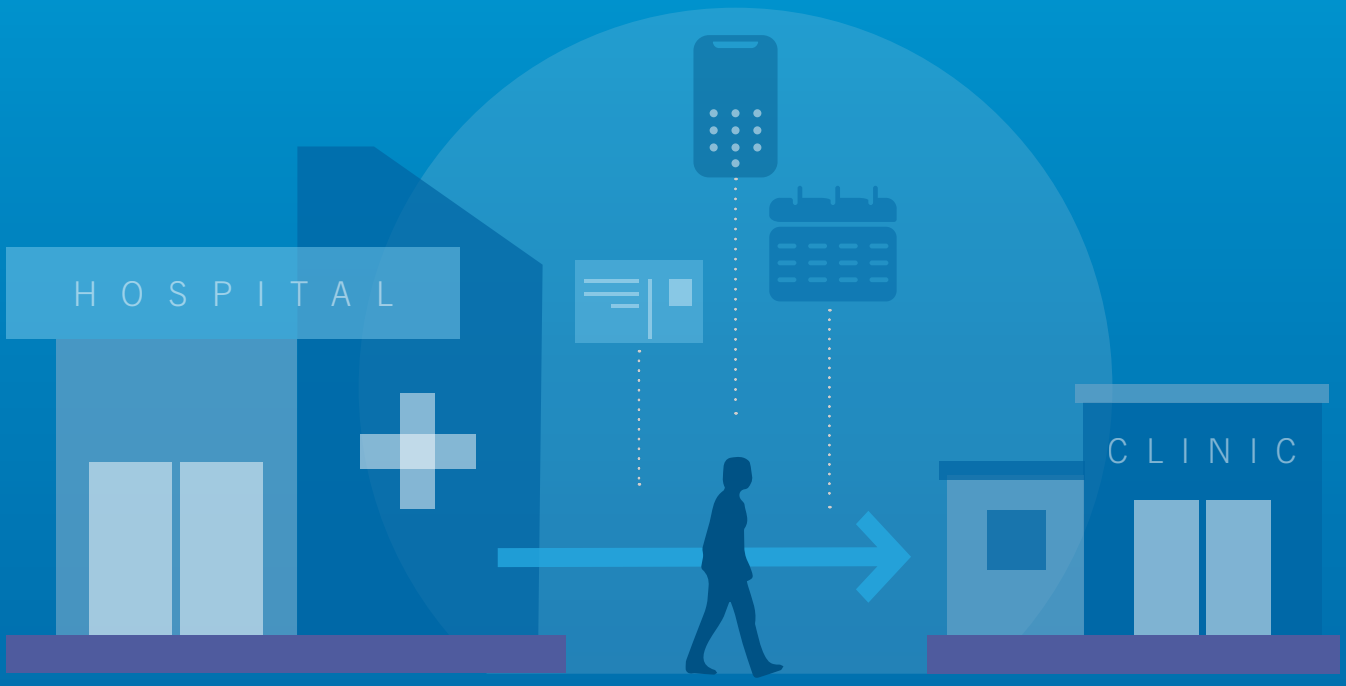

Emergency Department Best Practices:

Care Transitions for Individuals with Suicide Risk

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

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National Strategy for Suicide Prevention

This report advances Goal 8 of the 2024 *National Strategy for Suicide Prevention (National Strategy)*:

Goal 8: Implement effective suicide prevention services as a core component of health care.

OBJECTIVE 8.1: Implement effective services to identify, engage, treat, and follow up with individuals with suicide risk as standard care in public and private health care delivery.

OBJECTIVE 8.2: Develop and implement effective standard protocols to identify, engage, treat, and follow up with individuals with elevated suicide risk in health care.

OBJECTIVE 8.3: Address practice and policy barriers in order to implement effective emergency department screening, safety planning, and rapid and sustained follow-up after discharge in all emergency departments.

OBJECTIVE 8.4: Promote effective continuity of engagement and care for patients with suicide risk when they transition between different health care settings and providers, especially crisis, emergency, and hospital settings, and between health care and the community.

OBJECTIVE 8.7: Increase and leverage the use of electronic health records to track and support implementation of best practices for suicide prevention.

