Suicide Prevention Resource Center

Care Transitions from Inpatient to Outpatient Settings: **Applying Best Practices**

July 21, 2022

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Funding and Disclaimer

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Disclosures

No financial relationships or conflicts of interest to report.

About SPRC

The Suicide Prevention Resource Center (SPRC) is the only federally funded resource center devoted to advancing the implementation of the *National Strategy for Suicide Prevention*. SPRC is supported through a grant from the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).

SPRC builds capacity and infrastructure for effective suicide prevention through consultation, training, and resources for state, tribal, health/behavioral health, and community systems; professionals and professional education programs; and national public and private partners and stakeholders.

Land Acknowledgement

We acknowledge that the land that now makes up the United States of America was the traditional home, hunting ground, trade exchange point, and migration route of more than 574 American Indian and Alaska Native federally recognized tribes and many more tribal nations that are not federally recognized or no longer exist.

We recognize the cruel legacy of slavery and colonialism in our nation and acknowledge the people whose labor was exploited for generations to help establish the economy of the United States.

We honor indigenous, enslaved, and immigrant peoples' resilience, labor, and stewardship of the land and commit to creating a future founded on respect, justice, and inclusion for all people as we work to heal the deepest generational wounds.

AMERICAN PSYCHIATRIC ASSOCIATION

Medical leadership for mind, brain and body.

CME Credit

This activity is being accredited and implemented by the American Psychiatric Association (APA) as part of a subaward from the Suicide Prevention Resource Center (SPRC).

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education. The APA is accredited by the ACCME to provide continuing medical education for physicians.

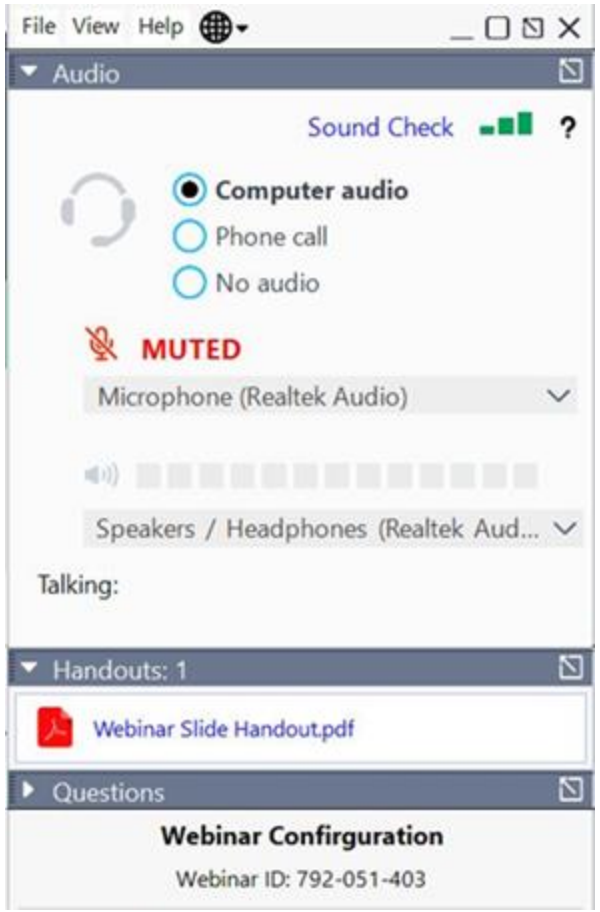
The American Psychiatric Association designates this live activity for a maximum of 1 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

The Suicide Prevention Resource Center is the sole owner of the activity content, including views expressed in written materials and by the speakers.

