Suicide Prevention in Emergency Departments Quality Improvement Initiative Year 2

FOCUS: *ED suicide care pathway development*

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Welcome!

Please put your name, position title, and organization in the chat box

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Thank you to our funders

The Four Pines Fund, The Vermont Department of Health – CDC Suicide Prevention Grant, The Vermont Department of Health – State Office of Rural Health, The Vermont Community Foundation

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Agenda

9:00 a.m.– 9:05 a.m.: Welcome & Agenda Scan

9:05 a.m. – 9:30 a.m.: Overview of Year 2 Project: Suicide Prevention in Emergency Departments Quality Improvement Initiative
Hillary Wolfley, Associate Director, Vermont Program for Quality in Health Care, Inc. (VPQHC)
Patrice Knapp, Strategic Quality Improvement Consultant, Vermont Program for Quality in Health Care, Inc. (VPQHC)

9:30 a.m. – 10:15 a.m.: Essential Elements of a Suicide Care Pathway
Dr. Edwin Boudreaux, Executive Vice Chair for Research, Dept. of Emergency Medicine University of Massachusetts Chan Medical School & Professor, Depts. of Emergency Medicine, Population & Quantitative Health Sciences, and Psychiatry PhD *Click here to access Dr. Boudreaux's bio*

10:15 a.m. – 10:30 a.m.: Next Steps, Questions & Discussion

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Housekeeping

- **Please stay on mute if not speaking**
- **Questions**: chat box, or raise hand/unmute yourself
- **This meeting is being recorded**
- **Recording and resources will be posted on the VPQHC website: https://www.vpqhc.org/edsp**
- **CEs available for:** *Social Work, Allied Mental Health Practitioners, Alcohol & Drug Abuse Counselors, and Certified Professional in Healthcare Quality*

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Meeting objectives

- After participating in this meeting, participants **will be able to describe components of the Year 2 Suicide Prevention in the ED QI Project**.
- After participating in this meeting, participants will be able to **discuss trends in suicide-related emergency department visits in Vermont**.
- After participating in the meeting, participants **will be able to describe the essential elements of a comprehensive suicide care pathway in the emergency department setting**.

The why

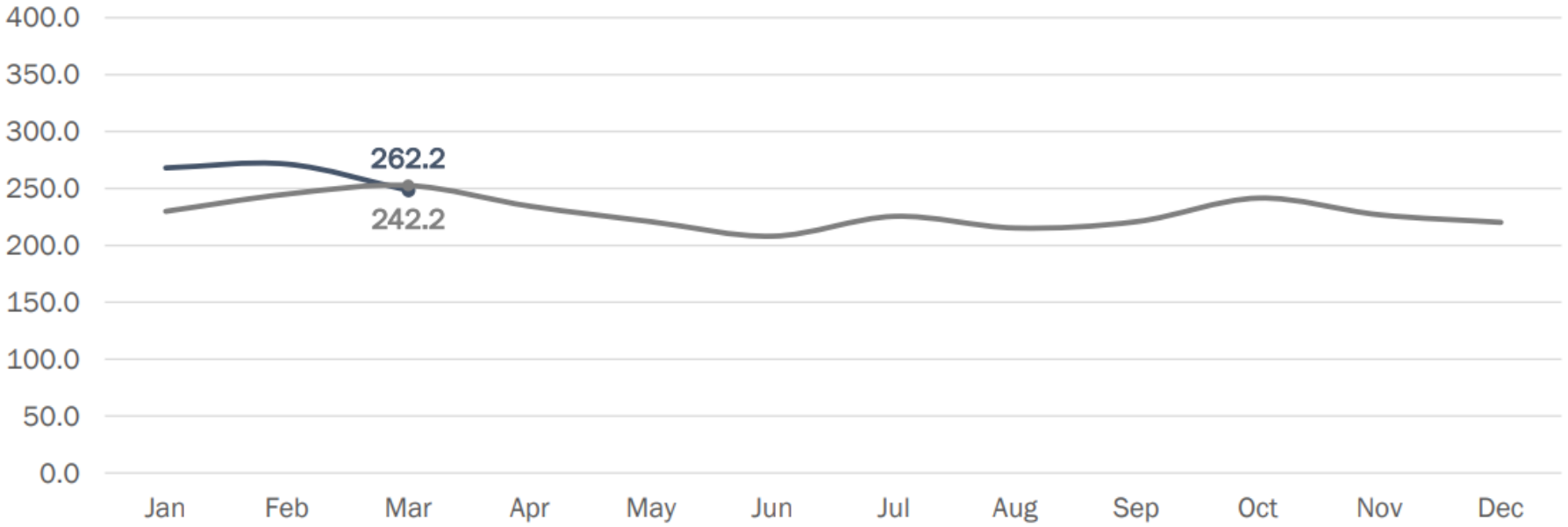
- Vermont has the highest rate of suicide death in New England.
- Suicide is the second leading cause of death for Vermonters under the age of 44.
- Suicide related emergency department visits are on the rise.
- Nearly half of individuals who die by suicide have visited an ED within the previous year.
- There are evidence-based strategies that can be implemented in the ED setting that research has shown can reduce suicide risk.

