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Charting and Checking for Suicidality in a Family Medicine Residency Clinic

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Abstract

Suicide is a leading cause of death in the United States, and many individuals who die by suicide are likely to have seen a primary care physician (PCP) within the month of their death. Thus, the goal of this quality improvement (QI) project was to examine suicidality documentation practices of interprofessional clinicians within a Family Medicine residency clinic, thus providing rationale for continued research and a template for other clinics to emulate. The QI project used the Plan-Do-Study-Act cycle to survey 28 Family Medicine residents, faculty, and trainees for the Plan stage of the cycle in 2022 and assessed their suicidality documentation practices in the electronic medical record. Results showed discrepancies amongst clinicians, particularly clinicians of different disciplines, in how often they check charts for suicidality, where they document in the chart, and how often they discuss that information with their patients. Future studies could assess the implementation of a protocol for recording and addressing suicidality to improve patient care and safety, improve residency training and team-based care, and provide behavioral health services in primary care settings.

Keywords: integrated primary care, suicidality, residency training, electronic medical records

Introduction

According to the Centers for Disease Control and Prevention (CDC) and reported by the American Foundation for Suicide Prevention (AFSP), 48,183 Americans died by suicide in 2021, making suicide the 11th leading cause of death that year (AFSP, 2023). This equates to 14.04 suicides for every 100,000 people, an increase from 12.5 for every 100,000 people in 2012. There were also 1.7 million suicide attempts in 2021. Thus, suicide is an issue that affects many people in the United States at a rate that has increased in the past decade. In terms of age, the group with the highest rate of suicide were those 85 and older (22.39 per 100,000), followed by ages 75 to 84 (19.56 per 100,000) and ages 25 to 34 (19.48 per 100,000) (AFSP, 2023). These figures show that suicide is a lifelong issue that may need to be addressed at any point of the lifespan.

In studies that have assessed engagement with healthcare leading up to a death by suicide, Walby et al. (2018) found that 25.7% of patients had contact with mental health services, either inpatient or outpatient in the year before their death. In contrast, Ahmendani et al. (2014) found that 45% of individuals in their sample had contact with their primary care physician (PCP) in the month leading up to their death. Notably, only 24% of these individuals had a mental health diagnosis. This places PCPs in a position where they are more likely going to be in contact with potential victims of suicide prior to their death than behavioral health professionals.

This claim is commensurate with recently published research finding that PCP visits are increasingly addressing behavioral health. For example, researchers have found that based on a sample of 109,898 PCP visits, those that addressed behavioral health concerns was 15.9% in 2016 and 2018, which is an increase from 10.7% in 2006 and 2007 (Rotenstein et al., 2023). Other research places the estimate as potentially high as 75% when including all types of behavioral health (Robinson & Reiter, 2016). These and other similar findings, as well as the high and increasing demand for behavioral health services according to the American Psychological Association's (APA) 2022 COVID-19 Practitioner Impact Survey, have prompted an ongoing push toward the integration of behavioral health in primary care. In this paper, the term "integrated primary care" is also known as "integrated behavioral health" or "primary care behavioral health" which combines medical and behavioral health services in a collaborative way during primary care visits (Agency for Healthcare Research and Quality, 2020). The PCP and the behavioral health consultant (BHC) work together with patients and families to address behavioral health (i.e., mental health and substance use issues) as well as behaviors that impact physical health conditions (e.g., chronic pain, diabetes, obesity). Integration of primary care behavioral health into primary care clinics has also been shown to address needs of marginalized communities that may not have access to behavioral healthcare (Bridges et al., 2015; Dueweke & Bridges, 2018).

Because many receive their behavioral health care from their PCP, and nearly half of those who die by suicide see their PCP within the month leading up to their death, integrated primary care clinics and the team-based care approach to primary care are uniquely positioned for suicidality assessment and prevention. However, there are no agreed upon standards and practices for screening for, documenting, or using information about suicidality in PCP visits.

