

Indian Health Service Suicide Risk Screenings, Evidence, Clinical Pathways & Treatment Priorities - Update

CAPT JOHN LESTER, PharmD, MAS

AREA CLINICAL INFORMATICIST

08/12/24



Suicide Risk Screening Presented By (1) ...

Pamela End of Horn, DSW, LICSW

National Suicide Prevention Consultant
Acting Zero Suicide Lead
Indian Health Service Headquarters
OCPS/Division of Behavioral Health

CAPT John Lester, PharmD, MAS – Health Informatics

Program Coordinator / Health Systems Analyst
Area Clinical Informatics Consultant
Phoenix Area Indian Health Service



Suicide Risk Screening Presented By (2) ...

Lisa M. Horowitz, PhD, MPH

Senior Associate Scientist / Pediatric Psychologist

Director of Patient Safety & Quality, NIMH

Office of the Clinical Director

Intramural Research Program

National Institute of Mental Health, NIH

Deborah (Debbie) J. Snyder, MSW, LCSW-C, ACC

NIH/NIMH Office of the Clinical Director

Senior Advisor to the Clinical Director

Deputy Director Patient Safety and Quality

Faculty Psychiatry Consultation Liaison Service



Getting Ready to Get Ready

[RPMS Recording and Material Library | Training \(ihs.gov\)](#)

- Complete RPMS EHR Health Information Technology (HIT) Assessment
- BCMA for Inpatient, Emergency Department, Urgent Care, Walk-in Clinic, Day Surgery, Radiology, IV Infusion
- Align BCMA Effectiveness with Oracle Health
- ADC Profiling for Inpatient, Emergency Department, Urgent Care, Walk-in Clinic, Day Surgery, Radiology, IV Infusion
- 24-Hour Pharmacy Support
- RPMS EHR for Inpatient & ED Configuration for Observation, ED Boarding, and other BPM Workflows in alignment with WRAP
- ED POCUS
- PAMPI Approach
- **STI & ASQ Initiative RPMS EHR Reminder Standardization Initiatives**
- RPMS EHR Standing Order Authentication
- Adding a Provider/Provide File Standardization Pharmacist Ordering Key



Ask Suicide-Screening Questions (ASQ) & Getting Ready to Get Ready

Facilities aligning with this initiative will be incorporating Best Practice workflow concepts that will perpetuate & prepare them for the future GDIT Oracle Health solution.



Learning Objectives

- **Describe** the public health crisis of suicide, especially among American Indian/Alaska Native population
- **Assess** population needs when identifying & using suicide screens within tribal communities
- **List** current evidence-based suicide risk screens available.
- **Discuss** application issues of suicide risk screens to American Indian/Alaska Native population
- **Define** the important difference between “screening” & “assessment”
- **Deliberate** how Clinical & Public health informatics Health Information Technology (HIT) tools in current use bolster suicide prevention and next steps with our current outpatient deployment



Scope of the Problem

- Suicide is a global public health problem
- Suicide is the 8th leading cause of death among all AI/AN across all ages
- Suicide Rate for AI/AN adolescents & young adults ages 15 to 34 (19.1/100,000) was 1.3 times that of the national average for that age group (14/100,000)
- 1/3 of all AI/AN youth deaths in 2020 were from something preventable: suicide



Recent Data

- **Suicide deaths from 2015-2020 in the National Violent Death Reporting System (NVDRS)**
 - **3,397 AI/AN**
 - **179,850 non-AI/AN suicides**
- **Nearly 75% of AI/AN suicides were among people ages 44 years and younger**, compared to 46.5% among non-AI/AN suicides
 - **Greatest proportion of suicides among AI/AN (46.9%) were among people ages 25-44 years**
 - **Greatest proportion of suicides among non-AI/AN (35%) were among people ages 45-64 years.**
- **Among suicide decedents, nearly 45% of AI/AN persons, versus 18.7% of non-AI/AN persons, resided in nonmetropolitan areas.**
- **AI/AN were more likely than non-AI/AN to disclose suicide intent prior to death.**



Key Findings

Among other findings, AI/AN persons were more likely to experience **relationship problems and circumstances associated with alcohol and/or substance misuse** (including reported alcohol use hours before death), compared with non-AI/AN.

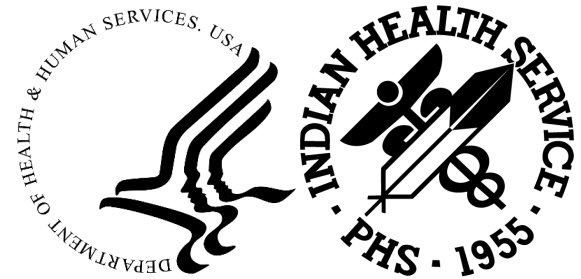
Nearly 55% of AI/AN persons experienced **relationship problems/losses**, compared with 42.2% among non-AI/AN.

- AI/AN persons compared to non-AI/AN persons were more likely to experience **intimate partner and family relationship problems, interpersonal violence victimization and perpetration, suicide of a friend/family member, & arguments/conflicts preceding death.**
- AI/AN persons compared to non-AI/AN persons had greater odds of alcohol and/or substance use problems, having experienced recent or pending crisis related to these conditions, & greater odds of alcohol use prior to suicide.

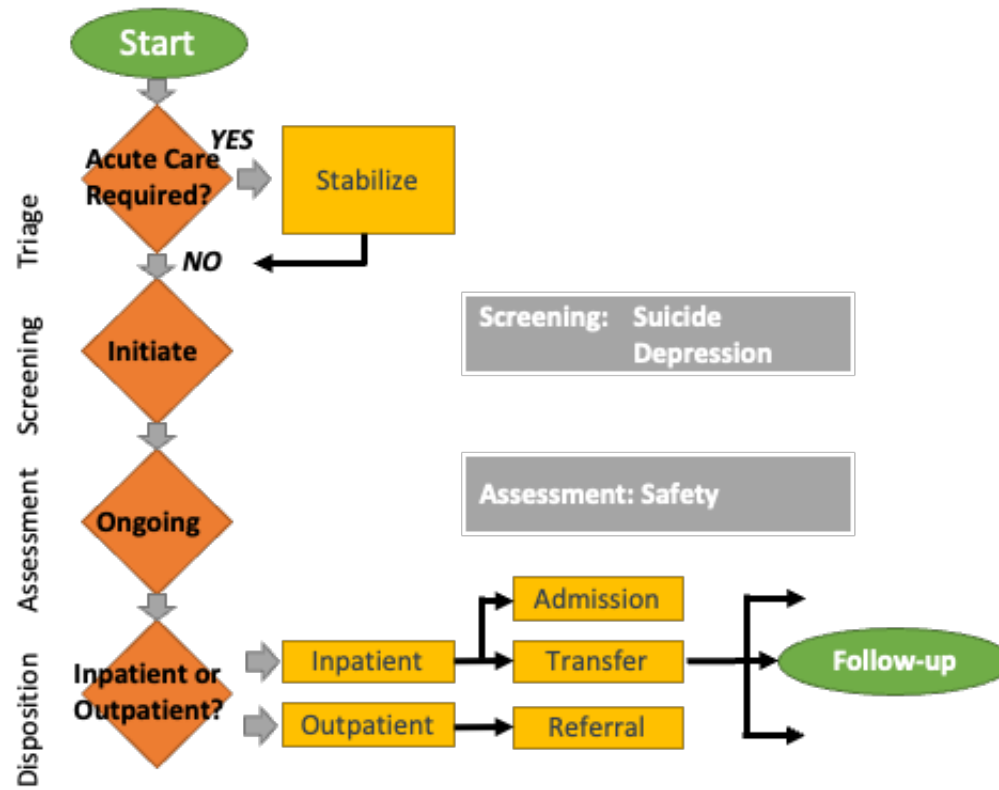


Suicide Risk Screening Clinical Pathway

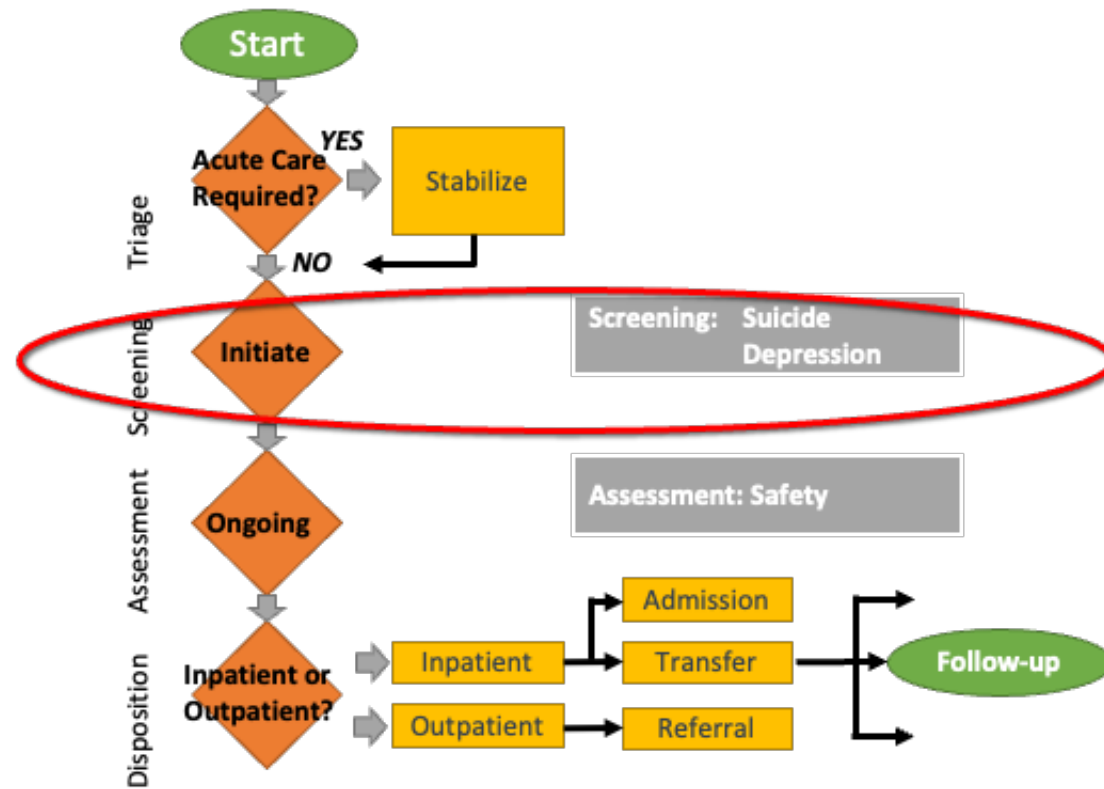
PAMELA END OF HORN, DSW, LICSW
NATIONAL SUICIDE PREVENTION CONSULTANT
ACTING ZERO SUICIDE LEAD
INDIAN HEALTH SERVICE HEADQUARTERS
OCPS/DIVISION OF BEHAVIORAL HEALTH



