Smart Text Call Intake

Education Tool

SCOPE

PATIENT POPULATION:

- Primary Care/Women's Health patients (18 years old +)

SETTING:

- Medical Center clinic
- Community Medical Group clinics

Participants

- Clinical Caregivers answering patient calls

GOAL

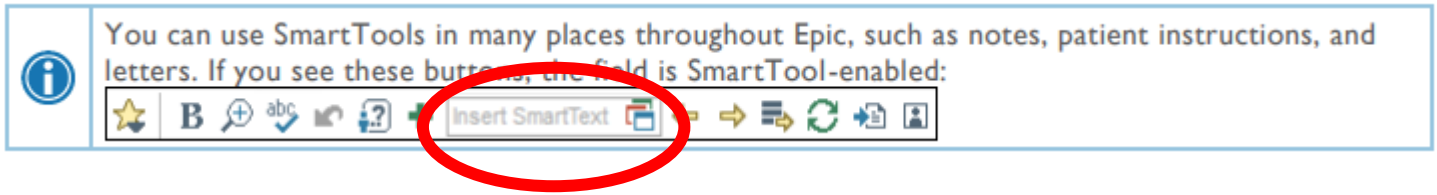
To provide safe and efficient patient care and clinical decision making with phone intake (triage).

Objectives

1. To appropriately decrease the number of patient calls/requests that are sent to the Provider In-basket
2. To standardize clinical information intake process
3. To standardize medical record documentation
4. To maximize scope of practice for clinic caregivers

WHAT IS A SMARTTEXT?

SmartTexts are standard templates or blocks of text used to write notes for routine visits or problems you treat often, such as diabetes.



SmartTexts can also be used to write routine patient instructions and other types of documentation.

1. Enter a few letters of the SmartText's name in the Insert SmartText field and press Enter.
2. Double-click a SmartText to insert it OR highlight and click enter.
3. Press F2 to complete any SmartLists and wildcards (***) in the SmartText.

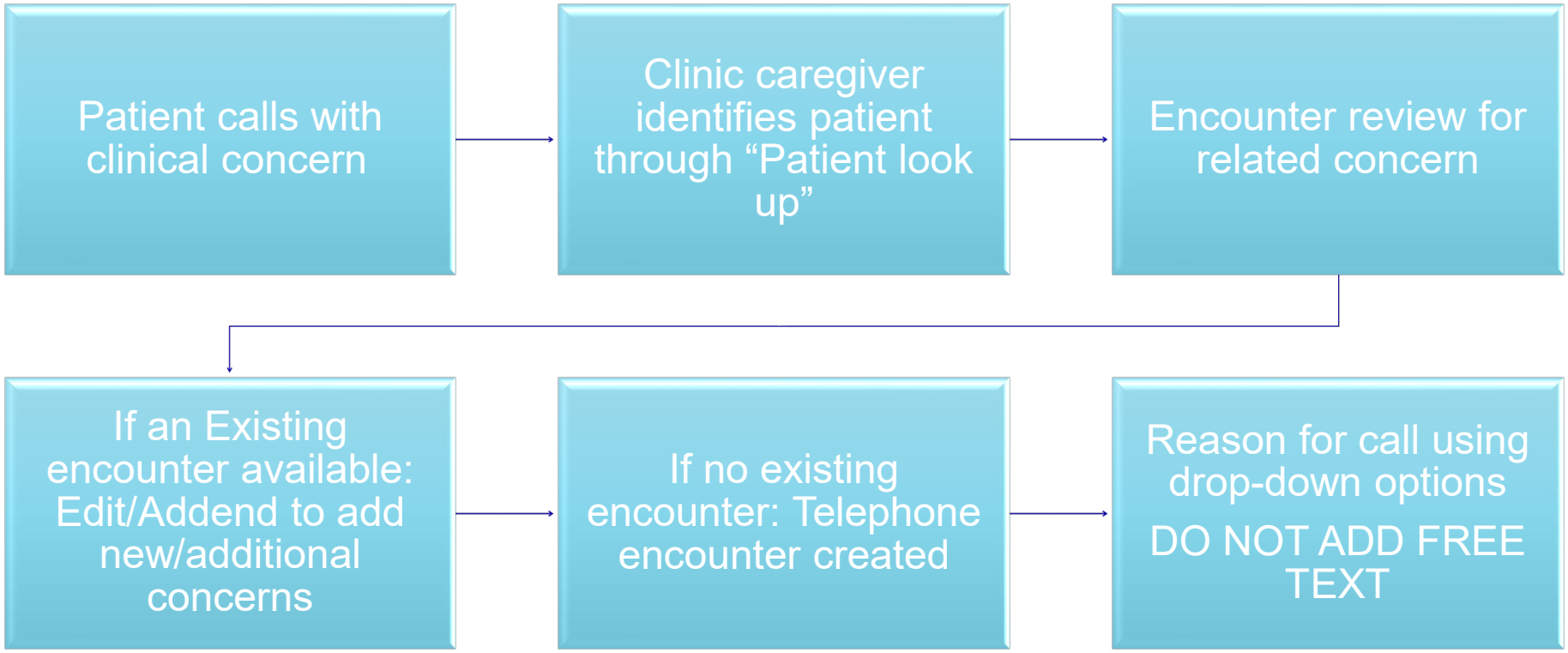
Preview the contents of a SmartText on the right-hand side of the SmartText Lookup window before adding it to your documentation.

REDESIGN OF CALL INTAKE

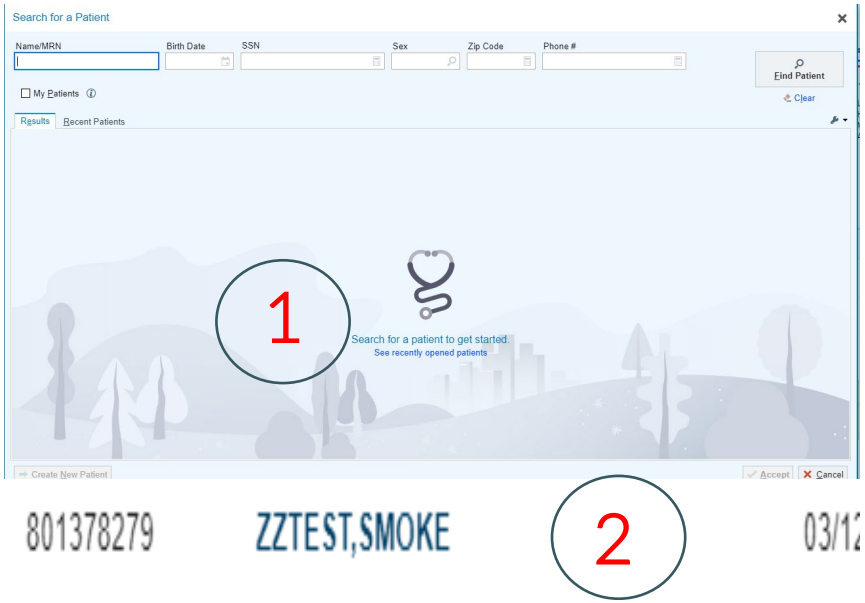
- The organization is piloting use of SmartText intake forms that are linked to the reason for call (Complete list with example in Appendix)
- Use of these SmartTexts will allow clinic caregivers to collect necessary information for appropriate clinical decision making within scope of practice
  - **RNs** to make clinical decisions and provide home advice
  - **LPNs** to collect clinical information to offer appointments and/or share provider advice
  - **Medical Secretaries/ASRs and MAs** to collect clinical information and follow clinic workflows
  - **Providers** to review clinical information collected and provide recommendations for care plan

THE HOW?

