

VA



U.S. Department
of Veterans Affairs

Suicide Prevention Program Guide

Office of Mental Health and Suicide Prevention

Last Updated: November 1, 2020

Contents

Purpose and Background	6
Letter from the Director	7
National Suicide Prevention Program	8
Facility Suicide Prevention Program	9
Suicide Prevention Staffing Model	9
Suicide Prevention Coordinator Responsibilities.....	10
Suicide Prevention Coordinator Primary Functions.....	11
Administrative Items	12
Program Directives, Memorandums, and Handbooks.....	12
National Suicide Prevention Calls.....	17
Email to Suicide Prevention Coordinator Groups.....	17
Suicide Prevention Program Tools and Resources.....	18
VA Talent Management System (TMS)	18
VA SharePoint Sites	18
Billing and Documenting Services in the Electronic Health Record	20
Telework	21
Tracking and Reporting	23
Tracking Responsibilities.....	23
Patient Record Flags Category I – High Risk for Suicide (HRS-PRF).....	23
High-Risk Flag (HRF) Patient Tracking Report Dashboard.....	26
Reporting Responsibilities	28
Issue Briefs (IBs)	28
Heads-Up Messages.....	28
Behavioral Health Autopsy Program (BHAP).....	29
Quality Management.....	30
Patient Safety Reporting	30
Root Cause Analysis	31
Quality Peer Reviews.....	32
Environment of Care.....	32
Mental Health Environment of Care (EOC) Safety	33
Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) Safety	34
Tracking and Reporting Tools.....	34
Self-Directed Violence Classification System (SDVCS)	34
International Classification of Diseases, Tenth Revision (ICD-10) Suicide-Related Behavior Diagnoses Coding.....	35
Suicide Behavior and Overdose Reporting (SBOR).....	36
Suicide Prevention Application Network (SPAN).....	39
Additional Tracking Tools.....	39
Enhanced Care Delivery	44
Identifying High-Risk Veterans	44
Other Than Honorable (OTH) Former Service Members, Ineligible Former Service Members, Humanitarian Care, Active Duty, or Other Non-Veteran Patients.....	46

Therapeutic Risk Management of the Suicidal Patient Model.....	47
Managing the Care of High-Risk Veterans	48
Enhanced Care Contact and Visits.....	49
Safety Planning	50
Lethal Means Safety Counseling	52
Financial Hardship Assistance for High-Risk Veterans Program.....	53
Case Consultations.....	54
Caring Communication Program	54
Other Types of Communication.....	56
Veterans Who Relocate.....	56
Inactivation of an HRS-PRF	56
Consultation and Advisory Committees	56
Suicide Postvention.....	57
Access and Referral	59
Access	59
Telephone and Voicemail	60
Referrals.....	61
Veterans Crisis Line (VCL) Referrals	61
Vets Prevail.....	64
Outreach and Awareness.....	65
Monthly Outreach Requirements	65
Training.....	66
Awareness Tables	67
Outreach and Promotional Materials	67
Gun Locks.....	68
Mailings	68
Partnerships and Coalition Building	69
Media and Marketing.....	70
Be There Campaign.....	71
Suicide Prevention Month (SPM)	71
Education and Training	72
Gatekeeper Training.....	72
VA S.A.V.E. Training.....	73
Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)	73
Homeless Veterans Program	74
Skills Training for Evaluation and Management of Suicide	74
National Initiatives to Enhance Suicide Prevention.....	75
REACH VET (Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment).....	75
Suicide Risk Identification Strategy.....	76
Safety Planning in the Emergency Department/Urgent Care Center (SPED).....	77
VHA National Strategy for Suicide Prevention	78
Suicide Prevention 2.0 (SP 2.0)	78
Telehealth Initiative	78

Community-Based Prevention Efforts	79
Mayor’s and Governor’s Challenge	79
Community Engagement and Partnerships – Suicide Prevention	79
Together With Veterans	80
Suicide Prevention NOW (SP NOW)	80
Available Materials	81
Resources	82
Appendix 1.1 Abbreviations	87
Appendix 1.2 Definitions	89
Appendix 1.3 National Suicide Prevention Program Contacts	91
Appendix 2.1 Instructions for Joining National SPC Monthly Call.....	93
Appendix 2.2 Email Review How-To for “VHA OMHSP Suicide Prevention Coordinator” Group	94
Appendix 2.3 Billing Responsibilities	98
Clinic Setup.....	98
Encounters.....	100
Historical Visits.....	101
Coding Guidelines.....	102
Labor Mapping.....	105
Workload/Productivity.....	107
Appendix 3.0 Suicide Prevention Responsibilities Tracking and Reporting Matrix	112
Appendix 3.1.1 Patient Record Flag	114
Accessing Patient Record Flags	114
Assigning a Flag.....	116
Subsequent Flag Actions.....	129
Entered in Error.....	131
Continuing a Flag.....	135
Inactivating a Flag.....	141
Reactivating a Flag	145
Transferring a Flag.....	148
Patient Record Flag Reports.....	157
Record Flag Management	163
Record Flag Transmission Management.....	165
Appendix 3.1.2 HRF Dashboard.....	168
Appendix 3.2.1 Issue Briefs and Heads-Up Messages.....	186
Appendix 3.2.2 BHAP and FIT-C.....	189
Appendix 3.3.1 Self-Directed Violence Classification Two-Page Handout	193
Appendix 3.3.2 ICD-10 Suicide-Related Behavior Decision Trees.....	194
Appendix 3.3.3 Suicide Behavior and Overdose Report Template Support Documents.....	197
Appendix 3.3.4 Entering SDV Events into SPAN	198
Appendix 4.1 Rocky Mountain MIRECC for Suicide Prevention Risk Stratification Tool	207
Appendix 4.2 Suicide Prevention Safety Plan Document, How-To, and Additional Resources	208
Appendix 4.3 Examples of Caring Communication Content.....	220
Appendix 5.1 VCL SPC Contact and Outlook Out-of-Office Reviews.....	222
Appendix 5.2 How-To for Medora/Crisis Line Consults.....	224
Appendix 5.3 VCL Clinical Care Coordinators	229
Appendix 6.1 Guidance for Entering Outreach into SPAN	230

Appendix 6.2 Partnership Summary 231
Appendix 7.1 S.A.V.E. A Trainer’s Guide 232
Appendix 7.2 Suicide Prevention Training Available on TMS 233
Appendix 8.0 Suicide Prevention Technical Assistance..... 235

Purpose and Background

The Suicide Prevention Program Guide (SPPG) has been created on behalf of the U.S. Department of Veterans Affairs (VA) and is designed to equip suicide prevention teams with the materials and resources necessary to serve effectively in their duties at VA medical facilities.

The SPPG is intended to be a living document that will evolve alongside VA's Suicide Prevention Program (SPP) as new initiatives and directives are issued. The SPPG is a practical document that is meant to supplement policy but is not a policy document. The only mandated position within the SPP is that of the suicide prevention Coordinator (SPC). As such, the SPPG is intended to support SPCs at each facility in carrying out their roles and responsibilities.

The tasks outlined in the SPPG may also be fulfilled and referred to by other SPP team members depending on the staffing compositions of VA facilities. SPP staff members should, therefore, review this guide to ensure that all requirements are met and that all program staff members are incorporated in its objectives. If facilities opt to have a lead SPC position, it is the responsibility of that person to ensure that all SPP members are fulfilling the SPPG requirements and have access to its resources.

Questions may be sent to the director of the National Suicide Prevention Program at VHA OMHSP SPP Actions (VHASPPActions1@va.gov) or to the field operations workstream at VHASPPFieldOperations@va.gov.

Letter from the Director

Dear Suicide Prevention Coordinators,

I am thrilled to provide you with the 2020 edition of the Suicide Prevention Program Guide. Aligned with the [National Strategy for Preventing Veteran Suicide](#), this guide is designed to highlight key aspects of the U.S. Department of Veterans Affairs (VA) Suicide Prevention Program (SPP) while providing a comprehensive overview of the roles and responsibilities mandated for suicide prevention coordinators (SPCs) and the suicide prevention teams that support them.

Suicide prevention is a top priority for VA. As the largest integrated health care system in the country, VA is committed to providing excellent care for at-risk patients in hospital-based settings. Among its top recent accomplishments, VA has standardized its universal screening and evaluation processes, developed predictive analytics programs to identify and engage more Veterans at risk for suicide, and found additional opportunities to involve patients, families, and community stakeholders in its prevention and treatment efforts.

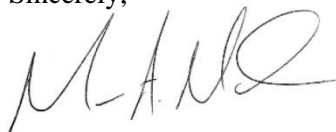
In building upon these successes, VA is leveraging a public health approach to prevent suicide among *all* Veterans, including those who do not — and may never — receive care within its system. Spanning a variety of sectors and settings, the aim of this approach is to uncover additional and more frequent touch points with Veterans in their communities while improving and standardizing crisis intervention services.

As suicide prevention experts, you are uniquely positioned to facilitate both aspects of this public health model. The care you provide to Veterans and their families is invaluable, and the creation and evolution of your role has helped us increase Veteran access to high-quality mental health care and services. For these reasons, and for so many more, you are an integral part of VA's foundation and the ultimate champions of our mission to save Veteran lives.

To support you in our shared and sacred mission, we aim to provide you with the absolute best tools and resources available, including the information provided in this guide. The SPPG outlines key aspects of the SPP, including your role within the program, and provides “how-to” guides to answer questions you may have on specific responsibilities and tasks. In addition to providing you with this information in publication form, we are always available as your support system and guides.

We are so appreciative for the work that you do every day on behalf of our nation's Veterans. Thank you for supporting these extraordinary men and women.

Sincerely,



Dr. Matthew Miller

Director

Suicide Prevention Program

Office of Mental Health and Suicide Prevention (OMHSP)

National Suicide Prevention Program

The U.S. Department of Veterans Affairs [National Strategy for Preventing Veteran Suicide 2018-2028](#) recognizes suicide as a national public health issue that affects people from all walks of life. To combat this complex and multifaceted issue, it calls for advance coordination across the federal, state, and local levels and for the widespread adoption of suicide prevention best practices.

To meet the ambitious goals set forth by the National Strategy for Preventing Veteran Suicide, VA has recruited and empowered the following program leaders to prevent Veteran suicide:

Title
Secretary of Veterans Affairs
Executive in Charge, Veterans Health Administration
Deputy Under Secretary for Health
Assistant Under Secretary for Health for Clinical Services
Executive Director, Office of Mental Health and Suicide Prevention
Director, Suicide Prevention Program

SPP has also expanded to include multiple workstreams that each play a vital role in implementing VA’s public health approach to preventing Veteran suicide. Information on these workstreams can be found below:

Workstream	Key Responsibilities	Contact
Field Operations	Equip clinicians and VA facility employees with suicide prevention training and resources to help them better serve Veterans in the field.	VHA OMHSP SPP Field Operations
Innovation and Program Development	Introduce new tools, technologies, and resources, such as the SP NOW and SP 2.0 initiatives, to keep VA on the cutting edge of suicide prevention best practices.	VHA OMHSP SPP Innovations
Policy and Planning, Education and Training	Educate policymakers, media members, and community leaders about Veteran-specific suicide prevention practices by providing resources and training on how to prevent Veteran suicide.	VHA OMHSP SPP Policy VHA OMHSP SPP Education
Data and Surveillance	Track suicide data across populations and identify practical insights to drive future work across all workstreams.	VHA OMHSP SPP Data Team
Research and Program Evaluation	Leverage high-quality suicide research and metrics to improve the SPP and implement new best practices.	VHA OMHSP SPP Research

Partnerships	Build coalitions across sectors to reach Veterans through a variety of networks and at various touch points.	VHA OMHSP SPP Partnerships
--------------	--	--

See [Appendix 1.3 National Suicide Prevention Program Contacts](#) for additional contact information.

Facility Suicide Prevention Program

Suicide Prevention Staffing Model

As mandated by the [VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics](#) each VA medical center and community-based outpatient clinic (CBOC) large enough to serve more than 10,000 unique Veterans per year must appoint and maintain at least one clinically trained SPC with a full-time commitment to suicide prevention activities. These SPCs must also have adequate support and sufficient resources to meet the responsibilities established by their parent medical centers and associated CBOCs. The Office of Mental Health and Suicide Prevention recommends labor mapping for SPCs as 90-100% administrative to ensure SPCs are accorded the ability to meet all of the national suicide prevention program requirements. This recommendation does not preclude a SPC from providing clinical care but recognizes the administrative demands of the program. Mechanisms for support may vary based on facilities' organizational composition but could involve the additional appointment of:

- Suicide Prevention Case Managers
- Peer Specialists
- Program Support Assistants
- Community Education and Partnership Coordinators
- Outreach and Education Specialists
- More than one SPC per facility
- Other positions assigned to the SP Team (e.g., Chaplain)

Medical center leaders may determine their own staffing compositions so long as all required suicide prevention responsibilities are accounted for and minimum staffing requirements for SPCs have been met. Although the division of roles and responsibilities may vary by facility, this guide is intended for SPCs, who lead SPP programs at the facility level.

In July 2017, the Veterans Health Administration (VHA) released a [VHA Memorandum 2017-07-33, Outpatient Mental Health and Suicide Prevention Hiring Initiative](#), sharing the results from a VA workforce study that recommended that each facility have a benchmark ratio of 7.72 outpatient mental health staff members per 1,000 treated mental health patients. Although this recommended target was not mandated or supported with funding, facilities are still encouraged to reach the recommended hiring target at their sites. The Memorandum includes an attachment with a breakdown of the number of suicide prevention staff members recommended for each facility to meet the 90th percentile of the benchmark ratio, 1 full-time equivalent (FTE) per 10,000 total facility uniques. Since the initial memorandum, the [Workforce Management and Consulting Office's Human Capital Management SharePoint site](#) has housed all facilities' quarterly reports specific to hiring mental health staff members (including suicide prevention).

Facilities are also required to enter all SPP staff and vacant positions into the **VHA Support Service Center Patient Centered Management Module (PCMM)**. Among its operational functions, PCMM ([VHA Directive 1406, Patient Centered Management Module \(PCMM\) for Primary Care](#)) allows facilities to set up health care teams, assign employees to positions within each team (including the full-time equivalent value), and partner

patients with team members. Facilities are required to report staffing numbers to the Office of Mental Health and Suicide Prevention (OMHSP) on a monthly basis by ensuring their suicide prevention staff members are entered into PCMM. SPCs do not have direct access to PCMM and need to work with their designated facility staff members to enter information into the application. SPCs do have access to both the [Suicide Prevention Staffing Summary - Quarterly by Facility](#) dashboard and the [Suicide Prevention Team Staff Report](#) that can assist facilities with ensuring that Suicide Prevention Program staffing is accurate.

Suicide Prevention Coordinator Responsibilities

Clinically trained and located at each VA facility, SPCs play an integral role in providing direct support to Veterans while fulfilling key outreach and training responsibilities as part of VA's public health model. Serving as subject matter experts for all matters related to preventing Veteran suicide, SPCs are responsible for identifying, case managing, and supporting high risk Veterans within facilities and coordinating strategies to increase the awareness and adoption of suicide prevention best practices within the community.

SPC responsibilities include the following:

- **Administrative Items:** Serving as facility subject matter experts (SMEs) and points of contact (POCs) for matters related to suicide, including prevention, intervention, postvention efforts, education and outreach, and suicide behavior and death reporting; collaborating with other SPCs and VA at-large to share best practices through multiple touch points; accurately documenting services rendered to improve the SPP overall
- **Tracking and Reporting:** Ensuring reporting mechanisms are implemented for all suicidal behaviors occurring within facility catchment areas; managing the Patient Record Flag Category 1 – High Risk for Suicide (HRS-PRF) process for all Veterans determined to be at a high risk for suicide; reviewing the nature of care provided using a variety of tracking and reporting tools
- **Enhanced Care Delivery:** Ensuring that enhanced care and services, including intensified treatment, safety planning, and follow-up care for missed appointments, are provided for high-risk Veterans; providing consultation to care providers actively involved with treating Veterans at elevated risk for suicide
- **Access and Referral:** Responding to referrals from staff members, the Veterans Crisis Line (VCL), and other touch points to ensure that at-risk Veterans immediately receive care and services
- **Outreach and Awareness:** Participating in suicide prevention outreach activities by distributing promotional materials, engaging with stakeholders at event awareness tables, and engaging with high-risk Veterans via the Caring Communication Program; working with Public Affairs Officers (PAOs) to encourage reporters to use safe messaging; providing VA S.A.V.E. and other gatekeeper training to community members
- **Education and Training:** Training both clinical and nonclinical staff within VA to identify and respond to Veterans who are at increased risk for suicide; providing training to community organizations and staff who have contact with Veterans

Note: Each responsibility will include further elaboration in a corresponding section of this document.

Suicide Prevention Coordinator Primary Functions

SPCs hold clinical positions at each medical center as part of VA's overall [National Strategy for Preventing Veteran Suicide](#). As such, they are expected to ensure that all VA facilities' SPP responsibilities for their parent medical centers and associated CBOCs are met. Veterans Integrated Service Networks (VISNs), VA medical centers, and CBOCs are also required to integrate each component of VA's SPP into their operations.

Per [VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics](#), SPCs serve as the champions of VA's suicide prevention activities and are required to perform the following functions:

- Tracking and reporting on Veterans who have attempted suicide or are at high risk for suicide
- Responding to referrals from the Veterans Crisis Line (VCL) and self-referrals from other sources
- Ensuring that all VA staff members have received discipline-appropriate suicide prevention training (VA S.A.V.E. training or equivalent)
- Collaborating with community organizations and partners to increase awareness of suicide prevention best practices and providing training to individuals who have contact with Veterans
- Providing general consultation to providers on available resources for suicidal individuals, as well as expertise and direction in the areas of system design to prevent deaths by suicide within their local VA medical centers
- Working with providers to ensure that monitoring and treatment is intensified for high-risk patients while making sure that those who are at elevated risk receive education and support about approaches to reduce risks
- Reporting to OMHSP on Veterans who attempted or died by suicide and sending OMHSP requested data, which is used to determine characteristics and risks associated with these groups of Veterans
- Making sure that providers follow up on missed appointments to ensure patient safety for high-risk patients and initiate problem-solving decisions about possible tensions or difficulties in patients' ongoing care
- Ensuring that medical centers have established a High-Risk for Suicide List (HRSL) of Veterans and a process for establishing Patient Record Flag Category 1 – High Risk for Suicide (HRS-PRFs), which includes:
 - Exclusively controlling all HRS-PRFs and limiting their use to patients who meet the criteria for being placed on the facility HRSL
 - Coordinating with facility committees that manage PRFs to incorporate the use of HRS-PRFs into overall facility flag processes
 - Assessing the risk for suicide in individual patients in collaboration with their treating clinicians and ensuring that those patients receive appropriate follow-up care for any missed mental health appointments
 - Establishing a system of reviewing HRS-PRFs at least every 90 days
 - Documenting, when appropriate, the nature of the follow-up care and plans for continuing treatment in the electronic health record (EHR)
 - Identifying training needs related to suicide prevention
 - Maintaining communication with the facility-designated advisory groups to keep them aware of flag placements and review outcomes

Administrative Items

VA uses a variety of systems and processes to help manage the care it provides to Veterans. As the key contributors to VA’s overarching suicide prevention operations at the facility level, SPCs are required to complete multiple administrative tasks, including the following:

- Implement facility suicide prevention strategies in accordance with VHA policies
- Use available online tools, training materials, and resources to enhance the care provided to Veterans and raise awareness among community stakeholders
- Engage with other VA members through multiple touch points, including monthly calls with leadership
- Contribute to facility business and patient care billing practices
- Document services rendered to support the accurate tracking of workload and productivity

Program Directives, Memorandums, and Handbooks

All facilities are required to implement suicide prevention activities in accordance with VHA directives, memorandums, and handbooks. [VHA Forms and Publications](#) maintains a searchable list of VHA directives, handbooks, manuals, under secretary of health memorandums, operational memorandums, and notices on the intranet. Per [VHA Memorandum 2016-06-47, Validity of VHA Policy Documents](#), policy documents remain in effect, regardless of an expiration date, until they have been formally rescinded, recertified, or superseded by a more recent policy or guidance.

Per [VHA Notice 2020-34, Mandatory Business Rules for Local Policy Development](#), facilities requiring additional detail or more stringent guidance than already nationally mandated are advised to develop their own standard operating procedures (SOPs) to meet facility needs. The Office of Regulatory and Administrative Affairs (ORAA/10B4) maintains an internal SharePoint site “[Resources for Implementation of VHA Policy](#)” that provides templates, training videos, and the ability to swap SOPs with other facilities.

Oversight bodies, such as the [Office of Inspector General](#) and accreditation bodies, such as [The Joint Commission](#), review not only the policies and SOPs that are in place, but also the extent to which facilities are following them. Therefore, it is critical that all facilities act in accordance with the directives, memorandums, and handbooks listed below:

Handbooks, Memorandums, and Directives	SPPG Section	SPC Responsibility
VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics , dated Sept. 11, 2008 (amended Nov. 16, 2015)	Suicide Prevention Staffing/Responsibilities	Facility Suicide Prevention Program
VHA Memorandum 2017-07-33, Outpatient Mental Health and Suicide Prevention Hiring Initiative , dated July 20, 2017	Suicide Prevention Staffing	Facility Suicide Prevention Program
VHA Directive 1406, Patient Centered Management Module (PCMM) for Primary Care , dated June 20, 2017	Suicide Prevention Staffing	Facility Suicide Prevention Program
VHA Memorandum 2016-06-47, Validity of VHA Policy Documents , dated June 29, 2016	VHA Policy Documents	Administrative Items

VHA Notice 2020-34, Mandatory Business Rules for Local Policy Development , dated Nov. 1, 2019	VHA Policy Documents	Administrative Items
VHA Directive 1082, Patient Care Data Capture , dated March 24, 2015	Billing and Documenting Services in the Electronic Health Record	Administrative Items
VA Policy Manual 01.1601D.07 Collateral Beneficiaries (Policy Manuals> 01. Community Care Policy & Planning>1601D: Non-Veteran Beneficiaries>07. Collateral Beneficiaries https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/content/554400000050942/Chapter-1-Collateral-Beneficiaries)	Billing and Documenting Services in the Electronic Health Record	Administrative Items
VHA Memorandum 2016-05-31, Mental Health Productivity Targets , dated May 24, 2016	Workload Productivity	Administrative Items
VHA Directive 1161, Productivity and Staffing in Outpatient Clinical Encounters for Mental Health Providers , dated April 28, 2020	Workload Productivity	Administrative Items
VA Directive 5011, Hours of Duty and Leave	Telework	Administrative Items
VHA Directive 2010-053, Patient Record Flags , dated Dec. 3, 2010	Patient Record Flags Category 1 – High Risk for Suicide (HRS-PRF)	Tracking and Reporting
VHA Directive 2008-036, Use of Patient Record Flags to Identify Patients at High Risk for Suicide , dated July 18, 2008	Patient Record Flags Category 1 – High Risk for Suicide (HRS-PRF)	Tracking and Reporting
VHA Memorandum 2020-01-11, Update to High Risk for Suicide Patient Record Flag Changes , dated Jan. 16, 2020	Patient Record Flags Category 1 – High Risk for Suicide (HRS-PRF)	Tracking and Reporting
VHA Memorandum 2008-04-04, Patients at High-Risk for Suicide , dated April 24, 2008	Patient Record Flags Category 1 – High Risk for Suicide (HRS-PRF)	Tracking and Reporting
VHA Notice 2020-13(1), Inactivation Process for Category I High Risk for Suicide Patient Record Flags , dated March 27, 2020	Patient Record Flags Category I – High Risk for Suicide (HRS-PRF)	Tracking and Reporting
VHA Handbook 1160.06, Inpatient Mental Health Services , dated Sept. 16, 2013	Patient Record Flags Category 1 – High Risk for Suicide (HRS-PRF)	Tracking and Reporting
Deputy Secretary for Health for Operations and Management (10N) –10N Guide to VHA Issue Briefs, dated March 19, 2018 http://oitlitappide12.r02.med.va.gov/IBTRacker/Docs/10N%20	Issue Briefs (IBs)	Tracking and Reporting

Guide%20to%20Issue%20Briefs%20(Updated%20Version%2003-29-18)%20(4).pdf		
VHA Memorandum Behavioral Autopsy Program Implementation, dated Dec. 11, 2012 https://vaww.cmopnational.va.gov/CR/MentalHealth/Publications/Resources%20for%20Sites%20Pre-Cerner%20Implementation/Suicide%20Prevention/20121211%20-%20Memo%20-%20Behavioral%20Autopsy%20Program%20Implementation.pdf	Behavioral Autopsy Program	Tracking and Reporting
VHA Directive 1190 Peer Review for Quality Management , dated Nov. 21, 2018	Quality Management	Tracking and Reporting
VA Directive 0321, Serious Incident Reports , date June 6, 2012	Patient Safety Reporting	Tracking and Reporting
VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook , dated March 4, 2011	Patient Safety Reporting	Tracking and Reporting
VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients , dated May 12, 2017	Mental Health Environment of Care (EOC) Safety	Tracking and Reporting
VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP) , dated July 16, 2019	Mental Health Environment of Care (EOC) Safety	Tracking and Reporting
VHA Memorandum 2017-07-09, ICD-10 Coding for Suicide-related Behavior , dated July 17, 2017	International Classification of Diseases, Tenth Revision (ICD-10) Suicide-Related Behavior Diagnoses Coding	Tracking and Reporting
VHA Memorandum 2017-09-22, Revisions to requirements for ICD-10 coding for suicide-related behavior , dated Sept. 5, 2017	International Classification of Diseases, Tenth Revision (ICD-10) Suicide-Related Behavior Diagnoses Coding	Tracking and Reporting
VHA Memorandum 2019-04-06, Suicide Behavior and Overdose Report Computerized Patient Record System (CPRS) Note Template Implementation , dated April 8, 2019	Reporting of Suicidal Behaviors	Tracking and Reporting
VHA USH Memorandum 10-2017-01, Access to Mental Health Services for Other Than Honorable Discharged Servicemembers , dated March 20, 2017	Other Than Honorable/Ineligible Former Service Member/Humanitarian /Active Duty/Other Non-Veteran Patients	Enhanced Care Delivery

VHA Directive 1601A.2, Eligibility Determination , dated Nov. 21, 2018	Other Than Honorable/Ineligible Former Service Member/Humanitarian /Active Duty/Other Non-Veteran Patients	Enhanced Care Delivery
VHA Handbook 1601D.05, Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) , dated Nov. 2, 2015	Other Than Honorable/Ineligible Former Service Member/Humanitarian /Active Duty/Other Non-Veteran Patients	Enhanced Care Delivery
VHA Directive 1660.06 VA-TRICARE Network Agreements , dated June 28, 2019	Other Than Honorable/Ineligible Former Service Member/Humanitarian /Active Duty/Other Non-Veteran Patients	Enhanced Care Delivery
VHA Directive 1230(2), Outpatient Scheduling Processes and Procedures , dated July 15, 2016 (amended Jan. 22, 2020)	No-Shows and Scheduling	Enhanced Care Delivery
VHA Memorandum 2013-06-05, Guidance on Patients' Failure to Attend Appointments (No-Shows) , dated June 25, 2013	No-Shows and Scheduling	Enhanced Care Delivery
VHA Directive 1232(2), Consult Processes and Procedures , dated Aug. 23, 2016	No-Shows and Scheduling	Enhanced Care Delivery
VHA Memorandum 2017-06-30, Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up , dated June 12, 2017	Post-Discharge Care/Safety Planning	Enhanced Care Delivery
VHA Memorandum 2018-06-18, Suicide Prevention Safety Plan National CPRS Note Templates Implementation , dated June 1, 2018	Safety Planning	Enhanced Care Delivery
VHA Memorandum 2008-04-04, Patients at High-Risk for Suicide , dated Apr. 24, 2008	Caring Communications	Enhanced Care Delivery
VHA Memorandum 2020-11-09, Guidance for Action Following a Suicide on a Department of Veterans Affairs (VA) Campus , dated Nov. 13, 2019 Attachment - https://dvagov.sharepoint.com/:b/s/VACOMentalHealth/visn2coe_sp/sp/EVkt9P7xa-RNoNcV6Di68xcBZVerfrhjiV_9YsxSGfUHg?e=Uhp0BH	Postvention	Enhanced Care Delivery
VHA Patient Safety Alert AL15-03 , dated Aug. 26, 2015	Voicemail for Mental Health Staff	Access and Referral
VHA Directive 1101.05(2), Emergency Medicine , dated Sept. 02, 2016 (amended March 7, 2017)	Referrals to SPCs	Access and Referral
VHA Memorandum 2019-07-32, Revised Access to Veterans Crisis Line Medora Application for Clinical Providers , dated July 8, 2019	Veterans Crisis Line	Access and Referral

VHA Directive 1503, Operations of the Veterans Crisis Line Contact Center , dated May 26, 2020	Veterans Crisis Line	Access and Referral
VHA Memorandum 2010-xx-xx, Suicide Prevention Coordinator Outreach Activities, dated Feb. 22, 2010 https://dvagov.sharepoint.com/sites/VACOMentalHealth/visn2coe_sp/sp/Memos%20Directives%20and%20Admin%20Items/Forms/AllItems.aspx?id=%2Fsites%2FVACOMentalHealth%2Fvisn2coe%5Fsp%2Fsp%2FMemos%20Directives%20and%20Admin%20Items%2FMemos%2F2010M%2F2010%2E02%5FSuicide%20Prevention%20Coordinator%20Outreach%20Activities%2Epdf&parent=%2Fsites%2FVACOMentalHealth%2Fvisn2coe%5Fsp%2Fsp%2FMemos%20Directives%20and%20Admin%20Items%2FMemos%2F2010M	SPC Monthly Outreach	Outreach and Awareness
VHA Directive 1071, Mandatory Suicide Risk and Intervention Interview Training for VHA Employees , dated Dec. 22, 2017	Employee Required Suicide Prevention Training	Education and Training
VHA Memorandum 2021-10-12, Agency-Wide Required Suicide Prevention Training , dated Oct. 15, 2020	Employee Required Suicide Prevention Training	Education and Training
VHA Memorandum 2017-04-28, Suicide Awareness Training , dated April 11, 2017	Employee Required Suicide Prevention Training	Education and Training
VHA Memorandum 2013-11-01, Improving the Culture of Safety in Mental Health Residential Rehabilitation Treatment Programs , dated Nov. 15, 2012	Patient Required Suicide Prevention Training	Education and Training
VHA Memorandum 2016-08-10, REACH VET: Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment , dated Aug. 10, 2016	REACH VET	National Initiatives to Enhance Suicide Prevention
VHA Memorandum 2021-11-13, Eliminating Veteran Suicide: Suicide Risk Screening Requirements and Implementation (Risk ID Strategy) , dated Nov. 13, 2020	Suicide Risk Identification Strategy	National Initiatives to Enhance Suicide Prevention
VHA Memorandum 2020-10-13, Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation (Risk ID Strategy) and the Safety Planning for Emergency Department (SPED) Initiatives , dated Oct. 17, 2019	Suicide Risk Identification Strategy/Safety Planning in the Emergency Department	National Initiatives to Enhance Suicide Prevention
VHA Memorandum 2018-09-22, Suicide Prevention in Emergency Departments (SPED): Suicide Safety Planning and Follow Up Interventions , dated Sept. 7, 2018	Safety Planning in the Emergency Department	National Initiatives to Enhance Suicide Prevention

National Suicide Prevention Calls

SPCs must participate in the National Monthly SPC Call, which is led by the SPP field operations lead from VA’s Central Office. These calls take place on the third Wednesday of every month at 3 p.m. Eastern time and are designed to facilitate discussion and provide learning opportunities related to VA’s current suicide prevention efforts. Calls are not limited to SPCs and should include all relevant SP team members to ensure information is reaching all levels of the facility suicide prevention program.

- The video and audio portion of the call is held on the Adobe Connect meeting. If you do not have speakers on your computer, please use VANTS for audio – 800-767-1750 and use access code 88031. *Please note that VANTS lines are limited – please use Adobe if possible.*

Each Veteran Integrated Service Network (VISN) has an assigned SPC lead. VISN SPC leads are required to also join the National Monthly VISN Leads Call, which takes place on the second Thursday of every month at 2 p.m. Eastern time. Like the National Monthly SPC Call, this meeting is designed to discuss ongoing and upcoming suicide prevention activities with a focus on those taking place at the VISN or at the state level. VISN SPC leads are responsible for sharing information with other suicide prevention staff members in their VISN and might consider holding a monthly call to streamline these communications.

- Both the audio and video portions of the call are transmitted via Skype. For audio, participants should call 844-376-0278 and use access code 7138891233.

For both calls, participants are required to mute their phone and are encouraged to participate via the chat box function on Skype.

Suicide prevention staff members who do not have monthly calendar reminders on Microsoft Outlook are encouraged to email Kim Woehr at Kimberly.Woehr@va.gov to request the invite.

Quick Reference:

Teleconference	Date/Time	Audio Information
National Monthly SPC Call	3 rd Wednesday of the month 3 p.m. Eastern time	<u>Audio on Adobe Connect</u> , use VANTS: 800-767-1750, access code 88031 if necessary
VISN Lead SPC Call	2 nd Thursday of the month 2 p.m. Eastern time	<u>SKYPE</u> : 844-376-0278, access code 7138891233

See [Appendix 2.1 Instructions for Joining National SPC Monthly Call](#) for specific guidance.

Email to Suicide Prevention Coordinator Groups

The electronic mailing list, VHASuicidePreventionCoordinators@va.gov, is designed to foster communication among all SPCs and members of SPP. Given the size of the mailing list, SPCs are expected to use this email sparingly and to check for resources in VA platforms before sending emails. Content shared through the mailing list must be thoughtful and respectful.

SPCs can also cut down on unnecessary emails by including their own email as the main recipient and adding the email group in the BCC line or by setting permissions to NoReplyAll. To add or remove members from this group, SPCs are advised to email Kim Woehr at Kimberly.Woehr@va.gov for assistance.

See [Appendix 2.2 Email Review How-To](#) for “VHA OMHSP Suicide Prevention Coordinator” Group for instructions on how to best use the email group and check its membership.

Suicide Prevention Program Tools and Resources

There are a variety of available tools and resources to help SPCs obtain key information related to their roles and to find opportunities to connect with others in the field on best practices. Information on these tools can be found below.

VA Talent Management System (TMS)

TMS is the system of record for all VA training, connecting personnel with more than 100,000 courses to support their professional development and improve the services they provide to the Veteran community.

SPCs are expected to use this platform for all mandatory education requirements and should refer staff to TMS for educational suicide prevention courses, such as those on safety planning, lethal means counseling, and VA S.A.V.E.

Access TMS at <https://www.tms.va.gov/SecureAuth35/>.

VA SharePoint Sites

VA uses **Microsoft’s SharePoint Server**, which provides a platform for document and file management.

SPCs are expected to use this platform to find and use resource documents, including management of Veterans Crisis Line instructions, materials for the Behavioral Health Autopsy Program, and guidance documents on VA’s various tracking and reporting tools.

The most commonly used SharePoint sites are the [Suicide Prevention](#) and the [Office of Mental Health and Suicide Prevention \(11MHSP\) SharePoint](#) SharePoint sites. The Suicide Prevention site includes the subheadings of:

- Tracking and Reporting
- Enhanced Care Delivery
- Access and Referral
- Memos, Directives, and Administrative Items
- Outreach and Awareness
- Training
- Evaluation and Research

Note: The [Suicide Prevention and Veterans Crisis Line parent](#) site houses the [SPC National Contact List](#).

The [Office of Mental Health and Suicide Prevention \(OMHSP\) SharePoint](#) site includes the subheadings of:

- OMHSP Communities of Practice Sites
- OMHSP Publications Repository
 - This site includes another [Suicide Prevention](#) heading with relevant directives, memorandums, and handbooks. *Note: The [VHA Forms and Publications](#) site is the authority on all controlled national policy within VHA. The publications section may include documents that are no longer current or have been archived.*
- OMHSP Discrimination, Bias, and Equity Resources
- COVID-19 Resources
- PEC Portal
- All-Inclusive First Friday and MyVA Access Call Materials
- Business Operations Site (e.g., labor mapping, coding, productivity)
- Partner Sites
- National Call Calendar
- VISN & Facility POCs
- Employee Support Toolkit
- Monthly newsletter and messages from the OMHSP Executive Director

It also includes a subheading of [Suicide Prevention](#). The subheading includes titled folders for:

- Risk Assessment
- Safety Planning
- Suicide Behavior and Overdose Reporting (SBOR)

There are numerous SharePoint sites including, but not limited to, the following:

- Suicide Risk Identification and Management
<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Home.aspx>
includes subsites for Suicide Risk Identification Strategy (Risk ID) and Suicide Prevention in the Emergency Department (SPED)
- REACH VET
<http://vaww.mirecc.va.gov/reachvet/index.asp>
- Program Evaluation and Resource Center (PERC) – Suicide Prevention
https://vaww.portal2.va.gov/sites/PERC/PEC_Portal/SitePages/Suicide%20Prevention.aspx
- Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)
<https://vaww.portal.va.gov/sites/OMHS/mhrrtp/default.aspx>
- Substance Use Disorder
<https://vaww.portal.va.gov/sites/OMHS/SUD/default.aspx>
- Primary Care-Mental Health Integration
<https://dvagov.sharepoint.com/sites/vhafocus-areas/primary-care/primary-care-mental-health-integration/SitePages/Home.aspx>
- VA Office of Mental Health and Suicide Prevention – SharePoint Communities of Practice
<https://vaww.portal.va.gov/sites/OMHS/default.aspx>
- VA Military Sexual Trauma (MST) Resource Homepage
<https://vaww.vashare.vha.va.gov/sites/mst>
- Women’s Mental Health
<https://vaww.portal.va.gov/sites/OMHS/WMH/default.aspx>
- VHA Telehealth Services
<https://vaww.telehealth.va.gov/index.asp>

Billing and Documenting Services in the Electronic Health Record

VA facilities use a variety of software packages to help document both inpatient and outpatient care delivery, including outpatient encounters, billable inpatient appointments in outpatient clinics, all billable inpatient professional encounters not captured elsewhere, all inpatient rehabilitative services, and all inpatient mental health professional services. These packages are used to accurately capture clinician workload, which in turn helps to determine budget allocations under [Veterans Equitable Resource Allocation \(VERA\)](#) and productivity metrics that allow facilities to identify possible staffing shortages relative to workload.

All encounter data must pass or be transferred into Patient Care Encounter (PCE), a system used to collect and manage all outpatient encounter information to accurately bill for services rendered, before ultimately being placed into the National Patient Care Database (NPCD), a repository that holds information about outpatient encounters, including diagnoses, procedure codes, and patient demographics.

Per the [VHA Directive 1082, Patient Care Data Capture](#), use of electronic encounter forms and documentation templates are required to meet compliance criteria to help to avoid omission of appropriate information and to support quality documentation and coding. VHA information systems were modified in January 2005 to enable the transmission of all encounters from PCE to the NPCD (or current data warehouse).

As clinical staff members, SPCs must follow all business rules required by VA for billing and documenting encounters. An **encounter** is a professional contact between the patient and the provider who is responsible for the diagnosis, evaluation, and treatment of the patient's condition. Per the [VHA Directive 1082, Patient Care Data Capture](#), this contact may take place face-to-face or via telecommunications technology. Used to document and bill for services provided directly to patients, encounters should be completed and captured within the electronic health record (EHR), known within VHA as the Computerized Patient Record System (CPRS), through use of the Direct Encounter Form or Event Capture System (ECS).

Some facilities, especially those with inpatient care, may opt to use the ECS instead of the Direct Encounter Form. ECS is an application that uses a combination of procedure codes that translate into billable encounters and facility- or VISN-specific procedure codes that capture nonbillable workload. Other facilities have moved to using outpatient clinics to document billable inpatient appointments through use of the Direct Encounter Form. SPCs must be familiar with the mechanism used at their facility to document and capture encounter information.

Encounters are tracked with [stop codes](#), three-digit numerical identifiers, created by the Managerial Cost Accounting Office, that are specific to each clinic and list the locations encounters may occur in (such as Hampton, Va.), the type of provider (such as a nurse or social worker), and the type of service provided (such as mental health or suicide prevention).

SPCs will use clinics that are specific to them and the services they are providing. When clinics are created, stop codes are built into each clinic to help track the workload for each encounter. This documentation is the primary method for billing services rendered and can also be used to track productivity. Stop codes are also essential for allowing tools, such as the High-Risk Flag Dashboard ([See High-Risk Flag Patient Tracking Report Dashboard section](#)), to correctly capture information for suicide prevention metrics.

Procedure codes are numeric or alphanumeric designations, created by the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA), which are assigned to specific types of services rendered. These should be selected based on the type and amount of time spent providing direct patient care.

Procedure codes fall into two categories:

- **Current Procedural Terminology (CPT) – Level 1:** Numerical codes that designate medical services provided on behalf of a patient
- **Healthcare Common Procedure Coding System (HCPCS) – Level 2:** Alphanumeric codes that designate services typically provided by nonphysicians that do not meet the criteria for CPT

AMA recommends — and CMS assigns and annually publishes — a relative value unit (RVU) for each procedure code. This value is a measure of the complexity and time required to perform a professional service. The RVU value is delineated into three components that, calculated together, determine the cost of providing a service: work performed, practice expense, and professional liability insurance expense. Productivity or workload is captured using these codes but focuses on the component of work performed, or wRVU. The VHA Office of Finance – Allocation Resource Center (ARC) maintains a [look-up site](#) to assist with determining the CMS Description and current “work” RVU value of CPT and HCPCS codes.

When a provider completes a clinical encounter in the EHR, the provider must select a procedure code that is appropriate for the type of clinical service being provided to a patient. It is this procedure code along with how the provider is labor mapped (e.g., the extent to which a provider engages in direct clinical care as opposed to administrative, educational, or research activities) that helps to determine a provider’s productivity. Because many of the tasks required by SPCs are administrative and therefore not billable, SPCs are expected to have lower rates of productivity, with respect to their wRVUs, than mental health staff members providing direct patient care in the form of psychotherapy.

The process of clinic set-up, labor mapping, procedure codes, and productivity can be very complex. This section is meant to provide a brief introduction rather than an in-depth “how-to.” Facilities should work with their Administrative Officers (AOs) for mental health to assist them with navigating through these requirements. OMHSP has multiple resources to assist SPCs and their supervisors with accurately calculating productivity. Facilities are encouraged to review the [MH Business Operations](#) folder on the [Mental Health Services SharePoint](#) site for numerous tools, including Excel-based trackers. OMHSP also has a team of specialists called the Quality Improvement and Implementation Consultants (QIIC) Team who provide technical assistance. They may be reached by contacting VHAOMHSPTAS@va.gov.

See [Appendix 2.3 Billing Responsibilities](#) for reference documents and specific guidance on clinic set-up, including required stop codes, labor mapping, and workload and productivity tracking.

Telework

OMHSP recognizes the ability of SPCs to engage in suicide prevention services that can be effectively delivered from the home through telework. Telework for SPCs supports the mission of VA by both prioritizing space at VA locations for staff that require the ability to engage in face-to-face care and maximizing flexibility to patients that may prefer services delivered to their home. [Public Law 111-292, Telework Enhancement Act of 2010](#), December 9, 2010, and Part II, Chapter 4 of [VA Directive 5011, Hours of Duty and Leave](#), require

VA determine eligibility of all employees to participate in telework and to notify all employees of their eligibility to telework. Should facilities determine SPCs are appropriate to telework, the following steps are provided to aid SPCs in facilitating this process.

Supervisors will need to complete the following:

1. Assist SPCs with determining the type of remote access required:
 - RESCUE VPN for government-furnished equipment
 - Citrix Access Gateway (CAG) for personally owned equipment

The [VA Remote Access \(RA\) Information and Medical Portal](#) explains the potential options in further detail.
2. Prepare Telework Packet that includes:
 - a. Certificate of completion for VA Telework Managers Module

Item No.	Course Name
VA 1366994	VA Telework Managers Module

- b. Determination of position suitability and employee eligibility for telework arrangements and completion of [Telework Eligible Notification Memorandum](#)
- c. Completed VA Form 0740 Telework Request Agreement

SPCs will need to complete the following:

1. Validate or complete a remote access request using the Self Service Portal in the [Remote Access Portal](#).
2. Provide certificates of completion for the following training modules:

Item No.	Course Name
VA 1367006	VA Telework Training for Government Employees
VA 310176	Privacy and Information, Security Awareness and Rules of Behavior
VA 4551375	Telehealth Emergency Plans Memorandum Self-Certification

3. Sign the Telework Eligibility Memorandum supplied by the supervisor
4. Complete [VA Form 0740 Telework Request/Agreement](#)
See this example of a completed VA Form 0740 [here](#).

Additional trainings are required to provide virtual care to Veterans including the following:

Item No.	Course Name
VA 4279741	Telehealth to Home Using VA Video Connect Provider
VA 4486527	Virtual Care Manager
VA 4551375	Telehealth Emergency Plans Memorandum Self-Certification

Additional resources specific to virtual care and alternative technologies may be found on [VHA Telehealth Services](#).

Tracking and Reporting

SPCs must make sure all Veteran suicide-related events within their facility's catchment area are accurately documented to share comprehensive information with other facility members and to ensure that Veterans at high risk for suicide receive appropriate care.

This responsibility comprises the following tracking and reporting functions:

- Ensuring patients determined to be at high risk for suicide have activated Patient Record Flags (PRF) Category 1 – High Risk for Suicide documented and managed in their electronic health records (EHRs)
- Reporting all Veteran suicides and suicidal behaviors by following the Centers for Disease Control (CDC) Self-Directed Violence Classification System (SDVCS) guidelines and using the International Classification of Diseases, Tenth Revision (ICD-10) Suicide-Related Behavior Diagnoses Coding tool
- Using the Suicide Behavior and Overdose Reporting (SBOR), the event section of the Comprehensive Suicide Risk Evaluation (CSRE), and the Suicide Prevention Application Network (SPAN) tools to track Veteran suicides and related behaviors
- Fulfilling reporting responsibilities to ensure that information about facility programs and patients is accurately articulated to VA leadership
- Sharing information about all suicide attempts and deaths with quality management teams and assisting facilities with the evaluation of care environments to prevent future suicide-related events on VA campuses

See [Appendix 3.0 Suicide Prevention Responsibilities Tracking and Reporting Matrix](#) for a shortcut list of all required items

Tracking Responsibilities

A significant aspect of the SPC role is tracking Veterans identified as having high risk for suicide. The first part of tracking is using Patient Record Flags (PRFs). Part of Veterans' EHRs, these flags are meant to denote immediate safety issues for patients whose behavior, medical status, or characteristics may pose an immediate threat to either their safety or the safety of others or may otherwise compromise the delivery of safe health care. The mechanism for placing PRFs incorporates a combination of steps in both the VistA and CPRS applications of the EHR.

The second part of tracking is managing Veterans who have active PRFs. SPCs oversee high-risk Veterans' care through a combination of chart review, interaction with treating clinicians, and an electronic dashboard that houses the facility list of identified high-risk Veterans.

Patient Record Flags Category I – High Risk for Suicide (HRS-PRF)

VHA uses an alert system called a patient record flag (PRF) to identify patients with a clear risk to safety that should influence treatment decisions. These alerts or flags are electronic in nature and are placed on the electronic health record. PRFs require local or VHA authority and are limited to "immediate clinical safety issues." For them to be effective, they must be used infrequently so that staff members do not become inured to

the alert. Safety must outweigh the ethical concerns of the potential stigma or potentially compromised privacy that could result from use of a PRF.

As part of their tracking responsibilities, SPCs are responsible for managing Patient Record Flag Category I – High Risk for Suicide (HRS-PRF). The HRS-PRF is a national flag that will appear anywhere a patient receives care within VHA and is the mechanism used by VHA to alert staff members to Veterans identified as high risk for suicide; it provides employees with instructions for maximizing safety during interactions with high-risk Veterans. The HRS-PRF does not indicate that a Veteran is in a constant state of imminent or high acute risk, but rather that the Veteran is within a period of increased risk. Placement of the HRS-PRF for 90 days specifies the time frame of that increased risk. However, the absence of HRS-PRFs does not indicate that patients are not at risk for suicide. All staff members must recognize that patients may be at risk for suicide, regardless of whether they have an HRS-PRF on their EHR. SPCs may provide case consultation to treating clinicians to provide guidance for the management of Veterans who are at increased risk for suicide but who do not meet criteria for HRS-PRFs.

There are currently four policy documents that govern the management of PRFs and, more specifically, the HRS-PRF. The salient points of each are covered below.

Per [VHA Directive 2010-053, Patient Record Flags](#), PRFs require all of the following:

- Ensuring a process is in place for requesting, assigning, reviewing, and evaluating the need for PRFs
- Making sure each PRF assigned is reviewed as appropriate per the specific PRF guidelines
- Ensuring each PRF is accompanied by a TIU Progress note with the title “Patient Record Flag Category I”
- Instituting procedures for flagging that are ethical, clinically appropriate, and supported by adequate resources, and ensuring that the PRF is used in accordance with the directive
- Ensuring that Veterans are notified when a PRF has been placed on their record, are informed of its contents, and are informed of their right to pursue an amendment to the PRF through the facility privacy officer

Specific to HRS-PRFs, [VHA Directive 2008-036, Use of Patient Record Flags To Identify Patients at High Risk for Suicide](#) mandates that SPCs are responsible for:

- Ensuring the facility identifies and tracks all identified patients at high risk for suicide with use of an HRS-PRF
- Managing the process of using HRS-PRFs to identify patients at high risk for suicide
- Exclusively controlling all HRS-PRFs and limiting their use to Veterans who meet the criteria
- Coordinating with the facility committees and their processes that manage PRFs, to incorporate use of the HRS-PRFs into the overall process of use of PRFs at the facility
- Assessing individual patients’ risk for suicide in conjunction with treating clinicians
- Identifying training needs related to prevention and management of suicide cases
- Ensuring, in conjunction with clinical treatment teams, that identified high-risk Veterans receive follow-up for missed mental health and substance use disorder appointments and that this follow-up is documented in the EHR
- Working with clinicians who refer patients for possible HRS-PRFs to determine if those flags are appropriate
- Maintaining communications with facility-designated advisory groups or committees to inform them of flag placements and the outcomes of HRS-PRF reviews; these groups or committees should assist

with making flag placement recommendations, provide guidance, and assist SPCs with the PRF determination process

- Maintaining a list of currently flagged Veterans and establishing a process for 90-day reviews
- Documenting the nature of the follow-up and plans for continuing treatment when appropriate

[VHA Memorandum 2020-01-11 Update to High Risk for Suicide Patient Record Flag Changes](#) elaborates on the HRS-PRF responsibilities of facilities and SPCs, including the following functions:

- Training clinical staff members regarding how and when to notify and refer patients for HRS-PRFs and ensuring that PRFs are appropriately entered, maintained, and reviewed in the EHR in accordance with VHA Directive 2008-036
- Training clinical staff members about what reporting tools to use to report suicidal behaviors; specifically, the use of the Suicide Behavior and Overdose Report (SBOR) and Comprehensive Suicide Risk Evaluation (CSRE) templates in the EHR to record all suicidal self-directed violence, including preparatory behaviors, that occurred within 12 months of the date of notification
- Collaborating with treating clinicians (as necessary) about tools to inform clinical judgment of risk of suicide, using available resources:
 - VA/Department of Defense Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide (<https://www.healthquality.va.gov/guidelines/MH/srb/>)
 - Rocky Mountain MIRECC – Therapeutic Risk Management Risk Stratification Table (https://www.mirecc.va.gov/visn19/trm/docs/RM_MIRECC_SuicideRisk_Table.pdf)
 - Suicide Risk Identification and Management and Suicide Prevention in the Emergency Department (SPED) SharePoint (<https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Home.aspx>)
- Activating an HRS-PRF for any patient determined to be eligible, in accordance with VHA Directive 2008-036, as soon as possible but no later than one business day after such determination by the SPC

In transferring ownership of HRS-PRFs, the transferring site SPC must:

- Facilitate the transfer of care for Veterans who are moving to a new VA facility
- Coordinate with the receiving SPC to transfer the HRS-PRF and schedule initial appointments with mental health personnel for the Veteran
- Confirm that Veterans’ new address and contact information have been updated in the EHR
- Notify the receiving site SPC about:
 - The Veteran’s projected move date
 - The scheduled first appointment at the new site
 - Other information that is relevant to the Veteran and their care

Only after these tasks have been completed may the SPC transfer the HRS-PRF to a new site of care.

In receiving ownership of HRS-PRFs, the receiving site SPC must:

- Accept transfer of the PRF once all the transferring site’s requirements have been met
- Attempt contact with Veterans who do not show for their first appointment at the new site

The transferring site is no longer responsible for transferred Veterans, even if Veterans fail to attend the first appointment and/or have not been seen at the new site.

[VHA Notice 2020-13, Inactivation Process for Category I High Risk for Suicide Patient Record Flags](#)

solidifies policy that the HRS-PRF is a Category I flag. It further elaborates on the HRS-PRF responsibilities of facilities and SPCs, including the following functions:

- Ensuring all HRS-PRFs are reviewed within +/- 10 days of the flag review date.
- Documenting minimum content for HRS-PRF reviews that includes all the following:
 - Veteran's engagement in clinical care
 - Clinical consultation
 - Attempted outreach for engagement
- Implementing caring communications via U.S. mail monthly for 12 consecutive months for all Veterans who have had an HRS-PRF once the HRS-PRF has been removed.

Veterans who have not engaged in VHA health care as evidenced by no showing and cancelling appointments or refusal to respond to phone calls and correspondence must continue to receive outreach efforts for the life of the HRS-PRF. Disengagement in care may *not* be the only criteria to remove the HRS-PRF and the initial HRS-PRF activation may not be removed prior to 90 days.

Facilities may remove an HRS-PRF prior to 90 days for ineligible former Service members (see [Other Than Honorable \(OTH\) Former Service Members, Ineligible Former Service Members, Humanitarian Care, Active Duty, or Other Non-Veteran Patients](#) section for further information) if there is evidence the facility has engaged in safety planning and provided community referrals, including care coordination efforts with community providers. These elements must be documented in the EHR.

VHA Directive 1166, once complete, will replace Directives 2008-036 and 2010-053 to create one directive for all PRFs. The new directive will update the language to reflect the change of the High Risk for Suicide PRF from a Category II to a Category I.

See [Appendix 3.1.1 Patient Record Flag](#) for step-by-step instruction on assigning, continuing, inactivating, reactivating, and transferring HRS-PRFs.

High-Risk Flag (HRF) Patient Tracking Report Dashboard

The **High-Risk Flag (HRF) Patient Tracking Report Dashboard** is a data repository that holds information about Veterans with HRS-PRFs. Hosted on the [HRF Dashboard homepage](#), this database ensures that patient care measurements are consistent with the metrics required by Strategic Analytics for Improvement and Learning (SAIL) for the mental health domain and those recommended by the Office of Inspector General (OIG).

The **High-Risk Flag Note Titles Used in the report dashboard** lists all the note titles used at each facility to document flag review, safety plans, and suicide behavior reports (SBRs). These elements are then used to populate the HRF Dashboard. *Note: Use of the standardized Suicide Prevention Safety Plan, the Suicide Behavior and Overdose Report, and the Patient Record Flag Category I High Risk for Suicide templates is required for all facilities.*

Providing a facility-level list of patients with HRS-PRFs, the HRF Dashboard allows SPCs to track clinical actions taken on behalf of these Veterans. As part of their tracking responsibilities, SPCs are responsible for monitoring the dashboard, which includes the following types of data:

- The date a safety plan was completed
- The date a flag is due for review
- The number of completed mental health visits within 30, 60, and 90 days
- The most recent mental health encounters a patient has experienced
- Inpatient admissions and other possible adverse events

As staff members complete and document care in the EHR, data is automatically transferred into the HRF dashboard for ease of reference. Based on this inputted data, the dashboard then makes calculations that feed into facilities' reports on the seven metrics for suicide prevention.

These metrics are listed in detail below, with those in bold representing the care metrics designed to improve oversight and accountability per OIG recommendations.

Measure Name	Measure Description
HRF1	Percentage of Veterans with a new assignment or reactivated HRF with a safety plan documented within seven days before or after flag initiation, or on or before discharge
HRF2	Percentage of Veterans with a new assignment or reactivated HRF who received at least four mental health visits within 30 days of flag initiation
HRF3	Percentage of Veterans with a new assignment or reactivated HRF who received at least one mental health visit between 31 and 60 days after flag initiation
HRF4	Percentage of Veterans with a new assignment or reactivated HRF who received at least one mental health visit between 61 and 90 days after flag initiation
HRF5	Percentage of Veterans with a new assignment or a renewed or continued HRF who received a case review within 100 days of flag initiation
HRF6	Percentage of Veterans with a continued HRF for suicide who received at least one mental health visit every 30 days while the HRF remained active
HRF7	A composite of the HRF1, HRF2, and HRF5 for the facility; each component counts for 33% of the total HRF7 score to create a transformed score on a facility's SAIL Mental Health Composite Measures Components Report dashboard

To view facility patient tracking reports for the HRF dashboard, SPCs are advised to bookmark the [HRF dashboard homepage](#) in their internet browser. HRF3, HRF4, and HRF6 can be viewed on the [Mental Health Information System](#) dashboard.

See [Appendix 3.1.2 HRF Dashboard](#) for more information on the HRF dashboard.

Reporting Responsibilities

In addition to tracking high-risk patients, SPCs are required to report all suicidal behaviors, using a variety of tools. Unusual or sentinel events, such as those that take place on a VA campus or with media involvement, have additional reporting requirements that include completing issue briefs, behavioral health autopsies, and case consultations. Each of these has specific requirements that will be elaborated on below.

Issue Briefs (IBs)

Issue briefs (IBs) are internal documents submitted by facility and VISN leaders that provide members of VA's Central Office with clear and concise information about unusual incidents, deaths, disasters, or other events that may generate media interest or affect the care of Veterans. Facility requirements and expectations are elaborated on in the 10N Guide to VHA Issue Briefs, dated March 19, 2018: [Deputy Secretary for Health for Operations and Management \(10N\) –10N Guide to VHA Issue Briefs](#).

To support facility leaders in creating IBs, SPCs are often asked to share subject matter expertise and background information that provides additional context.

While the requirements for issuing IBs may vary by facility, they are required for all suicide deaths or attempts that:

- Occur on VA property or in VA inpatient or residential care facilities
- Are expected to garner congressional or media interest
- Involve VA or community police officers in the events leading up to suicidal behavior
- Take place within seven days of discharge from VA inpatient or residential care facilities

While IBs are intended for internal audiences, they may be accessed by those outside of VA. Therefore, IBs must be written and submitted with this understanding.

Heads-Up Messages

Heads-up messages (HUMs) are created to immediately inform facility, VISN, and VA leaders of the known information surrounding sentinel incidents while key facts are still being gathered for IBs.

Heads-up messages should be sent to the VISN support teams assigned to SPCs' networks; this message satisfies requirements for the first notification of the event.

Should an incident arise in the media, VA leadership will search for prior submissions to see if the incident was previously reported. An IB must be submitted no later than two business days from the time of the incident.

The heads-up message should be reported within one business day. (Note: Incidents meeting the reporting criteria in [VA Directive 0321, Serious Incident Reports](#) must be reported within two hours of discovery.)

See [Appendix 3.2.1 Issue Briefs and Heads-Up Messages](#) for more information.

Behavioral Health Autopsy Program (BHAP)

BHAP is a program managed by VA's [VISN 2 Center of Excellence for Suicide Prevention](#). Initiated in November 2012 ([VHA Memorandum, 2012-12-11, Behavioral Autopsy Program Implementation](#)), it is used to systematically collect both quantitative and qualitative information related to all Veteran deaths by suicide reported to VA facilities. This includes the deaths of Veterans who were not registered in, enrolled in, or otherwise receiving VA care, so long as they are suspected to have died by suicide within a VA facility's catchment area. All information collected for BHAP is considered privileged and confidential under the provisions of 38 U.S. Code § 5705 Confidentiality of Medical Quality-Assurance Records.

BHAP uses a three-pronged system to increase VA's knowledge of the characteristics and contexts of suicide on the national level. These prongs are as follows:

- **BHAP Chart Analysis Tool (BHAP form):** A comprehensive review of a Veteran's EHR to identify contributory factors to suicide, such as psychosocial stressors and diagnoses
- **BHAP Family Interview Program:** Interviews conducted by BHAP team members using the Family Interview Tool-Contact Form ([FIT-C form](#)) with bereaved family members to introduce and explain the formal interview program and request their participation to understand the circumstances impacting the Veteran's life in the time before the death. The SPC's role in this process is to ask family members if they would be interested in speaking to the BHAP team about their loved one's death and submitting a FIT-C form that includes the family member's contact information.
- **Reviews of Care by SPCs:** An interview by a BHAP team member discussing a SPC's perspective of suicide prevention initiatives and possible areas for improvement, including a Veteran's death by suicide, identified difficulties, problems or barriers the Veteran may have experienced in his/her care, suggested actions that may have helped prevent the Veteran's suicide, and any direct action the SPC might have taken because of the care review

Note: The corresponding links to the BHAP and FIT-C forms open the location of the forms on the SPC SharePoint only. In order to access the forms, a local copy should be downloaded and saved and then opened by using Microsoft InfoPath.

