Hospital-Based Assessment of Depression and Suicide

Itai Danovitch, MD, MBA
Chairman, Dept of Psychiatry & Behavioral Neurosciences

Rosanne Arnold, MBA
Associate Director, Dept of Psychiatry & Behavioral Neurosciences
Objectives

- Why screen for depression?
- Why screen for depression in general medical hospitals?
- What are the regulatory requirements around depression and suicide?
- Case Example: Cedars-Sinai
- Future directions
Objectives

- **Why screen for depression?**
- Why screen for depression in general medical hospitals?
- What are the regulatory requirements around depression and suicide?
- Case Example: Cedars-Sinai
- Future directions
Mental health and substance use disorders are the leading cause of disease burden in the U.S.

Age standardized disability adjusted life years (DALYs) rate per 100,000 population, both sexes, 2015

- Mental health and substance use disorders: 3,355
- Cancers and tumors (Neoplasms): 3,131
- Cardiovascular disease: 3,065
- Injuries: 2,419
- Musculoskeletal disorders: 2,357
- Endocrine (diabetes): 1,827
- Nervous System: 1,463
- Chronic respiratory: 1,050
- Skin diseases: 642
- Sense organ disease: 624

Comorbidity is common

People with mental disorders: 25% of adult population

People with medical conditions: 58% of adult population

68% of adults with mental disorders have medical conditions

29% of adults with medical conditions have mental disorders

Source: Adapted from the National Comorbidity Survey Replication, 2001–2003 (3, 83)
6.7% of all US adults experienced at least one MDD episode in 2015.
# Impact of Depression

<table>
<thead>
<tr>
<th>Category</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disabling</strong></td>
<td>#2 cause of disability (WHO)</td>
</tr>
<tr>
<td><strong>Exacerbating</strong></td>
<td>Symptom burden; Course of illness; Clinical outcome; Adherence to self care; Satisfaction</td>
</tr>
<tr>
<td><strong>Costly</strong></td>
<td>Outpt visits; ED; Hosp; Pharm; LOS; Readmission; 50-100% higher health care costs</td>
</tr>
<tr>
<td><strong>Deadly</strong></td>
<td>Over 30,000 suicides / year; (38-76% of completers saw their PMD in prior mo)</td>
</tr>
<tr>
<td><strong>Treatment Works</strong></td>
<td>Therapy; Medications; Behavioral interventions; Self-Care</td>
</tr>
</tbody>
</table>
Screening for Depression in Adults

US Preventive Services Task Force Recommendation Statement

**DESCRIPTION** Update of the 2009 US Preventive Services Task Force (USPSTF) recommendation on screening for depression in adults.

**METHODS** The USPSTF reviewed the evidence on the benefits and harms of screening for depression in adult populations, including older adults and pregnant and postpartum women; the accuracy of depression screening instruments; and the benefits and harms of depression treatment in these populations.

**POPULATION** This recommendation applies to adults 18 years and older.

**RECOMMENDATION** The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up. (B recommendation)


*Grade B: The USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial.*
Objectives

• Why screen for depression?

• Why screen for depression in general medical hospitals?

• What are the regulatory requirements around depression and suicide?

• Case Example: Cedars-Sinai

• Future directions
Depression is over-represented in general medical inpatients

<table>
<thead>
<tr>
<th></th>
<th>Community</th>
<th>Primary Care</th>
<th>General Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Disorder</td>
<td>16%</td>
<td>21-26%</td>
<td>30-40%</td>
</tr>
<tr>
<td>Major Depression</td>
<td>2-6%</td>
<td>5-14%</td>
<td>8-18%</td>
</tr>
<tr>
<td>Panic</td>
<td>0.5%</td>
<td>11%</td>
<td>***</td>
</tr>
<tr>
<td>Somatization</td>
<td>0.1-0.5%</td>
<td>2.8-5%</td>
<td>2-9%</td>
</tr>
<tr>
<td>Delirium</td>
<td>1%</td>
<td>***</td>
<td>15-30%</td>
</tr>
<tr>
<td>Substance Use</td>
<td>2.8%</td>
<td>10-30%</td>
<td>20-50%</td>
</tr>
</tbody>
</table>

Depression is associated with increased cost of care

Claims expenditures for 6,500 Medicaid patients with and without MH/SUD service use

