Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 1166
TRANSMITTAL SHEET
November 6, 2023

PATIENT RECORD FLAGS

1. SUMMARY OF MAJOR CHANGES: This Veterans Health Administration (VHA) directive sets uniform policy for the ethical and appropriate use of Patient Record Flags (PRFs) and establishes the National PRF Advisory Board. ***NOTE:*** *Appropriate use and implementation of the Missing PRF is not addressed in this policy.*

a. Appendix A sets the appropriate use and implementation of the Behavioral PRF (BPRF).

b. Appendix B sets the appropriate use and implementation of the High Risk for Suicide PRF (HRS-PRF).

c. Appendix C establishes the roles and responsibilities in the National PRF Advisory Board Charter, including the process for creation of a new PRF.

d. With the rescission of VHA Directive 2010-053, Patient Record Flags, dated December 3, 2010, the Category II PRF is being phased out, and the term “Category I” previously used with PRF is eliminated.

2. LOCAL DOCUMENT REQUIREMENT: Department of Veterans Affairs (VA) medical facilities are required to develop and maintain a VA medical facility standard operating procedure (SOP) for management of HRS-PRF as per paragraph 2.n.(1).

3. RELATED ISSUES: VHA Directive 1160.08(1), Workplace Violence Prevention Program, dated August 23, 2021, and VHA Directive 1160.07, Suicide Prevention Program, dated May 24, 2021.

4. POLICY OWNER: The Office for Mental Health and Suicide Prevention (OMHSP) (11MHSP) is responsible for the contents of this directive. Questions may be referred to the VHA OMHSP Action Mailbox: vhaomhspactionmailbox@va.gov.

5. RESCISSIONS: VHA Notice 2022-06, Inactivation Process for Category I High Risk for Suicide Patient Record Flags, dated July 21, 2022; VHA Directive 2010-053, Patient Record Flags, dated December 3, 2010; VHA Directive 2008-036, Use of Patient Record Flags to Identify Patients at High Risk for Suicide, dated July 18, 2008; VHA Memorandum 2022-01-21, Standard Operating Procedure SOP for the Management of High Risk for Suicide Patient Record Flags (VIEWS 6783832), dated January 31, 2022; VHA Memorandum 2022-02-02, Suicide Prevention Program Enhancements: High Risk for Suicide Patient Record Flag Referral Process and Updated Progress Notes (VIEWS 06739759), dated February 2, 2022; and VHA Memorandum 2022-10-08, Update to High Risk for Suicide Patient Record Flag Changes (VIEWS 6017392), dated October 5, 2021, are rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of November 2028. This directive will continue to serve as national VHA policy until it is recertified or rescinded.

7. IMPLEMENTATION SCHEDULE: This directive is effective upon publication.

BY DIRECTION OF THE OFFICE OF THE UNDER SECRETARY FOR HEALTH:

/s/ Erica Scavella, M.D., FACP, FACHE
Assistant Under Secretary for Health
for Clinical Services/CMO

DISTRIBUTION: Emailed to the VHA Publications Distribution List on November 9, 2023.

NOTE: *All references herein to VA and VHA documents incorporate by reference subsequent VA and VHA documents on the same or similar subject matter.*

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PATIENT RECORD FLAGS

PATIENT RECORD FLAGS

1. POLICY

It is Veterans Health Administration (VHA) policy that a Patient Record Flag (PRF) is included in the patient's electronic health record (EHR) only when both of the following conditions are met: (1) it is necessary for Department of Veterans Affairs (VA) health care staff to know, in the initial moments of a patient encounter, information about the patient's behavior or safety status in order to protect the patient's health and safety, or the health and safety of other patients, VA staff or guests at the VA medical facility; and (2) the need to address the clear risk to safety outweighs the potential privacy concerns raised by the appearance of the PRF whenever the EHR is opened. ***NOTE:*** *There are currently three approved PRFs: Behavioral, High Risk for Suicide and Missing Patient. Requests for new classes of PRFs must go through the National PRF Advisory Board before they can be authorized and utilized. Appropriate use and implementation of the Missing PRF is not addressed in this policy. See VHA Directive 2010-052, Management of Wandering and Missing Patients, dated December 3, 2010.* **AUTHORITY:** 38 U.S.C. § 7301(b).

2. RESPONSIBILITIES

a. **Under Secretary for Health.** The Under Secretary for Health is responsible for ensuring overall VHA compliance with this directive.

b. **Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer.** The Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer is responsible for:

(1) Ensuring that the Office of Mental Health and Suicide Prevention (OMHSP) is appropriately resourced and funded to implement this directive.

(2) Ensuring that PRFs function and are used in accordance with the safety need for which they were developed.

(3) Supporting OMHSP with implementation and oversight of this directive.

c. **Assistant Under Secretary for Health for Patient Care Services/Chief Nursing Officer.** The Assistant Under Secretary for Health for Patient Services/Chief Nursing Officer is responsible for ensuring that Program Offices within Patient Care Services are appropriately resourced and funded to comply this directive.

d. **Assistant Under Secretary for Health for Operations.** The Assistant Under Secretary for Health for Operations is responsible for:

(1) Communicating the contents of this directive to each of the Veterans Integrated Services Networks (VISNs).

(2) Assisting VISN Directors to resolve implementation and compliance challenges in

all VA medical facilities within that VISN.

(3) Providing oversight of VISNs to ensure compliance with this directive and its effectiveness.

e. **Assistant Under Secretary for Health for Integrated Veteran Care.** The Assistant Under Secretary for Integrated Veteran Care is responsible for:

(1) Communicating the contents of this directive to VA medical facility staff responsible for administering community care benefits.

(2) Ensuring that community providers offering VA health care to referred VA patients with PRFs are routinely given patient-specific information needed to safely care for those patients. ***NOTE:*** *The Office of Integrated Veteran Care Community Care Field Guidebook, Chapter 3: How to Perform Care Coordination, describes the process in detail. See https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. This is an internal VA website that is not available to the public.*

f. **Executive Director, Office of Mental Health and Suicide Prevention.** The Executive Director, OMHSP is responsible for:

(1) Implementing standardized VHA usage of PRFs.

(2) Providing programmatic oversight of VHA usage of PRFs.

(3) Ensuring that policy related to PRFs in this directive is updated when necessary.

(4) Overseeing and reporting information and data related to PRFs and affiliated quality metrics, as required by VHA Directive 1160.07, Suicide Prevention Program, dated May 24, 2021.

(5) Establishing the National PRF Advisory Board, appointing its chair (see paragraph 2.h.) and issuing final approval or disapproval of applications for new classes of PRFs after reviewing recommendations from the National PRF Advisory Board.

g. **National Director, Workplace Violence Prevention Program.** The National Director of the Workplace Violence Prevention Program (WVPP) is responsible for:

(1) Ensuring that VA medical facility WVPP personnel have access to tools and guidance for standardized implementation of the Behavioral PRF (BPRF) in accordance with this directive.

