Identifying and Treating Patient Suicidality in Outpatient Clinic Setting and in Tele-health Model

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OBJECTIVES

- 1. Participants will be able to adapt the methods of how the University of Alabama at Birmingham (UAB) School of Nursing Providing Access to Healthcare (PATH) Clinic members have utilized in identifying patient suicidality.
- 2. Participants will be able to recognize the benefits in adapting a patient safety plan to an outpatient clinic.
- 3. Participants will be able to identify the pharmacology treatment options to treat these patients.
- 4. Participants will be able to adapt these methods to a patient in-person clinic or via tele-health.

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BACKGROUND OF IPCP CLINICS

Inception of Clinics:

- Need shown through frequent readmissions
- Nurse-led
- Interprofessional collaborative practice model
- Health Resources and Services Administration: Nursing Education, Practice, Quality and Retention (NEPQR) Funding.
- Partnership between UAB School of Nursing and UAB Hospital

Goals of Clinics:

- Improving patient experience of care
- Improving population health
- Reducing per capita cost of health care

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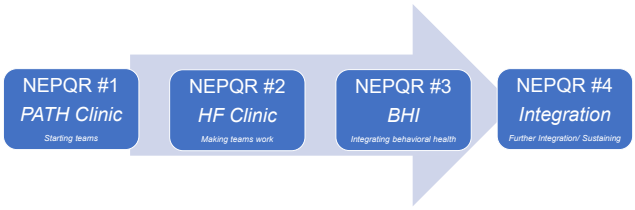
THE UAB NEPQR STORY



PATH CLINIC FOR DIABETES

- Providing Access to Healthcare (PATH)
- Initiated in 2012
- Comprehensive care
- Eligibility criteria:
  - Insulin dependent
  - A1C above 9
  - Uninsured
- Referrals from UAB Hospital as well as some community clinics
- Part-time, on medical campus
- Mental health services

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HRTSA HEART FAILURE CLINIC

- Heart Failure Transitional Care for Adults (HRTSA)
- Initiated in 2014
- Eligibility criteria:
  - Diagnosis of heart failure
  - Uninsured or underinsured (now seeing more)
- Referrals from UAB Hospital
- Part time, now full time medical campus
- As of July 1, 2017, sustained by UAB Hospital
- Started operating 40 hours per week October 2017

PRIMARY CARE PROVIDER ROLES

- Team at PATH Clinic: Nurse Practitioners, Resident Physicians and Attending Physician, Care Coordinator/CDE, Social Worker, Dietician/CDE, Patient Care Technician, Optometry, students of various disciplines
- Team at HRTSA Heart Failure Clinic: Nurse Practitioners, Clinical Nurse Leader, Social Workers, Patient Care Technician/Community Navigator, Collaborating Physician, students of various disciplines

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BHI PROJECT GOALS

1. Implement an effective model in which behavioral health is fully integrated into primary care and chronic disease management.
2. Incorporate nursing and other health professional students into the expanded IPCP behavioral health model in order to expose future providers to integrated, team-based care and the healthcare needs of vulnerable populations.
3. Develop and implement a plan for the long-term sustainability of the expanded IPCP model at both the PATH Clinic and the Heart Failure Clinic

BHI TEAM MEMBERS

- Psychiatrist: one day per month at each clinic
- PMHNP: one day per week doing chart review/recommendations/ seeing patients as needed
- LICSW: two days per week at each clinic
- Care Coordinator: 40 hours per week between clinics




BHI PROCESS

- All patients receive PHQ-9 and GAD-7 plus tobacco and SBIRT screening questions prior to seeing medical clinician.
- Patients with PHQ-9 > 9 receive screen for mood disorder (MDQ).
- Medical provider reviews results. Those who screen + for SBIRT questions are asked additional screening questions about alcohol/drug use.
- Patients who screen + for tobacco use are *advised* and *referred*.

