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Behavioral Health Patients: A Risk Management Overview

Hospitals and health systems face numerous barriers to the delivery of safe and efficient behavioral healthcare, including insufficient human and financial resources, rising patient loads, decreasing inpatient capacity and reimbursement roadblocks. According to the American Hospital Association, 55 percent of U.S. counties have *no* practicing psychiatrists, psychologists or social workers, and only 27 percent of community hospitals have an organized, inpatient psychiatric unit.[1] Yet due to de-institutionalization of psychiatric patients over the past several decades, there are fewer than 50,000 beds at specialized facilities nationwide,[2] and the vast majority of inpatient behavioral health services are provided in community hospitals and their networks.

In the current environment, many patients who present with complex behavorial health conditions – including mood, anxiety and substance-related disorders, as well as delirium, schizophrenia and dementia – must be stabilized by already hard-pressed emergency departments (EDs) and transitioned to outpatient and/or community-based services. Some of these patients slip through the cracks, creating exposure to such allegations as failure to refer, medication mismanagement, premature discharge, and inadequately addressing violence and aggression, among others.

According to the CNA *Hospital Professional Liability Claim Report 2015: Stepping up to Quality Healthcare and Patient Safety*, behavioral health claims rank second after perinatal claims in terms of severity, averaging $300,156 in total paid (i.e., indemnity or settlement payment plus legal and related expenses).[3] This figure is higher than the average total claim payment for surgery, medicine, emergency medicine, critical care, subspecialties and rehabilitation. (See Figure 1.) Lapses in patient assessment and monitoring are the costliest behavioral health claim allegations, followed by nursing-related care and patient abuse/professional conduct. (See Figure 2.) Permanent injury is the most frequent outcome and death the costliest, with suicide the cause of death in four of the 34 behavioral health-related closed claims. (See Figure 3.)

1 "Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes." American Hospital Association's *Trendwatch*, January 2012.

2 "Care of the Psychiatric Patient in the Emergency Department: A Review of the Literature," from the American College of Emergency Physicians®, October 2014.

3 The study examined a total of 591 professional liability claims involving perinatal care, inpatient medical, surgical, emergency care, rehabilitation, behavioral health and invasive procedures that closed between January 1, 2005 and December 31, 2014. Thirty-four of the claims arose from behavioral health occurrences.

To help organizations address major risk factors and deliver safer, higher-quality behavioral healthcare, this edition of *Vantage Point*® offers practical strategies designed to strengthen patient screening and assessment, management of psychiatric patients in the ED, inpatient management of comorbidities, environmental safety and patient discharge. The issue also includes a checklist of risk management initiatives covering a broad range of behavioral health-related safety issues and liability exposures.

Figure 1 – Average Total Paid for Closed Claims by Clinical Service

* "All other/not specified" includes sleep study and critical care claims, as well as claims with no specified clinical service.

Clinical service	Average paid expense	Average paid indemnity	Average total paid
Perinatal	$95,382	$320,097	$415,479
Behavioral health	$67,636	$232,520	$300,156
Surgery	$42,193	$222,205	$264,398
Medicine	$51,297	$212,160	$263,457
Emergency medicine	$69,816	$190,238	$260,054
Critical care	$34,697	$169,357	$204,054
Subspecialties	$39,118	$158,397	$197,515
Rehabilitation	$28,066	$125,694	$153,760
All other/not specified*	$11,515	$99,438	$110,953
Overall	**$52,563**	**$198,407**	**$250,970**

Figure 2 – Highest Average Total Paid for Behavioral Health Closed Claims by Allegation

Allegation	Average paid expense	Average paid indemnity	Average total paid
Assessment and monitoring	$86,806	$445,833	$532,639
Nursing-related care	$187,034	$300,000	$487,034
Patient abuse/professional conduct	$53,668	$279,444	$333,113
Credentialing	$27,404	$200,000	$227,404
Medication	$29,088	$155,834	$184,921

Figure 3 – Frequency of Behavioral Health Closed Claims by Outcome of Injury

Percentage of 34 behavioral health closed claims

PATIENT SCREENING/ASSESSMENT

Primary care is the sole source of treatment for more than one third of patients with a mental disorder who receive help.[4] To facilitate prompt and effective intervention, hospital and clinic staff should be trained to detect signs and symptoms of mental health disorders at the site of care. (See "Behavioral Health Patients and Primary Care" below.)

