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### Repository Citation

Houssan C, Morena A, Davis-Martin R, Larkin C, Boudreaux ED. (2018). Addressing Positive Suicide Screens in the Emergency Department: The Importance of Post-Discharge Follow-up. Community Engagement and Research Symposia. <https://doi.org/10.13028/r9ph-j278>. Retrieved from [https://escholarship.umassmed.edu/chr\\_symposium/2018/posters/3](https://escholarship.umassmed.edu/chr_symposium/2018/posters/3)

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# Addressing Positive Suicide Screens in the Emergency Department: The Importance of Post-Discharge Follow-up

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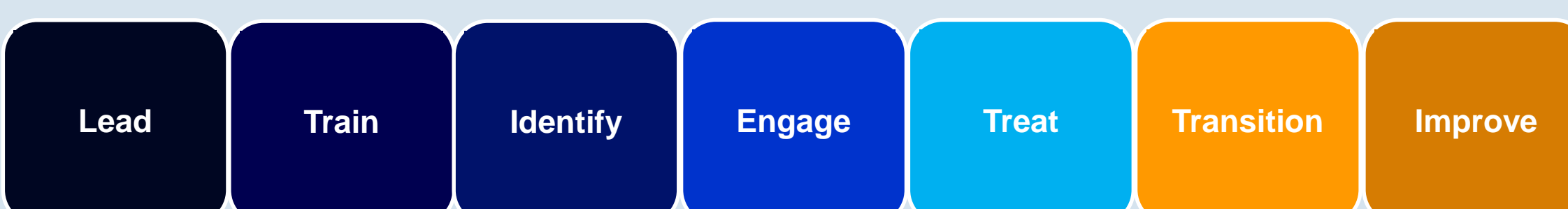
## Background

- Over 40,000 individuals die by suicide per year in the United States alone, making suicide the tenth leading cause of death<sup>1</sup>
- Many who die by suicide will make contact with an Emergency Department (ED) within the year before death<sup>2</sup>
- In 2016, the Joint Commission<sup>3</sup> recommended that universal screening for suicide risk (screening all patients regardless of complaint) is a best care practice in the ED setting
- By implementing universal screening, we will identify patients with occult suicide risk, meaning those presenting with a non-suicide related complaint who have suicide risk that is detected as a direct result of screening<sup>4</sup>. Such patients often get discharged without receiving a suicide risk evaluation, discharge instructions, or other behavioral health interventions<sup>2</sup>

## Zero-Suicide Model

- The current project focuses on an initiative to leverage the ED's pre-existing Behavioral Health Service (BHS) to implement safety planning, means reduction counseling, and care transitions for patients at risk of suicide by using the *Zero-Suicide Model*, a suicide-prevention care program that aims to prevent these patients from "falling through the cracks" in the healthcare system

### Components of the Zero-Suicide Model



- By adhering to these best care practices in the ED, the UMass healthcare system is ensuring that all patients with some level of suicide risk are being detected, and are receiving the highest-quality of care achievable during their encounter

### Defining Suicide Risk

Positive screen (any of the following)	Negative Screen
<ul style="list-style-type: none"> <li>Presenting with SI/SA as part of complaint</li> <li>SI in past 2 weeks</li> <li>SA in past 6 months</li> <li>Other clinical judgment suggesting patient is at risk for suicide</li> </ul>	<ul style="list-style-type: none"> <li>No SI in past 2 weeks AND No SA in past 6 months</li> </ul>

## Methods

- The BHS incorporated screening, identification, and outreach to patients whose suicide risk was not addressed during the ED encounter, beginning in November 2017
- A daily report identifying positive suicide risk was generated using a data visualization application, which extracts suicide risk data from the Electronic Health Record (EHR)
- An abbreviated chart review of the EHR was conducted for each patient to understand care and treatment received during their ED encounter and if outreach is needed
- Outreach calls were conducted by BHS within 48 hours of identification
- On the calls, patients were assessed for suicide risk, provided brief intervention, and offered a safety plan and/or other relevant resources including referral to treatment
- All patients with available addresses, both reached and not reached by phone, were sent a Caring Contact Card with information on suicide hotlines and psychiatric emergency services

## Barriers

### Barriers to SI Care during the ED Encounter:

- Patients were too ill to approach
- Language differences
  - BHS staff can only approach English or Spanish speaking patients
- Physician caseload
- Length of SI Evaluation
- Staff availability and communication with emergency mental health (EMH) services
  - EMH is overburdened and cannot get to the patients
  - Physicians consult EMH to evaluate low acuity patients BHS is trained to approach
  - Communication lapse between EMH and BHS therefore missing patients
- Stigma surrounding risk responsibility