SPCs are responsible for meeting the following requirements related to BHAP:

- Completing the BHAP Chart Analysis Tool (BHAP form) within 30 days of becoming aware of a Veteran suicide or suspected Veteran suicide (A BHAP should be completed for all events with an unknown or pending cause of death when there is a suspicion of suicide. BHAPs may be updated and corrected later should a formal manner of death indicate the death was other than suicidal in nature.)
- Following facility or VISN review processes before submitting BHAP forms
- Contacting the next of kin and telling them about BHAP, including the following:
 - A brief description of the program
 - An invitation to learn more if they agree to follow-up calls from FIT coordinators from the VISN 2 Center of Excellence (CoE) for Suicide Prevention

- Information about the interview process, including the following talking points:
 - The purpose of the interview is to learn from your experience to help identify new ways to prevent suicide among Veterans.
 - It should take between 30-60 minutes and will cover general questions about the Veteran's life, your (family member) recommendations for improvement in suicide prevention efforts, awareness of resources, and potential barriers to seeking assistance during times of distress.
 - The family interview seeks to obtain information on the context of risk, barriers to care, and suggestions for new programs to prevent suicide.
 - All information shared during the interview will be treated with the utmost confidentiality.
 - BHAP is not a research project but rather a quality improvement effort.
 - At this time, you are agreeing to receive a call from the Family Interview Team where you will learn more about the program and can agree or decline to participate at that time.
 - The Family Interview Team will be in contact no sooner than 60 days after the date of death to give you some time to grieve and process what has happened.
- Completing and submitting the FIT-C form for all Veterans who have died by suicide

Note: SPCs are encouraged to wait several weeks after the death of a Veteran to inform families about the family interview process. See the [Suicide Postvention](#) section for further information about the initial condolence contact after a suicide.

Once SPCs complete their portion of BHAP, a second contact is made by BHAP team members to further describe the process to family members who express interest in the program. Upon receiving confirmation, BHAP coordinators will make a third contact to perform the actual interview.

After the BHAP Chart Analysis Tool and family interviews are submitted, statistical staff and program analysts from the CoE will collect, process, and evaluate the information provided to uncover larger statistical trends and improve VA's SPP.

See [Appendix 3.2.2 BHAP and FIT-C](#) for further information about how to complete the required BHAP components.

Quality Management

Quality management is the process of overseeing all activities and related health care services to ensure that the delivery of care meets both internal and external regulatory standards. Patient Safety Managers (PSMs) are charged with ensuring that both patients and employees are operating within effective and safe guidelines. Although facility PSMs are primarily responsible for all quality management activities, SPCs are required to participate in those specific to suicidal behaviors, such as completing patient safety reports, engaging in environmental and program safety analyses, and contributing to peer reviews.

Patient Safety Reporting

Patient safety reporting is the mechanism used by VA to review and explore vulnerabilities within a system that may inadvertently lead to significant injury or death to a patient. This effort provides more awareness and insight into safety-related incidents, which increases the early detection and prevention of patient harm.

[VHA Handbook 1050.01](#), [VHA National Patient Safety Improvement Handbook](#), and [VA Directive 0321, Serious Incident Reports](#), refer to sentinel events which are defined by The Joint Commission as unexpected occurrences involving death, or serious physical or psychological injury, or risk thereof. These events include suicidal behaviors. Facility staff members are required to report these events to the patient safety manager, who is ultimately in charge of making sure leadership is notified through the National Center for Patient Safety.

The following patient protection events specific to suicide and suicide attempts must be reported to patient safety:

- Suicides
- Suicides within 72 hours of discharge (including discharge from the emergency department)
- Attempted suicides

In 2018, VHA began using the [Joint Patient Safety Reporting system](#) (JPSR), a web-based application, to standardize event capture and data management of medical errors and close calls/near misses for military and Veterans health systems. The Suicide Behavior and Overdose Report template is the primary mechanism used by VA to report all suicidal behavior events (See [Suicide Behavior and Overdose Reporting \(SBOR\)](#) section for further details). However, in addition to the SBOR and CSRE, the following suicidal behavior events are also required to be reported through JPSR:

- All suicide events for which a Root Cause Analysis (RCA) is required:
 - Suicide on an inpatient unit
 - Suicide within three days of discharge from a medical unit or the ED
 - Suicide within seven days of discharge from a mental health or residential unit
- All suicide behavior events by an enrolled Veteran on a VHA campus:
 - On VHA grounds and parking lots
 - Clinics
 - Inpatient units

SPCs are expected to work with the facility patient safety manager to ensure the required patient safety issues specific to suicidal behaviors are appropriately reported.

SPCs may also be expected to participate in the two mechanisms of review that stem from patient safety reports — RCA and quality peer review — both of which are protected categories of information, considered privileged and confidential under the provisions of 38 U.S. Code § 5705.

Root Cause Analysis

Per [VHA Handbook 1050.01](#), [VHA National Patient Safety Improvement Handbook](#), a **Root Cause Analysis (RCA)** is the focused review of, or process of identifying, basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls. This analysis is focused on systems and process issues, as opposed to individuals involved in events.

Although facility-based quality managers are responsible for completing all patient safety processes, including RCAs, SPCs may be expected to assist and, at times, lead the process for all RCAs involving suicidal behaviors.

There are specific guidelines as to the types of events that require RCAs, as mandated by the [Deputy Secretary for Health for Operations and Management \(10N\) – 10N Guide to VHA Issue Briefs](#). These include the following events related to suicidal behavior:

- Inpatient suicides
- Outpatient suicides within seven days of discharge from a mental health inpatient or residential treatment facility

Facilities may also require RCAs for suicidal behavior or incidents not listed above. As such, SPCs are expected to follow the guidelines set forth by their facilities while ensuring that the nationally established minimum RCA requirements are met.

Quality Peer Reviews

Per [VHA Directive 1190, Peer Review for Quality Management](#), quality peer reviews are part of a confidential, nonpunitive process for evaluating the health care provided by individual providers to ensure that all staff members are providing a standard level of care.

While quality management staff members are responsible for ensuring that these reviews take place in accordance with facility policies, SPCs should be familiar with the peer review process, as they may be called upon to provide reviews for other suicide prevention staff members. When asked to participate, SPCs are advised to follow the guidance provided by their facility's quality managers.

[Deputy Secretary for Health for Operations and Management \(10N\) – 10N Guide to VHA Issue Briefs](#) provides guidelines on the types of events that require peer reviews, which include the following suicidal behavior events:

- Inpatient suicides
- Attempted inpatient suicides
- Outpatient suicide within seven days of discharge from a mental health inpatient or residential treatment facility
- Attempted outpatient suicide within three days of discharge from a mental health inpatient or residential treatment facility

Facilities may also require peer reviews for suicidal behavior or incidents not listed above. As such, SPCs are expected to follow the guidelines set forth by their facilities while ensuring that the nationally established minimum peer review requirements are met.

Environment of Care

Consistent with standards set by The Joint Commission, medical centers are required to complete periodic environmental reviews to identify and address risks for suicide and suicide attempts that can occur while

Veterans are being treated in acute inpatient mental health units. VA also includes similar reviews for residential treatment facilities.

Mental Health Environment of Care (EOC) Safety

In accordance with [VHA Directive 1167, Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients](#), VA requires inpatient mental health units to complete a review of the environment every six months by using the Mental Health Environment of Care Checklist (MHEOCC). In January 2014, all facilities were required to use the [Patient Safety Assessment Tool \(PSAT\)](#), housed by VHA National Center for Patient Safety (NCPS), to report and track recommendations made via the MHEOCC. The PSAT is a web-based assessment tool managed by NCPS. The MHEOCC is updated every six months and may be found by logging into the PSAT site (<http://vaww.epsat.ncps.med.va.gov/WebPSAT/WebPSAT.html>). Access to the PSAT site is granted by the patient safety manager, patient safety officer, or other PSAT designee located at each facility.

To perform these reviews, facilities are expected to create Interdisciplinary Safety Inspection Teams (ISITs) consisting of the following participants:

- SPC
- Patient safety manager
- Facility safety officer
- Mental health unit nurse manager
- Physical health unit nurse manager
- Inpatient licensed independent practitioner
- Local recovery coordinator
- Outpatient mental health provider (such as a clinician, case manager, or peer specialist)
- A representative from the engineering department within the facility
- A representative from the environmental services department within the facility
- A pharmacist on staff

As members of the ISIT, SPCs are expected to provide their subject matter expertise on the environmental risks that facilities may face about suicide. ISITs use a risk assessment matrix to help determine the actions that need to be taken to improve facilities’ mental health environments. All ISIT team members and staff working on inpatient mental health units, including SPCs as both potential inpatient staff and members of the facility ISIT, are required to be trained as part of new employee orientation and annually thereafter. Training includes environmental hazards that represent a threat to suicidal patients, how to identify those hazards, and how to correct them. It must also include content and proper use of the MHEOCC tool.

Item No.	Course Name
VA 1290945	Mental Health Environment of Care Checklist (MHEOCC) Training – For Clinical Staff
VA 1290950	Mental Health Environment of Care Checklist (MHEOCC) Training for Non-Clinical Staff

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) Safety

MH RRTPs are residential rehabilitation and clinical care programs provided to Veterans with a wide range of mental health and substance use concerns. As part of its efforts to ensure all facilities are safe for both patients and employees, [VHA Directive 1162.02, Mental Health Residential Rehabilitation Treatment Program](#), requires all MH RRTP programs to “stand down” or suspend clinical operations for one day each year to focus on safety, security, and quality of care. MH RRTP clinicians are also required to undergo documented annual competency reviews for assessing risk for suicide.

MH RRTPs are required to complete Annual Safety and Security Assessments (ASSAs) of their environments before each Stand Down. SPCs are required to participate in both the Stand Down and the pre-Stand Down assessment of facility environments to assist with addressing suicide prevention content.

MH RRTPs may also incorporate their own requirements for suicide risk assessments and VA S.A.V.E. training criteria for admitted Veterans (see the [Suicide Risk Identification Strategy](#) and VA S.A.V.E. Training sections, respectively).

Tracking and Reporting Tools

SPCs are responsible for tracking and reporting all incidents of self-directed violence that are suicidal or of undetermined intent, including preparatory behavior. Self-directed violent events of individuals on active duty should also be reported. SPCs should report deaths by suicide for any individual for whom there is some indication that the person served in the military, in any capacity, for any length of time, and regardless of the type of discharge. This is done by using a variety of tools designed to standardize the process and ensure clear and accurate reporting.

Self-Directed Violence Classification System (SDVCS)

The **SDVCS** standardizes language related to how suicidal ideation and behaviors are identified and communicated within facilities. To support this identification and language standardization, the Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC) for Veteran Suicide Prevention developed a [Self-Directed Violence Classification System and Clinical Toolkit](#) using the guidelines in the [CDC’s Self-Directed Violence Surveillance Uniform Definitions and Recommended Data Elements](#).

This toolkit includes a decision tree to help SPCs, providers, and other staff members consistently identify the correct terms to use when reporting on suicide and associated behaviors. In addition, the nomenclature assists clinicians with identifying self-directed violent (SDV) behaviors that are not suicidal in nature, such as engaging in purposeful cutting or burning. It is important that clinicians also accurately identify behaviors where no suicidal intent is found to avoid erroneous classifications.

SPCs are responsible for using the correct nomenclature in all their tracking, reporting, and consultation tasks. As subject matter experts in suicide prevention, they are also expected to remind staff members of the importance of using consistent, accurate, and standardized language when discussing all suicides and suicide-related events.

For additional information and support, [the Rocky Mountain MIRECC for Veteran Suicide Prevention website](#) hosts a variety of resources, including vignettes, podcasts, and training videos about suicide-related nomenclature.

See [Appendix 3.3.1 Self-Directed Violence Classification Two-Page Handout](#) for further information.

International Classification of Diseases, Tenth Revision (ICD-10) Suicide-Related Behavior Diagnoses Coding

The ICD-10 Suicide-Related Behavioral Diagnoses Codes are used to standardize the documentation of suicide-related behaviors and events while allowing for the expedited evaluation of VA's SPP and the prompt development of related metrics. [VHA Memorandum 2017-07-20, ICD-10 Coding for Suicide-Related Behavior](#) and [VHA Memorandum 2017-09-22, Revisions to Requirements for ICD-10 Coding for Suicide-Related Behavior](#) require providers to use the diagnosis codes outlined in the ICD-10 clinical cataloging system when documenting suicidal behaviors and ideation in the EHR as part of completion of an encounter.

Among their tracking and reporting responsibilities, SPCs are required to make sure providers have received appropriate training and are using the ICD-10 diagnosis codes for all suicide-related behaviors outlined in this guide.

Below is a list of required ICD-10 codes:

ICD Code	Meaning
T14.91	Suicide attempts and interrupted attempts
T14.91XA	Initial encounters related to a suicide attempt (or encounters completed on only one day or only for one admission after providers became aware of the event)
T14.91XD	Subsequent encounters related to an attempt when a suicide attempt is the focus for care
T14.91XS	Encounters related to care for sequela of an attempt
Z91.5	Personal history of suicide attempt(s) to document a remote history of a suicide attempt in a new or established patient
R45.851	Suicidal ideation that leads to a referral, initiation, modification, or intensification of treatment <ul style="list-style-type: none"> • For admissions when suicidal ideation is present • For other encounters when suicidal ideation is the focus of treatment

In addition to the codes listed above, there are a variety of X, Y, T, and S codes that provide further information as to the intent and method used for events. This includes codes for injuries, overdoses, poisoning, and external causes.

The following should be considered when differentiating between codes for suicide attempts and other forms of self-harm:

- Suicide attempts and interrupted attempts should be coded using T14.91XA for initial encounters and T14.91XD for follow-up.
- Other acts of self-harm, such as cutting with intent to control emotional pain, can be documented using codes for the injuries, overdoses, poisoning, and external causes.
- The distinction should be based on clinical judgments about whether patients experience the wish or intent to die, with or without ambivalence about dying, or whether they have acted in spite of the belief that they could die.
 - It is the wish, intent, or belief that is relevant, not the actual danger associated with the behavior.
 - For example, overdose of a medication can be a suicide attempt, even if the provider knows that the amount of medication taken was safe.

The following should be considered when differentiating between codes for suicide attempts that were interpreted and preparatory behaviors:

- Suicide attempts that are self-interrupted or interrupted by others should be coded as an attempt using the T14.91 code.
- Suicidal ideation with preparatory behavior should be coded as ideation using the R45.851 code.
- Interrupted attempts occur when people put themselves at risk of dying by suicide and then decide not to continue. If there is no risk of death, this is considered preparatory behavior. For example:
 - If a person thinking of suicide walks across the Golden Gate Bridge to figure out how to climb the guardrails, that is preparatory behavior. If the person climbs on top of the guardrails to think about jumping, there is a risk of falling. Therefore, if the person climbs down, it is an interrupted attempt.
 - If a person thinking of suicide buys a gun or places a gun on the table in front of them, it is preparatory behavior. If they put a loaded gun in their mouth, there is a risk of the gun discharging. Therefore, if they put the gun down and seek help, that is an interrupted attempt.

Item No.	Active Dates in TMS	Course Name
VA 33885	Oct. 1, 2017 – Sept. 3, 2020	ICD-10-CM Coding for Suicide Attempts and Suicide Ideation

See [Appendix 3.3.2 ICD-10 Suicide-Related Behavior Decision Trees](#) for further information.

Suicide Behavior and Overdose Reporting (SBOR)

The **SBOR** is a national progress note template hosted on patients’ EHRs and the primary mechanism used to notify SPCs of Veterans who may be at elevated risk for suicide. This tool is designed to document Veteran suicides, attempted suicides, preparatory behaviors, and nonsuicidal overdose events that take place within a facility’s catchment area over the course of 12 months. These include events that may have involved someone on active duty and suicide deaths of Veterans not enrolled in VA’s health care system.

Adopted in April 2019, the SBOR ([VHA Memorandum 2019-04-06, Suicide Behavior and Overdose Report Computerized Patient Record System \(CPRS\) Note Template Implementation](#)) is the primary documentation source of suicide and suicide-related events, replacing all local and national Suicide Behavior Report (SBR) templates as well as most reporting of suicidal behaviors within the Suicide Prevention Application Network (SPAN). [VHA Memorandum 2020-10-13, Eliminating Veteran Suicide: Implementation Update on Suicide Risk Screening and Evaluation \(Risk ID Strategy\) and the Safety Planning for Emergency Department \(SPED\) Initiatives](#) released an updated version of a Comprehensive Suicide Risk Evaluation (CSRE) template in the EHR. A suicidal behavior event section has been embedded within the template that allows providers the ability to enter information about one suicidal behavior into that template rather than completing an SBOR for that event. [VHA Memorandum 2020-01-11, Update to High Risk for Suicide Patient Record Flag Changes](#) expanded reporting requirements from sole use of the SBOR to include use of the CSRE. All additional unreported events not completed within the CSRE must be entered in the EHR through use of the SBOR.

The SBOR incorporates questions about suicidal behaviors that will guide staff through making SDVCS designations. The information provided in these templates is meant to help SPCs make determinations about whether Veterans meet the criteria for HRS-PRFs. As a communications tool, the SBOR is not intended to be diagnostic or to require clinical judgment.

A [SBOR template](#) (or CSRE event section) should be completed by any VA staff member who learns that one or more of the following SDV behaviors have occurred within the last 12 months:

- Death by suicide
- Nonfatal suicide attempts
- Preparatory behaviors for suicide, such as writing a suicide note, stockpiling medications, or purchasing a firearm
- Behaviors with undetermined intent

In addition, staff members should report overdose events, including:

- Suicidal and accidental overdoses
- Fatal and nonfatal overdoses
- Severe adverse drug events

The SBOR should be completed by clinicians who meet [the SBOR Staff-Specific Guidelines](#), which include those listed below:

Staff	SBOR
MD/DO ¹	Yes
Licensed Psychologist (PhD/PsyD) ²	Yes
Clinical Pharmacy Specialist	Yes
LCSW/LMSW/LISW ³	Yes
LMFT ⁴	Yes
LPMHC ⁵	Yes
Addiction Therapist	Yes
LPN ⁶	No
RN ⁷	Yes

APRN: NP/CNS ⁸	Yes
PA ⁹	Yes
Peer Support Specialist	No
UAP ¹⁰	No
Psychological Technician, Social Work Assistant	No
Vocational Rehabilitation Specialist	No
Rehabilitation Counselor	Yes

¹ Medical Doctor/Doctor of Osteopathic Medicine; ² Doctor of Philosophy/Doctor of Psychology; ³ Licensed Clinical Social Worker/Licensed Master of Social Work/Licensed Independent Social Worker; ⁴Licensed Marriage and Family Therapist; ⁵ Licensed Professional Mental Health Counselor; ⁶ Licensed Practical Nurse; ⁷ Registered Nurse; ⁸ Advanced Practice Registered Nurse: Nurse Practitioner/Clinical Nurse Specialist; ⁹ Physicians Assistant; ¹⁰ Unlicensed Assistive Personnel, including Health Tech, Medical Assistant, and Nursing Assistant.

Note: A trainee in any of these categories may complete the SBOR with an appropriate co-signer.

Before completing the SBOR template, clinicians should review the EHR and the [CRISTAL Look-Up Tool](#) to determine if suicidal behavior events have already been reported. SPCs should expect one completed SBOR template (or CSRE event section) for each suicide-related event, recognizing that clinicians should not report multiple events on the same template.

SPCs are also required to review SBOR documentation for accuracy and to ensure information is updated as appropriate. To maximize this accuracy, addendums to the SBOR template and/or updating and modifying health factors (See [Removing and Adding Health Factors in Encounter Form](#) for instructions) may be necessary. SPCs should assist providers with this process or complete the modifications as part of their reporting requirements.

Notification of suicidal behaviors occurs from multiple sources, including through support and other non-clinical staff. These staff may not be able to complete required reporting tools (i.e., SBOR and CSRE). In order to facilitate receipt of information about all known suicidal behaviors in the catchment area, SPCs should ensure there are facility-specific reporting mechanisms and training in place for non-clinical staff who are notified of suicidal behaviors, including how these events will be documented in the EHR.

For more information on SBOR, SPCs are advised to see [Appendix 3.3.3 Suicide Behavior and Overdose Report Template Support Documents](#), review the Mental Health Services [SBOR folder](#) on OMHSP SharePoint or take the 30-minute TMS training linked below:

Item No.	Active Dates in TMS	Course Name
VA 38269	April 26, 2019 – April 26, 2022	Suicide Behavior and Overdose Report (SBOR) Recording

Suicide Prevention Application Network (SPAN)

[SPAN](#) is an application used to collect the following data:

- All deaths by suicide for Veterans who have no electronic health record (EHR)
- All outreach activities, including monthly totals of caring contacts to Veterans, completed by SPCs

SPCs must input all data each month and no later than the 10th day of the following month.

Up until the implementation of the SBOR in April 2019, SPAN was used as the primary reporting tool for tracking all suicidal behavior and managing high-risk patients. Although its purpose has been reduced to tracking the previously mentioned activities, SPAN is still maintained, as it holds historical data that may affect facilities’ annual summary reports, events for specific Veterans, and other patient-related data. To obtain access to SPAN, SPCs should contact Steven.Miller7@va.gov.

Note: Outreach provided by staff outside of the SP Team (e.g., Homeless Program, Caregiver Support) does not count toward required outreach activities for SPCs and should not be entered into SPAN.

See [Appendix 3.3.4 Entering SDV Events into SPAN](#) and [Appendix 6.1 Guidance for Entering Outreach into SPAN](#) for further instructions.

Additional Tracking Tools

In addition to the aforementioned tools, there are several other dashboards and tools available to help SPCs monitor patient care, identify potential gaps in services provided, and determine the extent to which facilities are meeting their mental health performance metrics.

Based on their compositions, facilities may appoint a variety of different champions to monitor these metrics, including SPCs, who are expected to understand the purpose and usage of all the below tools.

Tool	Purpose
<p><i>These dashboards contain data that is specific to individual patients. This data is considered protected health or personally identifiable information (PHI/PII) and requires permission to be accessed. Access is generally granted automatically to clinical staff who have Computerized Patient Record System (CPRS) access to PHI/PII.</i></p> <p>Select the link to review LSV SSN-level permission</p>	
<p>SBSR Dashboard</p>	<p>Suicide Behavior Summary Report Patient-level report tracks all facility-level fatal and non-fatal self-directed violent behavior events. This dashboard unites data from the SBOR, CSRE, and SPAN. It includes demographics such as:</p> <ul style="list-style-type: none"> ▪ Event date

	<ul style="list-style-type: none"> ▪ SDV classification ▪ Period of service ▪ Location of residence ▪ Treating facility and VISN ▪ HRS-PRF and REACH VET status ▪ Due dates for BHAP and FIT-C
<p>PDE Dashboard</p>	<p>Post-Discharge Engagement (PDE) Patient Tracking Report Patient-level report that tracks VHA mental health care engagement of Veterans in the 30 days after their inpatient and residential discharges for mental health and substance use disorders treatment.</p> <ul style="list-style-type: none"> ▪ Veterans with HRS-PRFs who have been admitted to a facility are tracked on this dashboard. They require four post-discharge mental health visits within 30 days — separate from post-HRS-PRF placement visits. ▪ Should be used in coordination with Facility PDE Dashboard Champion.
<p>REACH VET Dashboard</p>	<p>REACH VET (Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment) Patient Tracking Report Tool that uses predictive (statistical) modeling to identify Veterans at risk for suicide and other adverse outcomes, including suicide attempts, deaths from accidents, overdoses, injuries, all-cause mortality, hospitalizations for mental health conditions, and medical or surgical hospitalizations.</p> <ul style="list-style-type: none"> ▪ There is often overlap between Veterans identified by this model and those with HRS-PRFs. ▪ For some facilities, SPCs also serve as the REACH VET coordinator. SPCs should coordinate care with the REACH VET coordinator for those facilities who have a separate POC.
<p>SPED Dashboard</p>	<p>Safety Planning in ED/UCC (SPED) Suicide Prevention Detail Report Patient-level tool that identifies Veterans who are determined to be at intermediate or high-acute or chronic risk on the CSRE and are safe to be discharged home. The tool tracks whether those Veterans received a safety plan prior to discharge and indicates those who require enhanced care follow-up.</p> <p><i>Note: This tool also incorporates facility, VISN, and national-level, aggregate data.</i></p>
<p>I9 without Columbia and C-SSRS without CSRE</p>	<p>Depression/PTSD Screening – Associated Suicide Risk Identification Fallouts Dashboard Suicide risk ID process tool that provides two weeks of information sorted in reverse chronological order for identified Veterans who:</p> <ul style="list-style-type: none"> • Scored positive on the primary suicide risk screening but did not receive a same-day secondary screening • Scored positive on the secondary suicide risk screening but did not receive a same-day CSRE.

	<ul style="list-style-type: none"> Received a CSRE but not in a timely manner (i.e., same day as positive secondary screening) <p><i>This dashboard is NOT a current performance measure but is a worksheet that allows facilities to aid quality assurance (QA) and process improvement activities.</i></p>
--	---

Metrics	Purpose
<p><i>These dashboards contain summary or composite data that is specific to a facility but does not contain PHI/PII. Data is pulled from clinical care of at-risk and high-risk patients and summaries are specific to facilities.</i></p>	
PDE1 – Summary	<p>Mental Health Domain Composites – Measure Components Summary</p> <p>Part of the Continuity of Care Composite in MH SAIL, the PDE1 Summary is a metric created to provide the percentage of inpatient and residential mental health discharges with outpatient mental health care engagement within past 30 days of discharge from inpatient psychiatry, residential care, and non-mental health inpatient care.</p> <p>The percentage is created from the total number of:</p> <ul style="list-style-type: none"> Group 1 discharges with two mental health outpatient visits within 30 days of discharge Group 2 discharges with three mental health outpatient visits within 30 days of discharge Group 3 discharges with four mental health outpatient visits within 30 days of discharge <p>This total is then divided by the number of discharges from Mental Health Residential Rehabilitation Treatment Programs or medical treating specialties with principally diagnosed mental health conditions (Group 1), mental health inpatient discharges (Group 2), and discharges with an active high-risk flag or diagnoses related to suicide (Group 3).</p>
REACH VET – Historic Summary Metrics Report	<p>REACH VET – Overview of Implementation</p> <p>Tool designed to display aggregate, calculated facility percentages of Veterans in the top 0.1% of risk who are involved in specific care enhancement activities: coordinator assignments, provider assignments, care evaluation, and outreach provided within one, two, three, and four weeks of each month’s release date.</p> <p><i>Note: The report runs monthly on approximately the 15th of the month and reflects the previous month’s data.</i></p>
REACH VET Summary Report	<p>REACH VET – Overview of Implementation</p> <p>Clinical support tool designed to assist the field with tracking how well a facility is meeting the threshold for their REACH VET panel of patients. The tool displays both facility aggregates <i>and</i> patient counts of Veterans in the top</p>

	<p>0.1% of risk who are involved in specific care enhancement activities: coordinator assignments, provider assignments, care evaluation, and outreach provided to date.</p> <p><i>Note: The report runs nightly with a 1-2-day lag from data entry in the EHR.</i></p>
--	---

Tool	Purpose
<p><i>The following tools may assist SPCs by providing summarized data from multiple sources specific to individual patients and patient groups identified as having increased risk for suicide or other adverse outcomes. Data is meant to assist the SPC/provider with clinical care decision-making. SPCs should be familiar with these tools and encourage their use by clinical staff members.</i></p> <p><i>These dashboards contain data that is specific to individual patients. Information is considered protected health or personally identifiable information (PHI/PII) and requires permission to access. Access is generally granted automatically to clinical staff members who have CPRS access to PHI/PII.</i></p> <p>Select the link to review LSV SSN-level permission</p>	
<p>CRISTAL</p>	<p>CAPRI, REACH VET, Risk Indicators, STORM Tool for Analytic Look-Up (CRISTAL)</p> <p>Patient look-up dashboard that summarizes key information from a Veteran’s VHA medical records and provides estimates of risk for suicide, overdose, and other adverse outcomes based on predictive analytics.</p> <p>Provides data points to assist users with risk assessment and screening, case conceptualization, and treatment planning while augmenting traditional clinical risk assessment in a variety of settings.</p> <p>Includes all of the patient’s prior suicidal behavior <i>if</i> those behaviors were entered into a SBOR or CSRE templates. SPCs and clinical staff members should use CRISTAL in determining whether an SBOR has already been reported for a suicidal behavior event.</p> <p>CRISTAL streamlines clinical processes by centralizing information from three critical data sources:</p> <ul style="list-style-type: none"> • Compensation and Pension Record Interchange (CAPRI) • Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment (REACH VET) • Stratification Tool for Opioid Risk Mitigation (STORM)

<p>SPPRITE</p>	<p>Suicide Prevention Population Risk Identification and Tracking for Exigencies (SPPRITE) Report</p> <p>Tool used to assist providers in tracking patients identified as having a high risk for suicide by unifying critical patient-level information on high-risk patients from other dashboards (HRF, STORM, REACH VET, PDE).</p> <p>Allows providers to engage in integrated case management of high-risk patients, coordinate care and communication with providers in other settings, and easily export a patient list to facilitate outreach efforts.</p> <p>Enables SPCs to filter for patients who have had a recent suicide event reported at their facility and to export mailing lists for these patients.</p> <p><i>Note: There are plans to provide facility SPCs with aggregate numbers of patients who have had a reported event (by month, by SDV class, possibly other categories as well). This will come in a format outside of SPPRITE, though attempts will be made to try to link this data from SPPRITE if possible.</i></p>
<p>STORM Storm Implementation SharePoint site</p>	<p>Stratification Tool for Opioid Risk Mitigation</p> <p>Tool provides a risk-stratified list of patients with current exposure to opioid drugs or medications and predicts risk of overdose or suicide-related health care events or death.</p> <p>Provides recommendations tailored for a specific patient and tracks the patient’s receipt of relevant risk mitigation strategies.</p> <p>STORM includes:</p> <ul style="list-style-type: none"> • A summary report (national, VISN, and facility-level) • A patient report <p><i>Note: Although STORM provides information about any patient with increased risk of an adverse outcome secondary to opioid exposure, one of the adverse outcomes is death by suicide. SPCs should use and refer clinical staff to STORM as another tool for mitigating elevated risk. Data from STORM is included in the SPPRITE and CRISTAL dashboards.</i></p>

Enhanced Care Delivery

SPCs are responsible for identifying and supporting the care process for high-risk Veterans in collaboration with their treating clinicians. Enhanced care delivery involves completing assessments of suicide risk, ensuring proper care is provided, and maintaining communications with Veterans following discharge from acute or residential care settings.

This responsibility comprises the following functions:

- Collaborating with treating clinicians to assess risk and provide guidance about criteria for Patient Record Flags Category I – High Risk for Suicide (HRS-PRF) placements
- Ensuring that high-risk Veterans are receiving appropriate care following their HRS-PRF placements, including increased frequency of clinical care visits and follow-up after missed appointments
- Making personal contact with each identified high-risk Veteran (e.g., letters, face-to-face, telephone)
- Ensuring Veterans have engaged in safety planning and that safety plans are updated as appropriate
- Offering consultations to treating clinicians to assist them with managing Veterans at high risk for suicide

Identifying High-Risk Veterans

To provide access to the enhanced care and services that may prevent ongoing suicidality issues, Veterans should be identified as having a high risk for suicide as early as possible. [VHA Directive 2008-036, Use of Patient Record Flags To Identify Patients at High Risk for Suicide](#), [VHA Memorandum 2020-01-11, Update to High Risk for Suicide Patient Record Flag Changes](#), [VHA Memorandum 2008-04-04, Patients at High Risk for Suicide](#), and [VHA Handbook 1160.06, Inpatient Mental Health Services](#) indicate which Veterans should be placed on the facility High Risk for Suicide List (HRSL) and receive HRS-PRFs, including Veterans:

- Assessed as “acute high risk” for suicide based on a Comprehensive Suicide Risk Evaluation (CSRE)
- With a recent suicide attempt, including those referred to the SPC from the VCL and those who present for admission
- With recent suicidal preparatory behavior, especially with a firearm
- With severe, unabating suicidal ideation that has an acute presentation and includes intent and/or planning
- The inability to maintain safety independent of external support or help

Veterans with the following presentation should also be considered for placement on the HRSL:

- Admitted to an inpatient mental health facility with strong suicidal ideations, especially if they include intent of acting on the ideation
- Experiencing crisis in their lives and have had a prior suicide attempt

To aid in identifying high-risk Veterans, SPCs are responsible for ensuring the following processes are in place:

- Facilities have procedures by which clinicians may refer potential high-risk Veterans for flagging

- Clinicians use the Suicide Behavior and Overdose Report (SBOR) template or the Comprehensive Suicide Risk Evaluation (CSRE) template for reporting suicidal behaviors in the electronic health record (EHR)
- Facilities have procedures in place for notifying SPCs when SBORs or CSREs with suicidal behavior events are completed

Among their enhanced care responsibilities, SPCs are required to assist clinical staff members with consultation and formulation of risk. There are several tools to help clinicians with making these determinations, including the Suicide Risk Identification Strategy and the Therapeutic Risk Management of the Suicidal Patient Model. These tools will be reviewed in further detail below.

Notes about risk of suicide:

Risk of suicide and the need for a patient record flag need to be understood in the context of several related but distinct concepts:

- **At risk** – Veterans are chronically “at risk” or at “elevated” risk of suicide if they have certain historic risk factors (e.g., mental health diagnoses, history of suicide attempts). This level of risk can remain elevated over the course of the lifetime and is distinct from discrete periods of elevated suicide risk.

Patient Record Flag - Most “at-risk” Veterans will never go on to engage in self-directed violence or die by suicide, despite having various risk factors for suicide. Determining if a patient record flag is appropriate requires suicide risk assessment to identify warning signs or dynamic risk factors suggesting increased acute risk, above and beyond the Veteran’s baseline level of suicide risk. For example, the Veteran with a history of PTSD and substance abuse and a prior suicide attempt (indicating elevated chronic risk) might present with a recent job loss, breakup, and increase in the frequency and intensity of suicidal ideation, suggesting an acute episode of increased suicide risk.
- **Acute high risk** – Veterans are at high acute risk when current suicidal ideation is associated with the intent to die by suicide and the inability to maintain safety absent external support. Hence, high acute risk almost always requires hospitalization. This may include involuntary hospitalization if the Veteran does not consent. Veterans at high acute risk will typically have a plan for suicide, access to lethal means needed to carry out that plan, a recent history of suicidal behavior (e.g., researching methods for suicide, acquiring lethal means, writing suicide notes), and/or exacerbation of psychiatric illness. The high acute risk period is generally brief in duration (i.e., hours to several days).

Patient Record Flag - Veterans at high acute risk of suicide require placement of a patient record flag.
- **Chronic high risk** – Veterans are identified as being at high chronic risk if they have a significant history of suicidal ideation, history of self-directed violence, and risk factors, such as chronic mental health conditions, limited coping skills, and/or chronically unstable psychosocial status (e.g., homelessness or relationship conflict). High chronic risk denotes the tendency to become acutely suicidal in the face of emerging or increasing psychiatric symptoms or psychosocial stressors. Veterans at high chronic risk have a baseline level of increased risk of suicide that is much higher than the baseline typically encountered among most patients. Baseline suicide risk is specific to the individual Veteran, and a consequence of their unique combination of coping skills versus deficits, medical and psychiatric conditions, risk and protective factors, and psychosocial circumstances, among other factors.

Patient Record Flag – Veterans identified as high chronic risk do not require a patient record flag unless they are also assessed to be at high acute risk or are experiencing a period of elevated risk (see below). High chronic risk combined with moderate acute risk driven by recent events (e.g., job loss, relapse) warrants consideration of a flag, with the ultimate determination guided by clinical judgment attendant to the Veteran’s unique circumstances and clinical needs.

- **Imminent** – “Imminent” risk, or a similar term, is a legal term that is used for a state civil commitment process (involuntary hospitalization). Laws vary from state to state. *Note: The term “imminent” may be replaced by “substantial,” “gravely disabled,” “likely to injure self if not immediately detained,” “serious mental impairment,” or any other similar designation described in a state law for emergency mental health detention.*

Patient Record Flag – Veterans requiring involuntary hospitalization related to their suicide risk should be assessed as high acute risk and, therefore, require placement of a patient record flag.

- **Period of elevated risk** – Level of risk changes over time and is not static. Veterans who have recently attempted suicide or who have been recently discharged from acute care are known to be at increased or elevated risk of dying by suicide over a period of time. Their level of risk during this period is considered to be elevated above their established baseline level of risk.

Patient Record Flag – Once Veterans receive a PRF, the period of 90 days post-PRF placement is considered to be a period of elevated risk for suicide. During this period, risk may wax and wane until the Veteran’s acute risk factors stabilize. The PRF in this case allows continued monitoring over an elevated risk period (i.e., a PRF is present which triggers enhanced care including increased monitoring for safety).

Other Than Honorable (OTH) Former Service Members, Ineligible Former Service Members, Humanitarian Care, Active Duty, or Other Non-Veteran Patients

In some instances, SPCs are required to navigate VHA policy, patient safety, and facility-level latitude in order to determine appropriate care for patients who may or may not be eligible for care from VHA. Any Veteran or other patient receiving care from VA is subject to all of the same policies as any other Veteran and that includes having a high-risk flag, if warranted. SPCs will need to work with their facilities directly to determine if their facility plans to continue to provide care to a Veteran/patient outside of an emergency episode of care.

[VHA USH Memorandum 10-2017-01, Access to Mental Health Services for Other Than Honorable Discharged Servicemembers](#) expands provision of emergent mental health care for 90 days to Veterans with an “other than honorable discharge.” [VHA Directive 1601A.02\(1\), Eligibility Determination](#) references provision of emergency care for ineligible former Service members for an “episode of care” of up to 90 days with a possible extension and addresses VHA’s responsibility to ensure coordination of care utilizing community resources. Per [VHA Directive 1660.06, VA-TRICARE Network Agreements](#), VHA may provide care to active duty Service members if:

- The Service member needs emergency or urgent care. Care is provided first and then VA obtains TRICARE authorization for care once the patient is stabilized.
- The Service member needs routine care and has a valid TRICARE referral or authorization.
- The VA health facility where the patient is being seen has a VA/DoD sharing agreement that allows VA to provide care without referrals.
- The Service member is a “dual-eligible” beneficiary seeking care for service-connected conditions at a VA health facility.

Service members may be referred or self-refer. In addition to these national policy documents, facilities have some latitude to continue to provide care to Veterans due to safety concerns. In these cases, SPCs have a responsibility to ensure high-risk Veterans are being monitored and are receiving care, regardless of their ability to pay or what their eligibility is, until they are established in community care or determined to no longer have a safety need. If they never establish care in the community, SPCs are advised to continue the flag as with any other Veteran/patient until the person no longer meets criteria for the flag. In practice, this means

the SPC would be the primary provider for follow-up care and this follow-up care should be provided over the phone in order to avoid the Veteran getting billed “Humanitarian” rates for that care.

In addition to “Other Than Honorable Discharged Servicemembers” and “Ineligible Former Servicemembers,” VHA may also provide limited care to:

- Caregivers of Veterans under the Caregiver Support program
- Spouses/dependents in the form of Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) governed by [VHA Handbook 1601D.05](#)
- Veterans who only receive care for their service-connected (SC) condition that may not include MH care
- Veterans who only receive care specific to MST

Should any of these patient types meet criteria for an HRS-PRF, SPCs should work with eligibility and leadership at their facilities to determine how to proceed with the provision of care. These patients should be treated in a similar manner to ineligible former Service members (e.g., placement of an HRS-PRF until the patient is determined to no longer be eligible for the HRS-PRF or staff have transferred care to community providers). Facilities must balance:

- What VHA is allowed to provide by federal mandate
- Patient safety
- Facility-level latitude for management of these types of patients

Therapeutic Risk Management of the Suicidal Patient Model

Therapeutic risk management affirms the collaborative treatment and therapeutic alliance between clinicians and patients in crisis by avoiding defensive practices and seeking to find balance between the principles of autonomy, nonmaleficence, and beneficence.

The Rocky Mountain Mental Illness Research, Education and Clinical Care (MIRECC) for Suicide Prevention developed a model of [Therapeutic Risk Management of the Suicidal Patient](#) to assess and manage suicide risk. This model focuses on the augmentation of clinical risk assessment using structured instruments, stratifies risk with respect to both severity and temporality, and helps clinicians develop safety plans in collaboration with suicidal patients. The model and its components are fully described in a series of four articles published in the “Journal of Psychiatric Practice” and found below:

- [A Model for Therapeutic Risk Management of the Suicidal Patient](#)
- [Therapeutic Risk Management of the Suicidal Patient: Augmenting Clinical Suicide Risk Assessment with Structured Instruments](#)
- [Therapeutic Risk Management of the Suicidal Patient: Stratifying Risk in Terms of Severity and Temporality](#)
- [Therapeutic Risk Management of the Suicidal Patient: Safety Planning](#)

For a detailed overview of the model, reference the [2015 DCoE Webinar: Therapeutic Risk Management of the Suicidal Patient](#) and accompanying [presentation slides](#).

To further assist clinicians with conceptualizing suicide risk, the Rocky Mountain MIRECC also developed a stratification tool that reviews the essential components of each level of risk and includes recommendations to

guide appropriate clinical decision-making as a result. See [Appendix 4.1 Rocky Mountain MIRECC for Suicide Prevention Risk Stratification Tool](#) for further information.

Rocky Mountain MIRECC's free [Suicide Risk Management Consultation Program](#) is also an invaluable resource for clinicians working with Veterans with increased risk for suicide. Experts from the program help them with:

- Assessing and conceptualizing risk for suicide
- Addressing lethal means safety counseling needs
- Learning strategies for engaging Veterans at high risk
- Using best practices for documenting risk
- Providing support following the loss of a Veteran to suicide (postvention)

Therapeutic risk management of suicidal patients is a shared responsibility among care team members. In support of this, SPCs are responsible for:

- Using therapeutic risk management to assess risk when actively engaged with Veterans
- Consulting with clinical staff members who are assessing risk for suicide and educating them about risk stratification tools
- Consulting with clinicians and referring them to the [Suicide Risk Management Consultation Program](#) on behalf of Veterans
- Informing community partners about the Suicide Risk Management Consultation Program as *any* provider (VA or community) serving Veterans may utilize the program

SPCs and clinicians may place a consult by emailing srmconsult@va.gov.

Managing the Care of High-Risk Veterans

Case management is the practice of planning, facilitating, and coordinating care for health care patients. SPCs are responsible for case managing all Veterans with HRS-PRFs, although this process will generally focus on oversight and monitoring, rather than providing direct patient care. Since HRS-PRFs are usually placed for short durations, SPCs' involvement should come in the form of a supporting role to the Veteran's overall treatment team and primary providers. As such, once these flags are removed, SPCs will also likely withdraw from active engagement. For this reason, it is critical that care teams be familiar and comfortable with managing their patients throughout their crisis periods.

Acting as consultants to care teams, SPCs are responsible for the following case management tasks while monitoring Veterans with HRS-PRFs:

- Notifying Veterans of the placement of HRS-PRFs on their EHR and providing them with information about enhanced care services
- Confirming that Veterans receive enhanced care visits
- Ensuring that contact is made with Veterans who miss appointments
- Ensuring that Veterans have completed and receive a copy of their Suicide Prevention Safety Plan (SPSP)
- Acting as advocates and liaisons for Veterans as appropriate

- Ensuring that HRS-PRFs are reviewed a minimum of every 90 days for the lifetime of that PRF and that this review is documented in the EHR
- Providing outreach via U.S. mail through use of caring communication

Enhanced Care Contact and Visits

Enhanced care visits are a required component of suicide prevention plans for high-risk Veterans. SPCs are required to monitor completion of these visits through use of the High-Risk Flag Patient Tracking Report Dashboard. (See the [High-Risk Flag \(HRF\) Patient Tracking Report Dashboard](#) section for more information on how to track these visits.) The following schedule is required for enhanced care visits:

- Four visits with a mental health clinician within the first 30 days of the flag's placement
- One visit with a mental health clinician every 30 days thereafter for the lifetime of the flag

Enhanced care visits include a variety of touch points with high-risk Veterans. These are required to be face-to-face (including any video modality) unless telephonic visits are explicitly requested by the Veteran and this request is documented. Enhanced care visits must be documented in the EHR, and session content should focus on Veterans' suicidality, including the following factors:

- Periodic reassessments of suicide risk
- Initiation of and ongoing reviews of the SPSP
- Reviews of acute risk factors that led to Veteran risk for suicide
- Enhancement and strengthening of Veterans' protective factors

Veterans who miss their mental health appointments (i.e., enhanced care visits) should receive follow-up attention from mental health providers. SPCs' related responsibilities include the following:

- Confirming mental health providers follow requirements as set forth in [VHA Directive 1230\(2\), Outpatient Scheduling Processes and Procedures](#), which include contacting Veterans:
 - By appropriately trained staff who possess a scope of practice including evaluation and triage of high-risk behaviors
 - Via three documented contact attempts by telephone on three separate days
 - Via a letter that may follow the unsuccessful telephone contact attempts or be mailed as early as the same day as the first call
- Collaborating with the mental health providers as set forth in [VHA Memorandum 2013-08-02, Guidance on Patients' Failure to Attend Appointments](#) to determine the next appropriate steps by using clinical judgment and the predeveloped SPSP, if possible. Considerations should include:
 - Whether a welfare check is warranted
 - Sending the follow-up letter via certified mail
 - Whether contact of the next of kin, emergency contact, or other contact as listed on the Suicide Prevention Safety Plan is warranted

Safety Planning

Safety plans are prioritized lists of concrete coping strategies and resources Veterans create in collaboration with a care team provider to maintain safety and regain equilibrium. Safety plans are consistent with the recovery model, which views Veterans as collaborators in their treatment and supports empowerment, hope, and individual potential. Safety plans should be used during times of distress and are meant to both de-escalate crises and provide effective strategies to help Veterans avoid suicidal states.

Safety plans are *not* a “no-suicide contract.” Contracting not to engage in a suicidal behavior is not patient-centered and has no clinical effectiveness. While a no-suicide contract indicates what patients should not do, it does not provide them with strategies to help manage crisis.

In June 2018, VA standardized the use of the Suicide Prevention Safety Plan (SPSP) template in the EHR as mandated by [VHA Memorandum 2018-06-18, Suicide Prevention Safety Plan National CPRS Note Templates Implementation](#). SPCs are responsible for ensuring all clinical staff members at their facility use the SPSP, as well as the SPSP Review/Decline Progress Note title when documenting safety plans.

They are required for Veterans who:

- Are flagged as being at high risk for suicide
- Have engaged in a recent suicide attempt
- Have been admitted to a psychiatric acute care or residential treatment program

Safety plans should be completed:

- Before discharge from inpatient units
- Before discharge from residential rehabilitation treatment programs
- Within seven days before or after HRS-PRF placement
- Prior to a patient being discharged home from the emergency department/urgent care if that patient has been assessed as HIGH or INTERMEDIATE acute or chronic risk (see [Safety Planning in the Emergency Department/Urgent Care Center \(SPED\)](#) section for further details)

Safety planning is valuable because Veterans can experience feelings of intense distress and suicidality that fluctuate over time. Individuals who have experienced suicidal intent are also at elevated risk to have similar future crises. Safety plans are designed to break the cycle early, providing patients with tools to help them avoid reentering suicidal states. Once Veterans are aware that such periods of distress may recur but are temporary, they can proactively plan effective strategies for such periods by maintaining safety, reducing distress, and speeding recovery.

To maximize their value, treating clinicians should collaborate with Veterans by:

- Providing a paper copy, encouraging the Veteran to handwrite their own safety plans in first person to personalize their plans and ensure their relevance to the Veteran’s experience
- Helping the Veteran identify triggers and coping skills
- Transcribing the safety plan using the SPSP template in the EHR

- Providing a copy of the SPSP to the Veteran
- Periodically updating the SPSP when changes occur for Veterans with respect to triggers, coping skills, and personal and professional contacts

SPCs are responsible for ensuring all qualified clinical staff members are trained in using the SPSP template along with the SPSP Review/Decline Progress Note title, which is used to document when providers have reviewed an existing plan that has not been modified or when Veterans refuse to complete a SPSP. Although SPCs should collaborate with Veterans to develop safety plans, the primary responsibility for their completion lies with treatment providers.

Related to this function, SPCs are responsible for performing the following tasks:

- Tracking Veterans assessed to be at a high risk for suicide to ensure that safety plans are completed and updated at regular intervals
- Facilitating training for staff members on how to complete and regularly review safety plans with Veterans during follow-up care visits
- Ensuring that all safety plans are documented in the EHR and completed through use of the SPSP template

Per [Department of Veterans Affairs \(VA\) Suicide Prevention Safety Plan and Suicide Behavior and Overdose Report \(SBOR\) Templates Staff Specific Guidance](#), VHA staff members can develop safety plans if:

- There is a “Yes” next to the staff member’s credentials in the table below
- The local facility chief of staff concurs with this determination
- The staff member has documented training via the TMS course (VA-36232 Suicide Safety Plan Training Recording)
- Safety planning is within written scope of practice and/or competency per local policy

Position	SP Safety Plan
MD/DO ¹	Yes
Licensed Psychologist (PhD/PsyD) ²	Yes
Clinical Pharmacy Specialist	Yes
LCSW/LMSW/LISW ³	Yes
LMFT ⁴	Yes
LPMHC ⁵	Yes
Addiction Therapist	Yes
LPN ⁶	No
RN ⁷	Yes
APRN: NP/CNS ⁸	Yes
PA ⁹	Yes
Peer Support Specialist	No
UAP ¹⁰	No
Psychological Technician, Social Work Assistant	No

Vocational Rehabilitation Specialist	No
Rehabilitation Counselor	Yes

¹ Medical Doctor/Doctor of Osteopathic Medicine; ² Doctor of Philosophy/Doctor of Psychology; ³ Licensed Clinical Social Worker/Licensed Master of Social Work/Licensed Independent Social Worker; ⁴ Licensed Marriage and Family Therapist; ⁵ Licensed Professional Mental Health Counselor; ⁶ Licensed Practical Nurse; ⁷ Registered Nurse; ⁸ Advanced Practice Registered Nurse: Nurse Practitioner/Clinical Nurse Specialist; ⁹ Physicians Assistant; ¹⁰ Unlicensed Assistive Personnel, including Health Tech, Medical Assistant, and Nursing Assistant.

Note: A trainee in any of these categories may complete an SPSP with an appropriate co-signer.

For more resources and information on how to complete safety plans, SPCs are advised to take the TMS training listed below.

Item No.	Active Dates in TMS	Course Name
VA 36232	July 1, 2018 – July 1, 2021	Suicide Safety Planning Training Recording

See [Appendix 4.2 Suicide Prevention Safety Plan Document, How-To, and Additional Resources](#) for more information on safety plans.

Lethal Means Safety Counseling

Lethal means are objects (e.g., medications, firearms, sharp objects, cords, or rope) that could be used to cause self-directed violent behavior. Limiting access to lethal means saves lives. Facilitating lethal means safety is an essential component of effective suicide prevention and safety planning. Treating clinicians should discuss lethal means safety with any patient who is at risk for suicide, but particularly those who have been identified as “High” or “Intermediate Acute” or “Chronic” suicide risk. This discussion should be collaborative and respectful, especially when engaging in conversations with Veterans and Service members about access to firearms.

Temporary storage of firearms away from the patient’s home may be the safest option during periods of high risk. However, any step that increases time and distance between a firearm and a patient’s impulse to engage in suicidal behavior will reduce the risk of death by suicide. In scenarios where patients are unlikely to consider removing firearms from their home, on-site storage options, including use of gun locks or locking containers, storing firearms unloaded, or disassembling firearms may potentially reduce suicide risk.

Conversations about lethal means should also include access to medications, both prescribed and non-prescribed. Considerations should include the use of blister packets or limiting supplies of medications to the smallest amount necessary. Patients should be encouraged to dispose of old or expired medications through use of disposal kits or disposal bins at VHA and community facilities.

SPCs and treating clinicians should be comfortable with facilitating conversations about lethal means safety that emphasize patient autonomy and align with each patient’s values and preferences. The [MIRECC Lethal Means Safety & Suicide Prevention site](#) includes additional resources to assist SPCs and treating clinicians with engaging in this lifesaving effort.

Staff engaged in safety planning and lethal means safety counseling are advised to take the TMS training listed below.

Item No.	Active Dates in TMS	Course Name
VA 34560	September 30, 2020 – September 30, 2023	Lethal Means Safety Training Recording

SPCs may also refer non-VA staff to the TRAIN Learning Network site at www.train.org for a web-based self-study version of the [Lethal Means Safety Training Recording](#).

Financial Hardship Assistance for High-Risk Veterans Program

In October 2018, the Office of Community Care Facility Revenue Operations partnered through a [Memorandum of Understanding](#) with SPCs to create the Financial Hardship Assistance for High-Risk Veterans Program. VA has four financial hardship programs that may be offered to high-risk Veterans, including:

- Hardship - A Veteran has the right to apply for a hardship to qualify them for co-payment exemption for the remaining calendar year. A Veteran may be eligible if the Veteran’s gross household income has decreased. This enrollment may place them in a higher priority group.
- Waiver of Existing Debt - A Veteran has the right to request a waiver of part or all of their debt. If the waiver is granted, they will not be required to pay the amount waived.
- Repayment Plan - A Veteran has the right to establish a monthly repayment plan at any time during their enrollment in VA health care if they cannot pay their debt in full. Typically, a repayment plan cannot extend beyond three years.
- Compromise – A Veteran has the right to request a compromise. A compromise means that the Veteran proposes a lesser amount as full settlement of the debt.

The facility revenue manager (FRM) or other designee will work directly with and advocate for Veterans to assist them with the process of applying for one of the hardship programs as appropriate, up to and including a potential waiver of the debt.

In support of this process, SPCs are encouraged to:

- Reach out to the FRM and coordinate a process by which FRMs and SPCs can collaborate so that facility revenue staff may receive appropriate referrals
- Promote messaging that notifies Veterans that VHA will never refuse or turn down a Veteran seeking care if they have VA debt
- Assist facility staff with facilitating discussions around VA debt as part of their risk reduction strategy with Veterans
- Provide consultation and support as needed to facility revenue staff who are speaking with high-risk Veterans about debt management

SPCs are encouraged to take the following TMS training that outlines the financial hardship program.

Item No.	Course Name
VA 36532	Financial Hardship Assistance Program for High Risk Veterans

For questions about this program:

- SPCs should contact [VHA OMHSP SP Actions](#)
- Facility revenue staff should contact [VHA OCC RO FRM](#)

Case Consultations

Case consultations represent the interaction among SPCs and care teams on behalf of patients. As subject matter experts in suicide prevention, SPCs should expect that internal and external partners will consult with them on how to identify and manage care of Veterans who are at elevated risk for suicide.

Case consultation can include the following functions:

- Reviewing patient charts to provide input in consultations, including information on how to accurately document care provided to at-risk Veterans
- Identifying potential gaps in care and suggesting solutions
- Increasing staff skills and abilities in working with high-risk and chronically suicidal Veterans through coaching, training, and the sharing of suicide prevention best practices

SPCs should also consider referring staff members to the Rocky Mountain MIRECC for Suicide Prevention Consultation service. See the [Therapeutic Risk Management of the Suicidal Patient Model](#) section for further information.

Caring Communication Program

As mandated by [VHA Memorandum 2008-04-04, Patients at High-Risk for Suicide](#), SPCs are to make personal contact with high-risk Veterans via the U.S. mail through use of a caring contact strategy. The program is designed to strengthen Veterans' sense of social connectedness, reduce the likelihood of repeat episodes of suicidal behavior, and reach those who may be reluctant to seek treatment due to stigma.

The use of caring letters as part of a post discharge strategy to reduce suicide for patients who have experienced admission due to a suicidal crisis is one of the only strategies that has reduced suicide rates in randomized clinical trials. [VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide](#) recommends the strategy for a minimum of 12-24 months. "Non-demanding caring contacts" is also a part of the [Zero Suicide Toolkit](#), which was created by the Suicide Prevention Resource Center as part of the Zero Suicide Model. The Joint Commission now references the Zero Suicide Toolkit on its [Suicide Prevention Portal](#).

In particular, SPCs are required to:

- Send regular, brief, non-demanding notes to patients through the U.S. Postal Service to all Veterans whose HRS-PRF has been removed
- Begin sending caring letters within two weeks of a Veteran's HRS-PRF removal
- Continue sending caring letters for a minimum of one year, monthly, post-HRS-PRF removal

In order to be inclusive of Veterans who may not have a mailing address, SPCs may consider sending caring contact messages via text or email. SPCs should discuss these options with their facility privacy officer to ensure confidentiality and ensure a mechanism is in place for managing text or email communication from patients. Some studies ([Berrouiguet, S., Gravey, M., Le Galudec, M., Alavi, Z., & Walter, M. \(2014\). Post-acute crisis text messaging outreach for suicide prevention: a pilot study. *Psychiatry Research*, 217\(3\), 154–157](#) and [Toward mHealth Brief Contact Interventions in Suicide Prevention: Case Series From the Suicide Intervention Assisted by Messages \(SIAM\) Randomized Controlled Trial. *JMIR Mhealth Uhealth*. 2018 Jan 10;6\(1\):e8. doi: 10.2196/mhealth.7780](#)) have begun to review the use of other modes of communication for caring contacts but research is still lacking specific to established efficacy.

SPCs also have the option to send letters to:

- Veterans that are chronically on and off the HRSL
- Those who miss appointments, don't respond to phone outreach, or are difficult to locate
- Veterans referred to SPCs for review of HRS-PRFs, including those recently hospitalized or from Veterans Crisis Line consults

In addition to sending non-demanding letters, SPCs are required to perform the following related tasks:

- Creating and maintaining a list of Veterans who participate in the Caring Communication Program via Suicide Prevention Application Network (SPAN) or other methods used to track facility mailing lists
- Documenting the number of mailings sent in SPAN monthly no later than the 10th of the following month
- Ensuring deceased Veterans have been removed from the mailing list

In addition to the information stated above, SPCs are advised to note the following information related to the Caring Communication Program:

- A list of patients included on the mailing list has historically been housed in SPAN with SPCs manually entering this information. Facilities may continue to use SPAN to house the mailing list or may opt to use another method of creating and tracking the facility mailing list.
- Documentation in the EHR must include when a Veteran has been added to the Caring Communication Program and when the Veteran has been removed from the program.
- Documentation should also include a Veteran's preference, if provided, and a Veteran's refusal to receive caring communications.

Other Types of Communication

While other types of content may be sent, the required caring letter or postcard should not be accompanied by any other materials to meet the primary objective of “non-demanding” caring contact. Other types of content that may be sent separately to Veterans may include any or all of the following:

- Notifications of the placement or removal of HRS-PRFs
- Follow-up contact after missed appointments or phone calls
- Educational newsletters regarding a variety of topics, such as sleep hygiene or coping skills
- Information on VA, mental health, and community resources
- Birthdays and holidays

To ensure educational newsletters are meeting VA guidelines, content should be submitted to the facility Medical Media or Public Affairs Office for review and approval before sending.

Veterans Who Relocate

Responsibility should remain with the originating facility who inactivated the HRS-PRF. Caring communications should be non-demanding in nature and is about establishing social connectedness. Connection may occur with a Veteran regardless of where the Veteran lives or is receiving care. *Note: Should another facility providing care for the Veteran be interested in providing caring communications following HRS-PRF inactivation, staff should coordinate with the facility already providing caring contacts.*

See [Appendix 4.3 Examples of Caring Communication Content](#) for additional resources.

Inactivation of an HRS-PRF

[VHA Directive 2008-036, Use of Patient Record Flags To Identify Patients at High Risk for Suicide](#) requires HRS-PRFs on the EHR only for the duration of increased risk for suicide and that those HRS-PRFs be removed as soon as clinically indicated to do so, not less than 90 days after initiation or reinstatement. [VHA Notice 2020-13, Inactivation Process for High Risk for Suicide Patient Record Flags](#) expands on the requirements for reviewing and inactivating the flag.

