U.S. Department of Veterans Affairs

VA Suicide Risk Identification Strategy (Risk ID)

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ROCKY MOUNTAIN MIRECC

Disclaimer

This presentation is based on work supported, in part, by the Department of Veterans Affairs, but does not necessarily represent the views of the Department of Veterans Affairs or the United States Government.

VA Suicide Risk Identification Strategy (Risk ID)

VA Suicide Risk Identification Strategy (Risk ID) is a national, standardized process for suicide risk screening and evaluation, using high-quality, evidence-based tools and practices

Risk ID ensures fidelity to best practices for suicide risk screening and evaluation across the healthcare system

Risk ID outlines a clear process for:

WHO should be screened and/or evaluated,

WHEN screening and/or evaluation should occur,

HOW screening and/or evaluation should be conducted and documented

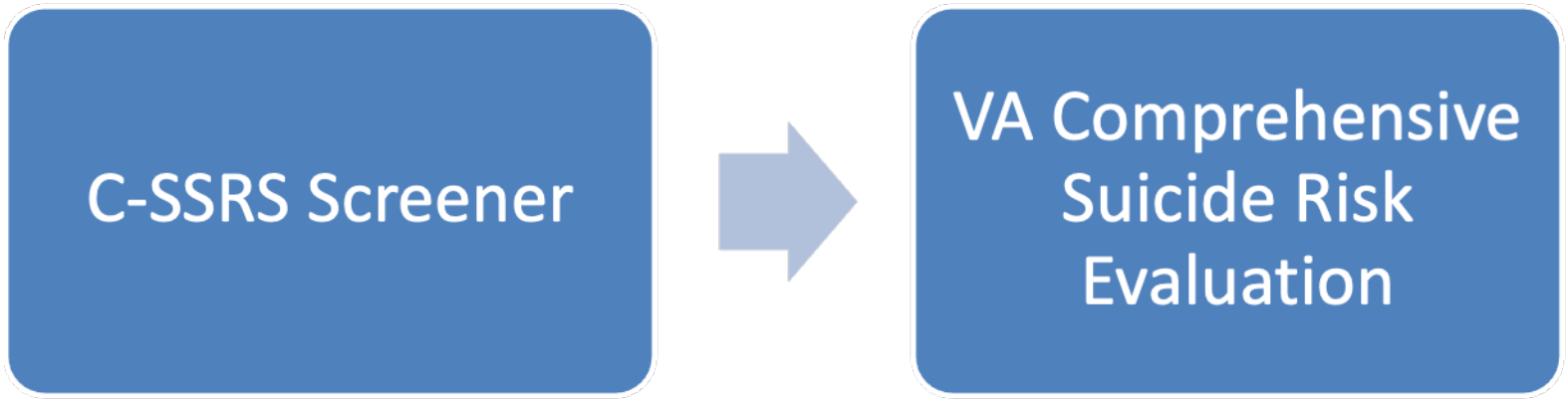
Risk ID: Three Types of Requirements

1. Universal Screening Requirement - The Annual Suicide Risk Screen Reminder is satisfied by appropriate staff, at a Veteran's encounter, when it is due.

2. Setting Specific Requirements – Specific clinical settings have additional screening and evaluation requirements

3. When clinically indicated - When a new behavioral health concern is evident, Risk ID screening is indicated.

Risk ID: Two-Stage Process



SCREEN: To detect who may be at risk for suicide and is need of further evaluation

EVALUATE: To inform clinical impressions about acute and chronic risk and associated disposition

*A positive C-SSRS requires the timely completion of the Comprehensive Suicide Risk Evaluation (CSRE).

