Depression Screening & Suicide Prevention

Julie Rickard, PhD  
jrickard@charter.net  
Wenatchee, WA  
509-881-8193

U.S. Suicide Data

- 43,000 per year
- 13.5% per 100K
- 1 every 13 min
- 10th leading cause of death
Leading Causes of Death by Age

Table 1. Leading Causes of Death in the United States (2015)

<table>
<thead>
<tr>
<th>Rank</th>
<th>Select Age Groups</th>
<th>10-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-64</th>
<th>65-74</th>
<th>75+</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Unintentional Injury</td>
<td>763</td>
<td>12,514</td>
<td>19,795</td>
<td>17,818</td>
<td>43,054</td>
<td>116,122</td>
<td>633,642</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Malignant Neoplasms</td>
<td>428</td>
<td>8,891</td>
<td>6,747</td>
<td>10,509</td>
<td>43,054</td>
<td>116,122</td>
<td>633,642</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Suicide</td>
<td>409</td>
<td>4,743</td>
<td>4,683</td>
<td>10,087</td>
<td>23,439</td>
<td>159,041</td>
<td>661,531</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Malignant Neoplasms</td>
<td>156</td>
<td>1,669</td>
<td>1,724</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Heart Disease</td>
<td>937</td>
<td>5,822</td>
<td>2,895</td>
<td>6,751</td>
<td>14,163</td>
<td>140,323</td>
<td>610,561</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Congenital Anomalies</td>
<td>394</td>
<td>846</td>
<td>2,861</td>
<td>6,212</td>
<td>13,278</td>
<td>40,731</td>
<td>110,561</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Malignant Neoplasms</td>
<td>158</td>
<td>758</td>
<td>1,988</td>
<td>3,307</td>
<td>12,116</td>
<td>75,355</td>
<td>50,847</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Congenital Anomalies</td>
<td>202</td>
<td>202</td>
<td>758</td>
<td>1,988</td>
<td>3,307</td>
<td>12,116</td>
<td>75,355</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Influenza &amp; Pneumonia</td>
<td>154</td>
<td>529</td>
<td>1,005</td>
<td>2,542</td>
<td>5,774</td>
<td>43,959</td>
<td>50,847</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Congenital Anomalies</td>
<td>156</td>
<td>443</td>
<td>829</td>
<td>2,124</td>
<td>9,452</td>
<td>64,193</td>
<td>100,000</td>
<td></td>
</tr>
</tbody>
</table>

