.9 per 100,000 individuals (VA National Suicide Data, 2017). Clearly, suicide is a significant problem in the United States. However, this problem is much larger and more widespread within the veteran community. This Doctorate of Nursing Practice scholarly project proposal will further identify the problem within the veteran community and recommend an evidence-based pilot study in a family practice clinic in Colorado Springs, Colorado, in order to address certain factors contributing to this problem. For purpose of this project, a veteran is defined as anyone who has ever served in the United States Military.

Problem Background

The suicide rate among Colorado veterans was nearly double the state's overall rate. According to Ribeiro et al. (2017), mental health was a common precipitating factor for suicide. As the VA (2017) explains, many stressors within military life, including deployment, family separation, and combat can increase a veteran's risk for mental health issues and depression. The United States Military is aware of this serious issue and has implemented numerous programs to assist veterans struggling with their mental health. In fact, in the Ribeiro et al. (2017) study it was found that in the geographical areas where suicides among veterans were the highest, there

were numerous veteran health facilities available to help support military suicide prevention efforts. Although these programs are beneficial to many, there is still an alarming rate of veterans who are afflicted with mental health conditions, ultimately leading to suicide. According to the Ribeiro et al. (2017) study, many veterans access civilian primary healthcare facilities shortly before taking their own life. The reason for these visits can vary but typically are due to some other ailment, such as high blood pressure, a sore back, or the flu. Even though these individuals were in the presence of a healthcare provider, no mental health concerns were noted. In fact, in a study by Fredricks and Nakazawa (2015), it was reported that many civilian healthcare providers do not even know if their patients have served time in the military. Understanding the veteran mental health concerns and military culture is vital if civilian healthcare staff are to intervene when an opportunity presents itself. However, as the literature will show in this proposal, a high number of primary care health workers are not prepared to properly assess a suicidal veteran, nor understand the available veteran resources.

Local Problem

The state of Colorado ranks among the highest in the nation for suicide (Colorado Health Institute, 2017). In fact, there has been an upward trend in suicides in Colorado since 2009. El Paso County has led the state of Colorado in the number of suicides for the past decade. One reason for this is that veterans are more likely to suffer from mental health issues than the civilian population, and El Paso County has the largest number of veteran residents in the state (VA National Suicide Data Report, 2017). Even though there are many military health facilities located in El Paso County, veterans will often seek medical attention from civilian healthcare providers. Most of the time the reason for their visit is not related to a mental health issue, however, herein lies an opportunity for intervention. Research has shown that patients feel more

comfortable seeing a primary care physician versus a mental health specialist (DeHay et al, 2015). Unfortunately, many civilian healthcare workers do not understand the stressors of military life nor feel comfortable discussing mental health with a veteran patient. As a result, they will not approach the subject. Primary care workers need to receive specific education in order to be prepared and equipped to discuss and screen for mental health issues with their veteran patients and make timely and appropriate referrals, when indicated.

Available Knowledge

Literature Review

When searching available literature, forming the problem statement into a question helps to narrow the search and develop the most relevant evidence (Reavy, 2016). A common format is to formulate the question into the population of interest (P), intervention to be implemented (I), the variable with which the intervention is compared (C), and the outcome desired (O) (Dang & Dearholt, 2018). For this review the searchable question developed was: Will nurses who work at a primary care clinic who complete a training course on veterans suicide prevention, have an increase in confidence and self-efficacy in caring for suicidal veterans as compared to before the training?

Key words for the research developed from the PICO question include: Veterans and suicide, nursing education, mental health, veteran versus civilian suicide rates, predictors of suicidal behavior, responding to suicide risk, as well as suicide prevention in the military. A search was conducted using The US Department of Veteran Affairs (VA), CINAHL, Medline, and ScienceDirect databases. In addition, several professional organizational websites and journals were also referenced to include the Journal of Psychological Nursing, American Foundation for Suicide Prevention, Colorado Department of Public Health, and American

Medical Association. The inclusion criteria for selecting relevant studies and articles included literature from peer-reviewed journals and professional websites between 2009 and 2019, written in English and focused on non-acute settings in the United States.

The initial search yielded 45 articles with potential applicability. After evaluation with the inclusion/exclusion criteria, 10 articles were selected for review. The search identified three quasi-experimental studies, four non-experimental studies, one clinical practice guideline, and four quality improvement projects.

The level II study (Balasubramanian et al., 2017) was a systematic review of a combination of randomized control trials (RTC) and quasi-experimental studies. The study provides evidence that when primary care with behavioral health integration is used, there was reduced depression severity in patients, and was perceived by patients as beneficial. The intervention consisted of removing the negative stigma of seeking help for a mental health or psychosocial problem, enhancing understanding of mental health, and changing policies and social norms. When Collaborative Assessment and Management of Suicidality was used, participants had significant positive results, showing this intervention is beneficial.

The four (Level III) non-experimental studies included in the review were systematic reviews of a combination of RCTs, quasi-experimental, and some non-experimental studies. One study (Bolster, Holliday, Oneal, & Shaw, 2015) found that once staff are trained in suicide assessment, they realized it was no different than assessing for any other type of illness and are then able to help those with suicidal tendencies. Another study (Knox et al., 2012), completed in partnership with the U.S. Department of Veterans Affairs (VA), evaluated the standardized gatekeeper training program, which included a scripted behavioral rehearsal practice session. The SAFE VET intervention is grounded on the tenets of Safety Planning. This incorporates

elements of 4 evidence-based suicide risk reduction strategies. First, the means of the veteran's individualized safety plan is discussed, which is tailored to the veteran's distinctive warning signs, internal coping strategies, contacts of family members or friends, and contacts of professionals or agencies who can offer crisis assistance, including VA's Suicide Hotline (now known as the VA's Crisis Line). The second element is teaching brief problem-solving and coping skills (including distraction). The last two sections include enhancing social support and identifying emergency contacts, as well as motivational enhancement for further treatment (Knox et al., 2012). The third research article (DeHay, Ross, & McFaul, 2015) found that PCPs (primary care physicians) who perceive themselves as competent in suicide prevention are more willing to assess and treat suicidal patients. And finally, in a similar article, the VA participated in an evaluation of a brief standardized gatekeeper training program and a scripted behavioral rehearsal practice session (Matthieu, Cross, Batres, Flora, & Knox, 2008).

Evidence obtained from literature reviews, quality improvement, program evaluation, financial evaluation, or case reports and/or the opinion of nationally recognized expert(s) based on experiential evidence is classed as a Level V of which there were two included in this review. The first evidence further emphasized primary care training, as primary care providers who perceive themselves as competent in suicide prevention are more willing to assess and treat suicidal patients. The second and final evidence literature review (Okolie et al., 2017) stated that the primary care setting is a good opportunity for suicide prevention intervention, as most suicide victims are known to have had contact with a primary care physician within a month of death. To properly care for these patients, primary care staff need to understand that they have the ability to reach patients suffering with mental health issues even though they are not mental health experts.

Since they are able to intervene through screening and referral, they need to have established appropriate clinic processes and education.

Synthesis of Evidence

In a systematic review conducted by Bolster et al. (2015) 54 articles found on suicide prevention training for nurses between 2006 and 2013 were analyzed. The study showed that most registered nurses (RNs) have little or no training in how to assess, evaluate, treat, or refer a suicidal patient. Because of this lack of training, RNs feel ill-prepared and afraid to talk to patients about suicide. The study found that with proper suicide prevention education and training, clinical staff (specifically nursing staff) realized there is no difference in assessing a possible suicidal patient than any other medical condition (Bolster, Holliday, O'Neal, & Shaw, 2015). This study also found that the consequences of nurses' attitudes impacted the quality of care patients received and resulted in patient feelings of worthlessness, hopelessness, and rejection. The researchers concluded that there is currently a lack of suicide prevention education and training of staff, which could impact whether a patient decides to end their life.

In a similar study conducted by DeHay et al. (2015), researchers concluded that PCPs have a greater opportunity to decrease suicides because of more frequent contact with an at-risk suicidal patient, through possible routine visits. However, the study found that, PCPs have received inadequate training on suicide prevention. PCPs who perceived themselves as competent in suicide prevention were more willing to assess and treat suicidal patients (DeHay, Ross, & McFaul, 2015). This study described a Suicide Prevention "Toolkit" and associated training curriculum that were developed specifically for dissemination to providers at any level from medical residents to seasoned practitioners. The toolkit curriculum presented in this research has been shown as useful option for providing medical students, residents, and

providers with evidence-based education and training in the assessment and management of suicide risk. In addition, a similar study surveyed 141 PCPs to determine perceptions of physicians in civilian medical practice on veterans' issues related to health care (Fredricks and Nakazawa, 2015). Researcher found more than half of healthcare staff reported they were not comfortable discussing health related exposures and associated risks veterans might experience and that they were unfamiliar with referral and consultation services for them.

In a similar article addressing training in Veteran suicide prevention for providers and staff, Matthieu et al. (2008) evaluated the effectiveness of the Veteran's Administration (VA) Gatekeeper training for suicide prevention. A total of 602 staff members underwent the Gatekeeper training with an additional training session entitled "behavioral rehearsal practice session". The participants were asked to answer a questionnaire about the training sessions and found positive training-related gains in satisfaction, knowledge and self-efficacy (Matthieu, Cross, Batres, Flora, & Knox, 2008). The researchers concluded Gatekeeper training for suicide prevention can increase the capacity of clinic staff to positively engage, identify, and refer veterans at risk for suicide to appropriate care.

Primary health care settings should incorporate behavioral activation to offer brief, evidence-based treatments that provide reliable symptom reductions to those with severe depression (Gros & Haren, 2011). Behavioral activation includes the process of evaluating the way behaviors and feelings influence one another. Behavioral activation is based on the understanding that depression often keeps people from doing the things that bring enjoyment and meaning to their lives (Behavioral Activation, 2018). This supports the idea that mental health treatment should not be reserved for specialists, but that primary care clinics can integrate mental health care within their own practices. In fact, when this is done, patients can experience a lower

level of depression and anxiety symptoms (Gros & Haren, 2011). A review of 21 suicide prevention interventions, Okolie et al. (2017) discovered that the primary care-based screening and depression management programs were most effective (Okolie, Dennis, Simon Thomas, & John, 2017). They propose the primary care setting allows for suicide prevention intervention, as most suicide victims are known to have had contact with a primary care physician within a month of their death. This intervention comes through improved recognition and detection of depression along with the optimization of depression management through collaborative care (Okolie, Dennis, Simon Thomas, & John, 2017).

In a quality improvement research study, Blair et al. (2018) showed that educating non-psychiatric nurses about suicide prevention improved self-efficacy in both assessment and inquiry about suicide risks, as well as improving nurses' confidence in implementing suicide prevention strategies (Blair, Chhabra, Belonick, & Tackett, 2018). Nurses in primary care settings are willing to engage in the deeper conversations of mental health, they just need to know how to do it. By providing Gatekeeper training to providers and nursing staff, the research has shown it will increase provider and nursing staff self-efficacy and confidence in assessment and providing effective suicide prevention care.

Several best practices are supported by the literature. The studies have shown that many providers do not feel adequately trained in suicide prevention and are not aware of issues facing veterans. The evidence by Bolster et al. (2015) and Blair et al. (2018), shows that through education and training at primary care facilities, there is an increase in nurse confidence in assessing an at-risk patient within the general population. This training and increased confidence would carry over into the veteran population as well. Without any additional suicide prevention

training, as Fredricks and Nakazawa (2015) research showed, nurses were not comfortable dealing with suicide assessments and making the proper referral for mental health care.

As DeHay et al. (2015) findings revealed, primary care facilities saw a higher volume of patients, in a possibly less threatening environment. With suicide prevention training and local referral education, primary care nursing staff would be uniquely positioned on the front line of suicide prevention and to potentially able to do the most good for suicidal veterans. If consistent and adequate suicide assessments are performed at local community primary care offices, or other such clinical facilities, more at-risk individuals could be properly identified and helped.

In a literature review conducted by Burnette, Ramchand and Ayer (2015) incorporate Bandura's theories (1997, 2001) for suicide awareness training (Burnette, Ramchand, & Ayer, 2015). They concluded there are four factors which may influence an individual's decision to intervene with a possible suicidal person:

1. Knowledge of Suicide
2. Beliefs and Attitude about Suicide Prevention
3. Reluctance to Intervene (stigmas of mental illness)
4. Self-Efficacy to Intervene (confidence/comfort levels)

(Burnette et al., 2015)

In conclusion, the entirety of evidence discovered demonstrates primary care clinic staff (including nurses, providers, and other clinical staff) are on the front line and could make a significant impact on the reduction of suicides. By educating primary care staff on suicide prevention, specifically of the high-risk veteran population, they will be more confident in general interaction, proper screening assessments and referrals.

Rationale

Theoretical Model

This quality improvement project will be comprised of educating adult nursing staff on veteran suicide prevention, including screening and referral, guided by Knowles (1980) theory of Andragogy of adult learning. Knowles theory identified 5 assumptions that one should consider with adult learners: self-concept, past learning experiences, readiness to learn, practical reasons to learn, and finally adults are driven by internal motivation (Knowles, 1980).

Adult learners are at a more mature developmental stage and have a more secure self-concept than children. Because of this, an adult learner's self-concept allows them to take part in directing their own learning. This characteristic also drives a need for self-directing (Knowles, 1980). For the project to be successful and the staff to retain the knowledge being presented, presentation of the lessons will be open to questions and answers, rather than only lectures. To further emphasize this, the project will include "Lunch and Learns", where local Veteran mental health experts will come to the clinic, providing opportunities for personalized and interactive learning.

The second assumption is that adults have past experiences they draw from as they learn (Knowles, 1980). Personal experiences help establish self-identity and are highly valued by the adult learner. The project will focus on areas of past clinical experiences and build on this with the new Veteran suicide prevention education. This will be reinforced with interactions with local experts at the lunch and learn sessions.

Many adults see value to learning new things, which is Knowles (1980) third assumption of readiness to learn. Because adults see value in learning they are serious and focused on what is being presented. Adults see learning as an investment in themselves and new learning increases

their self-concept. By keeping the presentations open for discussions, questions and comments, the educational sessions will assist in keeping the adult learners engaged with the content being presented.

Many men and women who enter the healthcare field do it to help other people who are sick and or injured. Knowles (1980) theorized that adult learners will have practical reasons to learn. Because of the increasing evidence-based practice research, professional clinicians must continue to learn to improve the care they provide. Because of this, healthcare workers are always striving to increase their knowledge and provide better care for their patients. Adults are most interested in learning subjects that have immediate relevance and impact to their job or personal life (Knowles, 1980).

The fifth and final assumption is that adult learners are driven by internal motivation (Knowles 1980). Healthcare clinicians, by nature are problem solvers, which Knowles theorized that adults are also problem centered in learning. By helping others, they are driven by an internal motivation to help and assist in solving problems. By using the Adult Learning theory to develop this project the staff participating in the education may be more receptive and willing to learn ways to identify Veterans in need.

Project Framework

Use of the Logic Model (Appendix C) is critical to identify and organize key elements of this project. For the long-term aim of reducing Veteran suicide in El Paso County, Colorado to be realized, specific short-term goals must be achieved. The use of the Logic Model identifies critical resources and activities planned in order to provide successful outcomes. By looking at what could be achieved within the time frame for this project, it was determined the short-term

goal of educating primary care staff through a pilot study at one local clinic was reasonable. The short-term goals are as follows:

1. By August 31, 2020, the clinical staff at the primary care clinic (10 providers, 2 nurses and 13 medical assistants) will demonstrate an increase in their self-efficacy & knowledge of Veteran suicide by at least 50%.
2. By June 7, 2020, a Veteran Resource Support Tool is available for the primary care clinic to use in discussing available resources with veterans and 95% of clinic staff acknowledge they are familiar with and know when and how to locate the resource.
3. By June 7, 2020, the clinical staff at the primary care clinic use the Veteran Patient Questionnaire screening tool for 75% of patients over 18 years of age.
4. During the months of June and July 2020, lunch and learns are held at the primary care clinic, with representatives from local suicide prevention organizations, with at least 50% of the staff attending each session.
5. By August 31, 2020, 75% of the veteran patients who are flagged as at-risk by the Veteran Questionnaire screening tool are taken through the clinic's already established Behavioral Health Worksheet for subsequent referral.
6. The participant's feedback with suggestions for improvement in education, screening tools and the referral process, are shared with the primary care clinic, the resource agencies, and administration, in the Fall of 2020.