TEAM GOALS

1. Expand Patient Access to Care:
   - Education and facilitation with resources
     - Medication access
   - Navigation of system
     - Appropriate referral to in-clinic or outside providers
     - Preexisting BH diagnoses
     - Adjustment disorder
   - Decrease stigma
     - Support on overwhelming quality of medical and BH diagnosis
     - Opportunities for support persons

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TEAM GOALS

2. Development of Provider Knowledge
   - Diagnosis and conditions
   - Resources
   - Decrease stigma, taboos
3. Increase Patient Activation:
   - Knowledge, skills and confidence of managing one's own health and healthcare.
     - Skill Development
     - Problem Solving
     - Peer Support

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OUTCOMES (UPDATE!)

- Since July 2016, approximately **773 patients** were introduced to BHI services between both clinics.
  - 100% of patients at both clinics are screened using PHQ-9 and GAD-7 at every visit
  - 100% of patients are screened for tobacco use and illicit drug use at each visit.
- Anecdotally, BHI practices and considerations increased in team members

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Suicide

Suicide is death caused by injuring oneself with the intent to die. A suicide attempt is when someone harms themselves with any intent to end their life, but they do not die as a result of their actions.

National Statistics:

- 10th leading cause of death for all ages (Centers for Disease Control and Prevention [CDC]), 2021).
- 2nd leading cause of death for youth and young adults between the ages of 10-34 (CDC, 2021).
- According to CDC, a person dies of suicide every 11 minutes (CDC, 2021).

Alabama Facts:

- In 2019, the Alabama suicide rate was 16.4 per 100,000 persons (804 deaths) making suicide the 12th leading cause of death in Alabama (Alabama Department of Public Health [ADPH], 2021).
- Data, however, has consistently shown a pattern of higher rates in Alabama than the U.S. average (ADPH, 2021).

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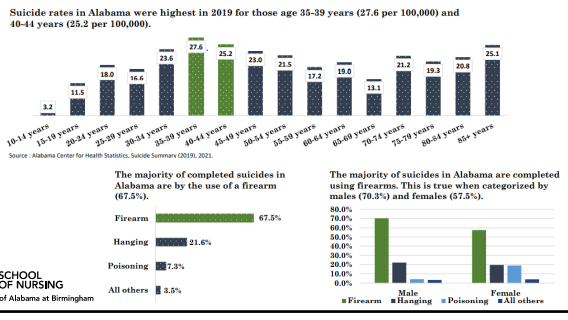
Suicide in Alabama



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Suicide Facts

Myths and Facts About Suicide

Myth #1: No one can stop a suicide.
- **Fact**: If a young person gets the help they need, they are less likely to be suicidal again.

Myth #2: Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact:** Asking about suicide lowers anxiety, opens up communication, and reduces the risk of impulsive acts.

Myth #3: Suicidal people keep their plans to themselves.
- **Fact:** Most suicidal people communicate their intent at some point near their attempt.

Myth #4: Those who talk about suicide don't do it.
- **Fact:** People who talk about suicide may try or even complete it.

Myth #5: Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact:** Suicide is one of the most preventable kinds of death.

Risk Factors for Suicide
- Previous suicide attempt
- Current talk of suicide or making a plan
- Social isolation
- Alcohol or drug abuse
- Giving away prized possessions
- Mental illness
- Recent attempt by friend or family member
- Depression
- Feeling hopeless, helpless, or worthless
- Strong wish to die or preoccupied with death

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(Alabama Department of Public Health, 2021)

Suicide Prevention

Surwhfwlyh#Idfwruv=
- Frslqj#dqg#suredqp 0vroylqj#vnloov
- Fxowxudo#dqg#hqdjlrxv#ehdlhiv#kdw#glvfrxudjh#xlflgh
- Frqqhfwhqv#wr#uhqgv/#dp l/#dqg#frp p xqlw|#xssruw
- Vxssruwlyh#hqdwlrqvkls#z lwk#fduh#surylghuv
- Dydlodeoh|#ri#sk|vlfdo#dqg#p hqwdo#kdoo#fduh
- Olp lwhg#dffhvv#wr#hvkdop hdqv#dp rqj#shrsdn#dw#lvn

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Suicide Screening

- Columbia-Suicide Severity Rating Scale (C-SSRS)
- Question #9 on PHQ-9: Any positive response warrants further investigation
  - "Thoughts that you would be better off dead or hurting yourself."