The following online resources can assist hospitals in training staff members to conduct quick behavioral health screenings in outpatient clinics, EDs and other primary care-based settings:

- "Core Competencies for Behavioral Health Providers Working in Primary Care," from the Eugene S. Farley, Jr. Health Policy Center, 2015.
- Delaney, K. et al. "Competency-Based Training to Create the 21st Century Mental Health Workforce: Strides, Stumbles, and Solutions." *Archives of Psychiatric Nursing*, August 2011, volume 25:4, pages 225-234. (Available for purchase.)
- "Essential Psychiatric, Mental Health and Substance Use Competencies for the Registered Nurse." *Archives of Psychiatric Nursing*, April 2012, volume 26:2, pages 80-110. (Available for purchase.)
- "Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals at Risk for Suicide," from the American Psychiatric Nurses Association, 2015.

BEHAVIORAL HEALTH PATIENTS AND PRIMARY CARE

- 80 percent of people with a behavioral health disorder visit a primary care provider at least once a year.
- 50 percent of all behavioral health disorders are treated in primary care.
- 48 percent of appointments related to psychotropic medications are with a non-psychiatric primary care provider.
- 67 percent of people with a behavioral health disorder do not receive specialized behavioral health treatment.
- 30-50 percent of patient referrals from primary care to an outpatient behavioral health clinic fail to materialize.

Source: ***Benefits of Integration of Behavioral Health***, Patient-centered Primary Care Collaborative, 2015.

Hospitals should maintain a record of training sessions held and attendees' names, as well as the results of staff members' competency testing.

A variety of screening and assessment tools are available, focusing on different types of presenting symptoms:

- CAGE Substance Abuse Screening Tool (for both alcohol and drug use).
- Columbia-Suicide Severity Rating Scale (C-SSRS).
- Hurt, Insulted, Threatened with Harm and Screamed (HITS) Domestic Violence Screening Tool.
- Patient Health Questionnaire (PHQ-9) (for depression).
- Primary Care Post-traumatic Stress Disorder Screens.
- UNCOPE Screening Instrument for Substance Abuse.

Organizations should select the most suitable tools in terms of ease of use, time required, and compatibility with workplace culture and patient population. By creating a mechanism to link completed screening tools to the electronic health record, organizations help ensure that critical findings are captured in the patient healthcare information database and are readily available to providers throughout the enterprise.

PSYCHIATRIC PATIENTS IN THE EMERGENCY DEPARTMENT

As inpatient care capacity declines, millions of patients with chronic psychiatric conditions are presenting to overcrowded and overwhelmed EDs across the country.[5] While there are no simple solutions to this problem, leading safety and professional associations have provided guidance to help hospitals better manage the influx. Resources include:

- A safety advisory for hospitals from The Joint Commission on alleviating ED boarding of psychiatric patients.
- A white paper from the American College of Emergency Physicians, which summarizes best practices regarding ED care of psychiatric patients.
- A white paper from the Emergency Nurses Association, which offers recommendations on behavioral health-related topics, including triage of psychiatric patients and communication issues.

4 Russell, L. "Mental Health Care Services in Primary Care: Tackling the Issues in the Context of Health Care Reform," from the Center for American Progress, October 2010.

5 "ACEP Member Testifies Before Congress About 'National Crisis' in Regard to America's Mental Health Patients." American College of Emergency Physicians® *Newsroom*, March 31, 2014.

