

Legislative Report: Suicide-Related Data Plan

IMPROVING THE TIMELINESS, USEFULNESS AND QUALITY OF DATA

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Legislative Report: Suicide-related Data Plan

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Executive Summary

Minnesota continues to see its age-adjusted suicide rate increase. According to the Minnesota Center for Health Statistics, in 2013 (the most recent complete data year) a total of 683 Minnesotans died of suicide – making it the ninth leading cause of death. The state’s age-adjusted rate of suicide has gradually risen from a low of 8.9 per 100,000 in 2000 (n=440) to 12.2 per 100,000 in 2013 (n=683). In 2013, the U.S. rate was 12.6.

Death by suicide is not experienced equally across age groups, genders, geography and culture in Minnesota. For example, in 2009-2013, Minnesota’s American Indian youth aged 10-24 had a suicide rate of 28.0 per 100,000 (n=30) – more than three times the rate among White youth and four times the rate among Asian/Pacific Islander youth. State agencies, grantees and stakeholder efforts recognize the need to collect and interpret data with the awareness that some communities and populations bear a disproportionate burden with regards to suicide and non-fatal self-directed violence (SDV).

In 2015, the Minnesota Suicide Prevention Task Force developed the MN State Suicide Prevention Plan (“the Plan”).¹ One of a number of key components of the Plan was the development of goals and objectives that focused on the data systems that help identify the scope of the suicide problem, identify high-risk groups, set priority prevention activities, and monitor the effects of suicide prevention programs. More specifically, state law requires that:

“The commissioner, in consultation with stakeholders, shall submit a detailed plan identifying proposed methods to improve the timeliness, usefulness, and quality of suicide-related data so that the data can help identify the scope of the suicide problem, identify high-risk groups, set priority prevention activities, and monitor the effects of suicide prevention programs. The report shall include how to improve external cause of injury coding, progress on implementing the Minnesota Violent Death Reporting System, how to obtain and release data in a timely manner, and how to support the use of psychological autopsies.” (Minnesota Statutes 2015, section 145.56, subd. 4)

This legislative report offers a detailed plan regarding the following MN State Suicide Prevention Plan objectives:

Objective 4.1 Improve the timeliness, usefulness and quality of suicide-related data to help explain the scope of the problem, identify high-risk groups and set priority prevention activities.

¹ <http://www.health.state.mn.us/injury/pub/SuicidePreventionStatePlan2015.pdf>

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Objective 4.2 Improve and expand the state, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data to help develop effective prevention efforts, especially at the local level.

Objective 4.3 Increase the number and quality of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors (also referred to as self-directed violence or SDV), risk factors and exposures to suicide to help better understand community suicide prevention needs and plan effective prevention and support services.

Objective 5.1 Monitor how the suicide prevention plan is being implemented in the state and local communities.

Background

In September 2015, Minnesota released The Minnesota State Suicide Prevention Plan: Goals and Objectives for Action 2015-2020.² Prepared by the Minnesota Department of Health (MDH) and the MN State Suicide Prevention Task Force, the plan was based on the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action released by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention.³ The MN State Suicide Prevention Task Force is comprised of members from an array of state and local agencies, organizations and family members directly affected by suicide and non-fatal self-directed violence (SDV).⁴

The goal of the Minnesota State Plan is to reduce suicide in Minnesota by 10 percent in five years, 20 percent in ten years; ultimately working toward zero deaths. Minnesota will see a significant reduction in suicides and SDV when we fully implement the five goals in the Minnesota State Suicide Prevention Plan:

1. Support healthy and empowered individuals, families and communities to increase protection from suicide risk.
2. Coordinate the implementation of effective programs by clinical and community preventive service providers to promote wellness, build resilience and prevent suicidal behaviors.
3. Promote suicide prevention as a core component of health care services.
4. Increase the timeliness and usefulness of data systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action.
5. Sustain suicide prevention efforts.

In accordance with Minnesota Statutes, section 145.56, subdivision 4, this report offers a "detailed plan identifying proposed methods to improve the timeliness, usefulness, and quality of suicide-related data...." The report describes how MDH and Suicide Prevention Task Force stakeholders plan to implement Goal 4 and its related objectives and Objective 5.1 of the Minnesota State Suicide Prevention Plan.

