Planning for Care Transitions: Using Best Practices to Improve Care for Individuals with Suicide Risk

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Disclaimer

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Agenda

- Comprehensive approach to suicide prevention
- Care transitions
- Best practices for inpatient to outpatient care transitions
- Considerations for individuals with SMI
- Q and A

Comprehensive Approach to Suicide Prevention

- Data-informed planning
- Evidence-based and informed strategies
- Interventions across socio-ecological levels
- “Upstream” primary prevention and suicide-specific care and treatment
- Coordinated and sustained cross-sector initiatives

Comprehensive Approaches to Suicide Prevention

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Care Transitions

- Between care or service settings
- Between levels of care
- Across encounters, visits, appointments
- Along continuum of crisis services
- Ensure continuity of care

Seamless Care Transitions

- Ensure connectedness throughout transitions
  - Collaborative teams
  - Human connections
  - Organizational connections
- Planning starts before “discharge”

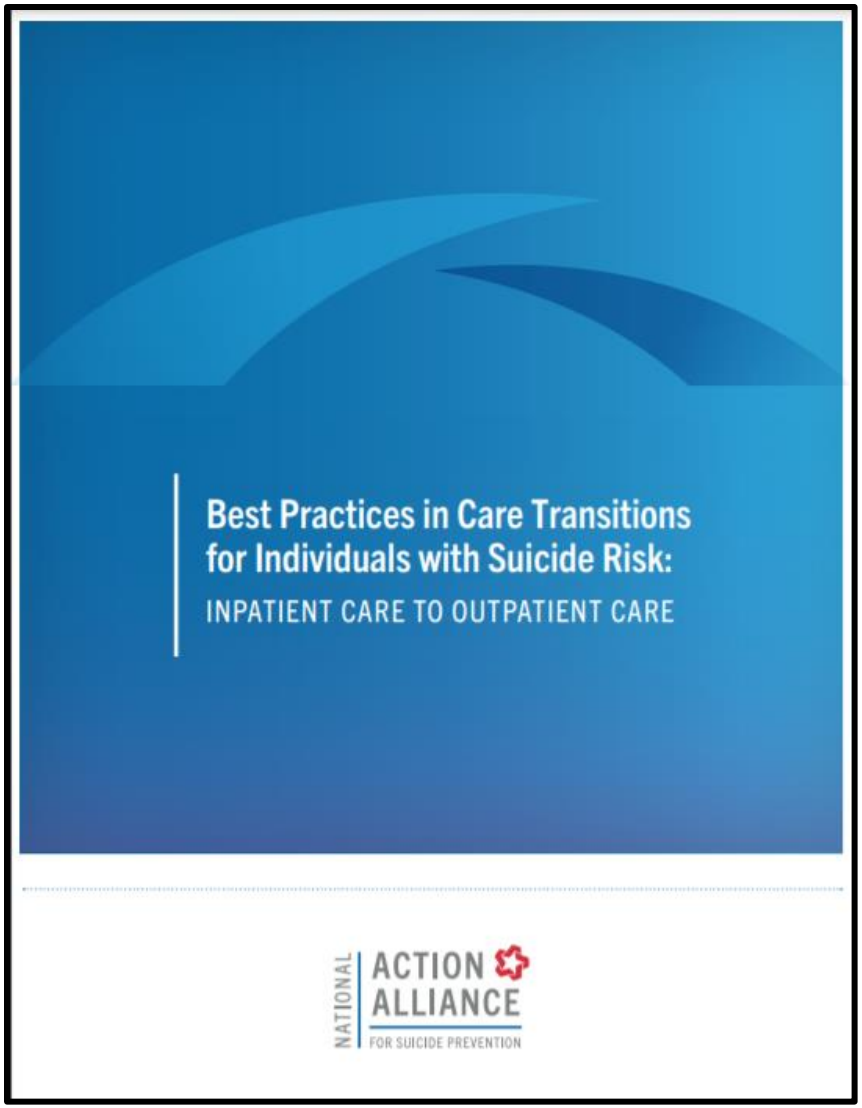
Transition from Inpatient to Outpatient Care

- In the month after patients leave inpatient psychiatric care, their suicide death rate is 300 times higher (in the first week) and 200 times higher (in the first month) than the general population. (Chung et al., 2019)

- A third of patients do not complete a single outpatient visit in the first 30 days after IP behavioral health care discharge. (National Committee for Quality Assurance, 2017)

- One out of seven people who died by suicide had contact with inpatient mental health services in the year before they died. (Ahmedani et al., 2014)

Transition from Inpatient to Outpatient Care



- Priority of the National Action Alliance for Suicide Prevention
- Resource suite includes:
  - Report
  - Handout
  - Video
  - Infographic
  - Inpatient Health Care Self-Assessment
  - Inpatient Care Transitions Action Planning Template

https://theactionalliance.org/healthcare/caretransitions

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Transition from Inpatient to Outpatient Care

Recommendations for Inpatient Providers

Administrative Preparation

- Develop relationships, protocols and procedures for safe and rapid referrals.
  - Begin discharge planning upon admission.
  - Develop collaborative protocols.
  - Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA).
  - Electronically deliver copies of essential records.

