Transcript – Supporting Care Transitions, Part 1

Going off to college is an exciting and emotional time for students and families. For many students, it is a new beginning, and their first chance to be independent, as well as their first time to manage their own healthcare. But, big transitions can also bring challenges, particularly for students who come to campus with mental health concerns. In this video, we will address the different transitions in care a student might face, as well as some general principles for supporting students through those transitions.

According to the Healthy Minds Study, at least 30% of students are currently or have been treated for a mental health concern in the past year. That includes seeing a therapist or using medication. This suggests that many students are actively in some form of treatment when they go to college. Some students will continue with their treatment providers from home. Some will look for professional support on or near the campus to continue treatment. And, others will see this transition as a time for a "fresh start" and want to try to be successful without support.

As their time in school progresses, some students will be referred to a mental health provider for the very first time. Others will find they need more support than they have, or that they underestimated their needs. And, some students will require longer-term or more specialized services than the campus counseling center can provide. When these situations arise, staff typically help the student locate services in the community. Finally, a small percentage of students will experience a mental health crisis that temporarily requires intensive off-campus services such as inpatient care.

These all represent important care transitions. A comprehensive suicide prevention plan builds in supports for transitions like these as a way to promote student wellness and recovery as well as to reduce risk for suicide.

Care transitions are times of increased risk for suicide. Many individuals fall through the cracks or never actually make a connection with the new provider. As one example, in the general population, over half of patients seen in the emergency department after a suicide attempt do not follow-up with an outpatient provider. There are many barriers to successful care transitions for students, such as scheduling challenges, difficulty locating appropriate and available providers, insurance coverage and costs of care, timely exchange of medical records, and transportation challenges. We must be thoughtful and creative to help students overcome these barriers to access the care they need to stay healthy and be successful.

So, how can we support students in making successful care transitions? There are a few general things we suggest you have in place first.

- A school must have a clear scope of service, and communicate that scope to staff, students, families, and community agencies, including the hospitals to which students are referred. Your scope of service outlines when a student can be seen at the counseling center versus when they need to be referred elsewhere. It might also include limits on the number or frequency of sessions, eligibility criteria, types of services provided, and options for crisis support. A scope of service is helpful with transition planning, for example, when a student has a crisis and is hospitalized, and then needs to be discharged to outpatient care. Your scope of service can also guide prospective students and families when an incoming student has extensive mental health needs and wants to find a therapist to continue their treatment while at college. Clearly communicating your scope of service up front will help avoid confusion and conflict later.

- Having a designated case manager or a care navigator is a valuable way to support transitions for students seeking community-based services. Many schools decide to have this person work in a non-clinical role and outside of the counseling center. This can make it easier to communicate with administrators, disability services, and community agencies about student needs and well-being. A case manager can also support students who are hospitalized, and help the healthcare team develop a reasonable discharge plan that can be implemented in the academic environment. They can check in with students who have recently returned from a hospitalization to see how they are doing and ensure the transition back to school as well as to outpatient care is going well. They can also make sure students are accessing needed campus resources, such as Disability Support Services and Tutoring.

- Successful care transitions also require strong relationships and formal agreements with community partners. If you have not already done so, get to know the healthcare providers in your community, including the community service board, inpatient programs, day treatment or intensive outpatient programs, emergency services/first responder units, and other organizations that are likely to assist in the care of students. Intentionally build relationships with agencies that accept student insurance. Develop a memorandum of agreement or memorandum of understanding (MOA/MOU) with community organizations such as the community service board and hospitals where students are referred. The MOU outlines how referrals are made, when and how consents are obtained, what information is shared between the organization and the school (with consent), when the school will be notified about admissions and discharges, how the hospital will involve the school in discharge planning, and who will be responsible for follow-up after discharge. MOUs can also address unique circumstances, such as when and how students are transported to the hospital for evaluation, or who notifies the parents or emergency contacts when a student is hospitalized and at what point in the process. If possible, campus and community representatives should come together to review and update these agreements annually.

- Timely delivery of medical records and communication between providers also helps promote smooth transitions. Ideally, releases are signed and records are shared electronically before a student is seen by a new provider. This helps the new provider gather important information on the student's response to treatment and identify potential barriers to care.

- Close the loop on communication between providers. When a student is referred to a new provider, that provider should contact the referral source to confirm that the student followed through on the referral whenever possible. This helps both parties be accountable for ensuring successful care transitions.

- Counselors, case managers, and support staff benefit from regular training on supporting care transitions. First impressions of a new provider, starting with the initial phone call, check-in, and paperwork, significantly influence an individual's willingness to follow through with treatment. Intentional check-ins during transition periods, reminders of appointments, supportive follow-up after missed appointments, and thoughtful questioning about barriers to successful care transitions, can help students successfully navigate moves between providers. Recurrent training in managing care transitions makes it easier to provide consistent care despite campus and community turnover, and reminds everyone how they can work together to support students during these critical windows in patient care.

- Finally, make it standard practice to involve natural supports during important care transitions. With the student's permission, you can educate family, friends, or others (such as coaches, faculty, and residence hall staff), about specific ways to help. If the student has a safety plan, have them share it with their key supporters. When natural supports are aware of a student's treatment and safety plans, they can provide encouragement and accountability during care transitions, as well as help the student recognize when they need to seek additional support.

Effective care transitions require all parties to be on the same page. This means regular training, clearly defined services, ongoing communication, and strong relationships between everyone involved in a student's care. Now that you have these critical elements in place, go on to the next video to learn about specific considerations for different types of care transitions.