RELIAS

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Care Transition Practices for Suicidal Individuals

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Today's Presenters

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Objectives

By the end of this session, participants will be able to:

- Understand what elevates risk during various care transitions
- Explore approaches to building collaboration, communication, and relationships among care transition organizations
- Identify opportunities and strategies for client transitions between outpatient and inpatient service settings

Suicide by the Numbers

https://www.cdc.gov/suicide/facts/index.html

Care Transition Data

- Suicide rates are 300 times higher for individuals in the first week and 200 times higher in the first month, after inpatient stay.

- Nearly a third of patients do not complete a single outpatient visit in the first 30 days, after inpatient stay.

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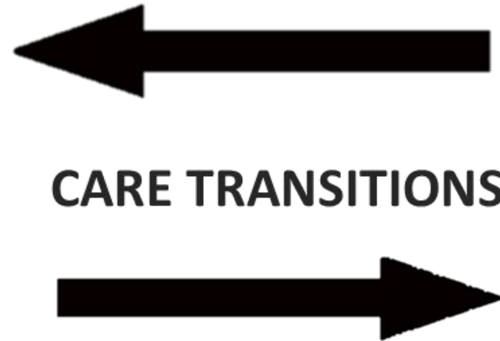
What are Care Transitions?



The movement of client between health care locations, providers, or different levels of care within the same location, as their conditions and care needs change

Types of Care Transitions

Source: NTOCC

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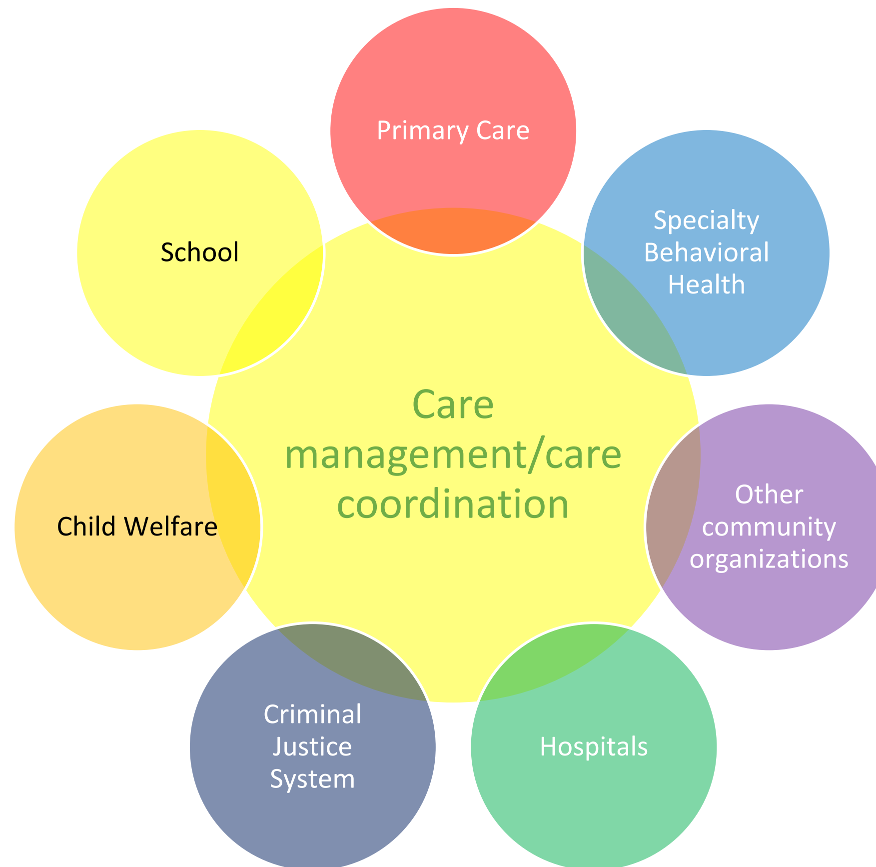
Care Management

Care management refers to activities performed by health care professionals with a goal of achieving the person-centered treatment to target outcomes with the person.

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

The Complex World of People and Care Transitions



Team-Based Care (TBC): Who is the Team?

Fundamental Definition

- At least two health staff who work collaboratively with patients and their caregivers – to the extent preferred by patient—to accomplish shared goals and achieve coordinated, high-quality care.[1]
- Inter-disciplinary (e.g., BH professional, PCP, SW, nutritionist, peer support specialist).[1]
- Clear roles, mutual trust, effective communication, measurable processes and outcomes.[2]

[1] Adapted from ACA definitions of team in Sections 2703 and 3502

[2] IOM White Paper: Mitchell, Wynia, Golden et al (October 2012), Core Principles and Values of Effective Team-based Health Care.

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High

Low

Cost / complexity of team

Multiple chronic conditions

Chronic condition with emerging co-morbidities

Single chronic condition

Acute, short-term illness

Risk factors for a chronic condition

No acute or chronic conditions

Low

High

Cost / complexity of patient and family needs

Note: This axis represents progression of medical needs but should also be interpreted to represent needs from social / situational complexity.

