

# *State Breakout 1D; Care Transitions in EDs*

## Care Transitions from Emergency Departments

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Suicide Prevention Resource Center

May 3, 2016

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# Why care transitions from EDs?

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- ✓ Over 800,000 ED visits for self-inflicted injuries annually (CDC, 2011<sup>1</sup>).
- ✓ Two thirds of people with a recent attempt (12 mos), visited an ED for any reason in the past year (Han, 2014).
- ✓ 44% of ED patients with suicidal ideation had a previous suicide attempt (Allen, 2013).
- ✓ 22% of people who died by suicide visited an ED in the 4 weeks prior to their death (Ahmedani, 2014).
- ✓ The risk of a suicide attempt or death is highest within the first 30 days after discharge from an ED or inpatient psych unit; Yet up to 70% of patients who leave the ED after a suicide attempt never attend their first outpatient appointment (Knesper, 2010).

# What it is

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A concept, not a specific intervention

**Identification  
Setting  
(ED)**



**Aftercare  
(Outpatient  
Mental Health)**

**Care Transitions  
Strategies\***

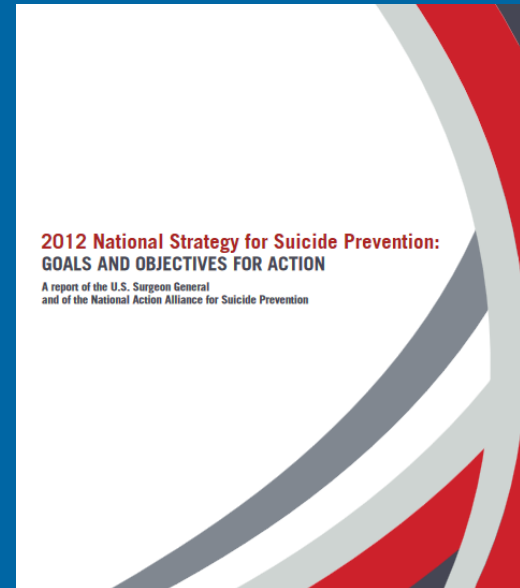
\*Can be developed and implemented by EDs, outpatient mental health providers, crisis centers, payers, and community-based organizations



**Sentinel** Alert  
**Event**

## Detecting and treating suicidal ideation in all settings

*Issue 56, February 24, 2016*



## National Strategy for Suicide Prevention: Goals and Objectives for Action

# What does a good care transition look like?

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- ✓ Appointment is made within 7 days of discharge
- ✓ Patient is safe/supported by informal caregivers and/or crisis center at home
- ✓ Patient receives follow-up phone between ED discharge and outpatient appointment
- ✓ PHI is transmitted to referral provider
- ✓ Patient attends appointment; Access barriers addressed
- ✓ Patient is contacted if missed appointment

# Care Transitions Interventions and Practices

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- 1. Rapid referral, open scheduling models**
- 2. Discharge planning**
  - Warm handoff
  - Discharge planning checklist
- 3. Follow-up**
  - Non-demand, caring contacts (postcards)
  - Follow-up phone calls or visits
- 4. Case management, care coordination**

# Care Transitions: Comprehensive Approaches

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- ✓ VA Model / SAFE VET
- ✓ Zero Suicide
- ✓ England & Wales Mental Health Service Recommendations (White, 2012)
- ✓ Project RED (Re-Engineered Discharge)



# Care Transitions: Facilitators

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- ✓ MOUs
- ✓ Transmit patient health information
- ✓ Electronic health records / HIEs
- ✓ Patient consent protocols
- ✓ Continuity of care flowsheets
- ✓ Community resource listing
- ✓ Informal caregiver involvement in d/c planning

