Youth Suicide Prevention in Primary Care (YSP-PC) (ages 14-24)

SAMHSA’s Garrett Lee Smith Memorial Act

Awarded to Pennsylvania Department of Public Welfare
# Youth Suicides (15 to 24 years old), by Pennsylvania County, 1990-2005

Targeted Counties: Lackawanna, Luzerne, Schuylkill

Data source: Pennsylvania Department of Health

- Less than 50 Youth Suicides
- 50+ Youth Suicides

Targeted Counties: Lackawanna, Luzerne, Schuylkill
Five Central Aims

• # 1: Create state and local stake holder groups

• # 2: Increase coordination between medical and behavioral health services

• # 3: Provide youth suicide “gatekeeper” training

• # 4: Introduce empirically supported therapies to local behavioral health providers

• # 5: Provide web-based screening tool
The Pennsylvania Model for Youth Suicide Prevention in Primary Care

Stakeholder Involvement

State-Level Community-Level

Coordination of Medical and Behavioral Health Services

Training PCPs Behavioral Health Providers

Screening

Referral to a Better Prepared Behavioral Health System

Evaluate Outcome and Report Back to Stakeholders
Aim # 1: Stakeholder Involvement

Stakeholder Involvement

State-Level
Community-Level
Barriers

• Chasm between medical and behavioral organizations and providers.

• Problems pertain to infrastructure, funding, licensure, shared medical records, and liability.

• Progress between MH and schools but not between MH and PCPs
State Level Stakeholders

State Agencies:
- Department of Public Welfare
- Department of Health

Medical Associations:
- PA Chapter of the American Academy of Pediatrics
- PA Association of Family Physicians
- PA Coalition of Nurse Practitioner
- Pennsylvania Association of Community Health Centers

Behavioral Health:
- Pennsylvania Community Providers Associations

Payers:
- Access Plus, Community Care
State Level
Suicide Prevention Task Forces

• Hosted four regional suicide prevention task force meetings
  • Over 35 counties represented by 137 participants

• Needs assessment, resource development, increased communication

• Activated their interest in the YSP-PC project
Other State Level Strategies

- State survey (N= 667) of PCPs regarding behavioral health needs and challenges

- Produced a series of training webinars

- Presentations at numerous state medical and behavioral health meetings

- Bi-monthly call with Pennsylvania Office of Medical Assistance to explore sustainability

- Participated in the start-up of a state wide learning collaborative

- Sponsored a state suicide prevention conference
County Level Stakeholders

• Collaboration with County MH/MR directors

• Funded part time liaison/navigator between PCPs and the behavioral health community
  • New focus has regional liaisons/navigators

• Worked with existing or helped start County Suicide Prevention Task Forces

• Creatively restructured resources rather than pay for new ones
Identifying Practices

- Mailings, outreach, hospital systems, and media

- Kick off meeting with schools, PCPs, clergy, police, and behavioral health providers

- Medical Assistance and County Coordinators did outreach at monthly meetings with practices

- Targeted medical home practices and FQHCs

- Word of mouth

- **Once identified:** Assessment of project readiness, set-up, training, and screening implementation
Aim # 2: Coordination of Behavioral Health & Medical Services

Stakeholder Involvement
State-Level
Community-Level

Coordination of Medical and Behavioral Health Services
State Survey Results (N=667 PCPs)

• Most practices do not have an in-house MH worker

• 45% report they cannot get quick MH appointments for suicidal patients and encounter long waiting list for non-urgent patients

• Only 24% report that the MH provider always or often let them know if a patient attends services
Other Challenges

- PCPs cannot get reimbursed for identifying and treating MH problems
  - Nearly 50% report submitting a medical diagnosis to provide mental health services

- Limited personal relationships between providers

- Overly restricted interpretation of HIPAA

- PCPs have a poor understanding of available resources
Models of Collaborative Care

• Coordinated
  • Routine screening for behavioral health problems conducted in primary care setting
  • Referral relationship between behavioral health and primary care
  • Routine exchange of information
  • PCPs to deliver brief behavioral health interventions using algorithms

• Collocated
  • Medical and behavioral health services in same facility
  • Enhanced informal communication between providers
  • Consultation to increase skills of both groups
  • Increase in level of quality of behavioral health services offered
  • Significant reduction of no-shows for behavioral health treatment

• Integrated
  • Medical and behavioral health services either in same facility or separate locations
  • One treatment plan with both medical and behavioral health components
  • Team works together to deliver care based on prearranged protocol
Barriers to Collocation

- Policy barriers related to licensure and billing:
  - Need to establish a satellite office
  - Who bills for screening?
  - How to bill for assessments?
  - How to bill for prevention work?

- Collocation is not cost effective if the PCP does not identify enough patients with MH problems

- Increased screening might help solve this.
Coordination of Services

- Screen and refer patients, but also improve the relationship and exchange of information between PCPs and behavioral health providers and agencies
Liaison/Navigator Role: Within Practices

• Identified interested PC practices to participate in the project

• Educated PCP about how to access services

• Created support material for accessing mental health services (phone numbers, office posters, wallet cards)

• Offered educational services about suicide and behavioral health assessment
Liaison/Navigator Role: Between Services

- Identified current and new behavioral health providers for partnership
- Set-up face to face meetings to discuss barriers and improved communication
- Invited behavioral health staff to suicide risk assessment trainings
- Left behavioral health release of information forms at the PCP office
- Behavioral health offices created a single point of contact or single contact person (PCP specialist) for PCP’s
- Assisted in patient referrals
  - Decreased over time as relationships between PCP’s and behavioral health providers improved
Primary Mechanisms of Success

- Relationship development

- Behavioral health community reaching out to PCPs

- PCPs screening enough patients to make it financially viable for the mental health providers to provide specialized services.
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