Safe Care Transitions for Suicide Prevention

Utah Zero Suicide Learning Collaborative
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utah department of human services
SUBSTANCE ABUSE AND MENTAL HEALTH

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For technical assistance and support in using this toolkit, please contact Kimberly Myers at the Utah Division of Substance Abuse and Mental Health, kmyers@utah.gov or visit zerosuicide.sprc.org.

Introduction

Transitions in care include discharge from hospital inpatient or emergency department, referral after suicide risk assessment in a primary care or crisis setting, or any time when a patient at risk of suicide is between care providers. These gaps in care are times of heightened risk, especially after discharge from inpatient care. A 2017 systematic review found that the post-discharge population has a rate of suicide that is 100 times higher than the general global population, specifically in the first three months after discharge (Chung et. al, 2017). Suicide rates generally peak in the first week after discharge from psychiatric inpatient care (Qin & Nordentoft, 2005; Appleby et al., 1999).

Strategies to promote continuity of care are needed to address these periods of heightened risk, particularly for individuals that are difficult to engage in treatment (e.g. underinsured, low socio-economic status individuals, and males). Many individuals undergoing care transitions experience a complete lack of support during high-risk transitions in care or when ongoing services are interrupted (e.g. an appointment is missed). These gaps in care are unacceptable for high risk individuals and changes in systems and practices are urgently needed.

The Larger Whole of Zero Suicide

Continuity of care strategies are an important piece of Zero Suicide, a systems quality improvement framework that has many components with evidence of effectiveness in reducing suicide attempts and deaths. The data assures us that when all of the Zero Suicide strategies are practiced in combination and through a lens of continuous quality improvement, that suicide deaths and attempt rates in health and behavioral health care systems are significantly reduced. To learn more, visit zerosuicide.sprc.org, or email Andrea Hood at ajhood@utah.gov.

Best Practice Menu of Strategies for Providing Continuity of Care

This section provides promising and evidence-based strategies for improving continuity of care, increasing engagement in outpatient treatment; and reducing suicidal ideation, attempts, and deaths. Each strategy is defined and different levels of adoption are presented, stratified by resources required and effectiveness. The "Good" classification often describes common current practices or a slight improvement to current practices, where "Better" and "Best" categories reflect movement towards ideal recommended best practices. The document begins by describing large systems reform/interagency strategies and gradually moves toward individual patient level strategies to ensure safe care transitions. The goal is to have entire systems shift towards best practice, with the most resource-intensive strategies primarily implemented with patients at highest risk of suicide.

Stepped Care

Stepped care refers to a continuum of treatment intensity based on the needs of the individual. Rather than relying only on traditional models of outpatient care and emergency departments only, stepped care offers a broader range of care including intensive outpatient, mobile crisis supports, crisis stabilization units, peer support, and other creative solutions to meet the needs of individuals in the least restrictive setting possible.

Good: Providing 24-hour access to crisis resources over the phone/SMS texting, and utilizing the Emergency Department for acute or imminent suicide risk

Better: All of the above, and providing intensive outpatient options, crisis stabilization units, walk in crisis centers, and/or mobile crisis.

Best: All of the above, and providing peer support, linked EHRs, and/or an "air traffic control" center to deploy mobile crisis and monitor availability of inpatient bed availability in real time (See http://bhltest2.com/ for more information and resources in reforming crisis care).

MOUs/MOAs

Memorandums of understanding (MOUs) with partner organizations (e.g. local hospital) outline the role that each entity has for screening, assessment, safety planning, discharge planning and follow-up to allow multiple agencies to coordinate care. MOUs can assist in providing clear arrangements for information sharing, including establishing procedures for access to relevant assessment information and policies around warm hand-offs/rapid referrals.

Good: Having informal agreements with identified contacts at referral agencies.

Best: MOUs or contracts provide rapid referral for clinical mental health services with a policy in place around care coordination (including warm hand-offs, rapid referrals, stepped care options); and includes defined information sharing (e.g. comprehensive evidence based suicide risk assessment, safety plan, discharge plan). Records and assessment information are shared directly through a linked electronic health record if possible.