² <http://www.health.state.mn.us/injury/pub/SuicidePreventionStatePlan2015.pdf>

³ <http://www.ncbi.nlm.nih.gov/pubmed/23136686>

⁴ For a full list of Task Force participants, see pages 4-5,
<http://www.health.state.mn.us/injury/pub/SuicidePreventionStatePlan2015.pdf>

Data-Related Goals and Objectives

Goal 4: Increase the timeliness and usefulness of data systems relevant to suicide prevention and improve the ability to collect, analyze and use this information for action.

Objective 4.1 Improve the usefulness and quality of suicide-related data.

Improving the timeliness, usefulness and quality of suicide-related data can help explain the scope of the problem, identify high-risk groups, set priority prevention activities, and monitor the effects of suicide prevention programs.

Objective 4.2 Improve and expand state, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.

Improving and expanding state, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data will help develop effective prevention efforts, especially at the local level.

Objective 4.3 Increase the number and quality of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors, suicidal behaviors, related risk factors, and exposure to suicide.

Increasing the number and quality of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors (also referred to as self-directed violence or SDV), risk factors and exposures to suicide will help to better understand community suicide prevention needs and plan effective prevention and support services.

Goal 5: Sustain suicide prevention efforts.

Objective 5.1 Monitor how the suicide prevention plan is being implemented in the state and local communities.

Monitoring how the suicide prevention plan is being implemented in the state and local communities will help to evaluate the quality and quantity of implementation and types of structures that may be more effective or efficient.

Objective 4.1

Improve the usefulness and quality of suicide-related data

The State Suicide Prevention Plan Objective 4.1 aims to improve the quality and usefulness of suicide-related data to help describe and explain the scope and extent of the problem, identify groups at high-risk, set priority prevention activities, and monitor the effects of suicide prevention programs.

Strategy 4.1.1

Fully Implement the MN-Violent Death Reporting System

The federally-funded National Violent Death Reporting System (NVDRS) is the only state-based violent death reporting system that helps states understand when and how violent deaths occur.⁵ This system links data from law enforcement, coroners and medical examiners, vital records and crime laboratories to obtain the most comprehensive data available on violent deaths, including homicide, suicide, unintentional firearm and undetermined deaths. In 2014, Minnesota had 840 violent deaths, 683 of which were suicides.

MDH began implementing the NVDRS in Minnesota (MN-VDRS) in the fall of 2014.

1. MDH will convene the MN-VDRS multi-disciplinary advisory committee (formed in the fall of 2015) twice a year to:
 - Help explain the death-related data system/source
 - Provide MDH with appropriate access to data sources
 - Improve the quality of data collected, interpret data findings, and disseminate key findings to inform prevention efforts.
2. MN-VDRS advisory committee will report its progress, action and recommendations to the Suicide-Statewide Epidemiological Outcomes Workgroup at least once a year.
3. MN-VDRS advisory committee will present or exhibit at the annual Minnesota Forensic Science Seminar to share data findings and recommend how data quality can be improved.
4. MN-VDRS advisory committee will publish data reports in September of each year (2016 through 2019) and by May of 2020.
5. MDH will evaluate the MN-VDRS in 2017 using national surveillance system guidelines to develop recommendations to improve its quality, efficiency and usefulness.

⁵ <http://www.cdc.gov/ViolencePrevention/NVDRS/index.html>

As MDH continues to implement the MN-VDRS, we expect to be able to identify high-risk populations like American Indian youth or middle-aged White males, or certain sub-populations such as jump-related deaths; and align policy and program responses and resources with specific needs in those communities or population groups.

Analyzing the MN-VDRS data may result in recommendations to improve the data to strengthen prevention programs.

Strategy 4.1.2

Establish a Suicide-Statewide Epidemiological Outcomes Workgroup (S-SEOW)

MDH will form and chair a Suicide-Statewide Epidemiological Outcomes Workgroup (S-SEOW), a multi-disciplinary team of data providers and users, to track and monitor implementation of the Minnesota State Suicide Prevention Plan Goal 4. The S-SEOW will be based on an existing SEOW that focuses on substance abuse-related data.⁶ S-SEOW will:

1. Meet twice each year starting in 2016 and will advise MDH on plan implementation.
2. Identify, analyze and share data from available state and local sources.
3. Assess and evaluate Minnesota's case finding system (assessment and public health surveillance) and suggest opportunities for improvement.
4. Create products that visualize data and add cultural context to best communicate the findings in order to inform prevention planning and policies.
5. Train communities to understand, use and present data in an effective way.
6. Track and monitor State Plan activities.

