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INNOVATIONS IN SUICIDE CARE AT UW MEDICINE

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Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

Innovations in Suicide Care at UW Medicine

UW PSYCHIATRY AND ADDICTION CASE CONFERENCE

MAY 15, 2025

DENISE CHANG, MD AND KATE COMTOIS, PHD, MPH

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OUTLINE

- Review various UW Medicine initiatives related to suicide care, including current research and quality improvement efforts as well as future innovations and opportunities

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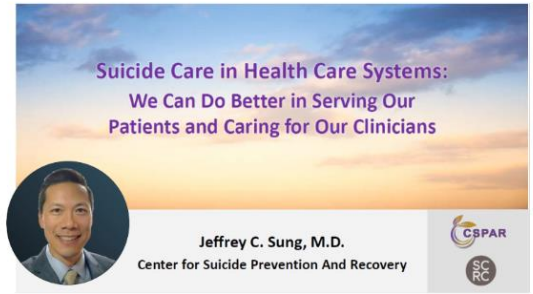
Center for Suicide Prevention and Recovery

Registration Open for Suicide Care Training!



The Suicide Care in Healthcare Systems live training is designed to provide you with an understanding of how best to serve patients across the suicide care pathway. The training aims to synthesize evidence-based suicide interventions and the Joint Commission and other suicide prevention expectations into two 4-hour parts.

Register

Spring 2025 Dates
Part 1: May 19, 8-12pm Pacific
Part 2: May 21, 8-12pm Pacific

Fall 2025 Dates
Part 1: Sep 8, 8-12pm Pacific
Part 2: Sep 10, 8-12pm Pacific

Register here: https://uwcspar.org/upcoming-training/upcoming-trainings-and-registration/

Virtual, live training: designed to provide you with an understanding of how best to serve patients across the suicide care pathway

Audience*:* Primary Care Providers, Psychiatrists, Psychologists, Behavioral Health Providers, Physician Assistants, Nurse Practitioners, and other clinical roles working in healthcare settings.

Length: 8 hours

Cost: $180.00 for Community Clinicians; Free to employees of UW Medicine, Seattle Children's, SCRC Affiliated Clinics, or VA Puget Sound; additional fee if claiming CE.

Continuing Education: 6.75 credits (with optional additional credit available)

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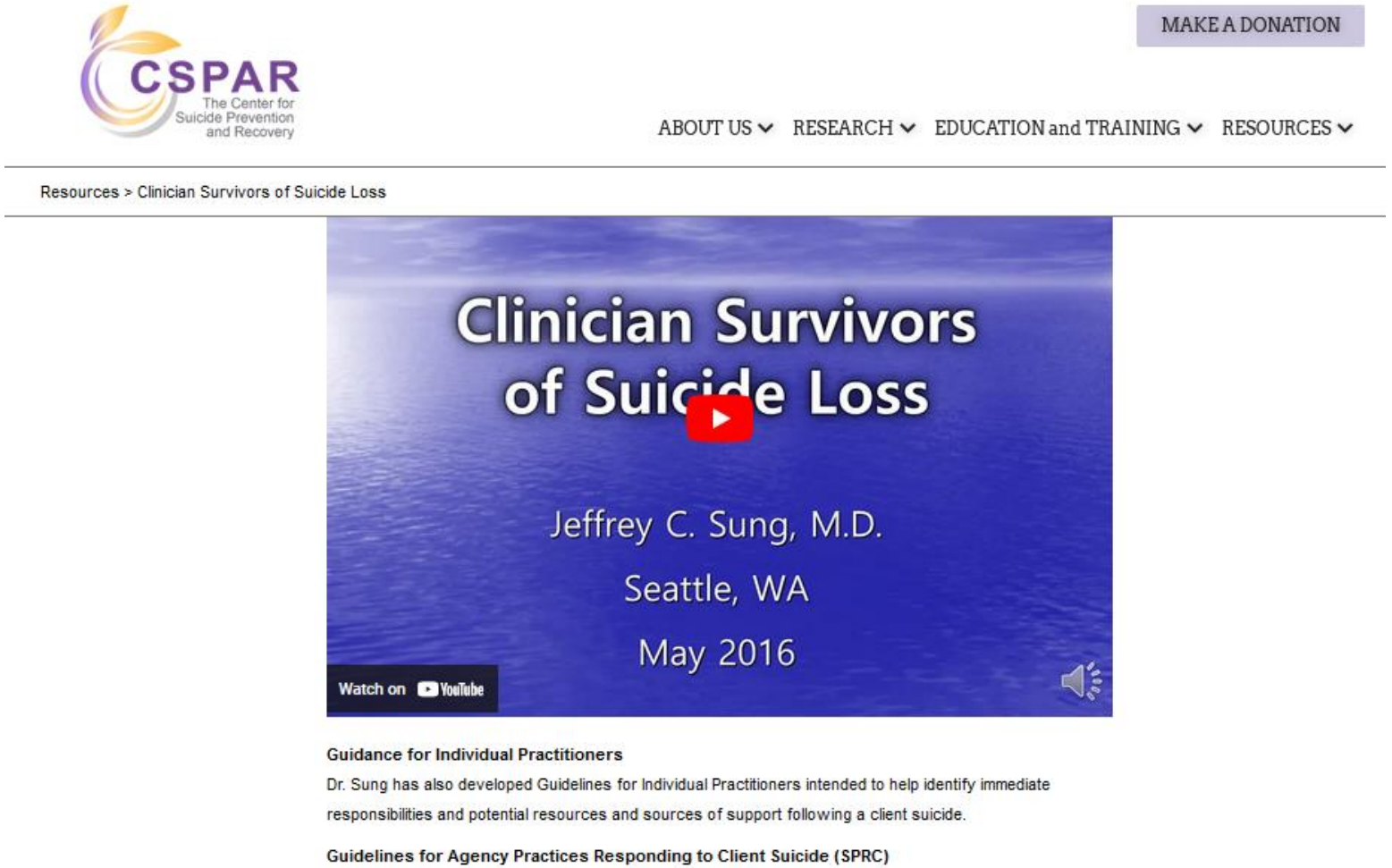

https://uwcspar.org/resources/clinician-survivors-loss/

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ADDRESSING SUICIDE RISK IN PRIMARY CARE TO REDUCE YOUTH SUICIDE

GARVEY INSTITUTE FOR BRAIN HEALTH SOLUTIONS INNOVATION GRANT

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Seattle Children's
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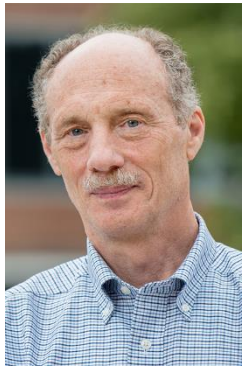
PRIMARY CARE

Project Leads

Sarah Danzo, PhD

Denise Chang, MD

Collaborators



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Co-Investigators

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Kalina Babeva, PhD

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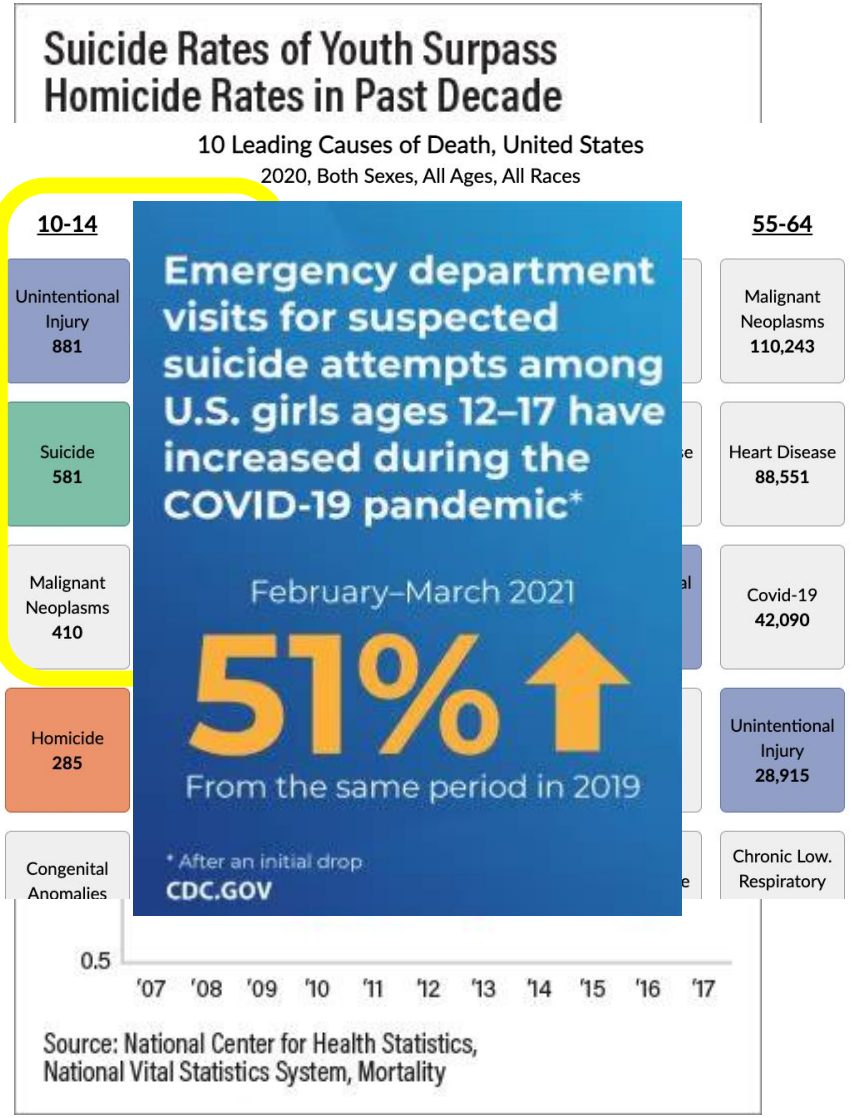
SUICIDE RISK AND PREVENTION

- **Suicide is a leading cause of death among 10–24-year-olds in the United States**
- **Nearly half of youth who die by suicide contact a primary care provider within one month prior to suicide**
- National guidelines recommend all medical settings screen for suicide risk
- Several barriers exist to implementing suicide screening and prevention in primary care (i.e., lack of infrastructure and training)



Project Aim

- Develop a **comprehensive suicide prevention program** for adolescents that can be efficiently and effectively delivered in primary care
- Leverage the access of primary care settings while addressing barriers and enhancing management of suicidal thoughts and behaviors (STB)

1

SCREENING

Implement effective screening protocols for evaluating suicide risk

2

ASSSESSMENT and INTERVENTION

Provide brief suicide risk assessment and intervention strategies

3

TRIAGE

Improve triage and referral pathways for youth with moderate- high suicide risk

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ASSESSMENT AND INTERVENTION

- INTERVENTION: Adapt a brief, evidence-based suicide intervention (initially developed for the emergency department) for use in primary care. Offering moderate-high risk patients next day appointments (or warm hand-offs) with BH team for safety planning.