How to Download Handouts

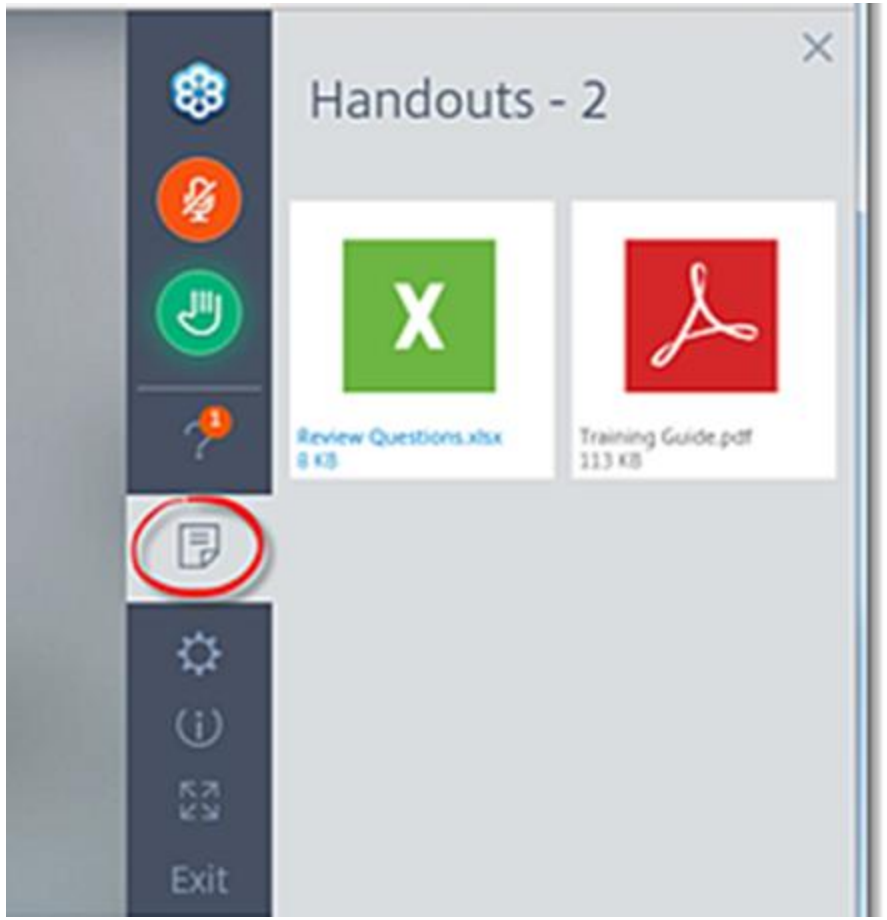
Desktop

Use the “Handouts” area of the attendee control panel.



Instant Join Viewer

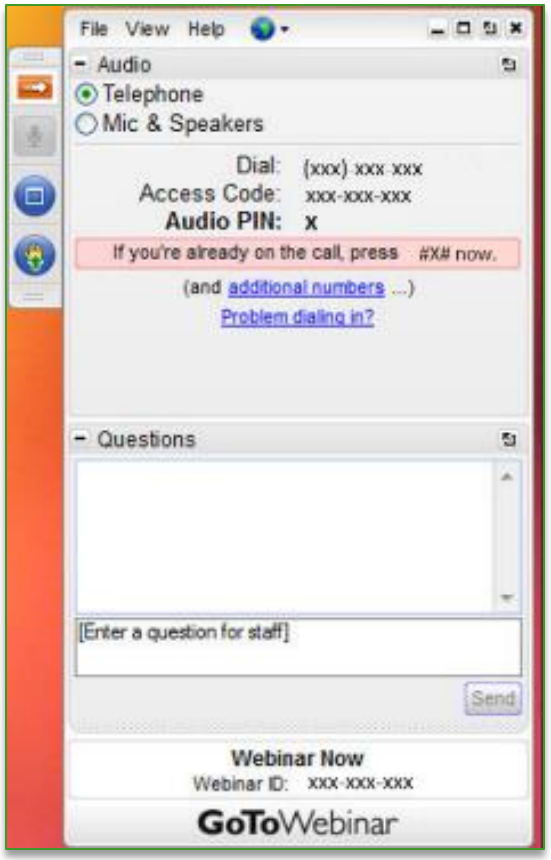
Click the “Page” symbol to display the “Handouts” area.



How to Participate in Q&A

Desktop

Use the “Questions” area of the attendee control panel.



Instant Join Viewer

Click the “?” symbol to display the “Questions” area.

Moderator

Julie Goldstein Grumet, PhD

Zero Suicide in Health Care Systems

Zero Suicide is useful for any system interested in providing the most effective and data-informed suicide care practices available.

Systems that adopt the Zero Suicide mission are:

- Challenging themselves to be high-reliability organizations.
- Embedding evidence-based interventions into care practice.
- Collecting data to measure both outcomes and fidelity.
- Improving continuously through training and protocols.
- Normalizing suicide prevention for clients, staff, and families.

Zero Suicide Framework

CORE COMPONENTS OF SAFE SUICIDE CARE

- These seven elements are critical to safe care.
- Represent a holistic approach to suicide prevention.
- Can and should be considered on a simultaneous continuum.