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Depression

Depression DSM-5 Diagnostic Criteria:

The DSM-5 outlines the following criterion to make a diagnosis of depression. The individual must be experiencing five or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
5. Fatigue or loss of energy nearly every day.
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
8. Recurrent thoughts of death, **recurrent suicidal ideation** without a specific plan, or a suicide attempt or a specific plan for committing suicide.

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U.S. Depression Statistics

- Percent of adults aged 18 and over with regular feelings of depression: 4.7%
- Percent of physician office visits with depression indicated on the medical record: 10.6%
- Percent of emergency department visits with depression indicated on the medical record: 11.2%
- More women are affected by depression than men.
- Depression can lead to suicide.
- There is effective treatment for mild, moderate, and severe depression.

(National Center for Health Statistics [NCHS], 2018)

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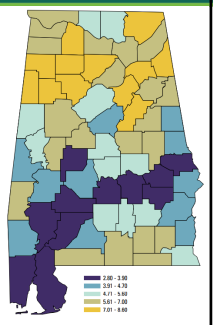
Depression Diagnosis Among Medicaid Recipients in AL in 2013

- Among Medicaid recipients, 61,779 (5.4 percent) had been diagnosed with depression.
- The problem is especially acute for rural residences (6.0 percent) compared to urban (4.9 percent).
- Depression is important because it leads to other health problems or suicide.
- At the county level, depression is highest in Jackson, Cherokee, and Etowah counties and lowest in Wilcox and Bullock counties.



(Alabama Department of Public Health, 2013)

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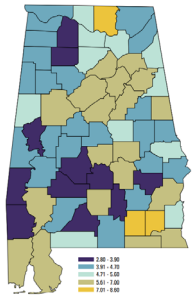
BCBS Members Filing Depression Claims in AL in 2013

- BCBS had 29,551 claims related to depression in 2013 or 1.4 percent of all claims.
- This problem was worse for urban residents (1.5 percent) compared to rural ones (1.2 percent) in this population.
- Alabama's BCBS depression claims make up a rate of 1.4 percent of claims.
- Claims are highest in Dale and Coffee counties. They are lowest in Greene and Lowndes counties.
- Females file claims much more frequently than males (26.3 percent versus 17.1 percent).
- The lowest rate occurs for ages less than 18 years (0.87 percent); the highest rate is for those 35-44 years of age (1.71 percent).

(Alabama Department of Public Health, 2013)



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Contributing Factors and Depression Prevention

- Depression results from a complex interaction of social, psychological, and biological factors.
- There are interrelationships between depression and physical health. For example, cardiovascular disease can lead to depression and vice versa.
- Prevention programs have been shown to reduce depression.
  - Coping skills
  - Exercise programs
  - Support

(World Health Organization, 2021)

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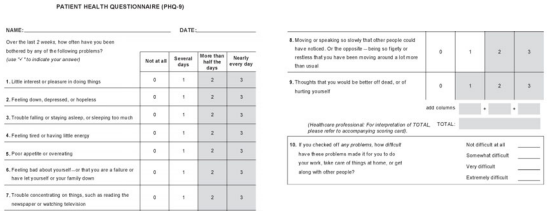
DEPRESSION SCREENER: PHQ-9



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? (use "√" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

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DEPRESSION SCREENER: PHQ-9

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓'s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder
- if there are at least 5 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder
- if there are 2-4 ✓'s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓'s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Mood Disorder Questionnaire

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

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MDQ: SCORING

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or "**Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

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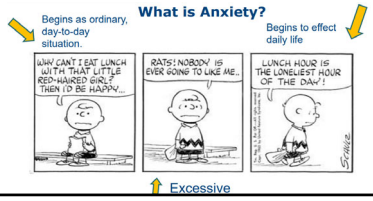
Anxiety

- Generalized anxiety disorder (GAD) can be a challenge to diagnose. People consider panic attacks a hallmark of all anxiety disorders, but GAD is different in that there are generally no panic attacks associated with the condition.
- A person may think they are "just worrying too much." Their struggles with constant worry may be minimized or dismissed and, in turn, not properly diagnosed or treated.