Specific Aims

Research has shown that there is a gap between mental health care and primary care providers that needs to be bridged (Gros & Haren, 2011). In addition, the level of self-efficacy among primary care staff when discussing mental health issues with patients, particularly

veterans, has been identified as lacking. To address this, the pilot study has four specific aims: educate the staff on veteran specific issues, integrate a suicide screening tool the staff can use for the veteran patient, increase staff's knowledge of local resources available for immediate support, and gather feedback from the staff on their experience with this project.

There is a significant amount of research on suicide prevention for veterans. Burnette et al. (2015) conduct a literature review of 53 peer-reviewed evidence-based articles on Gatekeeper training for Veteran suicide prevention interventions (Burnette et al., 2015). Burnette et al, summarized the evidence of gatekeeper veteran suicide prevention training consisted of four factors to be effective; knowledge of suicide, beliefs and attitude of suicide, reluctance to intervene, and self-efficacy to intervene (Burnette et al., 2015).

Of the four factors, the first two are based upon the idea of knowledge and awareness. What are the staff's perceived knowledge of suicide? Of veterans? What resources are available for at risk individuals locally? By facilitating an open discussion during education sessions, as well as with the local veteran mental health experts, awareness of suicide, screening and applicable referral resources will increase in the staff. The last two factors are based upon the action or non-action of staff due to perceived self-efficacy. Is there a reluctance to intervene? If so, why? The study concluded that with education, staff can feel more confident to discuss mental health with veteran patients and as a result, are more willing to initiate the conversation/intervention.

Context

Population

The target population of the project is the staff at the Primary Care. This consists of 10 providers (MD/DO/NP/PA), 2 nurses and 13 medical assistants. The demographics are varied,

with a mixture of ethnicity, age, gender, and experience in healthcare. The Health System will be further described in the following paragraphs.

Settings and Resources

This Health System is the largest health network in Colorado and Kansas, with 17 hospitals, 13 affiliate hospitals, health at home, urgent care centers and emergency rooms and Flight for Life Colorado, and meets the wellness needs of more than a half million people each year (██████ Health, 2019). Many of the people they care for are connected to the military in some fashion. The city of Colorado Springs, located within El Paso County, is the only county in the United States (US) that is home to 5 large military bases (4 large United States Air Force (USAF) bases and 1 large United States Army (USA) base). Despite having numerous military medical resources, many Veterans actually visit civilian healthcare facilities instead. This can be due to a variety of reasons, such as their insurance, medical necessity, or geographical location.

The primary care clinic in which this project's pilot study will take place is centrally located in Colorado Springs. It is a new stand-alone building, with approximately eight multidisciplinary health services located nearby, and it has ample parking. The clinic has 10 patient rooms, a staff kitchen/break area, a conference room, office areas, and the front desk facing its spacious waiting room. This project will utilize the conference room in the clinic as it provides the needed resources of seating, a large table and projection. Along with the clinical staff previously mentioned, its primary care network includes a Vice President, a Primary Care Director, as well as the specific clinic manager, all who have been informed and are supportive of the project details.

Congruence of Project with Organizational Mission and Needs Assessment

El Paso County is “military friendly”, meaning that it supports military members and their families through community activities, recognition, and resources. Those working in behavioral health are aware of the high suicide rate within the county and are actively working to intervene. Mt. Carmel and CSVHWA (Colorado Springs Veteran Health Wellness Agency) are two such facilities with a third facility yet to be determined. They each employ many professional counselors who specialize in Veteran mental and behavioral health, providing a variety of services to the community. They are also addressing the mental and behavioral health needs in the community. In a 2016 Community Health Needs Assessment (Community Health Needs Assessment, Penrose-St. Francis, 2016), it describes an initiative to incorporate behavioral health services into the system throughout neighborhood primary care practices. Currently, they have 4 primary care clinics within El Paso County.

Organizational Culture and Readiness for Change

This primary care facility joins the larger generalized group of primary care facilities that are referred to in the Community Health Needs Assessment (2016). It notes the lack of integration between Primary Care and Behavioral Health. By recognizing the social stigma attached to receiving mental and behavioral healthcare, they propose integrating such treatment into the primary care setting for patients to receive the treatment they need. In addition, the Community Needs Assessment refers to the fact that in the month before their death, many people who commit suicide visit their primary care physician (2016). This Health System wants to intervene by providing improved detection tools and support of primary care physicians to identify those at risk for suicide (Community Health Needs Assessment, 2016). This project aligns with their goals.

As an organization, they strive to help communities, families and individuals achieve optimal health. They are guided by their mission statement to extend the healing ministry of Christ by caring for those who are ill and by nurturing the health of the people in the community (Community Health Needs Assessment, 2016). They are a non-profit organization with a long list of awards and recognitions, including those from the American Heart Association/American Stroke Association, The Leapfrog Group, HomeCare Elite, The Joint Commission, HealthStream Research, American Nurses Credentialing Center Magnet Hospital Recognition Program, U.S. News & World Report and Healthgrades (██████.org, 2019). As seen in their Community Needs Assessment, continue to evaluate the gap between what is and what is desired and setting up a plan for how to make a difference.

This project will provide the Primary Care staff with education and tools necessary, specifically as it relates to Veterans. They will be better equipped to discuss mental health issues with Veteran patients, as well as be more aware of the local community resources available (Community Health Needs Assessment, 2016).

Strengths and Weaknesses

This Health System has recognized the barriers between behavioral health and primary care. As a result, they have instituted a mandatory field that must be completed before any progress in the patient chart can be made. This has been incorporated into the EPIC system (electronic health record platform) for each patient, in order to ask the questions designed to identify potential mental health issues. This clinic is already doing that, which is a strength. Their weakness, however, is not asking every patient of their veteran status. Since this is the classification which elevates individuals to be twice as likely to commit suicide, their veteran status should be routinely elicited. A weakness for the clinic is that the veteran patient

questionnaire will not be within EPIC, requiring the staff to use hard copies. One future goal of the pilot study is to change policy by incorporating the questionnaire into the computerized EPIC platform to be used during every initial patient in-processing.

Interventions

Logic Model

The project focus is to provide veteran specific suicide prevention education and training to primary care providers and staff (Appendix C). This will be accomplished through a pilot project at the Primary Care clinic. The pilot project will employ the VA's evidenced based pre and post training student tests to measure the primary care clinic's providers and clinical staff confidence in general interaction, assessment/screening, and referrals of possible suicidal veterans.

The educational content is provided through an evidence-based education module designed by the Veterans Affairs Office of Public and Intergovernmental Affairs and the PsychArmor Institute (VA and PsychArmor, 2019). Signs, Ask, Verify, Engage and Expedite (S.A.V.E) is a gatekeeper training video designed to present the specific myths, misinformation, and risk factors associated with suicide in the military. The staff will watch two education videos. The first video, entitled "15 Things Veterans Want You to Know", will describe how individuals can better understand veterans and the military community. The second video will instruct the participating clinic staff on how to properly assess and identify a veteran who may be suicidal by discussing signs and symptoms of suicidal thinking. The videos will also teach how to gain trust with the veteran, how to ask questions regarding suicidal feelings in a way to solicit honest answers from the veteran, and finally, how to refer the veteran for treatment. It is important to note, that although all clinical staff will participate in the educational element, only

those staff who are authorized based upon their medical training/education will be conducting the veteran patient interviews. This insures no one is practicing outside of their scope of practice and applicable state regulations are to be followed. A listing of local veteran resources will be provided in each treatment room for staff to disseminate to any veteran. This is to allow the veteran to see various resources available to them, should they need something now or in the future. It also helps to solidify the primary care clinic as a safe and understanding environment.

The criteria used in choosing an education module was as follows: the education needs to be evidence-based, no longer than 2 hours, free, and the instruction must be for providers and nursing staff and include content related to gaining trust of, assessing, and referring veteran patients. S.A.V.E. was chosen as it highlights the unique culture of military life and how that impacts the way these men and women may feel or think. It provides specific questions one can ask a veteran to better understand their mental state, and, as a result, learners are better equipped to discuss difficult topics with veterans and can see unique signs of an at-risk individual. The interventions that will be conducted with the clinical staff will include completing a pre-training test about the staff's self-efficacy and confidence about veterans and suicide (Appendix J). The clinic participants will then watch the educational videos, learn how to gain a veteran patient's trust, as well as how to ask questions about the veteran's possible suicidal feelings. The videos will be hosted by the project manager, who is knowledgeable of veterans after having over 20 years' experience with four of the services in the United States military. The video is provided to the public for free and no training is required for its use. Immediately following the education, the project manager will answer questions as well as discuss how to use the Veteran Patient Questionnaire (Appendix K). Additionally, the project manager will direct a role play simulation

exercise (which is provided in the S.A.V.E. education). This simulation exercise will reinforce the training the staff received by watching the training videos.

After the education has been completed, a new clinical process will be implemented using the Veteran Patient Questionnaire screening tool. During a patient's initial clinical check-in/routine screening, the staff will ask the patient (if over age 18), if they have served in the military. Only those staff who are authorized based upon their medical training/education will be conducting the veteran patient interviews. By using the Veteran Patient Questionnaire, the staff may identify at-risk individuals that otherwise may have gone undetected. The questions asked are from the S.A.V.E. curriculum and are designed with the intention of creating an open and safe environment for the patient. Copies of the questionnaire will be made by the project manager and the clinic manager, ensuring enough are placed in each exam room. A note will also be created in the EHR system by the clinic manager, reminding all staff to complete the patient questionnaire. There will be a secure drop box located in each exam room for the placement of the Veteran Questionnaire screening tool. If after administering the questionnaire, a veteran is determined to be at-risk, the staff will proceed to the clinic's already established "At Risk Workflow for Behavioral Health" (Appendix S). The first step in this process is the completion of the Columbia Suicide Severity Rating Scale, or CSSRS (Appendix R). Then, depending upon the patient's answers, the staff will continue to follow the "At Risk Workflow" sheet. For a moderate risk score, this includes creating a referral to a Behavior Health Clinic, completing a safety plan with the patient (Appendix T), and following up with the patient in two days. Low risk patients are scheduled for a follow up in one week. With both low and moderate risk individuals, the staff will also provide the patient with the Veteran Resource Support Tool (Appendix M). This is a list of local resources where veteran patients can receive various

assistance, depending on their specific need. Per the clinic's policy, all high-risk individuals receive medical transport to a hospital for further assessment.

It is important to note, that although all clinical staff will participate in the educational element, only those staff who are qualified based upon their medical training/education will be conducting the veteran patient interviews. A Medical Assistant may begin the process by asking the patient if they have ever served in the military. If the answer is no, they can note that on the questionnaire and drop it into the secure box. If the answer is yes, they will note that on the card and leave it for the Provider or Nurse (RN) to finish. This insures no one is acting outside of their professional scope of practice.

In the weeks following the initial education and training, representatives from the resource support programs will provide lunch. During this time, these experts on veteran mental health will discuss their facility programs with the staff and answer any questions. The clinic will also be provided lunch during these briefings to incentivize maximum participation.

At the conclusion of the project (August 2020), a post-test (Appendix O) will be used to measure the staff's confidence, self-efficacy, knowledge, and beliefs regarding the military and veteran mental health. This data will be compared to the pre- test results and analyzed in the following weeks. In addition, a group interview will be conducted to ask the staff specific questions to solicit feedback, specifically about the effectiveness of the education, the clinic process intervention, and the referral step (Appendix P). Also, a written evaluation questionnaire (Appendix Q) will be given to the participants asking for their individual feedback of the education (S.A.V.E.), the new patient screening process utilizing the Veteran Patient Questionnaire tool, as well the Veteran Resource Support Tool. The results of the project and lessons learned will then be communicated to the shareholders and the clinic.

The long-term goal of this project is to expand on the ‘lessons learned’ from the pilot veteran suicide prevention project by enacting new policies for primary care clinics in the future. These new policies include using the new Veteran Patient Questionnaire screening tool on every patient older than 18 in all primary care clinics. The easy to use screening tool questionnaire, begins with “Have you ever served in the military?” If the answer is no, nothing further is required using the screening tool by the staff. However, if the answer is yes, the tool will guide the staff through a series of four more questions. After examining the ‘lessons learned’, this questionnaire may need to be altered slightly, based upon actual feedback and patient response. Additionally, the goal is to eventually incorporate the Veteran Patient Questionnaire screening tool into EPIC, the organization’s Electronic Health Record platform. This would negate the need for paper questionnaires and would be a mandatory field that must be completed before moving on to the next section within each patient’s EHR.

To summarize, the educational video from S.A.V.E., combined with the lunch and learns, will provide the staff with the knowledge needed to confidently discuss mental health issues with their veteran patients. The use of the Veteran Patient Questionnaire screening tool will be a new process within the clinic, as the staff will now ask every patient over 18 years of age if they have served in the military. Acknowledging the veteran and having a general understanding of their military experience, will help the staff establish a safe, understanding environment for the veteran patient, with the hopes that they may be willing to share any difficulties they may be facing. In addition, a note will be made in the patient’s EHR indicating any volatile circumstances for suicide, to help with continued follow up by the clinic. This pilot project is designed to educate the participants on veteran issues and how they, as a Primary Care Clinic, have a unique opportunity to intervene. Feedback from the participants will be vital to evaluate

the educational format, as well as the clinical process change regarding veteran patient screening and subsequent referrals.

Correlation of Interventions with the Theoretical Model elements/phases

The project is focusing on teaching adult learners about Veteran suicide prevention through screening, assessment and when appropriate, referrals; therefore Knowles (1980) adult learning theory will be utilized to guide the educational components of this project. Knowles theory states that adult learners or in this case, professional primary care providers, nurses and staff, want to improve the services they provide so they will be intrinsically motivated to learn. By providing the initial evidence-based Veteran suicide prevention training S.A.V.E (phase 1), this acts on their readiness to learn in order to improve their skills for improved patient care, as well as increases their knowledge about veteran suicide. The education combined with the simulation training immediately following the videos, with the lunch and learns of local professionals (phase 2) will reinforce and sustain the knowledge gained. Additionally, according to Knowles (1980), the instructor's role to the adult learner is that of a mentor as well as an accessible reference. Therefore, the project manager will be accessible for the simulation of a possible suicidal Veteran, but also available for questions following completion of the training videos. As Knowles (1980) describes, adult learners need to have a direct input into their learning, including the planning and evaluation. Because of this, the participants will be told upfront that their input is warranted during and after the pilot project. Hopefully this will cause them to become even more engaged, realizing their opinion on the process and education will be valued.

Timeline

When establishing the timeline for this project, most events will fall into one of four categories: planning, implementation, evaluation, and dissemination. The timeline for this project is depicted in Appendix D. During the planning phase, the project manager will meet with the clinic manager, to clarify the mission of the project and the subsequent process change that will occur in the clinic. In addition, the physical resources needed will be ascertained. Also, the support resources will be identified and compiled for the development of the Veteran Resource Support tool. The provided referral information sheet will encompass a broad array of veteran mental health experts and resources in the local area. Some of these organizations will be asked to provide a ‘lunch and learn’ informational session for the staff during the months of June and July 2020. The day and time of the educational activity will be agreed upon with the primary care clinic and scheduled.

Project implementation begins with the educational offering to the staff in June 2020. A pre-test is used to gather their self-efficacy and knowledge. This will occur the same day as the education session. After the virtual lesson, the new process for the clinic will be discussed and implemented the following day. Over the following weeks, ‘lunch and learns’ will take place at the primary care office, helping the staff to understand more about veteran mental health issues and the resources available.

Upon the completion of the implementation phase (end of summer 2020), the staff will complete a post-test to determine their self-efficacy, knowledge and beliefs after their education and participation in this project. Data will be compared to the pre-test and analyzed to evaluate changes. In addition, the participants will be asked to complete an evaluation form to gather their perceptions of the training and value of the project as well as participate in a group interview to

provide feedback. The group interview will ask direct questions to gather information on the education, the process change and the referral procedure. It will be key to determine the value of the clinical process change and how the Veteran Patient Questionnaire screening tool could be improved. The project manager will gather data from the clinic on the number of patients identified as veterans who indicate some level of mental health risk and are flagged by the clinic for follow up, or are immediately processed according to the clinic's procedure for handling moderate or high risk (Appendix S). This data will be pulled by the clinic manager and given to the project manager for each week of the project. There will be no personal identifiers on this information, only a total number value. This number will be compared to the previous number of referrals the clinic completes.

The outcomes of the project, including the overall results from the staff tests and the final evaluation conclusions will be shared with the clinic. This information will also be shared with the leadership, as well as the participating community support organizations. The overall project results, including lessons learned and unintended consequences, will be summarized to provide key findings and future recommendations.