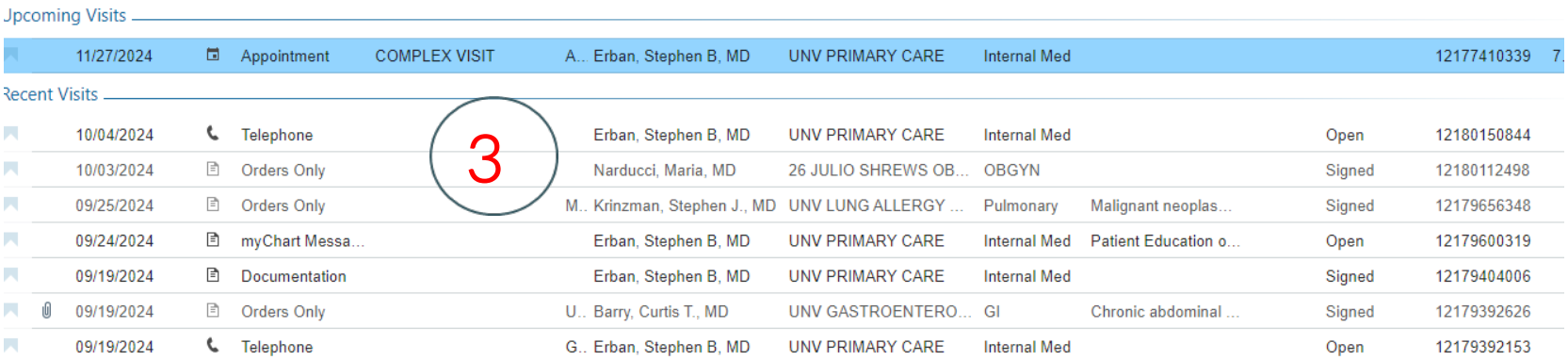
THE NEXT SLIDES WILL WALK THROUGH STEP BY STEP INSTRUCTIONS FOR USE OF AN INTAKE FORM

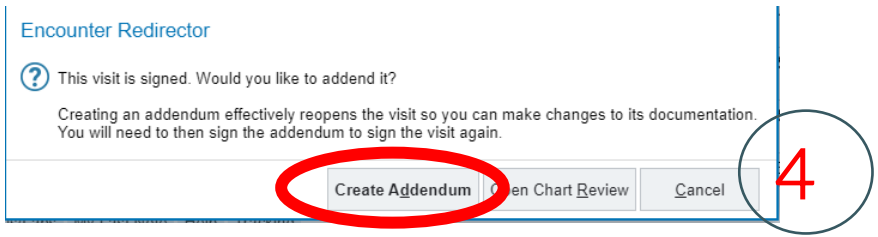


WORKFLOW FOR USE (CLINIC CAREGIVER)



1. Search for patient when call received
2. Verify correct patient with 2 patient identifiers and identify reason for call
3. Review chart in encounters tab for related reason for encounter
4. If encounter exists, right click and “Edit/Addend” appropriate encounter
5. Open new encounter if no existing encounter available

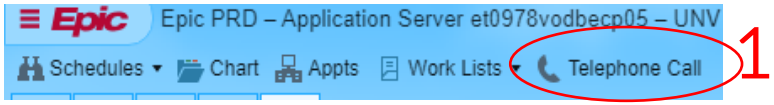


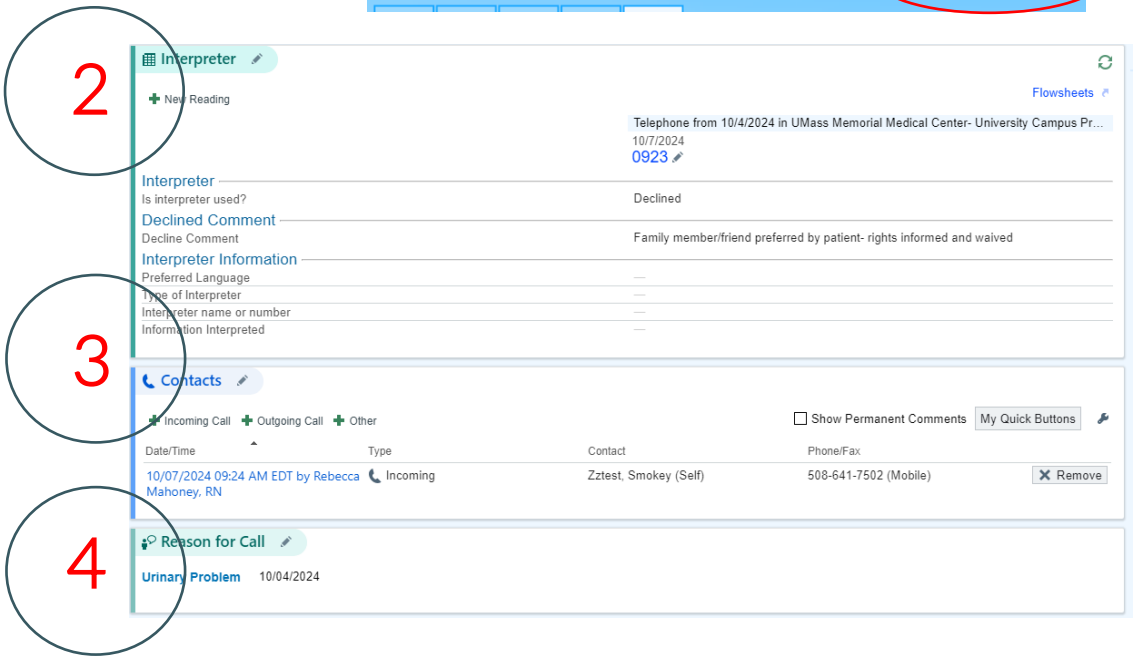


UMass Memorial Health | UMass Chan Medical School

WORKFLOW FOR USE (CLINIC CAREGIVER)

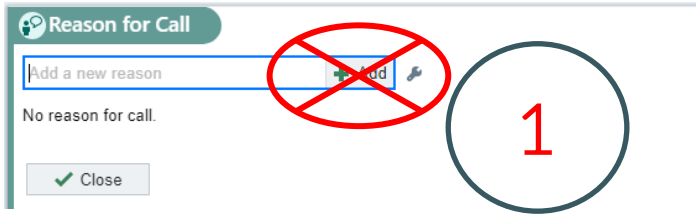
If no related encounter exists, use the telephone call button to open an encounter

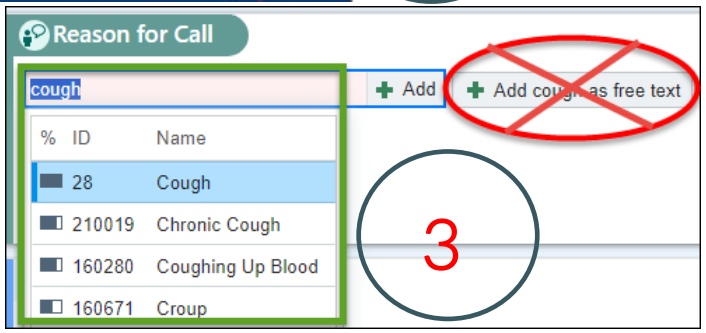


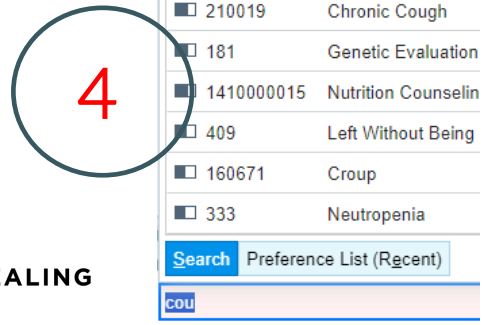


1. Use the Telephone call button in the global menu for a new encounter
2. Complete Interpreter section if applicable
3. Complete Contact section
4. Type Reason for Call, use the enter key on the keyboard to see drop down menu, select option from drop down, DO NOT use add button to add free text

WORKFLOW FOR USE (CLINIC CAREGIVER)

