Newer Developments in ED Operations and Alternatives

Topics

- Zero Suicide
- First Break Psychosis Care
- Telemedicine
- Warm lines
- Crisis centers
- Urgent care
- Crisis teams
- ACT Teams
- Diversion or respite units

Zero Suicide Initiative

Zero Suicide is a key concept of the 2012 National Strategy for Suicide Prevention, a priority of the National Action Alliance for Suicide Prevention (Action Alliance), a project of Education Development Center's Suicide Prevention Resource Center (SPRC), and supported by the Substance Abuse and Mental Health Services Administration (SAMHSA). The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and behavioral health systems are preventable. It presents both a bold goal and an aspirational challenge.

Zero Suicide Components 1-3

- Lead – Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include survivors of suicide attempts and suicide loss in leadership and planning roles.
- Train – Develop a competent, confident, and caring workforce.
- Identify – Systematically identify and assess suicide risk among people receiving care.

Zero Suicide Components 4-8

- Engage – Ensure every individual has a pathway to care that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.
- Treat – Use effective, evidence-based treatments that directly target suicidal thoughts and behaviors.
- Transition – Provide continuous contact and support, especially after acute care.
- Improve – Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

Topics Covered by Survey 66 Questions For Z S

- Section 1. Your Work Environment
- Section 2. Suicide Prevention within Your Work Environment
- Section 3. Recognizing When Patients May Be at Risk for Suicide
- Section 4. Screening and Assessing Patients for Suicide Risk
- Section 5. Training on Screening and Risk Assessment
- Section 6. Providing Care to Patients at Risk
- Section 7. Use of Evidence-Based Treatments That Directly Target Suicidality
- Section 8. Care Transitions
- Section 9. Training and Resource Needs

Sample Survey Questions

Please indicate how much you disagree or agree with each of the following statements.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
7. I am familiar with the "Zero Suicide" initiative.	☐	☐	☐	☐	☐
8. I understand my role and responsibilities related to suicide prevention within this organization.	☐	☐	☐	☐	☐
9. I believe suicide prevention is an important part of my professional role.	☐	☐	☐	☐	☐
10. The leadership at this organization has explicitly indicated that suicide prevention is a priority.	☐	☐	☐	☐	☐
11. This organization has clear policies and procedures in place that define each employee's role in preventing suicide.	☐	☐	☐	☐	☐
12. I have received training at this organization related to suicide prevention.	☐	☐	☐	☐	☐
13. This organization provides me access to ongoing support and resources to further my understanding of suicide prevention.	☐	☐	☐	☐	☐
14. I feel that my organization would be responsive to issues that I bring up related to patient safety.	☐	☐	☐	☐	☐

Steps to Implement Zero Suicide

1	Read the online Zero Suicide Toolkit.
2	Challenge your organization to adopt a comprehensive approach to suicide care, using the readings and tools in the Lead section of the toolkit.
3	Convene your Zero Suicide implementation team.
4	Discuss and complete the Zero Suicide Organizational Self-Study.
5	Create a work plan and set priorities, using the Zero Suicide Workplan Template.
6	Formulate a plan to collect data to support evaluation and quality improvement using the Zero Suicide Data Elements Worksheet.
7	Announce to staff the adoption of an enhanced suicide care approach.
8	Administer the Zero Suicide Workforce Survey to all clinical and non-clinical staff to learn more about staff's perceptions of their comfort and competence caring for those at risk for suicide.
9	Review and develop processes and policies for screening, assessment, risk formulation, treatment, and care transitions. Examine the use of electronic and/or paper health records to support these processes.
10	Evaluate progress and measure results. Revisit the Zero Suicide Organizational Self-Study to check your organization's fidelity to the core components of Zero Suicide. Collect data on the measures you selected in Step 6.

But We Can’t Do That

- Discuss with leadership = They should know what is happening
- Invite providers such as clinics and rehabilitation services to review the concept
- Offer to provide a warm hand off to any organization accepting the challenge
- Collect promises of acceptance
- Set up a rotating referral service
- Check on referrals every three months

First Break Psychosis

- 100,000 adolescents and young adults in the United States experience FEP each year
- Onset between 15-25 years of age,
- Initiate a trajectory of accumulating disability
- Early intervention with evidence-based therapies offers real hope for clinical and functional recovery
- Annual cost of schizophrenia over $70 Billion
- Frequent visitors to Emergency Care

RA1SE

Four interventions, each with their own manuals and materials

- prompt detection of psychosis,
- acute care during or following periods of crisis,
- recovery -oriented services offered over a 2-3 year period following psychosis onset
- Continuity of specialized care up to five years post-psychosis onset in order to consolidate gains achieved through initial treatment

RA1SE
Intensive Phase

- Team based assertive case management,
- Individual or group psychotherapy
- Family Therapy,
- Individual Resiliency Training, and Supported Employment/Education
- **Low** doses of select anti-psychotic agents

