

TRANSCRIPT OF AUDIO FILE:

THE PRIMARY CARE PROVIDER'S ROLE IN PREVENTING SUICIDE - 8-24-15

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BEGIN TRANSCRIPT:

MODERATOR: Hello everyone and welcome to the SAMHA-HRSA Center for Integrated Health Solutions webcast titled, “The Primary Care Provider’s Role in Preventing Suicide.” My name is Brie Reimann and I’m the Deputy Director for CIHS and your moderator for today’s webinar.

As you may know, the SAMH-HRSA Center for Integrated Health Solutions promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions whether seen in specialty behavioral health or primary care provider settings. In addition to national webinars designed to help providers integrate care, the center is continuously posting practical tools and resources to the CIH website providing direct phone consultation to providers and stakeholder groups and directly working with SAMHSA primary and behavioral healthcare and integration grantees and HRSA funded health centers. [00:59:00]

Before we get started – a couple of housekeeping items: to download the presentation slides, please click the dropdown menu labeled “Event Resources” on the bottom left of your screen. Slides are also available on the CIHS National Council website under the “About Us” Webinar section. During today’s presentation your slides will be automatically synchronized with the audio so you will not need to flip any slides to follow along. You will listen to audio through your computer speakers so please ensure that they are on and that the volume is up. You may submit questions to the speakers at any time during the presentation by typing a question in the “Ask a Question” box in the lower left portion of your player. Please note that we’ll take all questions at the end, but feel free to type them in as we go along.

Finally, if you need technical assistance, please click on the question mark button in the upper right corner of your player to see a list of frequently asked questions and contact info, if you need technical support. [00:02:00]

So again, my name is Brie Reimann, I’m glad to be here with you all today. We have a great presentation put together for you and our purpose for today’s conversation is to talk about a

practical approach to implementing suicide prevention in integrated care settings and also within behavioral health and primary care settings. So we're going to try and talk about a comprehensive approach to addressing suicide prevention. And you will have noted from the marketing of this webinar that we're really looking to go beyond just the 101 of suicide prevention. We really want to dive a little bit deeper into a practical approach and also hear about what that looks like on the ground.

So we have two presenters with us today. We're going to start out with Julie Goldstein Grumet who is the Director of Prevention and Practice for the Suicide Prevention Resource Center and then we'll hear from Virna Little who is the Senior Vice President of Psychosocial Services and Community Affairs at the Institute of Family Health. So now I'm going to go ahead and turn it over to our first presenter, Dr. Grumet, who will talk with us more about the Zero Suicide Approach. Julie? [00:03:10]

PRESENTER 1: Thank you, Brie. It's really a pleasure to be here. I've had some chances to work with the national council and attend your wonderful conference and have just met some really incredible people and seen the wonderful work that you're doing. So thank you so much for having me.

So the Suicide Prevention Resource Center provides the oversight to the Zero Suicide Initiative and it provides technical assistance to organizations watching this approach. We have a lot of resources available, both on our Zero Suicide website, zerosuicide.com, as well as on our SPRC website which is sprc.org. [00:03:48]

We have a lot of training courses and just general resources for healthcare practitioners so I encourage you to take a look. So first we're going to stop for a poll question. (Pause) So our first poll question is, "where are you implementing Zero Suicide?" [00:04:13]

I am not yet familiar with this approach. We have reviewed materials and are considering our first steps and we have taken, or we have taken the organizational self-study and developed a work plan. (Pause)

MODERATOR: Okay. We'll give everybody just a couple of moments to answer this poll question.

(Pause): [00:04:35 - 00:04:54]

MODERATOR: Great. Okay, so it looks like about 76% said that they were not yet familiar with this approach; 18% said that they reviewed the material and are considering their first steps; and about 5% said that they are taking the organizational self-study and developed a work plan.

PRESENTER 1: Great. Thank you. Well, that's exciting. I want to congratulate the 5% of you that have gone ahead and started to use these materials. And we definitely look forward to hearing your feedback. And I'm thrilled to know that some of you are really considering adopting this approach and again, we would like to support you in your work, look forward to feedback, resources that you might note are missing on the website that would help you to do this work and really encourage

you through today's webinar and perusing the website to consider adopting it, and the same with the remainder of you. Hopefully, we had encouraged you to take a look at the Archive webinar of what is Zero Suicide as we're not providing an in-depth overview on that today. So if you haven't already done so, all of our previous webinars have been archived on our Zero Suicide website including sort of an introductory webinar last August. So I really encourage you to take a look, take a look through our website. It has a very extensive toolkit. I'll tell you more about that in a moment. But it really helps you to walk through implementing this approach. [00:06:23]

So just to – why did we propose this approach? What is Zero Suicide about? Well, we know that many suicides take place in and around healthcare. About 40-50% of death have been within a month of a primary care visit. So people who are dying by suicide have been seen by their primary care providers. Approximately 15-20% of suicide deaths annually are among people receiving care in the mental health system. And about 10% of suicide deaths are among people who had visited the emergency department in the past two months. So they are seen in the healthcare system which means we need to improve our practices for better identification and treatment of those who come in seeking care. [00:07:06] (Pause)

Several states have already begun to look at where suicide deaths in their system occurred. It looks like about 15-20% of suicide deaths have been seen in the public mental health system in the year or two prior to their death. And this is probably an under-reporting. We know that incident reports don't always get done. There's inaccurate coding by the medical examiner. I'm sure where you've heard stories where the medical examiner is trying to spare the family pain and therefore doesn't record the death as a suicide, when in fact, we need to know about what our statistics are in order to really acknowledge the problem that exists and to make changes.