Measures

Both quantitative and qualitative data collection can help to bring depth to the evaluation of a project. The specific methods of data collection and analysis for this project are reflected in Appendix E, Outcomes and Evaluations Table. There were five short term outcomes for this project.

Outcome #1 stated that at the conclusion of the pilot project, the clinical staff at the primary care clinic, would have increased their self-efficacy & knowledge of veteran suicide by 50%. This outcome was measured by comparing the total results from the pre-test completed

prior to the education course and the results of the post test, completed at the conclusion of the pilot study. This test (Appendix J) was taken from S.A.V.E. (Signs of suicide, Asking about suicide, Validating feelings, Encouraging help and Expediting treatment) (VA and PsychArmor, 2019). A 5-point Likert scale was used throughout the test. According to LaMarca (2011), the Likert scale is the most universal method of data collection from surveys and has many benefits of which apply to this project. The purpose of the Likert scale is to measure attitudes, beliefs, and opinions, which is what is needed in analyzing the goal of increasing staff self-efficacy and knowledge. In addition, the responses are easily quantifiable, and the method is quick and inexpensive (LaMarca, 2011).

For Outcome #2, during the first week in June 2020, participants at the clinic indicated they understood the Veteran Resource Support tool that was available for veteran patients. In order to measure this outcome, data was gathered through a check-off sheet and brief competency exam of all staff, to ensure they had read through the resource tool and were aware of its location at the clinic (Appendix N). The Veteran Resource Support tool was developed with feedback from shareholders and community resource organizations. This data evaluation method was chosen as it is a simple, quick, and practical way to ensure staff have the understanding needed for offering veteran patients various services within the community.

Outcome #3 was beginning on June 9, 2020, the clinical staff at the Primary Care would use the Veteran Patient Questionnaire screening tool for 75% of their patients over 18 years of age. To ensure the staff were interviewing patients for veteran status and completing the veteran questionnaire, data was gathered by two means. First, the number of completed veteran patient questionnaires was collected by the project manager from the drop box and totaled each week. This included even the ones where the patient indicated they were not a veteran. This was to

successfully ensure the staff were using the screening tool on all adult patients seen in the clinic per day. Second, the project manager conducted weekly check-ins at the clinic to ensure staff participation and, when necessary, encouraged a greater number of staff to participate. The manager of the clinic was asked often if any concerns were reported from the staff. Feedback from the staff was addressed by the project manager in order to meet the staff's needs and to ensure the screening tool was being used. For example, the staff indicated they were running low on blank questionnaires, so more copies were provided.

During the months of June and July 2020, two 'lunch and learns' were held at the Primary Care Clinic. These were conducted by representatives from local suicide prevention organizations, with a desired minimum attendance of at least 50% of the staff at each session (Outcome #4). A sign in sheet was used to measure session attendance (Appendix L). The sign in sheet documented the total of the number of staff who attended each lunch and learn. This was used to calculate the attendance rate, and thus the number of participants learning about these local resources. The purpose of meeting with these organizations in an informal setting was to help solidify what the organizations do and how they can help. This in turn, leads the staff to feel more confident in their ability to discuss issues and resources with veteran patients, as indicated through their immediate verbal feedback.

Outcome #5 was by the end of the pilot project, 75% of the veteran patients who were indicated as at-risk by the Veteran Questionnaire Screening tool were designated for subsequent referral, as directed through the clinic's already established Behavioral Health Worksheet. When a provider completed the Behavioral Health Worksheet for a patient, it was entered into the clinic's system and flagged accordingly for follow-up. Outcome #5 was measured by comparing the total number of at-risk veterans as indicated after the questionnaire (collected every week in

the drop box), with the clinic's generated report of behavioral risk assessments. The clinical manager provided the total number of veteran patients referred out for behavioral health per week, and this number was compared to the number of at-risk veterans as noted from the completed questionnaires. This was to ensure the entire process was being completed for the veteran patients and they were indeed getting necessary follow-up and referrals.

Outcome # 6 focused on ways to gather the participant's feedback with suggestions for improvement, and to share this information with the Primary Care Clinic, the support agencies and administration in the Fall of 2020. In order to quantify the value of the pilot program and to gather suggestions on how the program can be improved for future implementation, the importance of accurately measuring Outcome #5 was critical. This data was gathered through group interviews with open ended questions. These questions were developed with input and collaboration from the stakeholders. (Appendix P). Group interviews have been shown to generate thoughtful discussion as ideas are freely shared. When the purpose of the interview is for feedback on a program (pros/cons) and not related to specific personal performance, negative groupthink is typically not a hindrance. The group interview was conducted by the project manager and notes were taken by a neutral party. In addition, a written evaluation form (Appendix Q) was given to the participants for any additional feedback they wished to share, and was provided for any individuals who were absent that day.

Analysis

For Outcome #1, the project manager analyzed both pre and post tests for the aggregate mean for each item, as well as the total items. The participants completed a matching information page with both tests, which protected their anonymity but allowed their results to be compared. For example, their favorite band and their pet's name are two questions asked and

used to match the pre and posttests. Since it is a small group, and a small number of questions, individual scores were generated for each question, in addition to the group score. This was important for the data analysis to identify any potential outliers or areas for further education. Next, the aggregated score of each question on the pre/post-test was compared to determine where change occurred and where there was still confusion/deficit of knowledge. This helped gather relevant action items to apply toward any future education programs. Both individual scores (pre and post) and group aggregated scores were displayed in a bar graph.

Outcome #2 was analyzed by collecting the short survey and ensuring the participants understood what the resource tool was and how to use it. Staff placed their names on the survey to ensure 95% staff completion and to identify anyone needing further education on the resource tool. The resource tool itself was developed by the project manager with feedback from the shareholders and community resource organizations.

To analyze the progress of Outcome #3, the completed patient questionnaires were placed in a secure box located in the office for collection. No personal patient information was on the forms. All answers from the screening tool were typed into the patient's chart under notes by the staff conducting the interview. At the end of each week, the screening tool forms were gathered, and the information recorded by the project manager. This number was compared to the number of adult patients seen at the clinic every day. This number of patients seen at the clinic every day was provided from the clinic's scheduler. The process of counting the questionnaires versus how many adult patients were seen, ensured the staff were completing the interviews. This is because even if the patient indicated they were not a veteran, that questionnaire was still turned in. In addition, personal conversations and email exchanges were held with the clinic manager every week to discuss the implementation of the veteran questionnaire screening tool. During this time,

the project manager asked if the staff had indicated any obstacles to conducting the interview and continued to remind the manager of the importance of completing the questionnaires.

Analyzing Outcome #4 required calculating the number of staff who attended the lunch and learn by using a sign in sheet (Appendix L). This was helpful to understand the accessibility of these events and if they were beneficial and should continue in the future. The number of lunch and learn along with the total number of participants was calculated. The actual sign in sheets were kept by the project manager, to protect the staff's privacy, and ultimately shredded.

To analyze Outcome #5, the clinic provided the project manager a report of the number of patients who were referred to behavioral health, through their already established Behavioral Health Worksheet. This was only a number, no patient information was disclosed. In the report, the clinic flagged anyone who was identified as a veteran. Then, that number was compared to the total number of at-risk veteran patients discovered. This was to ensure the entire process was being completed for veteran patients and they were getting the necessary referrals.

When analyzing Outcome #6, the data gathered was categorized into most common responses. This was used to collect participants' perceptions about the program and their feedback, to improve both the educational component and the clinical process in any future programs. During the group interview, participants were asked direct questions to gather information on the educational videos, the process change and the referral procedure. It was important to determine the value of the clinical process change and how the Veteran Patient Questionnaire screening tool could be improved. Aggregate data was used, with no personal identification of participants. This final report includes the findings and recommendations of how to incorporate suggestions into the next stage of project development.

Ethical Considerations

Ethical Considerations and Protection of Participants

This project was designed with ethical principles in mind. To ensure the protection of the participants (staff), any test or evaluation they completed was anonymous. There were personal identifiers in order to match the pre and post-test results, but these were abstract to not actually identify the individual. The aim of this pilot study was to gather honest feedback and accurate data to evaluate the efficiency of the training program, so the guaranteed anonymity of the participants was crucial. Only the project manager had access to the hard copies and subsequent computer files where the data was stored.

The questionnaires the staff used to interview veteran patients did not include any patient personal identifiers. However, if at any time the staff received answers from a patient identifying they were indeed at-risk, it was the staff's responsibility to communicate that with the provider and to ensure appropriate notes were made within the patient's electronic health record (EHR). In addition, they were to perform a follow up safety plan for the patient, if determined appropriate (Appendix T). The long -term goal of this project is to have the Veteran Patient Questionnaire screening tool embedded into the EHR system, but due to the time constraints and cost, it is not feasible to have it completed for this pilot project. So, for now, the results from the patient interviews were typed into the notes section. This interview process was much like when patients are asked the question "Do you feel safe at home?" Staff were to respond similarly with appropriate documentation and referrals. Guidelines regarding protection of privacy followed the clinic's standard protocol. The only individuals who had access to the patient's EHR were those staff at the clinic with a need to know. The project manager, although an employee of this organization, did not have access to the patient's EHR. The staff was reminded that any patient

referrals are protected by HIPPA (Health Insurance Portability and Accountability Act of 1996). All questionnaires were shredded by the project manager, after counting the number completed at the end of each week.

Finally, should any staff member have felt unsafe at any moment during the administration of the Veteran Questionnaire or subsequent conversations, they were to follow the clinic's already established protocol for unsafe situations. This included excusing themselves from the room and notifying another staff member of the situation. Decisions were to be made moving forward then based upon the individual situation, but at any time if the staff felt their lives were at risk, they were instructed to call 911.

Conflicts of Interest

The author of the project is an employee of this Health System but did not receive any pay for completing this study, nor was the study tied to his current position in any way (yearly evaluation, merit pay, etc.). In addition, all the work was completed on the author's own time. No other conflicts of interest were identified.

Biases

A potential bias in the project was the assumption that the S.A.V.E. video training was an effective educational tool. Although it had been used for over 10 years and had been shown to be effective, there was a possibility the education would not be well received. However, the educational offerings through 'lunch and learns' to which the clinic was exposed, could help offset this. It was also the author's personal bias that the project be successful, so that others can better understand Veterans and their specific needs. This bias was negated by the individual participants' anonymous feedback and the transparency of the data gathered. In addition, participants could be biased based upon their own personal history and any positive or negative

feelings regarding Veterans. However, by exposing the participants to the facts, the hope was they would view their personal perception in a new way and have a deeper understanding of the military community and Veteran struggles.

Threats to Quality

It was determined that for a successful pilot study, all the clinical staff would need to be educated and trained on the new procedure. This did prove to be a challenge as the project implementation was held during the summer months, when employees typically take vacation time. By holding a make-up training session, the goal was to catch those individuals who were absent for the first session. An additional threat to quality was because it was not possible to input the new veteran patient questionnaire into EPIC (during the time frame of the project), the staff were required to use hard copies. There were occasions where staff articulated they simply forgot to do the veteran patient questionnaire, due to the fact it was not a task required by the software system when completing a patient's check-in or exam. Even though copies were present in every exam room, not having the questionnaire easily accessible through the patient's EHR was a hindrance to having all the clinic's patients interviewed. This was addressed by the project manager through verbally reinforcing the importance of what they were doing during the weekly check-ins, as well as through the lunch and learn that were held at the clinic. In addition, cookies were brought into the office mid-way through the project implementation as a thank you to the staff, which hopefully also served as a reminder to continue interviewing patients.

IRB and project determination

The Institutional Review Board (IRB) for Catholic Health Initiatives (the parent organization), reviewed the initial application for this project and granted permission for it to be conducted. The final application was approved May 28, 2020 and is included in appendix (F).

Results

There were six short term outcomes for this project. Each outcome will be presented along with a brief overview of the steps of the intervention, processes, and results.

1. By August 31, 2020, the clinical staff at the primary care clinic (10 providers, 2 nurses and 13 medical assistants) will demonstrate an increase in their self-efficacy & knowledge of veteran suicide by at least 50%.

There were 11 participants who took the pre-test and participated in the training session, and 10 participants who completed the post-test. Due to the recent COVID pandemic, the clinic was required to limit their staff from 25 to 11 providers, nurses, and MA's, resulting in fewer participants than expected. Results of the pre and post-tests are shown in Appendix U. The staff showed an overall increase in their self-efficacy and knowledge of veteran suicide by 21%. In addition, for each question asked, the participants knowledge and confidence in veteran suicide increased, ranging from 10% (question #1) to 42% (question #5). Although there were positive results of increased self-efficacy and knowledge in comparing the pre and post-tests, the results were not sufficient to meet the goal of a 50% increase. It is recognized the goal of 50% was most likely overstated, and a more realistic goal would have been the typical 10% increase, which most studies use.

2. By June 7, 2020, a Veteran Resource Support Tool is available for the primary care clinic to use in discussing available resources with veterans and 95% of clinic staff acknowledge they are familiar with and know when and how to locate the resource.

The Veteran Resource Support Tool, which listed local organizations available to veterans in need, was provided to the staff. The resource was kept at the front desk so it could be

easily accessible and 100% of the staff indicated they were familiar with the tool. This was measured by all participants completing a check off sheet. This exceeded the goal of 95%.

3. By June 7, 2020, the clinical staff at the primary care clinic use the Veteran Patient Questionnaire screening tool for 75% of patients over 18 years of age.

Over the 44 days of project implementation, the average number of patients seen per day was 14. This number was less than anticipated, due to the COVID pandemic. After totaling the number of questionnaires received, it is determined that staff gave questionnaires to four to five patients per day. Therefore, the total percentage of patients being interviewed for veteran status was only 32%. This is below the goal of 75%.

4. During the months of June and July 2020, lunch and learns are held at the primary care clinic, with representatives from local suicide prevention organizations, with at least 50% of the staff attending each session.

Two separate lunch and learn lessons were held at the clinic. Out of the 11 initial participants, six attended the first session and seven attended the second session. This was measured by a sign in sheet. This equates to a 55% and 64% attendance rate, respectively, which exceeded the goal of 50% attendance.

5. By August 31, 2020, 75% of the veteran patients who are flagged as at-risk by the Veteran Questionnaire screening tool are taken through the clinic's already established Behavioral Health Worksheet for subsequent referral.

This goal was set to ensure any veteran patient who was found to be at-risk would receive follow-up support and behavioral health referrals as needed. The number of at-risk veteran patients, as noted through the veteran questionnaires, should match the number of referrals the clinic sent out for veteran patients. There were three patients identified as at-risk over the 44

days of project implementation. The clinic reported two veteran patients were referred out for behavioral health assessments, with the other patient being referred to a local veteran agency.

6. The participant's feedback with suggestions for improvement in education, screening tools and the referral process, are shared with the primary care clinic, the resource agencies, and administration.

The participant's feedback was elicited through a group interview, as well as an optional written evaluation form. The feedback given on S.A.V.E. the curriculum was positive.

Participants said it was easy to understand, valuable in clarifying some misnomers regarding veterans, and beneficial in helping them to better understand military life. Specifically, it helped them to understand why some veterans may be reluctant in asking for help or in expressing their mental health concerns. They acknowledged the need to know if patients are veterans, however they did not feel the Veteran Patient Questionnaire was the best way to gather this information. The suggestion was to have the Veteran Questionnaire embedded into the patients' EHR. The feedback and results of this pilot project were shared with the clinic and leadership via a written report.

Steps of Intervention and Details of Process Measures/Outcomes

The implementation phase began on June 9th, 2020 and was conducted by the project manager and clinical staff. As previously mentioned, due to the recent COVID pandemic, the clinic was required to limit their staff from 25 to 11 providers, nurses, and MA's, resulting in fewer participants than expected. During the meeting, participants took the pre-test to measure their self-perceived confidence in veteran suicide. The pre-test aggregated results were compiled and are shown in Appendix U, Table 1. A 5-point Likert scale was used for the six questions and

the maximum score possible was 30. An overall score of 59% shows there was an opportunity for increased self-perceived efficacy and understanding of veterans.

