Psychiatric Emergency Patient Navigator: Improving Outcomes

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Abstract

Mental health illness affects 1 in 5 adults nationwide. During a crisis these individuals inundate emergency departments. Once discharged home, many of these same individuals return to emergency departments in crisis again within 30 days of discharge. This indicates the need to bridge the gap in continuity of care and connect discharged patients with follow-up care. This pilot study implemented and evaluated the feasibility of patient navigators, who made a followup phone call to psychiatric patients discharged from the emergency department after a crisis within 48 hours of discharge from a New Jersey hospital, on 30 day readmission rates. Patient navigators were provided with information on how to conduct and document the follow-up. A total 322 discharged patients were followed-up between November 2019 and February 2020. Follow-up included help with navigating referrals given, aid in making an appointment and the patient's need to be re-evaluated if at risk and an assessment of any barriers in the ability to follow discharge plans. The follow-up phone call from a patient navigator in the psychiatric emergency department reduced readmission rates by 14% when compared with a similar period from the previous year. The results indicated that a follow-up phone call is a feasible intervention that has the potential to reduce thirty day readmission rates.

Keywords: psychiatric patient, psychiatric emergency department, discharge, telephone followup, intervention, callback.

Psychiatric Emergency Patient Navigator: Improving Outcomes

The National Institute of Mental Health (2016), has reported that 1 in every 5 adults suffers from a psychiatric illness in the United States. An estimated 44 million adults have been diagnosed with a mental health condition in the United States as of 2016 (National Institute of Mental Health, 2016).

Crisis situations occur on a daily basis, whether it is medical or psychiatric these situations are unpredictable. A crisis can be defined as an unplanned event that poses an imminent risk to the individual or others and their judgment is impaired (Joint Commission Panel for Mental Health, 2019). Many psychiatric patients use emergency departments for crisis management but utilize follow up care after discharge. However, mental health crisis in the United States have risen over the past years and has resulted in emergency rooms being inundated with patients experiencing a psychiatric crisis, some within thirty days of discharge (American College of Emergency Physicians, 2015). This indicates a need to examine follow-up care and resources available to better manage crises among psychiatric patients outside the hospital.

This issue impacts all the states in the U.S. Mental Health America's 2019 report, *The State of Mental Health in America*, ranked the fifty states using specific measures for mental illness such as adults with any mental illness, substance use disorder, serious thoughts of suicide, etc (Mental Health America, 2019). This report also documented the nationwide prevalence of mental illnesses and highlighted the lack of resources available to this patient population (Mental Health America, 2019). New Jersey ranked among the states that have a lower prevalence and greater access to care. However, even with lower prevalence and better access to care in New Jersey a large proportion of psychiatric patients still end up in hospital emergency rooms in crisis within thirty days of discharge; highlighting a lapse in follow up care. There is a need to examine outpatient follow-up care options for psychiatric patients and identification of care deficits outside the hospital so that psychiatric patients in crises do not end up in emergency rooms.

This pilot study was designed to explore the feasibility of a call-back intervention to address the identified problem.

Background and Significance

In the United States, it was estimated that approximately 136 million people visited the emergency department in 2015 (Albert & McCaig, 2015). The Centers for Disease Control and Prevention (CDC) reported that out of these hospital visits, between the years 2009-2011 there were over 380,000 visits related to schizophrenia yearly (2015). Mental Health America (2019), reported that New Jersey ranked 27th on access to care. In 2018, 587,000 people with mental healthcare needs were unable to access mental health care in New Jersey (Mental Health America, 2019). In addition, 4,493 psychiatric patients in crises were seen in psychiatric emergency departments in Morris County alone (New Jersey Department of Human Services, 2018).

Many psychiatric patients are unemployed, depend on welfare and rely on Medicaid (Szabo, 2014). Laszo (2014) reported that in the U.S. caring for individuals who are not able to support themselves and need assistance can amount to over \$444 billion in healthcare costs each year. These costs affect each individual taxpayer and in order to avoid tax hikes and keep taxpayers/voters happy elected officials end up making budget cuts to monies allocated for

mental healthcare (Howard, 2018). Furthermore, budgets for Medicaid and Substance Abuse and Mental Health Services Administration (SAMHSA) were reduced by billions and many state institutions were forced to close limiting the capacity to provide inpatient care (Howard, 2018). From 1970 to 2014, 77.4% inpatient psychiatric beds have been cut across the country (Nitkin, 2018). These closings led to reduced access and more displaced individuals. In New Jersey, two major facilities were forced to close their doors. Marlboro Psychiatric Hospital closed in 1998 which had the capacity to care for 780 patients (New Jersey State Commission of Investigation, 1995) and Hagedorn Psychiatric Hospital closed in 2012 with 515 beds (Livio, 2011). Both were closed due to budget cuts in order to save money and reduce the over-reliance on institutions (Livio, 2011). To mitigate the reduction in the number of inpatient beds, New Jersey established 23 psychiatric screening centers to address the needs of the mental health patients in communities, but number of patients ending up in crises in psychiatric emergency departments has risen. This indicates a gap in continuity of care after discharge which leads to higher rates of readmission for crisis management.

Needs Assessment

According to the World Health Organization (2018), mental illness is a social and economic burden worldwide. With over 300 million individuals affected, the diagnosis of depression alone is one of the main causes for disability across most of the world (World Health Organization, 2018). In the United States, the population with mental illness is growing in numbers and suffering. The National Alliance on Mental Illness (2019) reported that one in twenty-five Americans are living with a serious mental illness which substantially interferes with one or more major life activities. Each individual state handles mental health crises as their budgets allow. John Hopkins Hospital in Maryland expanded its psychiatric emergency

department by adding two beds per unit to accommodate the increase in the number of patients with a mental illness. Yet Johns Hopkins Hospital reported that even with these added changes the emergency department continued to care for 400 psychiatric patients monthly (Nitkin, 2018). In Georgia, the judicial system began to provide comprehensive mental health services for individuals who suffer from a mental illness and are involved in the criminal justice system. The mental health services have shown an improvement in the length of stay in hospitals and jails by over 75%, saving the state over one million dollars the first year (Szabo, 2014). Unfortunately, this system is for the psychiatric needs of the incarcerated population and does not provide care to the general population in need. Carolinas Health Systems (2017), which have locations throughout the United States, has been offering a Mental Health First Aid course for free in an effort to recognize the stigma associated with the diagnosis and as a tool to address the nationwide issue of mental health. Overall, there is a huge disparity between the needs of people with psychiatric problems and the services available to them. This is particularly true for patients in psychiatric crises. In order to address the cycle of relapse into crisis identification of gaps in continuity of care, evaluation of outpatient services available and utilization of outpatient care must be undertaken.

In New Jersey the implementation of psychiatric emergency services has allowed for the state to evaluate the mental health crisis in each county. Each hospital state wide has trained staff available to evaluate patients in the emergency department for crisis. Each county has a designated screening center; the screeners from these centers are responsible to go into the community or other hospitals in order to assess what level of care is required. Once the patients are evaluated and found to be safe to discharge they are given referrals to Wellness and Recovery or other outpatient services. Wellness and Recovery is an outpatient resource that is staffed by

clinicians, psychiatric advance practice nurses and psychiatrists to aid in the therapy and medication management of psychiatric patients. However, there is a gap in continuity of care and after discharge there is no current policy set in place for follow-up from the psychiatric emergency department staff.

The state of New Jersey is now looking at readmission rates and is implementing a new protocol of Early Intervention Support Services (EISS) which would address this issue. EISS is funded by the state and is currently being contracted to ten counties in New Jersey. These services provide up to 30 days of outpatient treatment for individuals who are experiencing issues severe enough that it would place them at high risk for re-hospitalization. The staff at EISS also provides support for patients to help them avoid returning to the emergency departments. EISS support includes community outreach and linking with therapists and advance practice nurses within 48 hours of experiencing a crisis (Monmouth Medical Center, nd.) This program is making its way throughout the state, but it continues to be a work in progress, no results have been reported as of February 2019.