Preparing for the Care Transition

- Involve family members and other natural supports.
  - Encourage family participation.
  - Include peer specialists.
  - Engage the school and community supports.

Preparing for the Care Transition

- Collaboratively develop a safety plan as part of pre-discharge planning.
  - Work collaboratively with the patient, family, and community supports.
  - Reduce access to lethal means at home.

Preparing for the Care Transition

- Connect with the outpatient provider.
  - Schedule an outpatient appointment.
  - Offer step-down care.
  - Partner with the outpatient provider.
  - Initiate personal contact between the patient and the outpatient provider.
  - Consider innovative approaches for connecting the patient with the outpatient provider.

During the Care Transition

- Follow up with the patient and outpatient provider.
  - Make a discharge follow-up call to the patient (within 24 hours).
  - Provide ongoing caring contacts to the patient.
  - Provide essential records to the outpatient clinician or case manager at the time of discharge.
  - Regularly meet.

Transition from Inpatient to Outpatient Care

Recommendations for Outpatient Providers

Administrative Preparation

- Develop relationships, protocols, and procedures that.
  - Establish good communication.
  - Establish policies and procedures.
  - Accept shared responsibility.
  - Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA).
  - Obtain copies of essential documents.
  - Arrange a conference call.
  - Train all staff.

Before the Care Transition

- Reach out to the patient and his or her family members and/or other natural supports.
  - Meet the patient and family members at the inpatient psychiatric setting.
  - If an in-person meeting prior to discharge is not possible, consider other ways to connect.

During the Care Transition

- Close the transition gap.
  - Triage intakes.
  - If the first appointment is more than 24 hours after discharge, reach out and contact the patient.
  - Schedule a clinical intake with a provider trained in suicide care.
  - Offer stepped care to patients with suicide risk, based on the client's need and your community resources.