Summary of 2023 Suicide-Related Emergency Department (ED) Visit Data (to date):

- The rate of suicide-related visits this year is higher compared to previous years (262.2 per 10,000 visits versus the 2020-2022 average of 229.8 per 10,000 visits).

Suicide-related ED visits are higher this year compared to previous years.

2023 and **3-year Average Rates** of Suicidal ideation and Self-Directed Violence per 10,000 ED Visits



Source: Electronic Notification for the Early Notification of Community-based Epidemics, 2020 - 2023.
Previous years are defined using the average rate of visits during 2020- 2022.
A suicide-related ED visit is a visit for suicidal ideation and/or self-directed violence. Suicide-related visits are determined using the patient's chief complaint and/or discharge diagnosis.

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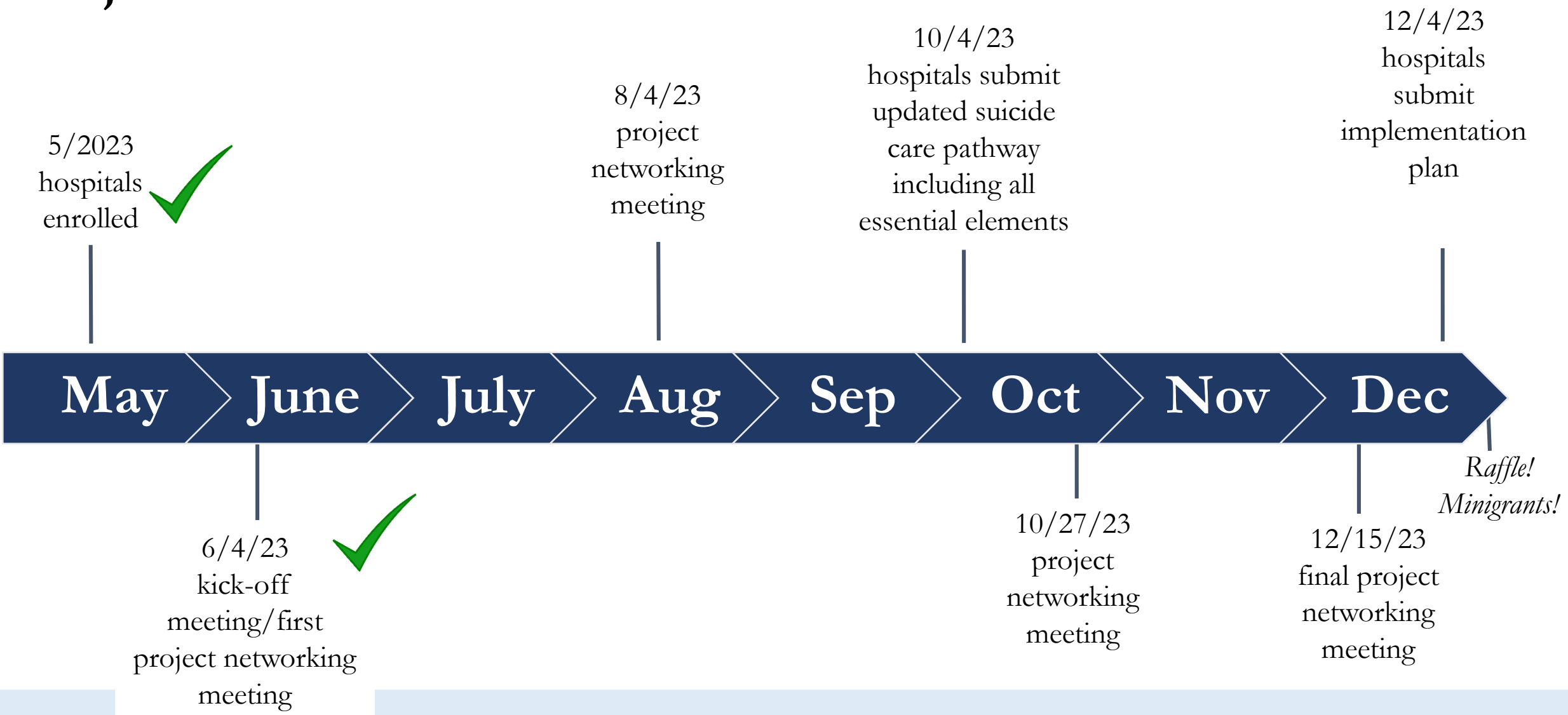
Project Timeline



