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

» OUTPATIENT

The transition from inpatient to outpatient behavioral health care is a critical time for individuals with suicide risk, their families, and the health care systems that serve them. Research from the United States and internationally has shown the highest risk period is immediately after discharge from inpatient care. The suicide rate for the first week after discharge for patients with identified suicide risk history is 300 times higher than the general population's suicide rate (Chung et al., 2019), and it is greatest in the first few days after discharge (Riblet et al., 2017). Recent research has shown that receiving outpatient care within seven days of inpatient discharge is associated with lower suicide death rates (Fontanella et al., 2020).

Released in 2019, *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient to Outpatient Care* was written to advance 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 following checklist will help outpatient health care systems assess their policies, procedures, and practices related to these recommendations.

ADMINISTRATIVE PREPARATION	1	2	3	4
Establish good communication. Work together with the inpatient facility to develop a shared understanding of your different roles, limitations, and creative solutions to collaboratively provide patient-centered support.	☐ We do not have collaborative communication with our inpatient providers.	☐ We have some collaborative communication with our inpatient providers.	☐ We have collaborative communication with most inpatient providers.	☐ We have collaborative communication with all of our inpatient providers.
Establish policies and procedures. Establish and regularly review policies and procedures for triage and prioritized referral acceptance appointments for patients with identified suicide risk history who are referred from inpatient care.	☐ We do not have policies or procedures for triage or referral acceptance from inpatient providers.	☐ We have general policies and procedures for accepting referrals from inpatient providers.	☐ We have general policies and procedures for both triage and accepting referrals from inpatient.	☐ We have policies and procedures addressing triage for every patient and priority acceptance from inpatient providers.

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Accept shared responsibility. Accept shared responsibility for achieving a supportive, safe, and successful transition to outpatient care.	☐ We accept responsibility for patient care after the patient attends the first appointment.	☐ We cooperate with the inpatient provider to find an appointment time that works for the patient.	☐ We collaborate with the inpatient provider to connect the patient with community supports in addition to outpatient care.	☐ We actively share responsibility with the inpatient provider for achieving a safe and supportive transition to outpatient care.
Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA). Work together with inpatient providers from whom your organization often receives patient referrals. Negotiate for expedited medical records sharing, especially before the first outpatient appointment post-discharge. Ensure the MOU or MOA includes other procedures needed to facilitate prioritized appointments and warm, personal connections during transfers of care.	☐ We do not have agreements with inpatient providers.	☐ We have informal agreements with inpatient providers.	☐ We have a formal agreement with one inpatient provider organization.	☐ We have MOUs/ MOAs or similar written agreements with our leading inpatient referral organizations.
Regularly meet with your inpatient provider. During routine meetings: • Review the care transitions process. • Keep communication open. • Share metrics. • Ensure both parties give and receive what they negotiated.	☐ We do not routinely meet with inpatient providers.	☐ We meet with inpatient providers on an ad hoc basis.	☐ We meet with inpatient providers a few times a year to review the care transitions process, share metrics, and ensure we are both receiving what we negotiated.	☐ We meet with our inpatient providers on a set schedule, e.g., quarterly to review the care transitions process, share metrics, and ensure we are both receiving what we negotiated.
Train all support staff. Ensure your staff are trained to greet patients with compassion and warmth to help the patient and family feel more comfortable at the first appointment.	☐ We provide staff orientation but no specific training.	☐ We provide training and orientation upon hiring new staff.	☐ We have staff training available on an optional basis.	☐ We provide ongoing staff training on client engagement and customer service.
Train clinicians. Ensure your clinicians are providing evidence-based (EB) care specifically for suicide risk (i.e., DBT, CBT-SP, CAMS, PST, ABFT).	☐ We have clinicians who are trained in EB care for behavioral health problems but not specifically in suicide care.	☐ We have clinicians who are trained in suicide risk assessment but not specifically in EB suicide care.	☐ We have some clinicians who are trained in EB suicide care.	☐ We ensure all clinicians are trained in EB suicide care.
BEFORE DISCHARGE FROM THE INPATIENT SETTING	1	2	3	4
Obtain copies of essential documents. Work together with the inpatient provider to obtain copies of documents critical to ensuring patient safety and a seamless transition before the first outpatient appointment.	☐ We request inpatient records after the first outpatient appointment.	☐ We routinely request inpatient records before the patient attends the first outpatient appointment.	☐ We routinely request essential records on the day of discharge.	☐ We routinely request essential records at the time of referral.