But regardless, it is obvious that often people are coming into contact with the public mental health system and/or are seen by their primary care physician in the time leading up to their death and therefore, we really are responsible to do more to recognize and respond to their needs. [00:08:00]

The Zero Suicide builds on the awareness that system-wide approaches have worked. The systems who have employed this comprehensive approach have found reductions in their rates of suicides for those in their care by as much as 70-75%. So when all of the components of Zero Suicide are employed people don't die by suicide at the same rate. And in fact, in some of these systems, their rates of suicide even for people with chronic mental illness are dropped down to what just the general population is, sort of 13 per 100,000. So that's incredibly significant given that statistics suggest that people who are struggling with serious and persistent mental illness sometimes have as much as a 20-times higher risk of suicide by comparison to those who do not have serious and persistent mental illness. So we really know that a comprehensive approach to care where our foot is consistently on the gas, can work.

The Zero Suicide initiative provides the framework and strategies for evidence-based and best practices in identifying and treating people at risk for suicide as well as what we would consider an organizational philosophy, meaning that we should strive to do better for people who come to us for care. I've heard people suggest that the name "Zero Suicide" is difficult. It's really aspirational. It's not a social marketing campaign. It's an organizational philosophy because there isn't a better number. [00:09:21]

We should strive for zero with the understanding that we will have to constantly review and improve our care. But it is a core responsibility of healthcare. And so questions to ask yourself include do we know what the rates of suicide are in our own population? For those who have been to see us even as much as six months ago. Or do we have special practices in place for our clients who we know are at risk for suicide? And something if you are considering adoption of this approach is how might you attach a Zero Suicide approach to your other successful and existing initiatives like trauma-informed care. So thinking about where this might fit in in a system that's already considering comprehensive approaches within other areas. [00:10:04]

This is the framework for providing systematic clinical suicide prevention and care. I know there's a lot going on in this diagram. But essentially you must have the leadership commitment to safety, accountability and transparency in an entire workforce, not just a clinical care team. That's competent, confident and caring. You also have to provide ways to systematically identify and assess for suicide risk, provide care that directly targets and treats that suicidality, not as other conditions like depression and anxiety and hope that the suicide goes away, but directly target the suicidality using effective evidence-based treatments. And then especially working with the patients during times of acute care transitions – post emergency department discharge, or psychiatric hospital discharge. And then all of this has to be wrapped up in a data review with ongoing quality improvements determined where changes can be made. [00:11:00]

This is our website. This is the landing page of our website. The green box on the top left is what we call our toolkit. It goes very in-depth through implementation resources and tools, walking you through each of the components I very briefly said a moment ago. The button on the left that says “get involved”, the greenish-blue button is the way to join our very active list served. People post questions about how to get started or things they're struggling with and we have hundreds of members on that list served that are very eager to share in your questions and help you consider better ways to do this care.

This is our Quick Guide to Getting Started. I know it's hard to see here, but I know the slides are available after today's presentation. Also the Quick Guide's available on our website. It really walks through the different steps and tools that you should utilize if you should adopt this approach. Some of you have already taken the organizational self-study that's available on the website. It's a great barometer of your current practices and it helps you sort of determine your strengths and your gaps in how to do comprehensive care along all of the different dimensions I just mentioned before and it goes into considerable depth across all of these dimensions from what kind of care we often are providing all the way up to best practices. [00:12:17]

We really encourage after you take that to create a work plan, think about what you might want to accomplish just in the next 90 days. And you may have to modify your electronic health record in order to collect data to determine how your care is progressing. And finally, the most important thing that I think I want you to think about as you're considering adoption of this approach is that it's really, it's a marathon. It's not a sprint. We've had many a site tell us that they're constantly reviewing and updating and developing new processes, materials to improve their care and therefore they're never really done. They don't see their approach to suicide care as sort of this year's thing of initiative. And then we move on to substance abuse and next year, trauma informed

care the year after. Suicide care becomes something that's embedded in the culture of your organization to providing effective quality care and then it really truly has the potential to save lives.

So I encourage you to take a look at our website, participate in the list serve and some webinars that the Suicide Prevention Resource Center has available. So I thank you so much for taking the time to think more about how you might get started in this approach. [00:13:26]

MODERATOR: Thank you so much, Julie. That really sets the stage for our next presenter, Dr. Virna Little, who will talk to us about really the practical approach to implementation around Zero Suicide.

