VISION ZERO:

A MODEL FOR ELIMINATING SUICIDE AND TRANSFORMING HEALTH CARE

Testimony Before the House Committee on Veterans' Affairs

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Good morning, Chairman Takano, Ranking Member Roe, and Members of the Committee. Thank you for inviting me to participate in this very important hearing on suicide prevention for America's veterans. I am Dr. Ed Coffey, a neurologist and psychiatrist, and Affiliate Professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, in Charleston, SC.

You requested that I share insights about the efforts of non-VA health care systems to establish comprehensive suicide prevention approaches. I am happy to do so. While as a physician I have always viewed suicide prevention as a key priority for my patients, my involvement in suicide prevention at a healthcare systems level began over 20 years ago, when I served as Vice President for Behavioral Health Services at the Henry Ford Health System in Detroit, MI (1996-2014). In that capacity I had the great pleasure to lead a team of incredible individuals who set out to radically transform a large mental health care delivery system by participating in the Robert Wood Johnson Foundation's "Pursuing Perfection National Collaborative." We chose to focus our initiative on "perfecting" the care of persons with depression, and by leveraging the power of an audacious goal – the elimination of suicide – we achieved dramatic and sustained reductions in patient suicide, as well as improved performance of our entire delivery system. Our approach to achieve these results has since been endorsed by numerous organizations – including The Joint Commission and the U.S. Surgeon General's 2012 National Strategy for Suicide Prevention – and recently SAMHSA has funded the implementation of the Zero Suicide model by numerous states, tribes, and health care systems across the US. In addition, the vision of "Zero Suicide" has inspired an international movement, and I am pleased to be supporting such implementation which is underway in Canada, Australia, New Zealand, the Netherlands, and the United Kingdom.

In my remarks today, I will briefly review the origin of our Zero Suicide model and discuss its key components. But first, by way of background I want to review some statistics that highlight the growing suicide crisis in our country.

The Suicide Crisis in America

This Committee is well aware of the growing tragedy of suicide in America.

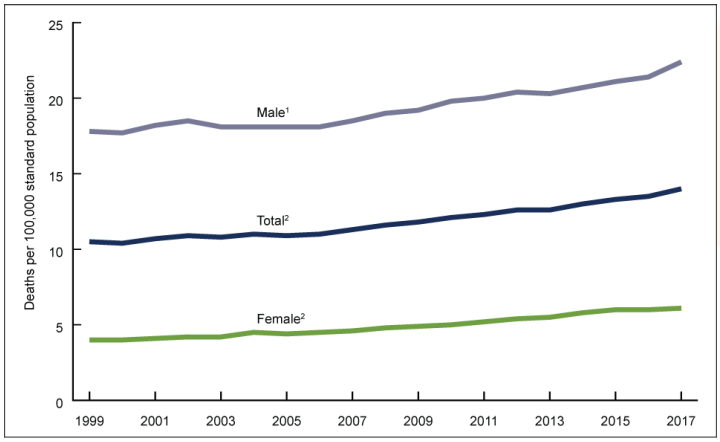
- While deaths from cancer and heart disease have declined in the US, the rate of death by suicide has increased 33% in the past 16 years (1999 – 2017) (Figure 1). That rate is actually accelerating more recently, and it is disproportionately higher in women and in people living in rural areas.
- The statistics are worse for veterans, where the incidence of suicide is 50% higher than the general adult population, and 80% higher in female veterans.
- Suicide is the 10th leading cause of death in the US, and the second leading cause of death between ages 10 – 34. In 2017, we lost ~50,000 Americans to suicide, ~6100 of whom were veterans.
- Many more Americans – ~1.4 million – report having attempted suicide each year, and over 10 million report seriously considering suicide.

In light of these grim statistics, a new approach to suicide prevention is clearly needed.

The Suicide Crisis:

Suicide Rates in the United States Have Increased 33% in 16 Years

Figure 1. Age-adjusted suicide rates, by sex: United States, 1999–2017



¹Stable trend from 1999 through 2006; significant increasing trend from 2006 through 2017, $p < 0.001$.
²Significant increasing trend from 1999 through 2017 with different rates of change over time, $p < 0.001$.
NOTES: Suicides are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes U03, X60–X84, and Y87.0. Age-adjusted death rates were calculated using the direct method and the 2000 U.S. standard population. Access data table for Figure 1 at: https://www.cdc.gov/nchs/data/databriefs/db330_table-508.pdf#1.
SOURCE: NCHS, National Vital Statistics System, Mortality.

The Origin of the Zero Suicide Model

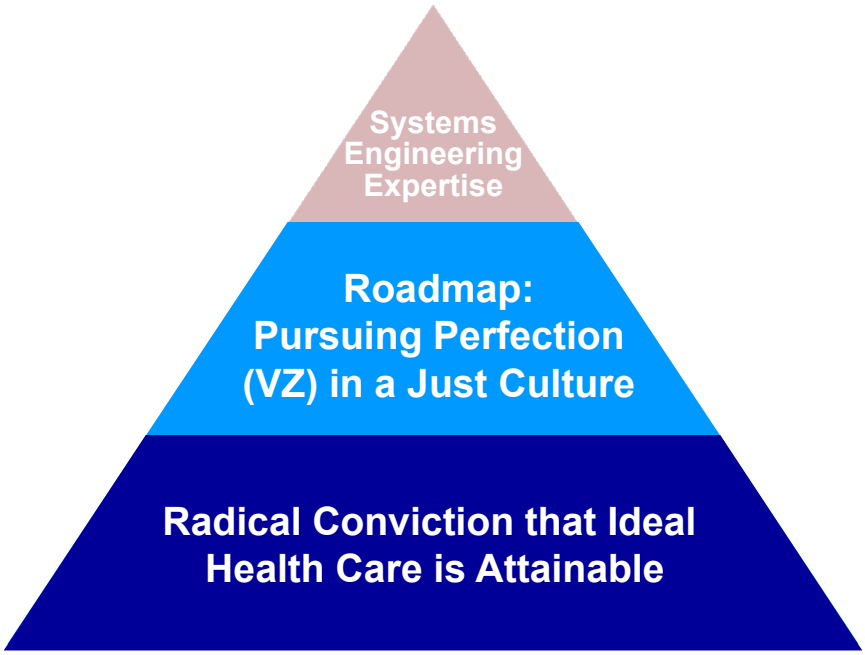
In 2001, the Institute of Medicine's *Crossing the Quality Chasm* report called for sweeping reform of the American health care system, and the Robert Wood Johnson Foundation together with the Institute for Healthcare Improvement responded with a $26 million national demonstration project – known as the "Pursuing Perfection National Collaborative" – that challenged health care systems to dramatically improve patient outcomes by redesigning all major care processes in order to deliver ideal care. At Henry Ford Health System, our participation in the first phase of Pursuing Perfection (we were not ultimately awarded an implementation grant) challenged us to create a workplace culture in which the performance goal was *perfection*, not just incremental improvement.

