Implementation of a Standardized Depression and Suicidality Screening Tool in a Pediatric Emergency Department

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Background

- 4 in every 100,000 children ages 10-19 commit suicide every year.[1]
- Rady Children's Emergency Department saw 96,500+ patients in FY2017. 2,600 where behavioral health complaints, which is a year-to-year increase of over 20% per year.
- A need was identified for a standardized tool to screen all patients age 12 years and older for at risk behaviors of depression and suicidality.

Objectives

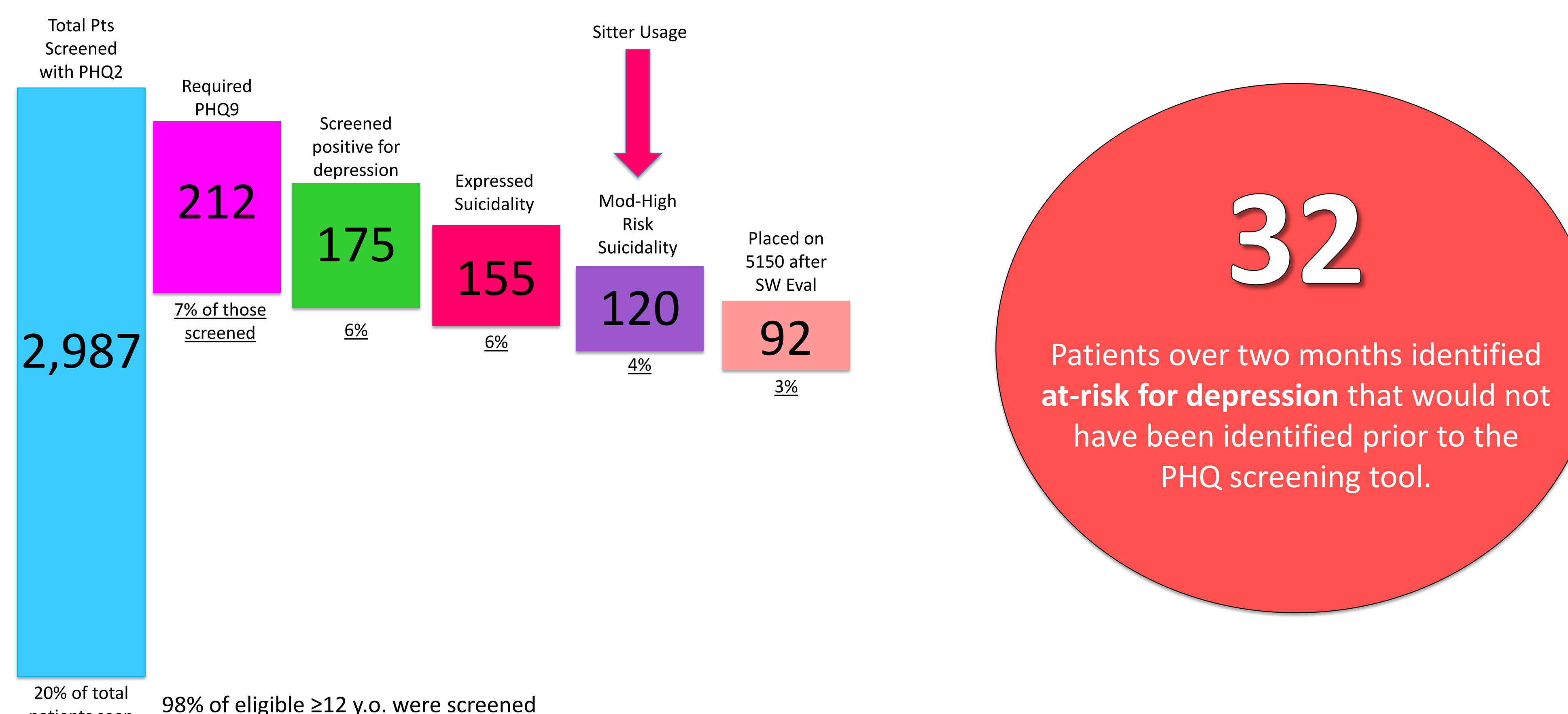
- Align with The Joint Commission National Patient Safety Goals and maintain compliance.
- Utilize a validated tool to screen patients.
- Implement safety precautions when necessary.
- Provide educational materials and community resources for patients who are at risk of "moderate to severe" (Score 10-19) depression.
- Decrease utilization of 1:1 sitters in the Emergency Department.
- Decrease percent of Social Work consults.

