New Jersey

Department of Children and Families

Division of Children's System of Care

Program Manual

2024

NEW JERSEY DEPARTMENT OF CHILDREN & FAMILIES

DIVISION OF CHILDREN'S SYSTEM OF CARE

CONTENTS

SECTION 1:
PURPOSE, DEFINITIONS, AND ACRONYMS

PURPOSE

Project Connect is an initiative program that facilitates youth and family access to behavioral health services post-discharge from a hospital emergency department or acute care setting following a suicide attempt or ideation. Studies indicate that as many as 50% of youth discharged home following a suicide attempt or ideation do not receive the necessary behavioral health care (Hoffman et al., 2023). This lapse in continued care is concerning as the risk of a repeated suicide attempt is highest within 30 days of discharge from an Emergency Department or psychiatric unit (Knesper, 2010). The National Suicide Prevention Hotline (2022) recommends care coordination programs to prevent repeat suicide attempts and to ensure connection to proper treatment. Project Connect fulfills this crucial role as a care coordination program dedicated to decreasing suicidality and suicide attempts among youth.

DEFINITIONS AND ACRONYMS

NJ DCF – The New Jersey Department of Children and Families (NJ DCF) is the state agency devoted exclusively to serving and supporting at-risk children and families. NJ DCF is committed to assisting and empowering residents to be safe, healthy, and connected.

NJ DOH – The New Jersey Department of Health (NJ DOH) is comprised of three branches: Public Health Services, Health Systems, and Integrated Health. Together, these branches strengthen New Jersey's health system, promote healthy communities, and improve the quality of health care in the state.

CSOC – The Children's System of Care (CSOC) serves youth under age 21 with behavioral, mental health, substance use needs, and youth with intellectual and developmental disabilities and their families. CSOC provides family driven and youth guided, community-based, culturally competent services and implements the Wraparound model to support individualized service planning for youth and their families.

CYBER – The electronic health record system utilized by the Children's System of Care. The electronic health record contains protected health information (PHI) such as demographic, diagnosis, and treatment services for youth and their families that call PerformCare for access to services. CYBER usage within CSOC

complies with the Health Insurance Portability and Accountability Act (HIPPA) of 1996 to ensure confidentiality is protected and maintained.

PerformCare – PerformCare is the Contracted System Administrator (CSA) for the NJ DCF Children's System of Care (NJ CSOC). PerformCare is the single point of access for CSOC services, which are available at no cost for New Jersey children and youth with moderate to high clinical needs. Families can reach PerformCare 27 hours a day, 7 days a week, at 1-877-652-762 and can learn more about CSOC services by visiting the PerformCare - New Jersey Children's System of Care (performcarenj.org) website.

MRSS – Mobile Response and Stabilization Services (MRSS) delivers services to youth vulnerable to or experiencing stress, coping challenges, emotional or behavioral symptoms, substance use, or traumatic circumstances that may compromise the youth's ability to function optimally and thrive within their environments. The goal of MRSS services is to stabilize the youth in the community. MRSS is available 24 hours a day, seven days a week, 365 days a year, and can offer up to eight weeks of stabilization and support services.

Project Connect – Project Connect is a no-cost care coordination program for youth discharged from a hospital or acute care setting following treatment for a suicide attempt or suicide ideation. The program is implemented by NJ DCF CSOC.

RCC – Regional Care Coordinator supports continuity of care for youth and their families post-discharge from the emergency department following a suicide attempt/ideation. The RCC will follow-up with caregivers to provide support, linkage to services, and assist with addressing any barriers.

Suicide Attempt – A suicide attempt occurs when someone harms themselves with any intent to end their life but does not die as a result of their actions (CDC, 2023).

Suicide Ideation – Suicide ideation is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide, often called suicidal thoughts or ideas (Harmer et al., 2023).

SECTION 2:

INTRODUCTION TO PROJECT CONNECT

Model Overview

In November 2020, the New Jersey Department of Health (NJ DOH) was awarded the Garrett Lee Smith Youth Suicide Prevention Grant by the Substance Abuse and Mental Health Services Administration (SAMHSA) to support DOH's Readiness to Stand United Against Youth Suicide (R2S Challenge). The NJ DOH transfers Garret Lee Smith grant funds to the NJ DCF to create and implement a care coordination program to assist New Jersey hospitals in connecting youth to services following a suicide attempt and ideation. The care coordination program as created and implemented by NJ DCF is *Project Connect*. The three main goals of *Project Connect* are to:

Increase Engagement in Community Mental Health Services for youth following discharge from hospital or acute care settings.

Reduce Unnecessary Emergency Department Utilization by connecting youth with appropriate community services.

Improve Safety and Well-being of youth and their families by ensuring they receive the necessary support and services.

Project Connect operates in partnership with hospitals to improve continuity of care post-discharge for youth with suicide ideation and/or attempts. Once youth are stabilized medically and safe for discharge, hospital staff will connect families with behavioral health services accessible through the NJ DCF Division of Children's System of Care (CSOC) via the Contracted Systems Administrator (CSA) or a different service as agreed upon with the family. Hospital staff will obtain consent from the caregiver to refer the family to Project Connect and will send the referral/signed consent form and supporting documentation to Project Connect.

The **Regional Care Coordinator (RCC)** plays a crucial role in ensuring the continuity of care for discharged youth referred to Project Connect. Upon receiving a referral from the hospital, the RCC contacts the family post-discharge, providing follow-up support and ensuring linkage and engagement with community behavioral health services. The RCC also helps address barriers to the youth's connection to recommended behavioral health treatment and can facilitate joint phone calls with the caregiver to the CSOC CSA to access services.

There are numerous **benefits to hospitals** participating in Project Connect, including:

Enhanced Continuity of Care: Hospitals engaged with Project Connect gain access to the Regional Care Coordinator (RCC), streamlining the process of continuity of care for discharged youth.

Improved Support for Patients and Families: By integrating Project Connect into discharge planning procedures, hospitals can enhance the level of support provided to youth and families following a suicide attempt or suicide ideation.

Access to Resources: Partnering hospitals will have direct connection to Project Connect for additional resources to address the needs of youth suicide, fostering a safer and more supportive environment.

Program Development Approach

The NJ DCF employed implementation science principles to create an effective and replicable care coordination program for youth discharged from a hospital after a suicide attempt or ideation. Implementation science provides frameworks that assess and guide the design and implementation of interventions to achieve targeted outcomes (Fixsen et al., 2015; Powell et al., 2015). For innovative programs grounded in literature but lacking rigorous evaluation, certain steps must be taken to build evidence for the model's effectiveness: defining the practice, developing implementation supports (such as training, coaching, and fidelity tools), and establishing data collection and evaluation procedures to enhance ongoing practice. Only after these foundation steps are in place can the desired outcomes be attained (Metz, 2016).

NJ DCF methodically applied the National Implementation Research Network's Active Implementation Framework and associated tools to organize and execute the development of the care coordination program. During the review of suicide prevention programs, three models were examined for best practices: the Caring Contacts intervention, Dupage County's follow-up model, and the SPI+ (Suicide Prevention Intervention Plus) model (Dupage Health, 2023; Skopp et al., 2022; Stanley et al., 2018). Please see Appendix C for further details on how the Active Implementation Framework was used for program development.

SECTION 3:
PRACTICE PROFILE & LOGIC MODEL

The Project Connect model comes to life in the Practice Profile. A practice profile is a tool for operationalizing an intervention so that staff, supervisors, and directors across implementing agencies clearly understand the practice. Utilizing a practice profile helps create consistency in implementation across practitioners and agencies. A practice profile includes guiding principles and essential functions.

Project Connect Guiding Principles

Guiding principles are the philosophy, values, and principles underlying the innovation. These guide the practitioner's decisions and ensure consistency, integrity, and sustainable effort across all practitioners (Fixsen et al., 2013; Metz et al., 2011).

Collaborative

Project Connect works collaboratively with hospitals, MRSS, PerformCare, and families to ensure youth are connected to appropriate resources.

Family Focused

Project Connect will support families by providing access to services tailored to each family's needs while honoring family voice.

Research-Informed

Project Connect is rooted in evidence concerning follow-up care and communication for youth experiencing suicidal attempts/ideation. Resources and information provided to families will be evidence-based or informed.

Supporting Children and Families

Project Connect supports youth and families through various activities, including providing information and linkages to community resources and offering psychoeducation and verbal support to caregivers after a youth suicide attempt/ideation. This support aims to improve the safety and well-being of youth and families.

Connection to Formal Supports

Project Connect will aid in connecting youth and families to community-based services, leading to greater access to and utilization of care.

Essential Functions and Observable Behaviors of the Regional Care Coordinator

Essential Functions are core intervention components (competencies) that must be present to ensure that the program is implemented as intended to achieve outcomes. Project Connect performs eight essential functions. Below is a brief description of each Essential Function.

Essential Functions	Description of Essential Functions at Project Connect
Advocacy	Staff advocate on behalf of families enrolled in the program to ensure access to services. Staff advocate for the program to promote its utilization with hospitals, families, MRSS, and PerformCare.
Research Skills	Staff may utilize research strategies to remain knowledgeable about best practices of suicide prevention and follow-up programs. Research skills are used to identify potential systems to expand the program, guide decision-making, and evaluate effectiveness.
Clear Communication	Staff shall communicate clearly and professionally with families and partners, verbally and in writing.
Collaboration	Staff shall collaborate effectively with families, systems, and other professionals to ensure youth are linked to services.
Responsiveness	Staff shall provide a timely response to referrals and contact families within established program time frames: two business days after referral and weekly follow-up.
Organization	Staff shall organize and maintain all information and materials related to Project Connect (i.e., files are securely stored in accordance with applicable federal and state requirements).
Knowledgeable About Services	Staff shall be knowledgeable about all aspects of Project Connect, including the referral process, connecting with families, maintaining data, hospitals served, training sessions, and materials related to the program.
Empathy	Project Connect staff shall display empathy when working with families during the very stressful and challenging time following a suicide attempt. Staff shall provide opportunities for families to express their concerns and needs and demonstrate empathy through skills including reflective listening.

