**Contact Information**
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Physician Organization Name: Spectrum Health Medial Group
Practice Name: Ambulatory Care Management Department
Practice Address: N/A
How many physicians in practice: N/A
Description of care team (number of care team members and their degrees/qualifications, at the time of the best practice activity): Behavioral Health Specialist (LMSW) and Care Manager (RN)

**Executive Summary (5-8 bullet points, must include summary of results)**
- Use of MiHIN Admission, Discharge, and Transfer (ADT) data and internal discharge notifications to identify patients discharged from ED or inpatient with risk of suicide.
- Behavioral Health Specialists (BHS) use the list of identified patients to conduct transitions of care (TOC) phone calls.
- This new process aligns with the Spectrum Health system-wide initiative of Behavioral Health integration and Zero Suicide.
- The new process utilizes standard Behavioral Health TOC assessment
- After implementing the new process, 66% of patients discharged from any emergency department with a diagnosis related to suicide had an encounter with an embedded behavioral health specialist.

**Category of Submission: Behavioral Health Intervention**

**Title of Submission: Behavioral Health Transition of Care Calls for Suicidal Patients**

**When did the intervention start and end? (1-2 sentences)**
SH Care Management leadership started work with SH Data Insights team in the summer of 2018 to build a report to flag internally and externally discharged patients with discharge diagnosis related to suicide and/or discharge disposition related to psychiatric hospitalization. The Behavioral Health Transitions of Care work was then operationalized with the use of this list and phone calls began in January 2019 and continue today.

**Goal of the Program/Intervention: (1-2 sentences)**
The goal of this intervention is to increase safety for patients discharged with suicide risk by connecting them with appropriate and timely resources, ensuring a clear understanding of plan of care during time of transition and helping patients to feel safe.

**Who developed the program/intervention, and how? (2-4 sentences)**
Our SH Ambulatory Care Management leadership worked closely with both the SH Data Insights team and the SH Quality department to develop a report that utilizes ADT data with built-in flags for discharge diagnosis and discharge disposition. Care Management leadership developed standard work for embedded behavioral health to support transitions of care phone calls specific to patients at risk of suicide.

**Description of the Program/Intervention (2-3 paragraphs):**
BHS (Behavioral Health Specialists) embedded in primary care receive a daily report each morning that shows all patients discharged the previous day from internal or external hospital systems. This report incorporates both internal data from our Epic system identifying patients discharged from a Spectrum Health hospital, and external data from MiHIN identifying patients discharged from an ED or hospital elsewhere in the state of Michigan. The report includes flags that identify patients who either 1. Had inpatient or ED admission and discharged home with diagnosis related to suicide or 2. Had inpatient or ED admission and discharged to a psychiatric facility. The BHS then outreaches to the patients to complete transitions of care phone conversation. The BHS follow standard work for this process and utilize a Transitions of Care (TOC) assessment template that includes important information such as: Patient risk assessment, changes to psychotropic medications, barriers to a safe transition including social determinants of health, patient understanding of follow up plan, outstanding patient needs and summary of next steps. The intention of this process is to have the BHS contact all patients discharging

from the ED or medical hospital with a diagnosis related to suicide. It is recognized that the first thirty days post discharge from a psychiatric hospital is also a risky time for patients, however, psychiatric hospitals do not supply information to MiHN which makes identifying discharge dates very difficult. The BHS is tasked with reaching out to psychiatric hospitals and scrubbing PCP schedules to identify those patients without discharge information being submitted to MiHN.

If a patient continues to endorse suicidal thoughts, the BHS completes the standard suicide assessment to assess patient risk and determine next steps to keep patient safe. If a patient endorses new psychotropic medications, discontinued psychotropic medications or change made to existing psychotropic medications, the BHS will consult with prescribing provider to see if there are outstanding medication needs or concerns related to their behavioral health treatment.