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Arrange a conference call between the inpatient and outpatient providers. • Discuss continuity of care information, such as the patient's: » History » Course of illness » Care and clinical approach » Medications » Safety plan » Discharge plans • Discuss outpatient care options based on the patient's and family's needs and community resources. • Discuss procedures regarding who will follow up with the patient and family during the care transition period.	☐ We do not contact inpatient clinical providers before the patient is discharged.	☐ We sometimes contact inpatient clinical providers before the patient is discharged.	☐ Most of the time, we consult with inpatient clinical providers before the patient is discharged.	☐ We consistently consult with inpatient clinical providers before the patient is discharged.
Meet the patient and family members in the inpatient psychiatric setting. Ideally, the meeting should be held in the inpatient setting and include the inpatient and outpatient providers, the patient, and the patient's family members or natural supports. Alternatively, a case manager or peer specialist could make the first connection.	☐ We do not meet in person with the patient and family before inpatient discharge.	☐ We sometimes meet in person with the patient and family before inpatient discharge.	☐ Most of the time, we meet in person with the patient and family before inpatient discharge.	☐ We consistently meet in person with the patient and family before inpatient discharge.
If an in-person meeting before discharge is not possible, consider other ways to connect: • Schedule a meeting via telemedicine or videoconference. • At a minimum, call the patient before discharge to make a personal connection and introduce him or her to the outpatient services.	☐ We do not talk with the patient and family before inpatient discharge.	☐ We sometimes talk with the patient and family over the telephone, or we have a video-conference with the patient and family before inpatient discharge.	☐ Most of the time, we talk with the patient and family over the telephone, or we have a videoconference with the patient and family before inpatient discharge.	☐ We consistently meet with the patient and family, in person, over the telephone, or through a videoconference before inpatient discharge.
Triage appointments. Schedule the patient's first appointment within 24–72 hours of discharge. At the very least, ensure the initial appointment is no later than 7 days after hospital discharge.	☐ We routinely schedule an initial appointment within 30 days of discharge.	☐ We routinely schedule an initial appointment within 8–14 days of discharge.	☐ We routinely schedule an initial appointment within 7 days of discharge.	☐ We routinely schedule an initial appointment within 24–72 hours of discharge.

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AFTER DISCHARGE FROM THE INPATIENT SETTING	1	2	3	4
Contact the patient if the first appointment is more than 24 hours after discharge. Use the outreach call to: • Confirm the scheduled therapy appointment date and time. • Problem-solve any barriers to attending the first appointment. • Build rapport. **Ensure a clinician is available to:** • Re-assess suicide risk. • Review the patient's safety plan or crisis response plan—including talking about safe firearm storage, safe medication storage, safe disposal of unused medication, and other safety concerns.	☐ We contact the patient to remind them of their appointment.	☐ We sometimes contact the patient to build rapport or re-assess suicide risk, in addition to reminding them of the appointment.	☐ Most of the time, we contact the patient to build rapport, problem-solve barriers, or re-assess suicide risk, in addition to reminding them of the appointment.	☐ We routinely contact the patient within 24–72 hours of discharge to build rapport, re-assess suicide risk, and remind them of their appointment.
Schedule a clinical appointment with a provider trained in suicide care. A clinician trained in evidence-based (EB) treatment of suicidality (i.e., DBT, CBT-SP, CAMS, PST, ABFT) should provide outpatient therapy for patients with identified suicide risk.	☐ No clinicians are specifically trained in providing EB suicide care.	☐ Some clinicians are specifically trained in and provide EB suicide care.	☐ Most clinicians are specifically trained in and provide EB suicide care.	☐ All clinicians are specifically trained in and provide EB suicide care.
Involve family members and other natural supports. Obtain consent and do the following: • Involve the patient's family and support people in therapy. • Provide them with education on suicidality and any co-occurring mental illness or substance misuse issues. • Provide links to resources for supports.	☐ We rarely involve the family or provide education to the family or other natural supports.	☐ We provide educational resources to the patient to share with the family.	☐ We contact the family after 2–3 sessions for consultation on the patient's progress.	☐ We routinely involve the family in attending the initial appointment and ongoing care.
Involve family members and other natural supports in safety planning. Partner with family members and other natural supports to increase home and community safety by increasing the amount of time between the suicidal impulse and immediate access to a firearm or other household risks.	☐ We do not involve the family or other natural supports in safety planning.	☐ We contact the family or other natural supports after the safety plan is completed.	☐ We sometimes involve the family or other natural supports in safety planning.	☐ We routinely involve the family and natural supports in developing a safety plan and ongoing monitoring.
Offer stepped care to patients with suicide risk based on their needs and the community resources. Ensure the patient receives the intensity and level of care needed after hospitalization.	☐ We rarely offer stepped care.	☐ We sometimes offer stepped care.	☐ Most of the time, we offer stepped care.	☐ We consistently offer stepped care.
Connect the patient with peer-to-peer support. Trained peer supports offer the patient an opportunity to learn from those in recovery for their suicidality.	☐ We do not offer peer-to-peer support.	☐ We connect some patients with peer-to-peer support.	☐ We connect most patients with peer-to-peer support.	☐ We consistently connect our patients with peer-to-peer support.

