Maryland eNewsletter

beacon health options

March 2018

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Welcome to Beacon Health Options Provider Newsletter

Suicide and Suicide Prevention

Our December 2017 Provider eNewsletter fall reflection reviewed the unfortunate suicide deaths occurring in the United States (Beacon Maryland Provider eNewsletter, 2017, p. 1). On behalf of Maryland's Zero Suicide Implementation Team, Beacon's in office newsletter highlight Maryland's suicide statistics (https://afsp.org/), musicians with lyrics to their personal struggle and thoughts of suicide (https://www.cnn.com/2018/02/03/us/logic-grammys-performance-suicide-prevention-calls-trnd/index.html), and training and resources for Beacon staff to handle incoming crisis calls. On a national level, with millennia of religious and philosophical background, suicide is today also a public and mental health priority.

According to the CDC, 42,773 Americans died of suicide in 2014, vastly outnumbering the number of homicides at 15,809, and placing it among the country's top 10 causes of death. Views regarding its treatment have evolved over the years. We now have an evidence base to support treating suicide as a condition in its own right, rather than focusing on treating co-occurring conditions.

Definition

Suicide is the act of deliberately killing oneself. Suicidal behavior is a complex set of actions ranging from suicidal ideation, planning and attempting.

A. Epidemiology: Suicide may occur at any age, but it is rare in children under (APA, 2013). Males are at a much higher risk – out of the 42,773 suicides in 2014, 33,113 were by males – though women attempt it more frequently. The US suicide rate stands at 13.4 per 100,000 population, which is above the world average of 11.4, and it varies across states. The suicide rate also varies by country. Regarding service utilization, in the month prior, almost half (45%) of people who die from suicide visited their primary care physician (PCP), but only a fifth (19%) visited mental health services.

B. Risk factors and comorbidities: One method to study completed suicide by psychological autopsies, and one paper divided the risk factors into demographic, stressful life events, and psychiatric diagnoses. Compared to those dying of natural causes, those dying of suicide are more likely to be male, Caucasian, and divorced, separated or widowed; suicide completers were also more likely to meet criteria for a depressive disorder a substance use disorder, as well as experience interpersonal difficulties during the six months prior to their death. Other strong correlates are diagnoses of bipolar disorder and schizophrenia; family history of suicide; and the absence of behavioral health care. For teens, bullying victimization has been associated with suicide risk.

Diagnosis

The *DSM-5* included among the "Conditions for Further Study" the following criteria for Suicidal Behavior
Disorder:

A. Within the last 24 months, the individual has made a suicide attempt.
B. The act does not meet criteria for non-suicidal self-injury – that is, it does not involve self-injury directed to the surface of the body undertaken to induce relief from a negative feeling/cognitive state or to achieve a positive mood state.
C. The diagnosis is not applied to suicidal ideation or to preparatory acts.
D. The act was not initiated during a state of delirium or confusion.
E. The act was not undertaken solely for a political or religious objective.

Specify whether:

- Current: Not more than 12 months since last attempt
- In early remission: 12-24 months since last attempt
- Screening: Two scales are available to screen for suicidal behavior, the Columbia Suicide Severity Rating Scale (C-SSRS) and the Suicide Assessment Five-Step Evaluation and Triage (SAFE-T).

"When we seek to discover the best in others, we somehow bring out the best in ourselves" William Arthur Ward

We Need To Talk About Suicide

Treatment

A. Psychopharmacology: There are no medications indicated for suicidal behavior. However, lithium, clozapine, and some antidepressants have been shown to reduce suicide risk.

B. Psychotherapy: Dialectical Behavior Therapy (DBT) is considered the most effective evidence-based psychotherapy for suicidal behavior. DBT was originally designed for suicidality in borderline personality disorder and is now recommended more generally. Compared to other non-behavioral psychotherapies, DBT is uniquely effective at reducing suicide attempts and increasing engagement with services. Cognitive Behavior Therapy for Suicide Prevention (CBT-SP) is a tailored version of CBT, specifically for individuals with suicidal thoughts and behaviors. Among people who recently tried to take their own lives, those receiving CBT-SP were 50% less likely to try again within 18 months com pared to those in usual care.