Facilities are required to ensure there is a process for managing HRS-PRFs, that includes inactivation, and is operationalized within a standard operating procedure (SOP). Clinical judgment should be used in determining whether to inactivate or continue an HRS-PRF. However, before inactivating an HRS-PRF, [VHA Notice 2020-13, Inactivation Process for High Risk for Suicide Patient Record Flags](#) requires facilities pay special attention to the following groups: patients engaged in care, patients not engaged in care, and patients who are former Service members that are ineligible for VHA care.

See [Other Than Honorable \(OTH\) Former Service Members, Ineligible Former Service Members, Humanitarian Care, Active Duty, or Other Non-Veteran Patients](#) section for further information.

Consultation and Advisory Committees

[VHA Directive 2008-036, Use of Patient Record Flags to Identify Patients at High Risk for Suicide](#) requires maintaining communication with facility-designated advisory groups or committees to inform them of flag placements and the outcomes of HRS-PRF reviews. This committee or advisory group should assist with making flag placement recommendations and advise the SPC in the HRS-PRF determination process, offering

guidance about HRS-PRF inactivation. SPCs are required to use clinical consultation to assist in the inactivation decision-making process. Consultation may include any or all of the following groups:

- The Veteran’s treatment providers
- A dedicated facility-level HRS-PRF interdisciplinary committee that reviews PRFs per local protocol
- [Rocky Mountain MIRECC Suicide Risk Management Consultation Program](#)
- Another facility-level designated advisory group

Interdisciplinary HRS-PRF review committees should include any or all of the following:

- Clinical pharmacists
- Licensed professional counselors/marriage and family therapists
- Nurses
- Physicians/nurse practitioners/physician assistants
- Psychologists
- Social workers
- Chaplains

Facilities that implement advisory committees should follow all the policies, SOPs, and other guidance documents regulating facility-level committees, including such items as agendas, member participation, appointment of a committee chair, roll call, and minutes.

Suicide Postvention

Suicide postvention builds upon suicide prevention efforts and is a combination of activities intended to support those who have experienced loss or bereavement from the death of someone by suicide, including medical professionals, Veterans, and Veterans’ family members, friends, and co-workers.

Immediate family members, especially parents, siblings, and children, are at an increased risk for suicide following the death of a loved one. Comprehensive postvention efforts should include practices that are aimed to reduce risk for suicide and promote messages of healing and encouragement. SPCs should work with their facilities to determine how to meet this need.

Suicide loss also impacts the workplace. It is critical that facilities create a suicide postvention plan that includes support for employees affected by suicide, which in turn supports the workplace as a whole. Best practices include the formation of a facility-level Suicide Postvention Team.

A Suicide Postvention Team is an interdisciplinary team (e.g., social work, medicine, psychology, chaplaincy, peer support) trained in suicide postvention best practices. The Suicide Postvention Team provides immediate, short-term, and long-term support for family and providers following a suicide loss. The [Suicide Risk Management Consultation Program](#) is available to assist VHA leadership and employees with the suicide postvention process, including training and consultation on how to develop and implement a Suicide Postvention Team, how to execute best practice suicide postvention strategies, one-on-one support for provider suicide loss survivors, and identification of gaps within facility postvention efforts. For assistance, SPCs are advised to request a consult by emailing srmconsult@va.gov.

The Rocky Mountain MIRECC has also created [Uniting for Suicide Postvention](#), an online platform which features multimedia resources designed to promote open dialogue about suicide loss. The site is structured to

meet the needs of three groups of suicide loss survivors: community, health care providers, and workplace. The [UPSVM suicide prevention podcast series](#) also is a great resource on postvention activities and includes information on practices for the workplace and on legal and ethical considerations following suicide loss.

OMHSP has also created the [Guidance for Action Following a Suicide on a VA Campus](#), which outlines the steps facilities need to take after a suicide has occurred on any VA campus, including recommendations for postvention efforts and recommended consultation with Rocky Mountain MIRECC.

Appropriate documentation of postvention services must include both the type of service being provided and the audience receiving the service. The following provides situational guidance to assist with making these determinations.

- **Historical note:** It is appropriate and acceptable to document content in a Veteran's EHR after death. However, any documented content after the death of a Veteran must be historical with no creation of encounters. This is advised if most of the postvention work being provided does not rise to the level of an encounter. Examples include providing information and referral for community or VA resources or referring family members to a benefits counselor for survivor benefits.
- **Collateral record:** It is appropriate to use collateral records to provide brief counseling or psychotherapy specific to bereavement or other postvention services to collaterals, such as spouses, adult children, or parents of a Veteran who has died. There is no limit to the number of collateral records that may be created. However, it is advisable for the provider to identify a primary collateral rather than creating multiple collateral records that contain only one documented note. Before providing care to a collateral, the SPC must ensure the collateral has been determined eligible to receive services from VA as designated by the facility health benefits advisor.

Note: 38 U.S. Code § 1783 - Bereavement counseling allows VA to provide care to immediate family members of a Veteran who has died. Per [VA Policy Manual 01.1601D.07 Collateral Beneficiaries](#), a collateral is a person, related to or associated with a Veteran (spouse, family member including newborn, or significant other) receiving care from VA. The person does not have to be a family caregiver in order to be designated as a collateral patient. To document direct care and support provided to a collateral patient, a separate medical record for the collateral should be generated by enrolling with the health benefits advisor. Encounters are created in collateral records in the same manner as that of Veterans and are subject to all the same business rules. There is no co-pay or third-party billing for collateral visits.

- **No documentation:** Many of the tasks completed by VA staff members after the death of a Veteran by suicide, such as completion of the FIT-C and BHAP, Issue Briefs, RCAs, etc. are administrative in nature and, therefore, should not be included in the EHR.
- **Clinic or team-level documentation:** Postvention care provided to employees in a group setting should not be documented in the employees' EHR. If employees are individually seeking care through the Employee Assistance Program, are seeking care as Veterans instead of employees, or are seeking care through employee health, documentation should occur as appropriate to those types of care. Facilities should consider using de-identified record keeping that includes departments or numbers of employees attending sessions. Content should also include what was covered, such as services and resources discussed. This kind of documentation is ideal for any kind of formal postvention team or by facility and clinic leadership.

The [Tragedy Assistance Program for Survivors](#) (TAPS) offers postvention services to the family of any Service member or Veteran who has died by suicide. TAPS and the VA have a formal partnership outlined in a [memorandum](#) of understanding. VA employees may make direct referrals to TAPS for survivors of Veteran

suicide who have granted permission for the referral by contacting the TAPS Military Survivor Helpline. Services provided include:

- **TAPS Military Survivor Helpline:** 24/7 support at 800-959-TAPS (8277)
- **Survivor Care Team:** Outreach and engagement by TAPS staff, many of whom are survivors of suicide loss
- **National Peer Support Network:** Trained volunteers providing peer-based support
- **Suicide Survivor Seminar and Good Grief Camp:** Healing event for adults and children, held annually since 2009
- **Casework:** Assistance navigating benefits, burials, records, financial and legal issues, etc.
- **Online community:** Message boards, blogs, and chats moderated by TAPS staff
- **TAPS Magazine:** Quarterly articles about suicide by TAPS survivors, staff, and experts
- **Counseling referrals:** Connections to a network of grief and trauma specialists for adults and children
- **Resource kits:** Customized care packages of suicide-specific literature and other materials
- **Community resources:** Customized list of local support groups, grief centers, children's resources, etc.

Access and Referral

As subject matter experts of suicide prevention at the facility level, SPCs must be readily accessible to Veterans, their families, and facility members who are in contact with patients. This includes responding to Veterans Crisis Line (VCL) consults and all other referrals.

This responsibility comprises the following functions:

- Acting as the primary point of contact and subject matter expert for the facility's suicide prevention program
- Having a telephone line with voicemail that is provided directly to the VCL staff
- Responding to all VCL consults in the web-based application known as Medora
- Being highly accessible by making contact information available on the VCL local resource page, on facility intra- and internet sites, to all VA staff members who interact with patients, Veterans and their family members, and partners in the community
- Providing continued contact with and monitoring of Veterans who have been identified as being at high risk for suicide

Access

To ensure their names and contact information can be easily found by all, SPCs are responsible for performing the following activities:

- Reviewing the [Veterans Crisis Line local resource page](#) and facility websites to confirm that their information is accurately listed
- Establishing coverage plans that include out-of-office messages in Microsoft Outlook so that other facility members know who to contact during SPCs' absence

- Creating voicemail messages that meet the standard set in [\(AL15-03\) Revised Voicemail Greetings for VA Desk Phones and VA Cellphones Issued to Mental Health Staff Members](#) to immediately facilitate help for those who need it
 - Issued in August 2015, this alert replaces and supersedes the previous Patient Safety Advisory AD08-03 issued on July 7, 2008 and revised on May 2, 2011.

See [Appendix 5.1 VCL SPC Contact and Outlook Out-of-Office Reviews](#) for more information.

Telephone and Voicemail

SPCs are required to facilitate access to care for Veterans who come into the system from referrals. This includes having a telephone line with a voicemail that is provided directly to the VCL staff. SPCs are encouraged to work with VA's information technology staff to set up a dedicated external phone line that allows callers to bypass the automated phone system and receive direct access without having to enter extension numbers.

SPCs must ensure their voicemail messages are compliant with [VHA Patient Safety Alert AL15-03](#), which requires all mental health staff with assigned desk phones or cell phones that have active voicemails to include the following outgoing message:

Example 1, standard greeting: **“Hello. You have reached the phone of [insert name and title]. If you are having a medical or mental health emergency, hang up and dial 911. If you are having thoughts of suicide, please hang up and call 1-800-273-8255, then press 1 at the prompt to reach the Veterans Crisis Line. That number again is one, 800, two, seven, three, eight, two, five, five, and then press one for the Veterans Crisis Line. Otherwise, please leave a brief message and I will return your call when I am able during regular business hours.”**

Example 2, out-of-office greeting: **“Hello. You have reached the phone of [insert name and title]. If you are having a medical or mental health emergency, hang up and dial 911. If you are having thoughts of suicide, please hang up and call 1-800-273-8255, then press 1 at the prompt to reach the Veterans Crisis Line. That number again is one, 800, two, seven, three, eight, two, five, five, and then press one for the Veterans Crisis Line. I am out of the office, returning August 31st. I will not have access to voicemail. Please leave a brief message and I will return your call when I am back in the office.”**

Text that is bold is required in its entirety and without revision. Italicized text may be modified to fit the needs of the provider and/or facility.

Facility chief mental health officers, or facility equivalents, and patient safety managers are responsible for ensuring that all mental health staff members comply with this requirement. While staff members who do not have activated voicemails are not required to activate their voicemails, all future voicemail activations for mental health staff members require use of the aforementioned outgoing messages.

Mental health staff members, including SPCs, should not provide personal cell phone information to patients. If personal cell phone numbers have been given in the past, they must provide patients with the updated and appropriate VA contact numbers to meet department requirements.

Referrals

The ability to easily access SPCs promotes and facilitates referrals, which may come to SPCs from a variety of sources, including:

- VA S.A.V.E. training
- VA's webpages
- Veterans and family members
- VA employees
- Community partners
- Veterans Crisis Line

SPCs are responsible for responding to consults from the VCL consult system, as outlined in more detail below.

Veterans Crisis Line (VCL) Referrals

SPCs are responsible for managing consults from the VCL, a collaborative effort established in 2007 between VA and the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA) designed to connect Veterans in crisis with caring, qualified responders. As such, SPCs should be familiar with [VeteransCrisisLine.net](https://www.veteranscrisisline.net) and understand how the crisis line operates.

Veterans, active duty Service members, and their loved ones can call the National Suicide Prevention Hotline at 1-800-273-TALK (8255) and press 1 for the VCL. In addition to calling, Veterans have the option of engaging in the online chat through [VeteransCrisisLine.net](https://www.veteranscrisisline.net) or texting to 838255. From here, Veterans can access confidential support and referrals if they are in crisis or having thoughts of suicide. VA employees staff the crisis line 24 hours a day, seven days a week, and during all holidays. Veterans that call will receive immediate, confidential assistance to ensure that they remain safe.

Consults sent by VCL are triaged as being emergent, urgent, or routine. This designation is determined by VCL call responders and is not intended to require specific action on the part of the SPC. In general, consults should be managed in the order they were placed to ensure all consults are responded to in a timely manner.

- **Emergent Consult.** An Emergent Consult is submitted by a VCL Responder when emergency services are dispatched to a medical or mental health emergency, or when a customer presents as an imminent threat to self or others.
- **Urgent Consult.** An Urgent Consult is submitted by a VCL responder when a customer agrees to present to a treating medical facility without an appointment and without the assistance of emergency services. *Note: The treating medical facility may be a non-VA medical facility.*
- **Routine Consult.** A Routine Consult is submitted by a VCL responder for non-urgent or non-emergent calls that require follow-up with the customer for reasons such as suicide ideation, depression, mental health issues, or other concerns.

Regardless of the type and level of triage designated for received consults, VCL responders are expected to document each call in the web-based application known as [Medora](https://www.medora.va.gov) and initiate consults to SPCs when

necessary and as requested by Veteran callers. SPCs are granted access to Medora using the same login information they use for the Computerized Patient Record System (CPRS) and VistA. SPCs should contact vhavclcacteam@va.gov if they need assistance gaining access to Medora or if they experience technical issues with the application.

For Veterans who request a referral, VCL responders will refer them to the SPC at their nearest VA medical center and send a consult through Medora. Responders will also place consults for all callers who receive emergent interventions, regardless of whether the Veteran requests a consult. The SPC will then assist Veterans with enrollment and follow their progress through each step of evaluation and treatment. Veterans ineligible for VA services or who decline services from VA are referred to community-based centers in their area. Veterans who choose to remain anonymous can also request consults to non-VA service centers within their local communities. For non-Veterans who do not require immediate rescue services, call responders may provide a warm transfer to the [National Suicide Prevention Hotline](#).

SPCs are required to coordinate with the local Office of Information and Technology (OIT) to obtain a secure voicemail-enabled telephone line that is provided directly to VCL staff. Urgent and Emergent Consults sent to the local SPC by the VCL responder will have a detailed voicemail and email from the VCL to ensure coordination of care. SPCs are further required to provide and ensure ongoing maintenance of contact information of current SPCs to the VCL in order to facilitate communication with VCL responders. SPCs may opt out of receiving telephone messages for routine consults by contacting [VHA VCL CAC TEAM](#). Each facility has its own email group to allow VCL call responders to quickly and easily communicate with SPCs. This email group does not have a reply option and is used as a one-way communication tool to support the VCL. To add or remove members from this group email, SPCs are advised to contact Kim Woehr at Kimberly.Woehr@va.gov for assistance. From there, they are required to process all consults through Medora, which involves performing the following functions:

- Regularly logging into the Medora application to view a list of new and outstanding consults
- Responding to all VCL consults within one business day or no later than close of business the following business day for any consults that take place over the weekend or on federal holidays
 - Updating the consult status of the pending consult (via quick save)
- Making three separate attempts to contact referred customers on three consecutive business days and one by mail
 - All attempts at contact should be documented in Medora with the date, time, and person responsible.
- Assisting customers with the enrollment process should they choose to seek VA care services
- Facilitating the resolution of the customer's needs identified in the consult and reassessing the customer for any potential risk
- Making consults to care team members as appropriate
- Closing the consult in Medora once customers have been reached or after attempting contact three times, while ensuring consults in Medora are closed and completed within three business days of receiving the consult including:
 - Filling out information for the sections "contact," "action taken/planned," and "Veteran response" (See [VHA Directive 1503 Appendix B, Suicide Prevention Coordinator Consult Closing and Quality Assurance Indicator](#))
 - Documenting detailed information about what actions have been taken to resolve issues identified in the consult
 - Providing appropriate follow-up to customers as clinically indicated and documenting such care in the EHR, even after consults have been closed in Medora
- Populating the consult in the EHR if Veterans are enrolled in VA care, utilizing and signing the EHR-templated "Veterans Crisis Line Note"

- This should occur if Veterans have any kind of record in the EHR, regardless of whether they are actively receiving care.

Notes About Veterans Crisis Line Consults

- **Veterans Crisis Line Consult View:** [VHA Memorandum 2019-07-32, Revised Access to Veterans Crisis Line Medora Application for Clinical Providers](#) added a new “view” to CPRS under the Tools tab. Historically, only SPCs have been able to view VCL consults in the Medora application until the closed consult is populated into CPRS. To improve safety and coordination of care, clinical providers with access to CPRS will now be able to view Medora consults for Veterans. Instructions for adding this new tool to CPRS were sent to clinical application coordinators. SPCs should assist their facilities with ensuring clinical providers have the consult view access.
- **Anonymous Callers:** Callers to the VCL can request assistance without providing their name or other contact information. In those instances, VCL responders will assist callers to the best of their ability. Anonymous callers needing further assistance may also be referred through Medora as a consult. SPCs are required to assist to the extent they are able.
- **Calls Without a Consult:** As part of their access and referral responsibilities, SPCs are expected to respond to “cold calls” and assist those callers to the fullest extent possible. In all instances, callers are provided contact information for SPCs and may reach out to them directly. This includes:
 - Contact from third-party members who reach out to SPCs on behalf of Veterans. In these instances, VCL consults will not be sent to SPCs in Medora.
 - Callers who refuse a consult with SPCs
- **Callers with Complex Needs (High Frequency):** Veterans may contact the VCL for a variety of reasons, including to combat feelings of loneliness. These Veterans may contact the VCL several times a week or even daily. When a consult is placed, SPCs are required to respond in the same manner as all other consults received from the VCL. To assist, the VCL has a clinical care coordinator team ready to consult and help facility SPCs with managing these high-frequency callers. They may be contacted through the email group [VHACAN VCL Clinical Care Coordinators](#).
- **Active-Duty Service Members:** In cases where VCL consults are sent to SPCs related to active-duty Service members, SPCs should return those consults to the VCL. The VCL will be referring those consults to Military One Source if routine and to the [inTransition Program](#) if urgent or emergent. inTransition, under the umbrella of the [Psychological Health Center of Excellence \(PHCoE\)](#), is a free, confidential program that offers specialized coaching and assistance for active-duty Service members, National Guard members, reservists, veterans and retirees who need access to mental health care.
- **International Calls:** In cases where VCL consults are sent to SPCs from Veterans who are located outside of the United States, SPCs should contact the [inTransition Program](#) at 1-800-424-7877. SPCs should provide all consult information to inTransition staff and they will complete outreach to the Veteran. SPCs should document this referral in the Medora application and populate the consult in the EHR as with any other consult.

Additional resources can be found in the [Medora Folder](#) on SharePoint or within this [SPC Crisis Center Response Training](#) tutorial.

See [Appendix 5.2 How-To for Medora/Crisis Line Consults](#) for further information.

Vets Prevail

[Prevail Health Solutions](#) has contracted with the Veterans Health Administration under a series of National Science Foundation grants that provided the groundwork for the Vets PrevailSM program. Vets Prevail (www.vetsprevail.org) is an innovative, online mental health tool that is tailored specifically to help Veterans ease their transition into life after military service. It specifically addresses re-adjustment challenges post-deployment. The program facilitates engagement by tailoring interactions to the individual and its content is rooted in Cognitive Behavioral Therapy, the standard of care for treatment of symptoms related to PTSD and depression. The program includes interactive multimedia e-learning lessons, peer support by other Veterans, and diagnostic self-assessments. Vets Prevail was developed through the collaboration of mental health researchers and clinicians at top universities and hospitals with the backing of the National Science Foundation and The McCormick Foundation.

As part of its programming, users may be routed to established resources within VHA, including directly to SPCs. As part of a Referral Wizard, the user is allowed to manually request assistance via direct referral, or the user is linked automatically through the assessment tool. Once either path opens the Referral Wizard, the user can link with a “VHA Health Coordinator.” In this case, the VHA health coordinator is a SPC. The Referral Wizard allows the user to search by zip code for the closest SPC using the search function of the Veterans Crisis Line Resource Locator. Users of Vets Prevail may remain anonymous until they request this referral. They are only required to enter their first name and a phone number where they can be reached. The user is provided with the name and phone number of the SPC. If the user chooses, they may initiate an email introduction to the SPC, providing the SPC with their first name and phone number. Once the SPC receives an email from the Vets Prevail Referral Wizard, the SPC is required to reach out to the user via telephone and assist as appropriate with linkage to VA resources.

In 2016 and 2017, Vets Prevail users had the following characteristics:

87%	Were not receiving VA MH care
58%	Lived in a rural area
53%	Were on a mobile device
26%	Were female
70%	Were using, or planned to use, the Veterans Choice program

The Vets Prevail user will receive the following message:

Dear Sara,

It's important to understand that, for privacy and security reasons, the VHA coordinators are not allowed to communicate with you through email.

We are passing through your number, so you can expect to be given a call by Michelle or another member of the local team soon.

The SPC will receive the following message:

A member of Vets Prevail in your area has agreed that speaking with a care coordinator to discuss options within the VHA would make sense.

Sara's phone number is 312-555-1212. Please have a member of the local SPC team give this number a call.

Thank you for the work you do, and please hit reply to...

1. The SPC should reply to the email alerting Vets Prevail staff they have received the referral.
2. The SPC should reach out to the user by using the telephone number provided in the email.
3. Efforts to contact the user should be made like any other cold referral to the SPC. The SPC should assist the user to the extent the SPC is able and refer to resources as appropriate.
4. If the user is revealed to have an active chart in the EHR, the SPC should document in the Veteran's EHR like any other phone call.

Outreach and Awareness

SPCs are responsible for conducting a variety of outreach initiatives designed to increase awareness of suicide prevention best practices. Among these responsibilities, SPCs are expected to improve the public's understanding and knowledge of suicide risk factors, military culture, lethal means safety, and the accessibility of available resources, such as the Veterans Crisis Line (VCL).

This responsibility comprises the following functions:

- Delivering at least five community outreach activities per month, including at least one community edition of VA S.A.V.E. training
- Sending Veterans personalized mailings and entering mail contact program information in the Suicide Prevention Application Network (SPAN) on a monthly basis (See [Appendix 6.1 Guidance for Entering Outreach into SPAN](#))
- Building partnerships and coalitions with stakeholders, nontraditional partners, and other community organizations to encourage the widespread adoption of suicide prevention best practices among Veterans, their families, and communities
- Providing educational activities for staff members and Veteran patients throughout the year and especially during Suicide Prevention Month (SPM) in September
- Working with local public affairs officers (PAOs) and members of the media to promote safe messaging and increase awareness of suicide prevention, intervention, and postvention best practices

Monthly Outreach Requirements

To uncover additional touch points in the community and increase VA's proactive measures to reach Veterans, SPCs are required to perform at least five community outreach activities per month. (Please remember that all outreach activities should be entered into SPAN – see [Appendix 6.1 Guidance for Entering Outreach into SPAN](#) for detailed guidance) These activities are separated into the following two event categories:

- **Veteran-Specific:** Events where the intended and invited audience comprises Veterans
 - Even if family members or friends attend with or instead of the Veteran, all events intended for Veteran audiences are deemed to be “Veteran-specific.”
- **Community-Specific:** Events anyone in the community may attend and the intended audience is not specific to Veterans
 - At this type of event, SPCs may or may not be aware of someone’s Veteran status and must act knowing that Veterans may choose not to self-identify.

In addition to audience targeted, SPCs’ outreach responsibilities are also divided into the specific types of intervention being provided. In total, there are five types of outreach interventions, which are outlined below:

- **Trainings:** Any prescheduled lectures designed to provide specific information on suicide prevention
 - These may take place out in the community or at facilities, but do not include courses that SPCs attend (even if they networked at the event), courses provided to Veterans at facilities, or courses provided to VA staff members.
- **Awareness Tables:** Designated and staffed tables that are clearly identified as promoting suicide prevention best practices at events, such as conferences, fairs, or any occasion where the SPC is both an attendee and a staffer at the table
 - Types of materials provided may vary, but are not limited to VCL information, *#BeThere* campaign materials, information on VA care eligibility and mental health services, and educational pieces on topics such as lethal means safety and symptoms of suicide
- **Mailings:** Providing letters to high-risk or formerly high-risk Veterans as part of the Caring Communication Program or sending communications materials to potential or previously established community partners
 - Mailings to Veterans may include caring letters, notification of placement or removal of HRS-PRFs, birthday cards, holiday greetings, and educational flyers.
 - Mailings to community members may include campaigns and outreach attempts to acquire new partners.
- **Partnerships and Coalition Building:** Any meeting or face-to-face interaction with one or more community organization working toward preventing suicide
 - This may include participating in community-wide suicide prevention event planning meetings and building coalitions within communities.
- **Media and Marketing:** Any medium that uses or responds to information about suicide or promotes a specified message to the public about this topic
 - This may include participating in interviews, promoting content on social media platforms, such as Facebook Live, and marketing campaigns on billboards, elevator wraps, and buses.

Training

SPCs are required to provide at least one VA S.A.V.E. training session to community members each month. This responsibility comprises the following components:

- Delivering the community version of VA S.A.V.E. training to community organizations that have contact with Veterans and their families
- Ensuring that all new Mental Health Residential Rehabilitation Treatment Program (MH RRTP) residents receive VA S.A.V.E. (or other approved gatekeeper training) within seven days of admission to the program
- Disseminating resources on suicide prevention, such as the [Clinician’s Guide to Safety Planning](#) and the [VA/Department of Defense Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide](#)

Awareness Tables

SPCs’ outreach responsibilities include staffing awareness tables at events that are clearly identified as promoting suicide prevention by the VA. These events may include conferences, fairs, and entertainment venues. The type of materials SPCs may choose to include as part of their awareness-building efforts can vary but often include promotional materials about the VCL and gun locks.

Outreach and Promotional Materials

Facilities have the option to receive shipments of promotional materials, such as stress balls, pillboxes, key chains, and magnets, that promote the VCL, *#BeThere*, and *Make the Connection*. These are typically sent to facilities on a quarterly basis and in bulk. SPCs should also consider working with facilities as needed to supplement promotional materials through local funds. In addition, during Suicide Prevention Month, OMHSP usually offers funds that can be used to supplement the purchase of promotional materials.

To request or share specific items, SPCs are invited to use the [VHA OMHSP Suicide Prevention Coordinators Email Group](#) to connect with other facilities. For shipment information, SPCs can contact Corey Terhune at Corey.Terhune@va.gov.

In managing the use of all promotional materials, SPCs are responsible for:

- Assigning points of contact for receipt of shipments
- Sharing items with other ancillary facilities and programs within the health care system, including Community-Based Outpatient Clinics (CBOC), Vet Centers, VA’s Homeless Program, Veterans Benefits Administration (VBA), and the National Cemetery Administration (NCA)
- Supplying outreach events with promotional materials as appropriate and planning for events that may require particularly large quantities of items
- Notifying facilities when shipments are arriving and making sure those facilities have ample space and ability to receive promotional items

SPCs are expected to be fiscally responsible when managing promotional materials. The overarching message of outreach is to provide information about seeking assistance, primarily through the VCL. Tips for managing materials include:

- Reviewing scheduled events and parcel materials ahead of those events
- Maintaining a supply of materials for VA staff to provide to Veterans seeking care at facilities, including stress balls, pillboxes, and wallet cards that include the VCL number, text, and/or chat information

- Conscientiously managing supplies by placing small quantities of items on the awareness tables and slowly replacing them as the supply runs low
- Starting conversations with individuals about their Veteran status and deliberately connecting with Veterans to hand out materials

The [VCL Shareable Materials](#) section of VeteransCrisisLine.net and [VA Suicide Prevention Resources – Start the Conversation](#) include a number of resources that can be downloaded and printed. SPCs should work with local VA facilities to print materials and refer community agencies to download and print materials.

See [Appendix 2.2 Email Review How-To](#) for “VHA OMHSP Suicide Prevention Coordinator” Group for specific guidance on messaging the SPC email group.

Gun Locks

In addition to sharing promotional materials, SPCs should promote lethal means safety education and interventions to Veterans, their families, and their communities as part of their outreach efforts. This includes educating audiences on safe storage practices, including using gun locks. (See [Lethal Means Safety Counseling](#) section for further information.)

SPCs may request gunlocks by contacting [Corey Terhune](#). SPCs are in charge of dispersing gun locks to all VA health care centers, including CBOCs, inpatient units, residential settings, and primary care settings within the catchment areas. Facilities should be cognizant of the amount of local storage space needed for maintaining gun locks on campus and request supplies accordingly. Although priority for distribution should be given to VA staff members, who can keep gun locks for Veterans that request them, VA will attempt to accommodate all requests for gun locks to the extent that funding and availability permit. Community partners requesting gun locks should be referred directly to Corey.Terhune@va.gov. SPCs may also consider referring non-VA partners to local law enforcement agencies or [Project ChildSafe](#), a National Shooting Sports Foundation program that provides free firearm safety kits.

When discussing lethal means safety, SPCs should respect military culture and Veteran sentiments toward firearms. It is important that SPCs do not give the appearance that VA is attempting to stifle or infringe on Veterans’ rights to own and use firearms. Thus, SPCs should only provide gun locks to Veterans who explicitly request or agree to have one. Similarly, if SPCs create bags of promotional items to provide at events, gun locks should not be included as part of the contents, as this would be an unsolicited receipt of a gun lock. Decisions or actions taken specific to individual Veterans’ access to firearms should be made in clinical settings and not at outreach events.

Facilities are prohibited from using gun locks as a locking mechanism for patient or staff lockers, bicycles, or any other non-firearm related use. As the point of contact for gun locks, SPCs are responsible for ensuring facilities comply.

Mailings

SPCs are required to maintain communication with Veterans via the Caring Communication Program following Veterans’ hospitalization or placement on the High-Risk Suicide List (HRSL). Regular, personalized notes sent through the U.S. Postal Service contribute to SPCs’ outreach requirements, although ongoing correspondence does not.

SPCs may also choose to send mailings to community partners that promote Suicide Prevention Month (SPM) and other suicide prevention-related events. They may also use this opportunity to share updates with existing partners or seek new members for coalition building.

Mailings should only be entered into SPAN *once per month* for Veterans and once per month for community partners. SPCs should enter the total number of mailings sent over the course of the month.

Partnerships and Coalition Building

In addition to leveraging the partnerships established by VA's national office (see [Appendix 6.2 Partnership Summary](#)), SPCs are encouraged to create and nurture relationships with a variety of stakeholders to uncover additional and more frequent touch points with Veterans. These may include stakeholders internal to VA and those in the community.

As part of their commitment to partner with internal VA stakeholders, SPCs should be resources for when others are managing the care of Veterans at risk for suicide. In building these types of partnerships, SPCs are encouraged to promote awareness and understanding of suicide prevention efforts taking place at the facility level and promote tools, such as the [Suicide Behavior Overdose Report \(SBOR\)](#) and the [Comprehensive Suicide Risk Evaluation \(CSRE\)](#). SPCs should also link and disseminate important suicide prevention resources to facility staff members, including:

- [VA Suicide Safety Planning Manual](#)
- [VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide](#)
- [VA Suicide Risk Identification Strategy and Management](#)
- [VA Make the Connection](#)
- [Rocky Mountain MIRECC for Veteran Suicide Prevention Resources](#)

VA internal stakeholders and partners may include:

- Chaplain Services
- Transition and Care Management (TCM) coordinators
- Patient Safety Managers (PSM)
- Health Care for Homeless Veterans (HCHV) coordinators
- Military sexual trauma (MST) coordinators
- LGBTQ coordinators
- Caregiver Support coordinators
- Members of the Women Veterans Program
- Local Vet centers
- Residential care teams
- Local mental health teams
- Volunteer Services
- Canteen Services
- Veterans Benefits Administration (VBA)
- National Cemetery Administration (NCA)

SPCs are also expected to develop relationships with external partners. Traditionally, outreach activities for external partners have been predominantly Veteran-centric, such as Veteran service organizations (VSOs). However, with the implementation of the public health approach, SPCs are encouraged to extend their outreach activities to include a broader base within the community. This may include facilitating coalitions and encouraging participation from state and local suicide prevention organizations, local crisis line groups, city, county and state government agencies, faith-based groups, school employees, first responders, financial institutions, and many others.

Some partnership-related activities include:

- Crafting blog posts for internal and external audiences that discuss the accomplishments of partner organizations
- Inviting organizations to have tables or speak at VA events
- Providing access to subject matter experts and data (if the memorandum of understanding permits)
- Disseminating information on the health care needs of Veterans, the Veteran experience, and the navigation of VHA
- Sharing community-focused toolkits, such as:
 - [A Toolkit for Safe Firearm Storage in Your Community](#)
 - [Community Outreach Toolkit](#)
 - [Community Provider Toolkit](#)
 - [VA Suicide Prevention Toolkit for Caregivers](#)

Media and Marketing

To foster the safe and accurate reporting of suicides, SPCs are expected to work with public affairs officers (PAOs) to provide subject matter expertise on both safe messaging and suicide prevention best practices. Serving as secondary media contacts and technical experts for media interviews, SPCs should feel empowered to not only work with the media to provide positive stories of hope and recovery, but also collaborate with their PAOs to request editorial revisions when reporters use inaccurate or inappropriate language.

As part of their media outreach responsibilities, SPCs will be held accountable for:

- Fostering awareness and promoting safe messaging around suicide
- Establishing relationships with facility PAOs for:
 - Social media — notifying PAOs of public events and activities that promote positive messages
 - Interviews — working with PAOs to prepare for and engage in interviews, while seeking opportunities to spotlight local prevention efforts
 - Monthly leadership toolkit — consulting with PAOs regarding the *Be There* Suicide Prevention Communications Toolkit to promote suicide prevention messages from the top-down
 - Negative media events — consulting with PAOs and facility leadership on how to manage negative media events if or when they arise

While working with their PAOs, SPCs should also help ensure that reporters use general best practices for reporting on suicide as stated in reportingonsuicide.org. These safe messaging best practices include:

- Avoiding misinformation and the use of terms such as “commit suicide,” “successful/unsuccessful suicide,” and “failed suicide attempt”

- Acknowledging that suicide is a complex issue and that there are usually multiple causes for a death by suicide
- Reporting on suicide as a public health issue
- Helping to provide information on risks and treatment of suicidality or connect the media to other colleagues who are suicide prevention experts, such as researchers or mental health professionals
- Reinforcing the fact that treatment works, and recovery is possible
- Providing readily accessible suicide prevention resources, including the VCL

To assist SPCs, facility directors and PAOs, OMHSP has several resources including the [Suicide Prevention Social Media Safety Toolkit](#) and the [Safe Messaging Best Practices](#) Factsheet.

Be There Campaign

Be There is a VA-developed campaign used to raise awareness about mental health and suicide prevention. Using integrated channels, such as paid media, billboards, and more, VA uses this campaign to educate Veterans and their families and community stakeholders about the suicide prevention resources available to them while promoting shared responsibility among everyone to ***Be There*** for Veterans.

The goal of the ***Be There*** campaign is to ensure that members of Veteran support systems understand how they can provide help and support. SPCs should understand how the ***Be There*** campaign supports Veterans and how they can help further facilitate this important message. They should promote the ***Be There*** campaign by sharing its resources and messages with Veterans and facility members.

Suicide Prevention Month (SPM)

SPM is an annual campaign that takes place every September and aims to inform and engage the general public about suicide risk and prevention practices. As part of VA's SPM efforts, SPCs are encouraged to leverage the national attention given to this campaign to increase facility and public awareness on mental health and suicide prevention.

In support of SPM, SPCs are responsible for planning and hosting activities at their facilities and in their catchment areas that promote awareness and education on suicide prevention best practices.

These activities may include:

- Setting up displays, exhibits, or awareness tables around the community
- Facilitating Facebook Live events to educate the public on risk factors and warning signs of suicide
- Encouraging facility and community participation in campaign walks or challenges
- Promoting content on social media, through interviews, with press releases, and via public service announcements
- Sharing the message with all divisions of the health care system and in the community to reach as broad of an audience as possible

SPCs should notify the National Suicide Prevention Program by contacting [VHA OMHSP SPP Field Operations](#) or [VHA OMHSP SP ACTIONS](#) if large-scale events are being planned that may significantly increase VCL call volume.

See [Appendix 6.1 Guidance for Entering Outreach into SPAN](#) for further instructions.

Education and Training

As mandated by the [VHA Directive 1071, Mandatory Suicide Risk and Intervention Training for VHA Employees](#) and [VHA Memorandum 2017-04-28, Suicide Awareness Training](#), all department arms of VA must be fully trained and able to respond to Veterans at risk for suicide. As suicide prevention subject matter experts at their facilities, SPCs are responsible for training both clinical and nonclinical staff on how to identify and respond to Veterans who are at elevated risk for suicide.

This responsibility comprises the following functions:

- Identifying suicide prevention training needs for facility staff members and confirming all required training is documented in the VA Talent Management System (TMS)
- Providing all staff members who have contact with patients, including clerks, schedulers, and administrative staff, with training on how to get immediate help when Veterans express intent or plan for attempting suicide
- Delivering other types of training programs, such as lethal means counseling or suicide risk evaluation, as requested by facility leadership
- Ensuring that all new Mental Health Residential Rehabilitation Treatment Program (MH RRTP) residents have taken suicide prevention gatekeeper training, modified VA S.A.V.E. training, or ACE training within seven days of admission into the program as mandated by [VHA Memorandum 2013-11-01, Improving the Culture of Safety in Mental Health Residential Rehabilitation Treatment Programs](#)
- Delivering the community version of VA S.A.V.E. training to community organizations that have contact with Veterans

Gatekeeper Training

One part of VA's suicide prevention strategy is early identification of Veterans who may be at risk for suicide. Gatekeeper training is part of screening and consists of educating family members, friends, and co-workers about the risk factors and warning signs for suicide and how to respond appropriately by connecting Veterans in crisis with the most appropriate sources of care. Within VA, gatekeepers consist of the many nonclinical support staff who have contact with Veterans and their families, such as schedulers, laboratory and pharmacy technicians, food service workers, and telephone operators. Gatekeeper training is part of VA's comprehensive approach to suicide prevention.

VA S.A.V.E. Training

VA S.A.V.E. training is a one-hour gatekeeper training program SPCs provide to Veterans and those who serve them. Developed by the VISN 2 Center of Excellence (CoE) for Suicide Prevention, VA S.A.V.E. training highlights facts about suicide within the Veteran population, dispels suicide myths, and counteracts misinformation. It also provides an overview of warning signs and risk factors for suicide and details the components of the VA S.A.V.E. model, which are:

- Signs of suicide
- Asking about suicide
- Validating feelings
- Encouraging help and Expediting treatment

SPCs are responsible for ensuring that all nonclinical staff members receive VA S.A.V.E. training within 90 days of enter on duty date (EOD) and annually thereafter. SPCs must provide this initial VA S.A.V.E. training during new employee orientations (NEOs) and should be granted a minimum of 60 minutes during NEO. SPCs should work with facility human resources and/or education departments to facilitate this training.

Information about the annual VA S.A.V.E. Refresher training and the VA S.A.V.E. Enduring Training, for new employees who miss face-to-face training, can be found below.

Item No.	Active Dates in TMS for CEUs	Course Name
VA 30535	Sept. 20, 2016 – Sept. 20, 2021	S.A.V.E. Refresher Training
VA 33770	N/A	S.A.V.E. Training for Employees Enduring Revision

See [Appendix 7.1 S.A.V.E. A Trainer’s Guide](#) or the VA [S.A.V.E. Training folder](#) on the SPC SharePoint for supporting materials. The Trainer’s Guide in the appendix includes a direct link to the PowerPoint slide deck.

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

Residents of Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) have been identified as an especially vulnerable population for death by suicide. To promote safety and encourage help-seeking behaviors, all patients admitted to MH RRTP are required to receive suicide prevention gatekeeper training within seven days of admission to the program. SPCs are responsible for ensuring this training has occurred, training identified facilitators who will provide the training, being available as a subject matter expert to the facilitator, and assisting facilities with identifying additional employees who can provide this training.

Gatekeeper training may include:

- Modified VA S.A.V.E. training
- VA ACE training

Homeless Veterans Program

To ensure suicide prevention is integrated within the VA Homeless Veterans Program, VA released the [10N VHA Memorandum 2018-06-07, Veterans Affairs Medical Center \(VAMC\) Homeless Program Integration With Suicide Prevention Efforts \(VIEW# 00062182\)](#), which mandates that each of its medical centers identify at least one member from the facility homeless program to also become a VA S.A.V.E. trainer.

This integration is designed to increase VA medical centers’ abilities to expand gatekeeper training opportunities within the community and especially within this vulnerable population. As part of their education and training responsibilities, SPCs are expected to assist homeless program coordinators with ensuring that staff members are trained and knowledgeable of appropriate suicide prevention resources. To assist homeless program staff in this effort, the VHA Homeless Program Office has links to the VA S.A.V.E. Trainers Guide and PowerPoint slide deck in its [VHA Homeless Programs Hub](#) library.

Skills Training for Evaluation and Management of Suicide

In April 2020, the VA web-based Suicide Risk Management Training for Clinicians course reached its sunset date and was replaced with the newly developed Skills Training for Evaluation and Management of Suicide (STEMS). The new training was developed to facilitate use of the [VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide](#) into the development of clinical skills for suicide risk assessment and management. Topical discussions include:

- Engaging Veterans in a discussion about suicide risk
- Assessing for and determining the level of acute and chronic suicide risk
- Effectively implementing a treatment plan to manage acute and chronic suicide risk

Through use of supporting information and micro-simulations, this knowledge-based course addresses practice gaps by providing training to health care providers — including mental health physicians (medical doctors and doctors of osteopathic medicine), nonphysician health care staff (physician assistants and health care professionals other than physicians), nurse practitioners, clinical nurse specialists, psychologists, social workers, and counselors.

[VHA Memorandum 2021-10-12, Agency-Wide Required Suicide Prevention Training](#) updates VHA Directive 1071, Mandatory Suicide Risk and Intervention Training for VHA Employees with the STEMS course. Facilities must ensure all health care providers complete suicide risk management training within 90 days of EOD and annually thereafter. SPCs will need to work with their facility’s TMS administrators and human resources staff to ensure staff members are assigned the correct training. The training serves as *both* the initial and annual requirement and is available in TMS as listed below.

Item No.	Course Name
VA 39351	Skills Training for Evaluation and Management of Suicide (STEMS)

Trainees are exempt from suicide prevention training requirements but are encouraged to complete this training as part of their overall education experience within VHA.

See [Appendix 7.2 Suicide Prevention Training Available on TMS](#) for further training opportunities.

National Initiatives to Enhance Suicide Prevention

As it is clear that suicide prevention is everybody's business, the Suicide Prevention Program in the Office of Mental Health and Suicide Prevention has collaborated with partners and stakeholders throughout VHA health care systems to enhance awareness, provide resources, and engage providers and staff in lifesaving suicide prevention activities. VA has developed a predictive analytics program to identify and engage more Veterans at risk for suicide, standardized its universal screening and evaluation processes, and enhanced the provision of evidenced-based care to Veterans identified as at risk in emergency room and urgent care settings. REACH VET, Risk ID, and Safety Planning in the Emergency Department, described below, engage facilities broadly to ensure that suicide prevention is everybody's business.

SPCs should be knowledgeable about the many companion initiatives VA is supporting. Management of these initiatives is not a requirement of SPCs. However, as the facility SMEs for suicide prevention, SPCs should be familiar with their requirements and able to assist their facilities with consultation. What follows is an overview of these initiatives. (See [Appendix 8.0 Suicide Prevention Technical Assistance](#) for information about technical assistance, including contact information, FAQs, and support calls.)

REACH VET (Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment)

In September 2016, VA implemented a predictive analytics program called **REACH VET**, or **Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment**. Supported by the Rocky Mountain MIRECC for Suicide Prevention and detailed in [VHA Memorandum 2016-08-10, REACH VET: Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment](#), this program uses statistical modeling to calculate and identify Veterans who are in the top 0.1% of the VHA population (approximately 6,000 Veterans across VA) for suicide risk (i.e., Veterans who have 43 times the calculated risk for suicide over one month and 16 times the calculated risk for suicide over the course of one year).

REACH VET acts as an early alert system, allowing VA to provide Veterans with enhanced care services that will maximize their health and well-being. Leveraging the data from Veteran EHRs, this model calculates the names of identified Veterans who remain in the top 0.1% on a monthly basis. Some of these Veterans may have already been identified as being at increased risk for suicide through clinical assessment, such as those with HRS-PRFs. Others may have never experienced symptoms or warning signs related to suicidal behaviors. In addition to being at increased risk for suicide, these Veterans are identified as having an increased risk for other adverse outcomes, such as accidental overdose, injuries, or medical illnesses.

Once Veterans have been identified through REACH VET, clinical providers are required to complete chart reviews to identify the care and potential gaps in care Veterans are receiving. In doing so, providers should pay special attention to screening evaluations for mental health conditions, as well as health and risk factors. Although there is no prescriptive requirement for providing specific types of enhanced care, providers are encouraged to consider the following actions for at-risk Veterans:

- Enhanced communication through caring letters
- Safety planning
- Increased monitoring for stressful life events
- Interventions designed to enhance coping skills

Providers are also required to acquaint Veterans with the REACH VET model, notify them of their increased risk status, and emphasize a discussion of potential enhanced care. They are also expected to discuss Veterans' access to care and their perceptions to determine whether current levels of care are adequately meeting Veterans' needs.

Each facility is required to have at least one identified REACH VET coordinator to oversee their facility list and train employees in using the program. For a full list of identified REACH VET coordinators, review the [Master REACH VET Coordinator list](#).

Training materials and resources are available on the [REACH VET SharePoint site](#). REACH VET also has its own [patient tracking report](#) and regularly scheduled technical assistance phone call. For more information and assistance, including the need to modify facility-identified REACH VET coordinator(s), facility staff are advised to contact VHAREACHVETsupport@va.gov.

Suicide Risk Identification Strategy

In May 2018, VA adopted the Suicide Risk Identification Strategy to implement standardized, evidence-based screenings for suicide risk, as well as structured methods for the subsequent evaluation of those who screen positive for risk for suicide.

The Suicide Risk Identification Strategy includes a two-stage process that involves screening all Veterans who receive VHA care. Annual screening is facilitated through the clinical reminder system through use of the Columbia-Suicide Severity Rating Scale (C-SSRS) Screener. A positive C-SSRS requires completion of a more detailed suicide risk assessment. An overview of the screening process is as follows:

- **Columbia Suicide Severity Rating Scale (C-SSRS) Screener:** Includes specific questioning about suicidal ideation, planning, and intent and a history of suicidal behaviors
- **VA Comprehensive Suicide Risk Evaluation (CSRE):** Informs clinical impressions about acute and chronic risk, as well as associated dispositions

Facilities are required to identify a Risk ID Facility Champion or point of contact to assist facilities with implementing Risk ID elements. A full list of [Risk ID Facility Champions](#) may be found on the Suicide Risk Identification and Management SharePoint site.

Training materials and resources are available on the [Suicide Risk Identification and Management – Risk ID Resources webpage](#). Risk ID also has its own [tracking report](#) and regularly scheduled technical assistance phone call. For more information and assistance, including the need to modify facility-identified Risk ID Facility Champion(s), SPCs and facility staff are advised to contact VHAECHRiskIDSupport@va.gov.

For more resources and information about the Suicide Risk Identification Strategy, SPCs are advised to navigate to the internal [Suicide Risk Identification and Management – Risk ID Resources webpage](#), which includes the following resources:

- Weekly technical assistance calls, including recordings and presentation materials from previous calls, on Thursdays at 2 p.m. Eastern Time; email VHAECHRiskIDSupport@va.gov to request a call invitation

- Setting- and Staff-Specific Guidance
- List of Risk ID Facility Champions
- Risk ID FAQ
- TA Call Presentation slide decks and recordings
- Paper copies of the screening instruments and the CSRE
- VHA memorandums supporting implementation
- Risk ID supporting research
- Lethal Means Safety
- Risk ID Standard Operating Procedure sample

SPCs may also take the TMS training courses listed below to gain additional insight.

Item No.	Course Name
VA 36829	Suicide Risk Screening and Assessment ID Overview Session Recording
VA 36816	Suicide Risk Screening and Assessment ID Primary and Secondary Screening Tools Recording
VA 39430	Suicide Risk Screening and Assessment ID Comprehensive Suicide Risk Evaluation (CSRE) Recording

Safety Planning in the Emergency Department/Urgent Care Center (SPED)

In September 2018, VA introduced an evidence-based suicide prevention strategy that targets Veterans presenting to the emergency department who have been identified at increased risk of suicide and are safe to be discharged home. Specifically, [VHA Memorandum 2018-09-22, Suicide Prevention in Emergency Departments \(SPED\): Suicide Safety Planning and Follow Up Interventions](#) requires Veterans assessed as HIGH or INTERMEDIATE acute or chronic risk using a Comprehensive Suicide Risk Evaluation (CSRE) to receive the following enhanced care:

- A completed safety plan prior to discharge home
- Post-discharge follow-up outreach to facilitate engagement in outpatient mental health care

Facilities are required to identify a SPED Facility Champion or point of contact to assist facilities with implementing SPED elements. A full list of [SPED Facility Champions](#) may be found on the Suicide Risk Identification and Management SharePoint site.

Training materials and resources are available on the [SPED Resources SharePoint site](#). SPED also has its own [tracking report](#) and regularly scheduled technical assistance phone call. For more information and assistance, including the need to modify facility-identified SPED Facility Champion(s), SPCs and facility staff are advised to contact VHASPED@va.gov.

For more resources and information about SPED, SPCs are advised to navigate to the internal [Suicide Risk Identification and Management – SPED Resources webpage](#), which includes the following resources:

- Weekly technical assistance calls, including recordings and presentation materials from previous calls, on Thursdays at 2 p.m. Eastern Time; email VHASPED@va.gov to request a call invitation
- List of SPED Facility Champions

- SPED FAQ
- Safety Planning Resource Documents
- Note Templates
- VHA memorandums supporting implementation
- SPED supporting research
- Lethal Means Safety

VHA National Strategy for Suicide Prevention

VA has made great strides in Veteran suicide prevention, especially in crisis intervention. SPCs have been at the forefront of this effort, both identifying and managing Veterans at high risk for suicide through the use of patient record flags and assisting Veterans after they have contacted the Veterans Crisis Line. VA has also standardized its universal screening and evaluation processes, developed predictive analytics programs to identify and engage more Veterans at risk for suicide, and found additional opportunities to involve patients, families, and community stakeholders in its prevention and treatment efforts.

But the agency by itself cannot adequately confront the issue. While VA encourages Veterans to seek and use its services and benefits, the reality is that many Veterans do not engage with VA. To serve all Veterans, VA must build effective networks of support, communication, and care across the communities in which Veterans live and work every day. With resources and services working in a coordinated manner, we as a nation can prevent these tragic deaths by suicide.

In building upon these successes, VA is leveraging a public health approach to prevent suicide among all Veterans, including those who do not — and may never — receive care within its system. To expand VA’s approach to prevent Veteran suicide nationwide, the Veterans Health Administration’s (VHA) executive in charge approved the implementation of Suicide Prevention 2.0 (SP 2.0) by the Office of Mental Health and Suicide Prevention (OMHSP). SP 2.0 expands OMHSP’s current efforts by taking a comprehensive public health approach to suicide prevention that blends equal weight and emphasis to community-based prevention and clinically based interventions. In addition to the longer-range goals of SP 2.0, VA began implementing prevention strategies in 2020, known as Suicide Prevention NOW (SP NOW), that could be completed within a relatively short amount of time, approximately 12 months.

Similar to the National Initiatives to Enhance Suicide Prevention, SPCs should be knowledgeable about their role in promoting and supporting the expansion of VHA’s vision for implementation of the national strategy. What follows is an overview of these initiatives.

Suicide Prevention 2.0 (SP 2.0)

Telehealth Initiative

In August 2019, the Department of Veterans Affairs and Department of Defense Evidence-Based Practice Work Group updated the [VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide](#) (CPG). VA determined it was imperative to align with recommendations of the CPG to provide evidence-based psychotherapies specifically targeting risk of suicide. In 2020, the Office of Mental Health and Suicide Prevention (OMHSP) and the Office of Primary Care (OPC) partnered to make evidence-based treatment for suicide prevention available across VHA through Clinical Resource Hubs (CRH), via a

telehealth modality. Within this partnership, the Suicide Prevention Program (SPP) and CRH leadership have collaboratively determined a staffing model to meet the clinical needs and capacity within each hub. The plan not only accounts for clinical staff, but includes administrative support, programmatic leadership, education and training components, and program evaluation. This initiative aligns VA care with the CPG, which recommends Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), Dialectical Behavior Therapy (DBT), Problem-Solving Therapy for Suicide Prevention (PST-SP), and a safety planning intervention (Advanced Safety Planning Intervention) for Veterans with a history of suicide attempt.

The provision of suicide prevention clinical resources within CRHs across VHA will be instrumental in addressing disparities in access to evidence-based suicide prevention treatment across the country, potentially lowering the risk of death by suicide in at-risk populations. It further provides clinicians with training in evidence-based protocols specifically targeted at suicidal ideation and behaviors.

Community-Based Prevention Efforts

The SP 2.0 Community-Based Interventions for Suicide Prevention (CBI-SP) model builds upon OMHSP's current efforts and reaches Veterans through multiple touchpoints by strengthening VA's focus on high-risk individuals in health care settings and embracing cross-agency collaborations and community partnerships to meet Veterans where they live, work, and thrive. SP 2.0 CBI-SP migrates three legacy initiatives into a comprehensive approach to community-based suicide prevention, addressing needs at state and local community levels. As part of VA's public health strategy, VA combines partnerships with communities to implement tailored, local prevention plans. They include the Governor's and Mayor's Challenges, Community Engagement and Partnership Coordinators, and Together With Veterans.

Mayor's and Governor's Challenge

VA and the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) [Service Members, Veterans and their Families \(SMVF\) Technical Assistance Center](#) developed the Governor's and Mayor's Challenges, a partnership that addresses Veteran suicide within communities and states. For state-level prevention, OMHSP is supporting expanding the Governor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families (Governor's Challenge), where state-level policymakers will partner with local leaders to implement a comprehensive suicide prevention plan, with a goal to reach all 50 states by the end of FY22. Originally initiated at the community level, the model was expanded in February 2019 to incorporate strategies at the state level called the Governor's Challenge. States work to identify top priorities, best strategies, lessons to take back home, an outline of needed technical assistance, and strategies they would use to evaluate their outcomes and performance. The challenges recognize there is no one plan that fits every state or community.

Community Engagement and Partnerships – Suicide Prevention

For local community action, OMHSP is supporting expansion across all Veterans Integrated Service Networks (VISNs) of a Community Engagement and Partnerships – Suicide Prevention (CEP-SP) program focused on community coalition building coupled with targeted outreach and education. This includes a comprehensive strategy to hire and train qualified community engagement and partnerships coordinators (CEPC), who will collaborate at the community, regional, and state levels to implement evidence-informed community-based suicide prevention interventions. The community-based interventions expand the capacity of VISNs to engage in community-based suicide prevention efforts in their region, thereby reducing population suicide rates among Veterans. This initiative began in VISN 23 and is being disseminated through a phased roll out over the next two years with the goal of reaching all VISNs and states by the end of FY22. CEPCs work to establish and lead new suicide prevention coalitions within their communities and to identify and support existing coalitions.

Coalition building is individualized specific to community needs. OMHSP will establish a Technical Assistance Resource Center to deliver targeted technical assistance to support the CEPCs in effectively implementing community-based suicide prevention. Although a core function of SPCs is to engage in community outreach, CEPCs take this outreach a step further by developing and organizing community partners and coalitions at the state and VISN level.

Together With Veterans

Rural Veterans have been identified as having a 20% increased risk of death by suicide when controlling for distance to VHA care, demographic factors, and mental health diagnoses. To decrease this risk, the [Together With Veterans](#) (TWV) strategy was created. It enlists rural Veterans and their local partners to join forces to reduce Veteran suicide in their community. It is funded by the VA Office of Rural Health (ORH) and is focused on empowering and supporting Veteran leadership for suicide prevention. TWV is Veteran-driven (Veterans provide permission and work together to implement TWV within their communities) yet collaborative with community partners (who play a key role in successfully supporting Veterans and their families). It is evidence informed by drawing on strategies from well-researched models that have been shown to effectively reduce suicide. TWV implements a five-phase process emphasizing partnerships that develop a unique suicide prevention action plan based on community-specific strengths and needs.

Suicide Prevention NOW (SP NOW)

SP NOW includes five planks and a total of 19 strategies, each with its own goals and outcomes, and is a mixture of both clinical and community-based interventions. The SP NOW Plan includes the following:

Plank 1: Lethal Means Safety: Securing Firearms, Medications, and Other Items to Save Lives

- Disseminate lethal means safe storage information to primary care (PC) providers, women’s clinics, Vet Centers, and mental health (MH) clinics during the COVID-19 pandemic
- Implementation of mandatory Lethal Means Safety Training to all mental health (MH) team members
- Implementation of a one-time mandatory Lethal Means Safety Training for pain, emergency department (ED), primary care (PC), and Veterans Crisis Line (VCL) teams
- Create shorter annual Lethal Means Training for MH, PC, pain, ED, and VCL teams
- Train Mission Act providers in Lethal Means Safety
- Integrate National Shooting Sports Foundation (NSSF) Toolkit for Community Based Coalition Work

Plank 2: Caring for Veterans in Specific Medical Populations

- Deploy Suicide Risk Screening and Assessment Process in medical oncology, radiation oncology, and pain settings
- Incorporate suicide prevention as part of Medical “Bad News” Delivery Training

Plank 3: Re-Engaging Prior VHA Users: Directly Reaching Veterans

- Reaching prior VHA users NOW

Plank 4: Suicide Prevention Program Enhancement

- Improve implementation of high-risk flag through improved utilization of inactivation criteria and standardization of local processes
- Create high-risk flag histories in CPRS
- Develop a high-risk consult/referral for SPCs to assist in decision-making and implementation
- Improve Suicide Prevention Safety Planning implementation
- Enhance REACH VET implementation
- Enhance SPED implementation

- Improve VCL consult hand-off and disseminate caring contact letters during COVID-19 pandemic
- Improve same-day 5-Point Screening for new patients
- Outreach to Veterans with suicide risk who screen/test positive for COVID-19 utilizing enhanced SPPRITE Dashboard

Plank 5: Reaching All Veterans Through Powerful Messages of Hope: Nearly 20 Million Veterans, Two National Campaigns

- Implement paid media targeted plan including COVID-19-specific messaging

Available Materials

- [Veterans Crisis Line Fact Sheet](#)
- [VCL Spread the Word Partner Fact Sheet](#)
- [VA Suicide Prevention Efforts Fact Sheet](#)
- [Women Veterans Fact Sheet](#)
- [Safe Messaging Best Practices Fact Sheet](#)
- [Safe Firearm Storage Matters Fact Sheet](#)
- [Be Safe: Prevent Self-Harm: Healthy Living Message](#)
- [Working Together to Implement VA’s Public Health Model for Suicide Prevention](#)
- [Veteran Suicide Data](#)
- [VA National Strategy for Preventing Veteran Suicide](#)
- [Firearm Safety](#)
- [Safety Planning Quick Guide for Clinicians Brochure](#)
- [Make the Connection – Spread the Word](#)
- [Office of Public and Intergovernmental Affairs](#) – VA media/news releases

“News releases” are published on the large data pulls of suicide statistics, including national and state-level data. This data is vetted and may be shared with media outlets. To locate suicide-related news releases under “Search VA News Releases” at the bottom of the homepage, type in “suicide” and a date range.

Search VA News Releases

Search for **(Required)**:

Search in:

Sort by:

Begin Date **(Required)**: (mm/dd/yyyy)

End Date: (mm/dd/yyyy)

Resources

- American Association of Suicidology
<https://suicidology.org/>
- American Foundation for Suicide Prevention Knowledge Network
<http://www.afsp.org/index.cfm?page>
- Defense Health Agency (DHA) Connected Health Mobile Apps
<https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Operations/Clinical-Support-Division/Connected-Health/mHealth-Clinical-Integration>
- Interactive Stories of Hope and Recovery – National Suicide Prevention Lifeline
<https://suicidepreventionlifeline.org/stories/>
- International Association for Suicide Prevention (IASP)
resources available in multiple languages
<http://iasp.info/>
- Lethal Means Safety
<https://www.mirecc.va.gov/lethalmeanssafety/>
- Means Matter Website
<http://www.hsph.harvard.edu/means-matter/>
- Mental Health Residential Rehabilitation Treatment Programs
[MHR RTP Program Locator v2](#)
- Reporting on Suicide
<https://reportingonsuicide.org/>
- Rocky Mountain (VISN 19) MIRECC for Veteran Suicide Prevention
<https://www.mirecc.va.gov/mirecc/visn19/>
- Substance Abuse and Mental Health Services Administration (SAMHSA) – Preventing Suicide
<https://www.samhsa.gov/suicide>
- National Suicide Prevention Lifeline
<http://www.suicidepreventionlifeline.org>
- Suicide Prevention Resource Center (SPRC)
<http://www.sprc.org>
- Therapeutic Risk Management of the Suicidal Patient
<https://www.mirecc.va.gov/visn19/trm/>
- VA Mental Health Suicide Prevention
<http://vawww.mentalhealth.va.gov/rc-suicideprevention.asp>
- VA Suicide Risk Management Consultation Program
<https://www.mirecc.va.gov/visn19/consult/>
- VISN 2 Center of Excellence for Suicide Prevention
<https://www.mirecc.va.gov/suicideprevention/>
- VA Mobile App Store – Mental Health
<https://mobile.va.gov/appstore/mental-health>





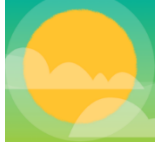
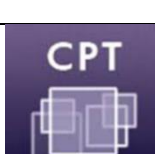
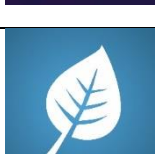
VA Mobile Health aims to improve the health of Veterans by providing technologies that expand clinical care beyond the traditional office visit.



