MI-CCSI
Partnering to Better Care

SOUTHLAKE CARE MANAGEMENT SESSION 2 WORKBOOK

CARE MANAGEMENT – PART 1

MI-CCSI
Center for Clinical Systems Improvement

Revision Date: 09.03.25

CONTENTS

AGENDA

Presenter	Topic	Time
Sue and Lynn	Welcome: Status with Action Items from Session 1	15 minutes
Sue	Care Management Process Patient Identification	10 minutes
Lynn	Comprehensive Assessment Medical Needs	15 minutes
Lynn	Comprehensive Assessment Social Needs	10 minutes
Sue	Comprehensive Assessment Behavioral Needs	15 minutes
Sue	Comprehensive Assessment AUD and SUD	15 minutes
Group	Wrap-up and Homework	10 minutes

Review the Team Roles and Responsibilities Document.

- Where are there opportunities for improvement (minimize rework, fill in gaps, clarify roles and hand-offs)?
- Identify the team member who will lead this quality improvement activity and monitor actions to implement changes.

As a team:

- Finalize the practices Team-based Care elevator speech.
- Create a draft of the patient/provider partnership agreement.
  - Establish a plan for implementation and use of these documents.

Review the communication tools. Select 1 tool to start with.

- Create a PDSA to identify what data you will collect to determine what is working and what requires modifications.
- Create an SBAR for one of the conditions the team would like to focus on (COPD, HF, Depression, Diabetes).
  - Discuss with the provider and clinical team members the key information needed from the situation and background for the condition in order to make decisions.

CASE MANAGEMENT KNOWLEDGE FRAMEWORK

CASE MANAGEMENT KNOWLEDGE FRAMEWORK

Horizon Blue Cross Blue Shield of New Jersey

Complex Case Management Trigger Events and Diagnosis Codes

Adult/Pediatric/High-Risk Maternity

Horizon Blue Cross Blue Shield of New Jersey's Complex Case Management Program is a free, voluntary service that offers care coordination and guidance to our members or their covered dependents when faced with a serious illness or condition. The member's physician and a Horizon BCBSNJ Care Manager will work collaboratively with the member to develop a treatment plan. The treatment plan will consist of both short- and long-term goals for our members or their covered dependents to achieve self-management of the illness or condition.

Horizon BCBSNJ identifies members for the Complex Case Management Program from many sources, including:

- Physician referrals
- Member self-referrals
- Predictive modeling
- Daily discharge logs
- Weekly re-admission reports

The following pages include a partial list* of trigger events and diagnosis codes for Complex Case Management services for adult, pediatric and high-risk maternity members. Triggers can be a diagnosis, an event, a circumstance or a behavior that represents an opportunity for case management intervention

**Horizon BCBSNJ reserves the right to modify this list at any time*

..

Trigger Events and Circumstances

- Acute or chronic condition/unstable home environment or lack of a qualified caregiver
- All hospice requests/end stage pre-hospice/terminal illness
- Cognitive rehabilitation
- Emergency Room (ER) readmission for same diagnosis within 30 days
- Extended acute hospital stay of more than seven days
- Extended (greater than six weeks) physical, occupational and/or speech therapy
- Extended (greater than six weeks) home intravenous therapy
- Extended (greater than six weeks) home health aide (HHA) and skilled nursing
- High dollar claimant (greater than or equal to$50,000 threshold)
- Maternity – referred at less than 36 weeks gestation:
  - 17P progesterone therapy
  - Complication in pregnancy
  - Infertility services with confirmed pregnancy
  - Inpatient admission not resulting in delivery/determination or fetal demise
  - Multiple gestations
  - Over 35 years of age
  - Under 18 years of age
- Member or physician referral
- Multiple comorbidities without a current treatment or unstable disease process
- Multiple ER visits
- Multiple hospital admissions within 90 days
- Neonatal intensive care unit (NICU)
- Nonparticipating claims greater than or equal to $5,000 or five or more nonparticipating services
- Pediatric open heart surgery
- Pharmacy needs of six or more medications
- Private duty nursing
- Severe trauma
- Specialized durable medical equipment (DME)
- Ventilator dependent
- Wound vacuum-assisted closure (VAC) devices