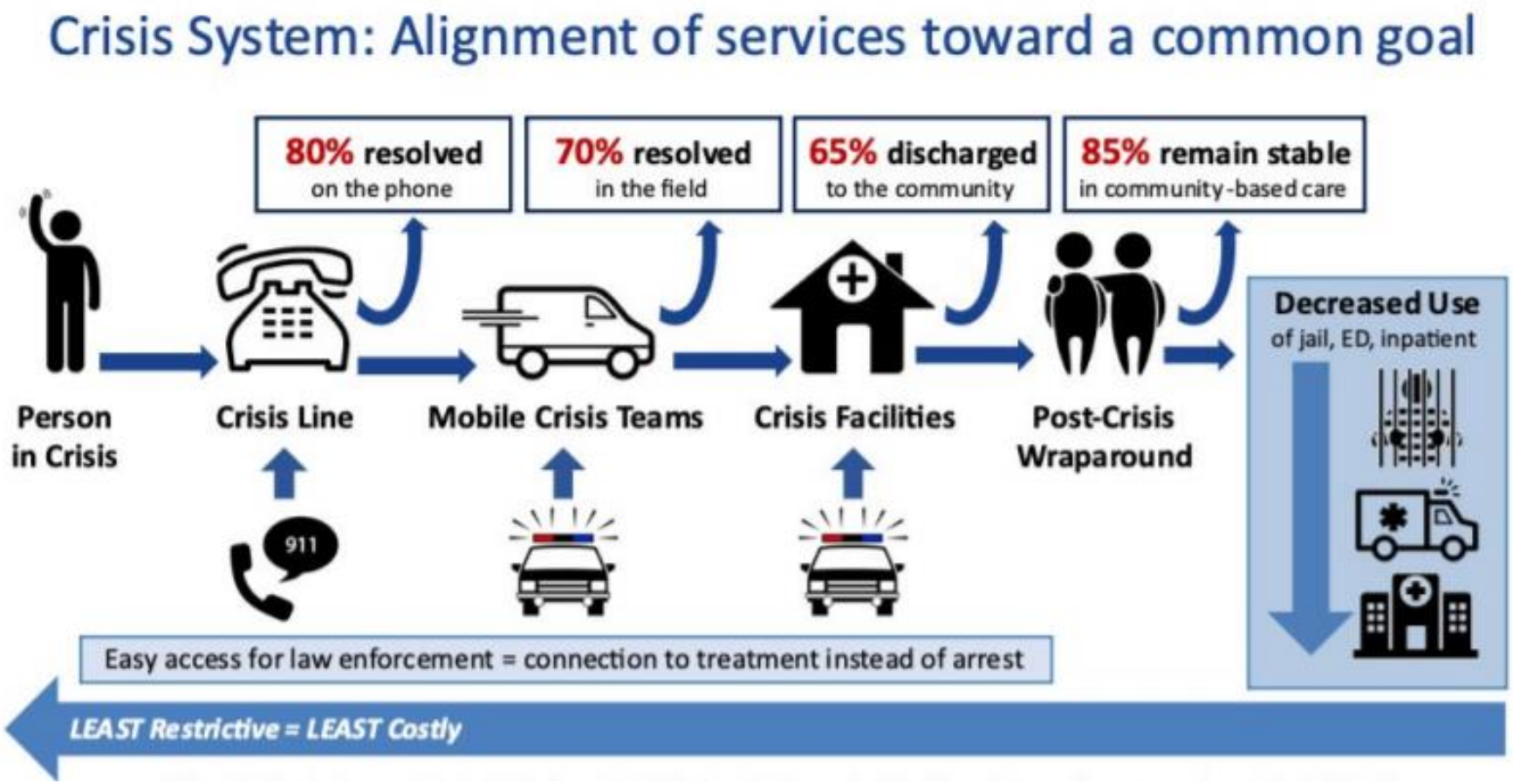
During the Care Transition

- Strengthen natural supports.
  - Involve family members and other natural supports.
  - Connect the patient with peer-to-peer support.
  - Engage the school.
  - Involve other adult supports for children or youth.

Follow Up

- Complete the circle.
  - Notify the inpatient provider that the patient has kept the outpatient appointment.
  - Follow up on missed appointments.
  - Regularly meet with your inpatient provider.
  - Share metrics.

Care Transitions across Crisis Continuum



Goal: Improved response to crisis from the request for help through the **transition** to the appropriate level of care.

Balfour, M.E., Hahn Stephenson, A., Winsky, J., & Goldman, M.L. (2020). Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies. Alexandria, VA: National Association of State Mental Health Program Directors.

Care Transitions across Crisis Continuum

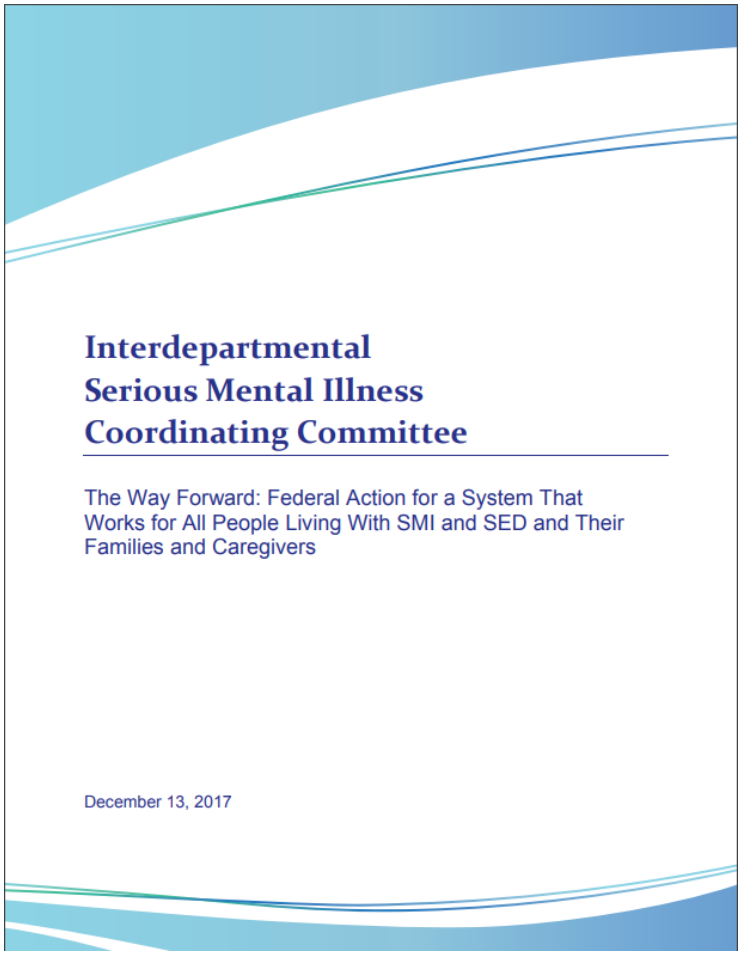
Table 1 - Continuum to Evaluate Crisis Systems and Collaboration

← CRISIS SYSTEM COMMUNITY COORDINATION & COLLABORATION CONTINUUM→				
Level 1	*Level 2*	*Level 3*	*Level 4*	*Level 5*
MINIMAL	**BASIC**	**BASIC**	**CLOSE**	**CLOSE**
Agency Relationships	*Shared MOU Protocols*	*Formal Partnerships*	*Data Sharing (Not 24/7 or Real-Time)*	*"ATC Connectivity"*

- Essential elements of crisis care:
  - Regional Crisis Call Center
  - Crisis Mobile Team Response
  - Crisis Receiving and Stabilization Facilities
- Collaboration involving health systems and community-based care is critical to a coordinated continuum of care and safe care transitions.

