BEHAVIORAL HEALTH COMMUNITY OF PRACTICE MENTAL HEALTH SCREENING TOOLS

Facilitator:

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BEHAVIORAL HEALTH COMMUNITY OF PRACTICE OBJECTIVES

Share best practices for screening and targeted assessments

Disseminate evidence-based treatment guidelines

Provide community resources for patient support

Build relationships through the behavioral health continuum of care

UK HealthCare

BEHAVIORAL HEALTH COMMUNITY OF PRACTICE EXPECTED OUTCOMES

Optimize patient care and extend existing resources:

- Community mental health centers
- Primary care providers
- Specialists
- Organizations

UK HealthCare

MENTAL HEALTH SCREENING IN PRIMARY CARE

Julie Gosky
Regional Director CCBHC Health Initiatives
New Vista

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Mental Health Screening in Primary Care

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Why is screening so important?

PREVALENCE, SEVERITY, AND EFFECTS OF MENTAL DISORDERS HAVE FAR-REACHING IMPACT

Mental health disorders impact

- Employment
- Victimization
- Suicide attempts
- Financial stability

Taken together, all of these suggest a significant clinical need to integrate screening into primary care practices. Primary care may be the only access point for patients.

What are symptoms I might see in Primary Care?

- Feeling sad or down
- Confused thinking or reduced ability to concentrate
- Excessive fears or worries, or extreme feelings of guilt
- Extreme mood changes of highs and lows
- Withdrawal from friends and activities
- Significant tiredness, low energy or problems sleeping
- Inability to cope with daily problems or stress
- Trouble understanding and relating to situations and to people
- Major changes in eating habits

What are symptoms I might see in Primary Care?

- Sex drive changes
- Excessive anger, hostility or violence
- Suicidal thinking
- Misuse of prescriptions
- Blackouts
- Legal issues
- Neglecting responsibilities at home/work
- Unsuccessful in stopping use
- Increased tolerance

Other signs of alcohol or drug abuse?

- DUI history
- BAC over 150mg/DL with patient walking around
- History of 2 or more non-sports related traumas, broken bones, head injuries, fights
- Injury while intoxicated
- Use of multiple pharmacies and multiple lost prescriptions

Common Screening Tools

- PHQ-9
- GAD-7
- CAGE AID
- AUDIT
- DAST

PHQ-9

- Screens for depression
- Ages 12+
- 9 questions
- Can be self administered
- Scores ≥ 10
- Still need to rule out medical causes of depression, normal bereavement and history or mania/hypomania
- Other variations available for different populations
- www.phqscreeners.com

0 to 4 points: No depression

5 to 9 points: Mild depression

10 to 14 points: Moderate depression

15 to 19 points: Moderately severe depression

20 to 27 points: Severe depression

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GAD-7

- Screens for anxiety, similar to PHQ-9
- Ages 12+
- 7 questions
- Can be self administered
- Score over 10 indicates a probable anxiety disorder, need for further evaluation
- www.phqscreeners.com

CAGE AID

- Screens for alcohol and drug abuse
- Ages 12+
- 4 questions
- Any yes indicates a need for further evaluation
- www.hrsa.gov/cage-aid-substance-abuse-screening-tool

C	Have you ever felt the need to **cut** down on your drinking or drug use?	Yes	No
A	Have people **annoyed** you by criticizing your drinking or drug use?	Yes	No
G	Have you ever felt **guilty** about drinking or drug use?	Yes	No
E	Have you ever felt you needed a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (**Eye-Opener**)?	Yes	No

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Other Alcohol and Drug Screening Tools

- AUDIT
- DAST
- Single Alcohol Screening Question
- CRAFFT (adolescents)

https://www.ncsacw.acf.hhs.gov/files/SAFERR_AppendixD.pdf

How To Respond To A Positive Screening

- Positive screening indicates a need for more assessment
- Positive screening does *not* provide a diagnosis
- Assist patient in accessing community resources
- Encourage patient to include family in their care
- 988
- Text 741741
- New Vista Helpline 800-928-8000

References

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- Mulvaney-Day, N., Marshall, T., Piscopo, K. D., Korsen, N., Lynch, S., Karnell, L. H., Moran, G. E., Daniels, A. S., & Ghose, S. S. (2018). Screening for Behavioral Health Conditions in Primary Care Settings: A Systematic Review of the Literature. *Journal of General Internal Medicine*, *33*(3), 335-346. https://doi.org/10.1007/s11606-017-4181-0

- www.phqscreeners.com

- www.hrsa.gov

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SCREENING TOOLS, BEST PRACTICES & HOW TO USE EHR TO IMPROVE PATIENT'S MENTAL HEALTH

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Suicide Screening Tools, Best Practices, and How to Use an EHR to Improve Patient Outcomes

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Lindsey Jasinski, PhD, MHA

HealthCare
The Power of Advanced Medicine

Suicide Data: Kentucky

Suicide is a public health problem and leading cause of death in the United States. Suicide can also be prevented – more investment in suicide prevention, education, and research will prevent the untimely deaths of thousands of Americans each year. Unless otherwise noted, this fact sheet reports 2020 data from the CDC, the most current verified data available at time of publication (March 2022).

13th leading cause of death in Kentucky

2nd leading
cause of death for ages 10-24

2nd leading
cause of death for ages 25-34

4th leading
cause of death for ages 35-44

8th leading
cause of death for ages 45-54

11th leading
cause of death for ages 55-64

18th leading
cause of death for ages 65+

Suicide Death Rates

	Number of Deaths by Suicide	Rate per 100,000 Population	State Rank
Kentucky	**801**	**17.74**	**19**
Nationally	45,979	13.48	

See full list of citations at **afsp.org/statistics**.

75.11% of communities did not have enough mental health providers to serve residents in 2021, according to federal guidelines.

Over **five times** as many people died by suicide in 2019 than in alcohol related motor vehicle accidents.

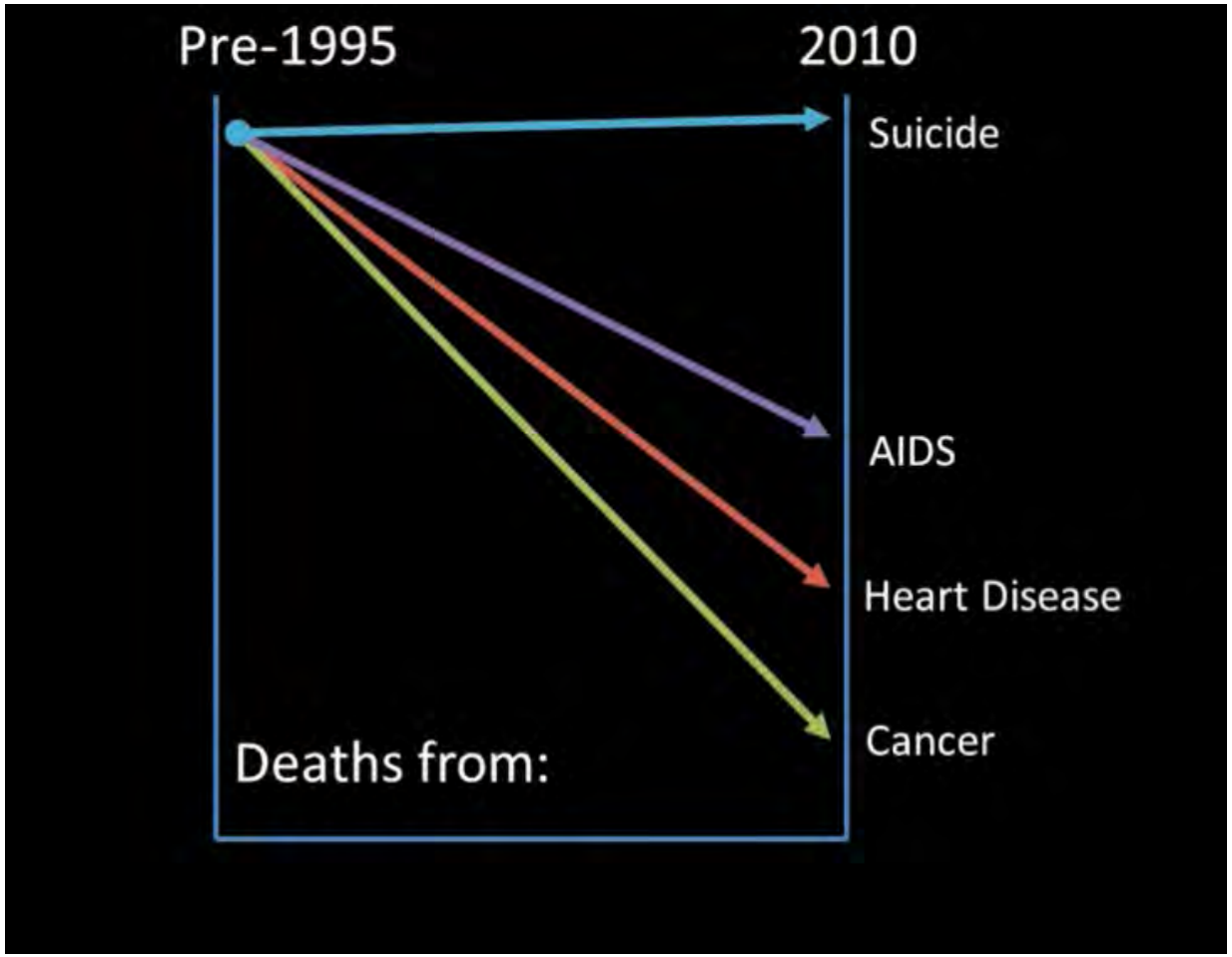
The total deaths to suicide reflected a total of **16,744 years** of potential life lost (YPLL) before age 65.

57% of firearm deaths were suicides.

65% of all suicides were by firearms.

American Foundation for Suicide Prevention

Suicide Deaths: Progress?



Percentage of patients who visited a provider before suicide

	PCP		MH Provider	
Patients	1 month	1 year	1 month	1 year
All	45%	77%	19%	32%
≤ 35 years	23%	62%	15%	24%
≥ 55 years	58%	77%	11%	8.5%

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Best Practices: TJC SE Alert 56- NPSG 15.01.01 Reduce the Risk for Suicide

Sentinel Event Alert

A compliment[illegible] of The Joint Commission
Issue 56, February

Detecting and treating s[illegible]

Published for Joint Commission-accredited organizations and interested health care professionals, *Sentinel Event Alert* identifies specific types of sentinel and adverse events and high risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in a *Sentinel Event Alert* when designing or redesigning processes and consider implementing relevant suggestions contained in the alert or reasonable alternatives.