Outcome #1 required the results of the pre and post-tests to be analyzed and compared (Appendix U). The post-test results were calculated in the same way as the pre-test and are displayed in green in Appendix U. The aggregate post-test scores show an overall increase in self-confidence and understanding for the participants of 21%, for the entire evaluation. The highest value that could be given on each question was “5”, with the lowest being “1”. Question number one, which asked if the participants had enough training to interact with suicidal patients in general, shows an increase of 10%, from 52% (2.6) to 62% (3.1) in the participants’ self-ranked increase in understanding or efficacy. To accompany this, question two asked if the participants were confident in their ability to discuss suicide with any patient. This shows an increase of 18% higher scores in the post-test., from 52% (2.6) to 70% (3.5). These findings show the pilot project was successful in providing training necessary for the staff to feel prepared and confident in their ability to interact with suicidal patients. For pre-test question three, participants agreed that veterans were more likely to commit suicide than the general population (78% or 3.9), however the post-test scores show an even higher agreement to this statement (98% or 4.9), which is an increase of 20%. Question four asked if participants were confident in their ability to discuss the topic of suicide specifically with a veteran patient. Post-test scores show an increase in confidence of 24%, from 64% (3.2) to 88% (4.4). The question which participants identified in the pre-test as having least confidence/awareness was number five, which asked if they were aware of community resources available for veterans. The average score for this pre-test question was only 36% (1.8). Data from the post-tests show an increase in this knowledge by 42%, ending with 78% (3.9). When looking at question six, which asked if

they understood the stressors in military life that could lead to mental health issues, the post-test scores show an increase of 22% awareness, from 54% (2.7) to 76% (3.8), showing a better understanding of complex issues veterans face. To summarize, the goal for Outcome #1 was that participants increase their overall self-efficacy and knowledge in veteran suicide by at least 50%. Upon examining the data, the overall increase was 21%. The cumulative pre-test scores averaged 59% (17.6), while the post-test cumulative scores were 80% (24). Although this is below the goal of a 50% increase, it still shows a positive relationship between the scores before and after the intervention.

Differences of observed versus anticipated outcomes are noted when analyzing Outcome #3, which is staff administering the Veteran Patient Questionnaire to 75% of all adult patients. Here, it is clear there were impacts because of the COVID pandemic. Throughout 2019, the clinic typically saw 40-50 patients per workday; this would have equated to at least 30 patients being interviewed per day for the project. However, because of the COVID pandemic, they had dropped their patient volume by 50% to 75%, hence averaging only 10-20 patients per day. Of these patients, some were teleconference visits. For these visits, the staff did not conduct any veteran interviews. Throughout the project implementation, a total of 198 questionnaires were completed and 29 patients were identified as a veteran, or 15%. The questionnaires were gathered over a period of 44 days. This averaged to four or five questionnaires given per day. To clarify, these were patients who stated they had served in the military, not patients who had been referred for behavioral health treatment. According to the total number of patients seen per day over the 44 days, (as provided by the clinic's scheduler), the average number was 14. With an average of four to five questionnaires being given per day, the total percentage of patients being interviewed was only 32%. This is below the goal of 75%.

Upon examining Outcome #4, the decrease of patients being seen in the clinic led to a positive result. Two separate lunch and learn sessions were held at the clinic. The goal for Outcome # 4 was to have at least 50% of the staff attend each session. In the first session, six participants of the total 11 were present. This equated to a 55% attendance rate. The second session had seven in attendance, which was a 64% attendance rate. Those who attended stated that when the office has a full patient schedule, the staff are not able to take a whole lunch hour, due to patient needs. Since the clinic did not have a full patient schedule, more staff were able to attend the lunch and learn sessions. In addition, at the conclusion of each presentation, three or four staff would stay afterwards to continue a discussion with the speaker on veteran mental health issues, notably something they would not normally be able to do if running a tight patient schedule.

Outcome #6 was critical to understand the value of this project and any suggestions for improvement, for both the educational and clinical process components. The participant's feedback was elicited through a group interview, conducted on August 6, 2020, as well as an optional written evaluation form. The questions that were asked during the group interview can be found in Appendix P. Overall, the results were positive, as staff indicated they understood military life more now and felt better prepared to discuss mental health with their veteran patients. This shared belief is substantiated by the results of the post-tests. Nine of the eleven participants were present for this discussion. The feedback given on the S.A.V.E. curriculum was positive. They said it was easy to understand, valuable in clarifying some misnomers regarding veterans, and beneficial in helping them to better understand military life. Specifically, it helped them to understand why some veterans may be reluctant in asking for help or in expressing their mental health concerns. They acknowledged the need to know if their patients are veterans

however, they did not feel the paper Veteran Patient Questionnaire was the best way to gather this information. Having to complete a paper questionnaire is an extra step in their already busy day. Also, because it is an additional step, it was often forgotten when meeting with patients. The suggestion was instead to have a questionnaire embedded in EPIC, which is the patient EHR platform. This would remedy the problem of forgetting to interview patients and would make it simpler. Because of the education provided in the video, participants said they were more confident in discussing military issues with their patients.

When discussing future implications of this pilot project, participants felt other primary care staff could benefit from the S.A.V.E. training program. They realize the high rate of suicide within our county, particularly within the veteran population, and know that continued integration between primary care and behavioral health care is needed. As most healthcare providers and nurses want to be a resource for their patients, the participants expressed feeling more equipped now to offer their patients connections to veteran community support groups. Their feedback, along with the results of this pilot project, will be shared with leadership in the coming months.

Contextual Elements and Associations that Interacted with Intervention

Due to the COVID pandemic, the number of staff working at the clinic for the months of June and July was lower than originally planned. In addition, since it was the end of the fiscal year, four providers chose to use their PTO (Paid Time Off) hours in the month of June because if not used by then, those hours would be lost. These two situations led to fewer providers and clinical staff, and subsequently a decrease in the number of patients seen per day. For this project, that meant not having the desired number of participants: staff and patients, from which to draw conclusions. Additionally, having to use a paper form to interview patients was not

convenient and therefore periodically forgotten by the staff. Not having 100% of the clinic's patients interviewed for veteran status impacted the project results since there is no way to know how many veterans were missed.

Unintended Consequences

During the initial training session with the clinic, in addition to the staff present in the room, there were also six other staff members present via teleconference. A teleconference with other clinics was not planned, so this was a surprise. The Family Practice Clinic had invited another clinic to join via phone as they believed the information would be beneficial for them as well. Although this other clinic did not receive the full training, nor participate in the clinical process change, they did indicate their desire to have the entire training presented and join in the efforts to become more aware of our community's veteran population and their needs. This was a good indicator of the recognized need for veteran suicide education and the potential sustainability of the project for the future.

It was predicted that the 'lunch and learns' would provide the participants with additional information regarding the community resources available for veterans, however a further application was discovered. The clinic expressed their frustration with some behavior health referrals for patient's being difficult to navigate due to insurance. During Mt. Carmel's presentation, the organization explained their behavioral health services were not dictated by insurance and were free to any veteran or their family needing assistance. The clinic and Mt. Carmel then discussed the process for referring their patients for assistance or treatment. As a result, there is now a new partnership between the Family Practice Clinic and Mt. Carmel to get veterans help as needed.

Missing Data

When the project was initially planned, the primary care clinic was seeing 40-50 patients per day. However, when this pilot project was implemented, they were only averaging 10-20 patients per day, due to the COVID 19 pandemic. In addition, of the 10-20 patients that were seen per day, the staff only interviewed 32%. This resulted in less data to analyze the effectiveness of the pilot study. Throughout the process of gathering and analyzing the data for each outcome, it was found that one participant was missing from the post-test. There were 11 staff who participated in the pre-test, however only 10 were present for the post-test. In addition, for the group interview at the end of the project, two participants did not attend and therefore their feedback was not available. Although a paper evaluation (Appendix N) was provided to these two participants, the written evaluation was not received.

Project Revenue/Expenses

The project's budget is detailed in Appendix G. Much of the project expenses were wages (\$5930.00) related to time spent for the participants to attend the training session and the time spent for the project manager to teach the course and perform subsequent follow-up activities. The materials, space, and equipment (\$550.00) needed for the project implementation was minimal. Since the project was conducted at a family practice clinic, most of the items required were already there, such as the room, chairs, laptop, and screen. Travel cost for the project manager was low, as the clinic is located close to his workplace. The actual accrued expenses of the project matched the projected budget except for one item. Initially the food for the lunch and learns' were to be provided by donations. However, no donations were made, therefore the expense of the lunches were covered by the project manager. It is the belief that had

it not been during the pandemic, organizations would have been more likely to provide support through providing refreshments. It is important to note, there was no revenue generated in year one of this project, therefore all expenses were covered by in-kind donations provided by the DNP project manager and the clinic. The projected and actual cost for this pilot project was \$6913.00.

When evaluating the projected two to three-year expenses for this project, the increase in expenses reflect the extension of veteran education sessions that will be held at the other three clinics. The personnel costs have been adjusted for salary increases, based upon employee average 3% wage increase yearly. Additional costs that will be required to input the veteran patient questionnaire into the electronic health record system are noted during this expansion time frame (see Appendix H). The Statement of Operations (Appendix I) shows entire expenses for the project totaling \$6293.50. These costs will be converted by in-kind donations and no revenue will be generated.

Summary

When exploring the topic of increased veteran suicide, many studies had been conducted discussing the reasons why such a trend exists and potential areas of intervention. One study, Fredricks and Nakazawa, 2015, identified a lack of training and awareness in civilian primary care staff on veteran mental health. This could be from misinformation, assumptions, or biases toward military members. The intervention of this pilot project sought to rectify any misconceptions of veteran patients and increase primary care staff's confidence in veteran mental health issues. Results from the post-test show participants did have an increase in their understanding of veteran suicide and an increased confidence in their ability to discuss these issues with patients, as well as offer referrals as necessary. The project had four specific aims, all

of which were met: educate the staff on veteran specific issues, integrate a suicide screening tool for veteran patients, increase staff's knowledge of local resources available for immediate support, and gather feedback from the staff on their experience with this project.

During the group discussion to evaluate the project, all participants expressed that the information offered through the education was helpful, comprehensive, and realistic. They agreed that veteran status should be obtained on all adult patients in the clinic, however they were not sure if the written veteran questionnaire was the best option. Suggestions for implementing a field within the patient's electronic health record or through another way was discussed. Another positive outcome of the pilot project was the increased understanding about why veterans have a high risk for suicide. In addition, findings show that after this project, the participants are more confident in their ability to interact with at-risk veterans. They recognize the problem of veteran suicide within El Paso County, CO and expressed their support for all Primary Care clinics to engage in veteran mental health training and screening. Stakeholders are currently discussing the offering of this training to other clinics, along with the idea of embedding veteran status questions within the database for patient's health records.

Interpretation

The data shows an increase in the participants knowledge and self-efficacy after the intervention. The feedback from participants included their belief that the education was an important step toward reducing stigma and fear about discussing suicide with a veteran patient. The staff were eager to learn more about veteran's high-risk factors and community support groups, as they recognize the large military presence our county has, and the disturbing trend of increased veteran suicide. The experience and findings of this study support the use of Knowles (1980) theory of Andragogy of adult learning. The five assumptions Knowles believed to be

important to adult learning were identified and incorporated throughout this project; the learner's self-concept, past learning experiences, readiness to learn, practical reasons to learn, and internal motivation (Knowles, 1980). Participants acknowledged their self-perceived confidence level and knowledge of veteran's mental health issues. They were aware of the high risk for veteran suicide and wanted to learn more so they can intervene whenever an opportunity presents itself.

Association of Interventions/Outcomes and Literature Comparison

The outcomes of the project support the findings in the research. Specifically, if nurses are educated through gatekeeper training, their self-efficacy is increased, thereby leading to a higher probability of intervention with at-risk patients (Matthieu, Cross, Batres, Flora, & Knox, 2008). Since veterans are a high-risk group, understanding their unique challenges provides an increased awareness of potential mental health concerns within that population. As the review of literature found, the four factors which can influence intervention behavior are knowledge, perceptions, reluctance, and self-efficacy. S.A.V.E., the educational curriculum, utilized for this project addressed all of these. It was theorized that through education of the participants, the knowledge of veteran mental health would increase, and subsequently any false perceptions of military life would be reduced. Once a foundation is laid of information and knowledge, reluctance to intervene is diminished as the participants feel more confident to discuss suicide with veteran patients (Burnette et al., 2015). However, to be able to discuss veteran related mental health issues with patients, nurses and clinicians must first know if their patient is a veteran. The process change implemented within the primary care clinic of interviewing all patients for veteran status provided this needed information. As studies have shown, just being a veteran makes an individual twice as likely to commit suicide as the general population, so asking this question is vital (VA National Suicide Data, 2017). Throughout the 'lunch and

learns', participants became aware of available local resources to support veterans in need and learned how to refer patients to these, if needed. The participants increased self-efficacy then lends itself to a higher probability of intervention when the opportunity presents itself (Matthieu, Cross, Batres, Flora, & Knox, 2008).

Impact on People and Systems

Research has shown that the integration of mental health with Primary Care is an important step in addressing mental health issues. A Community Needs Assessment acknowledges this and states its desire to provide clinicians with the education and tools needed to identify at-risk patients. Providing education to staff on veteran suicide and implementing a process change by which all adult patients are screened for veteran status will support the hospital wide goal of addressing mental health concerns within the community. The people impacted first are the staff who receive the training and any support staff who are directly involved in patient care. Their knowledge is then put into action through their interaction with veteran patients. These patients then benefit from an insightful healthcare worker who can identify needs and provide helpful resources.

Implications for Policy Development

As a result of this pilot project, it is recommended there be two policy changes within the Health System. The two suggested procedural policy changes are interwoven, as one cannot take place without the other. First, it will be important for all Primary Care staff to partake in a mandatory education program of veteran mental health. The S.A.V.E. curriculum was found to be effective through this pilot project, so the same format can be used. All current staff would be required to participate, and all newly hired staff would receive the training upon employment. In addition, the system wide electronic health record program would be modified to implement a

mandatory field within every patient's health record asking of their veteran status. Upon entering a positive response, the system would then take the nurse/provider to a list of questions to evaluate any mental health concerns. If implemented, these policies would provide a continuity of care to our veteran population among all Primary Care Clinics.

Limitations

Limitations of the pilot project include the small number of clinic staff and of patients involved in the project. The Likert scale is effective in comparing pre- and post-test results. However, by only having five options to choose from, there may not be enough choices to adequately quantify small, yet meaningful changes in learning and increased self-efficacy. If this evaluation was to be done again, the recommendation would be to use a scale of 1-10 for greater answer choices (LaMarca, 2011.)

With few patients being seen, due to COVID related issues, as well as fewer patients being interviewed for veteran status, this could have reduced the number of patients who were identified as at-risk. There is no way to know how many potential individuals were missed and subsequently who may have been flagged as at-risk and referred for treatment.

Conclusions

This pilot project has determined five key areas where change or improvement is needed. Primary healthcare workers must be given adequate education and training for understanding veterans if they are to intervene when a potential mental health crisis presents itself. Additionally, there needs to be a process in place by which providers and nurses can identify veteran patients. It is important to establish a system-wide response to the growing number of mental health concerns within the population by providing the veteran education to the other Primary Care facilities within El Paso County. This project demonstrated that this can be done at

minimal cost, utilizing the S.A.V.E. curriculum. Having the veteran questionnaire placed within the EHR would require a small, easy change be made within the platform. For the mission of the project to continue, the senior leadership at the Health System and the Board of Directors need to be advised of the findings and encouraged to implement the new policy. Since the concept of bridging the gap with mental health and primary care is a goal for the organization, this would align nicely. The need for a new approach to suicide prevention in El Paso County is ever present, and this project hopes its findings and recommendations will impact the lives of our Veterans.

