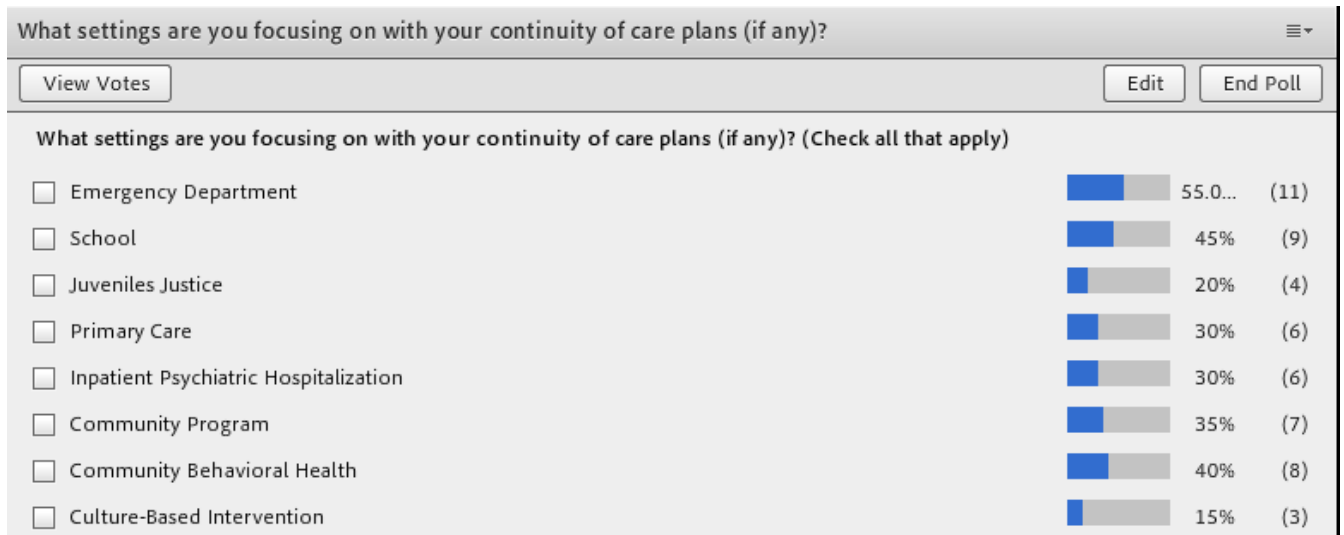




Continuity of Care
Cohort 9 State/Tribal Training Series
December 4, 2014, 3-4:30 p.m. EST

Recording Link: <http://edc.adobeconnect.com/p4q7edi9ies/>

Introductory Poll:



Notes from the four strategic areas presented:

ED-Crisis Center partnerships: South Dakota

Interview with Janet Kittams-Lalley, Executive Director of the Helpline Center, South Dakota

Why do you think it is important to have an ED-Crisis Center Partnership?

- Those who are most at risk for suicide go to the ED with an attempt, or ideation.
- It is important for the ED to have the crisis center resources available to share.

You worked on a pilot project with an ED in your community a few years ago. Can you tell us about it?

- They approached them and gave them resources. The resources are produced by NSPL – you can download them or request them from the SAMHSA Store.

- After an Attempt: A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department
- After an Attempt: A Guide for Taking Care of Yourself After Your Treatment in the Emergency Department
- They met with staff, the leadership team and did an educational training on their services and gave them the crisis line information.
- They did not create an MOU, but will have formalize one for this grant cycle.

With the new grant South Dakota has received, how do you plan to work with the EDs?

- In addition to making sure the ED knows about their services, they will be doing additional training:
 - Online Kognito for EDs
 - Means Restriction training
- They will also be setting up a system to do follow up calls.
 - Once the patient is ready to leave the ED, they will sign a consent form to give permission for the crisis center to contact them. The ED will send the discharge information and any safety planning discussed and appoints made to the crisis center. The Crisis center will then follow up with the patient in 24 hours (how was your ED visit?, What resources do you need?, etc).
- They will then bring in 4 other hospital systems over the course of the grant.

Challenges/lessons learned?