- SETTING: UW Medicine Primary Care clinics (Kent Des-Moines and Shoreline)
  - Peds BHIP Care Manager/Social Worker
  - Social Work Assistants (BA level trained staff)
  - Also involved PCPs, clinical staff
- GOALS:
  - Reduce risk for adolescent suicide and enhance patient safety
  - Reduce burden on primary care providers
  - Reduce unnecessary referrals to the emergency department
  - Expand access to critical suicide prevention services by expanding the behavioral health workforce
  - Create a sustainable and scalable intervention for primary care

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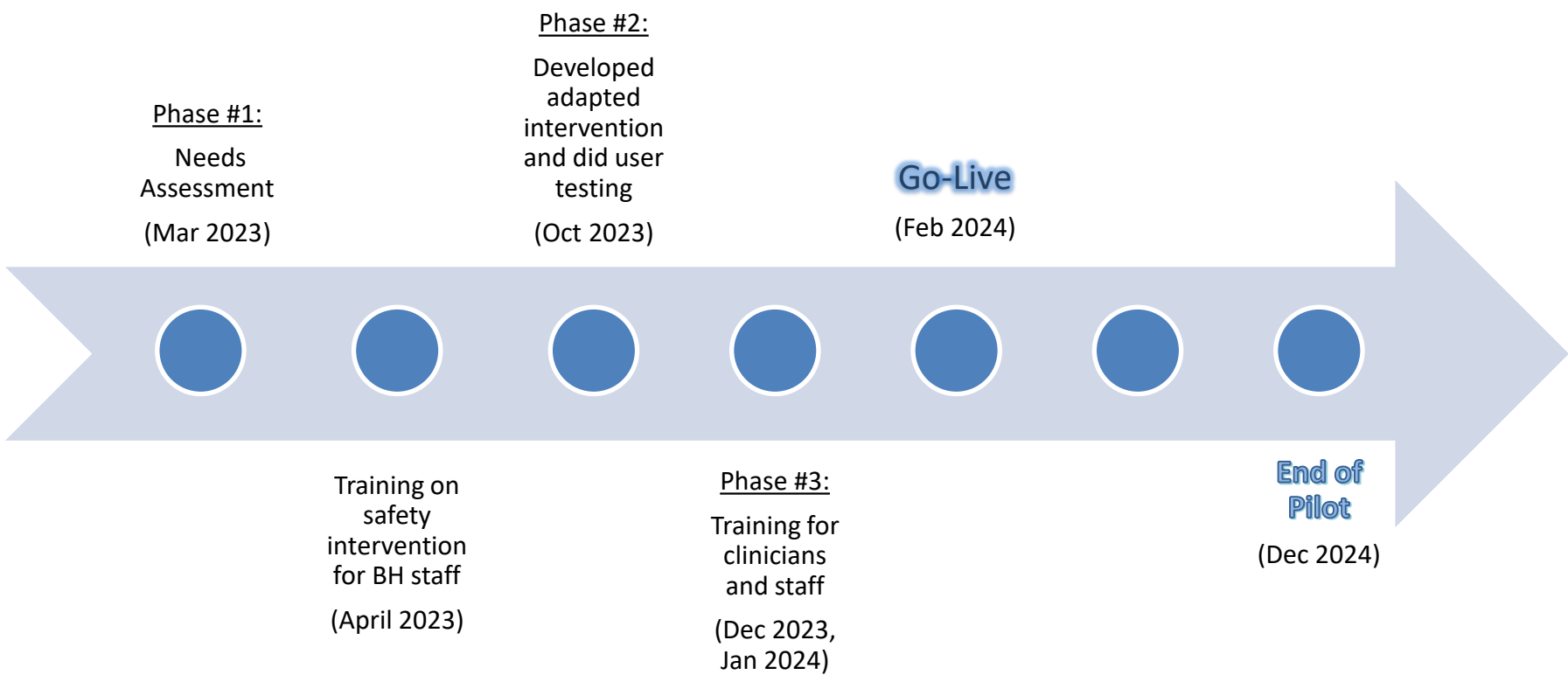
TIME LINE



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Epic Tips and Tools

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

	YES	NO
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

Assessing Suicide Risk	How to Access?
Fill out C-SSRS	• Suicide SmartSet (recommended) • Flowsheets • Specialty Tools Navigator
Review past C-SSRS responses	• Review Flowsheets
Add most recent C-SSRS responses to note	• Suicide SmartSet • Use **.CSSRSRECENTSELF**

Safety Planning	How to Access?
Fill out Stanley Brown Safety Plan	• Suicide SmartSet (recommended) • Specialty Tools Navigator
Add Stanley Brown Safety plan to chart note or AVS	• Suicide SmartSet • Use **.STANBROWN**
Add Stanley Brown Safety to MyChart message	• Use **.STANBROWN**

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DRAFT 6.1.24

PEDIATRIC SUICIDE CARE PATHWAY

UW MEDICINE PRIMARY CARE

Pediatric Patient Visit
If positive PHQ-9 question #9 or any concerns for suicide

→

Suicide Risk Assessment:
Complete additional assessment with C-SSRS Screener/Self- Report

↓

Suicide Risk Formulation
Consider risk factors and protective factors, current stressors and available resources

ADDITIONAL RESOURCES:
Recommend using Suicide SmartSet:
"UWM Suicide Risk Assessment/Care Plan"

SmartSet has links to:
Crisis info: .BHCRISISINFO
Lethal Means Counseling: .LOCK2LIVE
Coping and support plan (low risk): .COPINGCARD
Stanley-Brown Safety Plan Form and Referrals

↓

Clinical Risk Triage
Always use clinical judgment, the suggested risk levels and pathways below do not replace clinical judgment

LOW RISK

Passive SI (e.g. wishing to be dead) with no active suicidal thoughts, method, plan or intent

↓

Would benefit from a non-urgent MH follow-up?

NO → **PROVIDE PATIENT/FAMILY**
Offer lethal means safety counseling and coping/support planning to manage potential future suicidal thoughts
**see Additional Resources box*

YES ↓

REFERRAL TO MENTAL HEALTH CARE
Can refer to BHIP or to external MH

↓

PROVIDE PATIENT/FAMILY
Offer lethal means safety counseling and coping/support planning to manage potential future suicidal thoughts
**see Additional Resources box*

MODERATE RISK

Active SI without current plan or intent, Endorsement of recent (not current) plan and/or intent, or recent life-threatening self-harm

↓

SAFETY PLANNING
Review lethal means safety counseling and establish a safety plan with patient (and parent/caregiver if possible)
**if warm-off requested, contact social worker directly*

↓

REFERAL TO MENTAL HEALTH CARE:
Can refer to external MH if appropriate or Refer to BHIP
*(*mark STAT if urgent evaluation is needed)*

↓

PROVIDE PATIENT/FAMILY:
Crisis info: .BHCRISISINFO
**see also Additional Resources box*

HIGH RISK

Active SI with current plan, method and/or intent, recent suicidal behaviors or current life-threatening self-harm

↓

Imminent risk present and urgent MH evaluation needed?

NO → **SAFETY PLANNING**
Review lethal means safety counseling and establish a safety plan with patient (and parent/caregiver if possible)
**if warm-off requested, contact social worker directly*

YES ↓

INITIATE SAFETY PRECAUTIONS
Until able to obtain full MH evaluation

↓

TRANSFER
Send directly to ED for acute MH evaluation
**if warm-off requested, contact social worker directly*

↓

DOCUMENTATION
Document suicide risk level and plan of care, including any safety planning that was completed, and any other interventions or referrals that were provided

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Slide adapted from Dr. Jeffrey Sung's work on Adult Suicide Risk Screening Pathway

LESSONS LEARNED

Original intervention needed to be adapted to fit primary care setting:

- Clear instructions on each team member's role, as well as clear referral pathway and triage points, as well as when/how to hand-off patients
- Adapting safety planning intervention to be done in efficient, timely way
- Consideration for staff training level

HIGHLIGHTS:

- Completed needs assessment provided a lot of valuable information
- Provided suicide trainings to both PCPs and BH staff/clinicians
- Updated Epic tools to support clinical work
- Increased awareness and motivation to engage in suicide screening and assessment

"This has been so helpful and I've learned so much more about treating kids with SI and I think we're taking care of patients better"
- Primary Care Provider

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LESSONS LEARNED - CHALLENGES

- Low volume of referrals
  - Intervention designed for moderate-high risk and majority of patients are low risk
  - Small number of pilot sites
  - Sometimes going directly to Peds Social Workers instead of referral pathway
  - Variation due to time of year? No universal suicide screening?
- Intervention designed around patient visit workflow
  - However, some SI concerns were coming through phone calls or MyChart
  - Limited availability of PCP visits
- What to do about certain populations:
  - Patients already seen in ED for SI
  - Patients with chronic SI
  - Patients with outside mental health care
  - Disengaged patients

LESSONS LEARNED

- Implementation and operations: scheduling, resources, staff training/supervision, etc.

- PCPs appreciate having availability of warm hand-offs
  - Rare event, but very helpful when needed
  - Hard to plan for and build into templates and provide coverage
  - Tendency to utilize clinic social worker, especially if more assessment needed
- Sustainability
  - Need to think about setting, as well as scope and scale
  - Who will provide the intervention, what clinical training do they need?
  - What resources will be needed to expand
    - Supervision needs
    - Administrative and operational support
  - What reimbursement is available for services provided
  - Consider creating a centralized service

FUTURE DIRECTIONS

- With philanthropic support from the Four Pines Fund, we are in the beginning stages of planning for an expansion of services for suicidal patients

- Centralized hub for patients with suicidal thoughts/behaviors, staffed by behavioral health clinicians, to offer virtual visits for:
  - Warm hand-offs and care navigation
  - Brief intervention (e.g. crisis clinic model, caring contacts)
  - Could potentially be a service available to employees/staff/trainees
- Creation of comprehensive UW Medicine Suicide Care Pathway
  - Clinical pathway from screening -> assessment -> management and options to link patients to further behavioral health care
  - Care management for suicidal patients
- Future interventions from collaborations between various UW affiliates, such as:
  - Seattle Children's Hospital
  - UW Primary Care

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FUNDING

- Initially supported by philanthropic funding to strategically plan for the implementation of these services. Will seek to find ways to be a more self-sustaining clinical service.

- Explore ways to support centralized care model through:
  - Billable services
  - Other care management services reimbursed through value-based care (responding to elevated PHQ-9s)
  - Funding from the healthcare system for a centralized/shared service
  - Research funding to support implementation and evaluation

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LOOKING AHEAD….

