Inpatient Care Transitions

GLS Grantees' Annual Meeting
May 4, 2016

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Overview

- ✓ Background
- ✓ Practices and lessons learned from SPRC's Community of Practice
- ✓ New Hampshire – NAMI NH/New Hampshire Hospital
- ✓ Indiana - Community Health Network

Suicide Prevention Resource Center

Promoting a public health approach to suicide prevention

The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.

EDC Learning transforms lives.

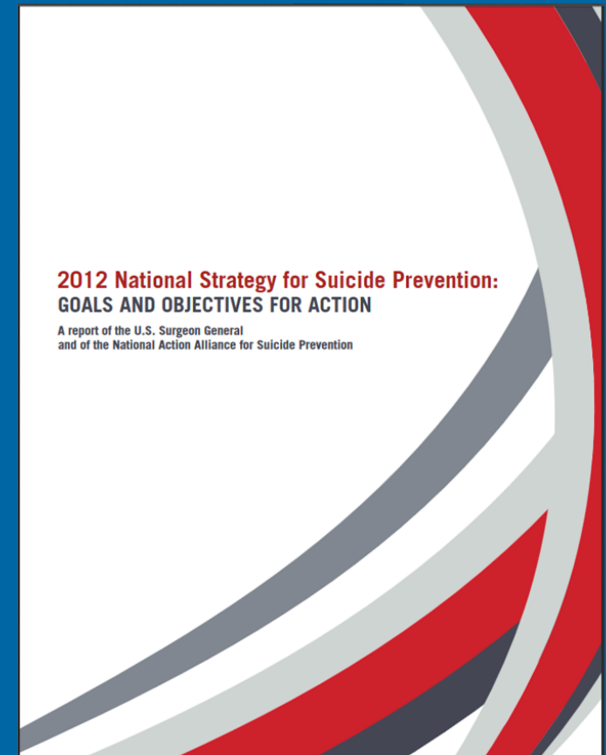
Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Background

2012 National Strategy for Suicide Prevention

Objective 8.4:

- Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.



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Suicide Rates Post-Discharge

New York: (2012)

- ✓ Of 17% of suicide deaths in public mental health care classified as inpatient related, vast majority (85%) were within 30 days of discharge.
- ✓ < 72 hours post-discharge: 2 times as many suicide deaths as on inpatient units
- ✓ 72 hours-30 days post-discharge: almost 4 times as many deaths as on inpatient units

High Risk Period

- ✓ "The periods just after admission, just before discharge and in the first weeks subsequent to discharge are the times of highest risk across all age groups." (Knesper, AAS & SPRC, 2010).
- ✓ In a study of almost 900,000 veterans treated for depression, Valenstein et al (2009) found that while all transitions were associated with increased risk , the highest risk was in the 12 weeks following discharge.

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SPRC Community of Practice, 2014-15

- ✓ Broad focus on care transitions
- ✓ 26 member organizations/partnerships
  - ✓ GLS grantees:
    - ✓ State, tribal, campus
  - ✓ State Coordinators

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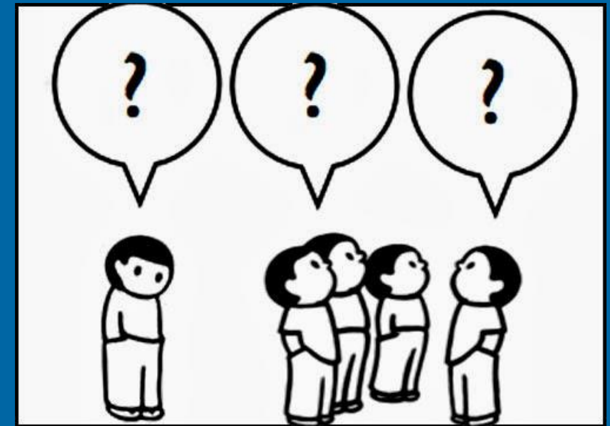
Barriers to Starting a Follow-Up Program