By July 1 of each even-numbered year, the S-SEOW and state program staff will author a biennial legislative report that summarizes an evaluation of the impact and outcomes of implementing the suicide prevention plan, including the activities described in this report regarding data access, analysis and quality improvement.

⁶ <http://www.samhsa.gov/capt/tools-learning-resources/data-prevention-planning-seow>

Strategy 4.1.3

Implement CDC's action plan for improving external cause of injury coding.

To evaluate the impact and effect of programs and policies on prevention, MDH must be able to accurately count events. This is particularly true for suicide and other self-directed violence, for which there may be stigma or other factors that affect identification and reporting.

In 2009 the CDC and stakeholders released the publication, Recommended Actions to Improve External-Cause-of-Injury Coding in State-Based Hospital Discharge and Emergency Department Data Systems.⁷

External cause codes define the means of death or injury, along with the location of the event. Medical records coding staff assign external cause codes to hospital records based on the medical record narrative supplied by the attending or treating physician.

The U.S. Centers for Disease Control and Prevention (CDC) National Center of Health Statistics assigns external cause codes to death records based upon the text provided by the coroner or medical examiner on the death certificate.

1. MDH will analyze the quality of external cause coded hospital data and publish reports on completeness, specificity and accuracy of external cause data annually.
2. MDH and partners will provide feedback to the State Trauma Advisory Committee and the Minnesota Health Information Management Association annually regarding the quality of external cause coded data.
3. MDH and partners will provide and/or encourage training for those charged with assigning external cause of injury codes within administrative data, such as emergency department and hospital discharge systems.
4. MDH will conduct (or sponsor) at least one external cause of injury coding training or informational session each year to relevant professional organizations of clinicians, nurses, health information specialists, medical epidemiologists, and hospital administrators.
5. MDH and advisory committees will identify and develop incentives, policies and approaches to training professionals on their roles in collecting high-quality external cause of injury data.

⁷ <http://www.cdc.gov/injury/pdfs/ecode-a.pdf>

Strategy 4.1.4

Promote the use of the self-directed violence uniform definitions and data elements developed by the CDC and Veteran’s Affairs.

Consistent data allow researchers to better understand the scope of the problem, identify high-risk groups and monitor the effects of prevention programs. S-SEOW will:

1. Identify existing state and local data systems that measure SDV.
2. Compare and contrast how SDV is defined in each of the data systems.
3. Make recommendations of how to best implement the use of the SDV uniform definitions and data elements.

In 2011 the CDC in collaboration with the Department of Veterans Affairs and the Department of Defense released the Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 1.0.⁸ This document improves our understanding of self-directed violence and standardized data collection across data systems in Minnesota and with other states, Tribal nations and other countries.

Strategy 4.1.5

Support the use of National Association of Medical Examiners’ standards related to investigating suicide deaths.

The National Association of Medical Examiners (NAME) has developed recommendations and published standards to guide death scene investigations for medical examiners, coroners and their staff members.⁹ Minnesota has a county-based system of medical examiners and coroners. While each office pursues training for its members through the year, the Hennepin County Medical Examiner’s Office and Minnesota Coroners’ and Medical Examiners’ Association coordinate and convene an annual forensic conference each autumn that includes training and exploration of current topics and issues.

To support the use of NAMEs standards, MDH will:

1. Annually monitor the percentage of suicides for which autopsy and toxicology screening is completed.

⁸ <http://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf>

⁹ http://www.mtf.org/pdf/name_standards_2006.pdf

2. Identify barriers to having an autopsy and toxicology screening done and make recommendations to Minnesota Coroners' and Medical Examiners' Association to overcome these barriers.
3. Present these findings and recommendations to Minnesota Coroners' and Medical Examiners' Association.

Objective 4.2

Improve and expand the state, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data to implement prevention efforts and inform policy decisions.

The State Suicide Prevention Plan Objective 4.2 aims to improve and expand the state, tribal and local public health capacity to routinely collect, analyze, report and use suicide-related data to help develop effective prevention efforts, especially at the local level.

Strategy 4.2.1

Release suicide data in a timely manner to local public health to identify suicide clusters and prevent contagion.

Suicide data needs to be timely, accurate, complete, local, and accessible in order to understand the scope of the problem, develop policies and programs to prevent suicides and identify and prevent contagion at the local level. Suicide data also needs to be useful to both professionals and to community members.