- Consider opportunities to build upon the existing work and align with other organizational priorities:

- Quality and value-based initiatives, like Primary Care Transformation Initiative (WA State HCA)
  - BH measures are a part of the performance metrics
  - Depression metrics include both screening and management
- What does this mean for UW Medicine Primary Care?
  - More PHQ-9s!
  - Both for depression screening AND follow-up (to track and document depression remission and response)
- Things to consider:
  - How can we leverage EHR tools to help do this work?
  - How to manage positive screens related to suicide?

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OTHER ORGANIZATIONS – SUICIDE CARE PATHWAYS

- Seattle Children's Hospital
  - Universal suicide screening with ASQ
- VA
  - Universal suicide screening (C-SSRS)
  - VA/DoD and Rocky Mountain Mental Illness Research, Education, and Clinical Center (MIRECC) guidelines
- Swedish and Kaiser, any many other organizations across the country (St. Luke's in Idaho)
  - PHQ-9- > C-SSRS
- Henry Ford
  - Universal suicide screening (C-SSRS) and lethal means counseling (regardless of risk)

- At UW Medicine we are a complex system
  - Need to an enterprise level approach

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EHR TOOLS - SCREENING

- Current primary care workflows are mostly paper based, some clinics utilize forecasting and send PHQ-9s ahead of visit via MyChart. Can we make this more efficient?

- Optimize use of electronic questionnaires, which can be completed via:
  - MyChart (sent ahead of time or assigned at check-in)
  - Tablets/kiosks
  - Completed in office on exam room computers
  - Can also be batch sent (for those that are missing PHQ-9s)
- Can have PHQ-9 automatically trigger a C-SSRS if Q9 is positive
  - Many other healthcare organizations are doing this already
  - Helps identify patients that need further assessment
- Utilizing these tools could help:
  - Make it easier to not only send out these surveys, but track and monitor patient response
  - Meet the metrics related to depression screening and management
  - Reduce staff/provider time currently spent on paper workflows

EHR TOOLS– RESEARCH/QI

- Research and data collection goals

- Utilizing standardized tools, allows us to:
  - Collect population data
    - Better understand suicidal population at UW Medicine
    - Provide insights to where new interventions may be needed
      - i.e. highlight common risk factors
  - Collect user information for future enhancements

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SUICIDE CARE RESEARCH CENTER

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Director, Suicide Care Research Center

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https://psychiatry.uw.edu/research/suicide-care-research-center/

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OVERVIEW

- Our perspective on suicide care
- Need for suicide care in outpatient medical settings
- UW Suicide Care Research Center to co-design solutions
  - 4 key mechanisms of change
  - Suicide Care Pathway model
  - Methodological approach – integration of human centered design and optimization
  - Our studies, team and plans

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OVER-REFERRAL TO THE EMERGENCY DEPARTMENT

- Many patients who disclose they are suicidal in healthcare are referred to the ED
- While for many medical issues there are active treatments provided in the emergency room

- Not so for mental health and suicide care – the emergency room is focused on triage, evaluation, and referral (to inpatient, transfer, home)

OVER-REFERRAL TO THE EMERGENCY DEPARTMENT

Consequences

- system overwhelm
- negative experiences for patients and clinicians
- frequently referral back to referring primary care clinician due to access issues

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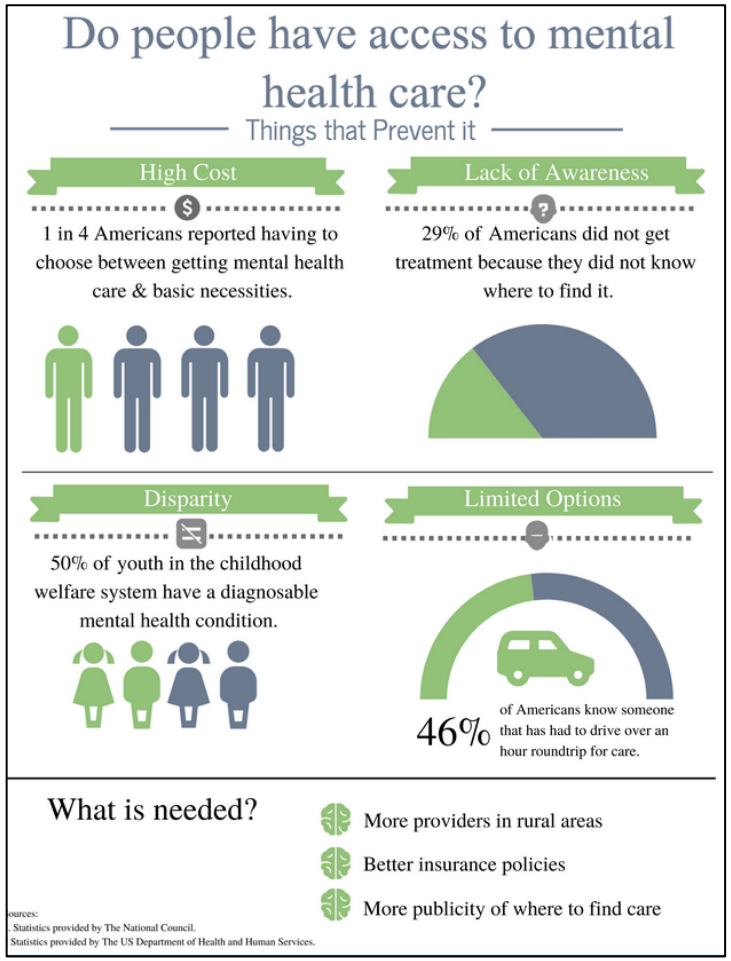
OUTPATIENT MEDICAL SETTINGS ARE A CRITICAL SOURCE OF MENTAL HEALTH CARE

Familiarity and accessibility

Lack of access to specialty mental health care



By Keegan McKoskey / April 11, 2019/ Magnify Mental Health

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INTEGRATED CARE MODELS INCORPORATE PSYCHOLOGICAL INTERVENTIONS

- Example: Collaborative Care (CoCM) meta-analysis
  - Small but significant reductions in suicidal ideation
  - No demonstrated improvements in suicidal behavior
- A minority of models incorporate evidence-based

Patient-Centered Care Team

Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals. The ability to get both physical and mental health care at a familiar location is comfortable to patients and reduces duplicate assessments. Increased patient engagement oftentimes results in a better health care experience and improved patient outcomes.

Population-Based Care

Care team shares a defined group of patients tracked in a registry to ensure no one falls through the cracks. Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice. Read how to identify a behavioral health patient tracking system in our Implementation Guide.

Measurement-Based Treatment to Target

Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools like the PHQ-9 depression scale. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved. Measurement-Based Treatment to Target is sometimes called Stepped Care.

Evidence Based Care

Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition. These include a variety of evidence-based psychotherapies proven to work in primary care, such as PST, BA and CBT, and medications. Collaborative care itself has a substantial evidence base for its effectiveness, one of the few integrated care models that does.

Accountable Care

Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided. Read more about accountability in our Financing section.

Source: aims.uw.edu/principles-of-collaborative-care/

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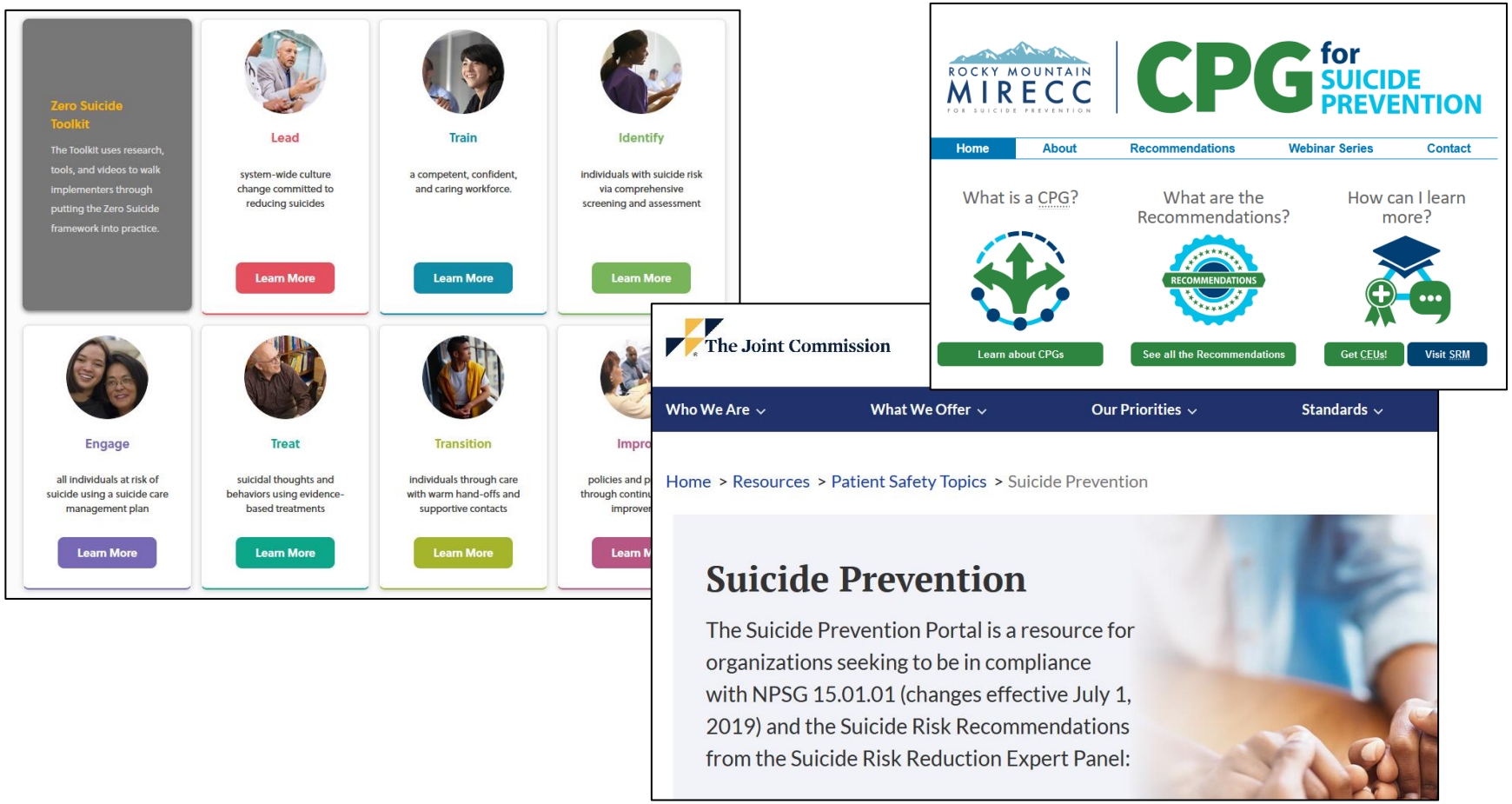
2011-2019 SUICIDE PREVENTION STANDARDS FOCUSED INCREASINGLY ON A "SUICIDE CARE PATHWAY"



