Prevention in Practice
» Care Transitions

Suicide Prevention Resource Center

NEW HAMPSHIRE HOSPITAL

"The ability to feel linked with other people can truly save lives. When individuals have a support network that is working directly with them to keep them safe, the probability of them maintaining their safety is substantially increased."

— Elaine de Mello
Connect Supervisor of Training and Prevention Services,
NAMI New Hampshire

Background information

As New Hampshire's only state inpatient psychiatric facility, New Hampshire Hospital serves adults and young people at high risk for suicide. For several years, the hospital has provided a care transitions program for its adult patients that aims to improve patient safety and reduce readmissions. In 2012, the National Alliance on Mental Illness New Hampshire (NAMI NH) consulted with the hospital about developing a more extensive version of that program for patients 24 and under and establishing a permanent aftercare liaison position to carry it out long-term.

At that time, NAMI NH held discussions with the state's Community Mental Health Centers and Regional Public Health Networks, identifying the need for targeted efforts to help young people transition safely from the hospital to the community. NAMI NH also asked parents, families, and caregivers what resources and supports they needed during and after their loved ones' hospitalization. Consultation with New Hampshire Hospital and conversations with community stakeholders led to a plan for strengthening care transitions among youth inpatients. NAMI NH outlined this plan in their Garrett Lee Smith suicide prevention grant proposal, implementing the program with grant funding from 2013 to 2016. The hospital then sustained the program long-term.

How it was done

The aftercare liaison, who is a master's level mental health case manager, joined the hospital in 2014. First, she reached out to the community and regional partners involved in program implementation to explain her role, build relationships, and learn about the youth served in their areas. She also began attending statewide and other meetings to form connections with key stakeholders, such as the state's Youth Suicide Prevention Assembly and Suicide Prevention Council. These partners were eager to collaborate with the aftercare liaison because of the extra support she provided to patients and the improvements she made to information sharing and problem solving. In the regions of the state with the highest suicide rates, the aftercare liaison set up regular meetings with Community Mental Health Centers to discuss how to make care transitions happen smoothly.

EDC Education Development Center

New Hampshire received funding for their suicide prevention efforts through the Garrett Lee Smith Suicide Prevention Act, which is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), and consultation and guidance from SAMHSA and the Suicide Prevention Resource Center (SPRC) at EDC.

New Hampshire Hospital treatment teams referred eligible patients to the care transitions program. The aftercare liaison worked with mental health center staff assigned to the hospital to set up procedures for obtaining a signed release of information early in a patient's hospital stay. That release of information helped facilitate sharing of key information during the patient's hospitalization and transition back to the community. A special communication agreement also allowed the aftercare liaison and mental health center staff to share confidential patient information, such as the name of the patient's therapist, whom the liaison could contact once she received a signed release of information.

The care transitions program was voluntary and tailored to meet the specific needs of each patient and their family. The liaison worked closely with the individual's support network—such as family, friends, school staff, coaches, and therapists—to develop an individualized plan to keep the patient safe in a crisis and connected to community resources. The liaison also provided the patient's family or caregivers with sources of educational materials and social support, such as NAMI NH programs. Working closely with the state's Regional Public Health Networks, the liaison connected patients with local resources, such as social activities and classes that patients felt would be helpful after leaving the hospital.

The liaison met with patients and a majority of the families prior to hospital discharge and, in most cases, contacted them via telephone within two days and met with them in person within seven days of discharge. She then maintained contact with individuals for about 90 days, both in person and by phone. The frequency and length of contact depended on the needs of the youth and their family. At every in-person contact, the aftercare liaison administered an assessment tool that measured hope, interpersonal support, and coping skills based on the youth's responses and information provided by the family and other contacts. Assessment scores allowed the liaison to assess the youth's progress and address any challenges, such as depressed mood or self-harm episodes.

