Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.

SPRC ED Protocol Project: Consensus Panel Welcome and RAND Expert Lens Orientation

June 20, 2013

Speakers

Richard McKeon
Suicide Prevention Branch Chief
SAMHSA

Dmitry Khodyakov
Behavioral/ Social Scientist
RAND Corporation

Edwin Boudreaux
Professor
University of Massachusetts Medical School

Sandra Schneider
Past President
American College of Emergency Physicians

Lisa Capoccia
Assistant Manager Provider Initiatives
SPRC

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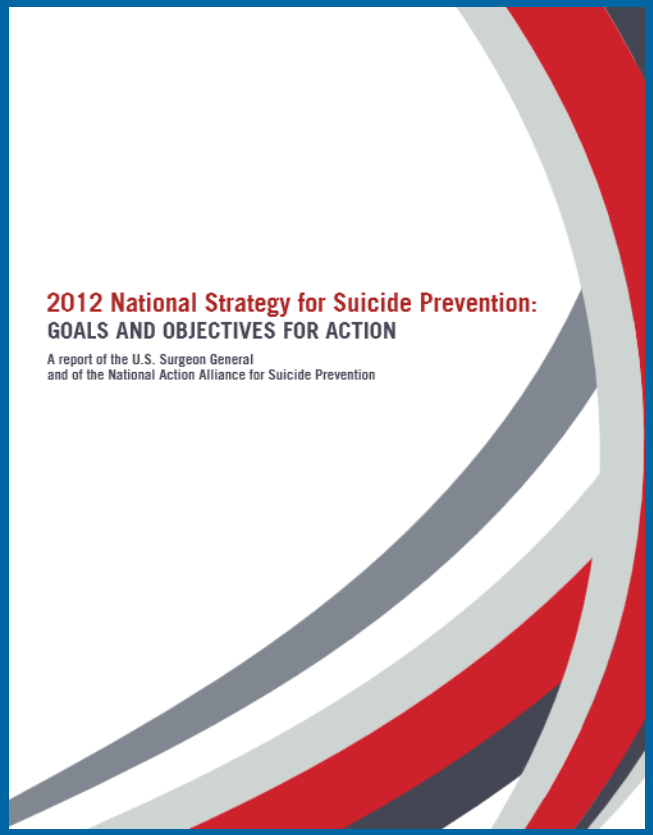
SAMHSA Perspective

Richard McKeon
Suicide Prevention Branch Chief
SAMHSA



Objective 9.6: Develop standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

EDs are key settings for providing services to persons with high suicide risk, particularly those who have attempted suicide. In 2009, 374,486 people were treated in EDs for self-inflicted injuries.[1]

Standardized protocols should be developed for use within EDs that allow for differentiated responses based on risk profiles and assessed clinical needs (e.g., intoxicated and suicidal, chronically suicidal,

PAGE 61

http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full_report-rev.pdf

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ED Protocol Project

- ✓ Goals
- ✓ Parameters
- ✓ Consensus panel roles
- ✓ Timeline

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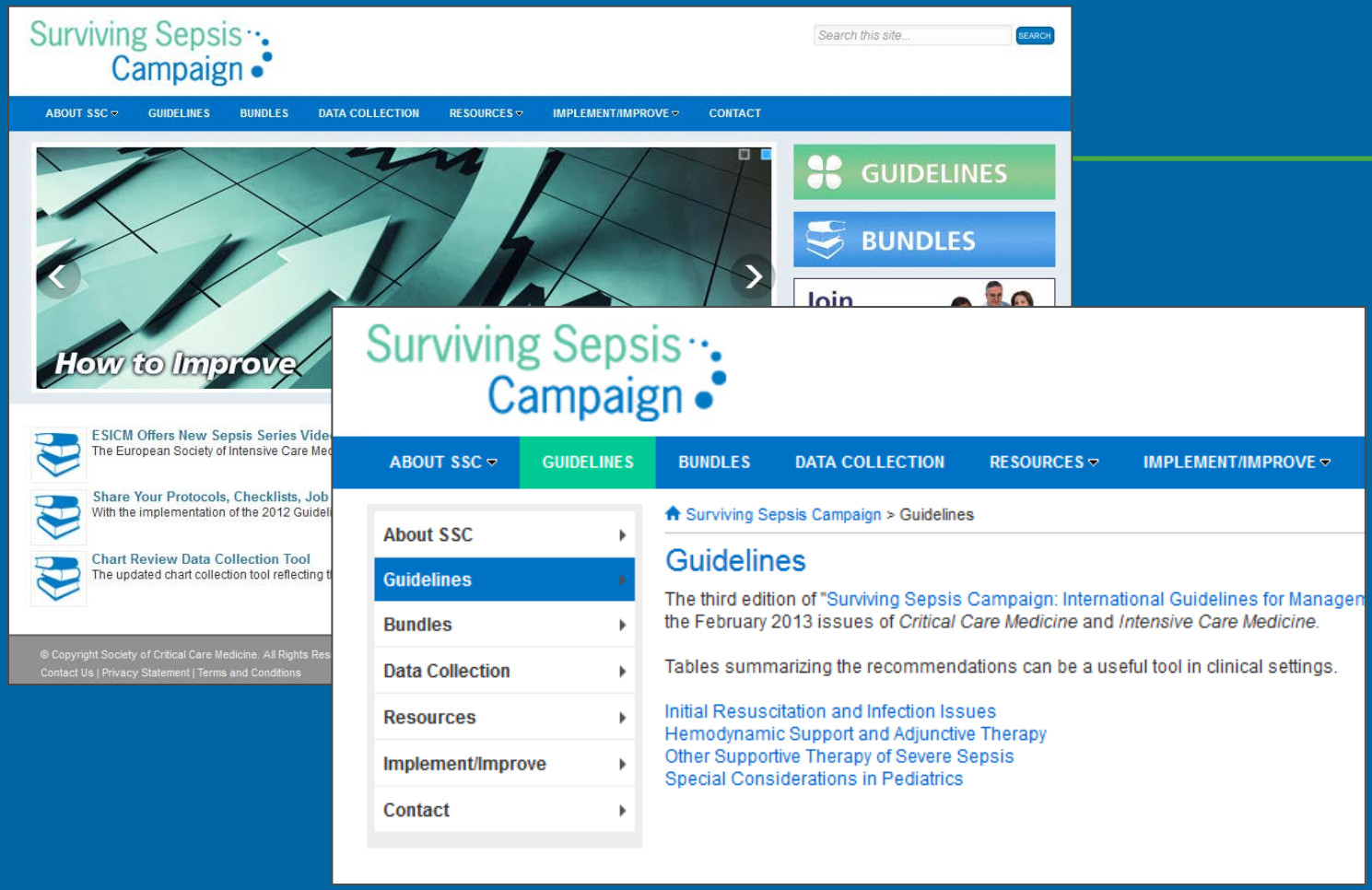
NEEDS / PROBLEMS		OBJECTIVES	GOALS	OUTCOMES
Risk of suicide is highest immediately after being discharged from an ED among patients at high risk for suicide **Suicidal patients have low rates of follow-up with outpatient care** **Gaps in research evidence on ED-specific tools and interventions**	Lack of feasible provider decision-support tools	Develop consensus on the best/minimum assessment variables to use for deciding which patients can be safely discharged	**ED product developed with consensus-based content on:** • **variables to assess for deciding which patients can be sent home** • **treatment protocols** • **discharge planning protocols** **and recommendations (non-consensus) on:** • **providing patient-centered care** • **addressing legal concerns** • **special populations** ➔ **Meets feasibility thresholds** ➔ **Wide dissemination** ➔ **Wide adoption**	**Period after ED discharge is no longer the highest risk period** **Decreased risk** **Increased adherence with follow-up appt.** **Patients follow safety plans** **Provider competence increases** **Improved patient experiences**
	Mental health consultation capacity			
	Inappropriate/unnecessary admission to inpt. psych for some patients			
	Boarding			
	Limited inventory/ adaptation of evidence based interventions for ED settings	Develop consensus on recommended treatment and interventions		
	Lack of discharge planning best practices	Develop consensus on recommended discharge planning practices; Include practices to address modifiable patient barriers		
	Patient-specific barriers to follow-up			
	Outpatient mental health system gaps			
	Provider legal concerns	Identify practices that demonstrate provider adherence to standards		
	Stigma	Identify patient-centered care practices		
	Occult suicide risk	**Not addressed by this project**		



