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DEPARTMENT OF VETERANS AFFAIRS
Veterans Health Administration
Washington DC 20420

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UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

**NEW JCAHO PERFORMANCE REQUIREMENT FOR MITIGATING
THE RISK OF SUICIDE**

1. Purpose. This Information Letter provides medical centers with guidance in implementing strategies necessary to comply with a new Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) National Patient Safety Goal (NPSG) that takes effect January 1, 2007. This new Goal calls for facilities to mitigate the risks of suicide through appropriate screening and action.

2. Background

a. JCAHO's NPSG goes into effect January 1, 2007 and requires organizations surveyed under the Hospital or Behavioral Health Care standards to conduct suicide risk assessment for any patient with a primary diagnosis or primary complaint of an emotional or behavioral disorder. *NOTE: At this time, JCAHO is not calling for suicide risk assessment of patients with secondary diagnoses or secondary complaints of emotional or behavioral disorders.*

b. JCAHO has noted that suicide ranks as the eleventh most frequent cause of death (third most frequent in young people) in the United States, with one person dying from suicide every 16.6 minutes. Suicide of a care recipient while in a staffed, round-the-clock care setting has been the most frequently-reported type of sentinel event since the inception of the JCAHO's Sentinel Event Policy in 1996. Identification of individuals at risk for suicide while under the care of, or following discharge from, a health care organization is an important first step in protecting the health and planning the care of these at-risk individuals.

c. Findings from the Center for Disease Control's National Violent Death Reporting System demonstrate that in the participating states, 21-25 percent of all suicides are among veterans; therefore, these issues are of special concern to VHA.

3. JCAHO NPSG 15, Requirement 15A. JCAHO NPSG 15, Requirement 15A, calls for mitigating the risk of suicide through the following steps.

a. Performing risk assessments that include identification of:

(1) Specific patient factors and features that may increase the risk for suicide, and

IL 10-2006-013
December 11, 2006

(2) Specific patient factors and features that may decrease the risk for suicide.

b. Ensuring that the patient's immediate safety needs and the most appropriate setting for treatment are addressed.

c. Ensuring the facility provides information, such as a crisis hotline, to at-risk individuals and their family members for crisis situations.

4. Recommendations for VA Medical Centers. It is strongly recommended that each facility take the following steps to comply with this NPSG:

a. Develop and implement strategies to properly assess, treat, and manage patients identified at risk for suicide. *NOTE: A Suicide Risk and Response Card has been developed by the Office of Mental Health Service (OMHS). The current version of the card can be obtained at <ftp://vaww.mentalhealth.med.va.gov/main/SuicidePocketCard.pdf>.*

b. Document the relevant risk factors for suicide in each patient's medical record.

c. Document treatment and the treatment setting in a manner that addresses the presence of (or absence of) relevant risk factors that increase risk for suicide and features that may decrease risk for suicide.

d. Provide the appropriate telephone number(s) for telephone calls during working hours and other times, in writing, to at-risk patients and/or significant others. Documentation of these instructions should be recorded in the patient's medical record.

e. Instruct patients and their significant others to call the facility's Emergency Department or Urgent Care Center if they have a crisis situation. If the VA facility does not have an Emergency Department or Urgent Care Center for after-hours care and the patient or significant other is unable to talk with an appropriately qualified clinical staff at the facility, the patient and/or the patient's significant other should be advised to contact local suicide prevention hotlines found through the Substance Abuse and Mental Health Services Administration (SAMHSA) national suicide prevention number at 1-800-273-8255 (1-800-273-TALK). SAMHSA is able to connect the caller with a local or regional resource. The operator at such a facility will also have access to this telephone number. *NOTE: This should be seen as an interim solution. VHA is in the process of enhancing its own internal capability to provide similar services.*

f. Ensure that the local or regional mental health hotline knows about VA as a resource in case a veteran should contact them. The Suicide Prevention Resource Center (available at www.sprc.org) has a state-by-state listing of crisis centers so VA facilities can identify organizations in their respective areas.

g. Ensure that the safety concerns in the design of the inpatient mental health unit (and its furnishings) are addressed.

h. Establish and implement a policy stating who is responsible for identifying and working with local agencies so that VA patients receive emergency support and referral to the VA as soon as possible.

6. Contact: Questions may be addressed to the Office of Patient Care Services' Office Mental Health Services, at (202) 273-8434.

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