Department of Veterans Affairs **VHA DIRECTIVE 2008-036**
Veterans Health Administration
Washington, DC 20420 **July 18, 2008**

USE OF PATIENT RECORD FLAGS TO IDENTIFY PATIENTS AT HIGH RISK FOR SUICIDE

1. PURPOSE: This Veterans Health Administration (VHA) Directive outlines policy and guidance for the proper use of Patient Record Flags (PRF) to identify patients that are at high risk for suicide. ***NOTE:*** *Identification and tracking of patients at high risk for suicide is a key component of VHA's national suicide prevention strategy.*

2. BACKGROUND: Suicide is the 11th leading cause of death in the United States. VHA mental health officials estimate there are 1,000 suicides per year among veterans receiving care within VHA and as many as 5,000 per year among all living veterans. The best single indicator that a patient is at increased risk of suicide may be a history of a prior suicide attempt. Some studies indicate that up to two-thirds of patients who commit suicide have seen a physician in the month before their death (subpar.5b). In July of 2007, the Department of Veterans Affairs (VA) opened a National Suicide Hotline staffed with mental health professionals who answer toll-free calls from across the country and work with local VA mental health professionals to help callers.

a. The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions.

(1) The clinician needs to consider frequent follow-up appointments, involving significant others in care planning and limiting access to means of harming oneself when possible.

(2) Front line staff needs to be aware that if they are concerned about a patient's safety they are to contact the provider or Suicide Prevention Coordinator (SPC) and be aware that these patients may present for care for a variety of reasons in order to obtain safety and help. After regular business hours, or if the provider or SPC cannot be contacted, local safety procedures need to be followed. The absence of a High Risk for Suicide PRF on a patient's record does not indicate that the patient is not at risk for suicide. Many times warning signs and risk factors are not known by VA clinical staff.

(3) All staff need to recognize that any veteran may be at risk for suicide, regardless of the flag status on the veteran's chart. In the event of concerns for suicide risk, referrals are to be made to the SPC.

b. The use of any PRF is restricted to addressing immediate clinical safety issues. As such, it is important to ensure that usage of a PRF is limited to only those patients at high risk, and

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only for the duration of the increased risk for suicide. The PRF is removed as soon as it is clinically indicated to do so. This is especially important to minimize the risk of undue stigmatization for the patient, and to maintain the value of the PRF system as an alert to an immediate clinical safety concern.

c. Carefully defined criteria for high risk for suicide (see subpar. 2d(2)) are necessary to ensure that the PRF is appropriately used and maintains its clinical safety value. This determination needs to be made cautiously, and a record flagged only in the event that additional care should be taken by everyone interacting with the patient to attend to the increased risk for suicide. Reporting of suicidal thoughts or a call to the national suicide hotline alone is not an automatic indication of high risk.

d. **Definitions**

(1) **Category II PRF.** Category II PRF may be locally established by individual Veterans Integrated Service Networks (VISNs) or facilities.

(a) Category II PRF's are currently used in various VHA facilities for a range of purposes. Some appropriate uses include flagging:

1. Patients who are enrolled in research trials involving investigatory pharmaceuticals,

2. Patients with documented drug-seeking behavior,

3. Patients at high risk for suicidal behavior,

4. Patients with spinal cord injuries, and

5. Homeless veterans who have urgent medical test results.

(b) The use of Category II PRF, should be strictly limited to information that is immediately essential for the delivery of safe and appropriate health care. A Text Integration Utility (TIU) Progress Note in the Computerized Patient Record System (CPRS) must also accompany all Category II PRF.

(2) **High Risk for Suicide.** Veterans may be determined to be at high risk for suicide for a variety of reasons and this is always a clinical judgment made after an evaluation of risk factors (e.g., history of past suicide attempts, recent discharge from an inpatient mental health unit), protective factors and the presence or absence of warning signs as listed on the VA Suicide Risk Assessment Pocket Card. The warning signs and high-risk criteria are described in the Suicide Risk Assessment Guide Reference Manual (see subpar. 5c). The following list, although not exclusive, contains indicators that a veteran may be considered at high risk:

(a) A current verified report or witnessed suicide attempt.

(b) Identification of current serious ideation that requires an immediate change in treatment plan, such as hospitalization.

(c) Presence of any of the following warning signs:

1. Threatening to hurt or plan to kill oneself.

2. Looking for specific ways to kill oneself and seeking access to such means, as pills, weapons.

3. Talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person.

(3) **SPC.** The SPC is a position funded at each medical center as part of VHA's national suicide prevention strategy. The incumbent in this position is clinically trained and has the responsibility for coordination of local suicide prevention strategies, and maintaining the High Risk for Suicide PRF locally.

(4) **Suicide Behavior Report (SBR).** The SBR is the documentation to be completed by a VA clinical staff member when they become aware that there has been a suicide attempt or significant suicidal behavior (see subpar. 2d (2)). The SPC may complete this report when a referral from the VA National Suicide Hotline, or from another source, such as a community facility, is received indicating that a patient has made a suicide attempt.

(a) This report is used to:

1. Provide required information for the National Patient Safety reporting requirements on suicide and suicide attempts. The National Center for Patient Safety has approved the use of the SBR and use of its data reporting requirements from the field.

