CARING FOR OUR PATIENTS: SUICIDE ASSESSMENT & IMPLEMENTATION PLAN

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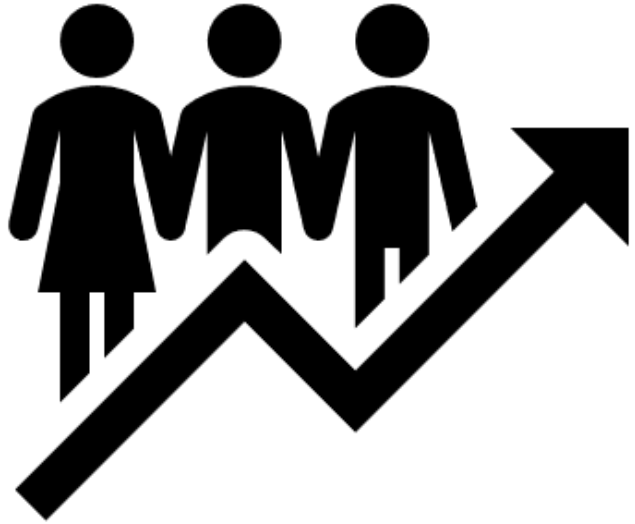
TCRHCC Chief Operating Officer

OBJECTIVES

1. Learn who is at risk for suicide
2. Review Suicide Stats – National, AI/AN, and Tribal data
3. CMS and TJC Regulations for Hospitals (non-Behavioral Health Setting).
4. Learn from the TCRHCC Experience— Implementing an organization-wide Suicide policy/prevention strategy for one rural hospital.

HOW HAVE YOU BEEN AFFECTED BY SUICIDE?

WHO IS AT RISK



WHO IS AT RISK?

1.Previous suicide attempts

- The risk is 2x higher within the first year after an attempt

1.Family history of suicide

1.Social isolation

Economic hardship

History of trauma or loss (including abuse as a child, bereavement)

Serious illness with physical or chronic pain or impairment

Access to lethal access couples with suicidal thoughts

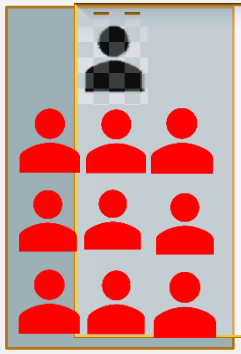
WHO IS AT RISK?

Alcohol abuse or drug abuse

Discharge from Psych care

Three times (or 200%) as likely the first week after discharge,

And, continues to be at high risk within the first year, and through the first 4 years after discharge

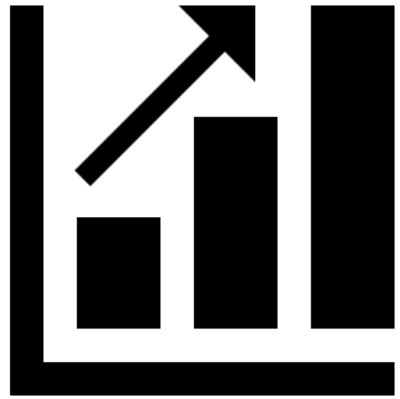


History of Mental illness

90% of suicide victims suffer from Mental or Emotional disorder

THERE IS NO SINGLE CAUSE TO SUICIDE. IT MOST OFTEN OCCURS WHEN STRESSORS EXCEED CURRENT COPING ABILITIES OF SOMEONE SUFFERING FROM A MENTAL HEALTH CONDITION

NATIONAL, TRIBAL, & TCRHCC (LOCAL) STATISTICS



NATIONAL SUICIDE STATISTICS

- Suicide is the 10 th leading cause of death in the US, and the 2nd leading cause for ages 10-34.
- In 2017, 47,173 Americans died by suicide
- In 2017, there were an estimated 1,400,000 suicide attempts
- In 2015, suicide and self-injury cost the USA $ 69 Billion
- From 2001-2017 the total suicide rate increased 31% from 10.7 to 14.0 per 100,000.
- The suicide rate among males remained nearly four times higher (22.4 per 100,000 in 2017) than among females (6.1 per 100,000 in 2017)

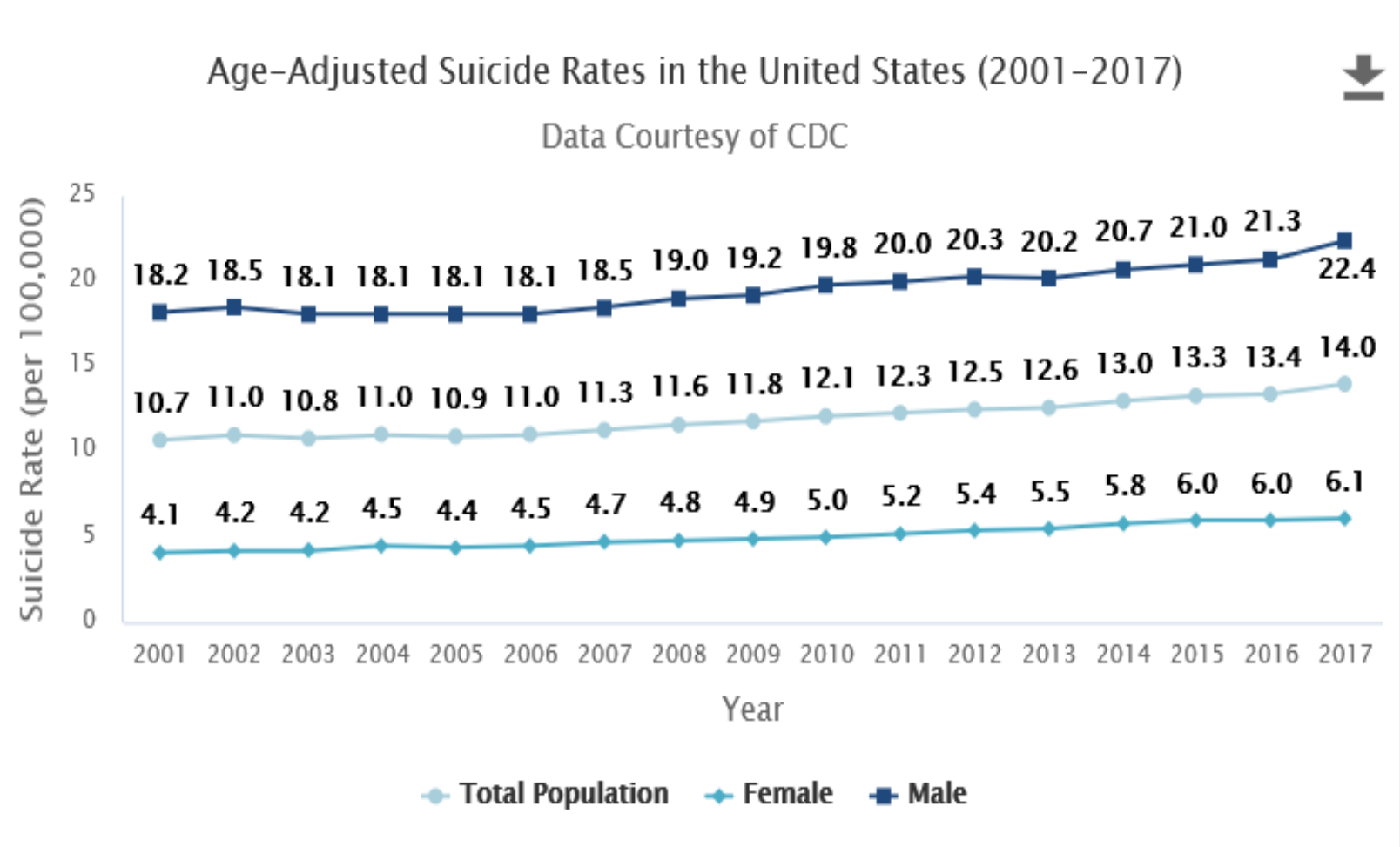
Leading Causes of Death in the United States (2016)