Anxiety

DSM-5 Diagnostic Criteria for Generalized Anxiety Disorder:

- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance)
- B. The individual finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (With at least some symptoms having been presents for more days than not for the past 6 months). Note: Only one item is required in children –
  - 1. Restlessness or feeling keyed up or on edge.
  - 2. Being easily fatigued.
  - 3. Difficulty concentrating or mind going blank.
  - 4. Irritability.
  - 5. Muscle tension.
  - 6. Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep

DSM-5 diagnostic criteria for Generalized Anxiety Disorder (cont.)

- D. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g., hyperthyroidism).
- F. The disturbance is not better explained by another mental disorder (e.g., anxiety or worry about having panic attacks in panic disorder, a negative evaluation in social anxiety disorder [social phobia], contamination or other obsessions in obsessive-compulsive disorder, separation from attachment figures in separation anxiety disorder, reminders of traumatic events in posttraumatic stress disorder, gaining weight in anorexia nervosa, physical complaints in somatic symptom disorder, perceived appearance flaws in body dysmorphic disorder, having a serious illness in illness anxiety disorder, or the content of delusional beliefs in schizophrenia or delusional disorder.)

Anxiety Statistics

- Percent of adults aged 18 and over with regular feelings of worry, nervousness, or anxiety: 11.2%
- Number of visits to physician offices with mental disorders as the primary diagnosis: 55.7 million
- Number of visits to emergency departments with mental disorders, behavioral, and neurodevelopmental as the primary diagnosis: 4.9 million
- Anxiety disorders are the most common mental illness in the U.S.
- Anxiety disorders are highly treatable, yet only 36.9% of those suffering receive treatment.
- People with an anxiety disorder are three to five times more likely to go to the doctor and six times more likely to be hospitalized for psychiatric disorders than those who do not suffer from anxiety disorders.
- Anxiety disorders develop from a complex set of risk factors, including genetics, brain chemistry, personality, and life events.
- It's not uncommon for someone with an anxiety disorder to also suffer from depression or vice versa. Nearly one-half of those diagnosed with depression are also diagnosed with an anxiety disorder.

(National Center for Health Statistics [NCHS], 2018)

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Contributing Factors for Anxiety

The causes of anxiety disorders aren't fully understood.

- Life experiences such as traumatic events appear to trigger anxiety disorders in people who are already prone to anxiety.
- Inherited traits also can be a factor.
- Medical causes- For some people, anxiety may be linked to an underlying health issue.

<u>Risk factors:</u>

- Trauma
- Stress due to an illness
- Stress buildup
- Personality
- Other mental health disorders
- Having blood relatives with an anxiety disorder
- Drugs or alcohol

(Mayo Clinic, 2018)

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Complications and Anxiety Prevention

Complications:

- Having an anxiety disorder does more than make you worry. It can also lead to, or worsen, other mental and physical conditions, such as:
  - Depression
  - Substance misuse
  - Trouble sleeping (insomnia)
  - Digestive or bowel problems
  - Headaches and chronic pain
  - Social isolation
  - Problems functioning at school or work
  - Poor quality of life
  - Suicide

Prevention:

- Get help early
- Stay active
- Avoid alcohol or drug use

(Mayo Clinic, 2018)

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ANXIETY SCREENER: GAD-7

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

GAD-7 Important Notes and Scoring

The GAD-7 is based on the diagnostic criteria for GAD described in DSM-IV. *However, the GAD-7 is also sensitive to severity of symptoms of social phobia, post-traumatic stress disorder, and panic disorder.*

Please note: This questionnaire is designed for use by a health professional. Since the questionnaires rely on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient (e.g., presence of DSM-IV GAD symptoms). A diagnosis of Generalized Anxiety Disorder should not be made based on GAD-7 scores alone.

A score of 10 or greater indicates that further evaluation is required.

Scoring Criteria: Total score (adding all the numbers) provides a possible score from 0-21.

GAD-7 Total Score Symptom Range

0-4 Minimal Anxiety
5-9 Mild Anxiety
10-14 Moderate Anxiety
15-21 Severe Anxiety

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SUBSTANCE USE DISORDER

- A substance use disorder (SUD) is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications.
- Researchers have found that about half of individuals who experience a SUD during their lives will also experience a co-occurring mental disorder and vice versa.
  - Co-occurring disorders can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorders, and schizophrenia, among others.
- While SUDs and other mental disorders commonly co-occur, that does not mean that one caused the other. Research suggests three possibilities that could explain why SUDs and other mental disorders may occur together:
  - Common risk factors can contribute to both SUDs and other mental disorders.
  - Mental disorders can contribute to substance use and SUDs.
  - Substance use and SUDs can contribute to the development of other mental disorders.