- ✓ Lack of staff to conduct follow-up activities
- ✓ Difficulty of communicating across systems
  - Releases of Information
- ✓ Liability concerns
- ✓ Staff attitudes towards

  attempt survivors



Getting Initial Buy-In

- ✓ Relationships
- ✓ Framing:
  - Quality Improvement
  - Return on investment
- ✓ Examples
- ✓ Legislation/State policy
- ✓ *The Joint Commission Sentinel Alert

Sentinel Event Alert

The Joint Commission

A complimentary publication of The Joint Commission
Issue 56, February 24, 2016

Detecting and treating suicide ideation in all settings

The rate of suicide is increasing in America.[1] Now the 10th leading cause of death,[2] suicide claims more lives than traffic accidents[3] and more than twice as many as homicides.[4] At the point of care, providers often do not detect the

Implementation

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Stabilization and Timing

- ✓ Treatment visit set up before discharge
- ✓ Stabilization follow-up within one day
- ✓ First treatment appointment within 7 days post-discharge
- ✓ Additional follow-up after initial appointment(s)
  - Up to 70% never make it to 1st appointment or don't go to more than a few appointments (Knesper, AAS & SPRC, 2010)

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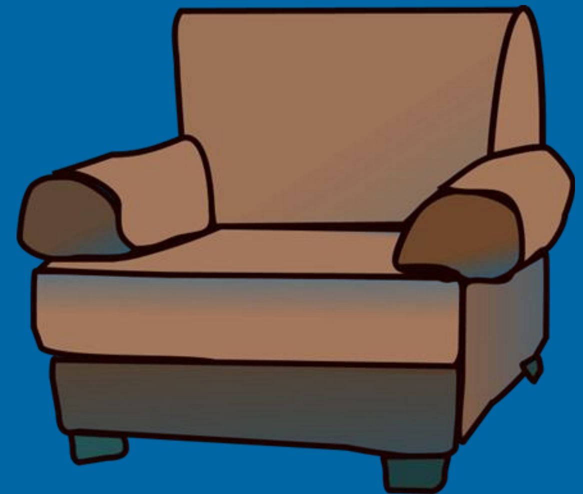
Follow-Up Format

- ✓ Postcards
- ✓ Phone, text, telemental health
  - In between therapy sessions
- ✓ Home visit
  - Mobile crisis team
  - Peers
  - Outreach workers



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Additional Ways to Improve Post-Discharge Outcomes

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Safety Planning

- ✓ Start to co-create plan at least 2 days prior to discharge
- ✓ Collaborative, skills-building
- ✓ Use a standardized template across the setting
- ✓ Outpatient plan differs from inpatient plan
- ✓ Communicate plan to family, supports

Family Education

- ✓ What to do if patient activates their Safety Plan
- ✓ Means safety
- ✓ Gatekeeper training / Warning Signs

Peers

- ✓ Peer support network
- ✓ Follow up
- ✓ Recovery movement
- ✓ Housing
- ✓ Respite centers
  - Run by certified peer support specialists

Resources & Citations

Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. Luxton D, June J, Comtois, K (2013). Crisis: The Journal of Crisis Intervention and Suicide Prevention, Vol 34(1), 32-41.

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

Higher-risk periods for suicide among VA patients receiving depression treatment: prioritizing suicide prevention efforts. Valenstein M, Kim HM, Ganoczy D, McCarthy JF, Zivin K, Austin KL, Hoggatt K, Eisenberg D, Piette JD, Blow FC, Olfson M. (2009). Journal of Affective Disorders. 112(1-3):50-8.

Post-acute Crisis Text Messaging Outreach for Suicide Prevention: A Pilot Study. Berrouiguet S, Gravey M, Le Galudec M, Alavi Z, & Walter M (2014). Post-acute crisis text messaging outreach for suicide prevention: A pilot study. *Psychiatry research*, 217(3), 154-157.

Transition: Zero Suicide Toolkit. http://zerosuicide.sprc.org/toolkit/transition

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Discussion

What are you doing in your grant to support **inpatient** care transitions / prevent further attempts, deaths, and rehospitalizations?