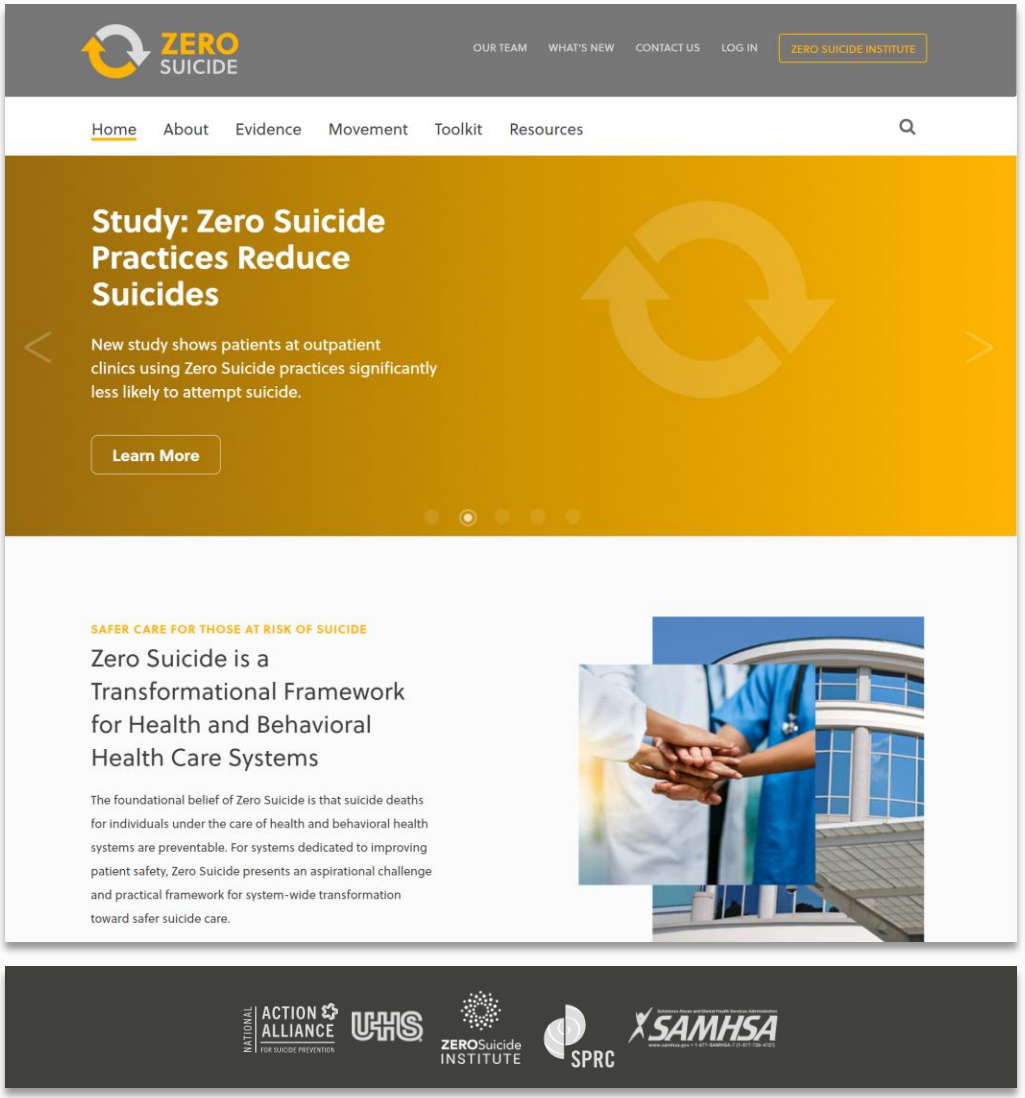
Zero Suicide Toolkit

Your practical guide to systemic change.

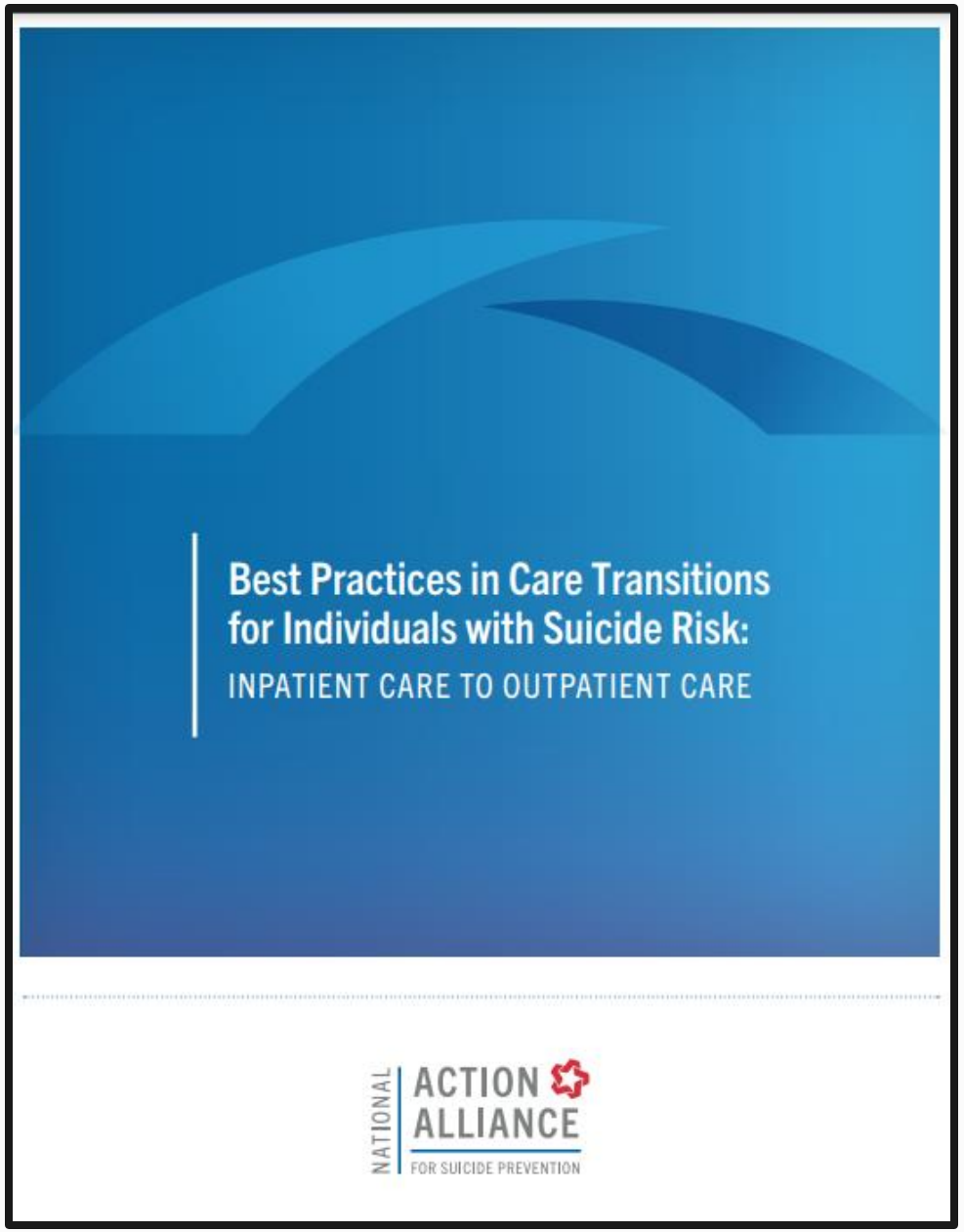
The online Zero Suicide toolkit offers free and publicly available tools, strategies, and resources.