(2) Ensuring that Appendix A, Behavioral Patient Record Flag, is updated as appropriate and its information is communicated to VISN and VA medical facility WVPP leadership.

(3) Serving as a subject matter expert (SME) for the BPRF and addressing

questions from VISNs and VA medical facilities. ***NOTE:*** *Information on requesting guidance from the WVPP office will be kept updated on the WVPP SharePoint (see https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/Home.aspx). This is an internal VA website that is not available to the public.*

(4) Serving on or assigning a designee to the National PRF Advisory Board.

(5) Overseeing and reporting information and data related to BPRFs and affiliated quality metrics.

h. **National Director, Suicide Prevention Program, Office of Mental Health and Suicide Prevention.** The National Director of the Suicide Prevention Program (SPP), OMHSP is responsible for:

(1) Ensuring that VA medical facility SPP personnel have access to tools and guidance for standardized implementation of the High Risk for Suicide PRF (HRS-PRF) in accordance with this directive.

(2) Ensuring that Appendix B, High Risk for Suicide Patient Record Flag, is updated as appropriate and that its information is communicated to VISN and VA medical facility program leadership.

(3) Serving as a SME for the HRS-PRF and addressing questions from VISNs and VA medical facilities. ***NOTE:*** *For process and contact information see the Suicide Prevention Program Guide (SPPG): https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators.* ***NOTE:*** *This is an internal VA website that is not available to the public.*

(4) Serving on or assigning a designee to the National PRF Advisory Board.

(5) Overseeing and reporting information and data related to HRS-PRF and affiliated quality metrics. ***NOTE****: For more information, see: https://dvagov.sharepoint.com/sites/OITBISL. This is an internal VA website that is not available to the public.*

i. **Chair, National Patient Record Flag Advisory Board.** The Chair of the National PRF Advisory Board is responsible for:

(1) Assembling a National PRF Advisory Board and maintaining required membership. ***NOTE:*** *See Appendix C for the National PRF Advisory Board Charter*.

(2) Convening meetings of the Board as needed, but at least semiannually, to conduct the business of the Board.

(3) Reviewing the use and functionality of PRFs in VHA, ensuring that PRF guidelines and practices meet the intent and requirements of this policy and are in the best interest of Veterans served by VHA (see Appendix C for the National PRF Advisory Board Charter).

(4) Overseeing the work of the Board in accomplishing the responsibilities identified in Appendix C.

j. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Communicating the contents of this directive to all VA medical facilities within the VISN.

(2) Ensuring that all VISN VA medical facilities comply with this directive.

(3) Ensuring that all VISN VA medical facilities have the resources to implement this directive.

(4) Overseeing and reporting information and data related to PRFs and affiliated quality metrics to the Executive Director, OMHSP.

k. **VA Medical Facility Director.** The VA medical facility director is responsible for:

(1) Ensuring that the VA medical facility complies with this directive and the specific processes for each PRF described in Appendices A and B. ***NOTE:*** *The role of the VA Medical Facility Community Care/Integrated Veterans Care Manager is located in the Office of Integrated Veteran Care Community Care Field Guidebook: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. This in an internal VA website that is not available to the public.*

(2) Ensuring the VA medical facility has designees from the VA medical facility Disruptive Behavior Committee (DBC) and the SPP who are responsible for initiating and maintaining PRFs and who have all necessary privileges and access for PRF management. ***NOTE:*** *These designees will often be the DBC Chair and Co-Chair and the Suicide Prevention Coordinator (SPC), but could include others as appointed.*

(3) Overseeing and reporting information and data related to PRFs and affiliated quality metrics to the VISN Director.

l. **VA Medical Facility Chief of Staff and Associate Director for Patient Care Services.** The VA medical facility Chief of Staff (CoS) and Associate Director for Patient Care Services (ADPCS) are responsible for:

(1) Ensuring that all clinical and clinical support employees working in positions which encounter PRFs understand the requirements for responding to a PRF.

(2) Communicating procedures developed by OMHSP to ensure that the VA medical facility uses PRFs in a manner that is ethical, clinically appropriate, supported by adequate resources and in accordance with this directive.

(3) Ensuring that a BPRF accompanies any Order of Behavioral Restriction issued by the CoS or designee and identifies the restrictions and appropriate staff response to

provide care safely. ***NOTE:*** *For more information see, VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.*

(4) Ensuring the DBC complies with the processes in Appendix A related to BPRFs.

(5) Ensuring that SPP personnel comply with the processes in Appendix B related to HRS-PRFs.

m. **Chair, VA Medical Facility Disruptive Behavior Committee.** The Chair of the VA medical facility DBC is responsible for:

(1) Directing the operations of the DBC in using BPRFs in accordance with this directive, including Appendix A.

(2) Managing the VA medical facility's BPRFs in accordance with this directive, including Appendix A.

(3) Ensuring that each VA medical facility's BPRFs are reviewed every 2 years or sooner, and that documentation of the review is placed within the Disruptive Behavior Reporting System (DBRS). ***NOTE:*** *For additional responsibilities of the Chair of the VA medical facility DBC, see VHA Directive 1160.08(1).*

n. **VA Medical Facility Suicide Prevention Coordinator.** The VA medical facility SPC is responsible for management of the HRS-PRF in accordance with the requirements in Appendix B. ***NOTE:*** *The SPC must work collaboratively with many entities within the VA medical facility to implement the following responsibilities, including clinical care providers and the HRS-PRF committee, if applicable.* Responsibilities include:

(1) Developing a VA medical facility SOP for referring, activating, reviewing, continuing, transferring, inactivating and documenting HRS-PRF in the EHR. ***NOTE****: A sample HRS-PRF management SOP is located on the High Risk for Suicide Patient Record Flag (HRS-PRF) Enhancements SharePoint site: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/High-Risk-Flags.aspx. This is an internal VA website that is not available to the public. Technical guidance for Patient Record Flags may be found in the Patient Record Flags User Guide: https://www.va.gov/vdl/documents/Clinical/Patient_Record_Flags/patient_record_flags_user_guide.pdf.*

(2) Exclusively controlling the management of HRS-PRFs and limiting their use to patients who meet the criteria of high acute risk for suicide.

(3) Collaborating with the patient's health care providers and applicable local advisory committees for HRS-PRF management.

(4) Coordinating care for patients with an HRS-PRF to facilitate enhanced care.

(5) Notifying a patient when an HRS-PRF is activated or inactivated in their EHR and informing the patient of their right to request to amend their EHR. ***NOTE****: See VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016, and VHA Directive 1907.01, VHA Health Information Management and Health Records, dated April 5, 2021.*

(6) Training VA medical facility health care providers on local procedures for HRS-PRF management as described in paragraph 2.n.(1).