Trigger Diagnosis

- Anoxic encephalopathy
- Asthma (inpatient admission greater than two ER visits within 30 days)
- Autoimmune diseases or HIV/AIDS
- Chronic kidney disease (CKD) (ER or admission)
- Chronic obstructive pulmonary disease (COPD)
- Cleft palate
- Clinical trials – outpatient setting
- Congestive heart failure (CHF)
- Coronary insufficiency syndrome
- Cerebrovascular accident (CVA) – stroke
- Diabetes (newly diagnosed/one inpatient admission or less than two ER visits within 30 days)
- Hemophilia
- Hypertension – uncontrolled (blood pressure)
- Hypogammaglobulinemia
- Intracranial hemorrhage
- Limb amputation
- Lupus
- Myocardial infraction (MI) – heart attack
- Multiple traumas
- Neuromuscular conditions:
  - Amyotrophic lateral sclerosis (ALS), also called Lou Gehrig's disease
  - Cerebral palsy
  - DiGeorge syndrome
  - Down syndrome
  - Guillain-Barré
  - Huntington's disease (HD)
  - Muscular dystrophy
  - Multiple sclerosis (MS)
  - Spinal muscular atrophy
- Parkinson's disease
- Pediatric gastrointestinal disorders:
  - Inflammatory bowel
  - Crohn's disease
  - Hirschsprung's disease
  - Malabsorption syndrome
- Premature infant
- Pulmonary hypertension
- Rare diseases
- Respiratory failure or distress
- Sex reassignment
- Sickle cell anemia
- Spinal cord injury (SCI)
- Systematic sclerosis
- Transplant candidates
- Traumatic brain injury (TBI)
- Unstable angina
- Wounds (non-healing/infected or open)

RISK-STRATIFICATION ALGORITHM

Step 1: Use objective data to risk stratify the patient.

HIGH RISK

Risk scoring data:	Utilization:	Clinical:
Significant claims history; significant severity according to ICD-10 or hierarchical condition category (HCC) codes, electronic health record (EHR), health information technology (HIT) database, etc.	• Three or more ED visits. • Any readmission. • One hospitalization related to chronic conditions. • Admission to hospice or palliative care.	• One unstable behavioral health diagnosis. • Two or more stable behavioral health diagnoses. • Three or more active chronic conditions. • Active cancer. • Clinical metric critically out of bounds (e.g., A1C > 9, stage D heart failure).

MODERATE RISK

Risk scoring data:	Utilization:	Clinical:
Moderate claims history; moderate severity according to ICD-10 or HCC codes, EHR, HIT database, etc.	• One ED visit related to chronic condition. • Any hospitalization.	• One stable behavioral health diagnosis. • Fewer than three active chronic conditions. • History of cancer. • Clinical metric moderately out of bounds (e.g., A1C < 9, stage B or C heart failure).

LOW RISK

Risk scoring data:	Utilization:	Clinical:
Low claims history; low severity according to ICD-10 or HCC codes, EHR, HIT database, etc.	• No ED visits or hospitalizations.	• No chronic health condition.

Step 2: Use subjective data to assign a risk-stratification level for the patient.

LEVEL 6

Patient is potentially in danger of dying or being institutionalized within the next year.

LEVEL 5

Patient has complications of chronic conditions or high-risk social determinants of health.

LEVEL 4

Patient has chronic conditions that are out of control but without complications.

LEVEL 3

Patient has chronic conditions but is doing well.

LEVEL 2

Patient is healthy with no medical problems but with out-of-range biometrics.