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Appendix A

Literature Review Summary Table

TITLE OF ARTICLE	AUTHORS	RESEARCH QUESTION OR AIM OF THE ARTICLE	TYPE OF STUDY (DESIGN)	DESCRIPTION OF SAMPLE (IF APPLICABLE)	OUTCOME MEASURES	RESULTS/KEY FINDINGS
1. Suicide Among Military Personnel and Veterans Aged 18–35 Years by County—16 States	Joseph E. Logan, PhD, Katherine A. Fowler, PhD, Nimeshkumar P. Patel, MA, and Kristin M. Holland, PhD, MPH	To examine stateside distribution of suicides by U.S. counties to help focus prevention efforts.	Data and qualitative content analysis, comparison design	Using 2005–2012 National Violent Death Reporting System data from 16 states (963 counties, or county-equivalent entities), this study mapped the county-level distribution of suicides among current military and Veteran decedents aged 18–35 years. This study also compared incident circumstances of death between decedents in high-density counties (i.e., counties with the highest proportion of deaths) versus	An estimated 262 (33%) current military suicides occurred in just ten (1.0%) counties, and 391 (33%) Veteran suicides occurred in 33 (3.4%) counties	Military and Veteran suicides are concentrated in a small number of counties. Mental health and intimate partner problems were common precipitating circumstances, all ten current military suicide high-density counties also had VHA facilities that might help support military suicide prevention efforts

				those in medium/low-density counties		
2.Health care contact and suicide risk documentation prior to suicide death: Results from the Army Study to Assess Risk and Resilience in Service members	Ribeiro JD1, Gutierrez PM2, Joiner TE1, Kessler RC3, Petukhova MV3, Sampson NA3, Stein MB4, Ursano RJ5, Nock MK6	Prior research has shown that a substantial portion of suicide decedents access health care in the weeks and months before their death. We examined whether this is true among soldiers.	Data and qualitative content analysis, comparison design, sample and control group	The sample included the 569 Regular Army soldiers in the U.S. Army who died by suicide on active duty between 2004 and 2009 compared to 5,690 matched controls.	Approximately 50% of suicide decedents accessed health care in the month prior to their death, and over 25% of suicide decedents accessed health care in the week prior to their death. Mental health encounters were significantly more prevalent among suicide decedents	Many soldiers who die by suicide access health care shortly before death. However, in most cases, there was no documentation of prior suicidal thoughts or behaviors
3.Risk Factors Associated With Suicide in Current and Former US Military Personnel	Cynthia A. LeardMann, MPH ;1 Teresa M. Powell, MS ;1Tyler C. Smith, MS, PhD ;1,2et	To prospectively identify and quantify risk factors associated with suicide in current and former US military personnel	Prospective longitudinal study with accrual and assessment of participants in 2001, 2004, and 2007.	Participants were linked with the National Death Index and the Department of Defense Medical Mortality Registry through December 31,	Unadjusted proportional hazards models revealed that those deployed to the current operations with or without combat were	The findings from this study do not support an association between deployments or combat with suicide, rather they are consistent with previous research indicating that mental health problems and substance use disorders increase suicide risk.

	al Michael R. Bell, MD, MPH ;4 Besa Smith, MPH, PhD ;1,3 Edward J. Boyko, MD, MPH ;5 Tomoko I. Hooper, MD, MPH ;4 Gary D. Gackstetter, DVM, MPH, PhD ;6 Mark Ghamsary, PhD ;7 Charles W. Hoge, MD8	including demographic, military, mental health, behavioral, and deployment characteristics.	Questionnaire data	2008. Participants were current and former US military personnel from all service branches	not significantly more likely to have a suicide death than those who did not deploy	
4. Suicide Assessment and Nurses: What Does the Evidence Show?	Cindy Bolster, MN ARNP Carrie Holliday, PhD ARNP Gail Oneal, PhD, RN Michelle Shaw, PhD, RN	This article reviews the state of the science of suicide assessment training for nurses.		utilized search engines: PubMed, CINAHL, PsycINFO, MEDLINE, and MEDLINE Approximately 54 articles were found between 2006 and 2013 re suicide prevention	Most registered nurses (RNs) have little or no training in how to assess, evaluate, treat, or refer a suicidal patient. Because of this lack of training, RNs feel ill-prepared and	Research suggests that once RNs are trained in suicide assessment, they realize it is no different than assessing for any other type of illness and are then able to help those with suicidal tendencies

				training for nurses. A review of abstracts eliminated non-research articles. Articles were also excluded if nurses were not part of the research focus. Nineteen articles were then reviewed	afraid to talk to patients about suicide.	
5. Outcomes of Integrated Behavioral Health with Primary Care	Bijal A. Balasubramanian, MBBS, PhD, Deborah J. Cohen, PhD, Katelyn K. Jetelina, MPH, PhD, L. Miriam Dickinson, PhD, Melinda Davis, PhD, Rose Gunn, MA, Kris Gowen, PhD, Frank V. deGruy III,	To show integrating behavioral health and primary care is beneficial to patients.	This study used a convergent mixed-methods design, merging findings from a quasi-experimental study with patient interviews conducted as part of Advancing Care Together, a community demonstration project that created an innovation incubator for practices	The study included 475 patients who screened positive for the diagnosis of major depression	The main quantitative outcome measure was change in the score on depression scale/questionnaire. Patient experience of integrated care, assessed from patient interviews, was the main qualitative outcome	Study provides evidence that when primary care-behavioral health integration is used, there was reduced depression severity in patients, and was perceived by patients as beneficial.

	MD, MSFM, Benjamin F. Miller, PsyD and Larry A. Green, MD		implementing evidence-based integration strategies.			
6.Perceptions of Physicians in Civilian Medical Practice on Veterans' Issues Related to Health Care	Todd Robert Fredricks, DO Masato Nakazawa, PhD	To assess civilian physician knowledge of veterans' issues using a survey	10 item survey distributed to physicians at 2 primary care medical conferences		More than half of the respondents reported they were not comfortable discussing health related exposures and associated risks that veterans might experience and that they were unfamiliar with referral and consultation services for veterans.	There is not a high level of comfort with any issue the survey discussed relating to civilian understanding of veterans

Appendix B

Memorandum of Understanding

This Memorandum of Understanding (“MOU”) is entered into this 18th day of November, 2019 by and between **Nathaniel Held**, Doctor of Nursing Practice (DNP) student at Boise State University (“Held”) and [REDACTED], a Colorado nonprofit corporation [REDACTED]

A. PURPOSE:

1. This MOU outlines the terms and understanding between Held and [REDACTED] whereby Held will pilot a program at the [REDACTED] clinic to educate [REDACTED] staff on Veteran mental health issues (the “Project”). The Project will include instituting a new process to identify and assist Veterans at risk for suicide within a family primary care practice setting.
2. The Project is to educate primary care clinical staff about military life and the unique environment Veterans face in order to increase staff self-efficacy in discussing mental health with Veterans.
3. Additionally, this Project will present various local resources available for at-risk Veterans. Held will proctor a training session with applicable [REDACTED] clinical staff via the Veteran Administration’s program, S.A.F.E. This will include evaluation of participant’s knowledge, self confidence level and familiarity with Veteran mental health. Held will introduce and assist in implementing a standardized questionnaire for staff to use with Veteran patients and provide informational sessions over the course of the Project from local representatives on the available Veteran mental health programs/resources. An evaluation of the participants and the Project will be assessed.

B. Background:

Suicide is an increasing problem within the United States and the state of Colorado ranks among the highest in the nation for suicide (Colorado Health Institute, 2017). In fact, there has been an upward trend in suicides in Colorado since 2009. Within Colorado, El Paso County has had the highest numbers of suicides for the past decade. Research shows that Veterans are more likely to suffer from mental health issues than the civilian population. El Paso County has the largest number of Veteran residents in the state. Research has found that many Veterans accessed primary healthcare facilities shortly before taking their own life. Although Veterans were seen by civilian healthcare staff prior to their suicide, the clinic staff may not have been adequately prepared to properly assess a suicidal Veteran or make appropriate referrals to local Veteran mental health resources.

C. Intended Project Outcomes:

1. Increased knowledge and understanding of the mental health issues Veterans face.
2. Improved self-efficacy in discussing mental health issues with Veterans.
3. Improved knowledge of available local resources and how to access such resources.
4. Increased awareness and sensitivity to Veteran mental health as integrated through the Primary Care setting.
5. Implement the process for Veteran's suicide risk screening tool to be utilized during clinic visits.

D. Duration:

1. Project planning phase: October 2019 – April 2020
2. Implementation: May 2020 – August 2020
3. Conclusion - Assessment/Debrief: March 2021-May 2021

E. Reporting:

1. The final Project report will be submitted to the staff at PSFPC in March 2021 and shall be shared with the leadership of [REDACTED] during the month of April 2021. Additionally, the Project report will be disseminated to the participating Veteran mental health referral organizations.

2. The Project will include a final report, an abstract, an oral presentation of the report and potential publication. Held will submit a final Project report for publication in ScholarWorks. ScholarWorks is a collection of services designed to capture and showcase all scholarly output by the Boise State University community, including doctoral dissertations and doctoral project reports.
3. No personal identifiers will be included in the report and all data will be reported in aggregate form. Held welcomes any comments or suggestions from [REDACTED] and/or [REDACTED] but reserves the right to publish findings and analysis according to professional standards and principles of academic freedom. For any work of a scholarly nature, Held agrees to not use [REDACTED] or [REDACTED] name in the work, but rather shall only refer to [REDACTED] and [REDACTED] as a general agency within the region.

F. **Miscellaneous:**

1. The Parties agree that no compensation will be paid for the collaboration outlined in this MOU.
2. Each party hereby represents and warrants that it is not, and at no time has been, excluded from participation in any federally funded health care program, including Medicare and Medicaid. Each hereby agrees to immediately notify the other party of any threatened, proposed or actual exclusion from any federally funded health care program, including Medicare and Medicaid. If either party is excluded from participation in any federally funded health care program during the term of this MOU, or if any time after the Effective Date it is determined that either party is in breach of this Section, this MOU shall, as of the date of such exclusion or breach, automatically terminate.
3. Each party shall comply with all applicable state and federal laws in performing its obligations hereunder and in interpreting the terms of this MOU.
4. Any provision that would jeopardize [REDACTED] or [REDACTED] Health's tax-exempt status, accreditation or licensure will be deemed void or, in the alternative, upon discovery of the provision, [REDACTED] and [REDACTED] Health may immediately terminate the MOU.

G. **HIPAA Business Associate:**

Held shall comply with the Business Associate Agreement attached to this MOU.

H. SIGNATURE PAGE TO FOLLOW

IN WITNESS WHEREOF, the parties have caused this MOU to be executed by their duly authorized representatives.

Held:

Nate Held

Date: 11/14/19

(DNP Student signature)

Nate Held, Boise State University DNP student

~~Organizational Health Initiatives Colorado, dba Penrose St. Francis Health Services~~

Brian Erling

Date: 11/18/19

(Organizational Contact signature and title)

Brian Erling, M.D.

CEO

HIPAA BUSINESS ASSOCIATE AGREEMENT

1. **Definitions.** Terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms in the Privacy Rule and Security Rule.

- a. **Breach.** “Breach” shall have the same meaning as the term “breach” in 45 CFR 164.402.
- b. **Designated Record Set.** “Designated Record Set” shall have the same meaning as the term “designated record set” in 45 CFR 164.501.
- c. **Electronic Protected Health Information or Electronic PHI.** “Electronic Protected Health Information” or “Electronic PHI” shall mean Protected Health Information that is transmitted in or maintained by electronic media.
- d. **Individual.** “Individual” shall have the same meaning as the term “individual” in 45 CFR 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
- e. **Privacy Rule.** “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E, as amended from time to time.
- f. **Protected Health Information or PHI.** “Protected Health Information” or “PHI” shall have the same meaning as the term “protected health information” in 45 CFR 160.103, limited to the information created or received by Contractor from or on behalf [REDACTED].
- g. **Required By Law.** “Required By Law” shall have the same meaning as the term “required by law” in 45 CFR 164.103.
- h. **Secretary.** “Secretary” shall mean the Secretary of the Department of Health and Human Services or his designee.
- i. **Security Incident.** “Security Incident” shall mean the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. An attempted unauthorized access means any attempted unauthorized access

that prompts Contractor to investigate the attempt, or review or change its current security measures and shall not include trivial attempts to breach the system operations such as pings and port scans.

- j. **Security Rule.** “Security Rule” shall mean the Security Standards for the Protection of Electronic PHI at 45 CFR Part 160, and Part 164, Subparts A and C.
- k. **Unsecured PHI.** “Unsecured PHI” shall have the same meaning as the term “unsecured protected health information” in 45 CFR 164.402.

2. **Obligations of Contractor**

- a. **Regulatory Compliance.** Contractor agrees that it shall comply with relevant portions of the Privacy Rule and the Security Rule as those regulations apply directly to Contractor.
- b. **Use of Protected Health Information.** Contractor shall not use and shall ensure that its directors, officers, employees, contractors and agents do not use PHI in any manner other than as permitted or required by the Agreement, this BAA or as Required By Law.
- c. **Safeguards Against Misuse of Information.** Contractor agrees that it will implement all appropriate safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this BAA. Contractor agrees that it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, maintains, or transmits on behalf of [REDACTED]. Contractor agrees to comply with the applicable requirements of Part 164, Subpart C of the Security Rule.
- d. **Mitigation.** Contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor in violation of the requirements of this BAA, including any Breach.
- e. **Reporting Breaches.** Contractor shall report to [REDACTED]:
 - i. Within five (5) days of becoming aware of a disclosure of PHI by Contractor, its employees, representatives, agents, or subcontractor that is not specifically permitted by this BAA;

- ii. Within five (5) days of becoming aware of any Security Incident; and
 - iii. Immediately by telephone following the first day on which Contractor becomes aware of a Breach of Unsecured PHI. Contractor shall provide a full written report to [REDACTED] Privacy Officer no later than five (5) days after providing verbal notice, or sooner if directed by C [REDACTED] Privacy Officer. Contractor shall include the following information in the written report: (A) detailed information about the Breach, and immediate remedial action to stop the Breach; (B) names and contact information of the Individual(s) whose PHI has been, or is reasonably believed to have been, subject to the Breach; and (C) such other information as [REDACTED] may request.
- f. **Agreements by Third Parties.** In accordance with 45 CFR §§ 164.308(b)(2) and 164.502(e)(1)(ii), Contractor shall enter into a written agreement with any agent or subcontractor that will create, receive, maintain, or transmit PHI and/or Electronic PHI on behalf of Contractor pursuant to which such agent or subcontractor agrees to: (1) be bound by the same restrictions, terms and conditions that apply to Contractor pursuant to this BAA with respect to such PHI, and (2) implement reasonable and appropriate safeguards to protect such information.
- g. **Access to Information.** In the event that Contractor maintains PHI in a Designated Record Set, Contractor shall, within five (5) days of a request by [REDACTED] for access to PHI about an Individual, make available to [REDACTED] such PHI for so long as such information is maintained. If Contractor uses or maintains PHI electronically in a Designated Record Set and if the Individual requests an electronic copy of such information, Contractor must provide [REDACTED], or the Individual or person properly designated by the Individual, as directed by [REDACTED] access to the PHI in the electronic form and format requested by the Individual, if it is readily producible in such form and format; or, if not, in a readable electronic form and format as agreed to by [REDACTED] and the Individual. In the event any Individual requests access to PHI directly from Contractor, Contractor shall within two (2) days forward such request to [REDACTED]. Any denials of access to the PHI requested shall be the responsibility of [REDACTED].

- h. **Availability of PHI for Amendment.** In the event that Contractor maintains PHI in a Designated Record Set, Contractor shall, within ten (10) days of receipt of a request from [REDACTED] for the amendment of an Individual's PHI, provide such information to [REDACTED] for amendment and incorporate any such amendments in the PHI as required by 45 CFR 164.526.
- i. **Accounting of Disclosures.** Contractor agrees to implement an appropriate record keeping process to document such disclosures of PHI as would be required for [REDACTED] to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR 164.528. Within ten (10) days of notice by [REDACTED] to Contractor that it has received a request for an accounting of disclosures of PHI regarding an Individual, Contractor shall make available to [REDACTED] such information as is in Contractor's possession and is required for [REDACTED] to make the accounting required by 45 CFR 164.528. At a minimum, Contractor shall provide [REDACTED] with the following information: (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure. In the event the request for an accounting is delivered directly to Contractor, Contractor shall, within two (2) days, forward such request to [REDACTED]. It shall be [REDACTED] responsibility to prepare and deliver any such accounting requested.
- j. **Access and Inspection.** Contractor agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of PHI received from, or created or received by Contractor on behalf of, [REDACTED] available to [REDACTED] or to the Secretary, in a time and manner designated by [REDACTED] or the Secretary, for purposes of the Secretary determining [REDACTED] and Contractor's compliance with the Privacy Rule.

- k. **Delegated Obligations.** To the extent Contractor is delegated to carry out [REDACTED] obligations under the Privacy Rule, Contractor shall comply with the requirements of the Privacy Rule that apply to [REDACTED] in the performance of such delegated obligations.

