Suicide Prevention with Behavioral Health Integration in Primary Care Clinics:
A Survivor Perspective

July 15, 2016

COL-Ret George D. Patrin, MD, MHA

“Family Practitioner in Pediatric Clothing” (Retired)
Healthcare-Family Advocate (NOT Retired!)

SERENDIPITY Alliance
“A voice for the voiceless — breaking the silence by listening to survivors”

“CAN WE TALK?”

“History repeats itself, opportunity doesn’t!”
Under Accreditation Council for Continuing Medical Education guidelines –

I have no relevant financial relationships or affiliations with commercial interests to disclose.

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“History repeats itself, opportunity doesn’t!”
Workshop Objectives

1. Apply lessons learned from the survivors’ perspectives with case studies to reverse suicide rates (save lives).

2. Understand ‘why” and “how” cognitive dissonance and behavior attribution theories explain ongoing suicides.

3. Identify crucial community care process changes and resourcing needed within truly integrated behavioral healthcare services to end suicide as a common scenario in our society.
Workshop Outline

A. Share YOUR issues!
B. Present family case presentations where community cultural and clinical practices missed the opportunity to provide timely cost-effective intervention highlighting missing key actions where prevention is possible.
C. Review the ‘why’ - cognitive dissonance, group-think, and attribution theory in well-meaning communities.
D. Describe components of a community primary care medical home (PCMH) staffing model with integrated multidisciplinary mental health care providers.
E. Reiterate procedures (actions) to implement ‘next Monday’ for organizations truly serious about achieving “zero suicides.”
F. Share YOUR successes!
Why are we talking about this…again?

42,773 people died in the US by #suicide in 2014.

US suicide rate increased 24 percent between 1999 and 2014 (CDC – 13/100,000 people)!

One is too many. “Zero Suicides” IS possible!
The Zero Suicide Learning Collaborative

Henry Ford Health System - inspired efforts in AZ, NY, TX, KY, other states. Website and Zero Suicides Toolkit available. Henry Ford Health System’s Perfect Depression Care reduced suicides by 82% over 8 years. http://catalyst.nejm.org/dramatically-reduced-suicide/

Magellan of Arizona – 42% reduction in suicide rate in those mental illness, 67% others over 5 years. AZ Dept of Health Services created Arizona Programmatic Suicide Deterrent System.

Kentucky Dept for Behavioral Health - a “never event” within the state’s health and behavioral health organizations.

Texas Dept of State Health Services Zero Suicide.

New York Office of Mental Health eliminate suicide deaths. The Institute for Family Health

Some are all talk, use terminology…no action.

USAF (at one time)
What are your issues?
What’s Preventing Us From Getting It Done?

1. Resources (staffing, time)
2. Training (ignorance)
3. “Sick-Care” (Non) System (payment)
4. Productivity Rewarded (overdependence on medication treatment modality)
5. Lack of Supportive Laws
6. Cultural (Legal) Stress

Exercise YOUR “circle of influence”?!
LET’S ALL REMEMBER:

*If this were easy, everybody would be doing it!*

*History repeats itself. Opportunity doesn’t.*
Community Collaborative Approach as Accountable Care Organization (ACO)

- Primary Care
- Healthcare Policy
- School Services
- Specialty Care Behavioral Health
- Internal Practitioners
- Research
- Education Training
- Prevention
- Network Practitioners
- Schools
- Spiritual Organizations

Person
Healthcare by a Patient-Centered Family-Driven Integrated Team

Child Development Center
Unit Support
Youth Center
Youth Groups (Scouts)
Chapel
Skears
Spiritual Organizations
Ending Suicide

What's missing from survivor’s* perspective?

