iStock/monkeybusinessimages

Development of a Suicide Prevention Toolkit for VA Home-Based Primary Care Teams

The U.S. Department of Veterans Affairs Home-Based Primary Care program (HBPC) serves Veterans with multiple comorbid physical and psychological conditions that can increase suicide risk. HBPC teams are uniquely able to implement suicide risk assessment and prevention practices, and the team's mental health provider often trains other team members. An online suicide prevention toolkit was developed for HBPC mental health providers and their teams as part of a quality improvement project. Toolkit development was guided by a needs assessment consisting of first focus group and then data from surveys of HBPC program directors (n = 53) and HBPC mental health providers (n = 56). Needs identified by both groups included training specific to the HBPC patient population and more resources if mental health needs could not be fully managed by the HBPC team. HBPC mental health providers within integrated care teams play a key role in clinical intervention, policy development, and interprofessional team education on suicide prevention. HBPC teams have specific learning and support needs around suicide prevention that can be addressed with a feasible, easily accessible clinical and training resource.

Michelle E. Mlinac, PsyD, ABPP, Ronald W. Smith, PhD, Kevin J. Siffert, PhD, Luis C. Richter, PsyD, ABPP, Pamela L. Steadman-Wood, PhD, ABPP, and Julie L. Wetherell, PhD, ABPP

Suicide remains a leading cause of death in the United States, with older adults, especially men, having high rates of death by suicide compared with younger adults (Centers for Disease Control and Prevention, 2013). It is estimated that older white men aged 65 and up die by suicide at a rate of 48.7/100,000 people. With fewer suicide *attempts* by older men than younger people, it is likely that more lethal means are used (Conejero et al., 2018). Around 58.1% of Veteran suicides are by someone over the age of 55 (U.S. Department of Veterans Affairs [VA], 2018). The Veteran population had an adjusted suicide rate 2.1 times higher than non-Veterans in 2015, though the rate among older Veterans (75+) is lower than non-Veterans of the same age cohort (U.S. Department of VA). In light of these statistics, suicide prevention is a high priority both for community providers and within the VA (Karel et al., 2020; Sachs-Ericsson, 2019).

Factors that increase the risk of suicide in older adults include mental and physical illnesses, limited social connectedness (Fässberg et al., 2012), and stressful life events such as a loss or new illness (Rubenowitz et al., 2001). Although a diagnosis of major depression greatly increases risk (Conwell et al., 2011), physical illnesses have high base rates in older adults and may increase risk in aggregate or when the illness limits mobility, physical functioning, or interferes with completion of instrumental activities of daily living (Conwell et al., 2010). Older adults who died by suicide were more likely to be living alone (De Leo et al., 2013), whereas those connected with family reported less suicidal ideation (Purcell et al., 2012).

The suicide risk factors discussed above are common in medically complex older adults who often require care due to living alone and having difficulties with mobility or leaving the home, limiting access to outpatient care. Research suggests that suicidal ideation is high in this population, but many risk factors are treatable, highlighting the need for suicide prevention efforts (Raue et al., 2007). Transition to care from inpatient facilities to home is a particularly vulnerable time for such patients. One study showed that Veterans recently discharged from VA nursing homes back to home had an increased death by suicide rate within the first 6 months postdischarge, highlighting a need for follow-up and transitional care (McCarthy et al., 2013).

Home-Based Primary Care Model

One model providing comprehensive care to this population has been Home-Based Primary Care (HBPC). As implemented within the VA, HBPC is an integrated, interprofessional model of care provided in a patient's home that typically includes primary care providers, nurses, social workers, mental health providers (typically psychologists), dietitians, pharmacists, and rehabilitation therapists who provide longitudinal primary care for older adults with complex chronic illnesses and functional impairments. HBPC program directors (commonly nurses or social workers) serve alongside the HBPC medical director to ensure that HBPC staff are providing timely quality care. Each HBPC program encompasses one or more teams, often based on geographical coverage areas in their regions. Although each HBPC program has only one program director, they may have more than one mental health provider (covering distinct teams or geographic catchment areas within the program).