3. **Permitted Uses and Disclosures**

- a. **Use or Disclosure of PHI.** Except as otherwise limited in this BAA, Contractor may use or disclose PHI to perform functions activities, or services for, or on behalf of, [REDACTED] as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Centura or the minimum necessary policies and procedures of [REDACTED].
- b. **Use for Business Purposes.** Except as otherwise limited in this BAA, Contractor may use PHI (i) for Contractor's proper management and administrative services; or (ii) to carry out the legal responsibilities of Contractor.
- c. **Disclosure for Business Purposes.** Except as otherwise limited in this BAA, Contractor may disclose PHI for Contractor's proper management and administrative services, provided that (i) such disclosures are Required By Law; or (ii) prior to making any such disclosure, Contractor obtains (A) written approval from [REDACTED] for such disclosure, (B) reasonable assurances from the third party that such PHI will be held confidential and used or further disclosed only as Required By Law or for the purposes for which it was disclosed to such third party; and (C) the third party agrees to immediately notify Contractor of any breaches of the confidentiality of the PHI, to the extent it has obtained knowledge of such breach.
- d. **Data Aggregation.** Except as otherwise limited in this BAA, Contractor may use PHI to provide Data Aggregation services to [REDACTED] as permitted by 45 CFR 164.504(e)(2)(i)(B) and if so requested by [REDACTED]

4. **Obligations of [REDACTED]**

- a. **Notifications to Contractor.** To the extent that a limitation, revocation, or restriction may affect Contractor's use or disclosure of PHI, ██████ shall notify Contractor of (i) any limitations in its notice of privacy practices in accordance with 45 CFR 164.520; (ii) any changes in, or revocation of permission by an Individual to use or disclose PHI; or (iii) any restriction to the use or disclosure of PHI that ██████ has agreed to in accordance with 45 CFR 164.522.
- b. **Requests.** ██████ shall not request Contractor to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by ██████.

5. **Term and Termination**

- a. **Term.** This BAA shall terminate when all of the PHI provided by ██████ to Contractor, or created or received by Contractor on behalf of ██████, is destroyed or returned to ██████, or, if it is infeasible to return or destroy the PHI, until protections are extended to such information, in accordance with the termination provisions in this Section 5.
- b. **Termination for Cause.** If Contractor breaches its obligations under this BAA, ██████ may, at its option: (i) exercise any of its rights of access and inspection under Section 2(j) of this BAA; (ii) require Contractor to submit to a plan of monitoring and reporting, as ██████ may determine necessary to maintain compliance with this BAA and such plan shall be made part of this BAA; or (iii) terminate this BAA and the Agreement, with or without opportunity to cure the breach. Contractor shall ensure that it maintains the termination rights in this Section for itself in any agreement it enters into with an agent or subcontractor pursuant to Section 2(f) hereof.
- c. **Effect of Termination.** Upon termination of the Agreement and this BAA, Contractor shall maintain no copies of the PHI and shall return or destroy all PHI that it maintains in any form. This provision applies to PHI that is in the possession of subcontractors or agents of Contractor. In the event that Contractor determines that returning or destroying the PHI is

infeasible, Contractor shall provide to [REDACTED] notification of the conditions that make return or destruction infeasible. Upon the mutual agreement of the Parties that return or destruction is infeasible, Contractor shall extend the protections of this BAA to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Contractor maintains such PHI. This section shall survive termination of the Agreement and this BAA.

6. **Indemnification and Liability.**

- a. [REDACTED]. [REDACTED] shall be liable for any and all claims, costs, and expenses, arising from and out of the acts or omissions of [REDACTED], its agents or employees, in the performance of the obligations under this BAA.
- b. **Contractor.** Contractor shall be liable for any and all claims, costs, and expenses, arising from and out of the acts or omissions of Contractor, its agents, employees, or subcontractors in the performance of its obligations under this BAA. In the event of a Breach by Contractor, its agents, employees, or subcontractors, Contractor will, at its expense, indemnify, hold harmless and, at [REDACTED] written request, defend [REDACTED] and its members, subsidiaries, affiliates, directors, trustees, officers, employees, agents and independent contractors, from and against any and all loss, cost, liability or expense (including costs and reasonable fees of attorneys and other professionals) arising out of or in connection with such Breach, including without limitation costs associated with the notification of Individuals, media, and credit monitoring that are a result of such Breach.

7. **Miscellaneous.**

- a. **Amendment.** Upon the enactment of any law or regulation affecting the use and/or disclosure of PHI, or the publication of any court decision relating to any such law, or the publication of any interpretive policy, opinion or guidance of any governmental agency

charged with the enforcement of any such law or regulation, [REDACTED] may, by written notice to Contractor, amend this BAA to comply with such law or regulation.

- b. **Regulatory Reference.** A reference in this BAA to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.
- c. **Entire BAA.** This BAA constitutes the entire agreement between the Parties with respect to its subject matter and supercedes all past and contemporaneous business associate agreements or provisions, promises, and understandings, whether oral or written, between the Parties that relate to Contractor's obligations as a business associate of [REDACTED].

Logic Model

Appendix C

Resources/Inputs	Activities	Outputs		Outcomes: Short term	Outcomes: Intermediate	Outcomes: Long term
<ul style="list-style-type: none"> Personnel: Project Manager - 1 hour of time spent discussing final details with clinic manager and deciding on a date for education/training of staff. Clinical staff – time spent attending the training IT: Computer/email for sending out calendar invite to all staff and reserving conference room (done during meeting and sent from the Manager), Screen already in conference room for projecting, Laptop needed for showing educational videos (Author to bring) Space: Conference room = 1 large table with surrounding chairs and chairs surrounding the room. Sits 30. Supplies: Pencils needed for 25 staff, 30 copies of pre-test and 30 copies of post-test, 	<ul style="list-style-type: none"> A final meeting with the Primary Care's clinic manager to discuss last minute details At this meeting, the education date is decided upon (target for meeting is mid May 2020), the conference room is reserved, and the staff receive an email from the manager with required attendance for upcoming training session A written 10 question test will determine the staff's understanding of Veteran mental health. This survey will be referred to as the <i>Pre test</i>. <p>The test is from the "15 Things Veterans wish you knew" from S.A.V.E. Gatekeeper Suicide Prevention education ("Signs," "Ask,"</p>	<ul style="list-style-type: none"> We have clarified expectations and the subsequent process change that will occur in the clinic We have secured the education date for the clinic We obtain a baseline and discover the staff's level of perceived self-efficacy and understanding of Veteran mental health and additionally, any biases are revealed. We show the education videos S.A.V.E. and as a result dispel any unknowns or assumptions regarding military and Veteran suicide We have the results of the post-education 	<p>The staff, who work at the Primary care clinic complete the test.</p> <p>(10 providers, 2 nurses and 13 medical assistants), the Clinic Manager</p>	<p>1. By August 31, 2020, the clinical staff at the Primary Care (10 providers, 2 nurses and 13 medical assistants) will increase their self-efficacy & knowledge of Veteran suicide by 50%. This is measured by comparing results from a pre test, completed prior to the course, and a post test, completed at the conclusion of the pilot study.</p>	<p>7. By summer of 2021, the additional primary care clinics' staff within the Health System (4 clinics) have increased their self-efficacy and knowledge of Veteran suicide by 50% through completing the S.A.V.E. education program. This is measured by comparing results from a pre and post test completed by participants.</p>	<p>9. Within 3 years, the staff at 15 Primary Care clinics in El Paso County have increased their self-efficacy and knowledge of Veteran suicide by 50% through the completion of S.A.V.E. education program. This is measured by the completion rates.</p>

Coffee/donuts brought to initial session (Author to bring)	<p>“Validate,” “Encourage” and “Expedite”)</p> <ul style="list-style-type: none">• A 75 minute education and training session is held (approximately the 1st week in June 2020), this includes dissemination of the pre-test, followed by 45 minutes to watch 2 videos from S.A.V.E. on Veteran suicide and military culture.• Approximately 7 days later, a make up session will be held for any staff who missed the initial session• A written 10 question test will determine the staff’s understanding of Veteran mental health post education. This will be given at the conclusion of the project implementation, approximately	tests and are able to determine the staff’s gained self-efficacy, knowledge and beliefs with Veteran suicide				
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	<p>Aug 31, 2020. This survey will be referred to as the <i>Post test</i>.</p> <p>The information on the test will be taken from the “15 Things Veterans wish you knew” from S.A.V.E.</p> <ul style="list-style-type: none"> Analyze data gathered from pre and post tests 					
<ul style="list-style-type: none"> Personnel: Project Manager -Time spent (2 hours) reaching out to assistance programs. Time spent (2 hours) compiling the information into one document. Time spent printing a check-off sheet/exam for the clinic staff. Time spent at the clinic (30 mins) to ensure the resource support tool is easily accessible to staff and check off has been complete. Clinical staff – time spent learning about the tool and completing check off sheet IT: A computer, phone, internet 	<ul style="list-style-type: none"> Contact Mt. Carmel, Colorado Springs Veteran Health Wellness Agency, and at least 3 other Veteran suicide prevention agencies to gather basic information of their services and explain the reason needed Compile the organization’s information into an easy to read, one-page document Make 30 copies of the resource tool and make 	<ul style="list-style-type: none"> Primary Care has an easy to read, up-to-date resource tool to help them if any Veteran patient expresses a potential need Veterans who are found to have various needs (through a patient questionnaire, to be discussed in next section), now have specific information on organizations that offer help/assistance 	Primary Care staff, Veterans, referral agencies who are listed on the resource tool, two administrative staff at the clinic	2. (PO) By June 1 2020, a comprehensive resource tool is available for the Primary Care clinic to give veterans who may need a variety of assistance; (CO) 95% of clinic staff acknowledge they have read the resource, comprehend it and know where it is located (this is measured through a check-off and brief competency exam of all staff to be completed within one week of		10. By 2022, a resource tool is available for 15 Primary Care Clinics in El Paso County to use in referring Veterans who need assistance.

	<p>sure staff know where it is located in the office, subsequent copies made by the clinic office staff</p>			the education program)		
<ul style="list-style-type: none"> Supplies: Copies of the Veteran patient questionnaire screening tool made for initial stocking of the office (approximately 100) 	<ul style="list-style-type: none"> After the education videos, instruct staff to use the paper Veteran questionnaire screening tool for every patient over age 18. Let them all read the questionnaire and answer any questions they may have Check in at the clinic 1 week after to make sure tool being implemented 	<ul style="list-style-type: none"> The new process change is implemented where every patient over the age of 18 is screened with the Veteran patient questionnaire; the patients' answers to the questions can lead the providers to provide the available resources or other action they deem fit as a clinical provider 	<p>The staff at the Primary Care, the Veteran patients, referral organizations</p>	<p>3. By June 7, 2020, the clinical staff at the Primary Care (10 providers, 2 nurses and 13 medical assistants) use the Veteran patient questionnaire screening tool for 100% of patients over 18 years of age, and treat/refer as necessary. This is 95% of all the adult patients seen in the clinic. Refer means to follow instructions from the Workflow Sheet based upon the patient's CSSRS. Treat could mean the patient shows signs of needing clinical intervention (medication) which would be done by the medical provider. This</p>	<p>8. By summer 2021, 3 additional primary care clinics use the Veteran patient questionnaire for every patient over the age of 18, and treat/refer as necessary. Refer means to provide the referral information to the patient for additional help. Treat could mean the patient shows signs of needing clinical intervention (medication) This study is only for the education of staff and the clinical process for identifying Veterans in need, not in any diagnosis warranted</p>	

				study is only for the education of staff and the clinical process for identifying Veterans in need and subsequent follow-up, not in tracking any diagnosis that may be warranted		
<ul style="list-style-type: none"> Personnel: Time spent by project manager and attendees (both speakers and participants) Space: Lunchroom/table and chairs Supplies: Flyers printed 	<ul style="list-style-type: none"> Organize the date of the lunch and learn with the clinic and ask veteran suicide prevention programs (who are represented on the resource list) to commit to one day. Time frame is one-hour informal, informational session during the lunch hour. Coordinate donations from local Veteran friendly restaurants for catered lunch for the clinic Reserve the lunchroom for the sessions 	<ul style="list-style-type: none"> Staff at the Primary Care are educated on available community resources and programs, leading to a better understanding of Veterans and the issues they face. 	The staff at the Primary Care, the local veteran help organizations	4. During the months of June and July 2020, lunch and learns are held at the Primary Care clinic, with representatives from local suicide prevention organizations, and at least 50% of the staff attend each of the sessions and learn about the resources. (measurement through a sign in sheet)		

	<ul style="list-style-type: none"> Advertise the sessions to the staff through calendar invites and informational flyers 					
<ul style="list-style-type: none"> Time spent 25 copies of feedback form 	<ul style="list-style-type: none"> An anonymous feedback form is given to staff for them to provide their lessons learned and suggestions for improvement (form provided by S.A.V.E.) 	<ul style="list-style-type: none"> The pros and cons of the training program are identified as a whole, and suggested improvements are noted 	The staff at the Primary Care	5. In August 2020, 75% of those staff attending the education/training rate achieving the learning objectives at agree/strongly agree or mainly true/very true after attending the program		
<ul style="list-style-type: none"> Time spent Computer for generating reports/documents 	<ul style="list-style-type: none"> results of the learners pre/post tests, and their anonymous feedback with suggestions for improvement are shared with key participants through a written report and a verbal briefing The administration is given suggestions for taking the pilot project to other primary care 	<ul style="list-style-type: none"> Shareholders learn the pros and cons of the project, along with suggestions for future action 	The staff at the Primary Care, the local veteran help organizations, the Administration	6. In Fall 2020, the results of the learners pre/post test, and their anonymous feedback with suggestions for improvement are shared with the Primary Care, the community support organizations and administration.		

	clinics within the system					
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Appendix D

Timeline

Activity	Fall 19	Spring 20	Summer 20	Fall 20	Spring 21
PLANNING					
Meet with clinic manager, confirm details of education, training and timeline of events					
Ensure clinic manager understand process change required in the clinic during the implementation of the project					
Make copies of pre and posttests, as well as written evaluation forms					
Make copies of Veteran Patient Questionnaire screening tool to be used in the clinic					
Research community programs for at-risk Veterans, determine services offered					
Compile resource support information sheet with specific information listed for patient and clinic use					
Ask veteran programs to participate in lunch & learns					
Ask veteran friendly food caterers to donate lunch for the staff					
Review educational module to ensure familiarity					
IMPLEMENTATION					
Hold the initial educational session with the primary care staff					
Data collection #1: Have staff complete the pre-test and watch the education videos (time allotted 50 mins)					
Explain new procedure in clinic – every patient over 18 asked the Veteran Patient questionnaire (time allotted 10 mins)					
Provide resource support tool to clinic (time allotted 2 mins)					
Process change: New procedure of patient screening to begin the following day, with a follow-up one week later to ensure compliance					
Support and Monitoring: Hold 3 Lunch and Learn sessions for the staff over the following 6 weeks (each session 60 mins open-house style), along with follow-up to answer questions					
Conduct a 2nd education session for staff who missed, (approximately 2 weeks after initial training) followed by 60 mins of availability to all staff for any questions					
Data collection #2: Staff to complete post-test (at clinic's staff meeting)					
Staff participate in group interview evaluation to gather their opinions and value of the project					

ANALYSIS					
Data collected from each test reviewed. These results compared and graphed in a bar chart					
Qualitative data from evaluations reviewed and documented					
Any compromises to data quality recognized and noted					
DISSEMINATION					
Results given to clinic (method TBD)					
Results provided via report disseminated to participating community veteran help organizations					
Results of project, lessons learned, and future recommendations given to leadership (method TBD)					
Final Report					

Appendix E

Outcomes Evaluation Table

Outcome	Data Collection Instrument / Data	Analysis Goal	Analytic Technique
<p>1. By August 31, 2020, the clinical staff at the Primary Care (10 providers, 2 nurses and 13 medical assistants) will increase their self-efficacy & knowledge of Veteran suicide by at least 50%.</p>	<p>Instrument Data will be gathered by comparing results from a test completed by the participants prior to the education, and then again completed at the conclusion of the pilot study. The questions will use the 5-point Likert scale.</p> <p>Data The instrument will assess the following:</p> <ul style="list-style-type: none"> • Understanding of military culture • Knowledge of the relationship between Veteran's and suicide • Perceived self-assurance in talking to Veterans about mental health • Confidence in how to refer at-risk Veterans for help <p>The project manager will analyze both pre and post test for the aggregate mean. The final results will be displayed on a bar chart. The participants will complete an identifying information page with both questionnaires, which will protect their anonymity but allow their results to be compared.</p>	<p>To quantify the staff's understanding of veteran suicide and prevention, and their subsequent confidence in discussing such issues with veteran patients.</p> <p>This tool was chosen because the S.A.F.E education program for veteran's has designed it as a way to capture participant's learning when exposed to the curriculum. There is also an ease in scoring, due to the small participatory group, and the data provided is of value to the shareholders.</p>	<p>Each pre and post score will be calculated and recorded in an Excel spreadsheet. Participants will be identified through a series of individual questions at the beginning, which will enable each participant's pre and post scores to be aligned (this individual data will be kept confidential.) The aggregated score of each question on the pre/post-test will be compared to determine where change occurred and where there is still confusion/deficit of knowledge. This can then be addressed through</p>

			revision/addition to future education programs. While individual scores for each question are being compared, the final report will show the aggregated scores for each question. This will be displayed on a table/chart.
2. By June 7, 2020, a comprehensive resource support tool is available for the Primary Care clinic for veterans who need assistance and 95% of clinic staff acknowledge they have read the resource.	<p>Instrument Data will be gathered through a check-off of all staff. This will be completed within one week of the training program.</p> <p>Data The instrument will assess the participants' understanding of what information is available on the resources sheet and where it is located within the office.</p> <p>This comprehensive resource support tool will be developed with feedback from the shareholders and community resource organizations and approved for use in the Scholarly Project.</p>	<p>To ensure the participant's awareness of the Veteran Resource Support tool.</p> <p>This data evaluation tool was chosen as it is a simple, quick and practical way to ensure staff have the understanding needed for referring Veteran patients for further help.</p>	<p>The 3 questions administered to participants will measure their understanding of what this resource is and how to find it in their practice. Staff will place their names on the questionnaire in order to ensure 95% staff completion and to identify anyone needing further education on the resource tool.</p>