Substance Abuse and Mental Health Services Administration. (2020). National guidelines for behavioral health crisis care: Best practice toolkit. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)



"Enhance coordination across federal agencies to improve service access and delivery of care for people with SMI and SED and their families."

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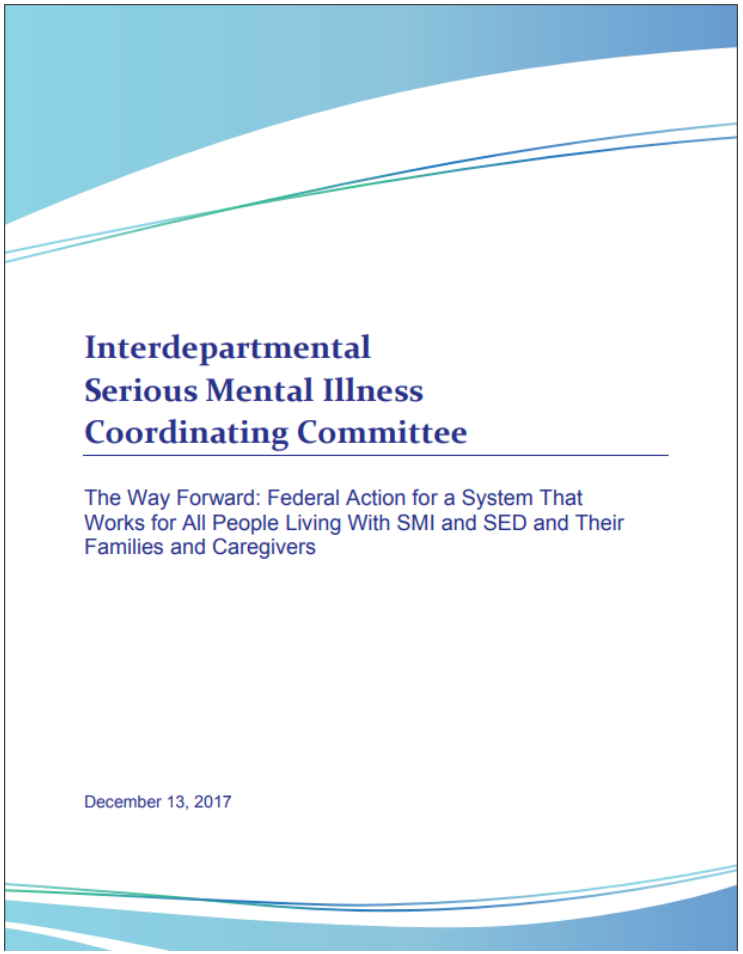

- Focus 3: Treatment and Recovery: Close the Gap Between What Works and What is Offered
- Recommendation 3.7: Advance the national adoption of effective suicide prevention strategies. All federal departments, including VA and DoD, should adopt Zero Suicide as a model for suicide reduction, and agree to develop and implement strategic plans with achievable and transparent targets for progress. Consider ways to widely disseminate and universally apply these strategies in the public health system.

