

Suicide Prevention Resource Center

Care Transitions Webinar:

Creating a Safety Net with On and Off Campus Partners

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**CASET Associates, Ltd.
caset@caset.net**

PROCEEDINGS

IRENE. CHO: Thanks, Sarah. We're so glad to have everyone here for the Care Transitions webinar.

Before we begin, I just wanted to acknowledge that the Suicide Prevention Resource Center, SPRC, is supported by CMHS. The views, opinions, and content expressed in this presentation do not reflect the views, policies, or opinions of CMHS.

Our team today is, myself, Irene Cho, and I'm a prevention specialist at SPRC. We also have Bonnie Lipton, also a prevention specialist and you just heard her in the beginning. And we are joining from SPRC.

You've already heard from Sarah. She and Chelsea Pepi are joining us to provide us with tech support to make sure that everything runs smoothly today. If you face any tech challenge, please let Sarah or Chelsea know in the chat throughout the webinar.

Here is the meeting agenda for today. As you can see, we have a pretty packed schedule. I will briefly go over SPRC's Effective Suicide Prevention Model. You will have a chance to hear about different care transitions models from three different campus grantees from diverse settings.

We've reserved some time for you to ask any questions after each presentation. So, please be ready to ask any questions you may have via chat. You will be muted until after the last presentation by University of Michigan. So, feel free to chat in throughout the webinar. We will let you know when you are unmuted. Now, I will turn it back to Bonnie for a quick poll.

BONNIE LIPTON: Hi, everyone. So, we're going to do a fun poll. We'd like to hear from you where you are you in the process of implementing care transitions.

As you see, we have check all that apply because I know that, you know, often, when we're doing this work, we're in many different levels.

So, just to read over what the different possibilities are, there's identifying gaps in services, developing new partnerships, assessing existing partnerships and providers, formalizing MOUS with providers – and MOUs are memorandums of understanding with providers, and evaluating your care transition efforts to make modifications. And then we also have other. If you have something else, please chat it in.

So far, it looks like about 73 percent of you are developing new partnerships. And a number of you are also identifying gaps in services. I'm going to give a few more moments for you all to click and maybe if you are clicking other to remember to chat in.

It looks like everyone has wrote in. So, the winner is developing new partnerships with 74 percent. 71 percent of you are identifying gaps in services. Also, many of you are assessing existing partnership and providers. While less of you, but still about one-third are formalizing MOUs with providers and evaluating your care transition efforts to make modifications. Great.

Well, that is really great and helpful for us to see where everyone is. I am going to turn it back over to Irene.

IRENE CHO: Thanks, Bonnie. Before we jump into the actual presentation, exciting presentation, I will briefly go over SPRC's Effective Prevention Model for Suicide Prevention.

As we all know, suicide is a complex problem and no single approach can solve it. You can learn more about SPRC's Effective Suicide Prevention Model after the webinar by viewing the microlearning video.

The Effective Prevention model includes three elements: strategic planning, keys to success, and comprehensive approach. Strategic planning can be considered as a process to help you select which strategies to focus on. Keys to success can be considered as important guiding principles to be incorporated during strategic planning and implementing your strategies. Lastly, the comprehensive approach is key strategies you could implement on your own campus.

Suicide prevention efforts should use a systematic, data-driven process to understand the problem set clear goals, and prioritize activities that are most likely to make a difference. This is a continuous process to consider as you carry out your grants.

These are key principles that can guide you as you implement your suicide prevention efforts on campus. Your efforts are more likely to succeed if you follow these five guiding principles.

This is a comprehensive approach to suicide prevention, which includes nine different strategies. Effective suicide prevention requires a combination of efforts that work together to address different aspects of the problem. Each strategy is a broad goal that can be advanced through an array of possible activities, such as programs, policies, practices, and services.

As mentioned in the previous slide, partnership is essential as it's hard for a single department to carry out all of these strategies.

Today, we will be focusing on care transitions, specifically how to support safe care transitions and create organizational linkages for students who may be at risk of suicide.

You will hear about how three different campuses have utilized various tools and practices to support at-risk students. Just before we begin, all of the slides will be available later. We will talk more about that later. Now, I will turn it back to Bonnie.

BONNIE LIPTON: Great. And so, I am delighted to introduce our first speaker. Luis Manzo is the Executive Director of Student Wellness and Assessment at St. John's University. He will be speaking to us today about creating a safety net with on and off-campus providers. Take it away, Luis.

Presentation: St. John's

LUIS MANZO: Thank you very much. Good afternoon, everybody. I'm going to talk to you a little bit about how we've created a safety net, here, at St. John's, and those care transitions and the collaborations we have that have been really effective. Specifically, I'm going to talk a lot about our crisis situations as our examples.

Just some context for you, St. John's University, we are located in Queens, New York. So, we're a large Catholic university, highly diverse student population. We actually have six campuses, but our main campus is here, in Queens. We also have a satellite campus in Staten Island. We have about 3,400 students who live in-residence.

So, more context. As the Executive Director of Student Wellness and Assessment, I oversee about seven areas that report to me, including our counseling center, disability services, campus recreation, wellness education and prevention health services, and our sexual violence office. They provide a variety of services to our student body. I wanted to give you that as an overview of some of our services that we provide.

But, specifically, when it comes to our safety net and the care transition, it all

starts with our gatekeepers.

What we've done probably now for the past I guess three or four years, we've really made a push in training as many student, faculty, and administrators who are what we would consider gatekeepers and who can identify students who are in distress, kind of recognize those warning signs, assess for suicidal ideation and behaviors, and then how to make those appropriate referrals.

We try to take a campus-wide approach to that. So, we're training our team in student wellness, but we're also training our partners in residence life and our residence directors, who are our administrators who live in-residence. We also train our resident advisors. Those are students who live among our students and those are about 70 or 80 students.

We train our public safety officers every year in our gatekeeper program in suicide prevention. We also – I should mention the program we use is adapted from Syracuse University, the Campus Connect program.

Our faculty and our adjunct faculty, we also work with HR to provide that training, as well as those individuals are also offered Kognito At-Risk. I should also say we train our peer educators, our students leaders.

So, we have like – I like to say like a critical mass of individuals on campus who are those gatekeepers, who can identify students and provide that first layer of a safety net.

In addition, I should mention some of our off-campus partners that we have. We're part of the VITAL program, the Veterans Integration to Academic Leadership. So, we work very closely with our local VA. As part of that collaboration, we actually have

someone from the VA on campus about once a week. In addition, we are set up for telemedicine here, on campus, so our VA students – or our veteran students, rather, can not only get enrolled with the VA, but also can receive medical services via telepsychiatry or telemedicine.

We also host regular meetings on campus with community providers to network with us and network with our team to strengthen our community relationships with different providers. That is something that we are always seeing as a – that needs to be nurtured and developed each and every year. So, that's one of the things that we do.

