Suicide Prevention Tools for Primary Care

March 28, 2013
Co-sponsored by the
SAMHSA-HRSA Center for Integrated Health Solutions (CIHS)
and the Suicide Prevention Resource Center (SPRC)
About the Center

In partnership with Health & Human Services (HHS)/Substance Abuse and Mental Health Services Administration (SAMHSA), Health Resources and Services Administration (HRSA).

Goal:
To promote the planning, and development and of integration of primary and behavioral health care for those with serious mental illness and/or substance use disorders and physical health conditions, whether seen in specialty mental health or primary care safety net provider settings across the country.

Purpose:
- To serve as a national training and technical assistance center on the bidirectional integration of primary and behavioral health care and related workforce development
- To provide technical assistance to SAMHSA PBHCl grantees and entities funded through HRSA to address the health care needs of individuals with mental illnesses, substance use and co-occurring disorders
The statements, findings, conclusions, and recommendations in this presentation are those of the presenter(s) and may not necessarily reflect the view of SAMHSA, HRSA, or the U.S. Department of Health and Human Services.
Slides for today’s webinar are available on the CIHS website at:

http://www.integration.samhsa.gov/about-us/webinars
How to ask a question during the webinar

If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. (left)

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. (right)
Today’s Presenters

Peggy West, PhD, MSW, Senior Advisor, Suicide Prevention Resource Center

Mimi McFaul, Psy.D., Director, WICHE Mental Health Program

Virna Little, PsyD, LCSW-R, SAP, VP for Psychosocial Services/Community Affairs, The Institute for Family Health
Webinar Goals

• Introduce the *Suicide Prevention Toolkit for Rural Primary Care* and its use with providers in primary care
• Learn how CHCs trained in suicide prevention are improving their knowledge, skills, and competency
• Lessons learned on how one Community Health Center implemented suicide prevention protocols in their agency
Overview of Presentation

• Share information about and resources available from the Suicide Prevention Resource Center (SPRC)
• Introduce the *Suicide Prevention Toolkit for Rural Primary Care*
• Review ways resources in the Toolkit can be used in a primary care setting
Who We Are

What is the Suicide Prevention Resource Center (SPRC)?

- Established in 2002
- Funded through a cooperative agreement by the Substance Abuse and Mental Health Services Administration (SAMHSA)
- SPRC serves individuals, groups, and organizations that play important roles in suicide prevention.
- Increase knowledge, build capacity, and promote collaboration.
- Nation’s only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention.
Who We Serve

- **Suicide prevention grantees**: Garrett Lee Smith Suicide Prevention Grantees funded by SAMHSA to support suicide prevention work in Campus, State, and Tribal communities.
- **State suicide prevention coordinators and initiatives**
- **College and university staff** involved in suicide prevention efforts on campus.
- **American Indian/Alaska Native communities**: Individuals working with native populations to support suicide prevention and mental health promotion.
- **Health and behavioral health care providers** who play a role in identifying and helping individuals at risk of suicide.
- **Professionals** in their community and organizations who can help reduce suicide rates among the populations they serve.
- **Anyone with an interest in suicide prevention**: Researchers, policymakers, public health professionals, suicide loss survivors, mental health consumer groups, and national and federal agencies and organizations
Services and Resources

Technical Assistance

Training  http://training.sprc.org
- CALM (Counseling on Access to Lethal Means)
- AMSR (Assessing and Managing Suicide Risk)
- Webinars (Self-Injury, Alcohol Use, Bullying)

Publications
- Weekly SPARK
- Customized Information Sheets (Foster parents, First Responders, Teachers)
- Toolkits/Resources (Seniors, LGBT Youth, Juvenile Justice, ED Poster)

Best Practices Registry
- Evidence-based suicide prevention programs and practices

National Action Alliance for Suicide Prevention
- Public-Private Partnership
- National Strategy for Suicide Prevention  
  http://actionallianceforsuicideprevention.org/nssp
The Weekly Spark

Sign up for The Weekly Spark at: http://go.edc.org/0ooq
Examples of SPRC Products and Services
The Best Practices Registry (BPR)

BPR: How to Ask the Question

ASIST/safeTALK
Jerry Swanner
Living Works
910-867-8822
usa@livingworks.net
www.livingworks.net

QPR
Kathy White
The QPR Institute, Inc.
888-726-7926
qinstitute@qwest.net
www.qprinstitute.com

Assessing and Managing Suicide Risk (AMSR)
Isaiah Branton
SPRC
202-572-3789
ibranton@edc.org
www.sprc.org

Recognizing and Responding to Suicide Risk in Primary Care (RRSR—PC)
Alan L. Berman
American Association of Suicidology
202-237-2280
berman@suicidology.org
www.suicidology.org

Operation S.A.V.E.: VA Suicide Prevention Gatekeeper Training
Janet Kemp, RN, Ph.D.
VA National Suicide Prevention Coordinator
585-393-7939
jan.kemp@va.gov

AT-RISK in PRIMARY CARE
Ron Goldman
Kognito
212-675-9234
ron@kognito.com
www.kognito.com
Why Primary Care?