Philosophy/ Approach: Integration of a care coordination system into the hospital settings for youth experiencing a suicide attempt or ideation aims to facilitate timely referrals, access, and connection to appropriate mental health treatment after hospital discharge.

Name of Initiative: R2S – Project Connect (Regional Care Coordinator - RCC)

Target Population: Youth (up to 18 years old) admitted to the emergency department or acute care setting following a suicide attempt or ideation.

RESOURCES	ACTIVITIES	SHORT TERM OUTCOMES	MID TERM OUTCOMES	LONG TERM OUTCOMES
Funding Funding is provided by the Garrett Lee Smith Grant awarded to NJ DOH (October 2020), a 5-year grant. There is a Memorandum of Agreement between DOH and DCF to implement the activities of the grant. There is no direct funding or costs for hospitals implementing Project Connect. **Location** New Jersey hospitals and NJ DCF. **Staffing** **CSOC:** • Regional Care Coordinator- Provides follow-up to referred	<u>Hospital:</u> **Identify Hospitals:** • Identify hospitals interested in partnering to enhance services for youth and families post-discharge. **Initiate Training for Hospital Staff:** • **Project Overview-** Develop and deliver an informational video for hospital staff outlining the objectives and referral process of the Project Connect Program, accessing PerformCare, obtaining caregiver consent, communication workflows and processes for, gathering and sharing data. • **Children's System of Care (CSOC) Information-** Develop or utilize materials that include PerformCare contact number and guidance on initiating CSOC services through PerformCare, Distribute these materials to hospital staff for reference. • ***ACTS Training (Adolescent & Youth Clinical Training for Suicide Prevention)-*** available to	Hospital staff will demonstrate increased knowledge of New Jersey's Children's System of Care, services available through the CSA, and Project Connect resources and referral processes. Hospital staff will exhibit increased	Youth and families will successfully connect with the CSA before hospital discharge, ensuring timely access to necessary mental health services. Youth and families will receive comprehensive support in navigating mental health services, fostering a smoother transition from hospital care to community-based support.	**Increase Engagement in Community Mental Health Services:** Project Connect seeks to enhance engagement in community mental health services for youth following discharge from

families, offers support, and facilitates connections to PerformCare and other community supports as needed. **Curriculum/Training Tools** PerformCare Public Service Announcement: www.performcarenj.org/families/behavioral/suicide.aspx Project Connect recorded training: Project Connect Training Video (youtube.com) Flyers tailored for hospital staff and families: DCF | PROJECT CONNECT (nj.gov) **Collaborations/Partnerships** • NJ DOH • GLS Evaluator • DCF OASI • Hospitals • Contracted Systems Administrator • System Partners/Community Services	Emergency Department staff from participating hospitals. Training is designed to increase knowledge and ability to recognize, assess, and manage suicide risk in adolescents • ***Society for the Prevention of Teen Suicide (SPTS) Tool Kit-*** Review with Emergency Department staff from participating hospitals. Toolkit includes family-centered suicide prevention education materials **Services Provided to Families:** **Provision of Information:** • **CSOC & PerformCare Services Information** – Hospital staff will provide families with documents explaining the services offered by Project Connect and PerformCare to facilitate access to community services. As part of the discharge plan and linkages to services, hospital staff will offer to conduct a joint call with the youth's caregiver to PerformCare to facilitate their continuity of care. • **RCC Information & RCC Release of Information-** Hospital staff will provide families with documents detailing Project Connect, and will request caregiver's consent. **Linkages:** • **Mobile Response and Stabilization Services (MRSS Services)** – If recommended during the caregiver's call to PerformCare, MRSS staff can meet with the family at the hospital, home, or other settings to initiate post-discharge stabilization services.	comfort and confidence in supporting youth and families during the discharge process.	Access to and utilization of behavioral health services available through and recommended by the CSA will increase. Youth will demonstrate a reduction in symptoms severity, indicating progress in their mental health recovery.	emergency departments or acute care settings. **Reduce Unnecessary Emergency Department Utilization:** By connecting youth with appropriate community services, Project Connect aims to reduce unnecessary visits to the emergency department. **Improve Safety and Well-being:** The ultimate goal of Project Connect is to

Data Collection Mechanism/Documentation • Excel files • Cyber Monitoring (RCC will monitor CYBER to verify if the youth was connected to services through PerformCare.) **Evaluation:** • GLS evaluator • DCF, Office of Analytics & System Improvement	• **Linkage to Regional Care Coordinator**- Hospital Staff will send the *Authorization for Release of Information and Consent to be Contacted Form* and supporting documentation to the RCC via secure email. • **Regional Care Coordinator Follow-Up and Linkages**- the RCC will contact the family post-discharge and for three weeks or until the family is connected with services, ensuring continuity of care and support. Additionally, the RCC will send Caring Contact postcards to instill hope and provide resources. **Psychoeducation on youth and behavioral and emotional health:** The RCC will provide psychoeducation to caregivers on behavioral and emotional health issues affecting youth, including suicidality and how to engage in conversation with youth post-discharge, in alignment with the Society for the Prevention of Teen Suicide's *Behavioral Health Toolkit*. **Empathetic Verbal Support:** The RCC will provide empathetic post-discharge support to families. Through compassionate interactions, the RCC will utilize reflective listening and validation skills to understand and acknowledge the experiences of youth and their families. Verbal support and encouragement will foster a sense of reassurance and empowerment during the challenging transition period following hospital discharge.			improve the safety and well-being of youth and their families by ensuring they receive the necessary support and services to achieve and maintain stability at home, in school, and in the community.

SECTION 4: PROGRAM SERVICES

Description of Services

This section provides a detailed description of the Project Connect program services. It describes the activities and essential functions required to be delivered within each phase of service delivery. Essential functions are **bolded** within the narratives of each activity. All providers must adhere to the service standards outlined in this section to ensure fidelity to the Project Connect model.

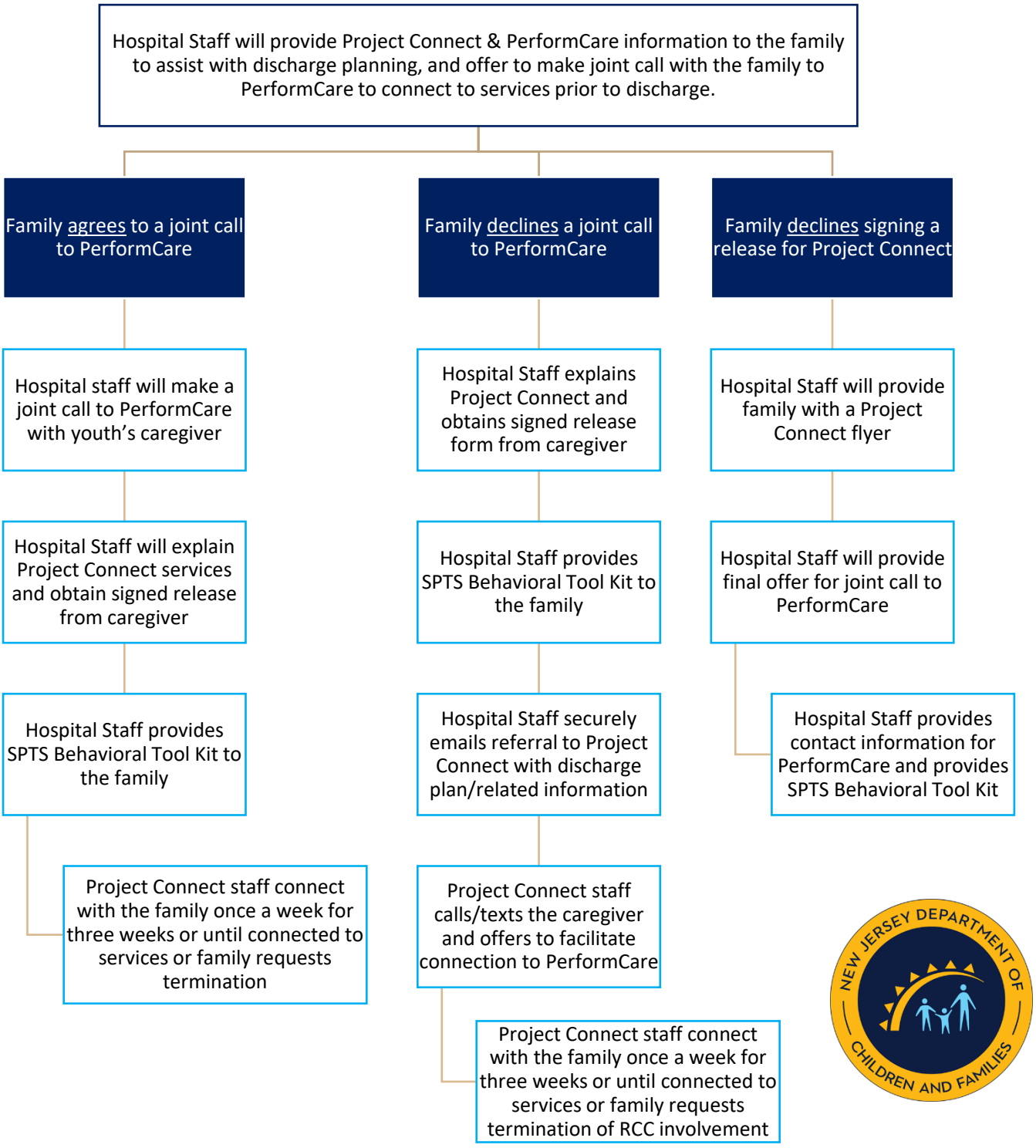
This section begins with a visual depiction of the Project Connect service delivery flowchart. Each phase of the service delivery process highlights the actions staff take and the timelines for the completion of tasks.

