Prioritizing Suicide Prevention and Mental Health in Medical, Educational and Child Welfare Settings

The webinar will begin at 1 PM (ET)

Call-in Number: 1-800-832-0736  Conference Room: 2884179

Webinar Website:  
http://gucchdtacenter.georgetown.edu/resources/TAWebinars.html

If you need assistance, call: 202-687-0308 or email irvinema@georgetown.edu

Prioritizing Suicide Prevention and Mental Health in Medical, Educational and Child Welfare Settings

Guy S. Diamond, Ph.D., Drexel University
Matt Briner, Medical Decision Logic, Inc.
Jodi Houlon, LSW, MPH
Sharon L. Hunter MSN CRNP AE-C
CHOP Care Network Chestnut Hill
Ivan Haskell, Ph.D., Mastery Charter Schools
Joel A. Fein M.D., M.P.H., The Children’s Hospital of Philadelphia
The Problem

- Suicide is the second leading cause of death for youth 14 to 25
- Nearly 500,000 admissions to the ED for suicide each year
- Only 14 to 20% of these youth receive treatment
- High emotional cost to families, high economic cost to health care system

Most Common Risk Factors for Suicide

- Depression and other mental illnesses
- Alcohol or substance abuse or dependence
- Impulsivity
- Physical or sexual trauma
- Alternative sexual orientation
- Family conflict/lack of support
- Previous attempts
The Challenge

How do we identify these youth before they make a suicide attempt or completion?

Several National Organizations Supporting Screening

The American Academy of Pediatrics (AAP)
The Society for Adolescent Medicine
The American Medical Association (AMA)
Surgeon General, 2012 National Strategy for Suicide Prevention
United States Preventive Services Task Force (USPSTF)
  2009 support depression screening in primary care
  2012 does not support suicide screening in PC
American Society of Addiction Medicine (ASAM)
Medicaid and CHIP providers new clinical quality reporting programs

- Children’s Health Insurance Program Reauthorization Act (CHIPRA; 2009)
- Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009
- Patient Protection and Affordable Care Act

Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.

Federally Qualified Health Centers

- Unified Data Systems (UDS)
- Health centers must do UDS reporting to HRSA as part of their FQHC grant funding
- As of 2014, depression screening required
Accountable Care Organizations Requirement for Shared Savings Program

ACO 18 (ACO-Prev-12) (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Screening in Child Welfare
CMS, March 27, 2013

Under the EPSDT benefit, eligible individuals must be provided periodic screening. Part of this assessment is an age appropriate mental health and substance use health screening. ...may reduce the effects of a condition if diagnosed and treated early.
Screening Tool Barriers

Over 200 screening tools have been developed, However…

- Most focus on a single domain (e.g., depression)
- Most focus on psychiatric symptoms while many non mental health providers think more about risk behaviors
- Most are paper-pencil administration and require hand scoring
- Few screening tools (less than five) have psychometric support

Barriers to Implementation

- Provider Barriers
  - Lack of training, lack of time, lack of tools
- Organizational Barriers
  - Access to MH services, no insurance coverage, no payment for screening
- MH Barriers
  - Long waiting lists, staff turnover
- Family and Patient Barriers
  - Low priority, treatment refusal or reluctance
Behavioral Health-Works: The Pennsylvania Response

• Program focused on integration of behavioral health resources into non mental health settings
• Three Goals
  • Training: Increase providers’ knowledge and comfort with mental health
  • Linkage between the Non-MH and MH services
  • Web-based screening tool targeting a wide range of adolescent risk behaviors

Current Progress

• Over 40 practices in 15 counties
• Mostly independent primary care offices but extending into several hospital systems
• School districts, community mental health agencies, emergency rooms, college health centers, GLBTQ community centers
• Screened over 20,000 youth
• Working with insurance co. for payment to the PCP for the screen
• Working with telemedicine to have sites use the screen before calling for consult
POLLING QUESTION

Click on your answer and it will be automatically tallied.