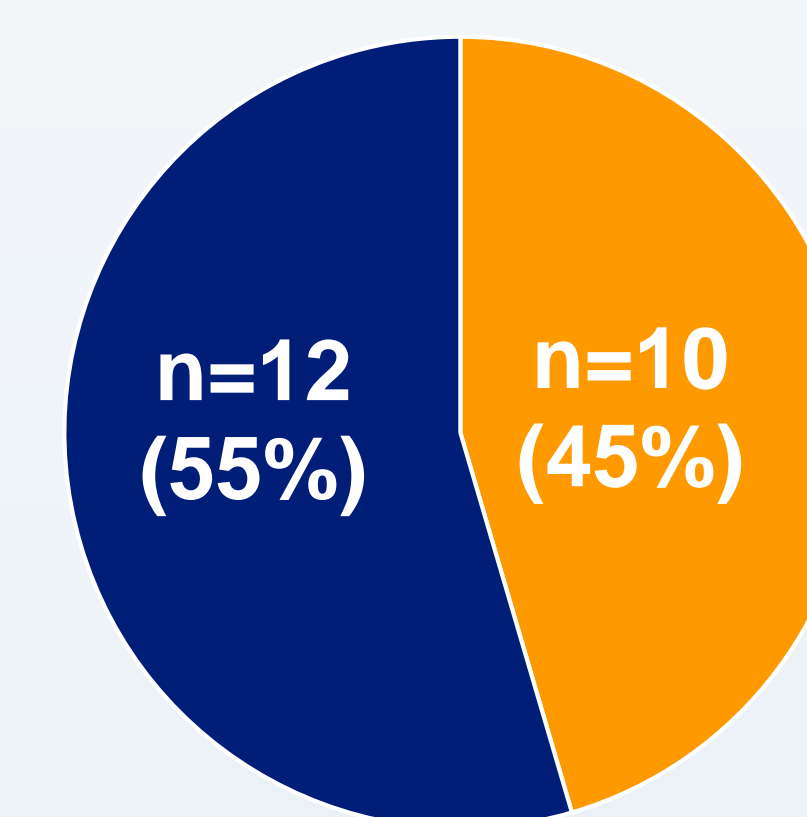
### Barriers in Follow-up Outreach:

- Unreliable contact information in the EHR
- Patients not answering during rescheduled calls
- Reluctance to complete safety plan

## Results

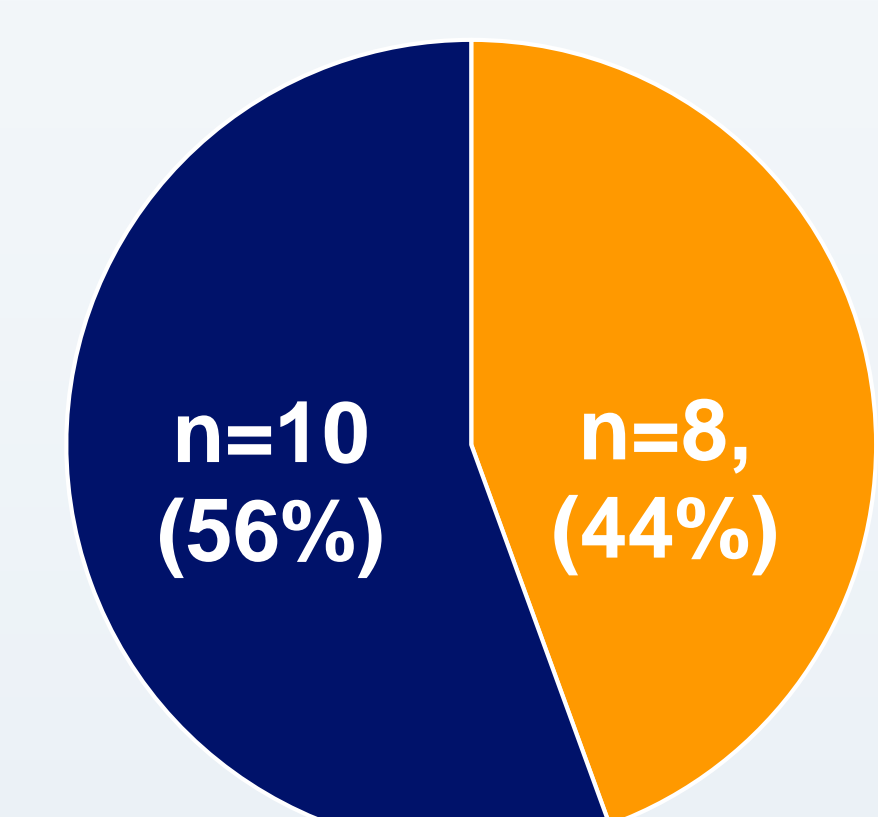
- Since November 2017 to mid- February 2018, 87 patients with positive suicide risk not addressed during the ED visit have been **identified**
- 40 (46.0%) were reached successfully by phone**
  - 22 (55.0%) declined to participate
  - 18 (45.0%) completed the assessment

### Patients Declining to Participate



Declined Service (orange)  
 Declined Intervention (dark blue)

### Completed Assessment Outcomes



Received Safety Plan (orange)  
 Negative Screen - No Safety Plan Required (dark blue)

- All patients with available addresses (62,71.3%) were sent Caring Contact Cards with information on suicide hotlines and psychiatric emergency services

## Discussion and Conclusion

- Despite these barriers, approximately 46 % of our patients were successfully contacted; around 50% reported they were content with their current services and the other fifty-percent received a telephone-based intervention. Twenty-five percent of total patients contacted received a safety plan.
- Incorporating screening, identification, and outreach to missed suicide positive patients has increased the number of patients receiving suicide risk evaluations and intervention, who otherwise would have been missed. Patients with occult suicide risk without behavioral health engagement are an incredibly important group to identify, because many benefit from this interaction by receiving a safety plan and behavioral health engagement/referral.
- We are continuing to improve communication with EMH and medical staff to avoid missed positive patients while still in the ED, improving BHS screening protocols for the identification of suicide positive patients, and maintaining up-to-date contact information for these patients.
- Together these practices will continue to increase the number of suicide positive patients identified, assessed, and treated, as well as solidify the suicide best care practices into daily workflow across the UMMHC system.

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**Acknowledgements:** The authors would like to thank the BHS Staff