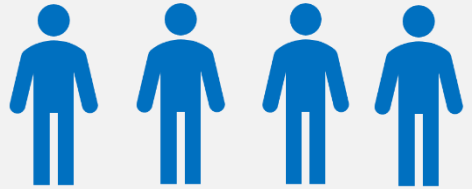
Data Courtesy of CDC

	Select Age Groups							
Rank	10-14	15-24	25-34	35-44	45-54	55-64	65+	All Ages
1	Unintentional Injury 847	Unintentional Injury 13,895	Unintentional Injury 23,984	Unintentional Injury 20,975	Malignant Neoplasms 41,291	Malignant Neoplasms 116,364	Heart Disease 507,118	Heart Disease 635,260
2	**Suicide 436**	**Suicide 5,723**	**Suicide 7,366**	Malignant Neoplasms 10,903	Heart Disease 34,027	Heart Disease 78,610	Malignant Neoplasms 422,927	Malignant Neoplasms 598,038
3	Malignant Neoplasms 431	Homicide 5,172	Homicide 5,376	Heart Disease 10,477	Unintentional Injury 23,377	Unintentional Injury 21,860	CLRD 131,002	Unintentional Injury 161,374
4	Homicide 147	Malignant Neoplasms 1,431	Malignant Neoplasms 3,791	**Suicide 7,030**	**Suicide 8,437**	CLRD 17,810	Cerebro-vascular 121,630	CLRD 154,596
5	Congenital Anomalies 146	Heart Disease 949	Heart Disease 3,445	Homicide 3,369	Liver Disease 8,364	Diabetes Mellitus 14,251	Alzheimer's Disease 114,883	Cerebro-vascular 142,142
6	Heart Disease 111	Congenital Anomalies 388	Liver Disease 925	Liver Disease 2,851	Diabetes Mellitus 6,267	Liver Disease 13,448	Diabetes Mellitus 56,452	Alzheimer's Disease 116,103
7	CLRD 75	Diabetes Mellitus 211	Diabetes Mellitus 792	Diabetes Mellitus 2,049	Cerebro-vascular 5,353	Cerebro-vascular 12,310	Unintentional Injury 53,141	Diabetes Mellitus 80,058
8	Cerebro-vascular 50	CLRD 206	Cerebro-vascular 575	Cerebro-vascular 1,851	CLRD 4,307	**Suicide 7,759**	Influenza & Pneumonia 42,479	Influenza & Pneumonia 51,537
9	Influenza & Pneumonia 39	Influenza & Pneumonia 189	HIV 546	HIV 971	Septicemia 2,472	Septicemia 5,941	Nephritis 41,095	Nephritis 50,046
10	Septicemia 31	Complicated Pregnancy 184	Complicated Pregnancy 472	Septicemia 897	Homicide 2,152	Nephritis 5,650	Septicemia 30,405	**Suicide 44,965**

National Institute of Mental Health, NIH. (2019, April)

NATIONAL SUICIDE STATISTICS



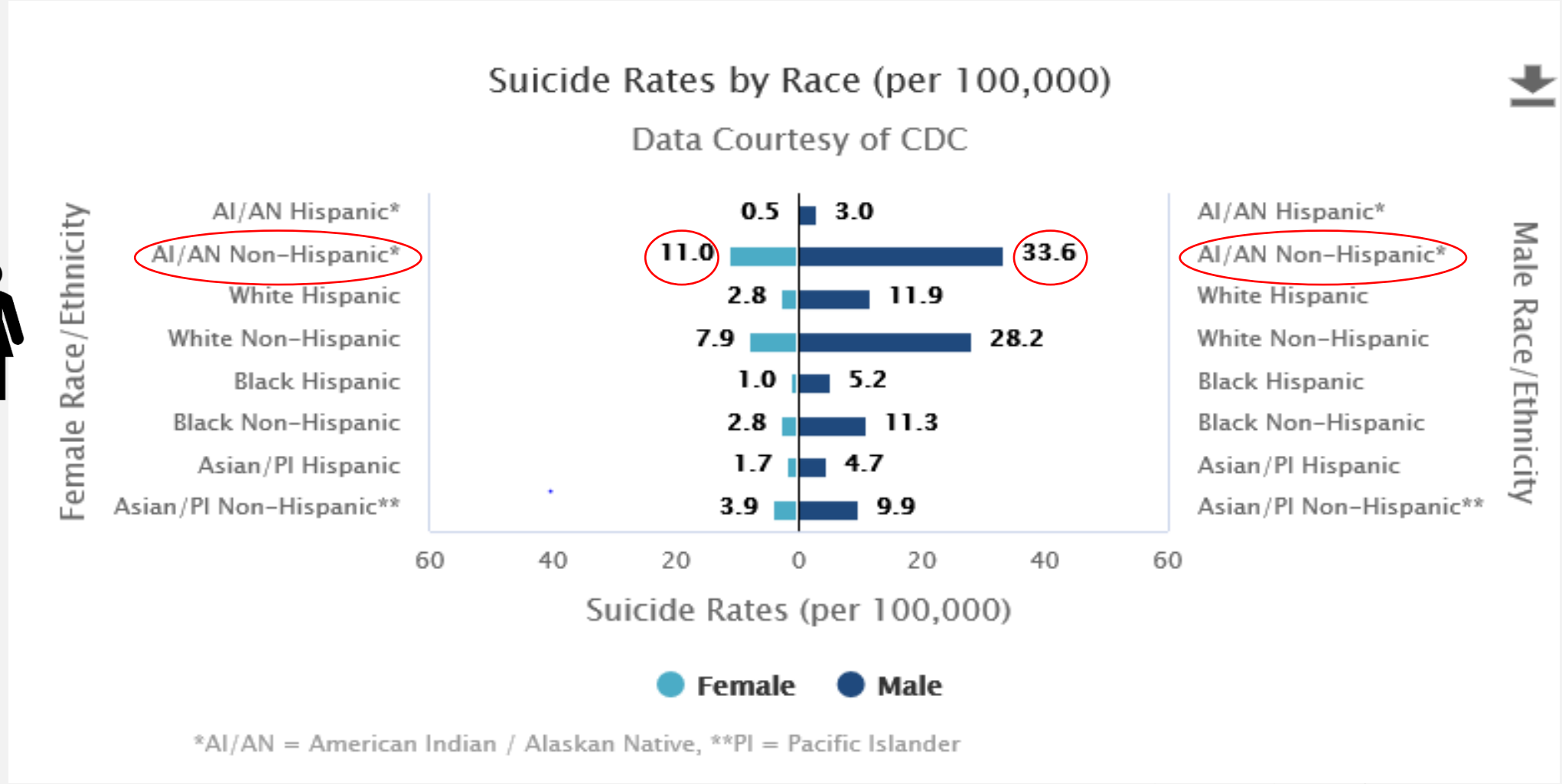


Male Suicide Rate 22.4 per 100,000
Four times higher than females

Female Suicide Rates 6.1 per 100,000

National Institute of Mental Health, NIH. (2019, April).

