Linking Individuals Needing Care (LINC):

A Care Transition Model of Care for Suicidal Youth

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Overview of FL's Care Transition Process

- Care coordinators at partnering sites are trained in a culturally sensitive, research and consumer-informed, skills-based training
  - Skills learned include engagement and rapport building strategies, crisis management and risk detection skills, case management (including documentation) strategies, and referral and networking strategies
- Care monitoring process starts during acute (in-patient) and post discharge
  - Engagement with client occurs *during* acute care to build rapport
  - Collaborative safety plan developed before discharge using "My Wellness Toolbox"
  - Multiple contacts over 90 days (or more if needed) to monitor suicide risk, coping behavior, strengths, and linkages to services
    - Contact points: 24-72 hours, 7 day, 14 day, 21 day, 30 day, 60 day & 90 day
    - Client functioning and linkage to services assessed using LINC developed forms: Care Monitoring form, Suicide Risk Triage form, My Wellness Toolbox and PHQ-9, CSSR-S, & agency biopsychosocial/risk assessments

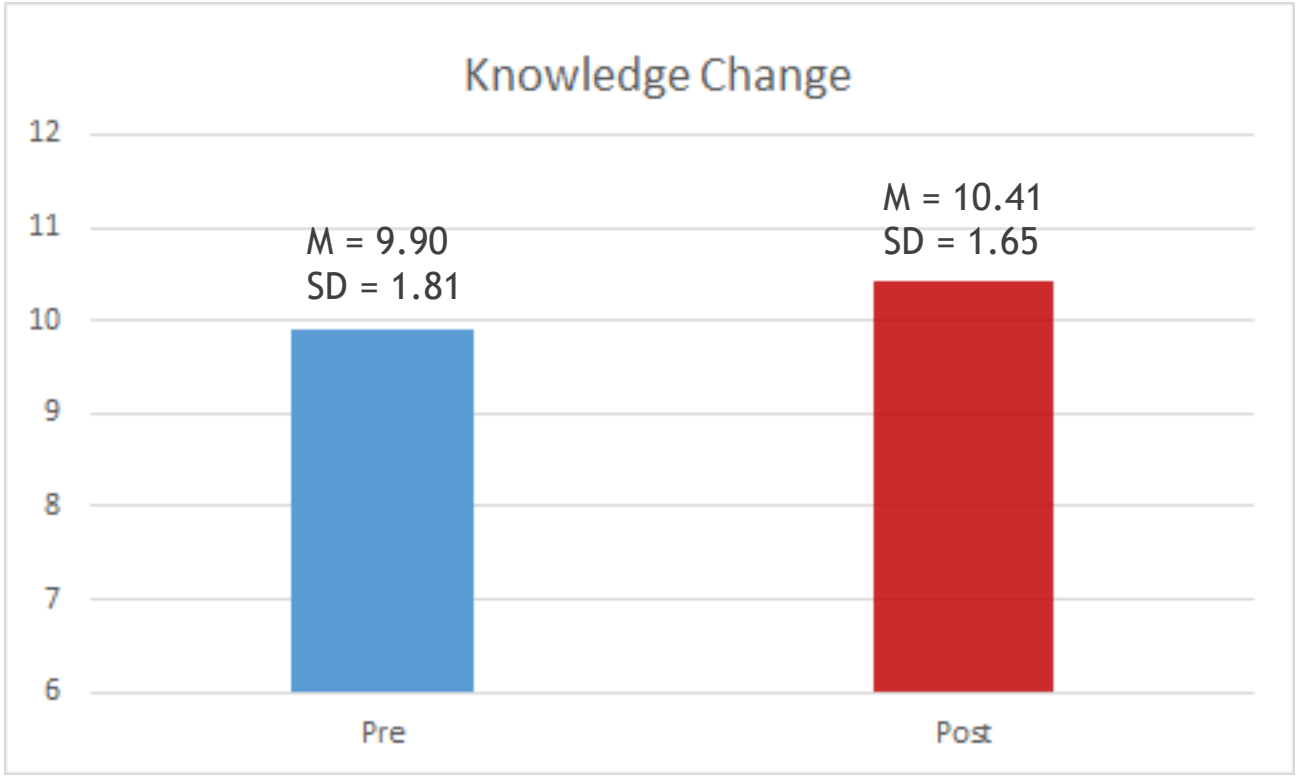
Strategies to Obtain Buy-in & Support

