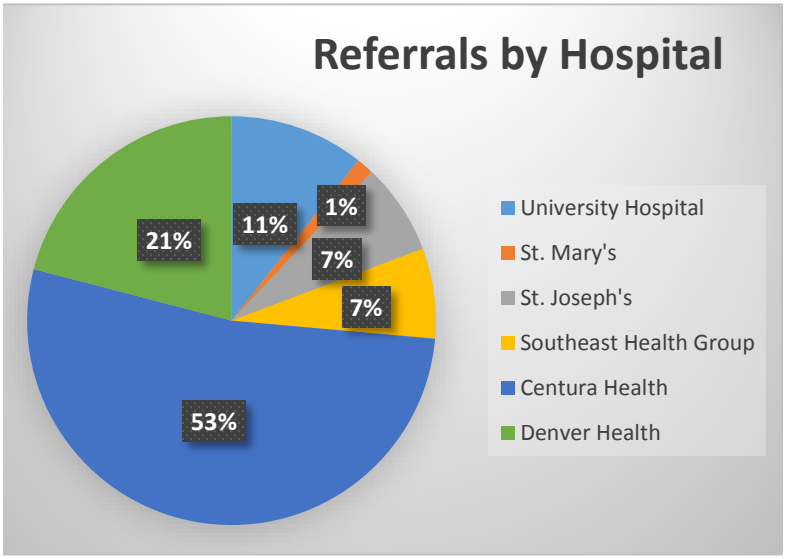
Hospital Follow Up Program
A Year In Review
July 2016

Commission Pilot Sites

- Arkansas Valley Regional Medical Center
- Denver Health
- Prowers Medical Center
- Southeast Colorado Hospital
- Saint Joseph's
- Saint Mary's

SAMSHA Funded Sites:

- Castle Rock Hospital
- Littleton Hospital
- Parker Hospital
- Porter Hospital
- Southlands ED
- Saint Anthony's North



Key Program Observations

Implementation:

Implementation phase requires patience. In some cases, it took months to fully implement the referral process. Common obstacles were around availability of staff to meet with RMCP and some sites' formal approval process (i.e. many layers of approval) and some sites' concerns around HIPAA (i.e. MOUs requiring approval, attorney buy in).

Considerations/Conclusions: The level of "higher up buy in" was different in all of our sites. There seems to be no clear correlation between higher referral numbers and how "high up" the approval went. What seems to have had the most impact on the program was having a champion in the ED who had the opportunity to incorporate follow up into the culture of the team. For some sites, this happened BECAUSE there was endorsement at a higher level, which drove the program as a priority. However, with other sites, the "front line" champions drove the program alone. Yet, in other locations, we were told there was administrative support, yet processes moved slowly at the team level. Clearly, having administrative prioritization is ideal…with buy in throughout the ranks. Gaining access to higher levels proved difficult in some sites. Clearly, the prioritization of this program differed from site to site. A "top down" and "bottom up" simultaneous approach to implementation, while time consuming, likely would result in the highest utilization of the program.

Training:

Most teams were supportive of the "concept" of hospital follow up from the start. However, sites where we had direct access to the staff that would actually MAKE the referral, overall, seemed to have higher referral numbers. During check ins, we realized some staff had their own interpretations of when follow up was helpful (i.e. only when someone wasn't already in treatment). Access to team meetings allowed RMCP to clarify the research and objectives of the program and likely increased staff buy in and understanding of the benefits.

Considerations/Conclusions: Direct training of staff most impacted by the program seems to have value. These teams seemed more engaged and also were able to engage in more conversations regarding feedback about the program. We feel there is value putting a "face with the program" in the ED environment. We are aware that there are many tasks and protocols to remember and implement in an ED. That face to face contact potentially could influence better utilization of the program and promote staff remember to offer the program to patients.

Re-Training:

Over time, the number of referrals commonly seemed to slip at many sites. Interest seemed to lag and we often heard that staff simply "forgot" to offer the program.

Considerations/Conclusions: As stated, we recognize that EDs are busy environments with many competing priorities. Staff turnover may be high. We recommend that a quarterly outreach be offered to each site/contact. The goal would be to offer retraining, updates on the program and regain interest in the program. While we attempted this throughout the year, regaining access to some teams proved difficult, largely due to time constraints of hospital staff and difficulty of getting teams together. Future considerations would include distributing printed materials or offering webinars as "easier" ways to get information in front of staff.

Protocols:

While there seemed to be general agreement about WHY we were doing follow up…there wasn't wide agreement about HOW we would do it. Sites were certainly curious about how others were making referrals, but in the end, each site customized their protocols to fit their own procedures, cultures and opinions about the program.