(7) Reporting, tracking, monitoring and maintaining records of all HRS-PRF patients through the EHR and SPP data systems according to the SPPG: https://dvagov.sharepoint.com/sites/VHAPERC/Reports/SitePages/HRF_home.aspx ***NOTE****: This is an internal VA website that is not available to the public.*

o. **VA Medical Facility Health Care Providers.** VA medical facility health care providers are responsible for providing enhanced care to patients with an HRS-PRF in accordance with Appendix B, paragraph 3.

3. PATIENT RECORD FLAG REQUIREMENTS

a. All PRFs must:

(1) Contain information about the patient's behavior or safety status that is necessary for VA health care staff to know in the initial moments of a patient's encounter to protect the patient's health and safety, or the health and safety of other patients, VA staff or guests at the VA medical facility.

(2) Be placed only after the appropriate assessment and evaluation has been completed by the responsible individual or group in compliance with this directive.

(3) Have an established review cycle, an efficient means for identifying and tracking PRFs due for review and a process for inactivation when the PRF is no longer necessary.

(4) Appear immediately in the EHR at all VA medical facilities and contain content consistent with the requirements identified in Appendices A and B, as applicable to respective PRF type.

(5) Be entered only by employees who have been trained in the technical aspects of entry, the appropriate criteria for placing the PRF and the conventions for security, format and terminology.

b. As with any other part of the EHR, information contained in a PRF may be released to a community provider to facilitate continuity of care and to address a patient's needs by providing health care in a safe and effective manner. When applicable, the community provider will receive information about all relevant suicide prevention or behavioral safety plans in use at the VA medical facility. A PRF must be afforded the same confidentiality and security as any other part of the EHR. More

information regarding the referral of patients with PRFs to community providers is available in the Office of Integrated Veteran Care Community Care Field Guidebook, Chapter 3: How to Perform Care Coordination, at https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. ***NOTE****: This is an internal VA website that is not available to the public.*

c. The existence of a PRF in the EHR must not:

(1) Be used as the sole reason for terminating an encounter, or for denying admission to a clinically indicated program or service to which a patient is otherwise eligible.

(2) Be used as the sole criterion on which an eligible patient's access to VHA health care, programs or services is determined.

(3) Be allowed to override the exercise of sound clinical judgment and appropriate provider action in a given health care encounter.

(4) Be used for administrative or law enforcement purposes.

(5) Be used punitively.

(6) Be used to prevent or restrict access to exercising privacy related rights such as filing a privacy complaint, amendments and viewing or requesting copies of health records.

NOTE: *Additional requirements specific to only one class of PRF are found in Appendix A (BPRF) and Appendix B (HRS-PRF).*

4. WAIVERS FOR NON-COMPLIANCE

a. OMHSP has established a process for accepting, approving and monitoring waiver requests in accordance with requirements in VHA Notice 2023-02, Waivers to VHA National Policy, dated March 29, 2023. If non-compliance with all or part of this directive is discovered, the VA medical facility must follow this OMHSP process until a resolution to the non-compliance can be made.

b. If non-compliance is identified and it is determined that it can be corrected within 30 days of identification, notification to OMHSP is required via email. This notification, once acknowledged by OMHSP, will act as a temporary waiver expiring 30 days from acknowledgement. Information in the notification includes policy number and section, reason for non-compliance, risk mitigation strategy until compliance can be achieved and an overall plan to resolve the non-compliance.

c. Non-compliance that is identified and determined to be uncorrectable within 30 days of identification or is not corrected within the temporary waiver timeframe must follow the OMHSP process to ensure the mitigation of the risk and meet the intent of this directive as written. This process is outlined on the OMHSP resource page at

https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/WAIVERS.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

5. DIRECTIVE RESOURCES

OMHSP has developed a resource page that includes information on specific mental health topics, points of contact and links to pertinent VHA directives that are related to mental health. These resource pages include program-specific policies, requirements and guidance that are critical to implementation. To access the OMHSP resource page, see https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

6. TRAINING

Those who are assigned responsibility for PRF management must complete appropriate training for activation, updating, editing and inactivation for flags as directed by current policy. ***NOTE:*** *Training requirements are listed in VHA Directive 1160.08(1) and VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.*

7. RECORDS MANAGEMENT

All records regardless of format (for example, paper, electronic, electronic systems) created by this directive must be managed as required by the National Archives and Records Administration (NARA) approved records schedules found in VHA Records Control Schedule 10-1. Questions regarding any aspect of records management can be addressed to the appropriate Records Officer.

8. BACKGROUND

Health care workers experience high rates of injury from violence in the work setting. Violence and disruptive behavior in VHA health care settings interfere with the consistent delivery of high quality and safe care to our nation's Veterans. In 1989, the *Journal of the American Medical Association* published a study by Dr. David Drummond and colleagues at the Portland VA Health Care System which demonstrated that future episodes of violence committed by patients could be reduced with appropriate identification and intervention planning. The use of electronic alerts which appeared in the EHR to inform staff of the appropriate interventions was cardinal to the success of the program. In 2003, VHA adopted the use of these PRFs nationwide. Over time, the types of available PRFs have multiplied. All PRFs serve the same purpose: to immediately communicate information needed in the initial moments of a patient encounter or lookup to promote the delivery of safe and effective health care.

a. **Behavioral Patient Record Flag.** The purpose of the BPRF is to identify patients who pose a significant risk for disruptive behavior or violence and to quickly describe appropriate measures staff should take to ensure safety and enable the provision of high-quality health care. DBCs at each VA medical facility conduct behavioral risk

assessments, develop intervention plans and manage the BPRF. This program has allowed VA medical facilities to safely serve disruptive patients who pose elevated risk of violence to staff, visitors and other patients. ***NOTE:*** *For more information on disruptive behavior, see VHA Directive 1160.08(1).*

b. **High Risk for Suicide Patient Record Flag.** The primary purpose of the HRS-PRF is to communicate to VA staff members that a patient has been identified as high acute risk for suicide. Individuals identified as high acute risk have elevated risk of dying by suicide for a period of time. The risk for suicide should be considered when making decisions about the patient (e.g., treatment and scheduling decisions). All staff members must recognize that any patient may be at risk for suicide, regardless of the HRS-PRF status on the patient's EHR (see SPPG for further information regarding the HRS-PRF process).