PRESENTER 2: So before we move on we'll go on to our next poll question. "What do you see as obstacles to implementing Zero Suicide?"

(Pause): [00:13:54 - 00:14:04]

MODERATOR: And so we have choices, leadership, staff preparedness and comfort, EHR, screening for suicide, competing priorities, or referral resources. I'll give everyone just a moment to respond.

(Pause): [00:14:18 - 00:14:32]

MODERATOR: Okay, it looks like about 25% said staff preparedness and comfort; about 25% said no EHR, and then competing priorities, and the remaining 25% said none of the above. (Pause) Thank you, Rose. Virna?

PRESENTER 2: Good afternoon, everyone. Thank you so much for taking time out of your day and thank you, Julie. You always do a wonderful job and I really appreciate the passion that you come to this work with. You're a hard act to follow. So I want to take a couple of minutes and talk to everyone about primary care settings in particular and I think, you know, as we go forward and Julie talked about Zero Suicide really focuses on healthcare and makes this a primary responsibility for healthcare providers. And a lot of times people ask, and particularly those in primary care settings ask me 'why primary care?' And so we talked a little bit about what the research shows. [00:15:49]

And what the research shows is that, you know, it's critical for primary care to ask that. Many people are connected to primary care who are not connected to the mental health system. And that's actually what our data shows here at the institute. We're a fairly large institution and where we look we see that many of the folks that have completed a suicide were actually known to our primary care providers and not to our licensed mental health centers. And that information was actually key to getting our primary care providers invested in doing this work. Also we talk a lot about new models of care. We talk about transforming the system. We talk about moving to preventative care. We talk about taking accountability and ACOs for the populations that we care for. And this work goes along with all of those efforts. [00:16:43]

When you think about all of the work that's being done around caring for populations and in transformation care projects, you can actually partner the Zero Suicide work with that work in your organization and it helps to not only move this work forward but to help support a lot of those efforts.

The other reason for involving primary care is technology and the move with electronic health records and really using those systems to leverage the work that you do. And we've been really working very hard with the vendors and the electronic health record systems and with primary care organizations, and many of them are now thinking about or actually embedding some of the work that we've done around suicide identification and prevention in their systems. Most of them have the PHQ9 built in now. Many of them are thinking about the Columbia Scale or thinking about some kind of change to help alert providers when a patient might be at risk for suicide. And so using the electronic health records and the development happening in primary care around electronic health records and technology can actually be critical in helping move this work along and can help move Zero Suicide efforts forward. [00:18:07]

Also thinking about why primary care, again, its depression screening has now become an expectation in primary care. It's required for federally qualified health centers and reported as part of their UDS. Again, most electronic records have it built into the system. There's a lot of initiatives around primary care looking at depression care and looking at reimbursement models for screening for depression and for identifying people who might be at risk. There's a lot of primary care initiatives that really go and support this work and can go hand in hand with doing Zero Suicide and suicide identification and prevention work. When we think about healthcare providers who are joint commissioned and it's a national patient safety goal and can actually be part of your joint commission work where you can use this joint commission preparation and certification as a catapult to help move some of this work forward. [00:19:15]

When you think about the NCQA or patient centered medical home projects and the work that a lot of primary care organizations are doing, this work fits in with all of those initiatives thinking about caring for patients as a team, thinking about identifying populations at risk and also part of that work is to stratify a population at risk which can actually be done with this population in patients who are at high risk or low risk for suicide.

Thinking about working in teams, thinking about sharing care plans. One of the most helpful ways that we found to bring a team together is to talk about a patient at risk for suicide and then develop a shared care plan. Those shared care plans are a huge goal for all of these initiatives and it's a good place to start doing shared care plan work is around patients who might be at risk for suicide. That's actually a place that a lot of organizations start doing shared care plans and so that might be something to think about because it helps both that initiative and then also helps support your Zero Suicide work in your organization. [00:20:28]

Thinking about what's happening in health care and thinking about using technology, really using the patient portals and leveraging patient portals to help support patients who are at risk and help support providers. So one of the things that we've done is really work with the portals so that patients can contact providers with information. They can access safety plans. They can communicate with providers. We can provide them with educational information and so a lot of

healthcare organizations are developing the patient portals and this is a really important way to try to communicate with patients to advance the Zero Suicide work and also gives us another way to build this work into primary care and what's happening in primary care settings.