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The rate of suicide is increasing it[illegible] death,[2] suicide claims more lives than[illegible] as many as homicides.[4] At the point of ca[illegible] suicidal thoughts (also known as suicide ideat[illegible] children and adolescents) who eventually die by su[illegible] them receive health care services in the year prior to d[illegible] reasons unrelated to suicide or mental health.[5-7] Timely, su[illegible] of care for those identified as at risk for suicide is crucial, as we[illegible]

Through this alert, The Joint Commission aims to assist all health care organizations providing both inpatient and outpatient care to better identify and treat individuals with suicide ideation. Clinicians in emergency, primary and behavioral health care settings particularly have a crucial role in detecting suicide ideation and assuring appropriate evaluation. Behavioral health professionals play an additional important role in providing evidence-based treatment and follow-up care. For all clinicians working with patients with suicide ideation, care transitions are very important. Many patients at risk for suicide do not receive outpatient behavioral treatment in a timely fashion following discharge from emergency departments and inpatient psychiatric settings.[8] The risk of suicide is three times as likely (200 percent higher) the first week after discharge from a psychiatric facility[9] and continues to be high especially within the first year[6,10] and through the first four years[11] after discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The suggested actions in this alert cover suicide ideation detection, as well as the screening, risk assessment, safety, treatment, discharge, and follow-up care of at-risk individuals. Also included are suggested actions for educating all staff about suicide risk, keeping health care environments safe for individuals at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.[12] The "Perfect Depression Care Initiative" of the Behavioral Health Services Division of the Henry Ford Health System achieved 10 consecutive calendar quarters without an instance of suicide among patients participating in the program. The U.S. Air Force's suicide prevention initiative reduced suicides by one-third over a six-year period. Over a period of 12 years, Asker and Bærum Hospital near Oslo, Norway implemented continuity-of-care strategies and achieved a 54 percent decline in suicide attempts in a high-risk population with a history of poor compliance with follow-up. Additionally, the hospital's multidisciplinary suicide prevention team accomplished an 88 percent success rate for getting patients to the aftercare program to which they were referred.[8] Dallas' Parkland Memorial Hospital became the first U.S. hospital to implement universal screenings to assess whether patients are at risk for suicide. Through preliminary screenings of 100,000 patients from its hospital and emergency department, and of more than 50,000 outpatient clinic patients, the hospital has found 1.8 percent of patients there to be at high suicide risk and up to 4.5 percent to be at moderate risk.[13]

The Joint Commission

www.jointcommission.org

2022 National Patient Safety Goal for Hospital and Behavioral Healthcare NPSG 15.01.01- Reduce the risk for Suicide replaced SE-56 in 2019

A TJC study estimated the annual inpatient suicide rate at 3.2 per 100,000 psychiatric admissions and 0.03 per 100,000 non-psychiatric admissions.

Based on data from 2018, (27 states reporting to the National Violent Death Reporting System and hospitals reporting to The Joint Commission's Sentinel Event Database):

Best Practices

	
Contracting for Safety	Individualized safety planning
Screen only	Follow-up with assessment and intervention
Send all patients with risk to the ED for inpatient evaluation	Tiered approach using quantified risk
Constant observation for any risk for suicide	Constant observation for patients identified as high risk for suicide, safety plan for moderate and low risk

Risk Levels

- Each location has a recommended set of actions depending on the patients response category

RISK STRATIFICATION	TRIAGE
High Suicide Risk	Likely to need a higher level of care, more observation and intervention; Admission generally indicated
Moderate Suicide Risk	Likely needs additional assessment or plan; Admission may be necessary; Determine appropriate treatment setting
Low Suicide Risk	Continue with usual care and communication; Outpatient referral may be appropriate

TOOLS DO NOT REPLACE CLINICAL JUDGEMENT

Suicide Screening Tools

- PHQ-9 (question 9)
  - Passive suicidal ideation
  - Primary care settings where fewer patients will screen positive
  - More detailed suicide risk assessment required if endorses passive ideation
- Ask Suicide Screening Questions (ASQ)
  - NIMH
  - 4 yes/no screening questions
  - 20 seconds to administer, toolkit with safety guides
  - Busy medical practices
- Columbia Suicide Severity Rating Scale (C-SSRS)
  - Validated for children, adolescents, adults
  - Passive and active, method, plan, intent, and suicidal behavior
  - Levels of risk
  - Training on how to administer free of charge

The Columbia-Suicide Severity Rating Scale (C-SSRS) at UKHC

All patients, > 12 years of age who are seen within UK HealthCare emergency department or directly admitted to an inpatient unit are initially screened using the C-SSRS tool

Patients < 11 years of age are screened only if they present with a behavioral health concern

If patient is screened to be low, moderate or high risk, further assessments are required.

Psychiatric intake to Complete: C-SSRS lifetime assessment, risk factors/protective factors, and patient safety plan

Patient assessment is completed by patient's RN every 12 hours until negative screen.

UKHC EMR: C-SSRS Screen

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen with Triage Points for Emergency Department

Ask questions that are bolded and underlined.	Past month	
Ask Questions 1 and 2	**YES**	**NO**
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?***	**Lifetime**	
Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.		
	Past 3 Months	
If YES, ask: ***Was this within the past three months?***		

Item 1 Behavioral Health Referral at Discharge
Item 2 Behavioral Health Referral at Discharge
Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions

C-SSRS (Short Version)

Responsible | Create Note | Show Row Info | Show Last Filed Value | Show Details | Show All Choices

Columbia Suicide Severity Rating Scale

Is patient awake, alert, and able/willing to answer questions appropriately?
Yes | No

1. Wish to be Dead (Past 1 Month)
No | Yes

Have you wished you were dead or wished you could go to sleep and not wake up?

Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.

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cssrs.columbia.edu

Reviewed by Jane K Palagi on 10/24/2022

General, non-specific thoughts of wanting to end one's life/die by suicide (e.g., *'I've thought about killing myself'*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period.

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6. Suicidal Behavior (Lifetime)
No | Yes

Have you ever done anything, started to do anything, or prepared to do anything to end your life?

For example: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.

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Calculated C-SSRS Risk Score (Lifetime/Recent)

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Columbia Suicide Severity Rating Scale - Is patient awake, alert, and able/willing to answer questions appropriately?

Previous row | Next row

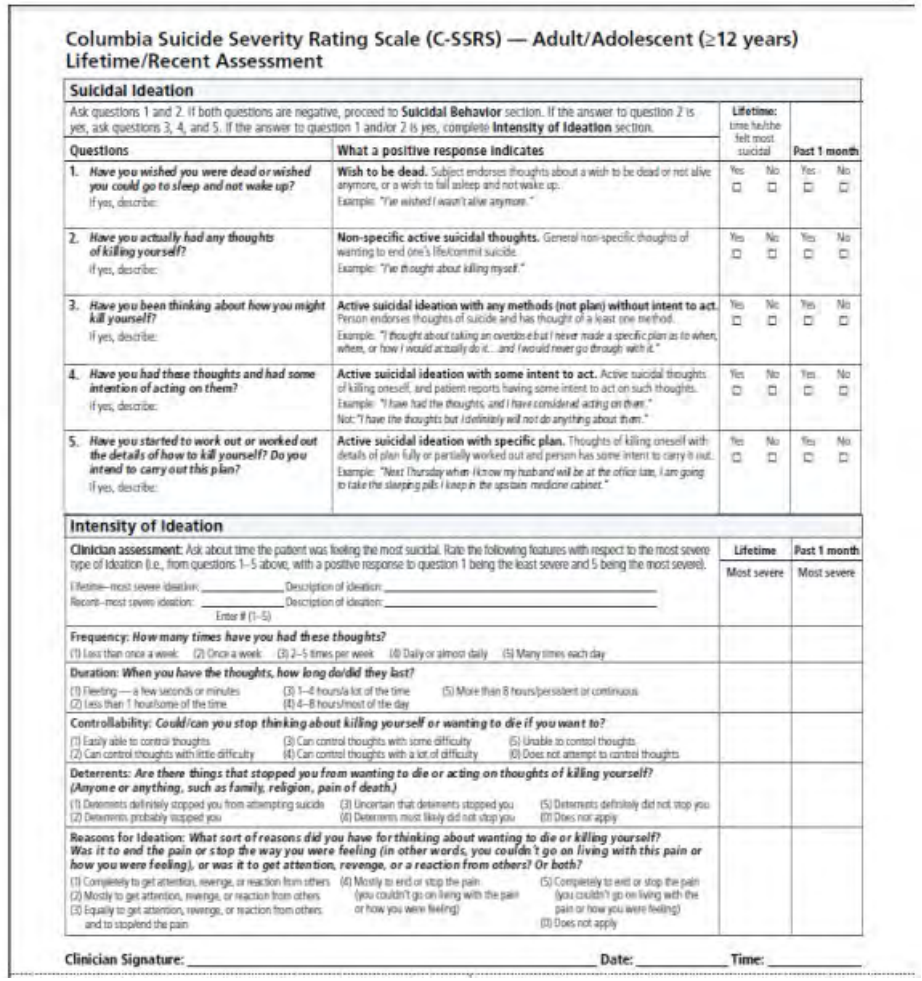
Group Information

If **YES** to question 2, ask questions 3,4,5, and 6. If **NO** to question 2, go directly to question 6.