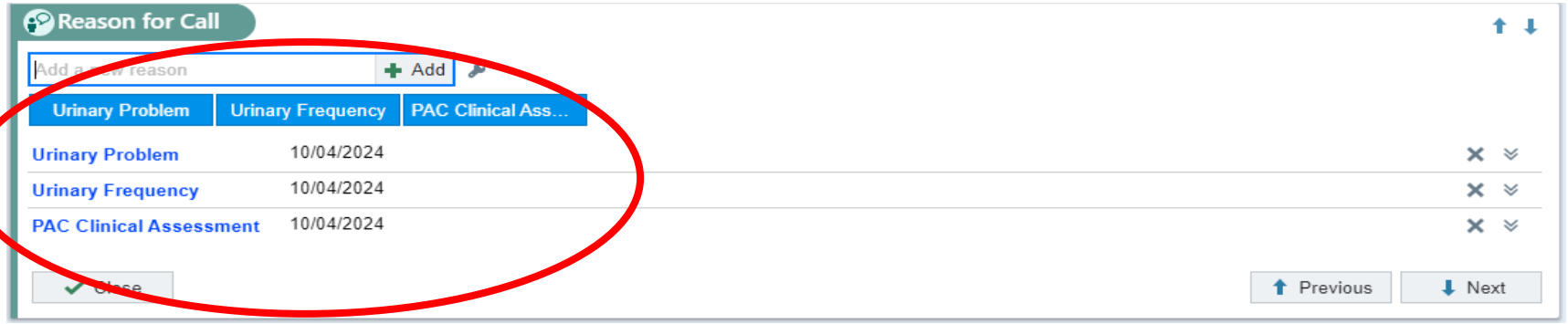






1. Start typing reason for call
2. Use the enter key on the keyboard to find an existing related reason [Example]: Cough = Cou + “Enter”
3. Epic drop down reasons must be used for Intake SmartTexts to link
4. Free text cannot be used to link smart Text

WORKFLOW FOR USE (CLINIC CAREGIVER)



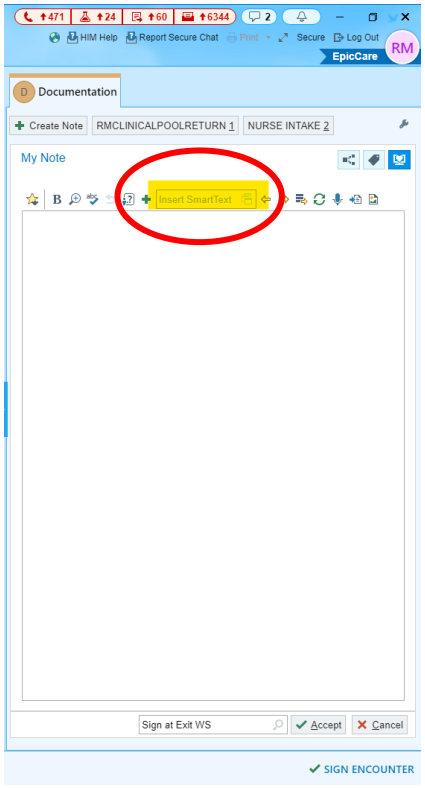
If reason for call is not related to symptom, staff will need to add a reason related to the symptoms

For example, PAC will send a message to the clinical pool for more information gathering with a reason like “PAC Urgent Nurse Scheduling Request”, “PAC Urgent Ebeep”, or “PAC Clinical Assessment”

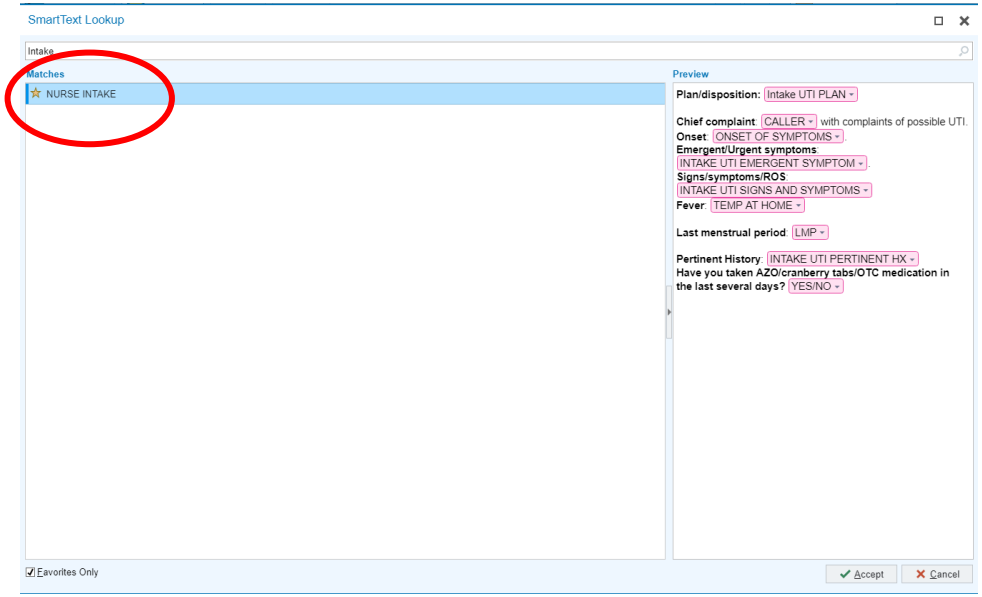
The clinic staff will need to add additional reasons like “UTI”, Urinary Frequency” or “Urinary Problem”

More than one reason can exist in this section

WORKFLOW FOR USE



In the Insert SmartText box, the user will type the word Intake

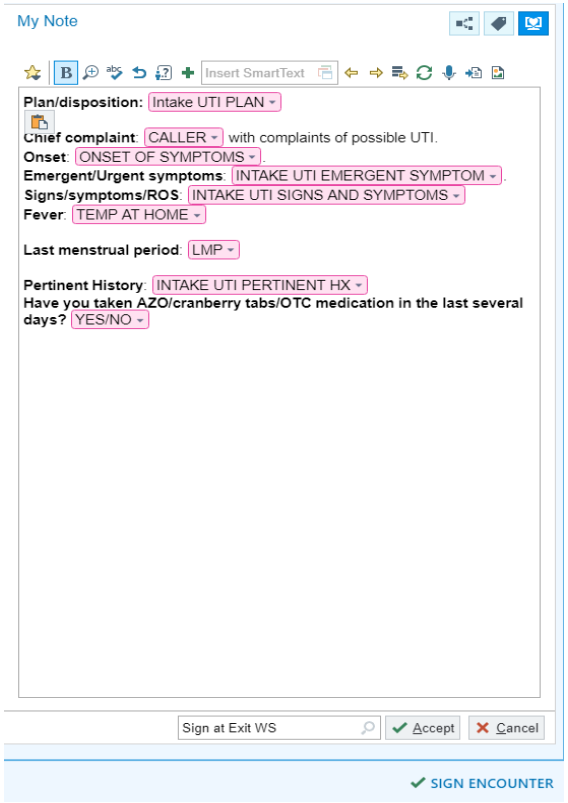


User will then select the appropriate related form

WORKFLOW FOR USE (CLINIC CAREGIVER)

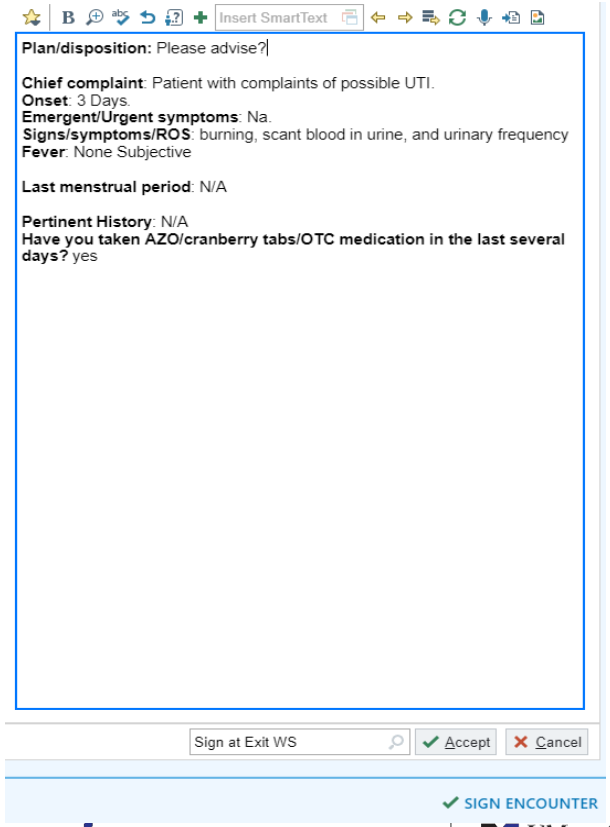
User will complete smart text –

Pro Tip The easiest way to move through the form is with the F8 to navigate (brings you to the top of the form) and F2 to move you through (navigating from field to field), spacebar, enter key, and arrows