Improving suicide care pathway = Improved outcomes in observational and quasi-experimental studies (Richards et al, 2024; Richards et al, 2021; Layman et al 2021)

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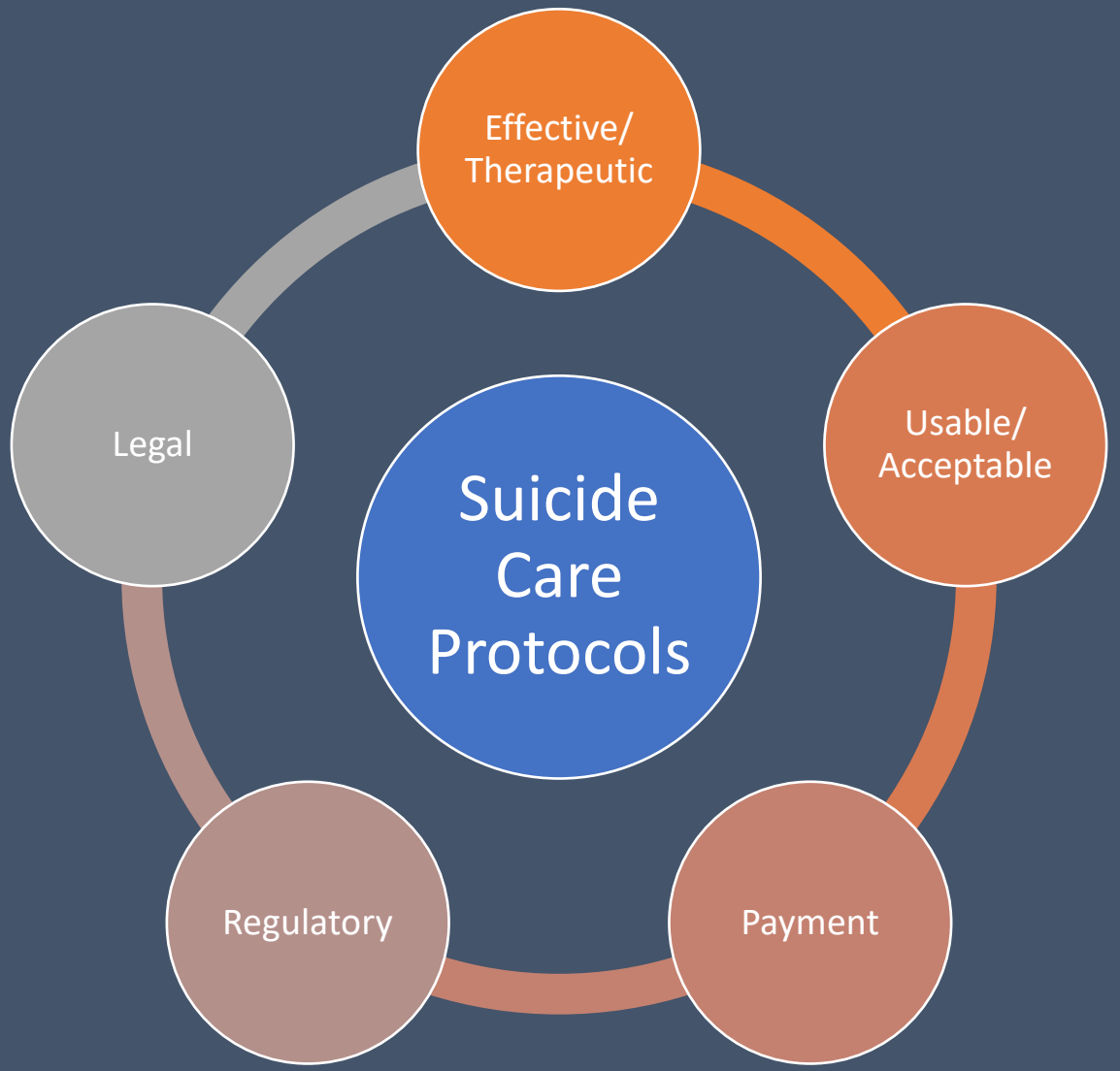
Suicide Care in Health Systems



OUR GOAL IS RECOVERY AND HUMAN CONNECTION

Suicide Care Research Center (SCRC)

- NIMH Practice-Based Suicide Research Center (P50)
- Initiated February 2023

Goal: Improve the design and delivery of suicide specific care in outpatient medical settings so they are effective, feasible in busy clinic environments and supportive of adolescent and young adult patients (age 13-30), their clinicians & their families

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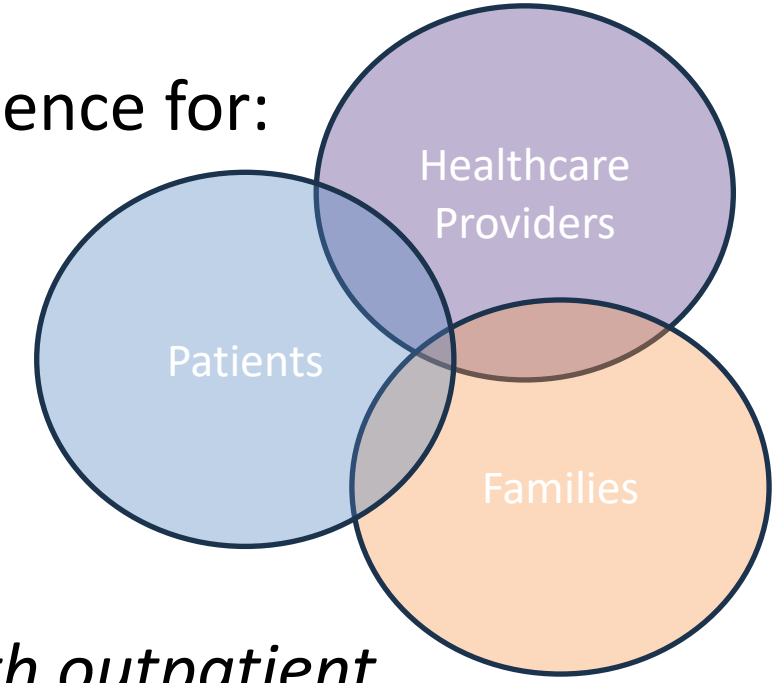
IMPACT OF IMPROVED EVIDENCE-BASED SUICIDE CARE IN OUTPATIENT MEDICAL SETTINGS

Potential for better care experience for:

- diverse patients
- their families
- their providers



hopefully to be felt across both outpatient medical settings and emergency departments

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FOUR KEY MECHANISMS

Clinical Mechanisms	Implementation Mechanisms
Therapeutic Alliance	**Usability and Acceptability**
Self-efficacy regarding suicide risk management • Patient • Family • clinicians	**Reach** • % suicidal patients who receive evidence-based suicide care • % trained clinicians providing evidence-based suicide care

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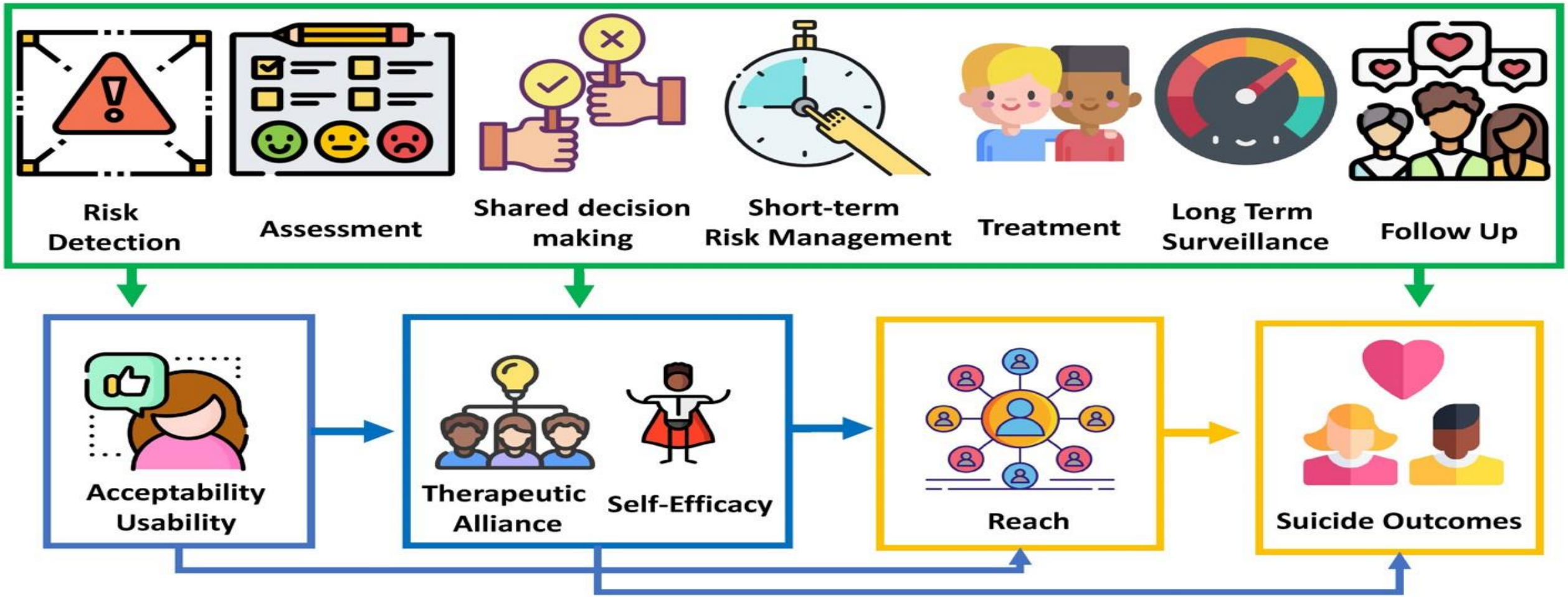
Suicide Care Pathway in Outpatient Medical Settings