Clinical Care Pathway (1)



Clinical Care Pathway (2)



Evidence-Based Pathway Aids

- Ask Suicide-Screening Questions (ASQ):
 - A brief instrument for the pediatric emergency department.¹
 - Validation of the ASQ for adult medical inpatients: A brief tool for all ages.²
 - Validated through research in inpatient and outpatient settings
- The Patient Safety Screener (PSS-3):
 - A Brief Tool to Detect Suicide Risk in Acute Care Settings.³
- Suicide risk screening in pediatric hospitals:
 - Clinical pathways to address a global health crisis.⁴
- Clinical Pathway for Suicide Risk Screening in Adult Primary Care Settings.⁵
- Recommended standard care for people with suicide risk:
 - Making health care suicide safe. Washington, DC: Education Development Center, Inc.⁶



Suicide Risk Screening

LISA M. HOROWITZ, PHD, MPH
SENIOR ASSOCIATE SCIENTIST / CLINICAL PSYCHOLOGIST
DIRECTOR OF PATIENT SAFETY & QUALITY, NIMH
OFFICE OF THE CLINICAL DIRECTOR
INTRAMURAL RESEARCH PROGRAM
NATIONAL INSTITUTE OF MENTAL HEALTH, NIH



Screening Definition¹

Process for evaluating the possible presence of a problem

E.g. Pain Screen – Used to determine if patient has pain or not



Screening vs. Assessment: What's the difference?

Suicide Risk Screening

- Identify individuals at risk for suicide
- Oral, paper/pencil, computer



Suicide Risk Assessment

- Comprehensive evaluation
- Confirms risk
- Estimates imminent risk of danger to patient
- Guides next steps



Evidence-Based Screening Tools Suicide & Depression

LISA M. HOROWITZ, PHD, MPH
SENIOR ASSOCIATE SCIENTIST / CLINICAL PSYCHOLOGIST
DIRECTOR OF PATIENT SAFETY & QUALITY, NIMH
OFFICE OF THE CLINICAL DIRECTOR
INTRAMURAL RESEARCH PROGRAM
NATIONAL INSTITUTE OF MENTAL HEALTH, NIH



Columbia-Suicide Severity Rating Scale (C-SSRS) Triage Version²

- Developed as a surveillance tool by Columbia University, the University of Pennsylvania, and the University of Pittsburgh
- Multiple versions for all ages in different settings
- Includes a triage guide to aid in clinical decision-making



Suicide Behavior Questionnaire - Revised (SBQ-R)²

- Developed by A. Osman
- Free four (4) item self-report questionnaire that asks about future anticipation of suicide-related thoughts or behaviors focusing on 12 years & older and adults



Beck Scale for Suicide Ideation (BSSI)³

- Proprietary tool developed by A. Beck & R. Steer
- Twenty-one (21) items that focus on suicidal intent in patients ages 17 years and older



Patient Health Questionnaire-9 (PHQ9)²

- A **depression severity index** tool used to monitor depression in ages 12 years and older
- Ninth item associated with suicide risk but poor indicator
- Free nine-item tool developed by R. Spitzer, J. Williams, & K. Kroenke under a grant from Pfizer, Inc.



Ask Suicide-Screening Questions (ASQ)²

- Free tool created for the medical setting that has an ASQ toolkit developed by the National Institute of Mental Health www.nimh.nih.gov/ASQ
- 20 second, 4-item suicide risk screening tool designed for youth & adults, ages 8 and older, in emergency departments, inpatient units, & primary care facilities
- Validated in medical and psychiatric patients
- Toolkit includes a Brief Suicide Safety Assessment available for positive screens



Can Depression Screening be Used to Effectively Screen for Suicide Risk?

LISA M. HOROWITZ, PHD, MPH
SENIOR ASSOCIATE SCIENTIST / PEDIATRIC PSYCHOLOGIST
DIRECTOR OF PATIENT SAFETY & QUALITY, NIMH
OFFICE OF THE CLINICAL DIRECTOR
INTRAMURAL RESEARCH PROGRAM
NATIONAL INSTITUTE OF MENTAL HEALTH, NIH



Patient Health Questionnaire - 9 (PHQ-9)

- 9-item depression screen assessing symptoms during the past 2 weeks
- Available in the public domain and commonly used in medical settings
- One “suicide-risk” question: Item #9

How often have you been bothered by the following symptoms during the past two weeks? *“Thoughts that you would be better off dead **or** of **hurting** yourself in some way”*

Families, Systems, & Health
2018, Vol. 36, No. 3, 281–288
© 2018 American Psychological Association
1091-7527/18/\$12.00 http://dx.doi.org/10.1037/fsm0000350

Inadequacy of the PHQ-2 Depression Screener for Identifying Suicidal Primary Care Patients


Aubrey R. Dueweke, MA, Mikenna S. Marin, BA, David J. Sparkman, MA, and Ana J. Bridges, PhD
University of Arkansas

Psychosomatics 2015;56:480–489
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Original Research Reports

Comparison of Electronic Screening for Suicidal Risk With the Patient Health Questionnaire Item 9 and the Columbia Suicide Severity Rating Scale in an Outpatient Psychiatric Clinic

Adele C. Viguera, M.D., Nicholas Milano, M.D., Laurel Ralston D.O., Nicolas R. Thompson, M.S., Sandra D. Griffith, Ph.D., Ross J. Baldessarini, M.D., Irene L. Katzan, M.D., M.S.

 **HHS Public Access**
Author manuscript
J Clin Psychiatry. Author manuscript; available in PMC 2017 February 01.

Published in final edited form as:
J Clin Psychiatry. 2016 February ; 77(2): 221–227. doi:10.4088/JCP.15m09776.

Risk of suicide attempt and suicide death following completion of the Patient Health Questionnaire depression module in community practice

Gregory E Simon, MD, MPH¹, Karen J Coleman, PhD², Rebecca C Rossom, MD³, Arne Beck, PhD⁴, Malia Oliver, BA¹, Eric Johnson, MS¹, Ursula Whiteside, PhD¹, Belinda Operskalski, MPH¹, Robert B Penfold, PhD¹, Susan M Shortreed, PhD¹, and Carolyn Rutter, PhD^{1,4}

Dueweke, 2018; Simon, 2016; Viguera 2015

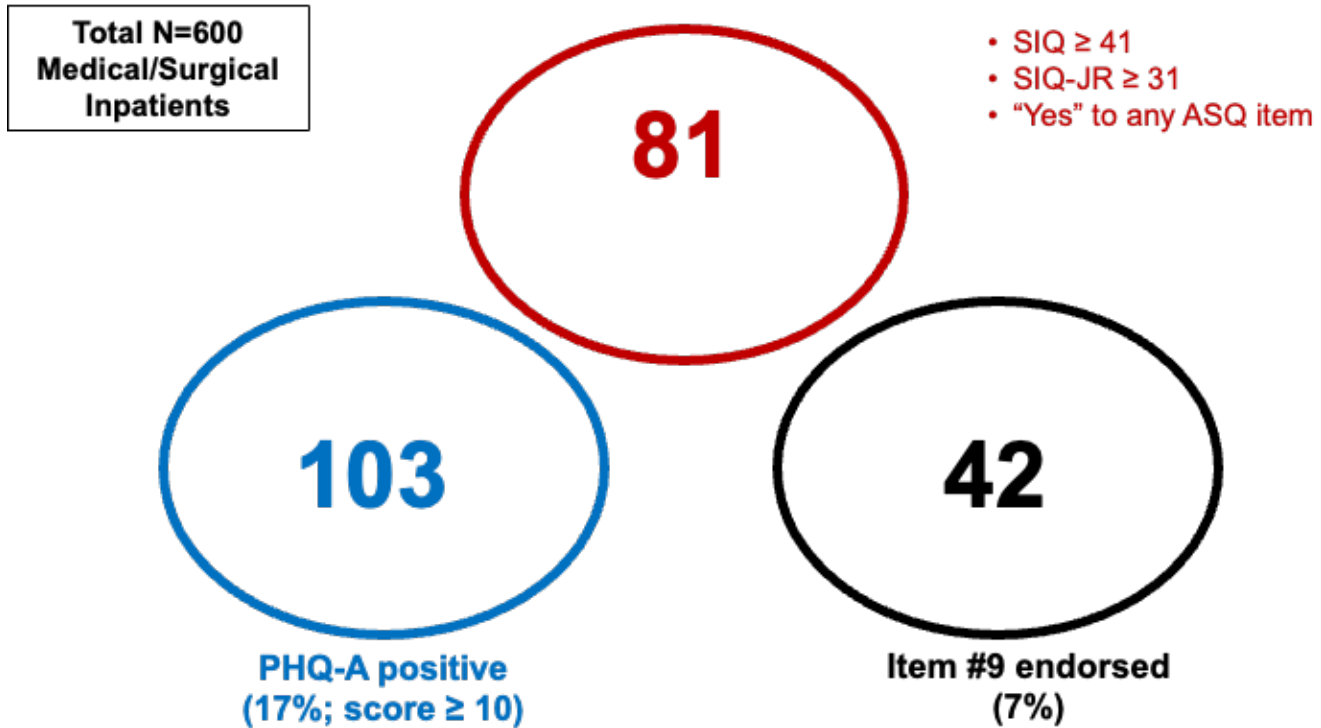
Depression Screening vs. Suicide Risk Screening

Ask Suicide-Screening Questions (ASQ) vs. Patient Health Questionnaire (PHQ)

LISA M. HOROWITZ, PHD, MPH
SENIOR ASSOCIATE SCIENTIST / PEDIATRIC PSYCHOLOGIST
DIRECTOR OF PATIENT SAFETY & QUALITY, NIMH
OFFICE OF THE CLINICAL DIRECTOR
INTRAMURAL RESEARCH PROGRAM
NATIONAL INSTITUTE OF MENTAL HEALTH, NIH