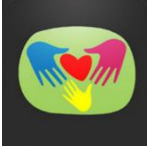





Apps are developed for both Veterans and VA care teams, offering safe and secure mobile access to patient data, and providing more opportunities for Veterans to be active participants in their health care.


VA Mobile Health underscores VA’s commitment to transforming the way care is delivered and to improve communications and health care coordination between Veterans and their care teams. VA recognizes that mobile health is emerging as an essential element of health care and is dedicated to providing the most up-to-date technologies to enhance patient experiences.

Download these free apps on either Android or iOS devices:



	<p>ACT Coach</p> <p>In ACT with a therapist and want added support? Find it here.</p> <p>iOS Android</p>
	<p>Anger and Irritability Management Skills (AIMS)</p> <p>Track, address, and manage anger better with AIMS.</p> <p>iOS Android</p>
	<p>Caring4WomenVeterans</p> <p>Resource to help deliver quality care to female Veterans.</p> <p>iOS Android</p>
	<p>CBT-i Coach</p> <p>Engaged in CBT-I and want extra support? The coach is here.</p> <p>iOS Android</p>
	<p>COVID Coach</p> <p>Support self-care and overall mental health during the coronavirus (COVID-19) pandemic.</p> <p>iOS Android</p>
	<p>CPT Coach</p> <p>App to enhance CPT treatment with a mental health provider.</p> <p>iOS</p>
	<p>Mindfulness Coach</p> <p>Be in the moment! Learn mindfulness to reduce stress.</p> <p>iOS Android</p>

	<p>Mood Coach</p> <p>Boost your mood through positive activities with this app.</p> <p>iOS</p>
	<p>Moving Forward</p> <p>Tools to keep you moving forward during times of stress.</p> <p>iOS</p>
	<p>Parenting2Go</p> <p>Develop skills to help connect with and parent your kids.</p> <p>iOS</p>
	<p>PE Coach 2</p> <p>Supplement PE therapy for PTSD with a health professional.</p> <p>iOS Android</p>
	<p>PTSD Coach</p> <p>Get the info, support, and tools you need to manage PTSD.</p> <p>iOS Android</p>
	<p>PTSD Family Coach</p> <p>Support and tools for those living with someone who has PTSD.</p> <p>iOS Android</p>
	<p>STAIR Coach</p> <p>Take the step, enhance STAIR in-person psychotherapy.</p> <p>iOS</p>
	<p>Stay Quit Coach</p> <p>Create a tailored plan to help you quit and stay smoke-free.</p> <p>iOS Android</p>







	<p>VetChange</p> <p>Change it up and develop healthier drinking habits.</p> <p>iOS</p>
---	---





▪ mHealth Clinical Integration – Military Health System Mobile Health Apps

<https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Operations/Clinical-Support-Division/Connected-Health/mHealth-Clinical-Integration>

DHA Connected Health mobile apps provide information and support to service members, veterans, and their families dealing with behavioral health issues and traumatic brain injury. Download these free apps on either Android or iOS devices:



	<p>Breathe2Relax</p> <p>Provides instruction on diaphragmatic “belly” breathing, which helps lower stress and reduce anxiety. Graphics, animation, narration, and videos lead users through several breathing exercises.</p>
	<p>Dream EZ</p> <p>Helps the user rewrite nightmares into less disturbing dreams for a better night’s sleep, using the principles of imagery rehearsal therapy (IRT).</p>
	<p>LifeArmor</p> <p>Has information on 17 common health concerns, including sleep, depression, relationship issues, and post-traumatic stress. Includes self-assessments to help measure and track symptoms.</p>
	<p>Navy Leader’s Guide Mobile App</p> <p>Provides guidance on what leaders can do about issues that affect sailors. Based on the Navy & Marine Corps Public Health Center website.</p>
	<p>Pain and Opioid Safety</p> <p>Serves those coping with pain by providing information, resources, and an effective mechanism for tracking pain. The app contains information and FAQs for patients on the use of opioids in pain management, as well as tools and materials for providers using opioids in clinical practice.</p>
	<p>Positive Activity Jackpot</p> <p>Helps users who may be overwhelmed by depression find nearby enjoyable activities. Can't decide? Let the app’s jackpot function make the choice. See “Resources” for a clinician’s guide.</p>

	<p>Provider Resilience</p> <p>Gives health care providers tools to manage burnout, compassion fatigue, and secondary traumatic stress, keeping them productive and emotionally healthy as they help others.</p>
	<p>T2 Mood Tracker</p> <p>Tracks a user’s range of emotions and behaviors to show how their life is affected by thoughts, moods, changes at home or at work, and events. Helps identify trends and triggers, and info can be shared with a health care provider.</p>
	<p>Tactical Breather</p> <p>Provides guided breathing instruction to gain control over heart rate, emotions, concentration, and other physiological and psychological responses during stressful situations.</p>
	<p>Virtual Hope Box</p> <p>Contains simple tools to help users with coping, relaxation, distraction, and positive thinking using personalized audio, video, pictures, games, mindfulness exercises, activity planning, inspirational quotes, and coping statements.</p>

Appendix 1.1 Abbreviations

ADPAC	automated data processing application coordinator
AFSP	American Foundation for Suicide Prevention
ASPI	Advanced Safety Planning Intervention
BHAP	Behavioral Health Autopsy Post-Mortem Analysis
C-SSRS	Columbia - Suicide Severity Rating Scale
CAC	clinical application coordinator
CBI-SP	Community-Based Interventions – Suicide Prevention
CBOC	community-based outpatient clinic
CBT-SP	Cognitive Behavioral Therapy for Suicide Prevention
CEP-SP	Community Engagement and Partnerships – Suicide Prevention
CEPC	community engagement and partnership coordinator
COB	close of business
CoE	centers of excellence
CPG	clinical practice guideline
CPRS	Computerized Patient Record System
CRH	clinical resource hub
CRISTAL	Capri, REACH VET, Risk Indicators, Storm Tool for Analytic Lookup
CSRE	comprehensive suicide risk evaluation
DBT	Dialectical Behavior Therapy
DoD	Department of Defense
EHR	electronic health record
EOD	enter on duty
FIT-C	Family Interview - Contact
FRM	facility revenue manager
HBPC	home- based primary care
HCS	health care system
HHS	Department of Health and Human Services
HRF	high-risk flag
HUM	heads-up message
IB	issue brief
LIP	licensed independent provider/practitioner
MH	mental health
MHTC	mental health treatment coordinator
MIRECC	Mental Illness Research, Education and Clinical Centers
NEO	new employee orientation
OIG	Office of the Inspector General
OMHSP	Office of Mental Health and Suicide Prevention
OPC	Office of Primary Care
ORH	Office of Rural Health
OTH	other than honorable
PAO	public affairs officer
PCMM	Primary Care Management Module
PCP	primary care provider
PDE	post-discharge engagement
PHI/PII	protected health information/personally identifiable information

PERC	Program Evaluation and Resource Center
POC	point of contact
PRF	patient record flag
PST-SP	Problem-Solving Therapy for Suicide Prevention
REACH VET	Recovery Engagement And Coordination for Health – Veterans Enhanced Treatment
RRTP	residential rehabilitation treatment program
SAIL	Strategic Analytics for Improvement and Learning Value Model
SAMHSA	Substance Abuse and Mental Health Services Administration
SBOR	suicide behavior and overdose report
SME	subject matter expert
SMVF	Service Members, Veterans, and their Families
SP 2.0	Suicide Prevention 2.0
SP NOW	Suicide Prevention NOW
SPAN	Suicide Prevention Application Network
SPC	suicide prevention coordinator
SPED	Suicide Prevention in the Emergency Department
SPP	Suicide Prevention Program
SPPRITE	Suicide Prevention Population Risk Identification and Tracking for Exigencies
SPRC	Suicide Prevention Resource Center
SPSP	suicide prevention safety plan
STORM	Stratification Tool for Opioid Risk Mitigation
SUD	substance use disorder
TAPS	Tragedy Assistance Program for Survivors
TMS	Talent Management System
TWV	Together With Veterans
VBA	Veterans Benefits Administration
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VistA	Veterans Integrated System Technology Architecture
VSO	Veterans service organization
USPV	Uniting for Suicide Postvention

Clinical Staff Designations

APRN/APN/NP/CNS	advanced practice nurse (<i>advanced practice registered nurse, advanced practice nurse, nurse practitioner, certified nurse specialist</i>)
CP/Psy.D./Ph.D.	clinical psychologist
LCSW/LCSW-C/ LICSW/LISW/LMSW	independent and/or advanced practice social worker (<i>licensed clinical sw, licensed certified sw - clinical, licensed independent clinical sw, licensed independent sw, licensed master sw</i>)
LMFT	licensed marriage and family therapist
LPC/LPMHC	licensed professional counselor/ licensed professional mental health counselor
LPN/LVN	licensed practical or professional nurse/licensed vocational nurse
PA	physician assistant
RN	registered nurse
RPH/Pharm.D.	clinical pharmacist
UAP	unlicensed assistive personnel

Appendix 1.2 Definitions

DEFINITIONS

- a. **Caregiver.** A caregiver is an individual who provides personal care services to the Veteran. NOTE: Within the Veterans Health Administration (VHA), caregivers may be eligible for assistance either through Veteran-linked services, including through one of two direct, caregiver assistance programs — the Program of General Caregivers Support Services (PGCSS) or the Program of Comprehensive Assistance for Family Caregivers (PCAFC) — through VHA’s Caregiver Support Program (CSP). For more information, see VHA Directive 1152(1), Caregiver Support Program, dated June 14, 2017, for detailed descriptions of eligibility criteria, support, and benefits for both the PGCSS and PCAFC.
- b. **Evidence-based clinical practice guidelines.** Evidence-based clinical practice guidelines are recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options. NOTE: The VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (CPG) addresses patient cohorts, serves to reduce errors, and provides consistent quality of care and utilization of resources throughout and between the VA and DoD health care systems. For more information, VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide, see: <https://www.healthquality.va.gov/>. The guidelines on this website are endorsed by the VA/DoD Evidence-Based Practice Work Group.
- c. **Gatekeeper training.** Gatekeeper training is an educational course designed to teach clinical and nonclinical professionals, or gatekeepers, the warning signs of a suicide crisis and how to respond and refer individuals to care. NOTE: Gatekeeper training generally refers to programs that seek to develop individuals' knowledge, attitudes, and skills to identify those at risk, determine levels of risk, and make referrals when necessary. For more information, see: http://www.sprc.org/sites/default/files/migrate/library/SPRC_Gatekeeper_matrix_Jul2013update.pdf. NOTE: This is a linked document outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.
- d. **Lethal means.** Lethal means are objects (e.g., medications, firearms, sharp objects) that can be used to engage in suicidal and nonsuicidal self-directed violence. NOTE: A shared understanding of terms associated with self-directed violence (SDV) in its various forms is critical. For more information regarding the VHA Self-Directed Violence Classification System and Clinical Toolkit, see: <https://www.mirecc.va.gov/visn19/education/nomenclature.asp>.
- e. **Postvention.** Postvention refers to activities that occur after a suicide that are designed to support those exposed to and impacted by the suicide and to ensure that resources and support are provided to the community (e.g., Veterans, family members) and VA employees. Postvention efforts occur immediately after a suicide and are ongoing in nature. NOTE: Postvention strengthens prevention efforts by mitigating risk of suicide and other negative effects associated with suicide exposure. Suicide postvention is an essential component of a suicide prevention plan.
- f. **Prevention.** For the purposes of this directive, prevention means participating in activities that are implemented prior to the onset of suicidal events. Prevention activities are designed to reduce the potential suicide events. For more information, see: <https://www.sprc.org/about-suicide/topics-terms>. NOTE: This website is outside VA control and may not conform to Section 508 of the Rehabilitation Act of 1973.

- g. **Public health approach.** The public health approach for suicide prevention, as described in this directive, maintains a focus on evidence-informed clinical and community-based strategies that organize efforts to prevent, identify, and counter threats to Veteran suicide prevention.
- h. **Risk factors.** Risk factors cause individuals to develop a disorder or predispose individuals to high risk for self-injurious behaviors. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.
- i. **Safe messaging.** Safe messaging means presenting accurate, safe, and responsible portrayals of Veteran suicide and related issues across communication mediums.
- j. **Safety plan.** A safety plan is a prioritized written list of coping strategies and sources of support that patients can use before or during suicidal crises. NOTE: The intent of safety planning is to provide a predetermined list of potential coping strategies, as well as a list of individuals or agencies that Veterans can contact in order to help them lower their imminent risk of suicidal behavior.
- k. **Suicidal behaviors.** Suicidal behaviors or self-directed violence are behaviors that are self-directed and deliberately result in injury or the potential for injury to oneself.
- l. **Suicide behavior overdose report.** The suicide behavior overdose report (SBOR) is an electronic health record template used for reporting suicide behaviors and nonsuicidal overdose events. NOTE: The suicide behavior overdose report (SBOR) is compiled at the VA medical facility level.
- m. **Suicidal ideation.** Suicidal ideation are thoughts of engaging in suicide-related behavior.
- n. **Suicide attempt.** A suicide attempt is a nonfatal, self-inflicted, potentially injurious behavior with intent to die as a result of the behavior.
- o. **Suicide.** Suicide is death caused by self-inflicted, injurious behavior with an intent to die as a result of the behavior.
- p. **Telehealth.** Telehealth is use of electronic information or telecommunications technologies to support clinical health care, patient and professional health-related education, public health, and health administration at a distance.
- q. **Warning signs.** Warning signs are behaviors that indicate a Veteran may be at risk for suicide.

Appendix 1.3 National Suicide Prevention Program Contacts

Who to contact	How to contact them	When to contact them
Suicide Prevention Program – Field Operations	VHA OMHSP SPP Field Operations	<ul style="list-style-type: none"> ▪ Group includes: <ul style="list-style-type: none"> • Brad Lanto – Director, Field Operations • Kim Woehr • Kristi Fredritz • Katie Rotolo • Nicole Theriot ▪ Field Ops will answer most questions or refer you to other workstreams at the National Program Office for assistance
	Kimberly Woehr	<ul style="list-style-type: none"> ▪ Add/remove SPCs from mail lists - VHA suicide prevention coordinators; facility-level email groups (e.g., VHA SPC AK-463 ANC Suicide Prevention Team) ▪ Invites to SPC calls ▪ Updates VCL Resource Locator ▪ Updates SPC National Contact List
VISN 2 Center of Excellence for Suicide Prevention	Steven Miller	<ul style="list-style-type: none"> ▪ Access to SPAN ▪ BHAP & FIT-C forms ▪ Access to SPC SharePoint
	Elizabeth Louer-Thompson	<ul style="list-style-type: none"> ▪ BHAP Program Coordinator
Veterans Crisis Line	VHA VCL CAC Team	<ul style="list-style-type: none"> ▪ access to Medora application ▪ anything technical regarding VCL consults/Medora
	Gregory Hughes	<ul style="list-style-type: none"> ▪ VCL liaison for SPCs
	VHA CAN VCL Complaints	<ul style="list-style-type: none"> ▪ Report VCL consult errors, including name, contact information on the part of the VCL ▪ Report if a consult was inappropriately labelled ▪ Report if you or the Veteran have concerns about how the call was handled
	Corey Terhune	<ul style="list-style-type: none"> ▪ VCL swag/shipments ▪ VCL logos ▪ Gunlocks
Rocky Mountain MIRECC for Suicide Prevention	VHA ECH Risk ID Support	<ul style="list-style-type: none"> ▪ Risk ID Strategy ▪ Risk ID FAQ
	VHA SPED	<ul style="list-style-type: none"> ▪ SPED Initiative ▪ SPED FAQ
	VHA REACH VET Support	<ul style="list-style-type: none"> ▪ REACH VET ▪ Common Questions Page
	VHA ECH SRM Consult	<ul style="list-style-type: none"> • Suicide Risk Management Consultation Program (including postvention)
	VHAHRFDashboardSupport@va.gov	<ul style="list-style-type: none"> ▪ HRF Dashboard ▪ Frequently Asked Questions

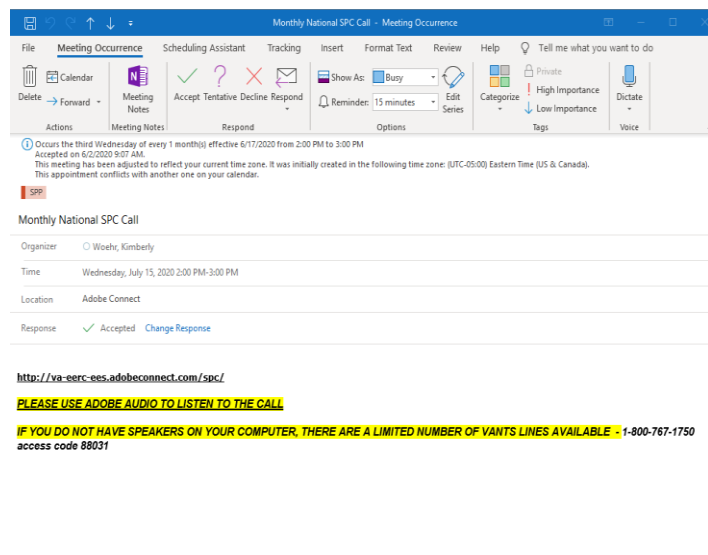
PERC (Program Evaluation & Resource Center)	VHA REACH VET Support	<ul style="list-style-type: none"> ▪ REACH VET Dashboard Common Questions
	VHA SPPRITE Support	<ul style="list-style-type: none"> ▪ SPPRITE Frequently Asked Questions

Appendix 2.1 Instructions for Joining National SPC Monthly Call

Step 1

Accept the calendar invite. Once accepted, the invite will be placed on your personal Outlook Calendar.

You will receive a reminder pop-up notice of the call 15 minutes prior, or you may navigate to the appointment on your calendar and open it. The Skype meeting and VANTS information will appear on the calendar invite. Skype is used for screen sharing/viewing. Audio is through VANTS.



Step 2

Click on the Adobe Meeting link:

<http://va-eerc-ees.adobeconnect.com/spc/>

Step 3

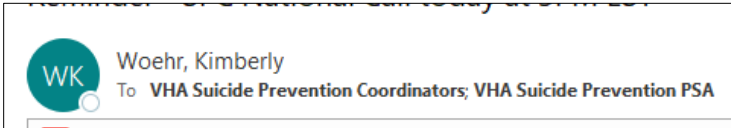
For audio, use Adobe Connect. If you don't have speakers on your computer, please use the **VANTS LINE: 1-800-767-1750, access code 88031**. *Please remember that there are a limited number of VANTS lines available, so please use Adobe when possible.*

Appendix 2.2 Email Review How-To for “VHA OMHSP Suicide Prevention Coordinator” Group

Instructions for checking facility SPC membership:

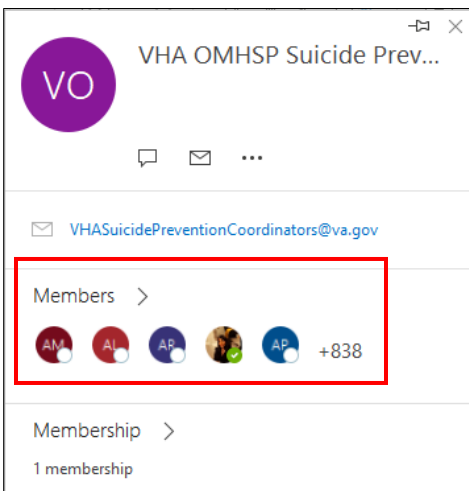
Step 1

In an email you’ve received as part of the group, double-click on the email group name.



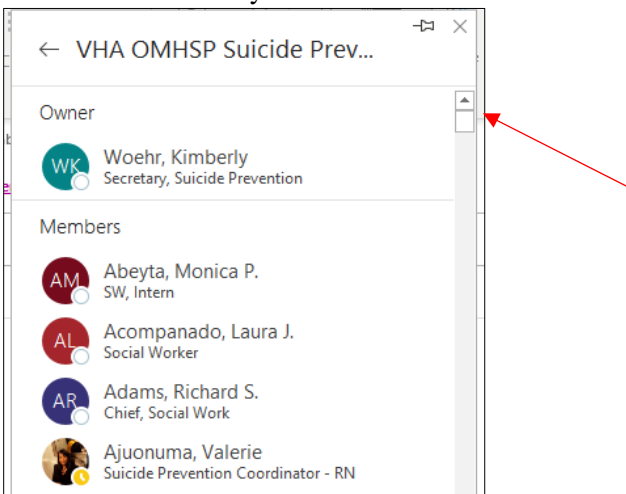
Step 2

Click on “Members”



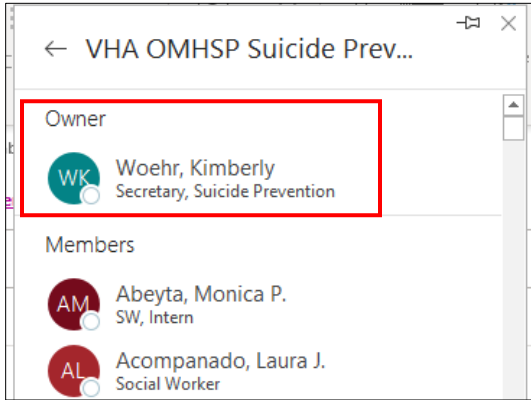
Step 3

Use the scroll bar to search the members list. Ensure facility staff members are included in the list and that former members of the facility team have been removed from the list.



Step 4

Email the owner of the email group if members need to be added or removed. This email group is owned by Kimberly.Woehr@va.gov.



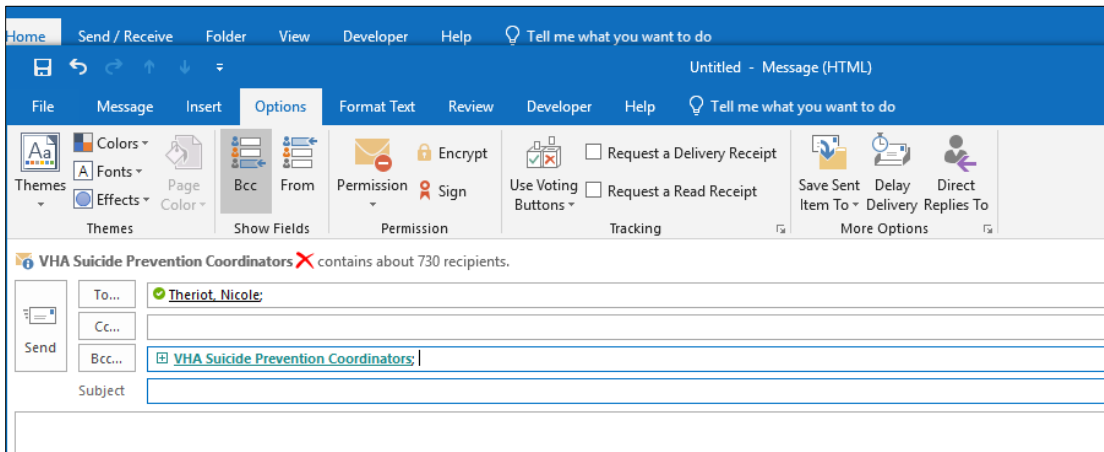
Instructions for Sending Emails Through the SPC Email Group

In order to ensure that staff members are not receiving emails on topics that are not of interest, when addressing the field, the SPC should complete one of two options: sending emails via the blind carbon copy option or modifying permissions to No Reply All.

Blind Carbon Copy (BCC):

Enter the email address into the BCC line of an Outlook email and send an email to yourself on the “To” line.

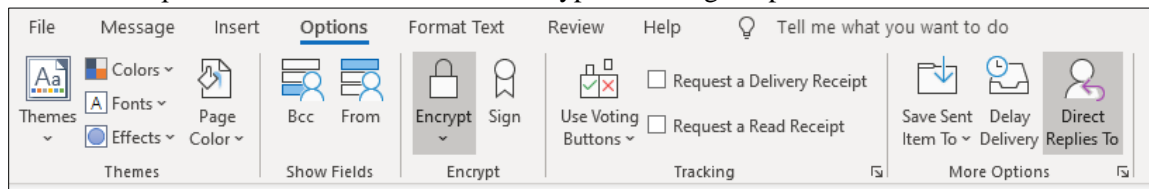
1. Select the “New Email” button.
2. Select the “Options” tab and look for the BCC view. Select it. This will open the BCC window in this and subsequent emails.
3. Add your name in the “To” line.
4. Add the SPC email group to the BCC line.
5. This will prevent anyone responding to emails from replying to all as the recipient names are hidden. This will facilitate communication between the person seeking information and others in the field and limit unnecessary emails to those not wishing to participate.



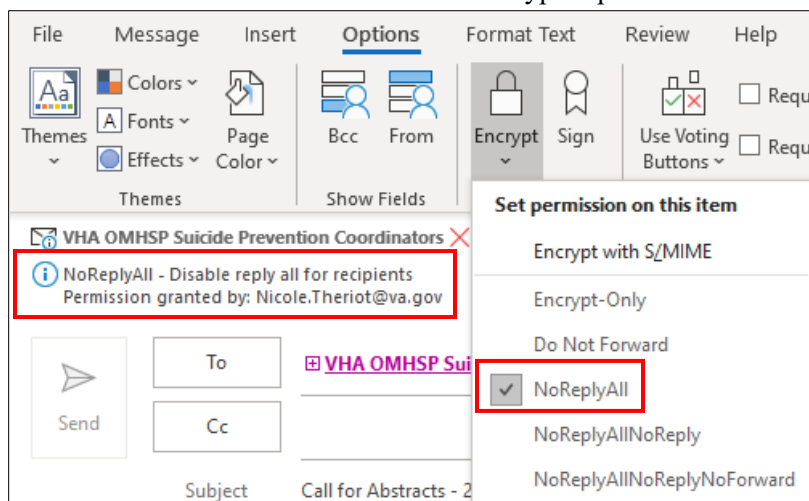
No Reply All:

Enable permissions that do not allow recipients to reply to the entire group (i.e., reply all)

1. Select the “New Email” button.
2. Select the “Options” tab and look for the “Encrypt” and “Sign” options.



3. Select the down arrow underneath the “Encrypt” option and then select “NoReplyAll.”



4. This will prevent anyone responding to emails from replying to all and facilitate communication between the person seeking information and others in the field. “Direct Replies To” will automatically populate as the sender of the email.

Review the following Rules of Engagement for participating in email distribution groups.

Rules of Engagement via Email Distribution Groups

Think before you send.

Before sending an email to a Distribution Group, ensure it:

1. Is beneficial, relevant and timely to share with the group
2. Is respectful of all persons
3. Cannot be addressed by a smaller group
4. Cannot be answered by quickly searching VA’s [intranet](#) or [SharePoint](#) or [Google](#))

5. Cannot be misinterpreted or taken out of context to harm someone
6. Will not hurt VA, Veterans, and/or VA employees if shared outside of the organization (e.g. with Congress, Media, etc.)
7. Does not contain PHI or PII or violate [VA's Code of Integrity](#) or the [Hatch Act](#)
8. Is consistent with VA policy and does not solicit anything inappropriately – donations, goods, QI or research participants for projects that have not been explicitly approved to post on this list etc.

NOTE: *(There may be exceptions or arrangements that make this material appropriate. Contact [VHA OMHSP SPP Field Operations](#) first.*

9. Does not promote products, training or viewpoints from a non-federal agency (even if they are free)

NOTE: *There may be exceptions or arrangements that make this material appropriate. Contact [VHA OMHSP SPP Field Operations](#) first.*

10. Uses *Reply All* only in situations where everyone will benefit from your response. We want to encourage meaningful discussion, but we can all cut down on email by avoiding inappropriate group responses such as 'Me too, Thank you, Remove me from the list', etc.

BONUS: Follow these [instructions](#) to be removed from (or added to) a group.

If you are unsure if this DG is an appropriate forum for your email, please contact [VHA OMHSP SPP Field Operations](#).

Appendix 2.3 Billing Responsibilities

Clinic Setup

You will need to ensure you have clinics in CPRS that allow you to document and complete encounters when you provide direct patient care. At minimum, you will need a face-to-face and telephone clinic. Clinics have names, typically with a standardized nomenclature, that tend to specify the location where you are providing care and the type of care you are providing (e.g., suicide prevention). You will need to request assistance from your supervisor or other designee at your facility to assist with getting clinics created. However, you will need to provide guidance to them about what clinics you need and the underlying stop codes for those clinics.

Stop Codes – DSS Identifiers

What are they?

- Three-digit codes used to standardize work completed in VHA outpatient clinics
- Primary Stop Code (P) – work group (main clinical program responsible for care)
- Secondary Stop Code (S) – credit modifier (type of service or provider)
- Codes are attached to clinics used to document encounters with the Veteran

Why are they needed?

- Ensures funding for services are billed to the correct program
- Ensures providers receive proper workload credit for their discipline and/or specialty program

How are codes designated?

- Individual
- Group
- Telephone
- Specialty/program

Organizational Categories		Examples:
Series 100–299	Ancillary and General Support Services	191 – CADHC F/U (P)
Series 300–399	Medicine and Primary Care Services	323 – Primary Care Medicine (E)
Series 400–499	Surgical Services	402 – Cardiac Surgery (E)
Series 500–599	Mental Health Services	527 – Telephone Mental Health (P)
Series 600–699	Various Special Programs	674 – Administrative Patient Activities (P)
Series 700–799	Other	719 – MHV Secure Messaging (S)

P = Primary

S = Secondary

E = Either

What are the primary stop codes for suicide prevention?

Mental Health Service/Product Line is responsible for all suicide prevention activities, regardless of your discipline or the program you are actively assigned to (e.g., nursing, social work, mental health). Many metrics for the Suicide Prevention Program are tied to the stop code of the clinic and require clinics with stop codes in the mental health series. Therefore, you need to operate from mental health clinics in CPRS.

Stop Code	Primary, Secondary, Either	Stop Code Name
502	Either	Mental Health Clinic Individual
527	Primary	Mental Health Telephone

Note: There are multiple stop codes that are specific to telephone, group, individual, and specific programs. Refer to the Active Stop Code¹ list for the full list that includes an explanation of how the codes should be used. A version is published twice per year.

Optional Stop Codes for Suicide Prevention

Stop Code	Primary, Secondary, Either	Stop Code Name
117	Secondary	Nursing
125	Either	Social Work Service
183	Secondary	Peer Specialist
510	Secondary	Psychology
550	Either	Mental Health Clinic (Group)
673	Secondary	Clinical Team Conference
719	Secondary	MHV Secure Messaging

Secondary stop codes are not required or necessary. However, they may further delineate discipline or type of service provided, such as in the case of group or clinical team conference.

Capture of nonbillable workload – option

Stop Code	Primary, Secondary, Either	Stop Code Name
674	Primary	Administrative Patient Activities (Non-Count CBO) records patient visit for administrative purposes only without provision of any medical assessment or intervention. Administrative activities include, but are not limited to, orienting new clients to primary care or other clinics in the VHA, updating means test and/or enrollment information,

¹ [Active Stop Codes – VHA Office of Finance, Managerial Cost Accounting Office](#)

		preparing advanced directives, etc. This Stop Code is not for exclusive use by any particular discipline. These activities are statistical in nature and are NOT to be coded.
--	--	---

What do I do with this information?

- Supervisors:
 - Ensure all clinics are stop coded correctly with both Primary and Secondary Stop Codes as appropriate.
 - Telephone clinics
 - Group clinics
 - Individual clinics
 - Provide guidance to facility staff responsible for setting up clinics in VistA
- Providers:
 - Ensure the correct clinic is chosen when completing an encounter (e.g., telephone, MH Social Worker, PTSD Group, etc.)
 - Specify correct clinic to MAS staff when scheduling

Encounters²

What are they?

- Professional contact between a patient and provider
- Provider has responsibility for evaluating, diagnosing, and treating a patient's condition
- Primary method of billing for services rendered

Encounters also allow tracking of productivity. However, this is secondary to their primary purpose, billing.

What are the types of encounters?

- Face-to-face with the patient (in any setting, e.g., inpatient, outpatient, the home, community facilities, etc.)
- Telecommunications technology with the patient (e.g., telephone, telehealth, clinical video conferencing)
- Secure Messaging
- Team conference with/without the patient

What are the required clinical components?

- Individual clinics
 - Example 1 - CC SPC SW
 - Location (Clown City OPC), Program (Mental Health/Suicide Prevention), Discipline (Social Work Service)
 - Stop Code Pair: 502:125 (Mental Health Individual:Social Work Service)
- Group clinics

² [VHA Coding Guidelines V.14, VHA Health Information Management Coding Council, 2017; VHA Directive 1082, Patient Care Data Capture](#)

- Example – SSM MH SAFETY PLANNING GROUP
 - Location (Sesame OPC), Program (Mental Health Group – Safety Planning), Discipline (Psychology)
 - Stop Code Pair: 550:510 (Mental Health Group:Psychology)

OR

- Location (Sesame OPC), Program (Mental Health Group – Safety Planning)
- Stop Code Pair: 550:000 (Mental Health Group:None)

Note: This option would allow any discipline to facilitate the group (e.g., psychology, social work, nursing, etc.). A secondary stop code is not required.

- Telephone clinics
 - Example – CC SPC SW TELEPH-X
 - Location (Clown City OPC), Program (Mental Health Group/Suicide Prevention), Discipline (Social Work), Telephone Designation - **required**
 - Stop Code Pair: 527:125 (Telephone Mental Health:Social Work Service)
 - Example – CC SPC TELEPH-X
 - Location (Clown City OPC), Program (Mental Health Group/Suicide Prevention), Telephone Designation - **required**
 - Stop Code Pair: 527:000 (Telephone Mental Health:None)

Historical Visits

What are they?

- Information that may be appropriate to document but does not meet all clinical criteria for an encounter

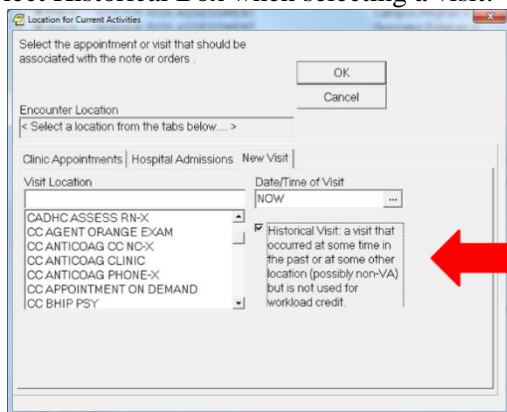
Examples:

- A provider contacts a Veteran by phone to inform them a form is ready for them to pick up. **No clinical content.**
- A provider contacts a Veteran who did not show up to an appointment. The provider reschedules the appointment. **No clinical content.**
- A provider attempts to contact the Veteran by phone but is unable to reach the Veteran, leaving a message on voice mail. **No contact with the Veteran.**
- A provider speaks with a community hospital case manager to discuss discharge planning on behalf of the Veteran. **No contact with the Veteran.**

Encounters completed over the telephone require ALL the elements of a face-to-face visit.

Stop code in the primary/first position MUST indicate a telephone stop code.

Must select Historical Box when selecting a visit.



- Do not have a designated “Primary Provider.”
- Do not complete an encounter form.
- Do not get billed.

Examples of nonbillable functions within the Suicide Prevention Program:

- Review of charts/records for staffing and behavioral health autopsies
- Participation in root cause analysis
- Completion of issue briefs
- Participation in environment of care rounds
- Committee staffing for high-risk Veterans
- Inputting data into SPAN
- Monthly mail-outs
- Staff consultation
- Education/training
- Community outreach
- All flagging responsibility – review for, initiation of, renewal, removal, transfer of flags

Coding Guidelines

There are two levels of procedure codes: CPT and HCPCS.

- Current Procedural Terminology (CPT) – Level 1
 - A list of procedure codes that designate medical procedures and services that are provided on behalf of a patient (i.e., surgical, medical, and diagnostic)
 - Numerical codes
 - American Medical Association (AMA), published annually

Example: 90834 – Psychotherapy Treatment Patient and/Family, 45 minutes
- Healthcare Common Procedure Coding System – Level 2 (HCPCS)
 - A list of procedure codes to designate procedures and services that do not meet criteria for a CPT code (typically provided by nonphysicians or non-LIPs)
 - Centers for Medicare and Medicaid Services (CMS)
 - Alphanumeric codes

Example: T1016 – Case Management, Each 15 minutes

There are thousands of procedure codes for all kinds of services. Procedure codes should be chosen based on the type of service being provided to a patient. There are two procedure codes that are referenced here because they are used most frequently by the majority of SPCs - telephone encounters and case management. For the full list of most commonly used procedure codes that may be appropriate for use by staff within the Suicide Prevention Program, see [Suicide Prevention Workload QuickGuide 2017](#) and [Suicide Prevention Program Summary Coding Guide 2017](#).

Telephone Visits/Encounters

Procedure codes

98966 – Telephone call, 5–10 minutes

98967 – Telephone call, 11–20 minutes

98968 – Telephone call, 21–30 minutes

See “Telephone Encounters” section for required elements. See “Historical Visits” section if telephone contacts do not contain all required elements.

- May only use one unit based on time spent providing clinical care
- May **not** add codes to each other to increase time spent on the call
- Maximum coding is for 30 minutes, regardless of how much longer the clinical contact may last
- May **not** use any additional codes, regardless of type of clinical service provided
- Care does not have to be initiated by the patient

All follow-up contacts with Veterans from the Veterans Crisis Line that occur by telephone AND meet the criteria for a clinical encounter require the use of telephone procedure codes only. No other procedure codes may be used for a telephone contact, regardless of the service that is being provided.

Illustrative Example of Telephone Encounter

Jill, a provider, contacts Mr. Dean by phone for follow-up. He contacted the Veterans Crisis Line reporting an exacerbation of his depressive symptoms. Mr. Dean’s prescriber adjusted his medication five days ago, increasing his dose. His next scheduled appointment is not for two weeks. Mr. Dean isn’t feeling any better.

9:30 a.m.	Jill contacts Mr. Dean by phone. They spend a few minutes discussing the graduation party of Mr. Dean’s oldest grandson over the weekend.
9:35	Jill assesses Mr. Dean’s depressive symptoms. He informs her his symptoms have actually worsened, including thoughts of suicide recently. He denies suicidal ideation at present and denies intent or plan. Jill completes a Suicide Risk Evaluation and a Suicide Prevention Safety Plan with Mr. Dean. They decide she will reschedule Mr. Dean for an appointment at the end of the week.
10:30	Phone call ends
Time spent in clinical contact with Mr. Dean	55 minutes

Time spent on the phone with Mr. Dean	60 minutes
10:30–10:50	20 minutes; Jill documents Mr. Dean telephone visit
Correct Procedure Code	98968 – maximum telephone time available for coding – 30 minutes

Jill was on the phone providing clinical intervention to Mr. Dean for 55 minutes, including the following clinical activity procedures:

- Psychotherapy Crisis Initial, 60 min – (30–74) minutes
 - OR
- H2011 (four Units) Crisis Intervention Service, per 15 minutes
 - OR
- S9484 Crisis Intervention, per hour

But Jill may **not** use these procedure codes because they require face-to-face care. The Centers for Medicare and Medicaid Services (CMS) do not recognize telephonic care as a vehicle for psychotherapy. Jill will only get clinical “credit” through the encounter system for 30 minutes, the maximum amount of time that can be billed for telephone visits. Had this visit been face-to-face with Mr. Dean, one of the above procedure codes may have been used instead.

Case Management:

T1016 – Case management, 15 minutes

Note the following:

- **Must** be face-to-face contact **with** the patient
- May not use for interaction with facilities or agencies on behalf of the patient
- May not use for interaction over the telephone
- Add additional units of T1016 for each additional 15 minutes

CPT codes that are **not** appropriate for encounters and may not be used.

There are two procedure codes that have often been used incorrectly by providers. They are 90885 and 3085F, described here. ALL clinical procedures completed by clinical staff require a review of a patient’s chart and subsequent documentation. These tasks are embedded within every procedure code and may not be accounted for separately. Patients may not be separately billed for chart review and documentation nor may time be added for either of those tasks. Procedure codes should be selected based on the amount of time spent in direct patient care with a patient.

- 90885 – Psychiatric Evaluation of Hospital Records
Mental health leadership has removed use of 90885 outside of e-consults. Chart review is an expected task for all procedure codes and is already built in to the RVU value of those codes. Chart review may not be billed separately.
- 3085F - Suicide Risk Assessment
Mental health leadership has recommended removal of this code.

These procedure codes may **never** be used for any billable encounter.

This code:

- Is primarily intended for new and recurring MDD only
- Is not appropriate for use as an “add-on code”
- Is an Administrative Category 2 code for CMS tracking

See Workload/Productivity section below for how to track time and report administrative activities.

Labor Mapping

What is it?

“Method for assigning labor costs and hours to a cost center, known as the Account Level Budgeter Cost Center (ALBCC). These cost centers indicate where the work occurred and houses the cost and hours for the products/services provided. Labor mapping provides data on how much it costs to run and support a clinical program. Showing correct productivity and workload for a program is important to managers to reliably benchmark the activity, and as indicated, justify additional expenditures or new positions. If labor mapping is not accurate, it will result in over- or under-inflated costs in the department, which could have an adverse effect on budgets and staffing. Labor mapping is cost, and cost follows workload. Always map providers labor time to the same locations where they collect workload.”

Labor mapping is generally split into two categories for most providers: time spent providing clinical care and time spent in administrative activities. It should be noted that “clinical time” for labor mapping is not defined in the same manner as “clinical time” for procedure codes which is limited to direct patient care services with the patient. For purposes of labor mapping, the definition of “clinical time” is much broader and includes all the following:

- Clinical Time:
 - Direct clinical care
 - Time spent reviewing patient data
 - Consulting about patient care with colleagues
 - Reviewing medical literature
 - Contacting the patient or caregivers to discuss their needs
 - Supervising trainees and/or other non-LIPs
 - Employee training
 - Continuing education
 - Breaks
 - Staff meetings
 - Team meetings
 - Driving time for clinical care
 - Committee work and other management support activities of a frontline clinician

Administrative time is also defined differently for labor mapping purposes versus procedure codes. There are three other categories for labor mapping that include the following:

- Education – Time spent providing formal training (i.e., didactic education, includes time spent preparing, as well as actual classroom/lecture time for the educator/presenter). This is NOT time spent receiving or attending training.

- Research – Time spent in formal, approved research by the medical facility
- Administrative Time – time spent on managerial or administrative duties, generally at the level of department, service, medical center, network, or nationally, both within and outside of VHA
 - Program planning (clinical program directors, program coordinators, etc.)
 - Performance appraisals (supervisors, service chiefs, etc.)
 - Time and leave certification
 - Hospital/facility-wide committees – requiring one or more hours per week (e.g., professional standards board, safety committee)

In general, suicide prevention staff will not be labor mapped with education or research time. Per [VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics](#):

Each VA Medical Center and very large CBOC must appoint and maintain a suicide prevention coordinator (SPC) with a full-time commitment to suicide prevention activities. SPCs in medical centers must have adequate support to meet these responsibilities in the parent medical center and in the associated CBOCs (except for those with their own SPCs). **NOTE: Mechanisms for support may include more than one SPC, appointing care managers for high-risk patients, or providing program support assistants.**

Very Large CBOCs = more than 10,000 unique Veterans each year

Example of determining labor mapping time:

Suicide Prevention Coordinator/Supervisor:

Assigned to oversee the suicide prevention program as well as conduct community outreach. The provider spends 80% of their time in SP program coordination and staff supervision/management activities. Twenty percent of time is spent in community outreach services with Veterans, including traveling to and from community agencies.

- Labor mapping:
 - 80% administrative
 - 20% clinical

Facilities may choose to share administrative responsibility among various suicide prevention staff, including but not limited to — coordinators, case managers, peer support, program support assistants. This task sharing may allow clinical staff the ability to continue providing patient care.

Facility XYZ consists of the following:

Facility	SP Staff	% Clinical SP	% Admin SP
Medical Center A	SPC	25%	75%
	PSA	0%	100%
Medical Center B	SPC	25%	75%
CBOC Z – very large	SPC	25%	75%
CBOC Y – very large	SPC	25%	75%
CBOC X - large	-	-	-
CBOC W – medium	-	-	-
Total	5 FTE	500%	
REQUIRED total SP	4 FTE	400%	

Facility XYZ includes two medical centers and two very large CBOCs (*10,000 uniques or more*). Facility XYZ is required to staff a minimum of four full-time SPCs with 100% of their time committed to suicide prevention activities. However, Facility XYZ also has a program support assistant to facilitate many of the administrative components of the program. This allows the SPCs to case manage Veterans on the High-Risk List, respond to VCL calls, and provide short-term therapy (three to four sessions per patient) and a safety planning group.

Facility XYZ is in compliance with required SP staff and activities and actually exceeds staffing requirements.

Facility ABC consists of the following:

Facility	SP Staff	% Clinical SP	% Admin SP	% Admin Other
Medical Center G	SPC	0%	50%	50% Homeless
CBOC H – very large	SPCM	50%	50%	-
CBOC I - large	-	—	-	-
CBOC J – medium	-	—	-	-
Total	1.5 FTE	50%	100%	50%
REQUIRED total SP	2 FTE	200%		N/A

Facility ABC includes one medical center and one very large CBOC (*10,000 uniques or more*). Facility XYZ is required to staff a minimum of two full-time SPCs with 100% of their time committed to suicide prevention activities. Facility ABC has opted to hire a SPCM instead of a SPC, but the SPCM’s time is assigned 100% to SP activities. In contrast, Facility ABC has a SPC that is splitting time between the SP Program and the Homeless Program.

Facility ABC is **not in compliance** with required SP staff and activities.

Workload/Productivity

Mental Health Services is required to track productivity³ for all clinical staff providing mental health services. [VHA Memorandum 2016-05-31, Mental Health Productivity Targets](#) recommended that 75-85% of a provider’s *clinically mapped time* be spent providing face-to-face or telephone care. In general, productivity is measured by wRVUs or work-relative value units that are assigned to CPT codes. When a provider completes an encounter, a CPT code is selected based on the type of clinical service being provided to a particular patient. CPT code data is captured through the Patient Care Encounter (PCE) system either through completion of an encounter form in CPRS or through the use of approved CPT codes in the Event Capture System. This data is then transmitted through PCE and is used in national reporting tools to demonstrate provider productivity.

There are **no** national targets for individual providers — from mental health or social work — for productivity. Targets should be individualized and modified based on the tasks a provider is completing.

³ [VHA Directive 1161, Productivity and Staffing in Clinical Encounters for Mental Health Providers](#)

There are several factors that impact productivity for suicide prevention staff specifically. They include:

1. Nonbillable tasks - Many of the tasks required by suicide prevention staff members are administrative in nature with reference to billing (i.e., nonbillable), but are clinical tasks with reference to labor mapping (e.g., flagging).
2. Low wRVU value - Some clinical tasks frequently performed by suicide prevention staff have a low wRVU value by default (e.g., case management, telephone care).
3. Administrative – non-encounterable - Other tasks are purely administrative and are not captured through the encounter system at all (e.g., training of VHA staff, outreach in the community).
4. Labor mapping – Suicide prevention staff should be appropriately labor mapped to reflect the significant amount of administrative work that is required. If labor mapping is not applied appropriately, providers may appear underproductive or overproductive.

Productivity is therefore expected to be low when using the method of capturing wRVUs. Facilities should modify targets accordingly to reflect the tasks being completed by suicide prevention staff. Some things to consider when setting targets:

- What should the target be for a provider in suicide prevention who is primarily clinical (e.g., 90-100%)? Is the assigned target too high? Too low?
- What other responsibilities does the provider have (e.g., chair of the professional standards board, supervision of a trainee for licensure)?
- Are they full time in the program or detailed to some other program (e.g., detailed to national suicide prevention office 25% of the time)?
- Does the provider complete many groups?
- What are the clinical tasks being provided? Are they primarily case management or do they also include psychotherapy for individuals and/or groups?
- What types of encounters are being completed (e.g., telephone or face-to-face, individual or group)?

Facilities may need to consider other methods of monitoring productivity outside of the standard wRVU calculation. In addition to using productivity to assist with maximizing use of an individual staff member, productivity may also impact staffing levels. Potential options for monitoring productivity include, but are not limited to, the following:

- Position-specific time studies to highlight the type and amount of work being completed
- Review of uniques and encounters (not just wRVUs)
- Capture of Historical Visits documented in CPRS (VistA Menu)
- Capture of Progress Note Titles documented in CPRS (VistA Menu)
- Use of administrative clinics (VistA Menu ACRP, local data capture only)

Note: Capture of workload outside of the RVU system of monitoring productivity is **not required**. These options should be considered as potential tools only.

OMHSP has created multiple tools to assist staff and supervisors with calculating productivity through the use of Excel-based trackers. These trackers use the following data elements:

- What tasks are a provider required to complete?
- What is a provider actually doing with their clinical time?
- How much of the clinical time is actually bookable time (i.e., scheduled appointments)?
- How many patients does a provider actually see?
- What are the wRVU values of the procedure codes most frequently used by the provider?

Tools in the [MH Productivity](#) subfolder on the [Office of Mental Health and Suicide Prevention SharePoint](#) site:

- Productivity Guidance, Directives, and FAQs
- Productivity Presentations
- Productivity Tool – Excel-Based Trackers
- wRVU by year

Examples of measuring productivity

Example wRVU productivity scenario:

Suicide Prevention Coordinator A

Labor Mapped	50% Clinical Time 50% Administrative Time
Annual RVU Target for SPC A	1,300 RVUs per year for 100% clinical time
SPC A Annual Target	650 RVUs per year for 50% clinical time

- Clinical tasks (billable) include:
 - Veterans Crisis Line calls
 - Safety Planning Group weekly meetings
 - Monthly telephone contact with HR Veterans
 - Weekly HR Veteran Drop-in Group

- Administrative tasks (nonbillable) include:
 - Flagging responsibility for all high-risk Veterans
 - Outreach
 - VA S.A.V.E. training at new employee orientation
 - Other staff training:
 - Lethal means counseling training
 - SDV Classification System
 - Safety planning training
 - Environment of care rounds for the inpatient psychiatric unit

Yearly Target RVU for 1 FTE with 100% CT: 1300

	FTE	% Clinical Time	RVU Target	Total No.	Total RVUs	% of Target	Encounters	Visits	Uniques
Q1	1.0	50%	162.5	309	171.05	105%	298	292	238
Q2	1.0	50%	162.5	-	-	-	-	-	-
Q3	1.0	50%	162.5	-	-	-	-	-	-
Q4	1.0	50%	162.5	-	-	-	-	-	-
Yearly Totals:			650	309	171.05	105%	-	-	-

KEY: ■ < 80% Below Target ■ 90% - 100% (At Target) ■ >100% (Over Target)

Detail of Top Procedures										
HCPCS	Description	Work RVU	Q1		Q2		Q3		Q4	
			No. RVUs	No. RVUs	No. RVUs	No. RVUs	No. RVUs	No. RVUs	No. RVUs	No. RVUs
90839	Psytch Crisis initial 60 min	3.13	5	15.65	-	-	-	-	-	-
90853	Group psychotherapy	0.59	60	35.4	-	-	-	-	-	-
98966	Hc pro phone call 5-10 min	0.25	20	5	-	-	-	-	-	-
98967	Hc pro phone call 11-20 min	0.5	200	100	-	-	-	-	-	-
98968	Hc pro phone call 21-30 min	0.75	11	8	-	-	-	-	-	-
T1016	Case Management (15 min)	0.5	13	7	-	-	-	-	-	-

Example
Example
Example
Example

SPC A -

- Has an individualized annual target of 650 wRVUs per year or 162.5 per quarter
- Used six procedure codes (see HCPCS column) a total of 309 times for Quarter 1
- Completed a combined total work RVU sum of 171.05 for Quarter 1 (more than the required 162.5)
- Is exceeding the individualized target RVU percentage for the quarter with a total of 105% of target for Quarter 1

Example time study of suicide prevention tasks:

SP Activity	Monthly	Quarterly	Avg Time Spent
VCL Consults	100	300	30 min/each
PRF Documentation (initiation, continuation, removal, transfer – VistA action & progress note titles) <ul style="list-style-type: none"> • 30 new PRFs • 20 monthly reviews • 5 transfers 	55	165	20 min/each (VistA & CPRS)
Staff Consultations	20	60	25 min/each
Outreach Events	5	15	2 hours/each
Mail-outs	75	225	6 hours/month
NEO – SAVE	2	6	90 min/15 attendees/session
Training – Safety Planning, Risk Assessment, Lethal Means, etc.	2	6	90 min/10 attendees/session
Behavioral Autopsies	8	24	3 hours/BHAP
FIT-Cs	8	24	30 min/FIT-C
Root Cause Analysis	-	2	12 hours/RCA
Group – Safety Planning, HR Veterans, etc.	4	12	1 hour/8 attendees/session
Issue Briefs	4	12	3 hours/IB
Monthly HRF Review Staffing/Committee	1	3	90 min/month

Resources

1. **Stop Codes**
 - [Active Stop Codes – VHA Office of Finance, Managerial Cost Accounting Office](#)
2. **Encounters**
 - [VHA Coding Guidelines V.14, VHA Health Information Management Coding Council, 2017](#)
 - [VHA Directive 1082, Patient Care Data Capture](#), March 24, 2015
3. **Required Documentation for Psychotherapy Encounters**
 - [VHA Chief Business Office 1601C.03.6.D.3.b Specific Mental Health Documentation Requirements](#) (Community Care National Portal Policy Manuals https://vaww.vrm.km.va.gov/system/templates/selfservice/va_kanew/help/agent/locale/en-US/portal/55440000001031/topic/55440000004673/Policy-Manuals. Policy Manual 01. Community Care Policy & Planning > 1601C Revenue for Veterans Benefits Claims > 03 Billing > Chapter 6 – Reasonable Charges and Billing Procedures: Topics J-O > Section D. Mental Health Reasonable Charges and Billing > 3. Documentation Requirements for Billing of Mental Health Services)
4. **Labor Mapping and Productivity**
 - [VHA Directive 1161, Productivity and Staffing in Clinical Encounters for Mental Health Providers](#), dated April 28, 2020
 - [VHA Memorandum 2016-05-31, Mental Health Productivity Targets](#), dated May 24, 2016
 - VA Financial Policy, Volume XIII, Chapter 3 <https://www.va.gov/finances/docs/VA-FinancialPolicyVolumeXIIIChapter03.pdf>
5. **Uniform Mental Health Services**
 - [VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics](#), dated Nov. 11, 2008 (amended Nov. 16, 2015)

Appendix 3.0 Suicide Prevention Responsibilities Tracking and Reporting Matrix

Tracking/Reporting Responsibility	Due date/time	How
-----------------------------------	---------------	-----

High-Risk Flags

PRF placement	Within one business day of determination a Veteran meets criteria	Patient Record Flag Category I – High-Risk for Suicide progress note title linked to PRF flag action
Four MH visits	Within 30 days of PRF placement	Encounter in the EHR
One MH visit	Monthly for the life of the PRF	Encounter in the EHR
Safety plan	+/- seven days of PRF placement	Suicide Prevention Safety Plan or SPSP Review progress note title
PRF review	+/- 10 days of PRF review date	Patient Record Flag Category I – High-Risk for Suicide progress note title linked to PRF flag action

Veterans Crisis Line Consults

New consult - action	Within one business day of receipt	Quick Save in Medora
Phone contact	Three separate contact attempts on three separate days	Quick Save in Medora
Letter contact	Anytime during the three separate attempts to contact	Quick Save in Medora
Close consult	Within three business days of receipt	Submit in Medora; populate in EHR if appropriate

Suicidal Behaviors

Notification of VISN/VACO		
Heads-up Message	Within two hours of awareness of the incident	HUM template to facility leadership
Issue Briefs	Within two business days of awareness of the incident	IB template to facility leadership
EHR Templates	Immediately upon notification of an event	SBOR or CSRE template
ICD-10 Suicide-Related Behavioral Diagnoses Codes	Immediately upon notification of an event	EHR encounter
Facility Patient Safety Manager	per facility guidance	per facility guidance
Behavioral Health Autopsy Program		
BHAP Form	Within 30 days of notification	BHAP Form submitted
FIT-C Form	Within 30 days of notification	FIT-C Form submitted
SPAN	By the 10 th day of the following month	Electronic entry

Outreach Events

Community Outreach		
five events	Monthly	SPC* participation
Includes one community VA S.A.V.E. training		SPC* presentation
Caring Contacts		
Non-demanding postcard/letter	one/month x12 consecutive months	U.S. mail
Documentation	Once when added, once when removed	EHR documentation for each patient Adding a comment to “risk of suicide” problem list?
	By the 10 th day of the following month	Electronic entry (one entry/month)

Suicide Prevention Training for all VHA Staff

VA S.A.V.E. Training	Within 90 days of hire — all nonclinical employees	In person by SPC* in NEO – TMS record of completion
	Annually for all nonclinical employees	TMS assignment and completion
Skills Training for Evaluation and Management of Suicide	Within 90 days of hire — all clinical employees	TMS assignment and completion
	Annually for all clinical employees	TMS assignment and completion

* Suicide prevention coordinator (SPC) may be substituted with any appropriate member of the facility Suicide Prevention Team.

Appendix 3.1.1 Patient Record Flag

Accessing Patient Record Flags

All patient record flagging actions are completed in the VistA system. Only completion of the TIU Progress Note title is completed and linked in CPRS. To manage patient record flags, a SPC will need to have access to the patient record flag menus in VistA. Every clinical provider who completes encounters in CPRS, including SPCs, will have an assigned primary menu that specifies the types of functions the clinician can complete within CPRS.

The following are what are called “secondary menu options.” SPCs will need to have the five secondary menu options added to their VistA account access:

- DGPF RECORD FLAGS MAIN MENU**
- DGPF TRANSMISSION MGMT**
- SD MH PROACTIVE AD HOC REPORT**
- SD MH NO SHOW AD HOC REPORT**
- SD MH NO SHOW NIGHTLY BGJ**

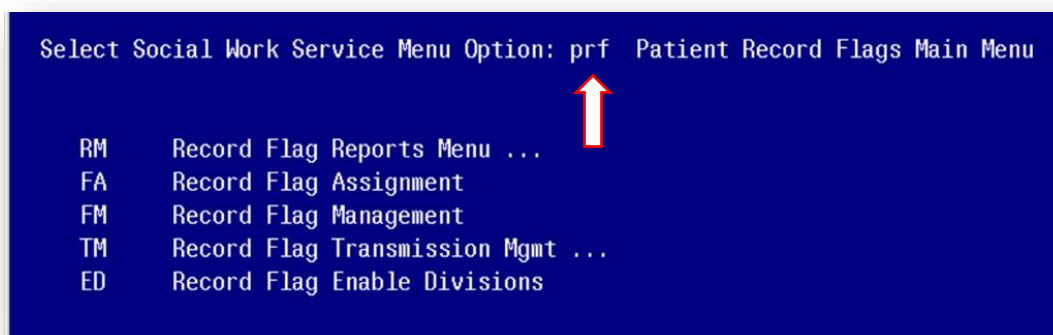
SPCs should notify their facility/department ADPAC and their supervisor to facilitate having these menu options added to their VistA profiles. The chart below includes further descriptive details of the menu options.