We selected for transformation the care of persons with depression, but we struggled initially to articulate what a vision of "perfect depression care" would look like. Finally, one of our staff suggested that if depression care was truly perfect, no patient would die from suicide. That stunning idea set in motion a debate that continues even today. Some have argued that a goal of no suicide is not realistic or achievable (e.g., How can we stop it if someone really wants to do it?), that it is overly simplistic, and that it could provoke distress among patients, family members, and health care providers that would only make matters worse. Our team challenged these assumptions and asked, If zero is not the right goal for suicide occurrence, what number possibly could be? Very quickly we came to realize that because of its radicalism, the goal of Zero Suicide provided the requisite galvanizing force essential to drive the hard work of transformation.

It should be noted that the concept of "zero defects" has been around since at least 1966, spreading to industries throughout the world, and recently, innovating to zero was called 1 of 10 megatrends for innovation. High-reliability organizations aggressively pursue perfection, an approach that has driven commercial aviation to achieve remarkable levels of safety. Why shouldn't this same approach be applied to health care?

The Zero Suicide Model

In our view, the Zero Suicide Model is an approach to system transformation that consists of three essential components (Figure 2):



- A radical conviction that ideal (perfect) health care is attainable.
  Such a conviction is fundamental to the model, as it provides the driving force essential for the hard work of relentless transformation. Absent such a radical conviction, implementing multimodal suicide prevention strategies is less likely to be effective and sustainable.
- A roadmap to achieve that vision.
  Performance is about "pursuing perfection," not simply incremental improvement. Such performance is made possible by a "just culture." A "just culture" is one that embraces the radical goal of perfect care, and that makes the pursuit of that care possible by viewing errors or near misses as system failures from which to learn and rapidly improve. In response to errors, a just culture asks "What happened and how?", not "Who did it?" A just culture seeks recovery, restoration, and improvement, not blame, punishment, or retribution.
- A requisite expertise in systems engineering.
  Teammates must be expert in promoting and implementing systematic evidence-based approaches. In our Perfect Depression Care Initiative, we focused on three key strategies: safety planning (particularly safe gun ownership), rapid access to definitive care, and managing the transitions of care. Teammates must also be quick learners when mistakes happen, so that they can rapidly correct system defects and continually improve to achieve zero defects.

With this model we were able to reduce the rate of suicide among our patients by 75%, even while over that same 10-year period the rate of suicide actually increased in the general population of the state of Michigan. As noted earlier, others are now adopting iterations of the Zero Suicide model and are describing similar positive results. Additionally, research (funded by NIH and SAMHSA) is underway to formally study the effectiveness of the Zero Suicide model.

Conclusion

As noted by the Institute of Medicine in its report *Crossing the Quality Chasm*, "In its current forms, habits, and environment, American health care is incapable of providing the public with the quality health care it expects and deserves. … The current care systems cannot do the job. Trying harder will not work. Changing systems of care will."

Zero Suicide is an example of how we might change our systems of care, and it provides a potential model for achieving dramatically improved performance, including the audacious goal of eliminating suicide. To be sure, suicide prevention is a very complex issue that involves clinical and socio-cultural-political components. Still, the Department of Veterans Affairs is in a position to address such complexity, and there is no reason why it couldn't become the world leader in dramatically improving systems issues such as health engagement, healthcare access, and the social determinants of health, among others. In addition, because veterans and service members are venerated in our society and widely acknowledged as expert in injury prevention, they have the opportunity to serve as the model for safe gun ownership in our broader society, and in so doing, catalyze a movement that would save thousands of lives.

Thank you again for the opportunity to participate in this hearing today, and to represent my many colleagues around the globe who have courageously embraced a vision of ideal care and Zero Suicide. I am happy to respond to any questions you may have.

Selected Supporting Documents

Coffey CE. Building a system of perfect depression care in behavioral health. Jt Comm J Qual Patient Saf, 33:193-199, 2007.

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Coffey CE. Perfect depression care and the origin of *Zero Suicides*. National Academies of Science, Engineering, and Medicine Workshop on Improving Care to Prevent Suicide Among People with Serious Mental Illness, Washington, DC, September 11, 2018. Proceedings published in: National Academies of Sciences, Engineering, and Medicine. 2019. *Improving Care to Prevent Suicide Among People with Serious Mental Illness: Proceedings of a Workshop*. Washington, DC: The National Academies Press. doi: https://doi.org/10.17226/

Coffey CE, Ahmedani BK, Coffey MJ. Challenges in suicide prevention research (letter). JAMA, 321 (11):1105, 2019.