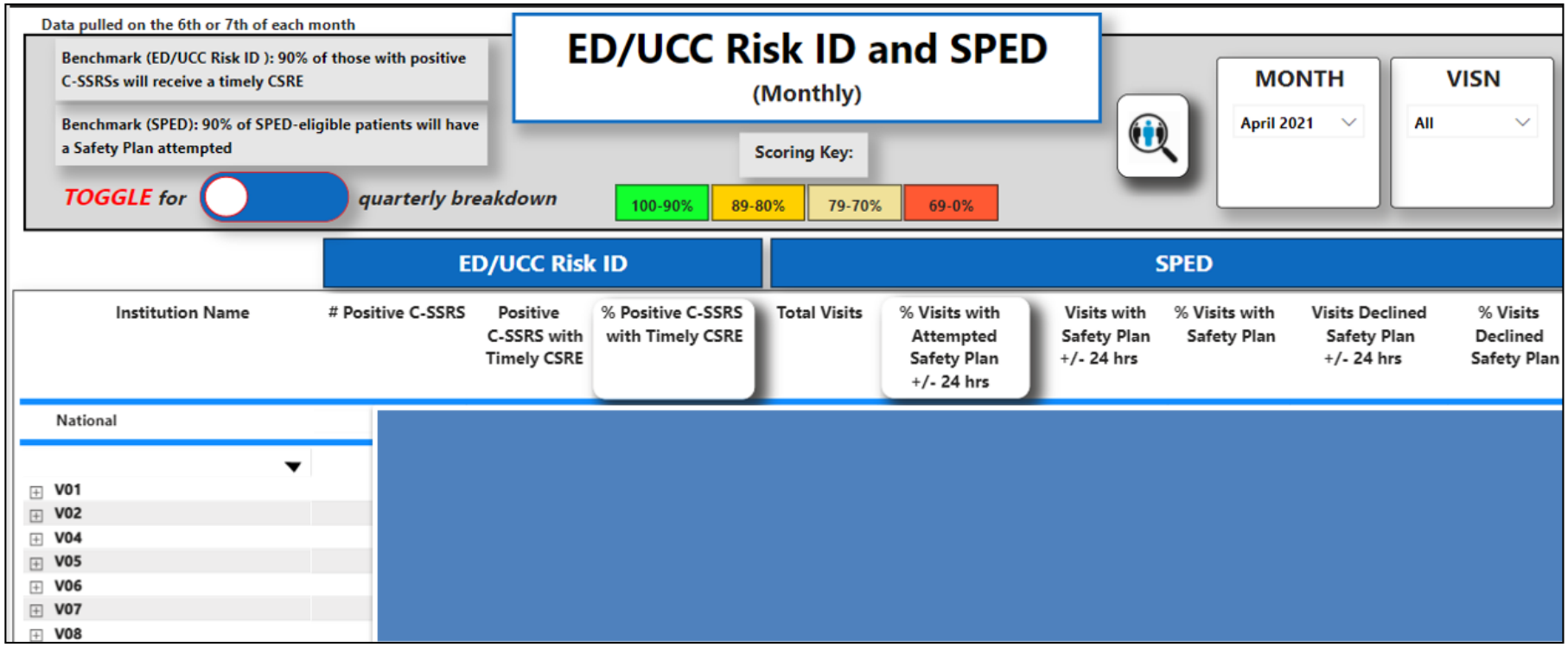
In ambulatory care settings, timely = same day as the positive C-SSRS
In inpatient, residential and ED/UCC settings, timely = within 24 hours of the positive C-SSRS

Risk ID: Minimum Requirements by Setting

Setting	Requirements (*in addition to Annual Screening*)
Emergency Department and Urgent Care Centers	C-SSRS Screener at each encounter (is embedded in the National Emergency Department/ Urgent Care RN Triage note)
Outpatient Mental Health	C-SSRS Screener during intake evaluation; as clinically indicated thereafter
Sleep Clinic	C-SSRS Screener at referral or intake; C-SSRS Screener must be completed during intake evaluation if > 30 days from referral; as clinically indicated thereafter
Pain Clinic	C-SSRS Screener at referral or intake; C-SSRS Screener must be completed during intake evaluation if > 30 days from referral; as
Opioid Treatm	
Mental Health Residential Rehabilitation Treatment Program	C-SSRS Screener within 24 hours of admission and CSRE during the first week of admission; updated CSRE within a week before discharge and C-SSRS within 24 hours before discharge
Community Living Center	C-SSRS Screener within 24 hours of admission and within 24 hours before discharge
Inpatient Mental Health	C-SSRS Screener within 24 hours of admission and within 24 hours before discharge
Inpatient Medical/Surgical	C-SSRS Screener within 24 hours of admission and within 24 hours before discharge
Inpatient & Residential Rehabilitation	C-SSRS Screener within 24 hours of admission and within 24 hours before discharge

