



VA Suicide Risk Identification Strategy (Risk ID)

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Disclaimer

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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 <u>high-quality</u>, <u>evidence-based tools and practices</u>

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







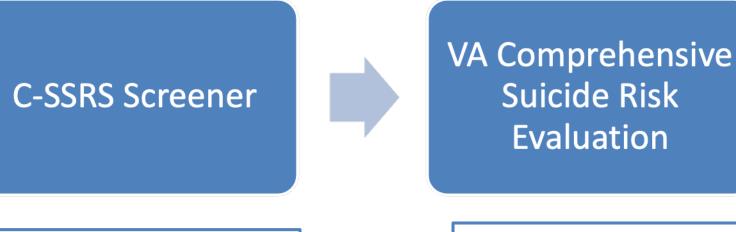
Risk ID: Three Types of Requirements

- <u>Universal Screening Requirement</u> The Annual Suicide Risk Screen Reminder is satisfied by appropriate staff, at a Veteran's encounter, when it is due.
- 2. <u>Setting Specific Requirements</u> Specific clinical settings have additional screening and evaluation requirements
- 3. <u>When clinically indicated</u> 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







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Setting		Requirements	(in addition to Annual Screening)	
Emergency Departi and Urgent Care Co			ner at each encounter (is embedded in the National partment/ Urgent Care RN Triage note)	
Outpatient Mental Health		C-SSRS Screer thereafter		
Sleep Clinic			ner at referral or intake; C-SSRS Screener must be ng intake evaluation if > 30 days from referral; as ed thereafter	
Pain Clinic			ner at referral or intake; C-SSRS Screener must be	
Mental Health Resid Rehabilitation Treat Opioid Treatm Program		n Residential	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	
Con	nmunity L	iving Center	C-SSRS Screener within 24 hours of admission an before discharge	d within 24 hours
Inpatient Ment		tal Health	C-SSRS Screener within 24 hours of admission an before discharge	d within 24 hours
Inpa	atient Med	lical/Surgical	C-SSRS Screener within 24 hours of admission an before discharge	d within 24 hours
Inpatient & Resident Rehabilitation			C-SSRS Screener within 24 hours of admission an before discharge	d within 24 hours





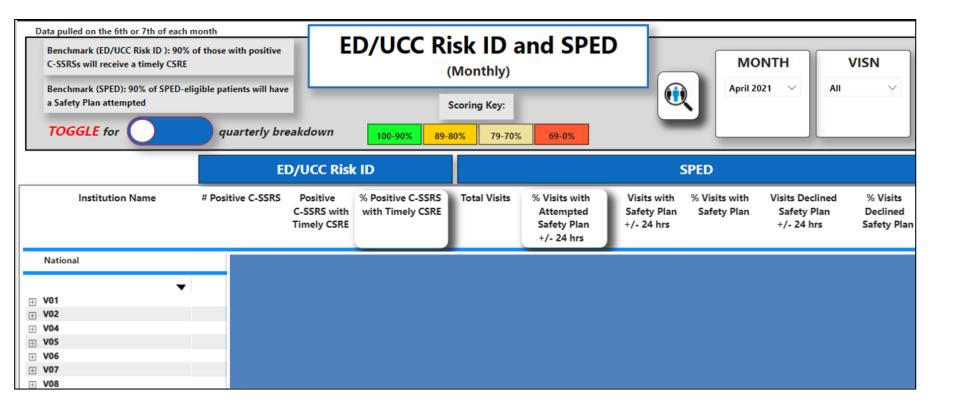
VA Risk ID Resources and Technical Support

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





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Key Points

Question Are population-level suicide

risk screening and evaluation feasible in

Veterans Health Administration medical

Findings In this cross-sectional study of

emergency department settings during

more than 4 million US veterans

screened in ambulatory care and

fiscal year 2019, the prevalence of

than in ambulatory care.

mental health treatment.

listed at the end of this article.

+ Editorial

suicidal ideation was 3.5%. Acuity of

suicide risk was greater among patients screened in the emergency department

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

+ Supplemental content and Audio

Author affiliations and article information are

settings and do they identify patients at risk for suicide?

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

Nazanin Bahraini, PhD; Lisa A. Brenner, PhD; Catherine Barry, PhD; Trisha Hostetter, MPH; Janelle Keusch, MPH; Edward P. Post, MD, PhD; Chad Kessler, MD; Cliff Smith, PhD; Bridget B. Matarazzo, PsyO

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 4101685 veterans in ambulatory care settings (mean [50] age, 62.3 [16,4] vars; 3771379 [019,%] make 2986 5974 [73139] [019,%] make 2986 5974 [73139] [019,%] make 2986 5974 [7319] [019,%] make 2986 5974 [56,29%] with the order of the primary suice screening. The prevalence of positive suicide screening results was 3.5% for primary screening and 2.9% in secondary screening in a D4 using variant (3.6, 2.9%) and (3.6, 2.9%)

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 setting compared with those in ambulatory care settings highlights the

Demographic Ambulatory care (n = 4 101 685) ED or UCC (n = 1 044 056)

2018-2019^a

Ambulatory care (II = 4 101 005)	ED 01 0CC (II - 1044 030)
62.3 (16.4)	59.2 (16.2)
3 771 379 (91.9)	932 319 (89.3)
330 303 (8.0)	111 736 (10.7)
2 996 974 (73.1)	688 559 (66.0)
695 039 (17.0)	266 708 (25.5)
34 434 (0.8)	7960 (0.8)
46 254 (1.1)	8326 (0.8)
30 606 (0.8)	8576 (0.8)
35 260 (0.9)	10 436 (1.0)
263 118 (6.4)	53 491 (5.1)
	62.3 (16.4) 3 771 379 (91.9) 30 303 (8.0) 2 996 974 (73.1) 695 039 (17.0) 34 434 (0.8) 46 254 (1.1) 30 606 (0.8) 35 260 (0.9)

Table 1. Patient Demographics for Patients Who Received the Primary Suicide Risk Screen by Setting,

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

	No. (%) of unique patients with item 9 response		
Result	AC (n = 4101685)	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.