- On their Board of Directors, they had a staff member from the hospital. That person was able to make the connection with the ED.

Using informal caregivers: Confederated Salish and Kootenai Tribes

Interview with Roxanna Coleman, Training Coordinator for Confederated Salish and Kootenai Tribes

Who are informal caregivers?

- Anyone in your community
- Clergy, Law enforcement, others
- They currently have group of 46 people -- Partners in Suicide Prevention & Intervention

What do the informal caregivers do?

- Need to do follow up with loss survivors/family
- Many times there is a time gap between someone wanting to seek help and actually getting the help they need, the informal caregiver will support them (keep them company at the ED, accompany them to an appointment, etc).

- They ask trained gatekeepers if they would be willing to put their training into action – which means that their names will be given to the Sheriff’s office as resources for when someone needs support before getting mental health treatment (within the realms of confidentiality).
- They want to create care packages to families -- help numbers, resources, food, you are not alone message -- from your community.

Telemental Health (TMH)

SPRC briefly talked about this strategy and mentioned 3 grantee examples.

Why use TMH?

- This technology is useful for areas where there are MH provider shortages, rural, other

Grantee examples:

- Carlton County, MN used TMH services to offer appointments during school.
 - Students can receive counseling from a mental health professional via video technology without leaving the school health center.
 - Reduces stigma because other students don't know what service they're getting
 - Reduces transportation barrier
- Hawaii: Using TMH to reintegrate client into community
 - Once a patient is discharged from an inpatient service and while they reintegrate back into their rural community, through TMH, they can continue talking with the same person they built relationship with.
- New Mexico: Student in crisis referred to MH but MH counselor not present immediately
 - TMH helped student talk to provider right away.
 - Once the MH counselor was available the next day, they met in person

3rd Party Referral Form – Oklahoma

Interview with Julie Geddes, Senior Field Representative at the OK Dept of Mental Health and Substance Abuse Services

- Form gives parents a tool and way to document the process
- Mental health providers value receiving this form
- The form allows providers to receive information about what transpired at school, particularly if the youth de-emphasizes their suicide risk once with the provider
- Getting the parent to sign before they leave is important
- Form will be used by other organizations as well, e.g., mobile crisis team, law enforcement, emergency response

- Can be modified for use by law enforcement or first responders

Notes from the State Grantee Break Out Session:

How are you already getting folks at high risk or who have attempted into ongoing care?

- In Tennessee, crisis is involved when a high risk individual is identified and crisis then refers for the appropriate level of care (Crisis continuum, crisis respite, stabilization, medically monitored crisis detox) which may include outpatient appointments. We do have same day/next day appointment capability.
- Community based and available before inpatient care
- Need to consider the less restrictive form of care before more restrictive care, and there is guidance provided to providers for doing this
- We are part of large health care system and we can direct schedule into our mental health center from the ED or have direct call to crisis department.
- Same day appointments and 24/7 crisis department - we are 5 hospital system. One medical record (although some MH records are under "break the glass" for confidentiality) also so that really helps.
- Implementing intensive care coordination for care transitions
- Working with a large hospital system to train physicians and how to get patients to MH providers. We provide them with a list of MH providers.

How is important information about the client's mental health care being shared from one setting to another?

- Currently, paper documents are faxed or emailed back and forth. We have some work to do here in TN to get to shared electronic records....
- School to ER or MH Facility by EMS or fax, then within EHR system, then via fax back to school.
- It is great to have fully integrated EMR - so ease of transitions from acute IP psychiatry and crisis and EDs. I did really like the third party referral form that we saw from earlier presentation. We also keep a list of not only MH services WITHIN OUR HEALTH CARE SYSTEM but also community resources since lots of folks use our ED after suicide attempt and are receiving MH services from other CMHC or providers

How do you get a list of MH providers? Do you know they all are trained to work with suicidal persons?