This section also describes the hospital recruitment, referral, engagement, and follow-up process; and highlights the underpinnings of service phases and the continuum of Project Connect services. It underscores the importance of the Project Connect team working collaboratively with families and other community partners to support implementation. The section identifies key alliances and emphasizes the importance of service linkage to ensure that families' unique needs and challenges are addressed.

Forms referenced can be found in the Forms and Tools section of the Project Connect Program Manual.

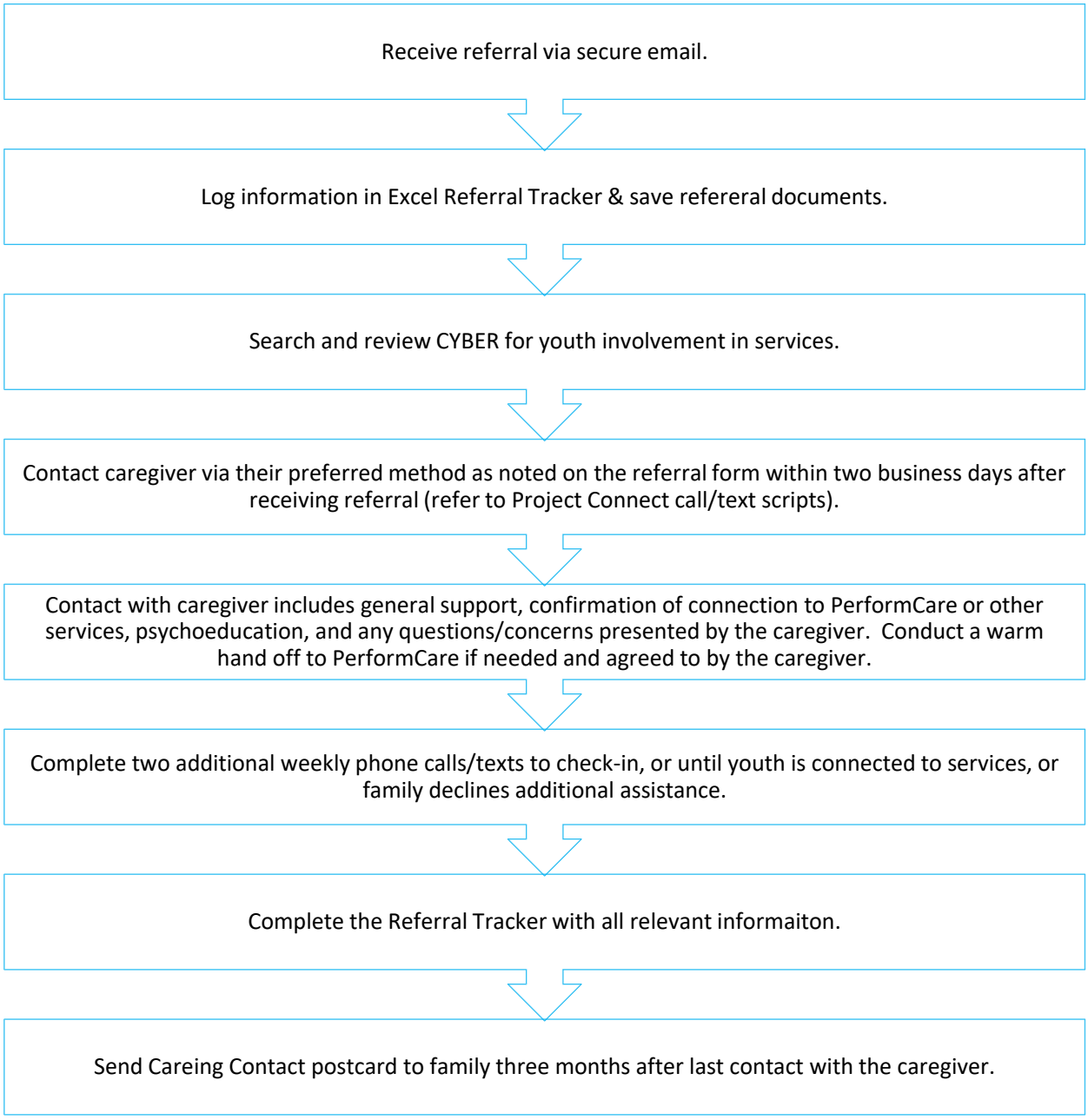
Service Delivery Flow Chart: Hospital Referral Activities

This document details connection points and the workflow for a hospital to refer to PerformCare and Project Connect.



Service Delivery Flow Chart: Regional Care Coordinator Activities

This document details the workflow of the RCC after a referral is received.



Hospital Recruitment Process

The Regional Care Coordinator, with support from CSOC leadership, is responsible for identifying hospitals interested in partnering with the program to enhance their discharge procedures for youth who have attempted suicide or presented with suicide ideation.

First, the RCC conducts **research** to identify potential hospital partners, gathering key hospital contact information (names, e-mails, phone numbers) via internet searches, other available public data, and existing partnerships.

After identifying hospitals for outreach and formulating **clear communication** and messaging, the RCC contacts key hospital staff via phone and/or e-mail to explain and promote Project Connect. During this initial contact, RCC describes the program and its benefits to both families and hospitals. The RCC **advocates** for the hospital to partner with Project Connect by highlighting the benefits of implementing the program, including:

> Increased Engagement in Community Mental Health Services: Project Connect seeks to enhance engagement in community mental health services for youth following discharge from hospital or acute care settings.
>
> Reduced Unnecessary Emergency Department Utilization: By connecting youth with appropriate community services, Project Connect aims to reduce the need for unnecessary visits to the emergency department.
>
> Improved Safety and Well-being: The goal of Project Connect is to improve the safety and well-being of youth and their families by ensuring they receive the necessary support and services.

If hospitals want to learn more about Project Connect, the RCC will schedule an information session for hospital emergency department decision-makers. Information sessions include a standard PowerPoint presentation on the current statistics available from DCF's Youth Suicide Report on NJ youth suicide attempts and NJ hospital utilization for youth with suicide attempts or ideation. It will also include Project Connect goals and explain the referral process, as well as brief information on the Children's System of Care. The information session can be conducted in-person or remotely. The PowerPoint can be updated as new statistics are available and is saved in the Project Connect program folder on DCF's shared drive.

If a hospital expresses interest, the RCC promptly **responds** within one business day. The RCC schedules an initial meeting with hospital decision-makers to discuss the integration of Project Connect into their healthcare system. If the hospital agrees to **collaborate**, the RCC schedules a logistics meeting to plan the program's rollout in their specific facility.

If required by the hospital, the RCC will facilitate the completion of a Memorandum of Agreement/Understanding (MOA/MOU) between NJ DCF and the healthcare system. The RCC will provide the hospital with a draft MOA developed by NJ DCF's legal team. The healthcare system's legal team can review the draft and make necessary changes. The RCC will aid in communication between DCF and the hospital until the legal document is finalized.

After implementation, the RCC invites the hospital implementation team to the monthly steering committee meeting review implementation progress, address barriers, adjust as needed, and celebrate successes; additional stakeholders may be added as appropriate.

Referrals and Enrollment Process

The partnership between hospitals and Project Connect provides youth and families with referrals to Project Connect for follow-up services and direct services through PerformCare before they leave the hospital.

Before completing any referrals, hospital staff will be **knowledgeable about the services** available after viewing the Project Connect training video. Hospital staff will be provided with all program materials, including the Authorization for Release of Information and Consent to be Contacted form, Project Connect Flyer for Hospital Staff, Project Connect Flyer For Family, and a Project Connect Job Aid for Hospital Staff to assist in the Project Connect referral process. Examples of each form can be found in this manual's Forms & Tools section.

The referral process starts when a youth is screened at a participating emergency room following a suicide attempt or ideation. The medical team will determine if the youth is medically cleared for discharge and create a safe discharge plan. If the plan determines that the youth can safely return home with outpatient services, the hospital will:

1. Refer the family to Project Connect.

2. Assist the caregiver in contacting PerformCare to access behavioral health services.

Referral to Project Connect

Once it is determined that the family is appropriate for a referral, the hospital staff will explain the Project Connect program to the family with clear **communication** and **empathy**. The hospital staff will explain the role of PerformCare and the Project Connect Regional Care Coordinator.

Hospital staff will briefly describe services available through CSOC's CSA PerformCare. and explain that the guardian initiates services by calling PerformCare, and that services are available at no cost to youth who reside in NJ and meet clinical criteria for services. After the PerformCare call, if the family is interested and eligible, MRSS will meet with them at their chosen location (hospital or home) and will **respond** within one hour of initiating the call. This meeting can also be delayed if the family prefers. Staff can refer to the Project Connect Job Aid to assist with descriptions of these services, which can be found in this manual's Forms & Tools Section.

Hospital staff will then explain to the caregiver that a Project Connect Regional Care Coordinator will be assigned to follow-up with them within two business days, either by phone or text, to determine if they were connected to appropriate services and offer support to address any barriers to care. Hospital staff should provide the family with the Project Connect Flyer and do their best to answer any questions about the program.

