Transitions to Care: Emerging Research & Best Practices

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Transitions of Care: Overview (Reminder from April)

- Purpose: To help King County residents transition effectively between different levels of care within our (complex) behavioral health treatment system. Transitioning between different levels is a risky time for individuals dropping out of recommended care, without having familiarity, relationships, and trust built in the new level of care.
- Examples:
  - hospital → outpatient clinic
  - crisis services → outpatient clinic
  - residential treatment ←→ outpatient clinic
  - diversion from legal system and connection to care
  - legal system → other levels of care

Identified Needs (from April)

- Pockets of effective care coordination and care transition programs, but support is not systemic, not currently able to meet the full need
- Lack of closed-loop referral tracking – was referral and connection successful?
- Lack of data-driven assessment of need for more intensive care transition support, including awareness of possible disparities
- Lack of easy and consistent communication between providers
- Need for connection to transitional housing and other social services and basic needs (transportation, benefits, food, clothing)

Best Practices in Care Transitions: What and Why?

- **Becky Stoll, LCSW, Senior Vice President for Crisis Services at Centerstone**
- **Centerstone** is a nonprofit health system specializing in mental health and substance use treatment for all ages. It operates facilities in FL,IL, IN, NC and TN and care within the military services division, which operates in all 50 states and 24 countries. It also operates its own Research Institute.
- Becky is responsible for leading both administrative and clinical operations for Centerstone's multi-state footprint, including an enterprise crisis call center, state and national 988 Suicide and Crisis Lifeline call/chat/text centers, mobile crisis response teams, crisis walk-in centers, crisis stabilization units and crisis residential facility.
- Becky currently serves as the Co-Chair of the 988 Suicide and Lifeline Steering Committee, on the American Association of Suicidology Advisory Council and the National Action Alliance for Suicide Prevention EXCOM.

Neuropsychological Underpinnings of Crisis Episodes

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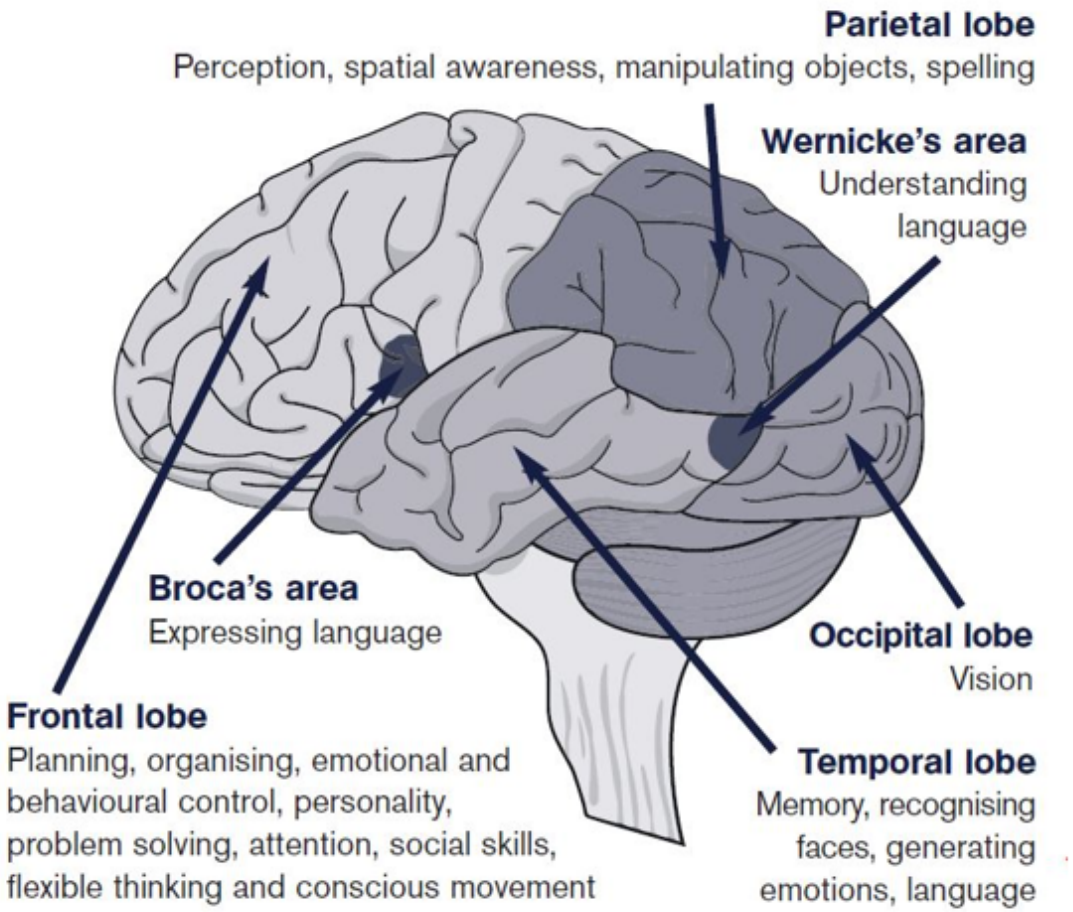
Crisis Events