http://www.survivingsepsis.org/Pages/default.aspx

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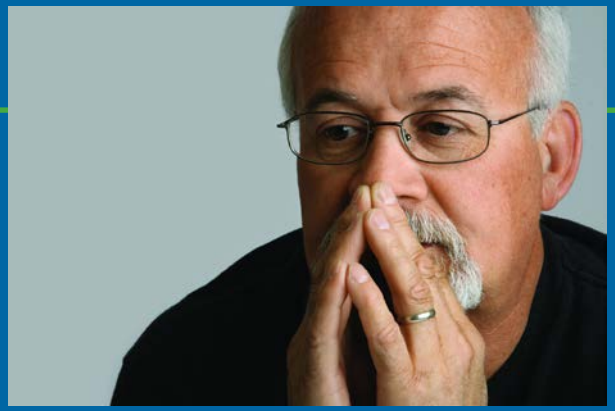
Project Parameters



- ✓ Adults
- ✓ EDs with limited mental health staffing
- ✓ Not universal screening
- ✓ For use with patients with known suicide risk
- ✓ Emphasis on feasibility

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Consensus Panel Composition

PROVIDER SECTORS	OTHER SECTORS
• Emergency medicine • Emergency nursing • Emergency psychiatry • Social work • Psychology • Crisis center services • Tele-psychiatry	• Consumer/patient/family • Research • Legal • Suicide prevention • Special population experts (e.g., substance abuse, pediatric, military) • Federal agencies (SAMHSA, CMS, NIMH) • Intervention/tool developers

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Consensus Panel Roles

- ✓ 8-10 hours over 6 months
- ✓ Study 1 (online)
- ✓ Study 2 (online)
- ✓ Webinars and email
- ✓ Think: ED patient, ED provider, ED setting

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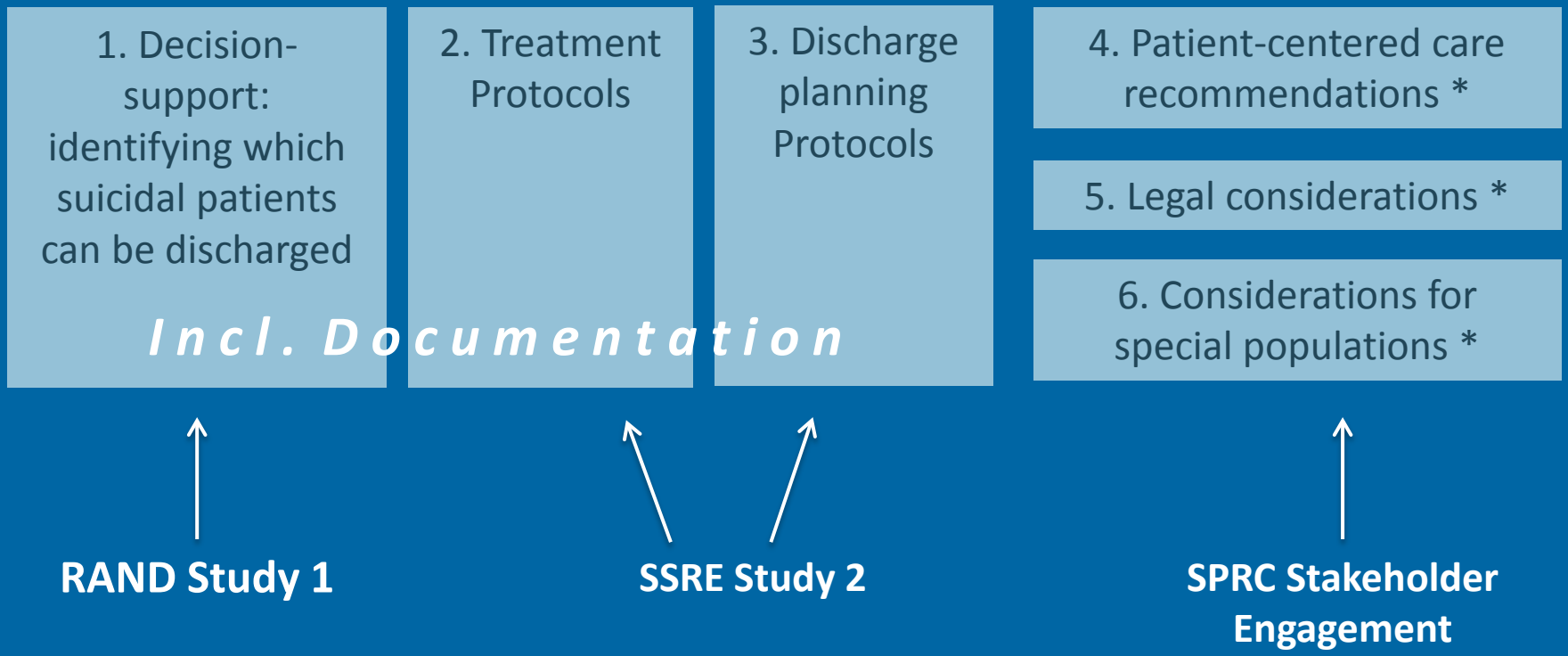
Product Content & Panel Input



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** Items 4-6 are not consensus-based*

Timeline

RAND Study 1	Jul/Aug 2013
SSRE Study 2	Sept
Draft protocol developed	Oct
External reviews	Nov
Pilot testing	Dec
Product development, training materials, dissemination	2014

