

# Care Transitions in Suicide Care: Challenges, Best Practices, Innovation, and Strategies



# Colleen Carr



Director

National Action Alliance for  
Suicide Prevention



# The Nation's Public-Private Partnership

---

**Bringing together influential public and private sector leaders** (representing automobile, construction, defense, education, entertainment, faith, forestry, health, insurance, justice, law enforcement, mental health, military, news media, sports, railroad, technology, and veteran services) **to advance the *National Strategy for Suicide Prevention*.**





# Today's Panelists

---



**Richard McKeon, PhD**  
Chief of the Suicide Prevention  
Branch, Center for Mental Health  
Services, SAMHSA



**Karen Johnson, MSW**  
Senior Vice President, Clinical  
Services and Division Compliance  
Officer, Behavioral Health Division,  
Universal Health Services



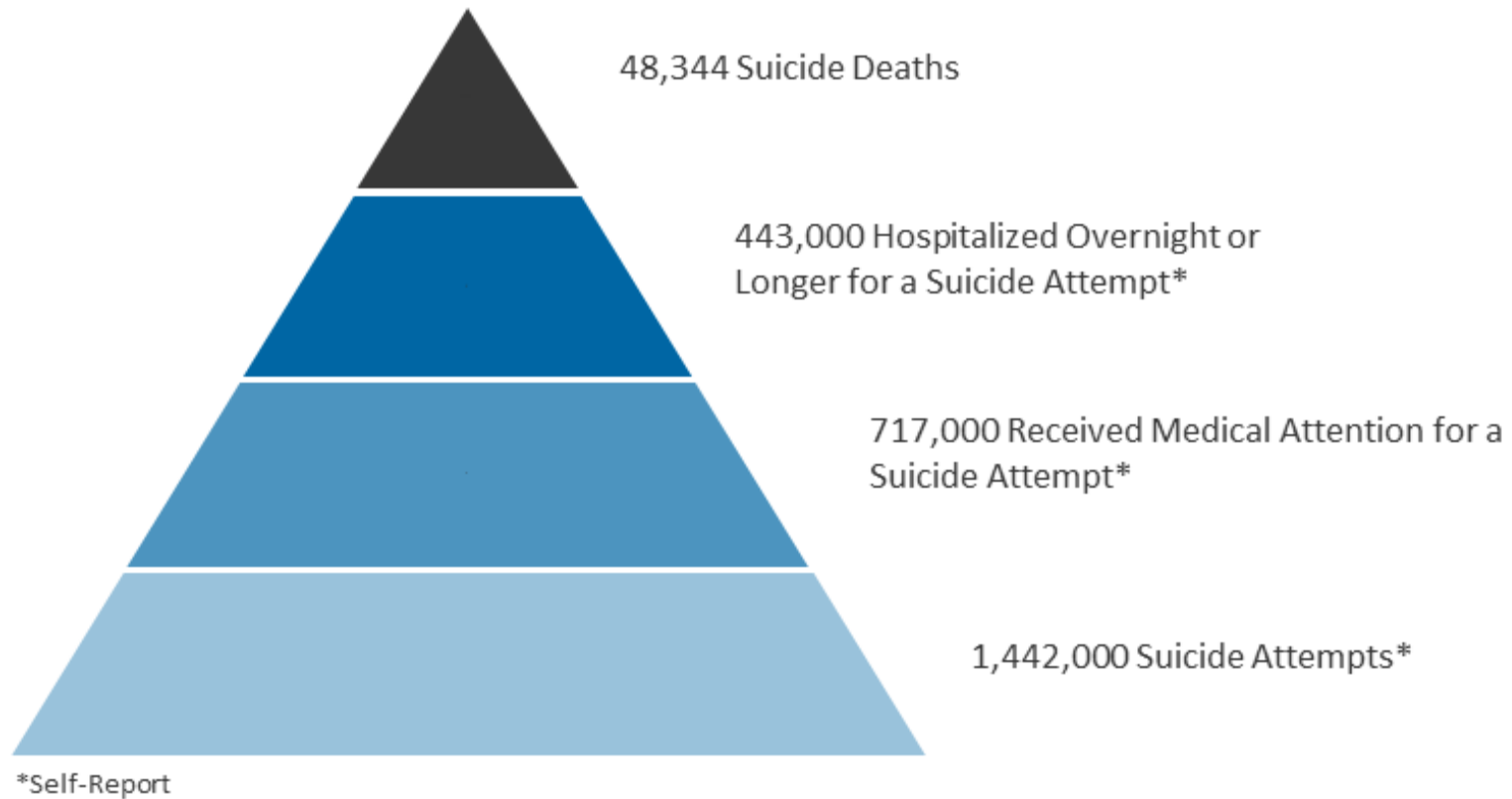
**Becky Stoll, LCSW**  
Vice President,  
Crisis and Disaster Management,  
Centerstone Health

