Best Practices in Care Transitions for Individuals with Suicide Risk:

INPATIENT CARE TO OUTPATIENT CARE

NATIONAL **ACTION ALLIANCE**
FOR SUICIDE PREVENTION

NATIONAL STRATEGY FOR SUICIDE PREVENTION

This report advances 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.

ABOUT THE NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION:

The National Action Alliance for Suicide Prevention (Action Alliance) is the public-private partnership working to advance the National Strategy for Suicide Prevention and reduce the suicide rate 20 percent by 2025. Support for Action Alliance initiatives comes from the public and private sectors. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding to Education Development Center (EDC) to operate and manage the Secretariat for the Action Alliance, which was launched in 2010.

TABLE OF CONTENTS

Introduction

The transition from inpatient to outpatient behavioral health care is a critical time for patients with a history of suicide risk and for the health care systems and providers who serve them. In the month after patients leave inpatient psychiatric care, their suicide death rate is 300 times higher (in the first week) and 200 times higher (in the first month) than the general population's (Chung et al., 2019). Their suicide risk remains high for up to three months after discharge (Olfson et al., 2016; Walter et al., 2019) and for some, their elevated risk endures after discharge (Chung et al., 2017). In the United States, **one out of seven people** (14.2 percent) who died by suicide had contact with inpatient mental health services in the year before their death (Ahmedani et al., 2014) and internationally, a recent meta-analysis yielded a higher percentage at 18.3 percent (Walby, Myhre, & Kildahl, 2018).

> **"Hospitalization is not designed to be the only treatment that patients need to restore them to wellness."**

Inpatient psychiatric care is designed to mitigate immediate risk, begin treatment, and prepare individuals for continuing care after hospitalization. Hospitalization is not designed to be the only treatment that patients need to restore them to wellness. They need follow-on care after discharge and referrals for outpatient behavioral health care. But all too often, patients fall through gaps in the behavioral health care system (National Committee for Quality Assurance, 2017), resulting in increased suicide risk and potential loss of life.

To help health systems and providers close these gaps in care, improve patient experience and outcomes, and prevent suicide deaths, the National Action Alliance for Suicide Prevention (Action Alliance)—working with health care and suicide prevention experts—developed *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care*. This guide does the following:

- Discusses the challenges in care transitions and the need for better care practices and care coordination from inpatient to outpatient behavioral health care

- Presents feasible, evidence-based practices that health systems and providers can take to improve patient connection and safety during inpatient to outpatient transition, and provides recommendations specific to both inpatient and outpatient settings

The information in this guide builds on current evidence about care transitions, as well as recommendations from these sources:

- *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe* (National Action Alliance for Suicide Prevention, 2018)

- *The Way Forward: Pathways to Hope, Recovery, and Wellness with Insights from Lived Experience* (National Action Alliance for Suicide Prevention, 2014)

The Action Alliance is committed to improving patient outcomes by working with health care system leaders and clinicians to close gaps in transitions of care. This report was developed to help improve and strengthen patient care and ensure that people at risk for suicide receive high-quality, evidence-based, continuous care that supports connection and recovery and ultimately saves lives.

The Transition from Inpatient to Outpatient Care

Inpatient and outpatient providers play important and yet different roles in the care of individuals with suicide risk. Inpatient care—which offers medically supervised programs in a hospital setting 24 hours a day, 7 days a week, and typically ranges from 48 hours to 10 days—is designed to mitigate immediate risk, begin treatment, and prepare patients for continuing care after hospitalization. Outpatient providers, on the other hand, have an ongoing role in providing a wide range of services to help patients move forward toward improved health and wellness. Ideally, behavioral health care is uninterrupted from inpatient to outpatient care. However, according to the HEDIS data set, nearly a third (30.3 percent) of patients do not complete a single outpatient visit in the first 30 days after inpatient behavioral health care in the United States (National Committee for Quality Assurance, 2017).

The care transition period is challenging for many reasons. The hospital has discharged the patient and is therefore no longer providing care. The outpatient provider has not yet seen the patient and therefore is also not providing care. So, during the care transition period, no one is providing clinical care; inpatient and outpatient organizations have a diffusion of responsibility for patient support; families are unsure how to best help their loved one; and patients are experiencing increased vulnerability and risk for suicide. As a result, lives are being lost.

Implementing Best Practices

Based in scientific research and informed by clinical practice, the recommendations in the next section are feasible, evidence-based strategies for caring for individuals with a history of suicide risk during the transition from inpatient to outpatient care. These strategies can guide inpatient and outpatient providers to actively take steps toward achieving a higher level of care before and during the care transition period.

Principles that can help guide organizational decisions and action include these:

- **Work as a collaborative team.** Instead of viewing inpatient and outpatient services as distinct entities, work together as a unified team and actively include both settings in planning for patient care. Employ a patient-centered approach that involves all providers, the patient, and the family and natural supports. Working together in tandem helps patients safely navigate the gap between care settings and continue the path toward improved mental health and wellness.

- **Cultivate human connection.** Look at each step or practice as part of a larger, holistic approach to working toward the health and safety of each patient by cultivating connections. Encourage contact between the outpatient provider and the patient prior to discharge. Find ways to build connections among the patient, family, and the natural supports. Make use of peer specialists and others with lived experience to support both the patient and the family during the care transition and throughout recovery.

- **Build bridges.** Take concrete steps to build a lasting structure for effective and safe care transitions.

  ◇ Establish, follow, and evaluate protocols to triage appointments and arrange for rapid referrals of patients with a history of suicide risk. Revise protocols as needed to improve the care transition process.

  ◇ Write formal agreements between inpatient and outpatient provider organizations to elucidate their roles, responsibilities, and commitments to rapid referral and triaged appointments. Ensure that both organizations' needs are met.

  ◇ Develop innovative strategies for narrowing the gap in care transitions.

  ◇ Maintain good communication through regular meetings between organizations to develop the partnership in patient care.

The interval between the inpatient and outpatient settings, no matter how brief, is a critical period for preventing suicides. By working together, taking concrete actions, and planning ahead, organizations can help ensure patient safety during the transition of care.

Recommendations for Inpatient Providers

The following recommendations are appropriate for inpatient psychiatric settings, such as hospitals, residential treatment centers, crisis stabilization units, behavioral health acute care units, or crisis respite centers. See the Resources section for specific tools to support these processes.