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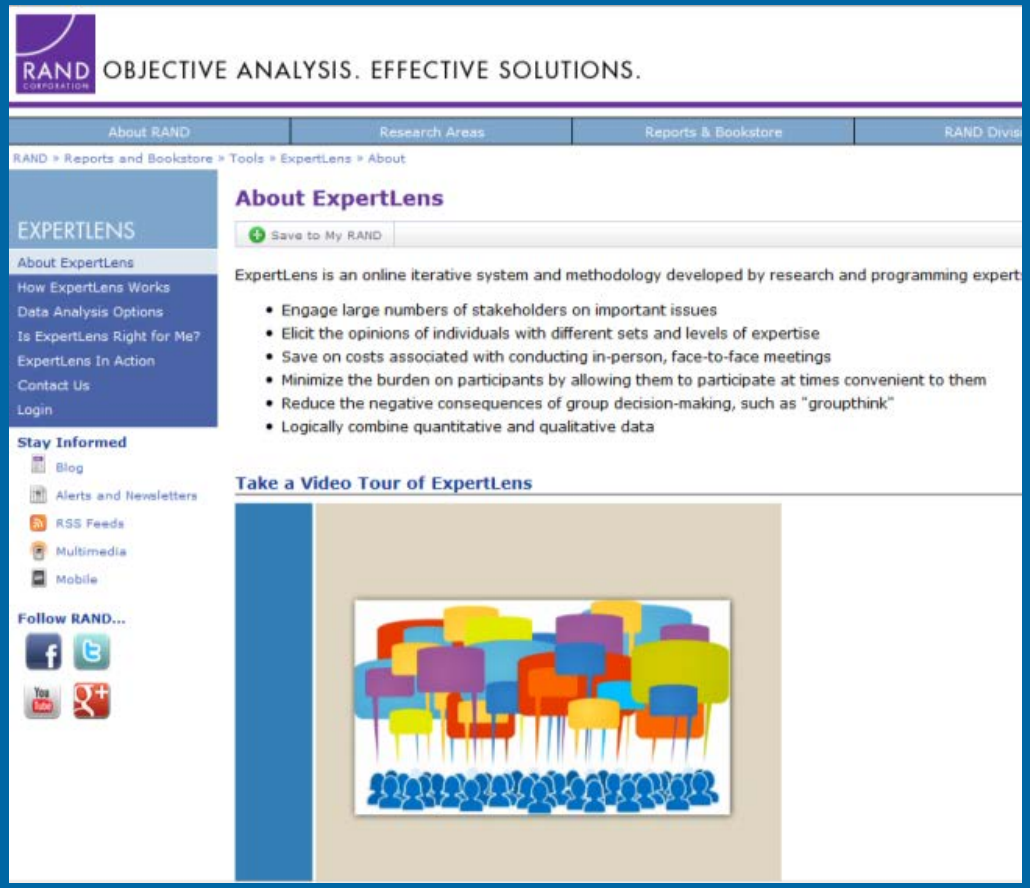
ExpertLens



http://www.rand.org/pubs/tools/expertlens.html

Examples of Recent ExpertLens Projects

- ✓ Continuous Quality Improvement
- ✓ HIV/AIDS
- ✓ Global trends in demography, migration, technology and education, inequality, employment, and empowerment for 2030
- ✓ Future of mobility scenarios

How ExpertLens Works

- **Three rounds**: Questions – statistical feedback and discussion - questions
- **Participants**: A group of stakeholders larger and more diverse than a traditional expert panel
- **Questions**: Rating and ranking questions are typically used in ExpertLens studies
- **Additional information**: Participants provide basic demographic information and share their study experiences

How ExpertLens Works, continued

- **Accessing ExpertLens:** Participants receive an email with login instructions, login name, and password from ExpertLens Administrator when study rounds are open
- **Passwords:** Passwords are case-sensitive
- **Browsers:** ExpertLens is best viewed in Firefox, Chrome, Safari, or IE 8. Participants can use iPads but not smart phones
- **Discussion:** Discussions are partially anonymous and moderated. Participants are strongly encouraged to actively contribute to discussions. Discussion digests are sent automatically to promote participation

How ExpertLens Works, continued

- **Changing your answers:** You can change your answers at any time while a round is open. Your last response will be the one used in the analysis
- **Saving data:** Your answers are saved automatically once you move on to the next page
- **Troubleshooting:** If you have technical problems, please send an email to expertlens@rand.org

Screening for Suicide: From Practical Clinical Trial Design to Practical Decision Making

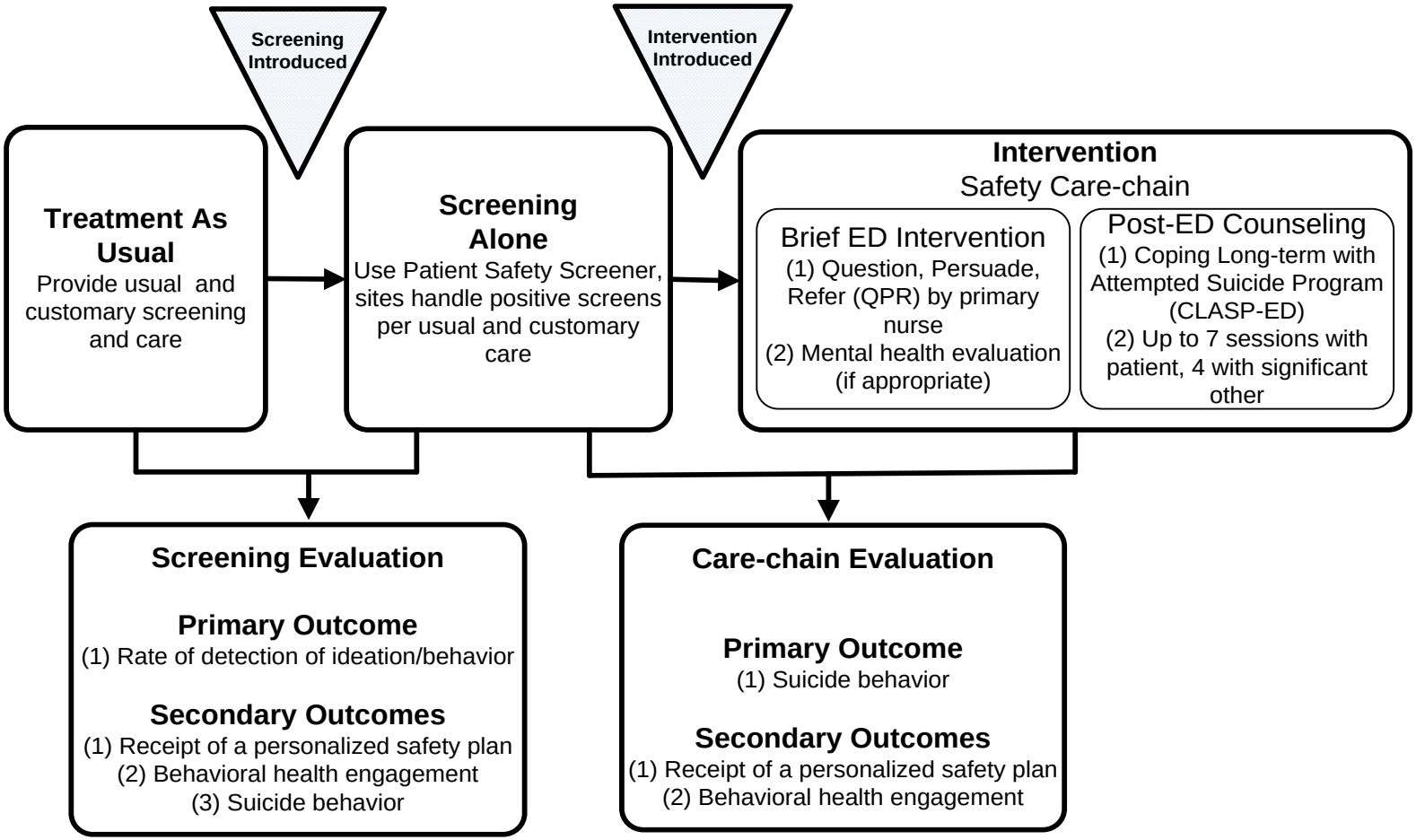
Lessons from the Emergency Department Safety Assessment and Follow-up Evaluation (ED-SAFE)
NIMH, U01MH088278