HBPC teams have several distinctions from community home-based primary care, namely mental health integration since 2007 and a funding structure that is independent of Medicare. Meanwhile, non-VA home-based primary care is growing and will likely continue to do so post-COVID, as recent studies have found improvements in patient quality of life and cost effectiveness (Cornwell, 2019; Schuchman et al., 2018). Non-VA models include Centers for Medicare & Medicaid Services' Independence at Home Demonstration Project that demonstrated strong results in its first 2 years and continues to expand (Rotenberg et al., 2018). Many models such as Medicare-funded temporary home care services do not often include a dedicated mental health provider, leading to trials of consult services for mental health needs (Reckrey et al., 2015) and training of physicians, nurses, or occupational therapists to assess for depression and then treat patients who evidence significant symptoms (Bruce et al., 2011).

The HBPC teams systematically address co-occurring mental health disorders and implement strategies toward suicide prevention in some of the most vulnerable, medically complex older Veterans. The HBPC program addresses these issues through an integrated stepped-care model, in which all team members can help to recognize and manage Veterans' mental health care needs, alongside psychologists and psychiatrists who provide more thorough home-based assessment

and treatment. HBPC teams can contribute to suicide prevention efforts with older Veterans in many ways, including frequent in-home contact with at-risk Veterans, identifying ways to reduce lethal means, and offering in-home access to safety planning and mental health treatment. Although suicide prevention educational and clinical interventions for VA staff have previously been described (De Santis et al., 2015; Marshall et al., 2014; Matthieu et al., 2008), and a toolkit format has been developed to address emergency preparedness for HBPC teams (Wyte-Lake et al., 2017), there has not been prior literature on supporting HBPC staff in suicide prevention.

The aims of this quality improvement project were to: a) identify risk management and suicide prevention practices across VA HBPC teams nationally, b) illuminate strengths and barriers to effective suicide prevention strategies in HBPC, and c) create a resource repository of best practice clinical resources and educational/team development tools for providers in suicide prevention for Veterans served in HBPC. This toolkit was intended to augment existing VA trainings suicide prevention available to all VA providers.

Methods

This project was driven by a national quality improvement workgroup of five HBPC psychologists representing HBPC teams across the United States. A human-centered design approach, that is, one that draws on feedback from stakeholders and future users, was utilized to produce a provider-friendly toolkit (Altman et al., 2018).

Needs Assessment

We conducted a needs assessment for HBPC teams assessing suicide prevention practices. Initial conception of the toolkit was driven by responses from six focus groups of HBPC staff from across the nation who responded to requests for participation posted on internal VA listserve groups of these occupations: two with HBPC program directors, two with mental health providers, and two with other team members (e.g., nursing, social work). Questions asked of participants centered on processes for evaluating and documenting suicide risk and managing care of Veterans identified to be at risk.

Two national quality improvement surveys were developed, implemented, and analyzed via SurveyMonkey to obtain information on current practices and future needs from two main stakeholder groups: HBPC program managers (a 9-item survey covering team service areas, challenges to team management of suicide risk, and perceived needs to improve suicide prevention) and HBPC mental health providers (a 51-item survey identifying step-by-step local processes for screening and management, barriers to addressing the special issues for HBPC suicide prevention such as comorbid dementia, palliative care, and areas for which they would like to provide further to their teams). Surveys received appropriate approval from VA leadership before respondents were recruited via the respective listserve for each group.

iStock/Dean Mitchell

Research suggests that suicidal ideation is high in this population, but many risk factors are treatable, highlighting the need for suicide prevention efforts.

Results

Participants

Across the 435 HBPC teams in place at the time of the surveys, 53 program directors and 56 mental health providers responded. The program directors represented a range of geographic areas ("Mostly Urban" 11.3%, "Mostly Rural" 28.3%, "Mixed" 60.4%), and oversaw 1 to 5 or more teams in these areas. Although most program directors reported at least one full-time dedicated HBPC mental provider, 11% of program managers said they had only part-time (i.e., less than one full-time employee) dedicated to the mental health care of their Veterans. Mental health provider respondents covered teams or entire HBPC programs whose average daily census ranged from 30 to 305 Veterans.

Needs Assessment

Themes emerging from surveying program directors included discomfort by some team members in identifying and treating suicidal ideation, need for additional team training, limited suicide prevention resources (especially in rural areas), and limited access to psychiatry support (e.g., inpatient psychiatric beds in local communities). See Table 1.

Mental health providers provided feedback on the varied processes for triage and completion of both brief and more comprehensive suicide risk evaluations, which informed educational materials later developed for the toolkit (Table 2). In addition to further education around suicide in context of dementia and end-of-life needs, respondents also endorsed other areas for further education including assessing suicide in the context of late life depression and working with families and caregivers to prevent suicide. Although formal analysis of the free-text responses was beyond the scope of this project, many respondents described being mindful of HBPC resources and endorsed competence in their ability to manage the psychiatric needs of patients admitted to their programs, for example, thinking of ways that outpatient providers or the family could partner to support Veterans with greater needs.