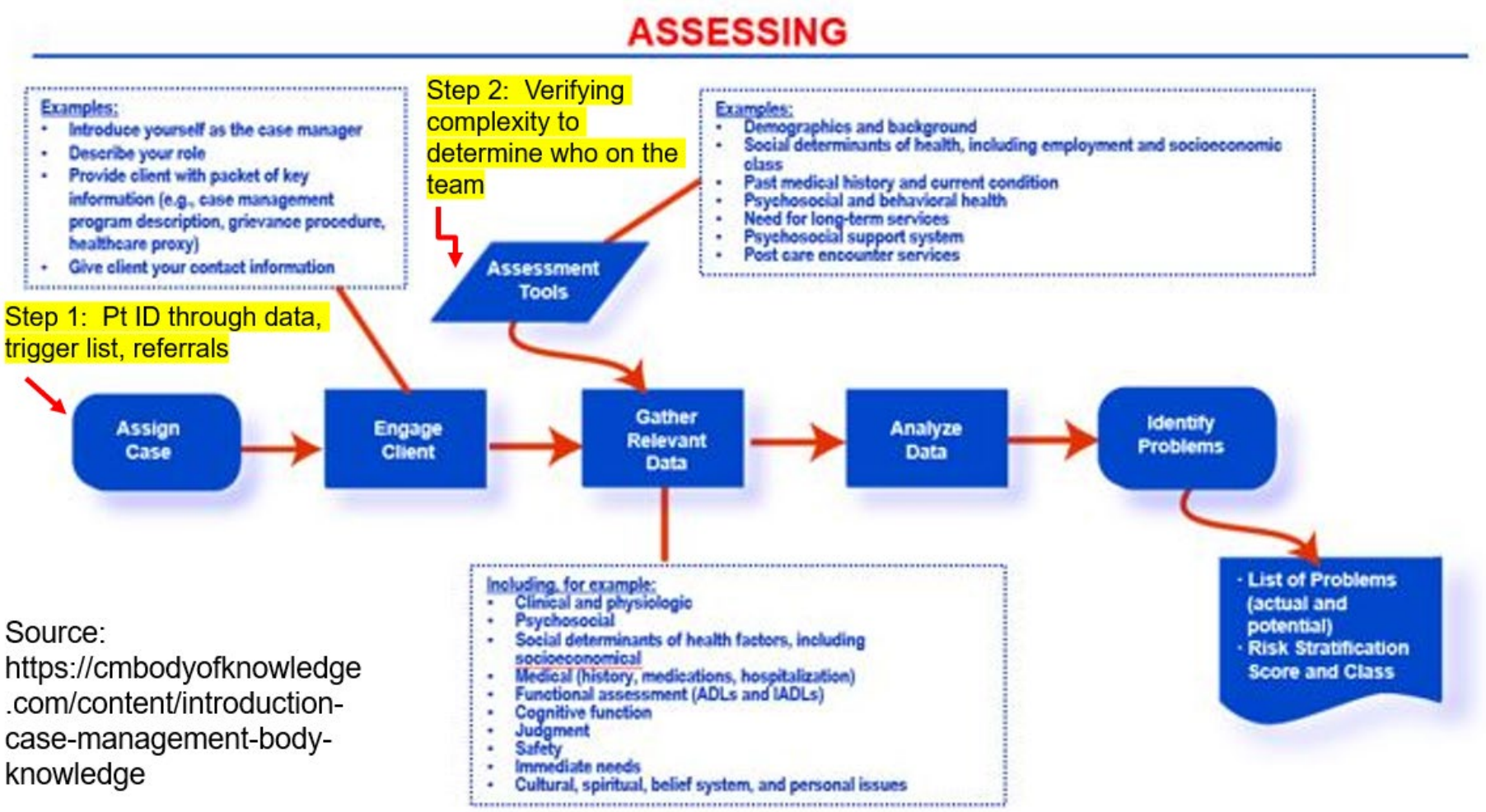
LEVEL 1

Patient is healthy with no medical problems and in-range biometrics.

AAFP FPM

***FPM* Toolbox** To find more practice resources, visit https://www.aafp.org/fpm/toolbox.

1 of 1



Source: https://cmbodyofknowledge.com/content/introduction-case-management-body-knowledge

Patient Demographics

- Full name, date of birth, and gender
- Preferred name
- Marital status/ family
    - Location of family members
- Contact information
- Address
- Insurance details
- Providers involved in care
- Primary language and communication needs
- Pharmacy used
- DME/Equipment Company used
- Advanced Directives completed and on file

Medical History

- Past medical history (chronic illnesses, surgeries, hospitalizations)
- Hospitalization/ER use history

- Family medical history (immediate family members, genetic predisposition)
    - Notable diseases in the family (eg- diabetes, heart disease, cancer)
- Current medical conditions and treatments

- Current medications (including dosages and adherence)
    - Over the counter meds, herbals and holistic treatments
- Allergies (medications, food, environmental)
- Preventive Services for age group completed?
- Immunization status

Health Status Assessment

- Current health status (including vital signs)
- Any deficits: Ability to hear/see- do they use assistive devices?
    - Last hearing check
    - Last eye exam
- Functional status (mobility, gait, transfer ability, activities of daily living)
    - Assistive device use?
- Cognitive function (memory, problem-solving skills)
- Mental health assessment (screen for mood/depression, anxiety)
- Pain assessment and management
- Fall risk/home safety assessment
- DME/equipment supplies use at home?
- **Review of Systems (ROS) if appropriate:**
    - Comprehensive inquiry into each body system to identify potential issues.