User will then route the note to provider –

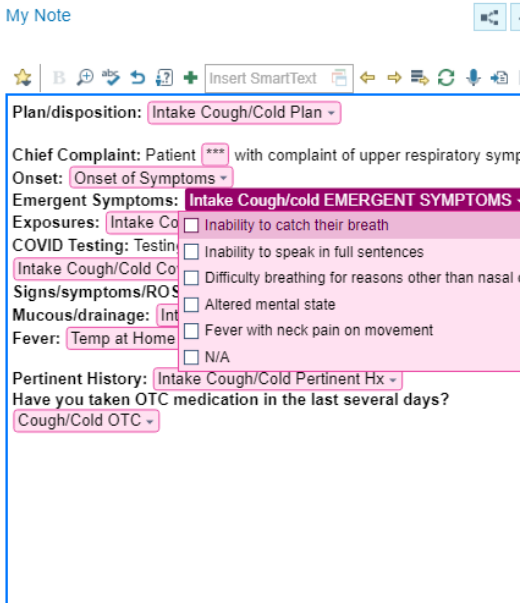
Pro Tip Use the routing function and send and close, do not “Sign Encounter” until all care is complete



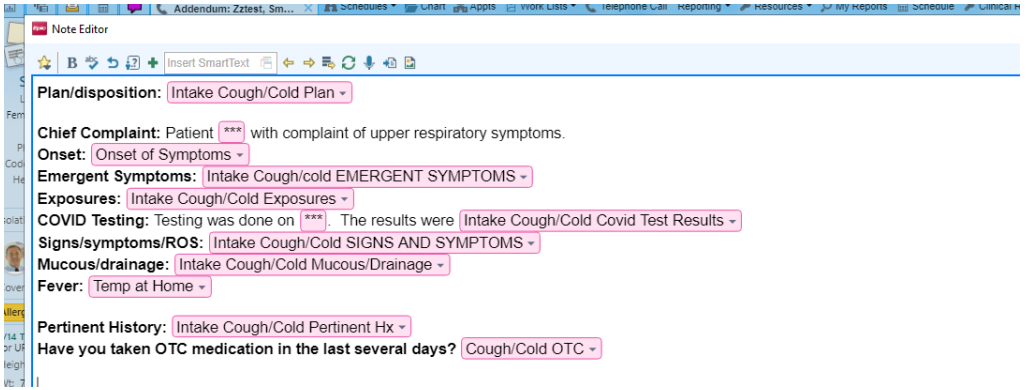
MOVING THROUGH THE NOTE

F2 to move through the note; as you move to each section you can select with the space bar, move up and down with arrow keys and select enter when the section is completed.

Using the mouse you can navigate, click on each option, then double click to select completed options.



F3 so you can see; this breaks out the note so that you can see it in a larger format.

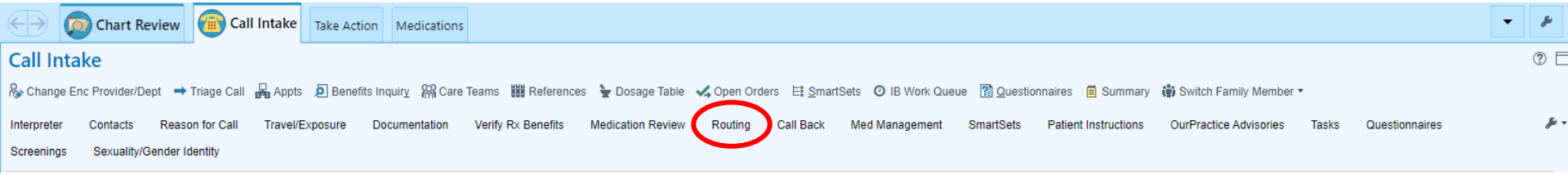


Dot phrases can still be used for example if you wanted to add allergies to the note, you just type **.ALLERGY**

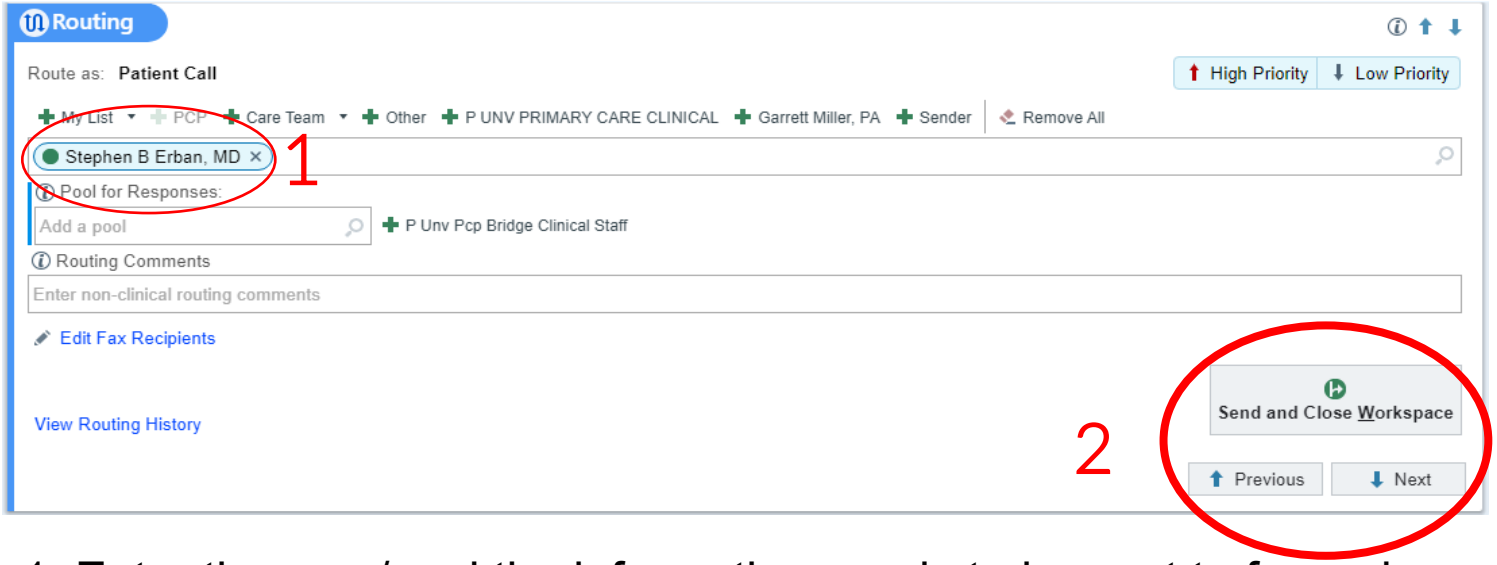
Free text can also still be used wherever you wish to add information that is not already in the text

WORKFLOW FOR USE (CLINIC CAREGIVER)

At the top of the call intake tab, use the **routing** button to navigate to the activity.