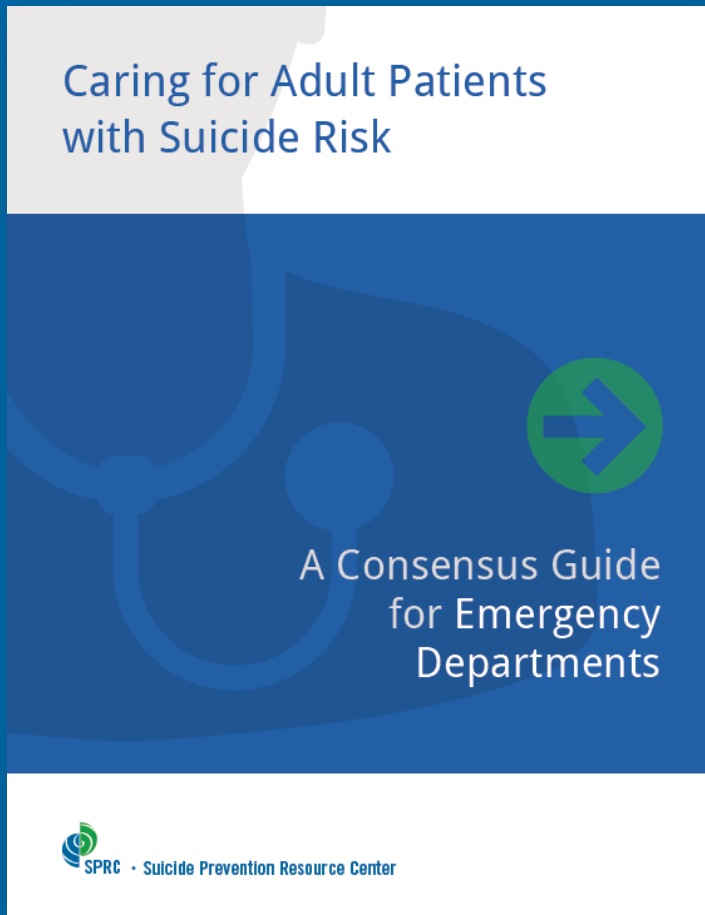




# Care transitions research examples

<b>Approach</b>	<b>Outcomes</b>
Postcards, texting, email (“ <b>Caring Contacts</b> ”)	Decreased suicides (Motto & Bostrom, 2001; Fleishmann, 2008) Reduced attempts, ideation (Luxton, 2012; Beautrais, 2010; Carter, 2007; Chen, 2010)
<b>Follow-up calls</b>	Decreased suicides (Fleischman, 2008) Accessed mental health services (Gould, 2012) Cost savings (Richardson, Mark, McKeon)
<b>Enhanced follow-up</b>	Lower suicide rates in VHA-served veterans (Kemp, Bossarte, 2012)
<b>Warm handoff</b>	Increased attendance at first appointment (Olson, 1998)
<b>Combined approaches</b>	Decreased suicides (While, 2012) Increased outpatient engagement (Boyer, 2000)

# Tools & Resources



[www.sprc.org/ed-guide](http://www.sprc.org/ed-guide)

[www.sprc.org](http://www.sprc.org)

# ED Guide – Brief ED-Based Suicide Prevention Interventions

Incorporate *crisis center/hotline information*

→	Brief Patient Education <sup>(1)</sup>	→ Include care transitions components
→	Safety Planning <sup>(1, 2)</sup>	
→	Lethal Means Counseling <sup>(2)</sup>	
→	Rapid Referral <sup>(1)</sup>	
→	Caring Contacts <sup>(1)</sup>	

# Discharge Planning Checklist

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- ✓ Involve the patient as a partner
- ✓ Make follow-up appointments
- ✓ Review and discuss the Patient Care Plan (discharge plan)
- ✓ Discuss barriers
- ✓ Provide crisis center phone number
- ✓ Discuss limiting access to lethal means
- ✓ Provide written instructions and education materials
- ✓ Confirm that the patient understands the Patient Care Plan
- ✓ Share patient health information with referral providers
- ✓ Communicate your concern

# Appendices

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- ✓ Suicide Risk Assessment: Information and Resources
- ✓ Sample Letter to Outpatient Mental Health
- ✓ Community Resource List Template
- ✓ Caring Contacts Sample Materials
- ✓ Key Elements of a Patient Care Plan
- ✓ Assessing Your Views toward Suicide



# Other Tools: Continuity of Care

*Suicide Attempts and Suicide Deaths Subsequent to Discharge from an Emergency Department or an Inpatient Psychiatry Unit*

## Continuity of Care for Suicide Prevention and Research

2

### Continuity of Care for Suicide Prevention: The Role of Emergency Departments

This report was commissioned by the SPRC in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Policy, provided overall direction of the American Association of Suicidology project. David J. Knesper, M.D., Michigan, is the author.

Continuity of care is maintained when one care provider links to another care provider, the transition in care is smooth and uninterrupted for the patient, and the essential clinical information is provided.

**Introduction to the Problem**


The goal of this paper is to highlight key steps emergency department (ED) providers can take to establish continuity of care for patients at risk for suicide, and thereby to substantially reduce the number of suicide deaths and suicide attempts that occur after discharge. The risk of suicide attempts and death is highest within the first 30 days after a person is discharged from an ED or inpatient psychiatric unit, yet as many as 70 percent of suicide attempt patients of all ages never attend their first outpatient appointment. Therefore, access to clinical interventions and continuity of care after discharge is critical for preventing suicide.

ED care providers are in a unique position to address this issue and set in motion a new chain of events to facilitate successful engagement with outpatient care. However, they face many challenges in addressing the needs of patients who may be suicidal due to the complexity of the ED environment, lack of resources, and complex nature of suicide risk. This paper is designed with these challenges in mind and presents the recommendations as a menu of options.

The recommendations in this paper are drawn from *Continuity of Care for Suicide Prevention and Research*, a report issued in 2011 by the Suicide Prevention Resource Center (SPRC), American Association of Suicidology, and U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), and from a panel of expert reviewers. Following them will help organizations implement national standards and goals relevant to ED care for patients with suicide risk, such as the Joint Commission's *National Patient Safety Goal 13.01.01* (also see for background the *Sentinel Events Alert: A follow-up report on preventing suicide*), and Objective 8.4 in the *National Strategy for Suicide Prevention*.

**The Recommendations**

Recommendations from the continuity of care report are summarized in separate sections below. Readers should select the most feasible options to implement depending on their organization's capacity, environment, and resources.

 SPRC | SUICIDE PREVENTION RESOURCE CENTER

Continuity of Care for Suicide Prevention after Emergency Department Visits | 1

## After an Attempt


A Guide for Your Family Member


## After an Attempt


A Guide in the Taking Care of Your Family Member

## National Suicide Prevention Lifeline: After an Attempt

A Guide for Taking Care of Your Family Member After Treatment in the Emergency Department

 U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Substance Abuse and Mental Health Services Administration  
www.samhsa.gov

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# Contact Information

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# Speakers

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