Social Determinants of Health

- Socioeconomic status (employment, education)
- Occupation and work environment (exposure history)
- Education and Literacy level
- Where does the patient live? (community, safety etc.)
- Access to healthcare
- Access to food/groceries
- Living situation (alone, with family, in a facility)
- Support systems (family, friends, community resources)
- Access to transportation and healthcare services

Lifestyle and Behavioral Factors

- Nutrition and diet habits
- Physical activity levels
- Substance use (smoking, vaping, alcohol, drugs)
- Sleep patterns and quality
- Occupation and work environment (exposure history)
- Travel history
- Living situation (alone, with family, assisted living)
- Support systems (friends, family, community resources)

Personal Goals and Preferences

- Patient's health goals and priorities
- Preferences for treatment and care approaches
- Advance care planning and end-of-life wishes

Care Coordination Needs

- Current care providers and specialists involved
- Need for referrals to other services (e.g., physical therapy, social work)
- Patient education and self-management support

Cultural and Spiritual Considerations

- Cultural beliefs and practices that may impact care
- Sensitivity to language and communication barriers
- **Spiritual Needs:** Exploration of spiritual beliefs and their impact on the patient's health and care preferences.

Patient and Family Education

- Understand patient's learning needs and preferences.
- What do they currently know/or how are they managing their current medical problems?
- Provide relevant education on health promotion, disease prevention, and self-management.

If Part of Role:

Physical Assessment

- **Vital Signs:** blood pressure, heart rate, respiratory rate, temperature, oxygen saturation
- **Head-to-Toe Examination:**
  - Inspection (appearance, posture, hygiene)
  - Palpation (tenderness, temperature)
  - Auscultation (heart and lung sounds)
  - Percussion (if applicable)
- Assess areas such as skin, eyes, ears, nose, throat, abdomen, extremities, and neurological function

Comprehensive Plan of Care

- Develop a personalized care plan based on assessment findings
- Set measurable goals and objectives
- Identify interventions and resources needed for patient success

Carolyn Jarvis's comprehensive nursing assessment model emphasizes a thorough, systematic approach to assessing patients in both physical and holistic dimensions. Regular use of this framework helps ensure that nurses capture essential information, facilitating effective diagnosis, care planning, and patient-centered care.

Reference:

Jarvis, C. (2020). PHYSICAL EXAMINATION AND HEALTH ASSESSMENT (8th ed.). Elsevier.

ASTHMA ACTION PLAN

For: _____ Doctor: _____ Date: _____

Doctor's Phone Number: _____ Hospital/Emergency Department Phone Number: _____

GREEN ZONE

DOING WELL

- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than _____
(80 percent or more of my best peak flow)

My best peak flow is: _____

Daily Medications

Medicine	How much to take	When to take it

Before exercise	☐ _____	☐2 or ☐4 puffs	5 minutes before exercise

YELLOW ZONE

ASTHMA IS GETTING WORSE

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

–Or–

Peak flow: _____to _____
(50 to 79 percent of my best peak flow)

1st **Add: quick-relief medicine—and keep taking your GREEN ZONE medicine.**

_____ (quick-relief medicine) _____ Number of puffs **or** ☐Nebulizer, once — Can repeat every _____ minutes up to maximum of _____ doses

2nd **If your symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**

☐Continue monitoring to be sure you stay in the green zone.

–Or–

If your symptoms (and peak flow, if used) do not return to GREEN ZONE after 1 hour of above treatment:

☐Take: _____ (quick-relief medicine) _____ Number of puffs **or** ☐Nebulizer

☐Add: _____ (oral steroid) mg per day For _____ (3–10) days

☐Call the doctor ☐before/ ☐within_____ hours after taking the oral steroid.

RED ZONE

MEDICAL ALERT!

- Very short of breath, or
- Quick-relief medicines have not helped,
- Cannot do usual activities, or
- Symptoms are same or get worse after 24 hours in Yellow Zone

–Or–

Peak flow: less than _____
(50 percent of my best peak flow)

Take this medicine:

☐_____ (quick-relief medicine) _____ Number of puffs **or** ☐Nebulizer

☐_____ (oral steroid) mg

Then call your doctor NOW. Go to the hospital or call an ambulance if:

- You are still in the red zone after 15 minutes AND
- You have not reached your doctor.