Prior to Discharge

1. Develop relationships, protocols, and procedures for safe and rapid referrals.

As noted in the introduction, the first week after discharge from inpatient treatment carries extraordinary risk for suicide, with suicide deaths occurring during this week at a rate 300 times higher than the global suicide rate (Chung et al., 2019). Therefore, it is crucial that patients receive an outpatient appointment as soon as possible after discharge from inpatient care and receive ongoing support until they attend that appointment. For referrals to be performed quickly and safely, inpatient facilities must already have relationships, policies, and protocols in place that will facilitate the referral process and support rapid outpatient appointment scheduling.

Begin discharge planning upon admission. Discharge planning begins within 24 hours after admission and sets a clear expectation that hospitalization is a brief period of treatment, and that post-discharge care is needed (Agency for Healthcare Research and Quality, 2019). The initial discharge goals may be very brief and may grow or develop during the course of treatment, building upon the initial needs, desires, and resources of the patient. Include the family

and natural supports in building the after-hospitalization discharge plan. Their involvement gives the treatment team critical insights and perspectives and also prepares the family and natural supports for discharge (Agency for Healthcare Research and Quality, 2019).

Develop collaborative protocols. To ensure rapid referrals to outpatient counseling for patients with a history of identified suicide risk, work collaboratively with outpatient provider leadership to expedite initial counseling appointments. Build a team approach for a swift and smooth transition from inpatient to outpatient care.

Negotiate a memorandum of understanding (MOU) or memorandum of agreement (MOA). Partner with outpatient provider organizations, to which your organization often refers patients, and write a formal agreement that details care coordination expectations. The agreements include expedited medical records sharing (e.g., transition plans, medications list, treatment plans, crisis/safety plans); tracking of admissions and discharges; coordination of specific services for patients with a history of suicide; active follow-up after discharge; and no-show follow-up protocols (SAMHSA, 2019). These types of agreements are becoming commonplace for ensuring care coordination between health care organizations. For example, Certified Community Behavioral Health Clinics are required to have partnerships or formal agreements with inpatient psychiatric facilities and other local health care provider agencies (SAMHSA, 2016). Partnerships and good communication are key to developing a smooth, seamless transfer of care with minimal delays and barriers. For examples, please see the Resources section.

Electronically deliver copies of essential records. Help the outpatient provider build on the care that your organization provided by ensuring it receives copies of essential records before the patient's first visit. Examples include current course of illness and treatment,

transition/discharge plans, treatment plans, medications list, crisis/safety plan, releases of information, and emergency contacts list. Send the records at the time of discharge and forward the discharge summary as soon as possible, preferably within 24 hours of discharge (Agency for Healthcare Research and Quality, 2019; Centers for Medicare and Medicaid Services, 2019).

2. Involve family members and other natural supports.

Encourage family participation. Family members and other natural supports offer perspectives on the patient's struggles and are sources of support and caring, within the hospital setting and upon discharge. Family and natural supports can include relatives, spouses, partners, and friends whom patients have identified as important to them (National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014). Involving the family and natural supports in the patient's care decreases stigma, increases the friends' and relatives' understanding of both suicide risk and any co-occurring mental health or substance misuse problems, underscores the need for ongoing care after hospitalization, and increases the likelihood of the patient engaging in outpatient care (Haselden et al., 2019).

People in the support network may need some support as well. Providing education and support to the family members and natural supports (e.g., through peer specialists, peer support groups, training, and linkages to other sources of support) can increase the efficacy of the natural support network for the patient outside the hospital (Agency for Healthcare

"Involving the family and natural supports in the patient's care decreases stigma."

Research and Quality, 2019). Create protocols and train staff on how to increase participation of family and natural supports. Ensure training is then put into practice.

Include peer specialists. Trained peer specialists have a personal experience with mental health care and are themselves in recovery. Peer specialists can positively connect with the patient from a personal perspective to provide social and emotional support, to answer questions about life after hospitalization, to offer hope for recovery, and to help problem-solve practical problems, such as transportation, applying for health insurance coverage, accessing veterans' benefits, obtaining medication refills, accessing local sources of support, finding stable housing, and many other questions.

Example: Saint Elizabeth's Hospital in Washington, D.C. makes use of peers to facilitate the transition from the hospital to community, especially for patients who have had longer stays. The hospital's peer support services assist with taking the patient to meet an outpatient provider, prior to discharge, for a transition meeting. In addition, a peer meets individually with the patient after discharge to review discharge plans, safety plans, and services. Patients reported the peers' assistance and support as useful and beneficial as they transitioned back to the community, given the peers' own experience and understanding of the community and services. (M. Gaswirth, personal communication, October 8, 2019).

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. With parental and student consent, share the safety plan with the school counselor and discuss ways the school staff (counselor, teachers, coaches) can support the student after hospitalization. Connect the school counselor with the outpatient behavioral health provider so both can support the student, within their appropriate roles.

Example: New Hampshire Hospital is dedicated to ensuring youth are connected to support in their community after discharge. The aftercare liaison works closely with the individual's support network—such as family, friends, school staff, coaches, and therapists—to develop an individualized plan to keep the patient safe in a crisis and connected to community resources. The liaison also provides the patient's family or caregivers with sources of educational materials and social support, such as NAMI NH programs. Working closely with the state's Regional Public Health Networks, the liaison also connects patients with local resources, such as social activities and classes that patients feel would be helpful after leaving the hospital. To learn more, visit SPRC Prevention in Practice-Care Transitions.

3. Collaboratively develop a safety plan as part of pre-discharge planning.

Work collaboratively with the patient and his or her family members and natural supports to develop a patient safety plan/crisis response plan (CARF International, 2019; Stanley & Brown, 2012). The safety plan (Stanley & Brown, 2012) or crisis response plan (Bryan et al., 2017) is a written strategy for coping with suicidal thoughts. This plan includes coping strategies that patients can use on their own; coping strategies that include family members, friends, or other supports; and resources such as crisis lines. Including family members and natural supports in developing the safety/crisis plan increases the safety at home, helps them understand the need for home safety practices, details helpful coping strategies, and explains the need for ongoing care with an outpatient behavioral health provider. Be sure to discuss and address any lethal means (items/methods) in the homes that may need to be secured or have reduced access. This includes firearms, certain types and quantities of medication, poisons, or other methods the patient has contemplated or identified. Experience in Zero Suicide (an evidence-based approach for transforming behavioral health care) suggests that rigorous and confirmed steps to reduce and remove lethal means are one of the most potent tools for preventing

suicide (National Academies of Sciences, Engineering, and Medicine, 2018). Follow up with family members to confirm they have improved safety at home by securing or reducing access to lethal means (items/methods) prior to discharge. Ensure that staff has the training to develop safety plans collaboratively and that expectations for this are clear, and check to make sure the approach is being implemented. To learn more about safety planning and talking with the patient and family members about lethal means, refer to the Resources section.

