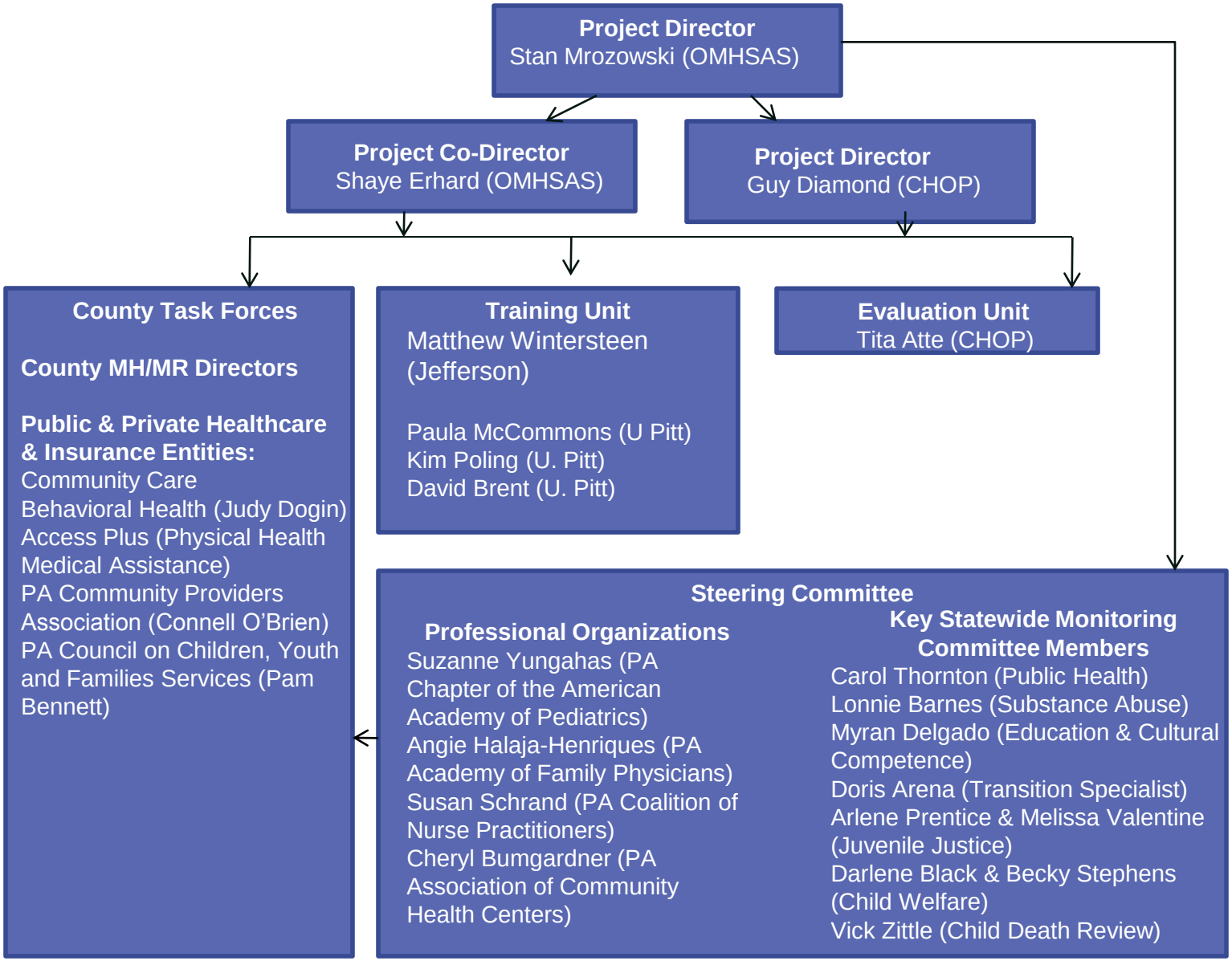
Youth Suicide Prevention in Primary Care (YSP-PC)

(ages 14-24)

