HEALTHY MINDS POLICY INITIATIVE

Suicide Prevention in Primary Care

Decreasing Oklahoma suicides through general health care

National trends show that suicide deaths have steadily increased in the U.S. since 2007, with youth suicide rates more than doubling in the same time period. In 2020, Oklahoma ranked 6th in the nation for suicide mortality, and the number of youth suicide deaths in the state was higher than the national average. Despite increased funding and research for prevention strategies, suicide has continued to persist as a public health crisis in the U.S. and in Oklahoma. We must strengthen efforts and explore innovative policy strategies to decrease suicide deaths across the state. This paper provides an overview of policy recommendations and best practices for suicide prevention in primary care settings.

Key Takeaways

- The evidence is clear: to become a leader in suicide prevention, **Oklahoma must ensure widespread screening, early intervention protocols, and provider training** in primary and general healthcare settings.

- Best practices are being adopted in Oklahoma now, and **the state has an environment ripe for additional expansion**. Early adoption of models such as Screening, Brief Intervention, and Referral to Treatment (SBIRT) are key examples.

- **Funding and regulatory barriers must be addressed** to ensure these efforts succeed. For example, the state's Medicaid program only reimburses physicians for SBIRT if a screening is positive.

Overview

In 2020, 869 Oklahomans lost their lives to suicide.[1] This is a 10% increase from 2019 and the highest number of suicide deaths the state has seen since 2006.[2] Suicide is the ninth leading cause of death for Oklahomans, with our state ranking sixth in the nation for suicide mortality.[1] As the world struggles to recover from the collective trauma of the COVID-19 pandemic, it is no wonder that a sense of hopelessness is threatening the lives of Oklahoma's most vulnerable individuals. According to INTEGRIS Health, one of Oklahoma's largest healthcare systems, emergency rooms saw a 117% increase in adolescent visits due to suicidal ideation.[3] Statewide characteristics such as large veteran populations, rural health disparities, substance misuse, high access to firearms, and high prevalence of adverse childhood experiences (ACEs) put Oklahomans at especially high risk. ACEs alone significantly increase risk, as the chances of attempting suicide are 30 times higher for adults with four or more ACEs.[4]

As examined in a recent comprehensive report, the integration of behavioral health care into primary care, or "integrated care," is a strategy that improves detection and treatment of mental

health conditions in primary care settings, ensures that more individuals get the help they need when they need it, and prevents future mental health crises that cost Oklahomans' lives and livelihoods. It can be an umbrella term for various models that combine behavioral and physical health care and work to improve whole-health outcomes using population-level strategies and coordinated, cohesive care.[5] Suicide deaths are both tragic and preventable, and integrating suicide prevention into primary care is an evidence-based strategy that could yield lifesaving benefits for our state.

The following strategies, recommended by the Suicide Prevention Resource Center (SPRC), lay out a roadmap to decrease Oklahoma's suicide rate through the integration of suicide prevention practices in primary care:[6]

- Train all healthcare professionals in suicide prevention practices and protocols
- Establish policies for routine suicide risk assessment, intervention, and referral
- Utilize evidence-based brief interventions, such as SBIRT, proven to help identify at-risk patients
- Increase communication and collaboration across healthcare providers to improve care transitions

Suicide Prevention in Primary Care: The Evidence

Primary care teams are uniquely positioned to identify risk and initiate intervention

Studies have shown that people who die by suicide are more likely to have seen a primary care provider (PCP) in the month before their death than any other healthcare provider.[7] Stigma, lack of awareness of resources, and general inaccessibility may prevent an individual forming a relationship with a therapist or psychiatrist who can detect suicide risk. However, among people who died by suicide, 83% visited a PCP in the past year, and 50% visited that same provider within 30 days of their death.[5] Especially during the COVID-19 pandemic, primary care facilities and emergency departments are flooded with individuals who may not only need treatment for physical symptoms, but may also have underlying behavioral health needs. In 2020, COVID-related stressors led to a peak of almost 45% for depression and anxiety, while the pre-pandemic baseline was around 20%.[8] Accessing services through primary care may be easier than other pathways because of its routine familiarity and it is more likely to be covered by insurance. For many individuals, primary care may be their only chance to get connected with much needed mental health services.

