Medical Emergency Department / Suicide Prevention Collaborations

SPRC 2017 Community of Practice Meeting 6: June 20, 2017
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Agenda

• Welcome
• Presentation from James Wright
• Presentation from Tom Kelly
• Group Discussion
• Action Plan Breakout Groups
• Breakout Group Debrief
• Wrap-up & Reminders
Financing Suicide Prevention
Intersecting with EDs

James Wright, LCPC
Public Health Advisor
Suicide Prevention Branch
Cures Act – 2016

• Zero Suicide in Health Care through Adult Suicide Prevention
  – Emergency departments eligible and must complete most activities (Screening, Assessment, Safety planning, Means reduction education, Rapid referrals, Follow up services: calls, face-to-face)
  – FOA currently out for $400,000/5 years

https://www.samhsa.gov/grants/grant-announcements/sm-17-006

Cures Act – 2016

- Strengthening community crisis response systems
  - Develop, maintain, or enhance a database of beds at inpatient psychiatric facilities, crisis stabilization units, and residential community mental health and residential substance use disorder treatment facilities, for adults with a serious mental illness, children with a serious emotional disturbance, or individuals with a substance use disorder.
  - Promote the integration and coordination between local public and private entities engaged in crisis response, including first responders, emergency health care providers, primary care providers, law enforcement, court systems, health care payers, social service providers, and behavioral health providers.
SAMHSA and Truven Health Analytics

• Background
  – Care Pays: ROI from Better Care Transitions (2012-National Council Magazine)
  – Hospital Readmission Among Medicaid Patients with an Index Hospitalization for Mental and/or Substance Use Disorder (2013- Journal of Behavioral Health Services and Research)
  – The Return on Investment of Post-discharge Follow-Up Calls for Suicidal Ideation or Deliberate Self-Harm (2014-Psychiatric Services)
Framework

- Focused on individuals who had suicidal behavior discharged from hospital and emergency department
- Individuals would receive an immediate post discharge follow-up call
- There is an increase of those who receive follow-up treatment within seven days of discharge
- There is a decrease in the 30-day hospital readmission rate
ROI Components

- Cost of Follow-up calls
- Cost of increase in follow-up treatment
- Savings from intervention

Used: 2006–2011 Truven Health MarketScan Commercial Claims and Encounters Database and 2006–2011 Truven Health MarketScan Multi-State Medicaid Database. Compared to reported Crisis Center cost through 8 center survey.
ROI Components

• The ROI was estimated for the 30 days after discharge and was calculated from a payer’s perspective (return gained for every $1 invested)

• Under base case assumptions, the estimated ROI was:
  – $1.76 for commercial insurance- hospital D/C
  – $2.43 for Medicaid- hospital D/C
  – $1.70 for commercial insurance ED D/C
  – $2.05 for Medicaid ED D/C

• The ROI would be greater than $1 for both payers and across both discharge settings as long as post-discharge contact could reduce readmission by at least 13.3%.
ROI Components

- Sensitivity analyses indicated a 77% probability (commercial) and an 88% probability (Medicaid) that the ROI would be greater than $1 among hospital discharges; the probabilities among emergency department discharges were 74% (commercial) and 82% (Medicaid).

Conclusions: The study supports the business case for payers, particularly Medicaid, to invest in post-discharge follow-up calls.
SAMHSA Crisis Center Follow-Up

- Current cohort – 6 crisis centers and 6 emergency departments/inpatient treatment
- Three-year grant (2016-2019)
- Purpose to systematically follow-up and provide care transition services with individuals identified as having suicidal behavior at ED or inpatient unit
- External evaluation calculating repeat hospital utilization among clients served (gets at potential readmission rate reduction for ROI)
- Collecting info on SP codes and procedures from ED to crisis center, including data transfer
SAMHSA Study

Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies – 2014

• Collaborative crisis services funding case examples from states
• The economic impact (cost savings) of crisis services due to reduced inpatient utilization: ED/inpatient psych (p.14)
  – Crisis stabilization
  – Community based residential crisis care
  – Mobile crisis
  – Peer crisis
  – Crisis lines/warm lines

Section 5: Financing Crisis Care: A Financial Crisis for Crisis Care

Crisis Care Funding vs. Emergency Care Funding

- It is revealing to compare mental health crisis care to other first responder systems like firefighting or EMS. There are striking similarities:
  - The service is essential.
  - The need for it is predictable over time, but the timing of crises is not predictable.
  - Effective crisis response is lifesaving, yet it is also much less expensive than the consequences of inadequate approaches.