**SOURCE:** Thomas et al, Psych Serv 56:1394-1401, 2005
Prevalence of depression across other medical conditions

Point Prevalence of Major Depressive Disorder

- General Population: 6.70%
- Diabetes: 12%
- ALS: 17%
- CHD: 19%
- Stroke: 24%
- Parkinson: 31%
- HIV: 36%
- MS: 40%
- SLE: 45%

NOTES:
ALS = amyotrophic lateral sclerosis; CHD = coronary heart disease; HIV = human immunodeficiency virus; MS = multiple sclerosis; SLE = systemic lupus erythematosus

SOURCE: Sadock BJ et al. Kaplan and Sadock’s Comprehensive Textbook of Psychiatry (9th ed.) Lippincott Williams & Wilkins: 2009; Psychosomatic Medicine; Sg2 Analysis, 2010
## Ex. Impact of depression on outcomes in CV disease

<table>
<thead>
<tr>
<th>Cardiovascular Illness</th>
<th>Impact of Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary artery disease</td>
<td>40% ↑ risk of cardiac events</td>
</tr>
<tr>
<td>Unstable angina</td>
<td>3x ↑ of cardiac death at 1year</td>
</tr>
<tr>
<td>Post-MI</td>
<td>4-6x ↑ mortality</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>50% survival vs. 78% survival</td>
</tr>
</tbody>
</table>

Single greatest predictor of cardiac death over 5 years is depression score in hospital after heart attack

Long-term survival (days post-discharge) after myocardial infarction (MI) in relation to Beck Depression Inventory (BDI) score during hospitalization

Screening for depression in hospitalized medical patients (Review of publications)

• **Addressed two questions:**
  – Performance of depression screening tools in gen hospital
  – Associations between depression and patient outcomes
    • PRISMA Guidelines; 1990-2016

• **Findings**
  – 20 Studies Assessed prevalence and validity
    • Prevalence 34% (15-60% range)
    • Sensitivity 78%; Specificity 80%
  – 12 Studies Assessed outcomes
    • Increased 30d readmission
    • Increased LOS
    • Increased morbidity/mortality
    • Decreased QOL

• **Overall**
  – Diverse instruments used; Brief instruments had good performance
  – Mental health training not necessary
  – Screening not particularly burdensome to patients or staff

General Medical Hospitals represent a significant opportunity to identify and treat depression

**Failure to Detect, Diagnose, and Treat**
- Only 13% of eligible patients have antidepressants begun in the hospital
- Only 11% of untreated depressions will begin treatment during the year after discharge

**Post-Discharge Impact**
- Increased risk of all-cause re-hospitalization
- Increased mortality in MI; Stroke

**Sentinel Events**
- Suicide is among the Top 5 sentinel events in The Joint Commission’s database

Objectives

- Why screen for depression?
- Why screen for depression in general medical hospitals?
- **What are the regulatory requirements around depression and suicide?**
- Case Example: Cedars-Sinai
- Future directions
Regulatory Requirements around Depression and Suicide

Suicide is among the Top 5 sentinel events in The Joint Commission’s database.

“The Joint Commission will place added emphasis on the assessment of ligature, suicide and self-harm observations in...inpatient psychiatric patient areas in general hospitals” (March 1, 2017)

<table>
<thead>
<tr>
<th>Joint Commission requirements related to detecting and treating patients with suicide ideation</th>
<th>Hospital</th>
<th>Ambulatory</th>
<th>Behavioral health</th>
<th>Home care</th>
<th>Nursing care center</th>
<th>Office-based surgery</th>
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<tbody>
<tr>
<td>Care, Treatment, and Services</td>
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<tr>
<td>CTS.02.01.01</td>
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<tr>
<td>Environment of Care</td>
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<td>EC.02.01.01</td>
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<td>EC.02.06.01</td>
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<tr>
<td>National Patient Safety Goal</td>
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<td>NPSG.15.01.01, EPs 1, 2, 3</td>
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<td>Performance Improvement</td>
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<td>Provision of Care, Treatment, and Services</td>
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<td>PC.01.01.01 EP 24</td>
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<td>PC.04.01.01</td>
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</tbody>
</table>
**Actions suggested by The Joint Commission**

<table>
<thead>
<tr>
<th>Detecting SI in Acute Care Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review each patient’s personal and family medical history for suicide risk factors.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Taking Immediate Action and Safety Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use assessment results to implement specific safety measures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education and Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate all staff in patient care settings about how to identify and respond to patients with suicide ideation.</td>
</tr>
</tbody>
</table>

Source: Sentinel Event Alert, Issue 56, February 24, 2016 (https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf)
# Risk Factors for Suicide in Hospitals