Source: Mitchell, P., M. Wynia, R. Golden, B. McNellis, S. Okun, C.E. Webb, V. Rohrbach, and I. Von Kohorn. 2012. Core principles & values of effective team-based health care. Discussion Paper, Institute of Medicine, Washington, DC. www.iom.edu/tbc.

Activating Care Management:

- Screening & Assessment using data
- Care planning
- Increasing health literacy through education
- Medication management & adherence support
- Risk stratification
- Population management
- Coordination of care transitions and care coordination

Source: McDonald KM, Sundaram V, Bravata DM, et al. Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies, Volume 7—Care Coordination. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services; June 2007.

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Developing a Care Pathway and Workflows

Create a Care Pathway

- How does one get on?
- How does one get off?
- Exceptions/what ifs….

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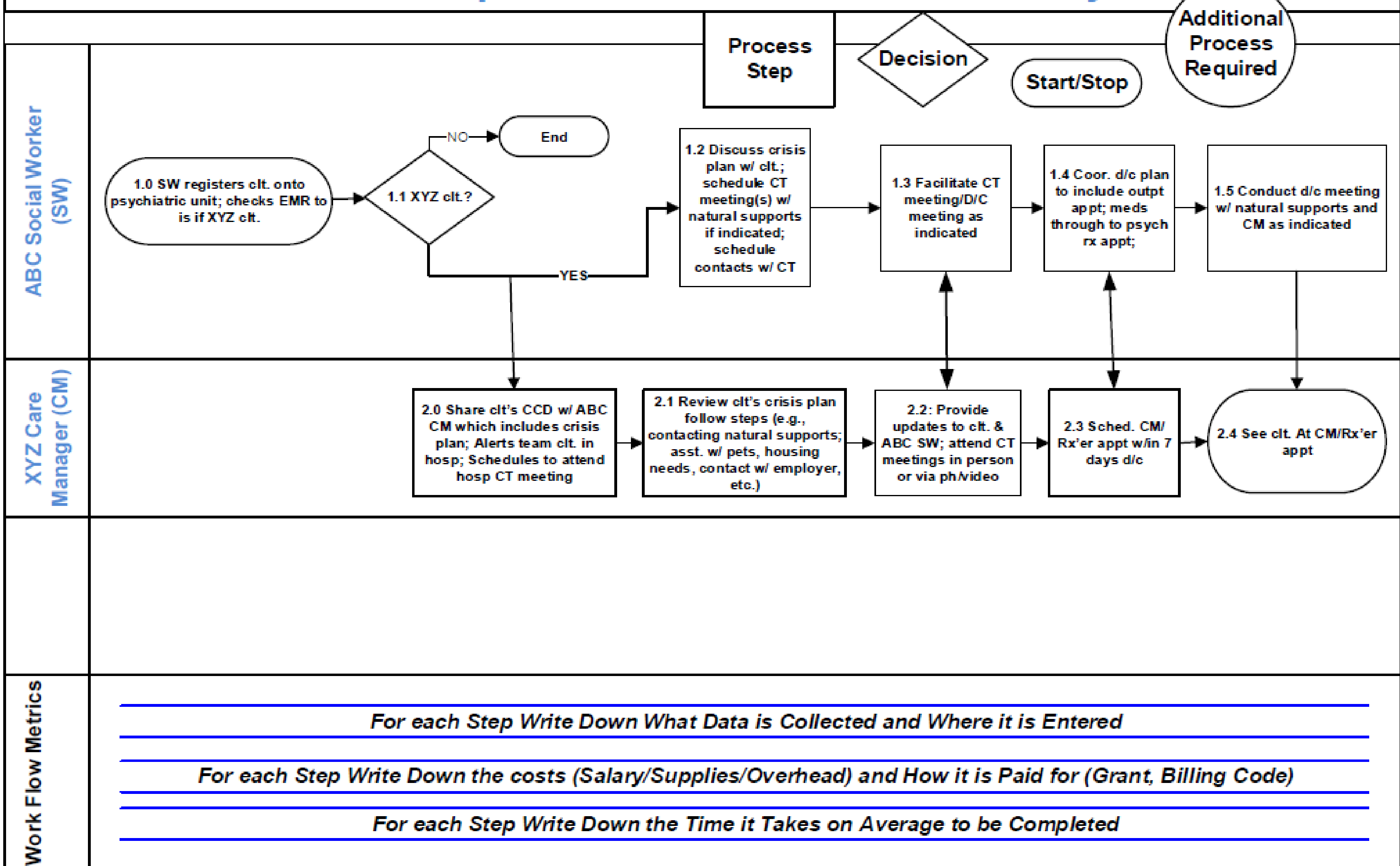
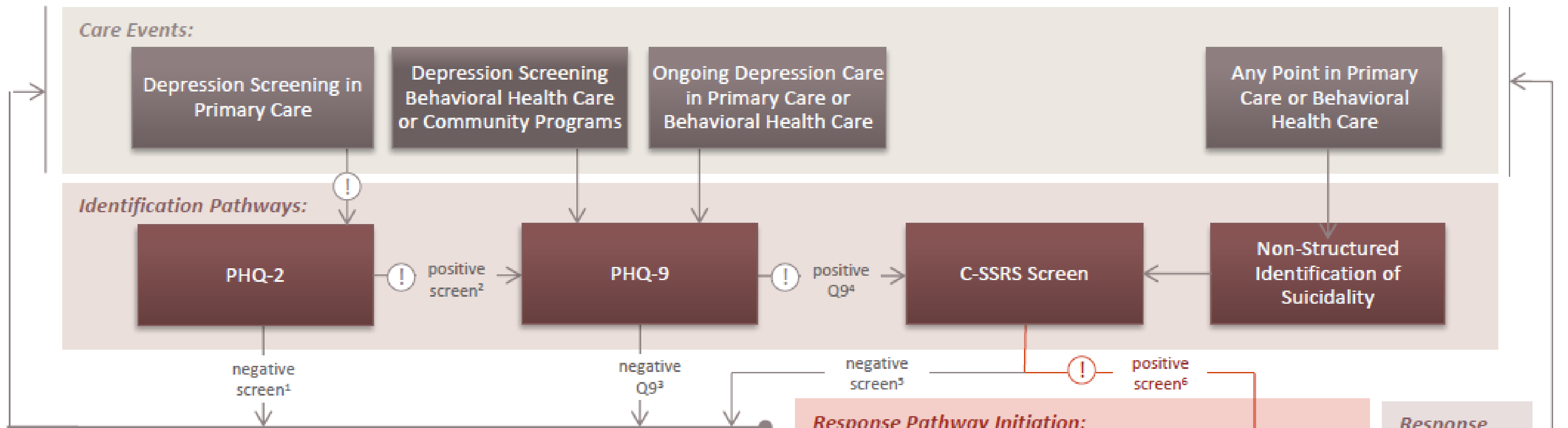

