**Title:** Increasing Early Detection of Youth Behavioral Risk, Improving Care Delivery and Addressing Suicide within Multiple Patient-Centered Medical Home Settings by Empowering Provider Teams and Integrating Risk Screenings into EHR-Driven Clinical Workflow

**Organization:** The Wright Center for Primary Care

**Topic:** The integration of the United States’ Substance Abuse and Mental Health Service Agency’s Garrett Lee Smith Youth Suicide Prevention in Primary Care program into The Wright Center’s primary care medical home Teaching Health Centers in Northeast Pennsylvania

**Date of Success Story:** 2008-2016

**Care and Related Service Setting:** Patient-Centered Medical Home (PCMH) primary care Teaching Health Centers; student health service medical home venues for a junior college and an allopathic medical school in Northeast Pennsylvania

**Meaningful Use Stage Attestation:** All Wright Center providers attest to Modified Stage 2

**Alternative Payment Model Affiliation (If Any):**
- 2010-2014: Medicare Shared Savings Programs (MSSP)
- 2010-2014: Pennsylvania Chronic Care Initiative (PACCI)
- 2014-present: Keystone Accountable Care Organization (KACO)

**Overview:**
Suicide, a huge, ubiquitous public health problem, is the third leading cause of death among those aged 10-14 and the second leading cause of death for those aged 15-34. Of 100,000 individuals, the average suicide completion rate in Pennsylvania is 13.3%; the very disheartening national average is slightly lower at 12.97%. Lackawanna County, PA, ranks higher than state and national averages with a startling suicide completion rate of 13.64%

Approximately half of all individuals receiving care in primary care venues present with psychiatric comorbidities. Studies show that 60% of psychiatric illnesses are treated in primary care. Of those who attempted suicide, 64% and 38% visited a doctor one month and one week respectively before the attempt. Notably, 83% of those who completed suicide received health care in the year prior. Evidence suggests that integrating Behavioral Health Screens (BHS) into the delivery of routine primary care promotes early identification and behavioral/medical interventions that can improve the health and functional outcomes of people with co-occurring medical conditions.

High-profile catastrophes and humbling prevalence have prompted widespread national acknowledgement of the disturbing scope of the suicide epidemic. National, federal and professional representatives mobilized to take action by funding the development of a long-term, collaborative tragedy prevention strategy. In 2008, the Garrett Lee Smith (GLS) Youth Suicide Prevention in Primary Care program was established and awarded by the United States Substance Abuse and Mental Health Service Agency (SAMHSA) to screen and address comprehensive behavioral risks, inclusive of suicide, in primary-care venues amongst youth ages 14-24.
This national collaborative aimed to increase strategic screening of young adults using a comprehensive BHS. The GLS BHS asks specific questions about the patient’s experience with sadness, anxiety, PTSD, self-mutilation, history of or current suicidal ideation, disordered eating, substance use, high-risk sexual behavior and bullying to provide a comprehensive behavioral and mental health assessment to the provider.

The high visibility of this national initiative prompted prominent organizations to commit support. As a result, a contract was awarded to The Pennsylvania Office of Mental Health and Substance Abuse Services that in turn was subcontracted to academic institutions to work with community-based organizations and primary care medical home innovators to integrate this program.

In 2010, the GLS Youth Suicide Prevention in Primary Care program awardee at Drexel University subcontracted implementation in Northeast Pennsylvania to the Advocacy Alliance, a non-profit mental health and disability support organization promoting recovery, resiliency, independence and support for those with mental illness. The first grant award cycle focused on Pennsylvania’s Lackawanna, Luzerne and Schuylkill Counties because the startling suicide prevalence in these areas surpassed the national mean.

The Wright Center engaged as a GLS Youth Suicide Prevention in Primary Care program participant concurrent with its immersion in primary care practice medical home redesign efforts through the Pennsylvania Chronic Care Initiative. The Wright Center’s ongoing practice transformation efforts converged integration of Electronic Health Record (EHR) Meaningful Use standards and Chronic Care Model guidance initially using diabetes as a population of focus to drive care delivery redesign.

It was clear that the workflow redesign framework used in regards to diabetes offered validating spread potential into the broader medical and mental health arenas. The GLS program presented a pilot opportunity for The Wright Center to model this workflow to integrate and strategically address the mental and behavioral health needs of young adults.

The team focused on integrating BHS into workflow without a significant amount of additional (perceived or actual) staff effort. To encourage buy-in, medical assistants, resident physicians and providers at The Wright Center were educated about the GLS program and trained as BHS champions. The medical assistants led workflow integration by providing a tablet and coaching to engage each patient at their annual well visit, placing emphasis on confidentiality. Patients completed the screen privately and results were summatively assessed at the point of care, immediately available for provider review.

