

Care Transitions

Goal 8: Agencies should have documented continuity-of-care procedures to promote access to and engagement in services for individuals identified as being at risk for suicide. Agencies should provide follow-up and bridging activities to reduce suicide risk during transition periods.

Rationale

Research has shown that individuals who have made a suicide attempt or present with a suicide crisis remain at high risk for a period of time. In fact, the risk of suicide is highest within the month immediately following discharge from the emergency department or psychiatric hospital. The greatest number of suicides occur within one week of discharge (Luxton, June, & Comtois, 2013). This period of time is critical for ensuring continued contact with caring professionals and supportive friends or family.

Unfortunately, research also demonstrates that only 25 to 50 percent of individuals attend a follow-up appointment after discharge (van Heeringen, et al., 1995). Many others will not remain in care beyond the third appointment. Therefore, ensuring that organizations are using effective, evidence-based strategies to assist individuals in engaging in outpatient care and providing support during this high risk time is absolutely critical.

Risk for suicide attempts and deaths is highest within one month after discharge and remains elevated during the next 12 months to 4 years.

Evidence suggests that social isolation and lack of social support are significant problems for individuals in this high-risk group (Trout, 1980). Individuals in this group have shared that having someone reach out to them and express concern and caring, even through a postcard or phone call, has been very impactful in their decision to not attempt suicide.

The use of effective care transition strategies has also been shown to be cost effective by reducing the costs related to expensive psychiatric hospital stays. A 2014 study by Richardson, Mark, & McKeon assessed the cost benefit of telephone follow-up calls after discharge and found \$1.76 return for every \$1 invested for insurance and \$2.43 for Medicaid patients discharged from hospitals. Results were \$1.70 for commercial insurance and \$2.05 for Medicaid following discharge from an emergency department.

Points of Intercept

The Texas public mental health system is tasked with supporting all individuals in the community with crisis care. This includes continuity of care activities during periods of high risk. The following key times represent points at which the community mental health

center may intercept a person at high risk of suicide:

- discharge from the emergency department,
- discharge from a state psychiatric hospital,
- discharge from a local psychiatric hospital,
- discharge from crisis alternative setting, and
- mobile crisis involvement.

In each of these situations, the individual is at elevated risk for suicide as well as high risk for not following through with mental health referrals. Each of these intercept points represent unique settings and situations and may require different strategies to support continuity of care and reduce suicide risk. Therefore, organizations should identify the strategies being used and monitor their success separately. The appendix to this toolkit provides a care transitions worksheet that can be used to plan and identify key strategies around care transitions for relevant intercept points. In addition, the Suicide Prevention Resource Center has developed a worksheet to document care transition strategies, which is also included in the appendix.

In addition, strategies should also be identified to follow-up with individuals who are engaged in services within the organization and in the Suicide Pathway if individuals fail to attend scheduled appointments. This type of follow-up ensures a rapid response to check in on the safety of individuals known to be at risk and communicates caring and concern from providers. Staff should be aware and trained on the organization's written procedures to support care transitions.

Care Transition Strategies

The following list includes strategies that have been shown to reduce the risk of suicide or increase engagement in care following crisis contacts. A summary of research results related to various outreach or bridging activities is included in the appendix. Although a description of each strategy is included, organizations need to engage in careful planning to identify how a strategy might be implemented within a particular setting.

Outreach refers to the different methods used to contact a patient. **Bridging** is the continuous and bidirectional connection with patients following discharge.

MOUs/MOAs – Organizations should consider establishing a memorandum of understanding (MOU) with partner organizations (e.g. local hospital) to outline the role that each entity has for screening, assessment, safety planning, discharge planning and follow-up. MOUs can assist in providing clear arrangements for information sharing, including establishing procedures for access to relevant assessment information and policies around warm hand-offs.

Follow-up appointments – Organizations should ensure that individuals have rapid access to initial outpatient appointments following discharge. The first outpatient

appointments should be scheduled within 24 hours if at all possible, but within 48 hours if not. Providers supporting care transitions, such as crisis staff, should have the capacity to schedule follow-up appointments while still engaged with the individual at risk. Reminder phone calls are also beneficial in improving attendance at scheduled appointments.

Warm hand-offs – Warm hand-offs enhance the transition by starting to build a new relationship with the referral provider or organization. The referring provider may arrange an introduction with the new provider in person, by phone or through telehealth technology. The referring provider may also make a linkage with another staff within the referral organization, such as a peer provider or continuity of care staff, who is responsible for maintaining care throughout the transition time for the person at risk.

Provider Communication – The care transition should be supported through effective communication between the originating provider and the receiving provider. Procedures should include gaining a release for provider communication. Providers should send documentation on the individual at risk prior to the scheduled appointment and follow up with a conversation between providers to share relevant information.