XYZ CMHC & ABC Hosp: Transitions of Care Pathway
Process Step
Decision
Start/Stop
Additional Process Required
ABC Social Worker (SW)
XYZ Care Manager (CM)
Work Flow Metrics
1.0 SW registers clt. onto psychiatric unit; checks EMR to is if XYZ clt.
1.1 XYZ clt.?
NO
End
YES
1.2 Discuss crisis plan w/ clt.; schedule CT meeting(s) w/ natural supports if indicated; schedule contacts w/ CT
1.3 Facilitate CT meeting/D/C meeting as indicated
1.4 Coor. d/c plan to include outpt appt; meds through to psych rx appt;
1.5 Conduct d/c meeting w/ natural supports and CM as indicated
2.0 Share clt's CCD w/ ABC CM which includes crisis plan; Alerts team clt. in hosp; Schedules to attend hosp CT meeting
2.1 Review clt's crisis plan follow steps (e.g., contacting natural supports; asst. w/ pets, housing needs, contact w/ employer, etc.)
2.2: Provide updates to clt. & ABC SW; attend CT meetings in person or via ph/video
2.3 Sched. CM/ Rx'er appt w/in 7 days d/c
2.4 See clt. At CM/Rx'er appt
For each Step Write Down What Data is Collected and Where it is Entered
For each Step Write Down the costs (Salary/Supplies/Overhead) and How it is Paid for (Grant, Billing Code)
For each Step Write Down the Time it Takes on Average to be Completed



Managing Suicidality: Clinical Pathways in Primary and Behavioral Health Care

Foundational Performance Metrics:

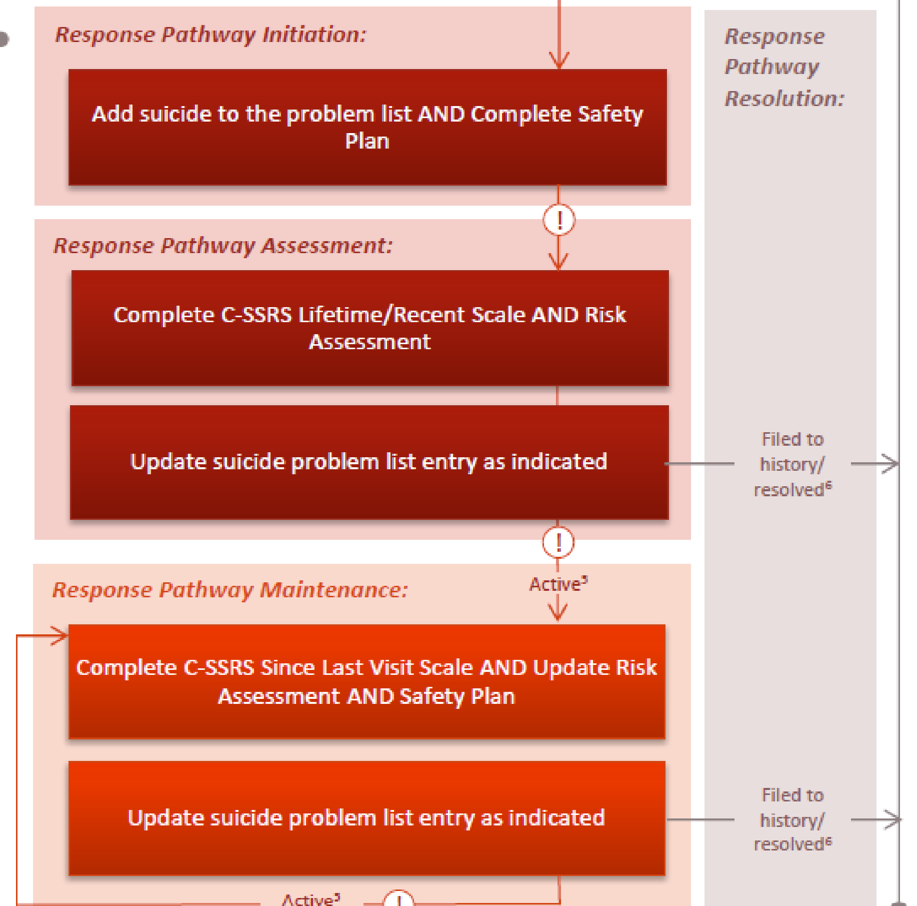
- ✓ Percentage of patients with a positive response to Question 9 (Q9)[2] on the Patient Health Questionare-9 (PHQ-9) that receive C-SSRS Screen with Triage Points (C-SSRS Screen).
- ✓ Percentage of patients with a positive C-SSRS screen[6] that have suicide added to the problem list.
- ✓ Percentage of patients with suicide active on the problem list that have a completed:
  - Safety Plan.
  - C-SSRS Lifetime/Recent scale.
  - Risk Assessment.

Icon Key:

(!) Indicates that Clinical Decision Support is in place to support movement along pathway.

Notes:

1. Negative on PHQ-2 is defined as a score of 0; Positive on PHQ-2 is defined as a score of 1-2.
2. Negative Response to PHQ-9, Question 9 is defined as a score of 0; Positive Response to PHQ9, Question 9 is defined as a score of 1-3.
3. Negative on C-SSRS Screen is defined as a response of "No" on Questions 2 and 6; Positive on C-SSRS Screen is defined as a response of "Yes" on Question 2 or 6
4. Active or File to History/Resolved is determined in accordance with guidelines included in Appendix A: Problem List Entry Guidance



Inpatient Care Transitions Workflow

Alliant Health Solutions
Care Transitions Workflow
Workbook Link

Care Transitions Workflow

The Care Transitions Workflow is a set of recommendations primarily from two evidence-based programs proven to reduce hospital readmissions: Project RED (Re-Engineered Discharge) and the RARE Campaign of Minnesota. This workflow provides staff members of inpatient psychiatric facilities an outline of key steps and considerations for assisting patients in successfully transitioning from inpatient care to outpatient support.

On Admission

1. Assess written and verbal language needs
2. Complete a Biopsychosocial Assessment
3. Identify support people (e.g., family, caregiver, and friends)
4. Identify Behavioral Health and Primary Care Physicians
5. Begin treatment and transition/discharge planning
6. Obtain Release of Information
7. Engage family/support people in patient's treatment
8. Notify patient's providers about admission

During Hospitalization

1. Schedule appointments for follow-up care in Behavioral Health and Primary Care. Behavioral Health appointment should occur within 7 days of hospital discharge
2. Arrange for post-discharge services or equipment (home health, Durable Medical Equipment, etc.)
3. Coordinate initial contact between the patient and any new referrals
4. **Perform Medication Reconciliation**
   (To be completed at each transition)
   - Consider patient's substance misuse history and other chronic conditions
   - Pay special attention to medications that can be misused/abused
   - Inquire about over the counter medications, vitamins, non-prescription and herbal supplements
   - Discuss benefit coverage and affordability of medications
   - Limit quantity of lethal medications when depression or suicidal ideation is present
   - Sign and date the reconciliation document
5. **Create Medication List**
   - Name of medication
   - Purpose of the medication
   - Potential side effects
   - Dosage, schedule and method of taking medications
   - Changes in medication regimen compared to admission
   - Anticipated dosage changes and titrations
   - Formulary availability, costs, generic alternatives
   - Possible medication interactions with alcohol, food, and over the counter medications and supplements
   - Disposal of discontinued medications
   - Date of the medication reconciliation
6. **Complete the Comprehensive Transition/Discharge Plan**
   (written in a method that meets health literacy standards)
   Should include:
   - Reason for hospitalization
   - Medication List
   - Self-care activities
   - Crisis plan including support person and their contact information
   - Follow-up appointments coordination (including aftercare provider name, date and location)
   - Preparation for follow up appointments (what to bring, questions to ask)
   - Process for obtaining pending tests results
   - Mitigations strategies for patient-identified barriers to adherence with discharge plan
7. Call patient's Behavioral Health and Primary Care Physician about upcoming discharge