Gatekeeper Training Options

SPRC/AFSP Best Practices Registry (BPR)

Suicide Risk Assessment for Non Mental Health Providers

• Emergency Rooms
• Primary Care
• Schools
• Police
• Mental Health Providers

Popular Examples

• **ASIST**: Applied suicide intervention skills training
  • $36 per person; 14 hours
  • $2,500 five day training the trainer

• **QPR**: Question Persuade and Refer
  • 1-2 hour; $29 per person
  • 8 hour: $500 train the training.
Recognizing and Responding to Suicide Risk in Primary Care (RRSR-PC-Y)

- Developed by the American Association of Suicidology
- Pertinent to PCPs
- 90-minute presentation
- Includes lecture, video demonstrations of techniques, and printed resources

Content of RRSR-PC-Y

- Suicide risk assessment
- Triage decision making
- Crisis Response Planning
- Interventions for Primary Care
- Documentation
Suicide Prevention Toolkit for Rural Primary Care
Suicide Prevention Resource Center (SPRC)

Why is Screening Helpful?

• Standardizes screening questions across patients and providers

• Adolescents or more likely to report psychosocial problems

• Facilitates patient-doctor conversations

• Increases early detection of risk behaviors

• Patients are more likely to receive care after being screened
Screening Tools

http://www2.massgeneral.org/schoolpsychiatry/screeningtools_table.asp

Depression and General Functioning Tools
All well validated

• PHQ 9
  • Depression, 2 or 9 item version
• Beck Depression Inventory
  • Depression, 5 or 21 items version
• CESD
  • Depression, 20 items
• CBCL- Child Behavior Check list
  • Broad band assessment, 9 domains, 140 items, parent, teacher, adolescent version
• The Pediatric Symptom Checklist (PSC)
  • General dysfunction, 35 items, parent report
Suicide Screening tools

- **SIQ**: Suicide ideation Questionnaire
  - 15 or 30 items, adolescent, suicide last month, paper
- **ASQ**: ASK Suicide-Screening Questionnaire
  - 4 items, suicide in the last few weeks. Paper
- **C-SSRS**: Columbia Suicide Severity Rating Scale
  - Very detailed suicide screening tool (e.g., ideation, intent, behaviors, etc.). Often used in FDA and pharmacology studies. Paper and web based

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Behavioral Health Screen (BHS)

- Suicide, risk behavior and psychiatric symptoms
- Covers areas recommended by the American Academy of Pediatrics as best practice guidelines for a well-visit
- Takes 7 to 10 minutes
- Generates summary report and follow-up recommendations in real time
- Strong psychometric properties
- In English, Spanish and Mandarin
- Version for the PCP, the ED, Schools and Adults.
Key Domains of BHS

- Medical
- School
- Family
- Safety
- Sexuality
- Being bullied
- Access to a gun
- Suicide and Self-Harm
- Depression
- Anxiety
- Trauma
- Substance use
- Psychosis
- Eating disorder
Why Web-Based Screening?

- Greater dissemination and accessibility
- Instant scoring of results, automated skip outs, preferred by adolescents
- Interface with electronic medical records
- Aggregates data for reports within a practice, treatment system, our county
- Can modify the tool to specific needs of an organization

Trending Reports

- Track Patient Over Time (up to 12 screens)
- Easily Identify Trends (depression, suicide, anxiety, traumatic distress, substance abuse, eating disorders)
- Quality Improvement & Outcomes

Why BH-Works…
## All GLS Sites

<table>
<thead>
<tr>
<th>Number Screened</th>
<th>Depression (moderate or severe)</th>
<th>Anxiety</th>
<th>Trauma</th>
<th>Eating Disorder</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>5050</td>
<td>1127 (22.3%)</td>
<td>1482 (29.3%)</td>
<td>1302 (25.7%)</td>
<td>150 (3.0%)</td>
<td>148 (3.0%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Positive Screens for Suicide</th>
<th>History of Suicidal Ideation</th>
<th>Current Suicidal Ideation</th>
<th>Current SI With Access to Gun</th>
</tr>
</thead>
<tbody>
<tr>
<td>862</td>
<td>652 (12.9%)</td>
<td>210 (4.2%)</td>
<td>34 (16.2%)</td>
</tr>
</tbody>
</table>

### POLLING QUESTION

Click on your answer and it will be automatically tallied.
Medical Decision Logic

Matt Briner
Director of Clinical Products
Medical Decision Logic, Inc.
Baltimore, Maryland

Allen Y. Tien, MD, MHS
President and Director of Applied Research
Medical Decision Logic, Inc.