During a crisis event, the prefrontal cortex (PFC), responsible for rational, higher-level thought, is turned off by the limbic system which activates our “fight or flight” response system.

Within the limbic system, the hypothalamus communicates with the rest of the body to preserve and regulate energy in preparation for the fight or flight response.

As our brain shifts during crisis response, accessing the neocortex (prefrontal cortex) becomes increasingly difficult.



From: About the brain | Headway

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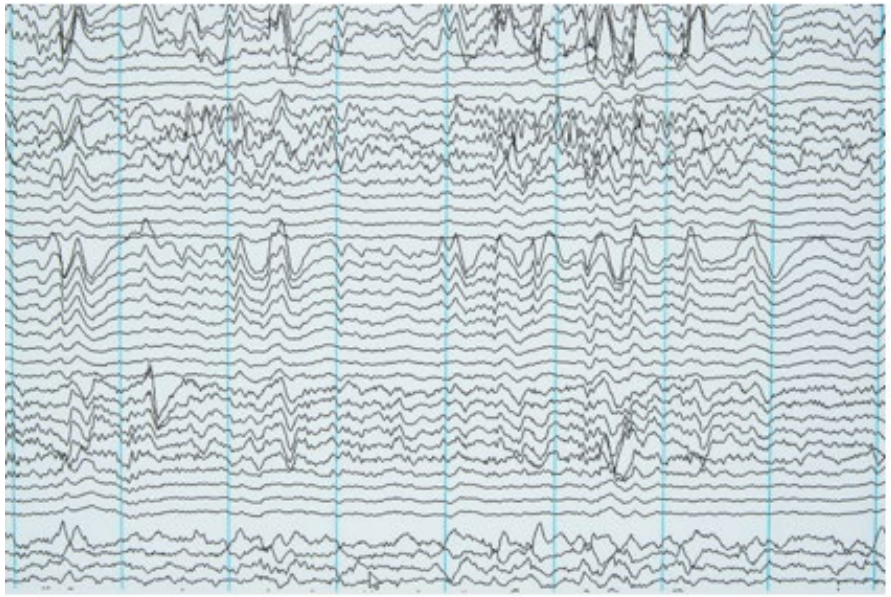
Consequences

During acute stress, “brain regions do not function in isolation, but are organized into functional networks of dynamically interacting regions” (van Oort et al., 2017).



- Short-term: These changes to our brain are intended to be adaptive.
- Long-Term: Extended or **consistent crisis stress levels can lead to significant shrinkage of the dendrites in the amygdala, increasing overactivity of the stress response.**
- Consistent activation of acute stress impacts the prefrontal cortex which impacts individuals’ **sense of control, resilience and can impair memory consolidation.**
- Ultimately, those who experience **several episodes of acute stress** are likely to experience **difficulties managing and coping with that stress** precipitating another episode.
- The more acute stress episodes an individual experiences, the more they will likely experience challenges managing those episodes as **accessing care becomes increasingly difficult when the prefrontal cortex is consistently impaired.**

“In both animals and human models there is a window of opportunity in the immediate hours of a perceived traumatic event, to reduce anxiety and confusion, restore stability and effective coping, and that this window is not wider than six hours” (Farchi et al., 2018).

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Psychological First Aid (PFA)

"PFA is based on an understanding that people affected by traumatic events will experience early stress reactions which may cause sufficient distress to impede adaptive coping and recovery"

(Farchi et al., 2018).