SPRC
June 20, 2013

ED-SAFE: Overview

- Two separate but related aims
  - Screening
  - Intervention
- Quasi-experimental clinical trial design
- Three sequential phases of data collection
  - TAU
  - Universal screening
  - Enhanced intervention (care-chain)

Figure 1: Overview of the phases and studies



Screening Evaluation: Objectives

- Test whether a standardized, universal ED screening for suicide risk increases detection of suicidal ideation/ behavior compared to usual care

- Test whether universal screening leads to improved process of care variables
  - Written safety planning
  - Mental health treatment initiation post-visit

- Test whether universal screening leads to improved suicide outcomes in the 12 months post-ED visit

Care-chain Evaluation: Objectives

- Test whether an intervention improves suicide outcomes over the 12 months post-ED visit
- Test whether an intervention leads to improved process of care variables
  - Written safety planning
  - Mental health treatment initiation post-visit

Risk Assessment

- Keyed to determining imminent risk
- To admit or not?

Who Can Go Home?

- Passive ideators with no active ideation, attempt
- Active ideators evaluated by MD and found to have no history of behavior or other active risk factors (don’t need psyc)
- Those evaluated by psychiatry and whom they deem are not emergent enough to warrant hospitalization.

Steering Committee

Edwin D. Boudreaux, PhD (Chair)
Health Psychologist
University of Massachusetts Medical School, Worcester MA

Carlos A. Camargo, Jr., MD, DrPH (Co-PI)
Emergency Physician, Epidemiologist
Massachusetts General Hospital and Harvard Medical School, Boston MA

Ivan Miller, III, PhD (Co-PI)
Clinical Psychologist
Butler Hospital and Brown University, Providence RI

Anne Manton, PhD, APRN, FAEN, FAAN
Psychiatric-Mental Health Nurse Practitioner
Cape Cod Hospital, Hyannis MA

Amy Goldstein, PhD
Clinical Psychologist, Chief, Child and Adolescent Preventive Intervention Program
National Institute of Mental Health, Bethesda MD

Investigators and Sites (continued)

Institution	Personnel	Role
Beth Israel Deaconess Medical Center	Kennedy, Maura, MD	Site-PI
Maricopa Medical Center	LoVecchio, Frank, DO	Site-PI
Memorial Hospital of Rhode Island	Uebelacker, Lisa, PhD	Site-PI
Ohio State University Hospital	Caterino, Jeffrey, MD	Site-PI
University of Arkansas Medical Center	Holmes, Talmage, PhD, MPH	Site-PI
University of Nebraska Medical Center	Zeger, Wes, DO	Site-PI

ED perspective

Sandra M Schneider MD FACEP
Past President
American College of Emergency Physicians
Professor, Chair Emeritus
University of Rochester