Upon Transition / Discharge

1. Provide copy of transition/discharge plan to patient
2. Provide prescriptions or medications
3. **Use the Teach Back Method**
   - Teach the written discharge plan in a way that the patient can understand
   - Educate patient about diagnosis and medications
   - Review with the patient how to respond if a problem arises
   - Assess the patient's understanding of the discharge plan
   - Have patient repeat or teach back the discharge instructions
4. Provide needed education or resource information

Post-Transition / Discharge

1. Expedite transmission of the discharge summary to aftercare providers
2. Make follow-up call to patient within 72 hours of transition/discharge

The RARE Campaign:
http://www.rarereadmissions.org/

Project RED Toolkit:
https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/index.html

Example of the Project RED After Hospital Care Plan

Health Literacy Resources

Elements of Teach Back

Quality Improvement Organizations
ALLIANT QUALITY

This material was prepared by Alliant Quality, the quality improvement group of Alliant Health Solutions (AHS), the Medicare Quality Innovation Network - Quality Improvement Organization for Alabama, Florida, Georgia, Kentucky, Louisiana, North Carolina, and Tennessee, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. 12SOW-AHSQIN-QIO-TO1CC-20-211

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Suicide and Electronic Health Records

- Address suicide in all sites, services, and programs
- Multiple areas in chart
- Need different workflows and tools fo different providers
- Use Decision Support

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Suicide on the Problem List

- Will show in all encounters
- Readily seen by providers of all disciplines
- Ability to report on characteristics of suicidal patients
- Could initiate a chart or banner of chart color change

Data Driven Care

- Population Health Management perspective
- Standardized screening tools, rescreening in a predictable way
- Helps to predict costs and outcomes
- Care pathways: standardize what we can, to leave space for what we can't.

Population of Clients At Elevated Risk for Suicide

- Knowing and tracking population
- How will you know if you have improved?
- Expect to do worse before you do better
- Establish definitions
- Helps establish or adjust care pathway criteria
- What can you track related to care transitions?

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Care Continuum Partnership

CARE TRANSITIONS

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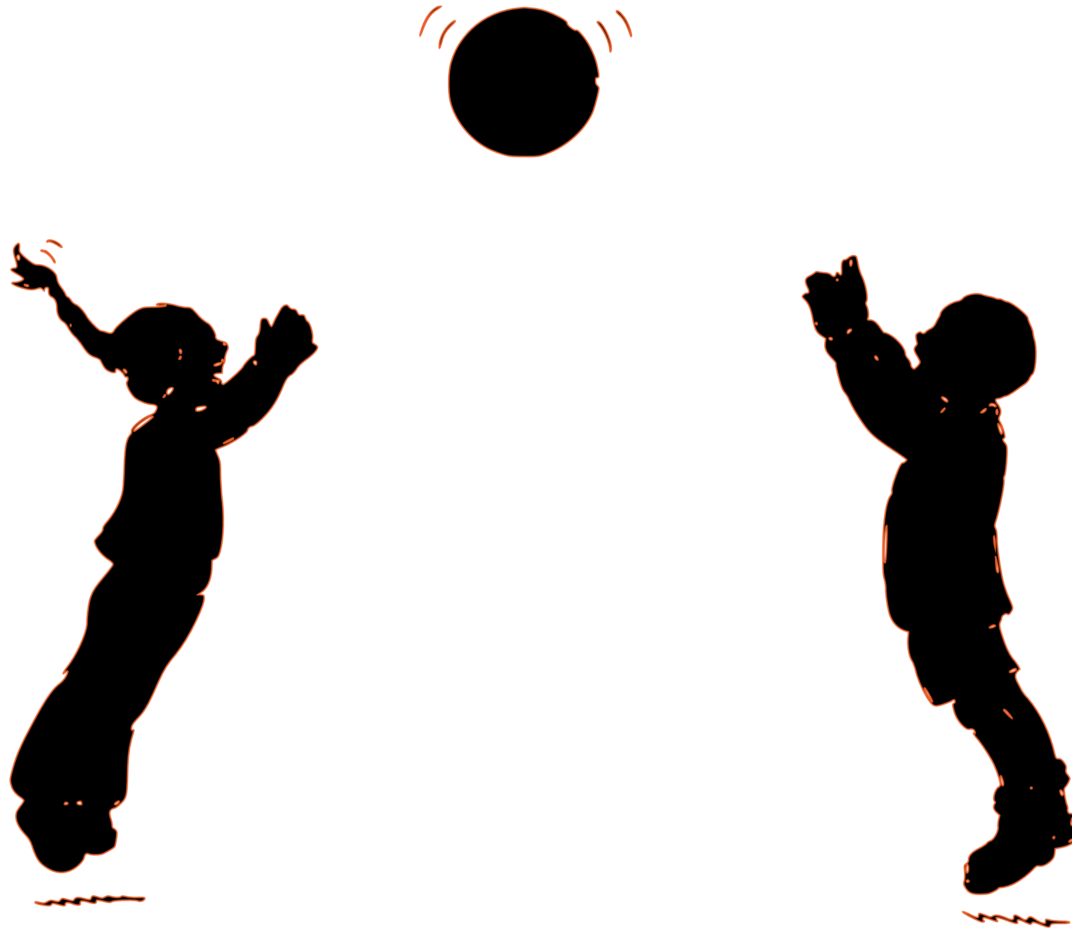
The “catch” is only as good as the “throw”



Batting the ball back and forth hurts everyone

Know Your Positions

Inpatient care is meant to:	Outpatient care is meant to:
• Mitigate immediate risk and stabilize • Beginning or shifting treatment/medication • Prepare for discharge and continuing care	• Provide initial care and/or continuing care • Provide a range of treatment services, as needed • Monitor for risk unable to be safely managed in an outpatient setting

Teamwork Makes the Dream Work

In order to set the stage for reciprocal communication, everyone must do their part.