> **"Ensure that staff has the training to develop safety plans collaboratively."**

4. Connect with the outpatient provider.

Schedule an outpatient appointment. With input from the patient and family, secure an outpatient behavioral health appointment at a date and time that the patient can attend, ideally within 24-72 hours of discharge and no later than seven days after discharge. Ensure that your staff follows your written policies and procedures for facilitating outpatient counseling and providing follow-up care (The Joint Commission, 2019). Talk with the patient, family members, and outpatient provider to identify and resolve any potential barriers to attending the appointment (e.g., transportation, childcare, insurance, housing) prior to discharge, when possible.

Offer step-down care. Consider what level of care may be most appropriate for the patient after discharge. For some patients, a step-down approach may be effective. A step-down level of care provides an intermediate level of service, in a less restrictive environment than inpatient care, but offers more frequent services than typical outpatient once-weekly therapy appointments. Examples of step-down

approaches include intensive outpatient care or partial hospitalization. Support your staff to ensure the patient receives the intensity and level of care that is needed after hospitalization.

Partner with the outpatient provider. Talk directly with the psychiatrist, psychiatric nurse, or behavioral health clinician who will treat the patient. Provide background on the patient's presenting problem, course of treatment, the clinical approach (e.g., Dialectical Behavior Therapy [DBT], Collaborative Assessment and Management of Suicidality [CAMS]), and details of the collaborative safety plan. Discuss identified barriers to outpatient care and answer the clinician's questions. Gather any outpatient paperwork that can be completed prior to discharge, help the patient complete it, and electronically send it to the outpatient provider to ease the paperwork burden during the patient's first appointment.

Initiate personal contact between the patient and the outpatient provider. A short conversation with the therapist or other members of the outpatient care team (e.g., peer support specialist, case manager) prior to discharge builds a clinical bridge across services. An in-person meeting is ideal, but a videoconference or a telephone call can begin the transition by building an initial rapport and triples the likelihood of the patient continuing in outpatient care (Boyer, McAlpine, Pottick, & Olfson, 2000).

Consider innovative approaches for connecting the patient with the outpatient provider. Look for ways to connect the patient and outpatient provider prior to discharge. For example, in some locations, outpatient providers meet the patient, family, and natural supports at the inpatient care setting. In other locations, other outpatient team members, such as a peer specialist or a case manager, meet the patient and then continue to connect with the patient and his or her family/natural supports in the interim between the care settings (and during ongoing care).

Consider telemedicine videoconferencing or even a phone call to introduce the patient, family members/ supports, and outpatient provider. This personal contact allows the therapeutic alliance to begin prior to discharge and gives the patient and outpatient provider an opportunity to discuss care options, problem-solve practical barriers to attending appointments (e.g., transportation, work schedule, childcare, insurance), and preferences for continuing care appointments.

Although these approaches may not be feasible for all locations and providers, they demonstrate creative approaches to building connections and closing the care transition gap. Take advantage of local behavioral health and community resources in creative ways like this.

After Discharge

5. Follow up with the patient and outpatient provider.

Provide essential records to the outpatient clinician or case manager at the time of discharge. Send the essential records, such as transition plan, collaborative safety plan, medications list, releases of information, and emergency contacts list to the outpatient provider upon making the referral or at the time of the patient's discharge—but no later than the day before the outpatient appointment. Confirm receipt with the outpatient provider or agency.

Make a discharge follow-up call to the patient. A follow-up call is standard practice for many types of hospital discharges (e.g., surgery) to support the patient before his or her first appointment for follow-up care (Agency for Healthcare Research Quality, 2019). Patients who are discharged after receiving behavioral health care should be no different and should receive a follow-up call within 24 hours of discharge (SAMHSA, 2019). During this contact (typically a phone call), the inpatient provider (typically a discharge educator or planner) checks in with the patient about his or her recovery. The conversation provides an opportunity to do the following:

- Review the discharge plan, check for understanding, and allow the patient to ask questions

- Review the collaborative safety/crisis plan and re-assess risk

- Help with problem-solving practical problems, such as any challenges getting to a scheduled outpatient appointment or getting prescriptions refilled

Maintain telephone contact until the patient attends the first outpatient appointment. Some hospitals have found that contracting with a crisis center, such as a National Suicide Prevention Lifeline Call Center, to make follow-up calls has been very effective in supporting the patient, re-assessing suicide risk, and maintaining a personal connection until the patient can be seen in outpatient care. If organizations cannot call the patient, provide "caring contacts" starting at 24 hours post-discharge.

Provide ongoing caring contacts to the patient. Caring contacts are brief, encouraging notes or messages (card, text, email) that do not require a response from the patient. These notes or messages have demonstrated positive outcomes (Berrouiguet, Courtet, Larsen, Walter, & Vaiva, 2018; Falcone et al, 2017) and strong support and endorsement from those with lived experience (Reger et al., 2018). Research indicates that sending multiple caring contacts (e.g., nine or more) over a long time has measurable impact in preventing suicides (Hassanian-Moghaddam, Sarjami, Kolahi, Lewin, & Carter, 2017) as opposed to one contact (Chen et al., 2013). The *VA/DoD Clinical Practice Guideline*

recommends sending periodic caring contacts for 12-24 months (U.S. Department of Veterans Affairs & U.S. Department of Defense, 2019). To have a strong impact, provide caring contacts and use the following schedule:

- Make the first contact within seven days of discharge (within 24 hours if telephone contact is not possible).

- Continue caring contacts for 12 months or more (Luxton, June, & Comtois, 2013; U.S. Department of Veteran Affairs & U.S. Department of Defense, 2019).

Consider creative ways your hospital can send caring contacts regularly while maintaining efficiency and preserving confidentiality. Sending caring contacts has been incorporated into the discharge process in many organizations through creative combinations of automation and protocol planning.

Example: One hospital puts two caring contact cards in the discharge packet materials so that staff can sign and mail these notes. The first one goes out the day after discharge and the second one the following week. The patient's name is then added to an electronic database of patients who receive ongoing caring contacts that are printed, signed, and mailed by an administrative staff member. Another hospital manages their caring contacts by having trained volunteers handwrite general encouraging notes and stuff them in colored greeting card envelopes (without any hospital references). The cards are given to an administrative support staff member who attaches the patient's mailing label and mails it. See the Resources section for examples.