9. DEFINITIONS

See VHA Directive 1160.08(1) for the following definitions: DBC and BPRF.

a. **Disruptive Behavior.** Disruptive behavior is verbal, non-verbal, written or electronic behavior by any individual that: is intimidating, threatening, or dangerous; has jeopardized or could jeopardize the health, safety or security of patients, VA employees or other individuals at the VA medical facility; would create fear in a reasonable person; interferes with the safe, secure and effective delivery of VA health care; compromises the ability of VA to engage in its mission of serving Veterans; or impedes the daily operation of the VA medical facility. Disruptive behavior does not depend upon the actor's stated intentionality or justification for the behavior, the presence of psychological or physical impairment, whether the person has decision-making capacity or whether the person later expresses remorse or an apology.

b. **New Service Requests.** When a unique need for a national PRF is identified, the appropriate program office may submit a New Service Request (NSR) to the National PRF Advisory Board. The case for the flag request is reviewed with supporting documentation, and the requesting entity is notified of approval status.

c. **Patient Record Flag.** The PRF is a national communication tool used to immediately alert personnel to the presence of behavioral or clinical safety concerns and to the actions, orders or treatment plans in place to limit the impact of these concerns. A PRF is created and owned by one VA medical facility and is visible in the EHR across all VA medical facilities. ***NOTE:*** *Category II PRFs are being phased out. VHA Directive 2010-053, Patient Record Flags, dated December 3, 2010, is rescinded upon publication of this directive.*

d. **Text Integration Utility Progress Note.** A progress note that may be entered into the EHR along with a PRF, and which in the Computerized Patient Records System (CPRS) is linked to the PRF alert when it displays on the screen. This note provides additional guidance to PRF users, and may summarize the rationale for the placement of the PRF. It does not replicate the PRF narrative.

10. REFERENCES

a. P.L. 116-214, § 201.

b. 38 U.S.C. §§ 1784A, 7301(b).

c. VHA Directive 1071(1), Mandatory Suicide Risk and Intervention Training, dated May 11, 2022.

d. VHA Directive1160.07, Suicide Prevention Program, dated May 24, 2021.

e. VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021.

f. VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022.

g. VHA Directive 1232(5), Consult Processes and Procedures, dated August 23, 2016.

h. VHA Directive 1601A.02(4), Eligibility Determination, dated July 6, 2020.

i. VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

j. VHA Directive 1660.06, VA-TRICARE Network Agreements, dated June 28, 2019.

k. VHA Directive 1907.01, VHA Health Information Management and Health Records, dated April 5, 2021.

l. VHA Directive 2010-052, Management of Wandering and Missing Patients, dated December 3, 2010.

m. Patient Record Flags User Guide. https://www.va.gov/vdl/documents/Clinical/Patient_Record_Flags/patient_record_flags_user_guide.pdf.

n. Program Evaluation and Resource Center. High Risk Flag Dashboard. https://dvagov.sharepoint.com/sites/VHAPERC/Reports/SitePages/HRF_home.aspx ***NOTE****: This is an internal VA website that is not available to the public.*

o. VA/DoD Clinical Practice Guidelines: https://www.healthquality.va.gov/guidelines/MH/srb/.

p. VA Innovation and Development Request Portal: https://epas.r02.med.va.gov/apps/idrp/. ***NOTE:*** *This is an internal VA website that is not available to the public.*

q. VA Office of Information and Technology, Business Intelligence Service Line: https://dvagov.sharepoint.com/sites/OITBISL. ***NOTE:*** *This is an internal VA website that is not available to the public.*

r. VA Rocky Mountain Mental Illness Research, Education, and Clinical Center (MIRECC): Therapeutic Risk Management-Risk Stratification Table: https://www.mirecc.va.gov/visn19/trm/docs/RM_MIRECC_SuicideRisk_Table.pdf.

s. VA Rocky Mountain Mental Illness Research, Education, and Clinical Center (MIRECC): Therapeutic Risk Management of the Suicidal Patient and the Suicide Risk Management Consultation Program: https://www.mirecc.va.gov/visn19/trm/.

t. VA Suicide Risk Identification and Management and Suicide Prevention in the Emergency Department (SPED) SharePoint: https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Home.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

u. VHA Disruptive Behavior Committee Guidebook: http://vaww.hefp.va.gov/guidebooks/disruptive-behavior-committee-dbc-guidebook. ***NOTE:*** *This is an internal VA website that is not available to the public.*

v. VHA Office of Integrated Veteran Care Community Care Field Guidebook: https://dvagov.sharepoint.com/sites/VHAOCC/CNM/CI/OCCFGB/SitePages/FGB.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

w. VHA OMHSP High Risk For Suicide Patient Record Flag (HRS-PRF) Enhancements SharePoint: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/High-Risk-Flags.aspx. ***NOTE****: This is an internal VA website that is not available to the public*.

x. VHA OMHSP Mental Health Policy Resource Page: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/MHPolicyResource.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

y. VHA OMHSP Official Policy Waivers: https://dvagov.sharepoint.com/sites/VACOMentalHealth/SitePages/WAIVERS.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

z. VHA OMHSP, Suicide Prevention Program Guide (SPPG): https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators. ***NOTE:*** *This is an internal VA website that is not available to the public.*

aa. VHA OMSHP, Workplace Violence Prevention Program (WVPP) SharePoint: https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/Home.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

bb. VHA OMHSP Workplace Violence Prevention Program, Patient Record Flags (PRF) & Orders of Behavioral Restriction (OBR):

https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/PRF.aspx. ***NOTE****: This is an internal VA website that is not available to the public*.

cc. VHA Program Evaluation & Resource Center, High Risk Flag (HRF) Dashboard: https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators*.* ***NOTE****: This is an internal VA website that is not available to the public*.

NOTE: *All VHA national policy (directives and notices) is located at: http://vaww.va.gov/vhapublications/ (internal) and http://www.va.gov/vhapublications/ (external). The external link is available to the public.*

BEHAVIORAL PATIENT RECORD FLAG

1. CRITERIA FOR BEHAVIORAL PATIENT RECORD FLAGS

a. The Behavioral Patient Record Flag (BPRF) is placed in an electronic health record (EHR) only after the Department of Veterans Affairs (VA) medical facility Disruptive Behavior Committee (DBC) conducts a behavioral threat assessment and determines that a significant behavioral safety risk exists (in compliance with VHA Directive 1160.08(1), VHA Workplace Violence Prevention Program, dated August 23, 2021) and that the need to address this clear risk to health and safety of patients, VA staff or guests outweighs the potential privacy concerns raised by the appearance of the BPRF when the EHR is opened.

b. The DBC Chair or other authorized individual may place an interim BPRF on an emergency basis when warranted by the level of imminent risk and when the clear risk to health and safety of patients, VA staff or visitors outweighs the potential privacy concerns raised by the appearance of the BPRF whenever the EHR is opened. This BPRF will be reviewed by the DBC as soon as possible, but not later than the next scheduled meeting.

c. Before a BPRF is activated, the DBC must determine from the behavioral threat assessment process that the presence of the BPRF is likely to enhance the provision of health care in a safe manner and is unlikely to exacerbate risk to the patient, other patients, visitors or staff.