PCSSmentor.org
Physician Clinical Support System - An Educational Resource for Those Addressing Suicide Risk in Primary Care

What is the Physician Clinical Support System (PCSS-P)?

The Physician Clinical Support System is a supported program that brings you curricula on alcohol, tobacco, and drug screening, as well as primary care settings. It is a system of support that provides resources to help physicians navigate these issues. When you sign up with PCSS-P, you are connected to a network of resources and mentors who can provide guidance and support.

There are similar systems for physicians and for other healthcare professionals who work in the field of mental health. These systems can help improve the quality of care and reduce the risk of suicide in patients.

Recognizing and Responding to Suicide Risk in Primary Care

Information Brochure

20% of those who died by suicide visited their PCP within 24 hours prior to their death.

You could be the last medical professional seen by a patient on the brink of a life or death decision.

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SAMHSA-HRSA Center for Integrated Health Solutions

Making it Better, Together.

NATIONAL COUNCIL FOR COMMUNITY MENTAL HEALTH COUNSELORS

American Association of Suicidology

Northeastern University College of Nursing Research Institute

Achieving the Promise:
Transforming Mental Health Care in America

EXECUTIVE SUMMARY

National Alliance for the Mentally Ill (NAMI)

American Psychiatric Association (APA)

National Institute of Mental Health (NIMH)

National Institute on Drug Abuse (NIDA)

National Institute on Alcohol Abuse and Alcoholism (NIAAA)

The President's New Freedom Commission on Mental Health
- Launched January 2013
- An online, interactive simulation
- Provides 1.50 CME & CNE
- Learn to screen and manage the treatment of patients with trauma-related mental health disorders
- Users engage in simulated conversations with virtual patient avatars

Developed by NYC Dept. of Health in collaboration with Kognito Interactive. Freely available to all NYC primary care providers.

View Demo: [www.kognito.com/pcp](http://www.kognito.com/pcp)
Risk Factors/Roles for Primary Care

Salient Risk Factors

• Depression
• Substance use disorders
• PTSD/anxiety disorders
• Chronic pain
• Physical illnesses, especially CNS disorders (TBI)

Roles

• Detection and treatment/referral
• Screening for suicide risk when indicated
• Surveillance for warning signs of suicide
Contact with Primary Care and Mental Health Prior to Suicide

<table>
<thead>
<tr>
<th>All Ages</th>
<th>Month Prior</th>
<th>Year Prior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>19%</td>
<td>32%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>45% (up to 76%)</td>
<td>77% (up to 90%)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Age &lt;36</th>
<th>Month Prior</th>
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<tbody>
<tr>
<td>Mental Health</td>
<td>15%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>23%</td>
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</table>

<table>
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<tr>
<th>Age &gt;54</th>
<th>Month Prior</th>
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<tbody>
<tr>
<td>Mental Health</td>
<td>11%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>58%</td>
</tr>
</tbody>
</table>

Primary Care in Rural

- More than 65% of rural Americans get their mental health care from their primary care provider
- Primary care providers are central to mental health delivery system in rural
- Why?
  - May be the only providers there
  - Less stigma in seeking care in a doctor’s office
  - May not self-identify with mental health symptoms but seeking care for physical symptoms with underlying mental health issues
Military/Veterans and Suicide: A population that may be at risk

• “Many young veterans come home from war and begin abusing drugs or alcohol, hoping to numb their feelings or feel alive again after coming down from the adrenaline rush of combat. They often have trouble reintegrating with their families and the civilian world, especially if they leave the service with its camaraderie and steady paycheck.” The San Diego Union-Tribune 2013

• “…physicians should be prepared to ask questions and screen these patients for depression and anxiety…These are illnesses or symptoms that are not always that apparent on the surface…It is not only important to have the opportunity to talk with veterans or patients on active duty, but also have an opportunity to talk with their families.” AMA President Jeremy Lazarus, JAMA 2013