Current practices in psychiatric emergency services (PES) include referral to outpatient services through Wellness and Recovery (W&R) after evaluation, when the patient is deemed safe to be discharged back into the community. Then the manager in PES compiles a daily list to send to Wellness and Recovery for their clinicians to follow up. Once W&R secures the list, there is no current policy of follow-up. The current policy in place at Wellness and Recovery states; "patients who are admitted to Wellness and Recovery will be offered an appointment within 24 hours of first contact" (See Appendix A). Current policy used by W&R uses the Columbia Suicide Severity Rating Scale as part of the risk assessment and safety plan. This policy unfortunately does not cover the procedure of how the follow-up is set up, who

communicates with W&R and manages the patients in the interim. For the current management at PES this is not possible and at times is not being done until a month later. The lapse in followup care results in more emergency department visits and multiple presentations in PES. The numbers of patients being evaluated in PES for the past five years are as follows:

> FY 2018 – Total patients seen – 4493 – Total # back after 30 days – 220 FY 2017 – Total patients seen – 4358 – Total # back after 30 days – 233 FY 2016 – Total patients seen – 4038 – Total # back after 30 days – 197 FY 2015 – Total patients seen – 4177 – Total # back after 30 days – 230 FY 2014 – Total patients seen – 4177 – Total # back after 30 days – 215

As noted above the number of patients seen in crisis in PES increased by 7.5% from 2014 to 2018. The number of patients back in crisis in the emergency department within 30 days of evaluation also rose. This is a growing problem that needs to be addressed.

Problem/Purpose Statement

Many patients seen in PES for crisis are discharged with referrals to outpatient care but end up in emergency rooms within thirty days of discharge. There is a need to follow-up with discharged patients to bridge the gap and connect discharged patients with outpatient care. There are currently no written policies in place that follow-up with the patient after discharge from the psychiatric emergency department.

Clinical Question

Will implementing a follow-up phone call from a patient navigator within 48 hours of discharge from the psychiatric emergency services lower the number of patients seen in crisis within thirty days of first presentation?

Aim and Objectives

The aim of the pilot study was to explore the feasibility of a patient navigator follow-up phone call intervention to address high rates of readmission to the PES by bridging the gap between PES and W & R in order to improve the quality of continuity of care and patient outcomes in the future. The objectives were as follows.

- 1. To develop a policy for psychiatric emergency services discharge follow-up.
- 2. To add a follow-up phone call intervention within 48 hours of discharge from PES.
 - a. Train patient navigators to make follow-up calls.
 - b. Create a script, so that every phone encounter with the patient would ask specific pertinent information and be linear.

Review of the Literature

A review of the literature was conducted between February and March 2019 by the primary investigator in order to objectively consider the research that has focused on the clinical question at hand. The question was: "Will implementing a follow-up phone call within 48 hours of discharge from the psychiatric emergency services lowers the number of patients seen in crisis within thirty days of the first presentation?" Initially, PubMed, PsychInfo, CINAHL, and Wiley Online were searched. The key search terms that began the search included: psychiatric patient, emergency and follow-up call. Each database entailed different search criteria in order to narrow results. The key terms for searching specific population included *psychiatric patient, emergency department, and psychiatric*. The search terms for outcome were: *readmission, post-discharge,* and *discharge*. As for intervention the key terms were: *telephone follow-up, callback,* and

intervention. These search terms used in different combinations as inclusive. Within each individual group; such as population or intervention, the Boolean term 'OR' was used. As the inclusion of all terms noted the Boolean term 'AND' was utilized. Filters were then applied to each database used to yield over 100 articles. The attached PRISMA flow diagram further illustrates the breakdown of the search with filters see Appendix B. The databases were examined and the process of elimination helped to develop the final review of core sources which were included in the table of evidence in Appendix C.

The first database assessed, PubMed, retrieved a total of 180 sources when all four key term categories (population terms, outcome terms, and intervention terms) were combined prior to filters being applied. Filters applied were full text, 5 years as timeframe, and only human subjects, resulting in 65 total sources. The 65 sources were further evaluated to further narrow down to exclude non-psychiatric patients. This resulted in three sources that were included for final review from this database.

Database PsychInfo yielded 241 sources when all 4 key terms were combined. With the use of filters that included full text, English language, and within the timeframe of 2014-2019 the results narrowed down to 88 sources. These sources were then evaluated further and three research articles were included for final review.

A search of CINAHL yielded 191 entries that included the four key term categories when combined. Once full text, the timeframe of published works 2014-2019, and English language filters were applied there were 45 sources left. These were further reduced by using the exclusion criteria used in the prior two searches and this group was also narrowed down to two remaining studies for final review. Finally, Wiley Online library database was searched and yielded 62 results using the four key term categories. Once again, full text, published between 2014-2019, and English language filters were applied, which narrowed the search to 27 articles. After further analysis, two research articles were included in the final review.

Grey literature on the topic was searched with the help of Google and the Mental Health Association (MHA) website. The search terms used were: *follow-up call, psychiatric patient, and emergency department*. This found two position statements about behavioral crises. These stated that individuals with mental illness encounter barriers to care due to lack of resources (Mental Health Association, nd). The MHA stated that obtaining more respite and crisis centers would reduce hospitalizations. These two position statements were found to be relevant to the project and were used in the final review of non-research evidence.

Psychiatric patients who visit an emergency department in crisis are given instructions on discharge and follow-up care. However, adherence to medical and psychiatric recommendations is low. Studies found that patients who were discharged from facilities were more likely to follow through with discharge plans if they received some type of follow-up intervention (Boudreaux, et. al, 2016; Gould, et al., 2018; Seaberg, et al., 2017; Stanley, et al., 2015). Interventions, such as a telephone call from a provider from the emergency department, made continuity of care easier on the patient (Boudreaux, et. al, 2016). Stanley, et al., 2015 found that the combination of interventions such as telephone follow-up and a safety plan increased outpatient behavioral health appointment attendance after a crisis. The link between crisis and recovery relies heavily on the patient, who at the time may be in a vulnerable state (Mental Health Association (1) (2), nd). Support services are a key component to adhering to aftercare instructions which will then lead to increased patient safety and improved patient outcomes.

Patient safety and outcomes can be quantified by the cost of each visit to the emergency department. Insurance companies and Medicare have started to penalize facilities that have higher rates of 30-day readmission of patients. The penalties can range from lowering reimbursement rates or not paying for certain diagnosis (Centers for Medicare and Medicaid Services, 2019). The cost of healthcare has been on the rise, which leads to improvement needs in preventative care measures. Studies show that it is cost effective to implement interventions for individuals being discharged from emergency departments (Denchev, et al., 2018; Heyland & Johnson, 2017; Seaberg, et al., 2017). Seaberg, et al., (2017) found that specifically using patient navigators facilitated patients in access to care and in finding barriers. Having this role in the hospital also was correlated with lowering cost and additional hospital visits. Increasing preventative measures for patients who are discharged from emergency departments will not only aid hospitals financially but also create a more patient-centered environment.

Patient-centered care is based on patients becoming more of an integral part of their care decisions. This autonomy allows for the patients to feel that what they feel is important and valued by their clinicians. Multiple studies showed that the use of interventions helped to make the patients feel hope and interested in their care (Cebria, et al., 2013; Ghanbari, et al., 2015; Gould, et al., 2018; Luxton, et al., 2013; Mousavi, et al., 2016). This positive trend in patient outcomes also lowered the risk of suicide attempts, suicide thoughts, and suicide reattempts. Patients felt accountable for their actions and helped in reducing their usage of the emergency department. These results reinforce the need to supply patients with support from discharge to follow-up, in order to increase patient satisfaction and safety.

During this literature review, there were several limitations discovered which may have an impact on the generalizability of the results. One limitation in multiple studies was that the population studied were patients who suffered from suicidal thoughts or those who have recently attempted suicide (Cebria et al., 2013; Denchev et al., 2018; Ghanbari et al., 2015; Gould et al., 2018; Luxton et al., 2013; Mousavi et al., 2016; Stanley et al., 2015). These results may limit the use of such interventions on improving patient outcomes for patients with other psychiatric diagnoses. All of the above-mentioned studies were also based on adult subjects ages 18 and over, so this would also limit the results if used with younger populations. In addition, researchers used different types of interventions, different duration of intervention and follow-up. For example, Cebria et al., (2013) noted that the patients in their study were contacted within 1 week, and again at 1, 3, 6 and 12 months. Whereas the study conducted by Heyland & Johnson (2017) followed patients for only the first 30 days after presentation. Many of the studies used more than one intervention. Overall interventions that supported the patient after discharge reported positive outcomes and improved mental health.