C. Implementation strategies for evidenced-based practices: Non-demand caring contacts, such as check-in phone calls or text messages, have been shown to reduce suicide rates. Additionally, the Collaborative Assessment and Management of Suicide (CAMS) therapeutic framework promotes collaborating with suicidal patients to improve engagement and to empower them as a partner in designing their own care plan, particularly a safety plan. Brief educational interventions, such as a one-hour, individual informational session combined with regular, long-term follow-up, have also been shown to reduce suicide deaths.

D. Suicide prevention strategies: The National Strategy for Suicide Prevention was released in 2012 with four directions: healthy and empowered individuals, families, and communities; clinical and community preventive services; treatment and support services; and surveillance, research and evaluation. This document builds on successful experiences both nationally – the US Air Force Suicide Prevention Program, for example – and internationally – such as the nine suicide prevention recommendations implemented by the UK public sector mental health service, which are as follows:

1. Providing 24-hour crisis teams
2. Removing ligature points (materials that could be used for suicide).
3. Conducting follow-up with patients within 7 days of discharge.
4. Conducting assertive community outreach, including intensive support for those with severe mental illnesses
5. Providing regular training to frontline clinical staff on the management of suicide risk
6. Managing patients with co-occurring disorders (mental and substance use disorder)
7. Responding to patients who are not complying with treatment
8. Sharing information with criminal justice agencies
9. Conducting multidisciplinary reviews and sharing information with families after a suicide

This National Strategy also led to the development of the Zero Suicide concept that holds that suicide deaths for individuals under care within health and behavioral health systems are preventable.

Continue...

We Need To Talk About Suicide

Summary and Takeaways

Suicide is tragically common but also mostly preventable and treatable. Measures can be taken at the individual level, at the health systems level, and at the social/community level to decrease its incidence.

Questions for Clinical Discussion

A. A year ago, a fascinating study found a significant increase in mortality, accounted in part by increase in suicide, among middle-aged, white non-Hispanic adults in the United States between 1999 and 2013. What factors could explain this increase?

B. What can be done to decrease suicide risk in the period post-discharge of psychiatric hospitalizations given we know this is a high-risk time?

C. A recent opinion in *JAMA* showed a correlation between the decline in psychiatric beds and the increase in the US suicide rate. How should we interpret these results in light of the National Strategy for Suicide Prevention priorities?

Key References and Resources for Further Information

The National Suicide Prevention Lifeline Phone Number is 1-800-273-8255. There are practice guidelines for the assessment and management of suicidal behaviors by the APA and the NHS/NICE. The VA/DoD has its clinical practice guideline for patients at risk for suicide here. SAMHSA has a collection of tools and initiatives on suicide prevention. Beacon's 2017 White Paper is on suicide prevention and the Zero Suicide initiative.

References

APA. (2013). *DSM-5*. Washington, DC: American Psychiatric Association Press.

Maryland State Hotline—Suicide Prevention Resources

Text:	741741
Apps:	"There is Hope" and "Suicide Safe"
Phone:	1-800-273-TALK (8255) National Suicide Prevention Lifeline
	1-800-422-0009 Maryland State Hotline
Websites:	www.afsp.org (American Foundation for Suicide Prevention)

There is help to prevent suicide

If you need help or want to get involved, contact the National Suicide Prevention Lifeline

"One of the secretes of life is to make stepping stones out of stumbling blocks." Jack Penn

Quality Management

Beacon Health Options and the Quality Department are involved in several initiatives related to suicide prevention.