• Recommend at well visits or intake asking about:
  ✓ Veteran status (ask everyone!)
  ✓ Injuries including head trauma
  ✓ Relationships
  ✓ Depression and Anxiety
Suicide and Special Populations

For Facts, Statistics, and Information on these special populations:
• African American
• Hispanic
• Elderly
• Youth
• LGBTQ
• Military and Veterans

*Please see the links below*
http://www.suicidology.org/resources/suicide-fact-sheets
http://deploymentpsych.org/topics-disorders/suicide
http://www.realwarriors.net/
http://www.thetrevorproject.org/
Why Primary Care?

Percentage of U.S. retail psychotropic prescriptions written from August 2006 to July 2007, by type of provider.

- Psychiatrists and addiction specialists: 13% (Total: 59%)
- General practitioners, obstetrician-gynecologists, and pediatricians: 6% (Total: 66%)
- Physician assistants and nurse practitioners: 8% (Total: 49%)
- All other specialties and psychologists: 9% (Total: 34%)


Ns represent prescriptions in thousands

1 month

*Up to 76% of Americans who die by suicide had contact with their primary care provider in the month prior to their death.

The Toolkit is available in 2 forms

• Hard copy (ordered through WICHE)

Includes 6 sections

• Getting Started
• Educating Clinicians and Office Staff
• Developing Mental Health Partnerships
• Patient Management Tools
• State Resources, Policy, and Billing
• Patient Education Tools/Other Resources
How to Get a Copy of the Toolkit


To order a Hard Copy: Hard copies of the toolkit are available for $25.00 through WICHE Mental Health Program. For more information, please contact Tamara DeHay at [tdehay@wiche.edu](mailto:tdehay@wiche.edu) (preferred option) or 303-541-0254
Using the Toolkit

• Quick Start Guide
• Office Protocol Development Guide
  *Office Practice Approach
  *Select materials that can be implemented in current practice
  *Determine roles for members of staff/care team
• Primary Care Suicide Prevention Model
Getting Started

QUICK START GUIDE

How to use the Suicide Prevention Toolkit

STEP 1: Communicate with staff about the new Suicide Prevention Initiative in your office. Determine who will be the lead coordinator in your office. That individual should familiarize himself/herself with the entire contents of the Toolkit.


STEP 3: Schedule necessary trainings for staff members according to the individual suicide prevention responsibilities determined in Step 2.

STEP 4: Develop a referral network to facilitate the collaborative care of suicidal patients. Use the “Developing Mental Health Referral Guidelines” material in...
Protocol for Suicidal Patients - Office Template
Post in a visible or accessible place for key office staff.

If a patient presents with suicidal ideation or suicidal ideation is suspected...

✓ ____________________________ should be called/paged to assist with evaluation of risk (e.g., physician, mental health professional, telemedicine consult etc.).

✓ Identify and call emergency support person in the community (e.g., family member, pastor, mental health provider, other support person).

If a patient requires hospitalization...

✓ Our nearest Emergency Department or psychiatric emergency center is ____________________________. Phone # ____________________________.

✓ ____________________________ will call ____________________________ to arrange transport.
   (Name of individual or job title) (Means of transport [ambulance, police, etc] and phone #)
   Backup transportation plan: Call ____________________________.

✓ ____________________________ will wait with patient for transport.
   ____________________________ will call ED to provide patient information.

   ____________________________ will document incident in ____________________________.
   (Name of individual or job title) (e.g. medical chart, suicide tracking chart, etc.)

✓ Necessary forms are located ____________________________.

✓ ____________________________ will follow-up with ED to determine disposition of patient.
   (Name of individual or job title)

✓ ____________________________ will follow up with patient within ____________________________.
   (Name of individual or job title) (Time frame)
Primary Care Suicide Prevention Practice Model

**Preparation Phase**
1. Develop office policies and protocols
2. Staff Education
   - All staff: warning signs, risk factors, protective factors, response
   - Clinicians – suicide risk assessment; depression screening and tx
3. Strengthen communication with mental health partners

**Prevention Practices**
1. Staff vigilance for warning signs & key risk factors
2. Depression screening for adults and adolescents
3. Patient education:
   - Safe firearm storage
   - Suicide warning signs & 1-800-273-TALK (8255)