Then what I'm going to talk a lot about today is our collaboration with Northwell Health and their Behavioral Health College Partnership, here, in New York City. They are the institution we go to when we need to hospitalize a student for mental health concerns.

What I would like to do now is just walk you through our crisis response process and how that – how we facilitate those transitions from somebody who is in crisis into some kind of treatment.

So, I'm going to start with our normal - what occurs during normal office hours. I imagine this occurs on many different colleges and campuses.

When a student is in crisis, it can be identified in a variety of ways, either by a faculty member, administrator, student, or themselves. We encourage those individuals if they call the counseling center, to actually walk the student over to the CCC, the Center for Counseling and Consultation. That way we can – we always have somebody what we call on-call for emergency situations. They will be seen on an as-needed basis, as first come, first serve.

Unfortunately, that doesn't always occur in that many of us receive notices from students or from faculty or from administrators that they saw a Facebook post or got an email or an Instagram post where someone is alluding to suicidal ideation or actions to take their own life. When that occurs, part of our system is we work very closely with our Dean of Students. We have our Dean of Students reach out to the student. We then – the Dean of Students will make a referral to the counseling center.

If the Dean of Students is unable to make connection with that student and depending on the severity of the concern and post that we've seen, we will activate Public Safety. Public Safety will find out where that student is on campus, wait for them after their class, and explain to them that the Dean of Students would like to see them and then escort them either to the Dean of Students or to the Center for Counseling and Consultation.

That, actually – I know it seems a little bit – sometimes, people say it's a little overkill, but it has worked very well for us in our process. Students see us as a caring community.

So, let's talk a little bit about afterhours. Of course, all of the crises never occur during 9-5. They're always occurring at 5:30 or 6 o'clock on a Friday or 3 a.m. on a Saturday evening.

This past year, we introduced a mental health helpline. This is open to all students. When they call, they will get connected to a licensed mental health provider, who will then – let me make sure – they are going to assess – part of their process is to assess the student for harm to self as well as to others. If it's a non-crisis situation, they provide support. They review self-care interventions, help the student cope with the

situation – pretty straight forward.

What we like about this is a report is created based on that interaction on the phone and then we, at the Counseling Center, or my team at the Counseling Center, rather, receives that report the next morning. They will actually do outreach to that student to provide wraparound and just say, hey, we saw that you contacted our helpline. We wanted to connect with you and see if you would like to follow up with somebody at the counseling center. See if they would make a referral. That's best case scenario.

In those situations where the counselor determines that the student is in need of immediate assistance and this is where they need to be evaluated in person by a mental health provider and be transported to the hospital. We rely on our collaboration with Public Safety. Public Safety knows all of our relationships with our community providers and also our relationships with local law enforcement.

If it is an off-campus student – remember, about two-thirds of our students live off-campus – Public Safety will facilitate a wellness check by local law enforcement, whether that NYPD or law enforcement in Long Island, New York State, wherever it might be.

The helpline will contact Public Safety and start that process. They will simultaneously also contact our counselor on call. We always have a CCC member as a backup to our helpline. I will allude to why we do that in a second.

In addition, if the situation is where the student is on campus, Public Safety will initiate our in-house hospitalization procedures. I'm going to talk more about that in one moment and how we talk about how we collaborate with a third party, Northwell Health.

I do want to explain to you how we work with Residence Life when it's – the call comes in not by the student, himself, but is identified by somebody else. When this occurs, more often than not – I'm going to use the example of the RA or the resident assistant – has identified a student that they are concerned about. They are specifically concerned that there is a threat to self or others. It's not just somebody who is having a panic attack or feeling down. It's someone who has expressed, for some reason, that they might do something to harm themselves or others.

In those situations, the RA is directed to contact our administrator on call, which is our Resident Director. There is always a Resident Director on call and who can arrive at the scene. So, the RA contacts the student – I'm sorry, the RD. The RD arrives on the scene, will introduce him or herself, and explain to the student who is in distress that we have this after hours mental health line. We would like to connect the student with that mental health helpline.

The RD is the one who initiates that phone call. We do that for very specific reasons because we want the RD to speak with the counselor first, identify him or herself to the helpline counselor, and explain to the counselor exactly why we're calling and we're calling because we have this information and we're concerned about the student's safety because he said or she said they might harm themselves. This kind of gives that helpline counselor – orients them to the situation and kind of gets them in the right place to think about what our next steps might be.

Before they get off the phone with the helpline counselor and hand the phone to the student, we're actually asking the student – we're asking the helpline counselor to say, hey, after you are done speaking with the student, we would like to speak with you

again to confirm disposition and make sure we can move everything smoothly, whatever the process might be. And then they hand the phone to the student to speak with the helpline counselor. They step aside to give them some privacy, but are still within earshot.

So, remember I talked about if the counselor determines that a student needs to – needs immediate assistance and we're talking transportation to the hospital, the helpline counselor will share that information with the Resident Director. That will start the process - since it's on campus, we're going to start our hospitalization process, our internal hospitalization process.

Here is how it goes. When that occurs, our Public Safety will contact our partner, Northwell Health. Northwell Health has their own – they have the Behavioral Health College Partnership, which is an inpatient unit just for college students.

Our Public Safety has their dispatcher number for their ambulance. They will send their ambulances to our campus. Public Safety will direct them to the appropriate location. The student will then be taken directly to a Northwell Health emergency room for evaluation and potential admitting to their unit.

At the same time, our RD is going to contact the student's emergency contact person and just notify them that your student has been taken to Northwell Health hospital for emergency reasons. We don't say if it's for physical reasons or mental health reasons. And we give them the contact information so they can call the hospital.

On the back end, also, as this is all going on, we do place a campus restriction or Public Safety will place a campus restriction on the student's account. That way we can track when the student returns to campus. They are also informed that when they come

back, we're going to ask them to check in with us, as well.

I should mention – I want to talk a little bit about Northwell Health's College Partnership. It's an excellent program. I think there actually was an NPR article or a report about it a couple months ago, but they have one of the state of the art in-patient units for college students. I think it serves over 70 colleges, here, in New York City.

Their unit is beautiful. Their staff is well-trained and up to date on evidence-based practices. They work very closely with colleges and universities. I can talk more about what we do with them. Especially not only when they're getting in to care, but also as they are exiting their facility.

Let me talk a little bit about that. When we start that process of hospitalization – so, Public Safety has sent the ambulance to our campus. The student is being transported to Northwell Health's emergency room for evaluation. At the same time, our counselor on call, who is notified by our helpline counselor, is calling Northwell Health. We have their ER – their attending physician's phone number. We call the attending physician. We let them know that a student of ours is coming in to the emergency room. We give them the information that we have like the name and what not, as well as we remind them about our process for returning, and then we ask them, if they could, to have the student sign any releases so we can help facilitate their return to campus because that is, ultimately, what we want to do.