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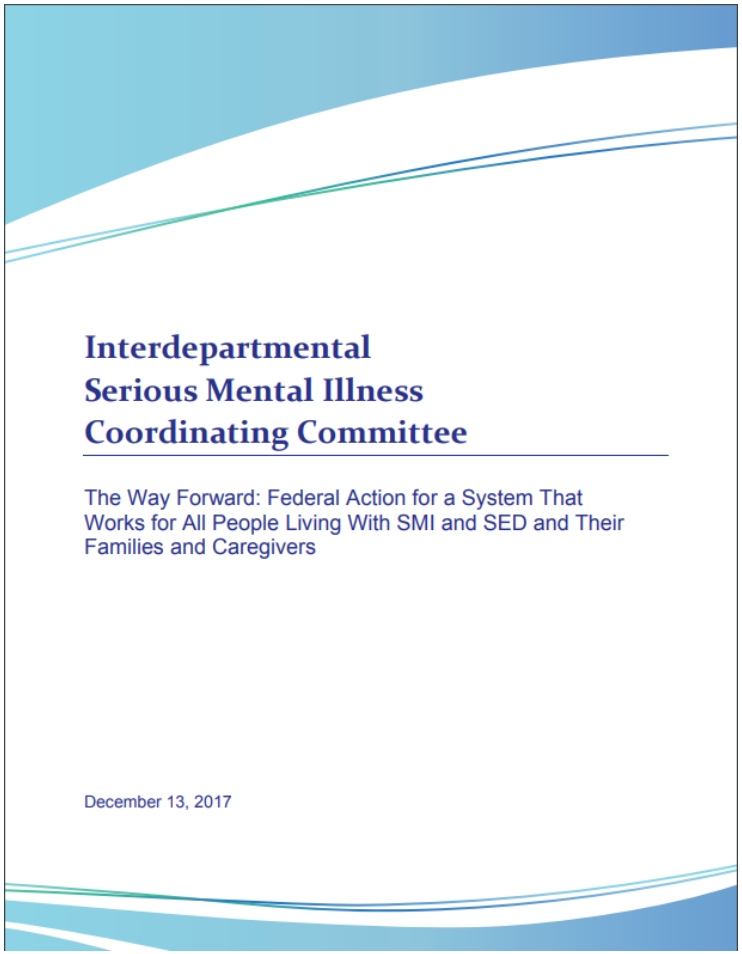
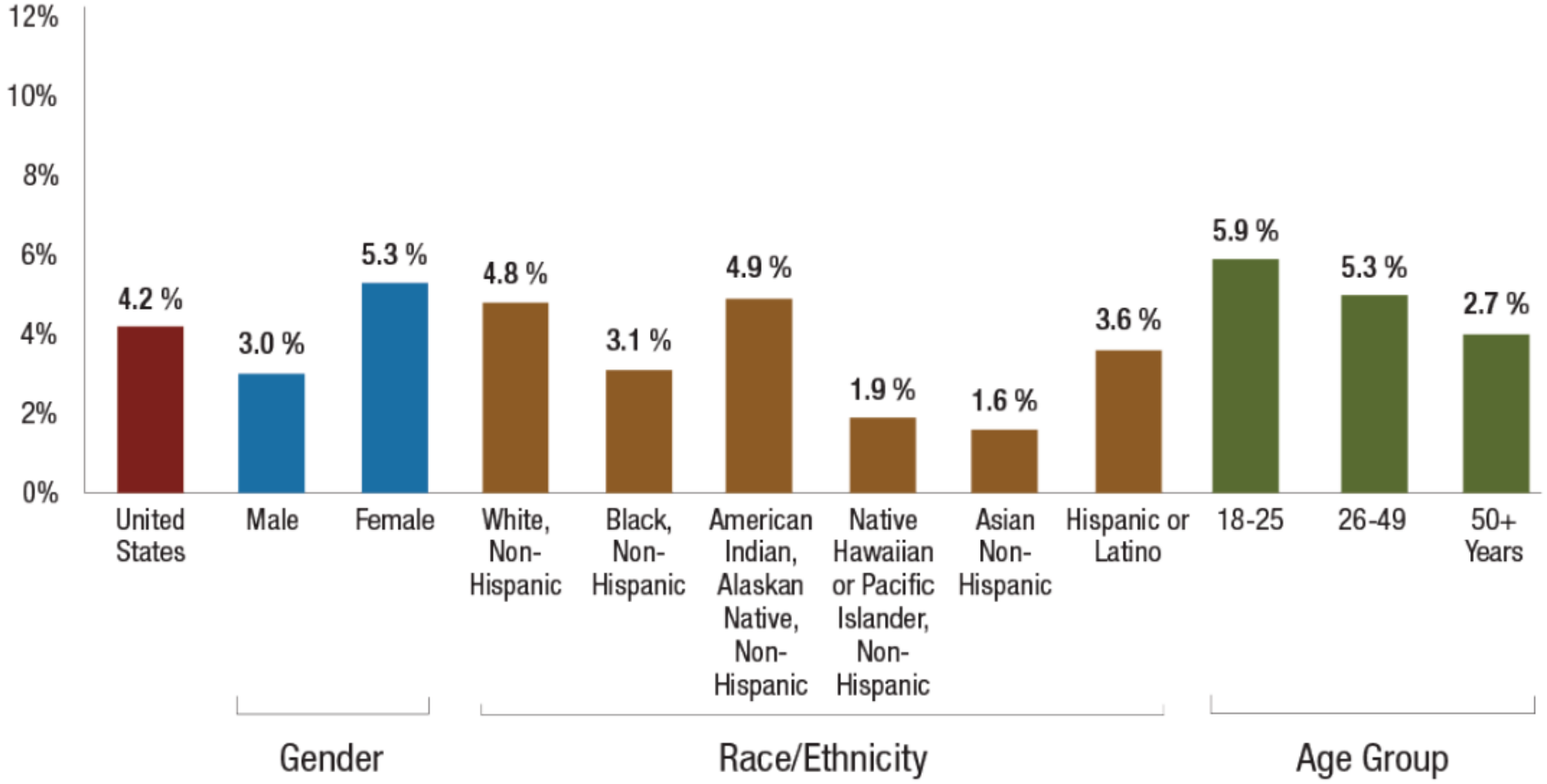


- Defining SMI (individuals 18 or older):
  - Currently or at any time in previous year had diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified in the diagnostic manual of the APA.
  - Has resulted in functional impairment that substantially interferes with or limits on or more major life activities.