2. ENTERING BEHAVIORAL PATIENT RECORD FLAGS

a. A BPRF is entered in the patient’s EHR under the authority of the VA medical facility Chief of Staff (CoS) through the Veterans Health Information System Technology Architecture (VistA) PRF application by the DBC Chair or other authorized and trained individual.

b. A BPRF must be activated in the EHR no later than close of business the next business day (excluding weekends and holidays) following the decision that it is necessary to convey information regarding recommended treatment or risk management strategy.

c. The DBC may enter a linked Text Integration Utility (TIU) progress note in the EHR when a BPRF is activated, modified, transferred or inactivated. While placement of a progress note is a preferred practice, the BPRF progress note may be omitted if its presence is deemed by the DBC likely to exacerbate the behavioral risk to staff or DBC members. The note is entitled “Patient Record Flag – Behavioral” and is found in the EHR “Progress Note Properties” box. This note must provide a summary of the rationale for the existence of the specific BPRF and provide more detail or background for the placement of the BPRF. The progress note must not simply duplicate or restate the BPRF.

NOTE: *At Oracle Cerner sites, the Note Type for BPRF will be PRF-Behavioral Flag Note. In the Note Title field, the user will indicate the current action, such as "Activate," "Modify," "Transfer," "Inactivate." This is a free form field.*

d. A BPRF must be objective, brief and free of redundant or inflammatory language. It should not mention specific crimes committed or alleged, use frightening language or incorporate legal terms such as "assault" or "rape." It must briefly describe the threat to safety and the action(s) to be taken. The narrative must avoid alluding to site-specific acronyms, abbreviations, processes, building names or other descriptors unique to the originating site which would have no meaning for other VA medical facilities where the patient may appear. There are three sections of one to two sentences each, as follows:

(1) PROBLEM: followed by one or two lines of text identifying the problem succinctly.

(2) ACTION: followed by the essential steps the staff is to initiate immediately.

(3) The third section contains the Disruptive Behavior Reporting System (DBRS) case number for the report and a sentence indicating that all disruptive behavior events should be reported via DBRS.

(4) Additional less urgent information may be placed in the TIU progress note (See paragraph 2.c. above).

e. If the elevated risk posed by the patient is highly site-specific (e.g., stalking of a particular provider) and the mitigating measures are burdensome (e.g., police escort), the site specificity should be noted briefly in the flag to minimize the disruption to the patient in settings where there is minimal assessed risk. More guidance on the use of BPRFs may be found on the PRF and Orders of Behavioral Restriction (OBR) pages of the Workplace Violence Prevention Program SharePoint (see https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/PRF.aspx) or DBC Guidebook (see http://vaww.hefp.va.gov/guidebooks/disruptive-behavior-committee-dbc-guidebook). ***NOTE:*** *These are internal VA websites that are not available to the public*.

f. Patients must be notified and educated on the OBR activation. Expectations for patient education and notification of an OBR activation are addressed on the BPRF and OBR pages of the Workplace Violence Prevention Program SharePoint and in VHA Directive 1160.08(1) (see https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/PRF.aspx or the DBC Guidebook at http://vaww.hefp.va.gov/guidebooks/disruptive-behavior-committee-dbc-guidebook). ***NOTE:*** *These are internal VA websites that are not available to the public*.

3. REVIEWING BEHAVIORAL PATIENT RECORD FLAGS

a. BPRFs must be reviewed at least every 2 years. There must be an efficient means of tracking review due dates available to those assigned BPRF management

responsibilities. ***NOTE:*** *Tracking and alerting is provided in the VistA PRF software. It must be provided when the Oracle Cerner application is implemented.*

b. In the review, the DBC will update the behavioral risk assessment by considering more recent DBRS reports and other clinical and patient-relevant data generated since the BPRF was placed. ***NOTE:*** *When an OBR is modified for any reason, its accompanying BPRF will be updated to reflect changes in the requirements of the OBR, even if the 2-year review is not due.*

c. Earlier review of a BPRF may be appropriate when: risk factors change significantly; significant new episodes of disruptive behavior occur; a patient with a BPRF requests a review; an earlier review was planned when the BPRF was placed; the patient's provider requests a review; or for other appropriate reasons.

4. OWNERSHIP AND TRANSFER OF BEHAVIORAL PATIENT RECORD FLAGS

a. Ownership of a BPRF resides with one VA medical facility at any given time. The owning facility may be changed dependent upon the needs of the patient. All VA medical facilities are required to implement, utilize and respond to BPRF, regardless of which facility originated the flag or has current ownership of the BPRF. The responsibility for ensuring the quality, timeliness, routine review and documentation in support of BPRFs belongs to the owning VA medical facility.

b. When a VA medical facility caring for a patient with a BPRF currently managed by another VA medical facility discovers information that could influence the status of that BPRF, the treating VA medical facility must contact the owning facility with the new information.

c. When a patient with a BPRF relocates their care to a new VA medical facility, the BPRF should be transferred to the new facility to facilitate the provision of safe and effective care. Either party may initiate this transfer as appropriate by contacting the point of contact (usually the DBC Chair) at the other VA medical facility.

(1) The first VA medical facility to be aware of the relocation of care must initiate the transfer by contacting the DBC Chair at the other facility, explaining the situation and requesting the transfer of the BPRF.

(2) This transfer is completed in the EHR Patient Record Flag software and is immediate. The sending facility cannot enter a linked TIU progress note after the transfer, but might consider placing an addendum regarding the transfer on the most recent BPRF progress note.

(3) Response to such inquiries must be timely.

(4) The transferring VA medical facility should provide information regarding the behavioral history and risk assessment which led to the placement of the BPRF.

5. INACTIVATION OF BEHAVIORAL PATIENT RECORD FLAGS

a. A BPRF must be inactivated when its usefulness or relevance has passed, as might happen when an updated behavioral risk assessment by the DBC indicates that the patient no longer poses a significant risk.

b. A BPRF must not be inactivated when a patient has moved care to another VA medical facility unless a review and updated risk assessment indicates that the BPRF is not needed, and this decision must be made in collaboration with the VA medical facility providing care to the patient.

6. PATIENTS REQUESTING AMENDMENTS TO BEHAVIORAL PATIENT RECORD FLAGS

a. **Amendments.** There is no appeal process for a BPRF. Because a BPRF is part of the EHR, a patient may request an amendment following the procedures maintained by Health Information Management Services for all requests to amend EHRs. The patient submits a request to the Privacy Officer at the VA medical facility which owns the BPRF. The VA medical facility Privacy Officer will review and process the request in accordance with VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016, which will include routing the request to the DBC Chair. Any amendment denial must be provided in writing to the patient and include appropriate appeal rights.

b. If the amendment request pertains to a BPRF which accompanies an OBR, the process for requesting a review of the OBR described in VHA Directive 1160.08(1) must be followed instead. ***NOTE:*** *For more information, see the PRF and OBR pages of the Workplace Violence Prevention Program SharePoint: https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/PRF.aspx. This is an internal VA website that is not available to the public.*

7. OTHER GUIDANCE ON BEHAVIORAL PATIENT RECORD FLAGS

Additional and updated guidance on the use of BPRFs may be found on the Workplace Violence Prevention Program SharePoint: https://dvagov.sharepoint.com/sites/VHAWVPP/SitePages/PRF.aspx%20. ***NOTE:*** *This is an internal VA website that is not available to the public*.