Suicide is about more than mental illness – it is a public health issue that is also linked to social determinants of health

The causes of suicide are complex, rarely caused by any single factor, and can be linked to social, economic, and environmental conditions that affect quality of life, also known as social determinants of health.[9] While diagnosed depression or other mental illness are commonly known risk factors, suicide is not always a direct result of mental illness, nor does someone have to have a mental health condition to be at risk for suicide. For example, in Oklahoma intimate

partner problems were linked to more youth suicides than diagnosed mental illness between 2012 and 2016 (see Table 1). Other risk factors include social isolation, financial difficulties, job loss, chronic pain and health conditions, substance misuse, alcohol use disorder, and easy access to lethal means of suicide, including medications and firearms.[6] Many of these risk factors are likely to be common among patients visiting primary care providers, and the integration of suicide prevention strategies into primary care practice can help providers identify individuals at risk of suicide who might have otherwise gone unnoticed.

Table 1

Leading Circumstances/Stressors Associated with Suicide for Youth Ages 10-24 Years, Oklahoma Residents, 2012-2016[10]

Intimate Partner Problem	39%
One or More Diagnosed/Treated Mental Health Problems	36%
Depressed Mood	29%
Argument	23%
Substance Abuse Problem	20%
Alcohol Problem	10%
Recent Criminal Legal Problem	9%
Job Problem	7%

Note: Oklahoma Violent Death Reporting System Victims may be coded for one or more circumstance.

Suicide prevention in primary care is a strategy recommended by local and national experts

In 2015, the Oklahoma Suicide Prevention Council published the Oklahoma Suicide Prevention Strategy, a five-year plan that outlined goals and recommendations to decrease suicide in the state. The plan included a goal to promote integrated care with a list of objectives for healthcare delivery systems and emergency departments. The plan recommended that healthcare delivery systems incorporate suicide prevention strategies to show continuous quality improvement efforts, and that providers implement collaborative and responsive protocols for delivering services to individuals with suicide risk.[11]

In March 2022, the American Academy of Pediatrics (AAP) and American Foundation for Suicide Prevention (AFSP), in collaboration with experts from the National Institute of Mental Health (NIMH), released a Blueprint for Youth Suicide Prevention. The blueprint recommends universal screening for suicide risk in clinical settings such as outpatient and pediatric clinics, emergency departments, community health centers, and urgent care settings.[12]

Policy and Practice Options: Three Examples

1.) Requiring Suicide Prevention Training for Healthcare Professionals

As of 2017, ten states have passed legislation mandating healthcare professionals to complete an evidence-based suicide prevention training program.[13] Of the ten states, six require training for mental health professionals and four require training for primary care professionals and mental health professionals (see Table 2). These training programs include education on suicide risk assessment, treatment, and management, as well as information on safety planning and lethal means counseling. Many of these state policies allow suicide prevention training to qualify as continuing education units (CEUs), which are often required for licensure renewal or reinstatement of mental health professionals. For physicians, these continuing education requirements are called continuing medical education (CME). Connecting suicide prevention training to CEU requirements is an effective way to equip and incentivize healthcare professionals to participate in suicide prevention efforts. All four states that have required suicide prevention training for primary care professionals have also seen a decrease in their suicide rates since implementing these policies in 2017 (see Figure 1).[14] A comprehensive list of evidence-based training programs can be found through the SPRC and Zero Suicide. Many of these trainings are free or low-cost.[15]