[1] Suicide Facts. (n.d.). Retrieved September 07, 2017, from https://save.org/about-suicide/suicide-facts/
[2] Kroenke K, Spitzer R, Williams W. The PHQ-P: Validity of a brief depression severity measure. JGIM, 2001, 16:606-616
[3] Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., . . . Mann, J. J. (2011). The Columbia–Suicide Severity Rating Scale: Initial Validity and Internal Consistency Findings From Three Multisite Studies With Adolescents and Adults. *American Journal of Psychiatry, 168*(12), 1266-1277.

Methods

- A committee was formed to oversee the implementation of the screening tool.
- The Patient Health Questioner (PHQ-9) and the Columbia Suicide Severity Rating Scale (CSSRS) were selected as the evidence based tools to screen patients for depression and suicidality.[2, 3]
- Worked with the hospital Epic builder to build the tool in Epic.
- Screening tool was introduced and education provided to the staff.
- Implemented "hard stop" when printing the AVS if screening not completed.
- Score-dependent "Best Practice Advisories"(BPA) were designed to advise staff what resources were needed for patients at risk for depression or suicidality.

Results: July – August 2017



Conclusion

- Successful implementation of the PHQ and CSSRS tools to screen all patients age 12 years and greater in the Emergency Department with 98% of eligible patients screened to date.
- Future improvement will include expansion of sitter usage tracking as it correlates to the CSSRS tool included with the PHQ-9.
- Additions will also include providing education/training to new employees during the on-boarding process.

EHR Tool

Patient Health Questionnaire (PHQ – 2): 2 Initial questions

Over the PAST 2 WEEKS- How often have you been bothered by

Feeling down, depressed, irritable or hopeless? — 0=Not at all | 1=Several Days

Having little interest or pleasure in doing things? — 0=Not at all | 1=Several Days | 2=More than Half the days | 3=Nearly every day | Temporarily Deferred- Patient Cognitively/Medically ... | Permanent inability to respond

Initial Screening Score (PHQ2)

(PHQ – 9): 7 Additional questions when indicated

Having trouble falling, or staying asleep, or sleeping too much? — 0=Not at all | 1=Several days | 2=More than half the days | 3=Nearly every day

Having a poor appetite, weight loss or overeating? — 0=Not at all | 1=Several days | 2=More than half the days | 3=Nearly every day

Having little energy? — 0=Not at all | 1=Several days | 2=More than half the days | 3=Nearly every day

Feeling bad about yourself- or feeling that you are a failure, or that you have let yourself or your family down? — 0=Not at all | 1=Several days | 2=More than half the days | 3=Nearly every day

Having trouble concentrating on things like school work, reading or watching television? — 0=Not at all | 1=Several days | 2=More than half the days | 3=Nearly every day

Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you were moving around a lot more than usual? — 0=Not at all | 1=Several days | 2=More than half the days | 3=Nearly every day

9 Thoughts that you would be better off dead, or of hurting yourself in some way? — 0=Not at all | 1=Several Days | 2=More than half the days | 3=Nearly every day

PHQ 9 Score

Columbia Suicide Severity Rating Scale (CSSRS): Lethality questions in response to question #9.

CSSRS: Suicidal Ideation - In the PAST MONTH

Have you wished you were dead or wished you could go to sleep and not wake up? — Yes | No

Have you actually had any thoughts of killing yourself? — Yes | No

Have you been thinking about how you might kill yourself? — Yes | No

Have you had these thoughts and had some intention of acting on them? — Yes | No

Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan? — Yes | No

CSSRS: Suicidal Behavior

Have you EVER done anything, started to do anything, or prepared to do anything to end your life? — Yes | No

How long ago? — Within the last 3 months? | Within 3-12 months? | Greater than a year ago?