RESOURCES

- » Information
- » Materials
- » Outcomes
- » Innovations
- » Research
- » Tools
- » Readings
- » Videos
- » Webinars
- » Podcasts



zerosuicide.edc.org


Best Practices in Care Transitions
for Individuals with Suicide Risk:
INPATIENT CARE TO OUTPATIENT CARE
NATIONAL
ACTION
ALLIANCE
FOR SUICIDE PREVENTION

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

» OUTPATIENT

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

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

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

The following checklist will help outpatient health care systems assess their policies, procedures, and practices related to these recommendations.

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

LEARN MORE: SuicideCareTransitions.org

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

ZERO SUICIDE

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

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

» INPATIENT

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

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

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

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

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

LEARN MORE: SuicideCareTransitions.org

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Care Transitions Action Planning

» OUTPATIENT PROVIDERS

The transition in care from inpatient to outpatient behavioral health care is a critical time for patients with suicide risk, their families, and the healthcare systems and providers who serve them. As a healthcare organization, reviewing your policies, procedures, and practices related to care transitions is the first step to improving care for those at risk for suicide. Please use this action plan, derived from *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care* to guide your work to improve continuity of care during the care transition.

ACTION PLAN (OUTPATIENT):

Recommendation	Action(s)	Position(s)/Person(s) Responsible	Resources needed	Potential Challenges	Deadline	Result
SAMPLE						
Establish good communication (with inpatient facility).	*Set regular meetings with the inpatient facility to focus on Care Transitions.*	*Intake coordinator*	*Representatives from the inpatient team, clinical providers, agency leadership*	*Difficulty connecting with inpatient partners, scheduling*	*April 2021*	*Recurring quarterly meetings, focused agenda, metrics*

LEARN MORE: SuicideCareTransitions.org

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

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Care Transitions Action Planning

» INPATIENT PROVIDERS

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. As a health care organization, looking at your policies, procedures, and practices related to care transitions is the first step to improving care transitions for those at risk for suicide who have received care with your organization. Please use this action plan, derived from *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care* to guide your work.

ACTION PLAN (INPATIENT):

	SAMPLE				
Recommendation	*Begin discharge planning upon admission.*				
Action(s)	*While taking initial history also request information about who will be supportive after discharge. Write an initial discharge development plan.*				
Position(s)/ Person(s) Responsible	*Clinicians, case management, nursing team*				
Resources needed	*Stakeholders from leadership, electronic medical records team, provider team, and nursing team*				
Potential Challenges	*Workflow changes, staff training, and compliance*				
Deadline	*April 1, 2021*				
Result	*Policy completed, workflow is written, staff are trained, and the first month compliance check is completed.*				