Psychoeducation – Providers engage in conversations with an individual to identify expectations regarding mental health treatment, provide information and clarify misconceptions, discuss potential barriers to attendance and problem solve. Psychoeducation should include an understanding of the individual's cultural beliefs about suicide and mental health treatment and the role these beliefs may play. Motivational interviewing techniques may also be useful in this strategy.

Mobile crisis follow-up – The mobile crisis team or other crisis providers maintain regular face-to-face or telephone contact with individuals at risk until the individual is engaged in community-based services. Research suggests that contact between the crisis provider and individual should continue beyond the first outpatient visit until clear engagement has occurred. Crisis follow-up activities include assessment of risk at each contact (for example, using the C-SSRS), review of the safety plan, and problem solving barriers to care.

Care navigators – Care navigators have been shown to be especially helpful in providing continuity across primary care and behavioral health systems and across hospital and outpatient settings. The care navigator can enhance these system relationships by serving as a liaison, improving communication across providers and facilitating access to care. The use of motivational enhancement strategies may increase the effectiveness of care navigation and care coordination.

Peer Specialist Support – Organizations can engage internal or external peer specialists to assist individuals at risk in navigating behavioral health systems and provide support and encouragement during the transition period and possibly beyond. One study demonstrated that utilizing peer support organizations in the discharge process shortened the length of hospitalization, reduced the use of hospital and ED services over 12 months, and reduced

the overall cost of care (Forchuk, Martin, Chan, & Jensen, 2005). The intervention was most beneficial for those individuals describing themselves as “lonely.”

Engagement of support network – Another strategy for improving care transitions is the involvement of caregivers in the individual’s life. This strategy includes involving supportive family or friends through education around the elevated risk period and inclusion in the discharge and transition planning. Persons in the individual’s support network can also be included in plans to reduce access to lethal means. Closing the loop can include post-discharge contacts with the caregiver to assess for any concerns, need for additional education and support, or barriers to accessing follow-up care.

Caring contacts – Several studies have examined the impact of follow-up contacts after discharge from psychiatric hospitals or emergency departments. These contacts are brief communications expressing care from a provider and have been delivered in person, by phone, letter or postcard, email, or text. Caring contacts follow a pre-set schedule and have ranged in studies from 1 to 24 contacts with most lasting for up to 18 months.

Different systems and organizational resources will require different combinations of care transition strategies. Across the various strategies described, improvement in attendance at outpatient treatment over the baseline rate ranged from 10 percent to 90 percent with 43 percent being the average improvement over baseline (Knesper, 2010).

Follow-Up for Individuals in Care (Suicide Risk Pathway)

Individuals in care may also withdraw from services during times of crises. Organizations should have clear procedures for outreach to individuals who have been identified as having elevated suicide risk if the individual fails to attend an appointment. Electronic health records can be an important tool in notifying responsible parties of the need to engage in active outreach, as well as raising awareness of crisis hotline staff or crisis providers of elevated risk.

Staff should immediately attempt to reach an individual at risk following a missed appointment either by phone or through a home visit. The staff member may also reach out to the individual’s support network with previously gathered consent. If the staff member is unable to reach the individual by the end of the workday, alternative strategies for outreaching should be planned. Options might include:

- outreach calls by the crisis hotline staff;
- home or community outreach visit by the mobile crisis team;
- home or community outreach visit by a Crisis Intervention Team or Mental Health Deputy.

Procedures should also include outreach by mail, preferably within 48 hours, if other outreach strategies fail to engage the individual at risk. Caring contacts (e.g., emails, postcards, texts) scheduled at regular intervals may also be beneficial in reducing risk if individuals choose to withdraw from treatment. When trying to decide what strategy to

use, be sure to engage the person at risk. Asking their preferred method of communication will further ensure a connection at a future outreach point.

Evaluating Success

Care transition strategies can range from simple and inexpensive to intensive. However, they have also been shown to be cost efficient by reducing repeated hospitalizations and ED use. To ensure the chosen strategies are meeting the agency's goals, staff should measure their impact and continue to identify potential gaps. Potential measures of the success of care transition or follow-up strategies include:

- Days/hours from referral to initial appointment;
- Days/hours from referral to initial visit;
- Attendance rate at initial appointment following referral;
- Hospital readmission rates (within various time frames);
- Hours to contact after missed appointment; and
- Percent of individuals re-engaged in care after missed appointment.

Moving Beyond – Community Expansion

Building partnerships within the community is essential to fostering effective care transitions. Creating a shared commitment for a suicide safe community can foster a willingness to address the elevated risk during times of care transitions. Behavioral health centers can assist in planning effective care transition strategies for other settings in which identification of suicide risk occurs. Outlining the roles of each agency within a MOU can be an effective way to support collaborative planning. Overlapping responsibilities, while not duplicating roles, can help weave together a stronger system to support the continuity of care across community providers. Technology can also support communication across providers, including the sharing of assessment records and follow-up communication.

References

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