## Patient Risk Factors
- Mental or emotional disorders
- Previous Suicide attempts or history of self-inflicted injury
- Suicidal thoughts or behaviors
- History of Trauma
- Drug or alcohol abuse
- Chronic or intense acute pain; Chronic medical disability
- Prescribed medications, including those known to cause behavioral changes
- Social isolation or antisocial behavior
- Social stressors

## Physical Environment
- Unsecured environment, such as access to stairways and unsecured windows
- Ability of visitors to bring in contraband
- Opportunities to be alone without supervision (e.g. bathrooms, closets)
- Access to anchor points for hanging
- Access to materials that can be used for self-harm (e.g. sharps, sheets, plastic bags, etc.)

## Systemic Care
- Inadequate care planning and observation
- Inadequate screening and assessment
- Insufficient staff orientation and training
- Inadequate staffing, including lack of one-on-one sitters for suicidal patients when necessary
- Lack of information about suicide prevention and referral resources
- Poor staff communication

Source: Lippincott Advisor
(http://advisor.lww.com/lra/document.do?bid=33&did=558497&hits=suicide,suicides)
HEDIS Depression Measures

HEDIS Depression Measures – Electronic Clinical Data

**Depression Screening and Follow-up for Adolescents and Adults (DSF)**
- NQF 0418, 0418:3132

**Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS)**
- NQF 0712

**Depression Remission or Response for Adolescents and Adults**
- NQF 0711 and 1884

*All measures are found in HEDIS 2018 Volume 2*
Depression CMS Quality Measures

**Merit-based Incentive Payment System (MIPS) Quality Measures**

**Preventative Care and Screening: Screening for Depression and Follow-Up**
- eMeasure ID: CMS2v6, Quality ID: 134, High Priority Measure: No

**Depression Remission at Six Months**
- eMeasure ID: N/A, Quality ID: 411, High Priority Measure: Yes

**Depression Remission at Twelve Months**
- eMeasure ID: CMS159v5, Quality ID: 370, High Priority Measure: Yes

**Bipolar Disorder and Major Depression: Appraisal for Alcohol or Chemical Substance**
- eMeasure ID: CMS169v5, Quality ID: 367, High Priority Measure: No

**Depression Utilization of the PHQ-9 Tool**
- eMeasure ID: CMS160v5, Quality ID: 371, High Priority Measure: No

**Maternal Depression Screening**
- eMeasure ID: CMS82v4, Quality ID: 372, High Priority Measure: No

Source: American Psychiatric Association
Objectives

- Why screen for depression?
- Why screen for depression in general medical hospitals?
- What are the regulatory requirements around depression and suicide?
- **Case Example: Cedars-Sinai**
- Future directions
Case Example: Depression Screening at Cedars-Sinai

**Need:** In Spring 2014, Cedars-Sinai launched a hospital-wide depression screening initiative. This was prompted by recognition that untreated depression leads to poorer health outcomes and affects treatment compliance for patients with medical illnesses, as well as a reorganization of mental health services within the medical center.

*Cedars-Sinai Medical Center by the numbers:*

- 886 licensed beds
- 58,000 inpatient admissions
- 90,000 emergency visits
- 254,668 patient days
- Over 15,000 employees
- 2,758 nurses
- 2,156 medical staff
Cedars-Sinai Units where Behavioral Health Patients are Treated

<table>
<thead>
<tr>
<th>Emergency Department Pavilion</th>
<th>Designated Inpatient Unit (Safety Quad)</th>
<th>Non-Designated Inpatient Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 3 bed unit within the Emergency Department</td>
<td>• 4 bed unit on our inpatient floors</td>
<td>• Patients with secondary behavioral health diagnosis may be placed in any other unit within the hospital</td>
</tr>
<tr>
<td>• Staff: dedicated nurse, mental health worker, and security guard</td>
<td>• Staff: dedicated security guard and nursing staff that are trained and experienced to treat patients with behavioral disorders</td>
<td>• Special safety precautions are enacted for individuals who screen for suicidal ideation</td>
</tr>
<tr>
<td>• Patients who require constant observation are placed in this unit</td>
<td>• Patients who exhibit assaulitive behaviors are placed in this unit due to the skilled staff in the unit</td>
<td></td>
</tr>
</tbody>
</table>
Case Example: Cedars-Sinai

SADPERSONS

ED (behavioral)

2° Risk Assessment

Hospital (all admissions)

PHQ2

PHQ9

2° Risk Assessment

S: Male sex
A: Age (<19 or >45 years)
D: Depression
P: Previous attempt
E: Excess alcohol or drug use
R: Rational thinking loss
S: Social supports lacking
O: Organized plan
N: No spouse
S: Sickness
Nursing Depression Risk Screen: PHQ2

Upon admission, the RN is presented with 2 primary screening questions related to depression:

- A “No” answer to both questions would end the screen.
- A “Yes” answer to either question would cascade to the PHQ-9 depression screening questions (next slide).