Integration of Behavioral Health into Primary Care

The Children’s Hospital of Philadelphia
CARE NETWORK, CHESTNUT HILL

Sharon Hunter MSN, CRNP
Jodi Houlon MSW, MPH
Practice Snapshot

- 13,000 active patients
- 50% African American, 40% Caucasian
- 30% HMO, 25% Medicaid, 45% traditional insurer - PPO or self
- 70% urban, 30% suburban
- Providers: 6 MDs & 3 PNPs
- Practice is a Certified Medical Home with 2 RN care coordinators & a social worker

IDENTIFYING NEED FOR CARE

General Guidance (open ended questions) for Screening in the EMR (HEADSS)

- Home & Environment
- Education & Employment
- Activities
- Drugs
- Sexuality
- Suicide/Depression
IDENTIFYING NEED FOR CARE

- “TIMING IS EVERYTHING”

- MEDICAL HOME EFFORTS

- PARTICIPATION IN GARRETT LEE SMITH SUICIDE PREVENTION PROJECT

IDENTIFYING NEED FOR CARE: OUR PRACTICE WORKFLOW

- PCP reviews schedule weeks in advance to flag pts. to be screened
- PSR/scheduler enroll pts. on BHS tool website prior to day of visit; at time of visit confirmation call, asks pt. to arrive 15 minutes early
- Pt. is roomed, completes tool on PC or iPad
- Nurse prints out results for PCP review
- Documentation in EMR progress note, BHS summary scanned into EMR
WHAT IF WE FIND A KID IN NEED OF HELP?

CHOP Chestnut Hill (18 months)

<table>
<thead>
<tr>
<th>Number Screened</th>
<th>Depression (moderate or severe)</th>
<th>Anxiety</th>
<th>Trauma</th>
<th>Eating Disorder</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>227</td>
<td>53 (23.3%)</td>
<td>70 (30.8%)</td>
<td>52 (22.9%)</td>
<td>6 (2.6%)</td>
<td>3 (1.3%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Positive Screens for Suicide</th>
<th>History of Suicidal Ideation</th>
<th>Current Suicidal Ideation</th>
<th>Current SI With Access to Gun</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>28 (12.3%)</td>
<td>4 (1.8%)</td>
<td>0</td>
</tr>
</tbody>
</table>
CHOP Primary Care
(3 sites)

<table>
<thead>
<tr>
<th>Number Screened</th>
<th>Depression (moderate or severe)</th>
<th>Anxiety</th>
<th>Trauma</th>
<th>Eating Disorder</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>476</td>
<td>75 (15.8%)</td>
<td>77 (16.2%)</td>
<td>56 (11.8%)</td>
<td>7 (1.5%)</td>
<td>3 (0.6%)</td>
</tr>
</tbody>
</table>

<table>
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<th>Total Positive Screens for Suicide</th>
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<th>Current SI With Access to Gun</th>
</tr>
</thead>
<tbody>
<tr>
<td>49</td>
<td>40 (8.4%)</td>
<td>9 (1.9%)</td>
<td>0</td>
</tr>
</tbody>
</table>

GETTING TEENS TO BEHAVIORAL HEALTH CARE

- “GO IT ALONE” APPROACH
- MH PROVIDER DIRECTORY LIST
- GETTING TO “BEST PRACTICE”
IDENTIFYING BEHAVIORAL HEALTH PROVIDERS

• “GOODNESS OF FIT”
  • Geographic Location of BH provider
  • Participation with a variety of insurers
  • Meet and Greet evening April 2012

BUILDING A PARTNERSHIP

• 2011- NORTHWEST HUMAN SERVICES
  • BH Provider for Medicaid patient population in Phila County, Montgomery County
  • 2012- Social worker added to care coordination team
  • 2012- monthly conference calls initiated- our Behavioral Health Collaborative began
  • 2013- CM Counsel joined our Collaborative
  • BH Provider for commercially insured
SOCIAL WORKER AS FACILITATOR

• POINT OF CONTACT PERSON FOR PRACTICE FOR BH REFERRALS

• RESOURCE PERSON FOR PARENTS

• RESOURCE PERSON FOR STAFF, PCPs

• CRISIS INTERVENTION

ONGOING DEVELOPMENT

• Expansion of the Collaborative to include more primary care as well as behavioral health groups.
• Collaborative as a forum for learning from each other
• Continue to improve access to behavioral health care for our patients and their families.
Mastery Charter Schools (MCS)
City of Philadelphia

Ivan Haskell, Ph.D.
Licensed Psychologist
Director of Social and Psychological Services