- Levered support from state partners ("gatekeepers"), working with regional systems that allocate state/county funding to local BHOs and other youth-serving systems (i.e., foster care, residential care, DJJ facilities)
  - Locating BHOs who have "shared" visions and missions
- Developed Memorandums of Understanding (MOUs)
  - Outlining shared benefits: *how we can help you, how you can help us*
- Used Joint Commission & NSSP recommendations, along with the Zero Suicide Initiative to advocate for "system change" with BHOs
  - Adhering to accreditation and best-practice standards (moving to EB practices & care)
  - Taking a proactive stance to address future state mandates in suicide prevention, intervention, postvention training, screening/assessment, treatment, and post-discharge care

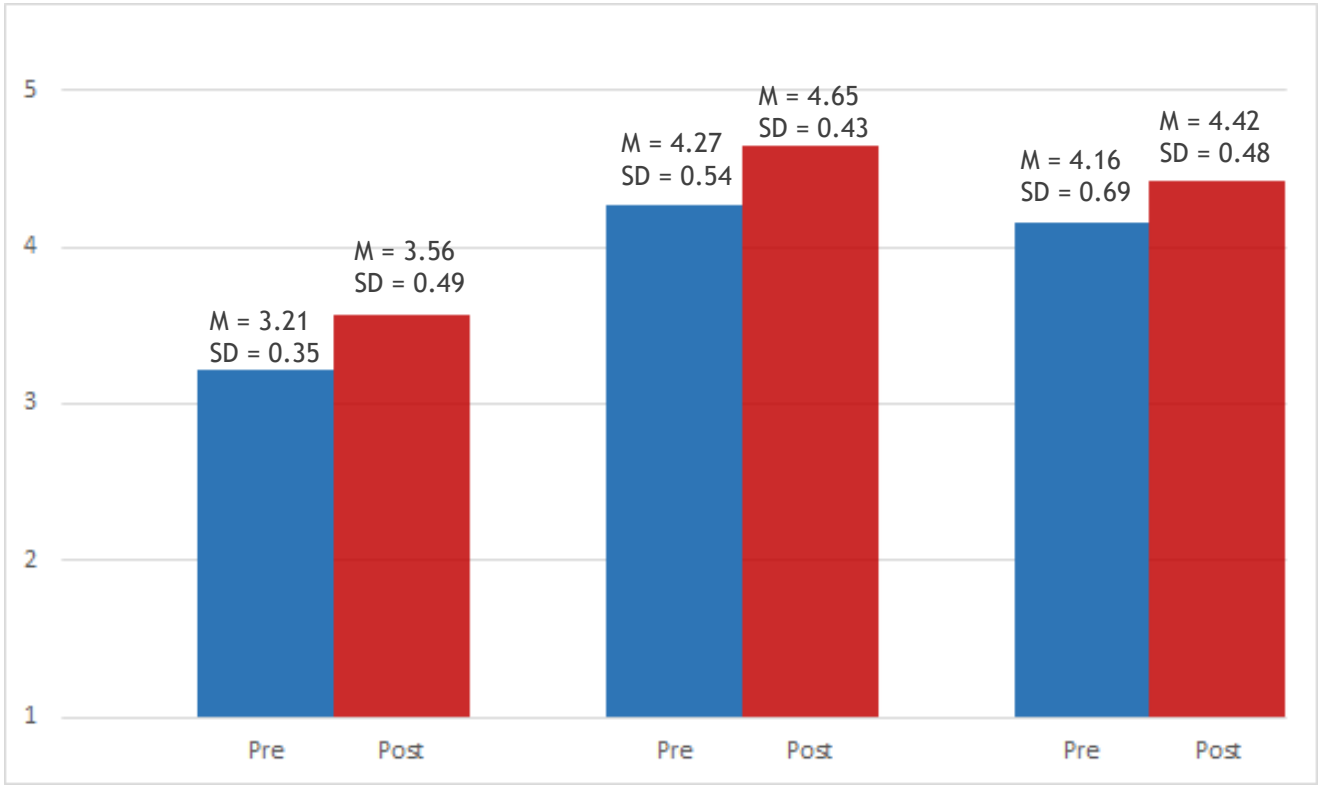
Evaluating Care Transition Processes

- Care Coordination Training Participants: 113 participants
  - Constructs measured by pre/post evaluation - Knowledge, Attitudes, Perceived Behavioral Control, Intentions
- Care Coordination Clients: 116 clients
  - Procedures - Clients were contacted at baseline, 30-days, 60-days, & 90-days
  - Measures - Depression scale (PHQ-9) and Suicide Risk Scale (C-SSRS)