Suicidality in Primary Care

It is widely agreed that suicidality and suicide risk should be thoroughly documented when discussed in a primary care visit, as documentation is imperative in facilitating and organizing patient care, especially when a patient care team has multiple providers (Stanley et al., 2019). There is a lack of agreement on the structure of this discussion, such as when and with whom it should take place. Currently there is a debate surrounding universal suicide screening (Runnels, 2023) with many advocates of implementing universal suicide screening in primary care (Goldstein Grumet & Boudreaux, 2023) and others who argue there is insufficient evidence to implement universal screening, thus PCPs should opt for indicated or selected screening (Bryan et al., 2023).

Proponents of universal screening offer evidence of increased opportunity to identify suicidal patients, improved detection of suicidality, and better use of follow-up interventions to reduce risk (Goldstein Grumet & Boudreaux, 2023). Furthermore, one study showed that universal screening can lead to cost savings in emergency departments (Dunlap et al., 2019), and in studies regarding pediatric universal screening, patients were supportive of the practice (Ross et al., 2016) and no iatrogenic effects were found (DeCou & Schumann, 2017).

Conversely, in a review of 86 articles covering 56 studies, O'Connor et al. (2013) concluded there are no clear positive or negative effects of universal screening and the instruments used have poor positive predictive power. In primary care there is a lower incidence of suicidal behavior (<1%) than in emergency departments (1% to 8%), the setting in which most of the research on universal screening has been conducted (Belsher et al., 2019). The low incidence of suicidal behavior in primary care makes diagnostic validity of screening measures difficult to ascertain, leading to potential false positives.

An additional point of contention Bryan and colleagues (2023) outlined against universal screening was the inaccessibility of evidence-based behavioral health services following a positive screen. This issue may be accounted for by team-based care, specifically integrated primary care behavioral health services. For example, in clinics with high levels of integration such as the clinic sampled for the current study, BHCs are available for same-day visits and can provide evidence-based treatments (e.g., cognitive behavioral therapy, acceptance-based interventions).

Some primary care clinics have opted to implement universal screening. One clinic found that post-implementation of universal screening, including a standardized note template, staff nurse's documentation of suicidality, mental health referrals, and mental health appointments scheduled significantly increased (Frick et al., 2021). Similarly, another study by Sherman et al. (2018) found that implementing a standardized note template increased documentation of suicidality from 57% to 78% following use of the standard note, then to 82% at follow-up. Therefore, though the recommendation to use universal screening is under debate, and use of a standard protocol at primary care clinics can improve detection of suicidality and help connect patients to follow-up behavioral health care.

Documentation is a pivotal part of all suicidality protocols, whether universal or indicated screening. In 2019, Stanley et al. wrote that documentation is a core clinical competency, and there is a lack of training in how to do this effectively for suicidality and suicide risk. Findings for both Frick et al. (2021) and Sherman et al. (2018) indicated that documentation can be improved with the correct support, which is commensurate with Foronda et al. (2016), who reported standardized tools may be effective in improving communication and care.

Finally, within interprofessional settings, communication between providers, particularly providers from different disciplines, is a vital part of patient care (The Joint Commission, 2023). Using variable formats to document important information within the same clinic may lead to miscommunications amongst providers and negatively affect patient care, pointing to the need for a standard practice when addressing life threatening concerns such as suicidality (Funderburk et al., 2020; Xierali et al., 2013).