The School Community

• Mission: Turning around troubled inner city schools
• 15 schools with 9,600 students
• High Trauma area where half the schools in zips
  • 30.1%-45% of adults report ≥ 4 ACES;
  • 45.1% of students report ≥ 4 ACES
• All schools have at least one social worker
• Most schools have contracted therapists--screen own clients
• At pilot school, therapists take lead on some non-client screens
Local Mental Health Resources

- Partnership with a local psychiatric hospital
  - If school screen indicates risk, refer for psychiatric assessment to determine appropriate LOC (inpatient; partial, etc.)
- Mobile crisis team/CRC
- Referral agreements/informal partnerships with 4-5 MH providers throughout city

Pre BHS Screening

<table>
<thead>
<tr>
<th>School Year</th>
<th>Total SW Screens</th>
<th>Did not result in referral for psychiatric assessment</th>
<th>Resulted in referral for psychiatric assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012 10 schools; 6750 students</td>
<td>392</td>
<td>228</td>
<td>164</td>
</tr>
<tr>
<td>2012-2013 12 schools; 7900 students</td>
<td>432</td>
<td>257</td>
<td>175</td>
</tr>
<tr>
<td>2013-2014 15 schools; 9600 students</td>
<td>158 (1/2 year)</td>
<td>84 (1/2 year)</td>
<td>74 (1/2 year)</td>
</tr>
</tbody>
</table>

Social workers screen students w/ statements of intended self-harm or desire to harm others. At elementary, also screen severely aggressive or dysregulated students.
Example referrals

- 17 year old male student: “Student brought knife to school, expressed suicidal ideation”
- 15 year old female student: “Student expressed (suicidal) ideation to another student”
- 16 year old female student: “Loose associations, paranoia, visual hallucination, trouble standing”

BHS Implementation at MCS

- Implemented pilot @ one school (Gratz)
  - Largest school, doing the most screening, most support staff (3 SWs, 3 therapists)
- Planned roll-out to remainder of secondary schools April 2014
- On-site meeting for staff for rollout. BHS described and demonstrated
Barriers to Implementation

• Minor issue: computer access
• Major issue: concerns regarding confidentiality of client info—specific to having subcontracted provider screen both clients and non-clients

Confidentiality/Access to BHS Record

• Therapy provider follows HIPAA/State MH Rules; SWs follow FERPA
• Contracted staff only facilitating screening, not directly asking questions. Therefore OK sharing screening result with school w/o additional release
• Printed results stored in chart if therapy client; otherwise in manila folder with other screens and “crisis letters”
• Results verbally summarized with hospital intake and parents (rather than giving physical copy.) If parents request, copy supplied
Staff and Student Receptivity

- Staff weren’t asking for a new process
  - All seasoned clinicians, comfortable screening
- Nevertheless, receptivity was good
  - Described benefits at outset
    - Validated tool
    - Increased breadth
    - not having to remember to ask right questions
    - possibility that students more forthcoming
- Launch issues
  - general hesitancy about change
  - getting adjusted to new process
  - Extra step
    - Value-added?

Staff and Student Feedback

- Screen gives SW “back up” when calling a parent to try to convince them to take child for assessment
- Adds substantially more info than before
- Majority of students accepted process well. Outlier: 1 student “balked” when asked to complete the screen
Current and Future Practice

Currently use: confirm reports of suicidal thoughts or behaviors

Plan: Increase use for general screening for referred non-crisis students at all secondary schools

Mastery Charter (Simon Gratz) (4 months)

<table>
<thead>
<tr>
<th>Number Screened</th>
<th>Depression (moderate or severe)</th>
<th>Anxiety</th>
<th>Trauma (92.3%)</th>
<th>Eating Disorder</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>12 (92.3%)</td>
<td>11 (84.6%)</td>
<td>12 (92.3%)</td>
<td>1 (7.7%)</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Current SI With Access to Gun</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>3 (23.1%)</td>
<td>7 (53.8%)</td>
<td>5 (71.4%)</td>
</tr>
</tbody>
</table>
Adolescent Behavioral Health Screening in the Emergency Department

Joel A. Fein M.D., M.P.H.
Emergency Medicine, The Children's Hospital of Philadelphia
Professor of Pediatrics and Emergency Medicine
The Perelman School of Medicine at the University of Pennsylvania
Director, The Philadelphia Collaborative Violence Prevention Center

Solve the Puzzle
How do we incorporate the Behavioral Health Screening into routine clinical practice in the ED?