Table 2

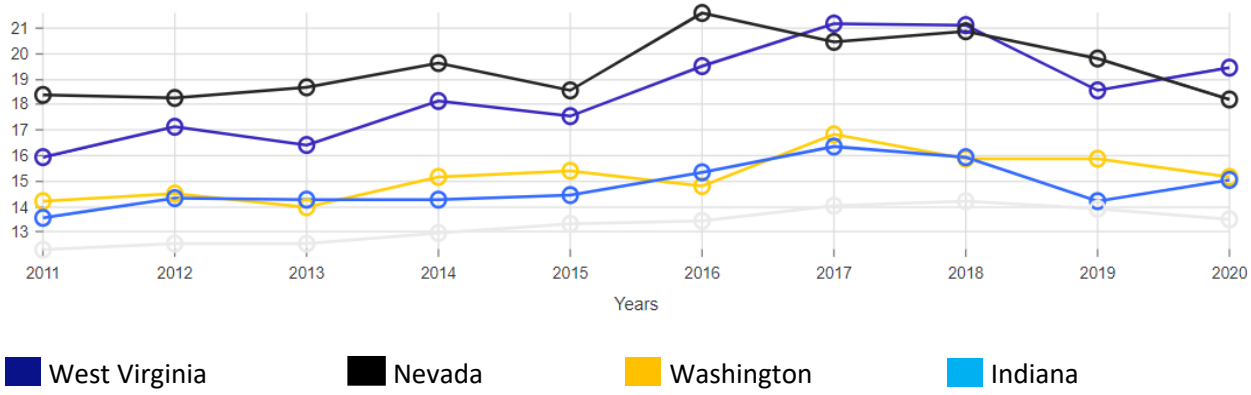
Suicide training by profession

State	Required Field	Details
West Virginia	Behavioral Health & Primary Care	House Bill 2804 **Required professionals:** Registered professional nurses (registered nurses and licenses practical nurses), advanced nurse practitioners, psychologists, social workers, professional counselors **Duration:** 2 hours for each renewal/reporting period for continuing education requirements
Indiana	Emergency	House Bill 1430 **Required professionals:** Emergency medical services providers **Duration:** Not specified
Nevada	Behavioral Health & Primary Care	Assembly Bill 105 **Required professionals:** Physicians, physician assistants, advanced practice registered nurses, osteopathic physicians, psychologists, certified autism behavior interventionists, detoxification technicians, alcohol, drug, and gambling counselors, marriage and family therapists, clinical professional counselors, social workers, licensed behavior analysts, licensed assistant behavior analysts

		Duration: Varies for profession
Washington	Behavioral Health & Primary Care	RCW 43.70.442 **Required professionals:** Chiropractors, dentists, dental hygienists, naturopaths, licensed practical nurses, registered nurses, advanced registered nurse practitioners, osteopathic physicians, osteopathic physician assistants, physical therapists, physical therapist assistants, physicians, physician assistants (does not include certified registered nurse anesthetists, osteopathic physicians and surgeons who hold a postgraduate license in osteopathic medicine or surgery, or physicians who are residents holding a limited license) Advisors, counselors, chemical dependency professionals, marriage and family therapists, mental health counselors, occupational therapy practitioners, psychologists, advanced social workers, independent clinical social workers, social worker associates **Duration:** 6 hours 1 time for non-mental health professionals, 6 hours every 6 years for mental health professionals

Figure 1

State Suicide Rates Per 100,000 Individuals[16]



2.) Establishing Screening, Assessment, and Intervention Protocols

Along with suicide prevention training, healthcare organizations should establish clear and structured protocols for universal suicide screening, assessment, and intervention. The SPRC recommends that all healthcare clinicians take the following three steps to approach suicide screening:

- Review each patient's personal and family medical history for suicide risk factors.
- Screen all patients for suicide ideation using a brief, standardized, evidence-based screening tool.
- Review screening questionnaires before the patient leaves the appointment or is discharged.[6]

Healthcare organizations can implement these simple steps into a written suicide prevention protocol. Providers should be expected to have introductory conversations with patients about their history and potential risk factors, following by a standard screening. There are several standardized screening tools available that assess for suicide risk, including suicidal ideation and attempts. Validated screening instruments include the Ask Suicide-Screening Questions (ASQ), the Columbia Suicide Severity Rating Scale (C-SSRS), and the Patient Health Questionnaire-9 (PHQ). A positive screen should be followed by a suicide risk assessment, safety planning, and linkage to treatment if needed.