1. MDH will provide more timely preliminary annual counts of suicide deaths. MDH will release 2015 preliminary count data by July 1st of 2016. MDH plans to release 2018 preliminary count data by May 1st, 2019.
2. MDH MN-VDRS program will explore providing monthly updates for MDH program staff.
3. MDH Minnesota Center for Health Statistics (MCHS) will continue to release official final suicide counts in time for World Suicide Prevention Day on September 10th of each year. S-SEOW (Suicide-State Epidemiological Outcomes Workgroup) will work with the MDH MCHS and the Office of Vital Records to assure that this standard is consistently met.
4. MDH and local public health will increase the number of local public health professionals, including tribal public health, who have registered with the Minnesota Office of Vital Records (OVR) to access timely suicide death data.

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5. MDH will incorporate county-level mapping and graphing options on the MDH mortality and morbidity online query data systems – Minnesota Vital Statistics Interactive Queries (I.Q.) and MDH Minnesota Injury Data Access System (MIDAS).^{10,11}
6. MDH and the S-SEOW will train local public health professionals on how to obtain, analyze, use and present suicide data and information in an effective manner.
 - provide technical assistance to local public health when requested,
 - conduct trainings at annual state health conferences.¹²
7. MDH will provide technical assistance to media and community members on how best to use the available online data query system tools listed below. This would include education of safe messaging and safe reporting on suicides to promote healing and decrease contagion.^{13,14}
 - MDH - Minnesota Vital Statistics Interactive Queries (death data)¹⁵
 - CDC – WONDER (death data)¹⁶
 - MDH – Minnesota Injury Data Access System (hospital treated self-directed violence data)¹⁷
 - CDC – WISQARS (death and SDV data)¹⁸

¹⁰ <https://pqc.health.state.mn.us/mhsq/frontPage.jsp>

¹¹ <http://www.health.state.mn.us/injury/midas/index.cfm>

¹² <http://www.health.state.mn.us/divs/opi/pm/conf/>

¹³ <http://reportingonsuicide.org/>

¹⁴ <http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/>

¹⁵ <https://pqc.health.state.mn.us/mhsq/frontPage.jsp>

¹⁶ <http://wonder.cdc.gov/>

¹⁷ <http://www.health.state.mn.us/injury/midas/index.cfm>

¹⁸ <http://www.cdc.gov/injury/wisqars/index.html>

Strategy 4.2.2

Establish suicide mortality review system

The distribution of suicides varies across subpopulations – children, working-age adults, race/ethnic groups, as well as the means and methods used in the suicide. Minnesota could improve its prevention efforts through suicide mortality reviews in order to help state agencies' and community partners' suicide prevention efforts with certain high risk subpopulations.

1. MDH in partnership with appropriate partners will form a suicide mortality review team by January 1, 2018 to review all suicides among children age 12 and under. This activity is authorized under the Commissioner's duty to collect and analyze Minnesota-specific data on suicide and suicidal behaviors. (Minnesota Statutes 2015, section 144.56, subd. 4(a)).
2. MDH will provide technical consultation to non-state organizations with legal authority to conduct their own suicide mortality reviews.

The mortality review process is a public health, evidenced-based practice that has been successfully used to inform prevention efforts for infant, child, and maternal deaths.¹⁹ A suicide case finding and response system that includes suicide death identification, reporting, review and response would provide essential information to evaluate and guide activities that could prevent future suicides and improve the measurement of suicide.

Much of the data surrounding a suicide death may be private or confidential. To further protect patient privacy, health data collected for the purpose of reducing morbidity or mortality has a special status in law and is not discoverable through legal action. (Minnesota Statutes 2015, section 144.658).

Suicide mortality review efforts will also analyze suicides occurring in regulated facilities, such as hospitals, nursing homes, and other residential facilities.

Strategy 4.2.3

Promote the use of psychological autopsies by AAS-certified individuals

A psychological autopsy has become a best practice postmortem procedure to reconstruct the proximate and distal causes of an individual's death by suicide.²⁰ Information gathered through the psychological autopsy can inform prevention efforts and support suicide death reviews, leading to systems and policy changes that can further prevent suicides.

¹⁹ <https://www.childdeathreview.org/>

²⁰ <http://www.suicidology.org/training-accreditation/psychological-autopsy-certification>

Psychological autopsies were developed in 1960 by the founding president of the American Association of Suicidology (AAS), Dr. Edwin Shneidman, and refined by others over the years.

The psychological autopsy also helps promote understandings to the often-asked "why?" raised by survivors about the suicide of their loved one, and it is used in case-control research studies to better determine risk factors for suicide, and helps to answer questions of causation in individual cases of suicide (e.g. where negligence may be alleged) and possible connection between cases (as in clusters of suicides).