HIGH RISK FOR SUICIDE PATIENT RECORD FLAG

1. CRITERIA FOR HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

a. A standardized referral within the electronic health record (EHR) is required for clinicians to refer patients at high acute risk for suicide for consideration of High Risk for Suicide Patient Record Flag (HRS-PRF) placement. This referral is a standalone order and includes functionality that will allow the order to open based upon options chosen from within the Suicide Behavior and Overdose Report (SBOR) or Comprehensive Suicide Risk Evaluation (CSRE). Clinicians will complete the order and submit for review by the Suicide Prevention Coordinator (SPC). ***NOTE:*** *Patients receiving care solely under the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020 (P.L. 116-214) who do not access any care through a Department of Veterans Affairs (VA) medical facility are not eligible for activation of an HRS-PRF.*

b. Essential features of high acute risk for suicide and requirement for placement of the HRS-PRF include, but are not limited to:

(1) A recent suicide attempt, or preparatory behaviors such as seeking access to lethal means;

(2) Suicidal ideation with intent to die by suicide that resulted in mental health inpatient care; or

(3) The inability to maintain safety independent of external supports.

2. ENTERING HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

a. Any patient referred and meeting criteria to be high acute risk for suicide must have an HRS-PRF placed in their EHR as soon as possible, but not later than 3 business days after referral for a PRF placement.

b. Each HRS-PRF in a patient’s record must be accompanied by the nationally standardized EHR alert and corresponding templated Text Integration Utility (TIU) progress note completed at the time the HRS-PRF is activated, continued, transferred or inactivated (see paragraph 10 of this appendix). ***NOTE:*** *Sites using the Oracle Cerner system may not have the ability to use the standardized, national note for documentation of flag actions. Therefore, these sites are exempt from this requirement until such time as a corresponding note is available in the Oracle Cerner system.*

c. The HRS-PRF should include only information that is immediately essential for the delivery of safe and appropriate health care.

3. MANAGING CARE OF PATIENTS WITH A HIGH RISK FOR SUICIDE PATIENT RECORD FLAG

a. SPCs are encouraged to notify patients within 14 days after activation and inactivation of the HRS-PRF.

b. Patients should receive enhanced care from VA medical facility health care providers that includes a review of the following care plan considerations:

(1) The patient's mental health diagnoses, their risk of suicide, and that the care plan appropriately addresses the patient's conditions and functional limitations.

(2) Specific treatments and interventions with the potential for reducing suicide risk.

(3) Ongoing assessment for suicidality and plans for addressing periods of increased risk.

***NOTE**: SPCs are responsible for monitoring and providing care coordination to facilitate enhanced care.*

c. Patients must have a Safety Plan completed within 7 days before or after HRS-PRF placement, or prior to discharge from inpatient or residential care, and it must be reviewed or revised regularly in collaboration among VA medical facility health care providers. The Safety Plan must be documented utilizing the national Suicide Prevention Safety Plan or Suicide Prevention Safety Plan Review/Decline Progress Note titles. ***NOTE**: Safety Plans are typically completed by the treating provider and further details on lethal means education, safety planning and guidance can be found in the Suicide Prevention Program Guide (SPPG). Health care providers are encouraged to include the patient's family and other social supports in the process of creating the Safety Plan. Health care providers must document the patient's decision to decline a Safety Plan in the EHR*.

d. Patients must be provided with four mental health appointments within the first 30 days after HRS-PRF placement and at least one mental health appointment monthly thereafter until the HRS-PRF has been inactivated. Content of appointments should include review or updating of the Veteran's Safety Plan, suicide risk mitigation strategies and enhancement of coping mechanisms. ***NOTE**: Mental health appointments must be face-to-face, which can include Clinical Video Telehealth (CVT) or VA Video Connect (VVC), unless the Veteran requests telephone contact.*

e. Patients with HRS-PRF must receive follow-up on missed mental health appointments in accordance with VHA Directive 1230, Outpatient Scheduling Management, dated June 1, 2022, and VHA Directive 1232(5), Consult Processes and Procedures, dated August 24, 2016.

4. REVIEWING HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

a. The HRS-PRF clinical review must be conducted and documented in the EHR national progress note template for the HRS-PRF described in paragraph 10 of this appendix. The HRS-PRF review must document the Veteran's engagement in clinical care.

b. All new and re-activated HRS-PRF must be reviewed every 90 days. ***NOTE****: Reviews must occur no earlier than 10 days before and no later than 10 days after the 90-day due date. All reviews are documented in the EHR.*

c. Continued HRS-PRF must be reviewed no earlier than 10 days prior or 10 days after the continuation review by date. ***NOTE****: Review dates for continued HRS-PRF may be up to 90 days from the last HRS-PRF date.*

d. VA medical facility health care providers must collaborate and consult with the SPC for HRS-PRF EHR reviews in accordance with licensure, position, credentialing or scope of practice.

5. OWNERSHIP AND TRANSFER OF HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

a. Ownership of a HRS-PRF resides with one VA medical facility at any given time. The owning facility may be changed dependent upon the needs of the patient. All VA medical facilities are required to implement, utilize and respond to HRS-PRF, regardless of which facility originated the flag or has current ownership of the HRS-PRF. The responsibility for ensuring the quality, timeliness, routine review and documentation in support of HRS-PRFs belongs to the owning VA medical facility.

b. The owning site SPC may only transfer an HRS-PRF once the following tasks for transferring have been completed:

(1) Facilitate the transfer of care to the patient's VA medical facility of choice at the new location.

(2) Coordinate with the receiving SPC to assist patients with scheduling initial appointments with mental health personnel.

(3) Confirm the patient's addresses have been updated in the EHR.

(4) Notify the receiving site SPC about the patient's projected move date, the scheduled first appointment at the new site and other information that is relevant to the patient and their care.

c. The receiving site SPC must:

(1) Accept transfer of the HRS-PRF once all the transferring site's requirements have been met; and

(2) Attempt to contact patients who do not show for their first appointment at the new site. ***NOTE****: The transferring site is no longer responsible for transferred patients, even if patients fail to attend the first appointment or have not been seen at the new site*.

6. INACTIVATION OF HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

a. Inactivation may be considered for one of the three categories listed below. ***NOTE****: The following elements contained in either paragraph 6.a.(1) or 6.a.(2), and 6.a.(3) (below) must be considered and documented in the patient's EHR*.