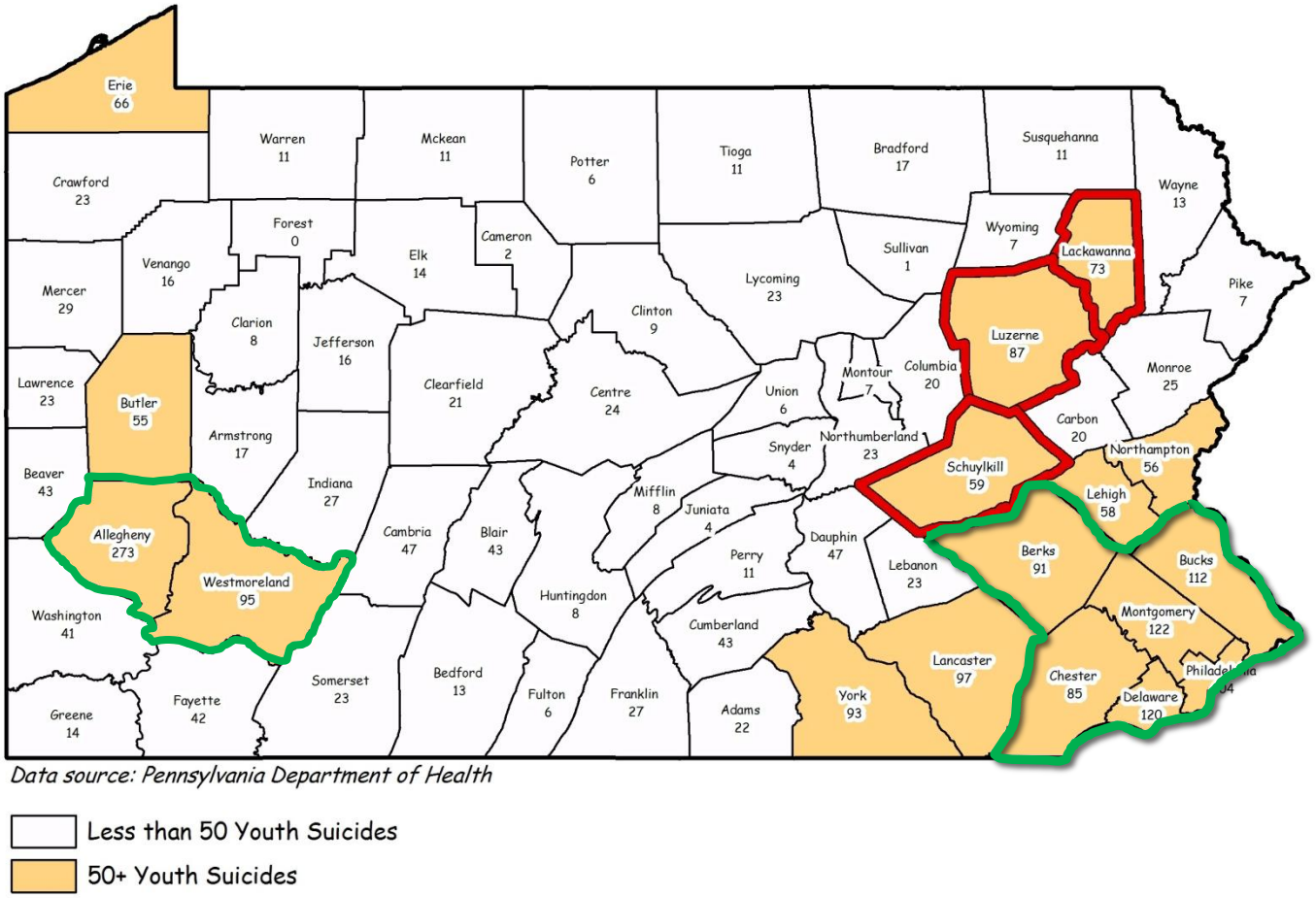
SAMHSA's Garrett Lee Smith Memorial Act

Awarded to Pennsylvania Department of Public Welfare

Pennsylvania GLS Team



Youth Suicides (15 to 24 years old), by Pennsylvania County, 1990-2005



Data source: Pennsylvania Department of Health

Less than 50 Youth Suicides

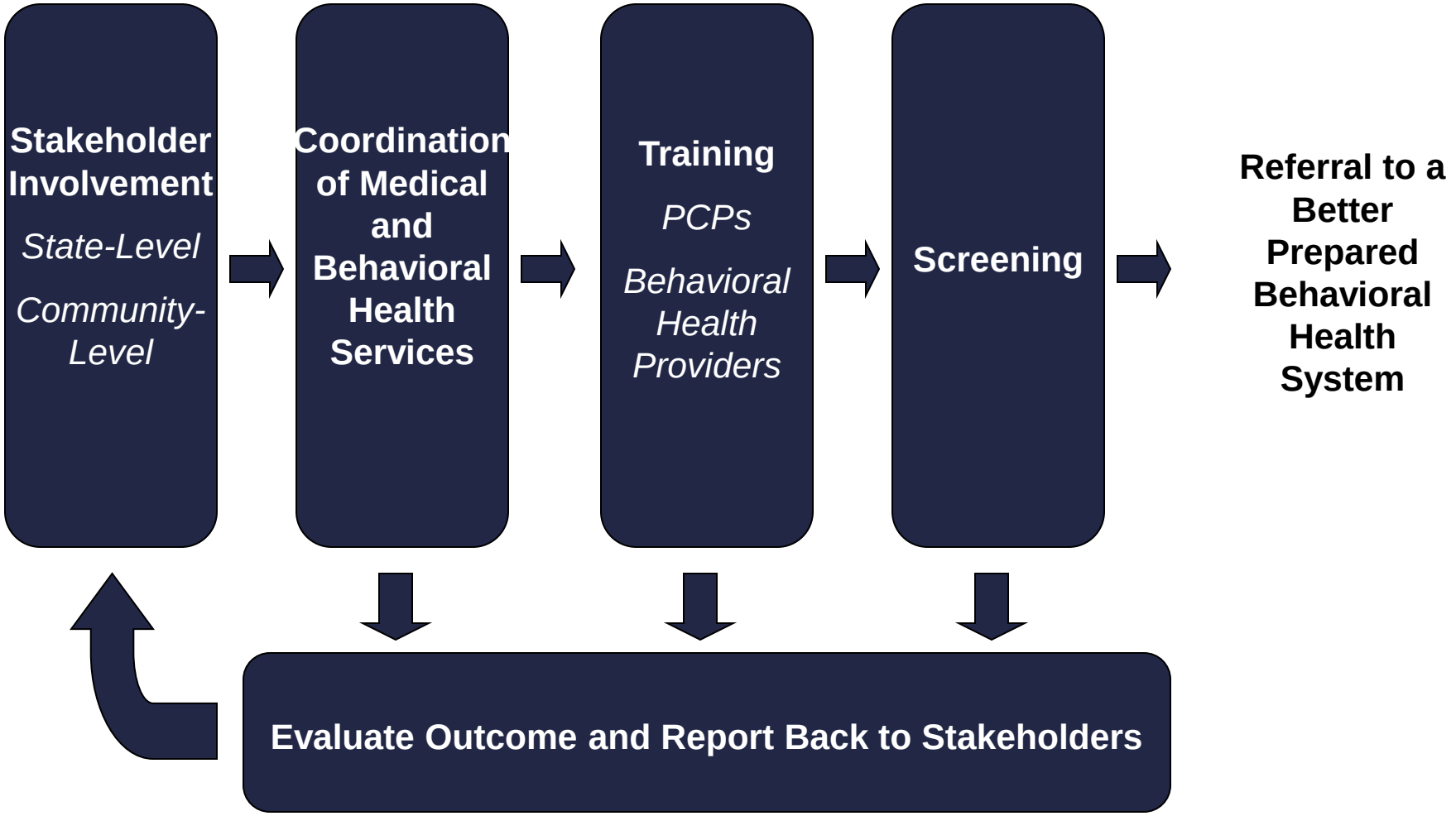
50+ Youth Suicides