DANGER SIGNS

- **Trouble walking and talking due to shortness of breath**
- **Lips or fingernails are blue**

- **Take _____ puffs of _____ (quick relief medicine) AND**
- **Go to the hospital or call for an ambulance _____ (phone) NOW!**

See the reverse side for things you can do to avoid your asthma triggers.

HOW TO CONTROL THINGS THAT MAKE YOUR ASTHMA WORSE

This guide suggests things you can do to avoid your asthma triggers. Put a check next to the triggers that you know make your asthma worse and ask your doctor to help you find out if you have other triggers as well. Keep in mind that controlling any allergen usually requires a combination of approaches, and reducing allergens is just one part of a comprehensive asthma management plan. Here are some tips to get started. These tips tend to work better when you use several of them together. Your health care provider can help you decide which ones may be right for you.

ALLERGENS

❒ Dust Mites

These tiny bugs, too small to see, can be found in every home—in dust, mattresses, pillows, carpets, cloth furniture, sheets and blankets, clothes, stuffed toys, and other cloth-covered items. If you are sensitive:

- Mattress and pillow covers that prevent dust mites from going through them should be used along with high efficiency particulate air (HEPA) filtration vacuum cleaners.
- Consider reducing indoor humidity to below 60 percent. Dehumidifiers or central air conditioning systems can do this.

❒ Cockroaches and Rodents

Pests like these leave droppings that may trigger your asthma. If you are sensitive:

- Consider an integrated pest management plan.
- Keep food and garbage in closed containers to decrease the chances for attracting roaches and rodents.
- Use poison baits, powders, gels, or paste (for example, boric acid) or traps to catch and kill the pests.
- If you use a spray to kill roaches, stay out of the room until the odor goes away.

❒ Animal Dander

Some people are allergic to the flakes of skin or dried saliva from animals with fur or hair. If you are sensitive and have a pet:

- Consider keeping the pet outdoors.
- Try limiting to your pet to commonly used areas indoors.

❒ Indoor Mold

If mold is a trigger for you, you may want to:

- Explore professional mold removal or cleaning to support complete removal.
- Wear gloves to avoid touching mold with your bare hands if you must remove it yourself.
- Always ventilate the area if you use a cleaner with bleach or a strong smell.

❒ Pollen and Outdoor Mold

When pollen or mold spore counts are high you should try to:

- Keep your windows closed.
- If you can, stay indoors with windows closed from late morning to afternoon, when pollen and some mold spore counts are at their highest.
- If you do go outside, change your clothes as soon as you get inside, and put dirty clothes in a covered hamper or container to avoid spreading allergens inside your home.
- Ask your health care provider if you need to take or increase your anti-inflammatory medicine before the allergy season starts.

IRRITANTS

❒ Tobacco Smoke

- If you smoke, visit smokefree.gov or ask your health care provider for ways to help you quit.
- Ask family members to quit smoking.
- Do not allow smoking in your home or car.

❒ Smoke, Strong Odors, and Sprays

- If possible, avoid using a wood-burning stove, kerosene heater, or fireplace. Vent gas stoves to outside the house.
- Try to stay away from strong odors and sprays, such as perfume, talcum powder, hair spray, and paints.

❒ Vacuum Cleaning

- Try to get someone else to vacuum for you once or twice a week, if you can. Stay out of rooms while they are being vacuumed and for a short while afterward.
- If you must vacuum yourself, using HEPA filtration vacuum cleaners may be helpful.

❒ Other Things That Can Make Asthma Worse

- Sulfites in foods and beverages: Do not drink beer or wine or eat dried fruit, processed potatoes, or shrimp if they cause asthma symptoms.
- Cold air: Cover your nose and mouth with a scarf on cold or windy days.
- Other medicines: Tell your doctor about all the medicines you take. Include cold medicines, aspirin, vitamins and other supplements, and nonselective beta-blockers (including those in eye drops).

U.S. Department of Health and Human Services
National Institutes of Health

NIH National Heart, Lung, and Blood Institute

NIH Publication No. 20-HL-5251
February 2021

For more information and resources on asthma, visit *nhlbi.nih.gov/BreatheBetter*.