VA Risk ID Resources and Technical Support

Additional Trainings
Printable screening laminates available!
Dashboards
TA Support Email address: VHAECHRiskIDSupport@va.gov
TA calls
Distribution lists


Data pulled on the 6th or 7th of each month
Benchmark (ED/UCC Risk ID): 90% of those with positive C-SSRSs will receive a timely CSRE
Benchmark (SPED): 90% of SPED-eligible patients will have a Safety Plan attempted
TOGGLE for quarterly breakdown
ED/UCC Risk ID and SPED
(Monthly)
Scoring Key:
100-90%
89-80%
79-70%
69-0%
MONTH
April 2021
VISN
All
ED/UCC Risk ID
SPED
Institution Name
Positive C-SSRS
Positive C-SSRS with Timely CSRE
% Positive C-SSRS with Timely CSRE
Total Visits
% Visits with Attempted Safety Plan +/- 24 hrs
Visits with Safety Plan +/- 24 hrs
% Visits with Safety Plan
Visits Declined Safety Plan +/- 24 hrs
% Visits Declined Safety Plan
National
V01
V02
V04
V05
V06
V07
V08

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Original Investigation | Health Policy

Assessment of Rates of Suicide Risk Screening and Prevalence of Positive Screening Results Among US Veterans After Implementation of the Veterans Affairs Suicide Risk Identification Strategy

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Abstract

IMPORTANCE In 2018, the Veterans Health Administration (VHA) implemented the Veterans Affairs (VA) Suicide Risk Identification Strategy to improve the identification and management of suicide risk among veterans receiving VHA care.

OBJECTIVES To examine the prevalence of positive suicide screening results among veterans in ambulatory care and emergency departments (EDs) or urgent care clinics (UCCs) and to compare acuity of suicide risk among patients screened in these settings.

DESIGN, SETTING, AND PARTICIPANTS This cross-sectional study used data from the VA's Corporate Data Warehouse (CDW) to assess veterans with at least 1 ambulatory care visit (n = 4 101 685) or ED or UCC visit (n = 1 044 056) at 140 VHA medical centers from October 1, 2018, through September 30, 2019.

EXPOSURES Standardized suicide risk screening and evaluation tools.

MAIN OUTCOMES AND MEASURES One-year rate of suicide risk screening and evaluation, prevalence of positive primary and secondary suicide risk screening results, and levels of acute and chronic risk based on the VHA's Comprehensive Suicide Risk Evaluation.

RESULTS A total of 4 101 685 veterans in ambulatory care settings (mean [SD] age, 62.3 [16.4] years; 3 771 379 [91.9%] male; 2 996 974 [73.1%] White) and 1 044 056 veterans in ED or UCC settings (mean [SD] age, 59.2 [16.2] years; 932 319 [89.3%] male; 688 559 [66.0%] White) received the primary suicide screening. The prevalence of positive suicide screening results was 3.5% for primary screening and 0.4% for secondary screening in ambulatory care and 3.6% for primary screening and 2.1% in secondary screening for ED and UCC settings. Compared with veterans screened in ambulatory care, those screened in the ED or UCC were more likely to endorse suicidal ideation with intent (odds ratio [OR], 4.55; 95% CI, 4.37-4.74; $P < .001$), specific plan (OR, 3.16; 95% CI, 3.04-3.29; $P < .001$), and recent suicidal behavior (OR, 1.95; 95% CI, 1.87-2.03; $P < .001$) during secondary screening. Among the patients who received a Comprehensive Suicide Risk Evaluation, those in ED or UCC settings were more likely than those in ambulatory care settings to be at high acute risk (34.1% vs 8.5%; $P < .001$).