SUICIDE RATES BY RACE (PER 100,000)



National Institute of Mental Health, NIH. (2019, April).

MORTALITY DISPARITY RATES AMERICAN INDIANS AND ALASKA NATIVES (AI/AN)

IN THE IHS SERVICE AREA
2009-2011 AND U.S. ALL RACES 2010
(AGE-ADJUSTED MORTALITY RATES PER 100,000 POPULATION)

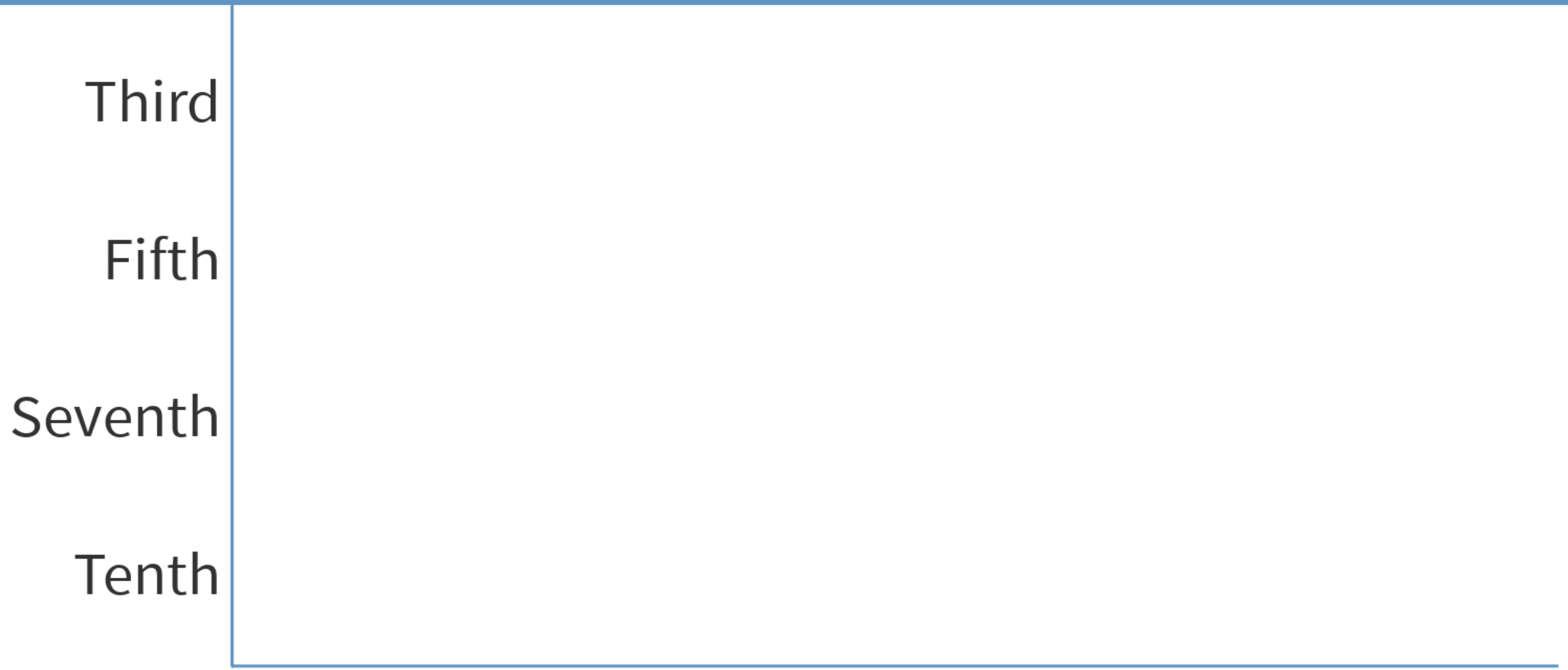
	AI/AN Rate 2009-2011	U.S. All Races Rate – 2010	Ratio: AI/AN to U.S. All Races
ALL CAUSES*	999.1	747.0	1.3
Diseases of the heart (heart disease)	194.1	179.1	1.1
Malignant neoplasm (cancer)	178.4	172.8	1.0
Accidents (unintentional injuries)*	93.7	38.0	2.5
Diabetes mellitus (diabetes)	66.0	20.8	3.2
Alcohol-induced	50.5	7.6	6.6
Chronic lower respiratory diseases	46.6	42.2	1.1
Cerebrovascular disease (stroke)	43.6	39.1	1.1
Chronic liver disease and cirrhosis	42.9	9.4	4.6
Influenza and pneumonia	26.6	15.1	1.8
Drug-induced	23.4	12.9	1.8
Nephritis, nephrotic syndrome (kidney disease)	22.4	15.3	1.5
Intentional self-harm (suicide)	20.4	12.1	1.7
Alzheimer's disease	18.3	25.1	0.7
Septicemia	17.3	10.6	1.6
Assault (homicide)	11.4	5.4	2.1
Essential hypertension diseases	9.0	8.0	1.1

* Unintentional injuries include motor vehicle crashes.

NOTE: Rates are adjusted to compensate for misreporting of American Indian and Alaska Native race on state death certificates. American Indian and Alaska Native age-adjusted death rate columns present data for the 3-year period specified. U.S. All Races columns present data for a one-year period. Rates are based on American Indian and Alaska Native alone; 2010 census with bridged-race categories.