If the family agrees to a Project Connect referral, the hospital staff member will provide the caregiver with the Project Connect Authorization for Release of Information and Consent to be Contacted form. The family will indicate on this form if they prefer to be contacted by phone or text. The signed form will be securely e-mailed to CSOC.ProjectConnect@dcf.nj.gov, along with the youth's discharge plan, doctor's note, or behavioral health assessment. This can occur after the discharge process with the family. The hospital staff will use an **organized** method to store consent forms and flyers.

Hospital staff can obtain additional forms and flyers on the Project Connect website (https://www.nj.gov/dcf/project_connect.html).

Call to PerformCare

Once the caregiver agrees to contact PerformCare, the hospital staff will guide them in making the initial call. PerformCare requires the caregiver to make this call; however, the hospital staff may assist if the parent wishes by initiating the call and/or providing the phone number, coaching the family on what to say when calling, or providing information with permission from the family. The family should be made aware of the following:

> When the family calls PerformCare, they will be presented with several prompt options. If a family is requesting help for their child, they will be routed to PerformCare's Member Services Department who will complete the registration process and route the caller to the most appropriate next step.
>
> Depending on the situation, some callers are then transferred to PerformCare's Clinical Department, at which time a licensed clinician will assist with telephonic triage, including identifying risk factors, emotional or

behavioral needs, life domain functioning, and caregiver strengths and needs.

Once the clinician makes a service determination, they will present options to the family. Some of these options include crisis intervention through MRSS or a comprehensive biopsychosocial needs assessment. It is expected that most youth referred through Project Connect will be eligible for MRSS. MRSS may arrange to meet with the youth at their home at an agreed-upon time or at the hospital **if the youth is being formally discharged.** Hospital staff shall establish an appropriate confidential space for on-site hospital Mobile Response services.

If the Family Declines Services

If the family declines to be referred to Project Connect, but is interested in calling PerformCare for assistance, this can proceed and the Project Connect flyer can be given to the family.

If the family is not interested in calling PerformCare at the hospital but agrees to a Project Connect referral, the hospital staff should obtain a signed copy of the Authorization for Release of Information and Consent to be Contacted form and securely e-mail the form and discharge plan or behavioral health assessment to the RCC who will contact the family.

Should the family not be interested in either Project Connect or services through PerformCare, the Project Connect flyer can be provided as a resource should they wish to seek assistance in the future.

Hospitals may have access to Mental Health Crisis Toolkits as created and provided by the Society for the Prevention of Teen Suicide (SPTS). These toolkits can be provided to families as they include resources and guidance for caregivers with youth experiencing behavioral health emergencies.

Regional Care Coordinator Family Contact

Upon receipt of completed referrals and release forms from hospital partners, the RCC will begin contacting the family. The RCC will **respond** to referrals by contacting the family within two business days.

Before initiating contact, the RCC will log all new referrals into the Project Connect Referral Tracker as they are received. The RCC will then review the referral and discharge summary or behavioral health assessment before contacting the family by call or text. With consent, the RCC can also view the youth's information in CYBER (NJ DCF CSOC's Management Information System) for additional information to inform the call to the caregiver.

Once the appropriate information has been reviewed, the RCC will call or text the caregiver and provide caring and **empathetic** follow-up to engage the

caregiver/youth. The RCC will utilize the RCC Scripts for Family Contact to ensure **clear communication** throughout all required components of the call, which include:

- Introducing themselves and the program to family
- Reminding the family of the purpose of the program
- Acknowledging the crisis the family is experiencing and listening to concerns and questions
- Finding out if the family has already been connected to PerformCare or other services

If connected to PerformCare, the RCC will determine the call's outcome and if the family utilized MRSS services. The RCC will inquire about any other services authorized for the youth. The RCC can offer other community referrals, such as Family Success Centers. The RCC will be **knowledgeable about the services** offered and help clarify any questions or answer any concerns from the caregiver.

If not connected to PerformCare, the RCC will offer to assist the caregiver in making a joint call by using a three-way call option or instruct the family on how to make the call if they prefer to do it on their own.

Empathy in connecting with families is essential to the Project Connect program. The RCC will be inclusive and welcoming to all referred families regardless of race, ethnicity, religion, gender, culture, or language. Whenever needed, an interpreter through Language Link will be utilized for families who do not speak English. If necessary, the RCC or interpreter will leave a voicemail about the program.

The RCC will follow-up with the caregiver via phone or text once a week for three weeks or until connected to services or the family requests termination of RCC involvement.

If no contact is made after two calls/texts to the family, a **Caring Contact postcard** will be mailed to the home. The Caring Contact postcard will also be mailed to all families referred to the RCC three months post-hospital discharge. This component is a **research-based** intervention that offers a short message of support. It shows the family that someone is thinking about them and is there to help if needed.

To **track** the outcomes of Project Connect, the RCC will document all referrals and pertinent information received from calls with family. This **organized** documentation is vital for data reporting on the program. See Section 4 Forms & Tools for more information.

Caring Contact Postcard

This postcard contains a message of support and resources. Caring contact postcards will be sent to all families three months following their initial referral and to families who did not respond to two attempts to be contacted by the RCC. The postcard includes a QR code for families to scan which links to a Project Connect user survey to evaluate the experiences of youth and/or caregivers referred to Project Connect.

PerformCARE
1-877-652-7624

2NDFLOOR YOUTH HELPLINE
888-222-2228

988 SUICIDE & CRISIS LIFELINE

FIRST-CLASS MAIL
US POSTAGE PAID
TRENTON NJ
PERMIT NO. 21

I wanted to send you a card to say hello and that I hope things are going well for you. If you would like to contact me, I would be happy to hear from you at 609-888-7111 and email: DCF-Suicide.Prevention@dcf.nj.gov.

Sincerely,

Project Connect
CSOC.ProjectConnect@dcf.nj.gov

Scan here to tell us what you think:

SECTION 5:
ADMINISTRATIVE OPERATIONS

Regional Care Coordinator Scripts for Family Contact

Below are scripts the RCC will utilize in calling or texting the family to initiate contact for the first time. Separate scripts are provided for speaking with a caregiver and a youth. The scripts include additional resources to be provided to the family at the time of contact if appropriate.

First Follow-Up Phone Call Script

RCC will refer to this script when calling the caregivers of referred youth.

Speak with the Caregiver:

Hello, this is (insert name) from Project Connect calling to speak with the parent or guardian of (youth's first name).

Thank you for taking my call. At the hospital, you agreed that it might be helpful to connect with someone for support in getting linked to services. Project Connect works with families after they get home from the emergency room/hospital for a suicide attempt or ideation to ensure connection to services and provide extra support. (Confirm caregiver understands this information).

Is this a good time to talk?

I want to let you know that the information discussed is confidential. The information would only be shared if it was reported to me that anyone was at risk of hurting themselves or others or if there was an allegation of child abuse/neglect. (Confirm caregiver understands this information.)

How are you doing? (If applicable – were you able to rest, eat, get sleep? or other basic need questions; allow time for hearing the caregiver's story, and validate their feelings).

How is (insert youth name) doing since being discharged from the hospital?

What has it been like since the hospital? (prompt if needed)

Did you call PerformCare or any other providers for assistance? As a reminder, PerformCare is the administrator of the Children's System of Care. It is the point of access to free behavioral health, intellectual, and developmental disability services as well as substance use treatment for youth in New Jersey. Families can also access Mobile Response and Stabilization Services by calling PerformCare. (Confirm caregiver understands and has the phone number 1-877-652-7624).

If yes:

What happened after the call?

(Ask the following specific questions if the question was unclear to the caregiver or as prompts to engage the caregiver in conversation about service connection)

Did MRSS meet with you?

If yes: What did they recommend?

Is there an outpatient appointment scheduled?

What questions can I answer for you?

If not: I can assist you now in making a joint call to PerformCare if you would like. (1-877-652-7624)

(If interested) Ok. When we connect with PerformCare, I will start the conversation and then transition to you. Once the connection to PerformCare is established, I will leave the call. The call will go silent for a moment while I connect to PerformCare. If we get disconnected, I will call you back. Please hold.

(If not interested) Ok. PerformCare is available by phone 24/7 to provide linkage to services and is available to all NJ residents (1-877-652-7624). PerformCare can connect to services in your area such as outpatient counseling. You may also wish to call 2-1-1, who can provide you with various resources for care in your area. These may include housing, food, healthcare, legal and childcare. The 211 service is free and confidential, multilingual, and accessible to people of all abilities. There are other options to connect with providers in your community, such as working with your private health insurance provider. Would you like more information on these services?

If yes – provide brief descriptions of each program, assess what the caregiver may be interested in, and provide website and contact information as relevant.

Insurance – If you call the phone number on the back of your insurance card, you can ask for behavioral health providers who are in-network with your insurance to access behavioral health services.

Family Support Organization - FSOs are family-run organizations that provide direct family-to-family peer support, education, advocacy, and other services to family members of children with emotional and behavioral problems.

Resource Net - Home - New Jersey Resource Net (njresourcenet.org) each NJ county has a ResourceNet website that highlights county-based programs, resources, and family events.

(NOTE: If the call is made to PerformCare, skip this question) Do you have a plan of how to respond if the youth experience another crisis? (If no, provide examples such as calling PerformCare for MRSS, 988, or going to ED. Let the caregiver know that the Regional Care Coordinator/Project Connect/your phone number is not a crisis line or helpline).

Do you have any questions about services right now?

If yes, respond appropriately. If no, move to the next question.

Is it ok to call next week to follow-up with you again?

If it is ok with you, and (insert youth's name) is available and would like to talk, I'd like to check in briefly to see how they are doing and if they have any questions. This is completely optional.