Gaps in the Literature

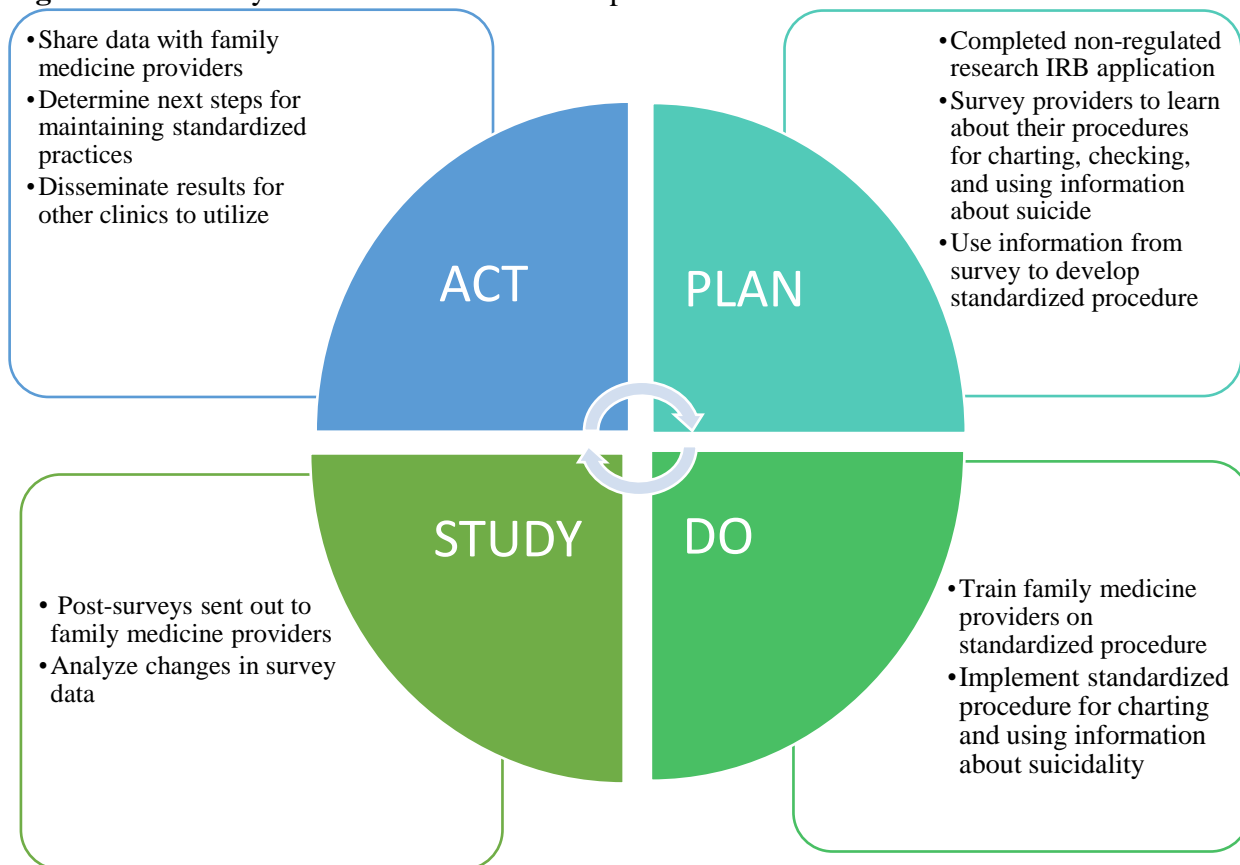
Beyond the lack of agreement on whether universal screening is the correct approach to suicidality, suicide remains a risk to the United States population, and primary care is a common point of contact for those who die by suicide. The lack of consensus among professionals about the most effective way to go about assessing for, documenting, and using information about suicidality in visits may lead to confusion and patients not receiving the care they need.

A second gap in the literature is inadequate research with integrated care clinics. With primary care clinics moving towards higher levels of integration, it is imperative that more studies are conducted in integrated settings, especially to shed light on how to effectively operate in interprofessional contexts. Additionally, in 2023 the Accreditation Council for Graduate Medical Education (ACGME) required Family Medicine programs to include integrated behavioral health in primary care in the core curriculum. Studies such as the current one will be necessary for improving the integration of behavioral health care into the landscape of patient care and clinical training.

Current Study

The current research attempted to address gaps in the literature by conducting an exploratory study to justify future research, provide information about practices in one integrated primary care clinic, and offer a template for other clinics to conduct similar quality improvement (QI) projects to improve assessment, documentation, and use of information about suicidality in primary care visits. Though not intended to be generalizable for larger populations, this information may rationalize continued research in the field about a standardized approach to suicidality in primary care visits, leading to more comprehensive care for suicidal patients in integrated primary care settings, and ideally impacting the rates of suicide in the United States.