7

Future of Emergency Care Series

Hospital-Based Emergency Care

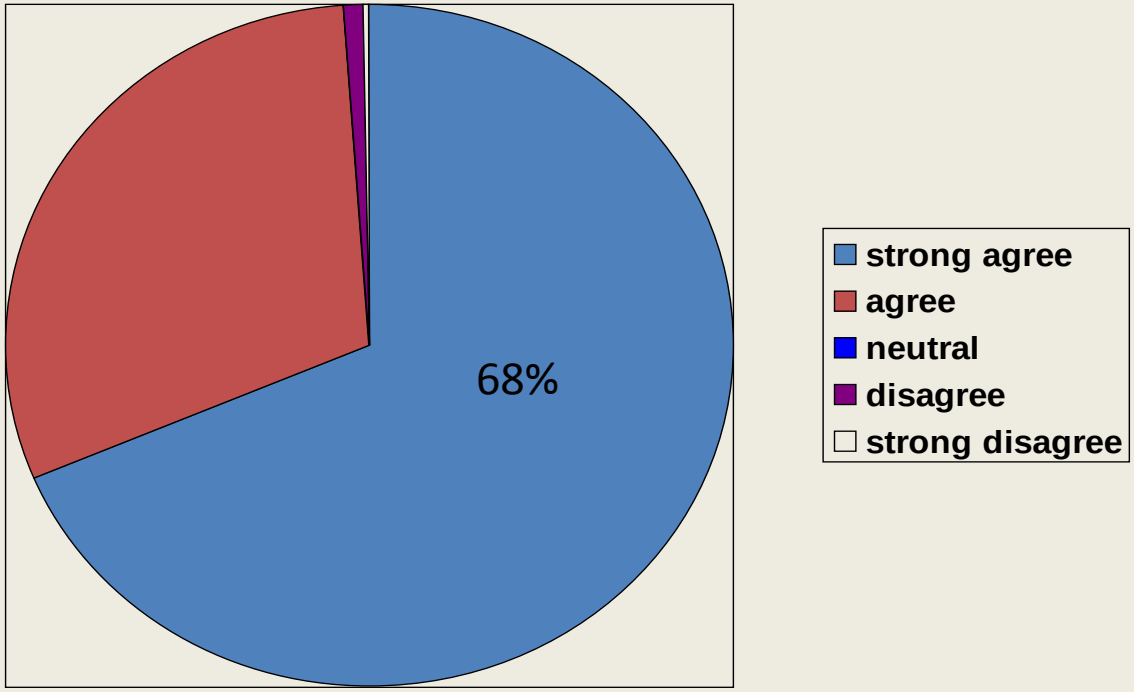
At the Breaking Point

Committee on the Future of Emergency Care in the United States Health System

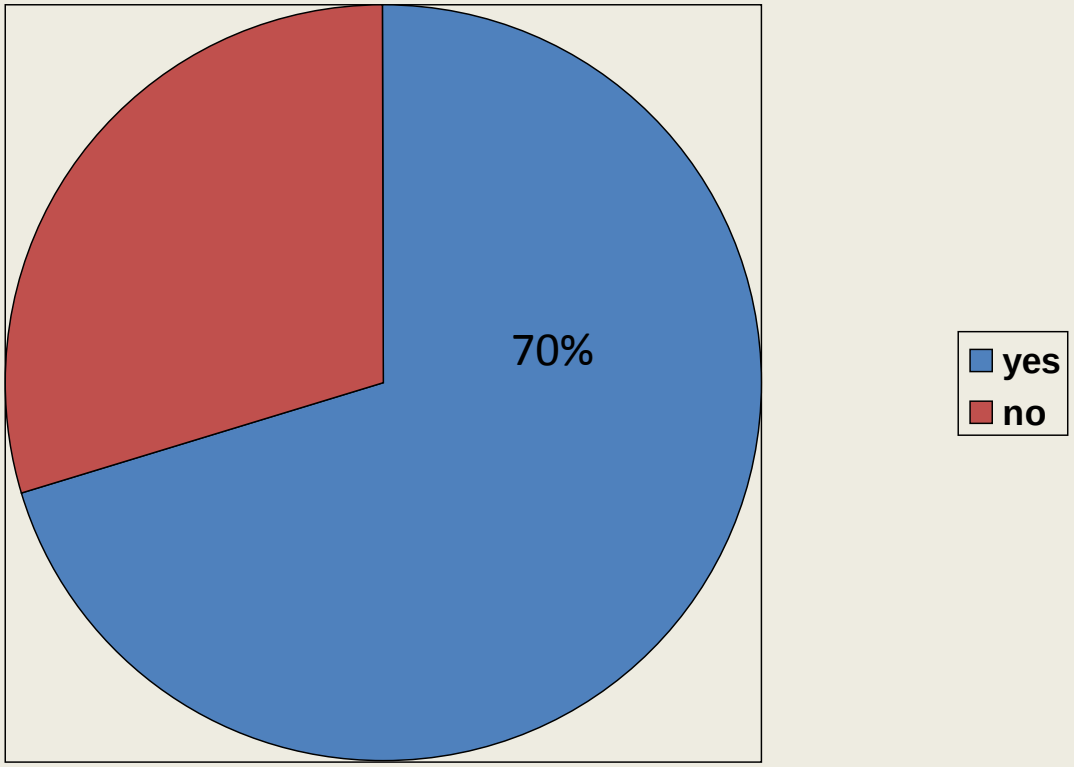
INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Advising the Nation. Improving Health.

Crowded conditions are harmful to patient care



Have you personally experienced a patient suffer harm as a result of crowding?




ΣΧΟΛΑΡΧΕΙΟΝ
ΑΝΩΤΑΤΟΝ
ΟΙΝΟ ΠΝΕΥΜΑΤΙΚΟΝ
ΙΔΡΥΜΑ

Bad for patients and hospitals

- Number one patient safety issue
- Increased adverse events
- Delays in care
- Increased mortality

Slate.com

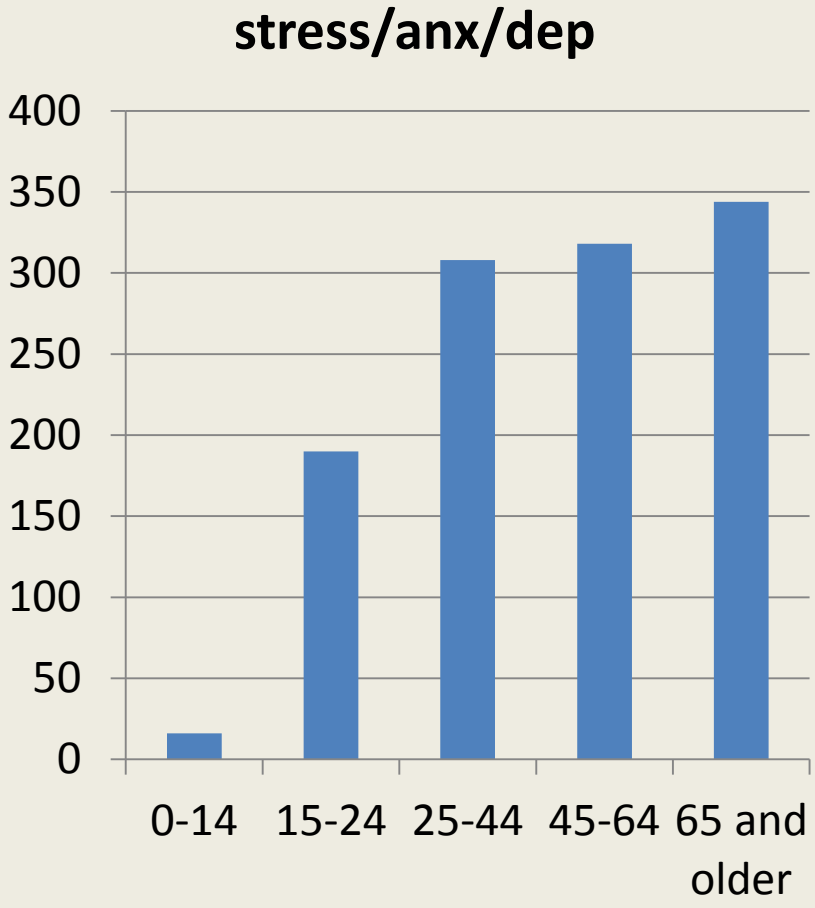
- **Waiting DoomHOW HOSPITALS ARE KILLING E.R. PATIENTS.**
- *By Zachary F. Meisel and Jesse M. Pines*
  Posted Thursday, July 24, 2008, at 6:54 AM ET
- Video of Esmin Green, who died in an E.R. waiting room

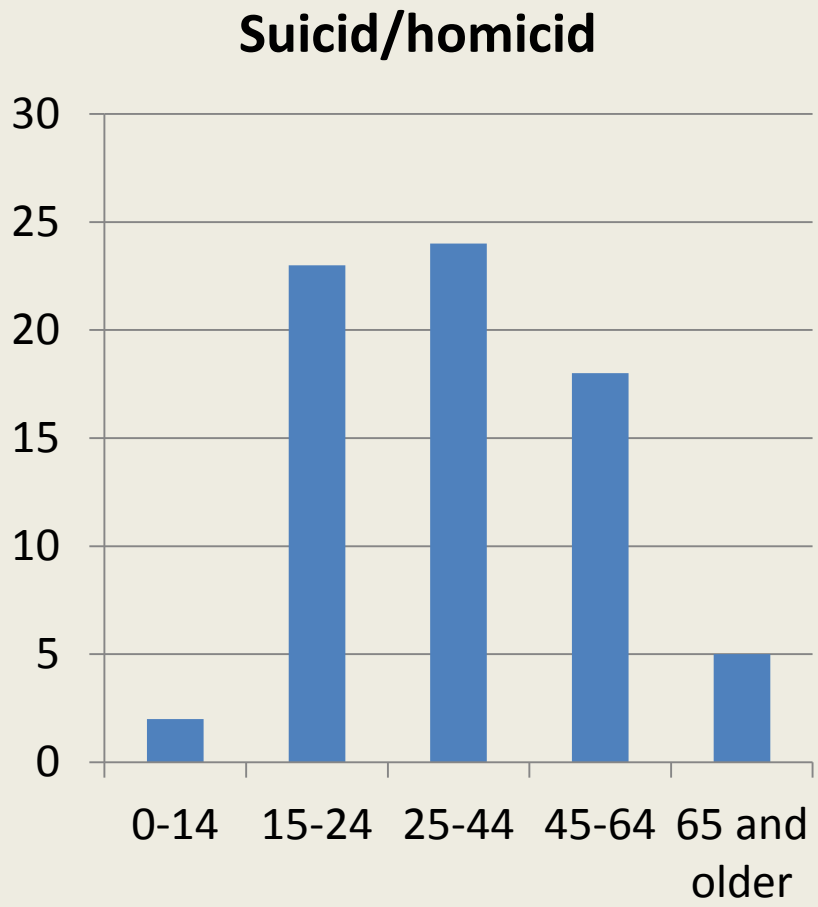
- Last month, Esmin Green, a 49-year-old mother of six, tumbled off her chair and onto the floor of the Kings County psychiatric E.R. waiting room in New York City. Members of the hospital staff saw her lying there but did nothing for about an hour. When Green was finally brought into the E.R., she was dead. An autopsy revealed that she died from a pulmonary embolism, which occurs when a blood clot forms in the leg, breaks off, and travels to one or both lungs. This can also kill long-haul airplane passengers who sit in one spot for hours:

The Evolving Role of Emergency Departments in the US 2013

- Primary source of admissions
  - 50% of all admissions
  - 2/3 of non-elective admissions
  - 4 of 5 PCP's tell pts to go to the ED for admission
    - Many barriers to direct admission
  - Major issue driving admissions is followup care

CDC report June 2013





ED visits per year per 10,000 population

- 2006 survey of state mental health authorities
  - 80% had shortage of MH beds
  - 34 states had shortage of acute care beds
  - 16 states had shortage of long term care beds

APA: The psychiatric delivery system is "fragile and beset by problems"

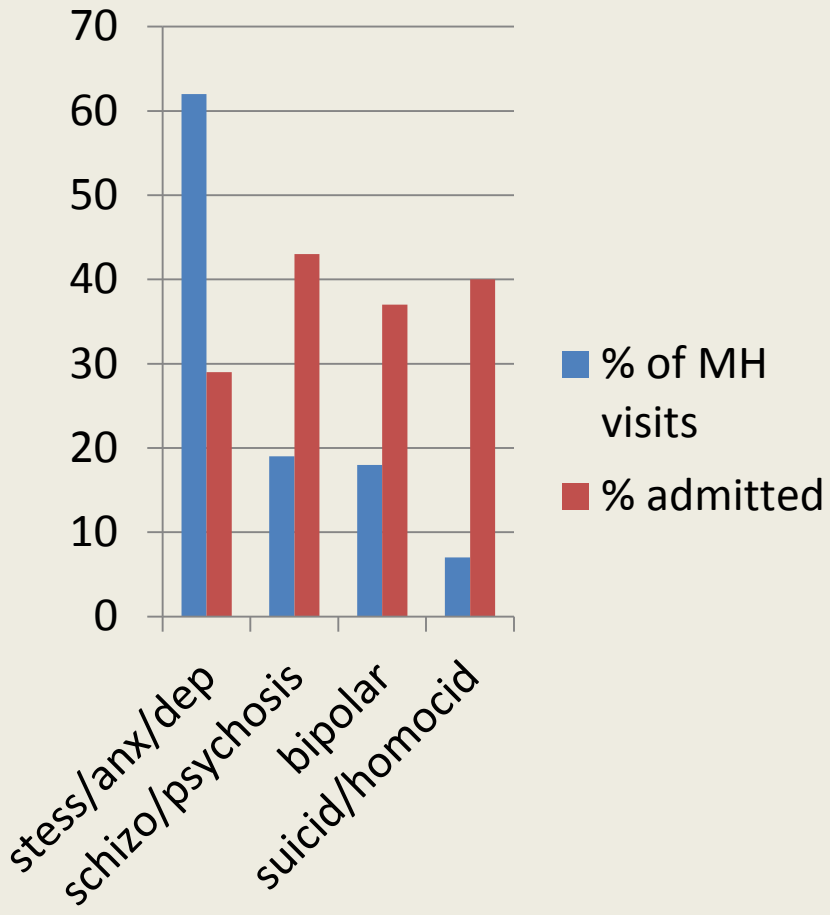
- 1 in 4 adults has a diagnosable mental illness
- 5-7% of the population suffer severe mental illness
- Visits to ED likely to increase
  - Mass experience
  - Increased use by newly insured (32% higher)
  - Increased use by newly uninsured (40% higher)
  - Catch up (New Zealand)

"A constant frustration"

CDC report June 2013

- 10% ED visits in NC had MH code
  - 31% are admitted (7X rate for ED overall)
- ED visits up 2008-2010 by 5.1%, for MH 17%

CDC report June 2013



Behavior Medicine in ED

- Deinstitutionalization since 1960's with emphasis on community care
- Funding transferred from state to local
- Community services uncoordinated, underfunded

"The ED is expected to solve society's problems"

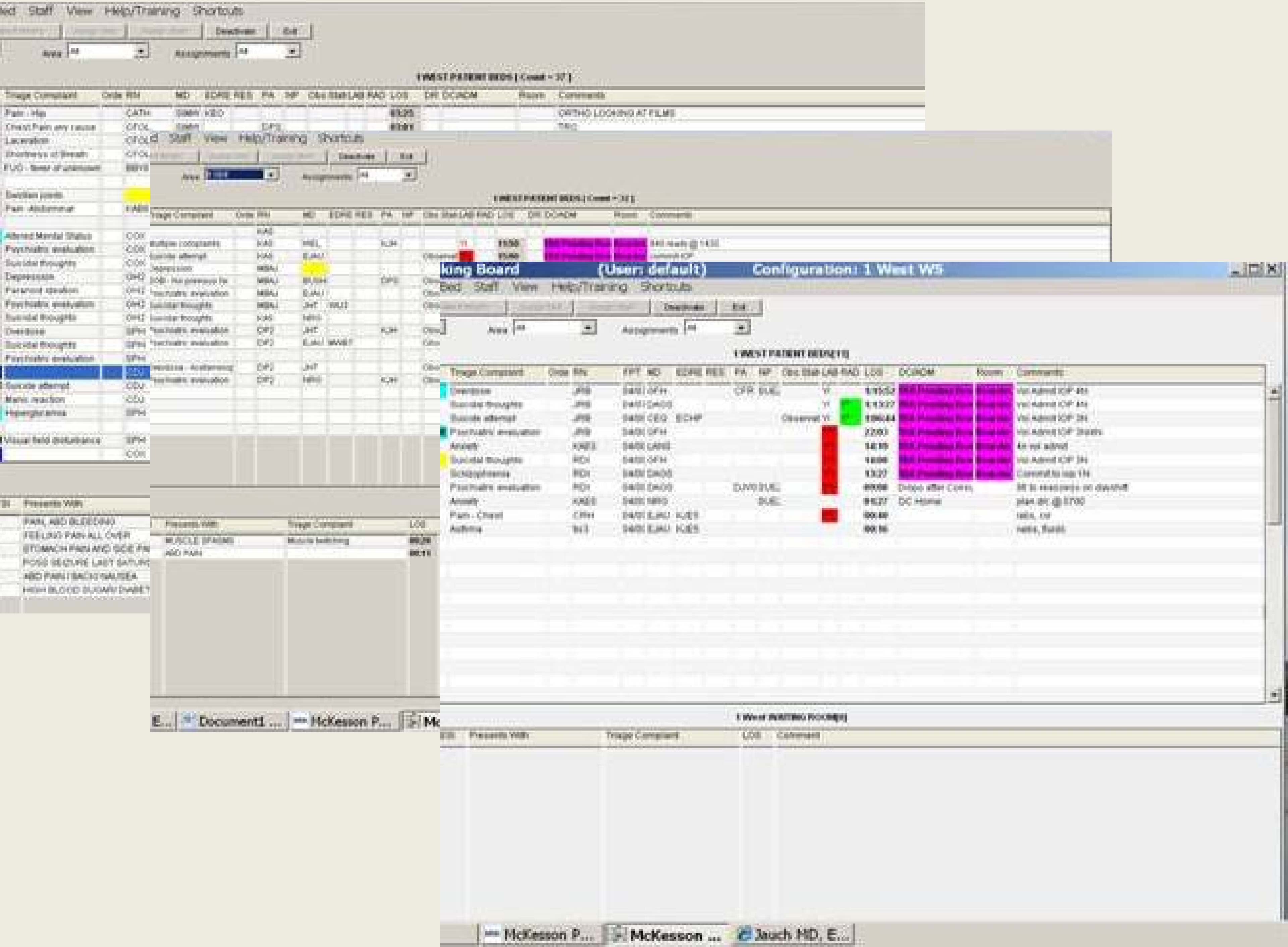
- Fl: increase in MH visits 40% in 4 years. 42% uninsured. 1 in 4 remain in ED >24 h
- MO: wait 2-3d, takes 60h for calls (4hwork) to transfer. Some pt transferred 500mi away
- NC: boarding up to weeks
- TX: held for hours to days
- GA: 10% of ED beds at any time
- LA: 5 MH pts in 17 bed ED took over 72h to place
- CA: MH visits to ED increased 38% in 10y while ED visits up only 8%