Past Year SMI Among Adults Age 18 or Older in the U.S. by Gender, Race/Ethnicity, Age Group: 2016



https://store.samhsa.gov/product/The-Way-Forward-Federal-Action-for-a-System-That-Works-for-All-People-Living-With-SMI-and-SED-and-Their-Families-and-Caregivers-Full-Report/PEP17-ISMICC-RTC

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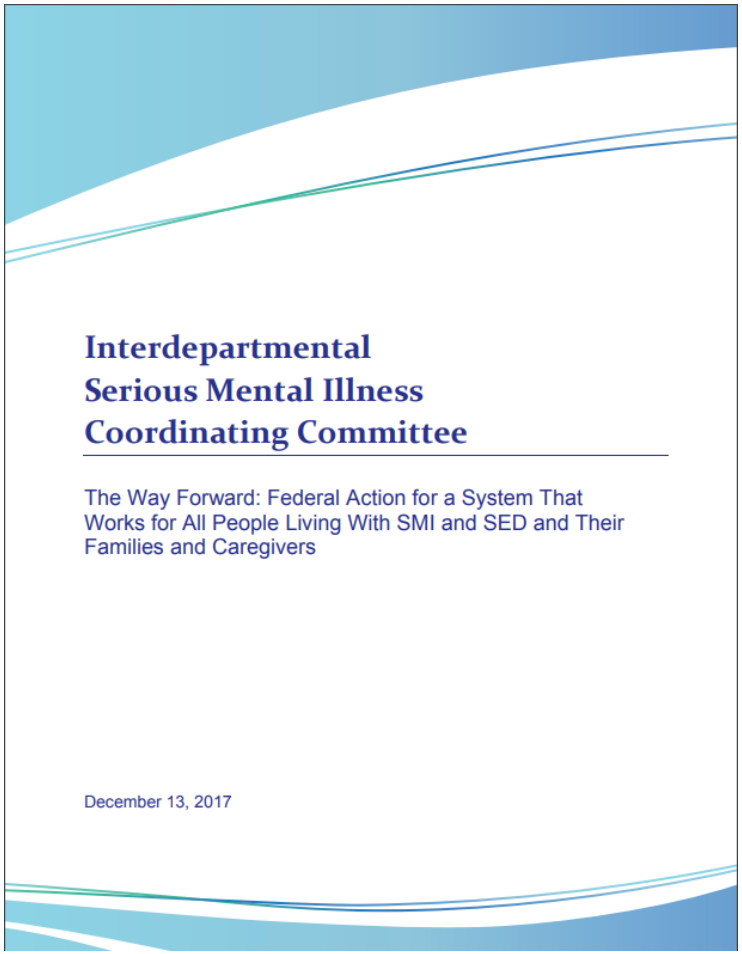
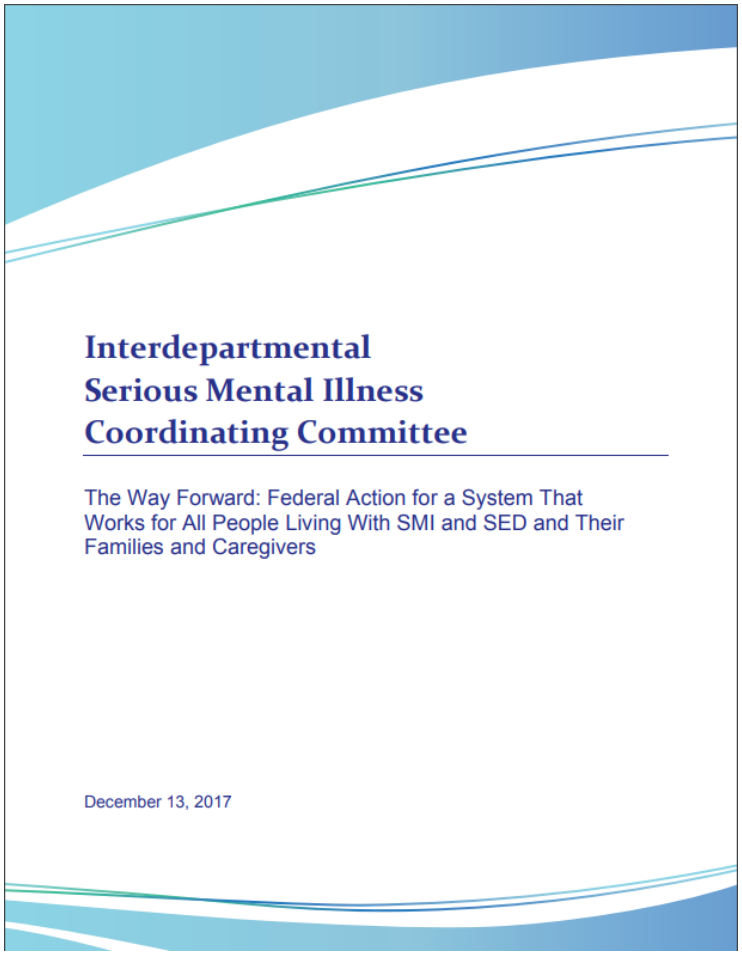