## > **Scope of the Problem**





# Scope of the Problem





# Transition from Inpatient Care 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)





# Seamless Care Transitions

---



**Work as a  
Collaborative  
Team**



**Cultivate  
Human  
Connection**



**Build  
Bridges**

# > Recommendations for Inpatient Providers





# Before the Care Transition



## 1. 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.

## 2. Involve family members and other natural supports.

- Encourage family participation.
- Include peer specialists.
- Engage the school and community supports.





# Before the Care Transition

---

## 3. 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.



## 4. 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.



# After the Care Transition



## 5. Follow up with the patient and outpatient provider.

- Provide essential records to the outpatient clinician or case manager at the time of discharge.
- Make a discharge follow-up call to the patient.
- Provide ongoing caring contacts to the patient.
- Regularly meet.





# Innovations in Care Transitions at UHS

---

- When the continuum is in place, *outpatient* therapists:
  - ❖ Facilitate *inpatient* groups to discuss aftercare options:
    - Intensive Outpatient
    - Partial Hospitalization Programs.
  - ❖ Attend *inpatient* treatment team meetings to identify and meet patients who are appropriate for continuing care in outpatient services.
- Institute daily discharge planning groups to discuss importance of compliance with continuing care.
- Create the opportunity to connect with outpatient provider prior to discharge from inpatient to develop rapport.

“ *Caring contacts are brief, encouraging notes or messages (card, text, email) that do not require a response.* ”

# > Recommendations for Outpatient Providers







# Prior To Care Transition



## 1. 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.

## 2. 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



## 3. Narrow 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.
- Involve family members and other natural supports.
- Offer stepped care to patients with suicide risk, based on the client's need and your community resources.
- Connect the patient with peer-to-peer support.
- Engage the school.
- Involve other adult supports for children or youth.
- Notify the inpatient provider that the patient has kept the outpatient appointment.
- Follow up on missed appointments.
- Regularly meet with your inpatient provider.



# Innovations in Care Transitions at Centerstone

---

- Intensive outreach/follow up during initial 30 days
  - 0 suicides
  - 92% did not return to emergency department