LEARN MORE: SuicideCareTransitions.org

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

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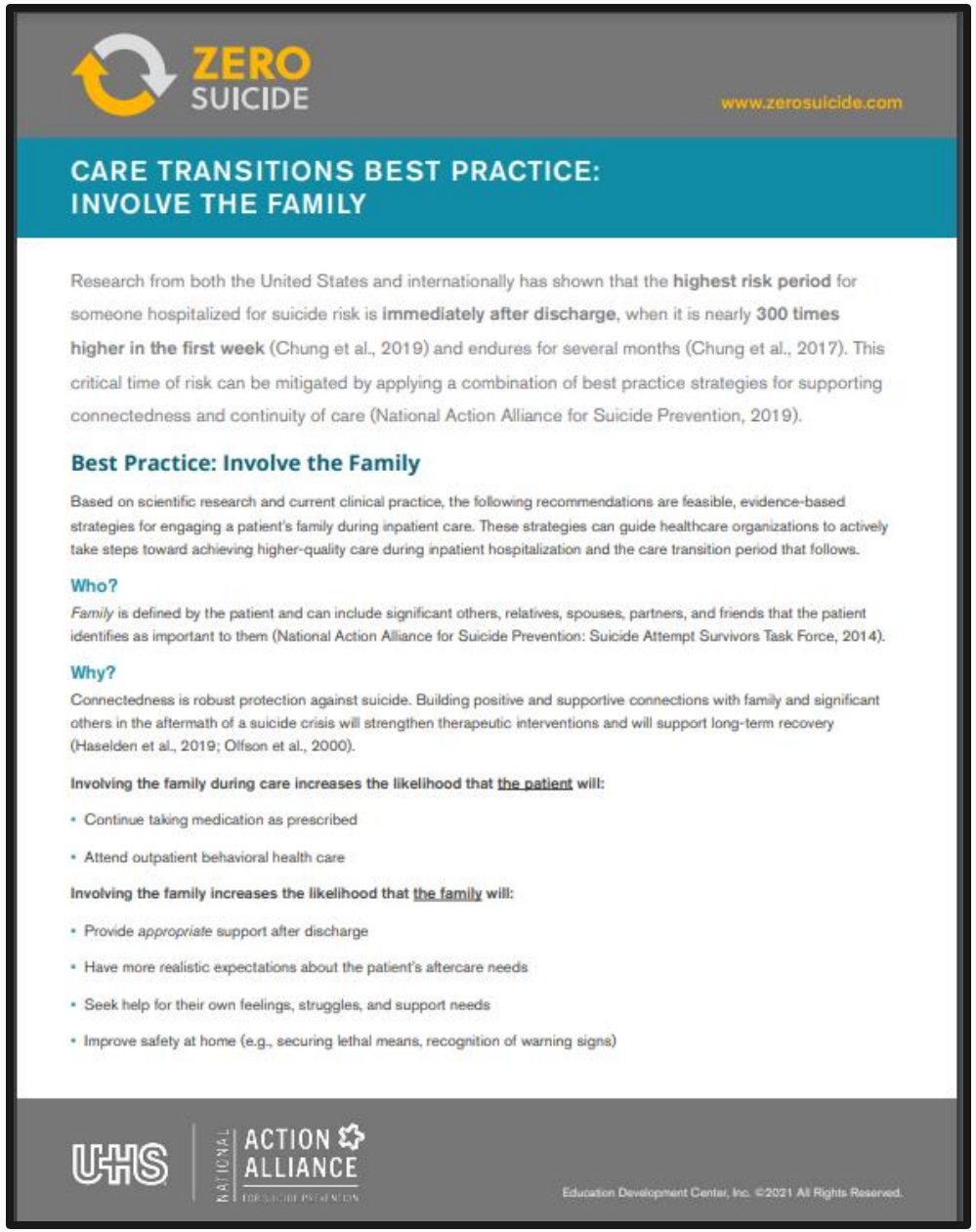


ZERO SUICIDE

www.zerosuicide.com

CARE TRANSITIONS BEST PRACTICE: INVOLVE THE FAMILY

Research from both the United States and internationally has shown that the **highest risk period** for someone hospitalized for suicide risk is **immediately after discharge**, when it is nearly **300 times higher in the first week** (Chung et al., 2019) and endures for several months (Chung et al., 2017). This critical time of risk can be mitigated by applying a combination of best practice strategies for supporting connectedness and continuity of care (National Action Alliance for Suicide Prevention, 2019).

Best Practice: Involve the Family

Based on scientific research and current clinical practice, the following recommendations are feasible, evidence-based strategies for engaging a patient's family during inpatient care. These strategies can guide healthcare organizations to actively take steps toward achieving higher-quality care during inpatient hospitalization and the care transition period that follows.

Who?

Family is defined by the patient and can include significant others, relatives, spouses, partners, and friends that the patient identifies as important to them (National Action Alliance for Suicide Prevention: Suicide Attempt Survivors Task Force, 2014).

Why?

Connectedness is robust protection against suicide. Building positive and supportive connections with family and significant others in the aftermath of a suicide crisis will strengthen therapeutic interventions and will support long-term recovery (Haselden et al., 2019; Olfson et al., 2000).

Involving the family during care increases the likelihood that the patient will:

- Continue taking medication as prescribed
- Attend outpatient behavioral health care

Involving the family increases the likelihood that the family will:

- Provide *appropriate* support after discharge
- Have more realistic expectations about the patient's aftercare needs
- Seek help for their own feelings, struggles, and support needs
- Improve safety at home (e.g., securing lethal means, recognition of warning signs)

UHS | NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

Learning Objectives

- Identify care transitions best practices for inpatient and outpatient settings that can be applied in your organization.
- Describe how care transitions best practice implementation tools can help inform practice improvement and training within your organization.
- Discuss the importance of family involvement in planning for care transitions.

Presenter

Jack Gettelfinger, MBA

BRIDGING THE CARE DIVIDE

Reducing gaps in care through ongoing connections and a strong continuum

Jack Gettelfinger, Director of Performance Improvement

The Ridge Behavioral Health System, UHS

Lexington, Kentucky

In 2016, The Ridge began a partnership with the National Action Alliance for Suicide Prevention to implement Zero Suicide, an initiative focused on ensuring that the system of care we provide to patients at risk of suicide is effective, caring, and competent.

- Universal Health Services (UHS) led the nation as the first inpatient behavioral health organization to implement the Assessing and Managing Suicide Risk (AMSR) framework.

In 2021, The Ridge continued its partnership with a care transitions pilot to join an important discussion regarding best practices in care transitions for individuals with suicide risk.

Because one life lost is too many.

Conducting an Organizational Self-Assessment

Our leadership team utilized the Zero Suicide Inpatient Organizational Self-Study to identify areas of strength and opportunities for improvement.