LEARN MORE BREATHE BETTER®

AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?[1]
   - ☐ Yes
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[4]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

12. How often does anyone, including family, insult or talk down to you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

The EveryONE Project®
Advancing health equity in every community

13. How often does anyone, including family, threaten you with harm?[8]
- ☐ Never (1)
- ☐ Rarely (2)
- ☐ Sometimes (3)
- ☐ Fairly often (4)
- ☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?[8]
- ☐ Never (1)
- ☐ Rarely (2)
- ☐ Sometimes (3)
- ☐ Fairly often (4)
- ☐ Frequently (5)

ASSISTANCE

15. Would you like help with any of these needs?
- ☐ Yes
- ☐ No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: _____
Greater than 10 equals positive screen for personal safety.

REFERENCES

1. https://www.va.gov/HOMELESS/Universal_Screener_to_Identify_Veterans_Experiencing_Housing_Instability_2014.pdf
2. Nuruzzaman N, Broadwin M, Kourouma K, Olson DP. Making the social determinants of health a routine part of medical Care. *J Health Care Poor Underserved.* 2015;26(2):321-327.
3. Hager ER, Quigg AM, Black MM, et al. Development and validity of a 2-item screen to identify families at risk for food insecurity. *Pediatrics.* 2010;126(1):e26-e32.
4. Cook JT, Frank DA, Casey PH, et al. A brief indicator of household energy security: associations with food security, child health, and child development in US infants and toddlers. *Pediatrics.* 2008;122(4):e867-e875.
5. Children's HealthWatch. Final: 2013 Children's Healthwatch survey. http://www.childrenshealthwatch.org/methods/our-survey/. Accessed October 3, 2018.
6. Garg A, Butz AM, Dworkin PH, Lewis RA, Thompson RE, Serwint JR. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE project. *Pediatrics.* 2007;120(3):547-558.
7. Aldana SG, Liljenquist W. Validity and reliability of a financial strain survey. *J Financ Couns Plan.* 1998;9(2):11-19.
8. Sherin KM, Sinacore JM, Li XQ, Zitter RE, Shakil A. HITS: a short domestic violence screening tool for use in a family practice setting. *Fam Med.* 1998;30(7):508-512.

AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION *Supported in part by a grant from the AAFP Foundation*

The EveryONE Project® *Advancing health equity in every community*

HOP19091130

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

TITLE: SUICIDAL OR POTENTIALLY SUICIDAL PATIENT CARE IN
PHYSICIANS OFFICE PRACTICES

POLICY OWNER: Quality Improvement Committee Chair
APPROVAL: _____

President & Chief Medical Officer,
POLICY STATEMENT/SCOPE: Encounters with patients who have thoughts of suicide can occur within the physician office setting. It is the responsibility of the health care team to provide support and assistance for maintaining the safety of patients who experience suicidal thoughts or behaviors.
PURPOSE: To outline the process for maintaining the safety of patients who are exhibiting suicidal thoughts and behaviors during an ambulatory care setting encounter.

RESPONSIBILTY: Physicians, Advanced Practice Providers, Clinical staff, Practice Leaders with entire office staff to provide support and assistance.

PROCESS / PROCEDURE:
I. Patient shows signs or symptoms of suicidality
1. Business Office associate

a. Phone
i. Remain on the phone with the patient
ii. Alert another associate or instant message the patient physicians care team or designee
iii. When transferring the call, remain on the call until they are transferred to physician/designee clinical care team

b. In person
i. Remain with the patient
ii. Alert another associate or instant message the patient physicians care team or designee
iii. Handoff to clinical team member who takes over.

2. Physician/Clinical Care Team/Designee
a. Determine risk level (**imminent/acute, moderate to high, chronic/lower)**
 Have you thought about hurting yourself?
 Sometimes others in situations similar to yours think about hurting themselves. Have you ever thought that way?
 I'm concerned about you and wonder if you sometimes wish you were dead or have ever thought about killing yourself. That is, patient's **intent, plans, and means.**
Physician & Clinic Practices 2 AMB 10/300

i. **Imminent/Acute Risk -Intent with lethal plan - This level always requires immediate action.**
1) On the phone
a. Confirm the patient's current phone number and location.
b. Instant message to practice/clinical leader who will notify/consult immediately with physician/designee.
c. Ask patient if they are currently safe while you complete an assessment.
i. If patient is unsafe, call 9-1-1. Attempt to keep patient on the line until police arrive.
1. If patient's support person is known, it is appropriate to contact the support person with or without patient's consent.
ii. If currently safe
1. Identify a family or friend in order to further assess risk level/strength of support system.
2. If patient and support person states they are safe, arrange for an appointment or send to hospital Emergency Department.

