Emergency Department Discharge TO CARE

(Telephone Outreach: Connect to Aftercare & Risk Evaluation):

Improving Patient Care and Systems-Based Practices

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Introduction

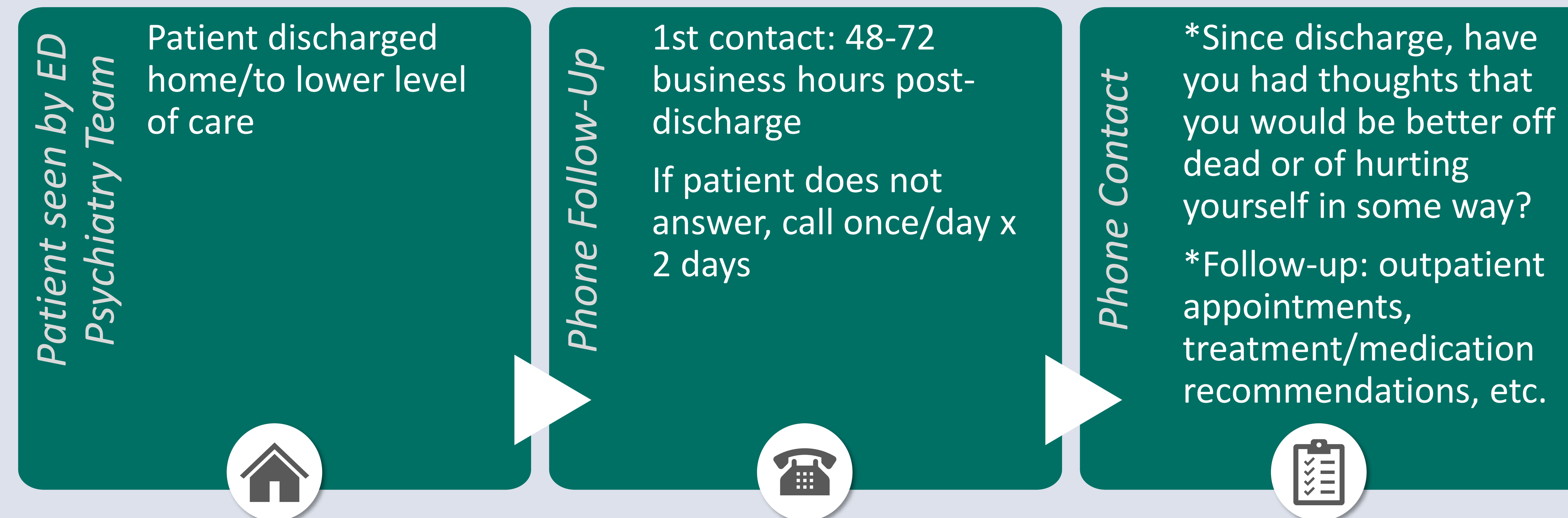
- Emergency Department (ED) utilization is rapidly growing nationwide.
- The number of patients presenting to the ED with primary psychiatric concerns continues to rise:
  - Psychiatric concerns are the **second most common ED presentation** (abdominal pain is the first)[1]
  - Patients with psychiatric concerns account for **4.45% of all annual ED visits**[1]
- When compared to ED patients receiving outpatient referrals for medical conditions, ED patients receiving referrals for psychiatric care are more likely to[2]:
  - Reach an answering machine
  - Obtain an appointment > 2 weeks away
  - Be referred elsewhere for insurance reasons

Studies investigating the effectiveness of follow-up contact post ED discharge for patients presenting with psychiatric concerns are limited.

Methods

- **Patients presenting to the ED with psychiatric concerns** are seen by the embedded ED Psychiatry service (led by Consultation-Liaison Psychiatry faculty).
- Patients **deemed appropriate for discharge to home/lower level of care** are consented for post-discharge follow-up contact.
- ED Psychiatric Social Worker calls patients **48-72 hours post-discharge for a total of 3 attempts**.
- Scripted questions regarding **outpatient follow-up, medication status/adherence, and suicidal ideation** (PHQ-9, Question 9) are asked.
- Telephone encounter **documented in electronic medical record**.