<p>3. By June 7, 2020, the clinical staff at the Primary Care (10 providers, 2 nurses and 13 medical assistants) use the Veteran patient questionnaire screening tool for 75% of patients over 18 years of age.</p>	<p>Instrument Data will be gathered through two means:</p> <ul style="list-style-type: none"> • Recording the number of veteran patient questionnaires by collecting the hard copies, which after completed will be deposited into a secure box at the clinic, which is to be compared with the clinic's total number of adult patients for the week • Personal weekly check-in's at the clinic and conversations with the practice manager to ensure staff participation <p>Data As mentioned above, the collection of this data is to ensure the vital step of interviewing veteran patients is being implemented consistently at the clinic. The number of questionnaires completed should match the number of adult patients seen in the clinic per week.</p>	<p>To ensure the veteran questionnaire is being used on patients over 18 years of age who indicate they have served in the military.</p> <p>This data evaluation tool was chosen as it is a simple, quick and practical way to ensure staff are completing the questionnaire so the project can proceed and be adequately evaluated.</p>	<p>The completed patient questionnaires will be placed into a secure box located in the office (even those who indicate they are not a veteran). No personal patient information will be on the forms. At the end of each week, these forms will be gathered and the information recorded. This number will be compared to the number of all adult patients seen in the clinic per week. This will provide documentation to show the staff is indeed questioning patients. In addition, conversations will be had with the clinic manager every week to discuss the implementation of the veteran questionnaire.</p>
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			<p>Since the manager is physically present on a consistent basis, they are able to keep a good pulse on the implementation of the questionnaire and remind the staff of the importance. This information is also important to communicate in the final report to show the effectiveness of the program and any challenges faced along the way.</p>
<p>4. During the months of June and July 2020, lunch and learns are held at the Primary Care clinic, with representatives from local suicide prevention organizations, with a minimum attendance of at least 50% of the staff for each session.</p>	<p>Instrument The data gathered will be through sign in sheets located at each lunch and learn. The sign in sheets will only be used to calculate the attendance and interest from staff. This information will not be shared with anyone in the organization and the sheets held only by the project manager.</p> <p>Data The instrument will show the total of the number of staff who attend each lunch and learn. This will be used to calculate the attendance rate, and thus the number of participants learning about these local resources.</p>	<p>To calculate the number of staff who attend the lunch and learn.</p> <p>This data evaluation tool was chosen as it is a simple, quick and practical way to evaluate the effectiveness and interest in lunch and learn.</p>	<p>The data will be used to calculate the number of staff who attend the lunch and learns. This will be helpful to understand the popularity of these events, and if they are beneficial to continue in the future. This feedback will be</p>

			shared in the final report.
5. Outcome #5 is that by August 31, 2020, 75% of the veteran patients who are flagged as at-risk by the Veteran Questionnaire screening tool are taken through the clinic's already established Behavioral Health Worksheet for subsequent referral.	Instrument This data is gathered by comparing the total number of at-risk veteran's as indicated after the questionnaire (collected every week in the drop box), with the clinic's generated report of behavioral risk assessments. The clinical staff will enter a note on the patient's charts who are a veteran, so that number can be compared to the total number of at-risk veteran patients discovered per week. This is to ensure the entire process is being completed for veteran patients and they are getting the necessary referrals.	To compare the number of veteran patients flagged as at-risk per the Veteran Questionnaire screening tool with the actual number of veteran patients who have a behavioral health analysis completed by the clinic.	The data will be used to show the clinic's follow through with the new process of at-risk veteran patient referrals that are warranted
6. The participant's feedback with suggestions for improvement, are shared with Primary Care, the community support organizations and administration, in the Fall of 2020.	Instrument This data is gathered through group interviews with open ended questions. Questions will be developed with input and collaboration from the stakeholders. Group interviews are shown to generate thoughtful discussion as ideas are freely shared. When the purpose of the interview is for feedback on a program (pros/cons) and not related to specific personal performance, negative groupthink is typically not a hindrance. The group interview will be conducted by the project manager, using structured questions developed with input from stakeholders. A neutral party will be present to take notes for accurate recording. In addition to the group interview, an anonymous paper questionnaire will be available for any staff member who wishes to provide feedback in this way (and for those who may be absent during the feedback group interview session.) Data	To quantify the value of the program, to include both the educational component and the clinical intervention, and to gather suggestions to improve the program for future implementation. This tool was chosen as it is cost-effective and most importantly allows for direct feedback from the participants, which is imperative for a pilot project.	The data will be used to gather feedback on specific elements of the project design. This will be completely anonymous, with no identification being attached to the staff participants. The data will be reviewed to better understand their perceptions about the program and gather feedback to both improve the educational component and the

	<p>The instrument will allow the following to be discovered:</p> <ul style="list-style-type: none">• Participant’s overall feeling of value of the educational component• Participant’s opinions regarding the lunch and learns (outside agencies providing education on veteran resources)• Participant’s perception of the patient interview process• Any personal stories of meaningful conversations held with patients		<p>clinical process. The final report will include this feedback and how to incorporate it into the next stage of project development.</p>
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Appendix F

DATE: May 28, 2020

TO: Nathaniel Held

PROJECT TITLE: [1565246-1] Improving Primary Care Staff Perceived Self Efficacy and Knowledge of Veteran Suicide and Subsequent Intervention of At-Risk Patients: A Pilot Project SUBMISSION TYPE: New Project

ACTION: DETERMINATION OF NOT HUMAN SUBJECT RESEARCH DECISION DATE: May 28, 2020
REVIEW TYPE: Administrative Review

Thank you for your submission to the [REDACTED] Institute for Research and Innovation Institutional Review Board ([REDACTED]). An individual designated by the [REDACTED] has determined this project does not meet the criteria for human subject research under the purview of the IRB according to federal regulations. The following documents have been reviewed in making this determination:

- [REDACTED] - Research Application - [REDACTED] - Research Application (UPLOADED: 05/20/2020)
- Conflict of Interest - Other - CCF05212020_0004.pdf (UPLOADED: 05/21/2020)
- CV/Resume - Yuki CV 03 11 2020.docx (UPLOADED: 05/9/2020)
- CV/Resume - Nathaniel Held ST Resume (1).docx (UPLOADED: 02/20/2020)
- CV/Resume - curriculum vitae TS 12-19 .docx (UPLOADED: 02/17/2020)
- CV/Resume - 2018-Vitae_Strohfus.rtf (UPLOADED: 02/17/2020)
- Letter - Response letter to IRB questions 5-20-2020 .docx (UPLOADED: 05/20/2020)
- Letter - MOU11162019.pdf (UPLOADED: 02/25/2020)
- Letter - 191118 MOU NHeld.pdf (UPLOADED: 02/25/2020)
- Other - Research Routing Form (UPLOADED: 05/21/2020)
- Other - FCOI Disclosure (UPLOADED: 05/21/2020)
- Protocol - NURS 603 final.docx (UPLOADED: 05/13/2020)
- Training/Certification - citiCompletionReport457029 - Biomedical HSR Yuki Asakura Dec 24 2019.pdf (UPLOADED: 05/9/2020)
- Training/Certification - citiCompletionReport457029 -Good Clinical Practice Yuki Asakura Dec 24 2019.pdf (UPLOADED: 05/9/2020)
- Training/Certification - citiCompletionReport457029 - HIPAA Yuki Asakura dec 24 2019.pdf (UPLOADED: 05/9/2020)
- Training/Certification - citiCompletionReport457029 - Social Behavioral Educational Researcher RCR Yuki Asakura Dec 24 2019.pdf (UPLOADED: 05/9/2020)

As defined by federal regulations, research is systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. 45 CFR 46.102(I)

A human subject, as defined by federal regulations, means a living individual about whom an investigator (whether professional or student) conducting research obtains (1) Information or biospecimens through intervention or interaction with the individual and uses, studies, or analyzes the information or biospecimens; or (2) Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable biospecimens. 45 CFR 46.102(e)

The [REDACTED] determined that this project does not meet the regulatory definition of research involving human subjects as defined by 45 CFR 46.

If you do not believe this determination is accurate, or should you wish to amend this project in any way that might impact this determination, please contact the [REDACTED].

Please note that it is your responsibility to obtain any additional local institutional or departmental required approvals prior to initiating your project.

If you have any questions at any time, please feel free to contact the [REDACTED] at 1-844-626-2299. Please include your project title and reference number in all correspondence with the [REDACTED] so that we can best assist you.

Thank you.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within [REDACTED] records.

Appendix G Expense Report

					Grand Total	\$ 6,913.00
Expense Category	Expense Description	Explanation of Expense	Type of Cost (variable/fixed)	Volume	Cost per Unit	Total
Personnel	MA/NP/PA/RN's wages	Primary care clinical staff participating in education program, to include post survey and completing evaluation. Hourly rate is an average based on organizational HR data.	variable	4 hrs X 25 staff=100 hrs	\$53/hr	
	Project Manager (serving as the Educator)	The Project Manager will be providing content to primary care clinical staff on Veteran suicide awareness and intervention, and facilitating question and answer session. Time also includes distributing and discussing competency exams and evaluations, and any administrative duties prior, such as assembling educational packets for the participants.	variable	15 hrs X 1	\$42/hr	\$ 5,930.00
Material & Supplies	Paper	25 educational packets to include 25 pre & post surveys, 5 advertisement flyers, 25 evaluations, 3 lunch and learn sign in sheets and brief competency exams, 100 patient Veteran questionnaires	fixed	2 reams of paper	\$10.00/ream	
	Pencils	50 pencils for both pre and post surveys and evaluation forms	fixed	2 boxes	\$2.50/box	\$ 25.00
Space	Conference room	Location for education sessions; providing the initial education to the staff, the make-up session for those absent, question and answer session, and 3 lunch and learns	fixed	1 room x 7 hours	\$25/hr	\$ 175.00
Equipment	Laptop and screen	Computer needed for administrative tasks, such as calendar invites, room reservations, etc. Also needed for disseminating the educational video and compiling evaluation/data results. Screen for education sessions	fixed	1 each	\$50/screen, \$300/laptop	\$ 350.00
IT	(see equipment)					
Travel	Gas mileage	Travel expense for Project Manager to and from primary care facility	variable	200 miles	\$.54/mile	\$ 108.00
Marketing/Advertising	(NA)					
Fees	(NA)					
Incentives	Coffee/donut breakfast Lunch	Breakfast for the staff for training day. Lunch to be provided during the lunch and learn sessions	fixed	1 time 3 luncheons for 20 people	\$25 \$100.00/per luncheon	\$ 325.00

Appendix H

Scholarly Project 3-year Budget Plan

Yearly Totals:		\$ 6,913.00	\$ 13,893.20	\$ 23,632.81	
Expense Category	Year 1	Year 2	Year 3	Rationale	
Personnel	\$ 5,930.00	\$ 11,783.20	\$ 21,086.01	<p>pilot yr 1 with 25 MA/PA/NP/RNs, expand in yr 2 to include the other 2 Centura primary care facilities (50 MA/PA/NP/RNs), in yr 3 at least 3 other primary care facilities (from a different organization) in El Paso County trained on Veteran mental health awareness (approx 75 MA/PA/NP/RNs). 1 Educator yrs 1 & 2. Associated Educators in Continuing Education and New Hire training for the additional 3 facilities involved yr 3. For each training session, there would still only need to be 1 Educator, so this cost is doubled for yr 2 (since doing 2 training programs), and it is trippled for yr 3 (since doing 3 training programs). An additional 3% increase in hourly wage has also been added for each year for both the Educator and the Staff attending the training. In yr 1, the number of hours for the Educator includes gathering staff feedback and summarizing results of the pilot program, where this will not be as cumbersome in yr 2 and 3, because the evaluation of the program will not be as intense, just a standard "evaluation" as most training classes require. Also, the time for yr 1 includes the Educator having to collect the paper patient Veteran questionnaires, whereas yr 2 and 3 they will be automatically recorded in EPIC during each patients' interview. The time for clinical staff to input into EPIC vs. make notes on the paper questionnaire is negligible. Estimate 10 hours for Educator at each facility in yr 2 and 3.</p>	
Material & Supplies	\$ 25.00	\$ 30.00	\$ 45.00	<p>yr 1 is all paper educational surveys and paper patient questionnaires, yr 2 paper surveys but now patient questionnaire is programed into EPIC (the electronic health record platform for Centura), in yr 3 the other 3 primary care facilities outside Centura also add the Veteran patient questionnaire to their EPIC system (after the initial training of their staff) Both these hospital systems use the same EHR platform so there can be shared information.</p>	
Space	\$ 175.00	\$ 350.00	\$ 525.00	<p>yr 1 is a single educational session, yr 2 requires 2 sessions, yr 3 is 3 sessions</p>	
Equipment	\$ 350.00	\$ 350.00	\$ 350.00	<p>the laptop and screen can be reused for each training session; the laptops for generating patient's EHR's already exist, this is just adding a step to the gathering and documenting of information on the patient. Any upgrades or replacement to laptops would be covered by the department's general cost fund and not have to come out of this project's budget.</p>	
IT	\$ -	\$ 480.00	\$ 576.80	<p>yr 1 no IT support needed, yr 2 and 3 IT needed to add Veteran patient questionnaire to EPIC. 2 staff x \$40.00/hr x 10 hrs (1 staff to add to Centura's EPIC, 1 staff to add to other organization's EPIC). In addition, average of 2 hours per year to do any updates/corrections/pull data as needed, etc. Yr 3. has 3% wage increase added to hourly rate.</p>	
Travel	\$ 108.00	\$ 225.00	\$ 350.00	<p>yr 1 requires traveling to just 1 clinic, yr 2 is 2 additional clinics, yr 3 is 3 clinics (adjusted for possible increase in gas prices)</p>	
Marketing/Advertising	\$ -			(NA)	
Fees	\$ -			(NA)	
Incentives	\$ 325.00	\$ 675.00	\$ 700.00	<p>yr 1 and 2, the Educator brings donuts and coffee to the initial staff training sessions, yr 3 is not measured as it would not be essential for the other organization to do this. The number of lunch and learns is doubled in yr 2, and quadrupled in yr 3. The organizations coming to provide this education are non-profit and do outreach at no cost. The cost of lunch has been adjusted for inflation.</p>	

Appendix I

Statement of Operations

Operating Income		\$ -
	Revenue Total	\$ 6,913.00
Source	Description	Amount
Educator (DNP Student)	hourly wages estimated @ 15 hrs x \$42	\$ 630.00
The Health System	in kind donations by organization and DNP student	\$ 5,300.00
	Expenses Total	\$ 6,913.00
Expenses	Description	Amount
Personnel	4 hrs X 25 staff=100 hrs @ 53.00/hr	\$ 5,930.00
Material & Supplies	paper & pencils	\$ 25.00
Space	conference room	\$ 175.00
Equipment	laptop & screen	\$ 350.00
IT	n/a	\$ -
Travel	gas mileage 200 miles @ .54/gallon	\$ 108.00
Marketing/Advertising	n/a	\$ -
Fees	n/a	\$ -
Incentives	breakfast & lunches	\$ 325.00
0		\$ -
0		\$ -

0		\$	-
0		\$	-
0		\$	-
0		\$	-
0		\$	-

Appendix J

Pre-Test

Introduction to Veteran Suicide Prevention Education

Brief questionnaires will be used to evaluate the impact of this suicide prevention education session and implementation of the pilot project to your clinic. Evaluation of education and intervention is essential to learn if it has an impact and how it may be improved. Therefore, please answer every question so that the evaluation can be informative.