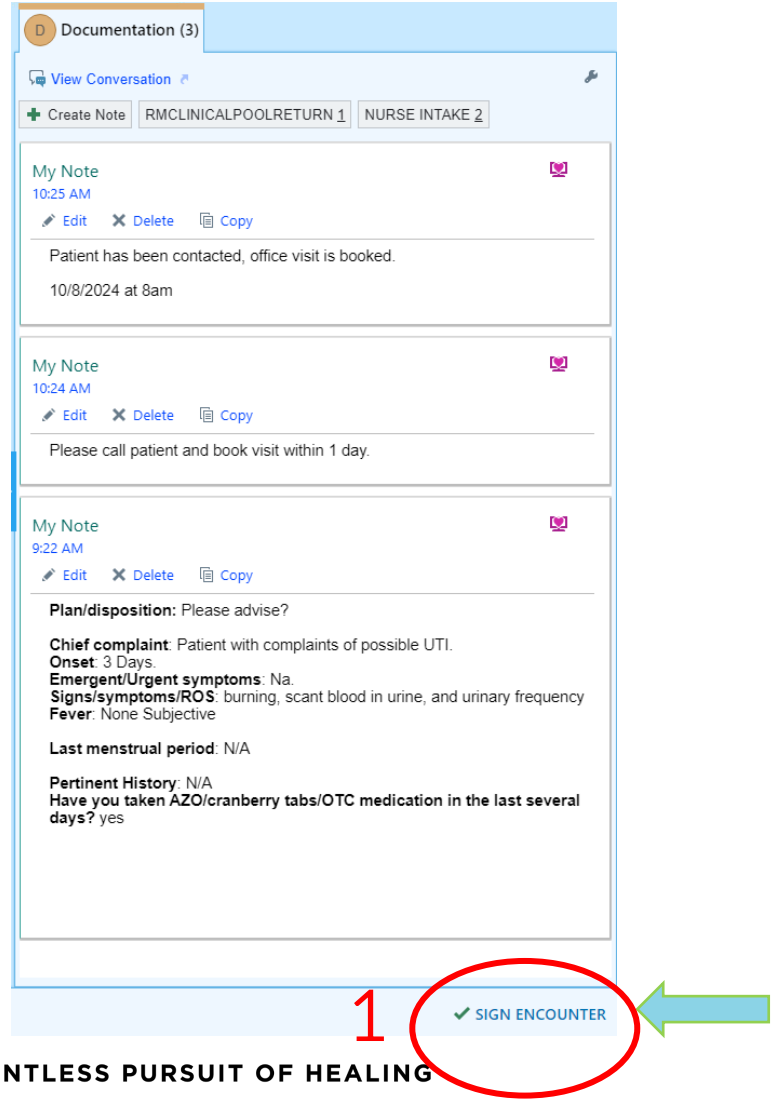
WORKFLOW FOR USE (CLINIC CAREGIVER)



1. Enter the user/pool the information needs to be sent to for review.

2. Send and Close Workspace should be used when items are not complete (For example: If there is still work to be done the encounter should not be signed until patient follow up and documentation is completed)

WORKFLOW FOR USE (CLINIC CAREGIVER)



1. Sign encounter when patient follow up and documentation is completed.

Caregiver initiates call intake with process per clinic workflow
"Reason for call"

RN to gather intake information

RN to provide recommendations for patient based on evidenced based practice using appropriate triage tools and/or experiential knowledge

RN to provide plan of care based on provider recommendation when needed after collaborative conversation and documentation in notes

LPN, MA, Medical secretary/ASR to gather intake information

Message routed to provider for recommendations per clinic workflow

LPN, MA, Medical Secretary/ASR to provide plan of care based on provider recommendations via documentation in notes

APPENDIX

Polyuria [191]
DYSURIA [950]
URINARY TRACT INFECTION [1410000014]
URINARY PROBLEM [563]
URINARY FREQUENCY [160605]
URINARY INCONTINENCE [349]
URINARY RETENTION [160607]
URINARY SYMPTOM [553]
URINARY URGENCY [343]
URINE LEAKAGE [403]
ABNORMALITY OF URINE [785]
BLOOD IN URINE [160279]
DIFFICULTY URINATING [160606]

Plan/disposition: Intake UTI PLAN

Chief complaint: CALLER with complaints of possible UTI.
Onset: ONSET OF SYMPTOMS.
Emergent/Urgent symptoms: INTAKE UTI EMERGENT SYMPTOM.
Signs/symptoms/ROS: INTAKE UTI SIGNS AND SYMPTOMS
Fever: TEMP AT HOME

Last menstrual period: LMP

Pertinent History: INTAKE UTI PERTINENT HX
Have you taken AZO/cranberry tabs/OTC medication in the last several days? YES/NO

SHORTNESS OF BREATH [100001]

SHORTNESS OF BREATH [948]

RESPIRATORY DISTRESS [160490]

URI [115]

COUGH [28]

CHRONIC COUGH [210019]

COUGING UP BLOOD [160280]

CROUP [160671]

Plan/disposition: Intake Cough/Cold Plan

Chief Complaint: Caller *** with complaint of upper respiratory symptoms.
Onset: Onset of Symptoms
Exposures: Intake Cough/Cold Exposures
COVID Testing: Testing was done on ***. The results were Intake Cough/Cold Covid Test Results
Emergent Symptoms: Intake Cough/cold EMERGENT SYMPTOMS
Signs/symptoms/ROS: Intake Cough/Cold SIGNS AND SYMPTOMS
Mucous/drainage: Intake Cough/Cold Mucous/Drainage
Fever: Temp at Home

Pertinent History: Intake Cough/Cold Pertinent Hx
Have you taken OTC medication in the last several days? Cough/Cold OTC

ALLERGIC REACTION [160030]
HIVES [56]
ITCHING [160476]
VARICELLA [160659]
CHEMICAL EXPOSURE [160094]
POISON SUMAC [146]
POISON OAK [145]
POISON IVY [160460]
ECZEMA [2090000002]
SKIN DISCOLORATION [160729]
SKIN PROBLEM [270]
SKIN RASH [871]
RASH [160482]

Plan and disposition: TRIAGE RASH DISPOSITION .

Chief Complaint: CALLER calling with complaints of rash.
Location of rash: TRIAGE LOCATION ON BODY

Emergent Symptoms: TRIAGE RASH EMERGENT SYMPTOMS
Fever: TRIAGE RASH FEVER ASSESSMENT
Onset of rash: ONSET OF SYMPTOMS
Signs and symptoms/ROS: RASH DESCRIPTORS
Description of rash: TRIAGE RASH APPEARANCE

Pertinent Hx: TRIAGE RASH PERTINENT HX .
Current home treatment: TRIAGE RASH CURRENT TX .
Effectiveness of current treatment: EFFECTIVE/INEFFECTIVE .

HUMAN BITE [160300]

FOREIGN BODY IN SKIN [160486]

ALLERGIC TO INSECT BITES AND STINGS [793]

TICK REMOVAL [160576]

SNAKE BITE [160529]

ANIMAL BITE [87]

BITE [153]

INSECT BITE [160314]

TICK BITE [1011]

Plan and disposition: TRIAGE INSECT BITE PLAN

Chief Complaint: CALLER TYPE OF INSECT

Location of bite: TRIAGE LOCATION ON BODY
Emergent symptoms: TRIAGE INSECT BITE EMERGENT SYMPTOMS

Injury occurred/onset: ONSET OF SYMPTOMS
Circumstances surrounding injury: TRIAGE INJURY CIRCUMSTANCES SURROUNDING
Associated symptoms/ROS: TRIAGE INSECT BITE ASSOCIATED SYMPTOMS
Pertinent hx: TRIAGE INSECT BITE PERTINENT HX
Current home treatment: TRIAGE INSECT BITE CURRENT HOME TX
Effectiveness of current home tx: EFFECTIVE/INEFFECTIVE

CONSTIPATION [160431]

GI PROBLEM [160246]

BLOATED [160071]

ABDOMINAL INJURY [110001]

ABDOMINAL CRAMPING [110000]

ABDOMINAL PAIN [110002]

Disposition/plan: TRIAGE DISPOSITION

Chief complaint: CALLER calling with complaint of abdominal pain.
Onset: ONSET OF SYMPTOMS.
Emergent/Urgent symptoms: TRIAGE ABD PAIN EMERGENT SYMPTOMS
LMP: TRIAGE LMP
Location: ABDOMEN LOCATION (PEDS EXAM)
Intensity of pain: TRIAGE INTENSITY
Quality of pain: TRIAGE PAIN CHARACTER
Associated symptoms/ROS: TRIAGE ABD ASSOCIATED SYMPTOMS
Travel: Have you traveled outside the United States within the last 3 weeks? 37396
Hydration: TRIAGE HYDRATION ASSESSMENT
PO intake: PO INTAKE

Pertinent history: TRIAGE PERTINENT HX FOR abd pain/DIARRHEA/VOMITING
Current home TX: OTC/Medications- OTC GI MEDS
Effectiveness of home treatment: EFFECTIVE/INEFFECTIVE

- PALPITATIONS [100004]
- BRADYCARDIA [160526]
- DYSPEPSIA [584]
- GASTROESOPHAGEAL REFLUX DISEASE [572]
- GERD [160679]
- RAPID HEART RATE [160481]
- IRREGULAR HEART BEAT [160319]
- HEARTBURN [160690]
- HEART PROBLEM [54]
- PAIN WITH BREATHING [160459]
- CHEST INJURY [160096]
- CHEST WALL PAIN [756]
- CHEST PAIN [100000]

Chief complaint: CALLER *** calling with complaints of Chest pain.