OBJECTIVE 8.8: Implement effective health care practice strategies that encourage safe and secure storage of lethal means among people at increased risk of suicide.

To download a copy, please visit: *National Strategy for Suicide Prevention*.

About the National Action Alliance for Suicide Prevention

The National Action Alliance for Suicide Prevention (Action Alliance) is a nonpartisan, independent, public-private national partnership for suicide prevention. The Action Alliance brings together the best thinking and resources from the public and private sectors to steward and advance the goals and objectives of the *National Strategy for Suicide Prevention (National Strategy)*—the road map for a comprehensive approach to preventing suicide. The Substance Abuse and Mental Health Services Administration (SAMHSA), through the Suicide Prevention Resource Center (SPRC) grant, provides funding to the Education Development Center (EDC) to operate and manage the Secretariat for the Action Alliance, which was launched in 2010. Learn more at theactionalliance.org and join the conversation on suicide prevention by following the Action Alliance on Facebook, X, LinkedIn, and YouTube.

Table of Contents

Introduction

As a steward of the 2024 *National Strategy for Suicide Prevention*, the National Action Alliance for Suicide Prevention (Action Alliance), through its Executive Committee partners and their organizations, have identified improving effective suicide prevention in health care as one of its five strategic priorities. In 2019, the Action Alliance and the Care Transitions Advisory Group released *Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care* (*Best Practices)* with evidence-informed recommendations for inpatient and outpatient mental health providers. Although many of those best practices recommendations are applicable to care transitions from any setting, including from emergency departments (EDs), there are unique considerations for EDs when discharging individuals at risk of suicide to outpatient mental health care.

To develop recommendations for EDs, the Action Alliance convened a group of health care and suicide prevention experts to form the Care Transitions Advisory Group Emergency Department Subgroup (ED Subgroup). The ED Subgroup worked to develop concrete recommendations ED systems could implement to improve patient outcomes post-discharge. The result is the *Emergency Department Best Practices: Care Transitions for Individuals with Suicide Risk* (*ED Best Practices*), which provides recommendations specifically for care transitions from EDs to outpatient care. These recommendations will help ED administrators and health care organizations incorporate best practices into the transitional care that patients receive after being identified as at risk for suicide. Together, the *ED Best Practices* recommendations and those in the *Best Practices* report form a comprehensive plan for care transitions from both ED and inpatient care to outpatient care for individuals at risk for suicide.

ED Best Practices, however, does not cover all the life-saving policies, programs, and practices that EDs can implement to screen and support patients at risk for suicide or all of the available evidence-based interventions. For additional information and implementation resources regarding health care, see:

- *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments*
- *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe*
- Action Alliance's work on care transitions
- Education Development Center (EDC) Zero Suicide Institute

EDs are integral in closing the gap in care for individuals who have been seen in an ED and identified to be at risk for suicide (death or attempt), but who do not meet the criteria for hospital or inpatient psychiatric care. A care transition occurs when a patient is discharged from one level of care with the recommendation/need for continued care at another level, resulting in a care gap between the discharge and the next level of care (e.g., inpatient to outpatient; ED to outpatient). When a patient is at risk of suicide, the care transition period can be a time of increased vulnerability. A patient who has been assessed and determined to not be at immediate risk for death by suicide may still need support and connection to outpatient follow-up.

Studies have shown a significant number of individuals lost to suicide had connected with health care systems, including EDs, in the days, months, and year leading up to their death.

- One study identified that over one-fifth of individuals who had died by suicide had visited an ED within two months of their death.[1]
- According to the Centers for Disease Control and Prevention (CDC), nearly 50,000 lives were lost to suicide in 2022.[2] For each life lost to suicide, there were approximately eight adult ED visits related to suicide.