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



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

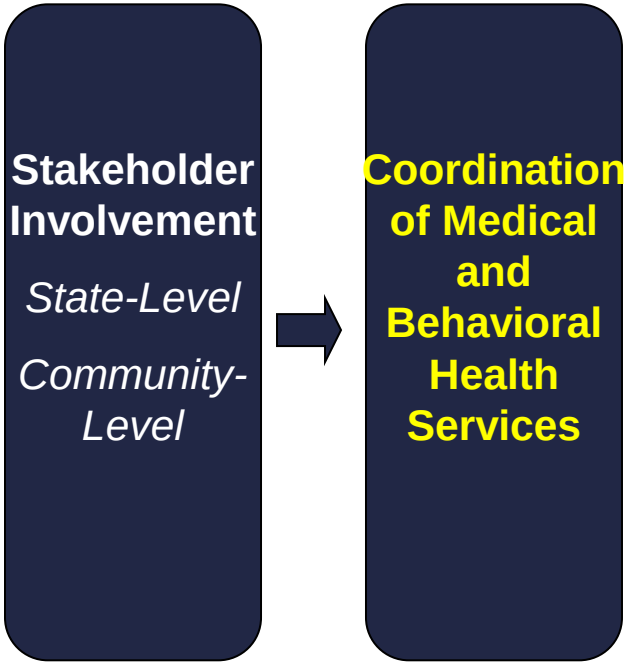
County Level Stakeholders

- 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 out reach 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



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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