Flowsheet Information

Columbia Suicide Severity Rating Scale	
Is patient awake, alert, and able/willing to answer questions appropriat…	
1. Wish to be Dead (Past 1 Month)	Yes
2. Non-Specific Active Suicidal Thoughts (Past 1 Month)	Yes
3. Active Suicidal Ideation with any Methods (Not Plan) Without Intent to …	Yes
4. Active Suicidal Ideation with Some Intent to Act, Without Specific Plan …	Yes
5. Active Suicidal Ideation with Specific Plan and Intent (Past 1 Month)	Yes
6. Suicidal Behavior (Lifetime)	Yes
6. Suicidal Behavior (Description)	sa
Calculated C-SSRS Risk Score (Lifetime/Recent)	High Risk

Lifetime/Recent or Since Last Visit Assessment



Columbia Suicide Severity Rating Scale (C-SSRS) — Adult/Adolescent (≥12 years)
Lifetime/Recent Assessment

Suicidal Ideation

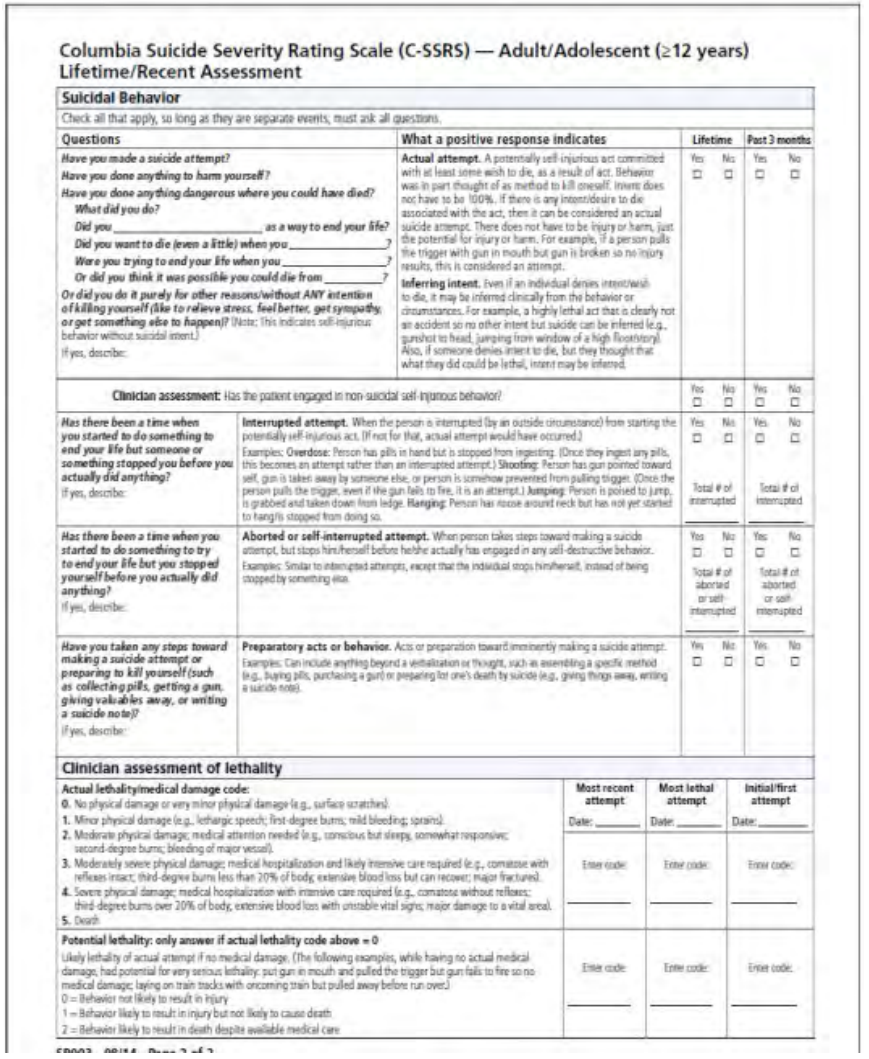
Ask questions 1 and 2. If both questions are negative, proceed to **Suicidal Behavior** section. If the answer to question 2 is yes, ask questions 3, 4, and 5. If the answer to question 1 and/or 2 is yes, complete **Intensity of Ideation** section.

Questions	What a positive response indicates	Lifetime: time he/she felt most suicidal		Past 1 month	
		Yes	No	Yes	No
1. *Have you wished you were dead or wished you could go to sleep and not wake up?* If yes, describe:	**Wish to be dead.** Subject endorses thoughts about a wish to be dead or not alive anymore, or a wish to fall asleep and not wake up. Example: *"I've wished I wasn't alive anymore."*	☐	☐	☐	☐
2. *Have you actually had any thoughts of killing yourself?* If yes, describe:	**Non-specific active suicidal thoughts.** General non-specific thoughts of wanting to end one's life/commit suicide. Example: *"I've thought about killing myself."*	☐	☐	☐	☐
3. *Have you been thinking about how you might kill yourself?* If yes, describe:	**Active suicidal ideation with any methods (not plan) without intent to act.** Person endorses thoughts of suicide and has thought of at least one method. Example: *"I thought about taking an overdose but I never made a specific plan as to when, where, or how I would actually do it…and I would never go through with it."*	☐	☐	☐	☐
4. *Have you had these thoughts and had some intention of acting on them?* If yes, describe:	**Active suicidal ideation with some intent to act.** Active suicidal thoughts of killing oneself, and patient reports having some intent to act on such thoughts. Example: *"I have had the thoughts and I have considered acting on them."* Not: *"I have the thoughts but I definitely will not do anything about them."*	☐	☐	☐	☐
5. *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?* If yes, describe:	**Active suicidal ideation with specific plan.** Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. Example: *"Next Thursday when I know my husband will be at the office late, I am going to take the sleeping pills I keep in the upstairs medicine cabinet."*	☐	☐	☐	☐

Intensity of Ideation

	Lifetime	Past 1 month
Clinician assessment: Ask about time the patient was feeling the most suicidal. Rate the following features with respect to the most severe type of ideation (i.e., from questions 1–5 above, with a positive response to question 1 being the least severe and 5 being the most severe).	Most severe	Most severe
Lifetime–most severe ideation: _____ Description of ideation: _____ Recent–most severe ideation: _____ Description of ideation: _____ Enter # (1–5)		
Frequency: *How many times have you had these thoughts?* (1) Less than once a week (2) Once a week (3) 2–5 times per week (4) Daily or almost daily (5) Many times each day		
Duration: *When you have the thoughts, how long do/did they last?* (1) Fleeting — a few seconds or minutes (2) Less than 1 hour/some of the time (3) 1–4 hours/a lot of the time (4) 4–8 hours/most of the day (5) More than 8 hours/persistent or continuous		
Controllability: *Could/can you stop thinking about killing yourself or wanting to die if you want to?* (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts		
Deterrents: *Are there things that stopped you from wanting to die or acting on thoughts of killing yourself? (Anyone or anything, such as family, religion, pain of death.)* (1) Deterrents definitely stopped you from attempting suicide (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply		
Reasons for Ideation: *What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words, you couldn't go on living with this pain or how you were feeling), or was it to get attention, revenge, or a reaction from others? Or both?* (1) Completely to get attention, revenge, or reaction from others (2) Mostly to get attention, revenge, or reaction from others (3) Equally to get attention, revenge, or reaction from others and to stop/end the pain (4) Mostly to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling) (0) Does not apply		

Clinician Signature: _____ **Date:** _____ **Time:** _____



Columbia Suicide Severity Rating Scale (C-SSRS) — Adult/Adolescent (≥12 years)
Lifetime/Recent Assessment

Suicidal Behavior

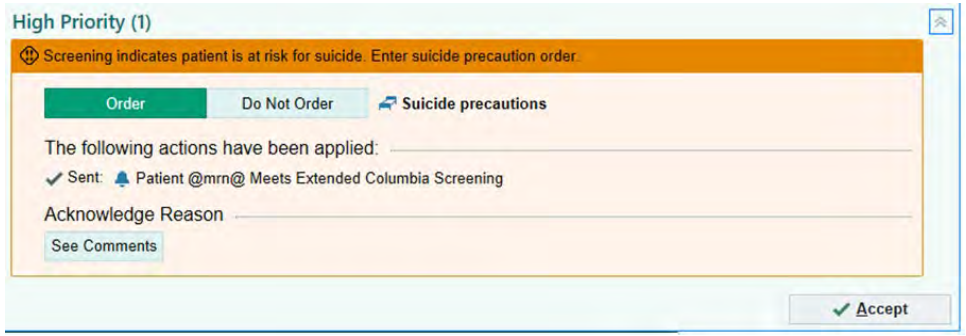
Check all that apply, so long as they are separate events, must ask all questions.

Questions	What a positive response indicates	Lifetime		Past 3 months	
		Yes	No	Yes	No
Have you made a suicide attempt? *Have you done anything to harm yourself?* *Have you done anything dangerous where you could have died?* *What did you do?* *Did you _____ as a way to end your life?* *Did you want to die (even a little) when you _____?* *Were you trying to end your life when you _____?* *Or did you think it was possible you could die from _____?* *Or did you do it purely for other reasons/without ANY intention of killing yourself (like to relieve stress, feel better, get sympathy, or get something else to happen)?* (Note: This indicates self-injurious behavior without suicidal intent.) If yes, describe:	**Actual attempt.** A potentially self-injurious act committed with at least some wish to die, as a result of act. Behavior was in part thought of as method to kill oneself. Intent does not have to be 100%. If there is any intent/desire to die associated with the act, then it can be considered an actual suicide attempt. There does not have to be injury or harm, just the potential for injury or harm. For example, if a person pulls the trigger with gun in mouth but gun is broken so no injury results, this is considered an attempt. **Inferring intent.** Even if an individual denies intent/wish to die, it may be inferred clinically from the behavior or circumstances. For example, a highly lethal act that is clearly not an accident so no other intent but suicide can be inferred (e.g., gunshot to head, jumping from window of a high floor/story). Also, if someone denies intent to die, but they thought that what they did could be lethal, intent may be inferred.	Yes ☐	No ☐	Yes ☐	No ☐
Clinician assessment: Has the patient engaged in non-suicidal self-injurious behavior?		Yes ☐	No ☐	Yes ☐	No ☐
Has there been a time when you started to do something to end your life but someone or something stopped you before you actually did anything? If yes, describe:	**Interrupted attempt.** When the person is interrupted (by an outside circumstance) from starting the potentially self-injurious act. (If not for that, actual attempt would have occurred.) Examples: **Overdose:** Person has pills in hand but is stopped from ingesting. (Once they ingest any pills, this becomes an attempt rather than an interrupted attempt.) **Shooting:** Person has gun pointed toward self, gun is taken away by someone else, or person is somehow prevented from pulling trigger. (Once the person pulls the trigger, even if the gun fails to fire, it is an attempt.) **Jumping:** Person is poised to jump, is grabbed and taken down from ledge. **Hanging:** Person has noose around neck but has not yet started to hang/is stopped from doing so.	Yes ☐	No ☐ Total # of interrupted	Yes ☐	No ☐ Total # of interrupted
Has there been a time when you started to do something to try to end your life but you stopped yourself before you actually did anything? If yes, describe:	**Aborted or self-interrupted attempt.** When person takes steps toward making a suicide attempt, but stops him/herself before he/she actually has engaged in any self-destructive behavior. Examples: Similar to interrupted attempts, except that the individual stops him/herself, instead of being stopped by something else.	Yes ☐	No ☐ Total # of aborted or self-interrupted	Yes ☐	No ☐ Total # of aborted or self-interrupted
Have you taken any steps toward making a suicide attempt or preparing to kill yourself (such as collecting pills, getting a gun, giving valuables away, or writing a suicide note)? If yes, describe:	**Preparatory acts or behavior.** Acts or preparation toward imminently making a suicide attempt. Examples: Can include anything beyond a verbalization or thought, such as assembling a specific method (e.g., buying pills, purchasing a gun) or preparing for one's death by suicide (e.g., giving things away, writing a suicide note).	Yes ☐	No ☐	Yes ☐	No ☐