**Intervention**
- Warning signs, major depression, anxiety, substance use disorder, insomnia, chronic pain, PTSD, TBI
  - No 
    - No screening necessary
  - Yes 
    - Questions to screen for suicidal thoughts
      - No 
        - Rescreen periodically
      - Yes 
        - Suicide Risk Assessment
          - Risk Management: referral, treatment initiation, safety planning, crisis support planning, documentation, tracking and follow up
Educating Clinicians and Office Staff

• A Primer for Primary Care Providers
  – 5 brief learning modules
    • Module 1- Prevalence & Comorbidity
    • Module 2- Epidemiology
    • Module 3- Prevention Practices
    • Module 4- Suicide Risk Assessment
      – Warning Signs, Risk Factors, Suicide Inquiry, Protective Factors
    • Module 5- Intervention
      – Referral, PCP Intervention, Documentation & Follow-up
Developing Mental Health Partnerships

- Mental Health Outreach Letter
  - Template letter for reaching out to mental health providers for collaboration

- SAFE-T Pocket Card
  - Designed by SPRC to be used by mental health experts
  - May be included with letter
Developing Mental Health Partners

Letter of introduction to potential referral resources template

• Increasing vigilance for patients at risk for suicide
• Referring more patients
• SAFE-T card for Mental Health Providers
• Invitation to meet to discuss collaborative management of patients
• NSSP recommends training for health care professionals
• Nationally disseminated trainings for MHPs
Patient Management Tools

• Pocket Guide for Primary Care Professionals
  – Designed for PCP’s specifically
• Safety Planning Guide
  – Used to guide the development of a safety plan
• Safety Plan Template for use with/by a potentially suicidal patient
• Crisis Support Plan for use with/by the family members/friends of potentially suicidal patients
• Patient Tracking Log for at-risk patients
### Suicide Risk and Protective Factors

<table>
<thead>
<tr>
<th>RISK FACTORS</th>
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<tbody>
<tr>
<td>Current/past psychiatric disorders: especially mood disorders, psychotic disorders, alcohol/substance abuse, TBI, PTSD, personality disorders (such as Borderline PD, Antisocial PD, and Obsessive-Compulsive PD).</td>
</tr>
<tr>
<td>Co-morbidity with other psychiatric and/or substance abuse disorders and recent onset of illness increase risk.</td>
</tr>
<tr>
<td>Key symptoms: anhedonia, impulsivity, hopelessness, anxiety/panic, insomnia, command hallucinations, intoxication. For children and adolescents: also oppositionality and conduct problems.</td>
</tr>
<tr>
<td>Suicidal behavior: history of prior suicide attempts, aborted suicide attempts or self-injurious behavior.</td>
</tr>
<tr>
<td>Family history: of suicide, attempts, or psychiatric diagnoses, especially those requiring hospitalization.</td>
</tr>
<tr>
<td>Precipitants/stressors: triggering events leading to humiliation, shame or despair (i.e., loss of relationship, financial, or health status – real or anticipated).</td>
</tr>
<tr>
<td>Chronic medical illness (esp. CNS disorders, pain).</td>
</tr>
<tr>
<td>History of or current abuse or neglect.</td>
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<table>
<thead>
<tr>
<th>PROTECTIVE FACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protective factors, even if present, may not counteract significant acute risk.</td>
</tr>
<tr>
<td>Internal: ability to cope with stress, religious beliefs, frustration tolerance.</td>
</tr>
<tr>
<td>External: responsibility to children or beloved pets, positive therapeutic relationships, social supports.</td>
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</tbody>
</table>
Patient Management Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

A Pocket Guide for Primary Care Professionals

Screening: uncovering suicidality
- Other people with similar problems sometimes lose hope; have you?
- With this much stress, have you thought of hurting yourself?
- Have you ever thought about killing yourself?
- Have you ever tried to kill yourself or attempted suicide?

Assess suicide ideation and plans
- Assess suicidal ideation – frequency, duration, and intensity
  - When did you begin having suicidal thoughts?
  - Did any event (stressor) precipitate the suicidal thoughts?
  - How often do you have thoughts of suicide?
  - How long do they last?
  - How strong are the thoughts of suicide?
  - What is the worst they have ever been?
  - What do you do when you have suicidal thoughts?
  - What did you do when they were the strongest ever?
- Assess suicide plans
  - Do you have a plan or have you been planning to end your life? If so, how would you do it? Where would you do it?
  - Do you have the (drugs, gun, rope) that you would use? Where is it right now?
  - Do you have a timeline in mind for ending your life? Is there something (an event) that would trigger the plan?