**Outcome:**
The GLS reporting structure of BHS results, referrals and follow-up were tracked through a web-based informatics platform, BH-WORKS, external to the practice’s EHR clinical workflow and under the stewardship of the primary grantee. In the original rollout, although the primary care provider and medical assistant were aware of individual patient BHS results at the point of care, the population level statistics were collected by the primary grantee and not immediately accessible or formally shared with the provider teams in a structured manner. Primary care teams, as a result, initially tracked referrals internally for high-risk patients but did not have direct access to the informatics platform necessary for provider-driven public health impact reporting typical of high-performing medical homes. The Wright Center added an in-house social worker who monitored results monthly, followed-up with high-risk
patients, offered counseling or resources, checked on previous referrals, ensured referral service provision and verified closure of care gaps.

In 2010, The Wright Center for Primary Care Mid Valley completed 1043 total BHS during young adult well visits and revealed startling positive screening results detailed below: depression-36%; anxiety-38%; trauma/PTSD-21%; eating disorder-3%; substance abuse-4%; and suicide-16%. Notably, of the 376 positive depression screens: 37% were mild; 13% were moderate; and 51% were severe.

Continual programmatic improvements since inception of this federal SAMHSA program now ensure that all results are tracked on a web-based, provider-accessible BHS website. The external Information Technology platform, stewarded by the SAMHSA grantee, now empowers providers with access to population-level data to better understand public health impacts and to drive learning through a culture of continuous clinical quality improvements.

By 2016, The Wright Center spread workflow and processes into its second program phase detailed below. Within its Mid Valley practice, a local community college and an allopathic medical school, 3988 total screens were completed and revealed the following positive results: depression-33%; anxiety-32%; trauma/PTSD-17%; eating disorder-3%; substance abuse-3%; and suicide-12%.
Organically, The Wright Center for Primary Care Mid Valley became a leading national practice in the GLS Youth Suicide Prevention in Primary Care program with incredible patient, family and provider team engagement. This success was possible because of notable top leadership commitment, high provider team satisfaction, global acknowledgement of the value of the process and humble recognition of the reality of the suicide epidemic.

Lessons Learned:
Bi-directional integration of medical and mental health screenings and services clearly requires intentional workforce development and collaborative training models. Integration of Behavioral Health Screens and related coordination of responsive care delivery into PCMH team-based workflow requires a team-based learning curriculum to support evidence-based practices. Leadership commitment, medical assistant/provider team communication and staff buy-in are critical success determinants.

The Northeast Pennsylvania regional Community Health Needs Assessment revealed the reality of behavioral and suicide risks amongst youth. The GLS BHS results generated authentic, humble, practice-level awareness that fueled clinical interventions and enrichment of a community resource referral network to close care gaps. Health Information Technology was an essential catalyst.

External systems for BHS metrics reporting that are not integrated into daily EHR PCMH workflow hinder population-level management at the provider team level and also create data reconciliation and outcomes assessment challenges. Additionally, automated alert functionality driven in the EHR to streamline the results within the timeline of the visit was precluded and would have been helpful to the provider teams.

Next-Steps/Future Vision:
Screening fosters the enrichment of a community resource network to close care gaps and needs to be strategically and intentionally nurtured to generate change. An enriched community resource network is essential to address public health problems like suicide.

Inadequate HIT interoperability with daily EHR-driven clinical workflow creates challenges in the referral tracking process that should be strategically and proactively addressed. Effective referral tracking responding to positive BHS is crucial and far from easy.

Population-level Health Information Technology (HIT) infrastructure integrated into daily EHR-driven clinical workflow promotes focus for higher purpose in the trenches of where care is delivered. Caring for patients and families fuels provider team engagement. This focus and understanding can generate team resilience for medical home operations and build a referral tracking system to close care gaps for behavioral health issues.

There have been so many lessons learned at The Wright Center while integrating the GLS BHS program into the PCMH care delivery model. Behavioral health clinicians and primary care providers play a vital part in delivering team-based care to individuals and populations with physical and behavioral health challenges. The need for integration of these services is undeniable to improve national health. Primary care physicians can be active advocates of preventive screening and proactively identify patients in need of behavioral health interventions who may not seek services on their own. Primary care graduate
medical education programs could and, to meet public trust, should lead collective address of the pressing national need to integrate primary care and behavioral health services.

**Contact Information:**
Linda Thomas-Hemak, MD, FACP, FAACP
President/CEO, The Wright Center for Primary Care and The Wright Center for Graduate Medical Education

**References:**
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2. Pirl, Beck, Safren, Kim, 2001