Warm Hand-offs

Warm hand-offs provide an introduction to the new care provider before the care transition, to build a relationship with the referred provider or organization and decrease no-shows. This contact could include care coordination dialogue (current provider to referred provider), and care navigation support (individual to referred provider). The referring provider may arrange an introduction with the new provider in person, by phone or through telehealth technology. Alternatively, the referring provider may make a linkage with another staff within the referral organization, such as a peer provider or continuity of care staff, who is responsible for maintaining care throughout the transition time for the person at risk.

Good: A policy is in place for peer support, support staff, or crisis worker from the receiving organization to be introduced to the patient before discharge or care transition over the phone.

Better: An in person meeting is arranged between the patient and the identified provider (or peer support, staff, or crisis worker) prior to discharge. *If inpatient, the patient would ideally begin outpatient treatment prior to discharge, with the referred care provider. Warm hand-offs of this kind may triple the odds of a patient engaging in outpatient behavioral health care (Boyer et. al, 2000).

Appointment Scheduling

Organizations do their best to ensure that individuals have rapid access to initial outpatient appointments following discharge/referral. Providers supporting care transitions, such as crisis staff, should have the capacity to schedule follow-up appointments while still engaged with the individual at risk. Consider use of telebehavioral health when appointments are not readily available. The sooner the follow up appointment can be scheduled the better, and the ideal is to maintain consistent contact with the patient during the care transition.

Good: Follow-up appointments are scheduled within 7 days, while the referring provider is still engaged with the individual at risk. Receiving provider provides reminder phone calls.

Better: Follow-up appointments are scheduled within 24-72 hours while the referring provider is still engaged with the individual at risk. Patients are engaged in scheduling their appointment and patient preferences and needs are taken into account. Reminder phone calls are provided to improve attendance at scheduled appointments, and a procedure is in place to identify no shows and attempt to contact them or their family members to ensure the patient is safe/activate crisis response if necessary.

Best: Follow-up appointments are scheduled within 24 hours while the referring provider is still engaged with the individual at risk (particularly important after discharge from inpatient care). Reminder phone calls are provided to improve attendance at scheduled appointments, and a procedure is in place to identify no shows and attempt to contact them or their family members to ensure the patient is safe/activate crisis response if necessary. Referring provider follows up with phone call to ask how the appointment went and if another referral is needed.

Provider Communication

The care transition should be supported through effective communication between the referring provider and the receiving provider. Providers should send documentation on the individual at risk prior to the scheduled appointment and follow up with a conversation between providers to share relevant information. Provider communication including communication of patient discharge plans prior to the first appointment may triple the odds of a patient engaging in outpatient behavioral health care (Boyer et. al, 2000).

Good: Once a Release of Information is in place, send the assessment and discharge paperwork, and treatment plan if applicable to the receiving provider, prior to or at the first appointment.
Better: Referring provider does all of the above, and communicates patient history, social/environmental context, assessment and diagnosis, over phone or email to receiving provider. Additional ROIs are put in place to facilitate ongoing care coordination with social supports and care providers.
Best: In person or over the phone treatment team meeting that includes the individual at risk, the individual's social support persons, and all applicable providers, case managers, school team, peer supports, or other services a person might need. Care coordination meetings recur as needed. Provider communication takes place between systems using MOUs and shared EHRs, for example when a crisis services provider communicates back to the outpatient provider, or vice versa.

Care Navigators/Community Health Workers/Case Management

Care navigators have been shown to be especially helpful in providing continuity across primary care and behavioral health systems and across hospital and outpatient settings. The care navigator can enhance these system relationships by serving as a liaison, improving communication across providers and facilitating access to care. The use of motivational enhancement strategies may increase the effectiveness of care navigation and care coordination. They also provide support to the patient to increase engagement in care.
Good: Providing care navigation services between treatment systems and settings.
Better: Having identified care navigators specific to behavioral health, and/or specific to populations such as Veterans, youth, refugee populations, etc.

Peer Specialist Support

Organizations can engage internal or external peer specialists to assist individuals at risk in navigating behavioral health systems and provide support and encouragement during the transition period and possibly beyond. One study demonstrated that utilizing peer support organizations in the discharge process shortened the length of hospitalization, reduced the use of hospital and ED services over 12 months, and reduced the overall cost of care

(Forchuk, Martin, Chan, & Jensen, 2005). The intervention was most beneficial for those individuals describing themselves as “lonely.”