Problem with typical funding patterns:

- No overall reliable source of funding
- Less than half of all funding comes from a dedicated/reliable source
- Single biggest source of funding is Medicaid billings - expensive and cumbersome way to bill for crisis care
- Lack of payment structure from Medicare and commercial/private health insurers (little to no support from mainstream health payers)
Additional Initiatives

• Crisis Response Network – Tempe, AZ use of Medicaid 1115 waiver
  – Phone based assessment- “Crisis Telephone Services”
  – Care transitions and follow up
  – MCOT dispatch
  – Emergency room-based assessments

• Billed under H0030 - Behavioral health hotline service
  – Description: Behavioral health hotline is a telephone service that provides crisis intervention and emergency management such as mental health referrals, treatment information, and other verbal assistance
Long Term Needs

• State by state analysis of ED suicide prevention coding, processes and reimbursement

• BH provider analysis of care transition and crisis services work pre- and post-ED engagement

• Ideally have description of both reimbursable and non-reimbursable services provided to estimate true costs
Contact Information

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Group Discussion: Financing

- What strategies have you used to finance care transitions?
- What about other suicide prevention initiatives? What has worked well, what hasn’t?
- If you haven’t done this already, what strategies might you consider?
Tom Kelly
Peer Support Training Coordinator
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Suicide Attempt Survivors Task Force
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The Lived Experience

Your presenter – Tom Kelly
Stories by thirty-four people who attempted suicide, told in their own words, plus accounts by twelve others about what it is like to be in despair and later to find something to live for!
Suicide Attempt Survivors

Policy decisions related to the suicide prevention field have historically been made by three groups: researchers, clinicians and family members of those who died by suicide.

There have been hundreds of support groups nationally for those bereaved by suicide but few examples of similar peer opportunities for those struggling with suicide.

In 2014, a National Action Alliance for Suicide Prevention Task Force will publish “Activating Hope” (provisional title) that will challenge these norms.
Recommendation 4.4

Practice: Professionals in the emergency department should provide collaborative and compassionate care in response to a suicidal crisis.
**Recommendation 4.5**

*Policy*: EDs should form partnerships with peer specialists and organizations that can offer support to patients and their family/friends while they wait for clinical care.
Recommendation 4.6

Program: Train peer specialists to help support and advocate for patients in emergency departments who are experiencing a suicidal crisis.
Recommendation 4.7

Policy: Promote use of mobile crisis teams, including a peer specialist who can use his or her lived experience as an asset during interventions.
Group Discussion: Lived Experience

✓ How are you including input from people with lived experience within your program or organization?

✓ Are there steps you’ve taken or could take to coordinate with peer support specialists?

✓ What types of trauma-informed care training have been successful within your organization?
Action Plan Breakout Groups

• While sharing your materials, please:
  – Identify one spokesperson for your team
  – Limit your remarks to four minutes when sharing your updates
  – You will have approximately three minutes for feedback
1. How are you doing in meeting your action plan benchmarks?
   A. JHH PED moved from selective screening to universal screening. We have partnered with KKI to begin screening patients with DD/ID/ASD which will hopefully inform us on screening in that population.

2. What changes have you made to your action plan since joining the CoP?
   A. We are on track with our action plan.

3. What barriers have come up since you completed your action plan?
   A. Even with Universal screening, not all nurses are complaint – just check off no to all ASQ questions.

4. What ideas do you have to address them?
   A. Brainstorm how to establish greater buy-in

5. What is your next milestone?
   A. Have been working with EPIC to extract inpatient EMR data and do QI; make a community resource list and identify possible rapid appointment options.
1. Changes: Emphasis of training staff has shifted from focus on screening tools used to comfort level with the topic of suicide. Benchmarks: Everything takes longer than you think – meeting planned for May with leadership is pushed back to July.

2. Barriers: Parkview System approach to change likes to incorporate all sites at once versus individual sites and do not have the capacity for training all sites at once. Possible Solution: identify Randallia ED as a “pilot site”.