A. A “service” mentality (“Who works for who” and “Who’s in charge?”)

B. Universal Community Mental Health Screening (shared with those with a “need to know”) with preventive “ROI” agreements BEFORE crises

C. Proper Resourcing for Prevention (‘Access’) Primary Care with Integrated Behavioral Health (the ‘warm hand-off’)

D. ‘Safety Net’ Training ('CPR for the Mind‘)

E. Informed Connectedness/ Collaboration/ Sharing/ Seamless

*Attempter (me) or “Family” (they)
BLUF*

Five Take Home ‘Must Do’ Actions
(for next Monday)

1. Ask - “Who’s your PCM?” (continuous relationship)
   (with signed ROI of ‘trusted’ family/friends)

2. Universal Screen Depression/ Suicidal Ideation

3. Establish Integrated Primary Care Teams with Behavioral Health and Case Management in PCMHs


5. Implement ‘Safety Net’ (Monitoring Plan) Process Training

Ultimately ALL successful ‘Zero Suicide’ programs have incorporated these tenants in their community processes.

*BLUF (Bottom Line Up Front)
Case #1

The Intervention That Never Happened Over 10 Days

15 Dec – 19 yo W,M. 1st acute appt for depression, ADHD med adjustment. Antidepressant given. No screen.

28 March – 2nd appt in 3 months w/ 2nd FP for depression, suicidal thoughts. Given new anti-depressant, ADHD med. No referral to “TRICARE” for mental health visit. (Depression screen was ‘lost.’)

3 Apr, Fri – Tells former girlfriend he will kill himself. She puts in “missing person report.” Goes home to parents. No search done.

4 Apr, Sat – Calls best friend detailing suicide plan. They believe “he’ll show up.”

5 Apr, Sun (0200) – Emails friends detailing suicide with will. 2nd “missing person report” called in. Police send weak APB w/o car info.

5 Apr, Sun - Stopped by security guard sleeping in car on private property with new shot gun & ammo in car, released after showing he knows how to set safety, empty chamber.

6 Apr, Mon (1400) - Parents learn of plan from girlfriend’s parents. Alert CA PD who issue new report.

6 Apr, Mon (late PM) – Parents and CA PD call Sprint for location – “cannot give out privacy info, must get a court order tomorrow”

7 Apr, 0300 – Patient contacts family w/goodbye emails. Parents again contact PD and Sprint, plead for message origination, - “wait ‘til business hours.”

7 Apr, 1400 - Sprint concedes, locates patient within 50 ft...found dead @ 1338 in motel room with shotgun wound to the heart (left $1000 - “sorry for the mess”)
How Can/ Why Does This Happen?

- **Group (Unit) Think**
  - Don’t question command, mission productivity at risk

- **Expectancy Theory**
  - Work harder, do more, outcome will change

- **Cognitive Dissonance**
  - “We did all we could do, not responsible”

- ‘(Conspiracy of) Denial’
  - Don’t discuss failures, “Pandora’s Box” (fear of legal action)
Service Mentality Focused on the Patient/Family

“Who works for who? Who’s *health plan* IS it?!?”

**IMPORTANT!**

Include “**Family**” as part of the team!

*Interpret HIPAA!*  *(Parity applies.)*

**The Person**
- Primary Care Provider Team
- Specialty Care Provider Teams
- Administrative Support Team
- Support Services Teams

Ownership, Knowledge, Shared Service Mentality!

Always ask: “Who’s the Patient?”

*Bring the service to them, or them to the service!*
Case #2
Non-Access to Outpatient Services With No Medical Home

- 37 yo W, M – psychotic, homeless: needs assessment, safety plan. (Not in his home State – visiting relatives.)
- 10 Year Hx - persistent mental health illness on 100% Social Security Disability Income
- Daily psychosis, cyclical paranoia coupled with depression and severe loss of self-esteem.
- Extremely loving and caring individual with ‘anosognosia,’ violent only to himself
- History of bizarre suicide attempts, self-harm