In addition to that phone call, our staff is trained to call the administrator who oversees the whole campus – the College Behavioral Health Program. So, we call that administrator and we just leave a message on her voicemail saying, hey, we have this student who was transported to the hospital on this day. If you could just keep track of

that person and follow them through your system.

The reason we do that is they have multiple inpatient units. We want to make sure that our student gets onto the unit with other college students, as opposed to the other general population. That way the student has a more positive experience has been our experience.

I should say we also make sure we're getting the appropriate releases. We're facilitating that after-care. Often times, there are calls with their social worker while the student is still in the hospital. Then we try to schedule that hospital discharge review appointment on campus that we ask all of our students to go through if they've been taken to the hospital.

Part of that appointment involves just ensuring that that student is no longer an imminent threat to self or others. We're assessing their level of functioning. But most importantly, we're figuring out what their after-care plan and what their plan is for moving forward. We also want to make sure they are aware of all the resources on campus, including our health-related leave process if they wanted to do that. And then we want to make sure to help reintegrate them to campus. So, that is kind of our – we'll say "mandated assessment" that students come in for after they've been to the hospital.

In addition, I should say some of the lessons learned – that we've learned from this process is it is important that you are monitoring this process every – on a daily basis. I receive almost every report from public safety each morning. In my inbox, I have a report of everything that occurred on campus from Public Safety. I also have a report from Res Life that is sent to me, as well.

And I look at that report and I am making sure that all the students were

appropriately – our procedures were followed appropriately. If not, I connect with the appropriate people to find out, okay, why was NYPD called as opposed to Northwell Health or why was the helpline used in this case and not that case. So, I want – always following up.

We meet with, as a team, Public Safety, Res Life, our counseling center staff, usually, on a yearly basis just to review our procedures just to review our procedures, make sure everyone is onboard. So, that is like our formal meeting.

And then we also have periodic check-ins at the beginning of each semester to make sure the process is moving smoothly. We also have those check-in meetings with Northwell Health to kind of check in with them to see if their process has changed in any way and how we can move forward.

That is an overall snapshot of our process here, at St. John's, and how we have worked to create a safety net.

I see a question is how many counselors do we have and how many students do we have overall? So, we have 20,000 students overall here, at St. John's. We have about eight counselors. That includes one counselor who is in our Staten Island campus. So, we are clearly not at the ratios that are set by IACS and AUCCCD. We are below that. And we are constantly working to try to advocate for additional counselors.

What about students assessed or observed in the ER but not admitted to the unit? This happens. Fairly common, actually. That's why, also, that phone call to the attending physician is so important by our staff, so we can give some collateral information if that will help their assessment. If those students who are not admitted to the unit, they are returned back to campus. Our Public Safety will transport them back to

campus. We have that arrangement. They can call Public Safety and will transport back to campus.

They do have to produce some paperwork for Public Safety because it's in the middle of the night, to say why they were released. I have asked our Public Safety officers to ask the student to contact – so, they come back to our Public Safety office before they can get back into the residence hall.

The way our campus is, we are a gated campus. In order to get back onto campus, you have to go through one gate after hours. That is right next to Public Safety, so they're going to go to Public Safety first before they get back into the residence hall. When they are at Public Safety, we do ask they call the mental health hotline again just to – for reverification. If we have the paperwork, they are admitted back into their residence.

I should say, though, the next morning, if they haven't been admitted, they are getting a phone call from our counseling center for a follow-up appointment because they did activate our system and we want to try to get them into the Center as quickly as possible the next morning to evaluate what is going on and how we can help them, especially why they weren't admitted.

BONNIE LIPTON: Luis, this is Bonnie. I can feed the questions to you, just to make life easier to you.

DR. MANZO: Thank you.

BONNIE LIPTON: So, what kind of gatekeeper training – excuse me, what kind of gatekeeper training is offered for students at St. John's?

LUIS MANZO: We've been offering – traditionally, we've been offering the

Syracuse University model, Campus Connect. Then we, actually, this past semester, just started collaborating with New York City Department of Health and Mental Hygiene in offering Mental Health First Aid, which isn't exactly a gatekeeper program, but the Campus Connect is our main program.

BONNIE LIPTON: Okay. Great. We had a question from West Campus. How did you create the partnership with the behavioral health hospital? And what suggestions do you have for building something like this from the ground up?

LUIS MANZO: So, I can't take credit for building that relationship. This was the brainchild of Northwell Health. They realized there was a need for inpatient services for college students. So, they established this unit and then started working with individual colleges to see if they wanted to pilot it with them. We were one of their first pilot schools to see if it would work, see if it would make sense for them financially.

So, they started that unit and then we kind of worked closely with them to make sure – not to make sure, but to provide them with referrals because we were having a lot of referrals.

We did not have to sign an MOU. I know everyone likes to sign MOUs. They did not want to sign an MOU. They didn't require it, so we didn't do it. That avoided a lot of legal concerns that we didn't have to tackle.

And also that we worked with them closely in terms of reimbursement and payment, especially if a student doesn't have insurance. They will work very closely to make sure that they will provide care even if the student doesn't have any insurance if it's in an emergency situation.

And then in terms of creating that program, I can't really speak to that. But it

seems, from talking with their administrators, is it's a very – I think this program has supported itself because – by getting the student – they're more likely to get students in who need care. They are getting the care for the amount of time they need and then they are returned back to campus, which many schools want them to do.

BONNIE LIPTON: Great. And earlier, you talked about the mental health helpline. Who are the staff running that helpline? And where did you guys get the funding to do that?

LUIS MANZO: So, the helpline actually is third party. We use Protocol for that. We just started that this past semester. So, it's a third party, but it's backed up by our counseling staff. So, this took a little bit of the burden off of our counseling staff from getting those calls in the middle of the night because Protocol has taken the lead on those. However, we do get some calls when there's more an extreme situation or hospitalization.

In terms of funding for that, two ways. First, I actually wrote this into one of our GLS grants. As I was waiting to hear back from SAMHSA if we received the grant, I was asked by my VP to write up a proposal for expanding services in the counseling center.

One of the things is I included not only additional staff, but I included the helpline as a means to – because what we were hearing from students – our student government president at the time was very active. What we were hearing from them was they felt they got good care when they came into the Center during regular office hours. In the evening, they felt there was really good – if there was an emergency situation, they would get care or we had a good process. But those in-between situations where they just needed to talk to somebody, students were lacking that and

they wanted that. They didn't want us to use one of the more general helplines like we have here, in New York City, like NYCWell. They wanted something specific to St. John's.

So, my solution was we'll create this mental health helpline. That will not only provide that – some level of care or assistance in the evening, but also our emergency procedures.

BONNIE LIPTON: Last question, what about students who return to campus without money for ongoing care in the community? How do you help them get the treatment they need?