Workflow



Results

Between 2/1/21-9/10/21, **711 patients** were seen by the ED Psychiatrist and/or the ED Psychiatric Social Worker.

Table 1. Patient eligibility for protocol.

Patients reached	
Follow-up protocol followed	400 patients
Patients not reached	
Patients **eligible**, but protocol not followed	75 patients
Patients **not eligible** for follow-up protocol *(e.g., discharged to higher level of care)*	236 patients

63.5% *(n=139)* of patients reached *(n=219)* had **initiated contact or scheduled an appointment with an outpatient clinic** at the time of telephone contact.

72.5% *(n=58)* of the remaining patients *(n=80)* **expressed their intention to follow-up with recommended outpatient treatment.**

Of the patients reached *(n=219)*, 86 received prescriptions for medications upon discharge. **67%** *(n=58)* reported filling those prescriptions upon discharge and also reported adherence.

Figure 2. Contact outcomes.

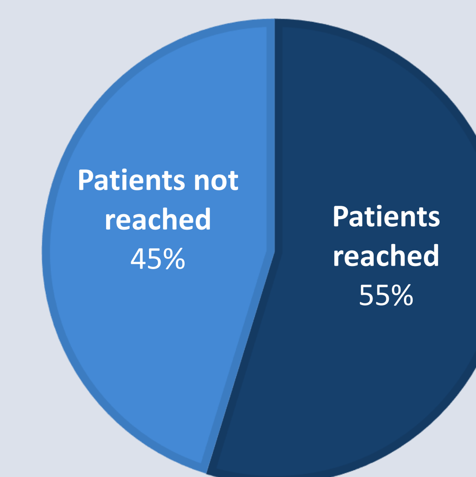


Figure 3. Patients reached successfully.

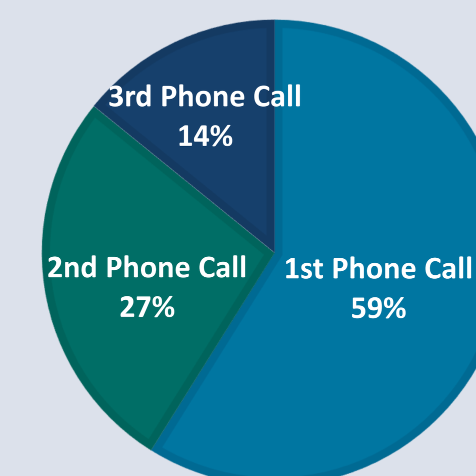


Figure 4. Phone calls required.

Discussion

As ED resources are progressively strained, there is a growing focus on addressing population health factors. ***Reducing barriers to accessing psychiatric care***, ***bolstering quality and efficiency of safe psychiatric care***, and ***optimizing resource distribution*** should be top priorities for Psychiatrists working collaboratively in these settings.

With this initiative, our team has demonstrated:

- Conducting telephone follow-up calls for all patients seen by our team and discharged to a lower level of care (e.g., home, Crisis Resource Center, etc.) is **feasible** from a time, staff effort, and cost standpoint.
- >50% of patients called were successfully reached *(Figure 3)*.
- Majority of these patients had initiated contact or were able to schedule an outpatient appointment *(Figure 2)*.
- Majority of patients who received a medication prescription to target psychiatric symptoms had both filled the medication and reported adherence *(Figure 2)*.

Proposed ***next steps/future directions***:

- Develop an **alternative contact workflow** for patients without working phones (n=45, 60%) who are eligible for follow-up contact but cannot be reached.
- Analyze **readmission data** for this patient group to assess broader impact *(e.g., cost, efficiency, workflow)* on overwhelmed healthcare systems.

References

1) Hooker, E. A., Mallow, P. J., & Oglesby, M. M. (2019). Characteristics and trends of emergency department visits in the United States (2010–2014). *The Journal of Emergency Medicine*, 56(3), 344-351. doi: 10.1016/j.jemermed.2018.12.025

2) Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center. (2010) Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit. Newton, MA: Education Development Center, Inc.