In summary, the reviewed literature reported consistent positive results for patients who had follow-up contact after being discharged from the emergency department. Follow-up interventions lessened the cost to the facility and improved outcomes for patients. Multiple articles also found a correlation between follow-up and compliance with outpatient (Boudreaux, et. al, 2016; Gould, et al., 2018; Seaberg, et al., 2017; Stanley, et al., 2015). Patient's response to the added level of interaction after discharge was also noted to have a positive trend. These findings highlight the effectiveness and need for creating a patient navigator role in emergency psychiatric departments.

Based on this literature review follow-up support of psychiatric patients after discharge from the emergency room after a crisis can improve the patients' health as well as reduce the risk of relapse following discharge.

Theoretical/Conceptual Framework

The Knowledge to Action (KTA) theoretical framework guided this project implementation. This framework was composed of two separate but integral sections: the creation of knowledge and the cycle of action (Field, Booth, & Gerrish, 2014). The two separate parts work individually and in conjunction. Knowledge creation includes identification of a problem and understanding the content of knowledge already in place. This leads to the active component of the framework in which an intervention is implemented. Barriers and facilitating factors are identified and inform the intervention. This is an iterative process and involves modification as needed. Evaluation process is also embedded and informs the implemented intervention. At conclusion, when the cycle is complete a monitoring of knowledge created and usage can be assessed (Dearholt & Dang, 2012).

Based on the review of the literature and the KTA framework, a follow-up intervention was conceptualized. The project started with an assessment and evaluation of the current practice in the psychiatric emergency department. Then, possible barriers and facilitating factors for the follow-up intervention were identified in coordination with stakeholders. A patient navigator role was designed to implement the follow-up intervention. A script was developed for the phone call and patient navigators who administered the follow-up calls were identified and trained. After training, the functionality of the role was assessed and then integrated in the psychiatric emergency department.

Methodology

Design of Project

This was a quality improvement project that examined the feasibility of a patient navigator follow-up phone call intervention in a psychiatric emergency department. Process and outcomes evaluation methods were used to assess the implementation of the intervention and pre and post intervention readmission rates.

Setting

The setting was a psychiatric emergency department in a suburban Northern New Jersey hospital. This facility reports over 4000 patient visits per year. In 2018, 220 patients were seen within thirty days of a crisis presentation in the psychiatric emergency department.

Study Population

No actual patients were recruited. Pre-intervention admission records, follow-up phone call logs and post intervention admission records were used to evaluate the intervention.

Subject Recruitment

No patients were recruited for this study. Two psychiatric emergency department current nursing employees were trained as patient navigators as per the developed intervention.

Consent Procedure

No consent was needed.

Risks/Harm/Ethics

There were no risks/harm to the participants during this study.

Subject Costs and Compensation

There was no cost involved in this study to the facility.

Study Intervention

The aim of this project was to investigate the feasibility of a patient navigator call-back (follow-up) intervention in the psychiatric emergency department. The intervention included the development of a follow-up policy and follow-up call, training of patient navigators and implementation of a call-back strategy in the psychiatric emergency department.

Background

The role of a patient navigator has been researched in multiple medical areas and originally started by Harold P. Freeman in 1990. This concept was originally created to address the barriers that patients encountered from cancer screenings, diagnosis, treatment and supportive care (Harold P. Freeman Patient Navigation Institute, nd.). Barriers that have been found to be experienced by patients across modalities are the following: financial barriers (including uninsured and under insured), communication barriers (such as lack of understanding, language/cultural), medical system barriers (fragmented medical system, missed appointments, lost results), psychological barriers (such as fear and distrust), and other barriers (such as transportation and need for child care) (Harold P. Freeman Patient Navigation Institute, nd.).

The role of the navigator is to provide support by following up with the patients after discharges from the emergency department and addressing identified barriers. The nursing staff who received the training as patient navigator were selected by the psychiatric emergency department manager and were required to have behavioral health background and training. Two patient navigators were trained as per the proposed intervention.

Intervention Process

The following steps delineate the procedure.

a. Developing a follow-up/navigation protocol.

i. A policy was developed for psychiatric emergency services discharge follow-up.

ii. The follow-up call.

a. A script was developed for the patient navigator to follow for each follow- up phone call. This script included questions pertaining to what the discharge instructions and referrals were, if barriers were encountered, what they were, how likely were patients to keep their post discharge appointments to outpatient services after a follow-up call (See Appendix E). The navigators kept a log of all follow-up calls.

b. A follow-up phone call was made to patients who received referrals to outpatient services within 48 hours of discharge from the psychiatric emergency room.

c. Patients were informed about the follow-up call as part of the discharge process. At this point verification of the best way to reach patient and times was assessed.

b. Implementation of the follow-up phone call with script.

i. Patient navigators were trained.

ii.Patient navigator follow-up phone call program was initiated.

c. Evaluation of the intervention

i. The rate of readmission before and after the patient navigator followup was implemented was compared: November 2018 thru February 2019 compared to November 2019 thru February 2020.

Outcomes Measured

The outcome of interest was the change in the number of patients seen in the psychiatric emergency department within thirty days of their first crisis presentation after the intervention was implemented.

Project Timeline

Project planning and development phase began in January 2019. The project was presented to the team members in May 2019. IRB approval was obtained on August 16, 2019. Recruitment began in September 2019. Project was implemented once IRB approval had been acquired in August 2019. Training of the two patient navigators began in September and completed by the end of October 2019. Project was implemented and data collection took place From November 2019 to February 2020. Evaluation, writing and presentation of DNP project occurred between February and May 2020. (See Appendix F)

Resources Needed/Economic Consideration

The costs incurred during this project were the sole responsibility of the primary investigator. These costs included training supplies and research expenses. The budget table is located in Appendix G.

Results

The project was implemented at the selected psychiatric emergency department in October 2019.

Process Evaluation

Process evaluation indicated that a policy for follow-up calls was drafted in coordination with stakeholders as proposed. Two staff were identified by hospital administration to be trained as patient navigators. Training involved following the script when making follow-up calls and keeping a log of all patients contacted. Once training was completed, patient navigators began to make phone calls from November 1, 2019 until February 29, 2020.

The Drafted Policy

1. Persons eligible for services are offered multiple recommendations when initially evaluated and given the information that they will receive a follow-up phone call from a patient navigator.

a. Within 48 hours of discharge from emergency services patient will be given a follow-up phone call to assess for risk and barriers to follow-up.

 b. During this time the patient navigator will help the patient navigate the referrals given and aid in making further attempts to gain an appointment or the patient's need to be reevaluated if risk is high.

2. Persons seen as high risk will have a welfare check mandated while on the phone with the patient navigator and the possibility of a community mobile may arise.

3. Through this process the patient's safety is the main priority of the patient navigator and hospital staff. Following the algorithm which is filled out during each phone call will aid in making quick assessments.

4. Assessments may include Columbia Suicide Severity Rating Scale, and if applicable a Safety Plan.

The Intervention

Follow-up phone call script. Appendix E includes the phone call script.

Patients contacted. Follow-up phone calls were made to adult patients that were: (1) seen in crisis at the psychiatric emergency department, (2) were not found to need psychiatric admission, and (3) were discharged with outpatient referrals.

During this time an excel sheet was created to track the following:

- Patient follow-up with discharge referral
- Current risk level
- Barriers encountered in following discharge instructions/referrals

Outcomes Evaluation

After the completion of the patient navigator phone call for follow-up, data analyses began. Follow-up phone calls were made from November 2019 until the end of February 2020. A total of 322 calls were made. A comparative analysis of admissions data for psychiatric patients was conducted for the period of November 2018 to February 2019 and November 2019 to February 2020 to assess the intervention. These data were obtained from the statistical information sent to the state on a monthly basis. There were 1441 patients seen in PES from November 2018 to February 2019 while 1357 patients were seen between November 2019 to February 2020. There was a 5.83% decrease in the number of patients presenting to the PES between the two comparison periods (Appendix H). The number of 30 day readmission rates was also compared. There were a total of 186 readmissions to the PES between November 2018 to February 2019 (comparison period), which was 12.91% of the total patients seen. While 157 readmissions were reported during the intervention period (November 2019 to February 2020), which is 11.57% of the total patients seen. There was a 15.59% decrease in the number of 30day readmissions after the implementation of the follow-up phone call.