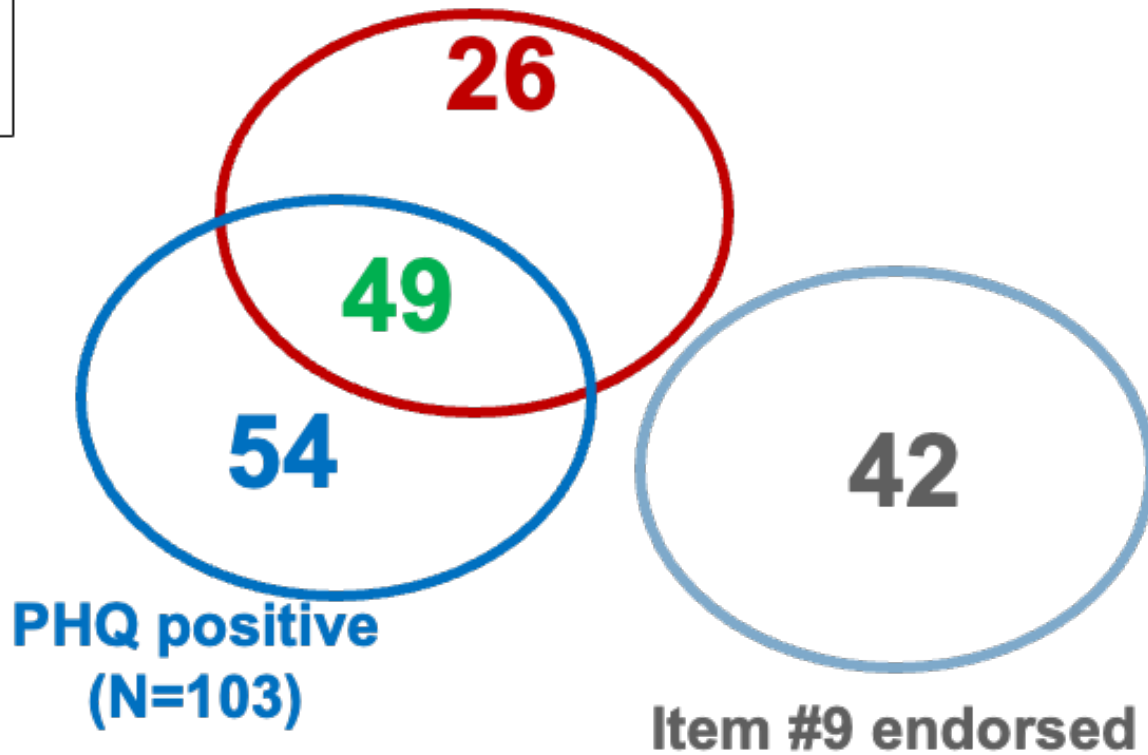


Suicide-Risk Positive (13.5%)



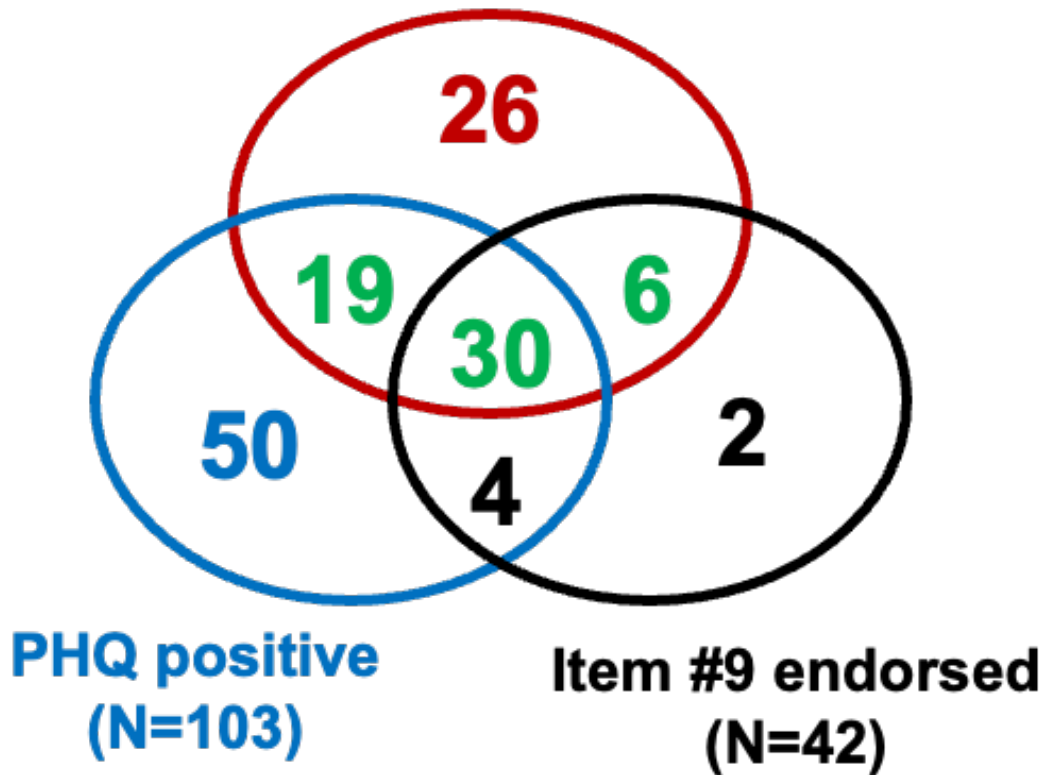
Suicide-Risk Positive (N=81) Part 1

Total N=600
Medical/Surgical
Inpatients



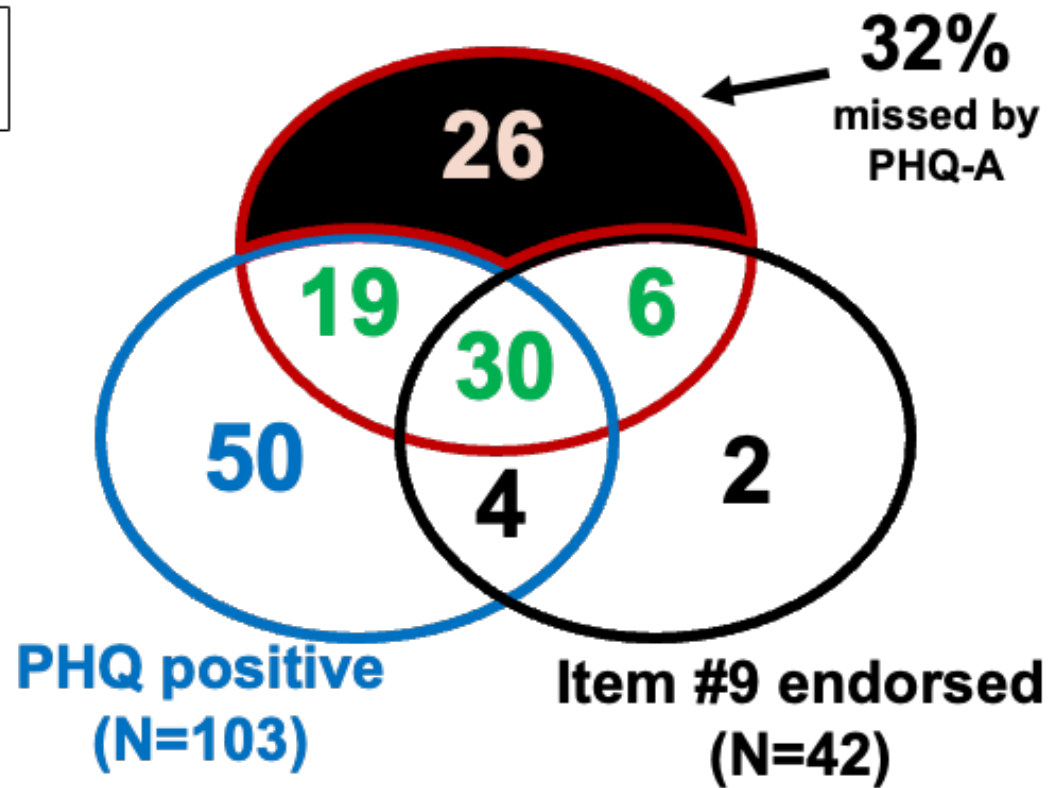
Suicide-Risk Positive (N=81) Part 2

Total N=600
Medical/Surgical
Inpatients



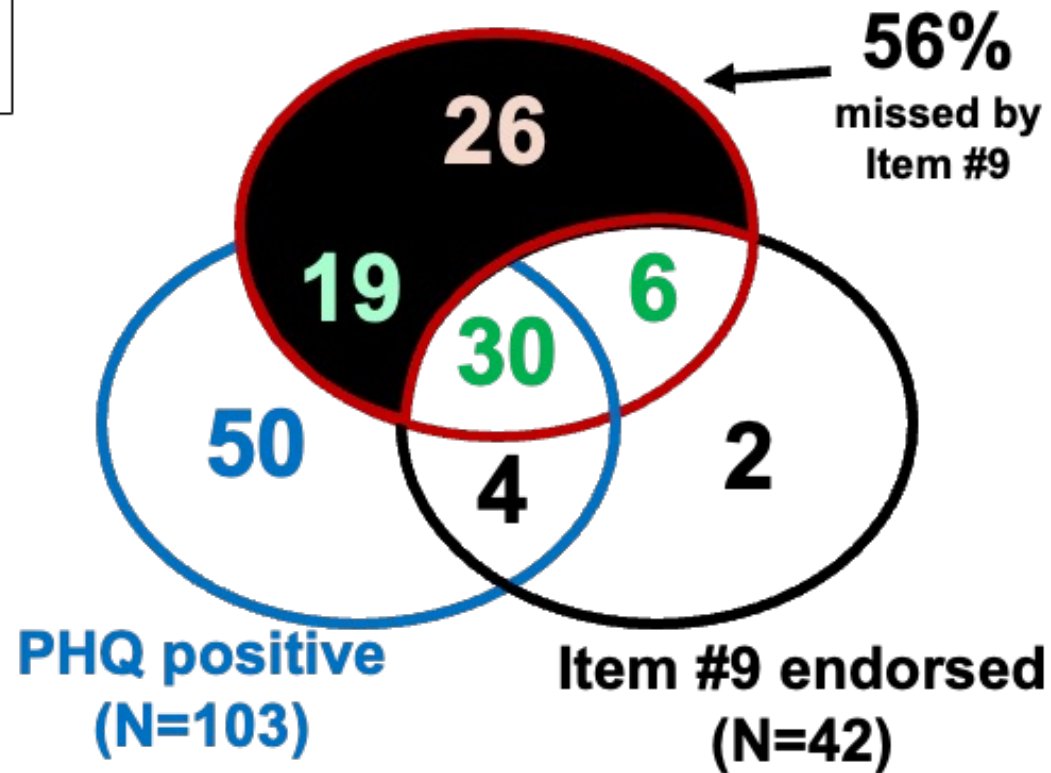
Suicide-risk positive (N=81) Part 3

Total N=600
Medical/Surgical
Inpatients



Suicide-Risk Positive (N=81) Part 4

Total N=600
Medical/Surgical
Inpatients



PHQ-2 -> PHQ-9 -> Suicide Risk Screen



PHQ-A with ASQ

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ Clinician: _____ Date: _____