"Simply a crime"

"Devastating state of affairs"

- NC: children held over 1 week
- ME: Waits 24-48h not unusual
- MD: holding 15-20 MH patients for 2-3ds in a 36 bed ED
- OR: regularly board at times >1week
- CT: Often send out of state
- NC: right now holding 4 MH patients – 14, 15, 10 and 44 hours
- CA: can take weeks to place
- KS: boarding 24-48h common

"As I write this 1/3 of our ED beds are fu
patients, ½ have been here >48h"



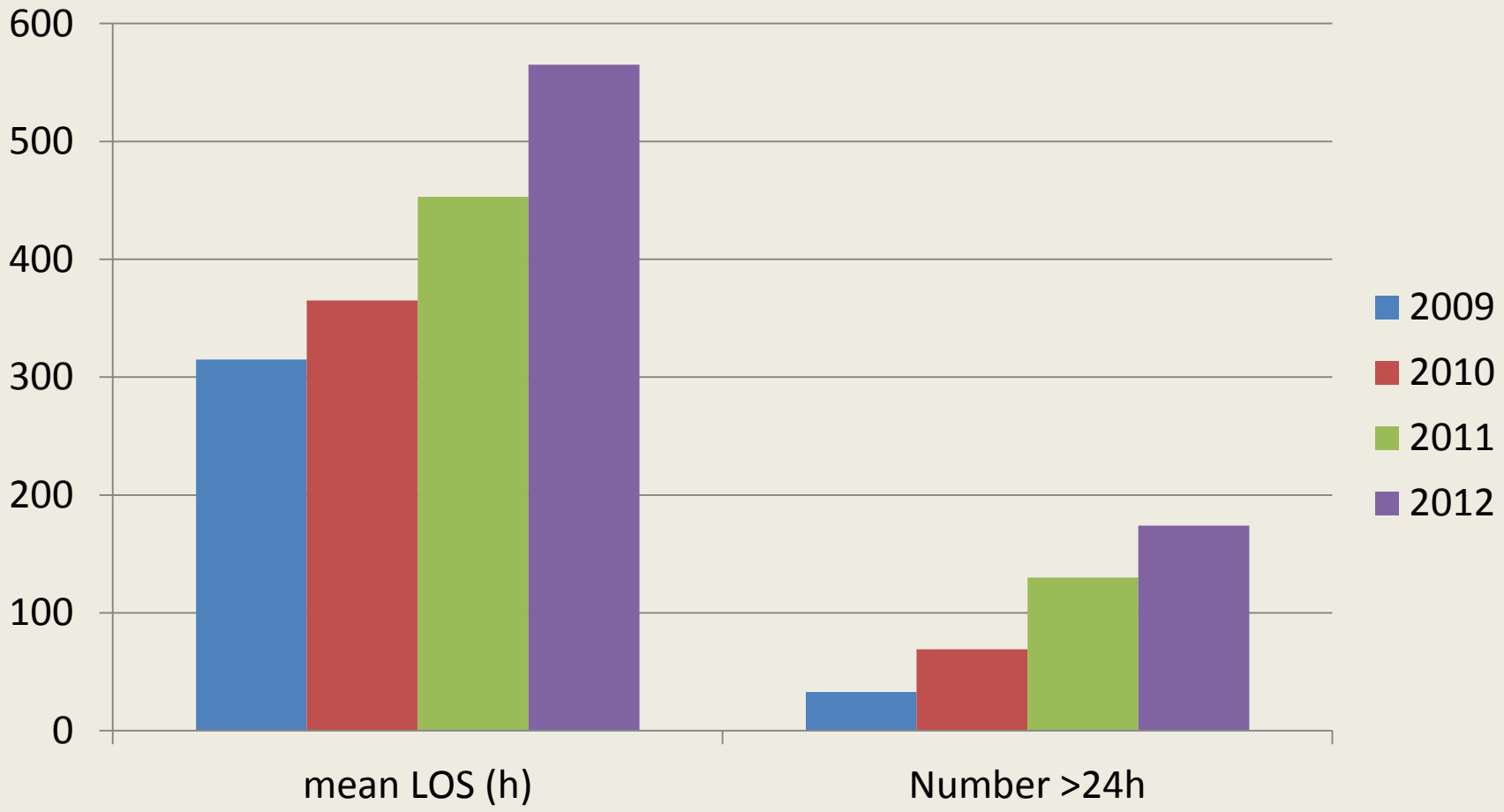
king Board (User: default) Configuration: 1 West WS
Bed Staff View Help/Training Shortcuts
Deactivate
Exit
Area
Assignments
Triage Complaint
Comments
Presents With
Document1 ...
McKesson P...
McKesson ...
Jauch MD, E...