The American Association of Suicidology offers a two-day, face-to-face training program in the psychological autopsy leading to certification as a ***Certified Psychological Autopsy Investigator***. Upon completion of the training, participants are able to effectively implement a psychological autopsy protocol and associated procedures to conduct, analyze, and understand how and why an individual died in the manner they did.

In order to achieve these changes, more social science and behavioral health professionals in Minnesota need to be trained and certified in conducting psychological autopsy. MDH is aware of only two individuals at this time in Minnesota who are certified to conduct psychological autopsies.

1. MDH and other state agencies will strategically identify and secure resources to support staff to be trained and obtain certification.
2. MDH in partnership with other state agencies, nonprofits, and colleges/universities will host a two-day AAS training program in Minnesota at least every three years.

Strategy 4.2.4

Obtain authority for analysis of other data sources to prevent and monitor suicides and self-directed violence

Other non-MDH data may offer additional data on self-directed violence and suicide deaths that currently are not analyzed. Obtaining authority for MDH to utilize these population-based data could further prevent suicide, self-directed violence, and risk and protective factors. For any expanded data analysis effort, MDH will remain in full compliance with Minnesota Statutes 2015, section 144.05, subdivision 5.

1. S-SEOW will work with MDH to systematically identify additional data sources for suicide-related analysis and obtain authority to securely access the data. Some examples of data systems are syndromic surveillance, mobile crisis services, emergency medical services, tribal law enforcement, Indian Health Services, etc.
2. MDH has an interest in exploring other data tools, such as the Minnesota All Payer Claims Database (MN APCD), to better understand the health care costs related to self-directed violence and suicide. This would require legislative authority for MDH to use the MN APCD for such an analysis. Because the MN APCD offers the ability to study health care costs of

illness burden and utilization over time and across multiple settings of care for virtually all Minnesotans, it could significantly enhance suicide prevention and treatment efforts.

Strategy 4.2.5

Enhance epidemiological capacity

MDH utilizes a variety of federal- and state-funded resources to analyze suicide-related data. These include federal MN-VDRS funding to analyze violence deaths (homicides and suicides) and state traumatic brain injury related funding (suicide gunshot wounds to the head and suicide hanging related anoxia are the two leading causes of brain injury death).

There needs to be an increase in epidemiological capacity throughout the state in order to implement all the activities included in this detailed data plan. MDH will work with and encourage partners to increase capacity to do data analysis and epidemiology.

1. MDH will continue to pursue opportunities to obtain suicide prevention and analysis funding, to increase the capacity of dedicated epidemiological staff.
2. MDH will encourage stakeholders, such as other state agencies, researchers and academicians, to conduct suicide-related studies and data analysis.
3. MDH and the S-SEOW will train local public health professionals on how to obtain, analyze, use and present suicide data and information in an effective manner.
 - provide technical assistance to local public health when requested
 - conduct trainings at the annual Minnesota Community Health Services conference and other appropriate state conferences.
4. MDH will provide suicide epidemiological training opportunities annually, such as field experiences, internships, fellowships, and traineeships. These opportunities will facilitate epidemiological study and analysis and train more professionals to do suicide-related epidemiological analysis.

Strategy 4.2.6

Encourage community capacity through community readiness assessments

A community readiness assessment helps a community integrate its culture, resources and level of readiness to more effectively address suicide prevention.²¹

²¹ <http://www.samhsa.gov/capt/tools-learning-resources/stages-community-readiness>

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1. MDH in 2016 will pilot having student interns from Minnesota universities and colleges do suicide prevention community readiness assessments.
2. MDH and the S-SEOW will encourage local public health and communities to do community readiness assessments and provide technical assistance.

To maximize chances for successful suicide prevention, the Community Readiness Model offers tools to measure readiness and to develop stage-appropriate strategies.²²

Matching an intervention to a community's level of readiness is absolutely essential for success. Interventions must be challenging enough to move a community forward in its level of readiness. However, efforts that are too ambitious are likely to fail because community members will not be ready or able to respond.

²² <http://www.samhsa.gov/capt/tools-learning-resources/stages-community-readiness>

Objective 4.3

Increase the number and quality of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors, suicidal behaviors, related risk factors, and exposure to suicide.

Increasing the number and quality of surveys and other data collection instruments that include questions on protective factors against suicidal behaviors, risk factors and exposures to suicide will help us to plan prevention and support services and to better understand community suicide prevention needs.