Clinician assessment of lethality

Actual lethality/medical damage code:	Most recent attempt Date: _____	Most lethal attempt Date: _____	Initial/first attempt Date: _____
0. No physical damage or very minor physical damage (e.g., surface scratches). **1.** Minor physical damage (e.g., lethargic speech; first-degree burns; mild bleeding; sprains). **2.** Moderate physical damage; medical attention needed (e.g., conscious but sleepy, somewhat responsive; second-degree burns; bleeding of major vessel). **3.** Moderately severe physical damage; medical hospitalization and likely intensive care required (e.g., comatose with reflexes intact; third-degree burns less than 20% of body; extensive blood loss but can recover; major fractures). **4.** Severe physical damage; medical hospitalization with intensive care required (e.g., comatose without reflexes; third-degree burns over 20% of body; extensive blood loss with unstable vital signs; major damage to a vital area). **5.** Death	Enter code: _____	Enter code: _____	Enter code: _____
Potential lethality: only answer if actual lethality code above = 0 Likely lethality of actual attempt if no medical damage. (The following examples, while having no actual medical damage, had potential for very serious lethality: put gun in mouth and pulled the trigger but gun fails to fire so no medical damage; laying on train tracks with oncoming train but pulled away before run over.) 0 = Behavior not likely to result in injury 1 = Behavior likely to result in injury but not likely to cause death 2 = Behavior likely to result in death despite available medical care	Enter code: _____	Enter code: _____	Enter code: _____

UKHC EMR: Alert and Lifetime Assessment



Suicidal Ideation			
1. Wish to be Dead (Lifetime)			Yes
Wish to be Dead Description (Lifetime)			
1. Wish to be Dead (Past 1 Month)			Yes
Wish to be Dead Description (Past 1 Month)			
2. Non-Specific Active Suicidal Thoughts (Lifetime)			Yes
Non-Specific Active Suicidal Thought Description (Lifetime)			
2. Non-Specific Active Suicidal Thoughts (Past 1 Month)			Yes
Non-Specific Active Suicidal Thought Description (Past 1 Month)			
3. Active Suicidal Ideation with any Methods (Not Plan) Without Intent to Act (Lifetime)			Yes
Active Suicidal Ideation with any Methods (Not Plan) Description (Lifetime)			
3. Active Suicidal Ideation with any Methods (Not Plan) Without Intent to Act (Past 1 Month)			Yes
Active Suicidal Ideation with any Methods (Not Plan) Description (Past 1 Month)			
4. Active Suicidal Ideation with Some Intent to Act, Without Specific Plan (Lifetime)			Yes
Active Suicidal Ideation with Some Intent to Act, Without Specific Plan Description (Lifetime)			
4. Active Suicidal Ideation with Some Intent to Act, Without Specific Plan (Past 1 Month)			No
Active Suicidal Ideation with Some Intent to Act, Without Specific Plan Description (Past 1 Month)			
5. Active Suicidal Ideation with Specific Plan and Intent (Lifetime)			Yes
Active Suicidal Ideation with Specific Plan and Intent Description (Lifetime)			
5. Active Suicidal Ideation with Specific Plan and Intent (Past 1 Month)			Yes
Active Suicidal Ideation with Specific Plan and Intent Description (Past 1 Month)			Patient reports cur...

Reassessment of Risk: Behavioral Health Unit or Inpatient Setting

- Nurse will re-assess risk using C-SSRS Since Last Contact at least every 12 hours ONLY for patients found to be high, moderate or low risk on initial screening in ED or on direct admission

- BHU patients will be assessed every 12 hours regardless of prior suicide history

- If patient no longer scores at-risk for suicide:
  - Nurse will notify primary physician team for continued need for 1:1 observation (if high risk level was assessed) and every 12 hour reassessments
  - Patients are re-assessed as needed if change in clinical presentation/behavior

UKHC EMR: C-SSRS Since Last Contact Follow Up Assessment

Suicidal Ideation (Since Last Contact)			
1. Wish to be Dead (Since Last Contact)			Yes
Wish to be Dead Description (Since Last Contact)			passive si
2. Non-Specific Active Suicidal Thoughts (Since Last Contact)			No
Non-Specific Active Suicidal Thought Description (Since Last Contact)			
3. Active Suicidal Ideation with any Methods (Not Plan) Without Intent to Act (Since Last Contact)			No
Active Suicidal Ideation with any Methods (Not Plan) Description (Since Last Contact)			
4. Active Suicidal Ideation with Some Intent to Act, Without Specific Plan (Since Last Contact)			No
Active Suicidal Ideation with Some Intent to Act, Without Specific Plan Description (Since Last Cont...			
5. Active Suicidal Ideation with Specific Plan and Intent (Since Last Contact)			No
Active Suicidal Ideation with Specific Plan and Intent Description (Since Last Contact)			states she feels lik...
Intensity of Ideation (Since Last Contact)			
Most Severe Ideation Rating (Since Last Contact)			
Description of Most Severe Ideation (Since Last Contact)			
Frequency (Since Last Contact)			
Duration (Since Last Contact)			
Controllability (Since Last Contact)			
Deterrents (Since Last Contact)			
Reasons for Ideation (Since Last Contact)			
Suicidal Behavior (Since Last Contact)			
Actual Attempt (Since Last Contact)			No
Has subject engaged in non-suicidal self-injurious behavior? (Since Last Contact)			No
Interrupted Attempts (Since Last Contact)			No
Aborted or Self-Interrupted Attempt (Since Last Contact)			No
Preparatory Acts or Behavior (Since Last Contact)			No
Suicide (Since Last Contact)			No
Actual/Potential Lethality (Most Lethal Attempt)			
Most Lethal Attempt Date			
Actual Lethality/Medical Damage Code (Most Lethal Attempt)			1
Potential Lethality Code (Most Lethal Attempt)			1
C-SSRS Risk (Since Last Contact)			
Calculated C-SSRS Risk Score (Since Last Contact)			Low Risk

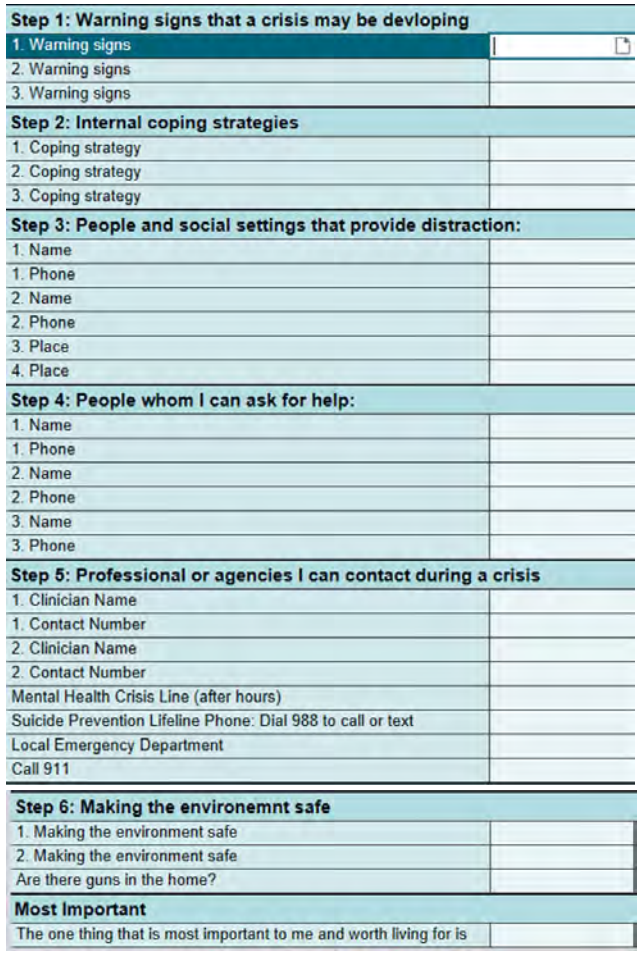
How to Use an EHR to Improve Patient Outcomes

Patient Safety Planning

- Documented series of gradually escalating steps that patient can follow, proceeding from one step to the next until they are safe
- Includes risk/protective factor identification, counseling, and education, as well as a recommendation for behavioral health follow-up care as soon as possible after discharge
- The safety plan is a living document that can be modified by the patient based on current needs and/or situation

UKHC Patient Safety Planning

- Stanley- Brown Safety Planning (6 steps)
- Warning signs, internal coping strategies, people and social settings that provide distraction, people whom I can ask for help, professional agencies I can contact during a crisis, making the environment safe