For patients who are treated in an ED for suicidal ideation or self-harm, the year following their ED visit has been found to be a time of increased risk of suicide death.[3] Notably:

- The risk of suicide attempts and death is highest within the first 30 days post-discharge from an ED.
- Nearly 70% of patients discharged from an ED after a suicide attempt never begin outpatient mental health treatment.
- Post-discharge, the risk of suicide increases with time to the first follow-up appointment. Continuity of care can reduce risk and readmission rates.[4]

Not all patients treated in an ED for suicidal ideation or an attempt meet the criteria for admission to inpatient care and will be discharged from the ED into the community. According to the Web-Based Injury Statistics Query and Reporting System (WISQARS), an estimated 211,605 young people aged 15–19 were seen in an ED from 2020 to 2021 for intentional self-harm, of which 63,471 were treated and released. An estimated 635,592 people age 20+ were seen in an ED for intentional self-harm, of which 162,715 were treated and released.[4] When a patient can seamlessly be discharge from the ED to outpatient treatment, the success of the care transition is influenced by ease of access through relationship-building with mental health organizations.[5]

While suicide may not always be the primary presenting concern, EDs can identify and support patients who may be at risk by conducting routine screening. Additionally, implementing care transitions practices, such as caring contacts and follow-up calls, have been found to be achievable and effective ways to assist vulnerable patients in the days following discharge.[6] Assisting the patient and offering support during care transitions can increase the utilization of outpatient care and decrease repeated ED admissions.[7]

Based on research and data on the risk of suicide associated with gaps in care, the Joint Commission issued a revised definition of suicide in its Sentinel Event Policy, which took effect on January 1, 2024. The revised definition includes, in part, death by self-injurious behavior within seven days post-ED discharge. Essential to the safety of patients at risk of death by self-injurious behavior is the recognition, matched with capacity, of an ED to assist a patient in continuation of care. Post-ED discharge planning protocols should identify people, positions, and processes to assist and verify that a patient at risk of suicide has received a warm handoff to their next step in follow-up care. A warm handoff is collaborative between the discharging provider and the receiving provider to ensure continuity of care.

ED administrators (e.g., medical director, chief, department chair, leadership team) can help reduce the risk of suicide and repeat emergency mental health crises by implementing care transitions best practices. See the Suicide Prevention Resources Center (SPRC) guidance on EDs and continuity of care for additional information.

EDs can develop policies, programs, and practices to identify individuals at risk for suicide and engage them in brief evidence-informed interventions shown to reduce future suicide attempts, deaths, and return ED visits while also increasing connection with community-based services and supports.[8] A key factor to the success of these processes is developing partnerships that can provide the steps each party must take to ensure a patient is connected to post-ED outpatient care.

Vignette—Suicide Attempt Lived Experience

Carmen is a 20-year-old Dominican female who moved to a large city for college. Although she made friends, she still felt isolated and struggled to adjust. She also experienced a sexual assault, isolation, financial issues, and substance abuse. After a suicide attempt, Carmen was taken by her roommate to an ED for treatment.

Carmen struggled to fill out intake forms. She felt overwhelmed, anxious, and embarrassed. She felt like everyone in the waiting room was judging her. Mental health was not openly discussed in her household growing up. The public setting of the ED waiting room felt humiliating.

Once in an exam room, Carmen's roommate and a friend were allowed to stay with her. She was grateful to have their support, even though she felt ashamed. English is Carmen's second language, which led to misunderstandings of intent when she shared her suicidal thoughts. A staff member told Carmen she may need to be admitted to an inpatient facility yet didn't ask about the events and stressors Carmen had experienced leading up to her suicide attempt. Financial issues were a major stressor in her life. The idea of costly medical care, not being able to work, and missing her college classes added to her distress. Carmen waited for hours in the ED uncertain as to what would happen next.