Care Coordination Training: Knowledge

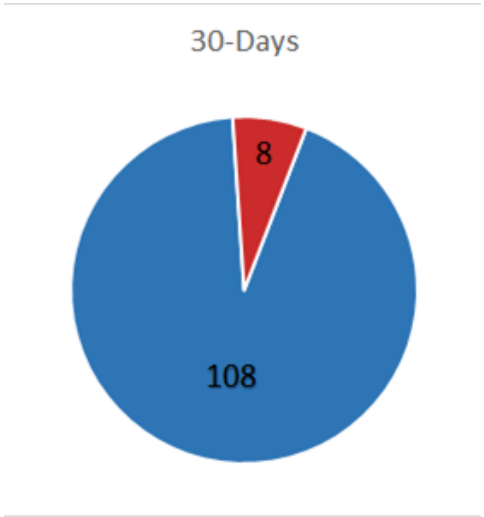


Care Coordination Training: Attitudes, PBC, & Intentions



Attitudes PBC Intentions

Care Coordination Client Retention: 30-, 60-, 90-Days



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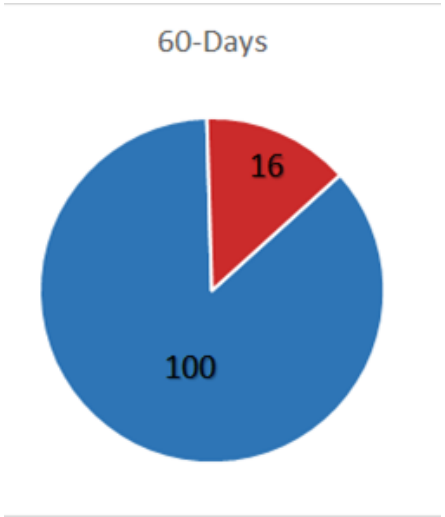

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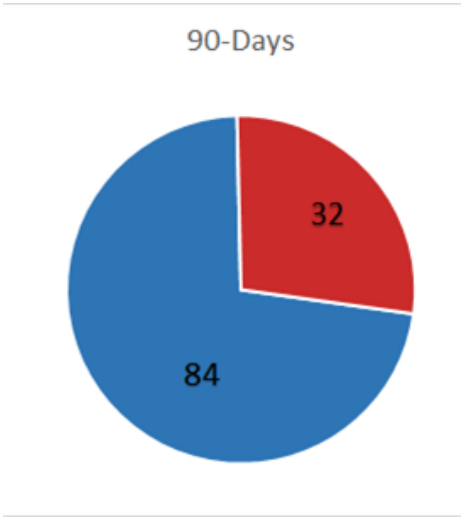