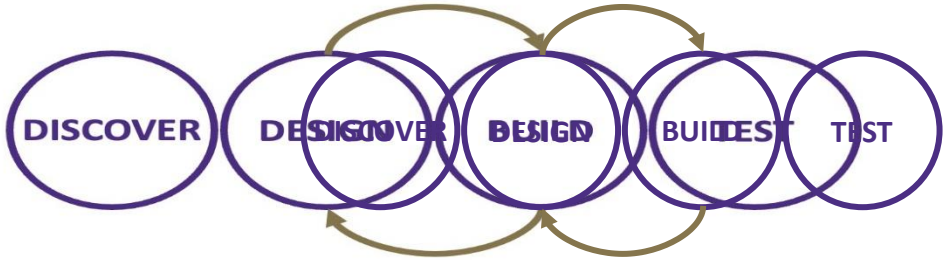
SCRC Methodology

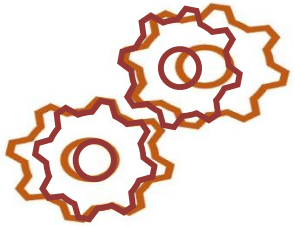
Human Centered Design (DDBT Framework) + Multiphase Optimization Strategy (MOST)

Preparation Phase

Optimization Phase

Evaluation Phase





Human C… of Co… | Human Centered Design of Components → Factorial Experiment Optimization Trials → Hybrid Implementation Trials | …rid …tion Trials

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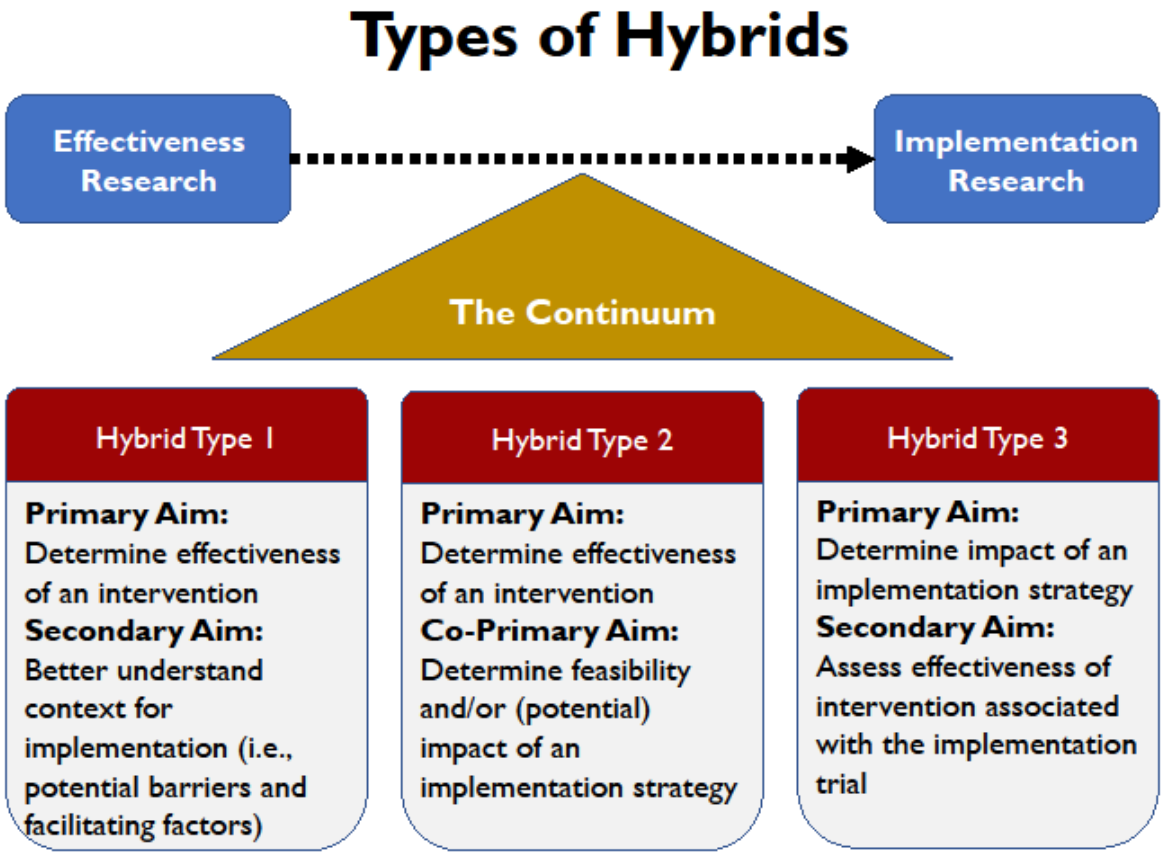
DDBT graphic adopted from UW ALACRITY Center

HYBRID EFFECTIVENESS IMPLEMENTATION TRIALS



Landes, S. J., McBain, S. A., & Curran, G. M. (2019). An introduction to effectiveness-implementation hybrid designs. *Psychiatry Research*, *280*, 112513. https://doi.org/10.1016/j.psychres.2019.112513

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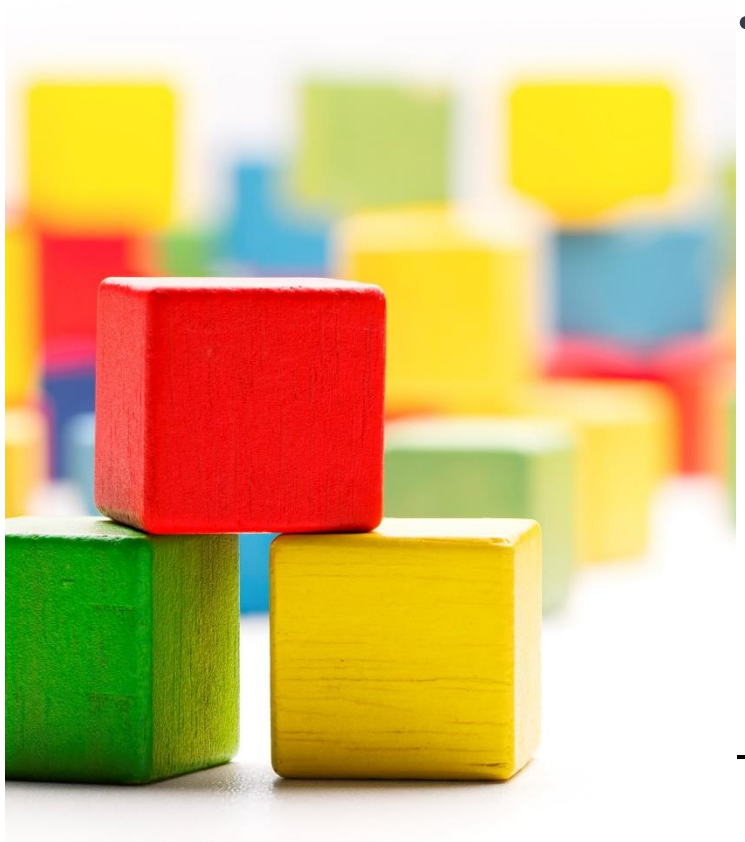
MOST OPTIMIZATION TRIALS



Focus

- Intervention components

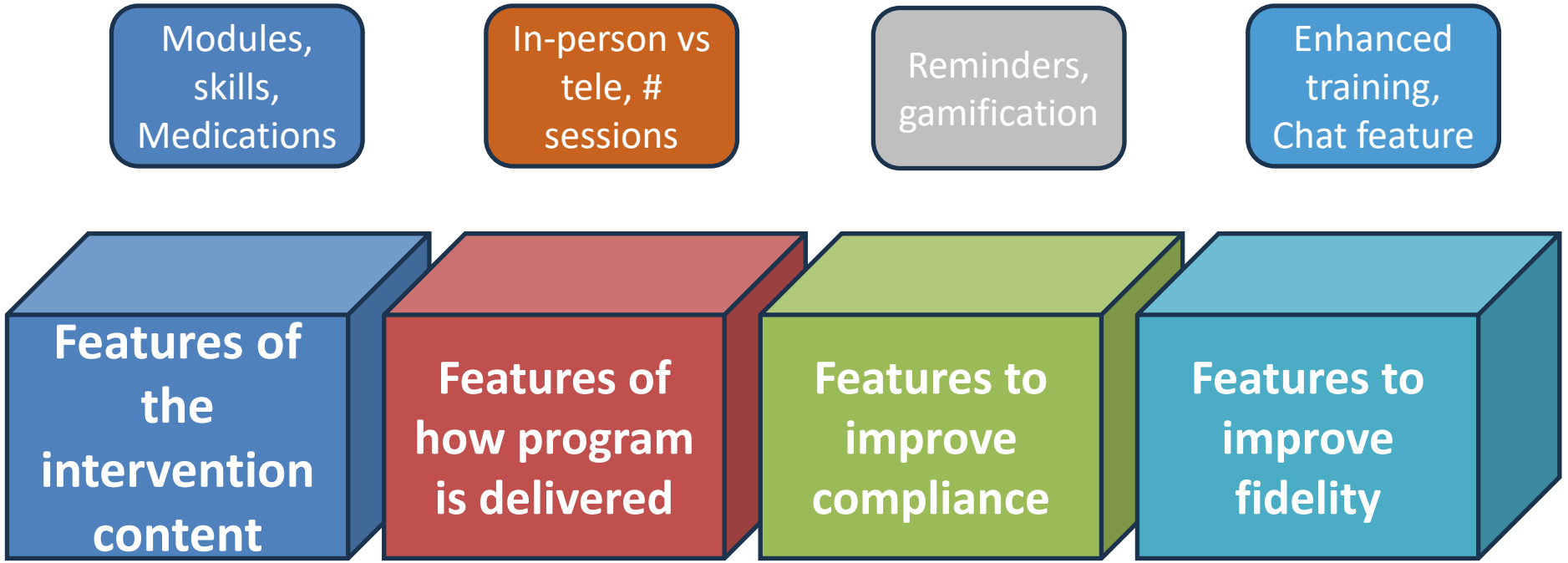
Goals

- Identify weak or ineffective components
- Determine magnitude of each component's effect
- Test whether one component improves or weakens the effects of another component (i.e., test interaction effects)