Each patient that was called back for follow-up was asked about follow-up with their discharge referral, assessed for current risk level and any barriers encountered following discharge. Out of the 322 patients 109 (33.8%) were able to follow through with the discharge recommendations from PES. The remaining 213 patients were unable to follow-up due to the following barriers (Appendix I):

- No insurance/ High cost
- Availability of appointments

- Not available/No answer/Wrong number/Number disconnected
- Language barrier
- Refuses follow-up care

Barriers to follow-up can be divided into two categories. The first was encountered by the navigators making the follow-up calls. Out of the 322 patients called, 187 could not be reached because the phone service was disconnected, there was no answer, the number was unreachable, and the patient was not available. Of the barriers reported by patients, health insurance coverage of benefits was most often cited. The providers patients were referred to either did not accept their insurance or out of pocket costs were too high. Another barrier was related to scheduling appointments. In some cases appointments conflicted with work or school schedules and in other cases limited to no evening or weekend appointment availability. Additionally, there were some patients who found that there was a language barrier when scheduling follow-up. Patients whose first language is not English had a difficult time following discharge instructions due to not being able to communicate with the staff in outpatient.

Maintenance and Security

During the data collection no identifiers were used in order to maintain records. Patient data such as name, contact info and discharge recommendation were mined from the PES follow-up book which remains on the unit at all times. Each call was assigned a number that was only recorded on the follow-up algorithm worksheet with no patient data. Training materials and call back lists are kept confidential in the psychiatric emergency services management office. Only the psychiatric emergency services manager has access to this information. Upon completion of this study all data will be destroyed according to the Rutgers University guidelines.

Discussion

The purpose of this quality improvement pilot study was to examine the feasibility of a patient navigator follow-up phone call intervention in a psychiatric emergency department with the goal to decrease the number of 30 day readmissions. The results of this study indicate that a follow-up phone call is feasible and can reduce the number of readmissions to PES and align with previously published research. Multiple studies have shown that follow-up phone calls not only improve outcomes for patients but also help in identifying barriers encountered which aligns with the results from the current study (Boudreaux, et. al, 2016; Cebria, et al., 2013; Denchev, et al., 2018; Ghanbari, et al., 2015; Gould, et al., 2018; Heyland & Johnson, 2017; Luxton, et al., 2013; Mousavi, et al., 2016; Seaberg, et al., 2017; Stanley et al., 2015). Exbrayat et. al. (2017) also reported a reduction in suicide attempts in patients who were followed up by a phone call after being seen in a psychiatric emergency department. A narrative review by Ghanbari et al. (2017), found that multiple studies showed that an increase in follow-up services made a significant difference in minimizing suicidal behaviors. The National Suicide Prevention Lifeline proposed the case that follow-up aftercare is an important and effective intervention to increase patient safety (2014). Additionally, follow-up care is a standard in care on medical units and should also be considered a necessity when dealing with patients suffering from a psychiatric crisis. In order to maximize continuity of care between emergency department crisis and outpatient services it is vital to make contact and identify barriers that keep patients from complying with their outpatient recommendations.

Some limitations were encountered in the conduct of this study. First, the study was implemented at only one PES location in a county in New Jersey. Hence, the total number of 30day readmissions may be an under estimation because some patients may have been admitted in crisis to a different hospital in the area. The sample population may not be representative of the population of New Jersey. All call backs were only administered to adult patients who were seen in crisis at the given location, no children and adolescents were a part of this study which would also limit generalizability. A large number of patients could not be followed-up because the phone service was disconnected, there was no answer, the number was unreachable or the patient was not available, therefore their outcomes could not be determined.

Overall, the project was well received, and stakeholders praised the intervention during the monthly behavioral health meeting and the project will be implemented as standard practice in the near future. The feasibility of the patient navigator project was established.

Implications

This pilot study used the Knowledge to Action theoretical model as framework. The following will discuss the implications to clinical practice, healthcare policy, quality and safety, education and economic benefits from this pilot study.

Clinical Practice

The role of patient navigator is currently used in many medical units as a resource to connect the patient with the resources needed. This study found that implementing a follow-up regimen in a PES is feasible and received well by the stakeholders. PES around the country can train a patient navigator to follow-up with discharged patients, thereby reducing readmissions as well as reducing costs. There was no follow-up from this department after discharge.

Healthcare Policy

The results of this study may influence changes in policy at the site of implementation and other psychiatric emergency departments like it. Adding a follow-up phone call to the discharge process by a patient navigator positively affected the outcomes of patients by reducing the number of 30 day readmissions. The policies at the selected site did not include follow-up phone calls by the psychiatric emergency department. Thereby, approximately 30% of individuals seen in crisis were not being supported after discharge from the PES. Multiple studies have shown that support after a crisis is needed and improves outcomes by reducing the number of readmissions to PES. Changing policy would allow for transition of care follow-up to become common practice. Each organization would be able to keep track of outcomes by better identifying their community's specific needs and barriers. The follow-up policy developed for this project was based on evidence from best practices and outlines follow-up processes to improve patient outcomes, and uniformly track care to maintain continuity of care for patients discharged from PES.

On a global level there is a need for countries to begin to initiate national prevention strategies that address the worldwide mental health crisis. The World Health Organization (2019) reported that suicides are preventable if there is a multisectoral approach that addresses effective preventive measures. These measures include follow-up care and community support which aligns with the results of the current study.

Quality & Safety

Quality improvement and safety is a main goal for most healthcare facilities and organizations. By improving the quality of care after discharge mental health crises can be

prevented. Mental health crises can be averted by identifying barriers and linking patients to outpatient resources. Therefore, follow-up on referrals and assisting with appointments will improve not only outcomes but quality of care.

Education

As the study results have shown, providing an added level of support by creating a new discharge follow-up protocol is a key component of better mental health outcomes. During the initial 48 hour period following discharge the patient is in need of added support and guidance which can only be given by trained individuals. Staff education should include a follow-up protocol in the decision tree as this is a key time to reach each patient following a crisis and can help in recognizing barriers experienced by patients. It is essential to educate healthcare workers on early identification of risk factors and treatment needs following discharge. Patients may also be provided with relevant information based on their evaluation outcomes and needs assessed during initial intake and follow-up phone call.

In addition, there is a shortage of mental health provider across the US. Many patients who are given referrals for follow-up find it difficult to get an appointment right away. Psychiatric emergency departments should be aware of these provider shortages and plan followup accordingly.

Economic

This pilot study suggests economic implications for hospital systems. Psychiatric patients account for 1 in 8 visits to the emergency department yearly. The Agency for Healthcare Research and Quality (AHRQ) reported that there has been a rise in psychiatric emergency visits by more than 50% (2014). Medicare and other insurance companies either do Version 3.28.20

not cover or partially cover multiple visits within thirty days presentation in emergency departments (Centers for Medicare and Medicaid Services, 2019). All of this creates a financial hardship not only for the health system but for the patient and their family. Each emergency department visit costs approximately \$2264 per visit (Healthcare Financial Management Association, 2019). If calculated in reference to the number of patients being seen in this psychiatric emergency department that is a cost of over 10 million dollars a year for 4500 patients in 2019 and a loss of 498,000 dollars on 30-day readmissions. These costs can add up and become a financial burden for individuals, states and the US. By using available resources after discharge, high cost emergency readmissions can be avoided.

Sustainability

This DNP pilot study is the initial step in changing the policies and procedures at the selected site. Improving overall patient outcomes is the end goal. Implementing the follow-up phone call policy will allow staff to reach out to patients after discharge, offer support for appointments, assessing risk and identifying and addressing barriers to ensure continuity of care and reduce 30-day readmission to the PES. The results of this study indicate that this intervention is feasible. The results will be presented at the monthly behavioral health management meeting at the site. The manager of PES will continue to collect and analyze more post-implementation data to see if this new protocol continues to improve outcomes and this study protocol may also be implemented on the psychiatric inpatient floors.