For hospitals with modest resources and support, the following measures can help improve the flow of behavioral health patients through the ED:

- *Coordinate with state or regional tele-psychiatry networks* for prompt consultations when a psychiatrist is unavailable on-site. This arrangement permits swift and expert evaluation of patients, while reducing length of stays in the "mainstream" of the ED.
- *Develop standard treatment protocols and tools* for use when no psychiatrist is available. Effective tools – such as a psychiatric medical clearance checklist and a protocol for treatment of agitated patients can reduce the length of ED stays by helping providers interpret findings and initiate treatment without delay.
- *Utilize observation units* staffed by medical professionals trained in behavioral health competencies for patients who present with complex conditions. Properly equipped observation units help increase efficiency by facilitating coordination of care and reducing resource utilization and ED stays. Such units also enhance safety by providing a secure environment for agitated patients, as well as those with active psychosis who may present a threat to themselves, staff or other patients.
- *Train the hospital rapid response team (RRT) in behavioral health emergencies.* To reduce the toll of mental health crises on the ED staff, some hospitals are cross-training their RRTs, thus bringing clinical expertise to the bedside of patients who exhibit active psychosis, substance use, uncontrollable anxiety and/or anger, or other signs of a significant mental disturbance or disruptive behavior. In addition to stabilizing patients, RRTs may help prevent claims alleging failure to respond to aggressive behavior or threats of violence.

For additional safeguards addressing the ED environment, see "Behavioral Health Patient Boarding in the ED," from the IAHSS Foundation, December 26, 2015.

MANAGING COMORBIDITIES

Two of three behavioral health patients exhibit at least one underlying medical condition, such as cardiovascular disease, diabetes, congestive heart failure, stroke or Alzheimer's disease.[6] If left untreated, comorbid conditions may lead to a downward spiral of poor patient outcomes and consequent liability exposure. (See "Behavioral Health Risk Exposures Across the Enterprise" on page 12.)

Some hospitals without dedicated psychiatric units assign a certain number of medical beds for behavioral health patients with serious medical concerns. This arrangement enables providers to focus on stabilizing chronic diseases that can exacerbate underlying mental conditions and lead to costly readmissions. It also facilitates handoff of patients at discharge time to other providers, advanced practitioners, therapists and social workers.

If resources permit, consider appointing a mental health specialist to help providers identify clinically significant findings, establish treatment regimens, prescribe medications, and initiate follow-up appointments with both primary care providers and behavioral health professionals. In lieu of such a dedicated specialist, use of clinical care pathways can help on-site medical providers enhance patient outcomes for the following higher-risk interventions:

- Intensive care admission.
- Electroconvulsive therapy.
- Treatment of active schizophrenia/early psychosis.
- Management of anxiety, depression and bipolar affective disorder.
- Suicide precautions.
- Dual diagnosis treatment planning.

Clinical pathways should include multidisciplinary roles, required consultations, mandatory communication parameters and documentation requirements in the areas of patient assessment, monitoring, intervention and evaluation.

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6 See Goodell, S. et al. "Mental Disorders and Medical Comorbidity." From the Robert Wood Johnson Foundation's Synthesis Project, Policy Brief #21, February 2011.

ENVIRONMENTAL SAFETY

Ensuring the safety of behavioral health patients and staff within a non-psychiatric inpatient setting presents a range of challenges, including, but not limited to, the threat of violence/aggression, elopement, slips and falls, and suicide and other forms of self-harm. A secure, well-maintained physical environment can significantly reduce the incidence of these adverse occurrences.

The effort to enhance environmental safety begins with assessment of inpatient care units. Resources include design guidelines to help behavioral health settings comply with safety codes and the Mental Health Environment of Care Checklist from the U.S. Department of Veterans Affairs National Center for Patient Safety. Useful information is also available from the Institute for Safe Environments of the American Psychiatric Nurses Association.