> **" Caring contacts are brief, encouraging notes or messages (card, text, email) that do not require a response."**

Regularly meet. Ongoing communication between partner organizations is critical to maintaining strong transitions of care. Keep communication open and ensure both parties are getting (and doing) what they agreed upon. Keep the lines of communication fluid to creatively explore together how to overcome organizational and practical barriers and best serve the care transition needs of the patient and his or her family.

Recommendations for Outpatient Providers

These recommendations for the transition from inpatient to outpatient care for patients with a history of suicide risk are appropriate for all outpatient behavioral health settings, including clinics, mental health centers, day treatment or partial hospital programs, group private practices, and, as feasible, solo private-practice therapists.

Prior to Discharge from the Inpatient Setting

Outpatient providers often have little contact with new patients before intake. Connecting with patients while they are still in the hospital will allow the patient and the outpatient therapist or care team member to begin to build a therapeutic alliance. The outpatient provider can answer questions; encourage patients to bring family members and other natural supports to therapy with them; review the collaborative safety plan; and share information on services, community supports, and peer resources. Beginning the therapeutic alliance prior to discharge triples the odds of the patient engaging in outpatient therapy (Boyer et al., 2000).

1. Develop relationships, protocols, and procedures that allow for safe and rapid referrals.

For these referrals to be performed quickly and safely, outpatient providers must establish relationships, policies, and protocols to facilitate the referral process.

Establish good communication. Cultivate a relationship between your agency and the inpatient facility. Work together to develop a shared understanding of your different roles, limitations, and creative solutions to collaboratively providing patient-centered support during the care transition.

Establish policies and procedures. Establish and regularly review policies and procedures for referral acceptance and preferential triage appointments for patients with identified suicide risk history who are being discharged from inpatient care. Those who are most in need of care should receive preferential appointments; that is, they should receive the first appointment if one appointment is available but multiple people want it. A patient's heightened risk for suicide in the first week after inpatient discharge places them at the top of the list of those most in need of care, and therefore prioritized intake scheduling is appropriate.

Accept shared responsibility. Accept shared responsibility for achieving a supportive, safe, and successful transition to outpatient care. Your organization is now part of a patient-centered care team that involves the inpatient provider, the family, the community supports, and the patient. This team needs your organization to take the lead in supporting and coordinating an effective and safe care transition. In accepting a referral from inpatient care for a patient who has been suicidal, your organization is accepting this shared responsibility.

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 (e.g., medications, transition plans, treatment plans, collaborative crisis/safety plans, releases of information, discharge summaries). Ensure the MOU or MOA includes other policies and procedures needed to facilitate prioritized appointments and warm, personal connections during transfers of care, such as in-person pre-discharge visits or telephone calls with the patient and the patient's support person. Your organization can begin the outpatient therapeutic process prior to discharge.

Obtain copies of essential documents. Work together with the inpatient provider to obtain copies of essential documents to ensure patient safety and a seamless transition before the first intake appointment. Examples include releases of information, transition plan, treatment plans, medications, and collaborative crisis/safety plan. Ask the inpatient provider to help the patient complete your initial paperwork or online forms

prior to discharge to ease the burden on the patient and family/supports at their intake appointment and to allow for improved early engagement between the patient, his or her family members, and your organization.

Arrange a conference call. Ideally, schedule a staffing conference call between the inpatient and outpatient providers to do the following:

- Share releases of information

- Discuss the patient's history, course of illness, care and clinical approach (e.g., DBT, CAMS), medications, discharge plans, and any known potential barriers to outpatient care (e.g., childcare, transportation, language)

- Arrange for delivery of inpatient records (crisis/ safety plan, medications, treatment plan, brief summary of treatment, transition plans, authorized release of information, and emergency contacts) through electronic health records transfer, fax, or other means

- Discuss care options based on the patient and family's needs and community resources, including step-down care

- Discuss procedures for who will follow up with the patient and family during the care transition period and in the event of a missed initial appointment

Train all staff. Support staff members are in the unique position, through their words and actions, to influence the patient's (and family's) first impression of the caring nature and quality of care that the outpatient office will provide. Greeting patients with compassion and warmth while getting the paperwork completed will help the patient and family feel more comfortable at the first appointment and can influence a patient's willingness to engage in treatment (Helleman, Lundh, Liljedahl, Daukantaité, & Westling, 2018). Consider arranging for a peer specialist to meet the patient in the waiting room for the first appointment and to help with the paperwork. Reinforce with support staff that they are

part of the care team. Consider offering ongoing training in mental health literacy and cultural competency to all staff to improve their interactions with clients and thereby support improved client engagement.

Train clinical staff in evidence-based treatment of suicidality. While there are many clinical approaches for behavioral health problems, only a handful of treatment approaches specifically address suicidality. For examples, see the Resources section.

2. Reach out to the patient and his or her family members and/or other natural supports.

Meet the patient and family members at the inpatient psychiatric setting. Ideally, the meeting should be held at the inpatient setting and include the providers, the patient, and his or her family members/ natural supports. If it is not feasible for the outpatient clinician to attend, consider having a hospital liaison or peer specialist do so.

Example: An innovative approach among three outpatient mental health centers in Texas ensures patients arrive at their intake appointments. Denton County MHMR, the Harris Center, and Tropical Texas Behavioral Health transport patients directly to their outpatient behavioral health office upon discharge from inpatient care. Family members are able to join the patient at the outpatient office that day for the first intake appointment. This allows the patient and family to immediately meet with their new care provider without a gap in care. Consequently, there are zero no-shows for the first appointment and high rates of engagement in continued therapy (J. Heise, personal communication, July 31, 2019).

If an in-person meeting prior to discharge is not possible, consider other ways to connect. For example, consider scheduling a meeting via telemedicine or videoconference. At a minimum, call the patient prior to discharge to make a personal connection,

introduce him or her to the outpatient services, and inquire about any special needs for the first appointment (e.g. transportation, childcare). After the call, forward information to the inpatient facility about your agency, such as answers to frequently asked questions, directions to the facility, or intake forms to be shared with the patient and his or her family.

After Discharge

3. Narrow the transition gap.

Triage intakes. 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 (Chung et al., 2019) and is greatest in the first few days after discharge (Riblet et al., 2017). Therefore, these patients are clearly among those most in need of services and eligible for prioritized, triage scheduling. Schedule the patient's first therapy intake appointment within 24 hours of discharge (Knesper, American Association of Suicidology, & Suicide Prevention Resource Center, 2010). Take the patient's special needs into account (e.g., work hours, childcare responsibilities), but work with the patient and clinicians to schedule an appointment within 24 hours of discharge and no later than seven days post-discharge.