Organizations can also use the electronic health record (EHR) to support suicide prevention protocols.[5] The Zero Suicide initiative recommends embedding automated prompts into the EHR system for each of the above steps.[5] For example, entry of a "yes" answer to a screening question about suicidal thoughts can then prompt an assessment protocol. Some EHR systems can also be configured to record safety plans, a list of referrals made and why, and a plan for follow-up. An alert can also be added to the records of patients who are being treated for suicide risk so that each time a patient is seen, EHR banners or pop-ups serve as a reminder to follow up on the patient's suicide status. It is important to note that effective suicide prevention goes beyond screening. Integrated care does not stop with screening. Having protocols in place for further assessment and intervention are key to the continuum of care. The goal of an established protocol is that all primary care staff should know how to screen a patient for suicide risk, what to do if a patient screens positive, where and how to transport a patient if they require hospitalization, and how to complete documentation and follow-up.[17]

3.) Streamlining Referrals and Quality Continuum of Care

Timely referrals and intentional follow up are a critical component of effective suicide prevention. The SPRC recommends these collaborative practices to support a quality continuum of care: [4]

- Create agreements with specific behavioral health practices that will take referrals.

- Ensure continuity of care by transmitting patient health information to emergency care and behavioral healthcare providers to create seamless care transitions.
- Make follow-up contacts (e.g., by e-mail, text, phone call) with the patient and check with providers to make sure that the person is receiving follow-up care.

In combination with suicide prevention training, screening, and intervention protocols, healthcare organizations can incorporate and adopt these practices into a comprehensive suicide prevention policy that establishes suicide prevention as part of the organizations culture, increasing patient safety and whole person care. Screening is the first step. If a patient screens positive, it is essential that a PCP engage in helping continue that conversation. Creating referral pathways eases the transition from a PCP's care to the care of a licensed mental health professional. Without these pathways, detection can only do so much.

Disseminating Best Practices: Oklahoma Considerations

When implementing new policies and practices, healthcare organizations must consider the costs, including costs related to planning, training, materials, technology, and service delivery. It is important to implement suicide prevention strategies that are financially stable and sustainable to ensure long-term success. Fortunately, many of the practices recommended in this paper do not pose a significant financial threat or burden to our state. In fact, the preventative nature of suicide prevention can hold significant long-term savings and cost-avoidance for healthcare systems.

The Oklahoma Department of Mental Health & Substance Abuse Services (ODMHSAS) provides free, online training to health professionals through a partnership with Kognito. Kognito's training, *At-Risk in Primary Care*, is a CE-certified virtual patient simulation experience designed to prepare primary care providers to screen patients for mental health and substance use, perform brief interventions using motivational interviewing techniques, and refer patients to treatment.[18] The department offers this training free of charge upon request from any primary care provider.

The use of evidence-based screening tools can also be done without significant financial expense. Most depression screeners like the PHQ-2 and PHQ-9 are covered annually through Medicaid and private insurers.[19] Effective suicide prevention protocols may require more than just an annual depression screening. Because of the extra time and intentionality required with prevention practices, incentivization is an important factor to consider. Currently, physicians can be reimbursed for administered standard mental health screening instruments under the Current Procedural Terminology (CPT) 96127 code. These standardized codes are used by Medicaid, Medicare, and private payers to uniformly describe the services rendered to patients. This reimbursement is only $4 per screening, which does not serve as an incentive to include a screening in an already limited visit time.[20] Primary care professionals might be more willing to

provide additional screening and suicide prevention services if they are receiving adequate reimbursement. Not only would incorporating proper coding and billing mechanisms support and enforce mental health parity laws, but it would also increase buy-in and financial sustainability for suicide prevention in primary care.