CALM training

Mock survey

Mock Survey & Regulatory Standards Technical Assisatnce Opportunity Overview

- **Onsite mock survey opportunity**
  - Suicide prevention-focused mock survey in the ED
  - Mock survey of another department of choice

- **Availability for regulatory standards questions**

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Mock survey details: ED suicide prevention focus

- **Environmental Risks for Suicide Assessment Checklist (ED)**
  - Review Year 1 findings and improvements if previously conducted or;
  - Assess environmental risks in the ED if not previously assessed in year 1

- **Essential Element Audit tool and chart review to evaluate:**
  - use of a valid screening tool
  - use of an evidence based suicide risk assessment for those who screen positive
  - level of risk and mitigation strategies
  - policies and tools related to care of the patient at risk for suicide
  - policies for counseling and follow up care
  - staff competency, training and "second victims" support
  - Improvement activities

Mock survey details cont.: other department of choice

- CMS/TJC standards
- Surveyed using a standard survey tool based on most common citations

VPQHC will be reaching out to enroll hospitals interested in this opportunity

What is a suicide care pathway?

Clinical care pathways are an important tool that are widely used in health services to systematically guide evidence-based healthcare. Clinical care pathways typically possess three defining characteristics. They:

- are used to translate guidelines or evidence into local structures
- detail the steps in a course of treatment or care in a plan, pathway, algorithm, guideline, protocol, or other inventory of actions
- standardize care for a specific clinical problem, procedure or episode of healthcare in a specific population.

A suicide care pathway within a health service is a clinical care pathway for the clinical care of people presenting with suicidality.

Source: NSW Agency for Clinical Innovation | aci.health.nsw.gov.au

Purpose of a suicide care pathway

- It outlines the course of care that has been established for an individual experiencing suicidality; when a person has suicidal ideation or has tried to take their own life.
- The pathway provides a structured approach to care and aims to reduce unnecessary, or unwanted variation, in service delivery.
- It aims to enhance teamwork, interdisciplinary care and facilitate smooth transitions within the service and for referral between organizations.
- It is based on best practice and the latest available evidence.
- It is a fluid (living) document that can be altered and adapted as new services are developed or when new evidence and best practices emerge.