Five core principles of Psychological First Aid:

1) to foster a sense of safety
2) to provide calmness
3) to induce a sense of self and community efficacy
4) connectedness
5) Hope

Hobfoll (2007)

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Six C's Approach

- Communication
- Commitment
- Cognition
- Continuity
- Control
- Challenge

More recent research expands on these principals and introduces a model based on the underpinnings o crisis:

(1) Hardiness

(2) Sense of Coherence

(3) Self-Efficacy

(4) Neuropsychology of the stress response.

Passiveness, Helplessness, Emotion – based reactions

ASR Symptom	SIX C's Intervention	Outcome
Loneliness	**C**ommitment for the person's safety	Person's Collaboration and Cooperation with the helper
Helplessness	**C**hallenge & **C**ontrol Ask to choose from simple available actions / options	Increased sense of Control and effective Coping
Non-controlled emotional reactions	**C**ognitive **C**ommunication	Motivation and ability to act effectively and to make and prioritize decisions
Confusion	**C**ontinuity Chronological Synchronization of the event: underline the ending of the event	Reductions of "flashbacks" / intrusive thoughts, understanding that the immediate threat is over

Active, Cognitive – based reaction, effective coping

Adapted from: Farchi, M., Levy, T. B., Gershon, B. B., Hirsch-Gornemann, M. B., Whiteson, A., & Gidron, Y. (2018). The SIX Cs model for immediate cognitive psychological first aid: From helplessness to active efficient coping. International Journal of Emergency Mental Health and Human Resilience, 20(2), 1-12.

Action Alliance for Suicide Prevention: Best Practice Recommendations – Inpatient to Outpatient

https://theactionalliance.org/resource/best-practices-care-transitions-video (3:02 min)

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Care Planning Tools

LEARN MORE: SuicideCareTransitions.org

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

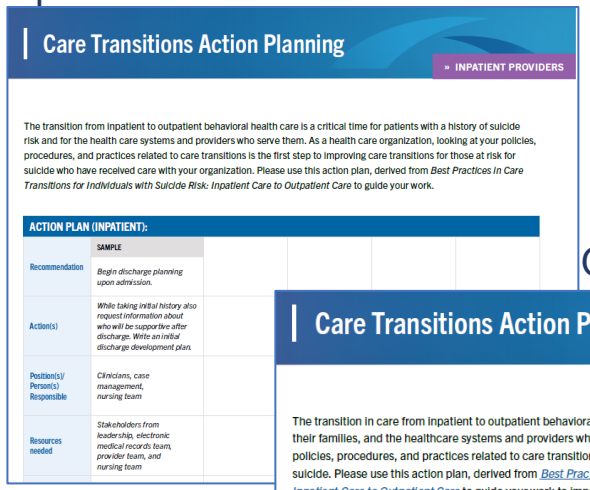
ZERO SUICIDE

This resource is supported by the generous contribution of Universal Health Services, Inc., Behavioral Health Division.

Links to tools available at *MIDD AC Website*

July 2025 Meeting Materials

Inpatient Providers



Care Transitions Action Planning

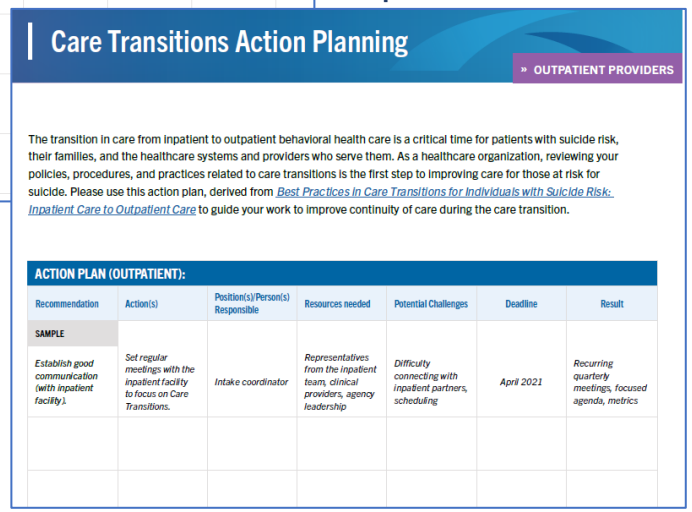
» INPATIENT PROVIDERS

The transition from inpatient to outpatient behavioral health care is a critical time for patients with a history of suicide risk and for the health care systems and providers who serve them. As a health care organization, looking at your policies, procedures, and practices related to care transitions is the first step to improving care transitions for those at risk for suicide who have received care with your organization. Please use this action plan, derived from *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care* to guide your work.