Instructions: How often have you been bothered by each of the following symptoms during the past nine weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way? <small>Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?</small>				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
 Yes No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
 Not difficult at all Somewhat difficult Very difficult Extremely difficult

Office use only: _____ **Severity score:** _____



Ask Suicide-Screening Questions

Ask the patient:

(1) In the past few weeks, have you wished you were dead? YES NO

(2) In the past few weeks, have you felt that you or your family would be better off if you were dead? YES NO

(3) In the past week, have you been having thoughts about killing yourself? YES NO

(4) Have you ever tried to kill yourself? YES NO
 If yes, how? _____ When? _____

If the patient answers yes to any of the above, ask the following question:

(5) Are you having thoughts of killing yourself right now? YES NO
 If yes, please describe: _____

Scan me!



nimh.nih.gov/ASQ

Universal Suicide Risk Screening

What to Do, How to Do It, & How to Implement

LISA M. HOROWITZ, PHD, MPH
SENIOR ASSOCIATE SCIENTIST / PEDIATRIC PSYCHOLOGIST
DIRECTOR OF PATIENT SAFETY & QUALITY, NIMH
OFFICE OF THE CLINICAL DIRECTOR
INTRAMURAL RESEARCH PROGRAM
NATIONAL INSTITUTE OF MENTAL HEALTH, NIH



Why did we choose the Ask Suicide-Screening Questions (ASQ)?

- Developed through research specifically for the medical setting with strong psychometric properties
- Validated through research with youth and adults
- Takes 20 seconds, easy scoring (any “yes” is positive)
- Free for public use
- Evidence-based, and does not overburden busy practice workflows
- Is the first step of a 3-tiered clinical pathway
- It’s a screening tool that can be **paired** with other assessment tools, such as the C-SSRS.





Suicide Risk Screening Tool

NIMH TOOLKIT

Ask Suicide-Screening Questions

Ask the patient:

1. In the past few weeks, have you wished you were dead? Yes No

2. In the past few weeks, would you be better off if you were dead?

3. In the past week, have you been having thoughts about killing yourself?

4. Have you ever tried to kill yourself? If yes, how? _____

When? _____

If the patient answers:

5. Are you having thoughts of killing yourself right now? If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions, no further action is needed.
- If patient answers "Yes" to any question, ask the following acuity question:
 - "Yes" to question:
 - Patient needs immediate attention.
 - Keep patient responsible for their own care.
 - "No" to question:
 - Patient needs further evaluation.
 - Alert physician.

Provide resources:

- 24/7 National Suicide Prevention Helpline: 1-800-273-8255
- 24/7 Crisis Text Line: Text HOME to 73477

ASQ Suicide Risk Screening Tool

Sensitivity: 96.9% (95% CI, 91.3-99.4)

Ask the patient:

1. In the past few weeks, have you wished you were dead? Yes No

2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No

3. In the past week, have you been having thoughts about killing yourself? Yes No

4. Have you ever tried to kill yourself? If yes, how? _____ Yes No

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? Yes No

ACUTE POSITIVE

84.0-90.5)

ents:
99.9)

96.9%

Horowitz, Bridge, Wharff, Ballard...Pao, et al. (2012) Arch Pediatr Adolesc Med

What happens when a patient screens positive?



Here's What Should NOT Happen

Do not treat every person who has a thought about suicide as an emergency



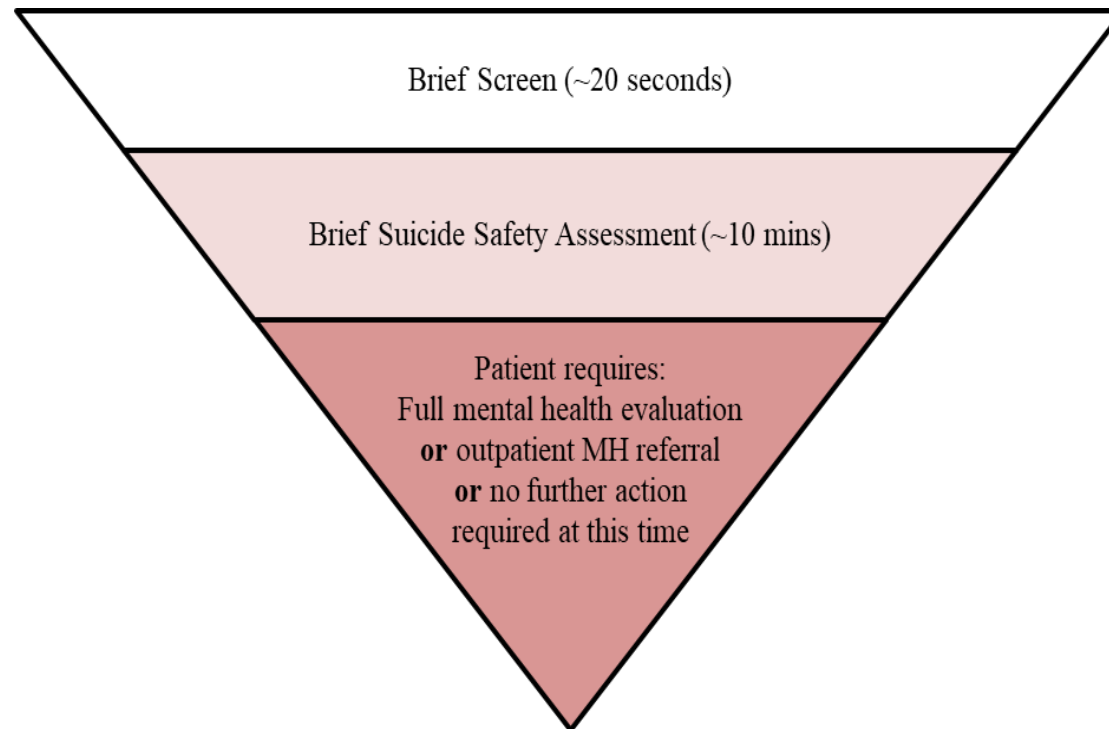
1:1
sitter



A clinical pathway is a guide to avoid unnecessary interventions



Clinical Pathway 3-tiered system Helps avoid overtaxing the system



Brahmbhatt, Kurtz, Afzal...Pao, Horowitz, et al. (2018) *Psychosomatics*

Screening Integration⁴

- Document results & mitigation plans in medical record
- Appropriately alert key ED staff to patient's disposition
- Accelerate or decelerate course of treatment
- Inform parent or guardian of results
- Activate in-hospital social work services
- Provide results to law enforcement, if legally required



System Integration⁴

- Conduct environmental risk assessments
- Universal suicide risk screening using an evidence-based & validated tool
- Evidence-based process to conduct a suicide risk assessment of all patients screening positive
- Establish policies & procedures for treatment & follow-up
- Monitor implementation & effectiveness of policies & procedures



Suicide Risk Screening ASQ Quality Improvement Pilot

PAMELA END OF HORN, DSW, LICSW
NATIONAL SUICIDE PREVENTION CONSULTANT
ACTING ZERO SUICIDE LEAD
INDIAN HEALTH SERVICE HEADQUARTERS
OCPS/DIVISION OF BEHAVIORAL HEALTH



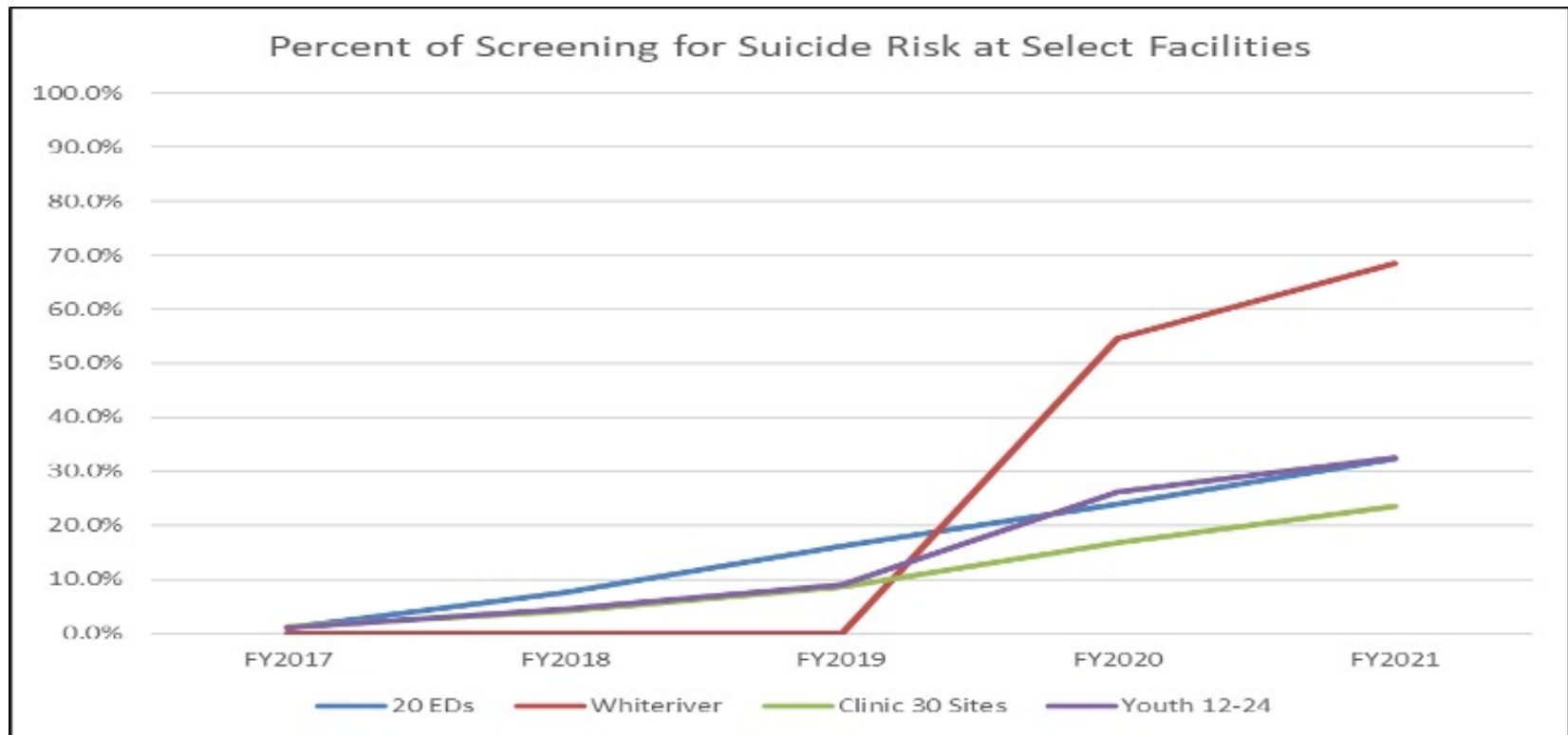
Pilot Site

Indian Health Service Federal Facility

- Direct Service Emergency Department with a Title 1 Behavioral Health Program
- Indian Registrants FY2019: 24,556
- PRC Delivery Area by County for Tribe*
 - Six-county coverage area
 - Total population 419,207