Assess suicide intent
- What would it accomplish if you were to end your life?
- Do you feel as if you’re a burden to others?
- How confident are you that your plan would actually end your life?
- What have you done to begin to carry out the plan? For instance, have you rehearsed what you would do (e.g., held pills or gun, tied the rope)?
- Have you made other preparations (e.g., updated life insurance, made arrangements for pets)?
- What makes you feel better (e.g., contact with family, use of substances)?
- What makes you feel worse (e.g., being alone, thinking about a situation)?
- How likely do you think you are to carry out your plan?
- What stops you from killing yourself?

Endnotes:
1 SAFE-T pocket card. Suicide Prevention Resource Center & Mental Health Screening. (n/d).
Assessment and Interventions with Potentially Suicidal Patients

Patient Management Pocket Card

Assessment and Interventions with Potentially Suicidal Patients

High Risk
- Patient has suicidal ideation or any past attempt(s) within the past two months. See right for risk factors and back for assessment questions.

Moderate Risk
- Patient has suicidal ideation, but limited suicidal intent and no clear plan; may have had previous attempt.

Low Risk
- Patient has thoughts of death only; no plan or behavior

High Risk
- Patient has a suicide plan with preparatory or rehearsal behavior
  - Patient has severe psychiatric symptoms and/or acute precipitating event, access to lethal means, poor social support, impaired judgement
  - Hospitalize, or call 911 or local police if no hospital is available. If patient refuses hospitalization, consider involuntary commitment if state permits
  - Take action to thwart the plan
    - Consider (locally or via telemedicine):
      1) psychopharmacological treatment with psychiatric consultation
      2) alcohol/drug assessment and referral, and/or
      3) individual or family therapy referral

Moderate Risk
- Patient does not have access to lethal means, has good social support, intact judgment; psychiatric symptoms, if present, have been addressed
- Evaluate for psychiatric disorders, stressors, and additional risk factors
- Encourage social support, involving family members, close friends and other community resources. If patient has therapist, call him/her in presence of patient.

Low Risk
- Patient has thoughts of death only; no plan or behavior
- Record risk assessment, rationale, and treatment plan in patient record. Complete tracking log entry, and continue to monitor patient status via repeat interviews, follow-up contacts, and community resources. Make continued entries in tracking log.
Patient Management

• “Safety Plan”
  – Collaboratively developed with patient
  – Template that is filled out and posted
  – Includes lists of warning signs, coping strategies, distracting people/places, support network with phone numbers

• “Crisis Support Plan”
  – Provider collaborates with Pt and support person
  – Contract to help- includes reminders for ensuring a safe environment & contacting professionals when needed
Patient Management

Safety Planning Guide

A Quick Guide for Clinicians

may be used in conjunction with the “Safety Plan Template”

Safety Plan FAQs?

WHAT IS A SAFETY PLAN?
A Safety Plan is a prioritized written list of coping strategies and sources of support patients can use who have been deemed to be at high risk for suicide. Patients can use these strategies before or during a suicidal crisis. The plan is brief, in the patient’s own words, and is easy to read.

WHO SHOULD HAVE A SAFETY PLAN?
Any patient who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the patient on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?
Safety Planning is a clinical process. Listening to, empathizing with, and engaging the patient in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN
There are 6 Steps involved in the development of a Safety Plan.

SAMPLE SAFETY PLAN

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 distraction:

1. Name __________________ Phone __________________
2. Name __________________ Phone __________________
3. Name __________________ Phone __________________

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 __________________
2. Clinician Name __________________ Phone __________________
3. Clinician Name __________________ Phone __________________

Step 6: Making the environment safer:

1. 
2. 

The one thing that is most important to me and worth living for is: ____________________________
CRISIS SUPPORT PLAN

FOR: _______________________________ DATE: __________________

I understand that suicidal risk is to be taken very seriously. I want to help__________________________ find new ways of managing stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
  - ________________________________
  - ________________________________
- Help__________________________follow his/her Crisis Action Plan
- Ensure a safe environment:
  1. Remove all firearms & ammunition
  2. Remove or lock up:
     - knives, razors, & other sharp objects
     - prescriptions & over-the-counter drugs (including vitamins & aspirin)
     - alcohol, illegal drugs & related paraphernalia
  3. Make sure someone is available to provide personal support and monitor him/her at all times during a crisis and afterwards as needed.
  4. Pay attention to his/her stated method of suicide/self-injury and restrict
Patient Management