So thinking again about the portals, many organizations, healthcare organizations have built the PHQ into the portals and allowing patients to fill out information electronically may before a visit or in between visits, and then identifying someone who might be at risk and someone who we may not have contact with in between visits that we now can reach out to or can reach out to us. So as primary care is developing the portals there are ways that you can support the Zero Suicide work as you go forward in doing that. [00:22:01]

So what I'd like to do is to take a moment and turn the presentation over to two women who have joined us today. I'll allow them to introduce themselves but what I'd like to do is to be able to really communicate out to people how important it is, particularly to the primary care providers, to be able to think about what they're doing internally for patients who are at risk for suicide and really trying to leverage technology and all of these other initiatives to be able to do this work. And I always try to tell organizations and providers, this work is not in addition to the other work you're doing or instead of the other work you're doing, it supports all of the work that you're doing and if someone is at risk then that is the most important thing going on for that person on that day and we need to rally the team around caring for them. And so I'd like to turn it over, I'm going to allow them to introduce themselves. [00:23:08]

My name is Yvonne Amador, a 58-year old Latino woman who suffers from mental illness and has a history of suicide attempts. Luckily, I had a teacher, a guidance counselor, a doctor who took time to listen, to hear and notice and seek help for me. Now, it is a struggle to live, no longer a struggle to die.

(Pause): [00:23:40 - 00:23:47]

PRESENTER 3: This poem is dedicated to Linda. This is my work. This is your homework.

Emotionally caring and remembered long after that night, unleashing an evil and facing the twisted truth I whorled like spin art encased the crazy circle and absolute darkness, a kaleidoscope only a silhouette that broke a sweat, exploding a panic beneath the surface. Undertows of dress rehearsals indicating light.

Unyielding, I fought it running out of oxygen by power of reasoning drowns in tears of fright as my body collapses. I couldn't have imagined that silent unknown where roses bloom in gardens of anxiety, feeling broken, confused, falling to pieces, splintering my very self.

These mirror images melt my thoughts together and ebb my tsunami adrenalin, piercing a whitewash of stardust (unclear) sediment lodged in my head which held together my losses and setbacks to still be a part of me and staying alone in my thoughts I felt the stab of heartache, a reality to share with no one. The snow falling in my mind is a restraining order for my thoughts that makes me feel different inside, stopping my whorls from colliding but yet remaining separate.

Still trying to push past this mental anguish my eyes are troubled and my heart is pounding, I became driven by instinct as my merry go distant becoming meaningless on the edge and destructive, angry, not feeling anything. These grainy images became a black hole, a dream, a spell. Crying and choking, my emotions flooded out in fits and glowed there in a world of bars on windows where there is no sense of time and perspective.

I live in a box of no attachments. Withdrawn, I am [Version Fullette] (ph). [00:26:06]

PRESENTER 2: Thank you for sharing. I wanted to just ask you very quickly before we transition to someone else. You and I talked a little bit before about you wanting to come in and attend an evening group in smoking cessation and some other. So it sounds to me like it's been helpful for you to be able to get other services where you seek medical and to get things all in one place. So if you had to send a message to primary care doctors listening to this today and who just heard your poem, what might you say to them?

PRESENTER 3: Take time. Ask the questions: are you depressed? How are you feeling? Are you sleeping well? Is your heart palpitating? How are you doing in school? If not, have a PA, ask it. Someone. Some kind of team, some kind of crisis unit that takes care of that extra luggage that we keep inside because we schlep it, we don't expose it to you guys. And when we keep it all bottled in and become reactive, that's when it all falls apart. And if we don't hurt ourselves we hurt others and when we do hurt ourselves we leave the others in pain. [00:27:32]

PRESENTER 2: Thank you. I really appreciate and I'm sure everyone does, the sharing.

PRESENTER 4: Good afternoon, my name is Nellie Gonzalez. I'm a 45-year old Hispanic lesbian and I'm honored to sit at this panel and share a couple of my experiences and a couple of suggestions that I feel would be beneficial to this process. I've had three suicide and my last attempt when I was hospitalized, I was surprised that the doctor went and called my primary care doctor, called my pain management doctor, and everybody else that I was involved with as far as my medical conditions were concerned. And when they did that it was more of a verification of the medications that I was on so they could also give it to me while I was on the ward. And after I was released I was surprised that my PCP and my pain management doctors all got back to me and asked me how was I feeling. You know, 'what happened?'

There's just, you know, it's kind of hard I would say for a PCP doctor to find out or to know if someone is suicidal. I understand that because it starts with building of a rapport with the patient. And if you don't have a rapport with a patient or the patient doesn't feel comfortable with the PCP, the patient is not going to be able to share anything with the PCP. [00:29:02]

If the patient is, you know, let's say in the LGBT population and they don't feel comfortable with the PCP, they're not going to share certain issues around that as well. And my experience with PCPs because I do have lupus, I really never had a doctor ask me do I have mental health issues or how do I feel being diagnosed with lupus? You know, doctors, you know, like my doctor who I've had for like probably five, six years, I have a rapport with her. So she knows what's going on with me. I can walk into my office and she can tell by my mood that something is also going on. So I think that doctors should ask clients, you know, do they have a history of mental illness? Do

they have a history of substance abuse? You know, are they seeing a therapist? You know, if they are diagnosed with a new illness, how do they feel about being diagnosed with this illness? Are they sharing their feelings about being diagnosed with this illness? Are they going to any type of support groups with other people with this same kind of illness? And also I think paying attention to the patient's mood, because any time you see a patient the patient's not going to be the same way every time you see them. You know. [00:30:23]

A lot of things could trigger suicide as well. Whether, you know, the cat died. You know, they missed their medication or they over-medicated. Sometimes a lot of people are not aware of the side effects of medication. A lot of times the doctor doesn't express to you that, 'yeah, you're going to take this medication for a certain amount of time, but you also have to be aware of these side effects which may also make you feel depressed, which may also make you feel suicidal.' So, in that, I want to close by saying that I think that doctors should just take out time and ask the patients just certain questions so they can have a better idea of the patient. Thank you.