Source: NSW Agency for Clinical Innovation | aci.health.nsw.gov.au

Desired outcomes of a suicide care pathway

- Patients experiencing suicidality are treated in a way that is co-designed, collaboratively developed, culturally safe, evidence based, inclusive, and equitable
- Unwanted variation in the clinical care of suicide is decreased
- Each person, their family, and carers, experience collaborative, culturally safe and integrated care
- Staff actively support referrals and communicate around transitions
- Staff have an awareness of the process of care for people experiencing suicidality, along with avenues for referral to services.

Source: NSW Agency for Clinical Innovation | aci.health.nsw.gov.au

Essential Elements of a Comprehensive Suicide Care Pathway

Dr. Edwin Boudreaux, PhD

Professor, Departments of Emergency Medicine, Psychiatry, and Population and Quantitative Health Sciences
University of Massachusetts Chan Medical School

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Essential Elements of a Comprehensive Suicide Care Pathway

1. Evidence-based screening
2. Mitigation
3. Suicide risk assessment
4. Interventions
5. Care transitions
6. Discharge planning
7. Post-discharge follow-up
8. Other considerations

Care pathway elements

A typical pathway in acute care must include the following performance elements, including being specific about who (what role?) completes each component, when it is completed, and how it is documented. This presumes that a complete environmental safety assessment has already been completed, and treatment locations have already been designated as ligature resistant or not. Pathways may differ based on ligature resistant status and location of care (medical vs mental health area). When this is the case, the specifics associated with the care pathway should be clear. Care pathways should be informed by people with lived experience; should be flexible to allow patient-centered, compassionate care; and should enhance, not over-ride, clinician judgement. Alterations to the care pathway for an individual patient should be documented as part of care decision making.

1. Evidence-based screening

Initial screening using an evidence-based screening tool should be completed. The care pathway should:

- Clearly identify which patients are to be screened, including if it is clinically indicated (those with mental health presenting complaints) or universal (all comers);
- Who (what role) will do the initial screening;
- When the screening will be done, e.g., triage vs initial assessment;
- The instrument to be used, including whether different instruments will be used for different age groups and settings; and
- How and where the screening should be documented in the record.

Ideally, the initial screening will lead to risk stratification, such as negligible, mild, moderate, or high risk. This initial screening is primarily for triage purposes and is conservative. Secondary screening or brief assessment by a trained clinician, such as the emergency physician, social worker, or mental health professional, can also happen to help further define or modify the individual's risk strata in situ.

1. Evidence-based screening *continued*

Examples of evidence-based screening tools include:

- PHQ-9
- C-SSRS Triage Version (aka C-SSRS Screener)
- National Suicide Prevention Lifeline Risk Assessment Standards
- The Patient Safety Screener
- ASQ Suicide Risk Screening Tool

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2. Mitigation

Safety precautions for those who screen positive should be deployed, tailored to the individual's risk level, with a primary focus on those who are designated "high" risk. This includes, when appropriate, making the environment (treatment location) safe, observation, and restricting access to lethal means (e.g., clothing that could be used as a ligature).

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3. Suicide risk assessment

The suicide care pathway should define who gets a comprehensive suicide risk assessment by a trained professional. This assessment should lead to a risk formulation and can be used to change the risk strata and mitigation procedures. It should consider acute vs. chronic risk and in situ risk within treatment locations, such as EDs and medical units vs. in the community.

Examples of evidence-based risk assessment tools include:

- SAFE-T
- C-SSRS Risk Assessment Version
- C-SSRS Severity Rating Scale Baseline Version
- Scale for Suicide Ideation – Worst (SSI-W; Beck et al., 1997)
- Beck Scale for Suicide Ideation (BSI; Beck & Steer, 1991)
- Assessment and Management of Suicide Risk (AMSR)

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4. Interventions

Brief interventions can help decrease suicide risk, help patients manage suicide-related symptoms after discharge, and promote continued engagement with treatment. These interventions include safety planning, Counseling on Access to Lethal Means (CALM), and other emerging interventions, like JASPR. Pathways should stipulate who should get the intervention, who delivers the intervention, and how interventions are documented.