The study utilized the Plan-Do-Study-Act (PDSA) cycle (Del Castillo, 2022). Based on the Shewart cycle, popularized by Edward Deming, and considered by many in the public health field to be an “excellent foundation for quality improvement,” the PDSA cycle relies on the principles of the scientific method to make healthcare systems more effective and efficient (Gorenflo & Moran, 2010, p. 1). The current study is a component of the “plan” part of the cycle, which includes defining the problem, describing the current process, collecting data on the current processes, identifying potential improvements, developing an improvement theory, and developing an action plan. The problem identified for the current study is a lack of standardized procedure for screening for, documenting, or using information about suicidality in PCP visits. The data collected provides information about the current process, and the discussion highlights potential improvements.

Figure 1: PDSA Cycle and Plan for Future Steps

Note. Figure outlines steps taken and future proposed steps for the PDSA cycle for the overall project. The current research comprises the Plan phase and informs the Do, Study, and Act phases.

Methods

Participants

Participants in the current study ($N = 28$) were residents, faculty, and trainees in an outpatient Family Medicine residency clinic in a large urban area in the Southern United States. Participants were recruited through an interoffice email asking them to complete a short survey. The sample was evenly split between attending physicians and trainees, with 46.4% ($n = 13$) being Family Medicine faculty, 37.5% ($n = 12$) being Family Medicine residents, and 10.7% ($n = 3$) being behavioral health trainees. Most participants identified as women (78.6%, $n = 22$) and White (67.9%, $n = 19$). Nearly half the sample identified as Hispanic or Latino (46.4%, $n = 13$). This sample represents a larger percentage of White and Hispanic Family Medicine practitioners than national figures from 2015-2019, however this was expected given the demographics of the location and patient population of the clinic (Jabbarpour & Westfall, 2021).

Table 1. Participant demographics

	Percent (n)
Position	
Family Medicine Faculty	46.4% (13)
Family Medicine Resident	37.5% (12)
Behavioral Health Consultant trainee	10.7% (3)
Gender	
Woman	78.6% (22)
Man	17.9% (9)
Self-described	3.6% (1)
Race	
White / European American	67.9% (19)
Asian	17.9% (9)
Black / African American	3.6% (1)
Native Hawaiian / Other Pacific Islander	3.6% (1)
Other	10.7% (3)
Ethnicity	
Hispanic / Latino	46.4% (13)

Note. N = 28. Survey was sent to 67 clinicians. Response rate was 41.79%

The sample size is small and restricted to one clinic because it is the exploratory first step for the Plan phase of the PDSA cycle. Larger data sets would be collected following the Act part of the cycle when considering applying the findings to other clinics and systems. The current data are foundational to those future steps.

Measures

The survey participants completed was created by the authors for the current study. The instrument was developed to determine current practices in the clinic regarding suicidality in visits. First, participants provided demographic information. Next, there were forced choice questions (yes, no, sometimes) for chart checking, documenting, and using information about suicidality in visits followed by various follow-up close- and open-ended questions depending on the participant's answer. Questions about what information was collected and where that information was documented were in the form of checklists. Percentages of times checked or documented were entered with free text, and influences on the decision to check or ask about suicidality were open-ended. The structure of the survey was based on previous QI research (e.g., Golden, et al., 2023) and developed to obtain information specific to the PDSA cycle and the goals of the current project, namely, to improve assessment, documentation, and use of information about suicidality in PCP visits.

Procedure

Participants were recruited through an interoffice email asking them to complete a short survey. The survey was sent electronically to 22 resident faculty and 45 residents and

trainees through the residency listserv in Fall 2022. Twenty-eight (41.79%) clinicians responded. All data were collected using Qualtrics, an online survey platform. All procedures were approved by the hospital's institutional review board (#20220829NRR).

Results

Descriptive analyses were completed to assess participants' responses. Frequency analyses were conducted for all multiple-choice items. Open-ended items were categorized by the first author, and frequency analyses were completed for those categorizations.