- Compared to the suicide rate for the general population in the United States:
  - Individuals with mood disorders (e.g. depressive and bipolar disorders) have a 25 times higher suicide rate.
  - Individuals with schizophrenia have a 20 times higher suicide rate.

Stacking Risk Factors



- Shortage of mental health care professionals, crisis care, inpatient beds
- Having SMI a risk factor alone
- 36% of adults with SMI have full-time employment
- Twice as many adults with SMI have incomes below the poverty line
- SMI is common among persons experiencing homelessness

NSDUH 2019 Data: Serious Mental Illness (SMI)

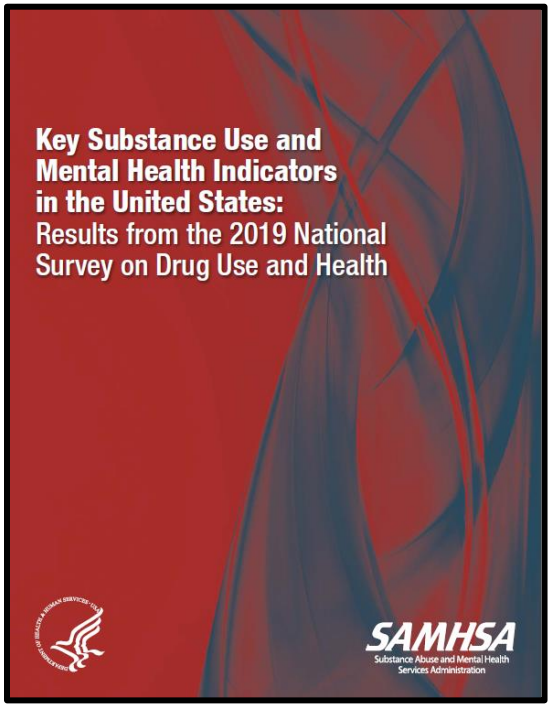
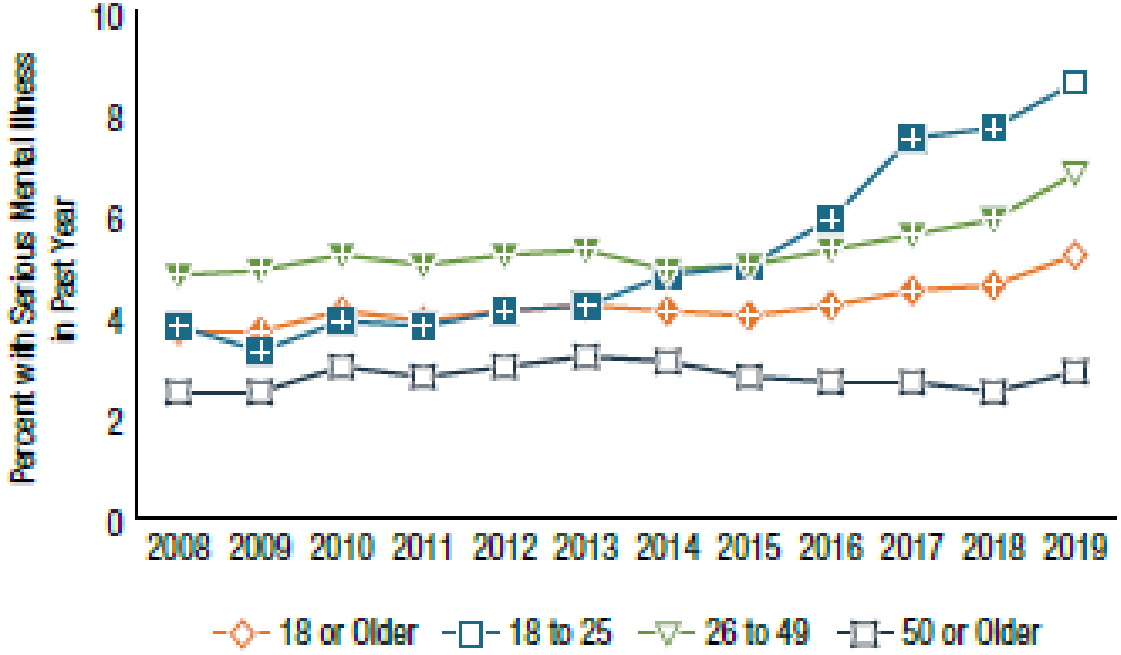


Figure 52. Serious Mental Illness in the Past Year among Adults Aged 18 or Older: 2008-2019



+ Difference between this estimate and the 2019 estimate is statistically significant at the .05 level.