Table 1. HBPC Program Director Needs Assessment Responses (*n* = 53)

Suicide prevention strategies that work very well	Team communication	82.0%
	Documentation of suicide risk	75.0%
	HBPC psychologist on staff	74.0%
Suicide prevention strategies that do not work well	Collaboration with outpatient psychiatry	24.4%
	Support from mental health case managers	37.5%
Challenges to addressing suicide prevention	Veterans refusing MH services	59.0%
	Poor cell phone coverage	52.0%
	MH needs too great	46.0%
Needs for inclusion in suicide prevention toolkit	Sample policy documents	53.0%
	Treatment plan documentation	48.0%
	Education modules for staff on managing/assessing risk	53.0%

Note. % refers to participant endorsement of strategies and challenges

Table 2. HBPC Mental Health Provider Needs Assessment Responses (*n* = 56)

Challenges to addressing suicide prevention	Veterans refusing MH services	86.0%
	MH needs too great	76.0%
	Low community psychiatric hospitals or beds	60.0%
Suicide prevention education needs	End of life/Death with dignity	65.0%
	Late-life depression	59.0%
	Working with families/caregivers to reduce risk	58.0%
Collaboration with local VA Suicide Prevention Coordinators	Yes	82.0%

Note. % refers to participant endorsement of challenges and needs

Development of the Toolkit

The workgroup developed new materials for the toolkit to address unmet needs identified by the surveys (Table 3). The workgroup created a 7-item training needs analysis tool served as a starting point for toolkit users, which directed them to resources based on their self-assessed learning needs and those of their teams. Examples of HBPC suicide prevention policy documents were included as references for other programs to develop or enhance. A recommended reading list of relevant literature on late-life suicide prevention was included. Six brief interprofessional training modules were developed addressing special HBPC population needs with regard to suicide prevention: geriatric depression, needs of Veterans in rural areas, pain, sleep disturbance, dementia, and end-of-life issues. These special consideration training modules were PowerPoint slide decks developed for HBPC mental health providers to provide team in-services, either as-is for brief trainings, or as a starting point for further development of a more comprehensive training. Additional training materials developed included role plays to encourage HBPC staff to practice assessing suicide risk and determining follow-up plans. Finally, these and other VA (e.g., safety planning materials) and non-VA materials (e.g., links to geropsychology clinical resources, support for gender and ethnic minority older adults, and resources for families and caregivers) were collated into the toolkit itself via hyperlinks to ensure easy access for busy providers who are often on the road making home visits. The toolkit is embedded in an online internal VA SharePoint site accessible to all VA HBPC staff nationwide.

Table 3. Toolkit Components

Toolkit Section	Sample Contents
Overview	Introduction to Toolkit Team Needs Assessment Tool User How-To Reading List Quick links to Internal and External Suicide Prevention Resources
Assessment Tools	Measures required by VA for as part of routine screening Supplemental local tools shared by HBPC MH providers
Safety Planning	Resources for Safety Planning for Older Adults
Psychotherapy Interventions	Treatment Planning Resources Suicide Prevention Presentations provided by VA expert
Policy/ Procedures	Sample Local HBPC Team Suicide Risk Management Procedures National Policy Resources and Administrative Documents
Training Materials	Role Plays for Team-Based Suicide Prevention Basic Starter Presentations for Adaptation by HBPC MH providers Rural Healthcare Pain & Suicide Dementia End-of-Life Care & Suicide Geriatric Depression Sleep & Suicide
Resources for Families/ Caregivers	Suicide Prevention Guide for Veteran Families Suicide Postvention Resources

Following creation of the toolkit, five HBPC mental health providers provided initial pilot feedback on feasibility and utility of toolkit items. Pilot testers self-rated how confident they were in various aspects of suicide prevention before and after testing the toolkit over a 2-week period. Across respondents, confidence improved in all aspects surveyed (e.g., assessing and managing suicide risk, creating local suicide prevention policies, and engaging in harm reduction strategies). Qualitative feedback indicated the toolkit was "largely complete," and contained valuable and comprehensive information for the HBPC population. Next, the toolkit link was sent to experts and stakeholders in late-life suicide/Veteran suicide prevention (both VA and non-VA) who suggested additional resources and provided input into the final toolkit makeup.