PRESENTER 2: Thank you and it sounds like it's been very helpful for you to have a doctor now that you can talk to and that also who knows you well enough that they can ask, you know, if – or notice if you are not feeling well or if things may have changed for you.

PRESENTER 4: Absolutely. Because prior – I was diagnosed with lupus in 2008. I've had my PCP since 2001. But once I had the diagnosis – when I was diagnosed with lupus that was hard for me to digest, you know, because nobody in my family had it. Well, my doctor sat with me and explained to me, you know, that I had to go through this, and that was very, very important.

PRESENTER 2: And sometimes though I think you brought in (unclear) point that sometimes patients who get a new diagnosis that might be very scary or might be very serious that sometimes that puts them at risk and sometimes it's really important. Or it's always really important that primary care providers make sure to ask and be aware.

PRESENTER 4: Yeah.

PRESENTER 2: Okay.

PRESENTER 4: Well, thank you.

MODERATOR: Well, thank you. Thank you so much for your stories and for something that you said that really struck me is just seeing the importance of just being asked the questions within a primary care setting. I think that that really speaks to, you know, the overall material here in terms of what we're trying to achieve with Zero Suicide and that it really is a sort of systematic approach to preventing suicide and oftentimes with providers we think that it's a really sensitive subject and that, you know, patients or clients won't be expecting to have these conversations within their primary care settings. But what you both really spoke well to is just the idea of the importance of having these conversations in the context of your healthcare visits. So I really appreciate you taking the time to share your stories and to provide that human connection to the issues. So thank you so much for joining us today. [00:33:06]

MODERATOR: I also wanted to say thank you to Virna and Julie for your presentations and I would like to open it up for questions now. We do have a few questions queued up and so please feel free to add questions as we go along and move through these. You can just add those in by typing in the chat box below that you see on the bottom left of your screen. So the first question that we have is what is the proper screening of ex-offender? Why was the District of Columbia not prepared and not having plans for post-traumatic stress disorders? (Pause) So I don't know. Virna or Julie, if you wanted to talk about screening for ex-offenders?

(Pause): [00:33:48 - 00:33:54]

PRESENTER 2: I guess I can take that one. I mean, for the institute and for many primary care providers who care for what I'll call safety net populations which includes individuals who have had contact with the criminal justice system or have spent time in the criminal justice system. You know, I think we really are, we use the standard PHQ2 for depression screening and then we've really been thinking about asking individuals about their criminal justice history in a very different way and thinking about what we might do to change services, but to provide better and more comprehensive services. But I think, you know, initially regardless of the population, it's important to ask the question and a lot of organizations are switching to the PHQ3. In other words, asking the first two questions and then taking question nine and asking patients directly about suicide as part of their screening process in many primary care settings. So that probably wasn't as specific as you wanted but in terms of moving the Zero Suicide work forward, that's probably a good step to take. [00:35:15]

PRESENTER 1: And then the only thing – this is Julie. I mean, I think the only thing I would add and Virna, you've taught me, probably more than anybody, about this: is really the idea of, you know, an ex-offender, somebody, or really anybody who presents with significant risk factors, right? So there are people who have been incarcerated, who then are able to have jobs and you know, to back to valuable relationships, and there are others who struggle with those issues, or substance abuse, and being mindful of not just screening annually, potentially, but screening during times that these transitions are occurring and the provider is aware. Or really considering what are the risk factors.

We know that middle aged men, for example, are at the highest rates for suicide in our country. So really thinking about if you have somebody who is a middle aged male with a history of incarceration and substance abuse, and they're undergoing a divorce, or they really can't locate employment, and they haven't been screened in a while. That's probably somebody you want to consistently screen – not just sort of screen once and then do it again a year later. [00:36:29]

PRESENTER 2: Thank you, Julie. And I think, you know, that brings an important point in terms of what we've started to do more and more – make sure that social determinants are on the problem list in our primary care setting and encouraging others to do the same because those are risk factors and it's important for providers to know for many reasons but one of them being suicide risk and to making sure that we have relationship problems, financial problems, and all of those on the problem list, and then making sure that we try to identify patients who may be more at risk. Thank you.

MODERATOR: Great. Thank you. Next question is: “for an organization just starting to implement screening for depression and/or substance use, what are the three steps that you recommend?”

