



Evaluation and Disposition of Medicaid-Insured Children and Adolescents With Suicide Attempts

Candice L. Williams, MD; William O. Cooper, MD, MPH; Leanne S. Balmer, RN; Judith A. Dudley, BS; Patricia S. Gideon, RN; Michelle M. DeRanieri, RN; Shannon M. Stratton, BS; S. Todd Callahan, MD, MPH

From the Divisions of General Pediatrics (Dr Williams and Dr Cooper), Adolescent and Young Adult Health (Dr Callahan), Department of Pediatrics, and Department of Preventive Medicine (Ms Balmer, Ms Dudley, Ms Gideon, Ms DeRanieri, and Ms Stratton), Vanderbilt University Medical Center, Nashville, Tenn

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Address correspondence to S. Todd Callahan, MD, MPH, Division of Adolescent and Young Adult Health, Monroe Carell Jr Children's Hospital at Vanderbilt, One Hundred Oaks, 719 Thompson Ln, Suite 36300, Nashville, TN 37204 (e-mail: todd.callahan@vanderbilt.edu).

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ABSTRACT

OBJECTIVE: Guidelines and quality of care measures for the evaluation of adolescent suicidal behavior recommend prompt mental health evaluation, hospitalization of high-risk youth, and specific follow-up plans—all of which may be influenced by sociodemographic factors. The aim of this study was to identify sociodemographic characteristics associated with variations in the evaluation of youth with suicidal behavior.

METHODS: We conducted a large cohort study of youth, aged 7 to 18, enrolled in Tennessee Medicaid from 1995 to 2006, who filled prescriptions for antidepressants and who presented for evaluation of injuries that were determined to be suicidal on the basis of external cause-of-injury codes (E codes) and ICD-9-CM codes and review of individual medical records. Chi-square tests and logistic regression were performed to assess the relationship between sociodemographic characteristics and documentation of mental health evaluation, hospitalization, and discharge instructions.

RESULTS: Of 929 episodes of suicidal behavior evaluated in an acute setting, rural-residing youth were less likely to be admitted to a psychiatric hospital (adjusted odds ratio [AOR] 0.72; 95% confidence interval [CI] 0.55–0.95) and more likely to be medically hospitalized only (AOR 1.92; 95% CI 1.39–2.65). Female subjects were less likely to be admitted to a psychiatric hospital (AOR 0.55; 95% CI 0.41–0.74) and more likely to be discharged home (AOR 1.44; 95% CI 1.01–2.04). Only 40% of those discharged to home had documentation of discharge instructions with both follow-up provider and date.

CONCLUSIONS: In this statewide cohort of youth with suicidal behavior, there were significant differences in disposition associated with sociodemographic characteristics.

KEYWORDS: adolescents; Medicaid; suicide

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WHAT'S NEW

In this statewide cohort of Medicaid-insured youth with suicidal behavior, those from rural areas were more likely to be medically hospitalized. Of youth discharged home after acute evaluation of suicidal behavior, a minority had documentation of a specific follow-up plan.

SUICIDE IS THE third leading cause of death in young people aged 10 to 24 years in the United States, accounting for approximately 4500 deaths every year.¹ Nonfatal suicidal behavior (suicidal ideation or attempted suicide) is even more common among youth and is an important predictor of future suicide attempts and completed suicide.² Annually, approximately 150,000 youth seek treatment in an emergency department after a self-harm event.^{3,4}

Because mental health care after suicidal behavior is critical to reduce the risk of future suicide,⁵ several

regional and national efforts have sought to improve and standardize the evaluation and treatment of adolescent self-injurious behavior.^{2,6–9} Guidelines from the American Academy of Child and Adolescent Psychiatry state that youth presenting to emergency departments with suicidal behavior should undergo mental health evaluation for assessment and triage.¹⁰ Hospitalization in a medical or psychiatric unit is recommended unless there is certainty about medical and psychiatric stability. In cases appropriate for outpatient follow-up, patient discharge to home/community is permissible if oversight from supportive adults in a safe/secured environment can be assured and if specific follow-up, including provider, date, and time, has been arranged.