Data courtesy of CDC
Chelan & Douglas Counties - Suicide by Year

- Chelan
- Douglas
- Both
Suicide by Age Group

High Risk Groups

- Teens
- Veterans
- Seniors
- LGBTQQ

Vulnerable Populations
## Risk Factors for Suicide

<table>
<thead>
<tr>
<th>Personal Characteristics</th>
<th>Life Experiences</th>
<th>Physical &amp; MH</th>
<th>Personality &amp; Outlook</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Membership in a vulnerable group:</strong>&lt;br&gt; * Men &gt;45 yo&lt;br&gt; * Small/rural community&lt;br&gt; * AI/AN or White&lt;br&gt; * Participation in Military&lt;br&gt; * LGBTQQQ</td>
<td>Childhood trauma (ACEs), hx &amp; recent trauma</td>
<td>Mental illness</td>
<td>Hopelessness</td>
</tr>
<tr>
<td><strong>Loss:</strong>&lt;br&gt; ✓ Breakup / divorce&lt;br&gt; ✓ Job demotion / loss&lt;br&gt; ✓ Loss of fnx&lt;br&gt; ✓ Death in family/ community, esp by suicide&lt;br&gt; ✓ Loss of stability (identity, eviction, deployment of family, $, sex violence)</td>
<td>Substance use / abuse</td>
<td>Impulsivity</td>
<td></td>
</tr>
<tr>
<td><strong>Prev suicide attempts</strong>&lt;br&gt; Isolation&lt;br&gt; Barriers to accessing care (MH or PCP)</td>
<td>Traumatic Brain Injury (TBI)</td>
<td>Aggression</td>
<td></td>
</tr>
<tr>
<td><strong>Access to lethal means</strong></td>
<td>Stroke</td>
<td><strong>Feeling like a burden</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Family History:</strong>&lt;br&gt; * Mental Illness&lt;br&gt; * Phys / Sex Abuse&lt;br&gt; * Substance Abuse</td>
<td>Changes in phys/mental fxn:&lt;br&gt; ✓ illness&lt;br&gt; ✓ Disability&lt;br&gt; ✓ Chronic pain&lt;br&gt; ✓ Chronic illness&lt;br&gt; ✓ Terminal illness&lt;br&gt; ✓ Loss of limb/s</td>
<td><strong>Capacity for self-harm</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Loss:</strong>&lt;br&gt; ✓ Breakup / divorce&lt;br&gt; ✓ Job demotion / loss&lt;br&gt; ✓ Loss of fnx&lt;br&gt; ✓ Death in family/ community, esp by suicide&lt;br&gt; ✓ Loss of stability (identity, eviction, deployment of family, $, sex violence)</td>
<td>Stroke</td>
<td>Ruminaton on death</td>
<td></td>
</tr>
<tr>
<td><strong>Prev suicide attempts</strong>&lt;br&gt; Isolation&lt;br&gt; Barriers to accessing care (MH or PCP)</td>
<td>Changes in phys/mental fxn:&lt;br&gt; ✓ illness&lt;br&gt; ✓ Disability&lt;br&gt; ✓ Chronic pain&lt;br&gt; ✓ Chronic illness&lt;br&gt; ✓ Terminal illness&lt;br&gt; ✓ Loss of limb/s</td>
<td>Unwillingness to seek help</td>
<td></td>
</tr>
</tbody>
</table>

## Protective Factors

<table>
<thead>
<tr>
<th>Individual</th>
<th>Relationship</th>
<th>Community</th>
<th>Societal</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 or more children</td>
<td>Married if male&lt;br&gt; Divorced if female&lt;br&gt; Involved with support group</td>
<td>Engaged in a variety of activities&lt;br&gt; ✓ Church&lt;br&gt; ✓ Book clubs&lt;br&gt; ✓ Knitting / sewing&lt;br&gt; ✓ Online&lt;br&gt; ✓ Exercise</td>
<td>Restricted access to means&lt;br&gt; Others that note changes in behavior</td>
</tr>
<tr>
<td>Problem solving skills&lt;br&gt; Conflict resolution skills</td>
<td>Active engaged in life&lt;br&gt; Caring for children&lt;br&gt; Feeling loved / cared for&lt;br&gt; Friends</td>
<td>Issue of driving has been addressed if unable to drive&lt;br&gt; Sense being part of something</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td>Positive outlook</td>
<td>Actively engaged in life&lt;br&gt; Caring for children&lt;br&gt; Feeling loved / cared for&lt;br&gt; Friends</td>
<td>Sense being part of something&lt;br&gt; Being checked on&lt;br&gt; Being told nice things&lt;br&gt; Reminded you have value</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td>Good social supports</td>
<td>Feeling loved / cared for&lt;br&gt; Friends</td>
<td>Sense being part of something&lt;br&gt; Being checked on&lt;br&gt; Being told nice things&lt;br&gt; Reminded you have value</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td>Pets</td>
<td>Caring for children&lt;br&gt; Feeling loved / cared for&lt;br&gt; Friends</td>
<td>Sense being part of something&lt;br&gt; Being checked on&lt;br&gt; Being told nice things&lt;br&gt; Reminded you have value</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td>Religious beliefs against suicide</td>
<td>Online group participation if unable to get out</td>
<td>Sense being part of something&lt;br&gt; Being checked on&lt;br&gt; Being told nice things&lt;br&gt; Reminded you have value</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td>Lack of capacity for self-harm</td>
<td>Engaged in church&lt;br&gt; Others participate in medical appts</td>
<td>Sense being part of something&lt;br&gt; Being checked on&lt;br&gt; Being told nice things&lt;br&gt; Reminded you have value</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td>Unfinished business</td>
<td>Engaged in church&lt;br&gt; Others participate in medical appts</td>
<td>Sense being part of something&lt;br&gt; Being checked on&lt;br&gt; Being told nice things&lt;br&gt; Reminded you have value</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td>Working or a purpose</td>
<td>Engaged in church&lt;br&gt; Others participate in medical appts</td>
<td>Sense being part of something&lt;br&gt; Being checked on&lt;br&gt; Being told nice things&lt;br&gt; Reminded you have value</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td>Sense of independence</td>
<td>Engaged in church&lt;br&gt; Others participate in medical appts</td>
<td>Sense being part of something&lt;br&gt; Being checked on&lt;br&gt; Being told nice things&lt;br&gt; Reminded you have value</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td></td>
<td>Removing weapons / means</td>
<td>Checking on the person regularly</td>
<td>Access to help when needed&lt;br&gt; Cultural beliefs that discourage suicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No bullying&lt;br&gt; Strong sense of values&lt;br&gt; Stable political climate&lt;br&gt; Limited social media / news access&lt;br&gt; Caring connections with providers</td>
</tr>
</tbody>
</table>
Purpose of Screening