Use your data on referral patterns and hours of service availability and use, and develop innovative strategies to create openings for these high-risk patients who are most in need of care. Some outpatient providers have set aside appointment slots every other day for hospital discharges based on their referral patterns. Others have scheduled appointment times during "open scheduling" or walk-in hours, giving the discharged patient preferential appointments. At the very least, ensure the initial appointment is no later than seven days after hospital discharge (CARF International, 2019).

Example: The U.S. Department of Veterans Affairs (VA) has expanded its policies for post-discharge mental health care so that treatment now includes four follow-up visits within 30 days. For veterans who have left the hospital against medical advice, they will receive follow-up within 24 hours of leaving the facility and no fewer than two appointments on separate days within the first seven days (Veterans Health Administration, 2017, 2019).

If the first appointment is more than 24 hours after discharge, reach out and contact the patient. Use the outreach call to confirm the first therapy intake appointment, build rapport, and re-assess suicide risk. This is also an opportunity to assess and problem-solve for any barriers to the first appointment (e.g., transportation, childcare). Outreach can be accomplished by team members, such as peer specialists, case managers, or hospital liaisons. Ensure a clinician is available to re-assess risk and take appropriate action to ensure safety and access care. Coordinate with the inpatient provider so the patient receives appropriate outreach contacts but is not overwhelmed by them.

Schedule a clinical intake with a provider trained in suicide care. A clinician trained in evidence-based treatment of suicidality should provide outpatient treatment for patients with identified suicide risk. Suicidality must be addressed specifically and directly, not assumed to be resolved through treatment of other behavioral health problems. See the Resources section for examples.

Involve family members and other natural supports. Involve the family in therapy, provide education on suicidality and any co-occurring mental illness or substance misuse issues, and provide linkages to resources for family support (e.g., certified peer specialists, peer-led support groups, and other community resources). Help create a healthier support system for the patient.

Family and close friends are often intimately involved in the suicidal crisis of a loved one. It is rare that the family and natural supports receive resources and support from the mental health community (Grant, Ballard, & Olson-Madden, 2015). As a result, they can feel significantly powerless, isolated, and guilty about what they did or did not do to help their loved one. They are often emotionally drained and exhausted, worried about their loved one, and may be paralyzed with ruminating fear that their actions could trigger a suicide attempt (Matulis, 2017; McLaughlin, McGowan, O'Neill & Kernohan, 2014). When these feelings are unaddressed, the family and caring supporters are left with little emotional space to provide the kind of support that the patient needs and that they want to be able to provide. Therefore, mental health professionals should acknowledge and address the impact that suicidal behavior has on the family and caring supporters and work to improve their health and resilience (McLaughlin et al., 2014).

A healthier family and support system improves the health and well-being of the patient (Agency for Healthcare Research and Quality, 2019). When family members better understand what they can do to support the patient, (e.g., what helps and what doesn't) and how they can better care for themselves, they can better support the patient.

Offer stepped care to patients with suicide risk, based on the client's need and your community resources. Ensure that the patient receives the intensity and level of care needed after hospitalization. Use a range of clinical and community services to support the patient's recovery.

Connect the patient with peer-to-peer support. Long-term peer support—through a certified peer specialist, peer support group, attempt survivor support group, or other community peer supports—offers the patient an opportunity to learn from those in recovery

for their suicidality and the opportunity to eventually be a support to others who have a history of suicidality (Davidson, Bellamy, Guy, & Miller, 2012). The mutual understanding and give-and-take of peer-to-peer support provides substantial emotional comfort, hope, and the opportunity for continued growth and recovery. Peers are a growing component of the behavioral health workforce. With standards and national certification in place, it is likely that peers will represent as much as 20 percent of the behavioral health workforce in the near future (Mental Health America, 2018).

Engage the school. For children or teenage patients, reach out to the school counselor to discuss supports and safety needs at school as the youth prepares for discharge. With parental and student consent, share the safety plan with the school counselor and discuss ways the school staff (counselor, teachers, coaches) can continue to support the student during school hours and school-sponsored activities. Help determine if any type of accommodation, health, or modification plan may be needed.

Involve other adult supports for children or youth. Engage, educate, and involve a network of adult supports (e.g., extended family members, coaches, teachers, youth group leaders) whom the youth has identified (and the parents have approved) to provide extra support. Results of youth-nominated support teams demonstrated positive effects *12 years later* (King et al., 2019).

Notify the inpatient provider that the patient has kept the outpatient appointment. Close the communication loop by informing the inpatient provider that the patient arrived for the scheduled appointment. Request any records that have not yet arrived (e.g., discharge summary) and thank the provider for the referral. Consider working together with the inpatient provider to review the process metrics for referrals and develop process improvements together. Look for

ways to include individuals with lived experience who are in recovery (e.g., peer specialists) to participate in this quality improvement process and inform the care transition efforts.

Follow up on missed appointments. If the patient does not show up for his or her first therapy intake appointment, follow up immediately during the missed appointment time, and if necessary, repeatedly thereafter by telephone, to reschedule. Notify the inpatient provider of the missed appointment and engage its help in contacting the patient. Assertively and persistently pursue contact with the patient, using first-line resources (e.g., telephone, personal contact, mobile crisis outreach team) and then second-line resources (individuals listed on the patient's safety plan and emergency contacts list received from the inpatient provider). Finally, use emergency welfare checks by first responders when the available information (e.g., records, information from family and supports, and clinician's decision) indicates highly acute and potentially imminent risk for suicide. Establish written protocols to follow when a patient is unresponsive to outreach efforts and specify criteria for when welfare checks will be requested.

Example: The VA has developed and expanded follow-up policies for missed behavioral health appointments. Staff is required to complete a minimum of four separate attempts to contact veterans who miss outpatient mental health or substance use disorder appointments to ensure veterans' safety and facilitate appropriate follow-up care (Veterans Health Administration, 2019). For veterans whose file indicates suicide risk, the follow-up must be conducted by staff members who are qualified to evaluate suicide risk (Veterans Health Administration, 2019).

Regularly meet with your inpatient provider. Review the process of care transition, keep communication open, and ensure both parties are getting (and doing) what they agreed upon. Discuss what is working well, how to maintain it, and what can

be improved. Keep the lines of communication open by meeting regularly to review the care transition processes and outcomes, to monitor progress toward shared goals, and to explore together how to innovatively overcome practical barriers in order to best serve the needs of the patient and his or her family.