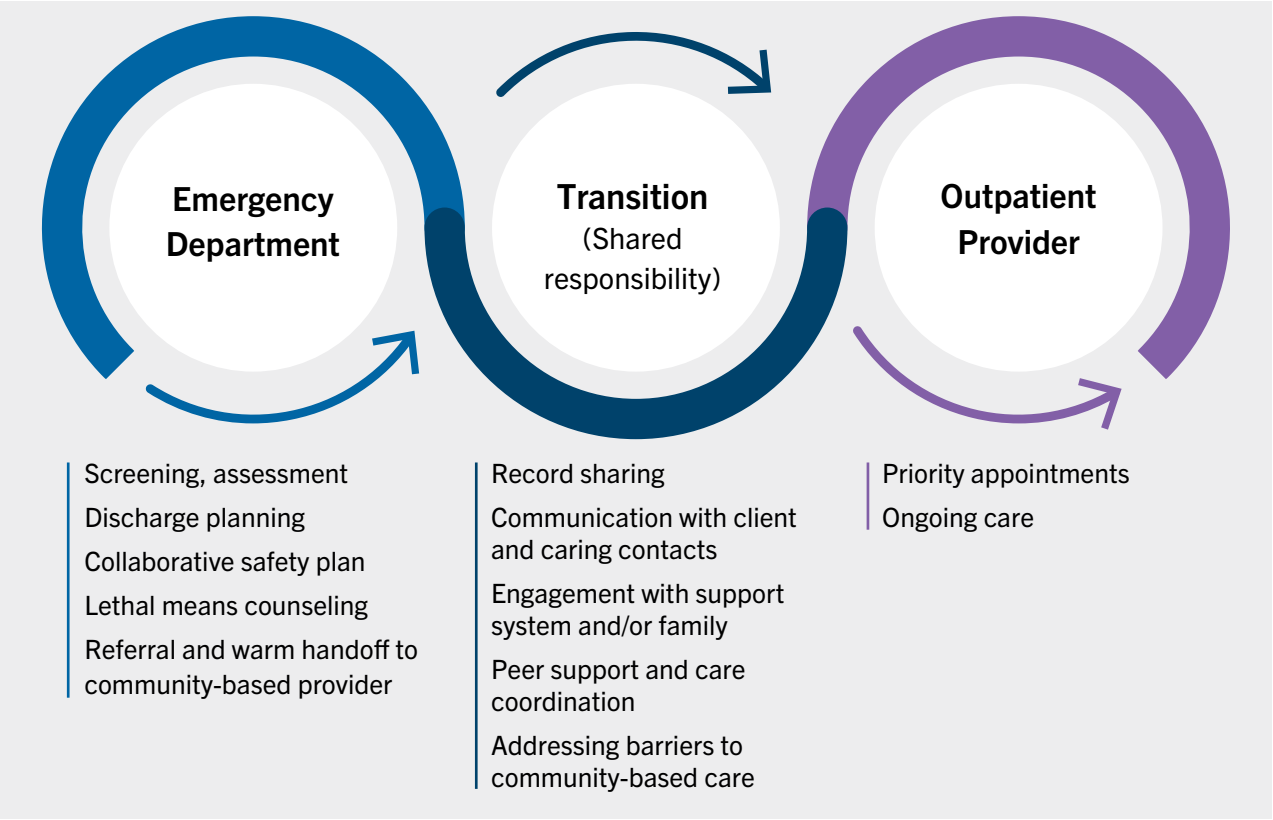
After an assessment by a culturally competent social worker and with the support of her friends, Carmen's suicidal ideation began to improve. She felt the immediate crisis had lessened. The social worker helped Carmen develop a safety plan and shared it with her roommate and a close friend. It was determined that Carmen could be safely discharged from the ED with a referral to outpatient care.

Following discharge from the ED, Carmen was assigned a case manager to help facilitate connecting with an outpatient provider. She was able to find an outpatient behavioral health clinician who was familiar with her cultural beliefs. The months that followed were difficult, but they led to Carmen getting the support she needed without returning to the ED.

— Based on the lived experiences of two attempt survivors

Recommendations for Emergency Departments

Successful care transitions include shared responsibility and linkages between EDs and outpatient behavioral health providers. Implementation of best practices includes evaluation and planning and the development of pre- and post-discharge protocols.



Evaluation and Planning

EDs can lay the groundwork for successful care transitions by engaging providers and developing procedures for safe and rapid referrals to a community or telehealth provider. Recommendations for EDs include the following:

Develop formal policies for mental health outpatient provider referrals, discharge planning, and collaborative care. Review and revise policies annually.