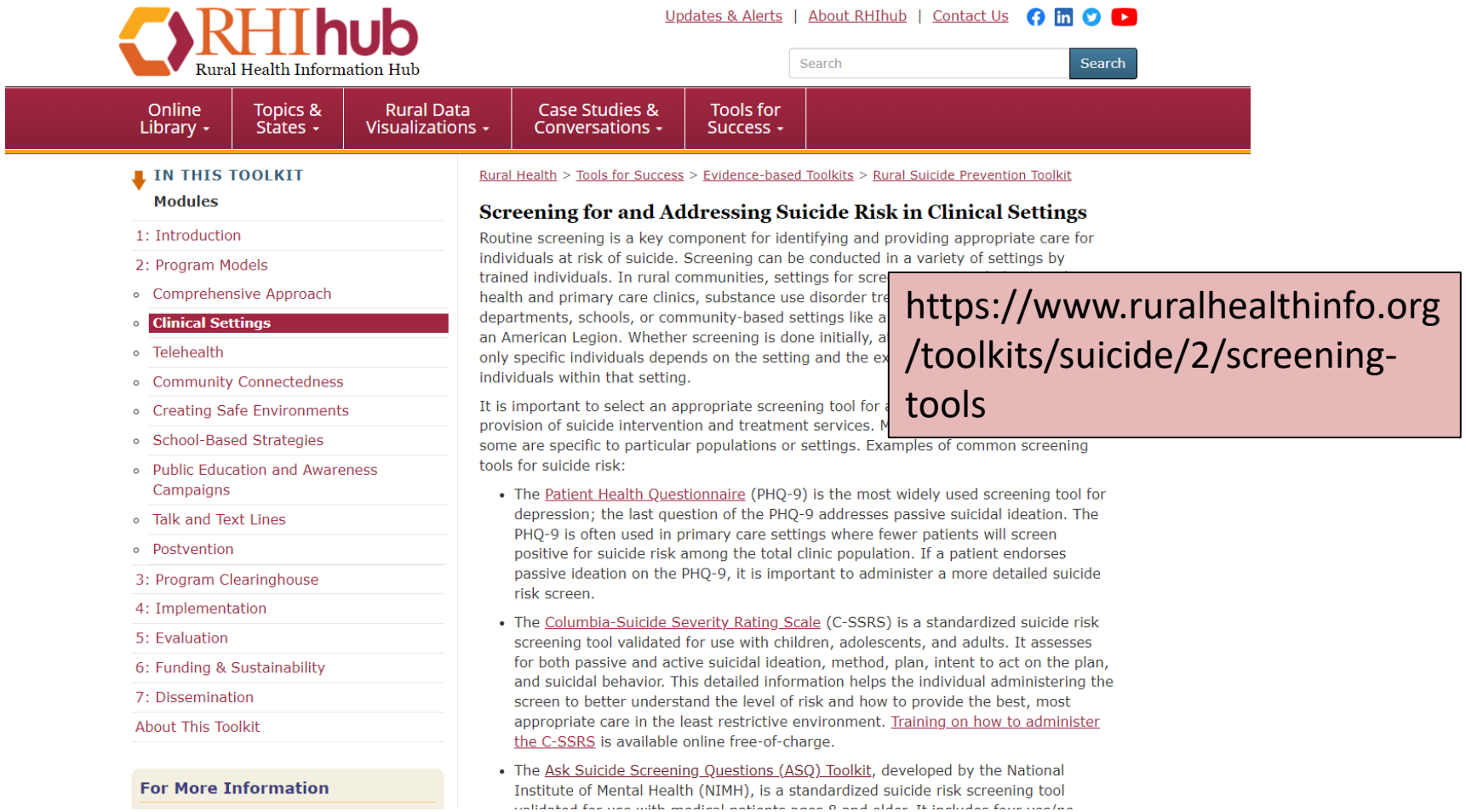


Step 1: Warning signs that a crisis may be devloping
1. Warning signs
2. Warning signs
3. Warning signs
Step 2: Internal coping strategies
1. Coping strategy
2. Coping strategy
3. Coping strategy
Step 3: People and social settings that provide distraction:
1. Name
1. Phone
2. Name
2. Phone
3. Place
4. Place
Step 4: People whom I can ask for help:
1. Name
1. Phone
2. Name
2. Phone
3. Name
3. Phone
Step 5: Professional or agencies I can contact during a crisis
1. Clinician Name
1. Contact Number
2. Clinician Name
2. Contact Number
Mental Health Crisis Line (after hours)
Suicide Prevention Lifeline Phone: Dial 988 to call or text
Local Emergency Department
Call 911
Step 6: Making the environemnt safe
1. Making the environment safe
2. Making the environment safe
Are there guns in the home?
Most Important
The one thing that is most important to me and worth living for is

UKHC EMR: Patient Safety Planning

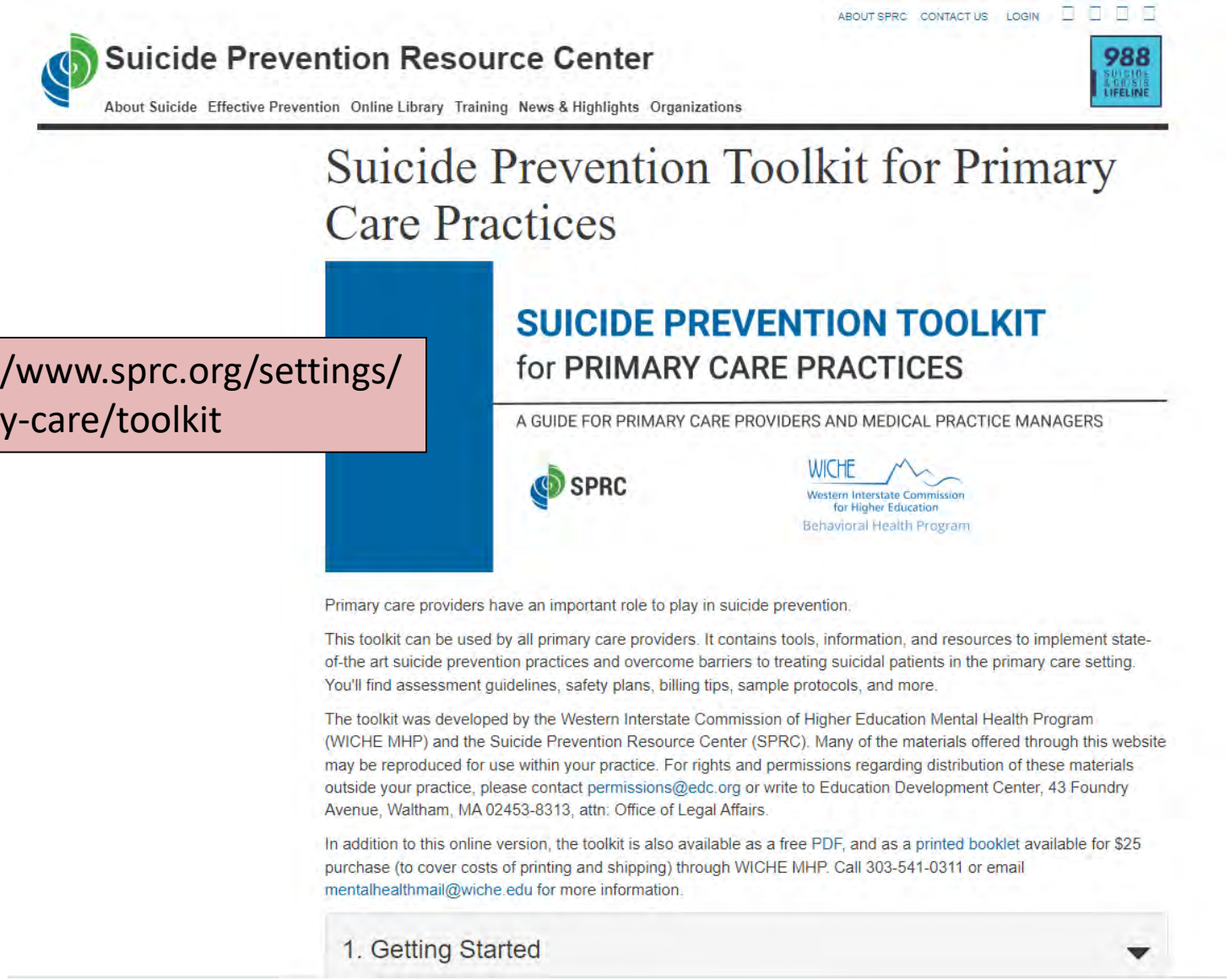
- UKHC formulates the patient safety plan upon admission for all patients screened as high, moderate or low risk for suicide
- Patients, family members and/or other support persons (identified by the patient) are invited and allowed to participate in plan formulation
- The nurse reviews the patient safety plan with patient and caregivers prior to discharge
- Includes our partners at New Vista for follow-up
  - Urgent appointment within 24-48 hour of discharge
  - 24-hour helpline

Screening Tools Resource



https://www.ruralhealthinfo.org/toolkits/suicide/2/screening-tools

https://www.sprc.org/settings/primary-care/toolkit



UK HealthCare Depression Screening & Response Policies: Ambulatory

Patty Hughes, DNP, RN, NE-BC
Chief Nursing Officer, Ambulatory

November 3, 2022

Depression Screening

Quality Measure

Description:

- **Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.**

Numerator:

- **Patients screened for depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.**

Denominator:

- **All patients aged 12 years and older at the beginning of the measurement period with at least one eligible encounter during the measurement period**

Exclusions: (Service Lines, Outliers, etc.)

- **Patients with an active diagnosis for depression or a diagnosis of bipolar disorder are excluded. Patients with any of the following are exceptions: patient reason(s), Patient refuses to participate, or medical reason(s); patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status; or situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (for example: certain court appointed cases or cases of delirium).**

Suicide Screening

TJC National Patient Safety Goal

Goal 15

The hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01

Reduce the risk for suicide.
Note: EPs 2–7 apply to patients in psychiatric hospitals or patients being evaluated or treated for behavioral health conditions as their primary reason for care. In addition, EPs 3–7 apply to all patients who express suicidal ideation during the course of care.