Results



Next Steps

Embed the ASQ within the IHS Emergency Department

Develop national metrics

Initiate new MOU with NIH/NIMH

Deploy in an Outpatient Setting



ASQ National Directive

Update - Friday Jan 13, 2023 IHS All Call Dr. Loretta Christensen, IHS Chief Medical Officer, announced that ASQ training was forthcoming & confirmed during a recent CMO meeting.

A national directive is forthcoming identifying the **Ask Suicide-Screening Questions (ASQ)** as the suicide risk screen supported for implementation across the Indian Health Service system*



Past Future Pilot Sites

Facilities Expressing Interest - January 19th 2023

- **Elko Service Unit (In Progress)**
- Uintah & Ouray Service Unit
- Crow/Northern Cheyenne Hospital
- Phoenix Indian Medical Center
- Hopi Healthcare Center



Contact Information

Pamela End of Horn, DSW, LICSW
Oglala Lakota

National Suicide Prevention Consultant
Indian Health Service

pamela.endofhorn@ihs.gov



References

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2. https://www.jointcommission.org/assets/1/18/Suicide_Prevention_Resources_to_support_NPSG150101_Nov201821.PDF
3. <https://www.pearsonclinical.com.au/products/view/44>
4. https://www.jointcommission.org/assets/1/18/R3_18_Suicide_prevention_HAP_BHC_11_27_18_FINAL.pdf



ASQ Reminder & Dialog

Ask Suicide Screening Questions

CAPT JOHN LESTER, PHARMD, MAS-HEALTH INFORMATICS
PROGRAM COORDINATOR / HEALTH SYSTEMS ANALYST
AREA CLINICAL INFORMATICS CONSULTANT
PHOENIX AREA INDIAN HEALTH SERVICE



ASQ Reminder Dialog Presented By...

Pamela End of Horn, DSW, LICSW

National Suicide Prevention Consultant

Acting Zero Suicide Lead

Indian Health Service Headquarters

OCPS/Division of Behavioral Health

CAPT John Lester, PharmD, MAS – Health Informatics

Program Coordinator / Health Systems Analyst

Area Clinical Informatics Consultant

Phoenix Area Indian Health Service



Collaboration

- National Institute of Mental Health
National Institutes of Health (NIH)
- Division of Behavior Health
- National Zero Suicide Initiative
- National Suicide Prevention
- National Council of Informatics – Clinical
Decision Support



Suicide Epidemic Informatics Response

NCI - Clinical Decision Support (1)

- **Theresa Chasteen, RHIT (Retired)**
Clinical Informatics Consultant
- **CDR John Collins, PharmD, BCPS**
Area Clinical Informatics Consultant
Oklahoma City Area Office
- **Pamela End of Horn, DSW, LICSW**
National Suicide Prevention Consultant
Acting Zero Suicide Lead
Indian Health Service Headquarters
OCPS/Division of Behavioral Health
- **CDR Donnie Hodge, PharmD, MS**
Clinical Informaticist
Claremore Indian Hospital
- **Lisa M. Horowitz, PhD, MPH**
Senior Associate Scientist/Clinical Psychologist
Director of Patient Safety & Quality, NIMH
Office of the Clinical Director
Intramural Research Program
National Institute of Mental Health, NIH
- **Deborah (Debbie) J. Snyder, MSW, LCSW-C, ACC**
NIH/NIMH Office of the Clinical Director
Senior Advisor to the Clinical Director
Deputy Director Patient Safety and Quality
Faculty Psychiatry Consultation Liaison Service
- **CAPT Katie Johnson, PharmD, MHIIM**
EHR Integrated Care Coordinator
Northwest Portland Area Indian Health Board (NPAIHB)



Suicide Epidemic Informatics Response

NCI - Clinical Decision Support (2)

- **Heather Kovich, MD**
Medical Officer/NCI Reminders Subject Matter Expert
Northern Navajo Medical Center
- **CAPT John Lester, PharmD, MAS**
Clinical Informatics Consultant
Phoenix Area Indian Health Service
- **Amanda Mackinnon**
Little Shell Health Center
Billings Area Indian Health Service
- **CAPT Elvira Mosley, MSHS, BSN, RN**
Clinical Informatics Consultant
Phoenix Area Indian Health Service
- **CAPT Amy Rubin, PharmD, MMI, CHTS-IS**
Area Clinical Informatics Consultant
Oklahoma City Area Office
- **CDR Heather Peterson, PharmD, BCPS, NCPS**
Health Informaticist/Clinical Pharmacist
Yakama Indian Health Center
Portland Area Indian Health Service
- **CAPT Nick Sparrow, PharmD**
Clinical Informaticist
Claremore Indian Hospital
- **David Taylor, MHS, RPh, PA-C, RN**
Clinical Informaticist
Clinical Informatics Deployment & Training
HIT Modernization
IHS Office of Information Technology

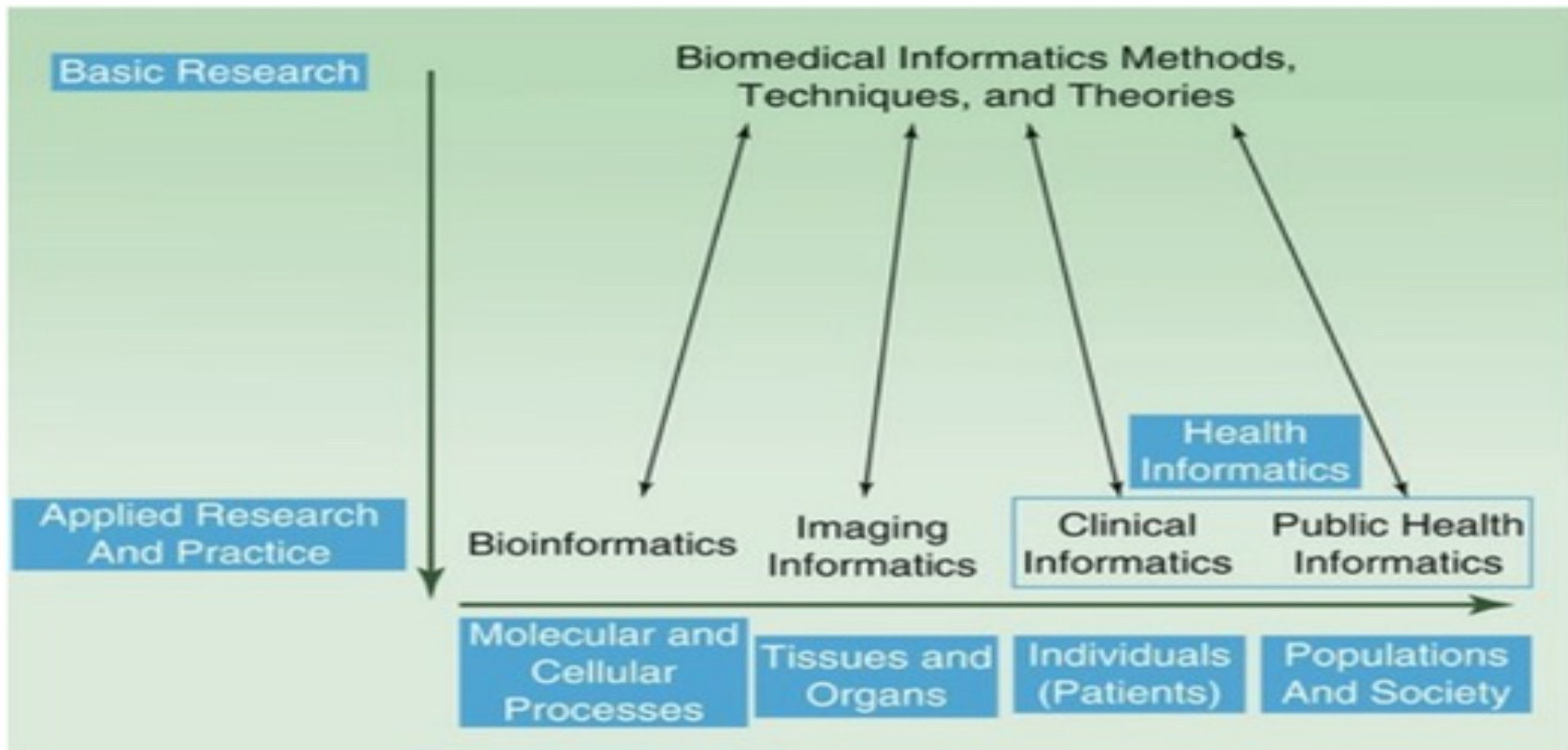


Suicide Epidemic Informatics Response Standardization of Processes

CAPT JOHN LESTER, PHARMD, MAS-HEALTH INFORMATICS
PROGRAM COORDINATOR / HEALTH SYSTEMS ANALYST
AREA CLINICAL INFORMATICS CONSULTANT
PHOENIX AREA INDIAN HEALTH SERVICE



Informatics Concepts



EHR Standardization Benefits

- Reduces resources dedicated to operations & maintenance
- Simplifies training, error identification & remediation
- Realizes Economies of Scale for processes
- Enhances clinical decision support pathways
- Enhances ability to interoperate with different systems & organizations
- Enhances reliability of quality and performance reporting
- Enhances ability to span episodes of care between organizations
- Enhances patient centricity & enhances continuity of care