Future Scholarship

The results of this project will be disseminated in poster and written form at multiple meetings. Poster presentation will begin at Rutgers University during DNP poster day in the

spring of 2020 and then at the monthly behavioral health management meeting. The monthly behavioral health management meeting is attended by the heads of all 23 PES crisis centers across New Jersey. Findings will also be presented at the Mental Health Association State meeting. Finally a manuscript will be submitted to the American Psychiatric Association.

Future studies should also follow-up with pediatric and adolescent patient's families as this population accounts for a large section of patients that are being seen in psychiatric emergency departments.

Conclusion

Supporting patients after a crisis is an essential step in the recovery process. As this pilot study has shown a follow-up phone call can significantly change outcomes of patients after crisis interventions from psychiatric emergency services due to the added level of support. The impact that these results will have on the care of psychiatric patients will continue to be assessed and improved upon depending on the population and resources at hand. The role of a patient navigator follow-up phone call continues to be a key element of outpatient psychiatric care. Further studies would be recommended in order to assess if this intervention would also be helpful in children and adolescents. A longitudinal study may also be able to better assess if throughout the year the number of 30 day readmission rates would be lowered by the utilization of a patient navigator call back. Ultimately in order to better assist the communities we serve, there needs to be an added level of support outside the hospital.

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		O BEHAV	UTPATIENT VIORAL HEALTH
Policy Name: Wellness and Recovery C Comprehensive Risk Assessment and Plar	enter: 1 of Ca	re	Dept.#
Date: 7/1/12	Revis	ion Date: 2	/15/2016
Approved by:	•		

Appendix A (Current Wellness and Recovery Policy)

POLICY STATEMENT:

It is the policy of **Sector Center receive a comprehensive risk assessment, identification of** immediate needs, and individualized Plan of Care with a primary goal of stabilizing the identified crisis and linking the person to the next level of care, as needed.

PROCEDURE:

1. Persons eligible for services are offered an appointment to the Wellness and Recovery Center within 24 hours of first contact to the program. The person may be scheduled for an appointment

or may come to the program as a walk-in without an appointment. The person is registered and participates in a financial screening at that time.

c. If the person does not show for the initial appointment, the clinician will contact the client by phone immediately. Within 24 hours, the referral source, if indicated, will also be contacted by phone. If the Initial Contact form indicates high-acuity symptoms, then an outreach will be completed within 24-72 hours of the missed appointment based on staff availability.

2. During registration an Authorization for Treatment form is signed noting that the individual's Rights and Responsibilities Booklet and Patient Information Guide are given to the person at that time.

- 3. The person is seen for the initial assessment by the clinician. Depending on the person's pre-admission assessment, this appointment may also involve a psychiatric evaluation.
- 4. Information and data is gathered with the individual to complete:
 - Health History Form
 - Consumer Learning Assessment
 - Plan of Care
 - Comprehensive Risk Assessment, including specialty modules as appropriate, and Treatment Diagnosis

- Authorization to Disclose Information form (where indicated)
- Columbia Suicide Severity Rating Scale, and if applicable a Safety Plan

5. At the time of intake, each person's physical and psychological status and social functioning are assessed. The person's identified service goals are developed with their input and a

provisional Plan of Care is developed.

6. In the event the person is assessed to be in crisis or at risk at the time of the intake, a psychiatric consult will be obtained with possible linkage to the Psychiatric Emergency Service (PES).

7. The following data is gathered during the Comprehensive Risk Assessment:

•Intake information review including demographic data, referral source, and identification of language and interpretation needs

- Presenting problem including current emotional and behavioral functioning, desired goals and valued roles, barriers, stressors and level of motivation for change
- •Mental status evaluation
- Risk Assessment including trauma history and current risk potential
- •Community resources utilized

•Mental health and substance abuse treatment history, including history of emotional and behavioral problems and response to treatment

- •Addictive behaviors and substance abuse screening
- Provision diagnosis and recommended level of care
- •DSM-IV-TR diagnosis and recommended level of care.
- 8. The clinician presents the intake at the next regularly scheduled treatment team meeting or daily morning meeting to review the disposition and recommended plan of care. Input from the team meeting/morning meeting is integrated into the overall service plan. Referral and linkage to other services is made, as appropriate.
- 9. All new enrollees are offered a follow-up contact within 2-3 days of the initial assessment. Contact type will be determined by the treatment team relative to the nature of the client's specific need and may include face-to-fact contact with a clinician, prescriber, or peer, or support calls. All appointments are generally offered within 48-72 hours following a client's initial assessment. The clinician will document in the EMR if a client declines an appointment in preference to one offered at a later date. The frequency of appointments are contingent on a client's needs and preferences. Clients typically are provided service no longer than 30 days. Additionally, the option of being placed on support calls will be discussed at intake with all new enrollees who may decide, in collaboration with the clinician, if this would be beneficial.

Appendix B: PRISMA Flow Diagram



PRISMA 2009 Flow Diagram



Appendix C: Table of Evidence

EBP Question: "Will implementing a follow-up phone call from a patient navigator within 48

hours of discharge from the psychiatric emergency services lower the number of patients seen in

crisis within thirty days of first presentation?"

P (population) = psychiatric patients

I (intervention) = follow-up call

C (comparison) = current policy (no follow-up call)

O (outcome) = lower the number of patients seen again in crisis within thirty days

T (time) = 3 month period

Article #	Author & Date	Evidence	Sample,	Study findings	Limitations	Evidence
		Туре	Sample Size,	that help answer		Level &
			Setting	the EBP		Quality
			-	Question		
1	Jason G. Boudreaux,	Quantitative	Sample:	Using a mobile	The study was	Level:
	Kathleen		Adult patients	outreach	done in three	III
	Crapanzano., Glenn		age 18 years	program to	stages which	Quality:
	Jones, Thomas		and older	explain the	do not take	В
	Jeider, Vincent		who were	discharge	into	
	Dodge, Marianne		sent from the	process and the	consideration	
	Hebert, & Jan		emergency	resources made a	what the	
	Kasofsky		room to the	seamless system	patient's	
	(2016)		Mental	of care.	baseline may	
			Health		have been at	
	Citation:		Emergency	Patients who had	different	
	Boudreaux, J.,		Room	contact with	phases	
	Crapanzano, K.,		Extension	providers over	(baseline,	
	Jones, G., Jeider, T.,		over 32	the phone after	transition,	
	Dodge, V., Hebert,		months.	discharge from	outreach) in	
	M., & Kasofsky, J.			the Mental	the study.	
	(2016). Using		Sample Size:	Health		
	Mental Health		1111 patients	Emergency	Data was	
	Outreach Teams in		from rural	Room Extension	observational	
	the Emergency		and urban	were more likely	and not	
	Department to		setting.	to attend their	random.	
	Improve			first outpatient		
	Engagement in		Setting:	appointments.		
	Treatment.					
	Community Mental			Making the		
	Health Journal,			connection		
	52(8), 1009–1014.			between the		

	https://doi.org/10.10 07/s10597-015- 9935-8			crisis and the aftercare easier on the patient.		
2	Ana Isabel Cebria1, Iris Pérez- Bonaventura, Pim Cuijpers, Ad Kerkhof, Isabel Parra, Anna Escayola, Gemma García–Parés, Joan Carles Oliva, Joaquim Puntí, David López, Vicenç Valles, Montserrat Pamias, Ulrich Hegerl, Victor Pérez-Sola, and Diego J. Palao (2013) Citation: Cebria, A., Pérez- Bonaventura, I., Cuijpers, P., Kerkhof, A., Parra, I., Escayola, A., Palao, D. (2015). (2013). Effectiveness of a telephone management programme for patients discharged from an emergency department after a suicide attempt: Controlled study in a Spanish population. <i>Journal</i> <i>of Affective</i> <i>Disorders, 147</i> (1-3), 269–276. https://doi.org/10.10 16/j.jad.2012.11.016	Quantitative	Sample: Convenience Sample Size: 991 patients from two different sites Setting:	Patients who were discharged from Sabadell after a suicide attempt were given a follow- up phone call protocol for a year. The control group was based out of the second facility Terrassa, who received no follow up calls. The group with the intervention had a reduction of the rate of reattempt of suicide in comparison to control group. (Sabadell 6% and Terrassa 14%)	Limitations: Difficulty contacting all the patients in the given time frames of the intervention (1 week, 1-3-6-12 months) Patients under the age of 18 years undergo an intensive intervention during the day in the hospital.	Level: II Quality: B