- Recognizing symptoms of depression
- Seeking treatment sooner
- Have high risk issues addressed
- Saving lives
- Helps label changes away from baseline you are seeing in the person

Screening is a MUST!

How often should I screen?

- SUICIDE SAFE CARE - recognizing when mood is worsening emotional or medical issues
- Scores can change visit to visit, week to week
- Patients coming in with a cold or pain can have unrecognized depression and/or suicidal thoughts
- Screening, when you actually tell the person WHY you are screening it is helpful...regardless of how often
- Once a year per CMS guidelines... ?? Once during each 4 month activity period or as clinically indicated for Care Coordinators...
Talking to Patients About the PHQ-9

**Script: In a medical setting**
We are asking patients to complete this screener on emotional wellness. Your provider will talk to you about the meaning of your scores during your visit.

**Script: In non-medical setting**
I have a questionnaire that I would like you to complete due to changes I have noticed in your mood. This will help us understand if there is something more we need to do about you (*being so sad, crying, being down*)...

PHQ - 9
Depression Screener

- Developed in 1994 as the PRIME-MD
- Now standard of care in Primary Care Practices across U.S.A.
- Based on the DSM-IV-TR
- Sensitivity (correctly identifies those with the disease) = 0.69/0.91.
- Specificity (correctly identifies those without the disease) = 0.84/0.80.
  - False positive rate was about 17%, false negative rate about 18%.

## PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

**NAME:**

**DATE:**

<table>
<thead>
<tr>
<th>Item</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>4. Feeling tired or having little energy</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>5. Poor appetite or overeating</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

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 at all

Somewhat difficult

Very difficult

Extremely difficult
Patient Complaints

- Unsure why they are completing the form
- No one talks to them about the form
- Form is difficult to understand
- Font is too small (I can’t read it)
- Things are bunched together
- Color of the form makes it difficult to see
## Depression Symptoms

<table>
<thead>
<tr>
<th>Emotional Symptoms</th>
<th>Physical Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadness</td>
<td>Fatigue / Tiredness</td>
</tr>
<tr>
<td>Loss of interest</td>
<td>Sleep disturbances</td>
</tr>
<tr>
<td>Anxiety / irritability</td>
<td>Headaches</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Psychomotor changes (restless)</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>GI upset</td>
</tr>
<tr>
<td>Guilt</td>
<td>Body aches</td>
</tr>
<tr>
<td>Suicidal thinking</td>
<td>Increased pain</td>
</tr>
</tbody>
</table>

## PHQ-9 Administration

- Ask the patient to complete the questionnaire
  - Patients tend to be more honest in responses
- Administer PHQ-9 when person is unable to see or read
  - When asking the questions. Try not to show judgment in their responses or coax them to respond differently
  - Voice should be slow & steady with well enunciated words
PHQ-9 Scoring

- Points from Q1-9 are added up for a total score
- Score of 10 or more indicates possible depression
- Scores on the lower end tend to cause less impairment in the individual, so less motivation to fix the issue
- Have handouts that you can discuss on depression
  - It is treatable and not something they must suffer with
- Offer a referral for proper assessment & treatment
- Document
- Follow up within 30 days or sooner (talk to supervisor on policy)