Tracking Log

- Log & Instruction sheet
- Provider uses:
  - Update PCP on suicide status of a patient
  - Remind provider of recent interventions or problems with regard to the patient’s treatment
Patient Education

Firearm Locking Devices

Suicide Warning Signs
Seek help as soon as possible by contacting a mental health professional or by calling the National Suicide Prevention Lifeline at 1-800-273-TALK if you or someone you know exhibits any of the following signs:

- Threatening to hurt or kill oneself or talking about wanting to hurt or kill oneself
- Looking for ways to kill oneself by seeking access to firearms, available pills, or other means
- Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person
- Feeling hopeless
- Feeling rage or uncontrolled anger or seeking revenge
- Acting reckless or engaging in risky activities—seemingly without thinking
- Feeling trapped—like there's no way out
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious, agitated, or unable to sleep or sleeping all the time
- Experiencing dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life
Suicide Prevention for Primary Care – Training & Data
Operationalize the Objectives

• Toolkit located in strategic location within the clinic
• Providers carry Pocket Card with them
• Use screening tools to identify at-risk patients
• Inquire about Suicide with all patients at-risk or demonstrating warning signs
• Utilize safety planning guide as an intervention strategy
Addressing the Realities of Suicide Prevention in Primary Care

Reimbursement

Time

Fear

Suicide Prevention for Rural Primary Care Practices
Trainings

• Trainings in 8 States + Guam (CO, TX, CA, ID, NM, AR, SD) and Webinars
• Flexible formats: 1 hour, 3-4 hours, 6 hours
• Total Trained = 463
• In person or via distance
• Audiences: Small rural clinics, FQHCs, Family Medicine Residency Programs, Rural Track Medical School Students, Physician’s Assistant Students, Behavioral Health Providers
Training Structure

• Pre-Test
• Modules in Toolkit
• Adapt to unique needs of practice/audience
• Ancillary Components: Joiner’s Model, Video, Case Vignettes, Suicide Assessment
• Post-Test
Survey Data

• Pre- and Post-Test Competencies Survey (Knowledge, Skills and Perceptions of Competence)  n = 283

• 17 multiple choice questions

• Survey questions in 3 areas of interest:
  • preparedness to screen for suicidal risk
  • knowledge of suicidal behavior
  • opinions about working with suicidal patients
Pre-test Practice Survey (past 3 months)

- 79% believed a patient’s behavior might indicate significant distress or depression
- 58% believed a patient’s behavior might indicate suicidality
- 55% had asked a patient whether s/he was considering suicide
- 20% had asked 6 or more patients whether s/he was considering suicide
Pre-test Practice Survey (past 3 months)

- 65% did not believe they had adequate knowledge of referral resource
- 44% referred at least one patient to mental health outpatient care due to a suicidal concern & 23% referred more than one
- 30% referred at least one patient for an immediate psychiatric evaluation due to a suicidal concern
Preparedness

• 40% more prepared after training

• Providers reported the most gain on performing a suicide risk assessment after training

• The increase in feeling prepared is statistically significant

• Meaningful gain with a medium effect size
Knowledge

• Increased from 68% to 79% of correct responses

• The increase in knowledge of 11% is statistically significant

• Meaningful gain with a small/medium effect size
Opinions

• Providers leaned toward the positive end of the scale at pre-test

• Prior to training respondents were least positive about having sufficient training and showed the most change with a 33% increase

• 20% gain in positive opinions is statistically significant

• The gain is meaningful with a small to medium effect size
Ideas for Next Development Stage

• Web-based Training
• Self-Guided Train the Trainer Manual
• Video – Role Plays in Primary Care Settings
• Ancillary materials for suicide prevention coalitions, state offices of primary care, public health, etc.
Suicide Identification and Prevention in a Community Health Setting

Virna Little, PsyD, LCSW-r, SAP
The Institute for Family Health
The Institute for Family Health

- Largest health center network in New York - all FQHC
- Health care services: medical, dental, and mental health
  - Special Populations
- Education and training programs
- Community outreach and advocacy
- Health information technology
Our Patients

- Diverse economic and social backgrounds
- Latino, African-American, Caribbean-American, or recent immigrants

Roughly 85,000 patients make about 400,000 visits per year
Our Service Area

- 18 full time and 8 part time centers
- Manhattan and the Bronx in New York City
- Mid Hudson Valley
Why ………