ACTION PLAN (INPATIENT):

	SAMPLE
Recommendation	*Begin discharge planning upon admission.*
Action(s)	*While taking initial history also request information about who will be supportive after discharge. Write an initial discharge development plan.*
Position(s)/ Person(s) Responsible	*Clinicians, case management, nursing team*
Resources needed	*Stakeholders from leadership, electronic medical records team, provider team, and nursing team*

Outpatient Providers



Care Transitions Action Planning

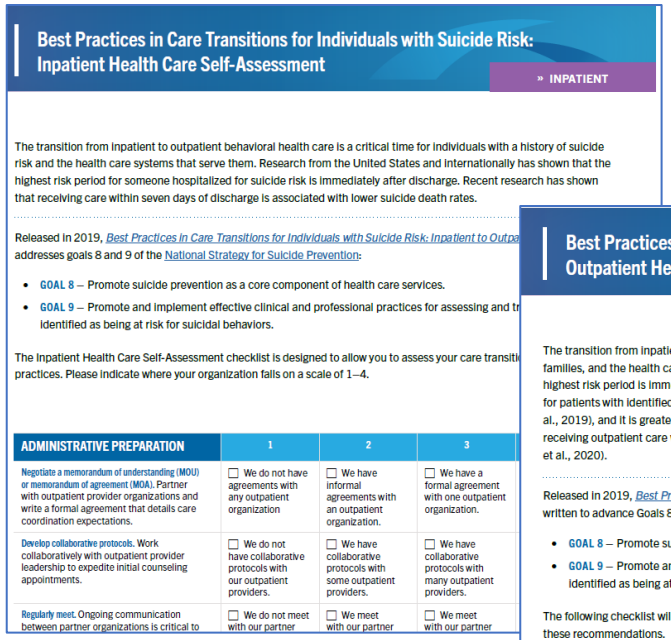
» OUTPATIENT PROVIDERS

The transition in care from inpatient to outpatient behavioral health care is a critical time for patients with suicide risk, their families, and the healthcare systems and providers who serve them. As a healthcare organization, reviewing your policies, procedures, and practices related to care transitions is the first step to improving care for those at risk for suicide. Please use this action plan, derived from *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care* to guide your work to improve continuity of care during the care transition.

ACTION PLAN (OUTPATIENT):

Recommendation	Action(s)	Position(s)/Person(s) Responsible	Resources needed	Potential Challenges	Deadline	Result
SAMPLE						
Establish good communication (with inpatient facility).	*Set regular meetings with the inpatient facility to focus on Care Transitions.*	*Intake coordinator*	*Representatives from the inpatient team, clinical providers, agency leadership*	*Difficulty connecting with inpatient partners, scheduling*	*April 2021*	*Recurring quarterly meetings, focused agenda, metrics*

Inpatient Self-Assessment



Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Health Care Self-Assessment

» INPATIENT

The transition from inpatient to outpatient behavioral health care is a critical time for individuals with a history of suicide risk and the health care systems that serve them. Research from the United States and internationally has shown that the highest risk period for someone hospitalized for suicide risk is immediately after discharge. Recent research has shown that receiving care within seven days of discharge is associated with lower suicide death rates.