• Too busy to add “one more thing”
• What do we do with the results?
• Refer for mental health - not so easy
• Quality assurance: Do no harm
Community based participatory research (CBPR)

- Discover common goals
- Bidirectional education
- Marry academic & community needs
- Transparency, relationships and trust
- Distribute research findings equally

Health Care Providers are a “Community”

...Community based participatory research (CBPR)

CBPR

- Collaborative approach to research
- Equitably involves all partners in research process
- Recognizes unique strengths of partners
- Begins with research topic of importance to community
- Aims to combine knowledge with action and achieving social change

WK Kellogg Foundation-funded Community Health Scholars Program
Behavioral Health Screen – Emergency Department (BHS-ED) Qualitative Study

• Participants:
  • 60 adolescent / caregiver dyads
  • 45 providers (nurses, physicians, social workers, psychiatrists)
  • Semi-structured interviews: elicit beliefs/barriers to screening in ED

BHS-ED: Qualitative Study Results

All groups generally supported screening

• Adolescents
  • Importance of provider sensitivity
  • Stigma, feeling singled out, confidentiality

• Caregivers
  • Need to be involved/give permission
  • Importance of resources for follow-up

• Providers
  • Time concerns / integration with ED workflow
  • Skills at introducing screen
  • Plan to address critical issues
• Integrated into ED workflow and clinical care
• Privacy for screening (screen in patient rooms)
• Thorough and sensitive introduction for teens/families: Slide show and brochure
• Clear and concise presentation of results
• Mechanism for mental health referrals
  • Age > 14 yrs can refer themselves


Key Domains
RED = BHS:ED

• Depression
• Suicide attempt
  Ideation Self-Harm
• Trauma
• Substance Use
• Safety
• Medical
• School
• Family
• Sexuality*
• Nutrition and Eating
• Anxiety

* Already in PC tool, coming soon to an ED near you!
Adolescent Computerized Behavioral Health Screening in the ED (BHS-ED)

Feasibility and Effects of a Web-Based Adolescent Psychiatric Assessment Administered by Clinical Staff in the Pediatric Emergency Department

Joel A. Fein, MD, MPH; Megan E. Pauller, PhD; Frances K. Burg, PhD, MEd; Matthew R. Wentersteen, PhD; Katie Hayes, RN; Allen Y. Tien, MD, MHS; Guy S. Diamond, PhD

Objectives: To determine the adoption rate of the Web-based Behavioral Health Screening-Emergency Department (BHS-ED) system during routine clinical practice in a pediatric ED, and to assess this system’s effect on identification and assessment of psychiatric problems.

Design: Descriptive design to evaluate the feasibility of a clinical innovation.

Setting: The ED of an urban tertiary care children’s hospital.

Participants: Adolescents from 14 to 18 years of age, without acute or critical injuries or illness, presenting with nonpsychiatric symptoms.

Intervention: The ED clinical staff initiated the use of the BHS-ED system, which identifies and assesses adolescents for depression, suicidal ideation, posttraumatic stress, substance use, and exposure to violence. Treating clinicians reviewed results and followed routine care practices thereafter.

Main Outcome Measures: Adoption rate of the BHS-ED system by nursing staff, identification rates of occult psychiatric problems, and social worker or psychiatrist assessment. Data were collected for 19 months before implementation of the BHS-ED system and for 9 months during implementation.

Results: Of 3919 eligible patients, 1327 (33.4%) were asked by clinical staff to get screened using the BHS-ED; of these 1327 patients, 857 (64.6%) completed the screening and 470 (35.4%) refused. During implementation, identification of adolescents with psychiatric problems increased significantly (4.2% vs 2.3%; odds ratio (OR) 1.70; 99% confidence interval [CI], 1.38-2.10), as did ED assessments by a social worker or psychiatrist (2.5% vs 1.7%; OR, 1.47; 99% CI, 1.13-1.90). Of the 857 patients who were screened with the BHS-ED, 401 (46.6%) were identified as having psychiatric problems (OSR, 4.58; 95% CI, 3.53-5.04), and 77 (8.9%) were assessed (OR, 3.12; 95% CI, 2.80-6.88).

Conclusions: In a busy pediatric ED, computerized, self-administered adolescent behavioral health screening can be incorporated into routine clinical practice. This can lead to small but significant increases in the identification of unrecognized psychiatric problems.

