State Breakout 1D; Care Transitions in EDs

Care Transitions from Emergency Departments

Suicide Prevention Resource Center
May 3, 2016
Lisa Capoccia, MPH
Why care transitions from EDs?

✓ Over 800,000 ED visits for self-inflicted injuries annually (CDC, 2011\(^1\)).

✓ Two thirds of people with a recent attempt (12 mos), visited an ED for any reason in the past year (Han, 2014).

✓ 44% of ED patients with suicidal ideation had a previous suicide attempt (Allen, 2013).

✓ 22% of people who died by suicide visited an ED in the 4 weeks prior to their death (Ahmedani, 2014).

✓ The risk of a suicide attempt or death is highest within the first 30 days after discharge from an ED or inpatient psych unit; Yet up to 70% of patients who leave the ED after a suicide attempt never attend their first outpatient appointment (Knesper, 2010).

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\(^1\) National Hospital Ambulatory Medical Care Survey
What it is

A concept, not a specific intervention

Identification Setting (ED) → Care Transitions Strategies* → Aftercare (Outpatient Mental Health)

*Can be developed and implemented by EDs, outpatient mental health providers, crisis centers, payers, and community-based organizations
Detecting and treating suicidal ideation in all settings

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National Strategy for Suicide Prevention:
Goals and Objectives for Action
What does a good care transition look like?

✓ Appointment is made within 7 days of discharge
✓ Patient is safe/supported by informal caregivers and/or crisis center at home
✓ Patient receives follow-up phone between ED discharge and outpatient appointment
✓ PHI is transmitted to referral provider
✓ Patient attends appointment; Access barriers addressed
✓ Patient is contacted if missed appointment
Care Transitions Interventions and Practices

1. Rapid referral, open scheduling models

2. Discharge planning
   • Warm handoff
   • Discharge planning checklist

3. Follow-up
   • Non-demand, caring contacts (postcards)
   • Follow-up phone calls or visits

4. Case management, care coordination
Care Transitions: Comprehensive Approaches

- VA Model / SAFE VET
- Zero Suicide
- England & Wales Mental Health Service Recommendations (While, 2012)
- Project RED (Re-Engineered Discharge)
Care Transitions: Facilitators

- MOUs
- Transmit patient health information
- Electronic health records / HIEs
- Patient consent protocols
- Continuity of care flowsheets
- Community resource listing
- Informal caregiver involvement in d/c planning
### Care transitions research examples

<table>
<thead>
<tr>
<th>Approach</th>
<th>Outcomes</th>
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| Postcards, texting, email ("Caring Contacts") | Decreased suicides (Motto & Bostrom, 2001; Fleischmann, 2008)  
Reduced attempts, ideation (Luxton, 2012; Beautrais, 2010; Carter, 2007; Chen, 2010) |
| Follow-up calls                  | Decreased suicides (Fleischman, 2008)  
Accessed mental health services (Gould, 2012)  
Cost savings (Richardson, Mark, McKeon) |
| Enhanced follow-up               | Lower suicide rates in VHA-served veterans (Kemp, Bossarte, 2012)                                                                       |
| Warm handoff                     | Increased attendance at first appointment (Olfson, 1998)                                                                                   |
| Combined approaches              | Decreased suicides (While, 2012)  
Increased outpatient engagement (Boyer, 2000)                                                                                           |
Tools & Resources

Caring for Adult Patients with Suicide Risk

A Consensus Guide for Emergency Departments

www.sprc.org/ed-guide

www.sprc.org
**ED Guide – Brief ED-Based Suicide Prevention Interventions**

Incorporate *crisis center/hotline information*:

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Brief Patient Education</td>
<td>(1)</td>
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<tr>
<td>Safety Planning</td>
<td>(1, 2)</td>
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<tr>
<td>Lethal Means Counseling</td>
<td>(2)</td>
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<tr>
<td>Rapid Referral</td>
<td>(1)</td>
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<tr>
<td>Caring Contacts</td>
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Include care transitions components
Discharge Planning Checklist

✓ Involve the patient as a partner
✓ Make follow-up appointments
✓ Review and discuss the Patient Care Plan (discharge plan)
✓ Discuss barriers
✓ Provide crisis center phone number
✓ Discuss limiting access to lethal means
✓ Provide written instructions and education materials
✓ Confirm that the patient understands the Patient Care Plan
✓ Share patient health information with referral providers
✓ Communicate your concern
Appendices

- Suicide Risk Assessment: Information and Resources
- Sample Letter to Outpatient Mental Health
- Community Resource List Template
- Caring Contacts Sample Materials
- Key Elements of a Patient Care Plan
- Assessing Your Views toward Suicide
Other Tools: Continuity of Care

store.samhsa.gov

www.sprc.org
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