The following additional measures can help protect patients and minimize exposure by creating a safer care environment:

- *Convert a small number of beds from general use to psychiatric intensive care*, in order to accommodate patients who present in an acute psychiatric episode and expedite patient admissions from the ED.
- *Establish "quiet rooms"* where agitated patients can be treated in a calm, safe environment.
- *Increase the number of safety and security rounds* on units and floors where behavioral health patients are treated.
- *Train staff to assess and manage acute psychiatric emergencies*, emphasizing the necessity of ongoing assessment of at-risk patients.
- *Emphasize to staff that they must never leave high-risk patients unattended*, even momentarily, and remind them that many inpatient suicide attempts occur in bathrooms.
- *Institute effective safety procedures*, including 1:1 monitoring when appropriate, body and belongings searches for drugs and other contraband, seclusion or unit restriction, supervised visits, removal of all sharp objects and securing of windows.
- *Remove hazardous objects*, such as weight-supporting fixtures and rods, shoelaces and belts, electrical appliances, razors and plastic trash-can liners.
- *Use trained personnel as observers or sitters*, rather than family members or volunteers.
- *Consider utilizing no-harm contracts*, in which patients promise to report suicidal impulses to staff and take a more active part in their recovery. Remember, however, that this intervention on its own cannot guarantee a safe discharge.

PATIENT DISCHARGE

Discharge planning is an important part of inpatient psychiatric care and should begin as soon as possible after admission to the hospital. To protect against potential allegations of failure to take due precautions at discharge, hospital documentation protocols should incorporate, at a minimum, the following strategies:

- *Explain the clinical reasoning behind the decision to discharge or transfer a patient*, including all supporting information.
- *Note in the record that family members and primary healthcare providers have been apprised of decisions regarding discharge or transfer*, and state whether they are in agreement with such decisions.
- *Document all discussion of suicide risk* among physicians, staff, patient and family.
- *Note any verbal threats by the patient directed toward another person*, and inform that individual of the danger in accordance with statutory requirements.
- *Create a written post-discharge care plan for the patient and family*, including appointments with outpatient providers, referrals to mental health clinics or substance abuse programs, and instructions on crisis management.
- *Instruct prescribing physicians to limit medication dosages and pill counts*, in order to minimize the likelihood of an overdose.
- *Instruct a family member or friend to remove any guns and other weapons or drugs/medications from the home of patients with suicidal history* until further notice, and to confirm the removal with a documented callback.

Undetected and untreated mental illness can wreak havoc on patients' lives and medical outcomes. By adapting and implementing the suggestions contained in this resource, hospitals and health systems can better identify at-risk patients, close existing service gaps, allocate resources more efficiently and address the unique risks associated with behavioral healthcare.

Checklist of Behavioral Health-related Risk Management Initiatives

The following questionnaire is designed to help hospitals and health systems evaluate the effectiveness of behavioral health-related policies and practices, as well as to focus organizational improvement efforts.

MEASURES TAKEN/POLICIES IMPLEMENTED	STATUS	COMMENTS
LEADERSHIP DIRECTIVES		
The executive leadership of the hospital or healthcare system promotes a culture of safety, as demonstrated by a willingness to examine and address root causes for chronic behavioral health-related risk trends, including:		
- Decreased inpatient or regional psychiatric/behavioral health beds.		
- Diminished outpatient psychiatric/behavioral health resources.		
- Delayed pre-authorization from insurance carriers, Medicare and/or Medicaid.		
- Difficulty in arranging timely consultations with psychiatric specialists and related services.		
- Lack of dedicated space for psychiatric/behavioral health patients in the emergency department (ED).		
- Inconsistent provider prescribing and practice habits.		
Proper licensing, accreditation and certification are verified and documented for all providers and staff who work with behavioral health patients in every type of therapeutic setting, including EDs and urgent care centers, inpatient units, outpatient clinics, behavioral health units and residential settings.		
Credentialing and peer review processes for physicians and allied healthcare staff are specific to behavioral health, and medical staff rules and regulations specify who is qualified to perform a suicide risk assessment.		
Liability exposures associated with the delivery of behavioral health services in all enterprise settings have been reviewed and measures enacted to minimize risks involving assessment and monitoring procedures, environmental safety, staff training and patient transfer protocols.		
A behavioral health intervention team has been formed, in order to expand the reach of experts in this area.		
There is a strong commitment to using the least restrictive interventions with behavioral health patients, and this intent is articulated in the hospital's or health system's mission statement.		
PROFESSIONAL CONDUCT		
Human resources policies and procedures are strictly and consistently enforced, as is the employee code of conduct.		
There is a formal pre-employment screening process for mental health staff, including documented background checks and verification of references, criminal records and registered sex-offender status.		
A written procedure exists for investigating and documenting all acts of real or threatened violence, abuse, harassment or assault aimed at behavioral health patients.		
Staff members are trained to respect the heightened confidentiality needs of behavioral health patients and to treat telephone inquiries about patient condition and admission status with discretion.		

