FAQ- Columbia Suicide Risk Screening

##### Q: Is the EHR Columbia suicide screening validated?

A: Yes, the corporate team worked closely with the Columbia Lighthouse Project team during the EHR development. The screening tool is based upon the validated Columbia suicide screener. The author, Columbia Lighthouse Project, approved the HCA EHR build as a correct electronic version of the validated screener.

##### Q: Is the 3-5 year old screening and script (on-screen yellow guidance) validated?

A: Yes, the script is based upon the Columbia script for “very young”. The Columbia Lighthouse Project team directed that the script is to be used for ages 3-5 and approved the EHR build/script.

##### Q: What is the evidence for screening patients beginning at age 3?

##### A: There is no change in screening age scope. The literature demonstrates suicide can occur in very young children, and the importance of identifying those at risk prior to attempts. In reviewing data from existing suicide screenings it is evident there are positive suicide screenings in children ages 3-5. We are now seeing trends of increasing occurrences in this young age group. The prevalence of suicide is higher among adolescents, but suicide can occur in children younger than 6 years of age and preschool aged children.(1) The American Psychiatric Association (APA) notes that suicide rates in the United States rise from ages 10-24 years old, then decrease and plateau until age 70 when suicide rates rise again.(2) Recent estimates find that 33 children between the ages of 5-11 years old die by suicide each year.(3) There are many factors that contribute to suicide risk in children including developmental and family related factors.(4) The lack of emotional maturity and cognitive maturity, defined as the inability to understand what suicide is or how to commit suicide, is thought to protect children from higher suicide risks that are seen with adolescents. However, literature suggests that children may understand the meaning of death by age 4 and the concept of suicide or how to commit suicide by age 8.(4,6)

*1. Shaffer D, Pfeffer CR. Practice parameter for the assessment and treatment of children and adolescents with suicidal behavior. J Am Acad Child Psy. 2001;40(7):24S-51S.*

*2. Jacobs DG, Baldessarini RJ, Conwell Y, et al. Practice Guideline for the Assessment and Treatment of Patients With Suicidal Behaviors. Am J Psychiatry. 2003;160(11 Suppl):1-60.*

*3. Bridge JA, Asti L, Horowitz LM, et al. Suicide trends among elementary school–aged children in the United States from 1993 to 2012. JAMA Pediatr. 2015;169(7):673-7.*

*4. Soole R, Kõlves K, De Leo D. Suicide in children: a systematic review. Arch Suicide Res. 2015;19(3):285-304.*

*6. Whalen DJ, Dixon-Gordon K, Belden AC, Barch D, Luby JL. Correlates and consequences of suicidal cognitions and behaviors in children ages 3 to 7 years. J Am Acad Child Psy. 2015 54(11):926-37.*

# FAQ

##### Q: Is it required for a 1:1 PSA to be within 6ft of the patient and must that be included in the policy?

##### A: The recommendation is to not include this piece into a policy. This may be part of practice with consideration for patient and employee safety.

##### Q: Is it acceptable to cohort patients identified as high risk for suicide?

##### A: In the non-BH (Behavioral Health) inpatient units, no. There is a regulatory requirement to provide a 1:1 physical PSA for patient screened at high suicide risk per the HCA suicide screening stratification (Columbia suicide screening stratification).

##### Q: What is the requirement for the Columbia reassessment/re-screener?

##### A: This is policy driven. For the non-BH units a reassessment is to be completed every 12 hours following a patient that has screened at risk for suicide. Please note that the reassessment/re-screen can be completed at any time there is a concern of an increase in risk.

##### Q: Is it required to have an order for the addition and/or removal in interventions such as a PSA?

##### A: For the non-BH (behavioral Health) units, no. There is no regulatory requirement for a provider order to direct the level of observation. The level of observation should be based on the risk level obtained from the Columbia suicide screening stratification and collaboration with the Physician/LIP. For the IP BH (Behavioral Health) unit, a nurse can immediately place a patient on the 1:1 observation status, but requires a provider order to remove the observation status.

# FAQ

##### Q: Will the new Columbia Suicide Screening risk stratification model increase FTE PSA utilization for suicide patients?

A: The change in utilization will depend upon on your facility practices and closely they are currently aligned with appropriate use of PSAs. High risk utilization may increase due to 1:1 regulatory requirement unrelated to the Columbia implementation if these patients are currently cohorted or virtually monitored. Better stratification could help to decrease potential current over-utilization with the low and moderate risk patient populations.

##### Q: Can the screening questions be directed to the parents, or am I required to ask the child?

A: According to the Columbia Lighthouse Project team, it is appropriate and in some situations recommended to direct the screening to the parent/guardian.

##### Q: How is a change in suicide risk stratification upon re-assessment to be managed?

##### A: A clinical conversation between the care team should occur to determine appropriate intervention and potential escalation/de-escalation. The outcome of the Columbia re-assessment (e.g. suicide risk stratification) may not be an actionable item alone. Sepsis clinical analogy: Temperature data point that is part of sepsis screening is a key assessment piece but does not alone drive the diagnosis and treatment of sepsis.