PRESENTER 2: So I think – I just want to make sure I heard the question – to start screening for depression for an organization that’s just starting their screening initiative? [00:37:36]

MODERATOR: Yes.

PRESENTER 2: I think there’s a couple of things to keep in mind. The first is to make sure they’re partnered with other organizational initiatives so that it can get more traction in that the other initiative supports this work and this work supports the other initiatives that you have going on. Make sure that you’ve got good systems in place because the first thing primary care providers say is, ‘well if I can’t make a referral or I don’t have something to do when somebody screens positive, then you know, these are not questions I’m going to ask or I’m not going to be on board.’

Also make sure that you’ve got good work flows in place and everybody knows what they’re going to do and when. And you’re going to do a work flow for who does what and when, but also a clinical pathway and really think about how you want to care and treat patients with depression in your organization.

And lastly I would also say to really think about, you know, putting in, or some thought around what your screening program is going to look like long term and where you might want to start. So sometimes it’s helpful to start with a smaller population or particular provider, so if you already are doing a quality improvement project with a specific population, maybe add depression screening there or if there’s a smaller practice or a particular physician who might be, you know, more interested in doing this work, start there and then spread it. [00:39:11]

MODERATOR: Great. Thank you. We have some other, kind of process questions so I’m going to just continue through those since we’re on this theme. Julie, did you want to add anything before I move on?

PRESENTER 1: No. Thanks.

MODERATOR: Okay. The next questions is: “at what age do you recommend screening for depression?”

PRESENTER 2: I think we now are sort of routinely, as are many primary care organizations, sort of routinely screening 12 and up, but actually given some recent experiences I think we’re looking at some additional standardized screening for younger children, you know, the primary care checklist or some of the other tools that might be out there particularly in some of the elementary schools where we provide care and services. But generally, most primary care providers are starting at 12 and up. [00:40:08]

MODERATOR: Great. Thank you. Next question –

PRESENTER 2: The only thing that I would add to that, actually, the only thing that I might add to that is that several practices sometimes start suicide screening at 12 and up, but they start screening for other psycho-social issues younger. So bullying, eating disorders, academic issues, family relationship issues, things like that might lead to thoughts of suicide or maybe issues, obviously that early intervention is best suited to address very early on. So I'm sure most of your practices have already incorporated many screenings around these other issues. But if not, then these are the types of things that people address earlier than age 12. [00:41:03]

MODERATOR: Great. Thank you. And "as a mental health agency, how can we best approach primary care physicians regarding these issues so that the gap can be closed?"

PRESENTER 2: It's important to think about establishing a strong relationship because many times what you hear from primary care providers is 'when I call, nobody will give me information, they say that there's no consent. When I try to refer somebody, there's no appointment.' And so I think the most important is to maybe have a liaison, somebody that is one key contact person that the primary care providers can call to get information to coordinate care, to do something to really establish a rapport with or to have someone that might be a feet on the street, you know, care coordinator type person assigned to the relationship where they can take patients back and forth and be a liaison. But I think it's important initially to really try to build and foster a relationship and it's much easier to do that if you have some dedicated people on each side working through all of the day to day kinds of issues that come up. [00:42:15]

MODERATOR: Julie, did you have anything to add to that?

PRESENTER 1: No, I think Virna's – I mean, establish great relationships with outside providers. I think the idea of having one person that you develop a relationship is crucial. It's impossible to call and talk to different people and there's staff turnover. I also think sometimes, quite honestly, going in with what it is that you can offer, so sometimes when you begin a meeting saying 'oh, we just want to work with you' and you don't really have sort of very set pieces of work that you've thought about in advance, nobody's really able to put them out on the table or they feel uncomfortable asking or they don't know that those are your – that you have the resources to do that. So sometimes coming in with a list of 'these are the six ways in which we could really support your work', you know, we could discuss. I think sometimes having that list in front of you gives a starting point sort of further down the lane. And then having ongoing meetings as well, so saying let's do this meeting every month, rather than sort of waiting until the time comes up. But that's saying both of you are aware that this is a priority, that you really are very interested in maintaining this relationship. And by having that scheduled and not cancelling it kind of allows both sides to recognize that this could be a really useful and strong relationship. [00:43:40]

The other piece – the only other piece I think I might add is sometimes having family advocates or people with lived experience play that role for you so that it's not sort of necessarily professional to professional, but rather some of the people in the community who are being treated by both agencies basically coming to each of you saying, 'why aren't you working together. My care could have been better-coordinated.' And that providers, therefore, might be more willing to see some of those deficits. Or at least if they're hearing about it from all these different angles it might make them more inclined to build this relationship faster. I think it's not that people don't want to build

the relationship – they either don't know how to or they're just too overwhelmed and it's always something they're interested in doing but it just keeps getting pushed to the back burner. [00:44:28]

MODERATOR: Great. Thank you. The next question is: “how important is it to be culturally responsive when assessing mental health?”

(Pause): [00:44:34 - 00:44:41]

PRESENTER 1: Do the women who are sitting with you want to answer that?