PCM Screen Safety Plan/ ROI Integrated PC Teams Same Day BH Access

‘Interventions’
- Relatives try to get him help through homeless shelter. Rejected (wait list). Agrees to go to county MH Crisis Center.
- 1st – Voluntary admission, family ignored at hosp, signs out AMA two days later.
- 2nd – One month later. Returned after wandering in the desert looking for his birth mother, dehydrated. Ejected from two ERs. Burning himself with cigarettes. Mental health warrant issued, brought to crisis by sheriff. Transferred to unknown hosp, family ignored, released five days later on Haldol.
- 3rd – Police pick up back on street next day. Court ordered treatment initiated. Returned to Home State after two months. Said “Wasn’t suicidal until you put me in there against my will.”
"The medical home is a point of access to health care that is organized around the patient’s needs built on a relationship between a patient and a physician. It is a primary health care base capable of providing 90% of health needs but also coordinating specialty referrals and ancillary services. The medical home is a source of first contact care and comprehensive care… It is a place where they get to know you.”

(Grumbach & Bodenheimer JAMA 2002;288:889-893.)

Consider – Wherever the person is… IS their ‘medical home.’

PCPCC
http://www.engagehealthiq.com/engagehealthiq-blog/2014/7/30/interview-amy-gibson-pcpcc-patient-experience-medical-home
The Accountable Care Organization
Patient-Centered/ Family-Focused/ Inclusive
Always ask…”what’s best for the patient?”

A Collaborative Community Approach
Integrated (Virtual) Teams
The Accountable Care Organization
Patient-Centered/ Family-Focused/ Inclusive
Always ask…”what’s best for the patient?”

Military/ VA Practitioners
(DIRECT CARE)

Non-Military Practitioners
(PURCHASED CARE)
(Non-Network Care)

The Patient (Family)
in “Med Home” Center

Training/ Education

Primary Care Teams
(Continuity)

Specialty Care Services
(Consult)

Timely Appointing/ Referral
Follow Up, Care Coordination,
Case Management

Medical -Network (Neighborhood)

A Collaborative Community Approach
Integrated (Virtual) Teams
Patient-Centered Medical Home (PCMH) Integrated Team Resourcing
(Population Based: 1365 to 3000 Reliant Beneficiaries)

**Core Primary Care Team**
1. Provider (MD, DO, NP, PA) (1.0)
2. RN (Treatment) (0.5)
3. LPN/Medic/(CNA) (2.0)
4. Medical Clerk/Admin Asst (0.5)
5. **Nurse Case Manager (N-CM) (0.5)**
6. Practice Manager/Admin (0.2)

**Integrated Team - Consultants ("Primary Care Specialties")**
- Behavioral Health (0.2)
- Social Work (0.2)
- Pharm D
- Nutrition
- Addiction/Pain Management
- Physical/Occupational Therapy (Exercise Physiology)
- Optometry
- Pathology (Lab)
- Radiology
- Central appointing, referral services
- Other specialty providers (based on population)

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<td>(Group Office)</td>
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(Data available if interested in recommended ratios of employees to full-time Provider.)
### Specialty Population Factors and Staffing/Room Ratios

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<th>AOC</th>
<th>Pop Factor* per Provider FTE</th>
<th>Support Staff Ratio per Provider FTE</th>
<th>Exam Room Ratio per Provider FTE</th>
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<td>2.5</td>
<td>2.0</td>
<td>0.6</td>
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<td>SOCIAL WORK (Under Revision)</td>
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<td>4.3</td>
<td>0.4</td>
<td>1.5</td>
<td>0.40</td>
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</table>

*Population factor is based on 1.0 FTE working the usual # of outpatient clinic hours per week as other average above average practices of that AOC do.
Rethink Skill Sets! Remove the Provider:Patient ‘bottleneck.’