<table>
<thead>
<tr>
<th>Depression Screen (PHQ-2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the past month, have you often been bothered by having little interest or pleasure in doing things?</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>During the past month, have you often been bothered by feeling down, depressed, or hopeless</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>
A PHQ-9 score would be calculated. A score > 12 would produce this BPA. The Depression POC would be added to the patient’s care plan.
Nursing Suicide Risk Screen: PHQ9—question 9

Suicide Risk Screen – “In the last 2 weeks, have you had thoughts that you would be better off dead or of hurting yourself in some way?”

For any response other than “Not At All”, immediately initiate suicide precautions and initiate a Suicide Risk Plan of Care, notify physician and recommend consideration of a psychiatry consult.

Secondary Suicide Risk Assessment: 1) Suicide inquiry; 2) Risk Factors; 3) Protective Factors
Secondary Suicide Risk Assessment and Documentation

- Clinical Assessment
  - Suicide Inquiry; Risk Factors; Protective Factors;
  - Risk Determination; Intervention

- SAFE-T (Suicide Assessment Five-step Evaluation and Triage)
- C-SSRS (Columbia-Suicide Severity Rating Scale)

### Risk Level/Intervention

**Assessment of risk level is based on clinical judgment, after completing steps 1-3**

**Reassess as patient or environmental circumstances change**

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK / PROTECTIVE FACTOR</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td>Moderate</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behavior</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td>Low</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent or behavior</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

**(This chart is intended to represent a range of risk levels and interventions, not actual determinations.)**

**DOCUMENT** Risk level and rationale; treatment plan to address/reduce current risk (e.g., setting, medication, psychotherapy, E.C.T., contact with significant others, consultation); firearm instructions, if relevant; follow up plan. For youths, treatment plan should include roles for parent/guardian.

Adapted from: SAMHSA SAFE-T (Suicide Assessment Five-step Evaluation and Triage) www.sprc.com
# Special Precautions for Patients Identified with Suicidal Ideation

## Behavioral Health Room Safety Checklist

This patient has been identified to be **high risk for suicidal behavior**, and the following steps listed below have been taken to modify the patient’s direct environment of care:

<table>
<thead>
<tr>
<th>Completed</th>
<th>Responsible Party</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Security &amp; Nursing</td>
<td>Patient searched and all belongings removed from patient</td>
</tr>
<tr>
<td></td>
<td>Security &amp; Nursing</td>
<td>Patient belongings have been labelled, itemized and safely stored in Security's patient belonging locker</td>
</tr>
<tr>
<td>Nursing</td>
<td>Notified EVS / Housekeeping</td>
<td>High risk patient by calling x3-4444 &amp; indicate to complete behavioral health room safety checklist</td>
</tr>
<tr>
<td>Nursing</td>
<td>Notified nutritional services</td>
<td>High risk patient by calling x3-4538 for disposable tray order. (Leave message if not answered.)</td>
</tr>
<tr>
<td>Nursing</td>
<td>Patient’s clothes, shoes / laces, and jewelry removed and dressed in hospital gown. If patient is wearing a bra, must be removed also. Send valuable items (jewelry, money wallet, narcotic medication brought from home) to Security. Lock regular items in the patient belonging lockers.</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Placed door designation signage</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Removed unnecessary IV poles</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Removed any unnecessary medical equipment</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Removed telephone &amp; telephone cord</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supervised phone calls only with either sitter or nurse</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Locked all cabinets with zip ties</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>Requested safety soap from supply management</td>
<td></td>
</tr>
<tr>
<td>Clinical Partner</td>
<td>Change bed linens to flat sheets only</td>
<td></td>
</tr>
<tr>
<td>Nurse / MHW</td>
<td>Disposable Utensil Counts: BEFORE entering the room</td>
<td></td>
</tr>
<tr>
<td>Nurse / MHW</td>
<td>Disposable Utensil Counts: AFTER entering the room</td>
<td></td>
</tr>
<tr>
<td>EVS</td>
<td>Removed plastic trashcan liners &amp; replace with paper liners</td>
<td></td>
</tr>
<tr>
<td>EVS</td>
<td>Removed any extra items from closets</td>
<td></td>
</tr>
<tr>
<td>EVS</td>
<td>Removed rubber gloves from cage</td>
<td></td>
</tr>
<tr>
<td>EVS</td>
<td>Removed hand sanitizer from cage &amp; soap in bathroom</td>
<td></td>
</tr>
<tr>
<td>EVS</td>
<td>Removed any extra bed linen from the room</td>
<td></td>
</tr>
<tr>
<td>EVS</td>
<td>Removed any extra chairs</td>
<td></td>
</tr>
<tr>
<td>EVS</td>
<td>Removed bottom of the privacy curtain</td>
<td></td>
</tr>
</tbody>
</table>