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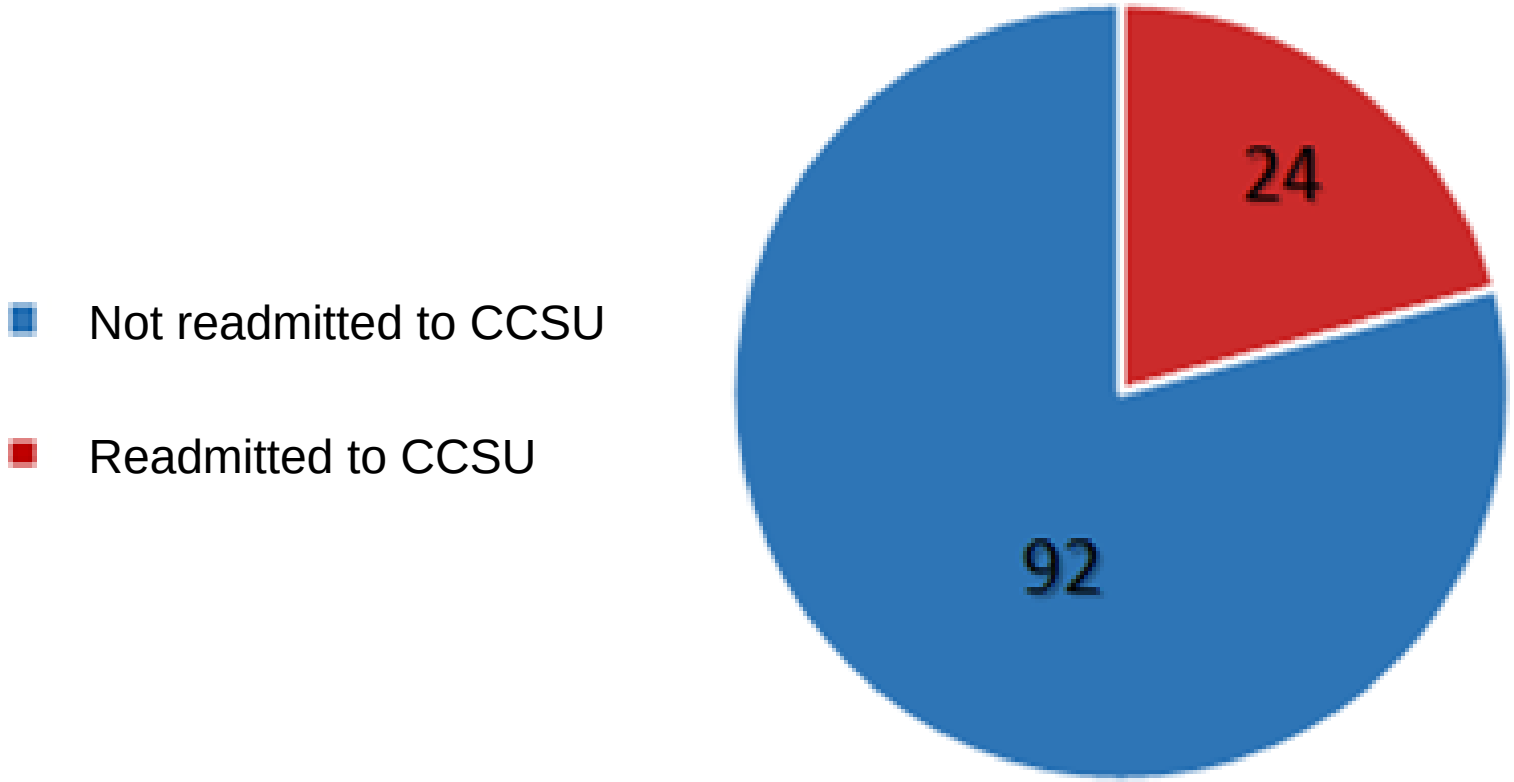
- Receiving care coordination services
- Dropped out of care coordination services