--Rationale for NPSG.15.01.01--

Suicide of a patient while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Element(s) of Performance for NPSG.15.01.01

sychiatric hospitals and psychiatric units in general hospitals: The hospital conducts an onmental risk assessment that identifies features in the physical environment that could be used empt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of or points, door hinges, and hooks that can be used for hanging). R (D)

onpsychiatric units in general hospitals: The organization implements procedures to mitigate the f suicide for patients at high risk for suicide, such as one-to-one monitoring, removing objects that a risk for self-harm if they can be removed without adversely affecting the patient's medical care, ssing objects brought into a room by visitors, and using safe transportation procedures when ng patients to other parts of the hospital.
: Nonpsychiatric units in general hospitals do not need to be ligature resistant. Nevertheless, facilities should routinely assess clinical areas to identify objects that could be used for self-harm emove those objects, when possible, from the area around a patient who has been identified as risk for suicide. This information can be used for training staff who monitor high-risk patients (for mple, developing checklists to help staff remember which equipment should be removed when ible).

en all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool. R
Note: The Joint Commission requires screening for suicidal ideation using a validated tool starting at age 12 and above.

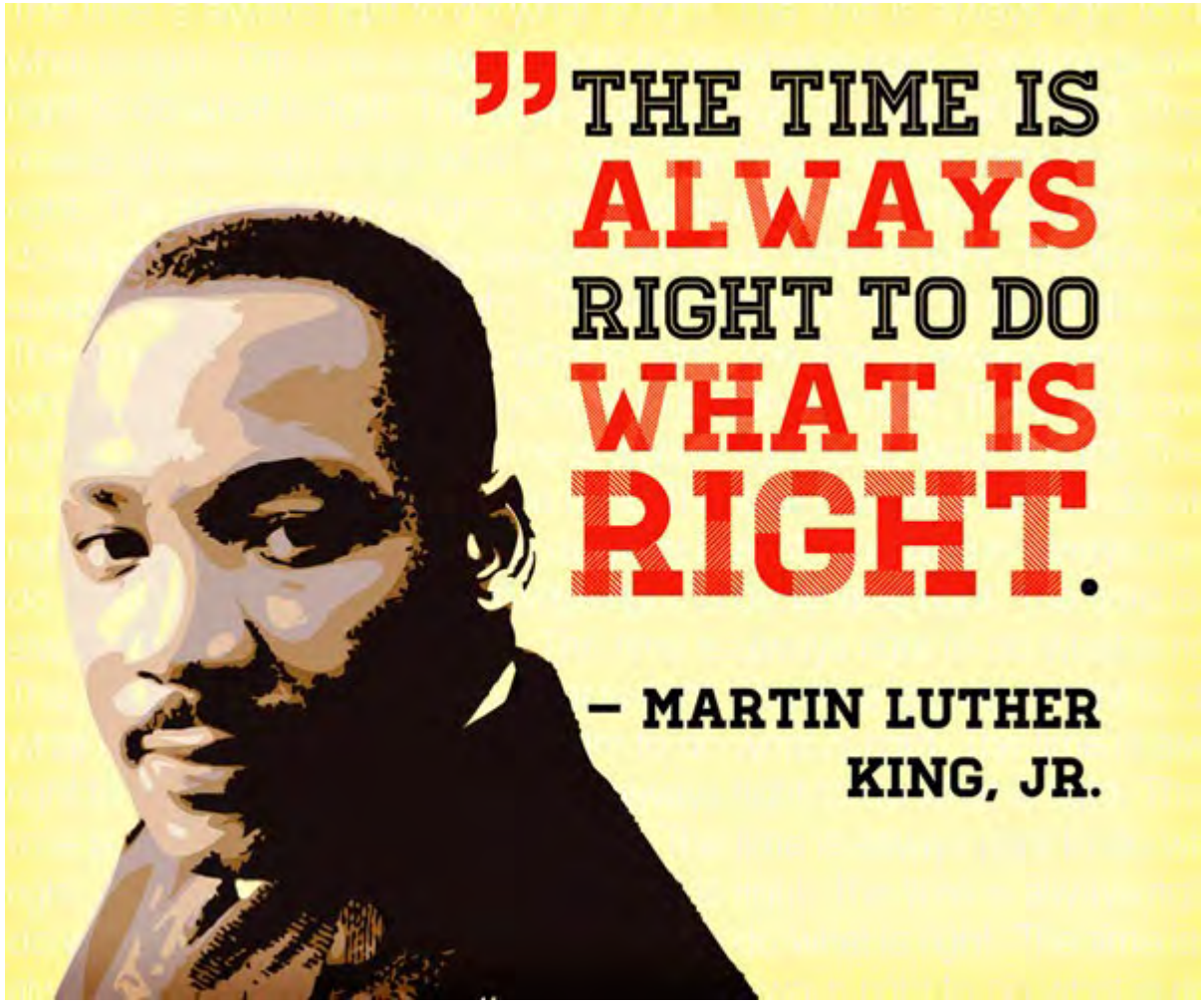
3. Use an evidence-based process to conduct a suicide assessment of patients who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. R
Note: EPs 2 and 3 can be satisfied through the use of a single process or instrument that simultaneously screens patients for suicidal ideation and assesses the severity of suicidal ideation.

4. Document patients' overall level of risk for suicide and the plan to mitigate the risk for suicide. R

5. Follow written policies and procedures addressing the care of patients identified as at risk for suicide. At a minimum, these should include the following: R (D)
- Training and competence assessment of staff who care for patients at risk for suicide
- Guidelines for reassessment
- Monitoring patients who are at high risk for suicide

6. Follow written policies and procedures for counseling and follow-up care at discharge for patients identified as at risk for suicide. R

7. Monitor implementation and effectiveness of policies and procedures for screening, assessment, and management of patients a compliance. R



Monitoring

University of Kentucky / UK HealthCare Ambulatory Services Protocol	Patient Rooming Protocol
Owner/Author: Sara Wellman, MSN, APRN, FNP-C	
Target Area: UKHC Ambulatory care clinics	
Personnel authorized to perform: RN, LPN, Medical Assistant	
Purpose: To outline the rooming process workflow to enable provider more time to spend directly interacting with the patient and family. To ensure the clinical staff obtain accurate and timely information, document this information, and provide effective communication with the patient and provider. This protocol is inclusive of all UK HealthCare Ambulatory clinics including telehealth appointments. A standardize rooming process supports the University of Kentucky Healthcare's commitment to providing outstanding patient service, experience, and quality of care. An organized, standard rooming process has been linked to increased provider productivity and practice efficiency (Sinsky, 2014).	

Definitions:

AIDET-Acknowledge, Introduce, Duration, Explanation, Thank you

Pre-rooming-preparation work completed before the patient arrives to assist in understanding existing conditions and treatment plan in order to focus attention during the visit on the collected information. (Sinsky, Sinsky, & Rajcevich, 2015)

Rooming-common tasks that need to be completed immediately prior to the provider seeing the patient. Can be in person visit or virtual visit

Handoff-the process of transferring care from one healthcare team member to another.

End of Visit-the point of care prior to the patient being discharged from the clinic/virtual appointment

place medication order in pending status for provider to approve/deny

9. Review and update history at each visit:
   - Medical history
   - Surgical history
   - Family history
   - Social History including tobacco, alcohol, substance use, sexual activity, ecigarettes/vaping, socioeconomic, SDOH

10. Complete the following screenings per policy/protocol:
    - **Falls risk screening**-per protocol
    - **Depression screening**-annual for ages 12 and above, every 3 months if pt has dx of depression
      **use age appropriate tool*
    - **Suicide screening**-per policy
    - **GAD-7**-age >=18 being seen for anxiety
    - **Hearing screen** as needed
    - **Vision screen** as needed

11. Review and address any Care Gaps/Health Maintenance as appropriate

12. Complete any needed point of care testing per ambulatory protocols

13. Review and reconcile immunizations at each visit

14. Additional task(s) as needed per specialty clinic workflow requirements

Scripting

- How screening is done is just as important as the questions that are being asked

- Sensitivity and compassion should be practiced with *all* patients

- Screening techniques:
  - Check your tone and rate of your speech
  - Use encouraging verbal responses
  - Non-verbal behaviors (nod head, attentive, compassionate facial expression, sit if you can).

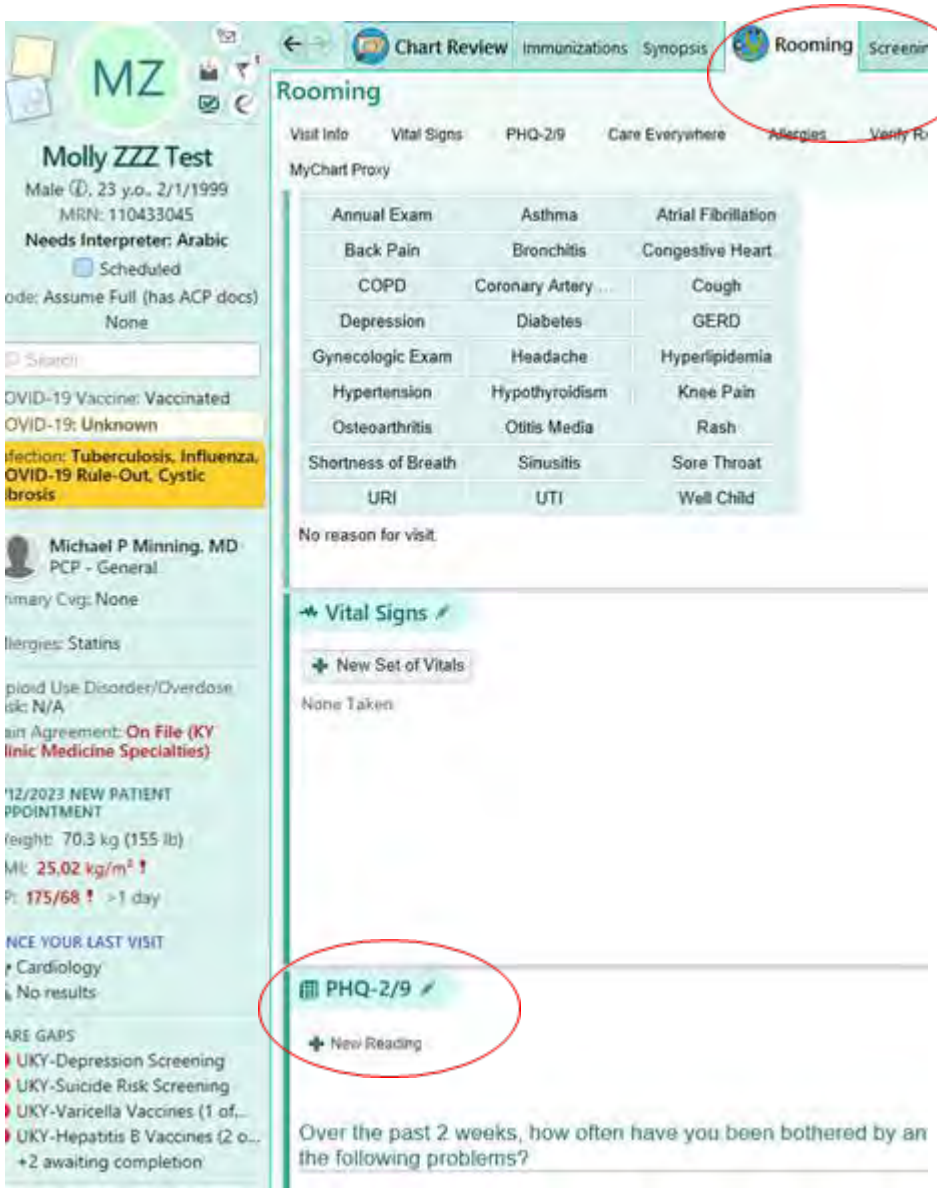
Scripting Techniques

“Because some topics are hard to bring up, we ask these same questions to all of our patients.”