Research on patients who touched primary care and had completed suicide

Several patients who completed suicide in 2010

Desire to train family practice residents

Organizational interest in addressing public health issues

Organizational interest in using technology to advance public and patient health
Interventions

Mandatory training for ALL agency staff
Provided free for our staff through community training initiatives

- safeTALK – 3 hour suicide alertness training for all non-clinical staff including front desk staff, administration, nursing, facilities
- ASIST – 16 hour suicide first aid intervention training for all clinical staff
- Improve comfort, knowledge and skill level of staff to identify and address patients at risk
Training

safeTALK – “Suicide Alertness for Everyone”
- Teach staff how to move beyond tendency to miss, dismiss or avoid suicide risk signs
- Apply “TALK” steps to connect persons with thoughts of suicide to first aid resources

ASIST – “Applied Suicide Intervention Skills Training”
- Teach professional mental health staff to provide suicide first aid interventions
- 2 day intensive training
- Role play heavy
Technology

Electronic health record implementation in 2003
EPIC electronic health record system
Decided to use technology to help in identification and prevention of suicide in primary care patients throughout system
PHQ9 Tool

Used consistently throughout health centers
Speak the same language
Attention to question 9

Please complete a PHQ-9 for this patient. Patient has a diagnosis of depression or patient's last PHQ-9 was abnormal, and patient has not had a PHQ-9 completed in the past 30 days.

Complete PHQ-9
<table>
<thead>
<tr>
<th></th>
<th>PHQ-9: Over the past two weeks, how often have you been bothered by the following...?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Little interest or pleasure doing things</td>
</tr>
<tr>
<td></td>
<td>0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day</td>
</tr>
<tr>
<td></td>
<td>Last Filed Value: <strong>No data filed</strong></td>
</tr>
<tr>
<td>2.</td>
<td>Feeling down, depressed, or hopeless</td>
</tr>
<tr>
<td></td>
<td>0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day</td>
</tr>
<tr>
<td></td>
<td>Last Filed Value: <strong>No data filed</strong></td>
</tr>
<tr>
<td>3.</td>
<td>Trouble falling or staying asleep, or sleeping too much</td>
</tr>
<tr>
<td></td>
<td>0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day</td>
</tr>
<tr>
<td></td>
<td>Last Filed Value: <strong>No data filed</strong></td>
</tr>
<tr>
<td>4.</td>
<td>Feeling tired or having little energy</td>
</tr>
<tr>
<td></td>
<td>0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day</td>
</tr>
<tr>
<td></td>
<td>Last Filed Value: <strong>No data filed</strong></td>
</tr>
<tr>
<td>5.</td>
<td>Poor appetite or overeating</td>
</tr>
<tr>
<td></td>
<td>0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day</td>
</tr>
<tr>
<td></td>
<td>Last Filed Value: <strong>No data filed</strong></td>
</tr>
<tr>
<td>6.</td>
<td>Feeling bad about yourself- or that you are a failure or have let yourself or your</td>
</tr>
<tr>
<td></td>
<td>family down</td>
</tr>
<tr>
<td></td>
<td>0 = Not at all 1 = Several days 2 = More than half the days 3 = Nearly every day</td>
</tr>
<tr>
<td></td>
<td>2 = More than half the days</td>
</tr>
<tr>
<td></td>
<td>Last Filed Value: <strong>No data filed</strong></td>
</tr>
<tr>
<td>7.</td>
<td>Trouble concentrating on things such as reading</td>
</tr>
<tr>
<td></td>
<td>2 = More than half the days</td>
</tr>
<tr>
<td></td>
<td>Last Filed Value: <strong>No data filed</strong></td>
</tr>
</tbody>
</table>
Suicide on the Problem List

“Blows” into all encounters

Readily seen by providers of all disciplines

Able to be reported on (number of patients)
# Zz Test, George

**Demographics**
- **Age:** 69 year old
- **Sex:** M
- **DOB:** 1/2/1944
- **MRN:** 1307981
- **Allergies:** Penicillin V Potassium
- **Language:** Greek
- **PCP:** DHALA, MINAKSHI
- **Insurance:** Medicaid NY
- **Other Patient Care Team Members:**
  - General
  - Relationship

**Problem List**
- **Suicidal ideation**
- **Diabetes Mellitus Type II Uncontr Uncompl**
- **HIV disease**

**Health Maintenance**
- **Flu Shot:** 9/13/2013

**Reminders and Results**
- None

**Care Team and Communications**
- None
- Recipients of Past Communications

**Significant History/Details**
- Smoking: Passive Smoker
- Smokeless Tobacco: Unknown
- Alcohol: Not Asked
- Language: Greek
- 1 open order

**Specialty Comments**
- None
Decision Support

Reminder to providers

Allows quick access to needed tools or resources

Can be “hard stop”

Ability to report on providers who “ignore” decision supports
Patient expresses suicidal ideation as indicated by most recent PHQ-9 or problem list diagnosis. Please open smartset and assess patient's ideation.