Indian Health Disparities, I.H.S. (2018, April

Suicide is the _____ leading cause of death among Navajo



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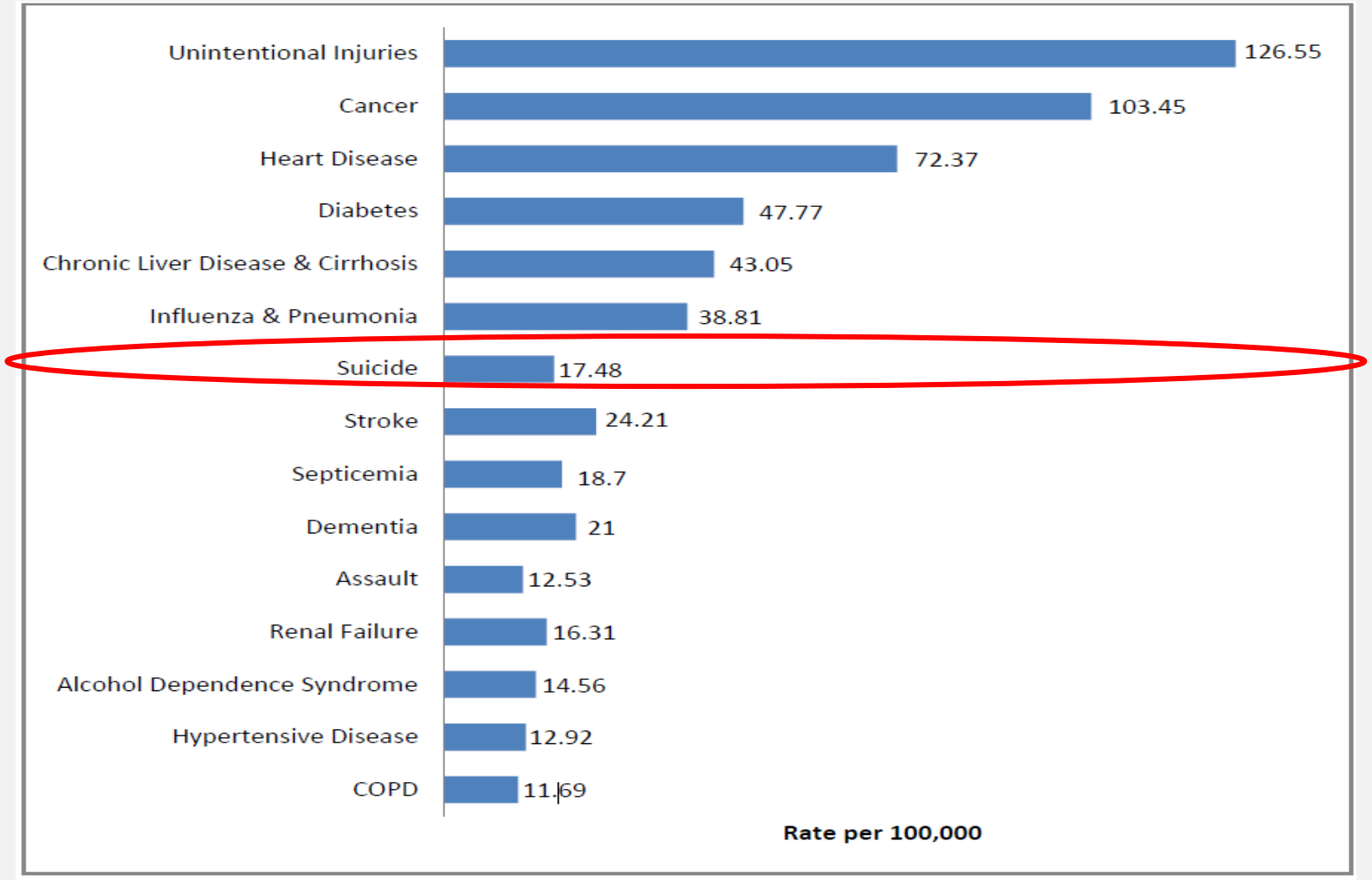
AGE-ADJUSTED MORTALITY RATE FOR THE 15 LEADING CAUSES OF DEATH ON NAVAJO, BOTH GENDERS



Navajo Nation Epidemiology Center Update (2016, May)

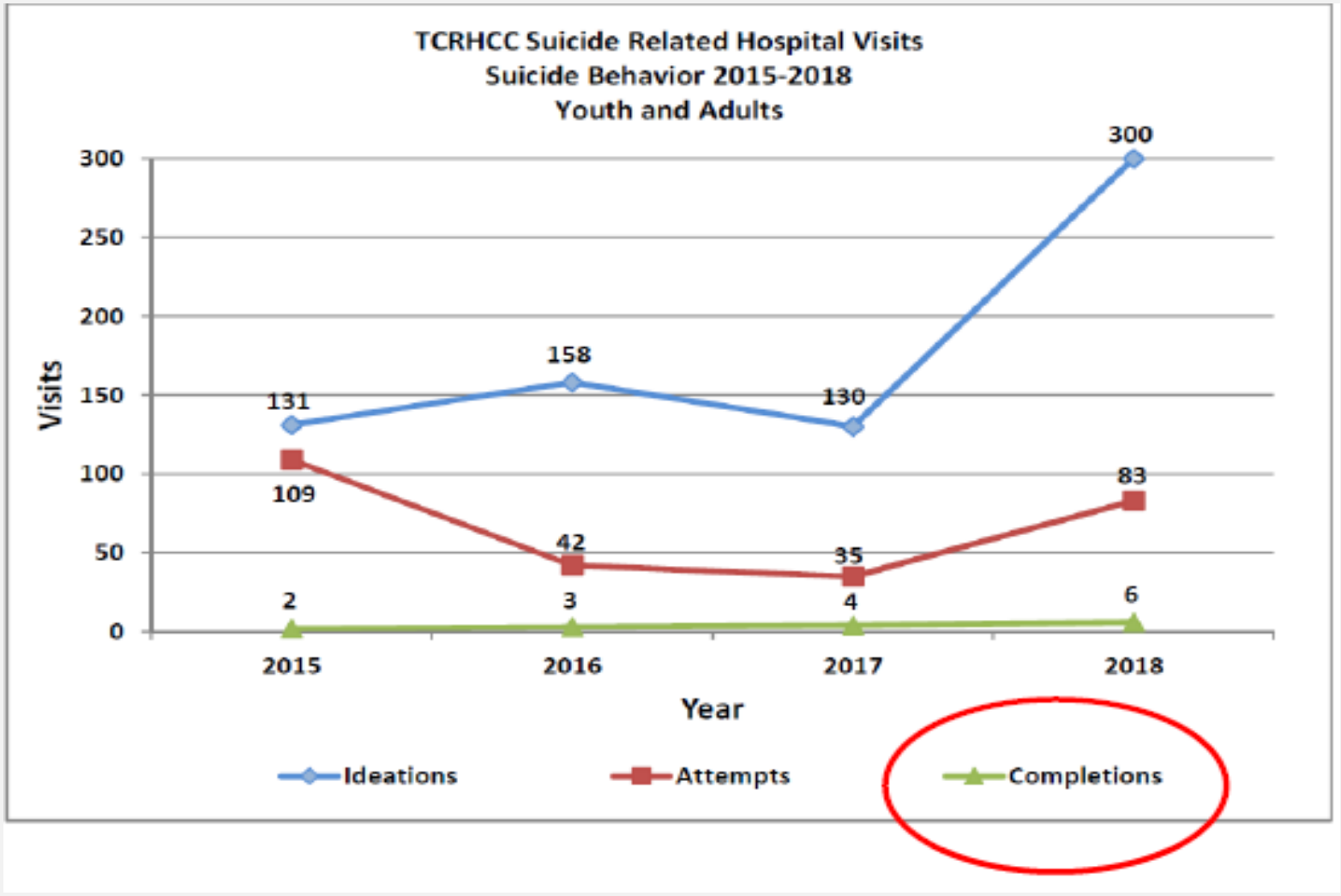
NAVAJO NATION EPI CENTER UPDATE –MAY 2016

Suicide is a significant contributor to mortality among Navajo – contributing to 3% of total deaths for Navajo