LUIS MANZO: All of our resident students are required to have some form of health insurance, but the majority of our students who are not resident students, we don't require that. So, if they are hospitalized, we do try to work with Northwell Health to see what their after-care plan will be and also if they don't have the means, how we can assist them with getting onto a program with sliding scale and/or if we need to get them on like emergency Medicaid or something like that.

I should say we're still working on this issue. This is a challenge for us, as well. That's one of the things we are recently hiring a care manager to help us kind of navigate that process even further and how we can strengthen that for our students who don't have the means to pay for services.

BONNIE LIPTON: Great. Thank you so much, Luis. That was a great presentation. Thank you, everyone, for all of your great questions. Irene, I will turn it over to you.

IRENE CHO: Thank you, Bonnie. I am so delighted to introduce our next

presenter, Dana Nowling, a community training manager from Plumas Rural Services, a non-profit providing services and opportunities for local residents by promoting health, education, prevention, and treatment.

She works closely with Feather River College and will discuss how they were able to leverage on and off-campus partners to provide support for at-risk students.

Without any further delay, I will turn it over to you, Dana.

Presentation: Feather River College

DANA NOWLING: Thank you so much, Irene. Yes, as Irene said, I actually work for a non-profit in our community called Plumas Rural Services. We are sort of unique in that we wanted to find an opportunity to apply for funding for suicide prevention because it's a huge issue in our community. However, we were unable to really gather the data and show the experience that we needed to be successful in applying for a grant on our own.

So, when the Campus Suicide Prevention grant came up and Feather River College was interested in applying, we actually partnered with them to apply for the grant and we were successful in that. So, it's actually the whole delivery of the grant has been a partnership from day one. So, I've been asked to share a little bit about partnerships in our community and how we build on those.

So, I'd just like to tell you a little bit about the campus and the college, itself. It sits on about 400 acres. And we're nestled in the Sierra Nevada Mountains in the Plumas National Forest.

The campus actually hosts a variety of wildlife. We have a resident deer herd. We actually have facilities for a trout hatchery, an equestrian center with house boarding

facilities. So, as you can imagine, it's a very rural setting.

We attract a lot of students from across the U.S. and abroad for our range of athletic programs, as well. So, as far as the population in our campus, it's actually the most diverse population in our county because of those that we attract mainly for athletics. But we're still predominantly a white population. For those who are coming to us that are from different ethnic backgrounds, that can be a bit of a challenge in finding a way to really fit in to the wider community.

Let me go on to the next – so, we're a two-year community college. We have about 2,700 students enrolled, but many of these are part-time. So, the equivalent is about 1,700 full-time students.

Plumas County, itself, is considered one of our frontier counties. We have less than 20,000 residents. It covers an area of 2,500 square miles with only 7.8 people per square mile. So, we're very spread out. We're just slightly smaller than St. John's, if you can imagine. Our nearest shopping center is about an hour and a half away from the county's feet. So, unlike more urban areas, the campus is not self-contained. We're very, very reliant on services provided by community partners.

So, it has only been for the last couple of years that we have had a wellness center and a full-time therapist on the campus. Previous to that, all students were referred to the county behavioral health department.

So, now that we do have a wellness center and a full-time therapist, she is busy full-time. A bit like what Luis was saying, we identified that the students especially who had more mild to moderate issues didn't really have any resource and someone to talk to. So, it has been a huge success, actually, offering that on campus now.

As far as why we wanted to apply for the grant to address the issue of suicide in our community is that we have 113 percent higher rate for suicide in our county compared to our state average. A lot of times, rural communities have that issue. We are no different.

One of the things that has been really hugely successful is a few years ago, our public health department created a network collaborative called 20,000 Lives. That reflects the number of people in our community. The goal of 20,000 Lives was really to bring people together to network and work together on issues that affect our whole community.

So, for example, we have a working group as part of this coalition to address the opioid crisis. We created a suicide prevention group as part of the 20,000 Lives collaboration. And we also have a veterans groups. We have several others, as well, but that's just an example of some of the topics that we come together to work on.

So, we don't create extra work, but we try to align the task of many different agencies to achieve their goals together more efficiently with less duplication of services. We try to leverage our limited resources more efficiently by working together.

Our strength really is in being able to – as a community, to address some common issues. When we applied for the Campus Suicide Grant, we were actually able to refer to the 20,000 Lives collaboration as the way that we would connect and work with our partner agencies and engage the community at large. So, when we think about actually addressing the campus, our campus isn't really self-sufficient. So, we actually have moved out into training the whole community because pretty much everybody in our community links in to a student because we are so small.

So, we have provided training not only on campus, gatekeeper training, but also in the community, as well. So, we do use a LivingWorks model, safeTALK, alertness training, and then ASIST suicide intervention skills training. We are recently now offering Mental Health First Aid training, as well. So, this is – worked really well to make sure that we provide care throughout the community for anyone who might come in contact with a student.

As part of the 20,000 Lives working group that we established in the beginning of – when we were awarded the grant, we actually started with a strategic planning meeting. I noticed some people were interested in identifying gaps in services and how you go about doing that.

So, we actually started off with gathering different community agencies and non-profits all together. We did a big strategic planning meeting, sharing with them about the grant and what our goals were. And then we invited them to do a gap analysis with us. We used real-life scenarios, clients – obviously, keeping the information confidential, but sharing different scenarios that had happened in our community that we were aware of and where we felt we did really well working together with different agencies and where we felt people were falling through the cracks and there were gaps in the way that we were referring people and then the response to those referrals.

And then we set up the group after that to meet once a month. We go over those goals that we set together for addressing some of these gaps and some of these issues that arose in the strategic planning.

So, our aim of our working group really is to make sure that we keep a conversation going. Because often times, you are awarded a grant and it lasts for a

couple of years and then once the funding goes away, the focus and the conversation stop around that particular issue. So, we're very keen to create sustainability by training local trainers to provide gatekeeper training and plans to continue that on even when this funding stops. We are in our final year.

So, some of the way we keep the conversation going is as a working group, we actually highlight – for our partners, say, for example, our domestic violence services in our community, for Domestic Violence Awareness Month, we actually do articles that are related to people who experience abuse and then how that relates to mental health and, particularly, suicide. And then we highlight their services along with our upcoming trainings and different services available for mental health.

We do the same for any kind of a day we can link into, such as Veteran's Day, Sexual Assault Awareness Month, highlighting the first responders recently. So, we try to work with the other agencies to see what's really relevant for them right now. And then we do press releases together or Facebook articles – that type of thing – and we share that out. So, that's how we kind of work together to make it – keep the conversation going to keep it relevant across our community.

One of the outcomes of our working group, one of the goals that we had, is that on the campus, there were no guidelines that were just easy to access for faculty. There was a larger procedure manual, but even that wasn't very detailed in how we respond to someone in crisis. So, we worked together with our working group to identify not only the protocol on campus, but also what some of our resources were out in the community.