2) Patient present in the office
a. Nurse or physician/designee stays in room with patient sending an instant message to practice/clinical leader, provider and fellow care team members who will:
b. **Off campus offices/clinics:** Activate 9-1-1 to bring patient to emergency room via ambulance.
c. **On campus offices/clinics:** Utilize office Social Worker, if available, or call Security if necessary to keep patient safe, then escort to the hospital Emergency Department.
d. Contact hospital Emergency Room, (**SM Express at 685-4800**) with pertinent Hand Off information and for further evaluation/disposition.

ii. **Moderate to High Risk - Current/acute thoughts with plan but no means or intent.** This risk level may not require immediate hospitalization but should be addressed clearly and specifically including statements such as: What keeps you from attempting to harm yourself? Substantiate that it is a good reason to live.
1) Patient makes threat on the phone
a. Notify/consult immediately with patient's physician/designee
b. If no access to lethal means, good social support, intact judgment; psychiatric symptoms have been addressed safe hand off to a mental health provider, significant other or family member who can assume follow up of the patient.
c. Offer the patient/support person information contact numbers and procedures if suicidal ideation worsens:
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to hospital Emergency Department
2) Patient present in the office
a. Notify/consult immediately with patient's physician/designee
b. If no access to lethal means, good social support, intact judgment; psychiatric symptoms have been addressed safe hand off to a mental health provider, significant other or family member who can assume follow up of the patient.
c. Offer the patient information about contact numbers and procedures if suicidal ideation worsens:
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to hospital Emergency Department
Physician & Clinic Practices 3 AMB 10/300

iii. **Chronic/Lower Risk -Chronic thoughts with no intent, plan, or means**
1) Patient makes threat on the phone
a. Discuss with designated provider within 24 hours;
b. Offer patient information about contact numbers and procedures if suicidal ideation returns or worsens
i. Suicide Hotline 1-800-273 TALK or 1-800-784.2433
ii. Proceed to ER
2) Patient Present in the office
a. Notify/consult with patient's physician/designee within 24 hours
i. Offer patient information about contact numbers and procedures if suicidal ideation returns or worsens
a) Suicide Hotline 1-800-273 TALK or 1-800-784.2433
b) Proceed to ER
iv. **Follow up and Documentation**
1) Following contact with the patient
a. Confirm all plans are in place and responsible parties have been notified
b. Determine next steps
i. Follow up with patient/family
ii. Follow up with facility/provider
iii. Provide any additional necessary information as necessary (medications, current plan of care, contact information, certification actions)
2) Documentation
a. Document in patient record
b. Documentation should include but is not limited to:
i. Assessment
ii. Screening tool (PHQ-9)
iii. Interventions and actions taken
iv. Follow up plan

REFERENCES: 2012 National Strategy for Suicide Prevention; Goals and Objectives for Action, Washington, DC: HHS, September 2012
Telephone Triage Protocols for Nurses, 4th Edition, Briggs, JK, Lippincott, Williams & Wilkins, 2012
CONCURRENT REVIEW:
Clinical Integration & Quality Improvement Date
Committee Chair
VP, Chief Nursing Officer, MHSM Date

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

For alcohol screens, define standard drinks

12 fl oz of **regular beer**	=	8-9 fl oz of **malt liquor** (shown in a 12-oz glass)	=	5 fl oz of **table wine**	=	3-4 oz of **fortified wine** (such as sherry or port; 3.5 oz shown)	=	2-3 oz of **cordial, liqueur, or aperitif** (2.5 oz shown)	=	1.5 oz of **brandy** (a single jigger or shot)	=	1.5 fl oz shot of **80-proof spirits** ("hard liquor")
												
about 5% alcohol		about 7% alcohol		about 12% alcohol		about 17% alcohol		about 24% alcohol		about 40% alcohol		about 40% alcohol

Ounces in a standard drink = 60 / % alcohol by volume

Two-Item Conjoint Screen (TICS)

(May be added to 2 single screening questions to identify more drug disorders)

1. In the last year, have you ever drunk alcohol or used drugs more than you meant to?
2. In the last year, have you felt you wanted or needed to cut down on your drinking or drug use?