Onset: ONSET OF SYMPTOMS
Emergent/Urgent symptoms: TRIAGE CHEST PAIN EMERGENT SYMPTOMS
Location: CHEST LOCATION
Intensity of pain: TRIAGE INTENSITY
Quality of pain: TRIAGE PAIN CHARACTER
Pertinent history: TRIAGE CHEST PAIN PERTINENT HX
Current home tx: TRIAGE CHEST PAIN CURRENT HOME TX
Effectiveness of home tx: EFFECTIVE/INEFFECTIVE

MORNING SICKNESS [160394]

NAUSEA/VOMITING IN PREGNANCY [544]

HYPEREMESIS GRAVIDARUM [120016]

VOMITING DURING PREGNANCY [160623]

VOMITING BLOOD [160278]

HEMATOCHEZIA [253]

BLACK OR BLOODY STOOL [160386]

DIARRHEA [35]

NAUSEA AND VOMITING [949]

VOMITING [120]

Disposition: TRIAGE DIARRHEA VOMITING DISPOSITION

Chief Complaint: CALLER *** . calling with complaint of (diarrhea and/or vomiting)
Onset: ONSET OF SYMPTOMS .
Emergent/Urgent Symptoms: Intake Diarrhea/Vomiting Symptoms
Frequency and consistency of (Diarrhea, vomiting): TRIAGE FREQUENCY AND CONSISTENCY
Fever: TEMP AT HOME
Travel: Have you traveled outside the United States within the last 3 weeks? Travel, yes/no
Hydration: TRIAGE HYDRATION LIST
PO intake: PO INTAKE
Pertinent history: TRIAGE PERTINENT HX FOR abd pain/DIARRHEA/VOMITING
Current home treatment: ***
Effectiveness of current home treatment: ***

DISC DISORDER [400]

NECK PAIN [160423]

MUSCLE PAIN [160406]

SPINE INJURY [1040000013]

BACK INJURY [155]

BACK PROBLEM [203]

BACK PAIN [12]

Plan/Disposition: TRIAGE BACKPAIN PLAN 2

Chief complaint: CALLER *** calling with complaint of back pain.
Onset: ONSET OF SYMPTOMS .
Emergent/Urgent symptoms: TRIAGE BACK PAIN EMERGENT SYMPTOMS
Location: TRIAGE LOCATION BACK PAIN
Intensity: TRIAGE INTENSITY BACK PAIN
Quality of pain: TRIAGE BACKPAIN CHARACTER
Associated symptoms/ROS: TRIAGE BACKPAIN ASSOC SX
Precipitating event: TRIAGE BACKPAIN PRECIPITATING EVENT
Pertinent History: TRIAGE BACKPAIN PERTINENT HX 2
Current home TX: TRIAGE BACKPAIN CURRENT HOME TX
Effectiveness of home TX: EFFECTIVE/INEFFECTIVE

PRESSURE BEHIND THE EYES [130035]

BLURRED VISION [130003]

EYE TRAUMA [130016]

EYE STRAIN [130018]

EYE PAIN [130017]

NEUROLOGIC PROBLEM [71]

SINUS PROBLEM [99]

RECURRENT SINUSITIS [390]

FACIAL PAIN [160194]

SINUSITIS [160713]

MORNING HEADACHE [703]

TRAUMATIC BRAIN INJURY [700]

HEAD LACERATION [160267]

HEAD INJURY [137]

MIGRAINE [160698]

HEADACHE [52]

Plan/disposition: TRIAGE HEADACHE DISPOSITION

Chief Complaint: CALLER calling with complaint of headache.
Onset: ONSET OF SYMPTOMS.
Emergent/Urgent Symptoms: TRIAGE HEADACHE EMERGENT SYMPTOMS.
Signs and Symptoms:
Location: ***
Intensity: TRIAGE HEADACHE INTENSITY
Pain Character: TRIAGE HEADACHE PAIN CHARACTER
Frequency: TRIAGE HEADACHE FREQUENCY
Associated Symptoms/ROS: TRIAGE HEADACHE ASSOC SYMPTOMS
Pertinent History: TRIAGE HEADACHE PERTINENT HX.
Current Home Treatment: ***
Effectiveness of Home Treatment: ***

ALCOHOL PROBLEM [3]

ADDICTION PROBLEM [160016]

DRUG PROBLEM [37]

DRUG/ALCOHOL DEPENDENCY [408]

HOMICIDAL [160299]

SELF HARM - DELIBERATE [160830]

PSYCH [697]

EMOTIONAL CRISES PSYCHOSOCIAL SUPPORT FOR SERIOUSLY I..

DELUSIONAL [160723]

PANIC ATTACK [160443]

MANIC BEHAVIOR [160380]

ALTERED MENTAL STATUS [160032]

AGITATION [160018]

AGGRESSIVE BEHAVIOR [160017]

BEHAVIOR PROBLEM [298]

SUICIDE ATTEMPT [160556]

SUICIDAL [160555]

ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED ..

ANXIETY [9]

DEPRESSION [32]

BH ADULT TRIAGE PATIENT/GUARDIAN calling with behavioral health concern.
What is your current location? ***
What is the best number to reach you if we get disconnected? ***
Is anyone there with you? BH IS ANYONE WITH YOU

Chief Complaint/Symptoms: BH CC/SX
Do you have a current behavioral health provider (therapist, psychiatric nurse practitioner, psychiatrist)?: CURRENT BH PROVIDER

Active SI/HI remain on the line and have someone Call 911
Homicidal or Suicidal Ideation:
Do you have any thoughts of hurting yourself or others? BH HOMICIDAL IDEATION

Domestic Violence:
Are you currently in a relationship with someone who is abusive or threatening? BH DOMESTIC VIOLENCE
Do you have concerns about your safety at this time? BH SAFETY

Suicide Prevention: Keeping our Patients Safe in Ambulatory Clinics

February 2025

Suicide Prevention in Ambulatory

Goal

To enhance knowledge on the ambulatory workflow related to conducting suicide risk screening and implementation of appropriate strategies to prevent suicide.

Learning Objectives

The learner will

- Verbalize the ambulatory suicide risk screening process
- Verbalize who should be screened for suicide risk
- Discuss/Demonstrate appropriate suicide prevention strategies to be implemented in the Ambulatory setting

Ligature Risks Awareness

- Ligature Risk: anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation
  - Some examples, include:
    - Coat hooks
    - Pipes
    - Radiators
    - Window and door frames
    - Handles
    - Hinges
    - Faucets
    - Belts
    - Sheets/towels
- Caregivers should be aware of ligature risk and ensure safe environment when a patient expresses suicidal ideation

Ambulatory Suicide Risk Screening Workflow

Who is screened for suicide risk?

1. Patients being evaluated or treated for a behavioral health condition as the primary reason for care

2. Patients who express suicidal ideation or suicidal behavior, either directly, through collateral report

(during rooming or a conversation with caregiver), or on a depression screen tool (PHQ-9, Edinburgh Post-Natal Depression Screen-EPDS)*

***PHQ-9 is completed in Primary Care with all new patients, annual physicals, and/or behavioral health as primary reason for visit**

Note: If a patient in any clinic tells you they are having thoughts of harming themselves- SCAN!