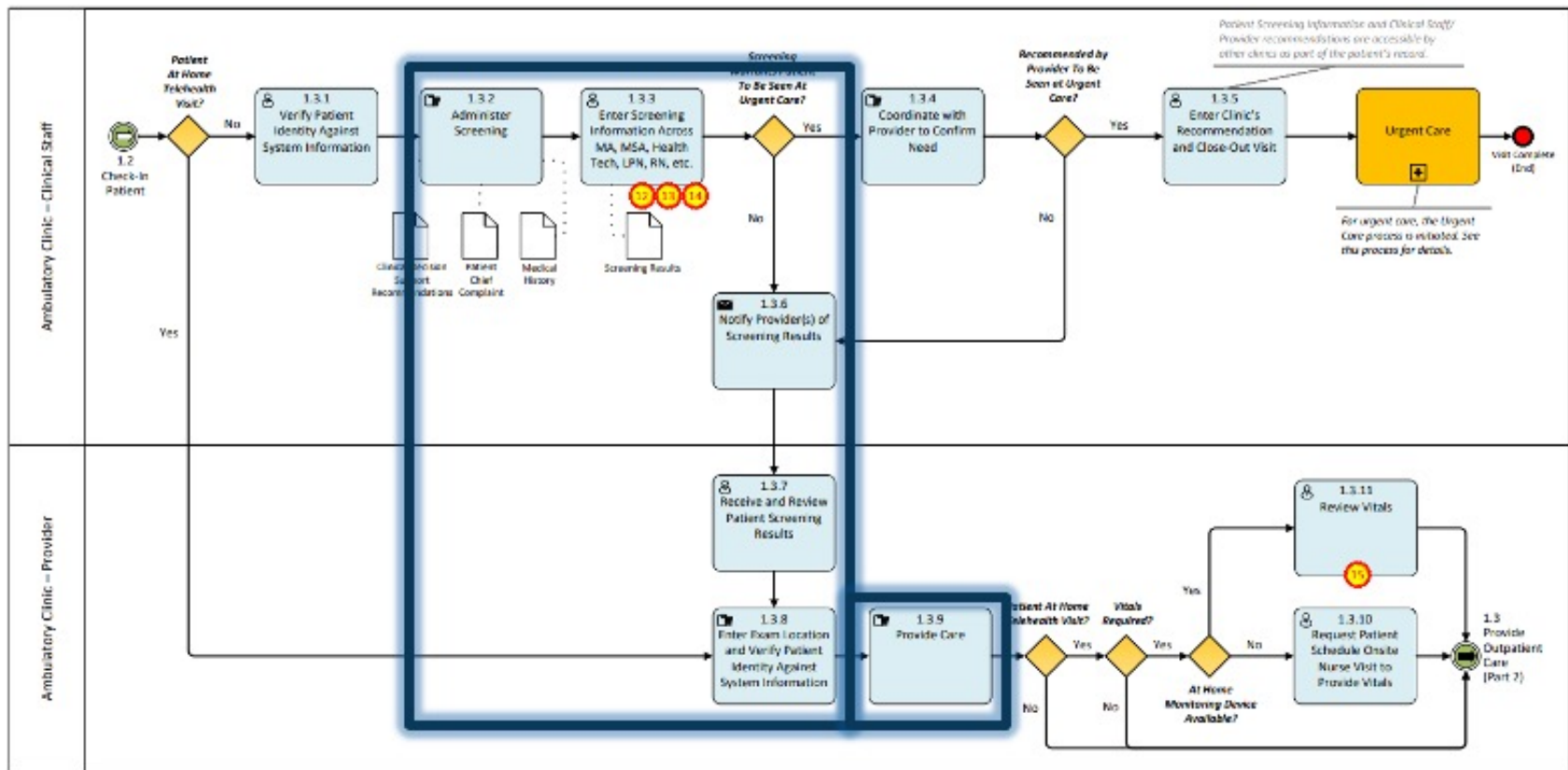
**National Council of Informatics
Clinical Decision Support (NCI-CDS)**

Develop CDS informatics tools to **assist Suicide Risk
Screening**

Reminder & Dialog to address Suicide Screening



Collecting Patient Information - WRAP



NCI – ASQ Dialog

- Standardizes documentation
- Provides refusal directions
- Orders local Consult
- Documents Suicide Screening Exam
- Documents Suicide related education
- Provides guidance on next steps



Ask Suicide Screening Questions (ASQ)

Ask the patient:

- 1. In the past few weeks, have you wished you were dead? Yes No
- 2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
- 3. In the past week, have you been having thoughts about killing yourself? Yes No
- 4. Have you ever tried to kill yourself? Yes No

If yes, how? _____

When? _____

*If the patient answers **Yes** to any of the above, ask the following acuity question:*

- 5. Are you having thoughts of killing yourself right now? Yes No



ASQ Dialog Displayed

Reminder Dialog Template: NCI-ASQ-240130

HIMC approval - Date - control number
Revision - date - control number

Ask Suicide Questions

-----Ask Suicide Screening Questions-----

Patient refused suicide screening exam
***** PLEASE ENTER REFUSAL IN THE PERSONAL HEALTH OBJECT *****

Ask Suicide Screening Questions.

ASK THE PATIENT:

ASQ 1. In the past few weeks, have you wished you were dead? Yes No

ASQ 2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No

ASQ 3. In the past week, have you been having thoughts about killing yourself? Yes No

ASQ 4. Have you ever tried to kill yourself? Yes No

If yes, how?

If yes, when?

Did the patient answer "YES" to any of the ASQ questions 1 to 4?

-YES

ASQ 5. Are you having thoughts of killing yourself right now?

-NO

Patient educated about At risk safety & prevention:

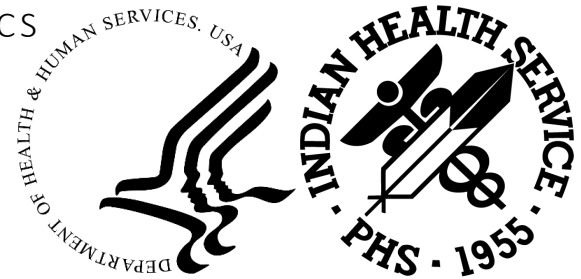
NEXT STEPS:

* Indicates a Required Field



ASQ Reminder Dialog Metrics

CAPT JOHN LESTER, PHARMD, MAS-HEALTH INFORMATICS
PROGRAM COORDINATOR / HEALTH SYSTEMS ANALYST
AREA CLINICAL INFORMATICS CONSULTANT
PHOENIX AREA INDIAN HEALTH SERVICE



ASQ Reminder Metrics Reminders Metrics – John Lester (1)

- Three (3) Month Time-Frame **Prior** to ASQ Reminder Deployment
- EHR ASQ Reminders Office Hours
December 14th, 2022
- Raw **not** Validated Data
~ 30 Facilities Reported
- Preliminary Data
- Self-Reported via “ask” after Office Hours
- Polls during Office Hours - **NOT** a Data Call

Note: Improper Reminder Configuration Affects Data Numbers

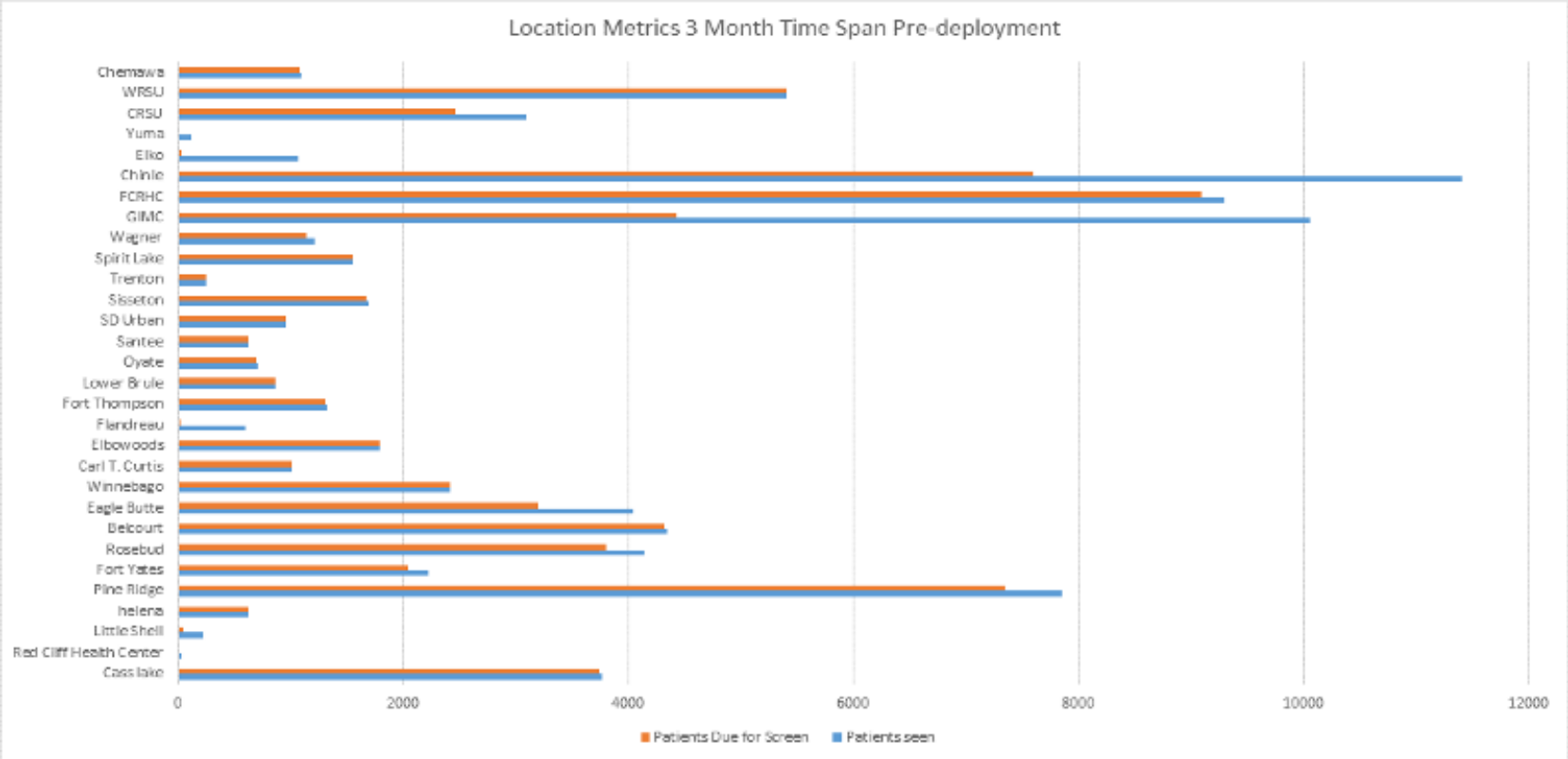


ASQ Reminder Metrics (1)