-OR-

“In order to provide the best care to our patients, we screen every patient for depression at each visit. Will you answer some questions for me?”

Documentation



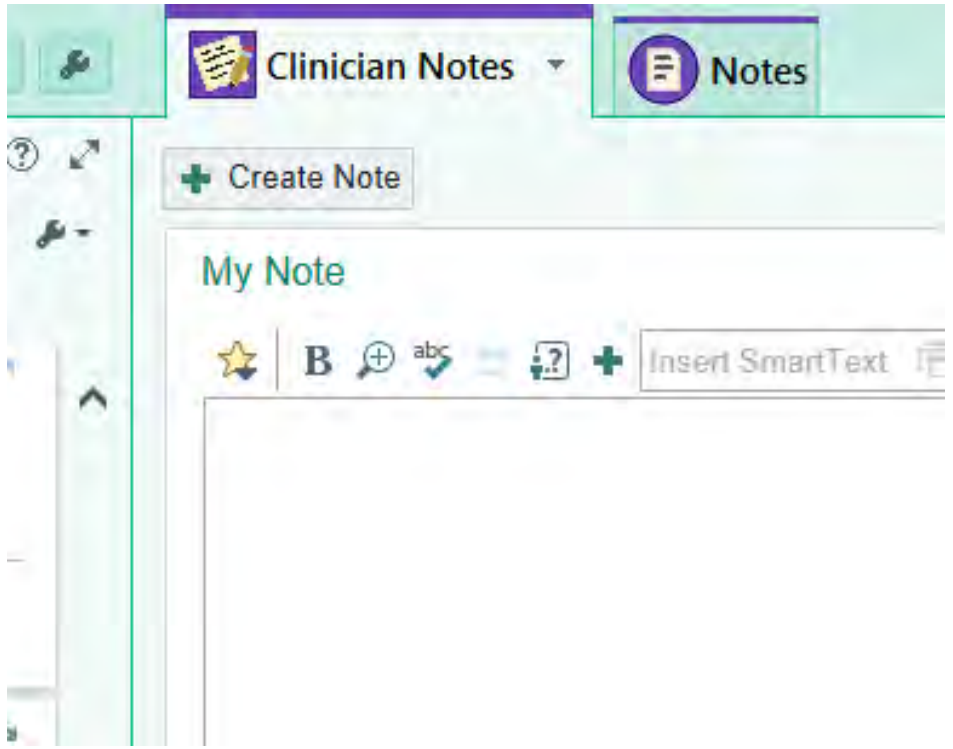
C-SSRS (Short Version)

New Reading at: 1538

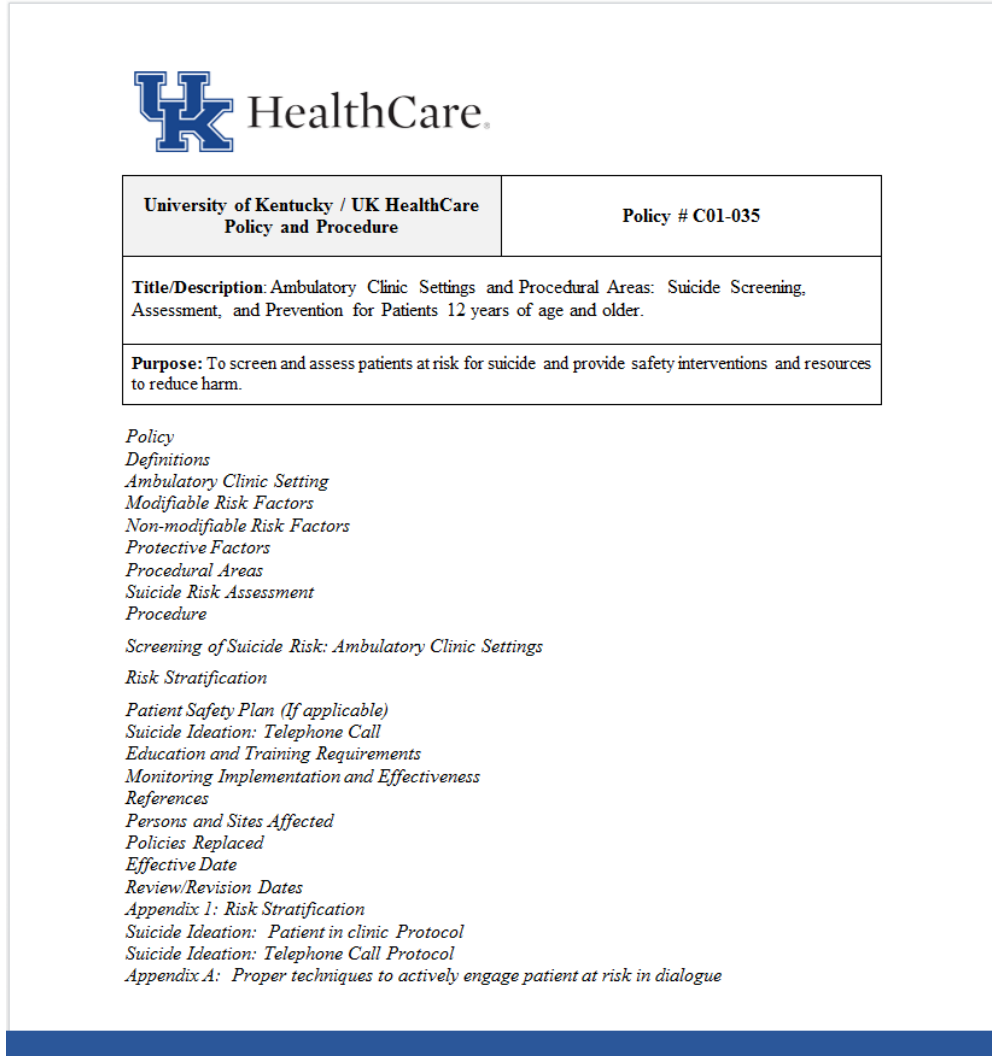
Suicide Assessment

Columbia Suicide Severity Rating Scale	Treatment fr 10/27/2022 1538
Is patient awake, alert, and able/willing to answer questions appropriately?	Yes
1. Wish to be Dead (Past 1 Month)	Yes
2. Non-Specific Active Suicidal Thoughts (Past 1 Month)	Yes
3. Active Suicidal Ideation with any Methods (Not Plan) Without Intent to Act (Past 1 Month)	Yes
4. Active Suicidal Ideation with Some Intent to Act, Without Specific Plan (Past 1 Month)	Yes
5. Active Suicidal Ideation with Specific Plan and Intent (Past 1 Month)	Yes
6. Suicidal Behavior (Lifetime)	Yes
6. Suicidal Behavior (Description)	
Calculated C-SSRS Risk Score (Lifetime/Recent)	High Risk

Chart suicide protocol initiated/stayed in Patient room until provider present



Policy



HealthCare

University of Kentucky / UK HealthCare Policy and Procedure	Policy # C01-035
Title/Description: Ambulatory Clinic Settings and Procedural Areas: Suicide Screening, Assessment, and Prevention for Patients 12 years of age and older.	
Purpose: To screen and assess patients at risk for suicide and provide safety interventions and resources to reduce harm.	

Policy
Definitions
Ambulatory Clinic Setting
Modifiable Risk Factors
Non-modifiable Risk Factors
Protective Factors
Procedural Areas
Suicide Risk Assessment
Procedure
Screening of Suicide Risk: Ambulatory Clinic Settings
Risk Stratification
Patient Safety Plan (If applicable)
Suicide Ideation: Telephone Call
Education and Training Requirements
Monitoring Implementation and Effectiveness
References
Persons and Sites Affected
Policies Replaced
Effective Date
Review/Revision Dates
Appendix 1: Risk Stratification
Suicide Ideation: Patient in clinic Protocol
Suicide Ideation: Telephone Call Protocol
Appendix A: Proper techniques to actively engage patient at risk in dialogue

The Suicide Policy has recently changed -

- Patients age 12 and above
- at every primary care provider or mental health provider visit
- screen using the PHQ-2/9 (age 12 and above) or PHQ-A (age 12-17)
- If a patient answers, several days, more than half days, or nearly every day to question, “over the last 2 weeks, how often have you been bothered with thoughts of you are better off dead or hurting yourself in some way?”, then a suicide risk screen has to be performed using Columbia screen C-SSRS (short version)
- If the patient is identified as low, moderate, high risk on the C-SSRS, implement the suicide protocol

Protocol

HealthCare

University of Kentucky / UK HealthCare Ambulatory Services Protocol	Suicide Ideation: Patient in clinic
Owner/Author: Patty Hughes DNP, RN, NE-BC Chief Nursing Officer-Ambulatory	
Target Area: UKHC Ambulatory care clinics, Patient Access, Health connections, Customer Service	
Personnel authorized to perform: RN, LPN, MA, PRA, CSS, PAR	
Purpose: To establish a high-quality process to ensure the safety and wellbeing of patients who are identified at risk for suicide or express desire to harm other(s) while in an ambulatory clinic.	