A month after release of the toolkit, a brief survey was sent to HBPC mental health providers to assess how they had implemented the toolkit within their teams. Though the response rate was low (n = 15), providers who had used the toolkit indicated they had reviewed most of the modules, vignettes, and role plays and were talking more with their teams and with patients about suicide. A follow-up outcome evaluation will be conducted in 2 years to further assess use of the toolkit, ease of navigation, implementation of resources by HBPC teams, and necessary changes to resources.

Discussion

The aim of this project was to create and disseminate a suicide prevention toolkit for HBPC mental health providers to use for team training in suicide risk and prevention for the population of medically complex older Veterans served by HBPC. Feedback from the initial needs assessment of HBPC program directors and mental health providers highlighted suicide prevention issues unique to HBPC programs, including staff training needs relevant to the challenges facing Veterans in the program, procedure guidelines, and accessing care partners and resources particularly in rural areas.

Future plans include continually updating toolkit content to remain responsive and relevant to the community, as well as continued dissemination to other geriatric mental health providers within VA so that resources can be broadly accessible to those working in similar venues such as Community Living Centers (e.g., nursing homes) and geriatric primary care/geriatric mental health settings. Effectiveness of the toolkit will be re-evaluated more broadly in 2 years after mental health providers have had more time to implement training and establish policies consistent with recent updates to VA suicide prevention goals.

Future Research

Future research on specific suicide assessment and intervention in the population served by HBPC teams is needed. Although understanding suicide risk and prevention in geriatric populations is a broad area of need, the following specific areas of investigation are recommended. First, having VA and non-VA base rate suicide data for homebound older adults is critical to

A human-centered design approach, that is, one that draws on feedback from stakeholders and future users, was utilized to produce a provider-friendly toolkit.

larger suicide prevention strategies in this area. Secondly, we encourage evaluation of mechanisms by which geriatric care teams, such as HBPC, can prevent suicide. For other HBPC clinicians who may not have the resources to undertake larger research studies, case studies or qualitative articles around suicide education and prevention strategies will provide ground-level insights that can drive bigger projects. Because caregivers play such a key role in the care of homebound older Veterans, we encourage the development of projects that describe their role in suicide prevention. This toolkit was not designed to address more systemic issues around suicide prevention for this population, including mental health staffing shortages or vacancies, collaboration of care with outpatient mental health providers, technological barriers (e.g., limited cell phone connectivity for patients and staff especially in rural areas), and accessibility of higher levels of mental health care like inpatient psychiatric beds. Finally, systems or community-level studies of how HBPC patients can obtain mental health care (particularly in rural areas) would add to an understanding of how programs can support Veterans in these areas.

This project demonstrates that clinician-driven quality improvement projects can be part of larger suicide prevention efforts within a national hospital system, particularly in a relatively new and growing area of gerontological practice like home-based primary care. For frontline clinicians who may not have time or resources to conduct research, outcomes of this project suggest quality improvement initiatives to address unmet needs are feasible. Local medical center leadership at each of the authors' locations were also instrumental in supporting this project.

For home care providers outside the VA, we would suspect similar issues in assessing and treating suicide in this population would be present, including poor provider cell phone coverage and limited access to psychiatric emergency services particularly in rural areas. Although those systems issues can be challenging, home care providers have a unique vantage point to connect with older adults in a meaningful way, in their homes. VA teams rely heavily on embedded mental health providers for team training and patient care, but non-VA models do not often include this dedicated role. Ensuring clear policies and procedures around suicide prevention can help provide consistent direction for providers who are often on their own on the road. Collaborative safety planning with patients at risk of suicide can help empower them and inform care planning interventions (Conti et al., 2020). As suicide prevention is the responsibility of all providers, taking time to practice suicide risk assessment conversations can help build comfort and confidence. Finally, although this suicide prevention toolkit described in this manuscript is internal to VA, resources for suicide prevention and other mental health needs for non-VA providers are available in the Community Provider Toolkit: https://www.mentalhealth.va.gov/community-providers/index.asp.