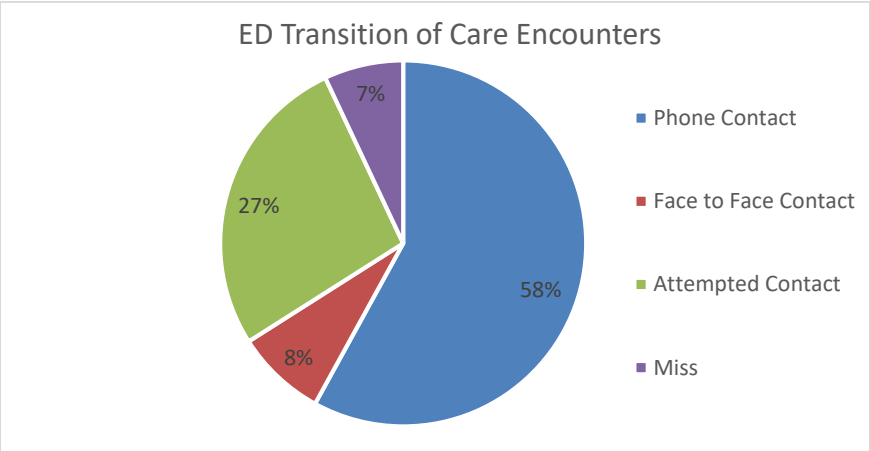
The BHS will reinforce patient follow up plan if there was detailed plan created at discharge or if not, will determine follow up plan of care with patient. They will also reinforce patient safety plan if there was one completed at time of discharge. The BHS will assess if there are further barriers to care such as: transportation to follow up appointments, inability to afford medications, insurance/co-pays and assess current level of social support. The BHS will work with patient to determine next steps. Next steps could include but are not limited to: Follow up with in-office BHS for behavioral health assessment, community-based outpatient therapy, intensive outpatient therapy, partial hospitalization, support groups, outpatient psychiatry or other applicable resources.

**How were patients identified for the program/intervention? (1-2 paragraphs)**
ADT data is used to identify patients who either 1. Had inpatient or ED admission and discharged home with diagnosis related to suicide or 2. Had inpatient or ED admission and discharged to a psychiatric facility.

**How was success measured? Please delineate whether metrics were process-based or outcome-based (2-3 paragraphs)**
To roll out this new process to the system, multiple factors had to be addressed. Discharge diagnosis codes had to be identified and later altered as it was identified that some patients we thought would be included were not originally. New standard work for the BHS's also had to be created and vetted.

Due to the factors mentioned above, our metrics are currently process-based. However, in the future we would like to move toward an outcome-based success measure. We will soon be monitoring ED utilization as well as PHQ and Columbia Suicide Severity Rating Scale scores.

**What were the program results? Include qualitative data/graphs (2-3 paragraphs)**
From January 1, 2019 through June 30, 2019 there were 166 patients discharged to home from the ED with a diagnosis related to suicide. Sixty-six percent (n=110) of those patients had either a phone (n=97) or a face to face (n=13) encounter with the embedded BHS from their PCP office. Twenty-seven percent (n=44) had at least three phone attempts and a letter sent but were unable to be contacted. Seven percent (n=12) were not contacted due to errors in the ADT list or following protocol. Ongoing conversations with Data Insights and the BHS team have improved workflow to decrease the number of missed patients.



Success Story:
Recently, a patient presented to the ED with suicidal ideation. For many years he has been using alcohol and marijuana to manage his symptoms, however, a recent divorce was exacerbating the suicidal thoughts. During the ED visit he was diagnosed with Bipolar Disorder, started on an SSRI and discharged home with a psychiatric appointment at Pine Rest. The patient was identified on the ADT list and a TOC call was made by the BHS the following day. During that conversation the patient stated that he had no intention of following up at Pine Rest because it is a faith-based organization and he is not religious. The BHS spoke with the patient's PCP who was agreeable to manage the patient's psychiatric medications if there was consultation with our collaborative psychiatric consultation process. The BHS was able to complete a biopsychosocial assessment with the patient, present that information to the collaborative psychiatrist and provide medication recommendations to the PCP. The patient has now been prescribed a mood stabilizer and is feeling calmer, crying less, and denies any suicidal ideation or substance use.

**Were any new tools, processes, or resources developed to aid in the implementation of the program/intervention?**
New tools and processes were developed to aid in the implementation of this new behavioral health intervention. ADT list with behavioral health flags, standard work and standard TOC behavioral health assessment.

**What are you proudest of regarding this submission? Why does this work matter? (1-2 paragraphs)**
Spectrum Health as an organization has worked hard over the past 4 years to identify and treat behavioral health conditions within the primary care space. This has included PHQ-4 as the new vital sign to screen patients for depression and anxiety at every visit, BHS embedded in primary care sites to complete behavioral health assessment, triage level of care needs and provide short term treatment and/or coordination of care to meet patients behavioral health needs, implementation of zero suicide initiative, and standard use of the Columbia suicide severity rating scale for any patient who scores positive on question 9 of the PHQ-9 related to suicidal thoughts.

Our ability to utilize data and create patient identification for these patients allows us to continue to advance our work and target at risk patients to not only prevent suicide, but also connect patients with appropriate resources.

**How will your organization use the funds if your submission wins? (1 paragraph)**
Our department would like to utilize these funds to help our clinical LMSW and RN CM staff have access to trainings that support their continuing education and advancement of skills specific to their unique role as an embedded primary care team member.