MEASURES TAKEN/POLICIES IMPLEMENTED	STATUS	COMMENTS
STAFF TRAINING		
Behavioral healthcare staff are trained in core clinical competencies, including, but not limited to:		
▪ Major psychiatric diagnoses and pathology, e.g., borderline personality disorder, bipolar disorder, psychosis/schizophrenia, anxiety disorders and depression.		
▪ Patient assessment (including suicide risk) and symptom management.		
▪ Appropriate use of and limits on mechanical and chemical restraint.		
▪ Patient seclusion, including documentation of justification.		
▪ At-risk patient monitoring and sitter observation.		
▪ Environmental safety awareness.		
▪ De-escalation techniques and communication with aggressive and/or violent patients.		
▪ Crisis and violence prevention.		
▪ Security protocols for apprehending agitated or violent patients.		
Mock behavioral health emergency scenarios are conducted on a regular basis to ensure compliance with stated protocols.		
Staff are instructed on accurate methods of incident reporting, including format and time frame.		
Staff performance evaluations are conducted at least annually to assess knowledge of standard operating procedures and proficiency in implementing them.		
Staff training and competency levels are documented in personnel files, including ongoing continuing education.		
CLINICAL POLICIES		
The following behavioral healthcare practices, among others, are governed by written policies and procedures:		
▪ Searches of patients and their belongings.		
▪ Assessment and management of high-risk patients, e.g., those who exhibit active suicidal or homicidal intent, aggression or self-harming behavior.		
▪ Patient monitoring and related documentation.		
▪ Patient observation.		
▪ Stabilization of patients with psychosis/agitation.		
▪ Suicide risk-screening and documentation.		
▪ Patient detoxification.		
▪ Use of restraints, stun guns, seclusion rooms and related techniques on patients who exhibit violent/self-destructive behaviors.		
▪ Visitor management.		
▪ Inter-hospital transfers.		
Special consideration is given to adolescent patients, especially in regard to consent and confidentiality issues, emancipated minor status and parental notification requirements.		
Policies, procedures and protocols are regularly updated and readily available online.		

MEASURES TAKEN/POLICIES IMPLEMENTED	STATUS	COMMENTS
PATIENT INTAKE AND SCREENING		
Patients are screened in primary care and emergency department settings to identify mental health disorders and possible medical etiologies.		
Patients with emergency or potentially life-threatening conditions are kept under constant observation until a treatment plan is established.		
Patients who present a risk of harm to themselves or others are removed to a designated safe room apart from the main flow of clinical care.		
Patients and personal belongings are searched to ensure removal of weapons, sharp objects, medications/illicit drugs, belts, shoelaces and other potentially harmful objects.		
Vital information is compiled and documented during the intake process, including ED triage record, risk and psychiatric crisis assessment findings, medication history and compliance, and clothing/personal belongings inventory.		
ASSESSMENT AND PLAN OF CARE		
Behavioral health conditions and symptoms are thoroughly documented, including suicide risk, borderline personality and bipolar disorder, psychosis, acute anxiety, depression and substance abuse.		
In consultation with behavioral health specialists, a written plan of care is created outlining treatment and behavior management strategies.		
A comprehensive behavioral management program is implemented, which includes the following strategies:		
▪ Problematic behaviors – e.g., frequent agitation, unpredictable verbal and physical outbursts, aggression, withdrawal – are addressed via a case management approach.		
▪ Limits are set on negative behaviors, and the reasons for these rules are explained.		
▪ Expectations are conveyed clearly and repeatedly.		
▪ Patients are made to understand that antisocial behavior has consequences.		
▪ Positive feedback is provided when appropriate.		
Patients are frequently assessed for major risks – including aggressive behavior, elopement, drug/alcohol impairment and acute detoxification with seizures or delirium – and the plan of care is updated accordingly.		
A treatment plan for suicide risk, if necessary, is created in consultation with behavioral health specialists and includes such strategies as 1:1 observation, visitor monitoring, safety contracts and ongoing therapy.		
MEDICATION MANAGEMENT		
Written guidelines exist for the pharmacological treatment of various conditions, including agitation, dementia and psychosis.		
No psychotropic drugs are administered prior to documented consultation with a psychiatrist and pharmacist, and the medical criteria for use are noted in the clinical care record.		
Written consent for psychotropic medication administration is obtained from the patient and/or legal guardian, and is reflected in the patient healthcare information record.		
Medication reconciliation occurs upon admission and discharge from acute care and psychiatric care settings, and medication profiles are shared with behavioral health navigators upon discharge.		