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Engage the school. With consent: • Reach out to the school counselor to discuss supports and safety needs at school. • Share the safety plan with the school counselor. • Discuss ways the school staff can continue to support the student.	☐ We rarely engage with schools to discuss supports and safety needs for the student at school.	☐ We sometimes engage with schools to discuss supports and safety needs for the student at school.	☐ Most of the time, we engage with schools to discuss supports and safety needs for the student at school.	☐ We consistently engage with schools to discuss supports and safety needs for the student at school.
Involve other adult supports for children or youth. With consent, engage, educate, and involve a network of adult supports whom the youth has identified to provide extra support (e.g., coach, extended family member, youth group leader).	☐ We do not involve other adult supports.	☐ We sometimes list other adult supports on the safety plan.	☐ We contact other adult supports and encourage them to support the youth.	☐ We consistently engage, educate, and involve other adults to increase the network of adult supports for the youth.
Policy – Follow up on missed appointments. Develop, maintain compliance, and train staff on your organizational policy and procedures for managing missed appointments for patients with a history of suicide risk.	☐ We do not have a specific policy for missed appointments.	☐ We have a general policy for managing missed appointments by any patient.	☐ We have a specific policy for managing missed appointments by patients with a history of suicide risk.	☐ We have specific policies for managing missed appointments by patients with a history of suicide risk, and train staff on these policies at least annually.
Procedure – Follow up on missed initial appointments. If the patient does not show up for their first appointment, follow up immediately during the missed appointment time and after that, if needed, to re-assess suicide risk and reschedule the appointment.	☐ We follow up with a letter to the patient.	☐ We follow up with a same-day telephone call to reschedule the appointment.	☐ We follow up within the appointment hour and follow suicide crisis procedures as indicated.	☐ We follow up within 10 minutes of the appointment start time and follow suicide crisis procedures as indicated.
Close the communication loop. Inform the inpatient provider that the patient attended (or missed) the first scheduled appointment.	☐ We do not notify the inpatient provider.	☐ We sometimes notify the inpatient provider.	☐ We notify the inpatient provider if the patient does not keep the first appointment.	☐ We routinely notify the inpatient provider about the patient's attendance on the day of the appointment.

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Fontanella, C. A., Warner, L. A., Steelesmith, D. L., Brock, G., Bridge, J. A., & Campo, J. V. (2020). Association of timely outpatient mental health services for youths after psychiatric hospitalization with risk of death by suicide. *JAMA Network Open, 3*(8):e2012887. https://doi.org/10.1001/jamanetworkopen.2020.12887

Riblet, N., Shiner, B., Watts, B. V., Mills, P., Rusch, B., & Hemphill, R. R. (2017). Death by suicide within 1 week of hospital discharge: A retrospective study of root cause analysis reports. *The Journal of Nervous and Mental Disease, 205*(6), 436–442. https://doi.org/10.1097/NMD.0000000000000687

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