**Patient Encounter Process**

- **RECEPTION:** Check In, Chief Complaint(s), Hx Review, Test Summary
- **MED TECH:** Vital Signs, HPI, PMH Updates
- **PROVIDER:** (V-HPI), (V-PMH), PE, Orders, Consults, (Education), (V-F/U Plan)
- **RN:** Education, Procedure(s), Follow-Up Plan
- **MED TECH/LPN:** Check Out (V-F/U Plan)

**Time In Clinic**

**Patient Check-In**

**Patient Check-Out**

**Screening/Wellness**

**Vitals**
Tool Kits are available

Integrated Behavioral Health Implementation Toolkit

Six steps to integrated behavioral health program success

Toolkit  |  March 26, 2015

Get surveys, checklists, templates, and tools for addressing six critical components of an integrated behavioral health program.

Behavioral health issues can exacerbate other health conditions and make patients less likely to comply with important care plan aspects.

Since most patients are diagnosed in the primary care setting, integrated behavioral health models can ensure patients follow through with referrals to mental health care.

Organizations who have reengineered Primary Care staffing and processes.

Southcentral Foundation Outpatient Clinic
Anchorage, Alaska/ Katherine Gottlieb, Pres/CEO
“Alaska native people shaping healthcare”
http://www.southcentralfoundation.com/
2011 Malcolm Baldrige National Quality Award

Family Team Care Medicine
Yorktown, Virginia/ Peter Anderson, MD (FP)
Author of “The Familiar Physician” and
“Lost and Found: A Consumer’s Guide to Healthcare”
http://www.aafp.org/fpm/2008/0700/p35.html
http://www.primarycareprogress.org/insight/3/profiles

https://www.pcpcc.org/care-delivery-integration
Give the time needed to do the job…up front!

**Booking Template**

"Emergency?" - Call **911** or Connect Caller to RN or Doctor On-Call if:

<table>
<thead>
<tr>
<th>Trouble Breathing</th>
<th>Burn Victim</th>
<th>Chest Pains</th>
<th>Head Trauma (Loss of Consciousness)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appointment Type</strong></td>
<td><strong>1st Time/Acute Same Day</strong></td>
<td><strong>Follow Up/Recurring/Routine</strong></td>
<td><strong>Established/Chronic/PE</strong></td>
</tr>
</tbody>
</table>

1. Start with:
   - 10 Minutes
   - 10 Minutes
   - 30 Minutes

2. Then for each "positive response" below give an additional 10 minutes…

   **A.** Have you had this more than FIVE days already or called and followed phone advice (which hasn't worked)? If "Yes"-
   - Add 10 Minutes
   - Not Applicable
   - Not Applicable

   **B.** Have you had this concern longer than a month, or if a follow-up, are you having complications? If "Yes"-
   - (See above)
   - Add 10 Minutes
   - Not Applicable

   **(Check provider availability at this point)**

   **C.** Is the same provider, or your PCMBN, available? If "No"-
   - Not Applicable
   - Add 10 Minutes
   - Add 10 Minutes

   **D.** Do you have any other issues to bring up today? If "Yes" (and appt available)
   - Add 10 Minutes
   - Add 10 Minutes
   - Add 10 Minutes

**Minimum-Maximum Appointment Length**

- **10 - 30 Minutes**
- **10-40 Minutes**
- **30-50 Minutes**
The Accountable Care Organization (ACO)

The PCMH Primary Care Team integrates the Comprehensive Care Plan (CCP)

1) All provider teams have a “need to know” – share the CCP
2) The patient owns their *comprehensive care plan and health status
3) A holistic approach
4) Don’t ‘hide’ behind HIPAA!
Case #3
Non-existent Long-Term Residential Mental Health Care

- 13 Year old AF Dep
- Home schooled until move from overseas to San Antonio (EFMP) location
- Nine admissions over 18 months
- Cutting
- Suicide attempt on New Year’s Eve in children’s home
- Airman father is not able to work
- Family disrupted, threatened
- “Used up’ her medical benefit (Tricare) of 150 days
- Tricare spent $380,000
- Family had to sign paperwork to ‘admit’ neglect/ and involve child protection, sent to children’s home
From November, 2012 to Jan, 2016.