Moving forward: Funding and Sustainability

With some of the highest suicide rates in the nation, our state now has the chance to respond to the suicide epidemic with intention, innovation, and system-wide collaboration. Oklahoma has already implemented similar behavioral health screening and integration strategies into primary care settings in response to the opioid epidemic. The state has made progress in substance misuse treatment and prevention through required training in primary care and by funding evidence-based screenings and interventions. A policy has been written into health agency code, mandating that doctors complete continuing medical education courses (CMEs) related to opioids and pain management prescribing. Both medical and osteopathic doctors who prescribe controlled substances are required to complete one hour of CMEs about pain management per licensure cycle.[21] Oklahoma has also implemented universal substance use screening in primary care using the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. Through the SBIRT OK Initiative, the Oklahoma Department of Mental Health and Substance Abuse Services plans to increase SBIRT model programming as a key performance measure in fiscal year 2022.[22]

Building upon existing initiatives, there are opportunities to enhance and modify SBIRT practices to also identify and address suicidal thoughts and behaviors. Oklahoma is currently working toward funding and utilizing the SBIRT codes for the Medicaid population. Under the current structure, physicians are not reimbursed for SBIRT. They are currently only reimbursed for the short intervention after the screening is administered; that reimbursement is just over $31. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) currently lists Medicaid reimbursement for the screening at $24, and for the brief intervention at $48 for every 15 minutes.[23] Reimbursement for these services will increase physician participation in screening and prevention practices. Once adopted, Oklahoma will define its own rate for reimbursing these services, but the reimbursement will likely be less than the reimbursement for the Medicare population and those with commercial insurance.

Currently, there are no existing policies in Oklahoma that require mental health or suicide prevention training for primary care professionals. House Bill 3741, which was introduced during the 2022 state legislative session but failed to gain the Legislature's approval, would have required physicians to complete one hour of suicide prevention training annually for licensure renewal. By advocating for and supporting bills like HB 3741, Oklahoma could become a pioneer for innovative suicide prevention strategy, becoming one of the first states in the region to require suicide prevention training for primary care professionals.

[1] American Foundation for Suicide Prevention. (2022, March). *Suicide data: Oklahoma.* Retrieved from: https://aws-fetch.s3.us-east-1.amazonaws.com/state-fact-sheets/2022/2022-state-fact-sheets-oklahoma.pdf

[2] Bryen, W. (2022, March 28). *Oklahoma suicides climb to highest point since 2006*. Oklahoma Watch. Retrieved from https://oklahomawatch.org/2021/08/17/oklahoma-suicides-climb-to-highest-point-since-2006/

[3] Toolis, B. (2021, August 24). *Mental health experts concerned with suicide rate in Oklahoma during the pandemic*. KOTV. Retrieved from https://www.newson6.com/story/61253e1d7e78e90bf3dfe500/mental-health-experts-concerned-with-suicide-rate-in-oklahoma-during-the-pandemic

[4] Centers for Disease Control and Prevention. (2022, April 20). *Priority areas*. Centers for Disease Control and Prevention. Retrieved from https://www.cdc.gov/injury/priority/index.html

[5] Healthy Minds Policy Initiative. (2021, July 29). *Integrating behavioral health into primary care in Oklahoma*. Retrieved from https://www.healthymindspolicy.org/integrated-care/

[6] Suicide Prevention Resource Center. (2020, January 1). *Primary care*. Retrieved from https://sprc.org/settings/primary-care