In this report, we addressed the need for suicide prevention in medically complex homebound older Veterans through creation and dissemination of an online repository of evidence-based resources to assist HBPC mental health providers and their teams with assessment and intervention for at-risk patients. Creation of the toolkit was guided by a needs assessment from HBPC program directors, mental health providers, and late-life suicide prevention experts, and will continue to be updated with further resources as guidelines change with further research. As future research investigates the utility of the toolkit for HBPC teams, we have provided areas of need for potential research in suicide prevention for patients served by HBPC programs.

Clinical Implications

- VA HBPC programs are uniquely positioned to provide suicide prevention strategies to a vulnerable at-risk group of older adults.
- VA HBPC mental health providers (and more broadly, psychologists in integrated care teams) play a key role in direct clinical intervention, policy development, and interprofessional team education in suicide prevention.

- VA HBPC programs have specific learning and support needs around suicide prevention that can be addressed with a feasible, easily accessible educational resource. ☗

Michelle E. Mlinac, PsyD, ABPP, is a Staff Psychologist, Home-Based Primary Care, VA Boston Healthcare System, and Assistant Professor of Psychology, Department of Psychiatry, Harvard Medical School, Boston, Massachusetts.

Ronald W. Smith, PhD, is a Geropsychology Fellow, VA Boston Healthcare System, and Clinical Fellow in Psychiatry, Harvard Medical School, Boston, Massachusetts.

Kevin J. Siffert, PhD, is a Staff Psychologist, Home-Based Primary Care, Michael E. DeBakey VA Medical Center, Houston, Texas.

Luis C. Richter, PsyD, ABPP, is a Staff Psychologist, Home-Based Primary Care, VA Puget Sound Healthcare System, Seattle, Washington.

Pamela L. Steadman-Wood, PhD, ABPP, is a Staff Psychologist, Home-Based Primary Care, Providence VA Medical Center, and Associate Professor, Department of Psychiatry and Human Behavior, Alpert Medical School of Brown University, Providence, Rhode Island.

Julie L. Wetherell, PhD, ABPP, is a Staff Psychologist, Home-Based Primary Care, VA San Diego Healthcare System, and Professor of Psychiatry, Department of Psychiatry, University of California, San Diego, California.

This project was funded by a 2017 VA Innovation Grant and supported with the resources and use of the facilities at the U.S. Department of Veterans Affairs. The authors wish to thank Dr. Michele Karel for providing ongoing consultation to the workgroup. The views above represent those of the authors and not necessarily the Department of Veterans Affairs.

The authors declare no conflicts of interest.

Address for correspondence: Michelle E. Mlinac, PsyD, VA Boston Healthcare System, Boston, MA 02130 (Michelle.mlinac@va.gov).

DOI:10.1097/NHH.0000000000000922

REFERENCES

Altman, M., Huang, T. T., & Breland, J. Y. (2018). Design thinking in health care. *Prevention of Chronic Disease, 15*, 180128. https://doi.org/10.5888/pcd15.180128

Bruce, M. L., Raue, P. J., Sheeran, T., Reilly, C., Pomerantz, J. C., Meyers, B. S., Weinberger, M. I., & Zukowski, D. (2011). Depression care for patients at home (Depression CAREPATH): Home care depression care management protocol, part 2. *Home Healthcare Nurse*, *29*(8), 480–489.

Centers for Disease Control and Prevention. (2013). *Web-based injury statistics query and reporting system*. http://www.cdc.gov/injury/wisqars/index.html

Conejero, I., Olié, E., Courtet, P., & Calati, R. (2018). Suicide in older adults: Current perspectives. *Clinical Interventions in Aging*, *13*, 691–699.

Conti, E. C., Jahn, D. R., Simons, K. V., Edinboro, L. P. C., Jacobs, M. L., Vinson, L., Stahl, S. T., & Van Orden, K. A. (2020). Safety planning to manage suicide risk with older adults: Case examples and recommendations. *Clinical Gerontologist, 43*(1), 104–109.

Conwell, Y., Duberstein, P. R., Hirsch, J. K., Conner, K. R., Eberly, S., & Caine, E. D. (2010). Health status and suicide in the second half of life. *International Journal of Geriatric Psychiatry, 25*(4), 371–379.

Conwell, Y., Van Orden, K., & Caine, E. D. (2011). Suicide in older adults. *The Psychiatric Clinics of North America*, *34*(2), 451–468.

Cornwell, T. (2019, October 8). *Home-based primary care: How the modern day "house call" improves outcomes, reduces costs, and provides care where it's most often needed*. Retrieved May 31, 2020, from https://www.healthaffairs.org/do/10.1377/hblog20191003.276602/full/

De Leo, D., Draper, B. M., Snowdon, J., & Kõlves, K. (2013). Suicides in older adults: A case-control psychological autopsy study in Australia. *Journal of Psychiatric Research*, *47*(7), 980–988.