MA

- Point in time
- 69% of hospitals responded (46 hospitals)
- 149 MH boarders – there for 5265 h
- 14% occupancy of ED (41% max)
- Max LOS 7.5 d; 46% over 24h, 12% over 3 d; 3% over 5 d
- Max ever 35d adult, 17d child

“When it is bad, it is very very bad”

MA – LOS over time
Single hospital



Loss of beds

- MO: lost 10-20% over 10 y; increase vol 10%
- SC: only 2 state hosp left, long waiting lists
- PR: Little available
- WA: lost 50% of MH inpt beds in 10 y
- NC: closure beds without OP care
- AL: Governor intends to close all by 1

Closures reported in every state that responded

"They come to us because there is nowhere else"

- Funding cuts
  - Cuts of Federal and state
  - Shifting from state to local, then cut
  - Cuts to OP care and extended care facilities
  - Funding based on historical needs
- Reimbursement
  - Matching funds required from counties
  - Most facilities won't take MA let alone self pay

"The decentralized, underresourced, disorganized MH system has recklessly collided with emergency medicine"

Hardest to place

- History of violence
- Children
- Pregnant
- Geriatric
- Patients with medical disease
- Anyone on a weekend

"Worst are the children, no one wants them and they know it"

Detention process

- Long, complicated
  - WA: must be sober; ED eval and 2 psych evals w 2nd eval from 'designated' MH professional – only 1-2 in each county. Takes min 4-6h, often >20h
  - TX: ED MD does not have power to hold
  - MA: 24h hold in ED, after that no power to hold
  - MD: ED often used as MH facility for court

  If admit patient to hospital cannot get to MH

  "They pace around like caged animals in a zoo"

"The largest provider of MH services is the jail. Sometimes people who can't afford their meds commit minor offenses to get locked up so they can receive the care they need – County Sheriff TX"

Patients/families

- *We put them in a windowless room with a 'sitter' staring at them day and night, with minimal exercise and non one paying attention to them, often not getting regular meals"*

Boarders without Doctors

Adaptations

- Violence training for all staff
- Reconfigure rooms in ED to create MH rooms
- Video/audio monitoring
- Medical clearance guidelines
- Telepsychiatry
- Peer counselors

"We are taking our most vulnerable patients and putting them in circumstances that would devastate the strongest of people"

12-Hour Wait Reporting for Emergency Department Patients Seeking Mental Health Services Time Period July 1 – Aug 5, 2009

In 2008, a similar study was conducted - ***no substantial improvement*** in wait times experienced by patients.

Recorded patients in need of mental health services waited in emergency departments for 12 hours or more after medical clearance.

- 95 % reported waits of approximately 48 hours
- 60 episodes of waits between 48 and 120 hours were reported
- 8 episodes were between 120 and 192 hours
- Close to 65% seeking placement in a short term care facility, county or state psychiatric, or forensic facility
- 50 % awaiting transfer to another bed type outside of their organization,
- More than 300 reported episodes required 1:1 supervision

Recommendations

- *data-based, consumer engagement*
- statewide needs assessment
- forego bed closures in state facilities
- Consider an expedited and more flexible Certificate of Need process for acute involuntary beds
- that are not financially supported by the state;
- Explore the integration of related budgets to fund coordinated delivery system;
- identify and incentivize innovative community-based programs
- Engage Federally Qualified Health Centers and other lower-cost clinics to provide timely medication management follow-up after discharge;
- Revisit the work of the Acute Care Task Force that was never released and integrate the work of the substance abuse/mental health work group

Outcome 3 years later?

- NO CHANGE

Successes

- AZ: collaboration with state to shift money from prevention/long term care to acute care
- TX: Bexar Co created sobering unit and crisis services to divert from jail and ED
- MN: increased # freestanding MH hospitals/beds – "*lucky*"
- MI: Community wide strategic plan-Gateway to Better Health – increased primary care visits, dental services, literacy. Diverted $ to ED care, integration of services, access to MH services

Successes

- GA: Under Federal Court order streamlined self med clearance, can now speak to psychiatrist, ambulance can transfer pt (not police), report LOS quarterly, telepsychiatry
- MT: Have enough beds, increased OP care after IP care. Rural areas have self organized and promoted MH issues

Successes

- NY: Some CPEP programs take responsibility for patients from start (no clearance); coordinated with OP services and mobile teams staffed by psychiatrists
- TX: Mobile crisis team comes to hospital with patient
- CA: in hosp MH evaluation teams cut evaluation by over 60%

Success

- CMS demonstration project - $75M to DC AL, CA, CT, IL, ME, MD, MO, NC, RI, WA, WV
- Part of ACA
- Provide better quality of care for less by reimbursing private hospitals for services previously not reimbursed (care for patients 21-64).
- 3 year program

Successes

- Central Oregon Health Council
  - www.cohealthcouncil.org
- Care coordination of frequent visitors
  - 274 patients in first cohort, 600 in second
  - >12 visits per year
  - MH or chronic pain or addiction
  - Primarily MA, didn't know PCP or kicked out of medical home

Successes

- St Mary's ME
- Developed behavioral ED
- State law requires insurers to pay for telehealth
- Telepsychiatry model
- Current payer mix requires 6.1 visits per shift to break even. Patient billed for service
- Contracted facilities pay fee to participate

Success

- St Anthony Hospital OK
- Changes: MHA admissions office in ED
- MH staff get cell phone instead of pagers
- Evaluation done prior to bed placement
- AM Discharges
- Descalation training for all ED staff
- Appointments on line
- Police to assist in transfer

- Increase in MH evals in ED 5150-5800
- Time in ED 240 m-150 m
- Percent MH lwbs 9-3.5%
- Identified need for
  - Community outreach after discharge
  - Standards for MH screening
  - Medication protocols for agitation
  - Transport protocols
  - Thruput on MH units and early discharges

Success

- South Carolina Hospital Association
- shortage of psychiatrists
- Solution telepsychiatry
- 10K consults between 3/08 and 5/12
- Had to link emr’s
- LOS decreased 50% (75 h in 09 to 37h)
- Net cost savings of $1K per episode of care

"My sibling was hit head on, once a graduate student now can barely hold a job. Now a MH patient, now is one of those 'throw away' people.

We are all just one car crash away from joining her"

Study 1: RAND Expert Lens

1. Decision-support: identifying which suicidal patients can be discharged

Incl. Documentation

2. Treatment Protocols

3. Discharge planning Protocols

4. Patient-centered care recommendations *

5. Legal considerations *

6. Considerations for special populations *

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** Items 4-6 are not consensus-based*

Imagine a patient in an ED has been identified for whatever reasons as having some non-zero suicide risk. Further imagine that this patient is being examined by an emergency physician or other non-mental health professional.

What questions, if answered in the negative, would allow the Emergency Physician to release the patient from the ED without further assessment by a MHP, or alternatively, if answered affirmatively would require a detailed suicide risk assessment (presumably by an MHP).

Study 1, continued

- ✓ Rate common risk assessment items
- ✓ What is the right number of items
- ✓ What is the right sequence

→ *Minimum items necessary for ED provider decision-making re: which suicidal patients can be discharged*

Contact

Questions/comments are welcome at any time:

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Information about SPRC

SPRC SUICIDE PREVENTION RESOURCE CENTER

The Weekly Spark

June 13, 2013

Read this newsletter on the web

Announcements

IHS's TeleBehavioral Health Center for Excellence hosts second webinar in its series on suicide prevention training *Understanding Suicide* will discuss the importance of shared definitions of suicide, the differences between warning signs and risk factors, how to use protective factors and how to identify warning signs and risk and protective factors.

For more information

Research

Comprehensive Suicide Prevention for College Campuses
This "Perspectives" piece offers a comprehensive framework for preventing suicide on college campuses that the authors contrast with the "standard" framework "which relies on referral to, and treatment by, mental health services." The authors acknowledge that this framework is similar to that being used by campus grantees of the Garrett Lee Smith Memorial Act. Read more

This research summary is based on information in: Drum, D. J., & Denmark, A. B. (2012) Campus suicide prevention: Bridging paradigms and forging partnerships. *Harvard Review of Psychiatry, 20*(4), 209-221.

National News

Study: Identifying suicide risk factors

The Atlantic

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