MEASURES TAKEN/POLICIES IMPLEMENTED	STATUS	COMMENTS
CRISIS RESPONSE		
A behavioral health rapid response team (BHRRT) is in place, and is governed by written policies and emergency activation criteria.		
The BHRRT adheres to established principles of crisis intervention, with team members trained to stabilize medical emergencies, conduct an immediate psychiatric evaluation, initiate crisis counseling, perform 1:1 observation, and assess and secure patient environments.		
SUICIDE PREVENTION		
Staff members are trained to assess and manage suicidal patients, with an emphasis on continuous evaluation.		
A suicide risk-screening tool is utilized to facilitate evaluation of risk factors and documentation of protective measures taken.		
Suicide assessment findings and safety measures are documented in the patient healthcare information record.		
Environmental hazards are removed from the immediate care environment, including weight-supporting fixtures, razors, plastic trash-can liners and unsecured window coverings.		
If hazards cannot be removed from the immediate care environment, high-risk patients are placed in isolation rooms where they can be closely watched.		
SITTERS/OBSERVATION/RESTRAINTS		
Higher-risk patients are attended by trained observers (rather than family members or volunteers) who report directly to a staff RN.		
Documentation guidelines are established for sitters, which include but are not limited to:		
- Room search results per shift.		
- Current suicide risk assessment, need for suicide precautions and measures implemented.		
- Patient behavior during the observation period.		
- Sudden changes in mood, eating habits or sleep patterns.		
- Education of family and patient regarding rules and rationales.		
- Evidence of any self-harming intent.		
- End-of-shift report to nursing staff.		
Sitters are instructed regarding hospital confidentiality polices, and their compliance is monitored.		
Sitters summon assistance when they leave the bedside to ensure that 1:1 observation continues even when the patient is sleeping.		
There is a written policy covering the use of mechanical or chemical restraints for patients under observation, which includes documentation of physician's orders, rationale for use, safety assessments and continued need.		
Patients are notified of the criteria for release from restraint/seclusion, and these criteria are followed scrupulously.		