2. Populate a national suicide prevention database, established as part of VHA's national suicide prevention strategy.

(b) The completion of this report may be an indication that a flag needs to be placed in the record, but it is not the sole criteria, nor is it necessary for placement of the PRF for suicide risk.

3. POLICY: It is VHA policy that all facilities must identify and track patients at high risk for suicide, using a Category II local PRF of High Risk for Suicide.

4. ACTION

a. **Deputy Under Secretary for Health for Operations and Management.** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for providing oversight to the VISNs and ensuring that the use of a Category II PRF for the identification and tracking of patients at high risk for suicide is appropriately implemented by the VISN's.

b. **VISN Director.** The VISN Director, or designee (the VISN Mental Health Committee or other comparable VISN group), is responsible for oversight and implementation of this Directive at the VISN level.

c. **National SPC.** The National SPC is responsible for oversight of training of facility SPCs in the appropriate use of the PRF system for identification and tracking of patients at high risk for suicide.

d. **Facility Director.** The facility Director, or designee, is responsible for:

(1) Ensuring that Category II High Risk for Suicide PRFs are originated and accessible through CPRS.

(2) Establishing a process for requesting, assigning, reviewing, and evaluating Category II High Risk for Suicide PRFs, and coordinating this with existing processes for managing the PRF Program.

(3) Ensuring training, by the SPC, of appropriate staff in determining when a Category II High Risk for Suicide PRF is to be entered, how PRFs are entered, and how PRF and PRF-related documents are to be maintained and reviewed.

(4) Evaluating the facility process to ensure that Category II High Risk for Suicide PRFs are assigned appropriately.

(5) Ensuring that each Category II High Risk for Suicide PRF in a patient's record is accompanied by a TIU Progress Note written at the time the Suicide PRF is established. The TIU titles utilized must be mapped to the national PRF title. The local title falls under the document class of PRF Category II, and the title will be PRF Category II--High Risk for Suicide.

(6) Ensuring a Category II PRF is used as a local alert for patients at high risk for suicidal behavior. This use of the Category II flag enables staff to be aware of a patient in need of close follow up, including outreach efforts if the patient misses or cancels an appointment.

(7) Ensuring when a High Risk for Suicide PRF is placed on a patient's chart, it is re-evaluated at least every 90 days to ensure that the PRF is promptly removed when the high risk status is resolved. This is based on clinical judgment of the conditions and behaviors involved

(8) Ensuring there is always an acting SPC when the Coordinator is absent.

e. **Chief of Staff (COS).** The COS is responsible for:

(1) Instituting procedures to ensure that the utilization of a Category II PRF for High Risk for Suicide and the associated processes for recommending such a PRF are ethical, clinically appropriate, supported by adequate resources, and used in accordance with this Directive.

(2) Providing for a response to patient requests for deactivation of their Category II PRF for suicide risk.

f. **Facility SPC.** The facility SPC is responsible for:

(1) Managing the process of using Category II PRFs to identify patients at high risk for suicide.

(2) Exclusively controlling all Category II suicide flags, and limiting their use to patients who meet the criteria of being placed on the facility high-risk suicide list.

(3) Coordinating with the facility committees and their processes, which manage PRFs, to incorporate the use of Category II PRFs into the overall process of utilization of PRFs at the facility.

(4) Assessing the risk of suicide in individual patients, in conjunction with treating clinicians.

(5) Identifying training needs relating to the prevention and management of suicide.

(6) Ensuring that patients identified as being at high risk for suicide receive follow-up for any missed mental health and substance abuse appointments in conjunction with the clinical treatment team, and that this follow-up is documented in the electronic medical record.

(7) Working with clinicians, who refer potential high risk patients for flagging, to determine the advisability of the flag.

(8) Maintaining communications with the facility-designated advisory group or committee to keep them aware of flag placements and outcomes of reviews.

(a) This committee, or other ad hoc decision making committees the facility may have in place, assists in making flag placement recommendations; they also serve as advisory groups for the SPC in the determination process.

(b) If acting, the SPC should also seek the guidance of these advisory groups.

(9) Maintaining a list of patients who currently have a flag, and establishing a system of reviewing these flags at least every 90 days.

(10) Documenting, when appropriate, the nature of the follow-up and plans for continuing treatment in the electronic medical record.

5. REFERENCES

a. Mental Health Initiatives memo, Deputy Undersecretary for Health Operations and Management, June 1, 2007.

b. Department of Veterans Affairs Office of the Inspector General. Implementing VHA Mental Health Initiatives for Suicide Prevention; May 10, 2007.

c. Suicide Risk Assessment Guide Reference Manual, which can be found at: http://vaww.mentalhealth.va.gov/files/suicideprevention/SuicideRiskGuide.doc ***NOTE:*** *This is an internal VA link not available to the public.*

6. FOLLOW-UP RESPONSIBILITY: The Office of Patient Care Services, the Director, Mental Health Services (116) is responsible for the contents of this Directive. Questions may be addressed to 202-461-7350.

7. RESCISSIONS: None. This VHA Directive expires July 31, 2013.

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