If speaking with youth after the caregiver: (ensure youth has verbal capacity and is at least 12 years old;)

Hi (insert name), this is xxx from a program called Project Connect. We check in with youth after they leave the hospital like you did to offer support and connection to services. Thank you for talking with me. Remember this is completely optional for you to speak with me and you can tell me if you don't want to talk.

Are you comfortable talking with me for a minute? (If yes, proceed. If not, try to schedule a time to call back.)

What has it been like for you since leaving the hospital?

Is there anything you would like help with now?

Do you have questions about anything?

If you haven't heard about 2NDFLOOR, I wanted to share with you that 2NDFLOOR is a confidential and anonymous helpline for New Jersey's youth and young adults. You can call or text them for guidance on finding solutions to the problems you may face at home, at school, or just in general. Their website is www.2ndfloor.org (888-222-2228). You can also call 988 if you are feeling suicidal or like you are in an emotional crisis.

Is it ok if I or another representative from Project Connect calls you back next week to check-in again?

Thank you for taking the time to talk to me today. If your caregiver would like to talk again, you can put them on (end call as appropriate).

During the call, if the caregiver or youth reports having active thoughts of suicide, advise them to call 988, go to the nearest ER or designated screening service, or call 911 for emergency services. Offer to call PerformCare for non-emergent crisis together (1-877-652-7624) for Mobile Response & Stabilization Services. If there is ever an emergency reported by the family, call 911.

If no answer – leave a message and call again within 48 hours:

Hello, this is xxx from Project Connect. Before leaving the hospital, you provided your information for us to follow-up with you about (insert youth's name). I am calling to check-in and support connection to services. Please give me a call back. My number is xxx-xxx-xxxx. Thank you.

Staffing & Partnership Roles

There are three essential roles needed to ensure successful implementation of Project Connect. The core role is the Project Connect Regional Care Coordinator position staffed by NJ DCF's CSOC.

The two additional roles come from staff within the partnering healthcare systems. Project Connect does not staff these hospital roles; rather, it relies on collaboration for the successful implementation of the program. These two roles are the hospital staff, and the hospital point of contact.

An additional essential partner to Project Connect is the Contracted Systems Administrator (CSA).

NJ DCF CSOC employs the **Regional Care Coordinator (RCC)**. The RCC partners with NJ hospitals to provide follow-up care coordination for youth being discharged from emergency rooms following suicide attempts or suicide ideation. The RCC is responsible for creating and maintaining partnerships with hospitals

implementing the program, providing access to relevant training and materials, and supports continuous quality improvement. The RCC conducts telephonic follow-up calls and text messages to caregivers following a referral from a hospital and ensures that the youth is connected to the Department of Children & Families – Division of Children's System of Care's Contracted System Administrator and other community-based supports as appropriate. The RCC maintains data on all aspects of the program, including hospital participation, referrals, family outreach, and outcomes.

The job description for Regional Care Coordinator can be found in Appendix A.

Hospital partners include the **hospital staff** designated to screen and treat youth presenting to the emergency department and who will incorporate Project Connect referrals into their practice. Positions within the hospital may vary according to the hospital's staffing structure. Hospital partners may include social workers, nurses, behavioral health screeners, customer service representatives, etc. Hospital partners collaborate with the RCC and send all referrals to the RCC via secure email.

Hospital partners also include the designated **Hospital Point of Contact** who serves as the link between the RCC and hospital staff implementing Project Connect. The Point of Contact assists in ensuring that their hospital staff are trained, reports any barriers to completing referrals to the RCC, and oversees Project Connect referrals being completed in their hospital. This person will also serve as a representation on the Steering Committee, which gives the hospital the opportunity to provide valuable guidance and recommendations that will shape the direction of the program and ensure that it meets the needs of youth and families. This is likely someone who is in the role of a director or supervisor of Emergency Department services or Behavioral Health services. The role will vary based on each hospital's structure.

The **Contracted Systems Administrator (CSA)** provides access to services available through the NJ DCF CSOC. They are responsible for the daily functions of the clinical department including triage of calls, care coordination, and utilization management. The CSA facilitates access to behavioral health, substance use, and intellectual/developmental disabilities therapeutic services, ensuring that every youth receives the right services at the right time as part of an integrated service plan. They make timely intensity of services determination based on urgency of need. This includes the management of emergencies, such as access to Mobile Response & Stabilization Services. The CSA may receive calls from the youth's legal guardian while in the hospital. During this call, the parent/legal should specify that they are being referred to Project Connect. The CSA staff will note the call is a Project Connect referral in their system and then continue to assess the family for appropriate services.

Regional Care Coordinator Training Pathway

Required training should be completed within the first two months of employment. RCCs should participate in additional related suicide prevention training as they become available to remain knowledgeable about best practices in this field.

NJ DCF CSOC's orientation process

This training is an introduction to the NJ DCF and reviews the culture, the vision, and purpose while providing a welcoming environment for all new team members. The training is an offsite, in person training the provides the foundation for new and transferring staff to succeed and includes presentations led by a variety of department representatives i.e., Human Resources, Office of Employee Relations, Office of Diversity, Equity, and Belonging (DEB), etc.

Understanding Continuous Quality Improvement (CQI)

This training reviews the principles of CQI, basic elements of CQI models, and common tools used in CQI. The course details the meaning of Continuous Quality Improvement and describes DCF's quality efforts.

Question, Persuade, Refer (QPR) suicide prevention

This training reviews three simple steps anyone can learn to help save a life from suicide. The training is a 2-hour presentation that covers the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. Just like CPR, QPR is an emergency response to someone in crisis and can save lives. This Gatekeeper training is available through the CSOC Training and Technical Assistance offerings and other entities.

Safety Planning trainings offered by Stanley Brown

This training reviews best practices for implementing a Suicide Risk Curve which is utilized by the provider and the individual to help visualize the path traveled that lead to the current state. The training provides a detailed review of the Safety Plan and demonstrates how it, in conjunction with the Suicide Risk Curve, can be utilized to help the individual identify effective mechanisms to avoid future suicide attempts and/or ideations. The training emphasizes the importance of collaboration, honesty, and understanding of warning signs, and creating and utilizing intervention plans. https://suicidesafetyplan.com/training/.

Motivational Interviewing

This training helps participants develop an understanding of Motivational Interviewing and to practice these skills in an interactive setting. The training

describes the theoretical context for the development of Motivational Interviewing and the four fundamental processes to elicit change.

NJ Wraparound Values and Principles

This training provides a foundation for understanding the values & principles of "Wraparound", a strengths-based approach to serving youth & families, and its application within the NJ Children's System of Care. The training reviews core values and principles of NJ Wraparound. The training describes how to incorporate functional youth & family strengths and resources within a cultural context to support individualized care planning. Additionally, it reviews how placing focus on identifying & prioritizing youth and family needs will ensure the success of any expressed, measurable outcomes.

Project Connect Hospital Partner Training

All hospital staff who are responsible for discharge planning for youth with suicide ideation/attempts should watch the short training video which is uploaded on DCF's YouTube channel (see below for link). The training offers brief statistics on youth suicide in NJ, explains Project Connect, and how to refer youth. This recording will be shared with applicable staff via email by their leadership. The recording can also be found on the Project Connect website for future reference.

Supporting documents provided to partnering hospitals include:

Authorization for Release of Information and Consent to be Contacted form

Project Connect Family Flyer

Project Connect Job Aid for Hospital Staff

These documents can be found in the Forms & Tools section of this manual and will also be available on the Project Connect website.

The training and materials can be found on YouTube and on the Project Connect website:

https://www.youtube.com/watch?v=x3BTvZpU7RQ

https://www.nj.gov/dcf/project_connect.html

Staff should report concerns/barriers with the referral process to their Hospital Point of Contact for Project Connect and/or to the RCC.

SECTION 6:
FORMS & TOOLS

Authorization for Release of Information and Consent to be Contacted Form

This form is completed by the family with support from hospital staff to make a referral to Project Connect; it gives permission for the Regional Care Coordinator to obtain the family's contact information and to contact the family.

Authorization for Release of Information and Consent to be Contacted

Project Connect – Regional Care Coordinator

Referring Hospital: _____

Referred by: _____

Youth & Caregiver Contact Information

Caregiver/Legal Guardian Name: _____

Youth Name: _____

Primary Language: _____

Preferred Phone: _____

Mailing Address: _____

Preferred method of contact: phone call ☐ text message ☐

Project Connect is a service from NJ's Department of Children and Families – Division of Children's System of Care and provides follow-up telephone support to caregivers and youth discharging from the hospital or emergency room following a suicide attempt or ideation. A Regional Care Coordinator will contact you to provide support and confirmation in connecting to services.

I authorize Project Connect to:

☐ **Contact me after discharge for follow-up care coordination** of services using the above contact information.

☐ **Contact me in the future for program evaluation purposes.** My contact information will not be shared for purposes other than Project Connect.

☐ **Review youth information in NJ DCF CSOC's Management Information System** to inform care coordination.

Parent/Caregiver Signature: _____ Date: _____

This Authorization Expires After 1 year from the Date Signed

*Pursuant to the Health Insurance Portability and Accountability Act (HIPAA) and associated privacy rules promulgated at 45 CFR Part 160 and Subparts A and E of 45 CFR Part 164, the Department of Children and Families and its subordinate division, are "Health Care Providers" to whom covered entities are permitted pursuant to 45 CRF §164.506 to release protected health information, excluding psychotherapy notes and records of substance use treatment, without patient authorization, provided that such information is provided for the **treatment activities** of the receiving health care provider. DCF asserts by this form that the information is being sought solely for treatment activities.*

Project Connect Flyer for Family

Hospital staff will provide a Project Connect flyer to the family of any youth admitted to the Emergency Department or hospital following a suicide attempt or experiencing suicide ideation. The flyer can be provided to the family even if they are not interested in a referral to Project Connect, as a resource they may be later interested in accessing.