Positive screen: Yes to either or both questions

Does not identify high-risk alcohol or drug use

Brown, Journal of the American Board of Family Practice, 2001

58

Interpreting Screen Results

- Screens identify most risky users, problem users and dependent individuals
- False-positives and false-negatives are not unusual
- Because of false-positives …
  - Positive screens are not definite indicators of risky use, problem use or dependence
  - Screens merely indicate which asymptomatic individuals should undergo further assessment
- Because of false-negatives …
  - Screens should not be administered to individuals with signs, symptoms, or high risk of substance use disorders disorders
  - **Negative screens are not sufficient to rule out SUDs for patients with chronic pain under consideration for opioid treatment**
  - Those individuals should undergo more in-depth assessment

AUDIT and DAST

AUDIT: In the past 12 months…	0	1	2	3	4
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10 or more
3. How often do you have 3 or more drinks on one occasion? *Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0*	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
				Total score =	

DAST-10: In the past 12 months…	Yes	No
1. Have you used drugs other than those required for medical reasons?		
2. Do you use more than one drug at a time?		
3. Are you always able to stop using drugs when you want to?		
4. Have you ever had blackouts or flashbacks as a result of drug use?		
5. Do you ever feel bad or guilty about your drug use?		
6. Do people in your life ever complain about your involvement with drugs?		
7. Have you neglected your family because of your use of drugs?		
8. Have you engaged in illegal activities in order to obtain drugs (other than possession)?		
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?		
Total score =		

Risk Category	Score		Management
	AUDIT	DAST	
Abstinence/Low-risk use	0 to 6 - female 0 to 7 - male	0	Reinforcement
High-risk use	7 to 15 - female 8 to 15 - male	1 to 2	Brief intervention
Problem use	16 to 19	3 to 5	Brief intervention
Likely dependent	20 to 40	6 to 10	Referral

CRAFFT - Part A - Questions

During the past 12 months, on how many days did you …	
… drink more than a few sips of beer, wine, or any drink containing alcohol?	____
… use any marijuana (cannabis, weed, oil, wax, or hash, by smoking, vaping, dabbing, or in edibles) or synthetic marijuana (like K2 or spice)?	____
… use anything else to get high (like other illegal drugs, pills, prescription, or over-the-counter medications, and things you snuff, huff, vape, or inject)?	____

"Zero" or "None" are the only negative responses. Any number greater than zero is a positive response.

CRAFFT - Part B - Questions

		Circle one:
C	Have you ridden in a **C**ar driven by someone (including yourself) who was high or had been using alcohol or drugs?	No Yes
R	Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in?	No Yes
A	Do you ever use alcohol or drugs while you are by yourself, or **A**lone?	No Yes
F	Do you ever **F**orget things you did while using alcohol or drugs?	No Yes
F	Do your **F**amily or **F**riends ever tell you that you should cut down on your drinking or drug use?	No Yes
T	Have you ever gotten into **T**rouble while you were using alcohol or drugs?	No Yes

CRAFFT Interpretation

Results		Category	Management
Part A	Part B		
Negative	–	Abstinence	Reinforcement
Positive	0	High-risk use	Brief intervention
	1		
	2	Problem use	
	3		
	4	Likely dependence	Referral to treatment
	5		
	6		

Review the Risk Stratification RSCM tool.

- Based on the practice goals and desired outcomes, how will the team identify patients who will benefit from care management activities?
- Based on the RSCM model, which activities will be delegated to the different roles?
  - Such as preventive, moderate or high risk patients.

As a team:

- Determine which conditions the team will screen or are currently screening for.
  - For new screenings, decide which screening tool you will use. Start with 1 if this is new.
  - Determine if the screening tool is available in the EHR. If yes, is the tool sufficient, or do you need to embed a new tool.
- Establish a plan for administering the screening tool to the patient. Who will do this?
- Establish a plan to share the results with the provider and actions for any positives.

Assessments

- From the screening, what is your process to start a comprehensive assessment?
  - How will you know who will require step 2 (conducting the comprehensive assessment by gathering subjective information) to verify complexity?
  - Discuss how the assessment will be documented and communicated across the team.
    - Where or how will this take place? (In person, telephonically, virtual)
    - How will the patient be assigned to the appropriate team member based on the complexity and needs of the patient (align with the roles and responsibilities table).