Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Health Care Self-Assessment

» INPATIENT

The transition from inpatient to outpatient behavioral health care is a critical time for individuals with a history of suicide risk and the health care systems that serve them. Research from the United States and internationally has shown that the highest risk period for someone hospitalized for suicide risk is immediately after discharge. Recent research has shown that receiving care within seven days of discharge is associated with lower suicide death rates.

Released in 2019, *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient to Outpatient Care* addresses goals 8 and 9 of the National Strategy for Suicide Prevention:

- **GOAL 8** – Promote suicide prevention as a core component of health care services.
- **GOAL 9** – Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors.

The Inpatient Health Care Self-Assessment checklist is designed to allow you to assess your care transition policies and practices. Please indicate where your organization falls on a scale of 1–4.

ADMINISTRATIVE PREPARATION	1	2	3	4
Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA). Partner with outpatient provider organizations and write a formal agreement that details care coordination expectations.	☐ We do not have agreements with any outpatient organization	☐ We have informal agreements with an outpatient organization.	☐ We have a formal agreement with one outpatient organization.	☐ We have MOUs/MOAs with our leading outpatient referral organizations.
Develop collaborative protocols. Work collaboratively with outpatient provider leadership to expedite initial counseling appointments.	☐ We do not have collaborative protocols with our outpatient providers.	☐ We have collaborative protocols with some outpatient providers.	☐ We have collaborative protocols with many outpatient providers.	☐ We have collaborative protocols with most of our outpatient providers.
Regularly meet. Ongoing communication between partner organizations is critical to maintaining safe and effective transitions of care. Set regular meetings, share metrics, and continue to assess the quality of the care transitions process.	☐ We do not meet with our partner organizations.	☐ We meet with our partner organization on an ad hoc basis.	☐ We meet with our partner organizations once a year.	☐ We meet with our partner organizations on a set schedule, e.g., quarterly.

LEARN MORE: SuicideCareTransitions.org

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

ZERO SUICIDE

This resource is supported by the generous contribution of Universal Health Services, Inc., Behavioral Health Division.

DURING CARE	1	2	3	4
Begin discharge planning upon admission. Discharge planning begins within 24 hours after admission.	☐ We initiate discharge planning on the day of discharge.	☐ We initiate discharge planning the day before discharge.	☐ We initiate discharge planning in the first few days after admission.	☐ We initiate discharge planning within 24 hours of admission.
Encourage family participation. Family members and other natural supports offer perspectives on the patient's strengths, struggles, and resources, and are sources of support and caring within the hospital setting and upon discharge.	☐ We rarely involve family members.	☐ We occasionally involve family members.	☐ We involve family members most of the time.	☐ We consistently involve family members.
Include peer specialists. Trained peer specialists can positively connect with the patient from a personal perspective to provide social and emotional support, answer questions about life after hospitalization, offer hope for recovery, and help problem-solve practical problems.	☐ We do not use trained peer specialists.	☐ We connect some of our patients with a trained peer specialist.	☐ We connect most of our patients with a trained peer specialist.	☐ We consistently connect our patients with a trained peer specialist.
Engage the school and community supports. For children or teens preparing for discharge, reach out to their school counselor to discuss supports and safety needs at school.	☐ We rarely connect with schools.	☐ We connect with schools some of the time.	☐ We connect with schools most of the time.	☐ We consistently connect with schools.
Involve other supports. With consent, engage, educate, and involve a network of supports the patient has identified.	☐ We do not involve other supports.	☐ We sometimes involve supportive others.	☐ Most of the time, we contact supportive others.	☐ We consistently involve supportive others.
Work collaboratively with the patient and their family members and natural supports to develop a patient safety plan.	☐ We do not involve the patient and family in developing a safety plan.	☐ We sometimes involve the patient and family in developing a safety plan.	☐ Most of the time, we involve the patient and family in developing a safety plan.	☐ We consistently involve the patient and family in developing a safety plan.
Schedule an outpatient appointment. Secure an outpatient behavioral health appointment. Ensure that your staff follows your written policies and procedures for facilitating outpatient counseling and providing follow-up care.	☐ We routinely secure an outpatient appointment within 30 days of discharge.	☐ We routinely secure an outpatient appointment within 8–14 days of discharge.	☐ We routinely secure an outpatient appointment within 7 days of discharge.	☐ We routinely secure an outpatient appointment within 24–72 hours of discharge.
Offer step-down care. Consider what level of care may be most appropriate for the patient after discharge.	☐ We rarely offer step-down care.	☐ We sometimes offer step-down care.	☐ Most of the time, we offer step-down care.	☐ We consistently offer step-down care.
Partner with the outpatient provider. Talk directly with the psychiatrist, psychiatric nurse, or behavioral health clinician who will treat the patient. Discuss identified barriers to outpatient care and answer the clinician's questions.	☐ We rarely talk directly with the outpatient clinician.	☐ We sometimes talk directly with the outpatient clinician.	☐ Most of the time, we talk directly with the outpatient clinician.	☐ We consistently talk directly with the outpatient clinician.

This resource is supported by the generous contribution of Universal Health Services, Inc., Behavioral Health Division.

Initiate personal contact between the patient and the outpatient provider. A short conversation with the therapist or other outpatient care team members before discharge builds a clinical bridge across services.	☐ We rarely initiate patient contact directly with the outpatient clinician.	☐ We sometimes initiate patient contact with the outpatient clinician.	☐ Most of the time, we initiate patient contact directly with the outpatient clinician.	☐ We consistently initiate patient contact with the outpatient clinician.
Consider innovative approaches for connecting the patient with the outpatient provider. Look for ways to connect the patient and outpatient provider before discharge (e.g., FaceTime, Zoom, phone call).	☐ We rarely consider innovative approaches.	☐ We sometimes consider innovative approaches.	☐ Most of the time, we use innovative approaches.	☐ We consistently consider innovative approaches.
AFTER DISCHARGE	1	2	3	4
Electronically deliver copies of essential records. Help the outpatient provider build on your organization's care by ensuring it receives copies of crucial records before the patient's first visit. Send the documents at the time of discharge and forward the discharge summary as soon as possible.	☐ We routinely deliver essential records within 14 days.	☐ We routinely deliver essential records within 5 business days.	☐ We routinely deliver essential records the day after discharge.	☐ We routinely deliver essential records on the day of discharge.
Make a discharge follow-up call to the patient. A follow-up call is standard practice for many types of hospital discharges. Patients should receive a follow-up call within 24 hours after discharge from behavioral health care.	☐ We do not make follow up calls.	☐ We routinely call the patient within 3–5 days after discharge.	☐ We routinely call the patient within 2–3 days after discharge.	☐ We routinely call the patient within 24 hours after discharge.
Provide ongoing caring contacts to the patient. Caring contacts are brief, encouraging notes or messages that do not require an action or response from the patient.	☐ We do not provide caring contacts.	☐ We provide 1–2 caring contacts in the first few days after discharge.	☐ We provide 3–7 caring contacts in the first few weeks after discharge.	☐ We provide 8 or more contacts over 9–12 months.

This resource is supported by the generous contribution of Universal Health Services, Inc., Behavioral Health Division.