41

3	Peter Denchev	Ouantitative	Sample:	This study found	Limitations:	Level:
-	Ph.D., Jane L.	C	Random	that not only is it		V
	Pearson Ph.D.,			cost effective to	Emergency	
	Michael H. Allen		Sample Size:	implement	departments	Ouality :
	. M.D., Cynthia A.		unknown	interventions for	vary, which	B
	Claassen Ph.D.			patients after	could result in	
	Glenn W. Currier		Setting:	suicide attempt	the inability to	
	M.D., M.P.H.		Emergency	or ideation: they	generalize	
	Douglas F. Zatzick		departments	also have a	these findings.	
	. M.D., Michael		••• r •••••••	positive effect on	8.	
	Schoenbaum			patients		
	PhD (2018)			outcomes.	Limited	
					evidence	
	Citation:			The use of three	exists, results	
	Denchey, P.,			interventions:	are based upon	
	Pearson, J., Allen,			postcards.	studies done in	
	M., Claassen, C.,			follow-up calls,	the past with	
	Currier, G., Zatzick,			and CBT.	the use of	
	D., & Schoenbaum,				these	
	M. (2018).				interventions.	
	Modeling the Cost-					
	Effectiveness of					
	Interventions to					
	Reduce Suicide Risk					
	Among Hospital					
	Emergency					
	Department					
	Patients. Psychiatric					
	Services, 69(1), 23-					
	31.					
	https://doi.org/10.11					
	76/appi.ps.2016003					
	51					
4	Behrooz Ghanbari, ¹	Qualitative	26 studies	Studies show	Limitations:	Level:
	Seyed Kazem	Narrative		that contact with		III
	Malakouti, ¹ Marzieh	review		the patient after	More RCT	
	Nojomi, ² Kaveh			being discharged	must be done	Quality:
	<u>Alavi</u> , ¹ and <u>Shiva</u>			has positive	in order to	В
	Khaleghparast ³			outcomes and	assess which	
	(2015)			reduction in	interventions	
				suicide	work best.	
	Citation:			reattempts.		
	Ghanbari, B.,					
	Malakouti, S.,			78.8% of		
	Nojomi, M., Alavi,			patients		
	K., Khaleghparast,			receiving phone		
	S., & Ghanbari, B.			follow-ups		
	(2015). Suicide			expressed it as		
	Prevention and			useful, 40.4% as		
	Follow-Up Services:			effect on their		
	A Narrative Review.			lives and 29.4%		
	Global Journal of			considered it		
	Health Science,			positively on		
	8(5), 145–153.			preventing		
	https://doi.org/10.55			suicide		

	39/gjhs.v8n5p145			reattempts.		
5	Madalum C. Cauld	Minad	Complet	The fellow up	Limitational	Lavalı
5	Maderyn S. Gould,	Mixed-	Sample:	The follow up	Dimitations:	Level:
	Alison M. Lake,	method	Random	call had stopped	Depending on	11
	Hanga Galfalvy,		~ . ~.	them from	the client's	
	Marjorie Kleinman,		Sample Size:	killing	self-report	Quality:
	Jimmie Lou		550 callers	themselves and	alone to	В
	Munfakh, James		who	had kept them	determine the	
	Wright, and Richard		expressed	safe.	value of the	
	McKeon		suicidal		follow-up	
	(2018)		ideation	The more follow	intervention	
	× ,		within	up phone calls	may be a	
	Citation:		48 hours of	the safer the	limitation due	
	Gould M S. Lake		their crisis	client felt and	to consistency	
	A M Galfalvy H		call were	ended up being	to consistency.	
	Kloinman M		aligible for	(2 calls aquatas	No	
	Munfoldh I I		follow up	(2 can's equales	domographia	
	Waight I &		ionow-up	colla four times	information	
	wright, J., α		C	cans four times	Information	
	McKeon, R. (2018).		Setting:	the odds)	was obtained	
	Follow-up with		S1x cr1s1s		from	
	Callers to the		centers in the		individuals	
	National Suicide		Lifeline		that were not	
	Prevention Lifeline:		network from		followed up,	
	Evaluation of		across the		making it	
	Callers' Perceptions		four U.S.		difficult to	
	of Care. Suicide &		census		compare the	
	Life-Threatening		regions		lack of	
	Behavior, 48(1), 75–				intervention	
	86. https://doi-				vs. the	
	org.proxy.libraries.r				intervention.	
	utgers.edu/10.1111/s					
	1tb.12339					
6	Michelle Heyland &	Qualitative	Sample:	Patients were	Limitations.	Level
Ũ	Mary Johnson	Quantantito	Convenient	given a follow	Limitations.	III
	(2017)		Convenient	up phone call 30	Not everyone	
	(2017)		Sample Size	days after the use	that visited the	Quality
	Citation:		16 clients	of the crisis	respite center	Quanty.
	Howland M &		10 chemis	respite contor	consonted to	C
	Lehran $M_{\rm c}(2017)$		Satting	respire center.	the study so	
	Johnson, M. (2017)		Setting.	0.40 of potionts	the require one	
	Evaluating an		Emergency	94% of patients	the results are	
	Alternative to the		respite center	and not require	not	
	Emergency		in Chicago.	ED use within 30	generalizable.	
	Department for			days. (15/16)		
	Adults in Mental				Sample size is	
	Health Crisis, Issues				small, so it is	
	in Mental Health				difficult to	
	Nursing, 38:7, 557-				determine if	
	561, DOI:				this tool would	

	<u>10.1080/01612840.2</u> <u>017.1300841</u>				be effective in this population.	
7	David Luxton, Jennifer June, and Katherine Anne Comtois (2013) Citation: Luxton, D., June, J., & Comtois, K. (2013). Can Postdischarge Follow-Up Contacts Prevent Suicide and Suicidal Behavior? A Review of the Evidence. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 34(1), 32–41. https://doi.org/10.10 27/0227- 5910/a000158	Quantitative	Sample: 11 studies – 10-randomized control trials 1- quasi- experimental Sample Size: Ranged from 128-1867 individuals Settings: Emergency departments and hospitals in multiple countries (France, Sweden, Iran, New Zealand, Cedereke, Monti, Ojenhagen, and Vancouver)	Three out of eleven studies showed significant reduction in repeat suicide attempt. Four studies showed trends towards a preventative trend. Overall studies showed that post-discharge interventions can be effective in reducing suicide deaths, attempts, and ideation.	Limitations: The interventions may not have been homogeneous. (variance in timing, number of and frequency of follow up contacts) More specific as to what about the intervention was most helpful. It may be difficult to determine if the interventions could be used for all patients with mental illness, not just to prevent reoccurrence of suicide.	Level: II Quality: B

0	Mantal Haalth	Desition	Comises and	T and 1
8	Mental Health	Position	Services are	Level:
	Association (1)	Statement 59	needed to reduce	IV
			occurrence of	
			mental health	Quality:
			crisis.	В
			Noted that	
			interactions with	
			individuals with	
			montal illnoss in	
			mentar miness m	
			crisis often result	
			in actions that	
			significantly hurt	
			recovery.	
9	Mental Health	Position	MHA position	Level:
	Association (2)	Statement 71	on promoting	IV
			wellness and	
			recovery and	Ouality:
			prevent mental	B
			illness and	2
			identify people at	
			risk as soon as	
			aumptoms	
			symptoms	
			become	
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10	Seved Ghafur	Quantitative	Sample:	Suicidal	Limitations:	Level:
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	Mahaki, ¹ and <u>Reza</u>		Sample Size:	over time with	study was 8	Quality:
	Bagherian-Sararoudi		55 patients	both	months and	В
	(2016)			interventions.	results may	
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	(2016). Effect of				The type of	
	phone call versus				contact,	
	face-to-face follow-				empathy, and	
	up on recurrent				guidance each	
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	individuals with					
	a history of multiple				This study was	
	suicide attempts.				also limited to	
	Advanced				patients who	
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	Research, 5(1).				themselves in	
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					population.	
11	David Seaberg MD	Quantitative	Sample	The amount of	Limitations:	Level
11	CDE EACED	Quantitative	Dandom		Limitations.	Level.
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	Stanton Elseroad		control trial	visits and costs	Data was only	
	<u>MD</u> , <u>Michael</u>			decreased	collected from	Quality:
	<u>Dumas MD</u> ,		Sample Size:	significantly	metro area	А
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	Jessica Whittle PhD		navigation	vs the control	system, which	
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1	Navigation for	1	1	integral part in	11am to /pm,	1