RA1SE Sites

http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml

- California: 2
- Colorado: 2
- Connecticut:
- Florida
- Georgia 2
- Indiana:
- Iowa:
- Louisiana: 2
- Michigan 3
- Minnesota: 2
- Mississippi
- Missouri: 4
- Nebraska
- New Hampshire: 2
- New Jersey
- New Mexico
- New York
- Oregon
- Pennsylvania
- Rhode Island
- Providence,
- Vermont

Health Technology for Relapse Prevention in Schizophrenia

5 components of the HTP were

(1) developing a relapse prevention plan with the MHTC,

(2) an interactive smartphone illness self-management system,

(3) a Daily Support Web site for psychoeducation for patients and family members,

(4) Web-based cognitive behavioral therapy skills for psychosis modules, and

(5) evidence-based psychopharmacological treatment.

The Prospects of Telepsychiatry

- Increasing evidence of value
- No limitation on what private health plans can allow
- Increasing demand for cost reduction and reduction in time in ED both can be helped
- New partnerships can achieve good results
- Obtain consults with complex cases
- Use warm lines
- Use 7 Cups?

Telemedicine Under CMS

- Available only when originated in a rural Health Professional Shortage Area, located outside of a Metropolitan Statistical Area (MSA) or
- In a rural census tract, as determined by the Office of Rural Health Policy within the Health Resources and Services Administration (HRSA); or
- A county outside of a MSA
- Must be pursuant to a written agreement
- Must be staff credentialed by home hospital
- May be Medicare Hospital or other entity as a contractor to requesting hospital
- May be people employed or "used-by"
- Might be modified by State Plan Amendment or Waiver

Other Telehealth Authorizations

- States can allow Medicaid telehealth services
- Center for Telehealth and Ehealth Law conducted 50 state survey found 39 states have some type of reimbursement for services via telehealth.
- Private insurers can allow telehealth services
- Having a written agreement and credentialing is central
- Hosting site needs to have adequate tele-communications capacity. Receiver may be somewhat less formal

States Mandating Telehealth Coverage

- California
- Colorado
- Georgia
- Hawaii
- Kentucky
- Louisiana
- Maine
- Maryland
- Michigan
- New Hampshire
- Oklahoma
- Oregon
- Texas
- Vermont
- Virginia

States Identified in Survey Auth. Some TeleMed

Alabama	Louisiana	Oregon
Alaska	Maine	Pennsylvania
Arizona	Michigan	South Carolina
Arkansas	Minnesota	South Dakota
California	Mississippi	Tennessee
Colorado	Missouri	Texas
Florida	Montana	Utah
Georgia	Nebraska	Vermont
Hawaii	New Mexico	Virginia
Idaho	New York	Washington
Illinois	North Carolina	West Virginia
Indiana	North Dakota	Wisconsin
Kansas	Oklahoma	Wyoming
Kentucky		

Seven Cups

- http://www.7cups.com/
- An on-demand emotional health and well-being service
- Bridging technology anonymously & securely connects real people to real listeners in one-on-one chat.
- Trained, compassionate listeners from all walks of life and have diverse experiences
- Listener doesn't judge or try to solve problems and say what to do, just listen. They understand. They give you the space you need to help you clear your head.
- Connect with a listener by requesting first available listener, or a specific listener

Warm Lines

- Suicide Prevention Resource Center http://www.suicidepreventionlifeline.org/
- List of state by state lines http://www.suicide.org/suicide-hotlines.html
- Potential for follow-up calls

Crisis Centers, non-ED Centers

- Free standing behavioral health emergency centers
  - Bexar county
  - RI Living Room
  - HMC/UW Crisis Center
- Free standing urgent care
- Crisis teams
- ACT Teams
- Respite or recovery units
  - Rose House
  - Others

Crisis Centers

- Separate from ED
- Well staffed with behavioral health professionals
- Full array of interventions
- May accept people directly
- Ambulance or Police bring people directly
- Includes detoxification
- Receives direct reimbursement

Examples

- Bexar Center for Health Care Services
- Harborview Crisis Solution Center
- Contra Costa Crisis Stabilization Center
- Recovery Innovations

Free Standing Urgent Care

- Usually just general health, but could choose to provide care
- Lack specialization
- Do not yet generally recognize the issue

Crisis Teams

- Teams usually mobile
- Often connected to a hospital
- Has a few members, may not have a physician
- May choose to admit to inpatient which often require an ambulance
- Usually follow up on people not admitted
- Often need some additional funding

ACT Teams

- A very specific model. Test for adherence to model
- Reimbursed by Medicaid
- Follow a specific group of people and work to avoid ED and hospital use
- Includes psychiatrist
- Expense justified based n alternative of inpatient

Respite and Recovery Centers

- Recovery Innovations Living Room
- Rose House
- NYS respite centers
- Hospital based respite beds