We identified the following areas to address:

- Involve other supports.
- Electronically deliver copies of essential records.
- Provide ongoing caring contacts to the patient.
- Consider innovative approaches for connecting the patient with the outpatient provider.

Involve Other Supports

With consent, engage, educate, and involve a network of supports the patient has identified.

- A facility chart audit of adult psychosocial data indicated low compliance in contacting the patient's support person, particularly on the substance use disorder (SUD) unit.
  - This patient population tends to have a more fragmented, fragile support system due to the nature of the disease and stigma.

- The following steps were taken to increase contact on adult psych and SUD units:
  - Coach therapists with messaging used at initial contact with the patient.
  - Use clear language with the patient and communicate reasons for contacting the support person.
  - Train intake staff to prioritize obtaining a contact on the release of information (ROI) when possible.

Frequency in contacting the patient's support person increased by 30% for our SUD unit.

Electronically Deliver Copies of Essential Records

2

Ensure the outpatient provider receives copies of crucial records before the patient's first visit.

1. Create a process that covers weekdays and weekends.
2. Assign roles and responsibilities.
3. Assure back-ups are in place.

Job Responsibility and Schedule for Faxing Transition (Discharge) Records

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
ADULT (UNITS: 1, 2 AND 3)	**Adult Unit Clerk** ------ *Case Coordinator when Adult Unit Clerk not scheduled to work*	**Adult Unit Clerk** ------ *Case Coordinator when Adult Unit Clerk not scheduled to work*	**Adult Unit Clerk** ------ *Case Coordinator when Adult Unit Clerk not scheduled to work*	**Adult Unit Clerk** ------ *Case Coordinator when Adult Unit Clerk not scheduled to work*	**Adult Unit Clerk** ------ *Case Coordinator when Adult Unit Clerk not scheduled to work*	**Switchboard** ------ *RN should bring copy of transition record to Switchboard at discharge*	**Switchboard** ------ *RN should bring copy of transition record to Switchboard at discharge*
YOUTH (UNITS: 4, 5 AND 6)	**Youth Unit Clerk** ------ *Case Coordinator when Youth Unit Clerk not scheduled to work*	**Youth Unit Clerk** ------ *Case Coordinator when Youth Unit Clerk not scheduled to work*	**Youth Unit Clerk** ------ *Case Coordinator when Youth Unit Clerk not scheduled to work*	**Youth Unit Clerk** ------ *Case Coordinator when Youth Unit Clerk not scheduled to work*	**Youth Unit Clerk** ------ *Case Coordinator when Youth Unit Clerk not scheduled to work*	**Switchboard** ------ *RN should bring copy of transition record to Switchboard at discharge*	**Switchboard** ------ *RN should bring copy of transition record to Switchboard at discharge*

Faxing coverage must be managed by the person responsible above and their supervisor.

Provide Ongoing Caring Contacts to the Patient

Caring contacts are brief, encouraging notes or messages that do not require an action or response.

Journey of Hope

Michael,

I am writing to follow up with you since your visit at The Ridge Behavioral Health System. I want to make sure you are well and on track to a healthier you.

A copy of your aftercare discharge plan and crisis safety plan was provided to you at the time of discharge. If you cannot find your copy or have a question, please call us at 859-269-2325.

Remember, recovery is not a one and done. It is a lifelong journey that takes place one day and step at a time. The Ridge is here to guide and support your journey to a happier, healthier you.

Jennifer Floyd Aranilla, RN
Chief Nursing Officer

Healthy Coping Skills

Take deep breaths.
Inhale and exhale slowly throughout the day when you are feeling stressed.

Slowly count to 10.
Repeat, and count to 20 if necessary.

Give back to your community.
Volunteer or find another way to be active in your community, which creates a support network and gives you a break from everyday stress.

Take a time out.
Practice yoga, listen to music, meditate, get a massage, or learn relaxation techniques. Stepping back from problems helps clear your head.

Talk to someone.
Tell friends and family you are feeling overwhelmed, and let them know how they can help you. Talk to a physician or therapist for professional help.

WE ARE HERE FOR YOU

Call us for a free assessment 24/7

(859) 269-2325 – *Inpatient*
(859) 410-7550 – *Outpatient*
(800) 753-HOPE (4673)

ridgebhs.com
Facebook.com/TheRidgeBHS

3050 Rio Dosa Drive
Lexington, KY 40509

Outpatient Services

The Ridge offers a comprehensive, multi-track Outpatient treatment program serving as a step-down as an alternative to inpatient care. These programs help provide rehabilitation and recovery for individuals who need intensive treatment but do not require inpatient care. We offer both PHP and IOP levels of care.

Partial Hospitalization Program (PHP) is a five day per week, four-hours per day structured, multi-disciplinary service.

Intensive Outpatient Program (IOP) is a four day per week, three-hours per day service, which provides a frequency of group psychotherapy and patient education beyond what the traditional outpatient visit can offer.

Adult Programs	Days	Time
Adult Mental Health PHP	M-F	9am-1pm
Adult Mental Health IOP	M-Th	9am-12pm

Outpatient Location
Prosperous Location (Adult)
101 Prosperous Place, Suite 280
Lexington, KY 40509

Telehealth options may be available. Call us today for more information.