CONCLUSIONS AND RELEVANCE In this cross-sectional study, population-based suicide risk screening and evaluation in VHA ambulatory care and ED or UCC settings may help identify risk among patients who may not be receiving mental health treatment. Higher acuity of risk among veterans in ED or UCC settings compared with those in ambulatory care settings highlights the

(continued)

Key Points

Question Are population-level suicide risk screening and evaluation feasible in Veterans Health Administration medical settings and do they identify patients at risk for suicide?

Findings In this cross-sectional study of more than 4 million US veterans screened in ambulatory care and emergency department settings during fiscal year 2019, the prevalence of suicidal ideation was 3.5%. Acuity of suicide risk was greater among patients screened in the emergency department than in ambulatory care.

Meaning Population-based suicide risk screening and evaluation in Veterans Health Administration medical settings may facilitate identification of risk among those who may not be receiving mental health treatment.

+ Editorial

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Table 1. Patient Demographics for Patients Who Received the Primary Suicide Risk Screen by Setting, 2018-2019[a]

Demographic	Ambulatory care (n = 4 101 685)	ED or UCC (n = 1 044 056)
Age, mean (SD),	62.3 (16.4)	59.2 (16.2)
Sex		
Male	3 771 379 (91.9)	932 319 (89.3)
Female	330 303 (8.0)	111 736 (10.7)
Race/ethnicity		
White	2 996 974 (73.1)	688 559 (66.0)
Black or African American	695 039 (17.0)	266 708 (25.5)
Native Hawaiian or Other Pacific Islander	34 434 (0.8)	7960 (0.8)
Asian	46 254 (1.1)	8326 (0.8)
American Indian or Alaska Native	30 606 (0.8)	8576 (0.8)
Multirace	35 260 (0.9)	10 436 (1.0)
Missing	263 118 (6.4)	53 491 (5.1)

Abbreviations: ED, emergency department; UCC, urgent care clinic.

[a] Data are presented as number (percentage) of patients unless otherwise indicated.

Table 2. Prevalence of Positive and Negative Screening Results by Setting, 2018-2019

Result	No. (%) of unique patients with item 9 response	
	AC (n = 4 101 685)	ED or UCC[a] (n = 1 044 056)
Negative item 9[b]	3 959 053 (96.5)	1 025 175 (98.2)
Positive item 9[b]	142 632 (3.5)	37 761 (3.6)
No C-SSRS Screener[c]	45 406 (1.1)	6958 (0.7)
Negative C-SSRS Screener[d]	80 226 (2.0)	12 977 (1.2)
Positive C-SSRS Screener[d]	17 000 (0.4)	21 909 (2.1)