PHQ-9 Scores and Proposed Treatment Actions *

<table>
<thead>
<tr>
<th>Total PHQ Score</th>
<th>Depression Severity</th>
<th>Proposed Treatment Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>None / Minimal</td>
<td>None / Acknowledge things going well.</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild</td>
<td>PCP acknowledge &amp; discuss, watchful waiting, repeat PHQ-9 at follow up visit</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate</td>
<td>Treatment plan &amp; follow up, bring in Integrated Behavioral Health provider (if available), or refer to Specialty Behavioral Health, consider pharmacotherapy. PHQ every visit.</td>
</tr>
<tr>
<td>15-19</td>
<td>Moderately Severe</td>
<td>Urgent (same day) referral to Behavioral Health (Integrated BH Provider, if available*, or Specialty BH Department). Active treatment with pharmacotherapy. PHQ every visit, and psychotherapy.</td>
</tr>
<tr>
<td>20-27</td>
<td>Severe</td>
<td>Immediate initiation of pharmacotherapy, Urgent (same day) referral to Behavioral Health (Integrated BH Provider, if available*, or Specialty BH). PHQ every visit, every provider.</td>
</tr>
</tbody>
</table>

*From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32:509-521
Scores

- Scores are only helpful if you know what to do with them
- Two scores on the PHQ.
  - The depression score (Q1 + Q9 = Total Score)
  - Function Score (Q10 alone) - with level of depression how are they functioning?
- Make sure to normalize any score a person has.
  - Low score - It looks like you are doing really well and we will periodically give you this questionnaire just to check on how this is maintained.
  - High score - It looks like you have a high score. It is not uncommon for people with medical conditions or _____ to have periods of depression. What are your thoughts on getting you in to see your doctor to talk about this and see what can be done?

PHQ-9, Question 9 (Suicide Question)

- Ask clarifying questions or screen further.
- Call Designated Mental Health Provider (DMHP) if person can’t be safe or you are unsure or 9-1-1
- Who else needs to be notified (family, caregiver, providers)
  - You can break confidentiality due to risk of harm
- Locate DMHP’s in your area
  https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/state-mental-health-crisis-lines
- Consult with a supervisor
What Helps Depression?

- Walking 4x per week, 20 min per time
- Multi-vitamins (avoid iron unless specifically needed)
- Water - improves efficacy of medication
- Sleep - Helps cognitive function
- Eating - Helps everything when it is balanced
- Light - Lights in the home, getting outside in the sun, full spectrum lamps
- Exercise - Even small goals make big differences

What Helps Depression?

- Support
- Lack of secondary gain
- Stable housing
- Stable relationships
- Consistent care providers
- People they can talk to
- Music - not the sad sappy stuff
- Avoiding the news
- Mindfulness, meditation, prayer
Screening Further with CSSRS

- Any patient with a score on the suicide question of 1, 2, or 3 should be further screened using the **Columbia Suicide Severity Rating Scale (CSSRS)** to determine level of immanency and risk.
- This CSSRS screen allows you to not worry if you missed an important area to ask about.
- Anyone can ask about suicide.
- Only RNs, Master’s clinicians, PhD/PsyDs, MD/DO can also do treatment planning with the person.
  - Work within your scope of practice.
  - Work within your role or job description.

Columbia Suicide Severity Rating Scale

<table>
<thead>
<tr>
<th>Answer Questions 1 and 2</th>
<th>In the Past Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> Have you wished you were dead or wished you could go to sleep and not wake up?</td>
<td>YES</td>
</tr>
<tr>
<td><strong>2)</strong> Have you actually had any thoughts about killing yourself?</td>
<td></td>
</tr>
<tr>
<td><strong>2)</strong> If YES to 2, answer questions 3, 4, 5 and 6</td>
<td></td>
</tr>
<tr>
<td><strong>3)</strong> Have you thought about how you might do this?</td>
<td></td>
</tr>
<tr>
<td><strong>4)</strong> Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts but you definitely would not act on them?</td>
<td></td>
</tr>
<tr>
<td><strong>5)</strong> Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</td>
<td></td>
</tr>
<tr>
<td><strong>Always Ask Question 6</strong></td>
<td>In the Past 3 Months</td>
</tr>
<tr>
<td><strong>6)</strong> Have you done anything, started to do anything, or prepared to do anything to end your life?</td>
<td></td>
</tr>
</tbody>
</table>

Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, held a gun but changed your mind, cut yourself, tried to hang yourself, etc.