- Acknowledge reason: [Input field]
- Refused

- Open SmartSet: SUICIDE ASSESSMENT preview
- Problem List
“FYI” and “Flagging”

Patient Highlights

Patient has an FYI of type All Clinical - Need to Know

Patient is suicidal. Patient must be evaluated at every visit.
Safety Planning - An interdisciplinary collaborative effort using the electronic record

My Safety Plan document

- Allows safety plan information to be available to all providers during all visits for review and/or modification
- Patients can access the document via patient portal for reference
- Community providers can see patients at risk through physician portals
- Provided in print to patients as part of after visit summary
- Signed by patient and provider
Safety Planning

Unprioritized

- Inability to set boundaries with family members
  - Overview: A patient reports stress caused by inability to say "no" as 5 on a scale from 1 to 5
  - Short term Goals: A patient to create a list...

- Substance abuse
  - Overview: Patient reports smoking cigarettes and using marijuana that has affected social functioning as well
  - Baseline Symptoms/Behavior: A patient

- Lack of Heat and Hot Water
  - Overview: Goal: Patient will have heat and hot water in his current apartment
  - Objective 1: Patient will call landlord to discuss ddtd

- Depression

Suicidal ideation

- Details: Code: V62.84 Noted: 3/21/2013
- Change Dx
- Resolve

Safety Plan

Ps Suicide Severity

Related Goals

Search for new item Add

None for this problem

Relevant Medications and Unsigned Orders (Past 5 years)

Search for new order New Order

None

Click here to select a pharmacy

Mark as Reviewed Never Reviewed

Close F9

www.integration.samhsa.gov
What is a Patient Portal?

A patient portal is a healthcare related online application that allows patients to interact with their healthcare providers.
Welcome to...
MyChart MyHealth

- Communicate with your doctor
- Access your test results
- Request prescription renewals
- View your recent clinic visits

NUEVO Mi Record Mi Salud En Español!

Your secure, online health connection

Your health is important to you around the clock—
Physician/Community Portals

- Hospital Emergency Departments
- Community Specialists
- Substance Abuse Programs
- Developmental & Mental Health Residential Programs
- Day Treatment Organizations
- Foster Care Agencies
- Skilled Nursing Facilities
- Health Home Agencies
- Food Pantries
Patient Snap Shot

Patient Care Coordination Note

Lurio, Joseph Thu Feb 2, 2012 3:47 PM

Mr ZZTest is scheduled to see HIV specialist Monday Feb 6 at 9AM and then report to DSS for face to face that afternoon at 1:30 PM

Ambulette arranged by worker to pick patient up at home at 7:30 am.

Demographics

Adam ZZtest
58 year old male

16 e 18th
NEW YORK NY 10003
212-206-5223 (H)
347-123-4567 (M)

Comm Pref.

Allergies

No Active Allergies
Last Reviewed by ZZtest, Md on 1/19/2011 at 12.00 PM

Medications

- Zolpidem Tartrate 10 MG OR TABS
- PLAN B 0.75 MG OR TABS
- DIOVAN 160 MG OR TABS
- CHLORTHALIDONE 25 MG OR TABS
- IBU 600 MG OR TABS
- CARIMUNE NF 6 GM IV SOLR
- CLOZARIL 25 MG OR TABS
- CLOZARIL 25 MG OR TABS
- LIPITOR 20 MG OR TABS
- TAMIFLU 75 MG OR CAPS
- METFORMIN HCL 500 MG OR TABS
- LIPITOR 10 MG OR TABS
- DEXTROSE 5% IV SOLN
- LIPITOR 40 MG OR TABS
- ASPIRIN 325 MG OR TBEC
How to Ask a Question

If you dialed in to this webinar on your phone please use the “raise your hand” button and we will open up your lines for you to ask your question to the group. (left)

If you are listening to this webinar from your computer speakers, please type your questions into the question box and we will address your questions. (right)
Thank you for joining us today.

Please take a moment to provide your feedback by completing the survey at the end of today’s webinar.
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