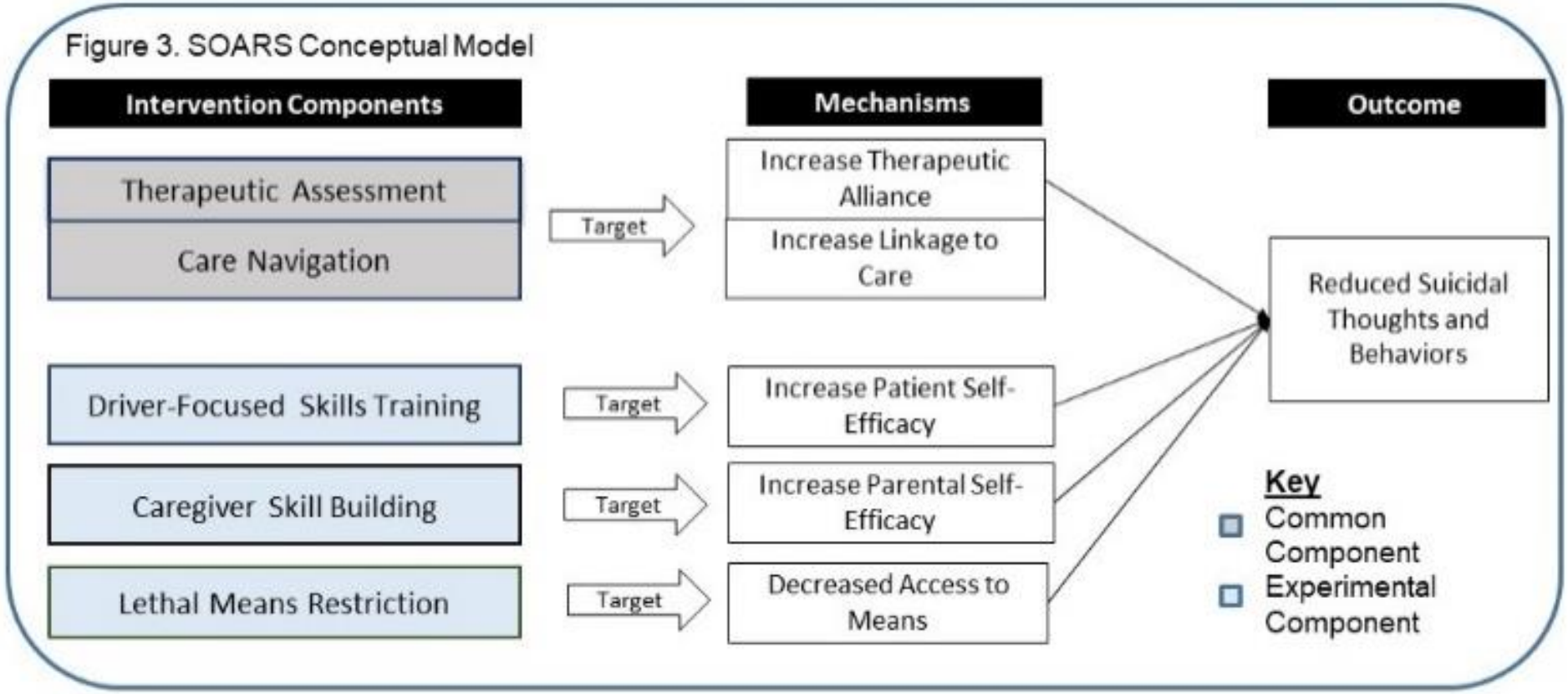
Research Design

– Often use factorial designs, but other designs possible

COMPONENTS: AN INTERVENTION'S BUILDING BLOCKS



SOARS STUDY – OPTIMIZING SUICIDE CRISIS CLINIC



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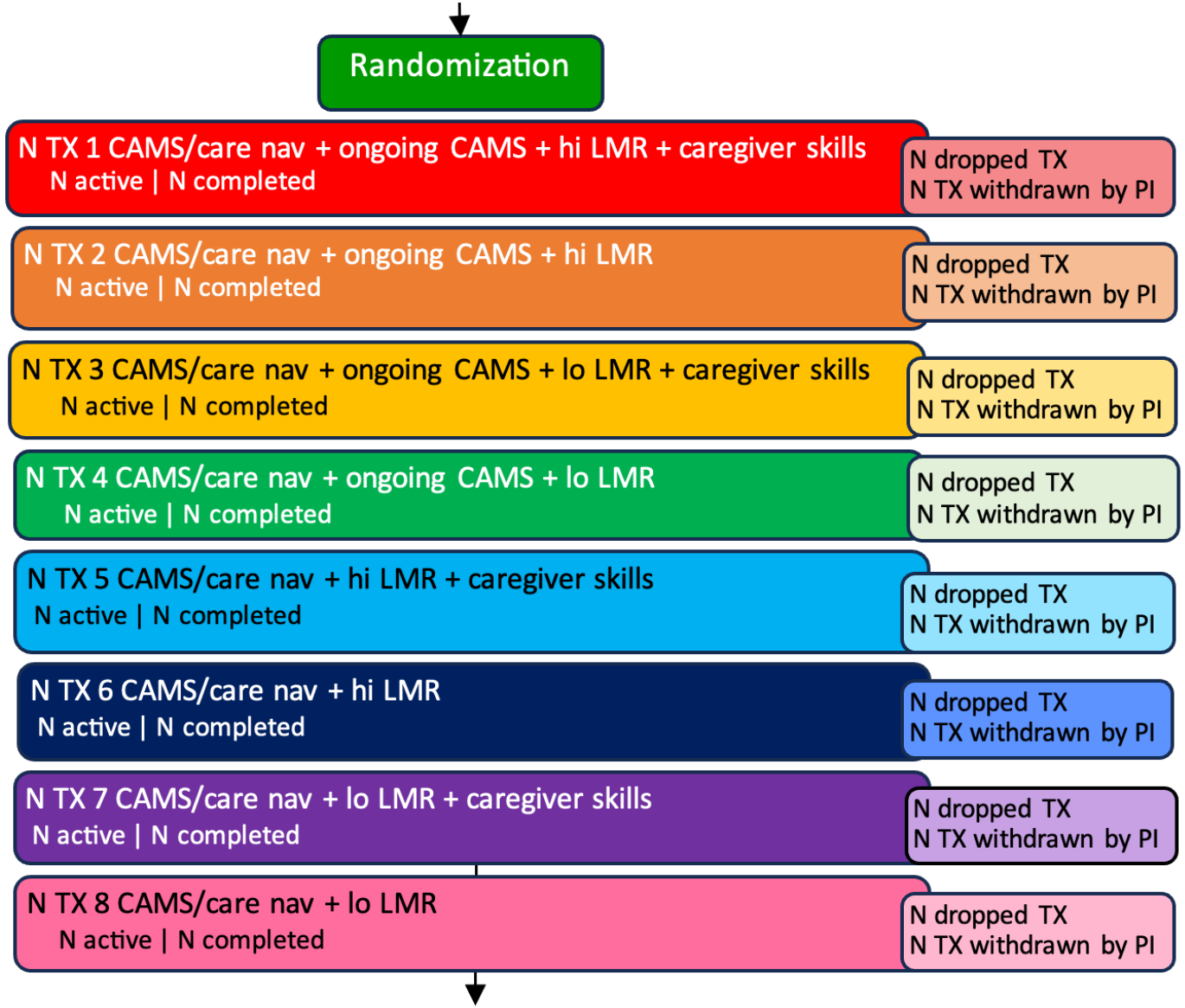
SOARS STUDY – OPTIMIZING SUICIDE CRISIS CLINIC



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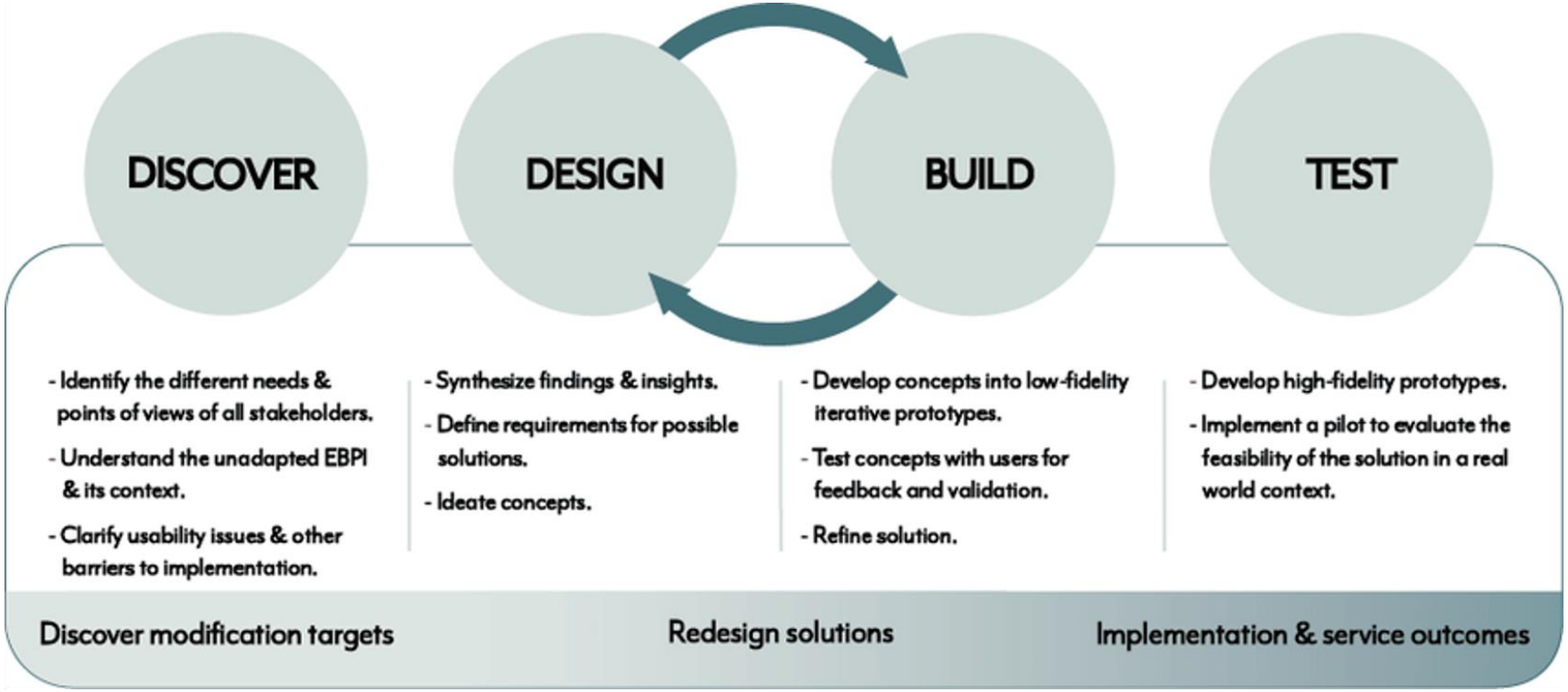
HUMAN CENTERED DESIGN

Co-design

Core principle of SCRC is that interventions need to be developed in partnership with the clinics where they will be used and with input from people with lived experience



Lyon AR et al. Use of human-centered design to improve implementation of evidence-based psychotherapies in low-resource communities: protocol for studies applying a framework to assess usability. JMIR research protocols. 2019 Oct 9;8(10):e14990.