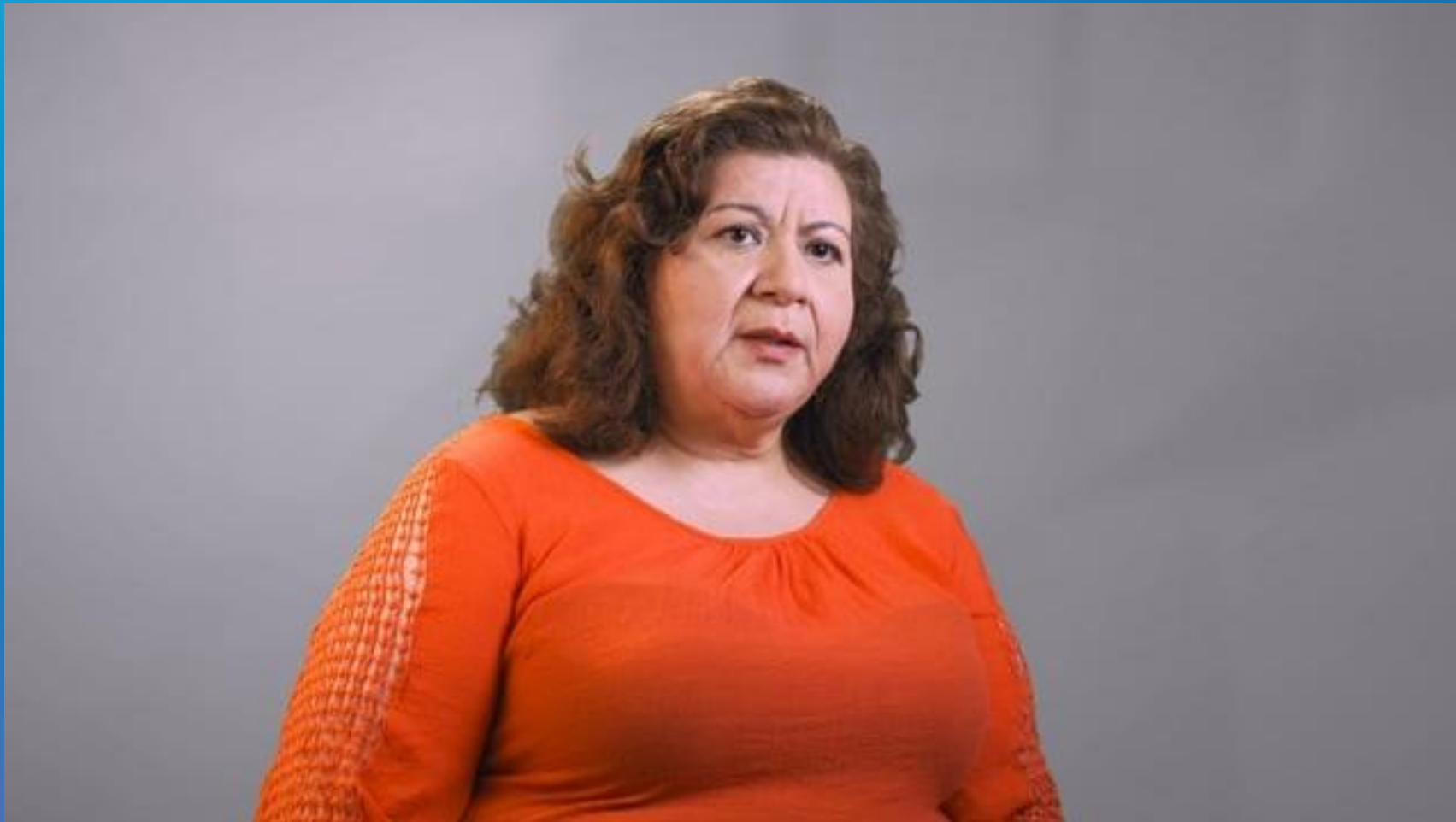
# Innovations in Care Transitions at Centerstone

---

- Cost Savings when using Best Practices in Care Transitions in outpatient care
  - \$412,328 in study 1
  - \$2M in study 2



➤ Impact on Lived Experience





# Discussion/Q&A

---



**Richard McKeon, PhD**  
Chief of the Suicide Prevention  
Branch, Center for Mental Health  
Services, SAMHSA



**Karen Johnson**  
Senior Vice President, Clinical  
Services and Division Compliance  
Officer, Behavioral Health Division,  
Universal Health Services



**Becky Stoll**  
Vice President for Crisis and Disaster  
Management  
Centerstone Health

## > Next Steps







# Together, We Can Do Better



**Work as a  
Collaborative  
Team**



**Cultivate  
Human  
Connection**



**Build  
Bridges**



**Best Practices in Care Transitions  
For Individuals with Suicide Risk:**  
INPATIENT CARE TO OUTPATIENT CARE

[SuicideCareTransitions.org](https://SuicideCareTransitions.org)



# References

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., ... Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, 29(6), 870–877. Retrieved from <https://doi.org/10.1007/s11606-014-2767-3>

Chung, D. T., Hadzi-Pavlovic, D., Wang, M., Swaraj, S., Olfson, M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. *BMJ Open*, 9(3), e023883. Retrieved from <http://dx.doi.org/10.1136/bmjopen-2018-023883>

National Action Alliance for Suicide Prevention. (2019). *Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care*. Washington, DC: Education Development Center, Inc.

National Committee for Quality Assurance. (2017). *Follow-up after hospitalization for mental illness (FUH)*. Retrieved from <https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/>

# CONNECT WITH THE ACTION ALLIANCE



[www.theactionalliance.org](http://www.theactionalliance.org)