Several nonclinical factors, including health insurance coverage and sociodemographic factors (age, gender, and geographic residence), are likely to be influential in the evaluation and disposition of youth with suicidal behavior. As the enactment of the Affordable Care Act increases the

availability and parity of mental health insurance coverage, the influence of sociodemographic characteristics on the provision of health care is of increasing interest. New initiatives, including accountable care organizations, which seek to integrate mental and primary health care in an efficient, cost-effective manner, require an understanding of how sociodemographic characteristics influence health care delivery. Small studies have documented the influence of health insurance coverage; however, there are few population-based data on the relationship of sociodemographic characteristics and the assessment and disposition of adolescent suicidal behavior.^{11–14}

The aims of this study were to identify and characterize variations in the evaluation and disposition of youth presenting for medical evaluation of suicidal behavior associated with sociodemographic characteristics. To address these aims, we utilized data from an ongoing study of youth in Tennessee's Medicaid population who were recently prescribed antidepressants and who presented for evaluation of injury episodes that were confirmed to be suicidal in nature. This cohort provided a unique opportunity to examine these factors in an insured population with well-characterized suicidal behavior that was relatively homogeneous in terms of psychiatric risk.

METHODS

The study was performed as part of a larger retrospective cohort study of antidepressant use and suicidal behavior in children and adolescents that included 80,183 youth (aged 6 to 18 years) who were enrolled in Tennessee's Medicaid Program (TennCare) between 1995 and 2006 and who were prescribed an antidepressant medication.¹⁵ The methods for identifying and confirming suicidal behavior in this cohort have been previously described.¹⁶ Briefly, TennCare claims data and linked death certificates were queried for International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), codes and external cause-of-injury codes (E codes) corresponding to potential episodes of suicidal behavior, as outlined previously.¹⁶ For each episode identified by these claims, medical records were sought and adjudicated to determine whether an injury was deliberately self-inflicted and whether intent to die was explicitly stated or could be inferred using definitions from the Columbia Classification Algorithm of Suicide Assessment.¹⁷ For the larger study, 87% of episodes identified by medical claims were obtained and had adequate documentation for adjudication.

For this study examining the evaluation and disposition of youth presenting with suicidal behavior, we excluded episodes of completed suicide. We reviewed 965 suicidal episodes (all episodes adjudicated as confirmed suicide attempts, preparatory actions toward suicidal behavior, and suicidal ideation only). We excluded 36 records (4%) that were incomplete or that indicated that the subject left against medical advice. For the remaining 929 suicidal episodes, medical records were reviewed by the principal investigator and trained research nurses to record key characteristics of the history, evaluation, and disposition. The

method of injury was characterized as cutting/stabbing, gunshot, hanging/asphyxiation, jump from height, ingestion, or other, or suicidal ideation only. Clinical documentation of prior psychiatric history and prior suicide attempts were recorded. Disposition was characterized as hospitalization (psychiatric [including youth transferred to a psychiatric hospital after admission to a medical hospital], medical only) or discharge to home or the community. We reviewed records for documentation of a mental health evaluation by a psychiatric physician or nurse, social worker, psychologist, counselor, or representative of a mental health organization at any time before discharge from the acute care or medical hospital setting. For youth who were discharged to home, we reviewed discharge instructions for documentation of a specific follow-up provider and date. Subjects were characterized as having received complete discharge instructions (both specific provider and date provided), partial discharge instructions (either specific provider or date provided), or no discharge instructions (neither specific provider nor date provided).

We recorded sociodemographic data including gender, age, race, and geographic residence of the parent/guardian. Gender and age at the time of the event were determined by medical record documentation. Because of differences in the epidemiology of suicide attempts between younger adolescents and older adolescents, age was subdivided into 2 groups (7 to 14 years and 15 to 18 years).¹⁸ Race was categorized as black, white, or other as self-reported by the parent/guardian and documented in administrative claims. Geographic residence using the parent/guardian's address was defined as rural, suburban, or urban using Standard Metropolitan Statistical Area definitions.¹⁹ We chose to focus on the geographic residence of the youth rather than where they sought care. Although youth may be more likely to seek care in a setting close to them, youth from rural areas may seek care from facilities in nonrural areas. When youth seek care outside of their community, disposition and follow-up are likely to be influenced by the availability of resources both at the treating facility and in the child's community.

In the larger study, we found that less than 1% of the suicidal episodes were repeat events; therefore, we performed chi-square analyses to assess the relationship between sociodemographic characteristics and receipt of mental health evaluation and disposition. Multivariate logistic regression models were created to estimate the odds of receiving a mental health evaluation, being hospitalized in a medical or psychiatric facility, or being discharged home, after adjusting for the other sociodemographic variables (race, age, gender, geographic residence). For youth who were discharged to home, models assessed the relationship between sociodemographic characteristics and the receipt of mental health evaluation and characteristics of follow-up instructions. Statistical calculations were performed by Stata v12.1 software (StataCorp, College Station, Tex).

Permission to use the study data was obtained from the Tennessee Department of Health and the TennCare Bureau. The study was reviewed and approved by the Vanderbilt University institutional review board.

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