(1) **Process for Patients Engaged in VA Mental Health Care.** HRS-PRF review must show evidence of reduction of clinical risk based on:

(a) Clinical consultation regarding HRS-PRF between the SPC and the patient's treatment providers and in conjunction with the VA medical facility-designated advisory group or committee.

(b) EHR documentation that includes review of the EHR by a clinical treating provider demonstrating reduction of suicide risk, in accordance with the VA/Department of Defense (DoD) Clinical Practice Guidelines, which can be located at https://www.healthquality.va.gov/guidelines/MH/srb/.

(c) Documentation of patient's engagement in clinical care.

(d) Completed Safety Plan or documented decline to complete a Safety Plan.

(2) **Process for Patients Who Have Not Engaged in VA Health Care.** The HRS-PRF may be inactivated after consideration of indicators and contra-indicators of acute high risk for suicide. Lack of engagement in treatment may not be the only considered indicator that informs the rationale for inactivation of the HRS-PRF. In addition to documenting all available indicators of risk, the rationale for inactivation in the EHR must also demonstrate:

(a) Attempts to engage the patient in care. ***NOTE****: SPCs or other treatment providers may attempt to engage patients in care.*

1. Attempts to engage in care include phone contacts and may additionally include caring communications.

2. Outreach efforts occur at least four times by phone in the first 30 days, and at least one time each subsequent month for the remainder of the HRS-PRF activation if the patient is not otherwise attending or scheduled for mental health or substance abuse treatment appointments. ***NOTE****: SPCs should consult with the patient's health care providers and applicable local advisory committees for HRS-PRF when patients are not responding to attempted outreach efforts to determine if additional outreach efforts are appropriate.*

(b) Attempts to reassess suicide risk and complete a Safety Plan is documented in the EHR;

(c) SPC's consultation with the patient's community treatment provider, as applicable, and documentation of this clinical consultation in the EHR regarding HRS-PRF, along with any additional consultation with the patient's health care providers and applicable local advisory committees for HRS-PRF.

(3) **Process for Patients Ineligible for VA Health Care.** In the rare instance that a patient with an HRS-PRF is determined to be ineligible for VA health care, VA medical facilities must provide the rationale and plan of care for removal of the HRS-PRF prior to the end of the 90-day review period. If VA medical facilities determine to remove HRS-PRF of a patient who is ineligible for VA care prior to 90 days, the EHR must document provision of community referrals, care coordination efforts with community providers and safety planning. ***NOTE****: VHA Directive 1601A.02(4), Eligibility Determination, dated July 6, 2020; VHA Directive 1660.06, VA-TRICARE Network Agreements, dated June 28, 2019; Veterans COMPACT Act of 2020, P.L. 116-214 § 201 (2020); and 38 USC §1784A reference provision of care for patients (e.g., ineligible former Service member, active duty Service member, humanitarian care) with emergent conditions. Referrals to community care are pursuant to paragraph 19 of VHA Directive 1601A.02(4).*

b. Patients must be notified of HRS-PRF inactivation and provided suicide prevention education materials and resources, to include contact information for the Suicide Prevention Team and the Veterans Crisis Line.

c. Patients must receive non-demanding caring communications through the United States Postal Service (USPS) for a minimum of 1 year, on a cadence determined by the Office of Mental Health and Suicide Prevention (OMHSP). ***NOTE****: More information on caring communications can be found in the SPPG: https://dvagov.sharepoint.com/sites/vhasuicidepreventioncoordinators.This is an internal VA website that is not available to the public.*

(1) SPCs may provide other VA medical facility approved modalities of caring communications, based on the Veterans preference, such as phone calls in addition to, but not in lieu of, the caring communications through USPS.

(2) Documentation in the EHR must include the patient's addition and removal from caring communications, and when provided, a patient's preferences or refusal of contact.

(3) Tracking must include a listing of all patients enrolled and number of contacts made across time and should be saved in a secured location electronically to protect all patient health information. ***NOTE****: Sample local tracking systems are available from OMHSP.*

7. TRAINING FOR HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

The SPC must educate clinical and non-clinical staff regarding local procedures for HRS-PRF management, such as:

a. Identification of patients who may be eligible for HRS-PRF placement.

b. Referral of patients to the SPC for consideration of HRS-PRFs.

c. Clinical management of patients with HRS-PRF.

d. Clinical review of patients' suicide risk for consideration of HRS-PRF inactivation.

(1) When assessing for suicide risk, staff should always consider the frequency of the patient's visits, changes in treatment modalities, and access to lethal means. ***NOTE****: The Veterans Health Administration (VHA) has developed the Suicide Risk Identification and Management SharePoint for guidance about the standardized, evidence-based screening for the risk of suicide, and structured methods for the subsequent evaluation of those who screen positive for suicide risk; visit https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Home.aspx.* ***NOTE:*** *This is an internal VA website that is not available to the public.*

(2) Resources are available to inform clinical judgement of suicide risk. ***NOTE****: See paragraph 8 (below) for additional resources.*

8. OTHER GUIDANCE FOR HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

The following resources provide additional information regarding suicide risk assessment:

a. Rocky Mountain Mental Illness Research, Education and Clinical Center (MIRECC):

(1) Therapeutic Risk Management of the Suicidal Patient and the Suicide Risk Management Consultation Program are available at: https://www.mirecc.va.gov/visn19/trm/.

(2) Therapeutic Risk Management-Risk Stratification Table: https://www.mirecc.va.gov/visn19/trm/docs/RM_MIRECC_SuicideRisk_Table.pdf.

(3) Suicide Risk Identification and Management and Suicide Prevention in the Emergency Department (SPED) SharePoint:https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Home.aspx. ***NOTE:*** *This is an internal VA website that is not available to the public.*

b. The VA/DoD Clinical Practice Guideline series "Assessment and Management of Patients at Risk for Suicide" (2019): https://www.healthquality.va.gov/guidelines/MH/srb/.

9. PATIENTS REQUESTING AMENDMENTS TO HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

There is no appeal process for an HRS-PRF. A patient may request an amendment to an HRS-PRF following the procedures maintained by Health Information Management Services for all requests to amend EHRs. The patient must submit a written request to the Privacy Officer at the VA medical facility where the HRS-PRF was entered. The VA medical facility Privacy Officer will process the amendment request in accordance with VHA Directive 1605.01, Privacy and Release of Information, dated August 31, 2016.

10. REQUIRED PROGRESS NOTE FOR THE HIGH RISK FOR SUICIDE PATIENT RECORD FLAGS

The entry of an HRS-PRF requires first the activation of the HRS-PRF Assignment Narrative and must have an accompanying TIU progress note for placement, review, inactivation and transfer of the flag. The HRS-PRF TIU progress note title is PATIENT RECORD FLAG – HIGH RISK FOR SUICIDE, with subheadings of:

a. PRF HIGH RISK FOR SUICIDE PLACED ON ELECTRONIC HEALTH RECORD;

b. PRF HIGH RISK FOR SUICIDE REVIEW, CONTINUE ACTIVE FLAG;

c. PRF HIGH RISK FOR SUICIDE INACTIVATED; and

d. PRF HIGH RISK FOR SUICIDE TRANSFER/CHANGE OF FACILITY OWNERSHIP.