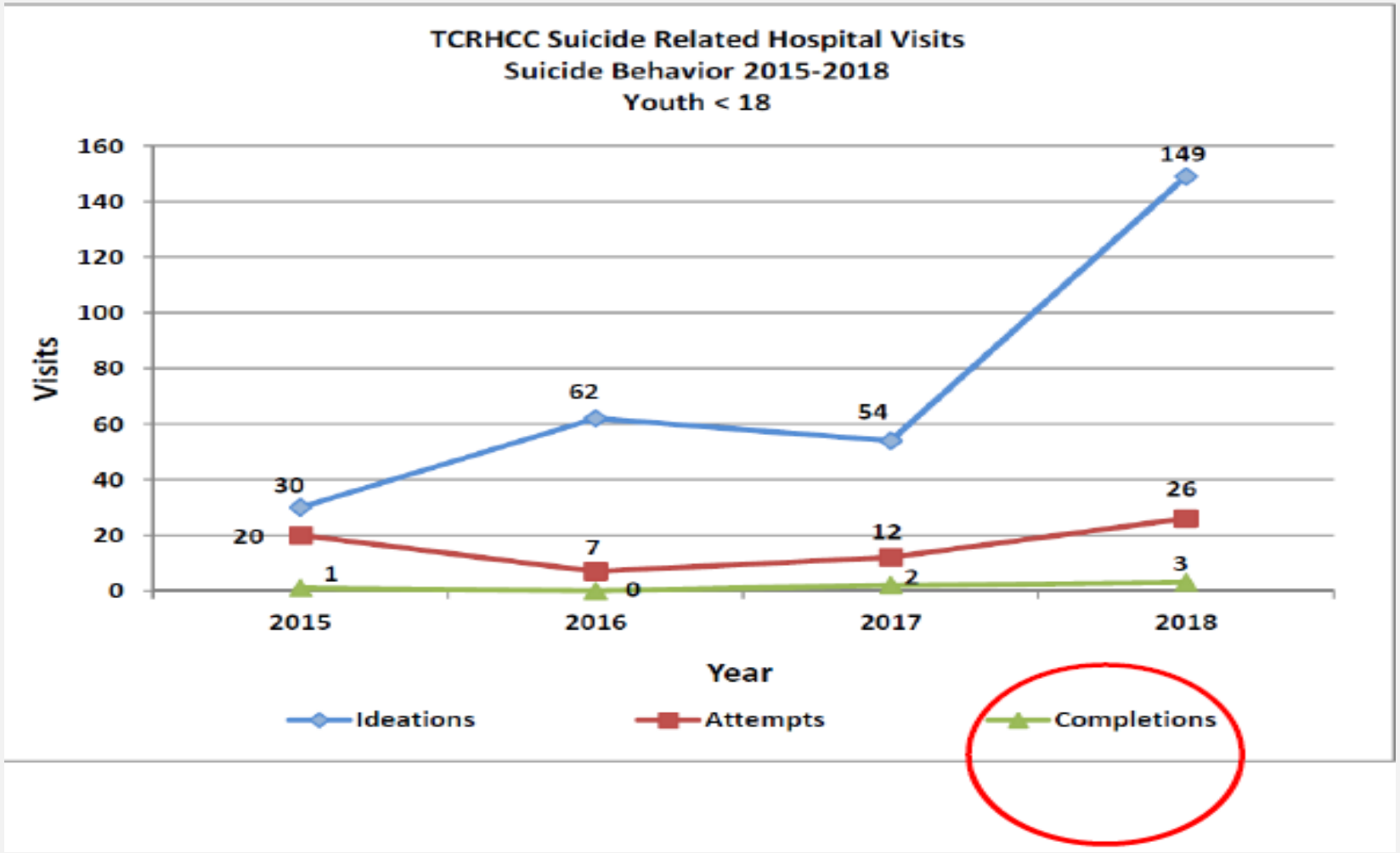
In 2010, the suicide rate among **Navajos** increased to 32.1 per 100,000, above the **National average** of 12.5 per 100,000.

- Suicide is the 7th leading cause of death for Navajo (both genders) at 17.48 per 100,000 (age-adjusted).
- Suicide is the 2nd leading cause of death for age group 10-19 at 26.40 per 100,000 accounting for 27.5% of all deaths for this age group.

TCRHCC STATISTICS 2015-2018
(YOUTH AND ADULTS)



TCRHCC STATISTICS 2015-2018 (YOUTH < 18 YEARS OLD)



REGULATORY MANDATES

HOW DO WE AVOID THIS?

Print Issue | E-Weeklies | Conferences | Webinars | White Papers | Multimedia | Lists

Physicians | Leadership | Strategy | Executive Moves | Transaction & Valuation | Human Capital & Risk | Patient Flow | Faci

Orthopedics | Patient Engagement | Pharmacy | Population Health | Legal & Regulatory | Compensation | Payers | Opioids | R

Clinical Leadership & Infection Control

CMS survey reveals serious deficiencies at South Dakota hospital

Ayla Ellison (Twitter | Google+) - Monday, August 20th, 2018 Print | Email

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CMS has placed the Indian Health Service hospital on the Rosebud (S.D.) Sioux Indian Reservation on "immediate jeopardy" status and will terminate the hospital's Medicare provider agreement Aug. 30 unless the deficiencies are corrected.

Here are five things to know:

1. CMS discovered the issues during a surveyof the hospital in late July. The incidents that led to the "immediate jeopardy" status were detailed in a report released Aug. 17, according to *The Wall Street Journal*.

Hospitals are SAFE places for all patients.

True

False

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HOSPITALS ARE NOT ALWAYS SAFE- SUICIDES OCCUR IN HOSPITALS

The Joint Commission Sentinel Event data from 2010-2014, found that 1,089 suicides occurred among patients who had received care or treatment from a hospital or ED, or had been discharged within a 72-hour period.

Why? Poor assessments

21.4 % of Joint Accredited hospitals and 5.14 % of Behavioral health settings were found to be non-compliant with the National Patient Safety Goal 15.01.01, which requires hospital to complete a risk assessment for suicide.

The Joint Commission. (2016, February 24).

MORE STATS ON HOSPITAL INPATIENT SUICIDES

- About 49 to 65 hospital inpatient suicides happen each year in the U.S. This is far lower than the widely cited estimate of 1,500 each year. Of these suicides, 75% to 80% were among psychiatric inpatients.
- Suicide rates were estimated at 3.2 per 100,000 psychiatric inpatient admissions and 0.03 per 100,000 non-psychiatric inpatients.
- Hanging accounted for over 70 % of suicides.
- About half of suicides occurred in a hospital bathroom, one-third in a bedroom and the remainder in a closet (4 %), shower (4 %) or other location (8%).
- The most commonly used fixture point was a door, door handle or door hinge (53.8 percent).

CMS – FOCUS IS TO CREATE A SAFE PATIENT ENVIRONMENT

CMS issued a 13-page memo to clarify the standards on Ligature Risk-

--This memo set the stage for increased guidance for psychiatric hospitals/behavioral health units and hospitals that care for patients at risk.

The Joint Commission (TJC) is working with CMS to ensure that patient care settings are safe and

How many of you work or seek care at a hospital accredited by one of the following agencies?

Joint Commission

Healthcare Facilties Accreditation Program (HFAP)

The Accreditation Association for Ambulatory Health Care (AAAHC)

Other

I don't know

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THE JOINT COMMISSION STANDARD FOR SUICIDE RISK REDUCTION

National Patient Safety Goal (NPSG) 15.01.01

Was introduced in 2007

The standard requires that the hospital identifies patients at risk for suicide.

- NPSG.15.01.01 applies only to psychiatric hospitals **and** patients being treated for emotional or behavioral disorders in general hospitals.

Rationale for NPSG 15.01.05

> 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.