Stay with the patient

Call for Help

Alert the Provider

Next, provider completes the suicide risk screener

Who screens patients for suicide risk in Primary Care and Women's Health?

During the Rooming process (or via electronic questionnaire pre-visit)

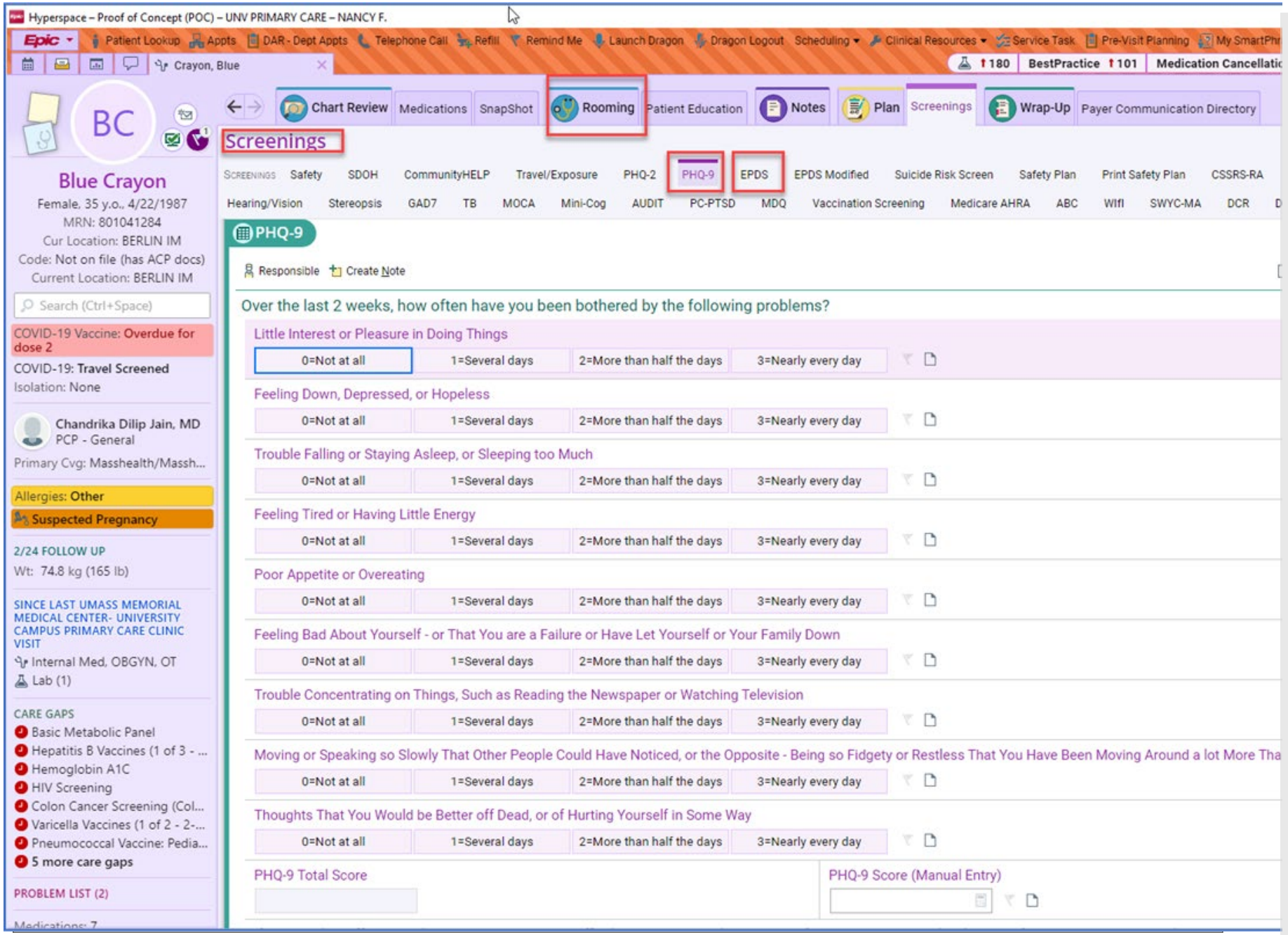
In Primary Care clinics, all patients that are 12 years of age and older are screened for depression by the MA or Nurse using the PHQ-9 Questionnaire

In some Women's Health clinics, patients are screened for depression by the MA or Nurse using the EPDS tool

The MA or Nurse enters the PHQ-9 findings into the Electronic Medical Record (EMR)/EPIC (either from paper questionnaire or verbal collection of PHQ-9/EPDS (must answer each statement)

If a patient screens positive for suicidal ideation on the PHQ-9 or EPDS an Our Practice Advisory (OPA) fires for the Provider

The Provider is responsible for acting on the OPA or for identifying the patient's level of risk for suicide and referring or creating a mitigation plan



PHQ-9 can be found in the Rooming tab, under Screenings

Edinburgh Postnatal Depression Scale: In the Past 7 Days

I have been able to laugh and see the funny side of things.

3=Not at all	2=Definitely not so much now	1=Not quite so much now	0=As much as I always could

I have looked forward with enjoyment to things.

3=Hardly at all	2=Definitely less than I used to	1=Rather less than I used to	0=As much as I ever did

I have blamed myself unnecessarily when things went wrong.

3=Yes, most of the time	2=Yes, some of the time	1=Not very often	0=No, never

I have been anxious or worried for no good reason.

3=Yes, very often	2=Yes, sometimes	1=Hardly ever	0=No, not at all

I have felt scared or panicky for no good reason.

3=Yes, quite a lot	2=Yes, sometimes	1=No, not much	0=No, not at all

Things have been getting on top of me.

3=Yes, most of the time I haven't been able to cope at all	2=Yes, sometimes I haven't been coping as well as usual	1=No, most of the time I have coped quite well	0=No, I have been coping as well as ever

I have been so unhappy that I have had difficulty sleeping.

3=Yes, most of the time	2=Yes, sometimes	1=Not very often	0=Not at all

I have felt sad or miserable.

3=Yes, most of the time	2=Yes, quite often	1=Not very often	0=No, not at all

I have been so unhappy that I have been crying.

3=Yes, most of the time	2=Yes, quite often	1=Only occasionally	0=No, never

The thought of harming myself has occurred to me.