NATIONAL PATIENT RECORD FLAG ADVISORY BOARD CHARTER

1. RESPONSIBILITIES

a. Evaluating proposals for new types of Patient Record Flags (PRFs), considering:

(1) The purpose of the proposed PRF;

(2) The described need for the PRF;

(3) The consistency of the PRF with the intent and provisions of this policy;

(4) The potential administrative and clinical ramifications of the PRF;

(5) The requirements for managing the PRF in the electronic health record (EHR) and Veterans Health Administration (VHA) data systems; and

(6) Whether VHA has the authority to implement and use the proposed PRF.

b. Deciding whether to endorse the new PRF request and forwarding the Board's recommendation to the Executive Director of the Office of Mental Health and Suicide Prevention (OMHSP) for final action.

c. Notifying the requesting entity of the Board's recommendation and of the final approval status after notification by OMHSP.

2. MEMBERSHIP

The National PRF Advisory Board consists of:

Title	Role
Designee from OMHSP responsible for the Advisory Board	Chair
Representative from Office of Patient Care Services	Member
Representative from each VHA National Program Office which owns an approved PRF	Members
Representative, Health Information Management System (HIMS)	Member
Representative, National Center for Ethics in Health Care	Member
Representative, Clinical Informatics and Data Management Office (CIDMO).	Ad Hoc Member
Representative, Department of Veterans Affairs (VA) Office of General Council (OGC)	Ad Hoc Member

Title	Role
Representative, VHA Privacy Office	Ad Hoc Member
Representative, Department of Defense (DoD) OR VA-DoD Liaison	Ad Hoc Member
Representative, National Center for Patient Safety	Ad Hoc Member
Representative, Office of Integrated Veteran Care	Ad Hoc Member

3. NEW SERVICE REQUEST FOR PATIENT RECORD FLAGS

a. **Entering the New Service Request.**

(1) Applicants for a new PRF use the New Service Request (NSR) process established by VA's Office of Information and Technology (OI&T). The online NSR application is available at: https://epas.r02.med.va.gov/apps/idrp/ and is accessed by selecting the link to Submit a New Software Request. ***NOTE:*** *This is an internal VA website that is not available to the public*.

(2) The application for a new PRF must include:

(a) Detailed explanation of the clinical safety issue to be addressed, including factors that make this request a high clinical safety priority that must be available in the initial moments of a patient encounter;

(b) Reason why a PRF is necessary;

(c) Alternatives to a PRF that have been explored;

(d) Proposed process for activation, management, renewal and inactivation of the PRF;

(e) Frequency with which an active PRF will be reviewed;

(f) Nature and availability of data on which placement of the PRF will be based;

(g) Inclusion and exclusion factors that will determine the appropriateness of the PRF;

(h) Factors that will be used to determine that the PRF is no longer necessary;

(i) Proposed management or monitoring of the PRF at the national level, to include an identified owning national program office;

(j) Potential administrative and clinical ramifications to Veterans of the PRF;

(k) Anticipated frequency of the PRF's use;

(l) Any applicable references (e.g., VHA directive or notice, Congressional Mandate, VA Secretary's performance measure, clinical literature) that may impact the Board's determination.

(3) When the Board reviews a PRF request and does not endorse it, the applicant may discuss with the Chair whether there would be value in resubmitting the PRF request with additional justification.

b. **Reviewing the New Service Request.**

(1) The National PRF Advisory Board is convened by the Chair when an NSR for a new PRF is received. The Board evaluates the NSR in light of this policy and of the merits and risks of the proposed PRF. The primary focus of the deliberation is whether the proposed PRF would enhance the quality, safety and efficiency of VHA's service to Veterans without impeding access to care or creating undue hardship for recipients of the PRF. The Board's evaluation includes at minimum the following questions:

(a) Does the proposed PRF contain information about a patient's behavior, medical or mental status that VA employees need to know in the initial moments of an encounter to protect the patient's health and safety, or the health and safety of other patients, VA staff or guests at the VA medical facility?

(b) How are the patient's circumstances and needs assessed to determine whether placement of the PRF is indicated?

(c) What are the sources of data on which the assessment will be based?

(d) Who assesses the patient's circumstances and needs, and what training is needed to prepare them for this duty?

(e) How will the patient be involved in determining whether the PRF should be placed?

(f) How will the PRF be documented in the EHR beyond the placement of the flag?

(g) What are the anticipated clinical responses to and impacts of the PRF? That is, how will the PRF impact decisions about treatment resources, locations, goals and plans of care?

(h) What are the anticipated administrative responses to and impacts of the PRF? That is, how will the PRF impact patients' interactions with local administrative offices or non-clinical personnel?

(i) What is the mitigation plan for the risk of the PRF being used inappropriately? Examples of such risks are to deny care, to terminate care, to limit or deny access to specific VHA programs or services, to use for administrative or law enforcement purposes or to use punitively?

1. What potential clinical ramifications of the PRF could harm the patient?

2. What potential administrative ramifications of the PRF could harm the patient?

(j) How will use of the PRF be monitored and overseen at the VA medical facility level, at the Veterans Integrated Service Network (VISN) level and at the national level?

(k) Are there plans to use data related to the PRF for reasons other than locally managing use of the flag on behalf of patients?

(l) What is the proposed schedule and process for reviewing and considering whether to continue, inactivate or terminate the PRF?

(m) In what situations will the PRF be released to community providers, and how are community providers likely to respond?

(2) The Chair invites ad hoc Board members to participate in the evaluation of the NSR when indicated.

(3) The Chair (or designee) contacts the individual or office requesting the new PRF for additional information as needed.

(4) The Chair strives to achieve consensus of Board members on whether to endorse the request. Should consensus not be attainable, the Chair may initiate additional deliberation or make a final determination on behalf of the Board.

(a) If the Board endorses approval of the PRF, the Chair (or designee) notifies the applicant of the recommendation and forwards the endorsed NSR to the Executive Director, OMHSP). makes the final determination and notifies the Board Chair, who then notifies the applicant of the approval or disapproval.

(b) In cases when the Board does not endorse the NSR, the Chair (or designee) informs the applicant of the Board's determination. The Chair also briefs OMHSP about the NSR, the Board's deliberations and the Board's recommendation.

c. **Approval of a New Category of Patient Record Flag.**

(1) The National PRF Advisory Board forwards its endorsement to OMHSP.

(2) The Executive Director of OMHSP reviews the National PRF Advisory Board's decision and clears it to move forward for implementation.