Examples of evidence-based interventions:

- Stanley-Brown safety plan
- Counseling on Access to Lethal Means
- JASPR

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5. Care transitions

Communication of risk across settings and locations of care should be defined in the pathway, including when moving from the ED to medical units, within medical units (ICU to acute care), from medical units to inpatient psychiatric units, and from acute care settings to outpatient settings.

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6. Discharge planning

Discharge planning should include consideration of resources to further mitigate suicide, including outpatient mental health services, crisis resources, and suicide prevention resources, like 988. To the greatest extent possible, the discharge plan should be specific, and delivered in a format that is understandable and health-literacy appropriate. Medical (primary care), mental health, and social service follow-up should be considered. Appointments for follow-up should be scheduled before discharge when possible.

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7. Post-discharge follow-up

Post-discharge follow-up contact should be carefully considered. Caring contact post cards and post-visit telephone follow-up calls are options. The care pathway should identify who is responsible for the cards/calls, content of the cards/calls, frequency, and time window(s).

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8. Other considerations

Care pathways can be initiated in outpatient settings or care pathways initiated in acute care can be transitioned to outpatient care. For example, an outpatient care pathway should create a new safety plan for an at-risk individual or state how an already established safety plan created in acute care will be reviewed and updated as needed in outpatient care. In addition, outpatient care pathways should consider:

- Stipulating criteria for coming "on" and "off" the pathway;
- Identifying the frequency of re-assessment and adjustment of care pathways;
- Identifying frequency of appointments with medical and mental health provider; and/or
- Identifying actions taken if a patient on the pathway cancels or no-shows an appointment.

All of these actions should be tailored to the patient's suicide risk strata.

Clinical vignette

- Tom: 66 YO man presents with foot wound, stepped on nail while gardening previous day
- Type 2 DM, HTN, hyperlipidemia, depression, prostate CA
- No overt distress, alert and fully oriented
- Denies tobacco, alcohol, drugs
- DC'd home and died by suicide the next day

- ***Could Tom's suicide have been prevented?***

Clinical vignette *continued*

- Tom: Because universal screening had been implemented, RN detected his suicidal ideation.
- To the surprise of staff, Tom had a well-thought out plan to make his suicide look like an accident so his sister could receive his life insurance.
- Secondary screening revealed multiple stressors, including 1 year anniversary of wife's death.
- Admitted to psychiatric facility.
- Discharged on antidepressant, connected with primary care, and had no further SI

- *Betz ME*, Schwartz R, Boudreaux ED. Unexpected suicidality in an older individual in an emergency department. Journal of the American Geriatrics Society, 2013;61(6):1044-1045. doi: 10.111/jgs.12290.

Next steps

Updating your suicide care pathway

1. Mapping the current state
2. Carrying out gap analysis using "*Essential Elements of a Suicide Care Pathway*"
3. Mapping desired future state that includes all essential elements

- *Due: October 5, 2023*

- *Ensure inclusion of individuals with lived experience & designated agency staff that support patients experiencing suicidality in your E*

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Process flow mapping and suicide care pathway guidance, resources, and templates available on the VPQHC website

https://www.vpqhc.org/edsp

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Date	Activity	Notes
Throughout project	CALM training	*Highly encouraged, voluntary; raffle at end of year*
Throughout project	Mock survey	
6/4/2023	Kick-off meeting (1st project networking meeting)	
8/4/2023	2nd project networking meeting	
10/4/2023	Submit final updated suicide care pathway	*Can submit one month in advance for prior review; use VPQ-provided template or other*
10/27/2023	3rd project networking meeting	
12/4/2023	Submit final implementation plan	*Can submit one month in advance for prior review; use VPQ-provided template or other*
12/15/2023	Final (4th) project networking meeting	

Please take the post-meeting survey!

Linked in chat box

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THANK YOU!

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