Chart Checking

Of the 28 clinicians surveyed, 21.4% ($n = 6$) reported that they always check their patients' chart for suicidality, 21.4% ($n = 6$) reported they do not check, and 57.1% ($n = 16$) reported that they sometimes check. Of those who indicated that they seek out information about suicidality during chart checking, they find that information in the problem list, Family Medicine notes, inpatient hospital notes, BHC notes, psychiatry notes, and using the search feature. Over half of providers who checked charts for suicidality reported looking at information within the past 12 months (57.2%, $n = 16$). Of those who selected "sometimes," the number of times they check charts for suicidality was typically 50% or less.

Table 2. Survey Responses

When chart checking prior to a visit, do you look for a history of suicidality?	
Yes	21.4% (6)
Sometimes	57.1% (16)
No	21.4% (6)
Where do you look in the chart to find a history of suicidality?	
Problem List	46.4% (13)
Family Medicine notes	53.6% (15)
Inpatient Hospital notes	21.4% (6)
Behavioral Health Consultant notes	57.1% (16)
Psychiatry notes	50.0% (14)
Search feature	3.6% (1)
When you are charting suicidality and suicide risk, where do you document that information in the chart?	
Body of Note	85.7% (24)
Problem List	32.1% (9)
Where in your note do you put that information?	
Assessment and Plan	67.9% (19)
History of Presenting Illness	21.4% (6)
Mental Status	10.7% (3)

Note. $N = 28$. Survey was sent to 67 clinicians. Response rate was 41.79%

Participants who reported they sometimes check charts for suicidality were asked to report what influences their decision to check. These responses were categorized. The most common influences for checking patients' charts for suicidality participants reported were diagnoses ($n = 7$; e.g., "history of psychiatric disorder"), reason for the visit ($n = 4$; e.g., "concern for suicidality"), and medications ($n = 2$; e.g., "use of antidepressant"). Reasons for not chart checking for suicidality were not assessed.

Documenting

When charting a visit, providers generally reported that they added that information to the body of their note, specifically in the history of presenting illness (HPI; 25.0%, $n = 7$) and assessment/plan (67.9%, $n = 19$). A smaller percentage reported that they document that information in the problem list (32.1%, $n = 9$). The three participants who reported that they documented suicidality in the mental status were the clinic's three BHC trainees. None of the family medicine residents or faculty reported documenting suicidality in the mental status. While the subsamples are too small for inferential analyses, this discrepancy in frequencies is notable within this sample.

Suicidality in Visits

When asked if they discuss suicide risk with patients during a visit if suicidality is found in the patient's chart, ($n = 11$) of providers reported yes, 14.3% ($n = 4$) reported no, and 35.7% reported sometimes ($n = 10$). Those who indicated they sometimes address suicidality in visits were asked to indicate the percentage of visits in which they address it. Results found the amount of times suicidality was addressed was typically 50% or less. See Table 2.

Those who indicated they sometimes addressed suicidality in visits were then asked what would influence their decision to discuss suicidality with their patient. Their open-ended responses were categorized. The most common reasons providers reported for discussing suicide and suicidality was what the patient says in the visit ($n = 5$; e.g., "they are saying things concerning for depression"), patient affect ($n = 3$; e.g., "affect appears down"), chart checking ($n = 2$, e.g., "I see something in the chart check"), and medication ($n = 2$; e.g., "going through medications with the patient").

Discussion

The current study aimed to conduct an exploratory study to assess current practices of checking for, documenting, and using information about suicidality in PCP visits in a Family Medicine residency clinic in order to provide foundational information for the Plan stage of a PDSA cycle QI project and justify future research. The goal of the overall project is to improve services for suicidality, as there is not a standard approach to suicidality in integrated primary care clinics.

Consistent with previous QI literature about suicidality in primary care (e.g., Frick et al., 2021; Sherman et al., 2018), the results showed discrepancies in how frequently practitioners check for suicidality while chart checking, where that information is documented, and how that information is used in visits. Furthermore, there was a notable difference between practices for Family Medicine practitioners and BHCs, specifically in where information about suicidality is documented.