Nursing is responsible for ensuring that all items listed above are complete prior to patient rooming. Checklist is to be incorporated into the change of shift report. |

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STOP SAFETY PRECAUTIONS

Please See Nurse Prior to Entering
Nursing Role

**ASSESS**
- Secondary risk assessment
- Environmental assessment (behavioral room checklist)

**ADVISE**
- Notify attending; Recommend consultation
- Notify social worker

**ASSIST**
- Nursing care plan; Monitoring level
- Education; Intervention
Social Work Role

ASSESS
- Psychosocial assessment; Collateral
- Depression and suicide risk assessment

ADVISE
- Supportive interventions; Education; Counseling
- Recommend consultation

ASSIST
- Case management; Resources
- Care coordination; Linkage to aftercare
Physician Role

ASSESS
• Ask about depression? Is patient distressed? Is depression interfering with care? Is there imminent danger?
  • Work-Up?: CBC, Lytes, LFTs, TSH, B12, RPR, HIV, toxicology

ADVISE
• Discuss findings of screen/interpretation with pt and team
  • Present diagnosis if appropriate; Psych consultation if indicated

ASSIST
• Educate; Monitor; Treat &/or Refer for follow-up
  • Brief counseling; Lifestyle recs; Medications
Implementation Metrics & Positive Screening Volumes

- Since tracking in January 2015, every month has consistently had 93%-95% complete depression screenings of total admissions.
  - There is a small percentage of “unable to assess” due to circumstances where the patient is unable to provide answers (ie. Trauma, delirium, etc.)
Secondary suicide assessment

• Goal: Documentation of 2° risk assessment on every patient with +SI

*July 18th flowsheet rows were added for nursing documentation of additional questions for patients who screen positive for suicidality.

• Compliance with documentation or risk assessment had been 15-62%. (Nurses were expected to document in a progress note). After addition of flowsheet rows compliance increased to 100%
Implementation Challenges

• **False negatives**
  – Some patients screen negative on admission and are identified later in their hospital stay when they present with depressive symptoms

• **Timing of screening**
  – Admission not always optimal time to screen (Ex: L&D moved screening to after delivery, and saw improvement in fidelity)

• **Workflows**
  – Short LOS cases may be discharged without a SW consult even though there is an order due to timing of discharge; Obs; Weekends
  – 2° suicide risk assessments not done on all patients until automation in EMR last year

• **Heterogeneity of assessment and intervention**
  – Comfort/training RN administering tool
  – Variability of MD & SW skills/approach

• **Care coordination**
  – After-care arrangements; Level of care transfers
What is the “ROI”?

**Mission**
- Provide high-quality, compassionate, patient-centered, holistic health care

**Value**
- ALOS for PHQ9+ patients had experienced a 6.2% reduction in days over 3 fiscal years
- Reduction in 30 & 90 day readmission rates

**Intangibles**
- No sentinel events
- Patient and provider experience
Objectives

- Why screen for depression?
- Why screen for depression in general medical hospitals?
- What are the regulatory requirements around depression and suicide?
- Case Example: Cedars-Sinai
- **Future directions**
How to deliver coordinated care across a system?
How to deliver a continuum of care? (Community Partnerships)
Integrating Care is as important as Delivering Care
Emerging technological solutions

NOTE: Virtual conferencing is defined as clinician-to-clinician consults, whereas virtual consults are provider-to-patient consults.

SOURCE: Sg2 Analysis, 2016
Support at Your Fingertips?

Innovation in the behavioral health technology space has increased with the advent of mobile apps for a wide range of mental health disorders.
Questions?