MEASURES TAKEN/POLICIES IMPLEMENTED	STATUS	COMMENTS
SITTERS/OBSERVATION/RESTRAINTS (CONTINUED)		
A Restraint Reduction Committee is established, which routinely audits health-care information records of patients requiring restraints/seclusion and analyzes data to identify performance improvement goals and staff training needs.		
Following use of restraints or seclusion, a documented debriefing occurs to ensure that these measures were both necessary and safely implemented.		
Special monitoring policies are in place for extended ED stay patients, including use of observational units.		
Visitors of patients under observation are subject to searches for potentially harmful objects and contraband intended for the patient.		
ENVIRONMENTAL SAFETY AND ELOPEMENT RISK		
Clinical settings have designated safe rooms where emergency/crisis patients can be securely and quietly treated.		
Criteria for use of safe rooms are delineated in written policy, and protocol strictly prohibits locking patients in seclusion as an elopement prevention measure.		
All mounted fixtures are designed to prevent attachment of cords, ties or other items that could be used for purposes of self-harm.		
Locks on bathrooms are free of anchor points and can be opened by staff from the outside.		
Electric and manually adjustable stretchers have been eliminated unless clinically indicated.		
Pillows and mattresses are free of plastic or vinyl, which may be used to suffocate others or oneself.		
Standard flat bed sheets are utilized, to prevent removal of elastic.		
Emergency call cords, if present, are short and/or permanently attached to beds or carts.		
Privacy curtains and tracks have been removed from the patient care area.		
Mirrors in bathrooms are shatter-proof and are affixed to the wall using tamper-resistant fasteners.		
Nursing stations and designated treatment areas are protected against unauthorized entry, and panic alarms are in place.		
Meal trays and utensils are disposable, with no metal or glass implements given to patients.		
Various precautions are in place to diminish the risk of patent elopement, including installing alarm-equipped exits and window-mounted tampering alarms, placing nursing stations in full view of entrances/exits, keeping patients in ED waiting areas away from exits and maintaining a security presence in common areas.		
Elopement prevention training is provided to all staff, along with regular refresher courses.		

MEASURES TAKEN/POLICIES IMPLEMENTED	STATUS	COMMENTS
DISCHARGE PLANNING AND REFERRAL MANAGEMENT		
Patients are discharged only after denying suicidal/homicidal ideation, and this denial is documented on the discharge record.		
Behavioral health patents are provided with a post-discharge care plan, which may include appointments with outpatient providers, referral to an integrated mental health clinic or substance abuse program, and instructions on crisis management.		
Family members and significant others are included in the discharge process whenever possible, and are informed of the signs of increased suicide risk and/or harmful behaviors.		
A housing assessment is completed to ensure that homeless mental health patients are not returned to the streets, and efforts to assist with housing are documented on the discharge record.		
The discharge record reflects warnings to family members and third parties of any verbal threats made by the patient against them.		
A designated behavioral health navigator manages referrals to outreach programs and/or integrated mental health clinics.		
Discharge instructions include follow-up care guidelines, as well as warning signs, prescriptions, and local and national mental health crisis hotlines.		

QUICK LINKS

- "7 Steps to Expand the Behavioral Health Capabilities of Your Workforce: A Guide to Help Move You Forward," from the American Hospital Association, 2016.
- Becker, A. "Report: Mental Health Care System Fragmented, Inadequate." *CT Mirror*, January 2, 2013.
- Daumit, G. "Patient Safety Events and Harms During Medical and Surgical Hospitalizations for Persons With Serious Mental Illness." *Psychiatric Services*, October 1, 2016, Volume 67:10, pp. 1068-1075. Available for purchase.
- Zeller, S. "Dedicated Psychiatric Emergency Services Reduce the Need for Inpatient Hospitalizations." CEP America. Posted April 30, 2015.

Behavioral Health Risk Exposures Across the Enterprise

PRIMARY CARE CLINICS

Inadequate risk screening and assessment
Chemically dependent patients
Difficult/manipulative behavior
Noncompliance
Drug-seeking actions

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EMERGENCY DEPARTMENTS

Alcohol intoxication
Drug overdose
Suicide attempts
Aggression/violence
Drug-induced psychosis
Self-inflicted injury
Security incidents, e.g., inappropriate use of force or stun gun

↓

INPATIENT UNITS

High readmission rate
Increased length of stay
Prescription drug interactions
Detoxification risks
Suicide attempts
Elopement
Untimely discharge

↓

COMMUNITY NETWORKS

Failed referrals
Inadequate risk screening
Uncoordinated handoffs
Medication mismanagement
Failure to follow up

↓

AGING SERVICES SETTINGS

Aggression directed against staff and other residents
Behavioral challenges
Dementia
Depression
Drug-seeking behaviors related to chronic pain
Elopement

CNA Risk Control Services

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