PRESENTER 4: What was the question again?

PRESENTER 2: So you want to repeat the question and, yes, I think this young woman in front of me would be wonderful to answer that question.

MODERATOR: Okay. Great. It's a great question. So “how important is it to be culturally responsive when assessing mental health?”

(Pause): [00:44:59 - 00:45:12]

PRESENTER 4: I believe it's very, very important because if – I can give you a perfect example. If I'm a lesbian and I know I have the opportunity to sit with a population of doctors that service the gay population, I'm going to be more comfortable to sit with them because they can identify with me versus the straight population who may have underlying issues that they're not going to share, you know? We don't know what they're religious beliefs are. We don't know what they really (unclear) of. All we know is that they're there to do a job. You know what I mean? But if – and when you see somebody who you don't identify with you're not going to share as much, you know what I mean? You're going to be kind of defensive, you know? But if you see that you're working with a population of people who are just like you, it's much, much easier.

PRESENTER 2: So it's critical.

PRESENTER 4: Absolutely. Then you have the Hispanic population which is very different than, we would say, the Caucasian population and African-American population because with the Hispanic culture, you know, they really don't share a lot. They keep everything within the family. They're not out there looking for services. They don't know how to look for services. It's different. It's just different issues.

PRESENTER 3: Very different issues. [00:46:32]

PRESENTER 2: Did you have –?

PRESENTER 3: I'd like to answer that a bit more differently because I'm always doing things different. I would like a doctor that talks to me about my mental disease, what the approaches are, what the possible outcomes can be, the severity of it are, the medications that you're on, the applications of two medications – not one. The long term usage. The other psychodynamic

therapies, the cognitive therapies, the grounding, the coping, the anger management. Give me a cocktail of tools that I can use to better myself with your help. Make this a journey of both the doctor and the patient. And I know that doctors have many, many patients and they're not going to remember, so if you could set up a team. I use all of those that I just said and that's why I'm well. I'm well in being in itself, but I do have mental illness and I have grown to accept that.

PRESENTER 2: So I think and also for a doctor or a team to be able to do that, it's important that they be able to understand that you being a female Latina, all of those pieces that make you who you are come in and they need to take that into consideration. [00:47:56]

PRESENTER 3: And also the distinction of whether you're conscious or you're reactive.

MODERATOR: Okay. Thank you. Our next question is: "what do you recommend as a best practice for suicide screening in a primary care setting that offers integrated services with an LCSW available? Should everyone be screened and if so, how do we best implement this in practice?"

PRESENTER 1: So I think it's important for everyone to be screened. And I think though, it's not critical that everyone be in behavioral healthcare when you talk about having an embedded LCSW. There are many patients who can be cared for by primary care providers who can be seen for depression or, you know, other symptom follow ups who can be monitored on medications, that there's a population of patients in the practice who would benefit from mental health services and care by the LCSW and using the LCSW to be able to provide those services and I think one of the most important things is to make sure that you know everyone on the team is aware when someone may be at risk. And one of the most important things we did is we did is we actually changed the color in the electronic health record so that there's a red banner, so that even if I'm a patient who is known to the LCSW and I come in for primary care, that the doctor can have the conversation or the LCSW can have the conversation and that, you know, you're really caring for the patients who need it most as a team and you're concentrating your team and that one embedded LCSW to really care for the patients who are at risk.

MODERATOR: Thank you, Virna.

PRESENTER 1: And if I might add, the only thing I would add to that, and this is Julie, is I think the idea of a comprehensive approach to suicide care has grown out of the concept that it can't be one clinician treating everybody at risk for suicide. That historically, that's how we've addressed suicide care is somebody gets identified, they go into the therapist's office, the therapist works with them and really does everything under the sun that they can to really care for that client but there's no system behind the clinician supporting the individual. So that became terrifying, really, for a clinician and it's not supportive enough for a client who's not only at risk for one hour a week or one hour every other week, but they really need a system behind them. [00:50:43]

So I just want to reiterate what Virna's saying which is it's not just the LCSW who's responsible for all the screening and seeing all the patients at risk for suicide the system is with an LCSW, or psychologist or somebody available in the system to help guide the practices to help see clients, to deliver psychotherapy, but the system is aware of when an individual is at risk and everybody

bears a responsibility in insuring that clients are cared for with everybody at all visits and at all service delivery sites.

PRESENTER 2: And I always get a little afraid when I hear that question because some times where a practice might say, 'well, now we have a social worker so they can do the screening and they can do the follow up.' And just to reiterate what Julie said, this is a team. This is primary care initiative and this is primary care and a health issue. And so it really does need to be a system approach. It needs to be a team approach and everybody has different responsibilities and different roles on the team and everybody is responsible for the care, support and treatment of someone who is at risk.