Good: A procedure is in place to consistently refer to external peer support organizations upon discharge such as NAMI Utah or the local mental health authority.

Better: Employing certified peer support staff to build relationships with patients before discharge or transition and continue working with patient during the transition in care.

Engagement of Support Network

This strategy includes involving supportive family or friends through education around the elevated risk period and inclusion in the discharge and transition planning. Persons in the individual’s support network can also be included in plans to reduce access to lethal means. Information should be shared regarding crisis services, the patient’s safety plan, community supports, and outpatient care.

Good: At least one person from the support network is involved in discharge and treatment planning. This has demonstrated to triple the odds of a patient engaging in outpatient behavioral health care (Boyer et. al, 2000).

Better: All of the above, and having a Release of Information signed by the individual receiving care to allow ongoing communication with support person, especially to ensure access to lethal means is reduced, and to check on a patient who no-shows for an appointment and isn’t responding to attempts to contact.

Psychoeducation

Providers engage in conversations with an individual to identify expectations regarding mental health diagnoses, treatment, and prognosis; provide information and clarify misconceptions, discuss potential barriers to treatment and problem solve. Psychoeducation should include an understanding of the individual’s cultural beliefs about suicide and mental health treatment and the role these beliefs may play, using motivational interviewing techniques.

Good: Provider gives the patient educational materials about their diagnosis, treatment, and treatment outcomes.

Better: Provider gives the patient educational materials and discusses them with the patient and the patient’s social supports. This psychoeducation should continue throughout the

treatment process.

Best: All of the above, and as part of treatment, provider increases access to social supports and examples of individuals living in recovery including peer support specialists.

Caring Contacts

Caring contacts can be done by staff in any program that has provided acute care (e.g., emergency department, crisis, or inpatient programs), by outpatient programs that provide ongoing care (during high risk periods, when an appointment is missed, or treatment is discontinued), or by crisis centers that can conduct follow-up under contract with other services (National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group, 2018). These contacts are brief communications expressing care from a provider and could be delivered in person, by phone, letter or postcard, email, or text. Caring contacts follow a pre-set schedule and have ranged in studies from 1 to 24 contacts with most lasting for up to 18 months. A review of the evidence supporting caring contacts found that various methods of supportive contacts can be effective (Luxton et al., 2013) Examples of caring contacts can be found on the Resources page of the Zero Suicide Website (http://zerosuicide.sprc.org/resources?type_1%5B%5D=tool&field_toolkit_tid%5B%5D=4).

Good: One or more emails, texts, or postcards are sent to the individual during care transitions.

Better: Phone calls are provided by support staff or peer supports in addition to or in lieu of the emails, texts, or postcards. Phone calls are considered a higher level of support because it allows crisis services to be activated if needed.

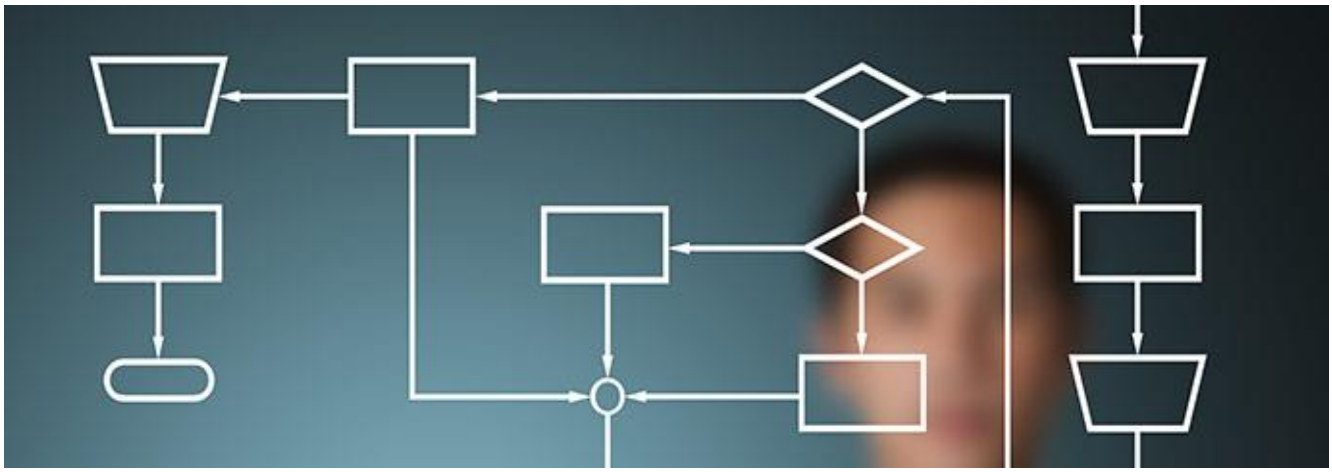
Best: Structured follow up and monitoring is provided via phone or in person by a nurse or mental health clinician in addition to emails, texts, or postcards. Phone calls or visits are used to assess risk, edit safety plan, and increase engagement in outpatient care. A policy is in place to determine how long caring contacts are given (e.g. until the person is engaged in care, until suicide risk is reduced, or for several months-years if neither of those conditions are met). Structured follow up and monitoring may also be used for patients already engaged in care between outpatient appointments.