PROJECT CONNECT

PROJECT CONNECT helps to ensure your family is connected to services in the community after your youth is discharged from a hospital following a suicide attempt or suicide ideation. A Regional Care Coordinator will reach out to your family to provide support and access to services.

For assistance with behavioral health and to access Mobile Response and Stabilization Services for crisis situations, call PerformCare (1-877-652-7624). PerformCare is available 24/7 to connect youth and families to individualized care for behavioral health, intellectual/developmental disability, or substance use treatment needs.

PerformCARE®
1-877-652-7624

For life threatening situations, please call 911.

This initiative is supported in part with funds from the SAMHSA Garrett Lee Smith Youth Suicide Prevention grant.

WEEKLY PHONE FOLLOW-UP FOR THREE WEEKS WITH A REGIONAL CARE COORDINATOR

HELP CONNECTING TO PERFORMCARE

ADDITIONAL SUPPORT FOR YOUR FAMILY

LINKAGE TO SERVICES

PROJECT CONNECT IS A FREE SERVICE THROUGH DCF

REGIONAL CARE COORDINATOR CONTACT:
609-888-7111

CSOC.ProjectConnect@dcf.nj.gov

Caregiver Guide for calling PerfomCare

This form will assist families in contacting PerformCare and assist hospital staff in guiding the caregiver on the process.

PROJECT CONNECT

Caregiver Guide for calling PerformCare

PerformCare, the Contracted Systems Administrator for the Children's System of Care, is the single point of access to CSOC's wide array of behavioral health, substance use, and intellectual and developmental disability services for youth and families throughout New Jersey. Families can access Mobile Response and Stabilization Services by calling PerformCare.

1. **Prepare for the Call:**
   a. Ensure you have up to an hour of uninterrupted time.
   b. Be prepared to discuss the situation and your child's and family's needs.
   c. Consider what support you may find helpful.

2. **Make the Call:**
   a. Dial 1-877-652-7624
   b. Listen for the recorded message & press #2 to connect with a PerformCare Member Service Associate
   c. Inform the Associate of your family's situation and include, ***"I have been referred by Project Connect."***
   d. Confirm that you are the primary caregiver for the reference youth.
   e. You will be transferred to a licensed clinician to complete a Triage.

3. **Answer Questions:**
   a. Be prepared to answer demographic questions about your child.
   b. Provide a brief overview of why you are calling.

4. **Possible Next Steps:**
   a. The representative will determine available services for your child.
   b. If appropriate, you will be connected to the Mobile Response Stabilization Services (MRSS) team.

5. **Engaging with MRSS:**
   a. The MRSS team can meet in person, at your home, an agreed location, or via telehealth.
   b. It's best to contact MRSS when you are ready to meet; they are dispatched within an hour of the request for service.
   c. Mobile Response is available 24/7 and offers up to eight weeks of stabilization services.

For additional support, contact the Project Connect Regional Care Coordinator via email: CSOC.ProjectConnect@dcf.nj.gov.

NEW JERSEY DEPARTMENT OF CHILDREN & FAMILIES — DIVISION OF CHILDREN'S SYSTEM OF CARE

Project Connect Hospital Quick Guide

The Project Connect Hospital Quick Guide is a reference tool describing the role of the Regional Care Coordinators and of the Hospital Staff.

Hospital Quick Guide

Project Connect Regional Care Coordinators will:

- Partner with hospital staff to support discharge planning for youth who have attempted suicide or experienced suicidal ideation.
- Follow-up post-discharge to ensure youth and families are connected to appropriate services.
- Serve as the family's point of contact to support the transition from hospital discharge to engagement in community treatment.
- Provide support for hospital staff to effectively implement Project Connect.

Hospital Staff will:

Inform the Caregiver

- Explain Project Connect
- Obtain Consent
- Provide flyer & SPTS Behavioral Health toolkit

Connect to PerformCare

- Explain PerformCare to Caregiver: single point of access to NJ's youth behavioral health system.
- Make call with Caregiver to PerformCare **1-877-652-7624**; press #2, and inform Member Associate *"referred by Project Connect."*
- Confirm space for the family to meet with Mobile Response Stabilization Services (MRSS) or MRSS can meet the family at another agreed upon location.

Make the Referral

- Send consent form and discharge summary or behavioral health assessment to: **CSOC.ProjectConnect@dcf.nj.gov**
- PerformCare and Project Connect utilize interpretation and translation services at no cost to the family.

Goals of Project Connect:

- Increase engagement in community mental health services after hospital discharge.
- Reduce Emergency Department and Hospital admissions for suicide attempts.
- Improve safety and well-being for youth and families.

CSOC.ProjectConnect@dcf.nj.gov

NEW JERSEY DEPARTMENT OF CHILDREN & FAMILIES
DIVISION OF CHILDREN'S SYSTEM OF CARE

Referral Tracker

Referrals received by RCC should be entered into the Project Connect referral tracker. RCC will complete all fields and place any pertinent comments in the NOTES column. RCC will save this information in the Project Connect folder on a Shared Drive for internal colleagues to view.

The referral tracker is an Excel spreadsheet. It includes the following data fields:

- Date of referral
- Hospital Name
- Youth name
- Youth DOB
- Youth Gender
- Youth CYBER ID (When applicable)
- Caregiver name
- Primary language
- Race/Ethnicity
- Sexual Orientation
- Phone number
- Address
- Call or Text preference
- Date of 1st contact attempt
- Date of 2nd contact attempt
- ICD diagnosis
- Services provided by RCC
- Reason for hospital visit
- Connected to PerformCare (Y/N)
- MRSS responded (Y/N)
- Attended Mental Health Appointment (Y/N)
- Re-Hospitalized (Y/N)Date of 2nd week call/text attempt
- Date of 3rd week call/text attempt
- Date Caring Contact Mailed
- Notes

SECTION 7: APPENDICES

Appendix A: Regional Care Coordinator Job Description

Project Connect Summary: Project Connect works in partnership with identified hospitals to enhance discharge planning for youth with suicide ideation and/or attempts. After youth are medically stabilized, screened, and determined to be safe for discharge home, hospital staff will complete a referral to Project Connect for interested caregivers, while also supporting the caregiver in calling the Contracted System Administrator to access behavioral health services. A Project Connect Regional Care Coordinator will make contact post-discharge to provide the family with follow-up assistance to ensure linkage and engagement with community behavioral health services.

Title: Regional Care Coordinator

Job Summary: The Regional Care Coordinator partners with NJ hospitals to provide follow-up care coordination for youth being discharged from emergency departments and acute care settings following a suicide attempt or ideation. The Regional Care Coordinator is responsible for creating and maintaining partnerships with hospitals implementing the program, providing access to relevant training and materials, and technical assistance. The Regional Care Coordinator conducts approximately 90 telephonic follow-up calls to caregivers and youth per month, following a referral from a hospital and ensures the youth is connected to the Department of Children & Families – Division of Children's System of Care's Contracted System Administrator and other community-based supports as appropriate. The Regional Care Coordinator maintains data on all aspects of the program including hospital participation data, referrals, and family outreach and outcomes. The max number of referrals received per Regional Care Coordinator is 40 referrals a month.

Job Responsibilities:

<u>Establishes relationships with hospitals & related facilities to implement Project Connect:</u>

Advocates with hospitals about the potential benefits of partnering with Project Connect.

Utilizes data regarding suicide attempts in New Jersey, to aid in decision-making on areas of NJ to target for Project Connect.

Prepares detailed reports, correspondence, and statistical material, as requested, and needed to carry out assigned tasks.

Develops, presents, and distributes informational materials about Project Connect to engage hospitals.

Partners with interested hospitals to integrate Project Connect into their healthcare system.

Responds promptly to requests for additional information and assistance.

Acts as liaison between the hospital systems and other training partners.

Shares information about the referral process for Project Connect, the hospital-based implementation plan, and overall goals as well as related services and training.

Ensures hospitals have access to program materials (link for training sessions, flyers, etc.) and responds timely to requests for more information/ materials.

Creates and presents materials explaining Project Connect for hospitals and other entities as needed.

Linkage to Families- Project Connect Caregiver Calls:

Conducts phone outreach to caregivers to initiate Project Connect services and provide support.

Has strong communication and interpersonal skills that display empathy, such as active listening and compassion.

Provides clear explanation of Project Connect to caregiver and youth, as appropriate, and promptly responds to referrals.

Connects family to the Contracted Systems Administrator and/or other community-based referrals as needed.

Documents all attempts of outreach and the outcomes.

Data collection and Reporting activities:

Maintains workplan and utilizes tracker to collect data on completed hospital information sessions and hospital participation in Project Connect.

The Regional Care Coordinator will maintain all data regarding to the program, including hospital participation data, referrals and family outreach and outcomes. The RCC will utilize recent data regarding suicide attempts in New Jersey, to aid in decision-making on areas of New Jersey to target for Project Connect.

Requirements:

Education: Graduation from an accredited college with a Bachelor's degree.

Experience: Familiarity with hospital systems and discharge procedures. Experience working with the Children's System of Care, Mobile Response & Stabilization Services, and PerformCare. Experience in suicide prevention and terminology, and local resources to provide the youth and families with support.

Skills & Abilities: Able to effectively collaborate with stakeholders. Understanding of confidentiality and HIPAA regarding medical records and identifying information of the youth and families who consent to follow-up care. Competency in using Excel, public speaking, data collection & reporting. Excellent written and oral communication skills. The ability to engage youth and families and build community relationships and partnerships.