(National Institute of Mental Health, n.d.)

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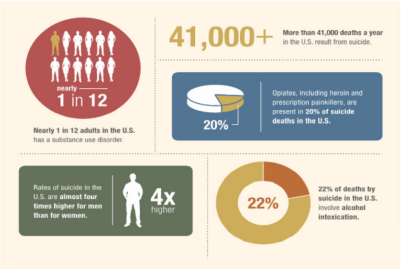
SUD and Suicide



(Substance Abuse and Mental Health Services Administration, 2016)

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SBIRT- Screening, Brief Intervention, and Referral to Treatment

- Screening, Brief Intervention, & Referral to Treatment (SBIRT) is an evidence-based approach to deliver early intervention and treatment services for persons with Substance Use Disorders (SUDs), and those at risk of developing a SUD.
- SBIRT is early intervention for individuals with non-dependent substance use to help before they need more extensive or specialized treatment. This approach differs from specialized treatment for those with more severe substance misuse or a SUD.

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SBIRT

SBIRT has 3 major components:

1. **Screening:** Screen or assess a patient for risky substance use behaviors with standardized assessment tools to identify the appropriate level of care (known as Medicare Structured Assessment). Screening quickly assesses the severity of substance use and identifies the appropriate treatment level.
2. **Brief Intervention:** Brief intervention increases substance use insight and awareness and motivates behavioral change. Engage the patient in a short conversation to increase their awareness of risky substance use behaviors, provide feedback, motivation, and advice. Medicare covers up to 5 counseling sessions.
3. **Referral to Treatment:** Refer patients whose assessment or screening shows a need for additional services to brief therapy or additional treatment through specialty care.

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SBIRT: STEP 1

STEP 1: *Ask about alcohol & drug use*

Alcohol use [33]
A drink is defined as: 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of spirits. See NIAAA Clinician's Guide, p. 24.

- Do you sometimes drink beer, wine, or other alcoholic beverages?
- How many times in the past year have you had 5 or more drinks (4 or more for women and men over age 65) in a day? *One or more is considered positive. If positive, patient is at risk for acute consequences (e.g. trauma, accidents). If score is greater than zero, ask:*
  - On average, how many days a week do you have an alcoholic drink?
  - On a typical drinking day, how many drinks do you have?
    If average exceeds 14 drinks per week for healthy men up to age 65 or 7 drinks per week for all healthy women and healthy men over age 65, patient is at-risk for chronic health problems.

Drug use [8]
How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? (If asked what non-medical reasons means you can say because of the experience or feeling the drug caused.) *One or more is considered positive.*

If positive, go to STEP 2. Your patient has at least RISKY alcohol and/or drug use.
If negative, reinforce their healthy decisions.

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SBIRT: STEP 2


STEP 2: *Assess for alcohol and/or drug severity*

CAGE-AID[27]

1) Have you ever felt that you ought to **Cut** down on your drinking or drug use?
2) Have people **Annoyed** you by criticizing your drinking or drug use?
3) Have you ever felt bad or **Guilty** about your drinking or drug use?
4) Have you ever had a drink or used drugs first thing in the morning **(Eye-opener)** to steady your nerves or get rid of a hangover?

*Each **Yes** response equals 1.*

SCORING

≤1 WOMEN & MEN | **RISKY USE**

> 1 WOMEN & MEN | **FURTHER DIAGNOSTIC EVALUATION & REFERRAL**

Responses to CAGE-AID questions may be used in your brief intervention.

Go to Step 3 to perform a brief intervention, p. 9.

All patients receiving CAGE-AID should receive a brief intervention.

