Northern Light Health℠

From the Office of Clinical Informatics

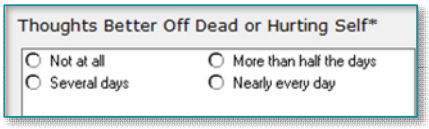
Primary Care and Pediatric Practices Suicide Risk – Screening & Assessment

June 25, 2024

In primary care and pediatric offices, universal suicide screening will be performed at every visit for patients 12 years and older. Patients who identify at risk of suicide will complete further screening and assessment with the provider and implement further interventions as needed, including safety planning.

Initial Suicide Screening Question

Medical Assistants will complete initial screening using Item 9, **Thoughts better off dead or hurting self**, on the PHQ2 plus or Item 10, **The thought of harming myself has occurred to me**, on the **Edinburgh Postnatal Depression Screening (EPDS).**

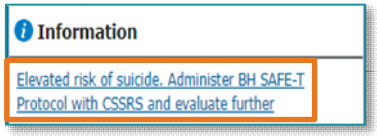


STEP 1: MA completes Depression Screening questions with patient, including asking item 9, **Thoughts Better off dead or hurting self**.

- The **Edinburgh Postnatal Depression Screening** including, item 10, **The thought of harming myself has occurred to me**, may also be used.

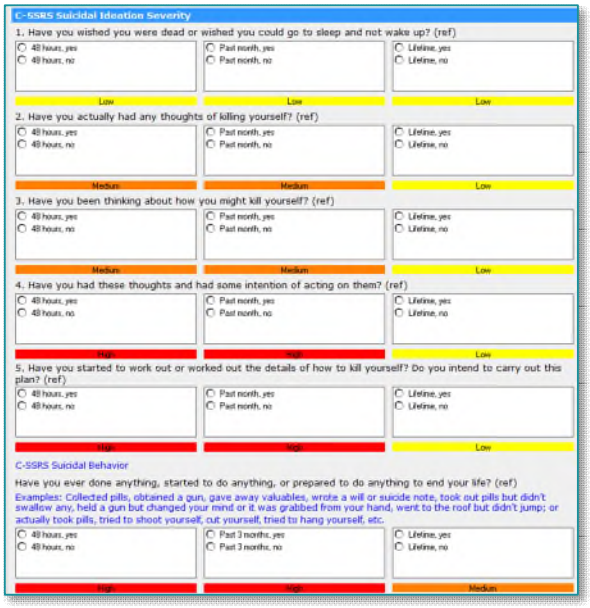
STEP 2: If responses are anything other than **Not at All,** a SmartZone alert will fire for the provider to complete the **BH SAFE-T Protocol with CSSRS PowerForm**.

- MA will communicate to provider there is a positive response to initial screening question.



Elevated Risk of Suicide Screening – CSSRS Suicidal Ideation Severity

Further suicide risk screening is performed by the provider using the **BH SAFE-T Protocol with CSSRS PowerForm**.



STEP 1: Select the **Elevated risk of suicide. Administer BH SAFE-T Protocol with CSSRS and evaluate further** Smart Zone alert.

STEP 2: Complete the first six questions on the form.

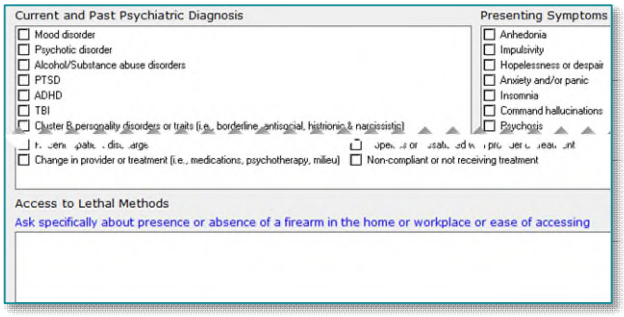
- Only select the most recent timeframe for each question.

NOTE: **If any of the orange or red questions have "Yes" selected, complete the entire form.**

If no red or orange are "Yes," proceed to Risk Level section and select "Low Risk" and enter in clinical justification text box *Patient screened low risk, no further assessment needed.*

Moderate or High-Risk Screening – BH SAFE-T Protocol with CSSRS Assessment

When a risk screening indicates a moderate or high range, further assessment is needed to determine a patient's suicide risk level.

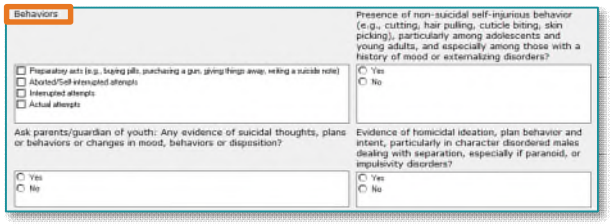


STEP 1: Within the **Suicide Risk Factors** section, scroll to complete the remaining questions.

STEP 2: Select **Protective Factors** section and complete **Step 2 questions**.

STEP 3: Select **Suicidal Ideation Intensity** section.

NOTE: **Behavior questions, located at the bottom of this section, are mandatory to complete. Additional questions in Step 3 are optional.**



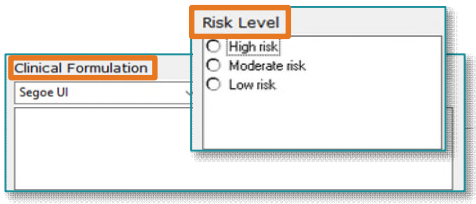
STEP 4: Select **Risk Stratification** section.

STEP 5: Select applicable responses, starting with high risk.

NOTE: **Reference responses in previous sections to determine the most appropriate boxes to select.**

STEP 6: Indicate **Risk Interventions** used.

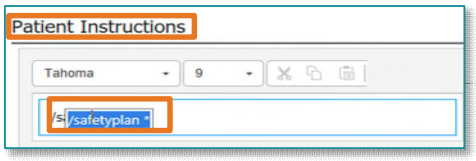
STEP 7: Select the **Risk Level** section to complete the **Risk Level** and **Clinical Formulation**.



NOTE: **The clinical formulation will not populate to the office note, tag the information to put into the note.**

Safety Planning – Patient Instructions

If an assessment is performed and patient is determined safe to go home, a safety plan is completed.



STEP 1: Navigate to **Patient Instructions** component.

STEP 2: Enter **/safetyplan**.

- Complete the questions and print the **Ambulatory Patient Summary** to provide the patient the Safety Plan information.

Reminder: **Ambulatory Visit summaries are available in the patient portal.**