Creating a Zero Suicide Implementation Team – We have established a team of individuals from different departments in Maryland who are committed to the zero suicide initiative. The team conducted a baseline survey in December to learn more about our staff's understanding of suicide and to identify training needs. In January, we launched an internal monthly Zero Suicide Newsletter highlighting suicide statistics, increasing awareness of suicide prevention resources, and promoting training opportunities. The January issue also included key results from the December staff survey.

Problem gambling and suicide awareness – March is Problem Gambling Awareness Month. The National Council on Problem Gambling (NCPG) estimates that one in five individuals with gambling addictions will attempt suicide, which is twice the suicide rate of individuals with other types of addictions. Recognizing gambling addiction is a risk factor and conducting suicide screening and assessments is extremely important. Beacon will be collecting data on the utilization of gambling services and potential outcomes. The Maryland Center of Excellence on problem gambling offer free webinar trainings designed to provide additional clinical training on a variety of topics. The webinars are offered once a month and awards one CEU for each webinar. For more information, please visit URL http://www.mdproblemgambling.com/webinars-2/.

Follow-Up After Hospitalization Phone Calls – Many studies have shown that suicide risk after discharge from psychiatric inpatient care is high. Beacon, in line with industry best practices, makes outreach phone calls to many consumers after a discharge from an inpatient hospital stay. The support specialist inquires about how the consumer is doing, if they have a follow up appointment scheduled, and will help schedule a follow-up appointment if needed. Beacon believes this initiative will have a positive impact to help individuals during this critical post discharge time.

Program Integrity

Treatment Plans – More Than a Requirement

One of the COMAR requirements for all levels of care and a component of a Beacon audit, is the presence of an individualized treatment plan. Whether it is called a care plan, treatment plan, a recovery plan, or a rehabilitation plan; the underlying intent of these plans is to improve the consumer's overall functioning and reduce risk. These plans should be based on a comprehensive assessment of the consumer's needs. The plan should map out goals, objectives, interventions and the associated timeframes for each. Not only is a good treatment plan required, but it can lead to better collaboration and more positive outcomes for the consumer. According to the Suicide Prevention Resource Center and the Zero Suicide Model (https://zerosuicide.sprc.org/) developing a good treatment plan is one way to reduce suicide risk.

Continue....

"When we change the way we see things, the things we see will change." Wayne Dyer

Suicide risk, as well as other types of risk, should always be assessed and included in care plans when indicated. It is important for all providers to reliably implement their treatment plans, continually reassess the consumers, and revise the treatment plans as required. Recognizing when a consumer may need a higher level of care or when suicide risk is elevated is also essential to preventing suicide.

Provider Relations

The new Medicaid **electronic Provider Revalidation and Enrollment Portal (ePREP)** is live! ePREP is the one-stop shop for provider enrollment, Re-enrollment, revalidation, information updates and demographic changes. Before entering ePREP, providers and/or their credentialers should visit the Department's ePREP's information page at health.maryland.gov/ePREP. To sign up in ePREP, visit ePREP.health.maryland.gov.

All existing Medicaid providers and new applicants must first sign up to create a User Profile and Business Profile before taking action within ePREP. For more information please review the following Provider Alert. If you experience any issues or need assistance, please call Medicaid's Provider Enrollment Helpline at **(844) 463-7768.**

Applied Behavior Analysis

The Maryland Engagement Center's Applied Behavior Analysis (ABA) team is excited to see the number of members accessing these services, throughout the state, continue to grow! We continue to receive calls from families seeking services for their children on a daily basis. In an effort to support both our providers and members, Beacon has designed a Referral Availability Survey that will be sent to providers monthly.

In this document, we will highlight the areas and times with the most members waiting for an ABA provider. This document should be utilized to keep us updated on your staffing areas. However, this can also be utilized to identify growth opportunities for your business. We encourage you to use this information when recruiting new staff. If you are consider hiring staff in an area that you do not currently serve, please email us at abamarylandproviderrelations@beaconhealthoptions.com to share this information. We may have members waiting for a provider in that area. We currently have the highest percentage of members waiting for services in Southern Maryland, especially Prince George's and Montgomery Counties.