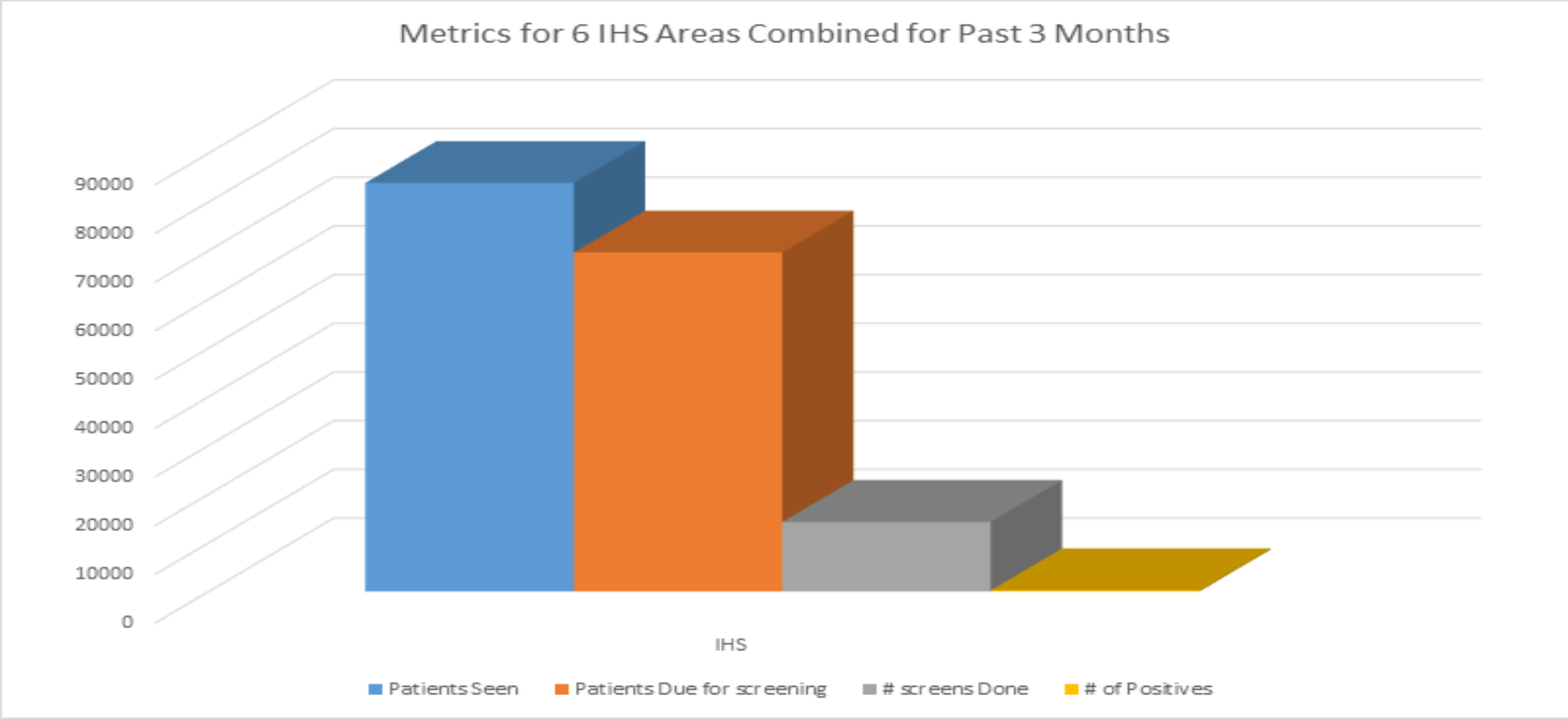
Area	Location	Patients seen	Patients Due for Screen	Pre-# Positive	Pre-Done
BEM	Cass lake	3766	3744	0	22
BEM	Red Cliff Health Center	40	0	0	40
BILL	Little Shell	233	50	5	183
BILL	helena	627	624	3	3
GPA	Pine Ridge	7849	7342	12	507
GPA	Fort Yates	2226	2046	5	180
GPA	Rosebud	4146	3805	35	341
GPA	Belcourt	4344	4325	0	19
GPA	Eagle Butte	4049	3209	0	840
GPA	Winnnebago	2422	2415	0	7
GPA	Carl T. Curtis	1009	1005	0	4
GPA	Elbowoods	1788	1788	0	0
GPA	Flandreau	605	22	0	583
GPA	Fort Thompson	1329	1318	1	11
GPA	Lower Brule	867	865	0	2
GPA	Oyate	709	700	0	9
GPA	Santee	625	625	0	0
GPA	SD Urban	964	964	0	0
GPA	Sisseton	1699	1672	5	27
GPA	Trenton	256	256	0	0
GPA	Spirit Lake	1554	1548	0	6
GPA	Wagner	1219	1149	22	70
NAV	GIMC	10061	4434	43	5627
NAV	FCRHC	9294	9097	7	197
NAV	Chisle	11404	7596	79	3808
PHX	Elko	1071	33	19	1038
PHX	Yuma	124	0	0	124
PHX	CRSU	3091	2467	1	624
PHX	WRSU	5404	5404	0	0
FOR	Chemawa	1101	1082	6	19



ASQ Reminder Metrics (2)



ASQ Reminder Metrics (3)



The Past Future

- Deploy Reminder & Dialog to an outpatient clinic
- Modification of Reminder Dialog to provide clarifying information to Clinician to best determine next steps
- Develop Reminder to alert staff of suicide screening requirement
- Determine best metric tools
 - **I.e.** iCare, Reminder Due Report
- Reminder to alert staff that patient is a positive within last 3 months
- Reminder to alert staff need of conducting a Suicide Assessment



Future Deployments

- Colorado River Service Unit – in progress
- HOPI Health Care Center – in progress
- Phoenix Indian Medical Center – in progress



Adapting Research Into Practice

- How adjustments through health informatics can save valuable time, resources, and not feel punitive to the patients.



Adapting Research Into Practice

The ASQ question #4 example

- ASQ was implemented and data was collected.
- 1/3 of positive screens will be a sole “yes” to the question “Have you ever tried to kill yourself?”
- Majority of these people may not need further mental health care.
- Once positive, always positive – we needed to account for this (true of any screening tool used that asks about past attempts).
- Add “Since last visit,” language.



Reminder Dialog Update

- Question four is the only **YES**
Since Last visit, have you tried to kill yourself?
- Incorporated Notice that user has completed screen
- Modified Consult request to be optional
- Changed Reminder notice to include “Risk”



Reminder Dialog Update Display

Reminder Dialog Template: NCI-ASQ-240130

***** PLEASE ENTER REFUSAL IN THE PERSONAL HEALTH OBJECT *****

Ask Suicide Screening Questions.

ASK THE PATIENT:

ASQ 1. In the past few weeks, have you wished you were dead? Yes No

ASQ 2. In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No

ASQ 3. In the past week, have you been having thoughts about killing yourself? Yes No

ASQ 4. Have you ever tried to kill yourself? Yes No

If yes, how?

If yes, when?

Did the patient answer "YES" to any of the ASQ questions 1 to 4?

-YES

ASQ 5. Are you having thoughts of killing yourself right now?

-NO

Discussed at risk safety, prevention suicide ideation & behavioral health referral:

[CLICK HERE] IF Question four is the only YES
Then ask "Since last visit, have you tried to kill yourself?"

[CLICK HERE] If you want to order a Social Work Consult

***** Suicide Risk Screen COMPLETE *****
*****Please follow local site guidelines and policies*****

*Indicates a Required Field

NCI – Ask Suicide Questions Reminder Alarm Clock - In Progress

Turns On Every 3 months for:

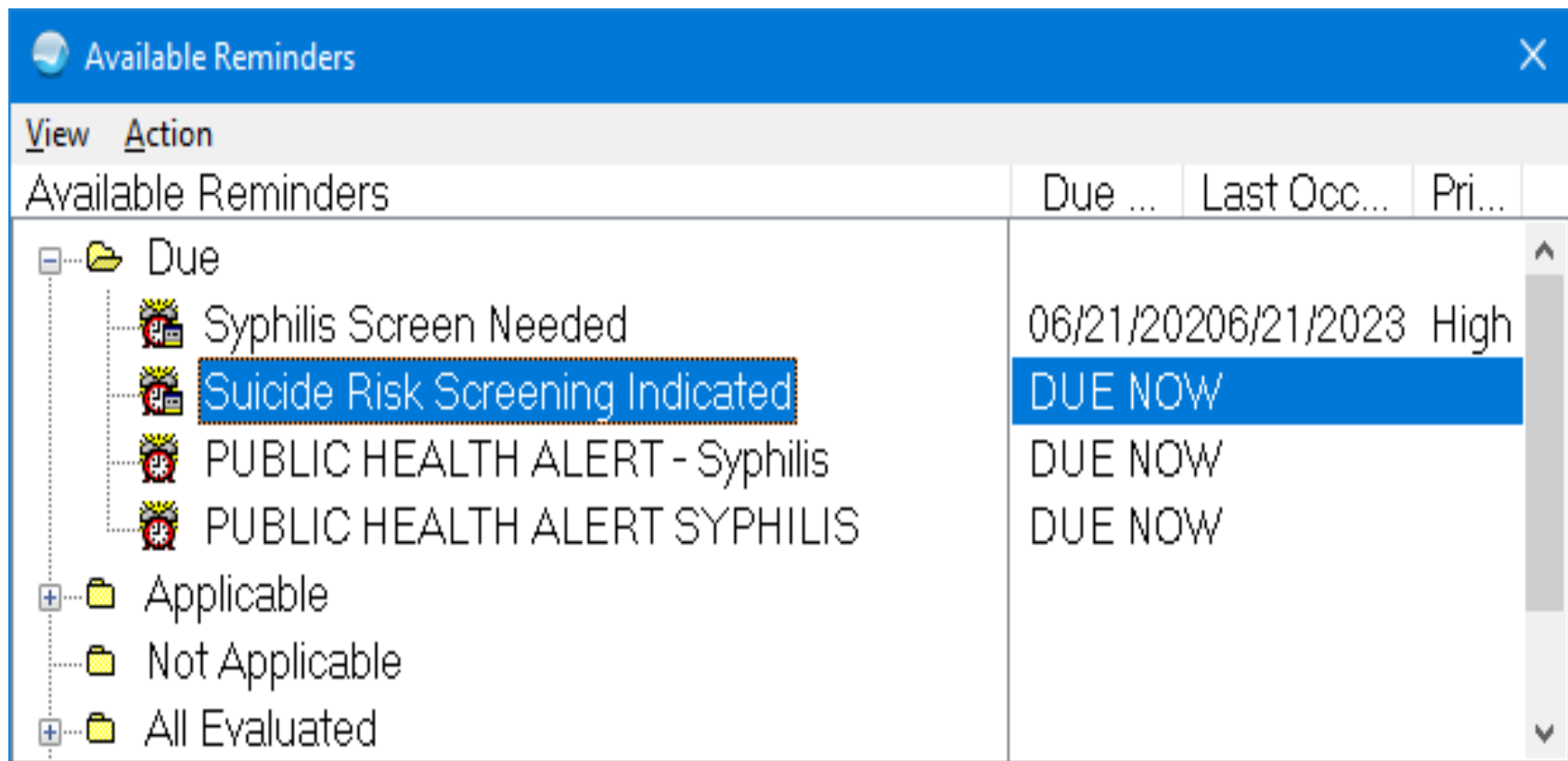
All patients Age 8 or older

Turns Off if the following is found in the last 3 months:

Suicide screening exam



Suicide Risk Screening Indicated



View		Action	
Available Reminders	Due ...	Last Occ...	Pri...
Due			
Syphilis Screen Needed	06/21/2020	06/21/2023	High
Suicide Risk Screening Indicated	DUE NOW		
PUBLIC HEALTH ALERT - Syphilis	DUE NOW		
PUBLIC HEALTH ALERT SYPHILIS	DUE NOW		
Applicable			
Not Applicable			
All Evaluated			

Facility Metric Tools

- iCare Panels
- Reminder Reports



iCare

Population management tool that can provide panels of patients reflecting what your searching in addition to numbers

- How many Scheduled visits in a defined timeframe
- Out of the scheduled visits how many patients had a suicide screening in a timeframe
- Out of the scheduled visits how many did not have a suicide screening in a time frame
- Out of the screenings done how many were positive



iCare - Display

Patient Visits in last calendar month	number of scheduled patients visits in last calendar month in emergency services, nursing, mental health, behavioral health & telemedicine	137	Jul 19, 2023 02:41 PM	LESTER,JOHN	LESTER,JOHN		Jul 19, 2023 03:00 PM	At Login	Jul 19, 2023 02:41 PM	Jul 19, 2023 02:41 PM
Patient with suicide screen in last calendar Month		4	Jul 19, 2023 02:43 PM	LESTER,JOHN	LESTER,JOHN		Jul 19, 2023 02:56 PM		Jul 19, 2023 02:43 PM	Jul 19, 2023 02:43 PM
Patients seen in last calendar month with positive suicide screen	List of patients that have positive suicide screening with a visit in the last calendar month	1	Jul 19, 2023 02:44 PM	LESTER,JOHN	LESTER,JOHN		Jul 19, 2023 03:00 PM		Jul 19, 2023 02:44 PM	Jul 19, 2023 02:44 PM
Patients without suicide screen last calendar month	List of patients that did not have recommended suicide screening with a visit in the last calendar month	130	Jul 19, 2023 02:50 PM	LESTER,JOHN	LESTER,JOHN				Jul 19, 2023 02:50 PM	Jul 19, 2023 02:50 PM



RPMS EHR Reminder Due Report

Easy to use but only provides specific information and requires a reminder definition

- Number of Patients seen
- Number of Patients applicable
- Number of Patients DUE
- Percentages



RPMS EHR Reminder Due Report - Display

Clinical Reminders Due Report - Summary Report

Facility: ELKO 8290

Reminders due 6/30/2023 - TOTAL REPORT for 6/1/2023 to 6/30/2023

Patients with Reminders

	Applicable	Due	%Appl	%Due	%Done
	-----	---	-----	----	-----
1 Suicide Screening Indicated					
	57	42	99	74	26

Report run on 58 patients.

57 – 42 = **15 patients** had a suicide screening in the last month.



Summary

1. Suicide is a major public health problem among AI/AN.
2. Universal screening in medical settings can save lives.
3. IHS recommends implementing suicide risk screening programs in medical facilities throughout the country.
4. Evidence-based tools, like the ASQ, and clinical pathways can make screening and management of those that screen positive feasible.
5. Health informatics can (make screening feasible, use data to improve processes, etc.)



Knowledge Questions

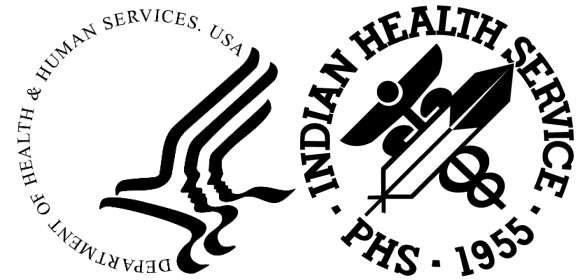


Knowledge Questions

1. What race/ethnicity has the highest rates of suicide?
2. Name a very brief suicide risk screening tool that was developed specifically for medical facilities
3. How do “screening” and “assessment” differ?
4. What CDS tools were discussed today?



Discussion





Biographical Sketch (1)

CAPT John Lester, PharmD, MAS – Health Informatics Program Coordinator / Health Systems Analyst Phoenix Area Indian Health Service

CAPT John Lester currently serves as a Clinical Informatics Consultant and Health System Analyst for the Phoenix Area. CAPT Lester is a Commissioned Officer in the United States Public Health Service and has been in the Indian Health Service since 2003. John earned his Doctor of Pharmacy (PharmD) from Nova Southeastern University in Florida, holds an NCPS in ambulatory care and Diabetes completed a PGY1 residency in Ambulatory care at Cherokee Indian Hospital and earned his Masters of Advanced Study (MAS) in Health Informatics from Arizona State University 2021. CAPT Lester has served in Omak, Washington; FCC Coleman, FL; Western Oregon Service Unit, OR; Sells Hospital, AZ; Sells Service Unit, AZ and Phoenix Area Office, AZ as a Pharmacist/Informaticist, Chief Pharmacist/Informaticist, Advanced Practice Pharmacist/Co-pharmacy Informatics officer and Clinical Informatics Consultant.



Biographical Sketch (2)

**Pamela End of Horn, DSW, LICSW
National Suicide Prevention Consultant
Indian Health Service Headquarters**

Pamela is responsible for oversight of the Suicide Prevention and Care Program. Her work focuses on policy development, program implementation and evaluation.

Pamela holds a Doctorate Degree in Social Work from the University of Pennsylvania and currently holds advanced practice licenses in North Dakota and Minnesota.

Pamela was born and raised in Pine Ridge, South Dakota and is an enrolled member of the Oglala Lakota Sioux Tribe of the Pine Ridge Indian Reservation.



Biographical Sketch (3)

Lisa M. Horowitz, PhD, MPH

Senior Associate Scientist / Clinical Psychologist

Director of Patient Safety & Quality, NIMH

Office of the Clinical Director

Intramural Research Program

National Institute of Mental Health, NIH

Dr. Lisa Horowitz is a Clinical Psychologist and a Senior Associate Scientist at the National Institute of Mental Health at NIH. Dr. Horowitz received her doctorate in clinical psychology from George Washington University, completed a Pediatric Health Service Research Fellowship at Harvard Medical School, and obtained a Masters in Public Health at the Harvard School of Public Health. The major focus of Dr. Horowitz's research has been in the area of suicide prevention in the medical setting that involves validating and implementing tools for clinicians, such as the Ask Suicide-Screening Questions (ASQ). She is also one of the co-authors of the Blueprint for Youth Suicide Prevention, released by the American Academy of Pediatrics this past March. Dr. Horowitz is collaborating with adult and pediatric hospitals, and outpatient clinics both nationally and globally, assisting with implementation of suicide risk screening and management of patients who screen positive using the ASQ Toolkit and Suicide Risk Clinical Pathways. She very much values her partnership with the Indian Health Service suicide prevention team, and looks forward to being part of the roll-out team for suicide risk screening in IHS facilities across the country.



Biographical Sketch (4)

Deborah (Debbie) J. Snyder, MSW, LCSW-C, ACC
NIH/NIMH Office of the Clinical Director
Senior Advisor to the Clinical Director
Deputy Director Patient Safety and Quality
Faculty Psychiatry Consultation Liaison Service

Deborah (Debbie) J. Snyder, MSW, LCSW-C, ACC received her Bachelor of Arts in psychology, cum laude, from Duke University and her Masters Degree in Social Work, Phi Kappa Phi, from the University of Maryland School of Social Work. She received post-graduate externship fellowship training at the Family Therapy Practice Center in Washington, D.C. She has her coaching certification from the International Coaching Federation. She completed the Stanford WellMDPhD Wellbeing Director's Course in the fall 2021.

Ms. Snyder has been on staff at the NIH since 1992. Currently, she holds the positions of Senior Advisor to the Clinical Director, Faculty on the Psychiatry Consultation Liaison Service and the NIH Hospice and Palliative Care Medicine Program & Deputy Director of Patient Safety and Quality at the NIMH. In addition, she serves as Deputy Chair of the GMEC subcommittee on resident wellbeing.

A major focus of her career has been as clinician and educator at the interface of medical and mental health. In addition, she is an organizational leader on the topics of enhancing staff and trainee wellbeing and reducing burnout.

In addition, Ms. Snyder conducts research in suicide risk screening in medical settings including hospitals, inpatient and outpatient settings. She helped develop the ASQ™, a suicide screening tool for medically ill patients, as well as the ASQ Toolkit to help guide institutions in the implementation of suicide risk screening.

Most recent awards include: the NIMH 2022 Director's Award for exceptionally supporting wide range of mental health services for NIH community by anticipating need for support, implementing new approaches of outstanding care and guidance and the NIH 2021 Director's Award for contribution and leadership to the NIH during the Covid-19 pandemic including standing up an entirely new resource to support NIH staff through an intramural staff telephone warmline during COVID-19.