Strategy 4.3.1

Increase the number of population health surveys that include Adverse Childhood Experience (ACE) module and standard resilience measures.

Increasing the number of surveys capturing information on these risk and protective factors (such as Adverse Childhood Experiences and resilience) will help us to better develop prevention programs and interventions as well as evaluate the impact of the state suicide prevention plan activities.²³

1. S-SEOW will identify which public health and population-based surveys currently include the ACE module and standard resilience measures.
2. S-SEOW and partners will make recommendations about what surveys should include the ACE and resilience measures.
3. S-SEOW will analyze and distribute key findings related to the ACE and resilience measures to inform prevention and evaluate the State Suicide Prevention Plan activities.

²³ http://www.health.state.mn.us/divs/chs/brfss/ACE_ExecutiveSummary.pdf

Strategy 4.3.2

Increase number of schools participating in the Minnesota Student Survey (MSS)

In order to better understand self-directed violence and suicide risk and protective factors for subpopulations, local communities and statewide; we need as many schools as possible to participate in the Minnesota Student Survey (MSS).^{24,25}

1. MDH and other state agencies will encourage schools to participate in the Minnesota Student Survey.
2. S-SEOW and the MDH suicide prevention program will provide technical assistance to schools and school-based prevention programs to interpret the MSS results and develop prevention plans to address their needs.

Strategy 4.3.3

Measure attitudes, beliefs and knowledge related to suicide, suicide prevention, and protective risk factors.

To further inform prevention activities, information needs to be gathered on attitudes, beliefs, and knowledge related to suicide and suicide prevention; as well as risk and protective factors.

1. S-SEOW will identify what surveys currently include questions related to attitude, belief and knowledge of suicide and suicide prevention and risk and protective factors.
2. S-SEOW will encourage surveys currently not including these measures to add them.
3. MDH and partners will work with researchers at Minnesota universities and colleges to develop a population-based survey to be administered in Minnesota to reach a diverse adult audience from urban and rural settings by 2018.
4. S-SEOW will analyze the identified survey questions and distribute key findings.

²⁴ <http://www.health.state.mn.us/divs/chs/mss/>

²⁵ <http://education.state.mn.us/MDE/StuSuc/SafeSch/MNStudentSurvey/>

Strategy 4.3.4

Develop a recommended minimum data set for health systems and public health data sets

Developing a recommended minimum data set for health systems and public health data sets to collect suicide related risk and protective factors and behaviors will help us better understand subpopulations with increased risk for suicide and recommend culturally-appropriate prevention strategies and better direct limited resources.

1. S-SEOW will identify current data systems that may have information on populations with known greater risk, including
 - American Indian youth
 - Individuals in justice and child welfare settings
 - Individuals who engage in non-suicidal self-injury (NSSI)
 - Individuals with certain chronic health conditions
 - Individuals with mental and/or substance use disorder
 - Lesbian, gay, bisexual and transgender (LGBT) populations
 - Members of the Armed Forces and veterans
 - Men in midlife
 - Older men
 - Suicide attempt survivors
 - Suicide loss survivors²⁶
2. S-SEOW will develop a minimum data set for health system and public health data sets based on the self-directed violence uniform definitions and data elements developed by the CDC and Veteran's Affairs.²⁷
3. S-SEOW will encourage identified data sets to include the recommended minimum data set developed

²⁶ <http://www.ncbi.nlm.nih.gov/books/NBK109909/>

²⁷ <http://www.cdc.gov/violenceprevention/pdf/Self-Directed-Violence-a.pdf>

Objective 5.1

Monitor how the suicide prevention plan is being implemented in the state and local communities

Monitoring how the suicide prevention plan is being implemented in the state and local communities will help to evaluate the quality and quantity of implementation and types of structures that may be more effective or efficient.

1. S-SEOW will establish an evaluation team to monitor and evaluate the implementation of the state plan.
2. MDH in 2016 will ensure that state grant-funded suicide prevention deliverables include state plan objectives and will develop standard measurements for all suicide grant funded efforts to monitor implementation and effectiveness.
3. MDH in 2016 will seek additional non-state funding to evaluate the suicide prevention program at the state and local level.

By July 1 of each even-numbered year, the S-SEOW and state program staff will author a biennial report that summarizes an evaluation of the impact and outcomes of implementing the suicide prevention plan, including the activities described in this report regarding data access, analysis and quality improvement.