Interested in Being a Provider?

To learn more about becoming an ABA provider, please visit our website at: http://maryland.beaconhealthoptions.com/autism/autism-info.html.
We also invite you to contact Josh Carlson, Manager of Provider Partnerships for ABA Services, by emailing: abamarylandproviderrelations@beaconhealthoptions.com

"Believe in yourself and all that you are. Know that there is something inside you that is greater than any obstacle."
Christian D. Larson

Beacon Lens

The Beacon Lens is a blog from Beacon Health Options. The focus of the blog is on rapid response to the most pressing and controversial issues in behavioral healthcare today.

- Probe the system to improve opioid use disorder treatment
- Serious mental illness and cancer: Treatment outside the box
- Stronger support for Americans who risk their lives for ours: Changes for veterans
- The Kennedy Forum Illinois: Mental health justice

Maryland Highlights

Beacon Health Options welcomes new Medical Director, Drew Pate, M.D.

Drew A. Pate, M.D., has been affiliated with Beacon Health Options since 2007 serving as the Medical Director for various regional and state health plans, as well as the medical professional supporting ABA Services and the Psychopharmacology Drug Initiative Program. He previously served as the Medical Director for the Mann Residential Programs and School at Sheppard Pratt Health System in Maryland, and he is a member of the Board of Trustees for the Brattleboro Retreat in Brattleboro, Vermont. He has also served as a physician surveyor for The Joint Commission, and is dually board certified in Psychiatry and Child and Adolescent Psychiatry.

March is Gambling Awareness Month!

On January 1, 2018 the Behavioral Health Administration (BHA) began reimbursement to substance use disorder (SUD) providers treating problem gambling through Beacon Health Options. The following providers are eligible for reimbursement:

- Ambulatory SUD programs for Level 1 (including OTPs) and Level 2.1
- Residential SUD programs for Level 3.3 and 3.5
- Outpatient Mental Health Clinics (OMHC)
- Federally Qualified Health Clinics (FQHC)
- Private Practitioners (either in a solo or group practice)

Providers must meet specific requirements for reimbursement. For more information please review Reimbursement for Problem Gambling Disorder Treatment Services (PDF), and please visit the Beacon Health Options website. Also, visit the MD Center of Excellence on Problem Gambling website to access the application.

Upcoming Webinars & Contact Information

ProviderConnect®

These webinars are designed to review the system and support the E-Commerce Initiative for network providers. To see a complete list of webinar training dates, please visit the following website http://maryland.beaconhealthoptions.com/provider/prv_trn.html.

Spring 2018 Webinars
Applied Behavioral Analysis Training
Provider Connect for Mental Health Providers
Provider Connect for Substance Use Disorder Providers
Supported Employment and the Core Service Agency
Supported Employment for the DORS Counselor
Provider Connect for PRP Providers
The Beacon System: Reporting for any Behavioral Health Provider
The Beacon System: Claims Processing for any Behavioral Health Provider
An Introduction to Intelligence Connect *(a tool for providers to generate reports)*

Contact Information	Phone #
Customer Service *(24-hour line)* *claims, eligibility & authorization inquiries*	(800) 888-1965
EDI Support *Username & passwords, direct claim submission inquiries,* *Reports & ProviderConnect® tech support*	(888) 247-9311
Applied Behavior Analysis (ABA) Josh Carlson, Provider Partnership Manager abamarylandproviderrelations@beaconhealthoptions.com	(410) 691-4067
Provider Relations Department marylandproviderrelations@beaconhealthoptions.com	(410) 691-1711
Maryland Reconsideration & Grievance grievances@beaconhealthoptions.com	(410) 691-4049
Maryland Department of Health (MDH) **Provider Enrollment** mdh.bhenrollment@maryland.gov Behavioral Health policy inquiries mdh.mabehavioralhealth@maryland.gov Telehealth inquiries mdh.telemedicineinfo@maryland.gov	(410) 767-5340