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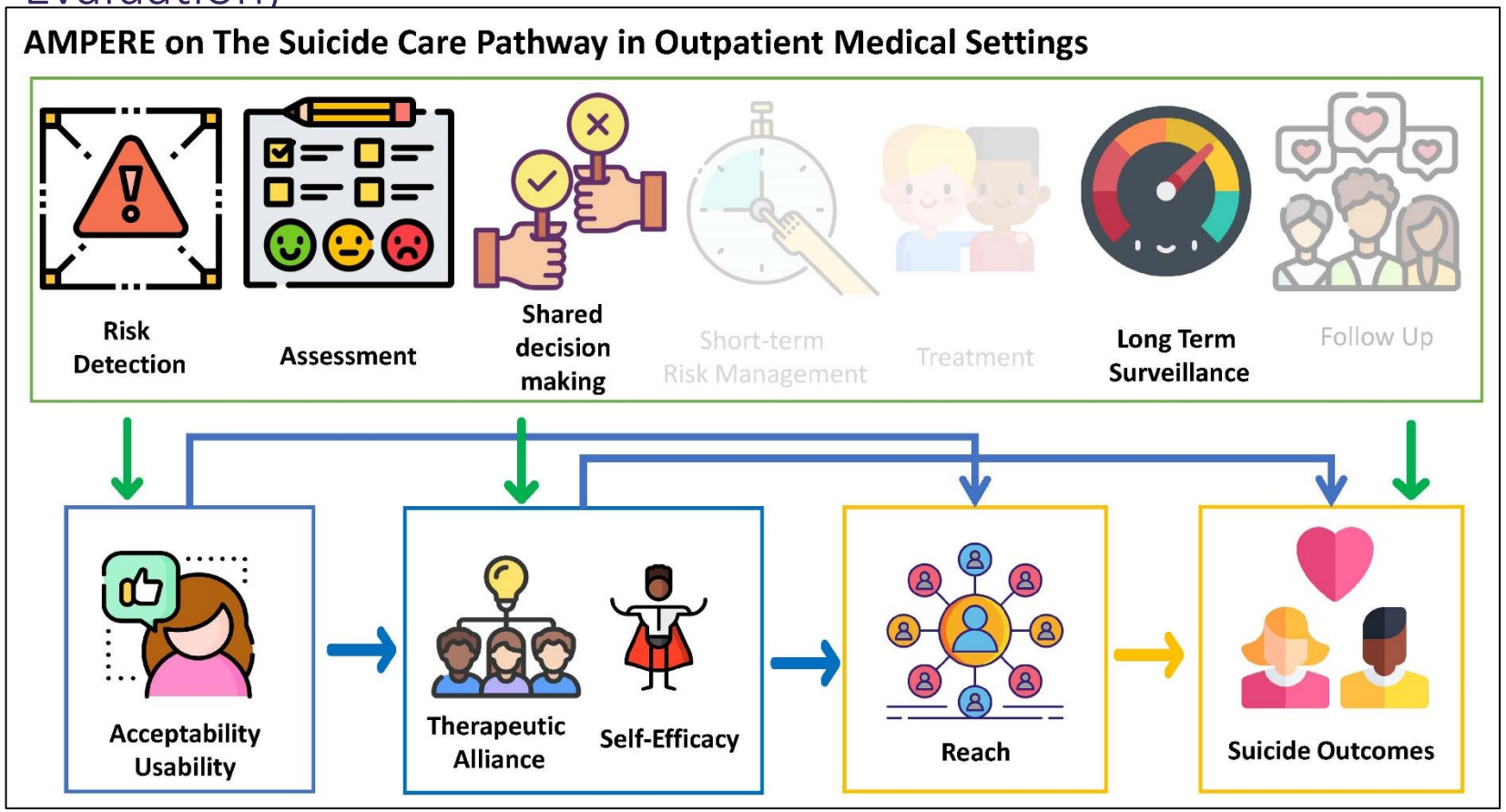
PILOT SYSTEM USING EMA FOR SUICIDE RISK MANAGEMENT

- AMPERE (Augmented Momentary Personal Ecological Risk Evaluation)



Principal Investigator: Ian Bennett

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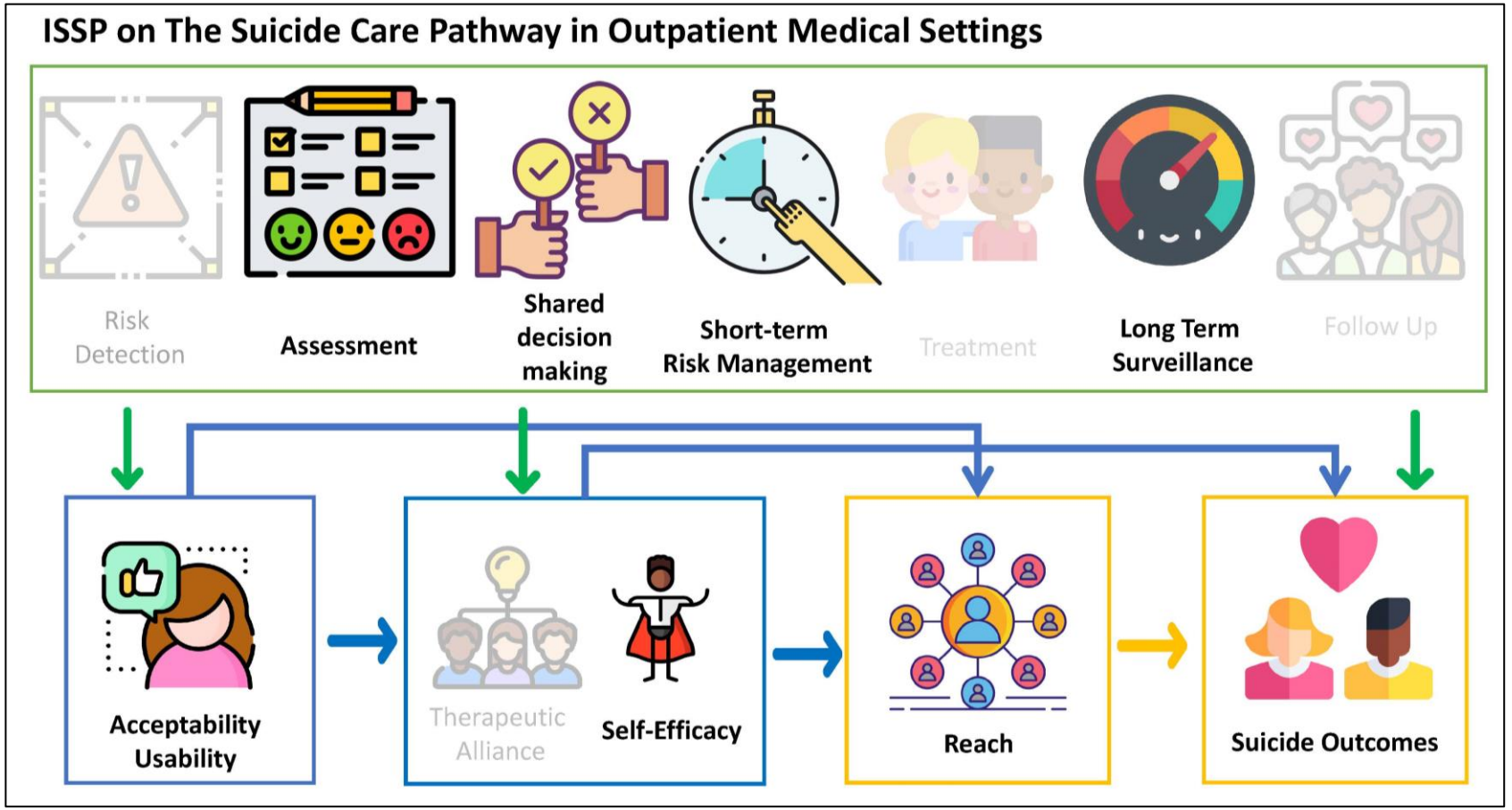
PILOT DIGITAL TOOL FOR ASSESSMENT & COLLABORATIVE SAFETY PLANNING

- ISSP (Integrated Screening and Safety Planning)



Principal Investigators: Laura Richardson and Cari McCarty

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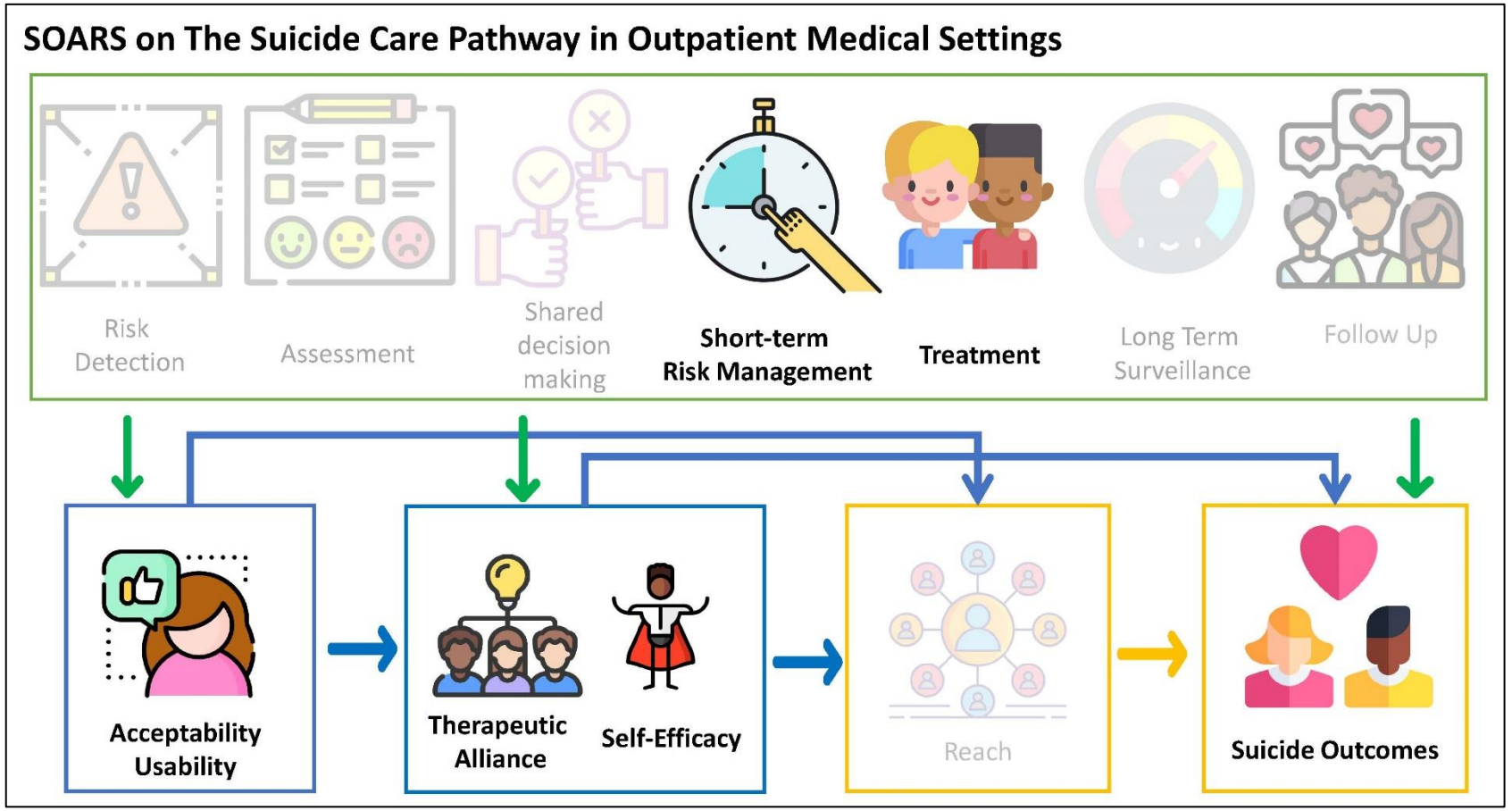
OPTIMIZATION TRIAL OF SUICIDE CRISIS CLINIC