Together We Can Do Better

Too many people are dying because we fail to follow evidence-based strategies to keep them safe during the care transition period. To save lives during the time between inpatient discharge and outpatient intake, both inpatient and outpatient organizations need to accept shared responsibility for the patient's care and work together. Collaborative, interorganizational teamwork requires communication, planning, and creativity.

The recommendations in this report provide a road map to jumpstart the process:

1. Develop formal relationships with your care continuum partner through MOUs, collaborative agreements, and shared protocols that allow for rapid referrals and safe transitions of care.

2. Write policies and procedures for ensuring continuity of care for patients who are about to be discharged from inpatient facilities. Involve individuals with lived experience to inform practices so that patients receive preferential, triaged appointments and arrive with necessary clinical information.

3. Involve family members and natural supports in treatment, safety planning, discharge planning, and ongoing care.

4. Use peers to provide outreach and support to both the patient and the family to increase social and emotional support, solve practical problems, and promote hope and ongoing recovery.

5. Offer step-down care to patients who may need an intermediate level of care between hospitalization and routine outpatient appointments.

6. Provide ongoing training to all staff, at all levels, in cultural competence; mental health and suicide literacy; patient vulnerability during the care transitions period; and the impact of warm, compassionate approaches within their service lane (e.g., support staff, case managers, clinicians) to patients with a history of suicidality and their families. Ensure clinicians are trained in evidence-based treatment specifically for suicidality.

7. Use available information within your organization system to examine referral patterns, length of care gaps, and days/hours of service availability and use, and apply that information to modify current practice and ongoing performance improvement.

8. Maintain good communication between organizations—meet regularly, close the feedback loop, follow up on no-show patients, establish collaborative care transition goals, and monitor progress toward meeting those goals.

9. Establish protocols for following up on missed appointments with patients who have a history of suicidality. Collaborate with inpatient providers to coordinate outreach and follow-up for patients who do not attend the intake appointment after discharge.

10. Develop metrics for measuring the impact of initiatives, assessing success in closing the care gap, and improving patient engagement. Follow a continuous performance improvement process for care transitions.

As an inpatient or an outpatient health care organizational leader, your organization is a crucial partner in the effort to prevent suicide during the high-stakes period of care transitions. Together, grounded in research and best practices, we can build a seamless continuum of care to save lives.

References

Agency for Healthcare Research and Quality. (2019). *Re-engineered discharge (RED) toolkit*. Content last reviewed February 2019. Rockville, MD. Retrieved from https://www.ahrq.gov/hai/red/toolkit/index.html

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., … Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine, 29*(6), 870–877. Retrieved from https://doi.org/10.1007/s11606-014-2767-3

Berrouiguet, S., Courtet, P., Larsen, M. E., Walter, M., & Vaiva, G. (2018). Suicide prevention: Towards integrative, innovative and individualized brief contact interventions. *European Psychiatry, 47,* 25–26.

Boyer, C. A., McAlpine, D. D., Pottick, K. J., & Olfson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *American Journal of Psychiatry, 157*(10), 1592–1598. Retrieved from https://doi.org/10.1176/appi.ajp.157.10.1592

Bryan, C. J., Mintz, J. Clemans, T. A., Leeson, B., Burch, T. S., Williams, S. R., & Rudd, M. D. (2017). Effect of crisis response planning vs. contracts for safety on suicide risk in U.S. Army soldiers: A randomized clinical trial. *Journal of Affective Disorders, 212, 264*–272. Retrieved from http://www.jad-journal.com/article/S0165-0327(16)31947-4/ppt

CARF International. (2019). *2019 behavioral health standards manual*. Tucson, AZ: Commission on Accreditation of Rehabilitation Facilities.

Centers for Medicare and Medicaid Services. (2019, September 26). *CMS' discharge planning rule supports interoperability and patient preferences.* Retrieved from https://www.cms.gov/newsroom/fact-sheets/cms-discharge-planning-rule-supports-interoperability-and-patient-preferences

Chen, W., Ho, C., Shyu, S., Chen, C., Lin, G., Chou, L., . . . Chou., F. (2013, Jul 17). Employing crisis postcards with case management in Kaohsiung, Taiwan: 6-month outcomes of a randomised controlled trial for suicide attempters. *BMC Psychiatry, 13*(191). Retrieved from https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-13-191

Chung, D. T., Hadzi-Pavlovic, D., Wang, M., Swaraj, S., Olfson, M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalisation. *BMJ Open, 9*(3), e023883. Retrieved from http://dx.doi.org/10.1136/bmjopen-2018-023883

Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. *JAMA Psychiatry, 74*(7), 694–702. doi:10.1001/jamapsychiatry.2017.1044

Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. *World Psychiatry, 11*(2), 123–128.

Falcone, G., Nardella, A., Lamis, D. A., Erbuto, D., Girardi, P., & Pompili, M. (2017). Taking care of suicidal patients with new technologies and reaching-out means in the post-discharge period. *World Journal Psychiatry, 7*(3), 163–176. doi:10.5498/wjp.v7.i3.163

Grant, C., Ballard, E. D., & Olson-Madden, J. H. (2015). An empowerment approach to family caregiver involvement in suicide prevention: Implications for practice. *Family Journal: Counseling and Therapy for Couples and Families, 23*(3), 295–304.

Haselden, M., Corbeil, T., Tang, F., Olfson, M., Dixon, L. B., Essock, S. M., . . . Smith, T. E. (2019). Family involvement in psychiatric hospitalizations: Associations with discharge planning and prompt follow-up care. *Psychiatric Services, 70*(10), 860–866. Retrieved from https://doi.org/10.1176/appi.ps.201900028

Hassanian-Moghaddam, H., Sarjami, S., Kolahi, A. A., Lewin, T., & Carter, G. (2017, January 2). Postcards in Persia: A twelve to twenty-four month follow-up of a randomized controlled trial for hospital-treated deliberate self-poisoning. *Archives of Suicide Research, 21*(*1*), 138–154.