Creating an Office Protocol for Transitions in Care

This section is intended to provide a practical guide for entities who wish to implement continuity of care strategies. Please review the following considerations to guide your protocol development and implementation.

1. Review the continuity of care options presented in the companion document (Best Practices Menu of Strategies for Providing Continuity of Care) and select options that are feasible for your agency.
2. Establish agreements with outpatient treatment providers to facilitate rapid referrals (ideally within 24 hours from inpatient settings and 72 hours from outpatient settings) for high-risk patients; and develop an office protocol to provide follow up contacts with discharged/referred patients that have identified suicide risk.
3. Considerations for follow up outreach may include staffing patterns and capacity of provider performing outreach to determine whether simple caring contacts or more structured follow up and monitoring will be provided. In developing office protocols, agencies should clearly define the following:
    a. Criteria of patients who will receive follow up contacts (discharged from psychiatric inpatient or ED, medium to high suicide risk identified by screening, referral to specialty provider for suicide risk, and/or patient at risk of suicide who no shows/refuses treatment/drops out of treatment)
    b. Goals and content of follow up outreach (engage in outpatient care, monitor risk, provide support)
    c. Staff member who will obtain a signed Release of Information to contact patient social supports and support/treatment team, and template for the ROI.
    d. Provider who will provide contact (therapist, nurse, peer support, case manager, or support staff). *Research indicates that having clinical staff perform this function is likely to have a greater impact on outcomes
    e. Types of contacts provided (call, text, email, and/or letter are most common; home visits are effective in hard to engage populations)
    f. Frequency of follow up contacts (daily or minimum of every three days is recommended during transition from inpatient psychiatric care)
    g. Minimum number of contact outreaches to be made and maximum number of attempts to be made prior before it is assumed they have dropped out of the program
    Criteria for how long the contacts will be provided could be based on research or based on individual patient needs.
    h. Create a template for Caring Contacts that can be mailed, emailed, or SMS texted if that will be part of your follow up efforts

4. Outline who is responsible for each Continuity of Care task in your organizational policy and train staff on both their role and resources available to patients. Provide regular suicide prevention training to all staff who will be interacting with patients.
5. Develop/define method for documenting and monitoring each Continuity of Care task. Consider building follow up procedures into the electronic health record, possibly including, but not limited to:
    a. Patient appointments inside or outside the organization
    b. An automated method of flagging no-shows that will result in staff prompts to take defined action to locate the person, ensure their safety, and reschedule the appointment or link them to a higher level of care if appropriate.
    c. An electronic method for sharing patient health information with the receiving provider.
6. Use quantitative and qualitative measures to determine the success of Continuity of Care efforts. Review 30 days in, and then regularly at predetermined intervals to refine process as needed.