We were able to come up with this – just a one-pager that each staff member

could have to refer to. It just gives some guidance in identifying is it an academic issue, is it a behavioral issue or a well-being issue. Then we have the crisis lines available for out of hours and all of the numbers just on an easy to see one-page for who to call should any of these situations come up.

The other thing that came out of that, as well, is then we did a matrix of priorities and who you would call first, second, and third, depending on the situation, which people found really useful. And what was great about this was that other community members helped us to design this, but then they also took it away and many of them used it to develop their own protocols in their own workplaces because many of the agencies didn't really have anything that was easy to understand and that would equip people to help somebody in crisis in their workplace, as well.

One of the other partnerships that has been strengthened is the one with our local hospital that serves our campus population. We've established a referral process between our campus therapist and the hospital. And we only have one health professional - this is how small we are. We only have one health professional in the entire county who can prescribe psychiatric medication. So, it was really important that we have a really clear process for helping students to engage with the health professionals.

They also do help them with their insurance needs. Because we do have a lot of students from out of state and out of the country and so they need some guidance on that sort of thing.

Okay, and lastly, I just wanted to speak for a moment about engaging our local agencies and non-profits and the ways that people might be able to do that. So, really

identifying, number one, the common goals. So, thinking of the different agencies that are in your community – so, for us, we engage heavily with public health department. They often do community assessments. They are doing one right now. So, we try to link in with them and see what are their goals for this community assessment, what do they need, and then how we might help them and bring suicide, in particular, into that assessment and helping us with gathering some of our data that we need.

Other departments are behavioral health, our social services, our schools, and other non-profits. So, for instance, in California, the schools have a mandate that they have to provide suicide awareness and prevention training. We have tried to link in with them, particularly looking at the high schoolers who will be transitioning into college and how we might be able to work together to provide some training.

So, that's just a way of identifying what are their goals and outcomes. Usually, behavioral health department has some kind of goals around reducing stigma and those sorts of things. So, we work with them together on different awareness campaigns.

What might they be offering that could tie into your objectives? So, figuring out what they are already doing that could help you meet your objectives.

So, in our community, a lot of our different services offer free trainings like around domestic violence, which has a clear link, as somebody who has been in a domestic violence relationship, they are three times more likely to die by suicide. So, we have a really clear link with them about how if we invite them to do some training, this could be considered prevention.

So, just really looking at what campaigns are already going on, what training in your community, and how you can involve them to help you reach your goals and work

together. So, I think I'm well out of time. I will hand it over to any questions.

IRENE CHO: Thank you so much for your great presentation, Dana. I just really love how you were able to leverage other existing efforts and bring all of the relevant partners into one table. That is super amazing.

So, now, I want to open up the floor for all of you for any questions you may have for Dana. Please chat in your questions. We will give a moment for people to type in any questions you may have. While we are waiting, I am just really blown away by all of the partnerships you were able to form. Were there any challenges you faced as you created a county-wide strategy to meet the needs of college students?

DANA NOWLING: I think that, historically, partnership – having the 20,000 Lives was really helpful because we already have a common place where we come together every quarter to meet.

There are some agencies that just historically were not as keen to partner with other people. We have had a lot of changes of leadership recently, which has been really refreshing because all the new leaders of the different departments seem to have more of a desire to collaborate and create partnerships.

There are a couple of agencies that it took a lot of going and meeting with them personally and really trying to identify how we could help them meet their goals and why it would be really important for them to join with us. So, it does take a little bit sometimes of going in and thinking about what's important for them in this and how can we help them meet their goals. Because a lot of people, their time and resources are limited. To expect them to come to one more meeting or give up their time and energy, we have to get into what's important for them and how they can relate to that.

IRENE CHO: Absolutely. That's one of the key strategies SPRC also highlights, what could you offer the partner, as well. So, I really love how strategic you were able to think about it.

You touch upon sustainability throughout your presentation. Since you are at your final stage for your grant, could you tell us a little bit more about how you plan to sustain all of these great efforts that you were able to create?

DANA NOWLING: Well, the main thing was we didn't have anybody locally who could deliver any of the gatekeeper training related to suicide alertness or prevention. So, we have used the funding to train people locally to deliver that. That enables us to keep it going, as far as before we were spending a lot of money to get somebody in maybe once a year to do a training. Of course, it is limiting how many people you can train in the community. So, we have local people to train now.

The other wonderful thing is that this grant and what we've built up over this last three years or two and a half years gave us the data and the experience we needed to apply for another grant through SAMHSA, which is a mental health awareness training grant. We were successfully awarded that. So, that is going to be huge in allowing us to train more facilitators and keep this going for another three years.

But what we're trying to do is work with our other agencies to decide when we have local funding, how they'll pool that together to make sure that we're able to keep offering this training even when that grant cycle ends.

IRENE CHO: I love hearing about how this GLS Campus Grant was able to well-position you to be awarded another grant. So, that is amazing to hear. It is really mind-blowing to hear all of the community partners you were able to bring together and form

all of those workgroups.

We thank you so much for all of your expertise that you've shared. If you have any more questions for Dana, feel free to type it in and she'll be able to answer anything through the chat. Thank you so much for sharing your informative presentation, Dana. Now, I will turn it over to Bonnie.

BONNIE LIPTON: Hi, everyone. I'm very happy to announce our next two speakers, Amanda Byrnes, the Coordinator of Case Management from University of Michigan, and Diana Parrish, Care Manager from University of Michigan. Go Blue. Diana, take it away.

Presentation: University of Michigan

DIANA PARRISH: Go Blue right back at you, Bonnie. Hi, everyone. Thank you so much for joining us. I'm going to get us started.

I just want to clarify that I work at University Health Service, which is the student health center on campus that is actually both physically and administratively separate from the student counseling center, where Amanda works. So, we'll be talking today about how we collaborate. But, again, just to clarify, I'm Diana and I work on the health service side of campus.

This is just a quick snapshot of what the University of Michigan looks like. As you can see, this is old data. We actually have more like 46,000 students now. It's a really large campus. This gives you a snapshot of who we are, all of the ways in which we are a diverse, robust community.

Also, of course, worth mentioning that students still struggle in various ways, even though we have this amazing, diverse community. A common question that those of us

in student life on campus are always asking ourselves is how are we supporting the students that we do bring here? Do we have the right infrastructure to make sure that they can be successful?

Another important data point that we're lucky to have is that we have a lot of students who are really struggling. Through internal data collection that my partners over at counseling and psychological services are always on top of, we know that 21 percent of our graduate students and 28 percent of our undergraduate students are reporting some degree of suicidal ideation in the past two weeks.

There's a lot of risk, absolutely, in our community that we are trying to stay on top of. I'll turn it over to Amanda for now and she and I are just going to jump back and forth as we go through the content with you today.

AMANDA BYRNE: Absolutely, and thanks, Diana. Hi, everybody. This is Amanda. Diana, I also appreciate you clarifying we are, indeed, in separate settings on campus. So, a lot of what we address today will be within this context of our broader campus climate and situation.