ELEMENTS OF PERFORMANCE NPSG 15.01.01

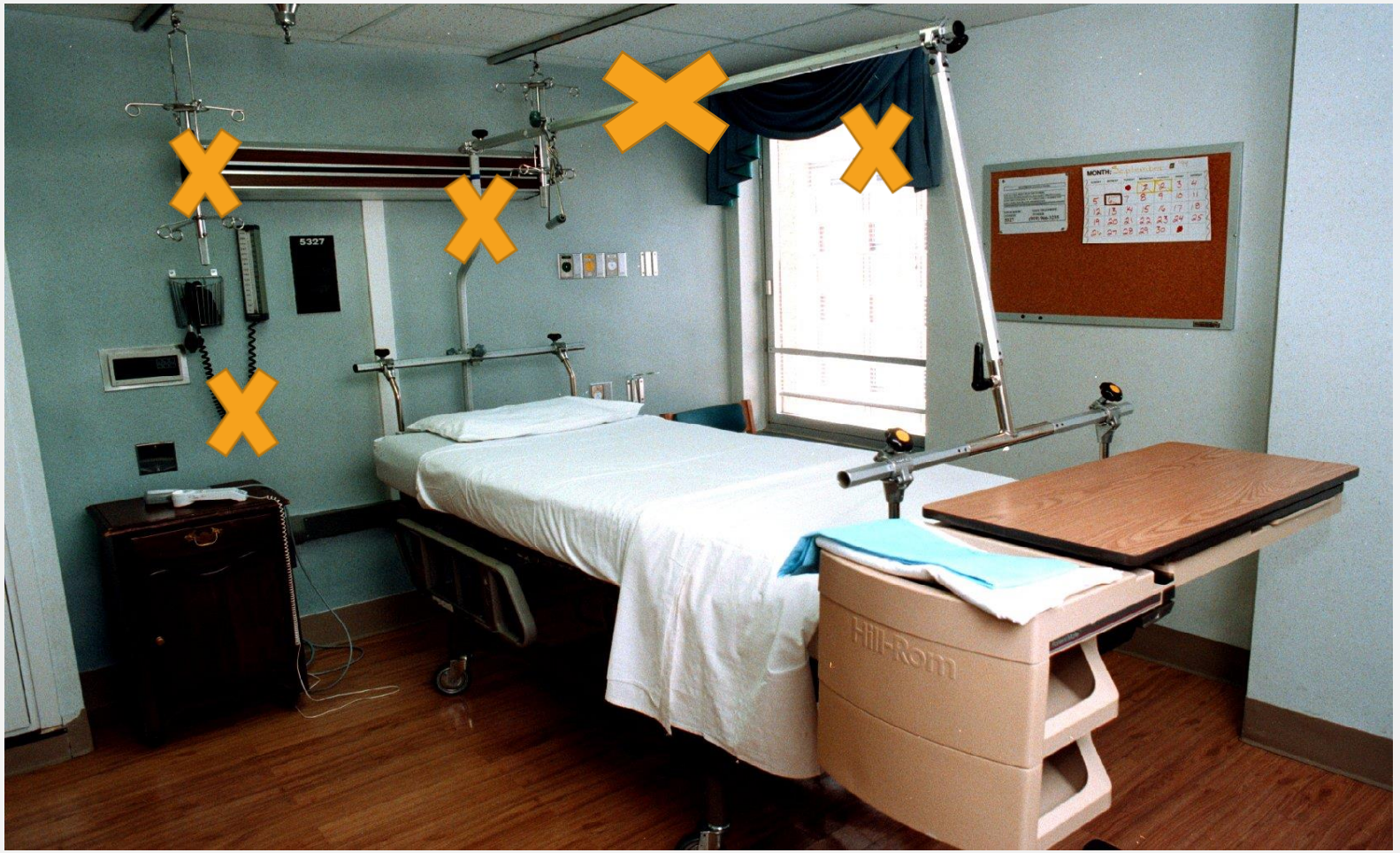
1. **Conduct a Risk Assessment.** Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.
2. **Address the Immediate Safety Needs.** Address the patient's immediate safety needs and most appropriate setting for treatment.
3. **Education at Discharge.** When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family.

NEW TJC STANDARD EFFECTIVE JULY 1, 2019

1. Seven new and revised Elements of Performance (EP) for NPSG 15.01.01:
2. Requirement will apply to ALL hospitals and Behavioral Healthcare settings where at-risk patients are cared for.
3. New screening requirement --Evidenced-based screening and assessment tools.
4. Ensure physical environment does not contain ligature risks (ligature resistant environment).

EP. 1 -- CONDUCT AN ENVIRONMENTAL RISK ASSESSMENT

- Assess clinical areas (patient room, bathroom, clinic area) and identify objects that could be used as an anchor point:
  - Hooks,
  - IV poles, Tubes/Cords
  - Door hinges,
  - Shower curtains/rods,



EP 2 & 3. SCREEN USING VALIDATED TOOL TO **SCREEN AND ASSESS** FOR SUICIDE RISK

Screen tools appropriate for population and age

- Changing the wording of questions is not advised, since it can alter the effectiveness of tool.

Screening every patient for suicidal ideation is not required (Universal Screening)

- Providers should be aware that patients can have co-morbid behavioral heath condition that can increase their risk.

Recommended Suicide Risk Screening and Assessment Measures

Instrument	Measures	Number of Items	Estimated Time	Scoring	Author / Publisher Information
The Behavior and Symptom Identification Scale 24 (BASIS-24)	Treatment outcomes by measuring symptoms and functional difficulties	24	5-10 minutes self-report	Total score + 6 subscale scores	For purchase: http://ebasis.org McLean Hospital 115 Mill Street, Belmont MA 02478-9106 (617) 855-2424 basisadmin@mclean.harvard.edu
Columbia-Suicide Severity Rating Scale (C-SSRS Screen)	Suicide-related ideation and/or behaviors	3 If yes to ideation, 6 items	> 2 minutes Rater-administered or self-report	No scoring required	Posner et al. (2011) No cost. http://www.cssrs.columbia.edu/index.html
Columbia-Suicide Severity Rating Scale (C-SSRS) Military Version	Suicide-related ideation and/or behaviors	Varies based on response	2-8 minutes, depending on density of suicide history Rater-administered or self-report	No scoring required	Posner et al. (2011) No cost. http://www.cssrs.columbia.edu/index.html
Patient Health Questionnaire (PHQ-9)	Depression	9	< 5 minutes self-report	Total score 1-4 = Minimal 5-9 = Mild 10-14 = Moderate 15-19 = Moderately Severe 20-27 = Severe	Spitzer et al. (1994) No cost. http://www.phqscreeners.com/
Scale for Suicide Ideation (SSI)	Suicide ideation	21	5-10 minutes clinician-administered	Total score + suicide intensity rating	Beck et al. (1979) For purchase http://pearsonassessments.com/pai/

Does your hospital or clinic screen patients at risk for suicide?

Yes **A**

No **B**

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EP 4. DOCUMENT LEVEL OF RISK AND PLAN TO MITIGATE

RISK STRATIFICATION

- Document the risk assessment
- Develop and document that plan to reduce the patient's risk for suicide

EP 5, 6, & 7

EP. 5 Develop and follow Policy and Procedure that addresses care of the suicide risk patient:

- Training and competency for Staff (MDs, RN, CMA, Sitters, Security officers, etc.)
- Guidelines for Reassessment
- Monitoring of patients at high risk for suicide