Helleman, M., Lundh, L., Liljedahl, S., Daukantaité, D., & Westling, S. (2018). Individuals' experiences with brief admission during the implementation of the brief admission skane RCT, a qualitative study. *Nordic Journal of Psychiatry, 72*(5), 380–386. Retrieved from https://doi.org/10.1080/08039488.2018.1467966

King, C., Arango, A., Kramer, A., Busby, D., Czyz, E., Foster, C., . . . YST Study Team. (2019). Association of the youth-nominated support team intervention for suicidal adolescents with 11- to 14-year mortality outcomes: Secondary analysis of a randomized clinical trial. *Journal of American Medical Association,76*(5), 492–498. Retrieved from https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2722847

Knesper, D. J., American Association of Suicidology, & Suicide Prevention Resource Center. (2010). *Continuity of care for suicide prevention and research: Suicide attempts and suicide deaths subsequent to discharge from the emergency department or psychiatry inpatient unit*. Newton, MA: Education Development Center, Inc.

Luxton, D. D., June, J. D., & Comtois, K. A. (2013). Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis, 34*(1), 32–41. doi:10.1027/0227-5910/a000158

Matulis, A. (2017). *Is this the night: Finding inner peace: A self-care guide for family and friends impacted by a suicidal crisis*. Taunton, MA: A Voice at the Table.

McLaughlin, C., McGowan, I., O'Neill, S., & Kernohan, G. (2014). The burden of living with and caring for a suicidal family member. *Journal of Mental Health, 8237*(5), 1–5.

Mental Health America. (2018). *National certified peer specialist (NCPS) certification: An overview of the development and launch of the first national, advanced peer support specialist certification*. Retrieved from https://www.mhanational.org/sites/default/files/NCPS%20White%20Paper%2011.2.18.pdf

National Academies of Sciences, Engineering, and Medicine. (2018). *Improving care to prevent suicide among people with serious mental illness: Proceedings of a workshop*. Washington, DC: National Academies Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK540128/

National Action Alliance for Suicide Prevention. (2018). *Recommended standard care for people with suicide risk: Making health care suicide safe*. Retrieved from https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf

National Action Alliance for Suicide Prevention, Suicide Attempt Survivors Task Force. (2014). *The way forward: Pathways to hope, recovery, and wellness with insights from lived experience*. Washington, DC: Author. Retrieved from https://www.sprc.org/resources-programs/way-forward-pathways-hope-recovery-and-wellness-insights-lived-experience

National Committee for Quality Assurance. (2017). *Follow-up after hospitalization for mental illness (FUH)*. Retrieved from https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

Olfson, M., Wall, M., Wang, S., Crystal, S., Liu, S., Gerhard, T., & Blanco, C., (2016). Short-term suicide risk after psychiatric hospital discharge. *Journal of the American Medical Association Psychiatry, 73*(11), 1119–1126. Retrieved from https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2551516

Reger, M. A., Gebhardt, H. M., Lee, J. M., Ammerman, B. A., Tucker, R. P., Matarazzo, B. B., ... & Ruskin, D. A. (2018). Veteran preferences for the caring contacts suicide prevention intervention. *Suicide and Life—Threatening Behavior*. Retrieved from https://onlinelibrary.wiley.com/doi/abs/10.1111/sltb.12528

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.

SAMHSA. (2016). *Criteria for the demonstration program to improve community mental health centers and to establish certified community behavioral health clinics.* Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/ccbhc-criteria.pdf

SAMHSA. (2019). *Care coordination agreements and care transitions.* Retrieved from https://www.samhsa.gov/section-223/care-coordination/agreements-transitions#requirements

Stanley, B., & Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice, 19*(2), 256–264. Retrieved from https://doi.org/10.1016/j.cbpra.2011.01.001

The Joint Commission. (2019). Suicide prevention portal. Retrieved from https://www.jointcommission.org/topics/suicide_prevention_portal.aspx

U.S. Department of Veterans Affairs, & U.S. Department of Defense. (2019). *VA/DoD clinical practice guideline: Assessment and management of patients at risk for suicide, Version 2.0.* Retrieved from https://www.healthquality.va.gov/guidelines/MH/srb/

Veterans Health Administration. (2017, June 12). *Eliminating veteran suicide: Enhancing acute inpatient mental health and residential rehabilitation treatment program discharge planning and follow-up* (VHA memo). Washington, DC: Author.

Veterans Health Administration. (2019, May 8). *Outpatient scheduling processes and procedures* (VHA Directive 1230). Washington, DC: Author.

Walby, F. A., Myhre, M. Ø., & Kildahl, A. T. (2018). Contact with mental health services prior to suicide: A systematic review and meta-analysis. *Psychiatric Services, 69*(7), 751–759. Retrieved from https://ps.psychiatryonline.org/doi/pdf/10.1176/appi.ps.201700475

Walter, F., Carr, M. J., Mok, P. L. H., Antonsen, S., Pedersen, C. B., Appleby, L., . . . Webb, R. T. (2019). Multiple adverse outcomes following first discharge from inpatient psychiatric care: A national cohort study. *Lancet Psychiatry, 6*(7), 582–589. Retrieved from https://doi.org/10.1016/S2215-0366(19)30180-4

Resources

Topic	Name	Type/Source	Link
Suicide Care	Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe	Recommendations, National Action Alliance for Suicide Prevention	theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf
	VA/DoD Clinical Practice Guideline: Assessment and Management of Patients at Risk for Suicide	Guideline, U.S. Department of Veterans Affairs/U.S. Department of Defense (VA/DoD)	www.healthquality.va.gov/guidelines/MH/srb/
	Evidence-Based Psychotherapy Shared Decision-Making Toolkit for Mental Health Providers	Resources, U.S. Department of Veterans Affairs (VA) and Education Development Center (EDC)	www.treatmentworksforvets.org/provider/
	Zero Suicide Toolkit	Toolkit, EDC	zerosuicide.sprc.org/toolkit/transition#quicktabs-transition=1
	Universal Health Services (UHS) Inpatient Suicide Care Management Plan Template	Template, UHS	zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/UHS%20Inpatient%20Suicide%20Care%20Management%20Plan%20Template.pdf
Suicide-Specific Therapy Approaches	Dialectical Behavior Therapy (DBT)	Website, Behavioral Tech	behavioraltech.org/
	Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP)	Webpage, Zero Suicide, Suicide Prevention Resource Center (SPRC)	zerosuicide.sprc.org/resources/cognitive-behavior-therapy-suicide-prevention-cbt-sp-treatment-model-feasibility-and
	Collaborative Assessment and Management of Suicidality (CAMS)	Website, CAMS-Care	cams-care.com/
	Problem-Solving Therapy (PST)	Website, University of Washington	aims.uw.edu/collaborative-care/behavioral-interventions/problem-solving-treatment-pst
	Attachment-Based Family Therapy (ABFT)	Website, Drexel University	drexel.edu/familyintervention/attachment-based-family-therapy/overview/