» For more information, see the following resources:

- Exploring Policy Change in the Emergency Department
- *Zero Suicide Toolkit:* Transition
- 988 Suicide & Crisis Lifeline: Best Practices: Follow Up (scroll down to see resources on follow-up)
- *Guidelines for Integrated Suicide-Related Crisis and Follow-Up Care in Emergency Departments and Other Acute Settings*

Collaborate with the community:

» Work collaboratively with outpatient providers to develop referral policies and procedures to expedite initial outpatient appointments and give providers the information they need for responsive care.

» Consider negotiating memoranda of understanding (MOUs) with outpatient providers that detail care coordination and expedited records sharing expectations.

» Ensure that copies of essential records are delivered electronically when an outpatient provider is identified for the patient—preferably before the patient's first outpatient visit.

Engage existing infrastructure:

» Develop partnerships with Certified Community Behavioral Health Clinics (CCBHCs). Certification criteria for CCBHCs (2.c.4 and 3.c.5) include maintaining working relationships with EDs to address the needs of clients who are admitted due to a mental health crisis and for care coordination upon discharge.

- To locate CCBHCs in your area, see the CCBHC Locator Map.
- Consider contracting with the local 988 Suicide & Crisis Lifeline provider and/or other community crisis services providers for follow-up calls to ensure the patient speaks with someone trained in mental health and suicide care between discharge and the first outpatient mental health appointment.
- Use the 988 Suicide & Crisis Lifeline center locator to find local call centers.
- See Crisis Centers and Follow-up Care for information on developing partnerships to support your ED.

EXAMPLE: Colorado Follow-Up Project

Supported by grant funding from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the Colorado Follow-Up Project is a multi-agency collaborative effort to support effective care transition services.

The Follow-Up Project's focus is on telephonic caring contacts made to patients discharged from an ED after experiencing suicidal ideation and/or behavior, self-harm, or other mental health or substance use crises. Colorado's state crisis hotline provider and hub for 988 provides this service 24/7. This partnership ensures patients are connected with experienced follow-up specialists who are trained in safety assessment, harm reduction, local resource linkage, and goal setting. Data from the Follow-Up Project indicates a reduction in service barriers and an increase in connections to post-discharge resources.

As of 2023, there were 71 EDs from across Colorado referring clients to the program, resulting in over 10,000 people receiving follow-up services within the last reported year.[9]

Develop and conduct internal system actions:

- Review referral lists and verify outpatient provider information quarterly to update insurance plans accepted, age ranges treated, and treatment modalities used. Confirm that the provider is accepting new clients.
- Provide employee training and evaluate staff knowledge and confidence with policies and procedures on care transitions.
  - See the Joint Commission's resource page on suicide prevention.
  - For guidance on assessing workforce preparedness to provide suicide care, see the Zero Suicide Institute's Workforce Survey Resources for survey questions, templates, and guidelines.
- Review post-discharge outcomes periodically to assess connection with an outpatient provider and/or follow-up care with a primary care physician.
  - At a minimum, develop a system to track and annually evaluate repeat ED visits of patients experiencing suicidality; patient connection and follow through with an outpatient provider; and patient feedback on care transition support. ED administrators should use this information to examine potential gaps in care transitions and connection to outpatient behavioral health care. The process can be part of an overall plan to track patients and report sentinel events.
  - For health systems that also provide primary care services, see the *Suicide Prevention Toolkit for Primary Care Practices.*
- Conduct a Root Cause Analysis (RCA) when an incident of self-inflicted injurious behavior resulting in death occurs within seven days of discharge.
  - Joint Commission-accredited EDs — Report all self-inflicted injurious behavior resulting in death that occurs within seven days of discharge (see The Joint Commission Sentinel Event Policy for additional information and all health settings covered). Participating in the voluntary reporting of self-injurious behavior sentinel events will contribute to the Joint Commission's Sentinel Event Database and assist with tracking events and metrics.

Prior to Discharge

A successful care transition begins before a patient leaves the ED. Preparing the patient and their chosen supports for the next steps in care and providing safety information and education can increase the chances of a successful transition to outpatient care.

Identify patient supports:

- Involve anyone who has been identified by the patient as a support (i.e., family members, friends, caregivers) in discharge planning and instructions, if they are present and willing. When talking with them, be sure to do the following:
  - Address language barriers so that everyone understands all discharge planning items and instructions.