Recommendations for <u>all</u> providers:

- Get together
- Get aligned
- Build out the team
  - Family, friends, community members
  - Peer Support and Lived-Experience Team Members

National Action Alliance for Suicide Prevention. (2019).

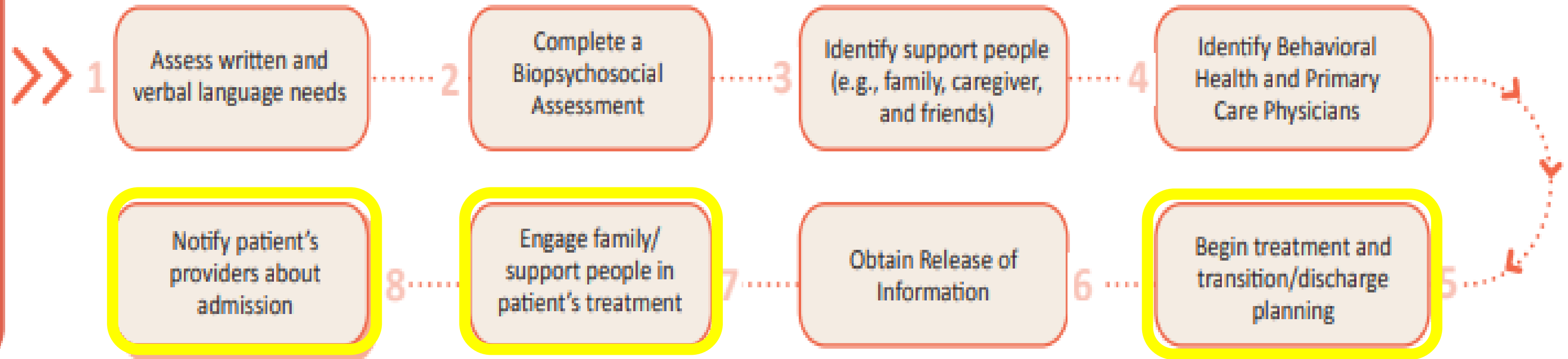
Teamwork Makes the Dream Work

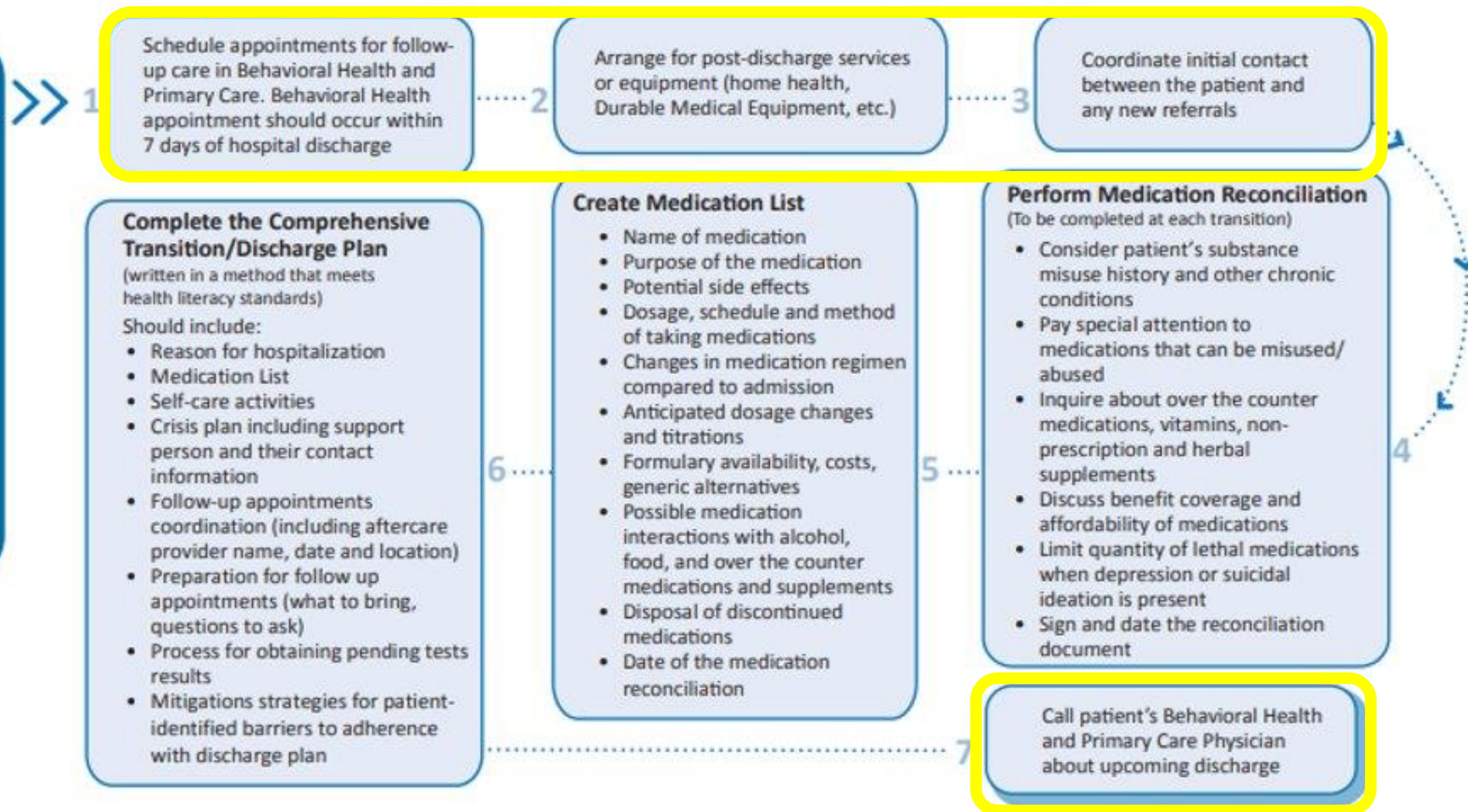
Recommendations for all providers (cont'd):