De Santis, M. L., Myrick, H., Lamis, D. A., Pelic, C. P., Rhue, C., & York, J. (2015). Suicide-specific safety in the inpatient psychiatric unit. *Issues in Mental Health Nursing, 36*(3), 190–199. https://doi.org/10.3109/01612840.2014.961625

Fässberg, M. M., Orden, K. A. V., Duberstein, P., Erlangsen, A., Lapierre, S., Bodner, E., Canetto, S. S., De Leo, D., Szanto, K., & Waern, M. (2012). A systematic review of social factors and suicidal behavior in older adulthood. *International Journal of Environmental Research and Public Health*, *9*(3), 722–745.

Karel, M. J., Wray, L. O., Adler, G., O' Riley Hannum, A., Luci, K., Brady, L. A., & McGuire, M. H. (2020). Mental health needs of aging veterans: Recent evidence and clinical recommendations. *Clinical Gerontologist,* 1–20. https://doi.org/10.1080/07317115.2020.1716910

Marshall, E., York, J., Magruder, K., Yeager, D., Knapp, R., De Santis, M. L., Burriss, L., Mauldin, M., Sulkowski, S., Pope, C., & Jobes, D. A. (2014). Implementation of online suicide-specific training for VA providers. *Academic Psychiatry, 38*(5), 566–574. https://doi.org/10.1007/s40596-014-0039-5

Matthieu, M. M., Cross, W., Batres, A. R., Flora, C. M., & Knox, K. L. (2008). Evaluation of gatekeeper training for suicide prevention in veterans. *Archives of Suicide Research*, *12*(2), 148–154. https://doi.org/10.1080/13811110701857491

McCarthy, J. F., Szymanski, B. R., Karlin, B. E., & Katz, I. R. (2013). Suicide mortality following nursing home discharge in the Department of Veterans Affairs health system. *American Journal of Public Health*, *103*(12), 2261–2266.

Purcell, B., Heisel, M. J., Speice, J., Franus, N., Conwell, Y., & Duberstein, P. R. (2012). Family connectedness moderates the association between living alone and suicide ideation in a clinical sample of adults 50 years and older. *The American Journal of Geriatric Psychiatry*, *20*(8), 717–723.

Raue, P. J., Meyers, B. S., Rowe, J. L., Heo, M., & Bruce, M. L. (2007). Suicidal ideation among elderly homecare patients. *International Journal of Geriatric Psychiatry*, *22*(1), 32–37.

Reckrey, J. M., DeCherrie, L. V., Dugue, M., Rosen, A., Soriano, T. A., & Ornstein, K. (2015). Meeting the mental health needs of the homebound: A psychiatric consult service within a home-based primary care program. *Care Management Journals, 16*(3), 122–128.

Rotenberg, J., Kinosian, B., Boling, P., Taler, G., & for the Independence at Home Learning Collaborative Writing Group. (2018). Home-based primary care: Beyond extension of the Independence at Home Demonstration. *Journal of the American Geriatrics Society, 66*(4), 812–817.

Rubenowitz, E., Waern, M., Wilhelmson, K., & Allebeck, P. (2001). Life events and psychosocial factors in elderly suicides: A case-control study. *Psychological Medicine*, *31*(7), 1193–1202.

Sachs-Ericsson, N. (2019). Scientific investigation of late-life suicide among older adults with major depressive disorder and cognitive impairment is imperative. *The American Journal of Geriatric Psychiatry, 27*(12), 1296–1298.

Schuchman, M., Fain, M., & Cornwell, T. (2018). The resurgence of home-based primary care models in the United States. *Geriatrics*, *3*(3), 41.

U.S. Department of Veterans Affairs. (2018). *VA National Suicide Data Report 2005-2015*. Office of Mental Health and Suicide Prevention. https://www.mentalhealth.va.gov/docs/datasheets/2015/OMHSP_National_Suicide_Data_Report_2005-2015_06-14-18_508.pdf

Wyte-Lake, T., Claver, M., Der-Martirosian, C., Davis, D., & Dobalian, A. (2017). Developing a home-based primary care disaster preparedness toolkit. *Disaster Medicine and Public Health Preparedness, 11*(1), 56–63.