Resources *continued*

Topic	Name	Type/Source	Link
Involving Family and Other Supports	Family-to-Family Educational Program	Webpage, National Alliance on Mental Illness	www.nami.org/Find-Support/NAMI-Programs/NAMI-Family-to-Family
	The Way Forward	Resource, National Action Alliance for Suicide Prevention	theactionalliance.org/sites/default/files/the-way-forward-final-2014-07-01.pdf
	Suicide Is Different	Website, Suicide Is Different	www.suicideisdifferent.org/
Safety Planning	Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version	Manual, Barbara Stanley and Gregory Brown	www.sprc.org/sites/default/files/resource-program/va_safety_planning_manual.pdf
	Patient Safety Plan	Handout, Barbara Stanley and Gregory Brown	suicidepreventionlifeline.org/wp-content/uploads/2016/08/Brown_StanleySafetyPlanTemplate.pdf
	Safety Planning Intervention	Website, Barbara Stanley and Gregory Brown	suicidesafetyplan.com/Home_Page.html
	Safety Planning Guide: A Quick Guide for Clinicians	Guide, SPRC	www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians
	SAMHSA Suicide Safe Mobile App	Mobile app, Substance Abuse and Mental Health Services Administration (SAMHSA)	store.samhsa.gov/product/SAMHSA-Suicide-Safe-Mobile-App/PEP15-SAFEAPP1
Lethal Means Counseling	Recommendations for Clinicians	Recommendations, Means Matter, Harvard School of Public Health	www.hsph.harvard.edu/means-matter/recommendations/clinicians/
	Recommendations for Families	Recommendations, Means Matter, Harvard School of Public Health	www.hsph.harvard.edu/means-matter/recommendations/families/
	Counseling on Access to Lethal Means (CALM)	Course, SPRC	www.sprc.org/resources-programs/calm-counseling-access-lethal-means
	Firearm Safety and Injury Prevention	Policy, American College of Emergency Physicians (ACEP)	acep.org/patient-care/policy-statements/firearm-safety-and-injury-prevention/
	Alabama Public Health Suicide and Home	Handout, Alabama Public Health	www.alabamapublichealth.gov/cdr/assets/Suicide_and_Home_brochure.pdf

Resources *continued*

Topic	Name	Type/Source	Link
Rapid Referrals	HelpPRO Therapist Finder	Database, HelpPRO	www.helppro.com/
	Therapy Finder	Database, National Suicide Prevention Lifeline	suicidepreventionlifeline.org/help-yourself/
Discharge Planning	Strategy 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning	Handout, Agency for Healthcare Research and Quality (AHRQ)	https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy4/Strat4_Tool_1_IDEAL_chklst_508.pdf
Care Transitions	Continuity of Care for Suicide Prevention and Research	Handout, SPRC	www.sprc.org/sites/default/files/migrate/library/continuityofcare.pdf
	Safe Care Transitions for Suicide Prevention	Recommendations, Utah Department of Human Services, Substance Abuse and Mental Health	dsamh.utah.gov/pdf/ZS%20Docs/Safe%20Care%20Transitions%20DSAMH%202018.pdf
Follow-up	Follow-Up Matters	Website, National Suicide Prevention Lifeline	followupmatters.suicidepreventionlifeline.org/
	Re-engineered Discharge (RED) Toolkit; Tool 5: How to Conduct a Post discharge Follow up Phone Call	Webpage, AHRQ	www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool5.html
Billing	Cheat Sheet on Medicare Payments for Behavioral Health Integration Services	Handout, University of Washington	aims.uw.edu/sites/default/files/CMS_FinalRule_BHI_CheatSheet.pdf
	Transitional Care Management Services	Handout, Center for Medicare and Medicaid Services	www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf
	Financing Suicide Care	Webpage, Zero Suicide	zerosuicide.sprc.org/resources/financing-suicide-care
Caring Contacts	Now Matters Now, Caring Contacts	Examples Zero Suicide	zerosuicide.sprc.org/sites/zerosuicide.actionallianceforsuicideprevention.org/files/nowmmattersnow.pdf
	Zero Suicide, Contact after Leaving Care	Resources, Zero Suicide	zerosuicide.sprc.org/toolkit-taxonomy/contactafter-leaving-care

Contributors

Care Transitions Work Group, National Action Alliance for Suicide Prevention

Wendy Farmer, LPC, MBA
President and CEO
Behavioral Health Link

Kristi Fredritz, MSSA, LISW-S
Implementation Lead, Suicide Prevention
Veterans Health Administration

Michael Hogan, PhD
Principal
Hogan Health Solutions, LLC

Karen Johnson, MSW
Senior Vice President, Clinical Services and Division Compliance Officer
Universal Health Services, Inc.

Michael Johnson, MA, CAP
Managing Director, Behavioral Health
CARF International

Nina Marshall, MSW
Assistant Vice President, Healthcare Finance
National Council for Behavioral Health

Annmarie Matulis
Chair, Impacted Friends and Family Committee, Lived Experience
American Association of Suicidology

Richard McKeon, PhD
Chief, Suicide Prevention Branch
Substance Abuse and Mental Health Service Administration

Tracey Medeiros
Certified Peer Specialist, Lived Experience
Community Counseling of Bristol County

Gillian Murphy, PhD
Director, Standards, Training, and Practices
National Suicide Prevention Lifeline

Stephanie Pacinella, MA
Vice President, Evolving Practice and Standards Development
Council on Accreditation

Stacey Paul, MSN, RN, APN/PMHNP-BC
Project Director, Clinical Standards and Survey Methods
The Joint Commission

Shelby Rowe, MBA
Suicide Prevention Program Manager
Oklahoma Department of Mental Health and Substance Abuse Services

Becky Stoll, LCSW
Vice President, Crisis and Disaster Management
Centerstone

Rick Strait, MS, LPC, CRDAC, CCDP, CGDC
Program Manager, Integrated Treatment for Co-occurring Disorders
Community Counseling Center

EDC Staff

Colleen Carr, MPH
Director
National Action Alliance for Suicide Prevention

Julie Ebin, MEd
Manager, Special Initiatives
Suicide Prevention Resource Center

Terresa Humphries-Wadsworth, PhD
Associate Project Director
National Action Alliance for Suicide Prevention

Erin Oehler, JD
Associate Project Director
National Action Alliance for Suicide Prevention

Caitlin Peterson, MS, MFT
Senior Project Associate
Suicide Prevention Resource Center

Kimberly Torguson
Associate Director, Communications
National Action Alliance for Suicide Prevention