	Patients Frequently Visiting the Emergency Department: A Randomized, Controlled Trial. Academic Emergency Medicine, 24(11), 1327–1333. https://doi.org/10.11 11/acem.13280			facilitating access to care, as well as addressing barriers.	visits occurring during the evening and night were not included.	
12	Barbara Stanley, PhD, Gregory K. Brown, PhD, Glenn W. Currier, MD, MPH, Chelsea Lyons, MS, Megan Chesin, PhD, and Kerry L. Knox, PhD (2015) Citation: Stanley, B., Brown, G., Currier, G., Lyons, C., Chesin, M., & Knox, K. (2015). Brief intervention and follow-up for suicidal patients with repeat emergency department visits enhances treatment engagement.(Report)(Author abstract), <i>105</i> (8), 1570–1572. https://doi.org/10.21 05/AJPH.2015.3026 56	Quantitative	Sample: convenience Sample Size: 96 veterans Setting: 5 Veteran Affairs emergency departments over a 6 month period	Two interventions (follow-up call and safety plan) were found to increase outpatient behavioral health appointment attendance.	Limitations: Study participants were predominantly white (66%) males (86%), which limits the generalizability of the study results. A major limitation was that the study was uncontrolled, and the standard of care may have differed from patient to patient. Resources at VA service facilities may also differ from non-VA facilities, so outcomes may also differ in the general public.	Level: II Quality: B

Appendix D

RUTGERS THE STATE UNIVERSITY OF NEW JERSEY NON-INTERVENTIONAL/METHODOLOGICAL RESEARCH PROTOCOL TEMPLATE

(HRP-503b)

STUDY INFORMATION

- Title of Project:
 Psychiatric Emergency Patient Navigator: Improving Outcomes
- **Principal Investigator Name** Rubab Itrat Qureshi, PhD
- **Principal Investigator Div. & Dept.** Associate Professor, Division of Nursing Science
- Principal Investigator Contact Info:



 Protocol Version and Date: Non-Interventional Template HRP=503b 4.1.19 Protocol Title: Psychiatric Emergency Navigator Protocol Version Date: April 2019

1.0 Research Design

1.1 Purpose/Specific Aims

The aim of the pilot study is to explore the feasibility of a callback intervention to address high rates of PES use among psychiatric patients by bridging the gap between PES and W&R. This will lead to improvement in the quality of continuity care and patient outcomes in the future. The objectives are as follows.

A. Objectives

- 1. To develop a policy for psychiatric emergency services discharge follow-up.
- 2. To add a follow-up phone call intervention within 48 hours of discharge from PES.
 - a. Patient navigators will be trained to make follow-up calls.
 - b. A script will be created, so that every phone encounter with the patient would ask specific pertinent information and be linear.

B. Hypotheses / Research Question(s)

Will implementing a follow-up phone call from a patient navigator within 48 hours of discharge from the psychiatric emergency services lower the number of patients seen in crisis within thirty days of first presentation?

1.2 Research Significance (Briefly describe the following in 500 words or less)

The following study will look at how the implementation of a patient navigator follow-up phone call intervention in the psychiatric emergency department will lower the number of patients being seen within thirty days of last presentation. Studies have shown that implementing an intervention of follow-up after patients are seen in the emergency department not only improves outcomes but also has a positive effect on their safety (Cebria, et al., 2013; Ghanbari, et al., 2015; Gould, et al., 2018; Luxton, et al., 2013; Mousavi, et al., 2016).

1.3 Research Design and Methods

The proposed project is a quality improvement project that will investigate the feasibility of a call-back intervention in a psychiatric emergency department. Evaluation methods will be used to assess the implementation of the intervention and pre and post intervention readmission rates.

A. Research Procedures

- a. Developing a follow-up/navigation protocol.
 - i. Develop a policy for psychiatric emergency services discharge follow-up.
 - ii. The follow-up call
- b. A script will be developed for the patient navigator to follow for each
- follow-up phone call. This script will include questions pertaining to what the discharge instructions and referrals were, if barriers were encountered, what were they, how likely are they to keep their post discharge appointments to outpatient services after a follow-up call (See Appendix E). The navigators will keep a log of all follow-up calls.

- c. A follow-up phone call will be made to patients who receive referrals to outpatient services within 48 hours of discharge from the psychiatric emergency room.
- d. Patients will be informed about the follow-up call as part of the
 - discharge process. At this point verification of the best way to reach patient and times would be assessed.
- e. Implementation of the follow-up phone call with script.
 - i. Train patient navigators.
 - ii. Start follow-up calls.
- f. Evaluate the intervention

i. Compare the rate of readmission before and after the patient navigator was implemented: November 2018 thru February 2019 compared to November 2019 thru February 2020.

B. Duration for Study and Each Subject

The duration of this study will be in two parts:

- 1. Training of individuals approximately 1 month
- 2. Implementing of patient navigator role and follow-up calls 4 months.

1.4 Preliminary Data

There is to date no policy in place at the psychiatric emergency department for behavioral health follow-up for transition of care from emergency department to outpatient resources from patients being discharged home.

1.5 Sample Size Justification

No subjects will be recruited for the study.

1.6 Study Variables

A. Independent Variables, Interventions, or Predictor Variables

N/A

1.7 Specimen Collection

A. <u>Primary</u> Specimen Collection

Not Applicable

- <u>Types of Specimens</u>: Not Applicable
- <u>Annotation</u>: Not Applicable
- **Transport**: Not Applicable
- <u>Processing</u>: Not Applicable
- <u>Storage</u>: Not Applicable
- Disposition: Not Applicable

B. <u>Secondary</u> Specimen Collection

- **Types of Specimens**: Not Applicable
- <u>Annotation</u>: Not Applicable
- **Transport**: Not Applicable
- <u>Storage</u>: Not Applicable
- Disposition: Not Applicable

1.8 Data Collection

A. <u>Primary</u> Data Collection

- **Location**: Hospital in Northern New Jersey.
- **Process of Data Collection**: Data will be collected for pre and post evaluation of number of psychiatric emergency department readmission comparison. The navigators will keep a log of all the follow-up calls, no patient identifiers will be used.
- <u>Timing and Frequency</u>: Training will occur over a one month period and the follow-up calls from the
 patient navigators will be administered November 2019 thru February 2020 and monitored over a 4
 month period.
- Procedures for Audio/Visual Recording: No audio/visual recordings will be done.
- <u>Study Instruments</u>: A script will be developed for the follow-up calls. No tools will be used in this study.
- <u>Ethnographic Studies, Interviews, Or Observation</u>: N/A
- **Subject Identifiers**: No identifying data will be obtained.

B. <u>Secondary</u> Data Collection

- Type of Records: The types of records that will be assessed at the end of this study will be the number of thirty day re-evaluations at the psychiatric emergency department monthly and the numbers of cases seen the year prior. No other data will be assessed.
- <u>Location</u>: The location of the data is in a secure computer in the psychiatric emergency room department manager's office, that only she has access to give information.
- <u>Inclusion/Exclusion</u>: Data that will be included is admission data within the date range of November 2019 to February 2020 in comparison to November 2018 to February 2019.
- Data Abstraction Form(s): N/A

1.9 Interviews, Focus Groups, Surveys, and/or Observations

- A. Administration
 - N/A
 - Timing and Frequency
 - Location
 - Procedures For Audio And Visual Recording
 - Person Identifiers

B. Study Instruments

N/A

- Evaluation Instrument Details
- Study Instruments For Ethnographic Studies
- Oral Histories Or Interviews General Framework
- Referral Information

2.0 Project Management

2.1 Research Staff and Qualifications

Rubab Qureshi PhD, Associate Professor Division of Nursing Science Fellow, Center for Urban Youth & Families http://nursing.rutgers.edu/cuyf/index.html Rutgers School of Nursing

Jacqueline Hunterton-Anderson, BSN, BHS, RN-BC currently in the DNP Psychiatric/Mental Health track expected graduation date May 2020.