Menu Option	Descriptor Name	Details
DGPF RECORD FLAGS MAIN MENU	Patient Record Flags Main Menu	This menu option contains all menus and options needed to assign, manage, and report patient record flag information.
DGPF TRANSMISSION MGMT	Record Flag Transmission Mgmt.	This option acts as a submenu containing options available to manage patient record flags transmissions.
SD MH PROACTIVE AD HOC REPORT	High Risk MH Proactive Ad Hoc Report	This report will list the appointments for a date range for patients with a high risk for mental health patient record flag.
SD MH NO SHOW AD HOC REPORT	High Risk MH No-Show Ad Hoc Report	<p>This report will list the patients who have the patient record flag for high risk for suicide and who did not show up for an appointment in a mental health or physical health clinic.</p> <p>The report will list the patient, emergency contacts, next of kin, future scheduled appointments. provider and results.</p> <p>Mental Health clinics are face-to-face Mental Health appointments defined in the "VA-MH NO SHOW APPT CLINICS LL" Reminder Location List.</p>
SD MH NO SHOW NIGHTLY BGJ	High Risk MH No-Show Nightly Report	This option should be used if you need to re-create the same report that is created by the scheduled SDAM BACKGROUND job after midnight each night. The option lists the no-show and no action taken appointments for Mental Health Clinics for the previous day

		<p>**This report should not be scheduled to run nightly, as it is kicked off by the Scheduling Nightly Background Job (SDAM BACKGROUND JOB) that should already be scheduled to run nightly on your system.</p> <p>This report is sent in a mail message to the members of the SD MH NO SHOW NOTIFICATION mail group.</p> <p>Future appointments will list on this report. The number of days of future appointments that will list is defaulted to 30 days in the future. A new parameter, SD MH NO SHOW DAYS, has been added to store the number of days to list future appointments for. This parameter can be edited by the user by using the option “[XPAR EDIT PARAMETER] Edit Parameter Values.”</p>
--	--	---

All SP staff members are not required to have these menus. Generally, a small number of people at a facility are designated as the person(s) responsible for PRF management. If SPCs do not have access and need it, they will need to follow facility instructions for requesting the menus. Typically, this is through a department ADPAC who submits an ePas (Electronic Permission Access System) request.

The following submenus are part of the DGPF RECORD FLAGS MAIN MENU. Each submenu will be reviewed in this section, including detailed “how-to” instructions.



Note: In this illustration, the clinician’s primary menu is the “Social Work Service Menu.” This clinician accesses the PRF menu (Patient Record Flags Main Menu) by typing in the letters “prf” at the prompt. SPCs primary menu may be/look different. How SPCs access the secondary menu may also look different. SPCs will need to work with their facility ADPAC to determine how to access the PRF menu after access has been granted.

In addition to the PRF menus, SPCs may also need additional access to divisions within their medical facility. The “division” SPCs have access to is typically dependent on their physical location and is usually a default. SPCs will need to work with their facility to determine if they need access to other divisions, such as CBOCs or that of the parent facility. It is recommended that SPCs place PRFs using the parent facility versus specific divisions unless SP programs split coverage of specific divisions within the medical system. SPCs should contact their local CAC to determine who grants this access, if necessary.

Examples of divisions within the James E. Van Zandt VAMC:

503	James E. Van Zandt VAMC
5039AA	VANURS Altoona
5039AF	STNURS PA, HOLLIDAYSBURG
503CNH	CNJ Altoona
503DR	JAMES E. VAN ZANDT VA – ALTOONA – NON VA HOSPITAL-CIVIL-NVAHC
503DS	NVAH Altoona
503DT	Stdom,PA,HOLLIDAYSBURG
503GA	Johnstown
503GB	DuBois – Clearfield
503GS	State College – Centre County
503GD	Huntington County
503GE	Indiana County
503PA	ALTOONA PA - PR RTP

Station 503 has numerous divisions. All divisions are not required to be “active” for a SPC to place a PRF. However, if multiple divisions ARE active for a station, SPCs will either need to have access to each of those divisions in order to place PRFs, or the facility will need to determine which division is appropriate to use for placement of PRFs.

SPCs will also need access to the Patient Record Flag Note Titles – Category I in CPRS. SPCs should contact their local CAC to request access to the list of Category I titles at their facility. Access to these note titles is not automatic. Category I PRF note titles do not usually display in the list of note titles except to those staff who have flagging capability.

RECORD FLAG ASSIGNMENT SUBMENU

Assigning a Flag

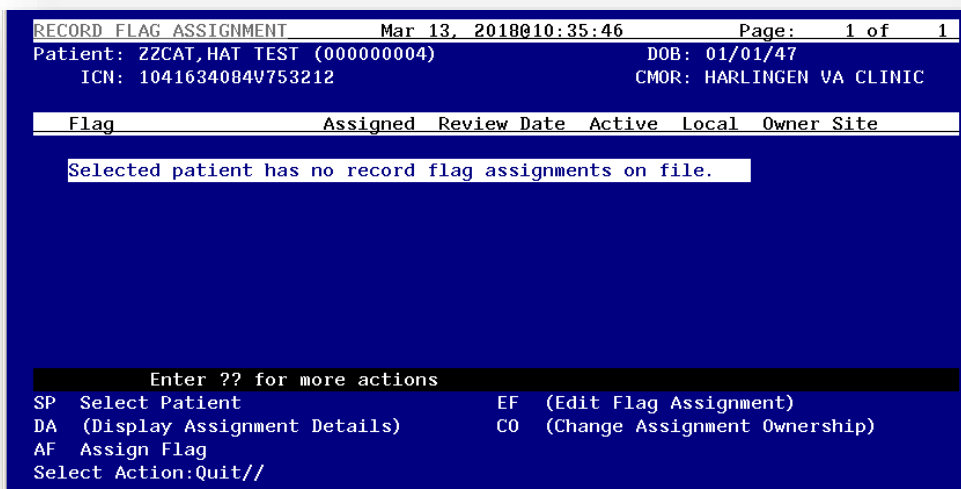
Step 1. In VistA – Using the **AF (Assign Flag)** action, assign the High-Risk Flag and save

Step 2. In CPRS — create a new note (selecting historical visit, the visit should not be encountered) selecting the TIU PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE. Link the TIU to the VistA flag.

In the following example, the SPC is going to place a PRF on the test patient:

Patient Name	DOB	SSN
HAT TEXT ZZCAT	1-1-47	000000004

Facilities may have a different list of test patients. This facility’s test patients all start with the letters ZZ as part of the last name. To practice, SPCs will want to determine which patients are test patients at their facility. Practice flag actions on test patients before completing any flag action on an actual patient.



SP Select Patient
 DA (Display Assignment Details)
 AF Assign Flag
 Select Action:Quit// **af** Assign Flag
 Select a flag for this assignment: **high risk**

Searching for a PRF NATIONAL FLAG
 HIGH RISK FOR SUICIDE ACTIVE CLINICAL
 ...OK? Yes// **[enter]** (Yes)

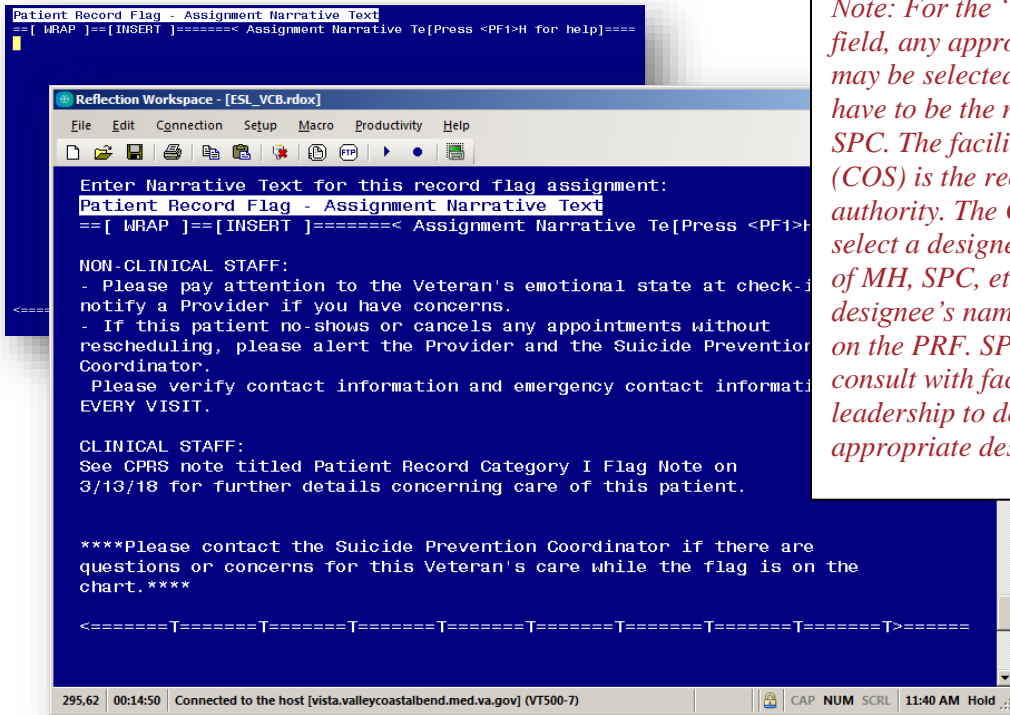
No Category I patient record flag assignments were returned from .

Enter Owner Site: ANYWHERE VA CLINIC// **[enter]** TX VAMC 123
 Approved By: **your name** LAST,FIRST FL 116B SOCIAL WORKER

Tip: Many of the entries are default. If modifications are necessary, type in the new text after the double backslash marks // and then hit enter.

 E.g. Enter Owner Site: ANYWHERE VA CLINIC//**[type] ANYTIME VA CLINIC**

Enter Narrative Text for this record flag assignment:



Patient Record Flag – Assignment Narrative Text

- Should limit the amount of privacy information shared
- Includes what staff should do to manage a high-risk Veteran

Copy and paste the text below into the VistA text box. VistA will not allow formatting (e.g., *italics*, **bold**, underline, ● bullets). To emphasize text, CAPITALIZE words or add a special character such as a – (dash) or * (asterisk) to separate text. (Note: There is no requirement to emphasize text.)

This Veteran has been assessed as being at high risk for suicidal behavior/self-directed violence.

NONCLINICAL STAFF:

- Please pay attention to the Veteran’s emotional state at check-in and notify a Provider if you have concerns.
- If this patient no-shows or cancels any appointments without rescheduling, please alert the Provider and the Suicide Prevention Coordinator.
- Please verify contact information and emergency contact information AT EVERY VISIT.

CLINICAL STAFF:

- See CPRS note titled Patient Record Flag Category I High Risk for Suicide Note for further details concerning care of this patient.

Please contact the Suicide Prevention Coordinator if there are questions or concerns for this Veteran’s care while the flag is on the chart.

To save text, type on the keyboard “Num Lock + e” or “Ctrl + e”

Enter Review Date: (MAR 13, 2018-JUN 11, 2018): 6/11/2018// [enter]

Tip: The default 90-day review date populates. If it needs to be changed, type in a new date after the double backslash // (e.g., a PRF continuation for only 30 days instead of 90).

E.g. Enter Review Date: (MAR 13, 2018-JUN 11, 2018): 6/11/2018// [type] 5/11/18

REVIEW OF ASSIGN FLAG DATA INPUT BEFORE FILING

Patient Name: ZZCAT,HAT TEST
Flag Name: HIGH RISK FOR SUICIDE
Flag Type: CLINICAL
Flag Category: I (NATIONAL)
Assignment Status: ACTIVE
Initial Assignment: 3/13/2018@11:40:28
Last Review Date: N/A
Next Review Date: 6/11/2018
Owner Site: ANYWHERE VA CLINIC
Originating Site: ANYWHERE VA CLINIC
Assignment Action: NEW ASSIGNMENT
Action Date: 3/13/2018@11:44:28
Entered By: LAST,FIRST
Approved By: LAST,FIRST
Record Flag Assignment Narrative:

Tip: VistA allows review once more prior to filing the PRF to ensure all the information entered is correct.

This Veteran has been assessed as being at high risk for suicidal
Type <Enter> to continue or '^' to exit: [enter]

Record Flag Assignment Narrative:

behavior/self-directed violence.

NONCLINICAL STAFF:
- Please pay attention to the Veteran's emotional state at check-in and notify a Provider if you have concerns.
- If this patient no-shows or cancels any appointments without rescheduling, please alert the Provider and the Suicide Prevention Coordinator.
Please verify contact information and emergency contact information AT EVERY VISIT.

CLINICAL STAFF:

See CPRS note titled Patient Record Category I Flag Note on 3/13/18 for further details concerning care of this patient.

Type <Enter> to continue or '^' to exit: [enter]

Action Comments:

New record flag assignment.

Do you want to review again? NO// [enter]

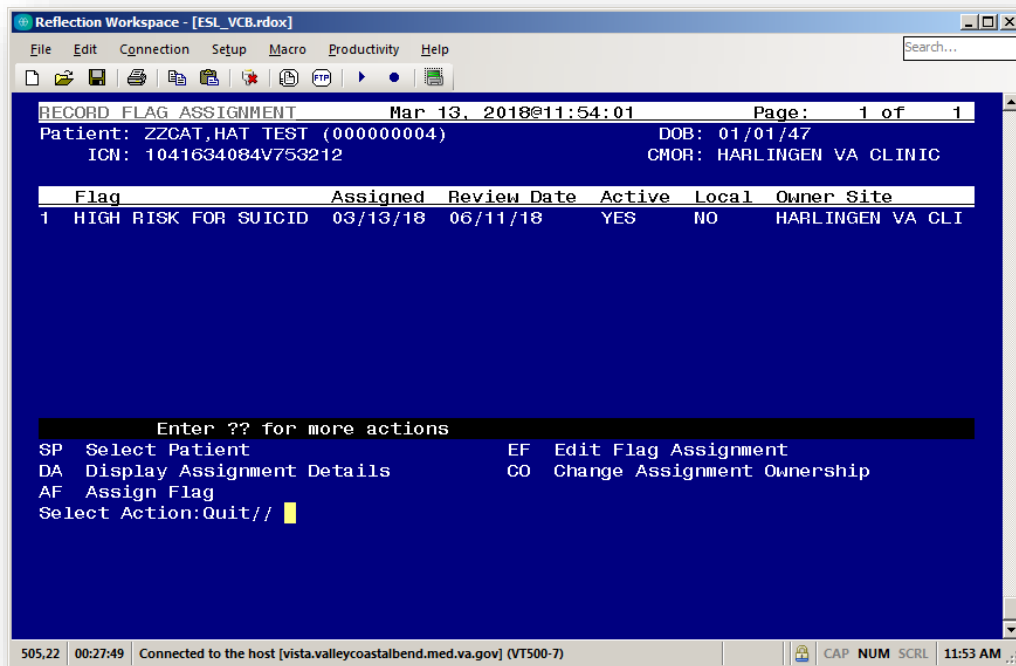
Would you like to file this new record flag assignment? YES// [enter]

Tip: If an error has been made (e.g., selected the wrong patient, pasted the wrong text, selected the wrong "review date") type in "no" rather than [enter]. VistA will not file the PRF. Selecting "no" will return the user to the Record Flag Assignment screen for the selected patient to begin the process again.

Filing the patient's new record flag assignment...

Assignment was filed successfully.

Type <Enter> to continue or '^' to exit: [enter]



The last [enter] command returns the screen to the Record Flag Assignment menu for the selected patient. The High Risk for Suicide PRF has been assigned successfully and is now listed as active for ZZCAT, HAT TEST (000000004).

In CPRS

Creating a PRF Progress Note

PRF progress notes may only be completed in CPRS when a PRF action has taken place in VistA. Creation of a progress note in CPRS is required for all PRF actions. This process will demonstrate how to create and link a progress note to a PRF action.

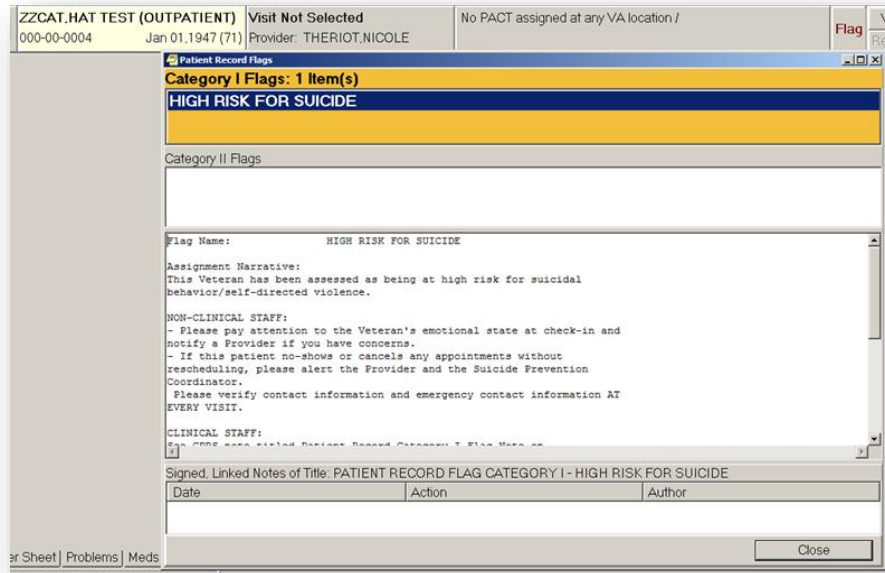
Note: This example uses test patient ZZCAT, HAT TEST (000-00-0004) and continues the action in the previous illustration. Use of this test patient is for illustrative purposes only. SPCs should use test patients in their CPRS systems.

Step 1

Navigate to CPRS and search for the patient with a new PRF action.

Step 2

Select “Close” to close the PRF pop-up box.



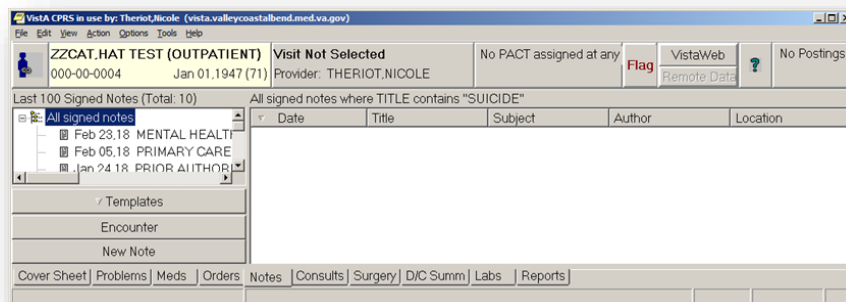
When the patient record opens, the pop-up shows immediately with the newly placed PRF.



Notice there is no linked progress note. The text box for linked notes is empty. If prior PRF actions and notes have been created, they will be displayed.

Step 3

Select the “Notes” tab.

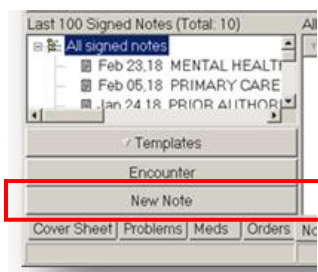


Step 4

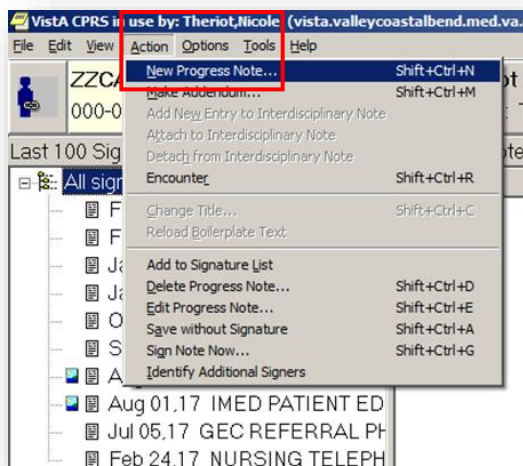
Select the “New Note” box

OR

“Action” + “New Progress Note”

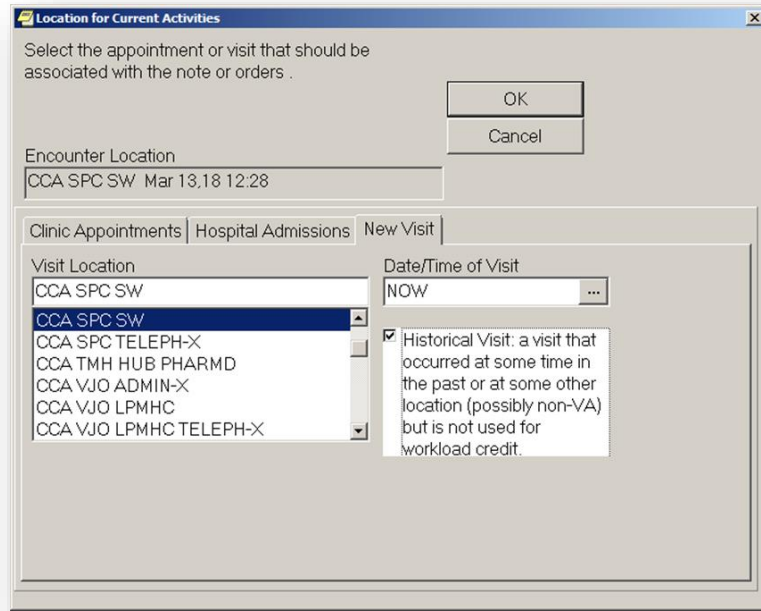


The Visit/Appointment box will open.



Step 5

Select “New Visit” and search for “Visit Location” (clinic name) by typing into the white space.



This illustration is using the clinic “CCA SPC SW.” Search for the name of the clinic that is appropriate to use when documenting in CPRS.

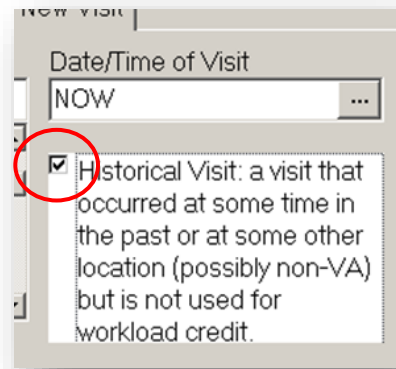
“Date/Time of Visit” default is NOW.

The date and time and the clinic selected will be visible in the “Encounter Location” box.

Step 6

Select “Historical” box.
Then select “OK.”

A new box will open allowing search and selection of a TIU Progress Note Title.



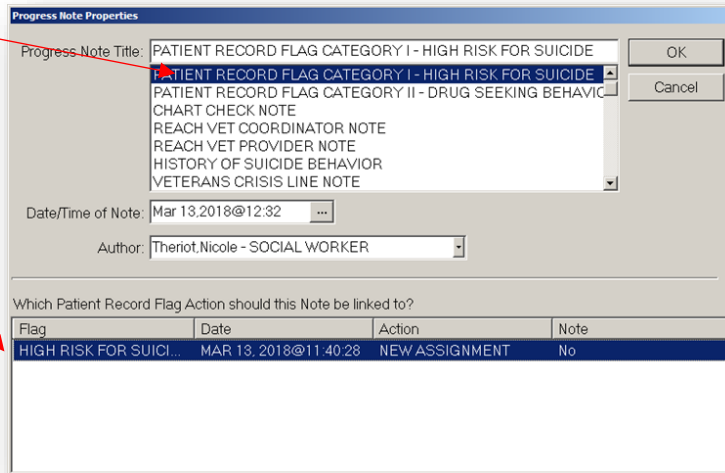
*****Note:** Placing a PRF is an administrative function and is *not* an encounterable activity. Selecting “Historical” is required in order to document the note without creating an encounter.*******
(See [Appendix 2.3 Billing Responsibilities Encounters and Historical Visits](#) for further information.)

Step 7

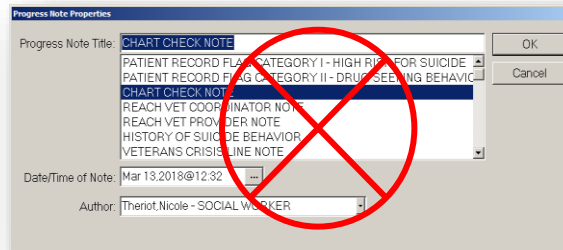
Search for the Progress Note Title PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE and select.

Step 8

The box below will appear. To link the note to the PRF action created in VistA, select the link to highlight.

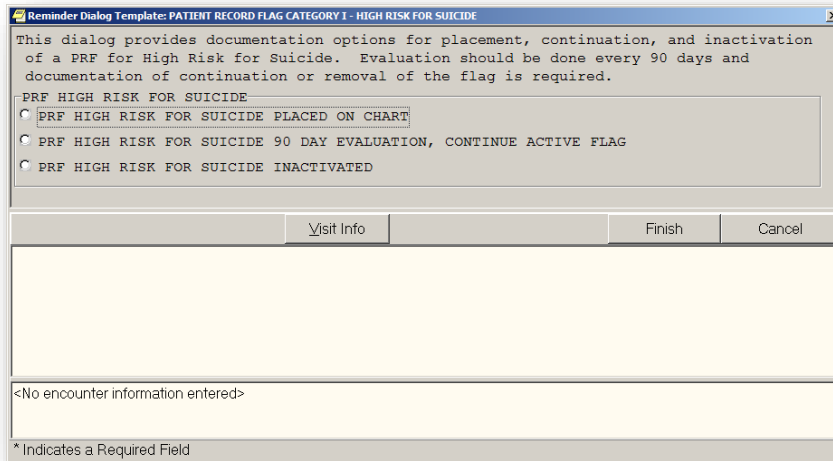


If the PRF note title is not visible in the list of progress notes, speak with facility CACs about being granted “permissions” to the title. Typically, only providers who have flagging ability in VistA have access to the corresponding progress note in CPRS.



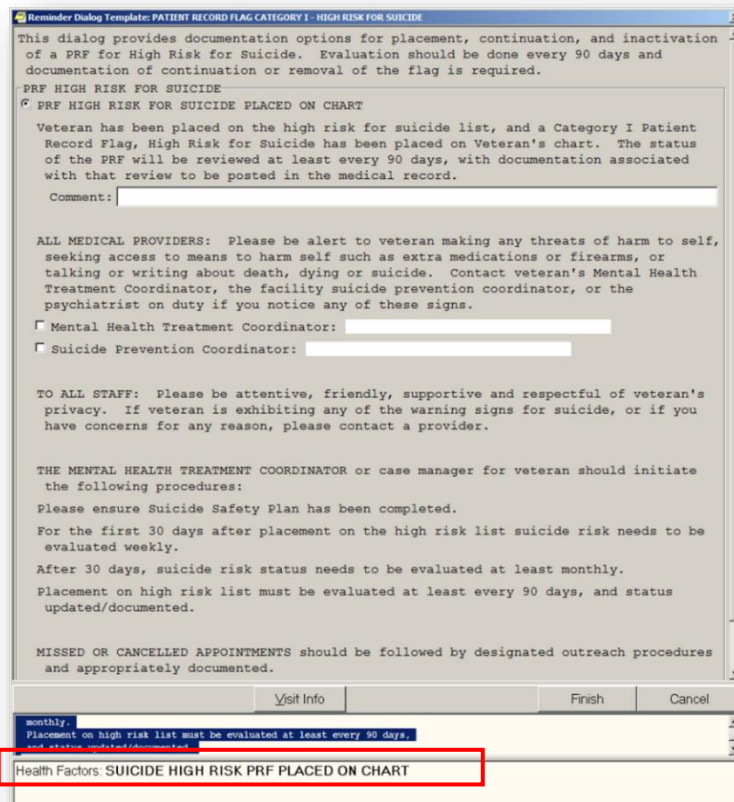
If the wrong progress note is selected, the box displaying the unlinked PRF action will not appear below.

Step 9
 Select the first option “PRF HIGH RISK FOR SUICIDE PLACED ON CHART”



This template (or something similar) should be the default when selecting the PRF note title. If it is not, speak with a clinical application coordinator (CAC) at the local facility.

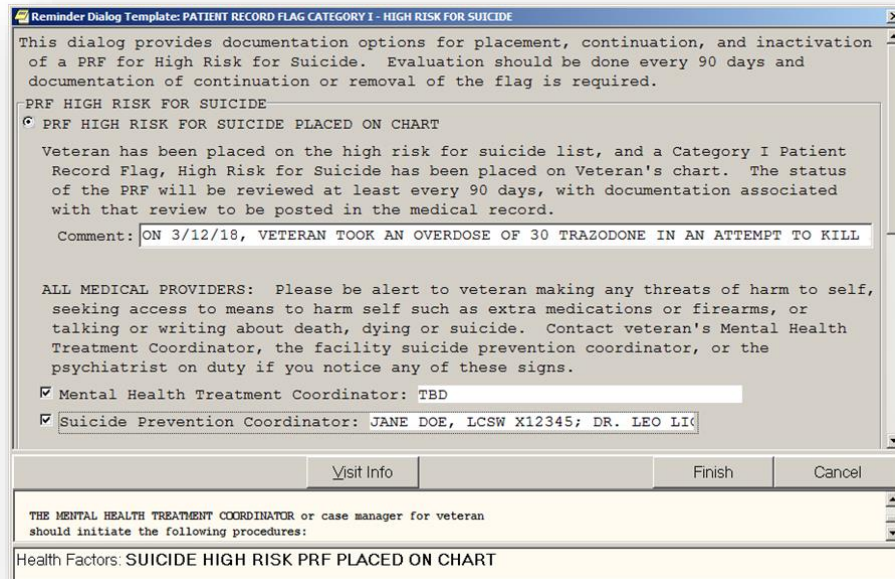
Step 10
 Enter text into the text fields as appropriate.



Notice a Health Factor has been added when PRF HIGH RISK FOR SUICIDE selection is made. Health Factors are data points that may be mined and tracked.

Step 11

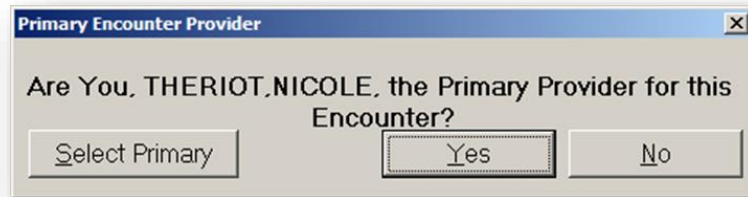
Once you have added your text, select “Finish” to populate the template.



The “Comment” field gives the opportunity to add more information specific to the SDV event. The text fields have a character limit. Once the template is populated, it may be edited, and/or additional information may be added as necessary before signing the note.

Step 12

The Primary Provider box will open and include your name. Select “Yes.”



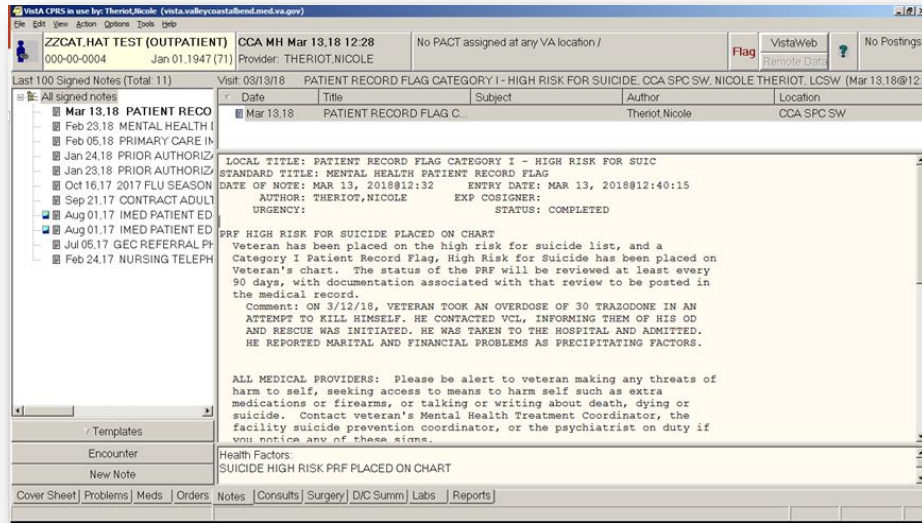
“Historical” should have been selected at the time of selecting a visit location so this will not generate an encounter. A designated “Primary Provider” is still required to sign the note.

Step 13

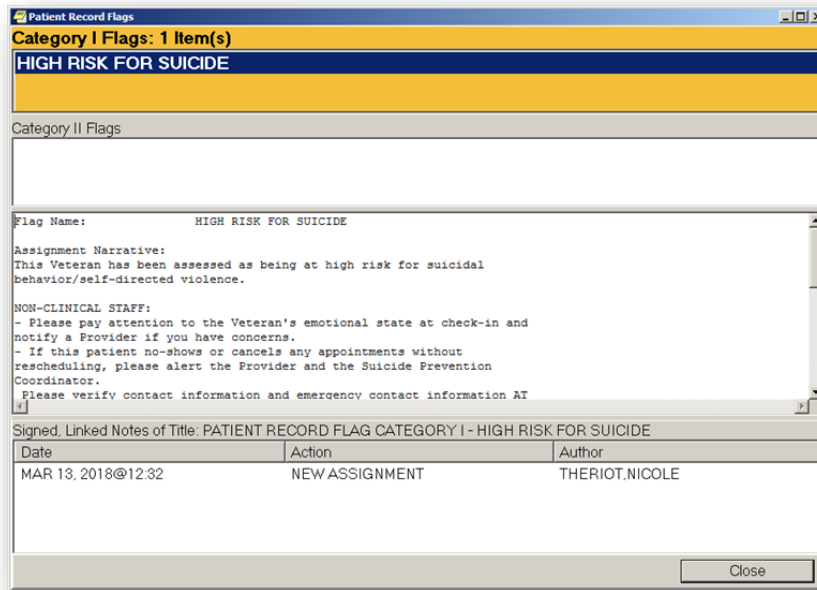
Review the note and modify or add text as needed by selecting “Edit” from the tabs at the top.

Step 14

Sign the note.



Notice the Flag box is now showing in red. Click on the box to verify the note just created is now linked to the flag action.



The Vista PRF text will open as a separate pop-up box. See the “Signed, Linked Notes of Title...” section at the bottom.

The CPRS progress note created is now linked to the PRF action and the note is visible in the Action field as a NEW ASSIGNMENT.

The steps needed to activate a new PRF are completed.

Subsequent Flag Actions

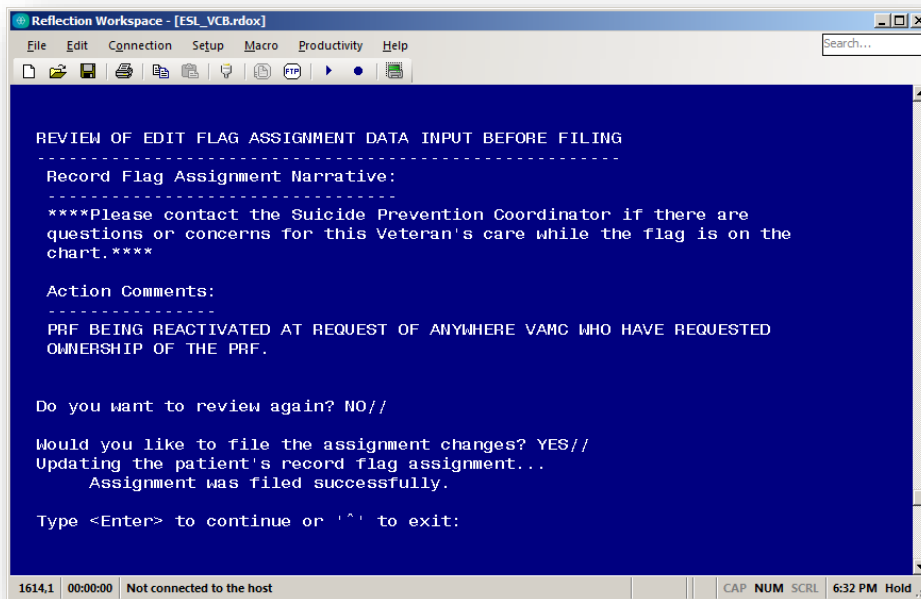
Once a PRF has been “assigned” and inactivated, it will never be “assigned” a second time. Subsequent actions of the flag, regardless of how many times or what the type of action is, will either use the **EF (Edit Flag Assignment)** action or the **CO (Change Assignment Ownership)** action.

```

SP  Select Patient          EF  (Edit Flag Assignment)
DA  (Display Assignment Details)  CO  (Change Assignment Ownership)
AF  (Assign Flag)
Select Action:Quit//
    
```

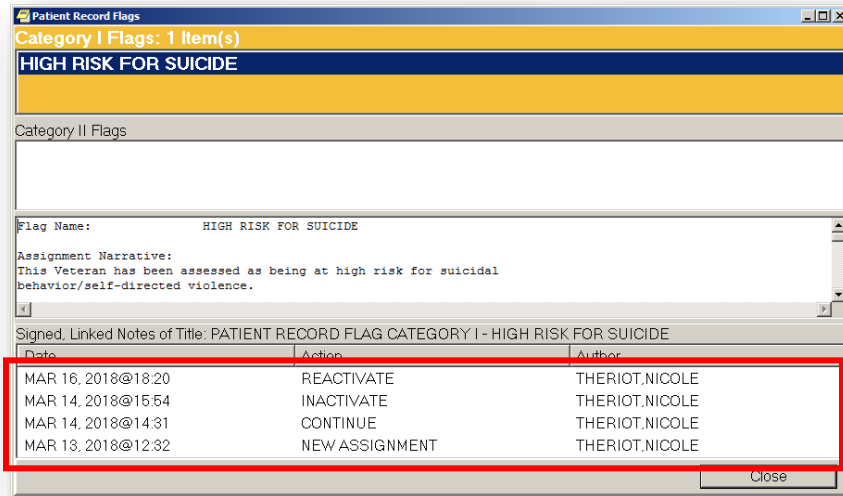
All other flag actions after the initial assignment – Entered in Error, Continue, Inactivate, Reactivate, and Change Assignment Ownership (Transfer) — require an “Edit Reason” or “Edit Assignment” text. The PRF text populated during the **AF (Assign Flag)** action will remain unless a SPC wants to revise it. “Edit Reason” text is:

- Shown after the Record Flag Assignment Narrative and is listed as “Action Comments”
- Not comprehensibly visible at the same time for every prior action completed
- Only visible in VistA, not CPRS
- Not visible except for the most recent

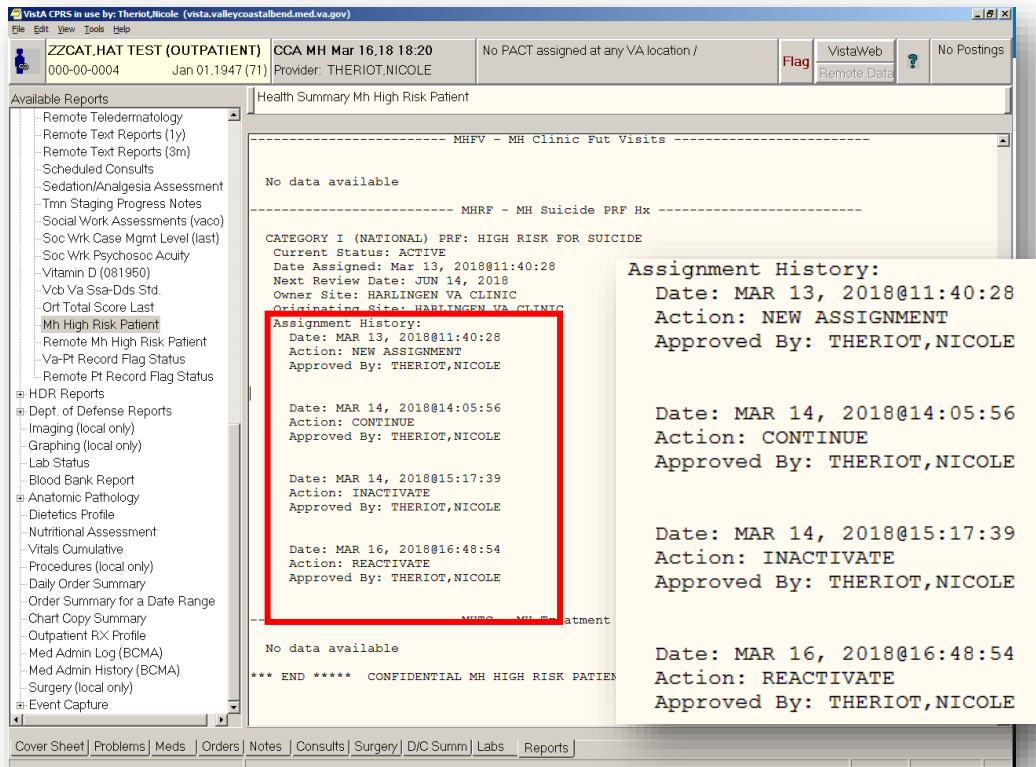


Flag actions are:

- Filed separately in VistA
- Visible in chronological order at the bottom of the PRF in CPRS if the action has a linked progress note (*Note – all flag actions in VistA REQUIRE an accompanying linked progress note in CPRS*)



- Visible under Health Summary of the Reports Tab in CPRS and populate as an Assignment History

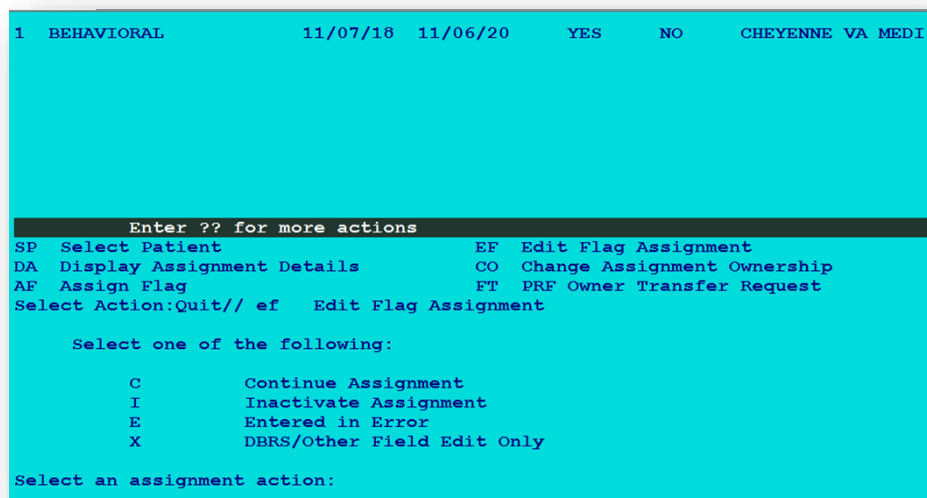


Examples of Patient Record Flag – Edit Assignment Text:

Inactivate	HIGH-RISK FOR SUICIDE COMMITTEE STAFFING COMPLETED. VETERAN'S RISK DEEMED TO BE LOWERED. APPROPRIATE FOR REMOVAL OF PRF.
Continue	UNABLE TO DETERMINE CURRENT LEVEL OF RISK AS VETERAN HAS HAD NO CONTACT WITH VA STAFF IN THE LAST TWO MONTHS. WILL CONTINUE PRF FOR 30 DAYS.
	HIGH-RISK FOR SUICIDE COMMITTEE STAFFING COMPLETED. VETERAN'S ACUTE RISK CONTINUES TO REMAIN ELEVATED. WILL CONTINUE PRF FOR 90 DAYS.
Entered in Error	PRF ENTERED ON WRONG PATIENT.
	PRF ENTERED IN ERROR FOR SDV EVENT OLDER THAN SIX MONTHS. VETERAN NOT ACUTE HIGH RISK AT THIS TIME.
Reactivate	PRF BEING REACTIVATED DUE TO NEW SDV EVENT.
	PRF BEING REACTIVATED AS VETERAN IS CURRENTLY ASSESSED AT ACUTE HIGH RISK FOR SUICIDE.
	PRF BEING REACTIVATED AT REQUEST OF ANYWHERE VAMC WHO HAS REQUESTED OWNERSHIP OF THE PRF.

Each facility should determine what text meets their needs/requirements. However, in general, “Edit Assignment” text should be brief.

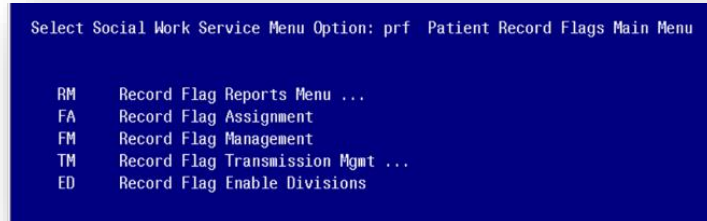
Entered in Error



Note: This action will delete an entire flag record, including any past PRF assignments, even if the past assignments were correct.

Step 1. In VistA —Using the **EF (Edit Flag Assignment)** action, continue the High-Risk Flag and save

Step 2. In CPRS — Create a new note (selecting historical visit, the visit should not be encountered) selecting the TIU PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE. Link the TIU to the VistA flag.



In VistA

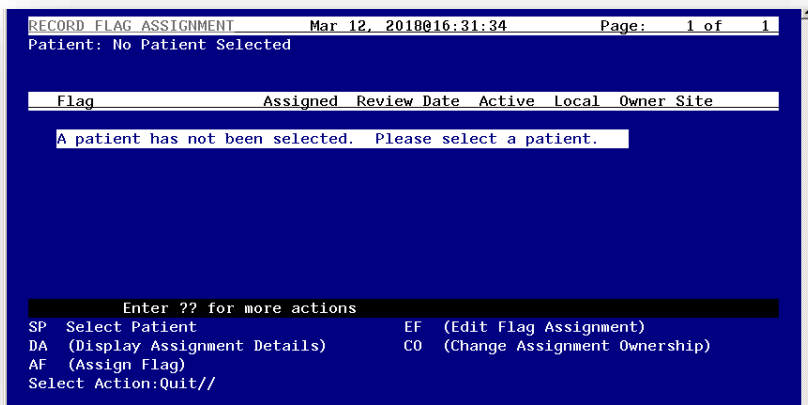
Everywhere text is highlighted **yellow** is a prompt to type a response or to hit enter.

Step 1

Select FA (Record Flag Assignment Menu)

Step 2

Select the appropriate patient



- SP Select Patient
 - DA (Display Assignment Details)
 - AF (Assign Flag)
 - EF (Edit Flag Assignment)
 - CO (Change Assignment Ownership)
- Select Action:Quit// **sp** Select Patient

Select PATIENT NAME: **any patient**

Step 3

Select “EF” – Edit Flag Assignment

Select Action:Quit// **ef** Edit Flag Assignment

Select one of the following:

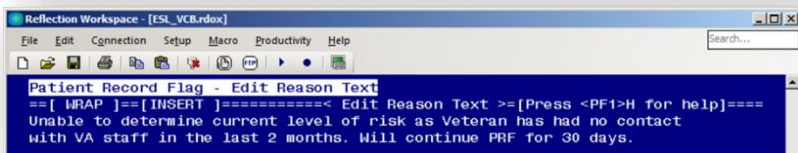
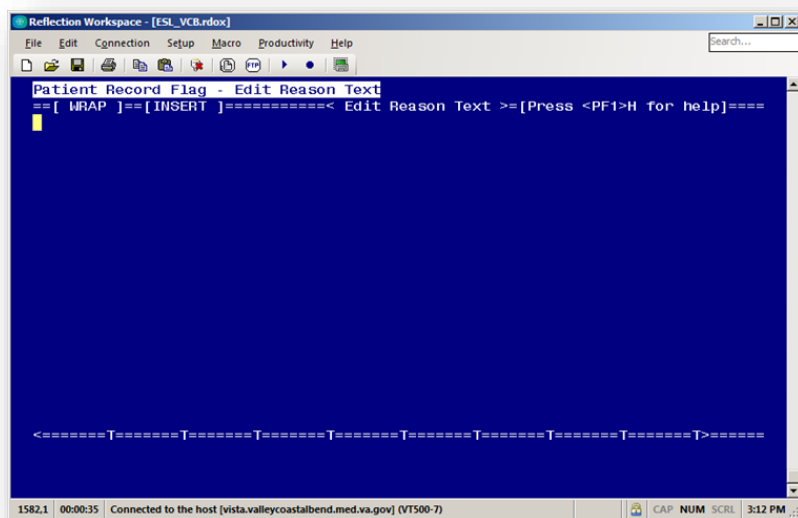
- C Continue Assignment
- I Inactivate Assignment
- E Entered in Error
- X DBRS/Other Field Edit Only

Select an assignment action: **e** Entered in Error

Would you like to edit the assignment narrative? YES// **n** NO

Approved By: **your name** LAST,FIRST FL 116B SOCIAL WORKER

Enter the reason for editing this assignment:



Step 4

In the Patient Record Flag – Edit Reason Text box, “Entered in Error” will prepopulate. Additional text is not required but may be typed in at this time.

Step 5

Save by typing “**Num Lock + e**” or “**Ctrl + e**”

Step 6

Review the text “Review of Edit Flag Assignment Data Input Before Filing” to ensure no other modifications are required. At the bottom, you should see the newly added comment. *Note: There will be no “review by date” to select as the PRF is being inactivated.*

Action Comments:

Entered in Error

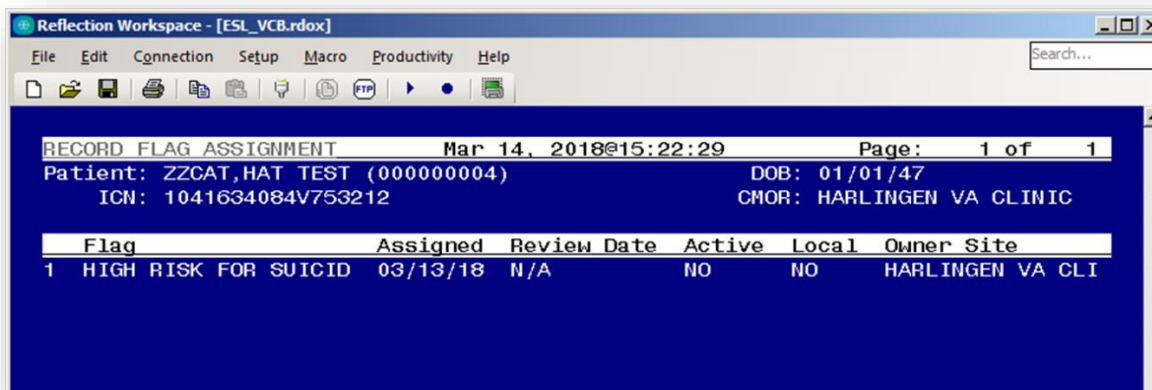
Do you want to review again? NO// [enter]

Would you like to file the assignment changes? YES// [enter]

Updating the patient's record flag assignment...

Assignment was filed successfully.

Type <Enter> to continue or '^' to exit: [enter]

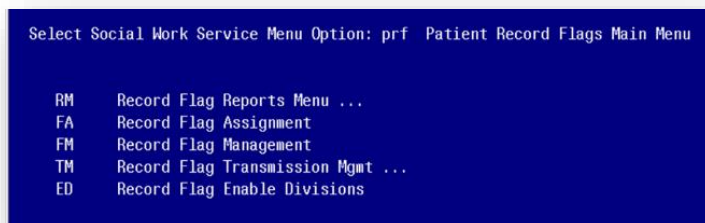


The “Active” column for the PRF indicates “NO” for ZZCAT, HAT TEST (000000004). The PRF has been successfully inactivated.

Continuing a Flag

Step 1. In VistA — Using the **EF (Edit Flag Assignment)** action, continue the High-Risk Flag and save

Step 2. In CPRS — Create a new note (selecting historical visit, the visit should not be encountered) selecting the TIU PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE. Link the TIU to the VistA flag.



In VistA

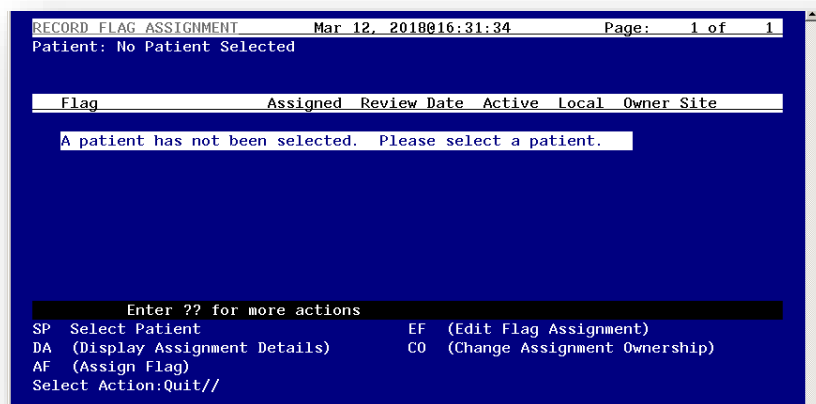
Everywhere text is highlighted **yellow** is a prompt to type a response or to enter.

Step 1

Select FA (Record Flag Assignment Menu)

Step 2

Select the appropriate patient



SP Select Patient

DA (Display Assignment Details)

AF (Assign Flag)

Select Action:Quit// **sp** Select Patient

EF (Edit Flag Assignment)

CO (Change Assignment Ownership)

Select PATIENT NAME: **any patient**

Step 3

Select “EF” – Edit Flag Assignment

Select Action:Quit// **ef** Edit Flag Assignment

Select one of the following:

- C Continue Assignment
- I Inactivate Assignment
- E in Error

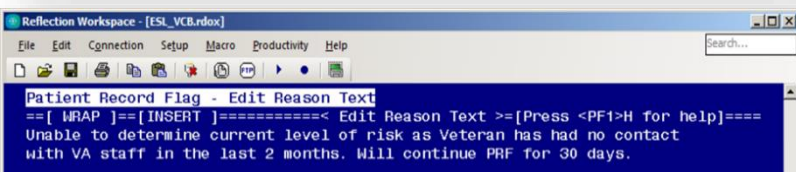
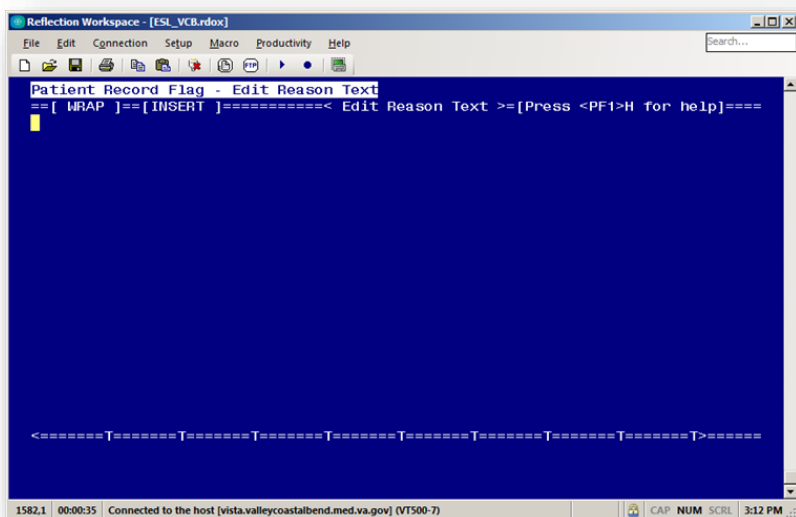
Select an assignment action: **c** Continue Assignment

Would you like to edit the assignment narrative? YES// **n** NO

*Tip: The actual narrative assignment does not require an edit. However, this is the opportunity to do so if it needs updating. If editing is needed, select **[enter]** after the YES// instead of “n” for no. The edit text box will open.*

Approved By: **your name** LAST,FIRST FL 116B SOCIAL WORKER

Enter the reason for editing this assignment:



Step 4

In the Patient Record Flag – Edit Reason Text box, type in text that specifies the reason the PRF assignment is being edited.

Text does not need to be long or involved and should simply state the reason for the “edit” action (i.e., why is the PRF being continued). (See Examples of Patient Record Flag – Edit Assignment Text in this appendix for examples.)

Step 5

Save by typing “Num Lock + e” or “Ctrl + e”

Step 6

Enter Review Date: (MAR 14, 2018-JUN 12, 2018): 6/12/2018// t+30 (APR 13, 2018)

Tip: The “review date” will always default to 90 days unless modified. In this example, the PRF is being continued for 30 days = t + 30. The actual due date may be typed (e.g., 4/13/18). Any number of days for the new review date may be selected if it does not exceed 90 days. If the “due date” does NOT default to 90, address this with facility CACs. The PRF is required to be reviewed a minimum of every 90 days.

t = today

t + 30 = today plus 30 days from today

t + 60 = today plus 60 days from today

Step 7

Review the text “Review of Edit Flag Assignment Data Input Before Filing” to make sure no other modifications are required. At the bottom, you should see your newly added comment.

Action Comments:

Unable to determine current level of risk as Veteran has had no contact with VA staff in the last 2 months. Will continue PRF for 30 days.

Tip: Note the new “edit assignment” text is also visible in addition to the original text added at the time of PRF placement.

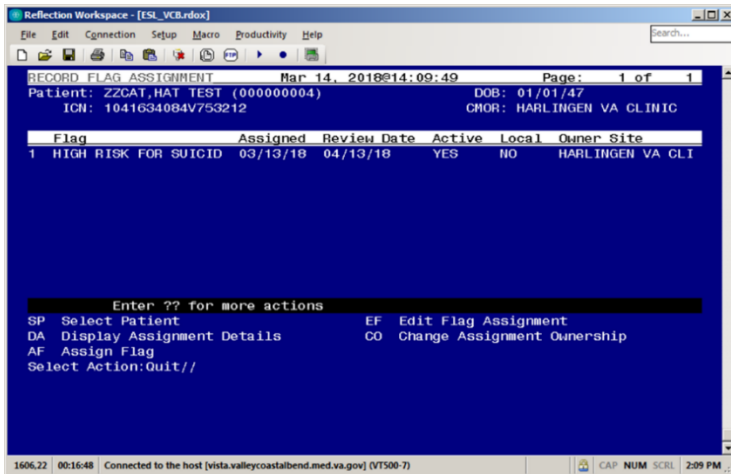
Do you want to review again? NO// [enter]

Would you like to file the assignment changes? YES// [enter]

Updating the patient's record flag assignment...

Assignment was filed successfully.

Type <Enter> to continue or '^' to exit: [enter]

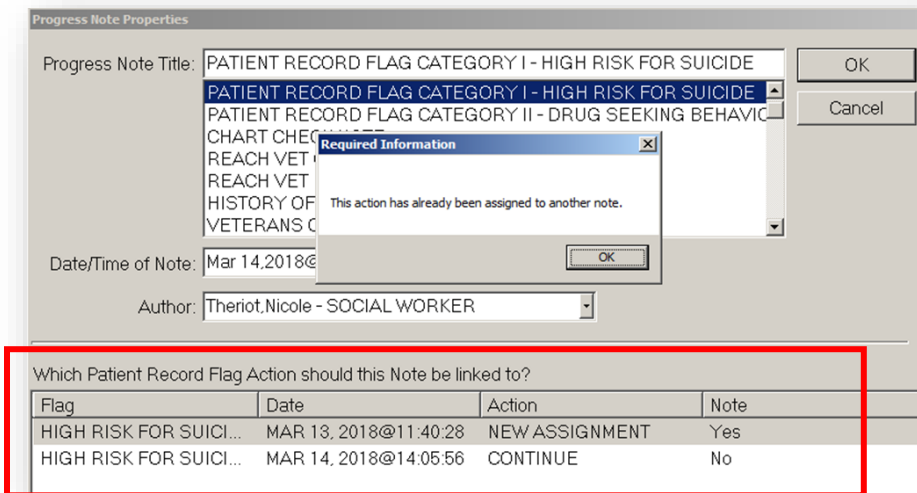


The PRF for ZZCAT, HAT TEST (000000004) has been successfully continued for 30 days.