You will be asked to fill out a questionnaire right now, before the education begins, and then after the pilot project is complete. The forms will be collected by the project manager and used only by him to evaluate the program. Once data has been extracted, they will be shredded.

In addition, at the end of the entire pilot project, you will be asked to participate in a brief question and answer session regarding your opinion on the education, training and the subsequent impact on patient care. This will help to determine any opportunities for improvement in future training and clinical processes.

Although the forms may have some contact information on them, it is only to compare pre/post results. You will remain anonymous. The questions below will be asked of you again at the end of the project and will be used to link your forms. Once the data has been extracted, the forms will be shredded.

Please answer each question:

1. Today's date
2. Age (circle): a. 18-24 b. 25-34 c. 35-44 d. 45-54 e. 55+
3. Month of birth: _____
4. Pet's name (or previous pet's name): _____
5. Favorite musician: _____

**Please turn to the next page and answer the questions.
Veteran Suicide Prevention Education (fill out *before* training)**

Please specify your level of agreement to the statement by indicating: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree. Circle one.

1. I have had an adequate amount of training to prepare me for talking with patients about suicidal thoughts/feelings.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
2. I am confident in my ability to discuss the topic of suicide with a patient.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
3. Veterans are more likely than the general population to commit suicide.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
4. I am confident in my ability to discuss the topic of suicide with a veteran patient.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
5. I am aware of community support programs to support at-risk veterans and can quickly pass along this information to those in need.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
6. I am aware of what stressors occur within military life that could lead to the feelings of hopelessness and despair.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree

Appendix K

Veteran Patient Questionnaire

Ask every patient 18 years and older:

1. Have you served in the Military?

If “no”, stop.

If “yes”, ask . . .

What branch? _____ What was your job? _____

2. Have you recently returned from an assignment, been deployed, separated from the Military, or gone through a loss of some sort?

If “no”, stop. Remind them if they ever have depressed thoughts, the Family Clinic is here to help. And thank them for their service.

If “yes” or “well sorta, kinda, a little, etc.” then ask . . .

3. Are you feeling hopeless about the future?

If “no”, stop. Remind them if they ever have depressed thoughts, the Family Clinic is here to help. And thank them for their service.

If “yes” or “well sorta, kinda, a little, etc.” then ask . . .

4. Have you ever had thoughts about taking your own life?

If “no”, stop. Remind them if they ever have depressed thoughts, the Family Clinic is here to help. And thank them for their service.

If “yes” or “well sorta, kinda, a little, etc.” then ask

5. When did you have these thoughts and do you have a plan to take your life?

Whatever answer is, follow up with resources and clinical protocol for at-risk suicide, including the CSSRS.

Appendix L

Lunch and Learn

Veteran Suicide Prevention Community Resources

Date: _____

Organization: _____

Please sign your name if you attended.

- 1.
- 2.
- 3.
- 4.
- 5.
- 6.
- 7.
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.

Appendix M

Veteran Resource Support Tool

Many veterans aren't aware of the free help centers, crisis hotlines and clinics available. Below is a collection of available resources that veterans can take advantage of at no cost.

Patriot Support Program	1-888-456-0968	24/7
Cedar Springs Hospital's treatment continuum includes TRICARE®-accredited programs for U.S. military service members, veterans and dependents. To honor the sacrifice of these men and women and their families, we offer care for their psychiatric, emotional, behavioral, cognitive, substance abuse and post-traumatic stress disorders. These programs offer a setting for military members and family to discuss and face the challenges that may arise from the demands of military life.		
Vets 4 Warriors	1-855-838-5444	24/7
This organization offers veterans and active duty military free, confidential peer support from other veterans. Connect with them on the Vets 4 Warriors website or by calling 855-838-5444.		
National Veterans Foundation	1-855-838-5444	24/7
The National Veterans Foundation's mission is to offer crisis management, information referrals and outreach for veterans in need. Call 1-855-838-5444 or visit the National Veterans Foundation website		
National Alliance on Mental Illness	719-473-8477	Staffed 9am- 5pm, weekdays
NAMI's phone line at 719.473.8477, at which callers can receive information on organizational and community resources.		

Appendix N

Acknowledgement of Veteran Resource Support Tool

Name:

Date:

Please answer the following:

1. I understand that 100% of patients over the age of 18 seen in this clinic, will be given the *Veteran Patient Questionnaire* screening during their clinical visit from now through July 31, 2020.

Yes

No

Need assistance

2. I am aware of the *Veteran Resource Support Tool* and know where it is kept at the clinic.

Yes

No

Need assistance

3. I have read the information on the *Veteran Resource Support Tool*.

Yes

No

Need assistance

Appendix O

Post-test

**Post-Veteran Suicide Prevention Education
(fill out at the end of the pilot program)**

Please specify your level of agreement to the statement by indicating: (1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree. Circle one.

1. I have had an adequate amount of training to prepare me for talking with patients about suicidal thoughts/feelings.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
2. I am confident in my ability to discuss the topic of suicide with a patient.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
3. Veterans are more likely than the general population to commit suicide.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
4. I am confident in my ability to discuss the topic of suicide with a veteran patient.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
5. I am aware of community support programs to support at-risk veterans and can quickly pass along this information to those in need.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree
6. I am aware of what stressors occur within military life that could lead to the feelings of hopelessness and despair.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree;
(5) Strongly agree

Appendix P

Veteran Suicide Prevention Pilot Program Evaluation Group Interview Questions

The following questions will be discussed during a group interview with participants at the conclusion of the project.

1. Do you think the S.A.V.E. training video was effective?
2. What did you learn that you feel will be the most helpful to your understanding of veteran mental health issues?
3. How has this training helped in your perception of veteran mental health?
4. Do you think the veteran patient questionnaire would be helpful to have embedded into EPIC?
5. What other questions do you feel would be important to ask veteran patients regarding mental health?
6. What resistance did you receive from patients when you attempted to ask them the questions?
7. What positive things occurred when you went through the questions with the patients?
8. How do you think this veteran suicide education program could be improved?
9. Do you think you are better prepared to discuss referral agencies with veterans who indicate a need?
10. How do you feel your clinic does overall trying to bridge the gap between mental health and primary care?
11. What could be done better?

Appendix Q

Veteran Suicide Prevention Pilot Program Evaluation

Please answer the following:

1. The S.A.V.E. education video provided me helpful information regarding stressors in military life and how they could impact veterans
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree
2. I feel better equipped to talk with veterans about mental health concerns.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree
3. I am aware of what resources are available in our area to help at-risk veterans.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree
4. I think veteran patients responded well to the questionnaire screening tool and were open to answering the questions.
(1) Strongly disagree; (2) Disagree; (3) Neither agree nor disagree; (4) Agree; (5) Strongly agree
5. The veteran suicide staff education could be improved by:

6. The clinical implementation of veteran questionnaires could be improved by:

Appendix R

COLUMBIA-SUICIDE SEVERITY RATING SCALE*Screen with Triage Points*

Ask questions that are in bold and underlined.	Past month	
Ask Questions 1 and 2	YES	NO
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) <u>Have you had any actual thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) <u>Have you been thinking about how you might do this?</u> E.g. "I thought about taking an overdose but I never made a specific plan as to when or where or how I would actually do it....and I would never go through with it."		
4) <u>Have you had these thoughts and had some intention of acting on them?</u> As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.	Lifetime	
	Past 3 Months	
If YES, ask: <u>Was this within the past 3 months?</u>		

Response Protocol to C-SSRS Screening

Item 1 Behavioral Health Referral at Discharge

Item 2 Behavioral Health Referral at Discharge

Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and Consider Patient Safety Precautions

Item 4 Psychiatric Consultation and Patient Safety Precautions

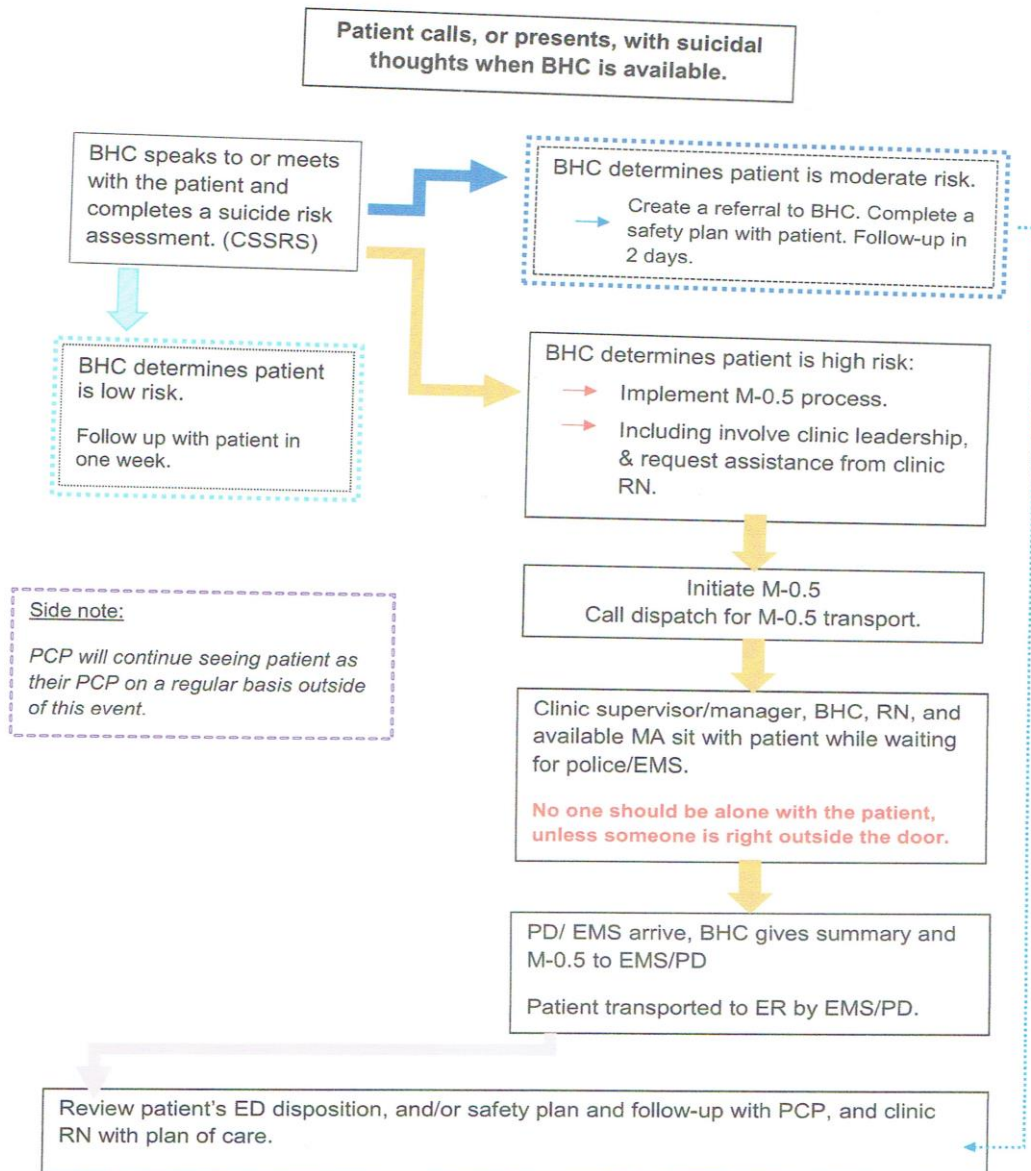
Item 5 Psychiatric Consultation and Patient Safety Precautions

Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and Consider Patient Safety Precautions

Item 6 3 months ago or less: Psychiatric Consultation and Patient Safety Precautions

Appendix S
Workflow Sheet

At Risk Workflow for Behavioral Health



Patient Label

SAFETY PLAN

Name: _____ DOB: _____
_____/_____/_____ Date: _____

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide a safe distraction:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Place _____
4. Place _____

Step 4: People whom I can ask for help:

1. Name _____ Phone _____
2. Name _____ Phone _____
3. Name _____ Phone _____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name _____ Phone _____
Clinician Pager or Emergency Contact #: _____
2. Rocky Mountain Crisis Partners: 1-844-493-TALK (8255)
3. National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Call 911
5. Go to your nearest Walk-In Crisis Unit at: _____
6. Go to your nearest Hospital Emergency Room

Step 6: Making the environment safe:

1. _____
2. _____

I agree to be bound to following this plan which I have personalized with my clinician.

Participant Signature: _____ Date: _____

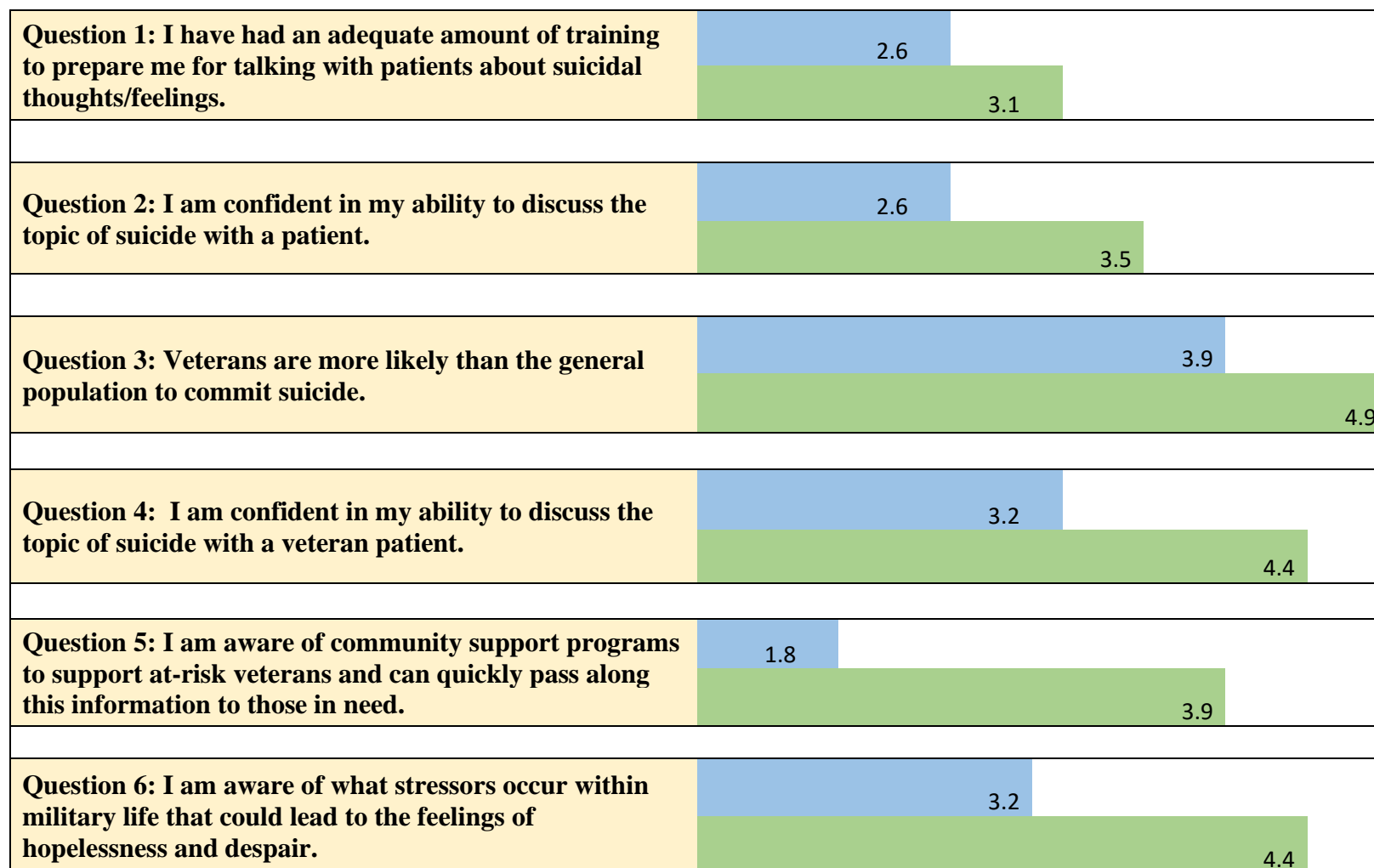
Appendix U

Self-Rating by Participants

1-5 scale

Aggregate Pretest Score is blue

Aggregate Post Score is green



All participants pretest and post-test score results combined = Pre: 17.6 Post: 24 Maximum total score possible 30