2.2 Research Staff Training

All individuals must obtain CITI training prior to participating in research studies at Rutgers University.

2.3 Resources Available

Resources are available at Rutgers University and at the facility in which the project will be implemented. No risk is involved in the training of the patient navigators.

2.4 Research Sites

Healthcare system in Northern New Jersey

3.0 Multi Center Research

Not Applicable

4.0 Research Data Source/s

4.1 Subject Selection and Enrollment Considerations

- A. Method to Identify Potential Subjects No subjects will be recruited.
- **B.** Recruitment Details No subjects will be recruited.
- C. Subject Screening
 - N/A
 - Inclusion Criteria All patients seen in crisis at the psychiatric emergency department.

Exclusion Criteria

Patient not discharged home from psychiatric emergency services.

4.2 Secondary Subjects

N/A

4.3 Number of Subjects

- A. Total Number of Subjects N/A
- **B. Total Number of Subjects If Multicenter Study** N/A

4.4 Consent Procedures

A. Consent Process

- Location of Consent Process
- Ongoing Consent
- Individual Roles for Researchers Involved in Consent
- Consent Discussion Duration N/A
- Coercion or Undue Influence
- Subject Understanding N/A
- B. Waiver or Alteration of Consent Process
 - Waiver or <u>Alteration</u> Details A waiver will be obtained.
 - Destruction of Identifiers N/A

 Use of Deception/Concealment N/A

a. Minimal Risk Justification

There is no apparent risk/harm anticipated during this study to the participants. There is a small possibility that harm may occur to the participant on their way to the facility, no greater than the average day to day risk.

- b. Alternatives N/A
- c. Subject Debriefing N/A
- C. Documentation of Consent
 - **Documenting Consent** N/A
 - Waiver of <u>Documentation</u> of Consent (i.e., will not obtain subject's signature) N/A

4.5 Special Consent/Populations

- A. Minors-Subjects Who Are Not Yet Adults
 - Parental Permission
 Not Applicable
 - Non-Parental Permission
 Not Applicable
 - Assent Process Not Applicable
 - Documentation of Assent Not Applicable
 - Reaching Age of Majority During Study
 Not Applicable
- **B.** Wards of the State
 - Not Applicable
 - Research Outside of NJ Involving Minors Not Applicable
- C. Non-English-Speaking Subjects
 - Not Applicable
 - Process for Non-English-Speaking Subjects Not Applicable
 - Short Form Consent for Non-English Speakers Not Applicable
- **D.** Adults Unable to Consent / Cognitively Impaired Adults (for interventional studies) Not Applicable
 - NJ Law-Assessment of Regaining the Capacity to Consent Not Applicable
 - Capacity to Consent
 - Not Applicable
 - a. NJ Law-Selecting A Witness Not Applicable
 - **b.** Removing a Subject Not Applicable

4.6 Economic Burden and/or Compensation for Subjects

A. Expenses

No expenses will be incurred by the subjects in this project.

B. Compensation/Incentives

No compensation will be given for participation in this study.

C. Compensation Documentation

N/A

4.7 Risks and Benefits to Subjects

N/A

- A. Description of Subject Risk And Benefits
 - Existing Condition/Disorder N/A
 - Additional Considerations N/A
 - Minimizing Risks N/A
 - Certificate of Confidentiality (CoC) .N/A
 - Risks to Non-Subjects N/A
 - Potential Benefits

The benefits from this project will improve patient outcomes and assess barriers being faced by the psychiatric mental health population.

5.0 Special Considerations

5.1 Health Insurance Portability and Accountability Act (HIPAA)

I will not be obtaining, creating, and using, and/or disclosing individually identifiable health information associated with a HIPAA-covered component or entity in the research.

5.2 Family Educational Rights and Privacy Act (FERPA)

N/A

5.3 General Data Protection Regulation (GDPR)

N/A

5.4 Code of Federal Regulations Title 45 Part 46 (Vulnerable Populations)

N/A no vulnerable populations will be in this study.

6.0 Data Management Plan

6.1 Data Analysis

The data that will be collected will be pre and post number of readmissions to the psychiatric emergency department; it will measure the feasibility of the intervention in the psychiatric emergency department.

6.2 Data Security

There will be no personal data used during this project, and information needed as to number of patients being seen will be held confidentially at the computer of the psychiatric emergency services manager's office.

6.3 Reporting Results

A. Subject Results Reporting

N/A B. Professional Reporting

Findings will be reported to Rutgers University as a dissemination of findings via poster and oral presentation.

6.4 Secondary Use of the Data

N/A

7.0 Research Repositories – Specimens and/or Data

No specimens or data will be stored during or after this study.

8.0 Approvals/Authorizations

A letter of site cooperation was obtained from the psychiatric emergency department where the training will take place. IRB approval from Rutgers University will be obtained prior to the study beginning. No hospital IRB required since there will be no access to patient data or data in general from the facility.

9.0 Bibliography

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Appendix E



Follow-Up Phone Call Script

Patient number:

Date of Original PES Evaluation:

Discharge Instructions/Referrals Given Upon Discharge:

Did Patient Follow-up Through with Discharge Instructions/Referrals:

Taking Medications:

Any barriers to follow-up?

Summary of Follow-Up:

Current Level of Risk:

Action Plan:



Version 3.28.20

Running Head: PSYCHIATRIC EMERGENCY PATIENT NAVIGATOR

Appendix F

Activity	Plan Start	Plan Duration	Periods May 2019	June 2019	July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020
Presentation of	May	1													
Proposal to Team	2019														
IRB Submission	May	3													
	2019														
Participant	Aug	1													
Recruitment	2019														
Project	Sep	2													
Implementation	2019														
(Education)															
Data Collection	Nov	2													
	2019														
Data Analysis	Jan	1													
	2020														
Evaluation/Writing	Feb	2													
	2020														
Presentation of	April	1													
Final Project	2020														
Graduation	May	1													
	2020														

Expenses	Cost	Total Cost	
Educational materials (paper training/software)	20 @ 0.15	\$3.00	
Binding of final project	5 @ 20.00	\$100.00	
Dissemination Poster	1 @ 75	\$75	
TOTAL BUDGET:		\$178.00	

Appendix G



Figure 1: Admission and readmission data from the hospital psychiatric emergency department during November through February 2018/2019 and 2019/2020.



Appendix I

Figure 2: The 322 patients that were contacted by the patient navigator were categorized into 6 common barriers encountered for follow-up after being seen in PES. The following were the 6 categories: 1- (109) no barriers, 2- (11) no insurance/cost too high, 3- (10) availability of appointments, 4- (187) no answer/unable to reach patient, 5- (2) language barrier and 6- (3) refuses follow-up recommendations.

Appendix J – New PES Follow-up Policy

			Psychiatr	ic Emergency Services		
Policy Name:	PES Patient Navigator – H Risk Assessment and Plan	Follow of Ca	•up re	Dept.#		
Original Date: 10/20/2019 Revis			ision Date: N/A			
Approved by:						

POLICY STATEMENT:

It is the policy of **sector and the sector and the**

PROCEDURE:

1. Persons eligible for services are offered multiple recommendations when initially evaluated and given the information that they will receive a follow-up phone call from a patient navigator.

- d. Within 48 hours of discharge from emergency services patient will be given a follow-up phone call to assess for risk and barriers to follow-up.
- e. During this time the patient navigator will help the patient navigate the referrals given and aid in making further attempts to gain an appointment or the patient's need to be re-evaluated if risk is high.

2. Persons seen as high risk will have a welfare check mandated while on the phone with the patient navigator and the possibility of a community mobile may arise.

3. Through this process the patient's safety is the main priority of the patient navigator and hospital staff. Following the algorithm which is filled out during each phone call will aid in making quick assessments.

4. Assessments may include Columbia Suicide Severity Rating Scale, and if applicable a Safety Plan.