In CPRS

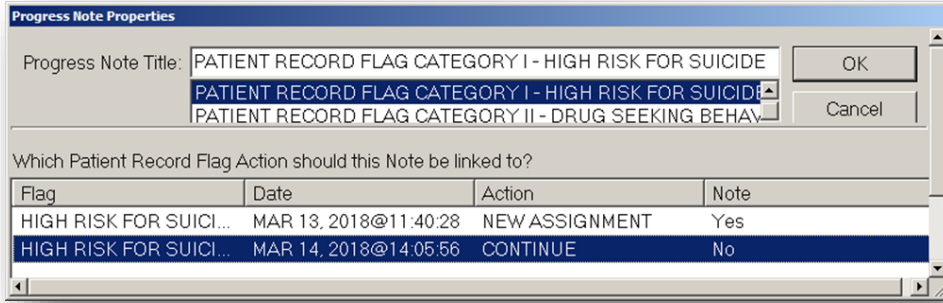
(Note: Full illustrations for these steps can be viewed under Assigning a Flag section of this appendix)

- Step 1.** Select the “Notes” tab
- Step 2.** Select the “New Note” box or “Action” + “New Progress Note”
- Step 3.** Select “New Visit” and the appropriate clinic
- Step 4.** Select “Historical” box
- Step 5.** Select the TIU title PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE
 “Which Patient Record Flag Action should this Note be linked to?” box will appear below

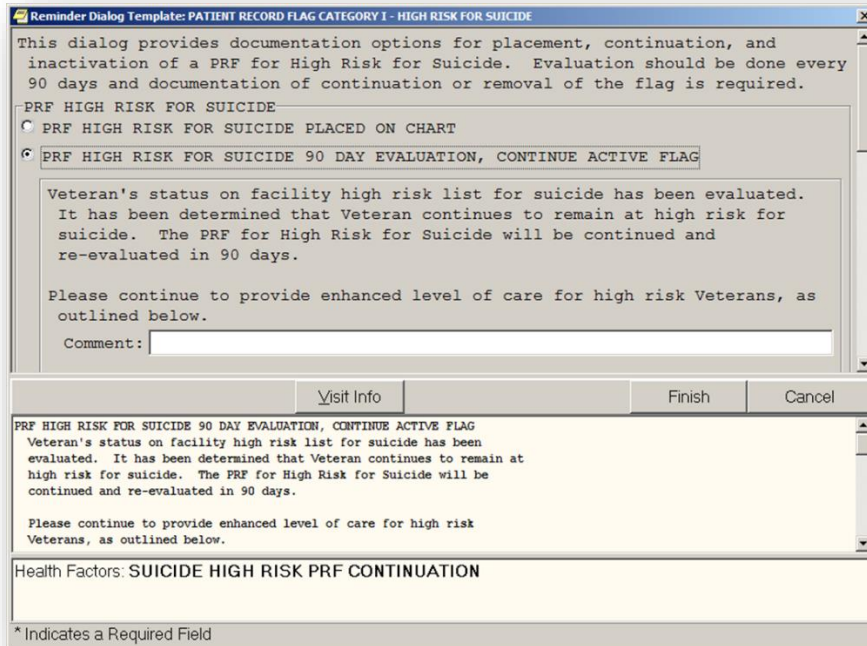


In this illustration, there are two possible Patient Record Flag Actions to choose from. One has a note attached, the new CONTINUE action does not. Selection of any progress note other than the Patient Record Flag note will result in an error message — “This action has already been assigned to another note.”

Step 6. Select the CONTINUE action link by clicking on it. Both should be highlighted. Then select “ok.”



Step 7. Once the template opens, select PRF HIGH RISK FOR SUICIDE 90 DAY EVALUATION, CONTINUE ACTIVE FLAG option. New text will appear below.



- The new text includes verification the PRF has been “evaluated” and that the Veteran remains at high risk for suicide.
- Notice the health factor has also been modified to reflect the PRF is in CONTINUATION status.

Step 8. Add text to the “Comment” section as necessary. Below is an illustration of populated text.

PRF HIGH RISK FOR SUICIDE 90 DAY EVALUATION, CONTINUE ACTIVE FLAG
 Veteran's status on facility high risk list for suicide has been evaluated. It has been determined that Veteran continues to remain at high risk for suicide. The PRF for High Risk for Suicide will be continued and re-evaluated in 30 days.
 Please continue to provide enhanced level of care for high risk Veterans, as outlined below.

Comment: PRF CONTINUED FOR 30 DAYS.
TREATMENT TEAM AND SP STAFF HAVE HAD NO CONTACT WITH VETERAN WITHIN THE LAST 60 DAYS, IN SPITE OF MULTIPLE EFFORTS TO OUTREACH. PRF CONTINUED TO ALLOW FURTHER ATTEMPTS TO OUTREACH TO VETERAN. PRF ASSIGNED 3/13/18.

ON 3/12/18, VETERAN TOOK AN OVERDOSE OF 30 TRAZODONE IN AN ATTEMPT TO KILL HIMSELF. HE CONTACTED VCL, INFORMING THEM OF HIS OD AND RESCUE WAS INITIATED. HE WAS TAKEN TO THE HOSPITAL AND ADMITTED. HE REPORTED MARITAL AND FINANCIAL PROBLEMS AS PRECIPITATING FACTORS.

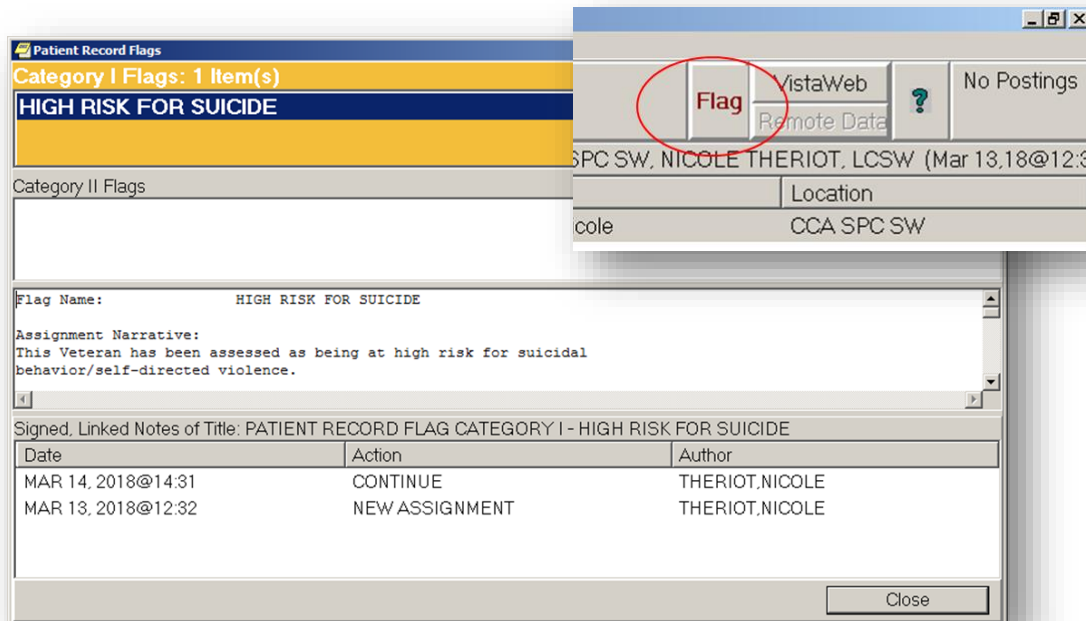
ALL MEDICAL PROVIDERS: Please be alert to veteran making any threats of harm to self, seeking access to means to harm self such as extra medications or firearms, or talking or writing about death, dying or suicide. Contact veteran's Mental Health Treatment Coordinator, the facility suicide prevention coordinator, or the psychiatrist on duty if you notice any of these signs.

Mental Health Treatment Coordinator: DR. TIP TOES
Suicide Prevention Coordinator: JANE DOE, LCSW X12345; DR. LEO LION X23456; NANCY NURSE, RN X56789

...text continues ...

Tip: Notice in this illustration, the “re-evaluated in” time frame has been modified from the default 90 days of the template to 30 days. (The template must be populated first.) This is the time frame selected in the Vista illustration above when the PRF was continued. They should match.

Additional text may be added in the “Comment” section. The section has a finite number of characters while the template is open but can be added to once the template has been populated.

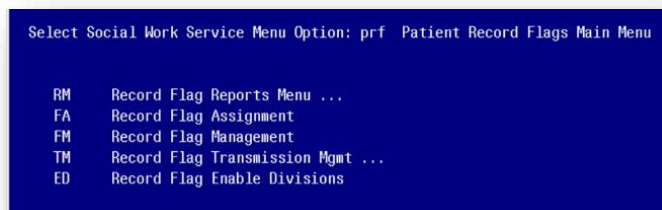


Step 9. Select “Finish” to populate the note and sign it. Open the Flag by selecting the Flag icon at the top right of CPRS. The new CONTINUE action has now been linked to a progress note.

Inactivating a Flag

Step 1. In VistA — Using the **EF (Edit Flag Assignment)** action, inactivate the High-Risk Flag and save

Step 2. In CPRS — Create a new note (selecting historical visit, the visit should not be encountered) selecting the TIU PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE. Link the TIU to the VistA flag.



In VistA

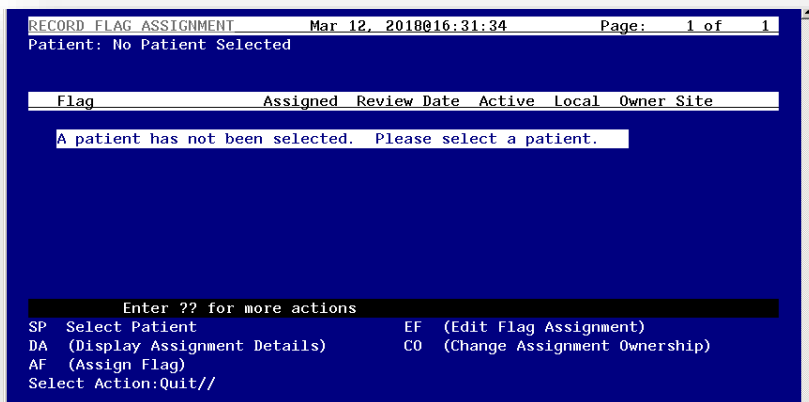
Everywhere text is highlighted **yellow** is a prompt to type a response or to hit enter.

Step 1

Select FA (Record Flag Assignment Menu)

Step 2

Select the appropriate patient



SP Select Patient EF (Edit Flag Assignment)
 DA (Display Assignment Details) CO (Change Assignment Ownership)
 AF (Assign Flag)
 Select Action:Quit// **sp** Select Patient

Select PATIENT NAME: **any patient**

Step 3

Select “EF” – Edit Flag Assignment

Select Action:Quit// **ef** Edit Flag Assignment

Select one of the following:

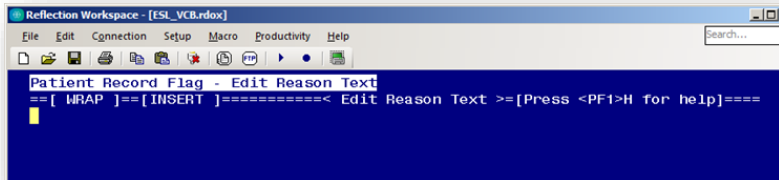
- C Continue Assignment
- I Inactivate Assignment
- E Entered in Error

Select an assignment action: **i** Inactivate Assignment

Would you like to edit the assignment narrative? YES// **n** NO

Approved By: **your name** LAST,FIRST FL 116B SOCIAL WORKER

Enter the reason for editing this assignment:



Step 4

In the Patient Record Flag – Edit Reason Text box, type in text that specifies the reason for editing the PRF assignment.

Text does not need to be long or involved and should simply state the reason for the “edit” action (i.e., why is the PRF being inactivated). (See Examples of Patient Record Flag – Edit Assignment Text in this appendix for examples.)

Step 5

To save your text, type “**Num Lock + e**” or “**Ctrl + e**”

Step 6

Review the text “Review of Edit Flag Assignment Data Input Before Filing” to ensure no other modifications are required. At the bottom, you should see the newly added comment. *Note: There will be no “review by date” to select as the PRF is being inactivated.*

Action Comments:

 High Risk for Suicide Committee staffing completed. Veteran's risk status no longer assessed as high acute risk. Appropriate for removal of PRF.

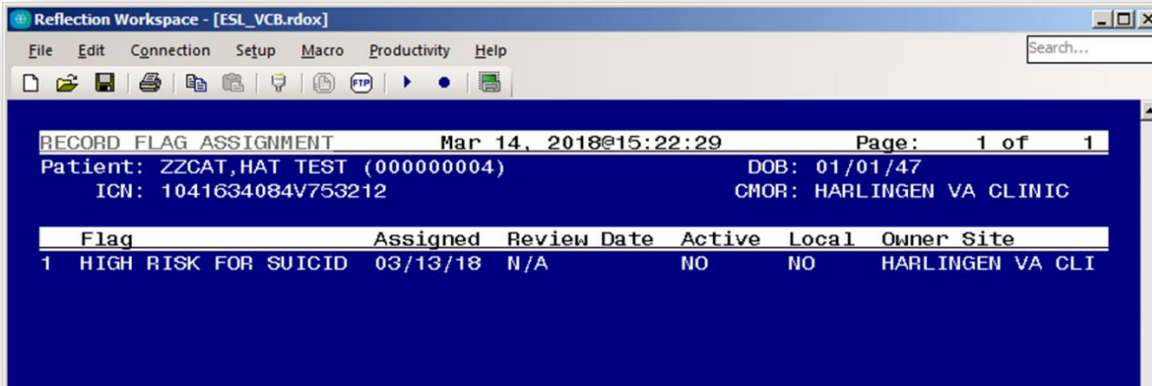
Do you want to review again? NO// **[enter]**

Would you like to file the assignment changes? YES// **[enter]**

Updating the patient's record flag assignment...

Assignment was filed successfully.

Type <Enter> to continue or '^' to exit: **[enter]**

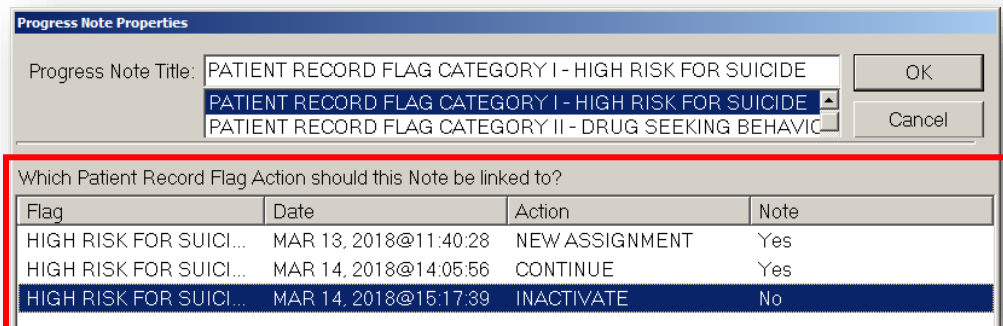


The “Active” column for the PRF indicates “NO” for ZZCAT, HAT TEST (000000004). The PRF has been successfully inactivated.

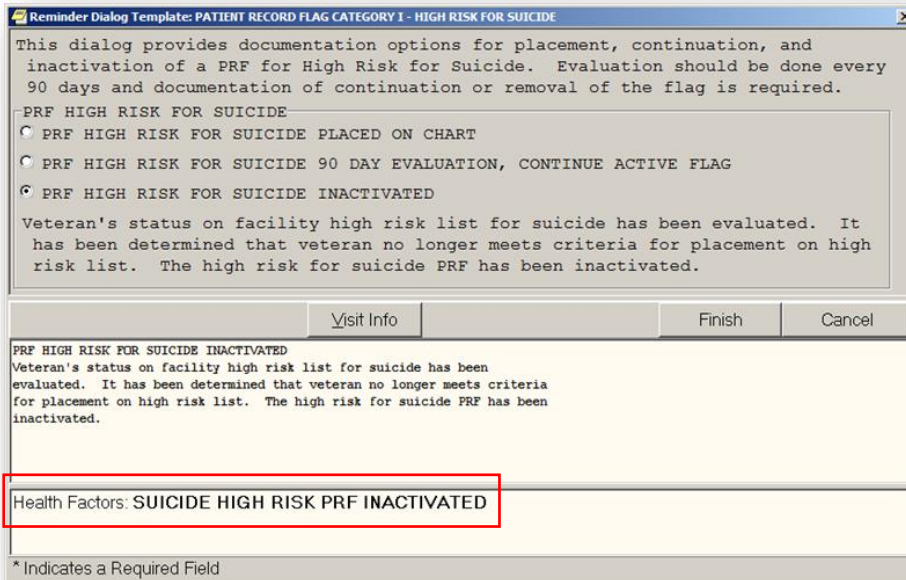
In CPRS

(Note: Full illustrations for these steps can be viewed in the “Assigning a Flag” section of this appendix.)

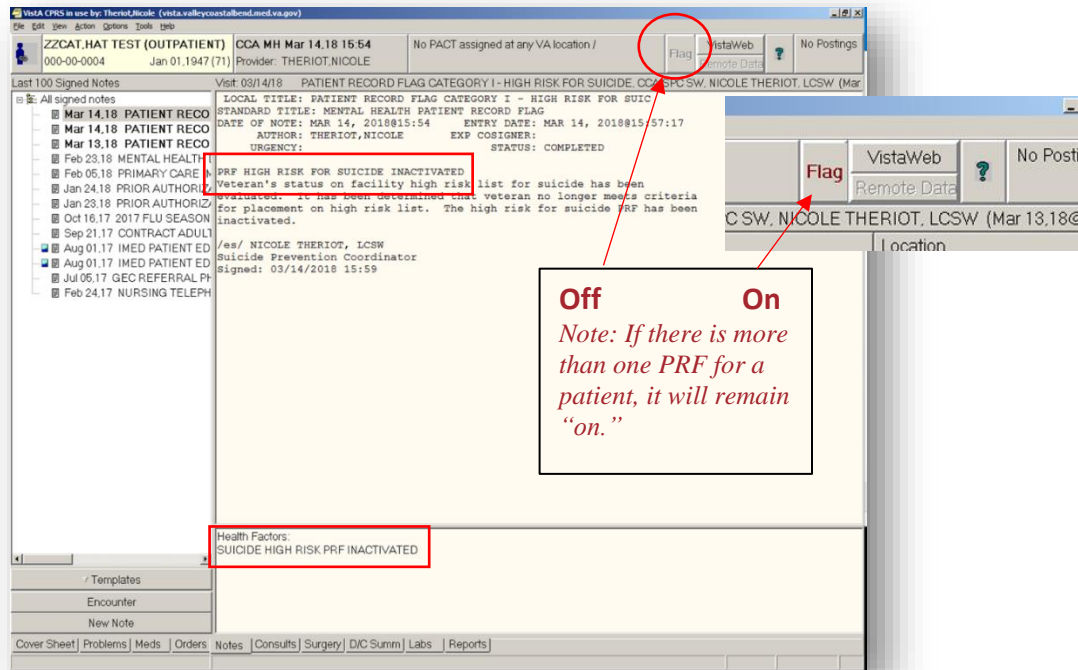
- Step 1.** Select the “Notes” tab
- Step 2.** Select the “New Note” box or “Action” + “New Progress Note”
- Step 3.** Select “New Visit” and the appropriate clinic
- Step 4.** Select “Historical” box
- Step 5.** Select the TIU title PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE. The “Which Patient Record Flag Action should this Note be linked to?” box will appear.
- Step 6.** Select the INACTIVATE action link by clicking on it. Both should be highlighted. Then select “OK.”



Step 7. Once the template opens, select PRF HIGH RISK FOR SUICIDE INACTIVATED option. New text will appear below. Note the corresponding health factor.



Step 8. Select “Finish” to populate the note and sign it. Note the “Flag” icon at the top right of CPRS is now grey indicating there is no longer an active flag.



Reactivating a Flag

Step 1. In VistA — Using the **EF (Edit Flag Assignment)** action, inactivate the High-Risk Flag and save

Step 2. In CPRS — Create a new note (selecting historical visit, the visit should not be encountered) selecting the TIU PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE. Link the TIU to the VistA flag.

In VistA

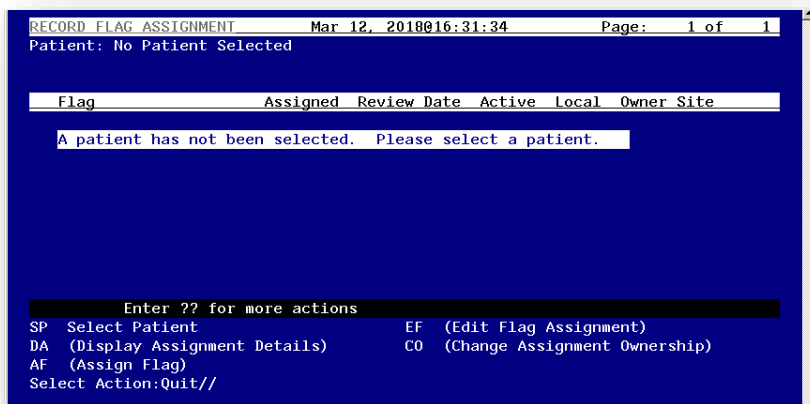
Everywhere text is highlighted **yellow** is a prompt for a response or to hit enter.

Step 1

Select FA (Record Flag Assignment Menu)

Step 2

Select the appropriate patient



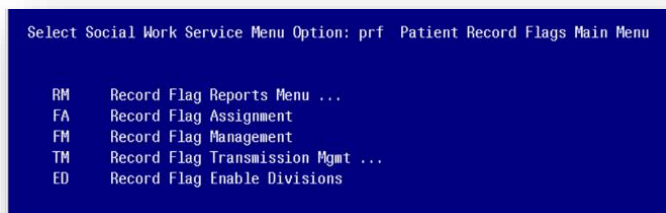
SP Select Patient

DA (Display Assignment Details)

AF (Assign Flag)

EF (Edit Flag Assignment)

CO (Change Assignment Ownership)



Select Action:Quit// **sp** Select Patient

Select PATIENT NAME: **any patient**

Step 3

Select “EF” – Edit Flag Assignment

Select Action:Quit// **ef** Edit Flag Assignment

Select one of the following:

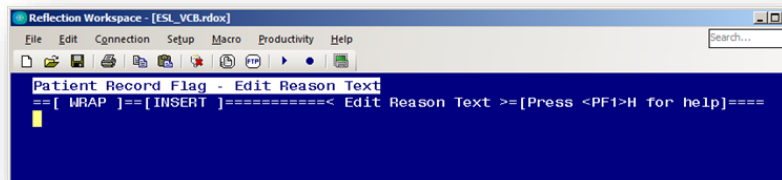
R Reactivate Assignment

Select an assignment action: **r** Reactivate Assignment

Would you like to edit the assignment narrative? YES// **n** NO

Approved By: **your name** LAST,FIRST FL 116B SOCIAL WORKER

Enter the reason for editing this assignment:



Step 4

In the Patient Record Flag – Edit Reason Text box, type in text that specifies the reason for editing the PRF assignment.

Text does not need to be long or involved and should simply state the reason for taking the “edit” action (i.e., why is the PRF being reactivated). (See Examples of Patient Record Flag – Edit Assignment Text in this appendix for examples.)

Step 5

To save, type “**Num Lock + e**” or “**Ctrl + e**”

Enter Review Date: (MAR 16, 2018-JUN 14, 2018): 6/14/2018// **[enter]**

Step 6

Review the text “Review of Edit Flag Assignment Data Input Before Filing” to ensure no modifications are needed. At the bottom, the newly added comment should be visible.

Action Comments:

PRF BEING REACTIVATED AT REQUEST OF ANYWHERE VAMC WHO HAS REQUESTED OWNERSHIP OF THE PRF.

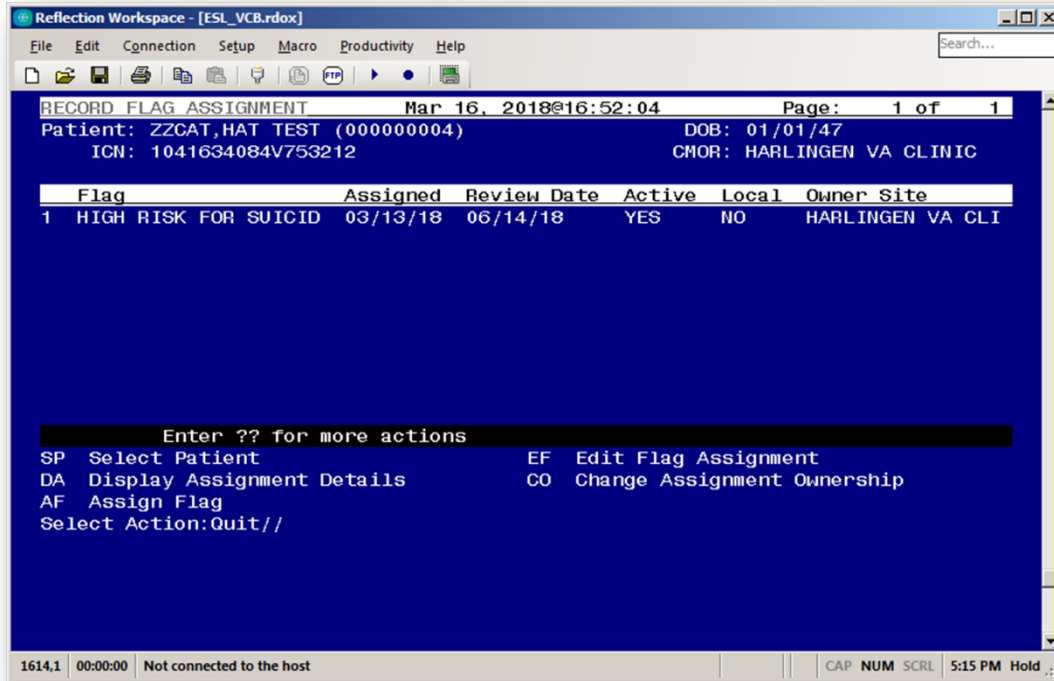
Do you want to review again? NO// **[enter]**

Would you like to file the assignment changes? YES// [enter]

Updating the patient's record flag assignment...

Assignment was filed successfully.

Type <Enter> to continue or '^' to exit: [enter]



The PRF for the “Active” column indicates “YES.” The PRF for ZCAT, HAT TEST (000000004) has been successfully “reactivated.”

In CPRS

(Note: Full illustrations for these steps can be viewed under Assigning a Flag section of this appendix)

- Step 1.** Select the “Notes” tab
- Step 2.** Select the “New Note” box or “Action” + “New Progress Note”
- Step 3.** Select “New Visit” and the appropriate clinic
- Step 4.** Select “Historical” box
- Step 5.** Select the TIU title PATIENT RECORD FLAG CATEGORY I – HIGH RISK FOR SUICIDE “Which Patient Record Flag Action should this Note be linked to?” box will open below
- Step 6.** Select the REACTIVATE action link by clicking on it. Both should be highlighted. Then select “ok.”
- Step 7.** Once the template opens, select PRF HIGH RISK FOR SUICIDE PLACED ON CHART option.
- Step 8.** Select “Finish” to populate the note and sign it.

Transferring a Flag

Transferring an INACTIVE Flag

In VistA

Everywhere highlighted text is **yellow** is a prompt for a response or to hit enter.

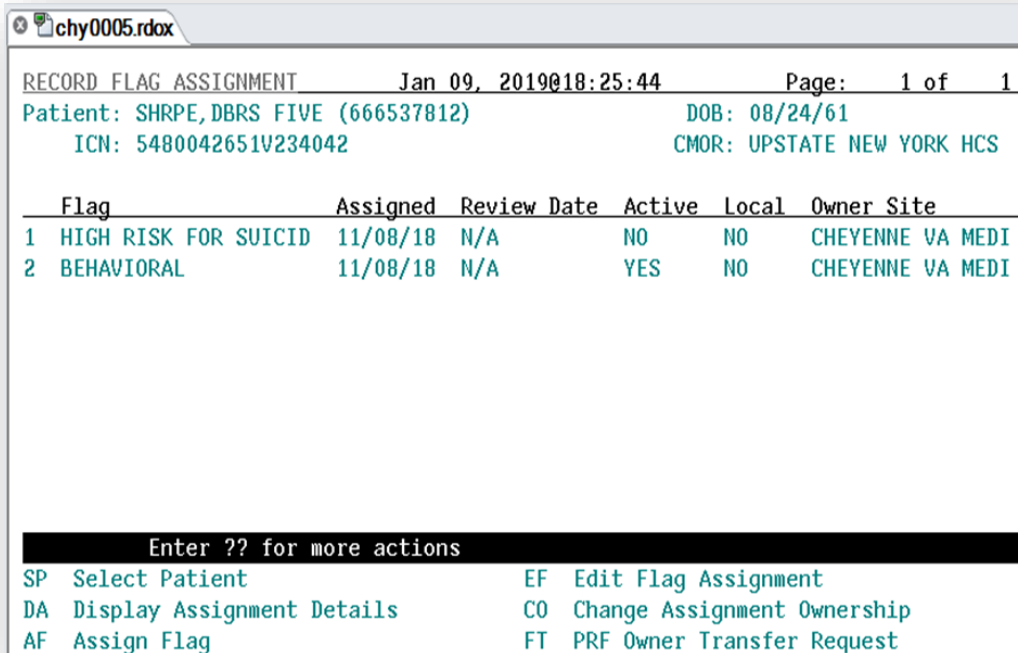
Step 1

Select FA (Record Flag Assignment Menu)



Step 2

Select the appropriate patient



SP Select Patient
 DA (Display Assignment Details)
 AF (Assign Flag)

EF (Edit Flag Assignment)
 CO (Change Assignment Ownership)
 FT (PRF Owner Transfer Request)

Select Action:Quit// **sp** Select Patient

Select PATIENT NAME: **any patient**

Step 3

Select “FT” – PRF Owner Transfer Request

Select Action:Quit// **ft** PRF Owner Transfer Request

Step 4

Enter a brief reason for the transfer request. Maximum of 80 characters, including spaces.

Ownership Request Reason: **Veteran is receiving MH care in Upstate New York HCS and attempted suicide [enter]**

You’re about to request ownership transfer of the following record flag assignment to division UPSTATE NEW YORK HCS (station #528)

Patient: SHRPE, DBRS FIVE
 PRF flag: HIGH RISK FOR SUICIDE
 PRF flag status: INACTIVE
 Current owner: CHEYENNE VA MEDICAL

Request reason: Veteran is receiving MH care in Upstate NY HCS and attempted suicide

Do you wish to send this request? NO// **y** YES

Note: The default is “NO.” Be sure to type “y” for yes or the word “YES” to request the transfer.

Transfer request sent successfully

Flag ownership automatically transfers within minutes. There may be a delay between the time the PRF is requested and the time it transfers. If you attempt to request the transfer again (of an inactive flag), you will get a message that the request has already been made.

Before ownership transfer – PRF is not active, Owner Site is Cheyenne VA

RECORD FLAG ASSIGNMENT		Jan 09, 2019@18:25:44		Page: 1 of 1	
Patient: SHRPE, DBRS FIVE (666537812)		DOB: 08/24/61			
ICN: 5480042651V234042		CMOR: UPSTATE NEW YORK HCS			
Flag	Assigned	Review Date	Active	Local	Owner Site
1 HIGH RISK FOR SUICID	11/08/18	N/A	NO	NO	CHEYENNE VA MEDI
2 BEHAVIORAL	11/08/18	N/A	YES	NO	CHEYENNE VA MEDI

After ownership transfer – PRF is active, Owner Site is Upstate New York

RECORD FLAG ASSIGNMENT Jan 10, 2019@14:40:10 Page: 1 of 1

Patient: SHRPE,DBRS FIVE (666537812) DOB: 08/24/61
 ICN: 5480042651V234042 CMOR: UPSTATE NEW YORK HCS

Flag	Assigned	Review Date	Active	Local	Owner Site
1 HIGH RISK FOR SUICID	11/08/18	04/09/19	YES	NO	UPSTATE NEW YORK
2 BEHAVIORAL	11/08/18	N/A	YES	NO	CHEYENNE VA MEDI

Transferring an ACTIVE Flag

In Vista

Everywhere text is highlighted **yellow** is a prompt for a response or to hit enter.

Step 1

Select FA (Record Flag Assignment Menu)

RM	Record Flag Reports Menu ...
FA	Record Flag Assignment
FM	Record Flag Management
TM	Record Flag Transmission Mgmt ...
ED	Record Flag Enable Divisions
TR	Record Flag Transfer Requests

Step 2

Select the appropriate patient

- | | |
|-------------------------------|--------------------------------|
| SP Select Patient | EF Edit Flag Assignment |
| DA Display Assignment Details | CO Change Assignment Ownership |
| AF Assign Flag | FT PRF Owner Transfer Request |

Select Action:Quit// **sp** Select Patient

Select PATIENT NAME: **any patient**

Step 3

Select “FT” – PRF Owner Transfer Request

Select Action:Quit// **ft** PRF Owner Transfer Request

Flag	Assigned	Review Date	Active	Local	Owner	Site
1	HIGH RISK FOR SUICID	01/09/19	N/A	YES	NO	CHEYENNE VA MEDI

Enter ?? for more actions	
SP Select Patient	EF Edit Flag Assignment
DA Display Assignment Details	CO Change Assignment Ownership
AF Assign Flag	FT PRF Owner Transfer Request

Step 4

Enter a brief reason for the transfer request. Maximum of 80 characters, including spaces.

Ownership Request Reason: **Veteran transferred care to Upstate New York [enter]**

You're about to request ownership transfer of the following record flag assignment to division UPSTATE NEW YORK HCS (station #528)

Patient: SHRPE, DBRS FIVE
 PRF flag: HIGH RISK FOR SUICIDE
 PRF flag status: INACTIVE
 Current owner: CHEYENNE VA MEDICAL

Request reason: Veteran transferred care to Upstate New York

Do you wish to send this request? NO// YES

Note: The default is "NO." Be sure to type "y" for yes or the word "YES" to request the transfer.

Transfer request sent successfully

Reviewing PRF Transfer Requests

This option will allow facilities to review all pending PRF transfer requests both from and to other facilities. The default view for this option will show pending transfer requests from other facilities. To review pending requests from the home facility, change the view within this menu option.

To	Transferring the PRF from home facility TO Facility A.	Facilities should routinely check VistA for pending transfer requests from other facilities.
----	--	--

From	Requesting a PRF FROM Facility A to the home facility.	Facilities requesting a PRF should also email and/or call the owning facility notifying it of the transfer request to expedite the transfer.
------	--	--

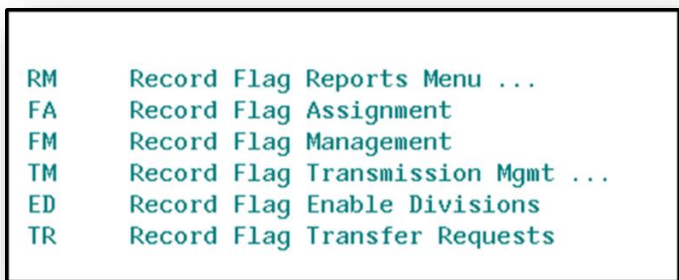
1. PRFs owned by a facility:

In VistA

Everywhere text is highlighted yellow is a prompt for a response or to hit enter.

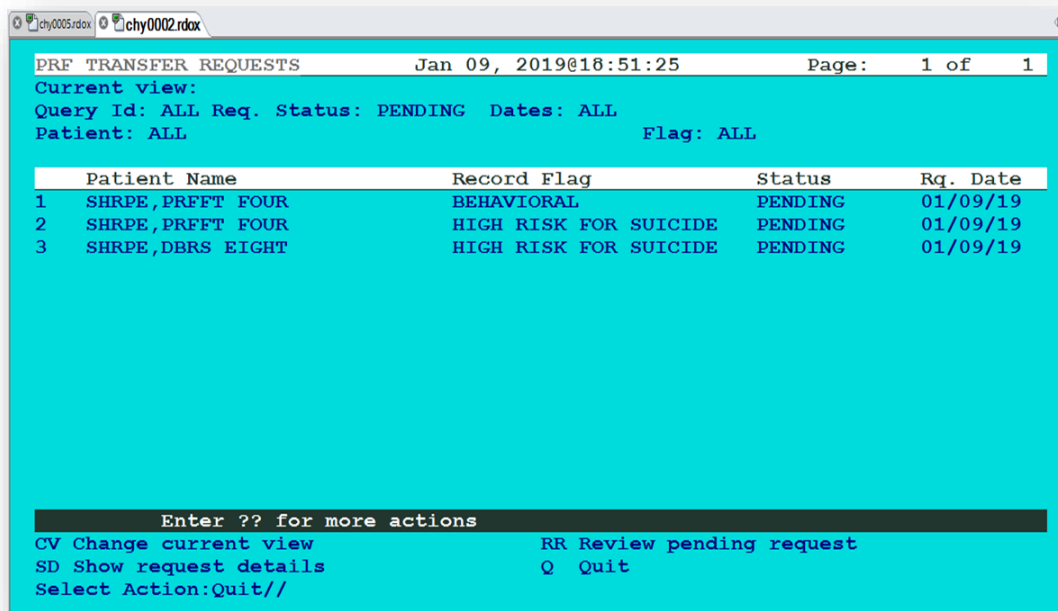
Step 1

Select **TR** (Record Flag Transfer Requests)



Step 2

Select RR (Review pending request)



CV Change current view
SD Show request details

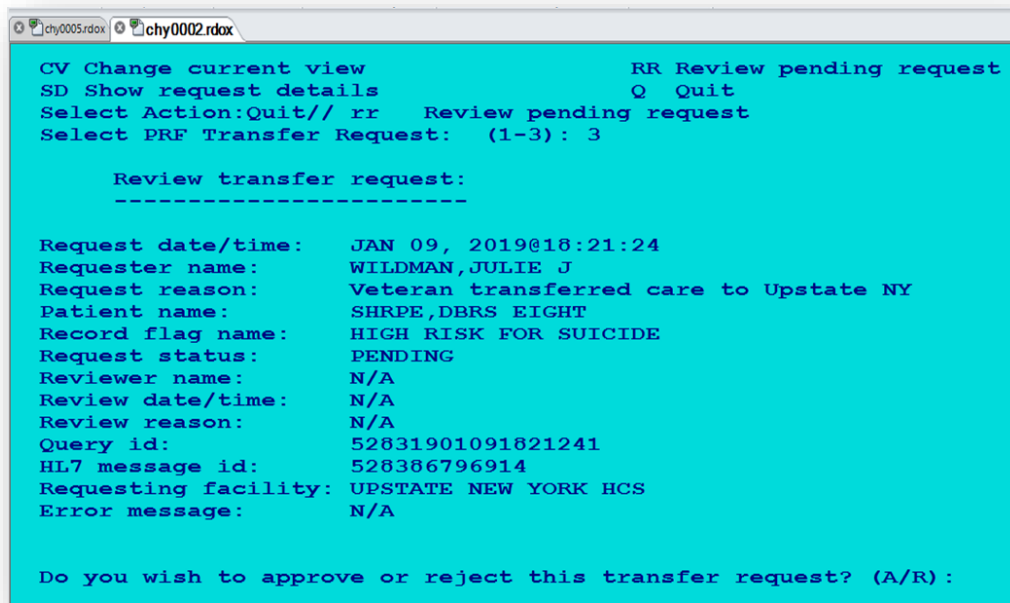
RR Review pending request
Q Quit

Select Action:Quit// **RR** Review pending request

Step 3

Select PRF Transfer Request (1-3)

Select PRF Transfer Request: (1-3): **3**



Details including the patient and the type of PRF request will display.

Step 4

Approve or reject the request

Review transfer request:

```

Request date/time:   Jan 09, 2019@18:21:24
Requester name:     WILDMAN, JULIE J
Request reason:     Veteran transferred care to Upstate NY
Patient name:       SHRPE,DBRS EIGHT
Record flag name:   HIGH RISK FOR SUICIDE
Request status:     PENDING
Reviewer name:      N/A
Review reason:      N/A
Query id:           52831901091821241
HL7 message id:    528386796914
Requesting facility: UPSTATE NEW YORK HCS
Error message:     N/A
    
```

Do you wish to approve or reject this transfer request? (A/R): **A**

Note:

If A = "approve" selected	No "reason" is required
If R = "reject" selected	Brief "reason" for rejection (80 characters or less required)
If no "reason" entered	Error message - indicating you MUST enter a reason
If "reason" entered is greater than 80 characters	Error message - indicating reason exceeds 80-character limit

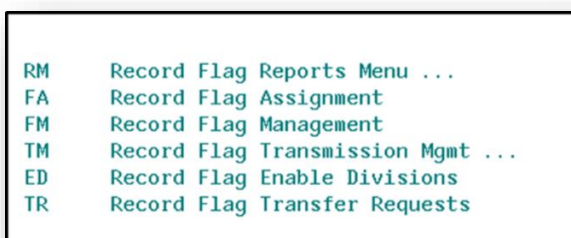
2. PRFs other facilities own

In Vista

Everywhere you see **yellow** highlighted text is a prompt for you to type a response or to hit enter.

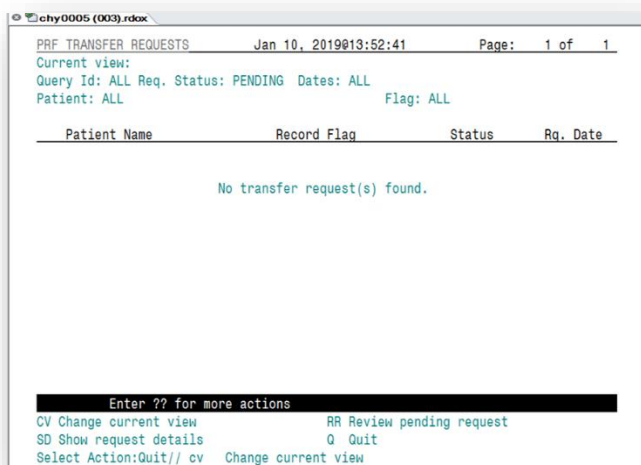
Step 1

Select **TR** (Record Flag Transfer Requests)



Step 2

Select RR (Review pending request)



Step 3

Select CV (Change current view)

CV Change current view RR Review pending request
SD Show request details Q Quit

Select Action:Quit// **CV** Change current view

View requests for all query IDs or selected query ID (ALL/S): ALL// **[enter]**

View requests for all patients or selected patient (ALL/S): ALL// **s** (Selected patient)

Select patient to view requests for: **type patient name**

View requests for all flags or selected flag (ALL/S): ALL//**S**

Select record flag to view requests for:// **High** (risk for suicide)

View requests for all statuses or selected status (ALL/S): ALL// **[enter]**

View requests for all dates/times or selected date/time (ALL/S): ALL//**S**

Note: Starting date defaults to the earliest request on file if ALL is selected. Choose “S” for “selected date/time” to enter a more recent date range.

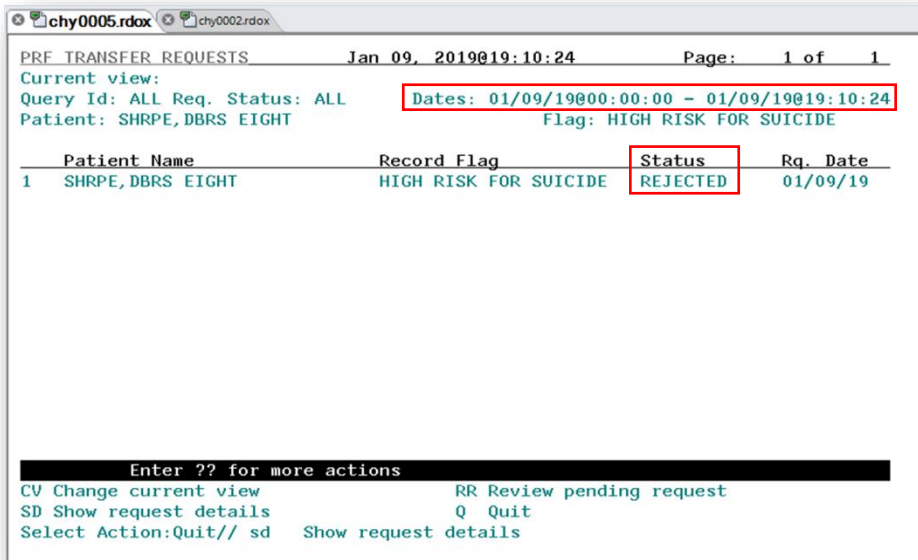
Enter the starting date of the requests to view:// **07/01/19**

Note: Defaults to the earliest request date. Type in the date the request was made. Options including typing in an actual date or a calculation as below.

*t = today
t - 5 = today minus 5 days from today
t - 10 = today minus 10 days from today*

Enter the ending date of the requests to view://**N** (now) or **enter a date**

Note: Ending date defaults to the most recent request on file. Type “N” for now or enter an actual date.



This illustration demonstrates a data pull from 01/09/19-01/09/19. It also demonstrates a request for PRF transfer that has been rejected. To see the reason the request was rejected, at the Select Action option, select SD to review the details.

CV Change current view RR Review pending request
 SD Show request details Q Quit

Select Action:Quit// **SD** Show request details

Transfer request details:

Request date/time: Jan 09, 2019@18:21:24
 Requester name: WILDMAN, JULIE J
 Request reason: Veteran transferred care to Upstate NY
 Patient name: SHRPE,DBRS EIGHT
 Record flag name: HIGH RISK FOR SUICIDE
 Request status: REJECTED
 Reviewer name: WILDMAN, JULIE J
 Review date/time: JAN 09, 2019@19:01
 Review reason: Veteran was just seen here today
 Query id: 52831901091821241
 HL7 message id: 528386796914
 Requesting facility: UPSTATE NEW YORK HCS
 Error message: N/A

Note: If a facility disagrees with the reason the PRF transfer request was rejected, proceed through the steps of requesting the transfer again and enter a rationale. Contact the person who rejected the transfer directly to discuss.

Return to the main menu.

- Step 1** Select “FA” Record Flag Assignment
- Step 2** Select “SP” to select the appropriate patient
- Step 3** Select “FT” – PRF Owner Transfer Request
- Step 4** Select record flag assignment (a number)
- Step 5** Type in ownership request reason (<80 characters)
- Step 6** Type in “YES” to send the request

Patient Record Flag Reports

Synonym	Submenu	Description
NLR	Assignment Action Not Linked Report	This option will be used to display or print all the PRF Assignment History actions that are not linked to a progress note.
FAR	Flag Assignment Report	This option enables a user to display or print all the patient assignments for Category I and/or Category II Patient Record Flags.
PAR	Patient Assignments Report	This option will be used to display or print all PRF Assignments of a patient for Category I or Category II Record Flags.
ADR	Assignments Due For Review Report	This option will be used to display or print all Category I or Category II Patient Record Flag Assignments that are due for review within a given date range.
BAR	Assignments Approved by Report	This option will be used to display or print all the PRF Assignment History actions for the person who approved the assignment of the record flag to the patient.
IAR	Assignments by Principal Investigator Report	This option will be used to display or print all the PRF Assignment History actions for a Principal Investigator. Only Research Type record flags will have a Principal Investigator assigned for that flag.

NLR Assignment Action Not Linked Report

Select Record Flag Reports Menu Option: nlr Assignment Action Not Linked Report

Select one of the following:

- 1 Category I (National)
- 2 Category II (Local)
- 3 Both

Select Flag Category: 1 Category I (National)

Select Beginning Date: (SEP 25, 2003-MAR 12, 2018): 010117 (JAN 01, 2017)

Select Ending Date: (JAN 01, 2017-MAR 12, 2018): t (MAR 12, 2018)

DEVICE: HOME// [enter]

Other selection criteria:

Record Flag Name: e.g. High Risk for Suicide

Flag Status: (A)ctive, (I)nactive, (B)oth

Who performed actions: (L)ocal facility, (N)on-local facility, (A)ll

Patient Record Flags				
Assignment Action Not Linked To A Progress Note Report				Page: 1
REPORT TYPE: Category I (National)		STATUS: Active		
FLAG: HIGH RISK FOR SUICIDE		ACTION BY: Other Facilities		
DATE RANGE: 08/08/2018 To 11/06/2018		PRINTED: Nov 06, 2018 6:14 pm		
CATEGORY: I (National)				
PATIENT	SSN	FLAG NAME	ACTION	ACTION DATE
SHRPE, PRFHL TWO	S9782	HIGH RISK FOR SUI	REFRESH ACTIVE	10/26/18
			REFRESH ACTIVE	10/26/18
Total Actions not Linked for Category I: 2				

FAR Flag Assignment Report

Select Record Flag Reports Menu Option: far Flag Assignment Report

Select one of the following:

- 1 Category I (National)
- 2 Category II (Local)
- 3 Both

Select Flag Category: 1 Category I (National)

Select one of the following:

- S Single Flag
- A All Flags

Select to report on a (S)ingle flag or (A)ll flags: Single Flag// s Single Flag

Select Record Flag Name: high risk FOR SUICIDE ACTIVE CLINICAL

Select Beginning Date: (SEP 25, 2003-MAR 12, 2018): 010118 (JAN 01, 2018)

Select Ending Date: (JAN 01, 2018-MAR 12, 2018): t (MAR 12, 2018)

DEVICE: HOME//;P-other;132 [enter]

Tip: Any date range may be queried. Note the larger the date range the longer it will take to pull the data.

Other selection criteria:

Flag owner: (L)ocal, (N)on-local, (A)ll

Flag status: (A)ctive or (I)nactive

Tip: This report pulls data by when a PRF was **FIRST** assigned. If a PRF has been reactivated, the initial assignment data will need to be included to pull that patient into your query.

Tip: If pulling a current roster of PRFs and a Veteran has an active PRF but is not included in the current date range, it is probably because the assignment date is older than the date range being pulled.

The report has been expanded to show when the PRF was last assigned, how many days the PRF has been active, whether the PRF is overdue for review, and how many times the PRF has been activated.

FLAG: HIGH RISK FOR SUICIDE								PRINTED: Nov 06, 2018	
Patient Name	SSN	Orig AssignDT	Last AssignDT	# Days Active	Review On	Overdue?	# Times Activated	Current Owning Site	
SHRPE,PRFFT ONE	S9875	10/04/18	10/05/18	33	01/03/19	No	9	BATH VAMC	
SHRPE,PRFHL TWO	S9782	06/06/18	10/09/18	29	01/24/19	No	4	UPSTATE NEW YORK HCS	

SUMMARY OF TOTAL ASSIGNMENTS		
Category I (National)	:	2
HIGH RISK FOR SUICIDE	:	2

PAR Patient Assignments Report

Select Record Flag Reports Menu Option: **par** Patient Assignments Report
 Select PATIENT NAME: **zzclaus, santa pat** E,SANTA PAT ZZCLAUSE,SANTA PAT 1-
 1-40 00000006 NO NSC VETERAN
 WARNING : You may have selected a test patient.
 Enrollment Priority: GROUP 5 Category: IN PROCESS End Date: 02/15/2011
 Select one of the following:
 1 Active
 2 Inactive
 3 Both
 Select Assignment Status to report on: Both// **[enter]**
 DEVICE: HOME// **[enter]** TELNET
 ...HMMM, JUST A MOMENT PLEASE...

PATIENT RECORD FLAGS

PATIENT ASSIGNMENTS REPORT Page: 1

Report Selected: Both (ACTIVE & INACTIVE) Printed: Mar 14, 2018@17:36

Patient: ZZCLAUSE,SANTA PAT 000-00-0006

FLAG NAME	CATEGORY	APPROVED BY	ENTERED	REVIEW DT	STATUS	OWNING SITE
1 BEHAVIORAL	I	THERIOT,NIC	08/24/13	N/A	INACTIVE	HARLINGEN V
2 HIGH RISK FOR S	I	THERIOT,NIC	10/11/13	08/02/15	ACTIVE	HARLINGEN V
3 DRUG SEEKING BE	II	THERIOT,NIC	08/24/13	N/A	INACTIVE	HARLINGEN V

ADR Assignments Due For Review Report

Select Record Flag Reports Menu Option: **adr** Assignments Due For Review Report
 Select one of the following:
 1 Category I (National)
 2 Category II (Local)
 3 Both

Select Flag Category: **1** Category I (National)

Select one of the following:

- S Single Flag
- A All Flags

Select to report on a (S)ingle flag or (A)ll flags: Single Flag// **s** Single Flag

Select Record Flag Name: high risk FOR SUICIDE ACTIVE CLINICAL

Select Beginning Date: **030118** (MAR 01, 2018)

Select Ending Date: **033118** (MAR 31, 2018)

DEVICE: HOME// **[enter]**

PATIENT RECORD FLAGS

ASSIGNMENTS DUE FOR REVIEW REPORT Page: 1

----- Printed: Mar 12, 2018@16:58

CATEGORY: Category I (National)

DATE RANGE: 03/01/18 TO 03/31/18

FLAG NAME: HIGH RISK FOR SUICIDE

PATIENT NAME SSN ASSIGNED REVIEW DT NOTIFICATION SENT

PATIENT NAME	SSN	ASSIGNED	REVIEW DT	NOTIFICATION SENT
Cuifrt, Jwijrl Rayilf	111111111	12/27/17	03/27/18	NO
Mctftgvbhyujnmkio, Miu	222222222	12/19/17	03/19/18	NO
Nuijkr, Kerifwk Leuf	333333333	12/19/17	03/19/18	NO
Ruijkmnhy, Rikjuyh II	444444444	02/10/16	03/19/18	NO
Siolkmj, Aplokij	555555555	12/28/17	03/28/18	NO
Vmnhjgb, Lolkiju C	666666666	10/20/17	03/21/18	NO

Total Review Assignments for Flag: 6

Note: " * " indicates that review date is past due

<End of Report>

Tips:

- This illustration searched for all the High Risk for Suicide PRFs with a due date in March 2018.
- In this illustration, "notification sent" is set to "NO." Work with Clinical Application Coordinators (CACs) at the facility to add names to the facility email group in VistA. This will allow SP team members to receive notification in VistA mail when PRFs are due for review. Notification via this mail is not required to review the report.
- The " * " that indicates when a review date is past due is based on the 90 day review date, NOT the 100 days of the HRF Dashboard. The HRF Dashboard metric allows an extra 10 days.

BAR Assignments Approved by Report

Select Record Flag Reports Menu Option: **bar** Assignments Approved By Report

Select one of the following:

- S Single Approved By Person
- A All Approved By Persons

Select to report on a (S)ingle Approved By Person or (A)ll: Single// **a** All Approved By Persons

Select one of the following:

- 1 Category I (National)
- 2 Category II (Local)
- 3 Both

Select Flag Category: Both// [enter]

Select one of the following:

- 1 Active
- 2 Inactive
- 3 Both

Select Assignment Status to report on: Both// [enter]

Select Beginning Date: (SEP 25, 2003-MAR 14, 2018): t-30 (FEB 12, 2018)

Select Ending Date: (FEB 12, 2018-MAR 14, 2018): t (MAR 14, 2018)

DEVICE: HOME// [enter] TELNET

...EXCUSE ME, LET ME THINK ABOUT THAT A MOMENT...

PATIENT RECORD FLAGS

ASSIGNMENTS APPROVED BY REPORT Page: 1

Date Range: 02/12/18 to 03/14/18 Printed: Mar 14, 2018@17:39

Approved By: CHIEF OF STAFF

Flag Name: BEHAVIORAL - Category I (National)

PATIENT	SSN	ACTION	ACTION DT	REVIEW DT	STATUS
BIKJMN,AOLMKIJ J	111111111	INACTIVATE	03/07/18	N/A	INACTIVE
BUIJKMN,DYUHJN PX	222222222	INACTIVATE	02/27/18	N/A	INACTIVE
DIKJUYH,CYHGBVF	333333333	CONTINUE	02/26/18	N/A	ACTIVE

PATIENT RECORD FLAGS

ASSIGNMENTS APPROVED BY REPORT Page: 2

Date Range: 02/12/18 to 03/14/18 Printed: Mar 14, 2018@17:39

Approved By: CHIEF OF STAFF

Flag Name: HIGH RISK FOR SUICIDE - Category I (National)

PATIENT	SSN	ACTION	ACTION DT	REVIEW DT	STATUS
AFRTDC,BFVG AKIJ	444444444	NEW ASSIGNMENT	02/22/18	N/A	ACTIVE
BPOLKIU,MDFRCV	555555555	CONTINUE	02/26/18	N/A	ACTIVE
BIKMJNH,JOLKIUM	666666666	CONTINUE	03/06/18	N/A	ACTIVE

PATIENT RECORD FLAGS

ASSIGNMENTS APPROVED BY REPORT Page: 5

Date Range: 02/12/18 to 03/14/18 Printed: Mar 14, 2018@17:39

Approved By: DOKIU,ATGBH

Flag Name: PREGNANCY LACTATION - Category II (Local)

PATIENT	SSN	ACTION	ACTION DT	REVIEW DT	STATUS
CRTYUIOPL,RDFGHJ	777777777	REACTIVATE	03/14/18	06/12/18	ACTIVE
		CONTINUE	03/14/18	06/12/18	ACTIVE
EPOIUYTR,AKJHGFD	888888888	NEW ASSIGNMENT	02/27/18	05/28/18	ACTIVE
GCFTYGV,SESDR	999999999	NEW ASSIGNMENT	03/07/18	06/05/18	ACTIVE

PATIENT RECORD FLAGS

ASSIGNMENTS APPROVED BY REPORT Page: 6

Date Range: 02/12/18 to 03/14/18 Printed: Mar 14, 2018@17:39

Approved By: DRFTG,MOIKUJY N

Flag Name: DRUG SEEKING BEHAVIOR - Category II (Local)

PATIENT SSN ACTION ACTION DT REVIEW DT STATUS

PATIENT	SSN	ACTION	ACTION DT	REVIEW DT	STATUS
FXDRFC,CIJNBHU I	000000000	CONTINUE	02/27/18	02/27/19	ACTIVE
LZSERDX,KRD HRTY	121212121	INACTIVATE	02/27/18	N/A	INACTIVE
PRDF,DESWQ SR	232323232	INACTIVATE	02/27/18	N/A	INACTIVE

PATIENT RECORD FLAGS

ASSIGNMENTS APPROVED BY REPORT

Page: 7

Date Range: 02/12/18 to 03/14/18

Printed: Mar 14, 2018@17:39

Approved By: PDRFGT,YTFREDW

Flag Name: BEHAVIORAL - Category I (National)

PATIENT SSN ACTION ACTION DT REVIEW DT STATUS

PATIENT	SSN	ACTION	ACTION DT	REVIEW DT	STATUS
MUYT,TPOIUY AJIU	343434343	NEW ASSIGNMENT	03/09/18	12/01/18	ACTIVE
NUHYTR,SFTRED WK	454545454	INACTIVATE	03/09/18	N/A	INACTIVE
PREF,ODERFTG VD	565656565	INACTIVATE	03/09/18	N/A	INACTIVE

Approved By: KJHYGFV,PKNHGB

Flag Name: HIGH RISK FOR SUICIDE - Category I (National)

PATIENT SSN ACTION ACTION DT REVIEW DT STATUS

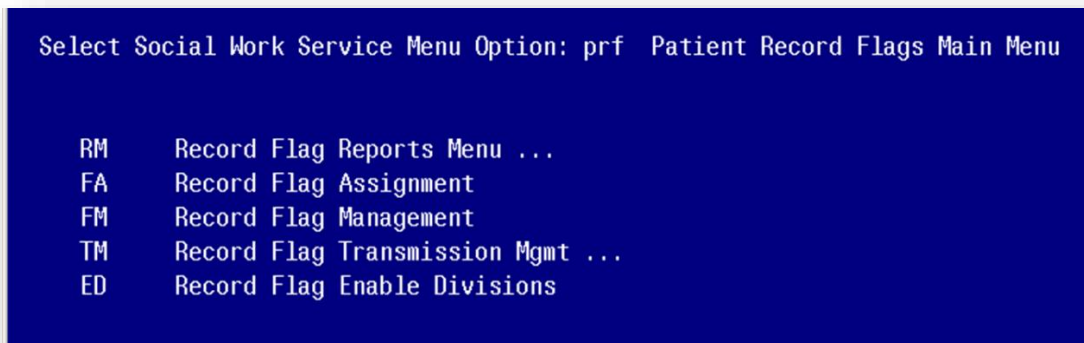
PATIENT	SSN	ACTION	ACTION DT	REVIEW DT	STATUS
ALKJHG,IFTGYH	676767676	NEW ASSIGNMENT	03/08/18	06/06/18	ACTIVE
COIU,FDRTFGYH L	787878787	NEW ASSIGNMENT	02/12/18	05/13/18	ACTIVE

Record Flag Management

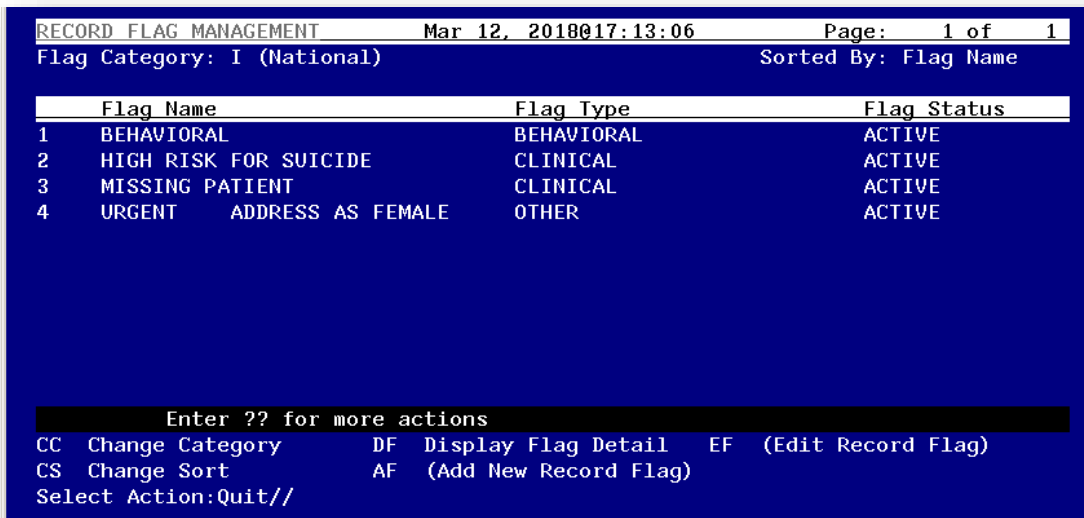
- Review of Category I and Category II flags and their details
- Allows flag managers to:
 - Modify the parameters of current Category II PRFs
 - Activate a new Category II PRF for the facility
 - Inactivate a no-longer-used Category II PRF

Note: Category I PRFs are nationally defined and controlled. Facilities may not create a Category I PRF.