Specifically, we will talk today about the development of our Clinical Care Management Team. So, this is a team developed several years ago on our campus to meet the needs of students who were experiencing high-risk or complex mental health situations.

So, on this large campus, we realized that a lot of students ran the risk, even with wonderful supports, of potentially being lost to care. We really kind of used this analogy of kind of getting stuck in the cracks. Moving between different settings where they were receiving care and maybe not having someone keeping track or making sure that they

knew how to access resources that were being suggested.

So, this is an effort to improve our existing partnerships. Broadly, again, continuity of care planning for those in high-risk mental health situations and ensuring they are not lost to care. More specifically, coordinating follow-up care for students who have been evaluated and/or admitted at the hospital. I will talk a little bit more about the hospital and what that means. And then coordination for students who are being seen at both the counseling center and the health service on campus, again, because those are not integrated. They are two separate places on campus.

So, this program developed for several reasons. Again, this is a large campus without an integrated health service and counseling center – two separate places. We also have a hospital system on campus. So, Michigan Medicine, previously the University of Michigan Hospital, is a huge place that does a lot of work. We recognize that not all campuses have a hospital as part of their system, but that is our context here.

The effort really was developed out of a few things, as I mentioned. So, in the 2013-2014 academic year, we, unfortunately, saw several student deaths on campus and among our student body by suicide that received some news coverage. So, this led to university regents, of course, both being concerned and also really being supportive of some enhanced coordination amount the resources that were already serving students on campus.

So, this began with both counseling center and that's CAPS, Counseling and Psychological Services, and UHS, University Health Service Administrators, taking that charge from the regents and talking to each other. Really trying to improve the

partnerships that already existed. We knew that we were talking to each other and keeping track of students who came out of the hospital, but were we doing that in the most effective, most organized way.

We were also seeing in our care manager roles in both of these places, a demonstrated need. We worked with students who maybe had appointments in both settings or an appointment at the hospital or were seen for an emergency situation at the hospital and weren't always clear about what came next or how to follow through on suggestions. So, this need was arising in multiple places. We really came together to try to address it.

A little bit of the data piece that backed up some of our efforts. We know that post-psychiatric hospitalization, suicide risk is high. We can see here it is 100 times the global suicide rate. So, we also were looking at what that means among our student body.

Of those students who walk into our counseling center, 38 percent were reporting some degree of suicidal thoughts, from passive ideation up through planned attempt. And 26 percent of U of M students, so this is including everyone who may not walk into the counseling center, were also reporting some degree of suicidal thinking.

Of course, there are other reasons that a student might experience a complex mental health crisis on campus, but really looking at, for our purposes, of course, suicide risk.

DIANA PARRISH: What does this team actually look like then? I do see the question that we already received. Currently, on the Clinical Care Management Team, it is only clinical staff. We will talk a bit about how we collaborate closely with our non-

clinical student life partners in a few slides.

So, myself and Amanda and one other social worker from my side of life university health service, we meet every week to review and discuss those student discharges from the psychiatric emergency room at Michigan Medicine and less often, but sometimes, students who are discharged from the inpatient unit at Michigan Medicine.

We review those discharges to see if we can already confirm that they are connected with their discharge plan as in they have already come for a follow-up visit at one of our units. Or, if we are going to reach out to the student over email to introduce ourselves and offer any support that they need in connecting with the resources that were offered to them at their discharge plan.

We also use this time and this partnership to keep very regular contact with the clinical staff at the psychiatric emergency room. This is very helpful, both for individual cases, where there is confusion about where a student may already be connected, parent emergency contact information, other decision-making pieces that might come into assessment such as are we coming up on a deadline to withdraw from the term that might have an impact on disposition. So, that's super helpful to have that partnership in place.

We also use that time to talk about cases where we are – where both units are serving a student together. The student isn't necessarily engaged in emergency care or coming out of emergency care, but is receiving mental health services both at CAPS and UHS. This space is very useful for helping to coordinate that care.

Also, to identify and troubleshoot problems that we see within the system. Are there gaps in these services? Are we hearing from our clients that there are some

access problems or particular points of confusion in terms of patient flow? We've identified some problems over the years that we've been meeting that we've been able to take to our leaders and troubleshoot and make some great solutions. So, the place has also been really valuable for that.

Just as some examples to help you think through how this space is so valuable for us, in terms of shared clients, something that might come up would be a client who is having a hard time getting in to see their UHS doctor for follow-up after no-showing to a scheduled visit. Maybe they mentioned to their therapist over at CAPS that I know I'm supposed to see Dr. Hong, but I never went to that appointment. I don't know how to reschedule. This space is really useful for making sure that we can pass that information back and forth and get the student reconnected where they need to be.

And then in terms of streamlined services, an example that we've been able to troubleshoot is we were able to suggest to our leaders the idea of a new two-way release of information form that would allow us to collaborate and communicate a bit more freely than we were previously restricted to with the previous version of the release of information that was in use.

Our attempt at a graphical representation of what this flow usually looks like. You can see that a student presents to the psychiatric emergency services department at Michigan Medicine. If they are not admitted to the unit, they are generally discharged with recommendations for connecting with specific therapists, follow-up care at the campus units, such as CAPS or UHS. And at the same time that they are discharging the student, they are also sending a secure email to us, the Clinical Care Management Team, that includes their medical record number, date of birth, initials, date of

discharge, and sometimes a little bit of detail about what their discharge plan entails.

So, that secure email sends a notification to the team that the student was seen at the psychiatric emergency room, they are being discharged, their plan is in their chart ready for you to review when it is time. So, that really connects us clearly and in a very – what we designed it to be – a very efficient, easy way to uniformly notify us when students are coming through the psychiatric emergency room.

This is just the template that we use for our outreach email. When we meet weekly to discuss these student discharges, much of the time – we'll show you this data in a few slides – we are able to see that they are already engaged with their discharge plan, have already come in for a follow-up appointment. If we are not able to easily identify it, our step is to send an email just like this to the student, introducing ourselves, and just asking if they need anything to make sure that they are connected to the services that were recommended.

AMADA BYRNE: This is Amanda. I'll just pick it back up. We do collaborate with other student support teams on campus. One of those teams that exists and has been functioning for a number of years is the Dean of Students Behavioral Intervention Team. So, in part of her individual care manager role, Diana participates on that team. That is a non-clinical – non-clinically focused team. Right? So, this is a team that is going to address all student concerns that are rising to a significant level on campus.

One of the focus areas for this Clinical Care Management Team – I keep saying the word clinical because the goal was to really keep these student concerns and content under a clinical umbrella. So, we are social workers engaging in this follow-up work. Obviously, working closely with our other student affairs colleagues, but really

keeping that mental health expertise intact.