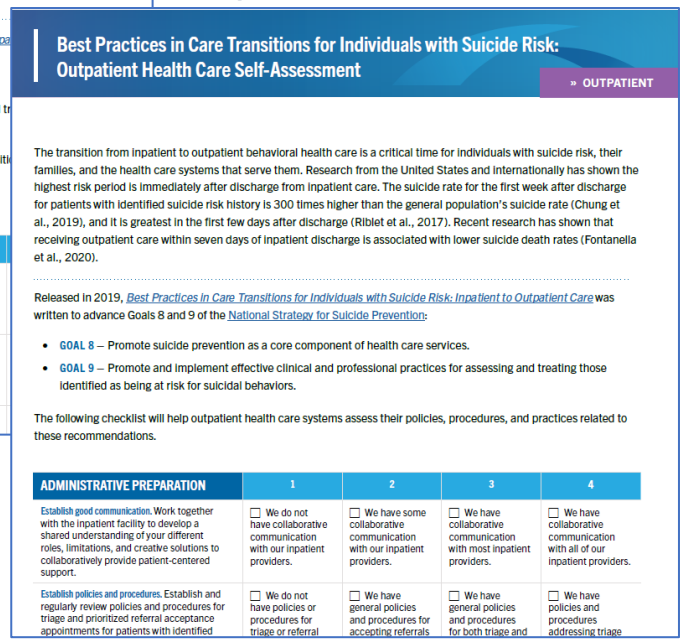
Released in 2019, *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient to Outpa* addresses goals 8 and 9 of the National Strategy for Suicide Prevention:

- GOAL 8 – Promote suicide prevention as a core component of health care services.
- GOAL 9 – Promote and implement effective clinical and professional practices for assessing and tr identified as being at risk for suicidal behaviors.

The Inpatient Health Care Self-Assessment checklist is designed to allow you to assess your care transiti practices. Please indicate where your organization falls on a scale of 1–4.

ADMINISTRATIVE PREPARATION	1	2	3
Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA). Partner with outpatient provider organizations and write a formal agreement that details care coordination expectations.	☐ We do not have agreements with any outpatient organization	☐ We have informal agreements with an outpatient organization.	☐ We have a formal agreement with one outpatient organization.
Develop collaborative protocols. Work collaboratively with outpatient provider leadership to expedite initial counseling appointments.	☐ We do not have collaborative protocols with our outpatient providers.	☐ We have collaborative protocols with some outpatient providers.	☐ We have collaborative protocols with many outpatient providers.
Regularly meet. Ongoing communication between partner organizations is critical to	☐ We do not meet with our partner	☐ We meet with our partner	☐ We meet with our partner

Outpatient Self-Assessment



Best Practices in Care Transitions for Individuals with Suicide Risk: Outpatient Health Care Self-Assessment

» OUTPATIENT

The transition from inpatient to outpatient behavioral health care is a critical time for individuals with suicide risk, their families, and the health care systems that serve them. Research from the United States and internationally has shown the highest risk period is immediately after discharge from inpatient care. The suicide rate for the first week after discharge for patients with identified suicide risk history is 300 times higher than the general population's suicide rate (Chung et al., 2019), and it is greatest in the first few days after discharge (Riblet et al., 2017). Recent research has shown that receiving outpatient care within seven days of inpatient discharge is associated with lower suicide death rates (Fontanella et al., 2020).

Released in 2019, *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient to Outpatient Care* was written to advance Goals 8 and 9 of the National Strategy for Suicide Prevention:

- GOAL 8 – Promote suicide prevention as a core component of health care services.
- GOAL 9 – Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

The following checklist will help outpatient health care systems assess their policies, procedures, and practices related to these recommendations.

ADMINISTRATIVE PREPARATION	1	2	3	4
Establish good communication. Work together with the inpatient facility to develop a shared understanding of your different roles, limitations, and creative solutions to collaboratively provide patient-centered support.	☐ We do not have collaborative communication with our inpatient providers.	☐ We have some collaborative communication with our inpatient providers.	☐ We have collaborative communication with most inpatient providers.	☐ We have collaborative communication with all of our inpatient providers.
Establish policies and procedures. Establish and regularly review policies and procedures for triage and prioritized referral acceptance appointments for patients with identified	☐ We do not have policies or procedures for triage or referral	☐ We have general policies and procedures for accepting referrals	☐ We have general policies and procedures for both triage and	☐ We have policies and procedures addressing triage