Preferred: Licensed mental health provider, i.e.: Licensed Clinical Social Worker, Licensed Professional Counselor, Licensed Psychologist. Experience delivering trainings to adults in the behavioral health workforce. Experience working with youth who have experienced suicidal ideations, behaviors, and attempts. Experience with crisis response and safety planning with youth and families.

Appendix B: Active Implementation Framework

The National Implementation Research Network (NIRN)[1] summarized implementation science through the following formula which has now been adopted by the Department as its organizing framework for managing the complexities of implementing programming for children and families:

This formula demonstrates that improved outcomes for children and families can be achieved when effective practice, effective implementation supports, and an enabling context all coexist. These elements have a synergistic effect. Desired outcomes are only achieved through the interaction of all three factors.

NJ DCF systematically utilizes the Active Implementation Framework and accompanying tools to help organize and strengthen programming with families. The visual of NIRN's Active Implementation Formula[1]1 below illustrates the specific components that are needed to factor into this equation. Programming, whether new or existing, is assessed for the presence or absence of each factor component. When absent, that component is co-created through a teaming structure that includes stakeholders with the necessary expertise for that component.

Below is a description of each of the components of the Active Implementation formula:

Practice Model Logic Model and Practice Profile	For an intervention or practice to be effective, it must be well-defined by a logic model and practice profile. A logic model is a roadmap that describes what results one hopes to achieve by doing specified activities. A practice profile is a tool for operationalizing

[1] Metz, A., Bartley, L., Maltry, M. (2017). *Supporting the Sustainable Use of Research Evidence in Child Welfare Services, An Implementation Science and Service Provider Informed Blueprint for the Integration of Evidence Based/Evidence Informed Practices into NJ Child Welfare System.* The National Implementation Research Network.

	an intervention so that staff, supervisors, and directors in implementing agencies have a clear understanding of what they are expected to do when implementing the practice. A practice profile includes guiding principles and essential functions. Guiding principles are the philosophies, values and beliefs that inform specific interventions. Essential functions describe the practice elements and promote consistency across staff and providers[2]
Implementation Supports Competency, Organizational, Fidelity	To ensure that staff are prepared to implement the practice well, staff selection criteria (job descriptions and interview protocol), skill-based training, and follow up coaching to reinforce the training must be in place. In addition, organizational supports such as clear administrative processes, data collection/data systems to support decision-making, and processes for systems coordination are needed so that the context in which the program is being implemented can be established, and to ensure that the factors connected to the implementation are hospitable for the intervention to succeed.[3] [4]
Teaming	Multi-level teaming structures move programs, practices, and strategies from an idea to full implementation and ensure consistent internal and external communication within teams and between teams. Teams meet regularly, have dedicated appointments, and work in a structured way with agendas, meeting notes, following up on action items, timelines, work plans and project management.[5]
Evaluation Plan and CQI	Data is used to support program implementation, ensure intervention fidelity, and assess child & family outcomes. Continuous Quality Improvement (CQI) involves developing a process for identifying, collecting, and analyzing data that are useful to make decisions on improvement. This should be an ongoing process[6].

[2] Metz, A. (2016). *Practice Profiles: A Process for Capturing Evidence and Operationalizing Interventions.* Chapel Hill, NC: National Implementation Research Network, University of North Carolina. Available online at https://nirn.fpg.unc.edu/sites/nirn.fpg.unc.edu/files/resources/NIRN-Metz-WhitePaper-PracticeProfiles.pdf.

[3] Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

[4] Metz, A., & Bartley, L. (2012). Active implementation frameworks for program success: How to use implementation science to improve outcomes for children. *Zero to Three Journal*, 32(4), 11-18.

[5] Metz, A., Bartley, L., Ball, H., Wilson, D., Naoom, S., & Redmond, P. (2015). Active implementation frameworks for successful service delivery: Catawba County Child Wellbeing Project. *Research on Social Work Practice*, 25, 415-422.

Appendix C: Project Connect Practice Profile

Activity: *Identify hospitals* interested in partnering to enhance their discharge procedures for youth following a suicide attempt.

Guiding Principle / Essential Function	Observable Staff Behaviors
Advocacy	RCC promotes the program to potential hospitals, explaining its benefits to families and hospitals.
Research Skills	RCC conducts research on potential hospital partners, gathering key contact information (names, emails, phone numbers). Utilizes data regarding suicide attempts in New Jersey to aid in targeting areas for Project Connect. Generates reports/documents that include data and hospital exploration information.
Clear Communication	RCC emails hospitals explaining Project Connect goals and the referral process. Develops flyers and materials for information sessions about Project Connect. Conducts PowerPoint presentations (virtual or in-person) explaining Project Connect, including NJ youth suicide statistics, hospital utilization, program goals, and referral processes. Offers Q&A opportunities.
Collaboration	After a hospital expresses interest, RCC schedules meetings with hospital decision-makers to discuss integrating Project Connect. RCC implement Continuous Quality Improvement (CQI) by collaborating with external stakeholders. Utilize and encourage stakeholders to provide feedback throughout the collaboration process; make applicable suggested adjustments.

Guiding Principle / Essential Function	Observable Staff Behaviors
Responsive	RCC responds within one business day to inquiries from hospitals about potential partnerships and provides additional resources as requested to aid in decision-making. RCC checks in with potential hospital decision makers as follow-up within two weeks of providing requested information.

Activity: *Present to Hospital Staff.* Provide materials to identified hospital staff on the project, explain to hospital staff their roles: linkage to PerformCare, consent documents, communication expectations, data gathering, and sharing.

Guiding Principle / Essential Function	Observable Staff Behaviors
Clear Communication	**Project Overview** RCC creates a Project Connect PowerPoint and records a high-quality information session. Shares a private link to the recorded training with hospital staff. Answers calls or emails from hospital staff within one business day. **Children's System of Care (CSOC) Information** Includes information about CSOC, PerformCare, and MRSS in the recorded session.
Organization	**Project Overview** Maintains an organized and up-to-date list of hospitals and key contacts. Stores the link to the information session for easy access.

Guiding Principle / Essential Function	Observable Staff Behaviors
	General Tasks Maintains and updates Project Connect workplan, organizing onboarding information and tasks.
Knowledgeable About Services	**Project Overview** Educates hospitals about Project Connect and responds to questions. Explains MRSS, PerformCare, and other related services.
Responsive	**Project Overview** Responds to hospital contacts within one business day by various communication methods. Provides all materials needed to implement the training. **CSOC Information** Supports CSOC and partnering hospitals in completing required legal documents and keeps parties informed of their status.

Activity: *Provide Information to Families.* Provide documents explaining CSOC and PerformCare to the family to assist with community services available for discharge/treatment planning.

Guiding Principle / Essential Function	Observable Staff Behaviors
Empathy	**CSOC & PerformCare Services** Hospital staff spends time face-to-face with youth and caregiver to review the discharge plan. Provides supportive presence during caregiver's call to PerformCare.

Guiding Principle / Essential Function	Observable Staff Behaviors
	Engages with family genuinely and listens to concerns. **Project Connect Information** Offers additional support through Project Connect referral.
Clear Communication	**Project Connect Information** Clearly describes Project Connect and the release of information. **CSOC & PerformCare Services** Responsive to patient and caregiver's needs. Instructs caregiver to call PerformCare to initiate mobile response prior to discharge.
Knowledgeable About Services	**Project Connect Information** Hospital staff is aware of the referral process to Project Connect. Answers patient and caregiver questions about the program. Seeks technical assistance from Project Connect staff when needed.
Organization	**Project Connect Information** Hospital staff organizes consents and flyers systematically. Ensures all required patient information is included on consent forms.
Responsive	**Project Connect Information** Provides referral to Project Connect within one business day of discharge.

Guiding Principle / Essential Function	Observable Staff Behaviors
	Gives feedback and suggestions for quality improvement to Project Connect. Sends agreed upon hospital data as scheduled according to grant reporting timelines.

Activity: *Linkages Provided to Families.* Ensure families are linked to Mobile Response and Stabilization Services (MRSS) and Project Connect for follow-up and support.

Guiding Principle / Essential Function	Observable Staff Behaviors
Empathy	**MRSS Services** MRSS staff meets family at hospital or home in a supportive and nonjudgmental manner. **Project Connect referral** Hospital staff securely emails the referral to RCC. **Project Connect Caregiver contact** RCC provides caring follow-up calls and acknowledges family difficulties.
Clear Communication	**MRSS Services** Explains options for meeting location according to family preference. **Project Connect Referral** Hospital staff sends documents to RCC via secure email or fax. Hospital staff follows up with RCC about any barriers to the referral process. **Project Connect Caregiver contact**

Guiding Principle / Essential Function	Observable Staff Behaviors
	RCC introduces self and program to caregiver/family. RCC reminds caregiver/family of follow-up call schedule.
Knowledgeable About Services	**MRSS Services** Describes process for mobile services and informs family of next steps. **Project Connect referral** Hospital staff are aware of how to refer a family to Project Connect. **Project Connect caregiver contacts** RCC assists family in calling PerformCare if needed. RCC will be familiar with community-based referrals and Cyber information access.
Organization	**MRSS Services** Follows program protocols for family response and documentation. **Project Connect referral** RCC organizes received referrals via referral tracker. RCC contacts families within 2 business days for follow-up. RCC maintains the list of referred youth, dates of contact, and outcomes. **Project Connect caregiver contacts** Documents call information systematically.
Responsive	**MRSS Services** Meets with family within MRSS timeframes. **Project Connect Referral**

Guiding Principle / Essential Function	Observable Staff Behaviors
	Hospital staff sends referral to RCC within one business day. RCC responds to calls from hospital staff within 2 business days. Provides additional consent forms and flyers when needed. **Project Connect caregiver contacts** RCC calls referred family within 2 business days of referral. RCC responds to family calls as soon as possible. Caring Contact postcards, mailed by RCC if no contact is made after 2 calls. Caring Contact postcards, mailed by RCC, 3 months post hospital discharge.