- We are working on creating an enhanced provider status complete with specific training, particularly with our military/veteranBH providers

- Provide list of providers at 16 CMHCs, have done AMSR training at the CMHCs so that the providers have suicide assessment and management-specific training
- Our center maintains a comprehensive mental health resource guide that we have available online through our website.
- SAMHSA has a resource directory as well at <http://findtreatment.samhsa.gov/>

Other comments/challenges to share:

- Providers that are not traditionally mental health are resistant to taking on any responsibility for suicide risk screening or follow-up. We are struggling to overcome attitudes that "it is not our responsibility".
- We are really working to change the culture by significantly increasing the conversation - getting people to talk more out loud about suicide. Also providing training so they know what to do and what to say.
- Schools that originally agreed to go GAIN-SS screening are afraid to do anything other than mandatory SA screening because of fear that the students would then need special education services that bring a cost to the table.
- This takes a lot of relationship building and time.
- Scope of the grant, and where we are looking to work (were working in lower grades, but now adding higher education), a challenge is finding ways to reach the groups that are harder to reach--like youth 18-24 outside of educational systems. We are engaging an EAP to try and reach those individuals.
- It's way too early in the grant for me to answer. Our subgrantees are counties that will be implementing the grant activities. They would benefit from this training - they are the hands-on people working directly with their providers.
- We are planning to do lots of gatekeeper type training - for ED staff, schools, churches, etc. to increase knowledge and comfort as well as know where and when to refer

Notes from the Tribal Grantee Break Out Session:

How you're getting high risk people into care:

- Becky Greear – YellowHawk Tribal Health Center
 - Local Community MH Authority is the first call for MH assessments in the ED
 - They call Becky G. / Yellowhawk and a MH provider will participate in the assessment and planning
 - Yellowhawk will advocate for the level of care they believe is needed
 - Increases likelihood that they'll receive immediate follow-up by the Yellowhawk team - within a few days
 - Next steps - formalize into a protocol

- Cohort 9 grant, will put a mental health provider in the medical clinic
- Dolores Jimerson is assisting with the behavioral health response on the medical side
- Also adding MH providers in schools - already seeing high need
- MH providers aren't in schools full time; limited days/hours
- Their experience reinforces the need for transmitting relevant information to the next caregiver
- Reservation - risk assessment is different if performed by an outside agency versus on the reservation
- Southcentral Foundation
 - Psychiatric emergency team sees patients at the hospital
 - Masters level clinicians can see people on a walk in basis
 - Clinicians can see people within a day or two of discharge from hospital
 - Referrals made for substance abuse treatment
 - They have a good relationship with the state hospital; acute inpatient beds are also available

Getting people into post-acute settings

- Thomasine Fife
 - Contracts facilitate access to inpatient services
 - Follow-up appointments are made
 - Electronic health record facilitates tracking (did follow-up occur?, etc.)
 - EHR helps with EIRF report, helps quality improvement efforts for the agency
- Non-clinical grantees will be working with clinical partners to implement continuity of care or care linkages strategies
- Southcentral Foundation relies on EHR - shared record; A challenge is the hospital is on a separate system
- Relationships with other organizations in the region are important
- Informal relationships are used, also MOUs, service level agreements

Areas to promote continuity of care in your grant; Next steps or needs related to Continuity of Care for suicidal individuals

- Response time when a person is in crisis --> making this a priority
- Making health and wellness a priority has sent a strong message
- Limitations - resources, overworked people, limited funding
- Aftercare is very important -- critical opportunity -- the follow-up has to be there
- Caring contacts - her community would respond to this approach
- Importance of relationships

- The role trauma plays in getting care in or out of the reservation (versus 'in town')
- Trauma informed care is important - particularly for care provided in town
- A few people doing a lot of work
- EHRs can help, but often the providers/helpers are out with patients and getting clinical information back into the record can be a challenge -- need a way to transmit information when mobile

What experiences do you have with follow-up, or would you like to learn more about?

- Checking in - not new
- We're in one building (integrating primary care and behavioral health) - this is new. Providers ask her questions before seeing a client. The relationship and checking in with patients
- For EIRF we track depression screen. Follow-up on positive screen is variable. We are looking to make the follow-up on a positive screen more consistent. Having a behavioral health provider right there can enable an immediate response to the positive depression screen.
- Different ways to follow-up on different levels of risk.
- Adding a LICSW and 3 MH professionals, stationed at different places throughout the reservation. These additional resources will provide support. Will enable us to catch early signs of suicide and respond to the PHQ-9.