One child. 9 Admissions.
Two cuttings episodes.
One suicide attempt.
Multiple threats to family.
No schooling.
End Suicide with Community MH ‘CPR’ Safety Net Training

1. Community Mental Health Safety (‘CPR’) Training/Education
   - Recognize signs and symptoms of depression with ACE/QPR/ASIST/SafeTalk/AMSR (DON'T wait until a crisis occurs!)
   - Initiate behavioral health participation with 1st observation.

2. Safety Net (Plan) (see SAMHSA SBIRT)
   http://www.integration.samhsa.gov/clinical-practice/SBIRT
   - remove “HIPAA Barrier,” go after needed information!
   - Implement Jensen Suicide Peer Prevention Protocol (JSP3) Safety Net
   - 6 Things You Can Do Today to Prevent Suicide
     by Randi Jensen, MA, LMHC, CCDC
     - Smart phone daily monitor (sent to Safety Team)
     - Include trusted “family” with release of information (ROI) form on 1st visit (BEFORE crisis)
Community-Wide & Personal

**Cultural Change Required to End Suicide**
BE an “Accountable Care Organization (ACO)” Member

1. Ask “Who’s your Primary Care Giver?” Continuity is King!

2. Integrate Primary and Specialty Care (PCMH) with case management, communicate, share information, remove silos, share case management. *(Insinuate yourself into PC.)*

3. Screen every visit for Depression/Suicidal Ideation. Enlist trusted “Family” members/advocates. **Sign informed choice Release of Information (ROI) forms on 1st meeting.**

4. Patient-Focused, Family-Driven Access!
Remember “Who’s the Patient” and provide ombudsmen assistance getting to the proper location/people.

Henry Ford's Perfect Depression Care Program

Can you make this happen in your Community?

- Establish a consumer advisory panel to help with the design of the program.
- Establish a protocol to assign patients into one of three levels of risk for suicide, each of which requires specific intervention.
- Provide training for all psychotherapists to develop competency in Cognitive Behavior Therapy.
- Implement a protocol for having patients remove weapons from the home.
- Establish three means of access for patients: drop-in group medication appointments, advanced (same-day) access to care or support and e-mail visits.
- Develop a website for patients to educate and assist patients.
- Require staff to complete a suicide prevention course.
- Set up a system for staff members to check in on patients by phone.
- Partner and educate the patient's family members.

Windows of Opportunity

“Seizing opportunity is not always easy. An ancient proverb states that many opportunities are missed because they come disguised as hard work.”

Joe M. Sanders, Jr., M.D., AAP Executive Director
Opportunity is waiting in our communities!

Questions?

COL (Ret) George Patrin, M.D.
patrin.patrin@gmail.com
georgepatrin@serendipityalliance.org
Cell 210-833-9152

Join the Team!
Managing (Measuring) Health ...or Cost?
(Know your resourcing model and outcome metrics!)

Fee for Service:  *Maximize # Visits  *Minimize Cost/ Unit Service

Capitated per Patient:  *Maximize Enrollment  *Minimize # Visits

Achieve Health Care System Equilibrium!
Veteran Guatemala Humanitarian Clown Trip

October 10-18, 2015
COL (Dr.) George Patrin
Pediatrician – Administrator – Commander - Advocate

18 April 1987 to 7 April 2009
PCMH Stakeholder Partners
Consultant SME Team Members

1. Customer Service/ Patient-Centered Educator
2. Coding (Charting, RVUs, ICD-10, Work Center Support)
3. Pain (Communication, Treatment, Referral Management)
4. Nutrition
5. Optometry
6. Pharmacy-D
7. PT
8. Special Programs/Developmental/Rehab
9. Data Analyst (Metrics Snapshot, Charts, Reports, Analysis)
10. Managed Care/ Quality/ TJC/ BSC
11. IM/IT Specialist (Software, Hardware)
12. Resource Management
13. Human Resources
14. Business Office/ Records
15. Preventive Medicine
16. Training/ Education