Appendix D: Communication Plan

A communication plan plays a pivotal role in developing and implementing Project Connect. It ensures that information flows effectively among all stakeholders, enhances engagement, and fosters transparency throughout the project lifecycle. The team utilized a four-step communication plan model.

Step 1: Establishing the Goals of the Communication Plan The communication plan's overarching goal is to ensure that all stakeholders are well-informed, engaged, and aligned with the project's goals. The plan aims to raise awareness and understanding of Project Connect among all stakeholders, including hospital staff, youth, families, and community mental health services. This comprehensive understanding helps build support and participation from all involved parties, ensuring the program's smooth implementation and operation. A critical goal of the communication plan is to engage and educate hospital staff on the benefits of Project Connect and the referral process. Following presentations, hospital staff will be able to engage families, obtain necessary consent, and make appropriate referrals, which is essential for the program's success. Another crucial objective is facilitating seamless coordination and communication between hospitals, the Regional Care Coordinators, and community mental health services. Clear communication channels ensure all parties are aligned, families receive timely support, and consistent follow-up on referrals. By providing effective communication and outreach, families receive the information, resources, and emotional support needed during and after the discharge process, reducing the risk of suicide and improving overall family well-being. Monitoring and reporting on program effectiveness is also a key goal. Regularly communicating the outcomes of youth and the impact of Project Connect to stakeholders through progress reports and success stories and

identifying areas for improvement fosters accountability and demonstrates the program's value. Finally, promoting continuous feedback ensures that the program remains effective and responsive to the needs of youth and families.

By addressing these goals, Project Connect will ensure the initiative is well-supported, effectively implemented, and continuously improved, leading to better mental health outcomes for youth and their families following suicide attempts or ideation.

Step 2: Defining Key Audiences

The communication plan targets several key audiences essential to the program's success. Hospital administrators and staff are critical in identifying youth at risk of suicide, obtaining consent, and initiating referrals to Project Connect for care coordination and support post-discharge. Equally important are the youth and their families who receive care coordination services from Project Connect. Families need a clear understanding of available resources, referral processes, and ongoing support options. Community mental health service providers constitute another vital audience, as they deliver essential behavioral health services and support to referred youth, ensuring continuity of care.

Regional Care Coordinators are pivotal in managing referrals, conducting follow-ups, and ensuring families are linked to appropriate services post-hospital discharge. Collaboration with the New Jersey Department of Children and Families (DCF) and the New Jersey Department of Health (DOH), along with oversight from the Substance Abuse and Mental Health Services Administration (SAMHSA) as the grant provider, underscores the importance of engaging governmental and regulatory agencies in supporting and sustaining Project Connect.

Each audience plays a pivotal role in the comprehensive approach to improving outcomes for at-risk youth and ensuring the program's effectiveness in addressing youth suicide prevention.

Step 3: Identifying Key Messages

In alignment with the Guiding Principles of Project Connect, the communication plan emphasizes continuity of care and coordinated efforts in a family focused manner. Project Connect aims to bridge the gap in behavioral health services post-hospital discharge for a suicide attempt or ideation by ensuring youth receive timely and appropriate support from community mental health services to reduce the risk of repeated suicide attempts. This underscores the program's approach to empower hospital staff to identify and refer youth and families who

may benefit from the support and care coordination activities of Project Connect.

The communication plan highlights the collaborative nature of Project Connect, spotlighting partnerships with hospitals, community mental health providers, regional care coordinators, families, and governmental agencies. The plan emphasizes the role of educating and supporting hospital staff, ensuring they are equipped with the knowledge and tools to effectively engage families, obtain consent, and make appropriate referrals to Project Connect.

Finally, the communication plan underlines the importance of engaging families in the care process, ensuring they are well-informed and actively supporting their child's journey to improved mental health. This family-focused approach enhances stakeholder collaboration and trust, reinforcing the program's dedication to strengthening youth safety and access to mental health services. These key messages collectively reinforce the program's commitment to improving the safety, well-being, and access to mental health services for youth in New Jersey following a suicide attempt or ideation while ensuring families are central to the process of care and recovery.

Step 4: Creating a Tactical Outreach Plan

The communication outreach plan for Project Connect is designed to effectively engage and inform key stakeholders throughout the program's implementation. It begins with developing clear and concise messages that emphasize the program's goals of enhancing access to mental health services for youth experiencing suicidality following hospital discharge. Key stakeholders include hospital staff, youth and families, community health providers, regional care coordinators, government agencies, and funders. Each group is targeted through tailored communication channels: hospital staff viewing presentations to educate them on the referral process; developing a website for broader dissemination of information; and print materials like flyers distributed to hospitals.

Regular feedback mechanisms, including surveys and meetings, are established to gather insights and assess communication effectiveness. Additionally, hospital staff will be invited to sit on the Project Connect Hospital Steering Committee. This Committee aims to convene monthly to revise implementation protocols, obtain feedback on the program manual and applicable forms, and address barriers during the rollout of the program. This comprehensive approach aims to ensure that Project Connect is well-supported, understood, and effectively implemented to improve youth mental health outcomes in New Jersey post-suicide attempt or ideation.

Stakeholder Group	Objective	Communication Channels	Tactics	Feedback Mechanisms
Hospital Staff	Educate on Project Connect & referral process	Presentations, Flyers, Printed Materials, Emails, Meetings	In-person, synchronous & asynchronous virtual presentations, ongoing check-in calls, hospital monthly Steering Committee	Surveys after presentations, ongoing check-in calls, Steering Committee meetings, Interviews and Focus Groups
Youth and Families	Inform about available services	Website, Flyers, Caring Contact postcards, Printed Materials	Dedicated website and program materials at the hospital	Interview and Focus Groups
Community Health Providers	Collaborate on the coordination of care	Email, phone calls	RCC will engage regularly with community providers to coordinate care	Interview and Focus Groups
Government Agencies	Alignment and support	Meetings, reports	Regular meetings with Project	Interviews and Focus Groups,

			Connect staff, Office of Applied Research and Evaluation, and Office of Strategic Development	ongoing meetings
Funder	Demonstrate program impact	Quarterly reports	Report quarterly on SAMHSA metrics	Annual report feedback
General Public	Raise awareness	Website and reports	Project Connect website and final evaluation report	N/A

Appendix E: Additional Resources

Adapted from Traumatic Loss Coalitions for Youth (needed if applicable)

NJ has several crisis helplines. One is the NJ Hopeline at 855-654-6735 and another is the National Suicide Hotline at 988. Youth can call the 2NDFLOOR helpline at 888-222-2228 to talk through any problems they may be experiencing, or text the 2NDFLOOR number for help. There is also a message board to chat with other youth for support on their website (2ndfloor.org). These centers are available 24 hours a day and staffed by trained volunteers.

Guidance for answers to common caregiver questions after a youth suicide attempt

SPTS guidance for parents - https://sptsusa.org/parents/the-immediate-crisis-is-over-where-do-we-go-from-here/

SPTS Toolkit – Online Parent/Caregiver's Toolkit: Guide to Navigating Youth Behavioral Health - now available online for parents to create a free account and gain free access to the toolkit (available in 14 different languages).

1. What do I tell people about what happened?

The best answer is "whatever makes you comfortable." There is no reason to feel embarrassed about getting help; however, there still is a lot of misinformation about mental health treatment. While it's not necessary to advertise where your child has been, there's also no need to lie.

Most providers recommend someone in the school have some basic information about your child's recent struggle. No one needs to know all the details, but it will be helpful for your child to have an identified adult at school who can speak if needed.

Academic pressure can be a trigger for youth, and for students who miss school, it can be challenging. They may need help in advocating with the school to create a plan. Find out what work needs to be completed. Schools might adjust deadlines, reduce the number of missed assignments, or change schedules to assist with returning to school. It might be helpful to have a call with school staff and behavioral health providers to make a plan.

2. How can I help my child come up with an explanation for friends about where s/he's been?

Some kids tell peers that they have been in treatment, but don't explain the reason why. Other kids have used the explanation that they have been "dealing with family problems." It's a way to acknowledge the question, without giving specific information. Another common answer is for kids to say they have been out sick dealing with a medical problem.

3. How much freedom do we give our child?

Phone, Computer, Friends – set realistic expectations and be open with your youth about what they are. It is okay to monitor closely and stay on top of their behavior and interactions with peers if they know that it's happening. You might involve the youth's counselor in discussions about phone rules.

Daily or weekly check-in meetings (they can be as short as five minutes) can help clarify rules for the week and give back privileges gradually. Have clear communication about rules.

Monitoring interactions may be necessary until your child is more stable. Many suicide attempts have been triggered by negative interactions on social media or text messages so knowing what your child is being exposed to may be necessary to help keep them safe. Let your child know that you may look at their phone until they are feeling healthier.

Hanging out with friends is important to discuss and plan with your child. Friendships are important to development. Consider having your child's friends come over to the house. Be sure to check in after these interactions to get a sense of how it went. A good way to see friends is in structured situations like school activities or sports. They provide the opportunity for peer interaction with adult supervision and with an area of focus.

4. What do I tell siblings?

For siblings, including them in a conversation about what's going on is important. Siblings know and understand more than we think, and withholding information tends to confuse them. Allowing siblings to ask questions and share their fears is helpful. Again, make educated choices about just how much information to give based on the ages of the siblings and discuss it with professionals.

Appendix F: References

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