**Any YES must be taken seriously. Seek help from friends, family, co-workers, and inform them as soon as possible.**
If the answer to 4, 5 or 6 is YES, immediately ESCORT to Emergency Personnel for care.

Risk Rating

- **High Suicide Risk**
  - Suicidal ideation w/ intent or intent with a plan in past 1 mth (#4, #5) Or
  - Suicidal bx w/in past 3 mths

- **Moderate Suicide Risk**
  - Suicidal ideation w/ method, **without plan, intent, or bx** in past 1 mth (#3) Or
  - Suicidal bx more than 3 months ago Or
  - Multiple risk factors and few protective factors

- **Low Suicide Risk**
  - Wish to die or SI w/o method, intent, plan or bx (#1, #2) Or
  - No hx of self harm Or
  - Risk factors are modifiable & strong protective factors

Documentation

- Your Clinical Observation
- Relevant Mental Status Information
- Methods of Suicide Risk Evaluation
- Warning Signs
- Risk Indicators
- Protective Factors
- Access to Lethal Means
- Collateral Sources Used and Relevant Information Obtained
- Specific Assessment Data to Support Risk Determination
- Rationale for Actions Taken and Not Taken
Documentation for Suicidal Patients

- Document immediately on suicidal patients
  - Late or missing documentation does not get to be added in later if the person dies. Basically it doesn’t exist
- What is the level of perceived risk?
- What is the likelihood of them following through?
- Do your actions match your perception?

What can be done?

- Understanding what to do when someone is identified as suicidal
- Know warning signs & risk factors
- Know local resources
- Have a pathway to care developed to manage crises
  - Community partners
What can be done?

- Smooth transitions in services
  - Changing providers
- Means restrictions
  - Remove the means
  - Communicate risk even when it is low

What can be done?

- Advocate to make sure something is being done & you agree with the plan
  - Only ~50% of people that admit to suicidal thinking will have it addressed at a MH or PCP visit
  - People struggling can’t advocate
Questions
People get better when they access help that knows what to do!

Other Resources

Webinar on older adults and depression:


RCW 43.70.442 Suicide assessment, treatment, and management training—Requirement for certain professionals—Exemptions—Model list of programs—Rules—Health profession training standards provided to the professional educator standards board. (Effective until January 1, 2017.)

http://app.leg.wa.gov/RCW/default.aspx?cite=43.70.442
Other Resources (cont.)

1. Suicide facts. Suicide Awareness Voices of Education website.  
http://www.save.org/index.cfm?fuseaction=home.viewPage&page_id=705e50f4-055b-1f1bd-867e811b404c94

2. Substance Abuse and Mental Health Services Administration. Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings.  

3. Suicide and depression. Suicide Awareness Voices of Education website.  
http://www.save.org/index.cfm?fuseaction=home.viewPage&page_id=705e50f4-055b-1f1bd-867e811b404c94
Other Resources (cont.)


5. Administration on Aging highlights. Administration for Community Living website. 

6. Older Americans Behavioral Health. Issue Brief 4: Preventing Suicide in Older Adults. 
http://www.aoa.gov/AoA_Programs/HPW/Behavioral/docs2/Issue%204_Preventing%20Suicide.pdf

7. Beck Depression Inventory. Encyclopedia of Mental Disorders website. 
http://www.minddisorders.com/A-Br/Beck-Depression-Inventory.html

Tips for Managing the Holiday Blues

Link to short video: 
https://www.youtube.com/watch?v=REOPKqTYKeo

Link to NAMI website: 
Certificate of Completion
Assessment Screening Tools: Depression and the PHQ-9

Presented by
Dr. Julie Rickard, PhD
Physician and Healthcare Consulting, LLC
Wenatchee, Washington

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for Health Home Care Coordinators and Allied Staff

Training Credit of 1 Hour

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