- Prepare alternative plays, when needed
- Know the rules and the playbook
- Know your stats
- Communicate
- Plan for curveballs
- Know the score

National Action Alliance for Suicide Prevention. (2019).

What a Play Might Look Like





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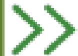
Upon Transition / Discharge



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Post-Transition / Discharge

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Other Care Transition Best Practices

- Plan logistics (transportation, financial barriers, pharmacy access, responsibilities, etc.)
- Medication list and reconciliation
- Medication home delivery or other easy access
- Warm handoffs, when possible
- Written admission and discharge summaries
- Live or recorded video introductions to the outpatient clinic and provider, when warm handoffs are not possible.
- Use of electronic and other resources for follow-up care

Expand Support

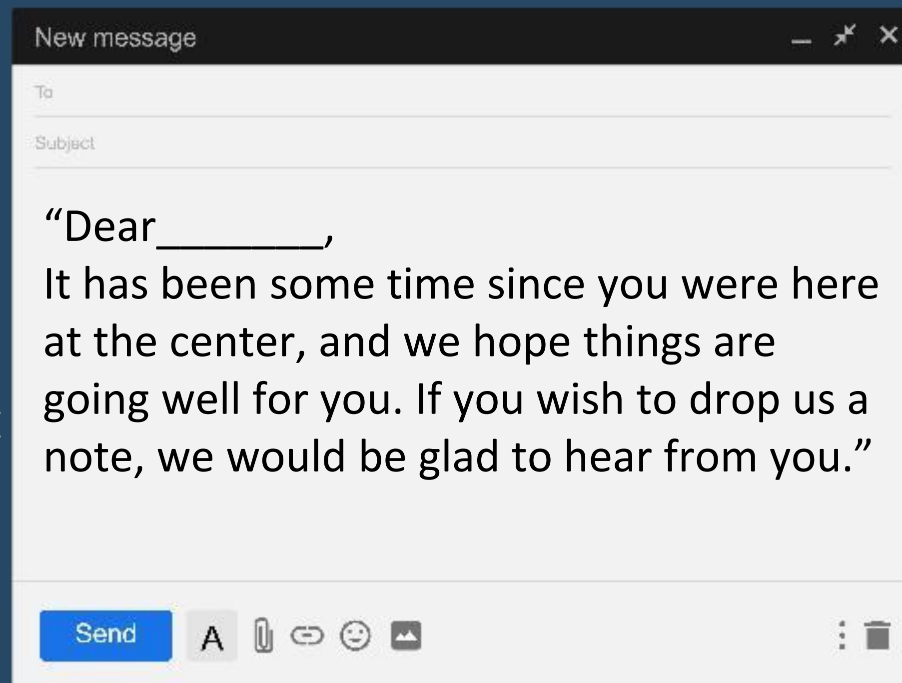
- Meaningful connections to others
- Community inclusion where it matters to clients
- Possible involvement in care
- Considerations around social isolation and loneliness

Non-Demand Caring Letters/Cards/Contacts

Letter, phone call, email or text message

Nonpunitive

Doesn't expect or require action from recipient



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Caring Messages

We asked over 1000 people. Here are the top results.
Please use and adapt these any way you like for those you care about.