Select **FM** [Record Flag Management]



Category I PRFs are displayed



To view Category II PRFs for the facility/VISN

- CC Change Category DF Display Flag Detail EF (Edit Record Flag)
- CS Change Sort AF (Add New Record Flag)

Select Action:Quit// **cc** Change Category

RECORD FLAG MANAGEMENT			
		Mar 14, 2018@17:03:09	Page: 1 of 1
Flag Category: II (Local)		Sorted By: Flag Name	
Flag Name	Flag Type	Flag Status	
1 DISRUPTIVE BEHAVIOR	BEHAVIORAL	ACTIVE	
2 DRUG SEEKING BEHAVIOR	BEHAVIORAL	ACTIVE	
3 HIGH RISK FOR SUICIDE	BEHAVIORAL	ACTIVE	
4 PREGNANCY LACTATION	CLINICAL	ACTIVE	

To display detail about a specific PRF such as when it was created or the purpose of the PRF

CC Change Category DF Display Flag Detail EF (Edit Record Flag)

CS Change Sort AF (Add New Record Flag)

Select Action:Quit// **DF** Display Flag Detail

FLAG DETAILS	
Mar 14, 2018@16:48:50	
Page: 1 of 2	
Flag Name: HIGH RISK FOR SUICIDE	Flag Status: ACTIVE
Flag Name: HIGH RISK FOR SUICIDE	
Flag Category: II (LOCAL)	
Flag Type: BEHAVIORAL	
Flag Status: ACTIVE	
Review Freq Days: 90	
Notification Days: 60	
Review Mail Group: DGPF BEHAVIORAL FLAG REVIEW	
Progress Note Title: PATIENT RECORD FLAG CATEGORY II - HIGH RISK FOR SUICIDE	
Flag Description:	

Patient is at high risk for suicide behavior.	
===== <Flag Enter/Edit History> =====	
1.	Enter/Edit On: 05/19/11@13:33:19
	Enter/Edit By: THERIOT,NICOLE
+ Enter ?? for more actions	
Select Action:Next Screen//	

Note: The Category II PRF for High Risk for Suicide was converted to a Category I PRF in October 2012. Facilities should NOT use a Category II PRF for High Risk for Suicide. This screen shot is for illustrative purposes only.

To modify the details of a PRF, such as the progress note title assigned or the default “review by” date or to inactivate a Category II PRF that is no longer used

Flag Category: II (Local)		Sorted By: Flag Name	
Flag Name	Flag Type	Flag Status	
1 DISRUPTIVE BEHAVIOR	BEHAVIORAL	ACTIVE	
2 DRUG SEEKING BEHAVIOR	BEHAVIORAL	ACTIVE	
3 HIGH RISK FOR SUICIDE	BEHAVIORAL	ACTIVE	

```

4 PREGNANCY LACTATION      CLINICAL      ACTIVE
  Enter ?? for more actions
  CC Change Category      DF Display Flag Detail  EF Edit Record Flag
  CS Change Sort          AF Add New Record Flag
  Select Action:Quit// ef Edit Record Flag
  Select Record Flag: (1-4): 3
  Enter the Record Flag Name: HIGH RISK FOR SUICIDE Replace [enter]
  Enter the Status of the Flag: ACTIVE// [enter] ACTIVE
  Enter the Type of the Flag: BEHAVIORAL// [enter] BEHAVIORAL
  Enter the Review Frequency Days: 90// [enter] 90
  Enter the Notification Days: 60// [enter] 60
  Enter the Review Mail Group: DGPB BEHAVIORAL FLAG REVIEW// DGPB BEHAVIORAL FLAG REVIEW [enter]
  Enter the Progress Note Title: PATIENT RECORD FLAG CATEGORY II - HIGH RISK FOR SUICIDE// [enter] PATIENT
  RECORD FLAG CATEGORY II - HIGH RISK FOR SUICIDE      TITLE
  Std Title: PATIENT RECORD FLAG
  Would you like to edit the description of this record flag? NO// [enter]
    
```

Note: This illustration makes no modifications and reviews the current details only.

Record Flag Transmission Management

- Includes two sub-menus
- When a Category I PRF is activated by a facility, all facilities with whom a patient has been registered for care should also be able to see the PRF displayed at their facility. These submenus allow flag managers to:
 - View and correct Flag Transmission Errors — view a list of facilities that did NOT receive the PRF display and allow the manager to re-transmit the PRF to those facilities.
 - Manually query the system for active PRFs that are not displaying at the HOME facility. Once the query is completed, any active Category I PRF will be visible.

Note: It is recommended to run this report after activating a PRF AND routinely (e.g., 1x/week) if activating many flags in a week.

Select **TM** [Record Flag Transmission Mgmt]

```

Select Social Work Service Menu Option: prf Patient Record Flags Main Menu

RM   Record Flag Reports Menu ...
FA   Record Flag Assignment
FM   Record Flag Management
TM   Record Flag Transmission Mgmt ...
ED   Record Flag Enable Divisions
    
```


Record Flag Manual Query

Select Record Flag Transmission Mgmt Option: **mq** Record Flag Manual Query

Select PATIENT NAME: **ZZcl**

- 1 ZZCLAUSE,SANTA PAT 1-1-40 000000006 NO NSC VETERAN
- 2 ZZCLAUSE,SANTA TEST *SENSITIVE* *SENSITIVE* NO NSC VETERAN

CHOOSE 1-2: **1** ZZCLAUSE,SANTA PAT 1-1-40 000000006 NO NSC VETERAN

>>> Active Patient Record Flag(s):

<HIGH RISK FOR SUICIDE> CATEGORY I

Do you wish to view active patient record flag details? Yes// **[enter]**

Patient: ZZCLAUSE,SANTA PAT (000000006) DOB: 01/01/40
ICN: 1017850005V426746 CMOR: HARLINGEN VA CLINIC

<<< Active Patient Record Flag Assignments >>>

- 1. Flag Name: <HIGH RISK FOR SUICIDE>
Category: I (NATIONAL)
Type: CLINICAL

Assignment Narrative:

Veteran has been added to the High Risk List for suicidal behavior due to reported behaviors that required an immediate treatment plan change such as hospitalization; Veteran's Electronic records will be reviewed at least every 90 days for evidence of continued or resolved risk factors, warning signs, and protective factors to consider continuance or removal from the High Risk List.

- 1. VETERAN'S MEDICATIONS SHOULD BE LIMITED TO 7 DAY SUPPLY FOR A
+ Enter ?? for more actions

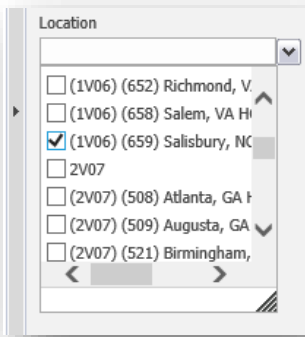
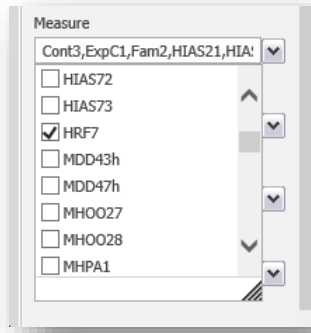
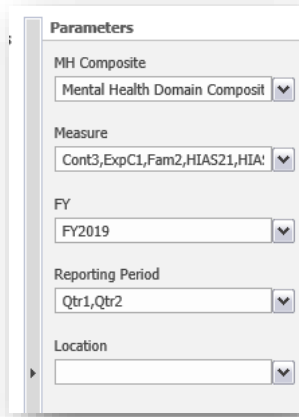
Select Action:Next Screen// **[enter]**

Continue hitting enter to navigate through the screens until the main menu appears. The flag will be visible at the home facility after running this command.

Appendix 3.1.2 HRF Dashboard

Facility-level scores for HRF metrics:

Once you open your facility SAIL dashboard, you may filter specifically for the HRF7 metric. Look for the Parameters section on the right side.



- Step 1. On the “Measure” parameter, de-select the default “Select All” option and scroll until you see HRF7. Select that metric.
- Step 2. (Optional) You may also filter for a different fiscal year and reporting period. The default is typically the current fiscal year (e.g., FY2019) and will include the quarters being reported for that fiscal year (e.g., Qtr1 = Quarter 1 (October 1 – December 31))
- Step 3. You will need to select your location. They are arranged by “Regions – 1-5,” then by “VISN,” “Station #,” and, finally, “Name of Health Care System.”

Example: (1V06) (659) Salisbury, NC =

Region (1-5)	1
VISN	V06
Station #	659
Name of Health Care System	Salisbury, NC HCS

Step 4. Then select “Apply”

The screenshot shows a 'Parameters' form with the following fields:

- MH Composite: Mental Health Domain Composi
- Measure: HRF7
- FY: FY2019
- Reporting Period: Qtr1,Qtr2
- Location: (1V06) (659) Salisbury, NC HCS

 An 'Apply' button is located at the bottom right of the form.

Scores are updated quarterly. There is usually a one-two month lag before the most recent completed quarter is updated. Scores should ideally increase in both percentage and transformed score. The graphic below represents the national composite or average score across VA for the first two quarters of Fiscal Year 2019.

The screenshot shows a report titled 'VA Mental Health Domain Composites Measure Components Summary'. It includes a 'Tip' box and a note about data from FY18Q4 onwards. The main table is titled 'Continuity of Care Composite' and shows data for FY2019 Qtr1 and FY2019 Qtr2.

Measure Description	Measure Name	Measure Weight	Preferred Direction	Deep Dive Tools	FY18 Nat'l Score 10th-50th-90th ptile	Location	FY2019 Qtr1		FY2019 Qtr2	
							Score	Std. Score	Score	Std. Score
Care process composite for Veterans at high risk for suicide	HRF7	1	↑	Link	-0.5; 0.4; 0.8	National	0.33	NA	0.50	NA
							HRF1 Score	91.31%	HRF1 Score	91.79%
							Transformed Score	0.5	Transformed Score	0.5
							HRF2 Score	90.86%	HRF2 Score	91.01%
							Transformed Score	0.5	Transformed Score	0.5
							HRF5 Score	89.40%	HRF5 Score	91.40%
Transformed Score	0.0	Transformed Score	0.5							

Scores lower than 90% will calculate a transformed score of “Zero” or a negative number. Ninety percent is the minimum score to “pass” the metric with a transformed score of 0.5.

It = less than gt = greater than

If raw score is lt 70%, then transformed score = -1.5.

If raw score is gt /=70% and lt 80%, then transformed score = -1.0.

If raw score is gt /=80% and lt 85%, then transformed score = -0.5.

If raw score is gt /=85% and lt 90%, then transformed score = 0.0.

If raw score is gt /=90% and lt 95%, then transformed score = 0.5.

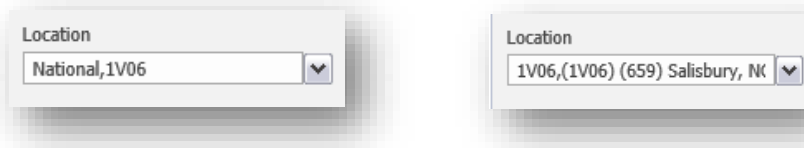
If raw score is gt /=95% and lt 98%, then transformed score = 1.0.

If raw score is gt /=98%, then transformed score = 1.5.

On the national graphic for FY19 Qtr1:

Metric	Raw Score	Legend	Transformed Score
HRF1	91.31%	If raw score is gt />=90% and lt 95%, then transformed score = 0.5.	0.5
HRF2	90.86%	If raw score is gt />=90% and lt 95%, then transformed score = 0.5.	0.5
HRF5	89.40%	If raw score is gt />=85% and lt 90%, then transformed score = 0.0.	0.0
HRF7	Composite	$(0.5 + 0.5 + 0.0)/3 =$	0.33

Consider selecting “National” on the parameter “Location” in addition to your facility to compare how your facility is doing in reference to the national average (i.e., higher or lower). You may also compare how your VISN is doing in comparison to the national average by selecting the region/VISN number (e.g., 1V06) or how your facility is doing in comparison to your VISN by filtering for those locations.



Penalty for Under Flagging- Care Process Composite HRF7 Score

In order to ensure facilities do not underuse flags to impact their SAIL scores, there is also a calculated penalty of -1 that will be applied to the scores for that facility.

****If the rate of assigned, reactivated, or continued high risk flags drops below 1 per 1,000 unique patients for your facility, your HRF7 score will have a -1 penalty added to the final standardized score.****

Example of facility with no penalty:

A	B	C	D
Facility	# of PRFs	# of Uniques	Rate of PRFs
XYZ Facility	175	33,149	5.3

Column B	= Count of Unique Patients with New, Reactivated, or Continued HRF Actions
Column C	= Total Facility Unique Patients
Column D	= Rate of HRF Actions/Assignments per 1,000 Facility Unique Patients = $[(B/C)*1000]$ $5.3 = [(175/33149)*1000]$

Facility XYZ has 5x the number of PRFs than is required. Facility XYG’s rate may go up or down; there is no penalty for a decrease in the rate AS LONG AS the rate of PRFs never falls below the number of 1.

Example of facility that will RECEIVE a penalty:

A			B	C	D
Facility			# of PRFs	# of Uniques	Rate of PRFs
EFG Facility			41	44,683	0.9

Column B	= Count of Unique Patients with New, Reactivated, or Continued HRF Actions
Column C	= Total Facility Unique Patients
Column D	= Rate of HRF Actions/Assignments per 1,000 Facility Unique Patients = [(B/C)*1000] 0.9 = [(41/44,683)*1000]

For Facility EFG to be in compliance with the rate of 1 PRF per 1,000 uniques, Facility EFG needs a minimum of 45 PRFs.

$$1 = [(45/44,683)*1000]$$

Actual rates vs minimum rates to maintain a rate of 1 PRF per 1000 uniques

Facility	# of PRFs	# of Uniques	Rate of PRFs	Required PRFs (minimum)	Rate of PRFs (minimum)
Facility A	92	40,276	2.3	41	1.0
Facility B	583	56,796	10.3	57	1.0
Facility D	88	73,986	1.2	74	1.0
Facility E	120	51,111	2.3	52	1.0

How Data is Pulled

How is data pulled into the dashboard?

HRF1 measures whether a Suicide Prevention Safety Plan has been completed within + or – 7 days of placement of a Patient Record Flag – High Risk for Suicide or of an inpatient discharge. It is tracked through completion of the progress note with the title Suicide Prevention Safety Plan within the EHR and the date that note was completed. Historically, facilities had their own progress note titles (e.g., Suicide Safety Plan, MH Safety Plan, etc.), which were fed into the dashboard and calculated to ensure they were being completed on a timely basis. As of 2018, there is a national template that is required to be used by all facilities. If you notice discrepancies with data for safety plans for your facility, you will want to ensure your facility is using the national, standardized template.

Safety Planning section for further information about this template and its requirements.

HRF2 measures whether four mental health visits were completed within the first 30 days of a PRF being placed. It measures this data primarily by stop code and will look for procedure code if a visit is completed via telephone. In order for visits to meet the metric requirements, a Veteran needs to be seen by a mental health provider who is completing a patient care encounter in a mental health stop coded clinic (e.g., 500 series — see stop codes in section 2.4.1 TOOLS Clinic Setup for further information) or using HBPC stop codes of 156 and 157. If a mental health provider is completing an encounter in a telephone clinic, the stop code must be

527 (mental health telephone clinic) AND the encounter must take 11 minutes or longer in direct clinical care. This is indicated through use of telephone procedure codes:

Non-Prescribers	
98967	HC Pro Telephone call, 11 - 20 minutes
98968	HC Pro Telephone call, 21 - 30 minutes
Prescribers Only	
99442	Phone E/M PHYS/QHP, 11- 20 minutes
99443	Phone E/M PHYS/QHP, 21- 30 minutes

Note: Eleven minutes of time does not include chart review or documentation and must be time spent in clinical care directly with the patient.

HRF5 measures whether a Veteran with an HRF received a PRF review within 100 days of placement of that PRF. The High Risk for Suicide PRF has a requirement of being reviewed every 90 days. The metric allows an additional 10 days of grace period to allow facilities some flexibility with how they staff and document staffing of high-risk cases. It is tracked through completion of a progress note title (e.g., Patient Record Flag Category 1 – High Risk for Suicide, Patient Record Flag Category I – High Risk for Suicide Assigned, etc.) used by facilities to document PRF actions.

How often is data updated?

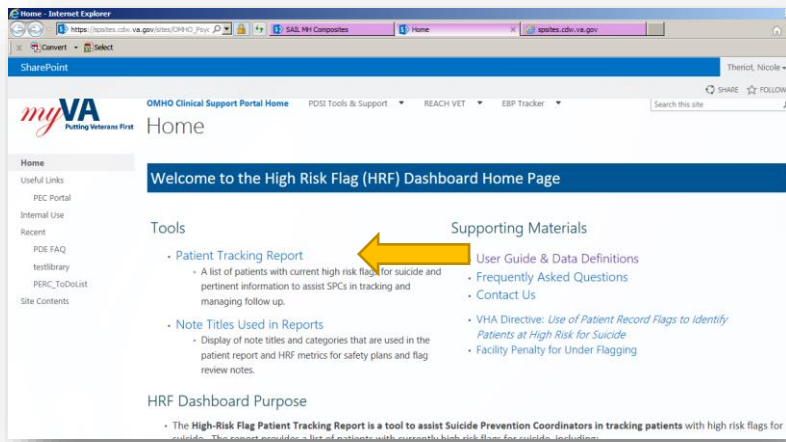
Data is automatically updated every night — it is NOT live data. There is a one-two day lag once an entry is made in CPRS.

What progress notes are used to pull data into the dashboard?

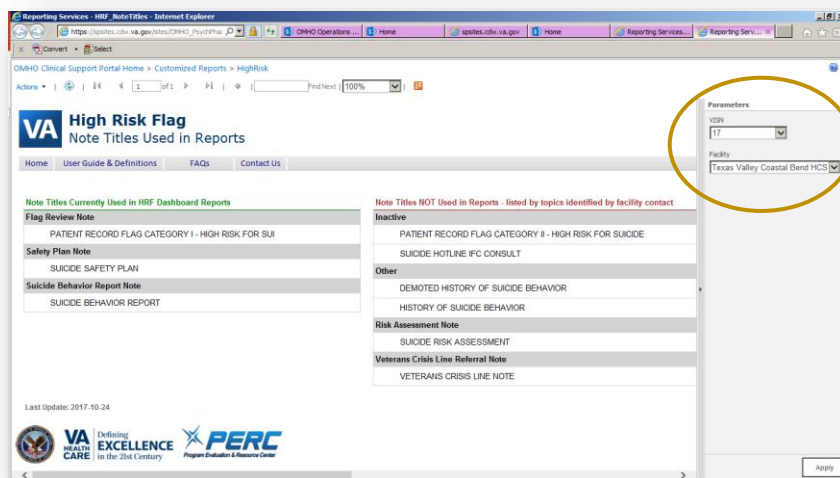
- **Flag Review Note:** A list of the facility’s note titles used to document activation, continuation, deactivation, or transfer of a patient record flag indicating high risk for suicide (HR1)
- **Safety Plan Note:** Suicide Prevention Safety Plan and Suicide Prevention Safety Plan Review/Decline used to document a new or reviewed safety plan (HR5)
- **Suicide Behavior Report Note:** Suicide Behavior and Overdose Reporting note specific to suicide attempts and behaviors documented in the EHR of Veterans with a PRF for high risk for suicide.

How do you know what progress notes are being used for your facility?

Facilities were required to notify the Program Evaluation and Resource Center of all the potential note titles used for suicide prevention when the dashboard was first created. To see a list of document titles for your facility that is currently being tracked within the dashboard, select the [Note Titles Used in Reports link](#) from the Home page.



Then filter for your facility-level information by selecting your VISN number first and then your facility name.



What if the note titles for my facility are not correct?

If additional note titles not currently listed on the dashboard are used at your facility to document Flag Reviews, contact the POC below and let them know which note titles should be added for your facility.

Point of Contact

For technical assistance, or to inform of other note titles that should be included for your facility, contact the HRF Dashboard Support Group at: VHAHRFDashboardSupport@va.gov

Note: Safety Plans and Suicide Behavior Reports are currently completed using nationally standardized titles. If your facility is not using these note titles, please speak with your facility leadership and/or the CACs at your site to ensure the standardized note titles are appropriately uploaded into CPRS at your facility.

Why are note titles documenting mental health visits not included on my Note Title Report?

The data on Mental Health Visit days is pulled from stop codes, not note titles. Any day where a patient had one or more mental Health encounters with a 500-series mental health stop code in the primary or secondary

position, or a HBPC stop code of 156 or 157, will be counted, regardless of whether that note title is pulled in or not. This includes clinical video telehealth and telephone encounters (11 minutes or longer).

How are mental health visits pulled?

Any mental health stop coded clinic (i.e., 500 series) in the primary or secondary position OR HBPC Psychiatry/Psychology

- General Mental Health
 - MH Individual, e.g., 502
 - MH Telephone, e.g., 527
 - MH Group, e.g., 550
- Specialty Mental Health
 - Homeless, e.g., 529 (HCHV Individual), 530 (HUD/VASH Telephone)
 - PTSD, e.g., Group 516
 - VJO, e.g., Individual 592
 - ICMHR, e.g., Telephone 546
 - SUD, e.g., Group 560
 - PRRC, e.g., Individual 582
- Primary Care/Mental Health Integration (PCMHI)
 - Individual 534
 - Telephone 534 (when in secondary position)
 - Group 539
- Home Based Primary Care (HBPC) – ONLY:
 - Psychiatrist 157
 - Psychologist 156

Note: This is not an exhaustive list of all 500 stop coded clinics (these codes are being used for illustration only). See [Managerial Cost Accounting Office Stop Codes site](#) for the full list of possible codes.

How many visits are required and when?

If the Patient Record Flag has been Activated or Reactivated:

- Day 0 – Day 30 = 4 visits (Day 0 includes the date the PRF was activated/reactivated.)
- Day 31 – 60 = 1 visit
- Day 61 – 90 = 1 visit

If the Patient Record Flag has been Continued:

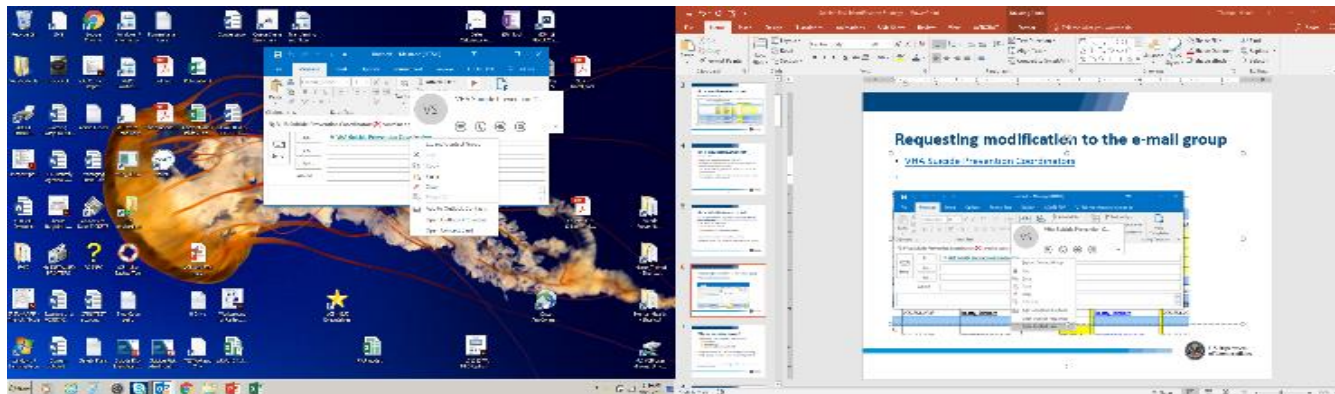
1 visit every 30 days until the flag is discontinued

- Day 0 – 30 = 1 visit
- Day 31 – 60 = 1 visit
- Day 61 – 90 = 1 visit

Note: When a PRF is “continued,” it will appear in the Day 0-30 column that usually requires four visits. However, once one visit is completed, the color will convert to “completed.”

Notes about visits

- Visits may occur at any time from Day 0 to Day 30, but must be on four separate days (i.e., two mental health visits on the same day will only be counted once)
- Telephone visits will be counted IF:
 - The encounter is documented in a 500-series stop coded telephone clinic
 - The encounter is 11 minutes or longer and uses one of the following CPT codes:



Note: Eleven minutes of “time spent” does not include chart review or documentation. Time included must be time spent providing clinical care directly WITH the patient.

- Visits will count on the date the PRF is placed, even if the PRF is placed AFTER the visit occurs, as long as it’s on the same date
- Inpatient visits occurring anytime on or after the date of the PRF will count
 - *Note: The [Post Discharge Engagement \(PDE\) Patient Tracking](#) requires an additional four visits post-discharge for High-Risk Veterans with a PRF.*
- The discipline of the clinician providing care for a specific mental health visit does not matter (e.g., social worker, nurse, psychiatrist, LMFT, etc.). However, the clinician must be providing care/documenting in a mental health stop coded clinic.
- Visits that are canceled or missed (no-shows) do not count toward credit for the metric; only visits with a completed encounter.
 - *Note: Appointments that are canceled or missed may NOT be counted as an encounter. Any documentation linked to that type of appointment MUST be administrative only. Encounters may only be completed when clinical care (e.g., a billable service) is being provided. Speaking with a Veteran to reschedule an appointment or leaving a message on a Veteran’s voice mail is not clinical care. See [Appendix 2.3 Billing Responsibilities](#) Historical Visits for further information.*

Viewing Your Facility Report

From the HRF Dashboard Home Page, select “Patient Tracking Report.” (Alternatively, you may access the patient tracking report as a saved site from your Internet Favorites or select the link [here](#).)

VA High Risk Flag Patient Tracking Report

1 Click arrow to move to next page of report.

2 Search for patient name.

3 Key:

- Item needs attention (has not been completed or needs to be updated soon)
- Item completed within target time frame
- Item not completed within target time frame

4 Access the dashboard User Guide.

5 View answers to Frequently Asked Questions.

6 Access the [Note Title Report](#) to see which note titles are being used on your facility's dashboard.

7 Send an email to the HRF Dashboard Support Group (VHAHRFDashboardSupport@va.gov) with questions, suggestions, or feedback about the dashboard.

When the report opens, the default view should present data from your facility. If it does not, look for the Parameters section:

1. Use the filter to find and select your VISN
2. Use the filter to find and select your Facility
3. (Optional) You may also choose to filter further by Flag Status or leave the default to ALL
4. Select "Apply"

VHA Suicide Prevention Coordinators

General | Member Of | E-mail Addresses

Display name: VHA Suicide Prevention Coc

Alias name: VHASuicidePreventionCoord

Owner: Woehr, Kimberly M.

Notes:

Members

- Acompanado, Laura
- Adams, Richard ASHVAM
- Adams-Lahti, Samantha
- Adkinson, Brian
- Ajuonuma, Valerie
- Albert, Peter
- Allain, Nicole L.
- Allen, Christina M
- Almeda, Sherrie L.
- Altamirano, Karol P.

Modify Members...

Add to Contacts Actions

OK Cancel Apply

You can select options to filter from three parameters:

VISN: The list of VISNs will display only the VISNs for which you have LSV permissions.

Facility: The list of facilities will display only the facilities for which you have LSV permissions. You can only select one facility from the drop-down list at a time.

Flag Status (optional): Select to filter by flag status (New, Reactivated, and/or Continued flags).

Report Elements (columns) and Definitions:

Flag Owner Institution: Palo Alto, CA HCS - Total Patients: 87 (Data Updated 6/7/2018 3:16 PM Central Time)

Patient Information	Patient Record Flag		
Name (Last 4)	Initial	Current	Current Flag Status

Total Patients: Above the table, the total number of patients with a current High Risk Flag at the selected facility will display. The date and time that the report was last updated will display as well.

Patient Information: Last Name, First Name, Last 4; name sortable by alphabetical order: A-Z; Z-A. Click the + next to the patient’s name to view the patient’s address, phone number, and age (DOB).

<div style="display: flex; align-items: center;"> + Patient Name (0000) </div>	4/3/2018	4/3/2018	◆ New
Home Phone: (999) 999-9999		Age (DOB): 100 (6/29/1918)	
Cell Phone: (999) 999-9999			
Address: 1 STREET NAME CITY, STATE, ZIP			

Flag Date: Based on Flag Action date in VistA

Initial: Date when the patient was first assigned a High Risk Flag for suicide

Current: Most recent date that a High Risk Flag was activated, reactivated, or continue for the patient

Current Flag Status: indicates whether the patient’s current flag is New, Reactivated, or Continued

◆ New
◆ Reactivated
Continued

Safety Plan:

Safety Plan		Most Recent Flag Review Note
Target	Most Recent	Note

Target: Indicates whether the target for HRF1 was met for the patient. For patients with a new or reactivated flag, the safety plan should be completed within 7 days before or after the current flag date. If the patient is inpatient when the flag is placed or is admitted to an inpatient unit within the first 7 days of flag activation, the safety plan should be completed on or before the day of inpatient discharge.

X	Target not Met – Safety Plan not completed within +/- 7 days of the new/reactivated flag, or by discharge date
✓	Target Met – Safety Plan completed within +/- 7 days of the new/reactivated flag, or by discharge date
!	Time remains to meet target
N/A	Patient has a continued flag and is not in the denominator for HRF1

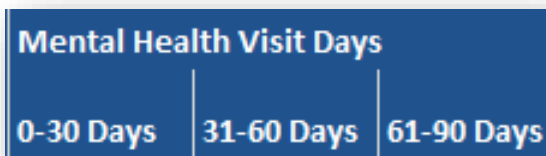
Most Recent Safety Plan Note: The most recent date a new or reviewed safety plan was documented.

Most Recent Safety Plan Note	
11/3/17	No Color - Safety Plan completed within the last 18 months
10/23/15	Yellow - Safety Plan completed more than 18 months ago OR flag was activated fewer than 7 days ago and Safety Plan has not yet been completed **Safety Plan needs attention**
8/3/17	Orange - Safety Plan note not completed and is overdue

Most Recent Flag Review Note: The most current date when a patient’s High Risk Flag was activated, continued, reactivated, or discontinued, based on note titles. Flag review should occur within 100 days of a new, continued, or reactivated flag.

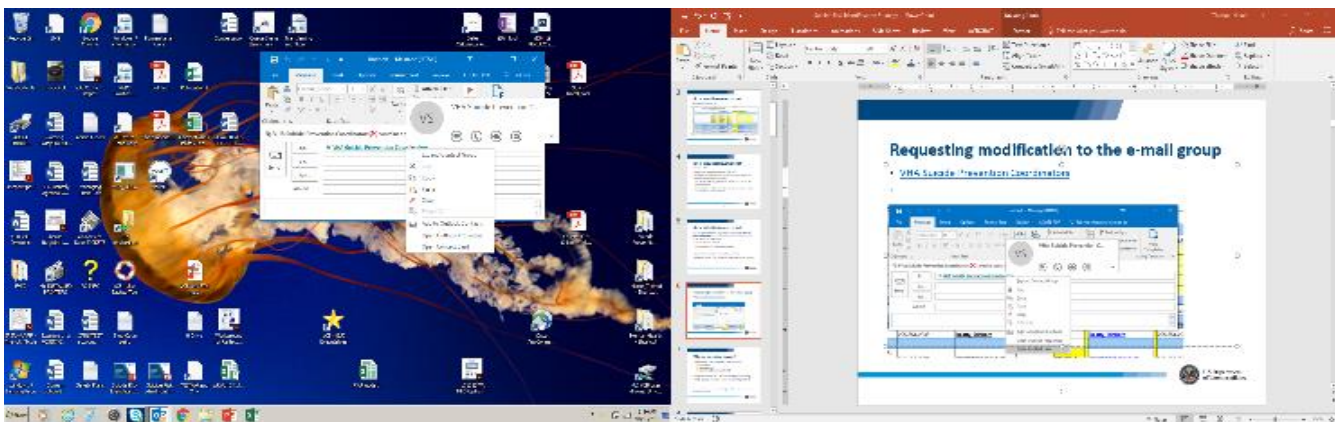
Most Recent Flag Review Note	
11/6/17	No color - The most recent flag review note was completed fewer than 84 days ago.
8/14/17	Yellow – The most recent flag review note was completed 84-100 days ago. The flag should be reviewed and either continued or deactivated imminently.
10/18/17	Orange – It has been greater than 100 days since the most recent flag review note has been entered. Flag review is overdue.

Mental Health Visit Days:



Mental Health Visit Days are days in which the patient had one or more encounters with 500-series stop codes. This includes mental health and homeless services, including clinical video telehealth and telephone services (11 minutes or longer). Encounters with Home Based Primary Care stop codes 156 and 157 are also counted toward this measure.

Primary or secondary 500-series mental health stop codes that indicate telephone encounters will only be counted if they are 11 minutes or longer, as indicated by attaching one of the following CPT codes to the encounter:



Note the color coding in this section. As a rule of thumb:

Mental Health Visit Days	
0	Orange – The patient did not receive the required number of visit days within the specified timeframe. **There is no longer time to meet the requirements for this timeframe.**
2	Yellow – The patient has not yet received, but still has time to receive, the required number of visit days within the specified timeframe. **Action is required to fulfill the required number of MH visit days.**
5	Blue – The patient has received the required number of visit days within the specified timeframe.
	Blank – the patient has not yet reached this timeframe

To see the date range for each 30-day window, hover over the number or the blank space with your cursor. You will be able to see the start and end dates for that window, as well as an indicator of whether the target was met, not met, or whether there is still time to meet the target.

18 (Data Updated 1/12/2018 11:17 AM Central Time)

Current	Current Flag Status	Inpatient	Most Recent Safety Plan Note	Most Recent Flag Review Note	Mental Health Visit Days		
					0-30 Days	31-60 Days	61-90 Days
11/9/2017	New		11/20/2017	11/9/2017	5	5	0
12/27/2017	New		1/3/2018	12/27/2017	11/9/2017 - 12/9/2017 Target Met		
11/2/2017	Reactivated		7/25/2017	11/2/2017	4	0	0

needs attention

met

not met

- Item needs attention (has not been completed or needs to be updated soon)
- Item completed within target time frame
- Item not completed within target time frame

See the example Dashboard with data as follows:

- Total Patients: 18 (Data Updated 1/12/2018 11:17 AM Central Time)

Mental Health Visit Days			
0-30 Days	31-60 Days	61-90 Days	Most R
5	5	0	
1			12/
12/27/2017 - 1/26/2018 Needs Attention (Time remaining to meet target)			

Mental Health Visit Days			
0-30 Days	31-60 Days	61-90 Days	Most R
5	5	0	1
11/9/2017 - 12/9/2017 Target Met			
4	0	0	11/

Mental Health Visit Days		
0-30 Days	31-60 Days	61-90 Days
5	5	0
1		
4	1/27/2018 - 2/25/2018	

Mental Health Visit Days			
0-30 Days	31-60 Days	61-90 Days	Most
5	5	0	
1			1
4	0	0	1
0	12/3/2017 - 1/1/2018 Target Not Met (Time period ended)		

Box is blank – time frame has not yet started

0-30 Days: The number of mental health visit days in the 30 days following the current flag date.

- New/Reactivated Flag - The patient will need mental health visits on at least 4 separate days during this period.
- Continued Flag - The patient will need at least one mental health visit during this period.

Mental Health Visit Days		
0-30 Days	31-60 Days	61-90 Days
0	Orange – More than 30 days have passed since the current flag date AND <ul style="list-style-type: none"> • New/Reactivated Flag – the patient had fewer than 4 visits during this period • Continued Flag – the patient had fewer than 1 visit during this period **There is no longer time to meet the requirements for this timeframe.**	
2	Yellow – 30 or fewer days have passed since the current flag date AND <ul style="list-style-type: none"> • New/Reactivated Flag – the patient has had fewer than 4 visits during this period • Continued – the patient has had fewer than 1 visit during this period **Action is required to fulfill the required number of MH visits during this timeframe.**	
5	Blue – The time period may be active OR may have passed since the current flag date AND <ul style="list-style-type: none"> • New/Reactivated Flag - The patient has received 4 visits during this period • Continued – the patient has received 1 visit during this period **No further action is required during this timeframe**	
Note: Visits will continue to count and accrue until the time frame has passed.		

31-60 Days: The number of mental health visit days in the 31-60 days following the current flag date.

- New/Reactivated/Continued Flag - The patient will need 1 mental health visit during this period.

Mental Health Visit Days		
0-30 Days	31-60 Days	61-90 Days
	0	Orange – More than 60 days have passed since the current flag date AND the patient had no mental health visits during this timeframe. **There is no longer time to meet the requirements for this timeframe.**
	0	Yellow – More than 30 but no more than 60 days have passed since the current flag date AND the patient has had no mental health visits during this timeframe. **Action is required to fulfill the requirements of this timeframe.**
	1	Blue – The time period may be active OR may have passed since the current flag date AND the patient has received 1 visit during this timeframe. **No further action is required during this timeframe**
	Note: Visits will continue to count and accrue until the time frame has passed.	
		Blank – The patient’s current flag date is fewer than 31 days ago

61-90 Days: The number of mental health visit days in the 61-90 days following the current flag date.

- New/Reactivated/Continued Flag - The patient will need 1 mental health visit during this period.

Mental Health Visit Days		
0-30 Days	31-60 Days	61-90 Days
		<p>Orange – More than 90 days have passed since the current flag date AND the patient had no mental health visits during this timeframe. **There is no longer time to meet the requirements for this timeframe.**</p>
		<p>Yellow – More than 60 but no more than 90 days have passed since the current flag date AND the patient has had no mental health visits during this timeframe. **Action is required to fulfill the requirements of this timeframe.**</p>
		<p>Blue – The time period may be active OR may have passed since the current flag date AND the patient has received 1 visit during this timeframe. **No further action is required during this timeframe**</p> <p>Note: Visits will continue to count and accrue until the time frame has passed.</p>
		<p>Blank – The patient’s current flag date is fewer than 61 days ago</p>

Recent Encounter Details:

MH Visits & Appointments			
Most Recent	Next Appt	Cancelled Upcoming Appt or Recent No Show	
6/26/2018	6/28/2018	6/13/2018	NO SHOW
6/12/2018		N/A	

Most Recent Visit:

Lists the date of the patient’s most recent mental health encounter in the 500 primary stop code series since the initial flag date.

Next Appointment:

Lists the date of the patient’s next scheduled mental health appointment. This will appear blank if the patient does not have an upcoming scheduled mental health appointment.

Canceled Upcoming Appointment or Recent No-Show:

If the patient has had a recent no-show or canceled mental health appointment (within the last 30 days), the date of the most recent no-show or upcoming cancellation will display here. The type of no-show or cancellation will appear; types include: No-Show, Canceled by Patient, or Canceled by Clinic.

Canceled visits that have occurred in the past will not appear in this column but will appear in the expanded list of the patient’s visits.

Visit Details:

To see a full list of the mental health visits, cancellations, and no-shows for the patient, click the symbol next to the patient’s name.

- Past appointments being counted toward the metric and upcoming appointments appear in grey.
- No-shows and cancellations appear in red.

06/21/18 10:30 AM	MENTAL HEALTH CLINIC - IND (502)	
06/20/18 8:30 AM	TELEPHONE MH (527)	CANCELLED BY CLINIC - 6/15/2018 11:59:00 AM
06/15/18 11:50 AM	TELEPHONE MH (527)	
06/15/18 11:00 AM	MH INTGRTD CARE IND (534)	CANCELLED BY PATIENT - 6/15/2018 11:11:07 AM
06/12/18 1:38 AM	TELEPHONE MH (527)	

Most Recent Mental Health Encounter Details:

Lists the date and types of the most recent mental health encounters since the initial flag date. This includes mental health and homeless services, including clinical video telehealth and telephone services (11 minutes or longer).

Note: Information includes the stop code of the clinic, e.g., 502 and the facility name where the appointment was held.

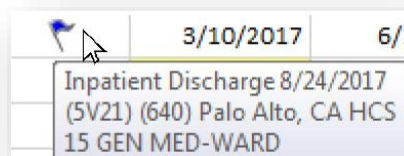
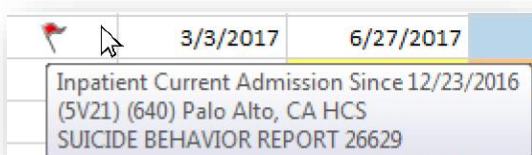
Most Recent Mental Health Encounter Details	
1/8/2018	502 Mental Health Clinic - Ind (Texas Valley Coastal Bend HCS)
12/27/2017	527 Telephone Mh (Texas Valley Coastal Bend HCS)
11/21/2017	596 Rrtp Admission Screening Srvcs (Big Spring, TX HCS)

Additional Clinical Details:



Most Recent Suicide Behavior Report	Inpatient	REACH VET Patient	Patient's Providers MH Treatment Coordinator	Primary Care Provider
--	------------------	--------------------------	---	------------------------------

Most Recent Suicide Behavior Report: Lists the entry date of the patient’s most recent Suicide Behavior Report note, if applicable.

Inpatient: A red flag in this column indicates that a patient is currently admitted to an inpatient or residential unit at a VA facility. A blue flag in this column indicates that a patient has been discharged from a VA inpatient or residential facility within the past 30 days. Hover over the flag with the cursor to see details about the inpatient admission or discharge or click to be linked to the PDE dashboard for further details.



REACH VET Patient: A flag will appear in this column if the patient is currently identified in REACH VET or has been identified in REACH VET in the past.

A red flag  indicates that the patient is currently identified in REACH VET at the top 0.1% statistical risk within their facility for suicide or other adverse outcomes. A yellow flag  indicates that the patient has been identified in REACH VET in the past. Click on the flag to view the patient’s information in the REACH VET dashboard.

Patient’s Providers: The patient’s assigned Mental Health Treatment Coordinator (MHTC) and Primary Care Provider (PCP) are displayed here. If a patient does not have an MHTC or PCP assigned at the station, this will display as *Unassigned*.

Appendix 3.2.1 Issue Briefs and Heads-Up Messages

Heads-Up Messages should be created using Arial 12 Font, in the following format:

HEADS UP

- 1) Facility Name:** Include site, parent facility (as appropriate), and VISN
- 2) What Occurred:** Summarize incident in 3-5 sentences; the IB following the incident should contain specific information. Include any immediate actions or resolutions that were taken.
- 3) When:** Date and time of incident
- 4) Have you notified other offices or programs?** Yes or No (If Yes, identify the appropriate VHA Central Office program office that was notified)
- 5) Additional details will be provided by:** When (within the next business day)
- 6) If there are questions, please contact:** Full name, position, location, phone number with area code and extension.

Issue Briefs should be created using Arial 12 Font, in the following format.

VHA ISSUE BRIEF

VISN # - Name of facility and (Location)

Issue Title: Summary of issue in one sentence

Date of Report: Date of notification

Brief Statement of Issue and Status: Date of occurrence (if different from date of report), background information; what happened and what the current situation is, chronologically.

Actions, Progress, and Resolution Date: Should chronologically include why this happened; what has been done to keep it from happening again; any media, VSO, and congressional involvement or interest

Indicate if Applicable: place an "X" next to the response reflecting the facility's action

- **Institutional Disclosure** ___ YES; ___ NO; ___ N/A
- **Clinical Disclosure** ___ YES; ___ NO; ___ N/A

Contact for Further Information: Name of subject matter expert, title, phone number with area code and extension.

The following template should be used when reporting incidents related to self-directed violence (e.g., issue briefs reporting on suicides, suicide attempts, or self-harm as a primary or associated category). Note: The mandated categories are aligned with requirements for reporting for the Behavioral Health Autopsy Program (Attachment I):

Mandated Categories	
Type of self-harm (based on self-directed violence classification system nomenclature)	
Known recent stressors that may have contributed to precipitating the event	
Brief summary of Mental Health care over past 2 years (include hospitalizations, residential care stays, evidence-based psychotherapies, the number of encounters, and other information as appropriate)	
Brief summary of medical/surgical care over past 2 years (include hospitalizations and other information as appropriate)	
Date and type of last MH appointment	
Date and type of last primary care/medical/surgical appointment	
Were there recent no shows for either MH or medical/surgical appointments and was follow-up done?	
Had suicide risk assessments been done within the past 2 years? <ul style="list-style-type: none"> • When (most recent assessment before the event)? • Determination? 	

<p>Was the Veteran on the High Risk List within the past 2 years?</p> <ul style="list-style-type: none"> • If so – date(s) flag placed on medical record • If so – date(s) flag deactivated 	
<p>Had a safety plan been developed?</p> <ul style="list-style-type: none"> • If so, data of last update? 	
<p>Date of Last Mental Health Screening and Screening Results</p> <ul style="list-style-type: none"> • PHQ-2 or PHQ-9 • PCL or PCL-5 • AUDIT-C • Other (Specify) 	
<p>Had the following been addressed in any way during the past 2 years? If so, provide a brief description</p> <ul style="list-style-type: none"> • Pain? • Insomnia? • Substance use? 	
<p>List current mental health diagnoses</p>	
<p>List of current medical surgical diagnoses</p>	
<p>List current VA medications</p>	
<p>List known non-VA medications</p>	



10N Guide to Issue Briefs (Updated Ver

or

[Deputy Secretary for Health for Operations and Management \(10N\) –10N](#)

[Guide to VHA Issue Briefs](#)

Appendix 3.2.2 BHAP and FIT-C

Following you will see a list of data definitions for each of the fields included in the BHAP chart review and FIT-C templates. They are meant to offer guidance to SPCs about sources that may be helpful when completing the BHAP chart analysis. In addition, information and instructions are included for how to complete both templates.



BHAP Data Definitions 2017.02.

or

[BHAP Data Definitions](#)



BHAP Chart Review + FITC forms Resour

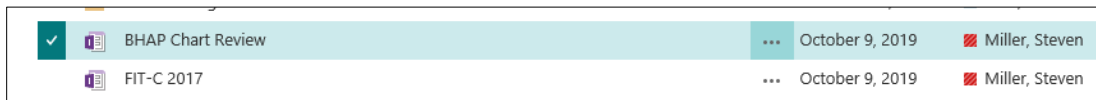
or

[BHAP Chart Review and FIT-C Forms Resource Guide](#)

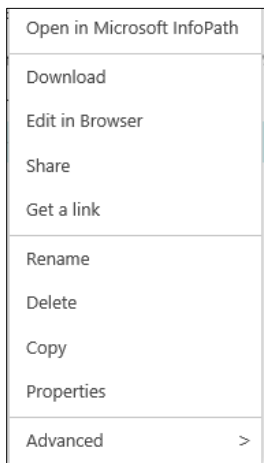
How to Use BHAP and FIT-C Forms

In order to ensure SPCs are using the most current version of the BHAP and FIT-C forms, SPCs are discouraged from saving blank forms. When a suicide occurs, SPCs are encouraged to navigate to the SPC SharePoint and download the forms needed for that particular event. Once completed, SPCs are encouraged to save copies to a local shared drive that is appropriate for storage of PHI/PII.

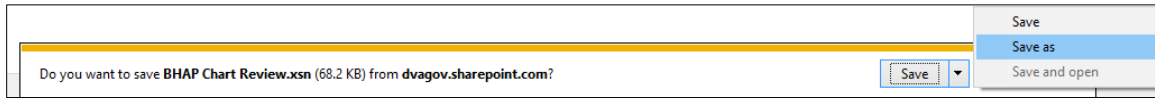
1. Select “Tracking and Reporting” tab on the [SPC SharePoint](#)
2. Scroll to the bottom of the page and look for BHAP Chart Review and FIT-C 2017 documents.



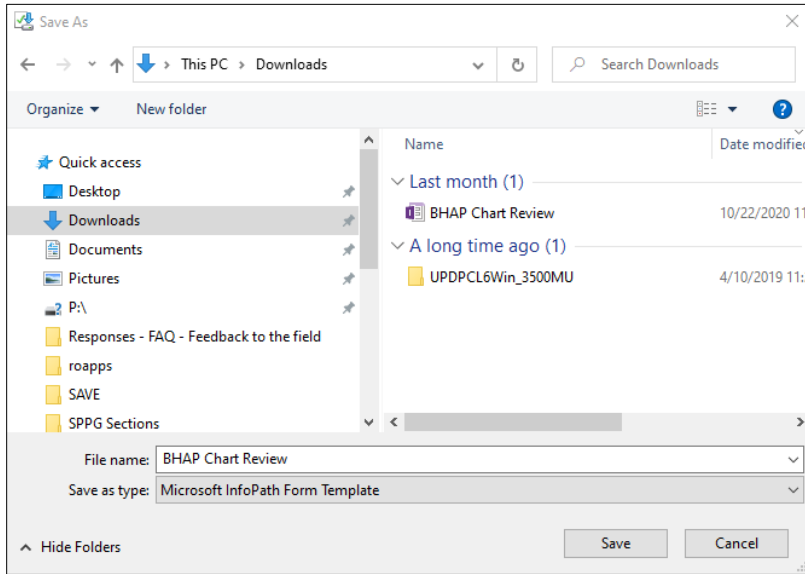
3. Right click on the document and select “Download” or “Open in Microsoft InfoPath.”



4. If you select “Open in Microsoft InfoPath,” the document should automatically open the Microsoft InfoPath application and open a new fillable BHAP Form.
5. If you select “Download,” select the down arrow next to the “Save” option and select “Save as.”



6. A new window (File Explorer) will open prompting you to select a “File” name for the document and allowing you to select a local location for storing the document.



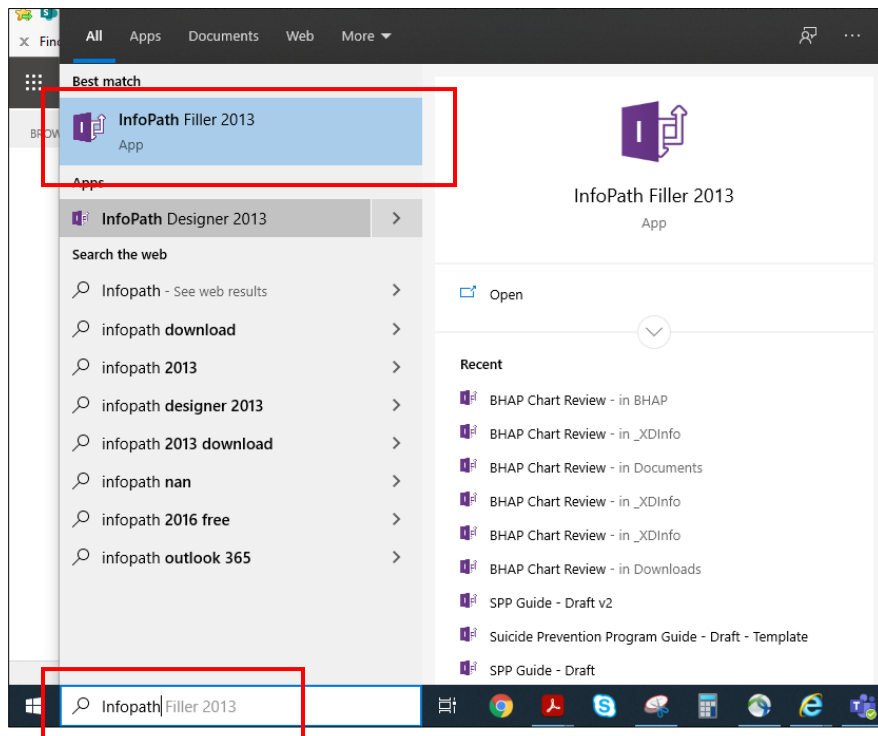
7. Rename your document and save it in a secure location that allows storage of PHI/PII. **Do not save the document to the SPC SharePoint.**

Example:

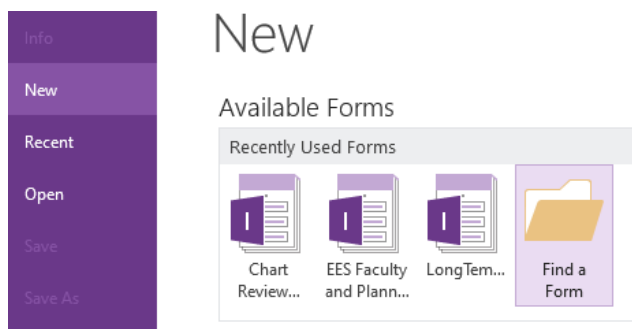


Then select “Save.”




- Open Microsoft InfoPath Filler 2013. If you don't see it readily available, use the "search" option on your taskbar to search for it. *(Note: If you are unable to open or find it, contact your local IT. InfoPath is no longer supported outside of filling documents and may not be loaded onto your computer.)*



- Select or open "InfoPath Filler 2013" and then select "Find a Form" or "Open" from the toolbar. (Either will open File Explorer to allow you to search for your file.)



10. Search for the document you just saved, select it, and then select “Open.”

Name	Date modified	Type	Size
 11.09.2020 BHAP Chart Review - Smith, John	11/9/2020 11:13 AM	Microsoft InfoPat...	69 KB
 BHAP Chart Review	11/9/2020 9:38 AM	Microsoft InfoPat...	69 KB
 FIT-C 2017	11/9/2020 9:38 AM	Microsoft InfoPat...	18 KB

File name: All InfoPath Form

Tools

Appendix 3.3.1 Self-Directed Violence Classification Two-Page Handout



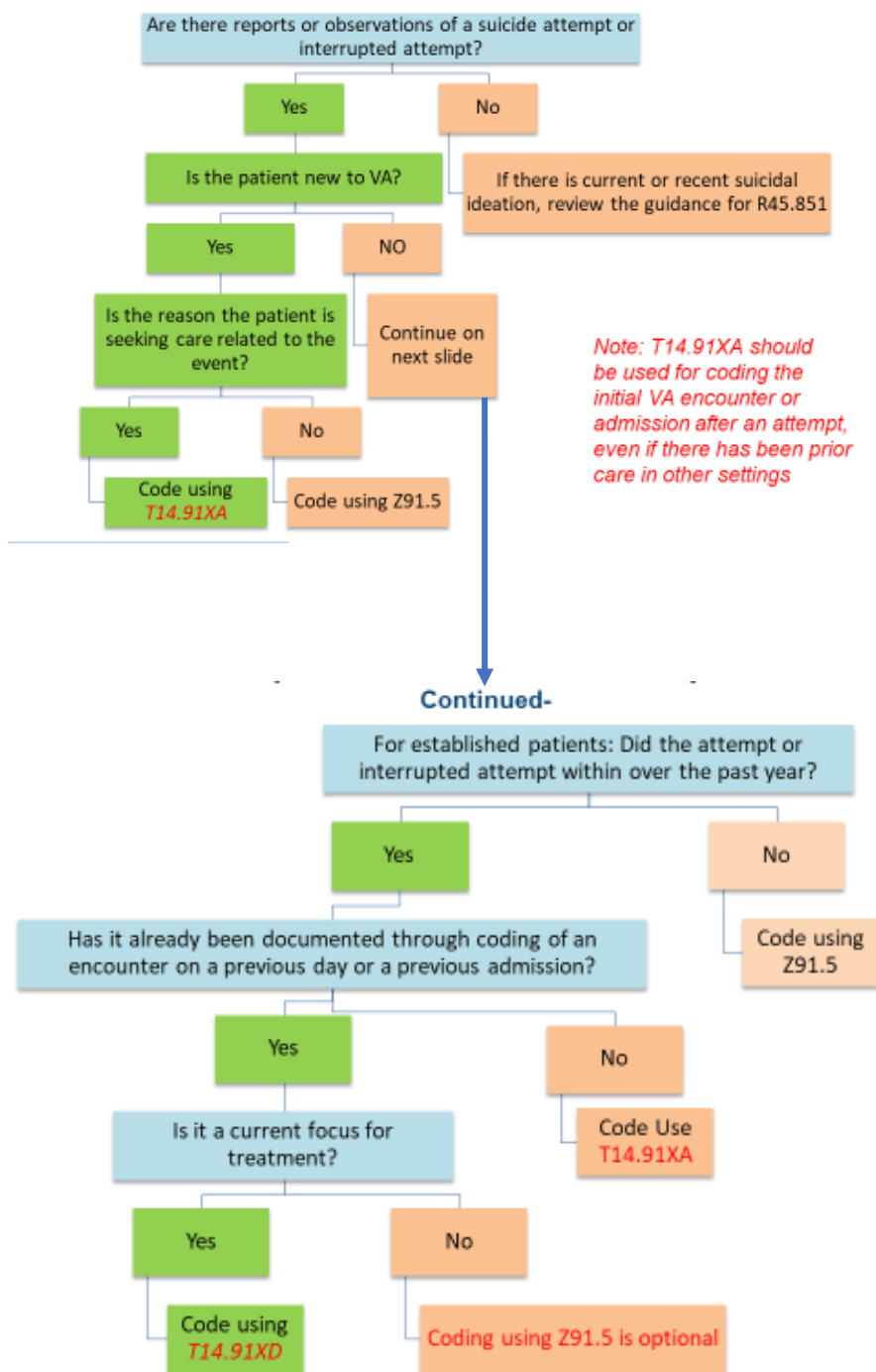
SDVCS Two Page
Handout.pdf

or

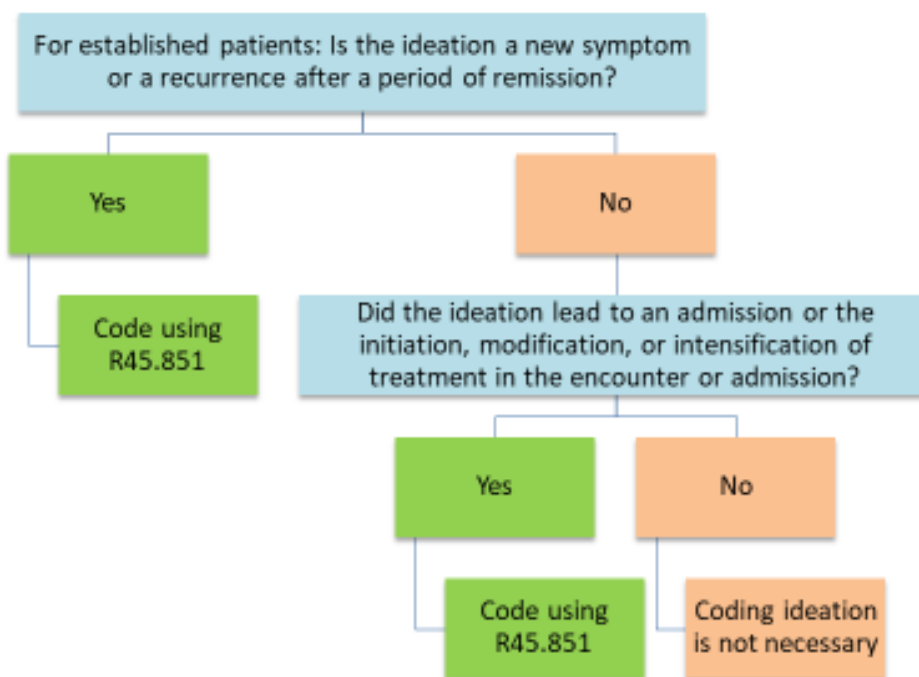
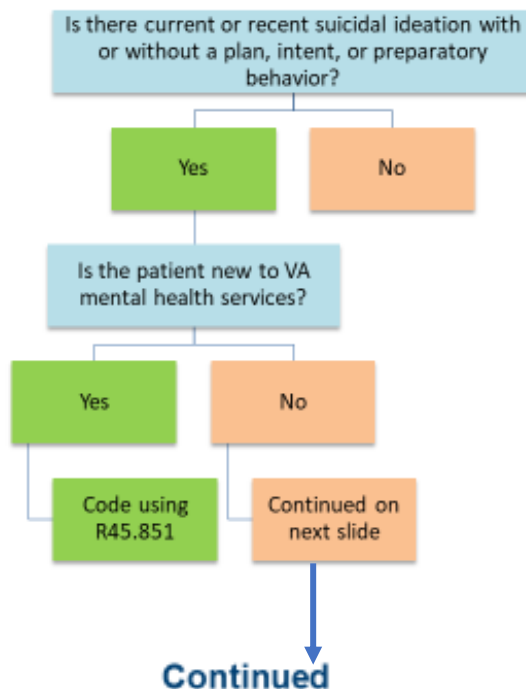
[Self-Directed Violence Classification Two Page Handout](#)

Appendix 3.3.2 ICD-10 Suicide-Related Behavior Decision Trees

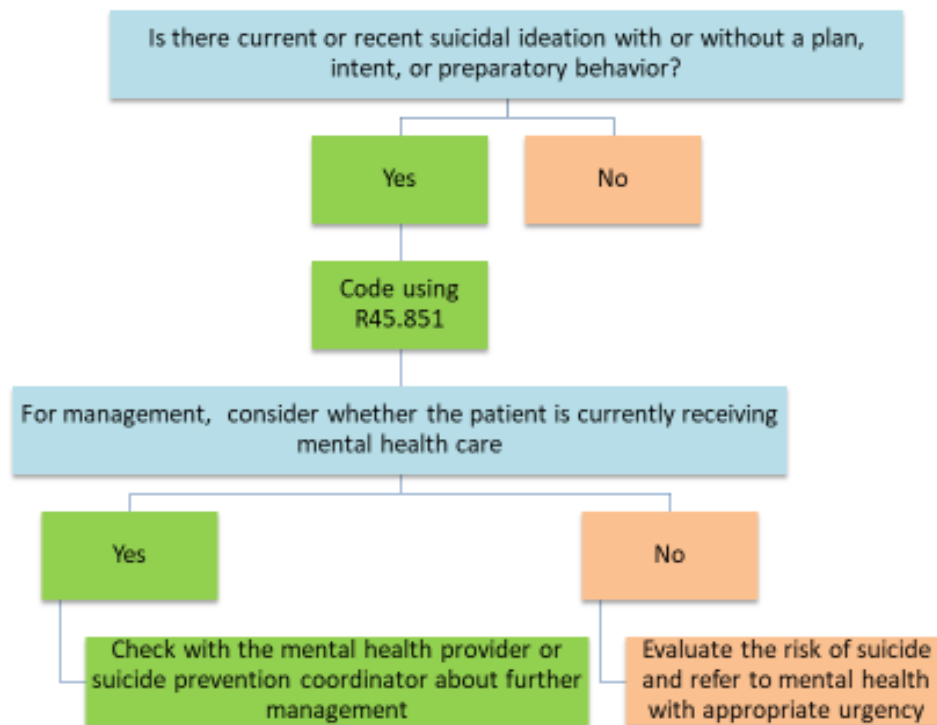
ICD-10-CM Coding for Suicide Attempts (T14.91 and Z91.5)



ICD-10-CM Coding for Suicidal Ideation (R45.851) For Mental Health Providers



ICD-10-CM Coding for Suicidal Ideation for Primary Care and Other Medical/Surgical Providers (R45.851)



Appendix 3.3.3 Suicide Behavior and Overdose Report Template Support Documents



SBOR Note
Template User Guide

or

[SBOR Note Template User Guide](#)

Mental Health Services SBOR folder on SharePoint

- [04082019 – Suicide Behavior and Overdose Report Computerized Patient Record System Note Template Implementation](#)
- [Removing and Adding Health Factors in Encounter Form](#)
- [SBOR FAQ](#)
- [SBOR Note Template User Guide](#)
- [SBOR Overview ppt slide deck](#)
- [SBOR Staff-Specific Guidance](#)
- [SBOR Template Provider Instructions](#)
- [SBOR Template Screenshots](#)
- [SBOR TMS Training](#)
- [SDV Classification System Clinical Tool](#)
- [Self-Directed Violence Classification System](#)

Appendix 3.3.4 Entering SDV Events into SPAN

Entering SDV Events into SPAN

Searching for a Client

Before adding new information, first determine if a patient has already been entered into SPAN. If the patient has already been entered, update data that is already there. If not, proceed to adding a “new” client (patient/Veteran).