Care Coordination Client: Readmission



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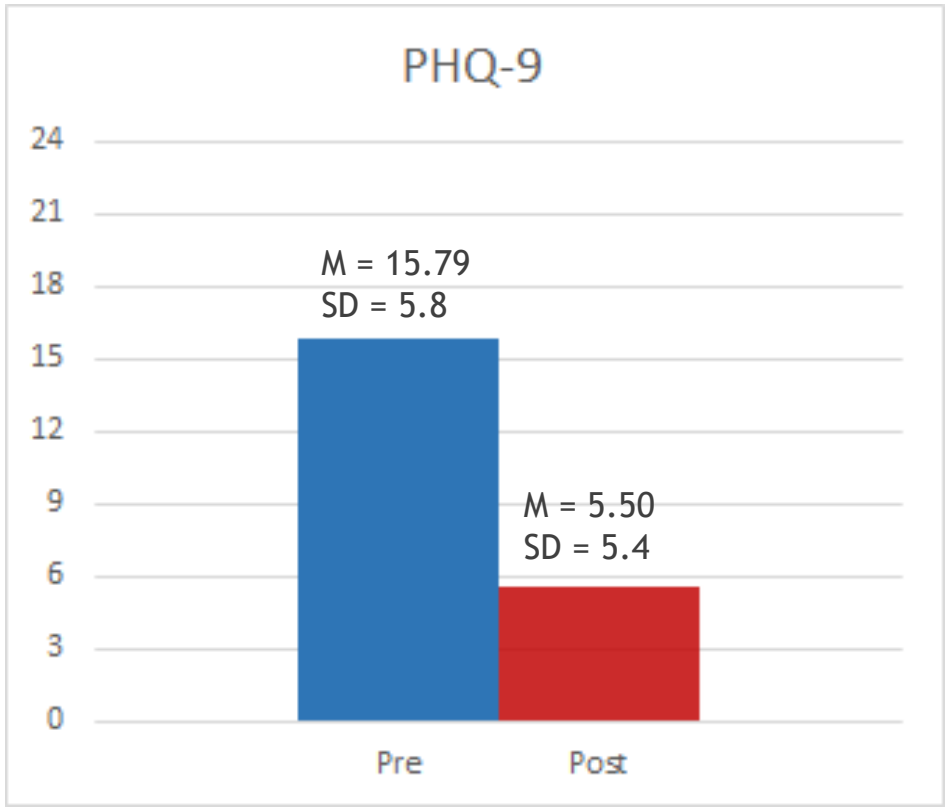
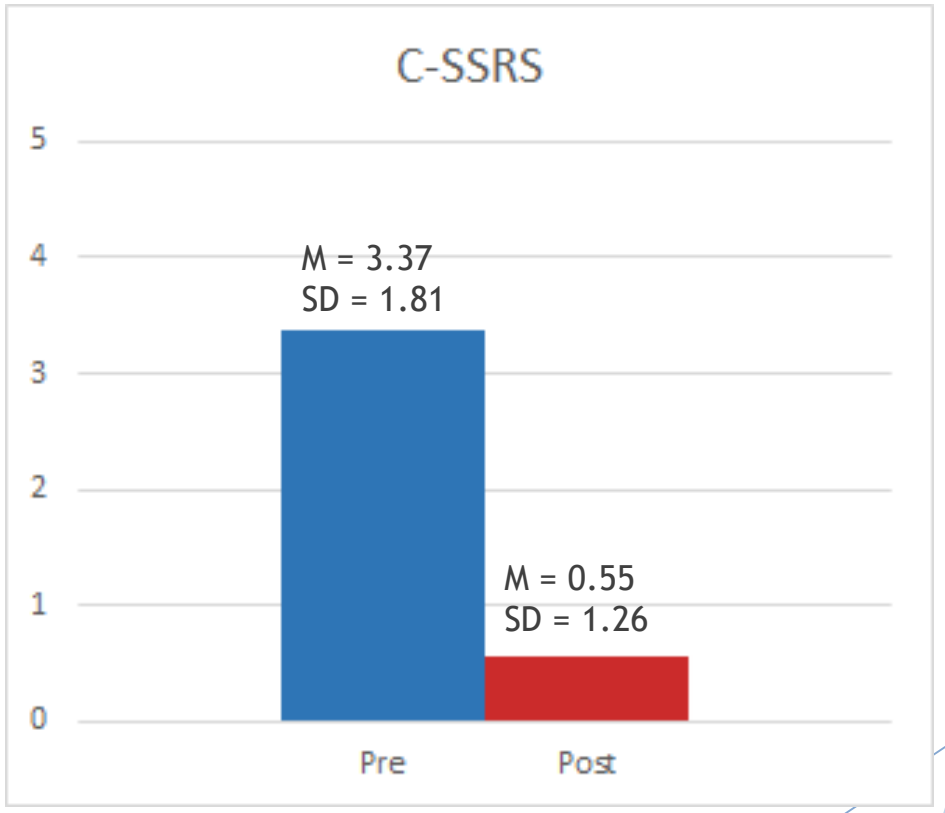
Care Coordination Client: Depression & Suicide Risk





Sustainability: Barriers & Solutions?

- Sustainability has been an integral part of our development and implementation strategies
  - If we can change the "system," we can help to ensure that our efforts are sustained post-grant funding
    - Infrastructure changes: internal trainers, policies and procedures, electronic health records, ZS
    - Ongoing awareness (community & agencies) = Changes in attitudes, norms, and expectations
      - Attending community events, becoming a member/actively participating in community boards/groups, hosting "community" suicide prevention trainings, being a part of the community's crisis response team
- Barriers?
  - Staff turnover, leadership changes, losing "champions" who have helped advance efforts, lack of funding, other "issues" become a greater priority
- Overcoming Barriers
  - Changing the "system"
  - Persistence and patience
  - Identifying related initiatives/funding resources to include suicide prevention

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