Zero Suicide System of Care

CENTERSTONE’S JOURNEY
Our Noble Purpose

Delivering Care That Changes People’s Lives
Delivering care that changes people’s lives
Centerstone at a Glance

- **Bringing Science to Service**
- Recognized national behavioral health leader, private, not-for-profit 501(c)(3) healthcare organization
- 170 year history
- Specializing in the treatment and rehabilitation of individuals with mental illness, addictions, traumas, and intellectual/developmental disabilities
- Five state primary footprint; specialized services spanning all 50 states
- CARF and Joint Commission Accredited
  - Including specialized CARF Accreditation – Adult and Children & Youth Health Home
In FY 2017
People Served
172,000+
49%-Male
51%-Female
All ages served

Services Provided
2,781,000+

Staff
5,000+ clinical and administrative staff and a national network of over 1,000 contract therapists.

Signature Service Lines
• Health Homes
• Integrated Primary Care
• MAT/Addiction Services
• Hospital and Crisis Services
• Active Military and Veterans
• Intellectual and Developmental Disabilities

Our Reach
Suicide deaths for people under the care of health and behavioral health systems are preventable.
Promote suicide prevention as a core component of health care services.

Promote and implement effective clinical and professional practices for assessing and treating those at risk for suicidal behaviors.
About Zero Suicide

» Is an aspirational goal
» Focuses on error reduction and continuous quality improvement
» Fills in the gaps that exist in suicide care
» Centers evidence-based practices
THE TOOLS OF ZERO SUICIDE
FILL THE GAPS

- Screening
- Assessment
- Risk Formulation
- Collaborative Safety Plan
- Treat Suicidal Thoughts and Behavior
- Continuity of Care

Avoid Serious Injury or Death

SUICIDAL PERSON

Adapted from James Reason’s “Swiss Cheese” Model Of Accidents
What’s different about Zero Suicide?

» Suicide prevention is accepted as a core responsibility of health care

» Patient deaths by suicides are not treated as inevitable

» Emphasizes data, best practices, and continuous quality improvement
Zero Suicide Is Not

- A marketing campaign
- An approach looking to place blame
- A quick fix
Joint Commission Sentinel Event Alert 56: Detecting And Treating Suicide Ideation In All Settings

“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.”
The *National Action Alliance for Suicide Prevention* outlined seven core components necessary to transform suicide prevention in health care systems:

<table>
<thead>
<tr>
<th>Lead</th>
<th>• Lead system-wide culture change committed to reducing suicide</th>
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</thead>
<tbody>
<tr>
<td>Train</td>
<td>• Train a competent, confident and caring workforce</td>
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<tr>
<td>Identify</td>
<td>• Identify patients at-risk of suicide using a suicide care management plan</td>
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<tr>
<td>Engage</td>
<td>• Engage all individuals at-risk of suicide using a suicide care management plan</td>
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<tr>
<td>Treat</td>
<td>• Treat suicidal thoughts and behaviors using evidence-based treatments</td>
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<tr>
<td>Transition</td>
<td>• Transition individuals through care with warm hand-offs and supportive contacts</td>
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<tr>
<td>Improve</td>
<td>• Improve policies and procedures through continuous quality improvement</td>
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</table>
Seven Elements of Zero Suicide

Zero Suicide: **Lead**

Zero Suicide: **Train**

Zero Suicide: **Identify**

Zero Suicide: **Engage**

Zero Suicide: **Treat**

Zero Suicide: **Transition**

Zero Suicide: **Improve**
Future/Ongoing Development

- Continued culture growth
- Training program
- Engagement Strategies
- Treatment Method (building our own)

- Interface with primary care
- Engaging payers
- Expanded EHR development
- Predictive modeling
Centerstone’s Journey in Tennessee
The Importance of CQI

Centerstone-Tennessee Suicides | Per 10,000 Seen

Suicide Rate
Treating the Whole Person
Opportunity for Physical Health
Improved Screenings

- 84% of those who die by suicide have a health care visit in the year before their death
- 92% of those who make a suicide attempt have seen a health care provider in the year before their attempt
- Almost 40% of individuals who die by suicide had an ED visit within a year but not a mental health diagnosis
Background

- Among people who die by suicide, only 45% have a mental health or substance use diagnosis in the prior year; only 14% have a mental health–related inpatient stay and 29% receive behavioral health outpatient treatment.
- Suicide prevention targeted only to patients in behavioral health settings will miss the majority of individuals at risk for suicide.
- 80% of individuals make a health care visit in the year before suicide and nearly 50% have a visit within four weeks of their death.
- Identification in general medical settings is vital.