One piece that has been a bit of a challenge, too, is to maintain clarity, especially for those working in the hospital in both the emergency room and the inpatient unit, about referring to Clinical Care Management Teams – so, those of us on the team, as an entity, providing follow-up care for students coming out of the hospital – versus maybe connecting with us in our individual care management roles at the Counseling Center and the Health Service.

So, just a quick example. It's possible that a social worker doing discharge in the psychiatric emergency room at Michigan Medicine might call me and say I just want to consult. Is this student appropriate for brief treatment at the Counseling Center? If not, do you have a lead on a therapist who is great at working with complex trauma? That's a wonderful individual consultation.

Different from sending that student discharge data to the Clinical Care Management Team so that we can email to say, hey, are you connected with that plan? No? Come in and see one of us. So, that has been a point that we have reiterated and maintain regular contact with the hospital staff about.

I will not go through all of this, but wanted to give you a snapshot of a flowchart that we made to help all of our colleagues in student affairs understand this work. Essentially, what CCMT does is layer a process on top of existing systems. If I had to give a quick one-liner, that's it. So, if you're thinking about this on your campus, what can you layer on top of what is already happening or layer in between what is already happening?

So, in our system, our Dean of Students Office has provided really wonderful,

particularly academic support to students who are on the inpatient unit at our hospital. A student can consent to having them come out. They will coordinate with professors to give that student some breathing room. That process remains. What this flowchart does is try to spell out what the Dean of Students continues to do and where CCMT comes in as a safety net to make sure that that discharge plan is happening.

There is some space built in there where you see that dotted line, where Dean of Students could say, hey, CCMT, did this student respond or I hope this student responded, you might want to do extra follow-up. Okay? We could also say, hey student, did you get connected with the Dean of Students Office, they could really help with academic support.

And then just looking at documentation. So, we're in two separate places on campus. We found a few tools that were really helpful to keep track of our students and which one of us has reached out, whether or not a student needs our outreach. We use M Box, which is the University of Michigan version of Drop Box. It is HIPAA and Michigan Mental Health Code compliant. It is also accessible across email platforms, which was important for us. I'm on the student affairs email on campus, which is the Gmail platform, and my colleagues over at University Health Service are on Outlook, which is consistent with the hospital system. So, this also meant that I had to add a second email account in order to send those secure emails. Just a little bit to figure out there. We'll talk a bit more about how that was challenging.

DIANA PARRISH: So, I think it's important to look back at how we were able to set all of this up. And the first step was for basically our bosses to meet with the hospital administrators over at Michigan Medicine. So, leadership from the Counseling Center

and the Student Health Center met with leadership at the hospital to talk about the gap that we were trying to fill with this Clinical Care Management Team and the process that we were proposing for how we could help fix this.

And that was wonderful. And those initial conversations were, of course, crucial to get everything going. And we're able to see with hindsight that that information did not trickle down very well to the front line social work staff actually working with our students.

So, it was only through later meetings between the Clinical Care Management Team, myself and Amanda and the other social workers involved, meeting directly with the social workers at the hospital that we were able to get much more clarity about our shared purpose, get the little minutia of the information transmission questions settled and clear to everyone. Things really started moving a lot more clearly once we were able to have those direct social worker to social worker conversations. So, that's something that we wanted to highlight.

We did draft a Memo of Understanding, an MOU. This seems like a good idea, particularly since we're in this strange role where they are both an outside stakeholder and a campus partner, Michigan Medicine that is. We thought it was a good idea to have a formal document that would explain exactly how we were going to work together in this capacity and what this would look like and who the involved players were so that we would always have that to fall back to.

We were also hoping that having an MOU in place would negate the need for individual releases of information to be signed to share this information about every student who was discharged from the psychiatric emergency room.

It took quite awhile for this memo of understanding to move through the different legal departments and administrators that needed to get eyes on it and approve it. And after many, many, many months, well over a year, it was actually determined by our Hospital Compliance Department that it wouldn't actually serve one of its chief purposes, which was to negate the need for individual releases of information. We were told that wasn't going to fly.

So, instead what we did was built a line item into the discharge plans at both the psychiatric emergency room and the inpatient unit that a student can check or not check, giving permission for us to receive this notification, before they sign their discharge plan. So, if you can imagine a discharge plan that has things like these are your treatment recommendations and then maybe a checkbox underneath that that says, yes, I would like you to notify by my primary care physician that I was in the emergency room today. Right underneath that, there is now a checkbox that says, yes, I would like you to notify a University of Michigan Student Life Social Worker that I was here so that they can follow up with me. Students either opt-in or opt-out based on that checkbox.

This is just a snapshot of what our lovely, but ill-fated MOU looked like.

Now, we have a little bit of data to share. In our pilot year, we received 34 referrals and notifications from the hospital, letting us know that students were either evaluated and discharged from the psychiatric emergency room or admitted to the inpatient unit.

In reviewing their chart, we were able to confirm for 53 percent of those students that they were already engaged in follow-up care after discharge. And then we did that

email outreach to 47 percent of those cases. As you can see, the vast majority did not respond to our outreach. Those who did generally were saying things like thanks for reaching out, I'm all set, I don't need anything.

We knew that 34 total referrals was nowhere near the amount of students that we know are going into the psychiatric emergency room every year. Thankfully, by year two, things have started to pick up a little bit. 97 total referrals, which was certainly closer to where we had been, but not quite. We still felt not quite meeting the numbers that we knew were going through there. Certainly, many – a big part of that gap can be explained by students declining to let the hospital notify us, absolutely. We also don't think that that is the full story, so we continue to try to chip away at that with our colleagues over at the hospital.

Again, I just want to say that for many of our students who we reach out to, they are not responding at all. And those who do respond almost uniformly, they tell us they don't need anything. But we can also very clearly see because they end up back in the psychiatric emergency room a month later or they walk in for crisis unscheduled services at one of our units, the Counseling Center or the Campus Health Center – we know that they are not actually fully engaged with a discharge plan, which is why they keep showing up for crisis services.

That's important because we can tell that we're still not totally meeting this gap of wanting to not allow students to get lost to care in between these various units.

So, Amanda is going to talk a bit about how we're thinking about this now.

MS. BYRNE: Absolutely. Thanks, Diana. In our last couple of minutes here, just a few quick things to consider in terms of the barriers we encountered and how you might

want to think about encountering these or avoiding them. Diana talked about the challenges in terms of communication. The people doing this work need to be part of these conversations from the beginning and empowered to talk to one another.

We really had to think about our different systems. So, you do need your technology folks involved at some point, even to help you conceptualize what the problems may be. You need a secure email system. Something, again, that is going to be HIPAA compliant, Mental Health Code compliant, whatever that looks like in your state.

I did see a question pop up about M Box. So, M Box is a Michigan version of Drop Box. Drop Box is a company that anyone can access. I don't know the specifics of how that was developed to be U of M specific, but I bet the Drop Box folks could talk more about that.