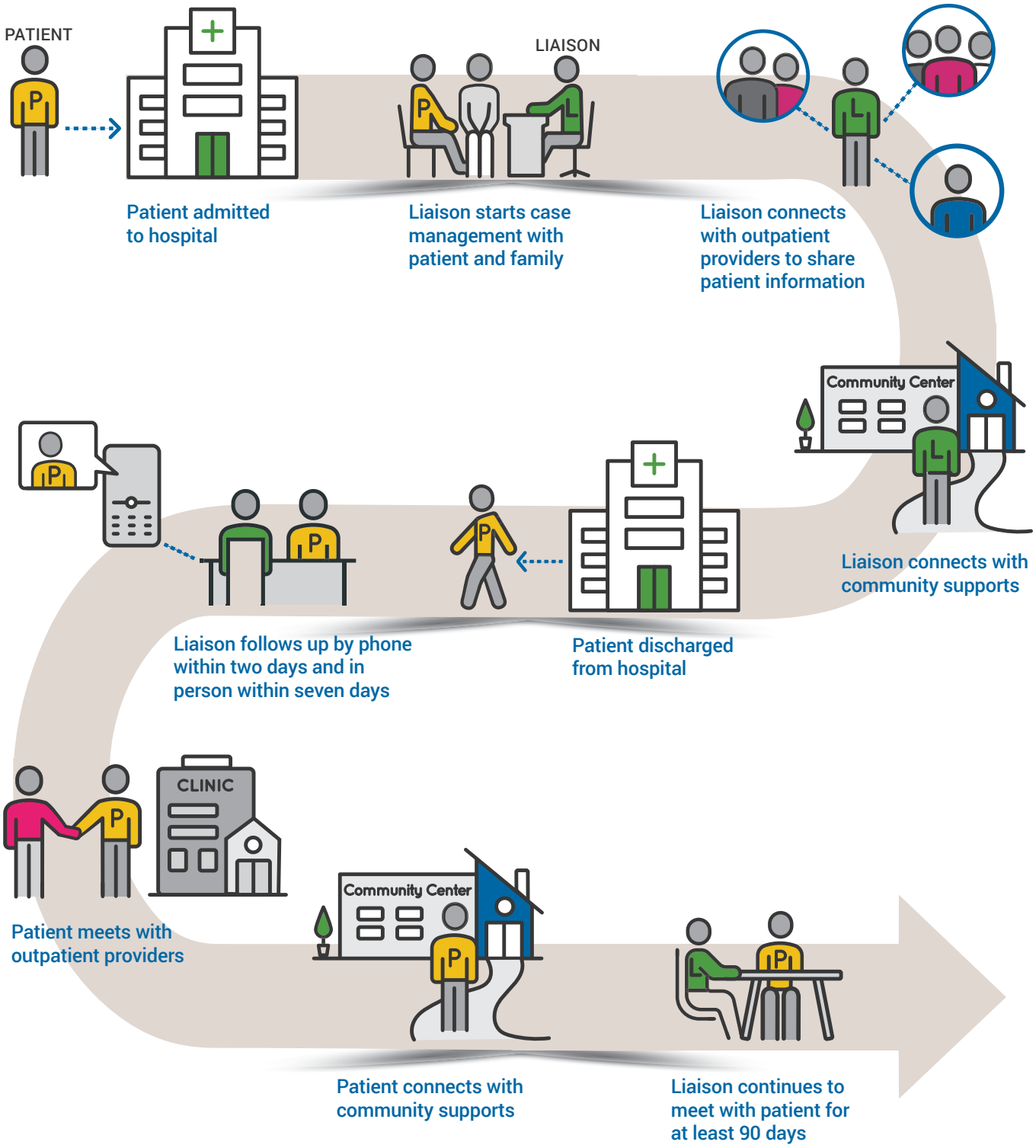
SAFE CARE TRANSITIONS

- It's important to help plan and coordinate a patient's transition from one health care setting to another, or to their home. Supporting safe care transitions is a key part of a comprehensive approach to suicide prevention.
- Research has shown that a patient's suicide risk increases immediately after discharge from an inpatient hospitalization. Providing follow-up support to the patient at this time can help reduce their risk of future suicide attempts.
- Steps to ensure effective care transitions include the following:
  1. Prepare for a patient's hospital discharge so they have resources and supports in place when they return home
  2. Follow up with a patient after they leave the hospital
  3. Help to coordinate a patient's behavioral health care in the community

Lessons learned

- **Partnerships:** Close collaboration between New Hampshire Hospital and NAMI NH during the planning process ensured that they were aligned in their goals and objectives. The aftercare liaison helped strengthen existing partnerships with the state's mental health centers and public health networks, which improved information sharing and problem solving. Attending regular meetings with partners and stakeholders helped the liaison stay informed of state suicide trends and receive important information, such as profiles of youth at risk.
- **Preventing Roadblocks:** NAMI NH identified and addressed potential challenges during the initial planning process. Initial meetings between the aftercare liaison, NAMI NH, and mental health centers helped identify

Care Transitions Pathway



barriers to information sharing, and regular follow-up meetings helped them quickly troubleshoot problems. New Hampshire Hospital ensured that the program was sustainable by embedding the aftercare liaison position in the hospital system before the grant ended.

» **Outcomes:** An initial assessment of the data suggests that the program led to more comprehensive planning to facilitate the patient's transition between the hospital and community and avoid readmissions. For example, mental health centers let the liaison know when a youth from their community was referred to the hospital so that she was prepared to support them at admission. Regular communication with the mental health centers and public health networks allowed the liaison to provide patients with referrals to resources and services in the community before discharge. She also connected patients and their families to key NAMI NH resources, including educational services, support groups, and therapeutic activities.

What comes next

» **Scale-Up:** New Hampshire Hospital and NAMI NH hope to expand this intervention to the hospital's adult population to provide them with a more extensive version of the current program. Ideally, this will be made available to other patient groups at high risk, such as older adults and those who have been involved with the justice system. They also hope to hire additional aftercare liaisons to carry out those efforts long-term.

» **Outcomes Evaluation:** New Hampshire Hospital plans to evaluate the effectiveness of the care transitions program by comparing patients' quantitative data—from assessment scores and readmissions—with the data of patients who did not participate in the program.

» **Replication:** Other health care systems in New Hampshire, as well as states across the country, have expressed interest in using this care transitions model in a variety of settings, including emergency departments, substance abuse treatment facilities, and tribal communities.

USEFUL RESOURCES

Crisis Now: Transforming Crisis Services:
https://go.edc.org/24mi

Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe:
https://go.edc.org/2ahn

Zero Suicide Toolkit: Transition:
https://go.edc.org/rnz9

Care Transitions: Best Practices and Evidence-Based Programs:
https://go.edc.org/ho9l

The Joint Commission's Sentinel Event Alert 58: Inadequate Hand-Off Communication:
https://go.edc.org/r76z

If you have questions or would like to learn more about how NAMI New Hampshire created their comprehensive approach, contact:

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