3. Next Milestone: June - survey of staff. July - leadership meeting with VP and Director to propose plan details.
1. How are you doing in meeting your action plan benchmarks? What changes have you made to your action plan since joining the CoP? We are making steady progress with the assessment and screening of the patient’s that come into the hospital. We have included a social profile in the triage questions, one of which addresses suicide. We have educated majority of nurses on suicide prevention and intervention. As new nurses are hired we will have trainings to include them as well. We have meet with the crisis team, the hospital CNO and CEO as well as the interim manager at the behavioral health organization to discuss a MOU or consent form to allow sharing of information in regards to patients that screen positive for suicide.

2. What barriers have come up since you completed your action plan? What ideas do you have to address them? As far as the follow up care and sharing of information we have reached a barrier. The director of our partnering behavioral health agency has resigned. They do not have a director at this time to engage in conversation in regards to the sharing of information and continuity of care.

3. What is your next milestone? We had hoped that by June we would have the MOU in place but that is not possible at this point in time. I have asked that when the new director is hired that we be informed in order to facilitate a meeting to discuss this and hopefully come to an agreement. We are going to focus on completion of the social profile and the process of assessment and screening at the hospital.
1. On track to implement new universal suicide risk screening policy in ED setting with additional supports for youth and young adults 10-24 y.o. that screen positive.

2. Barriers mostly centered around timeline (e.g. unexpected events, EHR build, finding time for staff training). Recognize importance of this planning stage and front-loading work rather than rushing for the sake of original timeline.

3. Continue work on defining pathway of care for people identified at risk of suicide & develop innovative ways to address challenges related to transition of care period (i.e. not enough outpatient providers, long wait times, developing whole person resiliency)
1. CNMC is ahead of schedule in meeting the action plan benchmarks. CNMC has modified the action plan to expand standardized screening throughout the health care system including dental and audiology clinics.

2. | Barrier                                                                 | Potential Solution                                                                 |
---|------------------------------------------------------------------------|------------------------------------------------------------------------------------|
| Current EMR’s technological capacity will make it challenging to embed suicide care pathway | Utilize grant funding to customize EMR to include suicide care pathway components   |
| Effectively tracking patients identified as at risk for suicide post discharge (i.e. Are they attending follow-up appointments? Are they in need of re-assessment?, etc.) due to limited staffing | Develop sustainable staffing model to support follow-up and care transition services |
| Inconsistency in processes when utilizing contracted staff to provide after hours assessments and referrals in Emergency Department | Collaborate with contracted state agency to develop standardized processes Authorize contract staff access to EMR to document |
| Inconsistency in provider coding in suicide attempts and potential suicidal behaviors/risk | Develop standardized coding protocol and train providers                           |
| Difficulty tracking suicide deaths within patient population            | Partner with Oklahoma Medical Examiner to cross reference data                     |

3. Upcoming milestones include: implementing standardized screening in optometry, identifying ways to track number of screenings completed in dental and audiology clinics and developing safer care transitions including expanding follow-up services.
1. Goals: *Achieved yet still Theoretical*
   - Develop Protocol for Intervention
   - Develop Follow-Up/Aftercare Response Protocol
   - Embed the Columbia CSSR-S Screen version

2. Leadership change!
   1. Continuing with efforts focused on Behavioral Health Staff/ Home Health Care Staff (attending to the training action plan)
   2. Patience, patience, patience
   Understanding Culture/ Resources
   1. A SWOT analysis for ED Leadership and stakeholders
   2. Calling on coalition members to inform practice
   3. Making training easier to access for staff (electronic web-based trainings)
   4. Including IT personnel in plan development to attend to EMR related concerns

3. Operationalizing and implementing protocol and strategies

Who should be at the table? What suggestions can be made for those hospitals without access to inpatient Behavioral Health? Has anyone experienced leadership change- what can we anticipate?
Breakout Group Debrief

• People who shared:
  – How was this activity for you?
  – What ideas will you try to implement?
Poll

Do we want to repeat the Action Plan feedback activity during our July meeting?

- Yes
- No
- Won’t be attending
Announcements & Reminders

• **Next CoP meeting:** 7/18, 3:00-4:30 pm ET

• **Coming to you via email:**
  - Notes/PPT and webinar recording
  - CoP resource document
Questions?

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