- SOARS (Swift Outpatient Alternatives for Rapid Stabilization)



Principal Investigator: Molly Adrian

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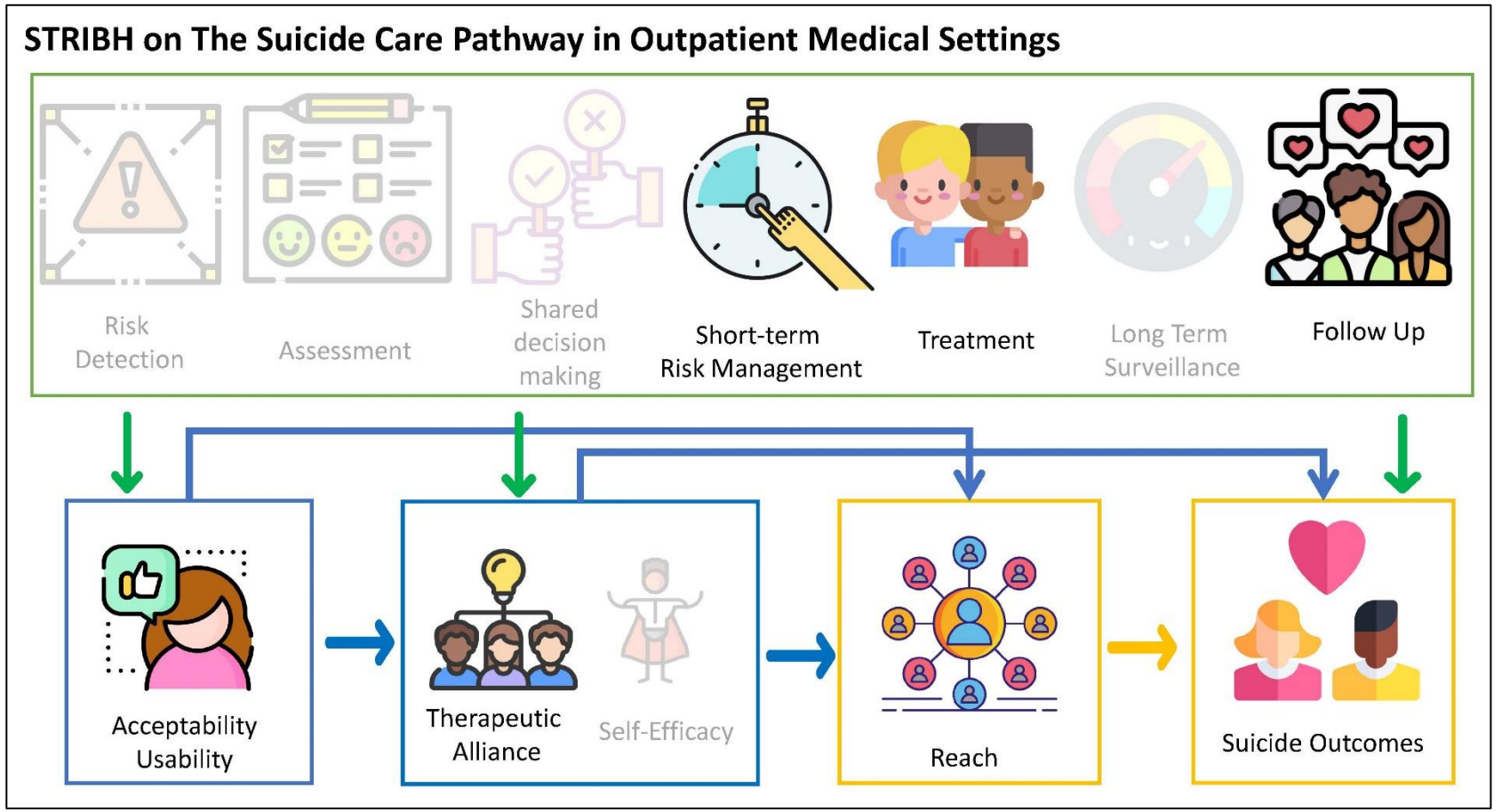
RE-DESIGN AND PILOT OF SUICIDE CARE INTERVENTION

- STRIBH (Suicide Treatment and Recovery in Integrated Behavioral Health)



Principal Investigator: Kate Comtois

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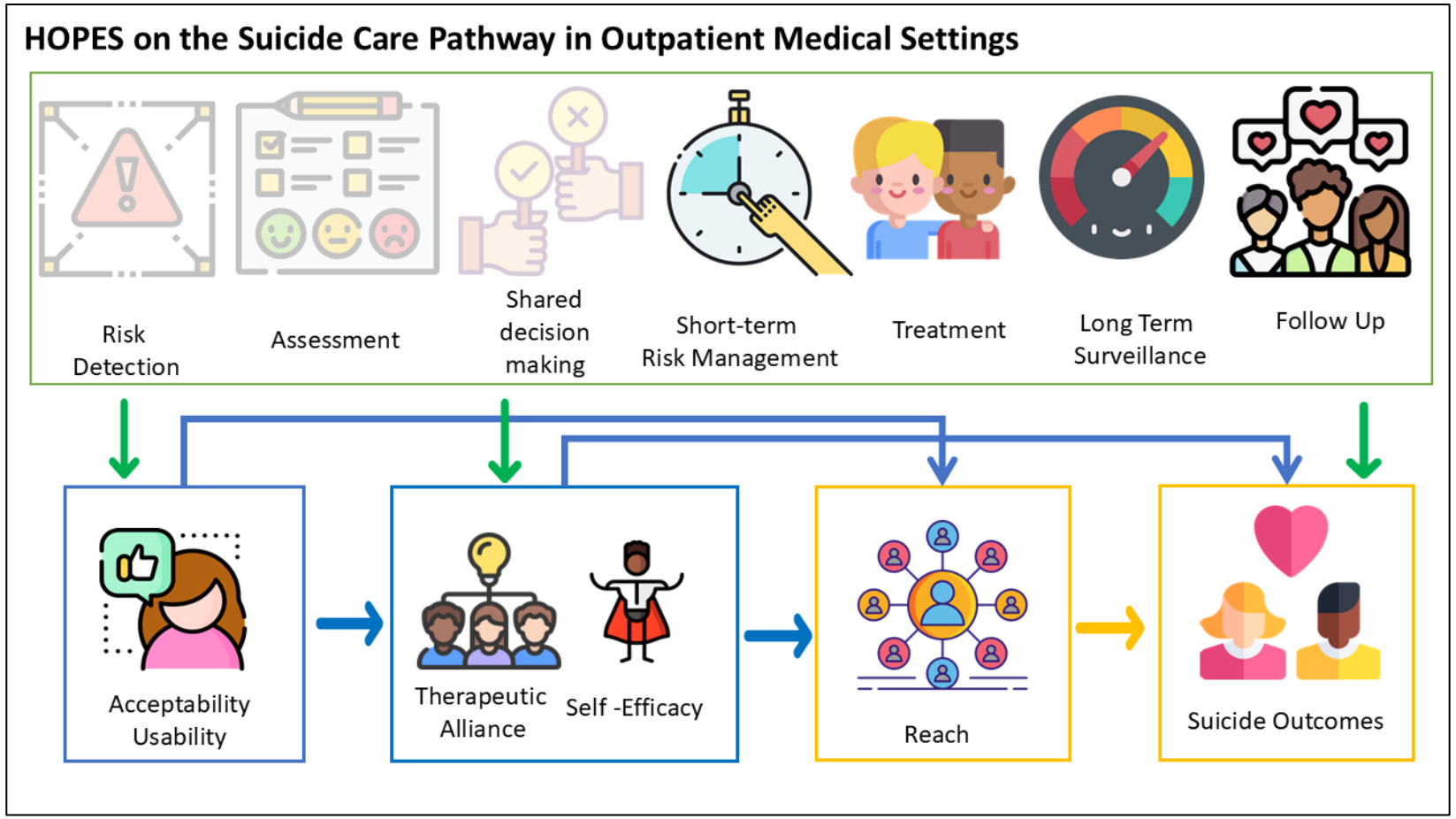
CO-DESIGN FOR CARING CONTACTS AND REMOTE MONITORING

- HOPES (Help, Outreach and Prevention for Suicide)



Principal Investigators: Denise Chang, Sarah Danzo, Patrick Wedgeworth

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SCRC AND UW MEDICINE

- Bringing best practices from across centers/organizations around the country to UW Medicine
- Developing partnerships within UW Medicine and Seattle Childrens as well as other outpatient medical networks across WWAMI
- Providing partner clinics and the region with training on suicide care and working with high risk and challenging patients
- Fund research projects with partnering clinics in UW Medicine (e.g. STRIBH, AMPERE and HOPES)
- Integration with Epic
  - How to get data out of the EHR to benefit suicide care and lead to clinical support tools
  - Support Epic development of tools for suicide care

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SCRC AND EPIC TOOLS

- Improved Epic tools for primary care and integrated behavioral health staff
- Building partnerships that benefit both SCRC and UW Primary Care
- Creates a platform into which new SCRC interventions can be built

- SCRC funds Epic tool development through BIME/ITHS Research IT and UW Medicine Information Technology Services
  - Epic programming
  - Human centered design
  - Expert input
    - Denise Chang, MD
    - Katherine Scott Davis, LICSW
    - Kate Comtois, PhD, MPH
    - Jeff Sung, MD

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COLLABORATIONS

- Working with and learning from both local and national organizations

- Other P50s (representing 6 other healthcare systems)
- Clinical organizations:
  - Kaiser
  - St. Luke's
  - VA
- Policy organizations:
  - Zero Suicide Institute
  - Action Alliance for Suicide Prevention
- Electronic Medical Record - Epic
  - Epic Suicide Brain Trust
  - Epic Caring Contacts team

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Questions?

UW Medicine

SPEAKER DISCLOSURES

✓ Any conflicts of interest?

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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OBJECTIVES

1. XXX
2. XXX
3. XXX

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