- Every patient discharged home receives a "Journey Letter" in the mail, signed by our chief nursing officer.
  - Journey of Hope (adult and youth psych patients)
  - Journey to Sobriety (SUD patients)
- This letter is a brief touch-base and offers resources within our continuum should the need arise.

A continuum of care that reaches underserved areas

4

- Inpatient
- Partial hospitalization (PHP) and intensive outpatient programs (IOP) (including in-person and telehealth)
- School-based programs (PHP/IOP)
- Individual therapy and medication management
- Sober living opportunities
- Electroconvulsive therapy (ECT)
- Graphic on the left posted on each hospital unit
- Stepdown coordinator continuously communicates the continuum to patients on-unit during their stay, identifies patients qualified and eligible to step down, and assists in the process
- Average triage rate of eligible clients YTD: 26%
  - Reasons declined: connected to community resource; not interested

Reducing AMAs and Assuring Safe Discharges

- The 24-hour "Notice of Intent to Leave" form was implemented to change the language and messaging surrounding discharge against medical advice (AMA).
- Notifies patients that they will be seen by a provider within 24 hours if they have requested an unplanned discharge. They can state their reason on this form.
- 24 hours assures there is time for the provider to review the case and allows the therapist time to secure a safe discharge plan should an unplanned discharge occur.

The Ridge

NOTICE OF INTENT TO LEAVE

Patient's Name _____ Unit _____

This is to notify you of my intent to leave the hospital, having previously admitted myself voluntarily.

I understand that my Notice of Intent to Leave will be reviewed with a decision by the provider within twenty-four (24) hours of submission.

I also understand that if my Notice of Intent to Leave is denied within that twenty-four (24) hour period, I may be placed on a 72-hour hold for up to three (3) days excluding holidays and weekends.

Patient Signature _____ Date/Time _____

Parent/Guardian Signature _____ Date/Time _____

Witness Signature _____ Date/Time _____

KRS 645.190 (2) requires that staff members receiving this notice must immediately date it and record its existence on the patient's medical chart.

Disposition of Intent to Leave
☐ 72-Hour Hold initiated by: _____ Date/Time _____
☐ Intent to Leave Rescinded: Patient/Guardian Signature _____ Date/Time _____ Witness Signature _____ Date/Time _____
☐ Discharge Discharging Nurse Signature _____ Date/Time _____

Copy to:

1. *Chart- Original*
2. *Patient's Physician*
3. *Director of Clinical Services*
4. *Director of Nursing*
5. *Primary Therapist*
6. *Case Management Supervisor*
7. *Patient Advocate*
8. *Nurse Manager*
9. *Program Direction*

DISCHARGE | Notice of Intent to Leave | Revised 8/2021

Using the Q and A box: Share one key takeaway from the presentation.

Presenter

Megan Williams, MA

ZERO SUICIDE

PASSING THE BATON

Care for clients transitioning to
outpatient treatment after hospitalization

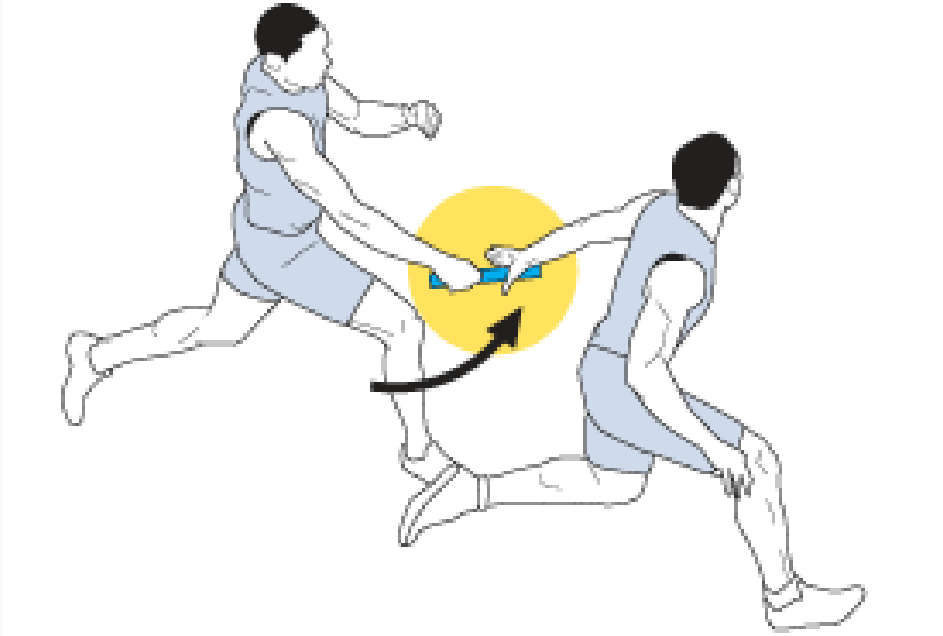
Megan Williams, MA

July 21, 2022

Ensure Successful Hand-Offs

Care transitions from inpatient to outpatient services are critical. How can we ensure a successful hand-off?

- Develop strong relationships with local inpatient providers.
- Engage client before discharge.
- Collaborate with client and family prior to discharge.
- Caring contacts.