MODERATOR: Thank you for that response. I just want to mention that we did have a question that really spoke to that. And I'm just going to read the question to see if there's anything in addition you can add. This question was around – I'll just read it. "Many primary care practices are group practices or large organizations with a specific practitioner being assigned on paper only. With the rotating staff it's difficult to engage clients on any specific occasion. Such a process does not foster the relationship and trust needed. Are there examples of organizations using multiple providers making modifications in their systems to reduce the diffusion of relationship factors?" And I read this question because I think this speaks really well to what you were just talking about in terms of a comprehensive approach, that it really is the entire team that is responsible and so I just wondered if there's anything else that you wanted to add about specific organizations that have done an excellent job in terms of the comprehensive approach. [00:53:03]

PRESENTER 2: I think those are the practices that are really going to have to do a lot around transformation and not just to support Zero Suicide work but to really support some of the things that are coming down in healthcare as a whole. You know, thinking about empanelment, thinking about accountability, thinking about working in care teams. So I think it's helpful to start to have things that are consistent across all providers. You know, the red banner is just spoke about, putting social determinants on the problem list so that regardless of what provider or who on a care team or what discipline sees the patient, they have an information and some systems in place for what they're required to do to care for and to support that patient. And I think that, you know, it's important to try to think about that as you go forward and do this work, because those are the practices that have a lot of work to do. But also it's not uncommon. Many primary care settings, particularly large ones have residency programs or training sites, you know, have specialists that rotate through and so I think, actually, many times that ends up being the rule and not so much the exception. But to really think about how you can divide people into teams and also how you can put systems in place that will span across all providers. [00:54:32]

PRESENTER 1: And this is Julie. The only other thing I might add to that is I think there are potentially training needs and systems like this around patient engagement. You know, if a physician is saying, if a physician is particularly biased, or who they think might be at risk and assesses people by saying things like, 'so you're not thinking about suicide, right?' And then kind of moves on, or 'you wouldn't do anything stupid, would you?' after someone has disclosed, 'well I'm really struggling with depression.' And I know that it's hard to hear these examples but I think they actually happen. And so in a case like that, of course, it's going to be difficult to foster relationships and trust in a large system if individuals feel that when they do disclose, they're not

going to be taken seriously. I think it's really getting mental health out in front of primary care physicians as much of their responsibility and something that they are, can be, and need to be effective in just as much as diagnosing any physical health problem. And in some cases that probably requires training in things that people don't often don't want to be trained in, especially the people who tend to need it the most are often people who tend to think about it the least. So I think systems like that, like Virna said, are going to have to think much harder about how to engage patients. [00:55:51]

But the idea of patient engagement is necessary. I mean I think we want people to come back to care after a particularly difficult appointment or a particularly difficult diagnosis, much the same as if a primary care doc said to their client, 'you know, you have diabetes now,' or, 'you need to lose 50 lbs.,' or, 'stop smoking.' Or any of those things that are really difficult to say to somebody that might cause the patient to feel they don't want to go back because they're embarrassed or don't want to deal with it. It's the physician's responsibility to keep them engaged in care. So I think that's something that these practices will just have to consider.

PRESENTER 2: Great. Thank you. And our final question that we have time for today is: "are there any tools which SAMHSA or others have created like mobile applications that we can integrate in our implementation of Zero Suicide?" [00:56:46]

Well, I'll go first and then maybe Virna has some additional thoughts. There is the SAMHSA mobile app. There's also the Safe-T which is an assessment tool that is developed by SAMHSA which is less about the actual questions to ask but more about the kind of general guidelines in assessing things to be considered. There is the primary care toolkit. It is developed by SPRC and it's available on the SPRC website and it's called the Primary Care Toolkit for Rural Providers but it's really actually relevant for any primary care physician. It speaks to many of the pieces of care where Virna was saying about organizations that are afraid to start screening or may start screening but actually have no processes in place for once they identify somebody at risk. The primary care toolkit really talks about some of those pieces that need to be thought through before you can invest in suicide care and that kind of approach. And then really looking through the Zero Suicide website there are so many tools that we've developed around collecting data, around getting started, your organizational study, creating a work plan. I think there's many resources once you dive deep into the toolkit you'll find have been very helpful in your implementation efforts. [00:58:05]

MODERATOR: Thank you, Julie.

PRESENTER 2: That was good. I don't have anything to add.

MODERATOR: Alright. Well, thank you so much for joining us. I want to thank all of the presenters that we had with us today and all of the participants for the wonderful questions that we had. If you do have additional questions for us following today's presentation, please send an e-mail to Integration@theNationalCouncil.org and we will do our best to answer any remaining questions for this webinar. And as I mentioned earlier, the slides and the recording to the presentation will be available on our website so if you have any trouble accessing those, please let us know as well.

And once you exit the webinar today you will be asked to complete a short survey. Please be sure to offer your feedback on today's webinar. This is the only way that we have to really improve upon these as we move forward. [00:59:03]

And again I just wanted to extend a thank you to all of our presenters for joining us today and have a great afternoon. Thank you very much.

GROUP: Thank you.

[01:01:00]

END TRANSCRIPT