Criteria and Delegation:

Indication/Criteria	Order/Action
1. Patient has been identified by the proper screening tool, per Ambulatory Clinic Settings and Procedural Areas: Suicide Screening, Assessment, and Prevention for Patients 12 years of age and older policy, to be low, moderate, or high risk for suicide. **AND/OR** 2. Patient expresses suicide ideation; desire to harm self. **AND/OR** 3. Patient expresses desire to harm other(s)	**DO NOT LEAVE PATIENT ALONE; must be observed at all times while in clinic.** 1. Ask for someone to get a provider. 2. If provider determines patient needs to go to ED: a. If family present and willing to escort patient to ED, obtain and document their commitment that they will take the patient to the ED. b. If no family, call 3-6215 (if dispatch reports wait will be longer than a couple of minutes, 911 may be utilized) Note: Dispatch will determine which ED c. Report must be called to the ED (ask to speak to charge nurse) 3. Engage patient in active dialogue while waiting for provider or transport. See Appendix A for Proper techniques to actively engage patient. 4. If patient tries to exit the room:

HealthCare

University of Kentucky / UK HealthCare Ambulatory Services Protocol	Suicide Ideation: Telephone call
Owner/Author: Patty Hughes DNP, RN, NE-BC Chief Nursing Officer-Ambulatory	
Target Area: UKHC Ambulatory care clinics, Patient Access, Health connections, Customer Service	
Personnel authorized to perform: RN, LPN, MA, PRA, CSS, PAR	
Purpose: To establish a high-quality process to ensure the safety and wellbeing of persons who are identified at risk for suicide or who express desire to harm other(s), when someone is on the phone with a staff member that is in an ambulatory area.	

Criteria and Delegation:

Indication/Criteria	Order/Action
1. Someone calls into an ambulatory area or while on the phone with a person, the person expresses desire to harm self and/or expresses suicidal ideation **OR** 2. Someone calls into an ambulatory area and expresses concern for another person's wellbeing/safety due to desire of harming self **AND/OR** 3. Someone calls into an ambulatory area and expresses desire to harm other(s)	**DO NOT PLACE PERSON ON HOLD FOR ANY REASON** **If caller hangs up, attempt to call them back in order to engage caller until help arrives** **Talk with caller as long as they will allow or until emergency responders arrive** 1. Initiate use of Active Rescue: Staff must take all action necessary to secure the safety of the caller and initiate emergency response with or without caller's consent. This may include fire dept, police, suicide hotline 2. Ask the caller for their address and phone number (if calling in regards to another person, make sure to ask caller for address and phone number of person expressing suicidal ideation or desire to harm other(s)) 3. Ask coworker to contact 911 and send help to the

FY23 Ambulatory Performance EOM September 2022

	Measure Name and NQF # (if applicable)	Measure Steward/ Developer	FY23 Target	UKHC All Payer 10.03.2022	MDP Y3 Threshold	UKHC MDP 10.03.2022
Amb. Enterprise Quality Measures	**Colorectal Cancer Screening**	NQF 34	≥65%	**69.35%**	58%	56.07%
	Breast Cancer Screening	NQF 2372	≥66%	**75.54%**	52%	**60.23%**
	Tobacco Use: Screening and Cessation Intervention	NQF 28	≥88%	**95.70%**	75%	**90.67%**
	Body Mass Index (BMI) Screening and Follow-Up	NQF 421	≥61%	51.35%	70%	47.39%
	Well-Child Visit, 3-6 Years	NQF 1516	≥77%	**76.72%**	90%	75.69%
Pediatric Measures	Childhood Immunization Status	NQF 38 (Combo)	≥50%	43.95%	70%	33.05%
	Well Child Visits, First 15 months	NQF 1392	≥69%	**68.83%**	75%	65.32%
Monitored Measures	30-day All-Cause Readmission Rate *(lower is better)*	Vizient	≤12.41%	*12.42%	≤11.45%	11.76%
	Diabetes Care: Hemoglobin (HbA1c) Poor Control (>9.0%) *(lower is better)*	NQF 59	≤12.7%	**6.88%**	≤40%	**11.12%**
	Screening for Clinical Depression and Follow Up Plan	NQF 418	≥83%	78.06%	65%	**66.02%**
	Medication Reconciliation Post-Discharge	NQF 97	≥70%	**75.72%**	70%	68.60%
	Statin Therapy for Patients with Cardiovascular Disease	CMS 347eCQM	≥76%	68.78%	80%	65.04%
	Controlling High Blood Pressure (Hypertension)	NQF 18	≥67%	**67.49%**	55%	**66.44%**
	Use of Opioids at High Dosage *(lower is better)*	NQF 2940 – PQA	≤4%	**2.36%**	≤1.5%	4.13%

HOW HAVE YOU SEEN BEHAVIORAL HEALTH SCREENING INTEGRATED INTO PRIMARY CARE SETTINGS?

PANEL DISCUSSION: HOW TO ADDRESS POSITIVE SCREENINGS IN YOUR PRACTICE

Mareen Dennis, MS, LPP
Director, Psychological Testing, UKHC

Ginny Lee Gottschalk, MD
Medical Director, Family and Community Medicine, UKHC

Patricia Hughes, DNP, RN, NE-BC
Chief Nursing Officer, Ambulatory, UKHC

Please enter your questions for our panelists into the chat!

UK HealthCare

PANEL QUESTIONS

How do you deliver depression screening to the patient who presents for a sprained ankle or an ear infection?

How do you promote the idea of whole-patient care to your patient?

How do you respond to someone who is suicidal but does not want help and/or is refusing care?

How to you address a patient who just wants a "quick-fix" for their behavioral health issue only with medication?

What do you see as the benefits of therapy?

Are there any common misconceptions of therapy that you would like to address?

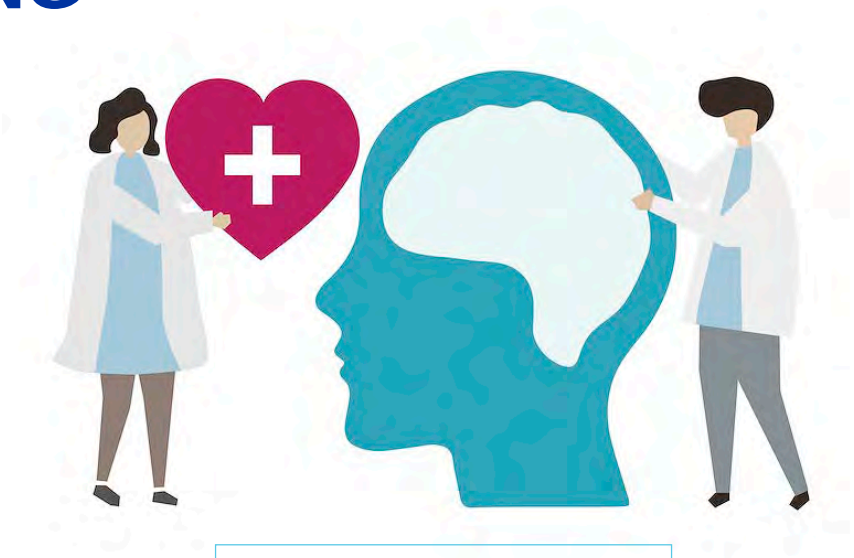
How do you encourage whole-person care to the provider that only has 10-15 minutes to spend with the patient?

UK HealthCare

QUESTIONS?

MENTAL HEALTH FIRST AID TRAINING

- Mental Health First Aid increases understanding and teaches people to safely and responsibly identify and address a potential mental illness or substance use disorder.
- We are offering free Mental Health First Aid Training classes to our attendees from January - April.



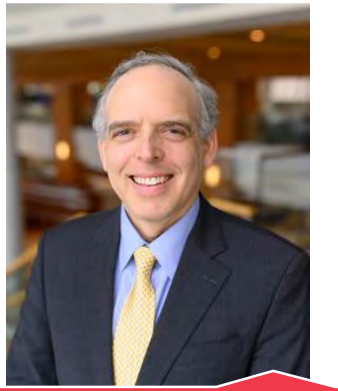
Register for Mental Health First Aid Training Here!

UK HealthCare

THANK YOU FOR PARTICIPATING!

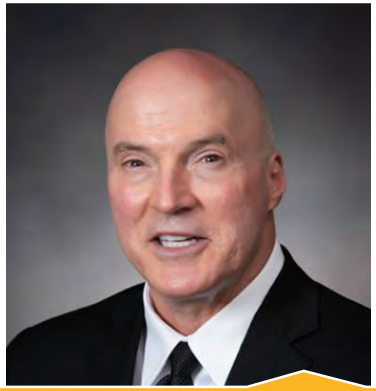
KENTUCKY REGIONAL EXTENSION CENTER
KYREC@UKY.EDU
859-323-3090

BEHAVIORAL HEALTH COMMUNITY OF PRACTICE LEADERSHIP TEAM



Seth Himelhoch, MD, MPH
Chair, Department Of Psychiatry, UKHC

Lindsey Jasinski, PhD
Chief Administrative Officer, Eastern State Hospital



Andrew Cooley, MD
Chief Medical Officer, Eastern State Hospital

Marc Woods, DNP, MSN, RN
Chief Nursing Officer, Eastern State Hospital

Julie Gosky
Regional Director CCBHC Health Initiatives, New Vista

Trudi Matthews
Senior Director Of Quality And Value Strategy, UKHC

UK HealthCare

BEHAVIORAL HEALTH COMMUNITY OF PRACTICE TEAM

Mindy Ross,
Behavioral Health Community of Practice Project Manager

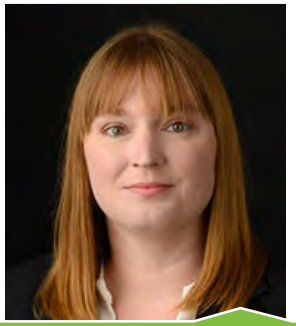
Jenni Jinright,
Healthy KY Initiative Manager

Lori Maddux,
Healthy KY Initiative Coordinator

Kelly Fountain,
Transformation Manager

Katie Sabitus,
Health Innovation Advisor

Katherine Shaw,
Business Development Assistant



Alicia Anderson,
Health Innovation Advisor

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NEXT WEBINAR: DECEMBER 1, 2022, 12-1PM ET