Develop Relationships with Inpatient Facilities

Hospital Liaison Program

Through Tennessee Medicaid funding, Centerstone has a hospital liaison program to build partnerships with local psychiatric hospitals to ensure clients have a successful transition from inpatient to outpatient services. The liaison's role includes:

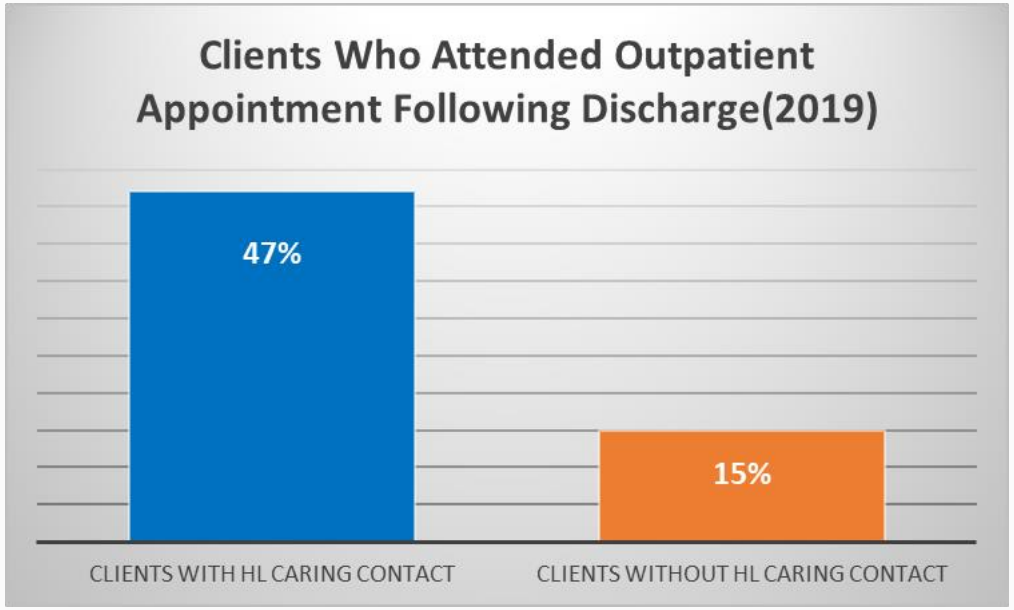
- Serving as point of contact for both inpatient hospital and discharging client
- Communicating on regular and/or ad-hoc basis with inpatient hospital staff to maintain strong coordination of care
- Ensuring discharging client is fully linked to outpatient services
- Coordinating scheduling with discharging client (and/or family members) and Centerstone staff
- Providing appropriate follow-up to clients upon discharge

Engaging and Collaborating with Clients Prior to Discharge

- Liaisons meet with clients prior to hospital discharge to coordinate outpatient treatment scheduling and build rapport before clients set foot in a Centerstone clinic.
- Excellent customer service is a large part of what our liaisons strive for when working with clients and families. Liaisons are sometimes a client's first interaction with the outpatient facility and customer service is key to engaging the client.

Caring Contacts

- Hospital liaisons and Centerstone support staff send text and voice reminders to clients before the first outpatient appointment.
- If a client does not show for the initial post-hospitalization outpatient appointment, clinicians make an outreach contact to the client in real time of missed appointment.
- Clinician, supervisor, and support staff work together to make additional outreach contacts to re-engage client in care.



Action Alliance's Best Practices in Care Transitions

- **Care Transitions Self-Assessment**
  - VP of health care integration and director of suicide prevention services met to collaboratively walk-through self-assessment.
  - Provided a barometer of where we are/were vs. best practice.
  - Supported decision-making for quality improvement measures.
- **Care Transitions Action Planning**
  - Discussed self-assessment in quality improvement meeting to identify two actions the organization could take immediately to improve care transitions.
  - Identified who needed to be responsible for change implementation.
  - Provided structure and outline for how we could accomplish action items.
  - Set attainable goals to build on.

Running with the Baton: Centerstone's Action Plan

- **Care transitions continue into outpatient treatment**
  - All clients scheduled for a hospital discharge appointment are automatically enrolled on the suicide prevention pathway due to increased risk of suicide after psychiatric hospitalization.
  - When a discharge appointment is missed, outpatient clinicians must call the client immediately (i.e., during the time the appointment was scheduled), then reach out later in the week to re-engage the client.
- **Evidence-based training for suicide prevention treatment**
  - Centerstone is piloting a suicide-specific specialty clinic where a small group of clinicians receive extensive training in evidence-based suicide treatments.
  - Zero Suicide grant with a goal to train all clinical staff in suicide-specific evidence-based practices in the next three years to ensure best care for those at highest risk for suicide.

Using the Q and A box: Share one key takeaway from the presentation.


Questions?

FOR MORE INFO

Visit zerosuicide.edc.org to learn more about Zero Suicide.

Join the Zero Suicide listserv at go.edc.org/ZSListserv

How To Claim Credit

Simply follow the instructions below. Email LearningCenter@psych.org with any questions.

1. Attend the virtual event.
2. Submit the evaluation.
3. Select the CLAIM CREDITS tab.
4. Choose the number of credits from the dropdown menu.
5. Click the CLAIM button.

Claimed certificates are accessible in My Courses > My Completed Activities

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