Step 3 and 4: Brief Intervention and Refer to Treatment

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BUILDING BUNDLES OF CARE

- *BHI Bundle of Care* was developed by Michele Talley, PhD, ACNP-BC, FAANP, current NEPQR: BHI Project Director
  - Development of the "Bundles of Care" as PATH clinic expands to a more collaborative and integrated model
  - Providing whole person care
  - Evidence based algorithms to treat multiple behavioral health disorders including suicide ideation, depression, substance use disorder, anxiety, tobacco use and diabetes distress
  - Identification of SDoH
  - Education of primary care providers

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BHI COLLABORATION WITH PRIMARY PROVIDERS

- Daily huddles that include diabetes and BHI teams
- Collaboration and conversation in real time during the patient appointment
- Provider education regarding behavioral health and mental health pharmacology
  - BHI Orientation for all new employees and students
- Updated BHI recommendations made by the PMHNP in the EMR
- Access to the psychiatrist and PMHNP for emergency consult if not present in clinic

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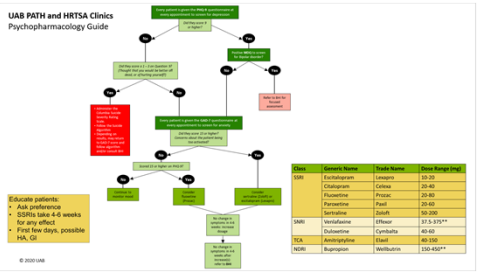
ANTIDEPRESSANT ALGORITHM



Class	Generic Name	Trade Name	Dose Range (mg)
SSRI	Escitalopram	Lexapro	10-20
	Citalopram	Celexa	20-40
	Fluoxetine	Prozac	20-80
	Paroxetine	Paxil	20-60
	Sertraline	Zoloft	50-200
SNRI	Venlafaxine	Effexor	37.5-375**
	Duloxetine	Cymbalta	40-60
TCA	Amitriptyline	Elavil	40-150
NDRI	Bupropion	Wellbutrin	150-450**

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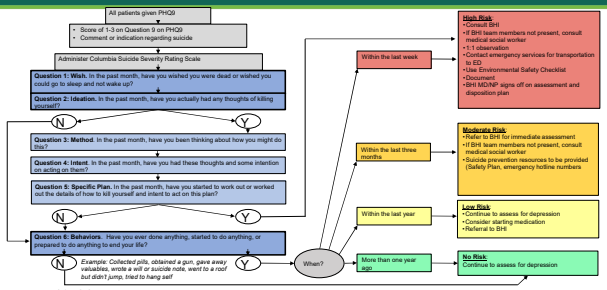
SUICIDE RISK ALGORITHM



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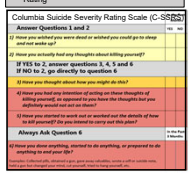
C-SSRS can be found in Impact
1. Ad hoc
2. Ambulatory
3. Columbia Suicide Severity Rating



No Risk: "No" to Questions 1, 2, and 6

Low Risk: "Yes" to Questions 1 or 2
"No" to Questions 3-6

Moderate Risk: "Yes" to Questions 1 or 2
"Yes" to Questions 3 or 6
"No" to Questions 4 and 5

High Risk: "Yes" to Questions 1 or 2
"Yes" to Questions 3 or 6
"Yes" to Questions 4 or 5

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Risk Factors

- ❑ Can't enjoy anything
- ❑ Anxiety and/or panic attacks
- ❑ Insomnia
- ❑ Hopelessness or despair
- ❑ Homicidal Ideation
- ❑ Psychotic disorder or command hallucinations
- ❑ Personality disorder
- ❑ Mood disorder
- ❑ PTSD or HX of abuse/trauma
- ❑ Substance abuse
- ❑ Impulsivity or aggression
- ❑ HX of Suicide
- ❑ Lack of social supports or increasing isolation
- ❑ Perceived burden on others
- ❑ Legal issues, incarceration
- ❑ Local suicide cluster or exposure to one via media
- ❑ Non-compliant with treatment

Protective Factors

- ❑ Ability to cope with stress or frustration
- ❑ Sense of responsibility to others
- ❑ Social supports
- ❑ Identifies a reason to live
- ❑ Religious beliefs
- ❑ Engaged in work, school, activities
- ❑ Fear of death
- ❑ Cultural, spiritual or moral attitudes against suicide

Instructions: The information provided illustrates an approach to assessing the safety of an individual with suicidal thoughts. It is based on the screening version of the Columbia Suicide Severity Rating Scale. Sources of information can include not only the patient but other individuals. The scale can guide decision-making, though the clinician's judgment should always take precedence (for example, if there is reason to think that a patient might be reluctant to report the full severity of suicidal thinking). The clinician should always keep in mind that suicide prediction is not an exact science; if worried, best to err on the side of seeking consultation.