Arch Pediatr Adolesc Med. 2010;64(12):1112-1117

Process Measures

- 33% of eligible patients approached for BHS-ED
- Reasons not approached (RN survey):
  - Time
  - Uncomfortable
  - “Did not need” it
- 65% of those approached completed
Screening Results of BHS-ED

Percentages reflect entire sample of screened patients (n=857)

<table>
<thead>
<tr>
<th>Depression</th>
<th>n (%)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>152 (17.7)</td>
</tr>
<tr>
<td>Moderate</td>
<td>29 (3.4)</td>
</tr>
<tr>
<td>Severe</td>
<td>8 (0.9)</td>
</tr>
</tbody>
</table>

Suicide (past history)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation</td>
<td>95 (11.1)</td>
</tr>
<tr>
<td>Plan</td>
<td>43 (5.0)</td>
</tr>
<tr>
<td>Attempt</td>
<td>47 (5.5)</td>
</tr>
<tr>
<td>Self-harm</td>
<td>86 (10.0)</td>
</tr>
</tbody>
</table>

Suicide (past 2 weeks)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation</td>
<td>31 (3.6) *8 subjects not included in analysis (incomplete data)</td>
</tr>
<tr>
<td>Plan</td>
<td>9 (1.1)</td>
</tr>
<tr>
<td>Attempt</td>
<td>6 (0.7)</td>
</tr>
<tr>
<td>Self-harm</td>
<td>9 (1.1)</td>
</tr>
</tbody>
</table>

Identification, Assessment and Referral Pre-Post Intention to Treat Analysis

Fein JA, Archives of Pediatric and Adolescent Medicine 2010;164(12):1112-1117.
Identification, Assessment and Referral
Pre-Post Pre-Implementation vs. Screened


BHS-ED
Current Status at CHOP

- Joint Commission survey: positively reviewed
- CHOP licenses it on annual basis
  - Nursing budget
  - Nurse leader is champion
  - Quality improvement
  - Updates
  - Data
- Penetration rates increases from 33% to 60%
### CHOP Emergency Department (9 months)

#### Number Screened

<table>
<thead>
<tr>
<th></th>
<th>Depression (moderate or severe)</th>
<th>Anxiety</th>
<th>Trauma</th>
<th>Eating Disorder</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>750 (37.5%)</td>
<td>0*</td>
<td>748 (37.3%)</td>
<td>0*</td>
<td>29 (1.4%)</td>
</tr>
</tbody>
</table>

#### Total Positive Screens for Suicide

<table>
<thead>
<tr>
<th></th>
<th>History of Suicidal Ideation</th>
<th>Current Suicidal Ideation</th>
<th>Current SI With Access to Gun</th>
</tr>
</thead>
<tbody>
<tr>
<td>396</td>
<td>288 (14.4%)</td>
<td>108 (5.4%)</td>
<td>20 (18.5%)</td>
</tr>
</tbody>
</table>

*Not Applicable – Using BHS-ED Version

### Additional Resources

- www.Brightfutures.org
- Suicide Prevention Resource Center.org
- American Foundation for Suicide Prevention.org
- American Association of Suicidality
- Suicide Prevention tool Kit for Rural Primary Care
- Primary Care Tool Kit, AAP
Primary Developers of the BH-Works system

• Guy Diamond, Ph.D.,
  Associate Professor, Drexel University
  (guy.diamond@drexel.edu)
• Joel Fein, MD, MPH Professor of Pediatrics at Penn, The Children’s Hospital of Philadelphia
• Matt Wintersteen, Ph.D., Associate professor, Thomas Jefferson Health Systems
• Stan Mrozowski, Pennsylvania, OMHSAS
• Allen Y. Tien, MD, MHS
  President, Medical Decision Logic, Inc.

To find out more about the Behavioral Health Screen

Matt Briner
Director of Clinical Products
Medical Decision Logic, Inc.
(mdlogix)
Baltimore, Maryland
www.mdlogix.com
www.bh-works.com
Questions & Comments

IMPORTANT LINKS

Evaluation Form: https://www.surveymonkey.com/s/TACenterWebinarEvaluation

Webinar Website: http://gucchdtacenter.georgetown.edu/resources/TAWebinars.html

Data Matters: http://www.gucchdgeorgetown.net/data/
Next Webinar:
National Perspectives and Federal Resources:
Trauma Informed Care in Child Serving Systems

April 17, 2014 at 1pm ET

Register at:
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