Considerations/Conclusions: Time; the biggest factor around which all protocol were developed. Our focus was frequently on how "easy and quick" we could make the referral process for hospital staff. We recommend that a referral be made verbally, on the phone, with the client. Written referrals were negatively impacted by factors such as technology failures

(i.e. fax machine won't work) or difficulty being able to read hand writing. In the future, we would consider a web based referral process where referral information could be entered into a secure portal to initiate the process. We feel this could allow for easier communication but also allow for referrals to be made when time allows in the busy ED (i.e. referrals entered at slow times in a shift rather than a demand to do ever referral in the moment on the phone). Development of this referral enhancement would be dependent on future funding opportunities.

Enrollment Criteria:

The targeted population for referrals was individuals who presented to an ED with suicidal ideation and who were discharged home. All sites used this criteria except Centura who expanded this definition to anyone who received a mental health evaluation. It is curious that numbers of referrals were as low as they have been, given the sites' self-report that referral rates were so high.

Considerations/Conclusions: While the program is clearly a suicide prevention effort, expanding the referral criteria could allow for even more individuals to be reached that could benefit from the program. Subjectivity by evaluators on if the person was "suicidal ENOUGH" could negatively impact the referral numbers. A broader criteria could also help push to prevention efforts upstream, perhaps identifying individuals who may be heading toward a suicidal crisis, but were not there yet, thus allowing the program an opportunity to prevent such an escalation. While there has not been an analysis done to compare patient numbers/referral rates/hospital size/etc, Centura's embracement of the program for ANYONE who receives a mental health evaluation leads us to believe a broader definition increased referral numbers nd allowed for the program t be more easily embedded into protocol. They do demonstrate a dramatic spike in referrals and we suspect their numbers are less susceptible to the subjectivity of if the person is "in a bad enough crisis." Casting a wider net ultimately may help ensure all who could benefit are referred AND may help encourage staff to refer to the program. Higher numbers, however, lead to higher cost of program operation and would need to be considered for future funding availability.

Data Collection:

Data collection remained a challenge throughout the year. Most hospital EMRs lacked the capacity to gather and/or pull information about suicidal patients. Across the nation, this is a theme that has challenged outcome measurement (e.g. recidivism rates). Hospital staff largely were tracking information manually and often reporting to us more anecdotally, rather than systematically. Resources were limited on both RMCP and hospitals to dedicate analysis of data and to specifically measure and evaluate hard outcomes.

Considerations/Conclusions: Data limitations have made it difficult to validate referral rates or numbers eligible patients. In an effort to make referral processes efficient, limited data was shared between hospitals and RMCP intentionally, as our priority was to provide lifesaving services rather than analyze data. RMCP referenced the national efforts in research around follow up and rooted the program on the foundation of prior published evidence. While the Commission desired more concrete outcome analysis, the data comparison project to do this effectively far exceeded the resources of the service project. There has been much discussion about various databases that exist that could be accessed/cross referenced/analyzed to further delve into the efficacy of this program. RMCP would support these efforts though maintains itself to be a service delivery provider, whom could participate in such a venture with additional resources and support. RMCP's participation in the SAMSHA funded Columbia Follow Up Study, however, allows Colorado to be represented in this national scale research project.

Funding:

The Commission Pilot sites were made possible by funding approved and provided through the Suicide Prevention Commission of Colorado. RMCP's award of the SAMSHA follow up grant allowed for the additional sites. The SAMSHA grant will be ending in September and while the Commission is able to continue to contribute to one more year of financial support, the dollar amount has decreased. Both RMCP and Commission members have been active in identifying potential future funding.

Considerations/Conclusions: While follow up is supported and encouraged through national planning (i.e. Zero Suicide and National Strategy for Suicide Prevention), thus far, foundation support has not come to fruition. RMCP is currently strategizing and consulting with hospital partners about the feasibility of site's contributing to the funding of their own programs. RMCP has created a pricing structure to provide to hospitals that are able to provide funding. This pricing structure is set to bill for services on a per case basis, rather than by per call basis or by size of the organization.

Summary of current funding status:

- **Confirmed Funding for Hospital Follow-Up Program**
  - St. Joseph's Hospital
    - $3,500 donation to program
  - Yellow Ribbon Suicide Prevention Program
    - $30,000 to continue providing Hospital Follow-Up services
- **Pending Funding for Hospital Follow-Up Program**
  - Proposal for Hospital Follow-Up services out to Centura
  - Proposal for Hospital Follow-Up services out to Centennial Peaks
  - Proposal being created for University Hospital
- **SAMHSA Funding for Hospital Follow-Up will end in September 2016**