Step 1

From the SPAN home page, select “Add Edit Client” from the *Select from the options below* list

OR

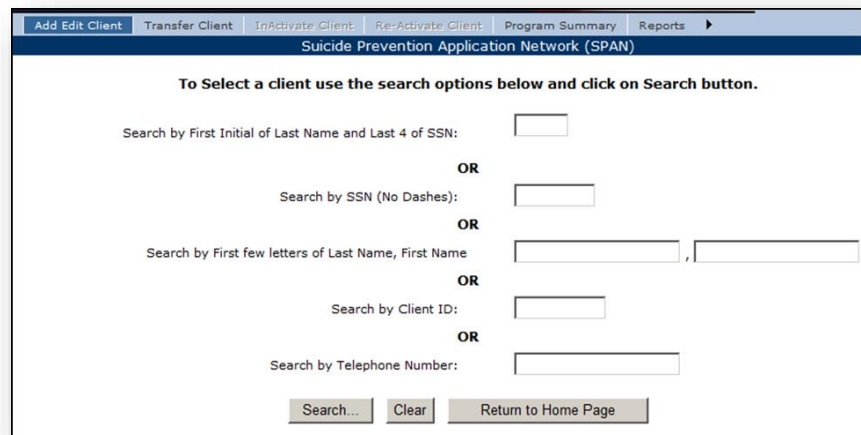
Select “Add Edit Client” from the tabs menu at the top



Step 2

Use one of the search parameters to find a patient.

- First initial and last 4 of SSN
- Full SSN
- Last name, first name
- Client ID
- Telephone number



Step 3

Test the function by looking for the test patient. In the first box, type in “T2223” (searching by first initial of last name and last 4 of SSN).

Client ID	19479631
Last Name	test2
First Name	zz2
Middle Initial	2
SSN	222222223
Telephone Number	5855555555

Step 4

A list of three patients populates at the bottom.

Find your patient and click on the “Select” link.

To Select a client use the search options below and click on Search button.

Search by First Initial of Last Name and Last 4 of SSN:

OR

Search by SSN (No Dashes):

OR

Search by First few letters of Last Name, First Name: ,

OR


Search by Client ID:

OR

Search by Telephone Number:

Search Results

Client ID	Last Name	First Name	Middle Initial	SSN	Date Of Birth	Client Active*	Re-Activate Client	Select Patient
19479631	test2	zz2	2	22222223	10/09/2014	Yes		Select
						Yes		Select
						Yes		Select



The following screen appears. Test patient “zz2 2 test2” already has data already entered SPAN. You can select any of the buttons available to review the data or “add” new data to this test patient.

- Update client
- Update plan
- Add new event
- Add new reminder
- Add new contact log

SPAN Home | Add Edit Client | Transfer Client | Inactivate Client | Re-Activate Client | Program Summary | Reports

Suicide Prevention Application Network (SPAN)

Client ID: 19479631	Name: test2, zz2 2	SSN: 22222223
Date of Birth: 10/09/2014	Sex: Male	Client Record Entered in Error?:
SP Staff: Gordon, Donald	Primary VAMC: 2 - 528A5 - Canandaigua	Secondary VAMC:
High Risk Indicator: No	Safety Plan: Yes	Mail Program:

Client Events

Client ID	Event ID	SPC	VAMC	Event Date	Event Entered in Error?	Select
19479631	105822	Gordon, Donald	2 - 528A5 - Canandaigua	01/22/2015	Yes	Edit/View

If the 'Add New Event' option is not available, please update the Client & Plan Screens to complete all required fields; using the 'Update Client' & 'Update Plan' buttons above

Current Reminder(s)

Client ID	Reminder ID	Last Name	First Name	MI	SSN	Type	Start Date	Next Review Date	End Date	Entered In Error	Select
19479631	20635	test2	zz2	2	22222223	Reminder	06/14/2016	06/15/2016		No	Select

If the 'Add New Reminder' option is not available, please update the Client & Plan Screens to complete all required fields; using the 'Update Client' & 'Update Plan' buttons above

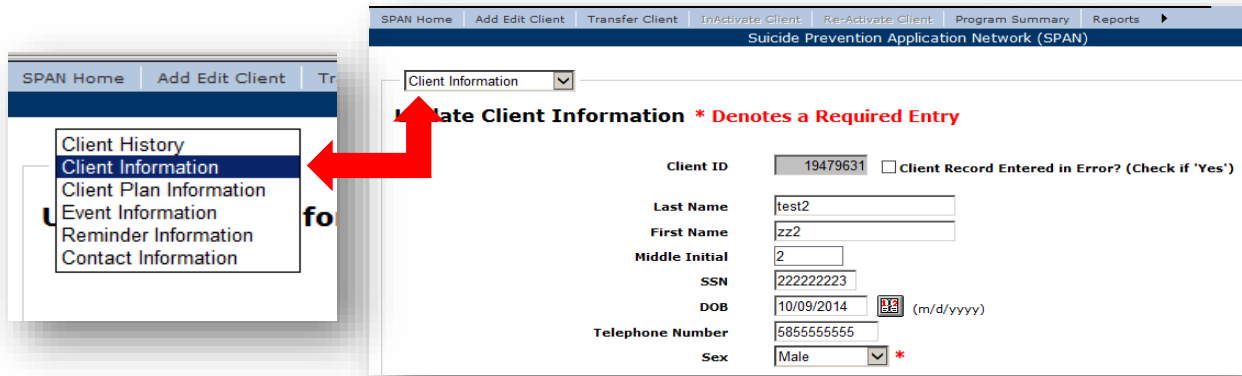
Contact Logs

There are currently no contact logs available in the Database for this client! Insert a new contact log below by clicking the Add New Log button.

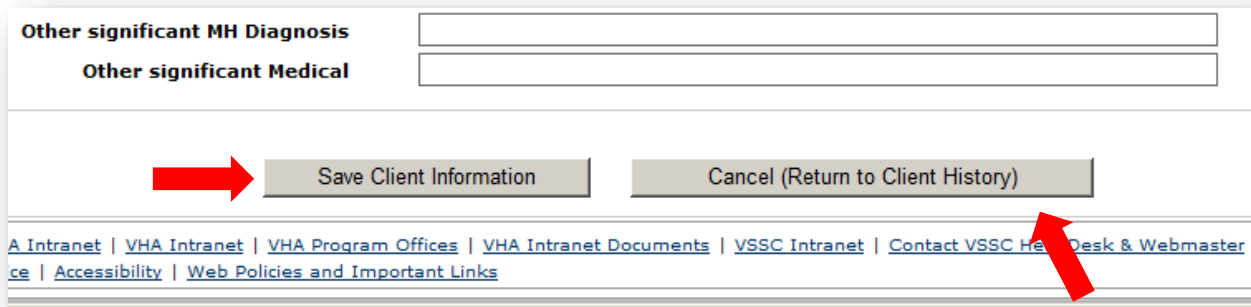
If the 'Add New Contact Log' option is not available, please update the Client & Plan Screens to complete all required fields; using the 'Update Client' & 'Update Plan' buttons above

USA.gov | VA Home | VA Intranet | VHA Intranet | VHA Program Offices | VHA Intranet Documents | VSSC Intranet | Contact VSSC Help Desk & Webmaster | Intranet Privacy Policy | Ho FFAR Act Notice | Accessibility | Web Policies and Important Links

Tip: Once you navigate from the page shown above, all further navigation for the specific patient is completed via the pull-down menu at the top. The current tab will be displayed.



At the bottom of every page, there is a “Save Client Information” button. Be sure to select before navigating off the page if you have entered new information.



If after reviewing, you determine information is correct and no modifications are required, select “Cancel (Return to Client History)” to navigate off the current tab.

Entering a New Client

The default is always to search for a patient before entering a new one. If you attempt a search and the patient is not already entered in the system, you will receive a message in red font “SSN OR Name not found in the system ...”

Step 1

Select the “Add New Client” tab at the bottom.

To Select a client use the search options below and click on Search button.

Search by First Initial of Last Name and Last 4 of SSN:

OR

Search by SSN (No Dashes):

OR

Search by First few letters of Last Name, First Name ,

OR

Search by Client ID:

OR

Search by Telephone Number:

Search Results

SSN OR Name not found in the system, please click on 'Add New Client' button to add a new Client record

* Client Active - If Client Active = 'No' prior to editing the Client or Event screens, please re-activate the record via the Re-Activate Client option

Search... Clear Add New Client Return to Home Page

Step 2

Navigate through the form, entering information as requested.

Only the fields with a red asterisk * are required. Other fields may be left blank and will still allow you to populate an entry.

Tip: Information for Veterans not enrolled or registered in VA may be spare. However, enter information into SPAN even if information is not complete.

Suicide Prevention Application Network (SPAN)

Client Information

Add New Client * Denotes a Required Entry

Client ID Client Record Entered in Error? (Check if 'Yes')

Last Name

First Name

Middle Initial

SSN

DOB / / (m/d/yyyy)

Telephone Number

Sex *

Client Type

Compassionate Care (Humanitarian) (yes/no)

Military Era

VA Enrolled *

Primary VAMC *

Secondary VAMC

SP Staff *

History of - determined by SPC chart review

PTSD (yes/no)

Depression (yes/no)

Alcohol Substance Abuse(yes/no)

Drug Substance Abuse(yes/no)

Bipolar (yes/no)

Schizophrenia (yes/no)

Other significant MH Diagnosis

Other significant Medical

Step 3

Select “Add New Client” again at the bottom of the screen to save.

Tip: If you click off the screen without selecting the button, the information entered will not be saved.

Tip: For Veterans not registered (deaths by suicide), ignore the following sections:

- High Risk Indicator
- Safety Plan
- Treatment Plan
- Mail Program

The screenshot shows a web form for adding a new client. It is divided into four main sections:

- High Risk Indicator:** Contains four fields: 'High Risk' (dropdown menu with a red asterisk), 'Date first identified as high risk' (text input with '(m/d/yyyy)' placeholder), 'Was High Risk flag added to CPRS' (dropdown menu), and 'Date High Risk flag added in CPRS' (text input with '(m/d/yyyy)' placeholder). Below these are two more date fields for 'Date High Risk Flag last modified in CPRS'.
- Safety Plan:** Contains three fields: 'Is a Safety Plan currently in place?' (dropdown menu), 'Why is a safety plan Not in place?' (dropdown menu), and 'Date Safety Plan completed or updated' (text input with '(m/d/yyyy)' placeholder).
- Treatment Plan:** Contains two dropdown menus: 'Treatment Plan Followed at Contact Plan' and 'Contact Plan'.
- Mail Program:** Contains five fields: 'Added to Mail Program' (dropdown menu), 'Client Street Address' (text input), 'Apt No' (text input), 'City' (text input), 'State' (dropdown menu), and 'Zip (5 digit)' (text input).

At the bottom of the form are two buttons: 'Add New Client' and 'Cancel (Return to Client History)'.

Step 4

Navigate to the “Event Information” option. Select “Add New Event” or “Click here to Add New Event.”

Tip: Once a patient has been entered into SPAN, an infinite number of events may be entered for that patient.

The screenshot shows the 'Event Information' section of the system. At the top, there is a dropdown menu labeled 'Event Information'. Below it is a heading: 'Track Events for test2, zz2 (SSN: *****2223) * Denotes a Required Entry'. Below the heading is a table with the following data:

Client ID	Event ID	SPC	VAMC	Event Date	Event Entered in Error?	Se
19479631	105822	Gordon, Donald	2 - 528A5 - Canandaigua	01/22/2015	Yes	

Below the table is a button that says 'Click here to Add New Event'.

Step 5

Navigate through the form, entering information as requested.

Note: The “Client Name,” “Date Event Was Submitted” (default is the date you are entering), and “Person Submitting Event” (you, the SPC) fields are already populated.

Add new Event for test2, zz2 (SSN: ***2223) * Denotes a Required Entry**

Client ID: 19479631
 Client Name: test2, zz2
 Event ID: 0 Event Entered in Error? (Check if 'Yes')
 Date Event Was Submitted: 05/09/2017
 Person Submitting Event: Nicole Theriot
 VAMC submitting Event: Please Select *
 SP Staff: Please Select *

Current Event

Number of known prior Attempts: Please Select
 Notification of Event Through: Please Select
 Notification of Event Through - Other:
 Event Date: (m/d/yyyy) *
 Did Event Occur During Active Duty?
 Is the Event Date an Estimate or Actual: Please Select

Is there any indication that the person engaged in self-directed violence behavior, either preparatory or potentially harmful? Yes *

Did the behavior involve any injury? No *

Was the behavior preparatory only? No *

Was the behavior interrupted by Self/Other? Yes *

Is there evidence of Suicidal intent? Yes *

SDV Classification: Suicide Attempt, Without Injury, Interrupted by Self/Other *

Method Used

OVERDOSE Pills (nos) Rx Meds Tylenol Alcohol Cocaine
 Heroin Benzodiazepine Lithium Other (nos)
 OVERDOSE - Other:

PHYSICAL INJURY Slit Wrist Hanging Jump from Height
 Cut Neck Jump in front of Auto/Train Ingest Poison/Chemical
 Suffocation Self-Immolation Drowning
 Electrocution Explosion Stabbed/Cut Self

GUN Gun to Head Gun to Body With Police
 Threat Other
 GUN - Other:

AUTO Carbon Monoxide Run into Object With other Auto
 Run off road Other (nos)
 AUTO - Other:

Other Other (nos) Not Provided
 Method Used - Other - Other:

Step 6

Fill in as much information as you know. Once completed, select “Add new Event Information” to save the entry.

Step 7

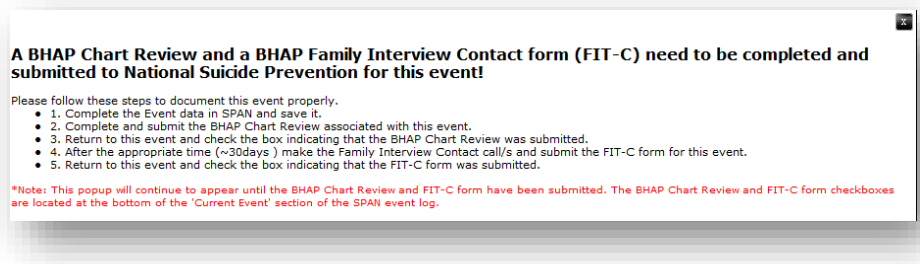
Once SDV information is entered and a classification of “Suicide” is returned, two new fields will appear.

See Section 6.6.2 Error! Reference source not found.

Step 8

Once the BHAP requirements are completed, return to this form and check the boxes.

Note: If you leave the Event section without checking the BHAP boxes or return to Edit/View the Event, a pop-up will appear to remind the SPC to complete the BHAP requirements and select the check boxes indicating completion.



Appendix 4.1 Rocky Mountain MIRECC for Suicide Prevention Risk Stratification Tool



RM_MIRECC_SuicideRisk_Table.pdf

2 pages

or

[MIRECC Suicide Risk Stratification Table](#)

Appendix 4.2 Suicide Prevention Safety Plan Document, How-To, and Additional Resources



Patient Safety
Plan.pdf

or

[Patient Safety Plan](#)



Safety Plan -
Provider Instruction:

or

[Safety Plan - Provider Instructions](#)

[Safety Plan – Provider Version \(Brief\)](#)

[Safety Plan Note Template FAQ](#)

[Webinar Slides – TMS Safety Prevention Plan Training](#)

[VA Safety Planning Intervention Manual \(2018\)](#)

[Safety Plan Template Screenshots](#)

SUICIDE PREVENTION SAFETY PLAN

If the Veteran declines to complete the safety plan OR if you are reviewing an existing safety plan with the Veteran and no changes are needed, please complete the *****SUICIDE PREVENTION SAFETY PLAN REVIEW/DECLINE***** note to document the review or decline.

If creating a new safety plan, or if, upon review, changes need to be made to an existing safety plan, continue with this note, completing ALL fields and incorporating changes.

The safety plan is a written list of coping strategies and sources of support that Veterans who are at risk for suicide can use before or during a crisis. The rationale for using a safety plan is to help Veterans recognize when they are experiencing a crisis and to use specific strategies to avert a crisis and prevent them from acting on their suicidal thoughts and urges. The safety plan serves as an emergency plan to use during crises when problem-solving abilities often diminish.

The safety plan is a brief, easy-to-read document that uses the Veteran's own words. To foster collaboration, it is best to complete a paper-and-pen version of the plan with the Veteran before entering it into CPRS. The template allows for a limited number of characters per line and a limited number of lines. Once you click 'finish,' however, you can add beyond those character and line limits for cases where the Veteran has developed a particularly robust and detailed safety plan. Veterans must be given a hard copy of the safety plan, as it may serve as a reminder to engage in strategies to reduce risk. Many Veterans may also choose to enter much of the safety plan information into a related smartphone app, such as MY3 or Virtual Hope Box.

Before introducing the safety plan template or form, it is recommended that the clinician ask the Veteran to briefly describe their crisis that was associated with an increased risk for suicide. For example, the clinician may ask, "Would you tell me what happened when you experienced a crisis and were in danger of acting on your suicidal feelings?" Offer empathy and support when asking about the crisis. From the Veteran's description, it is helpful for the Veteran to identify the warning signs associated with the beginning of the crisis and to observe how suicidal thoughts come and go as the crisis diminishes. The rationale for obtaining this information is for the Veteran to see how it may be possible to avert or de-escalate a crisis by recognizing when a crisis begins or worsens and then using coping strategies and other sources of support in a step-by-step way. Explain that suicidal feelings do not last indefinitely and that having strategies to cope in place beforehand can help manage a suicidal crisis and allow the crisis to pass without engaging in suicidal behavior.

Inform the Veteran that once the Veteran recognizes the warning signs, then they should follow the steps described on the safety plan. If following the coping strategies described for one step is unhelpful for de-escalating the crisis, then encourage the Veteran to go to the next step on the safety plan and continue to follow the steps until the crisis diminishes and the risk for suicide is lower. However, also inform the Veteran that it is not necessary to follow this list of strategies before reaching out for help.

After the safety plan is developed, review the entire safety plan with the Veteran, assess the likelihood that the safety plan will be used, and problem-solve with the Veteran any barriers to using the plan. Discuss where — specifically — the Veteran will keep the safety plan. Evaluate whether the content and format are appropriate and feasible for the Veteran's capacity and circumstances.

Reviewing the Safety Plan

Review the safety plan periodically with the Veteran and family members (if appropriate) when the Veteran's circumstances or needs change. The clinician may ask:

- (1) Do you remember the last safety plan you developed?
- (2) Have you actually used the safety plan?
- (3) If so, was the safety plan helpful for preventing you from acting on your suicidal thoughts and urges? If not, why not?
- (4) How can the safety plan be revised so that it can be more helpful to you?

Collaboratively Completing Specific Steps of the Safety Plan

When completing each of the following six steps of the safety plan (listed below), the clinician collaboratively works with the Veteran to: (1) understand the reasons for each step, (2) brainstorm ideas by asking the Veteran for suggestions or offering choices to identify specific warning signs, coping strategies, or resources, and (3) ask for feedback to improve feasibility and remove barriers for each response. The safety plan is not simply a form to be filled out without involvement of the clinician.

Time Requirement for Safety Planning

The time required for safety planning varies, but it is not meant to be a quick process. It generally takes 20-30 minutes or longer to complete a new safety plan; updating a safety plan may take less time but should still be thorough.

Safety Planning Resources

- For VA educational materials for safety planning, including the updated safety planning manual, educational videos, and other resources, visit <https://vaww.cmopnational.va.gov/CR/MentalHealth/Suicide%20Prevention/Forms/AllItems.aspx> for more information.
- For additional support in safety planning (including lethal means safety counseling), please contact the VA Suicide Risk Management Consultation Program (email srmconsult@va.gov or visit <https://www.mirecc.va.gov/visn19/consult/index.asp> for more information).

TIP: Filling out the note template

- You will not be able to click FINISH until boxes have been clicked and content is written in required sections. If you need information elsewhere in the chart to complete a required section you can type a few characters, such as Xs or Is, as placeholders so you can search for the information you need and eventually complete the note and sign it.
- The template only allows a few entries per section and so many characters per entry. Some Veterans can create a robust safety plan with many more interventions per section. You can add those interventions AFTER you have clicked FINISH and turned the template into a normal note.

Remind the Veteran:

Please follow the steps described below on your safety plan. If you are experiencing a medical or mental health emergency, please call 911 at any time. If you are unable to reach your safety contacts or you are in crisis, please call the Veterans Crisis Line at 1-800-273-8255 (Press 1).

Step 1: Triggers, Risk Factors, and Warning Signs

Purpose: Explain to the Veteran that it is important to identify and recognize specific warning signs when a crisis is occurring or escalating to remind the Veteran to use the safety plan. Identify specific thoughts, images, emotions, physical sensations, or behaviors that occur during crises and record them using the Veteran’s own words. If the Veteran has described the suicidal crisis, you will already have a sense of the warning signs. If the Veteran is struggling to identify warning signs, you can help by making suggestions derived from the crisis narrative.

Note that triggers describe external life events that occur that may be associated with a crisis and warning signs generally indicate how the Veteran is reacting to these events. Risk factors are those clinical characteristics or experiences associated with imminent suicide risk.

TIP: Given that warning signs serve as a reminder to use the safety plan, it is important that they are specific and not vague signs. Examples of vague signs are “thinking about the future,” “feeling upset,” “feeling out of it,” and “arguing.” Work with the Veteran to identify vague signs and make them more specific.

TIP: It is better to identify warning signs that are internal rather than external events. For example, if the Veteran identifies a financial setback as a warning sign, ask, “What could be your reaction to this setback that indicates that you are experiencing a crisis?”

Ask: How will you know when you are in crisis and that the safety plan should be used?
What are your personal red flags?

Specific examples of warning signs:

- Thoughts: “I feel worthless.” “I feel like a burden to my family.” “It’s hopeless; things won’t change or get better.” “There is no way out other than to kill myself.”
- Having racing thoughts, thinking about many problems with no conclusions (feeling overwhelmed)
- Intense emotions: Feeling very depressed, anxious, angry, shame
- Physical sensations: Not sleeping, loss of appetite
- Behavior: Isolating self, pacing, giving things away, crying a lot, drinking more than usual

1. _____

2. _____

3. _____

4. _____

5. _____

Review: After warning signs have been identified, remind the Veteran that the presence of warning signs are an indication that the safety plan should be put into action. Explain that the plan should ordinarily be used in a stepwise fashion unless the Veteran needs emergency rescue.

Step 2: Internal Coping Strategies

Purpose: Explain to the Veteran that the purpose of internal coping strategies is to help take the individual’s mind off one’s problems to prevent escalation of suicidal thoughts and prevent making a suicide attempt. The clinician should ask Veterans to identify specific behavioral activities that can serve as strong distractors to suicidal thinking without contacting another person. The warning signs identified in Step 1 do not have to be addressed, specifically, during this step. Engaging in problem-solving or responding to specific thoughts is often challenging to do during a crisis. The best strategies here are simple, easy-to-use and absorbing.

TIP: Activities that are vague are less likely to be used or helpful than specific ones. For example, “Watching a (specific) comedy show is better than watching television.” Identifying activities that are meaningful, enjoyable, soothing, or offer hope are helpful as long as they serve as effective distractors from one’s problems.

TIP: Do not endorse distracting activities that are likely to increase suicide risk, such as “having a few drinks,” “sharpening knives,” “cleaning my firearms,” etc.

TIP: Consider sharing information or working with the Veteran to create a Virtual Hope Box as a coping strategy. You can find more information about Virtual Hope Box and how to install it on a smartphone here: <https://vawww.cmopnational.va.gov/CR/MentalHealth/Suicide%20Prevention/Safety%20Planning/Virtual%20Hope%20Box.docx>.

Ask: What can you do, on your own, to help you to stay safe and not act on your suicidal thoughts or urges in the future?

What have you done in the past to stay safe?

1. _____
2. _____
3. _____
4. _____
5. _____

Review: Assess the likelihood of using internal coping strategies and explore potential barriers for each response listed on the safety plan. Ask: “How likely do you think you would be able to do this strategy during a time of crisis?” If doubt about use is expressed, ask: “What might stand in the way of you thinking of each of these activities or doing them if you think of them?” Use a collaborative, problem-solving approach to address potential roadblocks and identify alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

Purpose: Encourage engagement with people and social settings that provide distraction. Clinicians and formal health or mental health care providers should not be included in this step. Remind the Veteran to use Step 3 if Step 2 does not resolve the crisis or lower risk.

If the Veteran does not want to reveal social contacts, it is okay to leave this section blank after discussion, but in such cases, the clinician must select the items at the bottom of this section, stating that:

- Veteran describes a lack of social contacts.

Otherwise, this section will be considered incomplete.

The Veteran can also use a nickname or first name only for the contact if he/she does not want to provide full names. Phone numbers for contacts should be listed on the safety plan, even if the Veteran already has those numbers memorized or stored elsewhere.

Ask: Other than mental health providers and counselors, who can you contact who helps take your mind off your problems or helps you feel better?

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Veteran describes a lack of social contacts

Ask: What public places, groups, or social events help you take your mind off your problems or help you feel better?

Examples of social settings include community events, beaches, parks, coffee shops, malls, churches, clubs, 12-step meetings, aftercare groups, support groups, Veterans organizations, and Vet center social events.

TIP: Specific places should be identified rather than vague places. Be sure that the identified person or place, such as going to the bar, does not increase suicide risk. Also, places that are readily accessible and frequently available are best. Social activities that require advanced planning are not typically helpful here.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Review: Assess likelihood that the Veteran will contact others or visit places or events listed during a crisis; identify potential barriers and resolve them. Ensure that listed places are ones that the Veteran would be willing to visit and believes they are likely to visit. Do not list places or events (such as AA meetings, church services, Vet center events) that the Veteran has never visited in the past and that the Veteran may have no real intent to visit but “sounds good” to the clinician.

Step 4: Family Members or Friends Who May Offer Help

Purpose: Explain to the Veteran that next step on the safety plan involves telling a family member or friend that he/she is in crisis and needs support. Instruct the Veteran to use Step 4 if Step 3 does not resolve the crisis or lower risk. Help the Veteran distinguish between individuals who are distractors (Step 3) and individuals who can help resolve the crisis.

If the Veteran does not want to reveal his/her distress to family members, it is okay to leave this section blank after discussion, but you must select one or both items at the bottom of this section, stating that:

- Veteran describes a lack of family or friends
- Veteran chooses not to disclose distress to friends or family

Otherwise, this section will be considered incomplete.

As with Step 3, nicknames or first names can be provided, but phone numbers should be included.

TIP: This step is an opportunity to encourage the Veteran to share their completed safety plan with trusted family and friends if they are so willing. The Veteran may ask family members or friends to use or follow the safety plan if they observe that the Veteran is in crisis.

TIP: If the Veteran discloses having no friend/family support, then consider interventions to address social isolation or social skills, such as social skills training, peer support, intensive referral to mutual help, group therapy, behavioral activation, etc.

Ask: Who are friends or family members who should be included in your plan?

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

- Veteran describes a lack of family or friends
- Veteran chooses not to disclose distress to friends or family

Review: Assess likelihood individual will engage in this step; identify potential obstacles and problem-solve. If the Veteran expresses doubt about use of this step, role-playing and rehearsal may be useful.

Step 5: Professionals and Agencies to Contact for Help

Purpose: List professionals/services to reach out to if previous steps did not resolve the crisis. Instruct the Veteran to use Step 5 if Step 4 does not resolve the crisis or lower risk.

This section should not be left blank; if the Veteran does not name any other professional contacts, list yourself as a provider to contact, if appropriate to your role. List the numbers in the order the Veteran would call them.

Ask: Who are the mental health professionals or professional peer supports who should be included in your plan?

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

If you are unable to reach your safety contacts or if you are in crisis, please contact any of the following services:

- **Veterans Crisis Line:** 1-800-273-8255, Press 1
- **Veterans Crisis Line Text Messaging Service:** Text to 838255
- **Veterans Crisis Line Chat:** <https://www.Veteranscrisisline.net/Chat>

*Call “911” in an emergency

Ask: If you need to go to an urgent care center or emergency department, where will you go?

Facility name: _____

Facility address: _____

Facility phone number: _____

Local VA emergency number: _____

*Call “911” in an emergency

Review: Assess likelihood individual will engage in this step; identify potential barriers to seeking professional help or services and assist in problem-solving to overcome these barriers. If the Veteran expresses doubt about use of this step, role-playing and rehearsal may be useful.

Step 6: Making the Environment Safe

Purpose: Assess whether the Veteran has thought about a method or developed a specific plan to kill himself/herself, and reduce access to all lethal means, regardless of Veteran’s stated method(s)/plans(s). Determine the Veteran’s access to lethal means and collaborate with Veteran to find acceptable, voluntary options that reduce access to those means and make the environment safer. These actions may include locking up or finding temporary off-site storage for excess medications, firearms, knives, or other weapons. Explain to the Veteran that having ready access to lethal means places the Veteran at greater risk for suicide and does not allow enough time for the Veteran to use the coping strategies or sources of support listed on the safety plan.

Motivational interviewing principles and a Veteran-centric approach are helpful guides to this conversation. If reluctance is expressed, ask the Veteran to identify the pros and cons of having access to the lethal method.

Planning barriers to access is a multistep process and may include follow-up with the Veteran and/or a trusted person to confirm that the action plan was implemented.

TIP: If the Veteran declines to disclose ownership of lethal means, explore his/her concerns. Reframe the clinical rationale and reassure the Veteran that reducing access to means is a highly effective strategy to prevent suicide. Suicide attempts often occur impulsively and a delay in accessing means can provide the individual time to become calm and apply the steps in their safety plan.

If the Veteran expresses that a firearm is necessary for self-protection, explore alternatives, including alternative means of self-protection that could not be used as a means for suicide.

TIP: Do not limit discussion of a lethal object to the one the Veteran identifies as most likely. Limiting access to any means immediately available is important even if the Veteran states that they would never use that particular means.

Ask: What items in your environment might you use to hurt yourself?

TIP: These may include weapons, firearms, drugs, medications, household toxins, alcohol, or other potentially lethal items. If the Veteran has a plan for suicide, be sure to explore access to the means for that plan.

Ask: What can we do to make the environment safer?

TIP: Discuss ways of eliminating, reducing, or slowing access to potentially harmful items.

Ways to make my environment safer and barriers I will use to protect myself from these other potentially lethal means: _____

Tell the Veteran: VA has some tools to offer you (Veteran) if you have access to certain potential lethal means.

Ask: Do you have access to firearms?

Yes No

If the Veteran has access to firearms:

- Discuss firearm safety with the Veteran, including:
 - Asking how firearms and ammunition are stored
 - Considering options for improving safe storage, such as using gun locks and giving the key to a trusted friend/relative, removing the firing pin and giving it to a trusted friend/relative, or temporary off-site storage of the firearm when feasible.

a. Did you discuss firearm safety with the Veteran?

Yes No If not, explain why not: _____

b. Did you offer Veteran a gun lock?

Yes No If not, explain why not: _____

Ask: Do you have access to opioids?

Yes No

If the Veteran has access to opioids, discuss:

- Opioid safety and provide education on overdose identification and naloxone reversal
- [Education for patients prescribed opioids \(English\)](#)
- [Education for patient with opioid use disorder \(English\)](#)
- Other education materials, including materials in Spanish:
<https://dvagov.sharepoint.com/sites/VACOMentalHealth/OEND/default.aspx>

Did you discuss opioid safety and provide overdose education with the Veteran, including the use of naloxone?

Yes No If not, explain why not: _____

Did you offer a naloxone prescription to the Veteran?

Yes or No If not, explain why not: _____

Yes, and ordered naloxone prescription

Yes, and provider notified of request for naloxone prescription

Yes, and patient declined naloxone prescription

No, naloxone prescription not needed at this time
If not, explain why not: _____

These are the people who will help me protect myself from having access to dangerous items:

Name _____ Phone _____

Name _____ Phone _____

Choose one below regarding the Veteran’s current physical address:

Veteran’s current physical address:

Street: _____

City/State/Zip: _____

Ensure that the Veteran’s physical address is up-to-date in CPRS.

Veteran declines to share current physical address

Ensure the Veteran and/or caregiver has been given a copy of the safety plan

Veteran has been given a copy of this safety plan

Yes No Comments/explain why no safety plan provided:

Select Yes if the Veteran received a copy of the safety plan in any format, including a copy of the progress note, a handwritten copy filled out in session, etc.

Caregiver (if relevant and Veteran provides permission) has been given a copy of this safety plan

Yes No N/A – Veteran does not have a caregiver
Comments/explain why no safety plan provided:

Other Resources

My3 smartphone application (copy of safety plan on smartphone)

Virtual Hope Box smartphone application (create a hope box to remember good things in one’s life)

MakeTheConnection.net (source of Veteran-related resources and information)

VetsPrevail.org (online therapy and/or chat with trained peer support; can access online or on smartphone)

Safety Contacts

Explain to the Veteran that, in the event you are unable to reach the Veteran and are concerned about his/her safety, you would like to be able to contact someone who may be able to provide you with information about the Veteran’s whereabouts/well-being. Ask the Veteran if he/she has a family member, friend, or other trusted person who he/she would allow you to call to enquire about his/her safety.

Provider may contact the following people to check on safety (include phone number):

Name: _____ Phone: _____

Release of Information is on file for contact Yes No

Name: _____ Phone: _____

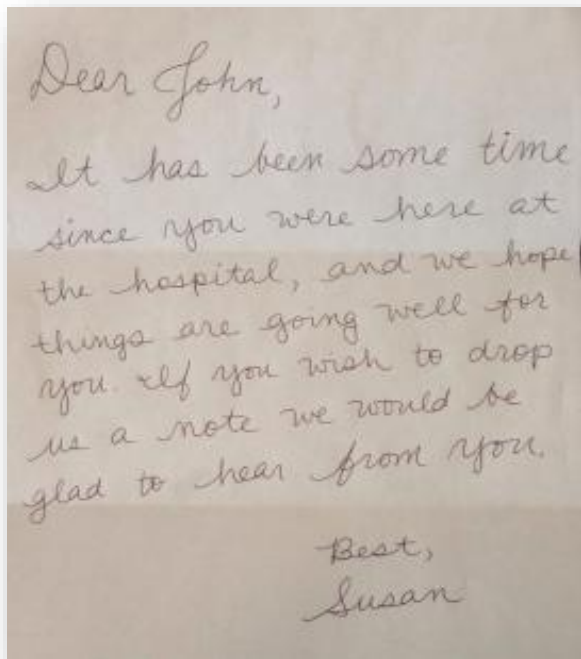
Release of Information is on file for contact Yes No

Veteran declines to designate a safety contact

Appendix 4.3 Examples of Caring Communication Content

Caring content for a mailing may include:

- “It has been some time since you were here at the hospital, and we hope things are going well for you. If you wish to drop us a note, we would be glad to hear from you.”
- “This is just a note to assure you of our continuing interest in how you are getting along.”
- “Just a note to say that we hope things are going well, as we remain interested in your well-being. Drop us a line anytime you like.”
- “We realize that receiving a letter periodically expressing our interest in how things are going may seem a bit routine. However, we continue to be interested in you and how you are doing. We hope that our brief notes will be one way of expressing this.”
- “I wanted to send you a card to say “hello” and that I hope things are going well for you. I appreciate seeing you when you visit. I included a variety of resources that you might find helpful. If you would like to contact me, I would be happy to hear from you at (phone number).”
- “You might recall that I sent you a card a few weeks ago. I thought I would write again to just say “Hi” and that I hope you are doing well. I included some resources on a separate sheet in case they are helpful. If you would like to connect, I would be happy to hear from you at (phone number).”
- “I wanted to write to say that I hope you are doing well. I included a few resources on a separate sheet that I hope you might find helpful. I hope you are having a good day. If you would like to contact me, I would be happy to hear from you at (phone number).”
- “I wanted to drop you another card in the hope that it might brighten your day. I hope that if you used any of the resources I sent last time that you found them helpful. If you would like to contact me, I would be happy to hear from you at (phone number).”
- “I thought I would reach out again to wish you well. I hope you are having a good day. I included a resources card that I hope you find helpful. If you would like to touch base, I would be happy to hear from you at (phone number).”



Reference:

Stanford Social Psychological Answers to Real-World Questions (SPARQ)

<https://sparq.stanford.edu/solutions/caring-letters-prevent-suicide>

Other resources:

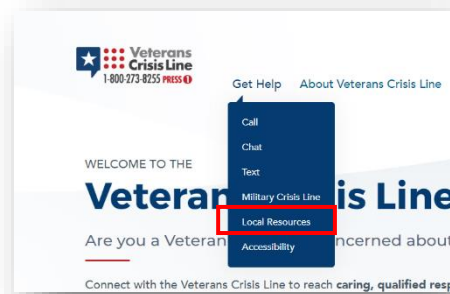
- [Caring Letters Intervention: Information & Procedures](#): Educational PowerPoint to be printed and shared
- [Caring Cards Template](#): Caring cards to be completed by or on behalf of REACH VET providers
- [Order REACH VET Resource Cards - click here for the order form](#) (scroll down to see the REACH VET Resource Cards to be mailed with each caring card)
- [Caring Card Mailings Spreadsheet](#): Administrative tool for tracking the recommended mailing schedule

Appendix 5.1 VCL SPC Contact and Outlook Out-of-Office Reviews

Veterans Crisis Line Local Resources SPC Contact

Step 1

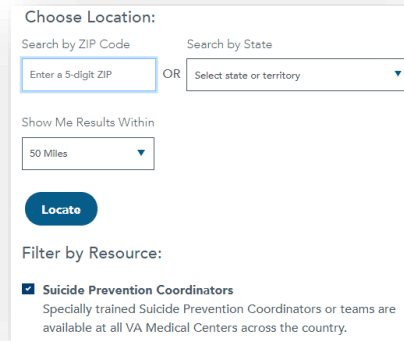
On the main page VeteransCrisisLine.net, select the “Get Help” link and then navigate to the “Local Resources” page



Step 2

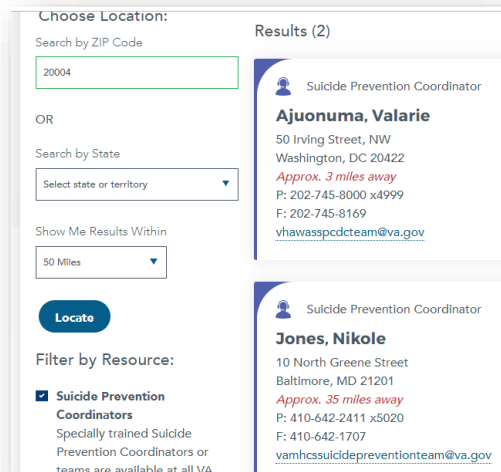
Scroll down the page until you see “Filter by Resource” section. Select the “Suicide Prevention Coordinators” box.

Tip: The search parameters in the example are within a 50-mile radius. Increase or decrease the distance from the site you are searching for.



Step 3

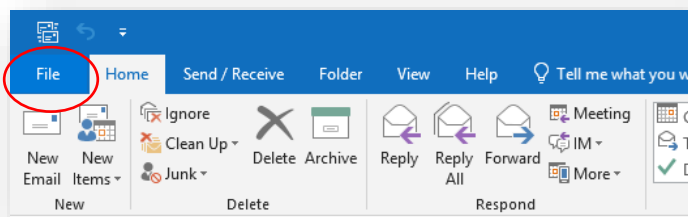
Search your facility listing by ZIP code or by state or territory. This example searches for area code “20004” (Washington, D.C.). Review the contact information for your site to ensure it’s correct.



Outlook Out-of-Office Instructions

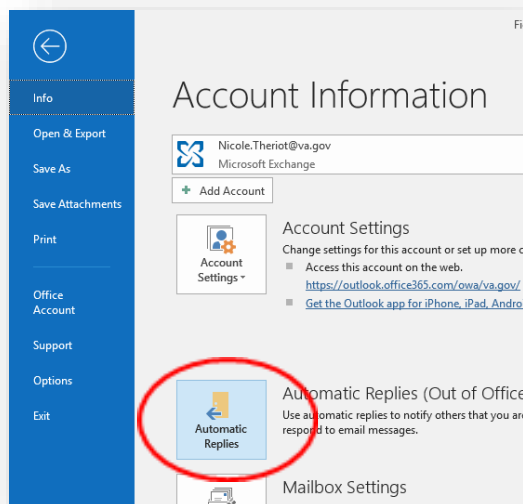
Step 1

Select the “File” tab in Outlook



Step 2

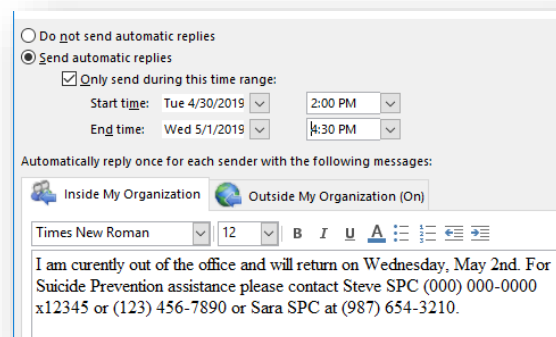
Look for the Automatic Replies (Out of Office) button and select it.



Step 3

Select “Send automatic replies.”

You have the option of leaving the automatic reply time frame open until you turn it off. Or you may select “Only send during this time range.” The automatic reply will start and stop dependent on the preselected time frame.



Step 4

Type in the out-of-office message. You may use the same message for “Inside My Organization” and “Outside My Organization,” or you may use a different message for each.

Tip: Copy and paste from the menus does not work in the message section. Use your mouse to select the text and then use the keyboard keys “Ctrl + c” to copy and “Ctrl + v” to paste.

Appendix 5.2 How-To for Medora/Crisis Line Consults

SPC Crisis Center Response Guide

- 1) **Login**
 - a. VistA Access and Verify Codes
 - b. Change your codes using VistA CPRS
 - c. <https://vaww.vcl.aac.va.gov/response/>
 - d. [SPC SharePoint Site Medora Help Section](#)
- 2) **Referral List**
 - a. *Open Referrals For This Facility*: A listing of all open call responses which have never been opened/reviewed previously or those calls that the *Quick Referral Save* button has not been enabled. Once the *Quick Referral Save* is enabled, the record is moved to *In Progress Referrals*.
 - b. *In Progress Referrals*: Lists all open call responses previously viewed but not returned to the Hotline SSA for close out.
 - c. *Open Referrals For No Facility*: Lists all open call responses that have no VA site identified for follow-up by a SPC.
- 3) **Find Previous Calls**: Allows a SPC to retrieve via read only closed referrals by date range. This function can also be used as a report mechanism to identify the total number of calls for a specific time period. To access this feature, click on the button at the top of the page labeled *Find Previous Calls*.
 - a. If you wish to look at all closed referrals for a specific time, select a date range and click the *Is Closed* box. If you wish to include all the referrals that remain open, you would unclick the *Is Closed* box. If you are looking for a specific referral and know the approximate date, put in that date range, and click the *Is Closed* box. You may now search the resulting list. When you wish to return to the open referrals page, click on the *Return to Referrals List*, or click *Logout* if you wish to end your session.
- 4) **Referral Detail**
 - a. Once a call is selected, the *Hotline Call Detail* log sheet created by the Hotline HSS responders appears on the *Hotline Call Detail* tab.
- 5) **Find Veteran**
 - a. The response application allows the SPC to change data only in the Veteran information area of the record.
 - i. In order to view Veteran information in *Hotline Call Detail* while using *Find Veteran* tool, have your Internet Explorer window maximized and have the *Hotline Call Detail* scrolled to the top.
 - b. Some referrals will not have complete or accurate Veteran information. Once the SPC is able to identify a Veteran as a registered patient, they can locate the Veteran using their local VistA system. Use the *Find Veteran* tool in the Veteran information area of the *Hotline Call Detail*.
 - i. Enter name, last name initial + last four digits of SSN (or full SSN)
 - ii. Once search criteria have been entered, click *Find Veteran*. A list of potential matching patients will be shown in the box. (If there are more names available than shown in the scroll box, click the down arrow button to see them.)
 - iii. Click on a specific Veteran in the *Select Veteran* section. Information will autofill from the patient's VistA file into the "Patient Name," "SSN," "Age," and "Gender" fields in the *Patient Info*.

- iv. You must wait for the application to complete this process before you can then *Select Veteran*. Once you *Select Veteran*, the Veteran information is moved to the Veteran information area of the *Hotline Call Detail*.
- v. Complete a *Quick Referral Save* to lock this information in the Veteran information area of the *Hotline Call Detail*.

Note: Applicable High-Risk for Suicide Patient Record Flags (PRFs), if applicable, should now be shown on the patient file.

6) **Enable Editing**

- a. If any other information in the *Veteran Info* area needs to be corrected, it must be done manually using the *Enable Editing*. This includes “Is Veteran,” “Active Duty,” “Veteran Status” and “Nearest Facility to Veteran.” To enable this feature, the SPC must go to the Veteran information area and click *Enable Editing*.
- b. Once all changes are made, click on *Submit Changes*; a confirmation will be displayed, and you will be returned to the updated form.

7) **Changing the Location of a Referral**

- a. If the patient has been sent to a SPC or facility in error, after clicking *Enable Editing*, locate the “Nearest Facility the Patient” box and select the correct facility. Then click *Submit Changes to Call Info*.
- b. Always contact that VA SPC directly if you change the location of a referral.

8) **Quick Referral Save**

- a. Located below the “Response Data” box. This is used to confirm “Referral” response within 24 business hours (one day) alerting the Hotline SSA that the referral has been received and is now being worked on by SPC.
- b. You can also add any immediate notes regarding the patient.
- c. This should be completed as soon as possible after receipt of the referral. This option is provided to allow communication between the SPC and SSA at the hotline.
- d. Clicking this button will not pass information to CPRS. A progress note will only be created when the SPC clicks on the *Save Referral WITH Progress Note* button at the end of the form.

9) **Patient Outcomes**

- a. Directly to the right of the “Response Data” patient identifier box is the “Patient Outcomes” area. Included in this area are checkboxes to quickly identify the outcome of your work with the patient. Multiple boxes may be checked, based on your follow-up.
- b. Select at least one outcome.

10) **Patient Follow-Up Details:** This box is a free-text area that allows the SPC to add additional content to the progress note that is passed to CPRS.

- a. Use [SPC CONSULT CLOSING AND QA INDICATOR](#) Template to close “Referrals”
- b. Under each section (Contact, Action Taken/Plan, and Veteran’s Response)
 - i. Erase the responses that do not apply, leaving only the responses that do apply
 - ii. Do not erase the numbers in front of the options you keep (these are used in data coding)
 - iii. Cut and paste the remaining information into the space for free text in the “Progress Notes Additions” section

11) Does Patient Have Patient Record Flag for High Risk for Suicide on Chart?

- a. Shown strictly for informational purposes and cannot be updated from this form. The SPC would have to add the flag in CPRS if indicated.

Note: When *Find Veteran* tool used, the Applicable High Risk for Suicide Patient Record Flags (PRFs), if applicable, should now be shown on the patient file.

12) Toggle Progress Note Save On/Off

- a. Clicking this button will allow the SPC to turn on or off the ability to create a progress note from the application. Information from the *Referral Details* will automatically be inserted into the progress note. Additionally, the information from the response application, including *Patient Outcomes* and *Patient Follow-up Details*, will be included in the progress note.

13) Progress Note

- a. Note titles: “Veterans Crisis Line Note”
 - i. In the text box provided, enter enough text to help identify the progress note title that will be used within CPRS and click *Get Note Titles*; the system will then refresh. Once the refresh process is complete, click the down arrow and click *Select Note Title*. Select the *Veterans Crisis Line Note* title.
- b. Find locations:
 - i. If there is no appointment on which to attach the note and you still need to write a progress note, you must choose a location for the note. Every progress note must be linked to a location. The SPC will have to identify the correct clinic location to be used for documenting the response to the hotline referral. Follow the same process to populate the location as you did for note titles. Enter enough information in the search fields to narrow the pick list.
- c. Select appointment
 - i. This feature allows a note to be attached to a specific appointment. If an appointment(s) has been set up for the patient, click on *Get Patient Appointments*, and the system will refresh. Once the system is refreshed, click on the *Select Appointments*. If an appointment(s) is scheduled, the appointment date will appear in the drop-down box; select the appropriate appointment to link the progress note with.

14) Historical Note

- a. The historical option is used to document efforts to reach a Veteran who has been referred from the hotline. If you do not reach the Veteran but want to provide documentation of the facts that she/he was referred from the hotline and you attempted to reach him/her, check the “Historical” box.
- b. You finalize the response form by clicking *Save Referral WITH Progress Note*. Once that is done, your note will appear as an unsigned progress note in CPRS, and no encounter information will be entered. It will appear on the author’s list of view alerts, and the user will have to go into CPRS to sign the note and enter encounter data.
- c. The response application cannot pass encounter information to CPRS, so in those cases where the SPC interacted directly with the Veteran in a face-to-face or telephone contact, the “Historical” box should be left unchecked, and the note and encounter completed in CPRS.

15) Save Referral WITHOUT Progress Note

- a. Use this field only if a Veteran is not eligible for VA care. Information is entered only to the VCL database.
- b. This field is activated by selecting *Toggle Progress Note Save On/Off* and turning the *Progress Note* settings off. This will NOT send a note to CPRS and will only save the information to the VCL database. The *Save Referral WITHOUT Progress Note* field is now activated and SPC can enter a note and save response data.

16) Save Referral WITH Progress Note

- a. You must use the *Find Veteran* tool just before creating the CPRS Progress Note.
- b. When clicked, the referral is processed in CPRS and also entered in the VCL database.
- c. When the *Save Referral WITH Progress Note* button is clicked, a “Progress Note Confirmation” box is displayed.
- d. The note is then passed to CPRS as an unsigned note. Confirm the note was transferred immediately. A CPRS alert for an unsigned note is also generated. The user will then go into CPRS to complete the encounter and sign the note.

17) VCL Review - The final process is for the SSA at the Hotline to review the input and notes and either close the referral or contact the SPC for more information.

- a. Use the [SPC CONSULT CLOSING AND QA INDICATOR](#) template or the referral will be returned to you for correction.
- b. Under each section (Contact, Action Taken/Plan, and Veteran’s Response)
 - i. Erase the responses that do not apply, leaving only the responses that do apply
 - ii. Do not erase the numbers in front of the options you keep (these are used in data coding)
 - iii. Cut and paste the remaining information into the space for free text in the “Progress Notes Additions” section

18) VCL Analytics Team

- a. [Anna Barnard](#), clinical applications coordinator/phone: 585-362-2076
- b. [R. Garrett Fenton](#), clinical applications coordinator/phone: 585-259-8480
- c. [Jason Jones](#), clinical applications coordinator/phone: 313-623-5333
- d. [Thomas A. Messmer](#), clinical applications coordinator/phone: 585-208-5625
- e. [VHA VCL CAC TEAM](#)

SPC CONSULT CLOSING AND QA INDICATOR

Appendix A – SPC CONSULT CLOSING AND QA INDICATOR (most recent version 9-8-15)

CONTACT (erase all that do not apply and include ALL that DO apply; AT LEAST 1 must remain)

- (1) Initial phone attempt made within 24 business hours (mandatory) and Veteran reached.
- (2) Minimum of 3 attempts made (2 by phone and 3rd by phone/and or mail) with no contact.
- (3) Contact cannot be made (reasons and any other follow-up is documented).
- (4) OTHER:

ACTION TAKEN/PLAN (erase all that do not apply and include ALL that DO apply; AT LEAST 1 must remain)

- (5) SP staff and/or other clinical staff connected with Veteran. Risk assessed and needs addressed as indicated.
- (6) Wellness check
- (7) Reviewed with Veteran and/or caller how to access emergency mental health resources
- (8) Veteran not located--No further action warranted
- (9) Consult to VISN 19 Suicide Risk Management Consultation Team
- (10) OTHER:

VETERAN'S RESPONSE (erase all that do not apply and include ALL that DO apply; AT LEAST 1 must remain)

- (11) Veteran is aware and in agreement with plan
- (12) Veteran ineligible for services and was provided community information/resources
- (13) Not applicable-unable to reach Veteran
- (14) Veteran declined all possible referrals and alternate options offered
- (15) Veteran discontinued call-unable to assess
- (16) OTHER:

COMMENTS on any additional information up to this point (optional):

Any further follow-up will be documented in CPRS. PLEASE CLOSE CONSULT.

Appendix 5.3 VCL Clinical Care Coordinators



VCL Clinical Care
Coordinators (CCC) |

or

[VCL Clinical Care Coordinators](#)

Appendix 6.1 Guidance for Entering Outreach into SPAN



Guidance for
Entering Outreach i

or

[Guidance for Entering Outreach into SPAN](#)

Appendix 6.2 Partnership Summary



Partnership
Portfolio-Sept2019 (

Appendix 7.1 S.A.V.E. A Trainer's Guide



S.A.V.E. A Trainers
Guide August 2020.

or

[S.A.V.E. A Trainers Guide August 2020](#)

Appendix 7.2 Suicide Prevention Training Available on TMS

Core Suicide Prevention Training Modules

Item No.	Course Name
VA 38269	Suicide Behavior and Overdose Report (SBOR) Recording
VA 36829	Suicide Risk Screening and Assessment ID Overview Session Recording
VA 36816	Suicide Risk Screening and Assessment ID Primary and Secondary Screening Tools Recording
VA 39430	Suicide Risk Screening and Assessment ID Comprehensive Suicide Risk Evaluation (CSRE) 2.0 Recording
VA 36232	Suicide Safety Planning Training Recording
VA 30535	S.A.V.E. Refresher Training
VA 39351	Skills Training for Evaluation and Management of Suicide (STEMS)
VA 33885	ICD-10-CM Coding for Suicide Attempts and Suicide Ideation

Additional Suicide Prevention Training Modules

Item No.	Course Name
VA 36532	Financial Hardship Assistance Program for High-Risk Veterans
VA 9427	Increase Your Suicide Prevention Skills with Older Veterans
VA 38735	Whole Health and Suicide Prevention Partnership
VA 31765	Managing Suicidal Veterans in Home Telehealth
VA 33560	REACH VET Provider Program Training
VA 38666	A Meaningful Employment: A Suicide Prevention Strategy (March Enduring)
VA 39117	How to Teach Suicide Prevention Clinical Practice Guidelines to Health Care Professional Trainees
VA 34560	Lethal Means Safety Counseling to Reduce Suicide Risk
VA 37097	EMchat: Suicide Prevention Safety Planning in your Emergency Department: Everyone's Business
VA 37072	The Best Medicine for Educating our VA and non-VA Health Care Teams on Veteran Suicide Prevention: Environment of Care
VA 37513	Treating PTSD and Suicide Risk: Separating Myth from Fact
VA 21550	TIP (Treatment Improvement Protocol) 50: Addressing Suicidal Thoughts and Behaviors in Substance Abuse Treatment
VA 39130	Community Hospices- Suicide Prevention in Vietnam Veterans

Public Health Series

Item No.	Course Name
VA 37529	Suicide Prevention - Public Health Model-Introducing VA's Public Health Approach to Preventing Veteran Suicide
VA 37551	Suicide Prevention - Public Health Model-Data 101
VA 37660	Suicide Prevention - Public Health Model-Media Safe Messaging Social Media Recording
VA 38179	Suicide Prevention - Public Health Model-Community Engagement Models Recording
VA 38180	Suicide Prevention - Public Health Model-Partnerships 101 Recording
VA 38346	Suicide Prevention - Public Health Model-Lethal Means Safety Education Recording
VA 38676	Suicide Prevention - Public Health Model-Enhancing Partnerships with Homeless and Employment Programming Recording
VA 38856	Suicide Prevention - Public Health Model-Suicide Postvention Recording
VA 39194	Suicide Prevention - Public Health Model - Organizational Change Management

Appendix 8.0 Suicide Prevention Technical Assistance

Area of Assistance/Initiative	Group(s) Responsible	Contact	FAQ Support	Support Calls
Mental Health Process Improvement (<i>labor mapping, coding, productivity, metric support, etc.</i>)	National Mental Health Quality Improvement and Implementation Consultants (QIIC) Team	VHA OMHSP QIIC (VHAOMHSPTAS@va.gov)	Productivity FAQs	3 rd Friday 2 p.m. EST
REACH VET	MIRECC/PERC	VHA REACH VET Support (VHAREACHVETsupport@va.gov)	Common Questions Page	1 st Monday 1 p.m. EST
Suicide Risk Identification Strategy (Risk ID)	MIRECC	VHA ECH Risk ID Support (VHAECHRiskIDSupport@va.gov)	Risk ID FAQ	Thursdays 2 p.m. EST
Suicide Prevention in the Emergency Department (SPED)	MIRECC	VHA SPED (VHASPED@va.gov)	SPED FAQ	Thursdays 2 p.m. EST
Suicide Prevention Program Operations	SPP Field Operations	VHA OMHSP SPP Field Operations (VHASPPFieldOperations@va.gov)		Office Hours 1 st Wednesday 3 p.m. EST