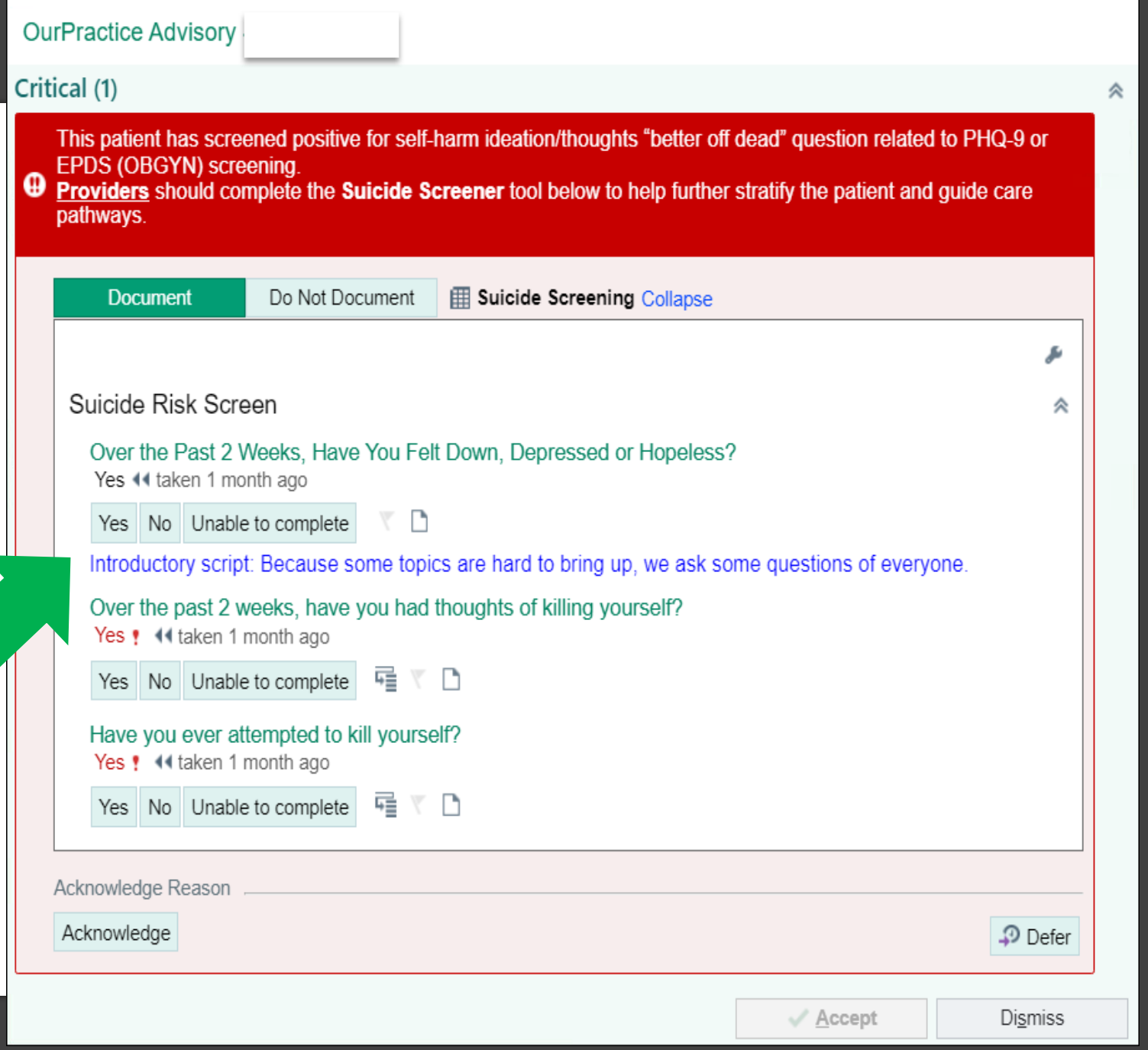
3=Yes, quite often	2=Sometimes	1=Hardly ever	0=Never

EPDS Total

EPDS can be found in the Rooming tab, under Screenings

OPA that fires for Provider with positive PHQ-9 or EPDS

Provider to complete Suicide Screen



Patient expresses suicidal ideation in Ambulatory Clinics

During the Rooming process (or while in clinic)

If patient shares thoughts of suicidal ideation or suicidal behavior

The MA or Nurse to **SCAN**

SCAN

Stay with the patient

Call for Help

Alert the Provider

Next, provider completes the suicide risk screener

Patient expresses suicidal ideation in Ambulatory Clinics

The Provider to complete the Suicide Risk Screen

The Provider is responsible for determining appropriate plan of care for patient and/or referral for care

What Happens After the Suicide Risk Screen is Complete?

- The Provider completes the Suicide Risk Screen to help determine appropriate plan of care for patient and/or referral for care
- A risk strata (category) is then determined
  - Negligible, Mild, Moderate, High
- If mild or higher, Provider confirms patient's and primary contact's contact information
- Provider then follows the Care Pathway associated with the risk strata (category)

Suicide Risk Strata

Mild Risk	Moderate Risk	High Risk
Medical Provider: Consider the following actions: a. Offer patient a referral to a BHP b. Readminister suicide risk screener as patient's condition warrants *Behavioral Health Provider*: a. Offer patient a follow-up behavioral health appointment or have member of the treatment team reach out by phone within 10 days. b. Develop and/or reinforce safety plan, as appropriate c. Complete CSSRS Risk Assessment when the patient's clinical condition allows it Readminister suicide risk screener as patient's condition warrants	*Medical Provider*: Consider the following actions: a. If BHP on site and if they have access: consult for same day evaluation or make a next day appointment. b. If no BHP on site or if no prompt access: Call 988 (24/7, can quickly help triage risk, find help) Transfer to ED, if BHP or ESP deems it necessary (ambulance, family member, or caregiver) c. Readminister suicide risk screener as patient's condition warrants *Behavioral Health Provider*: a. Consider escalating the intensity of treatment or changing or adding treatment modality b. Develop and/or reinforce safety plan, as appropriate c. Complete CSSRS Risk Assessment when the patient's clinical condition allows it d. Readminister suicide risk screener as patient's condition warrants	*Medical Provider*. a. Do not leave the patient alone, ensure immediate environment is safe, and consider the following actions: b. If BHP on site and if they have access: consult for same day evaluation, with suicide risk assessment and safety plan, if feasible. c. If no BHP on site or if no prompt access: call 988 (24/7, can quickly help triage risk, find help) d. Consider engaging security or police per clinic protocol e. Transfer to ED, if BHP or ESP deems it necessary (ambulance, family member, or caregiver) f. Readminister suicide risk screener as patient's condition warrants *Behavioral Health Provider*. a. Do not leave the patient alone, ensure immediate environment is safe, and consider the following actions: b. Consider calling 988 (24/7, can quickly help triage risk, find help). If ESP is not appropriate or possible, consider transfer to University ED c. Consider engaging security or police per clinic protocol d. Complete CSSRS-RA and/or Safety plan when the patient's clinical condition allows it e. Offer patient a follow up behavioral health appointment or have a member of the treatment team reach out by phone within 10 days.

Telephone workflow

- Obtain Patient information
  - Can you tell me your name, location, date of birth and phone number?"
    "Can you tell me the best number to reach you at as well as your location in case we get disconnected?"
- Ask Patients why they are calling:
  - "Could you please tell me why you are calling?"
  - Examples of Patients at immediate Suicide Risk
    "I am standing on a bridge, and am going to jump into the lake"; "I'm going to take all these pills now"; "I have a gun to my head"; "I need help right now"
  - Examples of Patients who may not be in immediate danger
    "I *wish I was dead"; "I'm thinking of taking some pills"; "I want to end it all"; "I need help"; "I'm sad and want to talk to someone"*
- If/when the nurse is immediately available
  - EBEEP the nurse and keep the caller on the phone
  - Express concern: "I am very sorry to hear you are having such a rough time. I want to get you some help".
    Obtain permission to place caller on hold: "Now, I am sorry for this, but I will have to put you on hold for a little while, because I need to try and get the best service to help you. Is that OK? OK, great, please don't hang up. If it takes a while, I'll try to check back in with you to let you know what's happening. If we get disconnected for some reason, I'll call you back at the number you gave me."

Telephone workflow

- **If patient is an immediate suicide risk:**
  - **Dial 911** (or 9-911 or your emergency #) and keep the caller on the phone- DO NOT put the patient on hold or transfer the call
- **If the patient verbalizes that they are thinking about killing themselves but are not in immediate danger**
  - **Call 988-** Suicide and Crisis Lifeline and keep patient on the phone until a warm-handoff can be provided
    Make sure to check in with patient if the transfer takes a while
- **Notify**
  - The patient's Health Care Provider (HCP/PCP) or specialty physician
  - Via an in-basket message, a phone call, or Epic secure chat regarding patient's situation so the Provider is aware and can follow-up if available.
  - Please include steps taken, for example 988 called or patient connected to Emergency Services Program

In Review

- Suicide is one of the leading causes of death, leading to 45,000 deaths each year
- UMass Memorial Medical Center has a multidisciplinary approach to improve suicide screening and prevention with patients at risk for self-harm and/or suicidal ideation
- Ambulatory MAs and Nurses screen patients per policy for depression
- If a patient screens positive for suicidal ideation, a BPA fires for the Provider to determine suicide risk and a mitigation plan
- A risk category will be determined from the Suicide Risk Screen
- Ambulatory MAs, Nurses, and Providers work together to implement appropriate strategies to keep the patient safe

Resources

- Procedure (2023): Suicide Risk Screening in Ambulatory Care
- Workflow, Job Aids, FAQs: Suicide Prevention in Ambulatory | The Hub (umassmemorialhub.org)