Though we were unable to assess this difference using inferential statistics, it is indicative of different protocols for different disciplines within the clinic. Integrated primary care clinics are uniquely positioned to provide more complete behavioral health services than non-integrated clinics. However, disciplines documenting vital health information differently may cause confusion or miscommunication and lead to visits that do not address serious behavioral health concerns (Funderburk et al., 2020; Xierali et al., 2013). This claim is commensurate with a large amount of research connecting interprofessional miscommunication to poor patient outcomes (The Joint Commission, 2023). Therefore, the results point to the importance of a standard protocol for practitioners of all disciplines (e.g., physicians, physician assistants, BHCs, pharmacists) to improve team-based care in integrated primary care clinics. This conclusion is supported by a review of interprofessional communication in healthcare by Foronda et al. (2016) which found that standardized tools can be effective in improving communication and, in turn, improving care in interprofessional settings.

The findings of the current study provide the information necessary for the Plan stage of the PDSA cycle. Based on these findings, standardized training and tools can be developed to implement in the clinic for the Do stage. The findings may also be useful for other integrated primary care clinics looking to begin their own PDSA cycle to address the issue of suicidality. There is still disagreement in the field about implementing universal screening and what the best approach to address suicidality should be (Runnels, 2023). Therefore, at this point in time, clinics are responsible for finding the approach that is most effective for their providers and patients.

Interprofessional Implications

In describing a team-based approach to primary care, the current study highlights that in the absence of a standard protocol for asking about, documenting, and using information about suicidality, it is possible that providers of different disciplines in the same clinic operate differently. This may stem from variable training, visit focus, time constraints, or a combination thereof. No matter the origin, these differences may lead to miscommunication, which in turn affects care. Thus, it may behoove integrated primary care clinics to implement and test a standardized practice in order to improve patient care, specifically for the serious issue of suicidality, in order to improve patients' behavioral health care.

Limitations and Future Directions

Though the findings are important for the PDSA cycle and can inform QI projects for other clinics, there are several important limitations to discuss. First, the findings are not considered to be generalizable, as the sample only represents one clinic. Therefore, the findings must be viewed within this context. Future studies may focus on sampling an array of integrated primary care clinics to better describe practices of the population.

A second limitation is the uneven demographic samples that preclude inferential analysis of the group differences. It would be valuable to know if there are demographic factors of the providers (e.g., race, gender, position in the clinic, discipline, training) associated with how they address suicidality with their patients. This limitation precludes a more comprehensive discussion of how diversity-related issues impact how PCPs address suicidality. Future studies would benefit from collecting more data to assess these potential differences, specifically the difference in documentation practices between physicians and

BHCs when working with marginalized populations (Bridges et al., 2015; Dueweke & Bridges, 2018).

In a similar vein, the lack of information about the patient population is an additional limitation. It would be helpful for future studies to assess how patient characteristics (e.g., race, gender, chronic diseases, presentation) affect how providers address – or don't address – their suicidality. This information would also be imperative for a holistic assessment of how diversity in the patient population impacts care for suicidality. As a later part of the PDSA cycle, namely the Study phase, changes to patients' care as well as patients' experience of the suicidality protocol may be assessed and considered as the protocol is improved.

Finally, the current study represents the first phase of a four-step QI cycle. Future studies can be completed at each step to provide comprehensive information about the entire PDSA cycle from start to finish. See Figure 1 for details about the full PDSA cycle for the current project.

Conclusions

The current study, though exploratory in nature, provided foundational information for the Plan phase of a PDSA QI project aimed at improving care for suicidality in integrated primary care. Data collection assessed how practitioners in an integrated primary care clinic check for, document, and use information about suicidality in PCP visits. Findings revealed varying practices in all three areas, with a notable difference between Family Medicine physicians and BHCs. These findings are consistent with previous literature and have implications for interprofessional healthcare settings, as implementing a standardized procedure for addressing suicidality in primary care can improve care for this serious issue.

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