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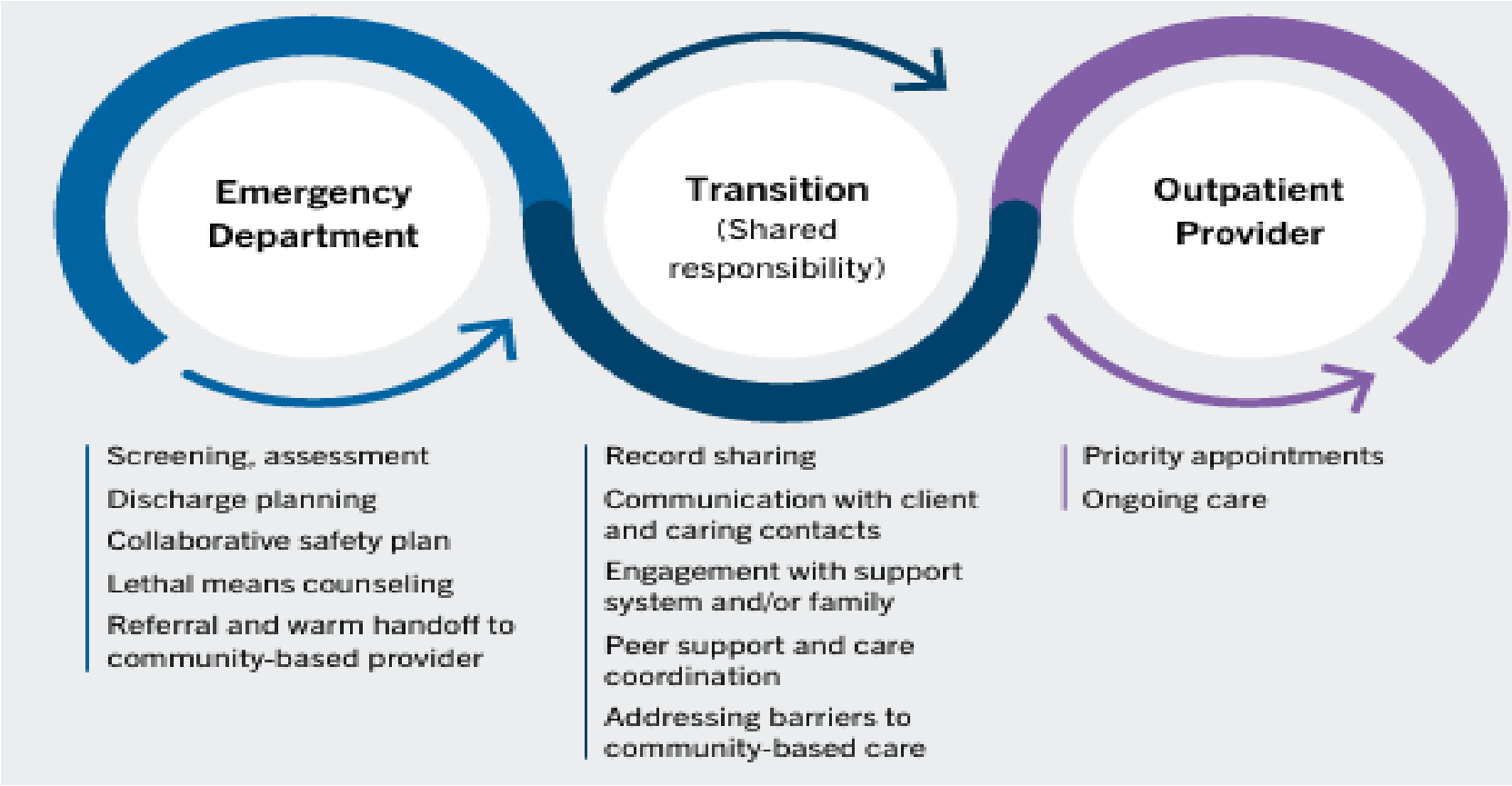
Recommendations for Emergency Departments

Successful care transitions include shared responsibility and linkages between EDs and outpatient behavioral health providers. Implementation of best practices includes evaluation and planning and the development of pre- and post-discharge protocols.



From Action Alliance for Suicide Prevention, “Emergency Department Best Practices” https://theactionalliance.org/sites/default/files/aa-edbest_practices-2024-final_0.pdf

Care Coordination and Closed-Loop Referral Platforms

findhelp

student health hub

What is the potential role for MIDD?

- After maximizing other funding sources for Care Transitions (Medicaid, state funds, Crisis Care Center Levy, etc), leveraging MIDD to support system-wide best practices
- Addressing the needs of the Care Transitions workforce
- Implementation of Care Coordination and Closed-Loop Referral technology solution(s)