- Work collaboratively with the patient to develop an individualized safety plan as part of pre-discharge planning. Be sure to address strategies to temporarily restrict access to lethal means. For more information on the components to be included in the safety plan, see the video *How Emergency Departments Can Help Prevent Suicide among At-Risk Patients: Five Brief Interventions*.

Plan ahead:

» Address acute modifiable risk factors that may impact successful care transitions (e.g., acute intoxication, withdrawal, physical injury).

- Identify long-term risk factors, such as housing and food insecurities and other psychosocial factors, for follow-up with the outpatient provider and/or case managers.

» Develop a plan for the seven days immediately following discharge (e.g., outpatient clinician release, consent for follow-up, call from internal or third-party provider).

» If it is known who the outpatient provider is or will be, have the patient sign a release of records to that provider before discharge.

» If available, refer the person to their insurance company's care management personnel.

Make the connection:

» Where available, connect the patient to peer specialists to assist the patient post-discharge. Peer specialists can offer support and assist the patient to problem-solve any barriers to outpatient care.

» Connect the patient with an outpatient provider. If the ED and outpatient provider are in the same health care system and have the available infrastructure, schedule an outpatient appointment before discharge. The first outpatient appointment should be within 24 to 72 hours of discharge and no later than seven days after discharge.

- The National Committee for Quality Assurance (NCQA) recommends follow-up after an ED visit for mental illness and/or self-harm within 7 to 30 days.[10]
- Some major insurance providers are tracking this follow-up occurring within seven days (can be the same day as the ED visit).[11, 12, 13]

Workforce Shortage

Connection with an outpatient mental health provider post-ED discharge is an established best practice. However, the United States is currently experiencing a national shortage of psychiatrists and other mental health providers. Individuals who are most in need, those who are underserved, and minority populations are disproportionately impacted. Community capacity and availability of mental health providers impacts outpatient care usage.[14] Full implementation of *Best Practice*s and *ED Best Practices* recommendations will require enhancement of the workforce infrastructure (e.g., availability of providers, payment/financing, and use of electronic health records for timely record sharing). The Action Alliance and its partners continue to engage national leaders, providers, and payors to address the mental health system infrastructure and to advance the goals of the 2024 *National Strategy for Suicide Prevention*, which include:

GOAL 6: Build and sustain suicide prevention infrastructure at the state, tribal, local, and territorial levels.

GOAL 9: Improve the quality and accessibility of crisis care services across all communities.

GOAL 14: Create an equitable and diverse suicide prevention workforce that is equipped and supported to address the needs of the communities they serve.

- If the patient needs to connect with a provider who is not in the ED-affiliated health care system, provide the patient with a list of verified community providers that have an MOU in place with the ED. Where possible, contact the provider prior to the patient's discharge to arrange for a warm handoff for the patient.
- Provide the patient with information on whom to contact within the ED or health care system if the outpatient provider does not respond within 24 to 72 hours and/or does not have availability within seven days.
- Following up with a behavioral health provider is best. However, when a provider is unavailable in the area and/or the appointment wait time exceeds seven days, follow-up with an established primary care physician (PCP) can be part of the care transitions plan to provide assistance until a provider can be identified and the first outpatient behavioral health appointment scheduled.
  - If the patient does not have a PCP, a referral to a PCP to address physical and mental health concerns is needed.
- Provide all patients who may be at risk for suicide and are being discharged from the ED with information about the 988 Suicide & Crisis Lifeline. Download and print or order resources from SAMHSA's *988 Partner Toolkit*. Provide patients with information about other local crisis resources if available.

After Discharge

After a suicidal crisis, caring contacts (e.g., postcards, letters, phone calls, emails, texts) provided to patients post-ED discharge have been found to reduce suicide attempts and deaths.[15] Follow-up after ED discharge can be an effective way to engage the patient during care transitions until a warm handoff to an outpatient provider occurs. To learn more about the benefits of follow-up and caring contacts, visit Follow-up Matters.