We found that to be a really helpful shared record, but it does have some challenges. It's not great for running numbers and for doing evaluation. We may think about that in the future. So, that's that limited functionality piece. We originally used fax machines. People are not a fan of having to walk over and send a fax if it's something they could send via secure email.

Then medical record access – I am jumping around a little bit here. So, the University Health Service and the hospital share MyChart access. The Counseling Center does not. We work on Titanium. This has been another piece where individual staff – so, myself, our clinical director – have gained MyChart access so that we can check in and the care managers at UHS, Diana and our colleagues, have gained Titanium access. So, both of those are read-only, I need to view this in an appropriate

way access. So, something to think about if you are on different systems.

I won't go over – I'm already talking about quite a few of the ways you might consider this. Really think about the size of your campus and are you integrated. If you're not in an integrated system, what is the culture like? Are you siloed culturally – right – on campus, sort of kept apart in terms of history and how your units connect? And what can you do to build or increase those partnerships?

Then I'll just briefly mention sustainability. Diana, I hope it's okay I'm just blazing through these last couple. Our care manager roles and the Clinical Care Management Team are matching funds in terms of our campus grant. So, this work will continue beyond the campus grant. We are fortunate in that way. I believe that's what we have for today.

BONNIE LIPTON: Great. Thank you, Diana and Amanda. That was great.

We want to encourage people to chat in any other questions or you can verbally say them. Chelsea, if you can unmute everyone because we're going to have a discussion in a bit. So, you can verbally ask your questions or chat them in.

Diana and Amanda, I had just a question. You talked about the importance of breaking down silos so everyone can work together – oh, I'm just going to keep this on the references slide, in case anyone wanted to get those down. Again, the slides will be on the SPRC website.

So, what are your suggestions for people on how they can help break down silos, especially if you have multiple different groups and organizations on campus? What are kind of your lessons learned there that you would recommend for new Garrett Lee Smith grantees?

DIANA PARRISH: That's a great question. I certainly would say we're always learning how we can do that best. I think that one of the things that helped us be successful was having identified champions at the units that we really needed to collaborate closely with, people who are close to the work, who have a lot of passion for improving the system of care and breaking down those silos.

Identifying just one person at a unit who can be that contact for you, that has been I think really useful for us and helps us have consistent messaging to both the individual leadership of our units, but also the leadership of the university, as a whole, about the ways in which we are already seeing this help to chip away at these problems we all see. I would say that that's a tidbit that has been helpful for us. Do you have anything to add, Amanda?

AMANDA BYRNE: I agree. And I would just say, you know, really come with data and come with examples. I think those have been helpful in illuminating the necessity of this work and potentially the impact. Those are informing us as we think about what else could this team do and are we still best meeting the needs of students.

BONNIE LIPTON: When you say example – I love that you say come with data. But what do you mean when you say come with examples? Are you thinking like case – not a case study, but, you know, hey, we worked with this one student and this happened and it would have been great if y had occurred? Can you give an example of what you mean by an example?

AMANDA BYRNE: That's a meta question. Yes. And, essentially, what you just said. The idea of paying attention when you're working with a student and maybe coordination of care is going really, really well.

So, I'm thinking of a student – this might have been a couple of years ago already – who I saw in my individual care management role at this counseling center. Student had never been to our University Health Service, but he had a history of psychiatric care elsewhere. He was looking to get connected. Being on campus, for various reasons, made more sense than going to a private psychiatrist in the community. And I was able to call Diana and kind of in this CCMT relationship, say is there any way this student could jump primary care.

We were working within the contours of someone who really had some significant mental health history. Moving the system in an appropriate way to get that student where they needed to be more quickly.

I think some examples of when that doesn't happen right – a student coming out of the hospital maybe today and three weeks from now walking into either of our settings and saying I was in the hospital a month ago and I still haven't gotten any care. Well, gee, I wish that student had had an opening to say I'm not getting what I needed before they were feeling they needed to walk in. Does that help?

BONNIE. LIPTON: Yes, it does. That is exactly – I had a feeling that's what it was, but I wanted to make sure. Thank you so much. That was great. Well, thank you for the presentation. It was great hearing from you guys. Irene, I will throw it over to you.

IRENE CHO: Thanks, Bonnie. So, this was a lot of information we fit into our presentation – or our webinar. We wanted to hear a little bit more from you and move into a quick discussion. So, feel free to chat in any key takeaway that resonated with you from this webinar or feel free to share verbally. All of you have been unmuted. So, if you want to share your thoughts verbally, feel free to do that. Just as a reminder, the

presentation slides will be available. We will be sending a recording next week.

So, feel free to chat in your question or something that resonated with you. I know Catherine earlier mentioned using visuals to demonstrate what you do for your campus partners. I thought that was a great key takeaway. If there is any other things that you plan to do/implement after this webinar, feel free to share verbally or chat in through the – chat it in. I see a few folks chatting in, so I will give a moment for people to chat in or share verbally.

LINDA WOLSZON: This is Linda from Texas Christian University. I just wondered about Michigan – so in discharging – I mean seeing students after they've been discharged from inpatient care, for us, that's a scope of care issue like do we have enough therapists to provide the level of care we think somebody needs given that high level of risk following inpatient. Does the University of Michigan's Counseling Center, do they assume the care for students who have been discharged?

AMANDA BYRNE: I can give some answer there. We didn't get into it in this presentation, but we agree with you. So, we don't have the capacity, even though we have a large counseling center, to see every student who has been discharged from the hospital.

So, the goal is really that the hospital staff might make a referral to a community provider who is set up to do more ongoing, open-ended therapy. We do brief counseling, short-term counseling here, at the Counseling Center. What CCMT is doing is really just providing that opening for a student to let us know if they have not made contact or been seen by that community provider yet.

Our hope then is that if they have not made that connection, they can come in and

see any one of us at the Health Center or the Counseling Center in our care management capacity. We can do some close tailored referral work and kind of support them therapeutically maybe for two sessions-ish, until they make that connection.

Does that help to answer that question?

LINDA WOLSZON: Yes, it really does. Thank you so much.

AMANDA BYRNE: I will also note that at the Student Health Center, separate from the Counseling Center, we do see a lot of students after discharge from a patient unit for ongoing medication management. Usually, they are sent directly to our psychiatrist, at least initially, and then once they are in a more stable place, transitioned to our primary care doctors.

IRENE CHO: Thank you for that clarification. I want to be mindful of time. So, I just wanted to share these resources that could really help you with implementing care transitions on your campus. As mentioned before, please note that all other recording and slides will be available on the SPRC website. We will send out an email once it's ready.

I just want to thank all of the presenters and all of the participants who asked such insightful questions. I'm glad to hear that so many people found this webinar super helpful and will be sharing with campus leadership and hopefully, this will be a start or sustaining of your campus care transition efforts. So, thank you so much for everyone who joined our presentation today.

Hope everyone has a great rest of the day. Thank you.

(Whereupon, the meeting adjourned.)