[7] Ahmedani BK; Simon GE; Stewart C; Beck A; Waitzfelder BE; Rossom R; Lynch F; Owen-Smith A; Hunkeler EM; Whiteside U; Operskalski BH; Coffey MJ; Solberg LI; (2014, February 15). *Health care contacts in the year before suicide death*. Journal of General Internal Medicine. Retrieved from https://pubmed.ncbi.nlm.nih.gov/24567199/

[8] https://www.healthymindspolicy.org/wp-content/uploads/2021/09/COVID-General-Update-September-2021.pdf

[9] The Association of Clinicians for the Underserved. *Suicide Prevention in Primary Care: A Toolkit for Primary Care Clinicians and Leaders* (pp. 1-15). Centene Corporation. Retrieved from https://zerosuicide.edc.org/sites/default/files/suicidesafercareguideforprimarycareproviders.pdf

[10] Oklahoma State Department of Health (2020, January). *Oklahoma Youth and Young Adult Suicide Report.* Retrieved from https://oklahoma.gov/content/dam/ok/en/health/health2/documents/ips-okvdrs-youth-and-young-adult-suicide-report-oklahoma-2020.pdf

[11] The Oklahoma Suicide Prevention Council. (2020). *Oklahoma Strategy for Suicide Prevention* (pp. 1-44). Retrieved from https://sprc.org/sites/default/files/OK%20state%20plan%202017.pdf

[12] American Academy of Pediatrics. (2022, February 18). *Strategies for clinical settings for youth suicide prevention*. Patient Care. Retrieved from https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/

[13] Graves, J. M., Mackelprang, J. L., Van Natta, S. E., & Holliday, C. (2018). *Suicide prevention training: Policies for health care professionals across the United States as of October 2017*. American Journal of Public Health, 108(6), 760-768.

[14] American Academy of Pediatrics. (2022, February 18). *Strategies for clinical settings for youth suicide prevention*. Patient Care. Retrieved from https://www.aap.org/en/patient-care/blueprint-for-youth-suicide-prevention/strategies-for-clinical-settings-for-youth-suicide-prevention/

[15] Zero Suicide. *Suicide care training options.* (2016). Education Development Center. Retrieved from: https://zerosuicide.edc.org/sites/default/files/2020-11/2020.11.18%20Suicide%20Care%20Training%20Options_0.pdf

[16] American Foundation for Suicide Prevension (2022, February 17). *Suicide statistics.* Retrieved from https://afsp.org/suicide-statistics/

[17] Montana DPHHS. *Suicide prevention in primary care settings*. Retrieved from https://dphhs.mt.gov/suicideprevention/toolkit/primarycare

[18] Oklahoma Department of Mental Health and Substance Abuse Services. (2020). Kognito at-risk in primary care. Retrieved from https://oklahoma.gov/odmhsas/learning-and-education/training-institute/at-risk-primary-care.html

[19] Medicare Rights Center. (2019, November 12). *Depression screenings*. Medicare Interactive. Retrieved from https://www.medicareinteractive.org/get-answers/medicare-covered-services/preventive-services/depression-screenings

[20] Oklahoma Health Care Authority. (2022, January 1). *Title XIX Fee Schedule*. Retrieved from https://oklahoma.gov/ohca/providers/claim-tools/fee-schedule.html.

[21] AMA Ed Hub. *Oklahoma State CME requirements*. Retrieved from https://edhub.ama-assn.org/state-cme/Oklahoma

[22] Slatton-Hodges, C. (2021) *Fiscal year 2022 budget hearing.* Oklahoma Department of Mental Health and Substance Abuse Services. Retrieved from:
https://oklahoma.gov/content/dam/ok/en/odmhsas/documents/about/public-information/presentations/FY2022-Budget-Hearing.pdf

[23] Substance Abuse and Mental Health Services Administration. (2022, April 14). *Coding for screening and brief intervention reimbursement.* Retrieved from: https://www.samhsa.gov/sbirt/coding-reimbursement