Follow up with the patient and outpatient provider:

- Call the patient within 24 to 48 hours of discharge to review their discharge plan, review their safety plan, and assist with problem-solving any barriers to attending the first appointment with an identified provider. Follow-up calls and caring contacts may be initiated by designated ED staff, hospital social workers, or through a contracted service with local 988 call centers.
  - After the initial contact with the patient, designated health care staff should maintain weekly telephone contact for the first 30 days after discharge or until it is confirmed the patient attended their first outpatient appointment.
- Provide patients with ongoing caring contacts that do not require a response (e.g., card, text, email).
- Send all necessary information to the patient's identified care team (e.g., outpatient mental health provider, case manager, primary care provider) within 24 to 72 hours and no later than seven days after discharge.

Information to Send

Send the following information to the outpatient provider who has been identified for the patient:

- ✔ ED visit records, including any evaluation conducted by a behavioral health provider (e.g., clinician, crisis worker, psychiatrist, psychiatric advanced practice provider)
- ✔ Discharge plan
- ✔ Safety plan

Program Highlight

The Chickasaw Nation Department of Health in collaboration with the Chickasaw Nation Department of Family Services in Ada, Oklahoma, have implemented multiple processes and workflow practices that help facilitate transitions of patients discharged from the ED who are at risk of death by self-injurious behavior. For example, the ED embedded a clickable consult process for behavioral health follow-up into the ED nursing templates so that the case management team receives notification of all patients needing post-discharge care and follow-up regardless of the hour and day they come in.

The most successful addition has been the implementation of a monitoring tool identified as the Suicide Care Pathway (SCP). This system, which is outside of agency electronic health records, is utilized by a case management team to monitor patients identified as being at risk for suicide (low, moderate, high risk) and the contacts and attempts made with the patient for follow-up. The system also includes documenting the methods of follow-up the patient received.

Additionally, a contract has been established with Heartline, an in-state backup call center for the 988 Suicide & Crisis Lifeline and Lifeline Chat, to assist in post-discharge patient contacts.

Since early 2022, these practices have helped the Chickasaw Nation successfully monitor patients at risk of death by suicide, coordinate follow-up care, and address any identified barriers to accessing mental health services.

Recommendations for Outpatient Providers Supporting EDs

Outpatient providers can work collaboratively with EDs by developing partnerships to support their efforts to connect discharged patients (outpatient clients) with care and ensure a smooth transition. For full guidance on care transitions as well as information on the care gap after inpatient discharge, see the *Best Practices* report.

Establish MOUs with EDs that include expectations for policies and procedures that allow for safe and rapid referrals. It is important to cultivate a relationship between outpatient providers and the ED by doing the following:

- Develop policies for referrals to triage intakes and preferential appointment times for clients recently discharged from an ED.
- Track patient follow-up with outpatient care:
  - Notify the ED MOU contact when the client has kept the first outpatient appointment.

- Notify the ED MOU contact if the client misses the first outpatient appointment and outreach efforts are unsuccessful.

» Obtain essential records from the ED visit within 24 to 72 hours after discharge but no later than seven days after discharge. What to request:

- ED visit records, including any evaluation conducted by a behavioral health provider (e.g., clinician, crisis worker, psychiatrist, psychiatric advanced practice provider)
- Discharge plan
- Safety plan

» Review MOU compliance annually and identify any needs for improvement.

When triaging intakes, obtain information regarding the reason for the ED visit before the first outpatient appointment. If the first outpatient appointment is with a nonclinical staff person, such as a case manager, be sure:

» To review the safety plan to ensure that the client understands how to use it effectively.

» The client knows whom to contact, if needed, before the next appointment.

- To maintain contact with the client until they have had their first appointment with the outpatient clinician.

Together We Can Do Better

Collaborative efforts between EDs and outpatient providers can narrow the gap during transition of care, decrease repeat ED visits for suicidality, and increase outpatient care follow through. Partnerships and shared responsibility during the transition can assist individuals and provide them with a warm handoff to the next phase of their treatment. Together, ED and outpatient health care organizational leaders can work toward a seamless continuum of care that ultimately saves lives.

Appendix A

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Endnotes

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