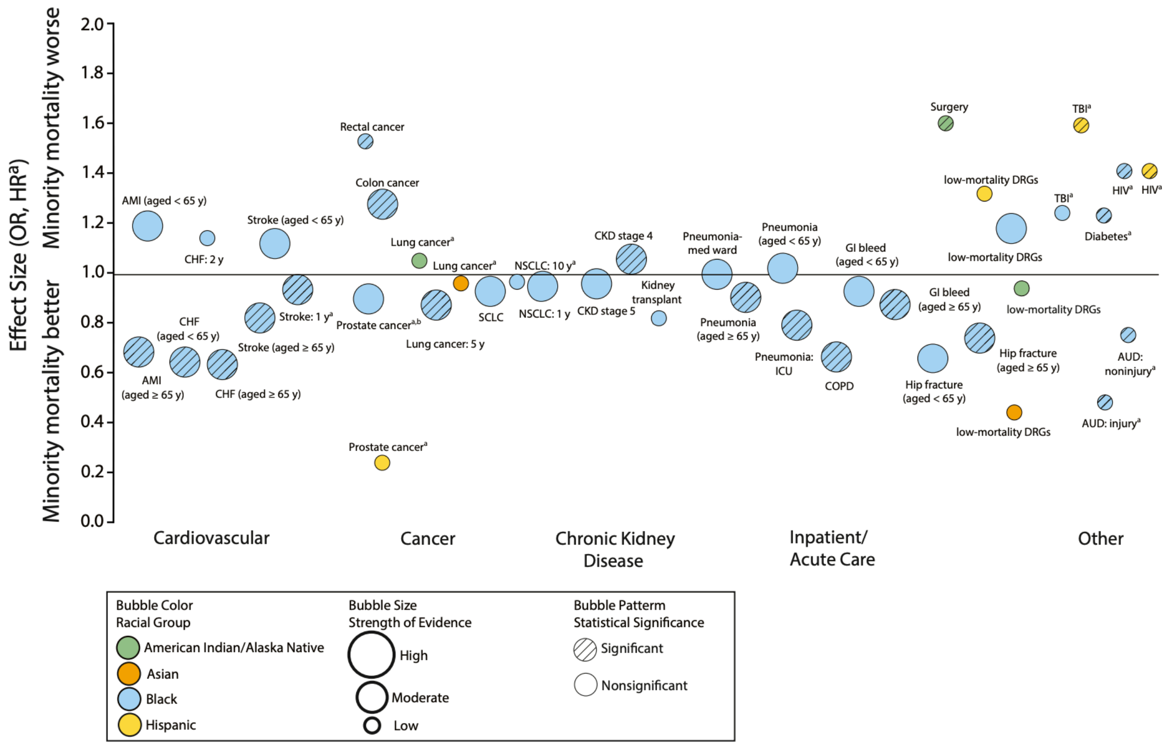
Abbreviations: AC, ambulatory care; C-SSRS Screener, Columbia Suicide Severity Rating Scale Screener; ED, emergency department; UCC, urgent care clinic.

[a] In the ED or UCC cohort, categories are not mutually exclusive. For example, because unique individuals in the ED could have multiple encounters, they could have been counted in multiple categories if screening results differed during these encounters. In such cases, they would be counted only once in each category.

[b] A total of 22 569 unique people in the ED or UCC cohort had a positive item 9 response and negative item 9 response on 2 separate encounters.

[c] In the AC cohort, 1691 of those with no C-SSRS Screener result went from a positive item 9 response to a Comprehensive Suicide Risk Evaluation; in the ED or UCC cohort, 2346 of those with no C-SSRS Screener result went from a positive item 9 response to a Comprehensive Suicide Risk Evaluation.

[d] A total of 2110 unique people in the ED or UCC cohort had a positive C-SSRS Screener result and a negative C-SSRS Screener result on 2 separate encounters.



Note. AMI = acute myocardial infarction; AUD = alcohol-use disorder; CHF = congestive heart failure; CKD = chronic kidney disease; COPD = chronic obstructive pulmonary disease; DRGs = low-mortality diagnosis–related groups; GI = gastrointestinal; HR = hazard ratio; ICU = intensive care unit; NSCLC = non–small cell lung cancer; OR = odds ratio; SCLC = small-cell lung cancer; TBI = traumatic brain injury.

[a]Denotes a hazard ratio and not an odds ratio.

[b]Disease-specific mortality.

FIGURE 1—Evidence Map of Risk of Mortality for Racial/Ethnic Minorities vs Whites in the Veterans Health Administration: United States, October 9, 2006–February 2, 2017


Mortality Disparities in Racial/Ethnic Minority Groups in the Veterans Health Administration: An Evidence Review and Map

Supporting Providers Who Serve Veterans

Free consultation and resources for any provider in the community or VA who serves Veterans at risk for suicide.

Request a consult:
srmconsult@va.gov

#NeverWorryAlone

- **Risk assessment**
- **Lethal means safety counseling**
- **Conceptualization of suicide risk**
- **Best practices for documentation**
- **Strategies for how to engage Veterans at high risk**
- **Provider support after a suicide lo (Postvention)**

www.mirecc.va.gov/visn19/consult

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