Methods

- Compared 2,674 suicide deaths between 2000-2013 with 267,400 in control group
- Reviewed 19 physical conditions for association with suicide
Physical Conditions Associated with Suicide Risk after Adjustment for Age and Sex

<table>
<thead>
<tr>
<th>Condition</th>
<th>Other Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back Pain</td>
<td>*Brain Injury, CHF</td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>*HIV/AIDS</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Migraine</td>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>Psychogenic Pain</td>
<td>Renal Disorder</td>
</tr>
<tr>
<td>*Sleep Disorders</td>
<td>Stroke</td>
</tr>
</tbody>
</table>

Multiple morbidities were present in 38% of suicide cases versus 15.5% of controls

**Bold** = after additional adjustment for MH & SUD
* = greater than 2x increase in risk
Commonly diagnosed conditions associated with suicide risk include: **back pain**, **sleep disorders**, and **traumatic brain injury** (*TBI increases odds of suicide nine-fold*). Patients with these conditions are primary targets for suicide prevention.

Patients with multiple chronic conditions are also at significantly increased risk for suicide.

Given that nearly every physical health condition is associated with suicide, widespread suicide prevention efforts in all healthcare settings seems warranted.
Chronic Pain and Suicide

% Chronic Pain

- 2014: 38%
- 2015: 35%
- 2016: 36%
- 2017: 43%
Patients Receiving *Only* Psychopharmacology Services

Data analysis showed that there were many patients with severe mental illness receiving psychopharmacology services without psychotherapy and/or other support services.

In some sites, the number of patients receiving psychopharmacology-only services was significantly higher than the number receiving psychotherapy services.
Psychopharmacology-Only Services
Suicide Deaths in 2015

- 39% Psychopharmacology-Only Services during last 90 days
- 67% Instability on medications in last 3 visits
- 67% Behavioral / Emotional instability in last 90 days
- 89% need for Psychotherapy or Case Management
- 56% Referred and never seen / dropped out
- 100% No SI or attempts acknowledged in last 3 visits
- 78% Benzodiazepine / 22% Hypnotic
- 0% Mobile Crisis call in past 3 months
- 11% Mobile Crisis call in 12 months
- 0% Inpatient in past 3 months
- 33% Inpatient lifetime
The Mechanism to Implement Appropriate Level of Care

- Reports from Analytics identifying Psychopharmacology-only patients in past 90 days
- Clinic operations structure to review high-risk and other patients
- Treatment engagement coordinator position in major clinics
- Case management / care coordination assessment for all TennCare (Medicaid) intakes and PRN
- Screening of commercially-insured patients before direct scheduling of psychiatric evaluations
Redefining Patient-Centered Care

- Engaging patients at appropriate levels of care by adhering to our professional recommendations...
- ...as opposed to a “Have It Your Way” approach to treatment
Patients **Suitable for Psychopharmacology Services without Psychotherapy**

- Must show a pattern of stable behavioral / emotional functioning without significant clinical risk
- Have no present therapeutic need for psychotherapy, case management or other community-based services to:
  - Monitor and promote emotional stability and reality testing
  - Closely monitor mental status and clinical risks
  - Obtain housing, entitlements or community support services
- Have the support of the Psychiatrist or Nurse Practitioner via documentation of a statement in the psychiatric progress note that indicates suitability of the patient for psychopharmacology services only
- Patient is amenable to receiving psychopharmacology services only
Patients Ineligible for Psychopharmacology Services Without Psychotherapy

- Have reported recent or current suicidal or homicidal ideation and/or attempts and/or are currently enrolled in the Suicide Clinical Pathway
- Are new patients; with the exception of new patients for whom there is adequate documented history that the eligibility criteria are met to receive psychopharmacology-only services
- Are not stabilized on their medications; or who are non-adherent which could result in hospitalization; or who are taking medications with concerns about possible misuse or abuse
- Show marked instability or fluctuations in their behavioral and emotional functioning
- Refuse therapy, case management and/or other community-based services when these services are clinically indicated and recommended by the treatment team
- Had a mobile crisis assessment in past 3 months
- Patients discharged from an inpatient psychiatric hospital or A&D inpatient or residential facility within the past 3 months
- Diagnosis of chemical dependency/abuse with significant recent or current use
- Had a recent arrest or criminal conviction
Psychopharmacology Only Services

DISTINCT PATIENTS*

2015 | 5,521 patients

2016 | 5,033 patients 10%↓

* Patients who received only Psychopharmacology Services during the calendar year
Our Approach

**Existing**

- A formatted note
- Psychiatric review of systems
  - Radio buttons
- Mental Status Exam
  - Carry forward
  - Category dropdowns
  - I have reviewed...
- Risk Assessment

**Changes**

- Decreased the number of Psychopharmacology-Only Patients
- Improved Psychiatry staff’s ability to refer for other clinical services via EHR enhancement
- Therapy staff member to assist with assessment
  - Columbia Suicide Severity Rating Scale and for Follow-up as Appropriate
Potential Interventions in Primary Care

- Routine screening for suicide
- Safety and Treatment Planning
- True integration of physical and mental health care
- Potential for onsite mental health
- Relationship with mental health referral source for those with no onsite presence
- Access to Psychiatrist for consult
- Use of telehealth
- Building and leveraging EHR functionality
Q&A

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