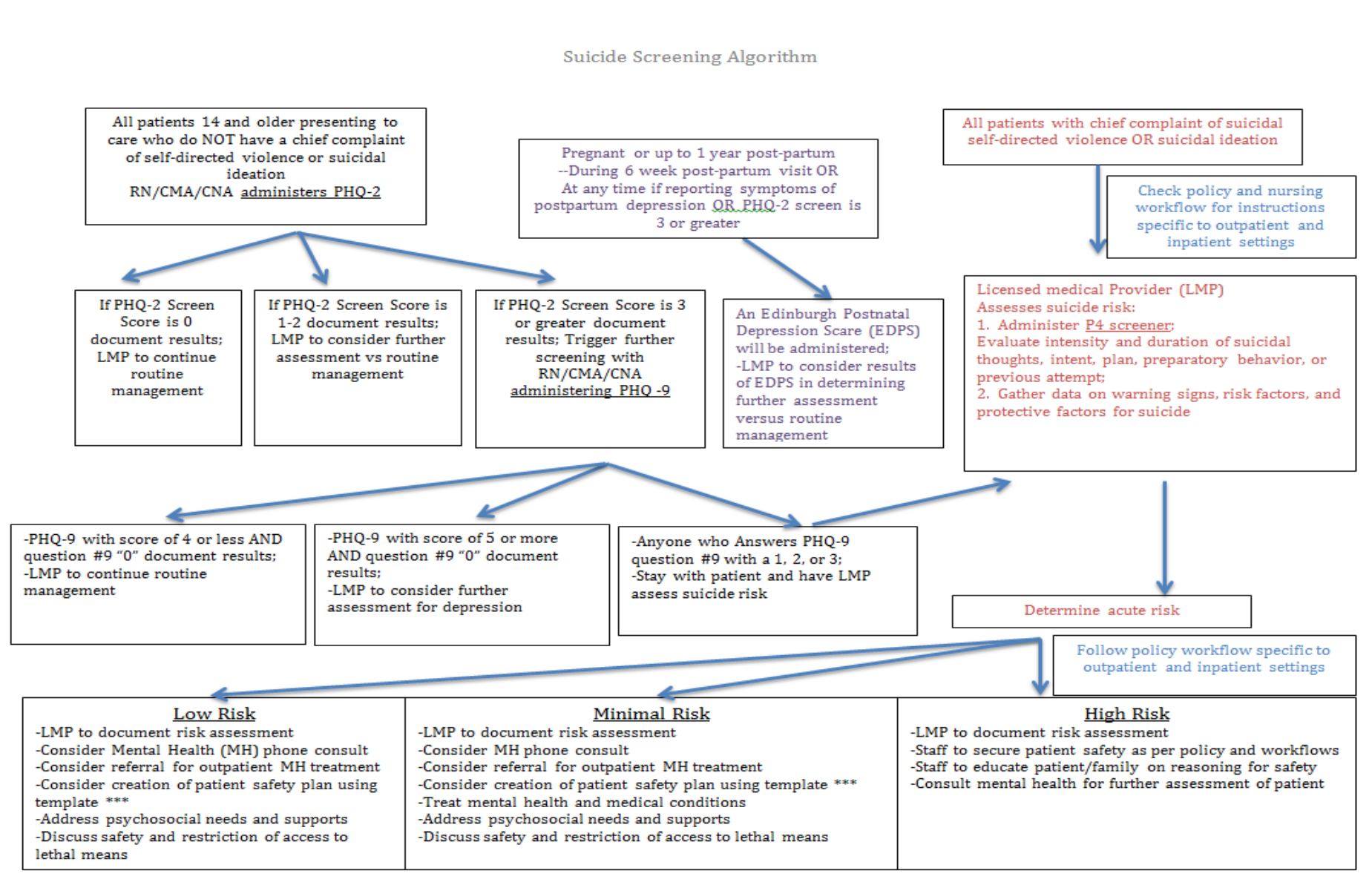
EP 6. Provide process for counseling and follow-up care at discharge for patient at risk

EP. 7 Monitor implementation and effectiveness P&P, address any needs for improvement in complying with P&P.

TCRHCC'S APPROACH TO NEW REQUIREMENTS

1. Developed an Interdisciplinary Team:
    - MD, (ED, Clinic Chiefs Peds and Adults, IM Chief, Mental Health MD.
    - RNs (ED, Clinic, ICU)
    - Community Health/MSPI
    - Senior Leaders (Chief Quality Officer, Chief Medical Officer, Chief Nurse Officer, etc.).
2. Meet once each month
3. Review compliance with Suicide Policy
4. Community Health Updates

TCRHCC SCREENING & ASSESSMENT



PHQ-2 SCREEN

TOOL 1. The Patient Health Questionnaire-2 (PHQ-2)

Instructions: Print out the short form below and ask patients to complete it while sitting in the waiting or exam room.

Use: The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a "first-step" approach.

Scoring: A PHQ-2 score ranges from 0 to 6; patients with scores of 3 or more should be further evaluated with the PHQ-9, other diagnostic instrument(s), or a direct interview to determine whether they meet criteria for a depressive disorder.

Patient Name: _____ Date of Visit: _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than one-half of 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

Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. *Med Care*. 2003;41:1284-1292. ©2007CQAIMH. All rights reserved. Used with permission.

PHQ-9

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 asleep, 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're 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 fidgety 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 in some way	0	1	2	3
Column Totals	_____	+ _____	+ _____	
Add Totals Together	_____			

10. If you checked off any problems, how difficult have those 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

PHQ-9 Score	Provisional Diagnosis	Treatment Recommendation *Patient Preferences should be considered*
5-9	Minimal Symptoms*	Support, educate to call if worse, return in one month
10-14	Minor depression ++ Dysthymia* Major Depression, mild	Support, watchful waiting Antidepressant or psychotherapy Antidepressant or psychotherapy
15-19	Major depression, moderately severe	Antidepressant or psychotherapy
>20	Major Depression, severe	Antidepressant and psychotherapy (especially if not improved on monotherapy)

** If symptoms present ≥ two years, then probable chronic depression which warrants antidepressants or psychotherapy (ask "In the past 2 years have you felt depressed or sad most days, even if you felt okay sometimes?")*

++ If symptoms present ≥ one month or severe functional impairment, consider active treatment

SAMHSA-HRSA Center for Integrated Health Solutions

P4 SCREEN

Have you had thoughts of actually hurting yourself?

NO YES

4 Screening Questions

1. Have you ever attempted to harm yourself in the past?

NO YES

2. Have you thought about how you might actually hurt yourself?

NO YES → [How? _____]

3. There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life some time over the next month?

a. Not at all likely _____
b. Somewhat likely _____
c. Very likely _____

4. Is there anything that would prevent or keep you from harming yourself?

NO YES → [What? _____]

	Shaded ("Risk") Response	
Risk Category	Items 1 and 2	Items 3 and 4
Minimal	Neither is shaded	Neither is shaded
Lower	At least 1 item is shaded	Neither is shaded
Higher		At least 1 item is shaded

RISK STRATIFICATION - LEVEL OF RISK CARE PLAN

Low

- No need for 1:1
- Low risk environmental checklist (implements of harm, confiscation of belongings)
- Consider outpatient MH referral for intake evaluation
- Discuss discharge plan based risk reduction counseling, consider safety plan, provide crisis hotline

Min

- Likely no need for 1:1, discretion of care team
- Encourage MH consult and coordinated discharge plan with MH
- Low risk environmental checklist
- Discuss safety needs upon discharge -- based on risk reduction counseling, safety care plan, crisis hotline, MH referral/appointment

High

- High Risk
- 1:1 sitter
- Full SI precautions –secure patient safety
- Educate patient and family
- In person MH consult in ED

SUICIDE IS A PUBLIC HEALTH CONCERN

- Suicide is associated with mental illness and substance abuse, psychosocial trauma and loss, family and personal history of suicide attempt.
- Most suicides have social, psychosocial, and economic factors
- Strategies require collaboration at several levels – government policy, health care providers, schools, families, and community.