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.

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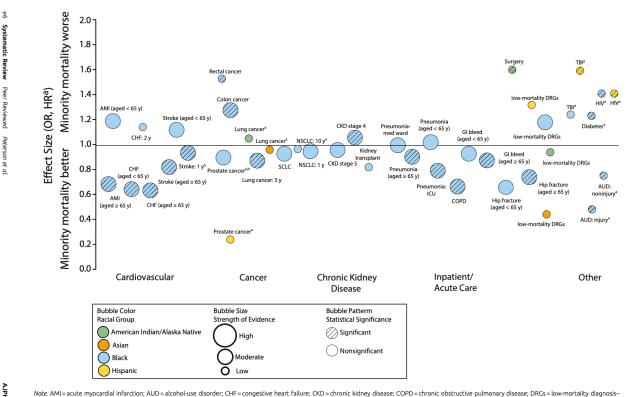




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^aDenotes a hazard ratio and not an odds ratio.

^bDisease-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

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.

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

	with multiple studies in the same association and autoame, we posted them
writed as "the medi series, and shameful health saw tour of our time."	remeried based rates bibl using random effects models (StatuBase) services
Although the 2014 US-Alfordable Care Act-mandated national insurance	2.8.0. StatuDirect UM, Albincham, England). We created an evidence map
coverage expension has led to significant improvements in health care cov-	using a bubble plot format to represent the evidence base in 5 dimensions:
enope and access, its effects on life expectancy are not until nown. The vector are	odds ratio or HR of mortality for racial/lethnic minority group versus whites,
wealth Administration (VAA), the largest US integrated health care system, has	clinical area, strength of evidence, statistical significance, and racial group.
a sostained commitment to health equity that addresses all 3 stages of health	
disparities research: detection, understanding determinants, and reduction or	Main Basalits. From 2840 stations, we included 25 studies. Studies were large
elimination. Despite this, racial obparities still exist in the WMA acress a wide	Init 10 0003 and involved nationally representative sohorts, and the majority
range of clinical areas and service types.	were of fair quality. Most studies compared mortality between Black and
	white veterans and found similar or lower mortality for Black veterans. How-
Eldjectives. To inform the health equity research agenda, we synthesized	ever, we found modest mortality deparities 048 or 08+1.81, 1.525 for Black
evidence on racial/ethnic mortality disparities in the MAA	vetarans with stage 4 chronic kidney disease, colon cancer, diabetes, HV,
	redial cancer, or stroke; for American Indian and Kasha Native veterans.
Search Matheds. Our research librarian searched MEDUNE and Cochrane	undergoing noncardiac major surgery, and for Hispanic valueans with HV or
Central Registry of Centralled Trials from October 1984 through February	traumatic brain injury (med. low shring[5].
2017 using terms for racial groups and departies.	
	Author's Conclusions. Although the 1997's equal access health care system
Selection Oritoria, We included studies if they compared mortality between any taskdothyse mission and community asterian senses or between dfl.	has reduced many recipiethric markelity disparities present in the private service strength feature radia to the base service in the private for the service of the service
any racial/ethnic minority and noniminority retarian groups or between dif- forent minority ensures in the USA (PDO)/PEDD# (ED02011071102), bite made	sector, our review identified monsility doparties that have persisted manip for Back vehicles in secent clinical areas, iterative hencing most montality
herent minority groups in the VHAL (PROSPERIO# OR0422115311)104) Me made study wirection decisions on the basis of prespectified eligibility oritoria. They	
	disparties were supported by single studies with impractial findings, we could
were finit made by 1 reviewer and checked by a second and disagreements were related by conservus, bequeridad review).	not draw strong canclusions about this evidence. More disparities research is needed for American Indust and Hadia Notion. Acan. and Hisaans veterans
were residued by consensus (sequencial review).	Is needed for American Indian and Alabia Nation, Asian, and Hispanis veterans, ownail and for more of the langest life expectancy caps.
Bata Collection and Analysis. Two reviewers sequentially abstracted data on	
prespectified psyciation, autome, setting, and study design characteristics.	Public Health Implications. Because of the relatively high prevalence of
Two reviewers sequentially graded the strength of evidence using prospecified.	diabetes in black veterams, Further research to better understand and reduce
orbaria on the basis of 5 key domains: study limitations (study design and	this mortality deparity may be prioritized as having the greatest potential
internal validity), consistency, directness, precision of the evidence, and	inpact. However, other montality disparities affect theosands of veterans
reporting bases. We cynthesized the evidence qualitatively by grouping	and cannot be ignated. (An J Public Health 2018;108+1-e11. doi:10.2105/
studies first by racial/lethnic minority group and then by divical area. For areas	









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

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)