SAMPLE OFFICE PROTOCOL

For Referring Agency, Prior to Discharge

1. _____ will provide brief patient education (including printed materials) that helps the patient and family understand the patient's diagnosis, the concept of recovery, the options for treatment and support, and the purpose and probable duration of treatment. Identify and address barriers to accessing treatment (e.g. logistical barriers, financial concerns, or beliefs regarding treatment and recovery).
2. _____ will obtain patient consent through an ROI to share patient health information with patient's support team, follow up with patient and social supports after a missed appointment, and provide follow up outreach to the patient. Support team may include prescribing medical provider, behavioral healthcare providers, key social supports, wraparound service providers (i.e. housing, employment services, peer specialists, vocational rehab, relevant school personnel, etc). Identify preferred contact methods with patient for follow up care: call, text, email, or mail, and contact information.
3. _____ will define with patient the goals and duration of follow up contacts (e.g. follow up until re-linked to treatment, follow up until specific stressor is past, or follow up until suicide risk assessment shows reduced risk).
4. _____ will provide the patient with assistance navigating the options for treatment and recovery supports described in #2 above. (Preferably a peer or case manager).
5. _____ will collaborate with the patient to create/revise their safety plan and ensure they have a copy. The patient will be asked to write the plan in their own words and/or repeat it back to ensure they understand.
6. _____ will facilitate a phone call with the patient and identified provider at receiving agency, to promote rapport and adherence to discharge treatment plan. When this is not possible, arrange an in-person or telephone meeting with a peer specialist, crisis worker, or other staff from the receiving agency.
7. _____ will send patient records to identified provider(s) at receiving agency in advance of the appointment, and follow up that records were received.
8. _____ will contact new provider at receiving agency to review patient information, emphasizing suicide assessment, prior health and behavioral health care, and identified barriers to treatment, prior to the first appointment.

For Referring Agency, Following Discharge

1. _____ will contact the patient within 24–48 hours after they have transitioned to receiving care provider to promote adherence to treatment plan, engagement in services, and safety. Document all contacts or failed contacts.
2. _____ will contact the receiving agency to confirm attendance at scheduled appointment, address clinical questions or identified barriers, and/or to review appropriateness of referral where applicable.
3. If patient no-shows to scheduled appointment, _____will attempt to contact patient and applicable supports as identified prior to discharge.
4. _____ will follow up with ____ (#) caring contacts over _____ (time period) after discharge or referral, using method of contact preferred by patient (phone, text, email, letter), until they are engaged in care, risk is reduced, or they decline continued follow up contacts. The content of these contacts may be drafted to provide an “open door” for care, and provide interpersonal connectedness and support.
5. _____ will review EHR on a _____ basis to determine that the office protocol is being followed, discuss with staff, and revise process as necessary.

SAMPLE OFFICE PROTOCOL

For Receiving Agency

1. _____ will prioritize appointments to be scheduled as soon as possible when suicide risk is present, using predetermined process. Best practice would be scheduling them within 24 hours, particularly when referred from higher levels of care or when risk is high.
2. _____ will contact patient within 24 hours prior to scheduled appointment for an appointment reminder, to answer questions and address any barriers to accessing treatment or appointment. (If support staff make reminder calls they must be trained in suicide prevention and able to consult with provider if concerns arise.) Ensure documentation of all contacts or failed contacts.
3. _____ will flag no-shows in EHR and communicate with provider. _____ will make phone calls to locate the person, ensure their safety, and reschedule the appointment or link them to a higher level of care if necessary.
    a. If patient cannot be reached, _____ will contact referring agency and request they contact patient social supports.
4. _____ will review EHR on a _____ basis to determine that the office protocol is being followed, discuss with staff, and revise process as necessary.

"It is critically important to design for zero even when it may not be theoretically possible…It's about purposefully aiming for a higher level of performance."

Thomas Priselac
President and CEO of Cedars-Sinai Medical Center

ADDITIONAL RESOURCES

For information and resources about all components of Zero Suicide:
http://zerosuicide.sprc.org/

For examples of caring contacts:
http://zerosuicide.sprc.org/resources?type_1%5B%5D=tool&field_toolkit_tid%5B%5D=4

For online training “Structured Follow Up and Monitoring”
http://zerosuicide.sprc.org/sites/zerosuicide.sprc.org/files/monitor_suicidal_individuals/course.htm

For more information about suicide prevention in the Emergency Department Setting:
https://www.sprc.org/edguide

For more information about suicide prevention in the Primary Care setting:
https://www.sprc.org/settings/primary-care

For information and resources after a suicide attempt or loss:
https://afsp.org/find-support/

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