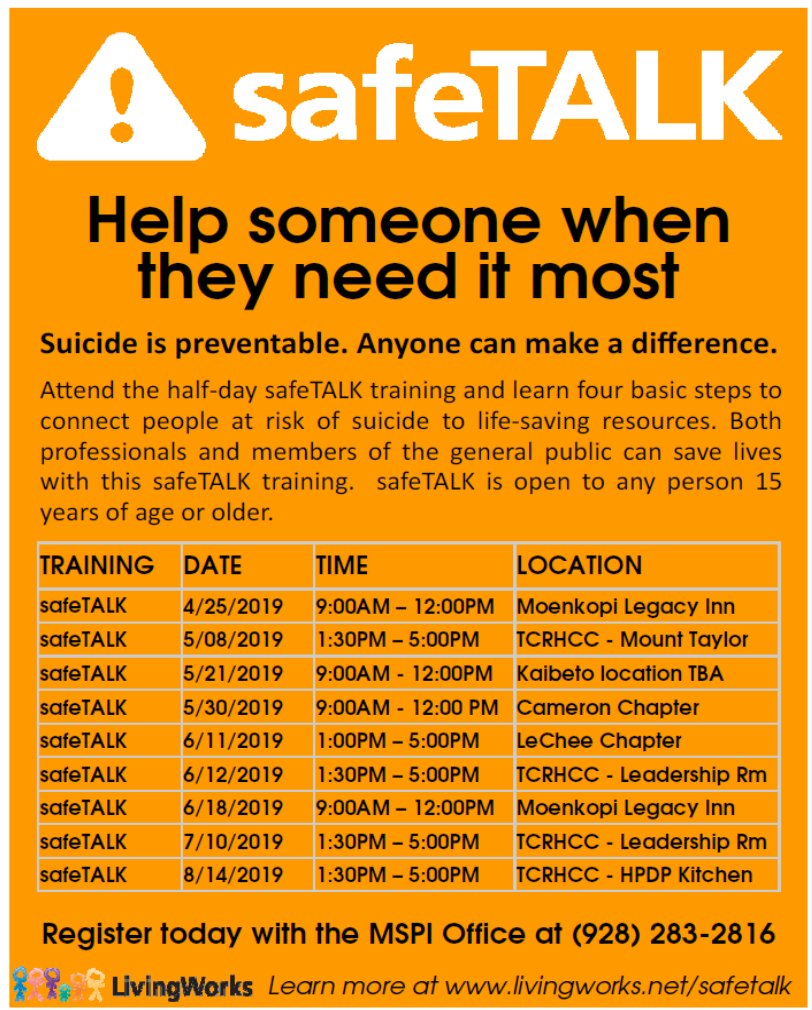
THE TRAGEDY OF SUICIDE

"Suicide – too often a consequence of ***untreated mental illness and substance abuse disorders,*** *and as such a preventable condition- remains on the list as the 10th leading cause of death for adults and second leading cause of death among youth." (McCance-Katz, E.F., 2019).*

The article cites several studies and cites several factors associated with Suicide Risk:

- Lower Socio-economic Status
- Lack access to mental health (and behavioral health) care
- Not having a positive response to care received
- Lack of community support "essential for stabilizing

COMMUNITY AWARENESS & TRAININGS

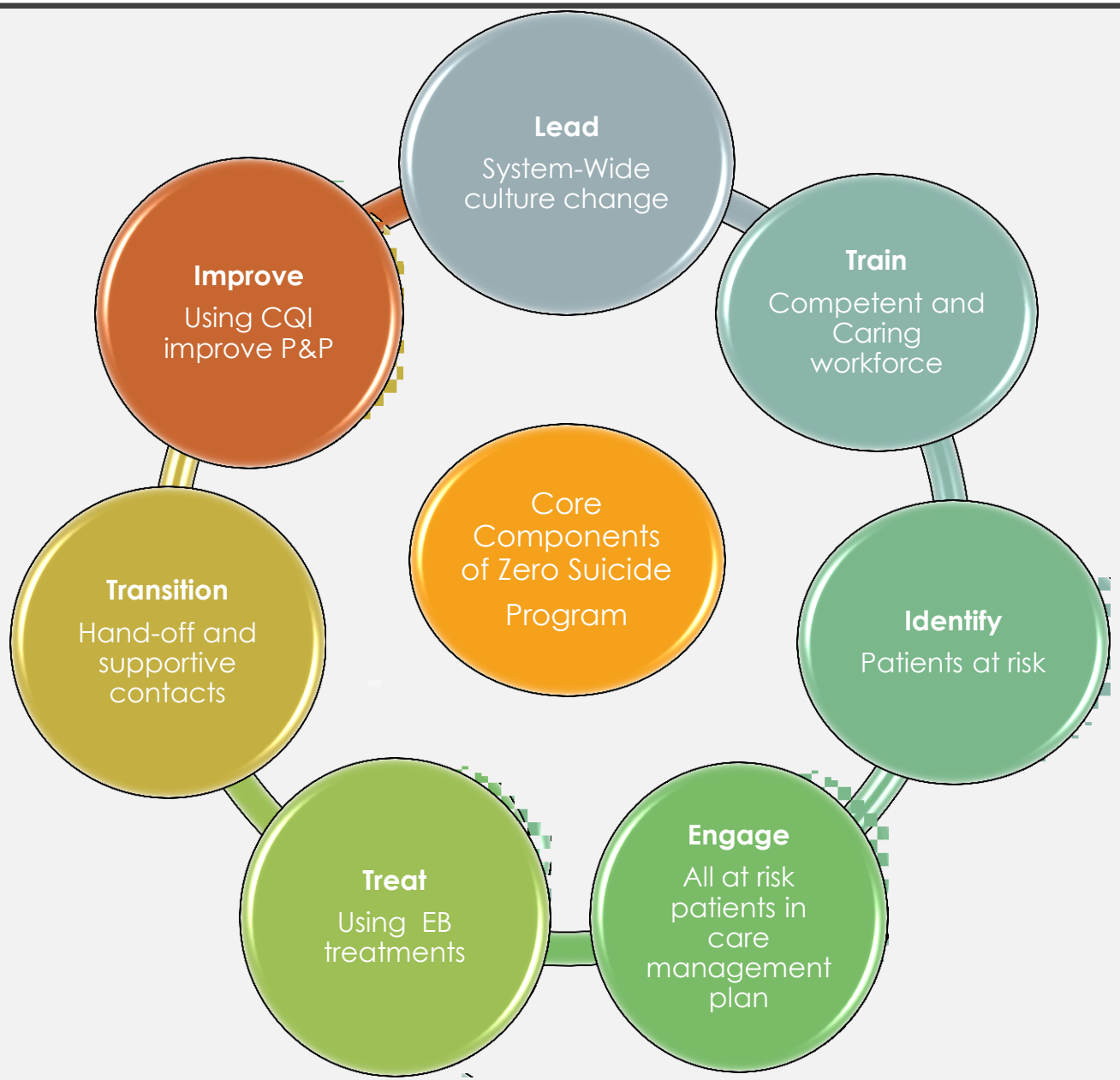


PARTNERSHIPS & IMPROVED RESOURCES

Combating the issues will require partnerships and improved resources.

- Navajo Nation Behavioral Health services are primarily care coordination.
- There are No rehab services on the reservation. Patients in rehab services require familial support, which is not possible when the patient is sent away from home for treatment.

ZERO SUICIDE INITIATIVE




NATIONAL
SUICIDE
PREVENTION
LIFELINE
1-800-273-TALK (8255)
suicidepreventionlifeline.org

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