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Helping Patients with Mental Illness Engage in Their Transitional Care

REACH Dissemination Committee, Maine, USA

Helping Patients with Mental Illness Engage in Their Transitional Care

REACH
Research Evidence-to-Action for Community Health

Transitional Care Clinics

- Treat patients with a mental illness for **90 days after a hospital stay**
- Connect patients to mental health services for **ongoing care**
- Effective transitional care **can keep patients from going back to the hospital**

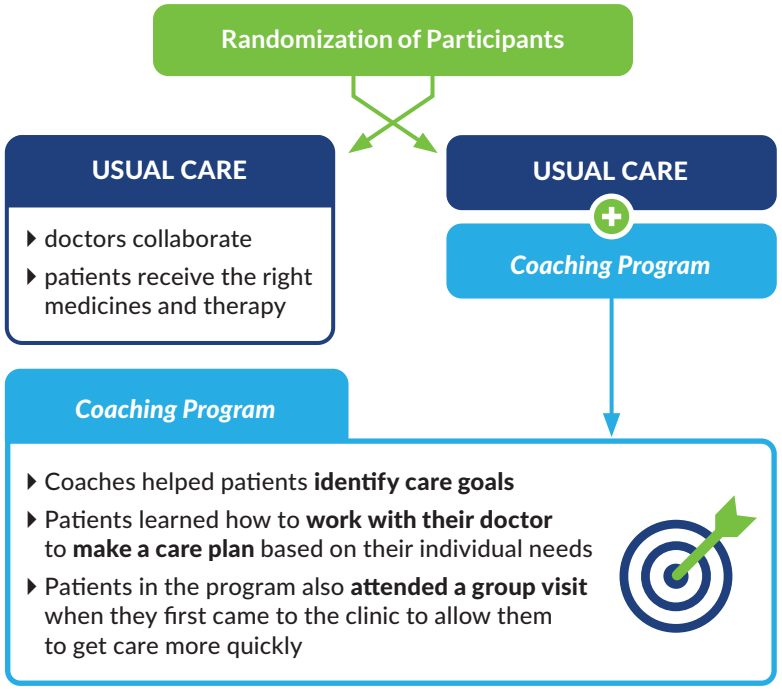
LOCATION & POPULATION

- **Bexar County, Texas**

- **326 patients** getting mental health transitional care after a hospital stay/ER visit
- **49%** Hispanic
- **41%** White
- **7%** African American
- Average age: **38**
- **55%** Women

STUDY DESIGN

*Patients had coaching in **shared decision making**. Shared decision making is a process where patients and doctors make decisions together **based on the patient's individual needs**.*



FINDINGS

- **Between the groups, no difference was found in:**
  - How often patients went to their **appointments**
  - **Mental health** symptoms
  - Number of **hospital and emergency room visits** after leaving transitional care
  - Patient and doctor ratings of **doctor's communication skills**

- **Of patients in the program, 38% didn't attend any appointments**
  Results might be different if more patients went to these appointments.
- **The study only included patients at one clinic**
  Results might be different in other locations or settings.

Key Take-Away

Engagement focused care that includes group intake and shared decision making coaching may improve quality of life for individuals with behavioral health challenges who are transitioning from hospital to community care. This is a particularly relevant model in systems where there is a provider shortage.

REFERENCES

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