MOVING AWAY FROM A NO HARM CONTRACT…

- Signed commitment from the patient that they will not do anything to harm themselves or anyone else
  - Signed before a specific date-next appointment to be reassessed resigned if needed
- Steps the patient would take before engaging in harmful behavior
- Its not an actual legal contract
- Identifying risk, but taking the patient at their word
- There is no evidence it works and could provide a false sense of security
- The same document for every patient

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…TO A SAFETY PLAN

- Specific to each patient
- That plan involves a sequence of specific actions the patient can take
- It ensures that the patient knows exactly what to do if they feel their mental state deteriorating, even if you aren't immediately available.
- The safety plan is one component of a more comprehensive safety strategy:
  - frequency of contact
  - involving other health care professionals
  - increasing social support
  - assessing access to lethal means

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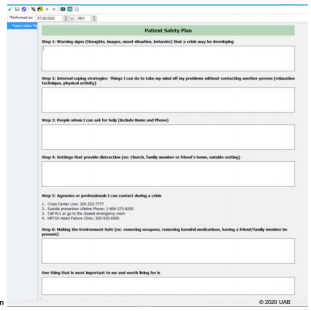
PATIENT SAFETY PLAN



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IMPLEMENTATION AND FOLLOW UP

Implementation

- Moderate or High Columbia Suicide Screening
  - Also need to consider risk factors and protective factors
- Completed in clinic or via telehealth appointment
  - Print out a copy for the patient in clinic
  - Will be amended for patient as their needs and circumstances change
    - Will review with patient at subsequent appointments
  - Send email encrypted copy to the patient and confirm receipt
    - Can be printed for at next clinic appt

Follow up

- Antidepressant RX
- F/U with LICSW for therapy
- Check in calls with BHI Care Coordinator

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ASSESSING AND TREATING: PRE COVID

- Patients only seen physically at the PATH clinic
  - Typically on a monthly basis
  - Screenings at each visit filled out by each patient- offered in English and Spanish
  - Reviewed by PCP and BHI team
  - Assessing suicidality and taking action, if needed
    - A safe place to go with friends/family
    - Assessment of home environment
    - Calling 911 and EMS transporting to ED
    - In person filing of petition
  - Scheduling follow ups in person

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ASSESSING AND TREATING: COVID

- March 2020: quick transition to telehealth model in a matter of days
- Voice to voice due to patients SDoH and clinic technology limitations
- Developing a process to screen patients prior to their visits over the phone
  - Completed by BHI Care Coordinator
- Keeping patients at risk of self harm safe
  - Team effort
- Ordered smart phones for patients and tablets for BHI team to utilize for telehealth

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MOVING TO A HYBRID MODEL

- Patients returned to clinic in May 2021
- Patients are seen in person and via telehealth (voice to voice)
- Opportunity to see those patients in clinic that have acute suicidality and are in the process of being up titrated on antidepressants
- Patients with a telehealth appt are still screened over the phone
- Patients in person fill out their screeners independently and are able to meet with the BHI Care Coordinator in a triage role
- Pilot program using grant-funded cell phones
  - "Face to face" sessions
  - Facial expressions and nonverbal cues missed under a mask

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KEEPING PATIENTS SAFE IN CLINIC SETTING

- Stay with the patient or another team member to sit with them to keep safe and also to reduce elopement risk
- Assess the room for any items that patient could use to self harm
- Consult PMHNP/Psychiatrist regarding next steps
- Involve family or friends if possible
- Provide resources and safety plan
- Make follow up while patient is in clinic

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KEEPING PATIENTS SAFE WHILE ON THE PHONE

- Stay calm
  - Get the patients location
  - Call emergency contacts
- Figure out a way to ask your team for help
- Have a teammate stay with you
- Just keep talking!
- Stay on the phone until a family member/friend/law enforcement has arrived
  - Communicate with them as needed

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