Dear you. Yes you! Remember that one time you felt connected to the universe. No one can take that away from you. It's yours.
— Ursula Whiteside

You may feel you don't matter and see no future. But you do. Yet it is there - please let it evolve because the world needs you and your contribution.
— Kristine Laaninen

You're a human being, not a human doing. Your worth is intrinsic, and your strength is likely greater than you think it is.
— John Brown

Live. If only, at times, because it is an act of radical defiance.
— Ursula Whiteside

If I could fill the world with more people who feel the world, I would. Understanding suffering is a heavy burden to carry at times for sure - but you are never a burden for feeling it.
— Nina Smith

Your story doesn't have to end in this storm. Please stay for the calm after the storm. The possibility of a rainbow. Maybe not tomorrow or next week, but you can weather this.
— Breanna Laughlin

When things have been rough, I think of things or touch items that give me a sense of pride, joy, encouragement, or hope. Sometimes memories that remind me I'm okay and things often change quickly. I don't know if that would help for you.
— Daniel DeBrule

This is part of a poem from Jane Hirschfield, "The world asks of us only the strength we have and we give it. Then it asks more, and we give it."
— Sara Smucker Barnwell

I've been there - that place where you'd do anything to stop the pain. It's a dark, suffocating birth canal to a better place...Life changes can suck; but nothing ever changing sucks more.
— Kathleen Bartholomew

Just like winter, the long dark days slowly get shorter until there is more light than dark. Please believe this while you wait to see the light.
— Debbie Reisert

Please don't stop fighting. You are being prepared for something far greater than this moment.
— Breanna Laughlin

Things can be completely dark for some of us somteimes. I don't know where you are at today, or if this message can shine through, but I'm here sending you a tiny bit of light - a light beam.
— Ursula Whiteside

This is a favorite line of mine from Desiderata, "You are a child of the universe, no less than the trees and the stars; you have a right to be here."
— Andy Bogart

I was trapped in the Dark Place. Drowning in it. Lost in the fog. Sinking in the quicksand. Unable to get out. Slowly, slowly, slowly: I am. You might be able to too. Just get through today.
— Amy Dietz

I've found this Franklin D. Roosevelt quote helpful, "A smooth sea never made a skilled sailor." We'll be prepared for something bigger.
— Ursula Whiteside

now matters now

NowMattersNow.org

Wanting to be rid of pain is the most human of impulses. You are brave to hold that. You are worth so much. Because you exist. And breathe air. Contingent on nothing else.
— Sara Smucker Barnwell

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Continued Discussion and Further Support

Team and Partner Collaborations

- Team discussions on successes and improvements
- Collaborate with care continuum partners
  - How will you communicate
  - How will you assess how things are going
  - How will you evolve together

Relias Courses Related to Suicide

General Courses related to Suicide

- Suicide Risk Assessment using ASQ (Microlearning)
- Assessing Suicide Risk Using the C-SSRS (Microlearning)
- Assessing and Screening for Suicide Risk
- Overview of Evidence-Based, Suicide-Specific Interventions
- Lethal Means Counseling
- Effective Intervention in the Aftermath of a Suicide
- Community-Based Interventions to Reduce Suicide Risk
- Suicide Screening for Direct Care Staff
- Preventing Suicide in Adults: The Role of Paraprofessionals
- Approaches to Preventing Psychiatric Hospitalizations and Readmissions
- Cultural Considerations Related to Suicide (Coming Soon)

Relias Courses Related to Suicide

Children and Adolescent Specific Courses

- Reducing Suicide Risk in Adolescents and Transition Age Youth
- Preventing Suicide in Youth: The Role of Paraprofessionals

Knowledge Exam

- Evaluating and Intervening to Reduce Suicide Risk: Exam

Veterans

- Preventing Suicide Among Veteran Populations

Care for Clinicians

- Managing Reactions When Working with Suicidal Clients: A Guide for Clinicians
- Podcast: Processing a Client Dying by Suicide (Coming Soon)
- Behavioral Health Leaders: Supporting Clinicians after a Client Death (Coming Soon)

Relias Courses Related to Crisis

Crisis

- Key Steps for Supporting Someone in Crisis (Microlearning)
- Verbal De-escalation Strategies (Microlearning)
- Preventing and De-escalating Crisis Situations
- Crisis Management Basics for Paraprofessionals
- Crisis Management Approaches for Telehealth Services
- Crisis Management Approaches for Telehealth Services with Children and Adolescents
- Helping Children Cope in Crisis
- Behavioral Health System of Crisis Care
- Engaging Family Members in Crisis Planning

Related Relias Simulations

In Session Simulations

- In Session: Practicing Clinical Skills to Prevent Suicide in Children and Adolescents
- In Session: Practicing Clinical Skills to Prevent Suicide in Young Adults
- In Session: Practicing Clinical Skills to Prevent Suicide in Adults
- In Session: Practicing Clinical Skills to Prevent Suicide in Older Adults
- In Session: Practicing Clinical Skills for Safety Planning

Crisis Simulations for All Staff

- Crisis Management Across Health and Human Services
- Verbal De-escalation Practice (Coming Soon)

Presentation Evaluation

https://www.surveymonkey.com/r/PDFQYD9

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Thank you!

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Further Questions and Discussion

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Presentation Evaluation

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