- 5.2% of adults in the U.S. had SMI in the past year (13.1 million people).
- About one third of adults with SMI did not receive mental health services.

https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

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NSDUH 2019 Data: SUD and SMI

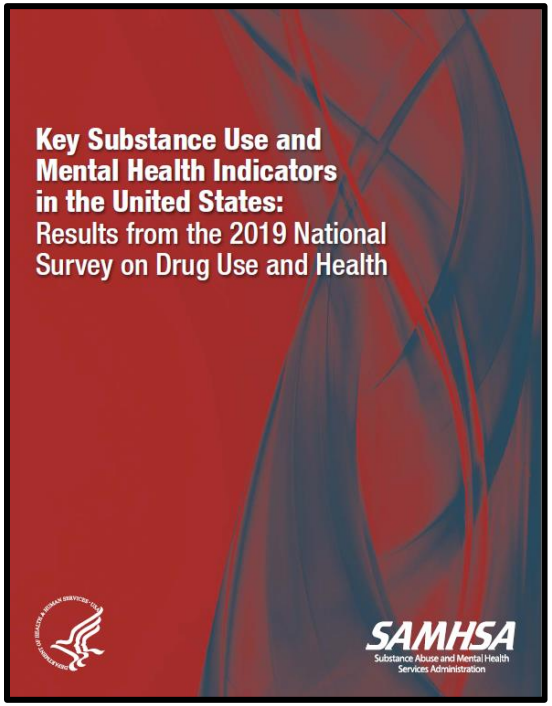
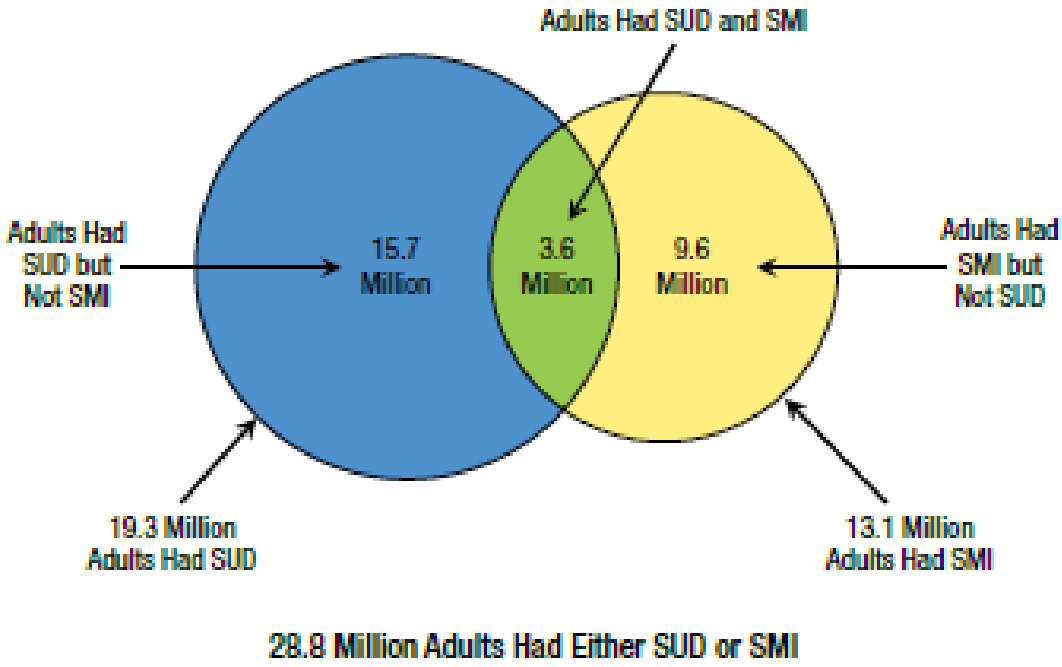


Figure 58. Past Year Substance Use Disorder (SUD) and Serious Mental Illness (SMI) among Adults Aged 18 or Older: 2019



- 1.4% of adults had co-occurring SMI and SUD in the past year (3.6 million people).
- About 1 in 3 adults with co-occurring SMI and SUD received neither type of care.

https://www.samhsa.gov/data/sites/default/files/reports/rpt29393/2019NSDUHFFRPDFWHTML/2019NSDUHFFR1PDFW090120.pdf

Care Transitions and Individuals with SMI

- Incorporate social determinants of health in planning care transitions.
- Decreased likelihood of receiving mental health services.
- Redefine/think broadly about natural supports.
- More complex and proactive follow-up contact necessary.

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