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Improving Suicide Risk Detection and Management in Primary Care

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Executive Summary: Clinical Practice Guideline

Improving Suicide Risk Detection and Management in Primary Care

by

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Summary

Suicide remains a significant public health concern in the United States, with rates increasing over the past decade despite national prevention efforts. The lack of standardized, evidence-based screening and safety planning protocols in primary care contributes to missed opportunities for timely intervention. This project aimed to address this gap by implementing a clinical practice guideline (CPG) to improve the identification and management of suicide risk within a primary care setting. The practice-focused question asked if implementing a standardized guideline using validated tools improves suicide risk detection and management in primary care. The purpose was to improve the detection and management of suicide risk in primary care using evidence-based strategies aligned with current national guidelines. Analytical strategies included an AGREE II appraisal by five expert panelists, yielding a high overall mean score of 6.5/7, indicating strong methodological quality and endorsement. Following training on the new guideline, descriptive statistics from chart audits showed improved documentation of suicide risk assessments, screening tool usage, and intervention timeliness. Results showed an 83% compliance rate, indicating high early adoption and usability among staff. Most non-compliant cases reflected incomplete documentation rather than omission of screening. Thematic analysis of provider feedback revealed themes of usability, effectiveness, and implementation barriers. Findings demonstrated enhanced screening practices, positive provider perceptions, and expert support. The CPG aligns with organizational goals for patient safety, and suicideprevention, by promoting culturally competent, evidence-based care. It supports positive social change by reducing stigma and fostering a more inclusive and responsive health care environment.

Background

Suicide is the 11th leading cause of death in the United States, disproportionately affecting marginalized populations (Centers for Disease Control and Prevention, 2023). Primary care providers (PCPs) often encounter at-risk patients but frequently lack standardized tools and protocols, contributing to under-detection of risk (National Action Alliance for Suicide Prevention [NAASP], 2021). This project addressed the gap in practice by implementing a CPG designed to improve suicide risk identification and management.

The following practice-focused question emerged from this gap: What evidence-based interventions can improve suicide risk detection and management in primary care? National guidelines recommend validated tools such as the Patient Health Questionnaire-9 (PHQ-9), Columbia-Suicide Severity Rating Scale (C-SSRS), and Safety Planning Intervention (SPI; American Psychiatric Association, 2023; Substance Abuse and Mental Health Services Administration, 2020). These tools are supported by high-quality evidence from randomized controlled trials and systematic reviews, as indicated by a GRADE rating. The implementation of this CPG was supported by evidence from these sources, demonstrating the efficacy of these tools in identifying and addressing suicide risk.

Clinical Practice Guideline Development

An expert panel of five professionals reviewed the draft CPG. The panel included two board-certified psychiatrists, two family nurse practitioners with QI expertise, and one licensed clinical social worker specializing in suicide prevention. Panelists were selected for their clinical and academic expertise in suicide prevention and primary care.

The AGREE II instrument evaluates the quality of clinical practice guidelines across the following six domains (Brouwers et al., 2017):

1. **Scope and Purpose**

   Assesses the overall aim of the guideline, specific health questions, and the target population.

2. **Stakeholder Involvement**

   Examines the degree to which the guideline represents the views of its intended users, including relevant professionals and patients.

3. **Rigor of Development**

   Evaluates the process used to gather and synthesize evidence, and the methods for formulating and updating recommendations.

4. **Clarity of Presentation**

   Assesses the language, structure, and format of the guideline, ensuring recommendations are specific and unambiguous.

5. **Applicability**

   Considers the likely barriers and facilitators to implementation, strategies to improve uptake, and resource implications.

6. **Editorial Independence**

   Evaluates whether the content is free from bias due to competing interests or funding sources.

The panel rated domains on a 7-point Likert scale and provided qualitative feedback as well. Suggested edits focused on clarifying workflow steps and enhancing cultural competency language. The CPG was revised based on the feedback received from the expert panel to ensure it was clear, feasible, and culturally sensitive.

The guideline was both developed and implemented within a primary care setting to improve suicide risk assessment practices. Development was guided by a comprehensive review of current evidence-based sources, including recommendations from the Substance Abuse and Mental Health Services Administration (SAMHSA), The Joint Commission, American Psychiatric Association (APA) guidelines, and peer-reviewed literature on validated screening tools such as the PHQ-9 and Columbia-Suicide Severity Rating Scale (C-SSRS).

Following development, the guideline was implemented through provider education, integration of the tools into clinical workflows, and follow-up support. To evaluate implementation outcomes, a total of 50 patient charts were reviewed for pre- and post-implementation. The chart audit revealed a significant improvement in the documentation of suicide risk assessments, consistent use of screening tools, and appropriate follow-up plans when risk was identified. These findings suggest that the guideline enhanced provider's adherence to evidence-based suicide prevention practices.

Results

The expert panel scored the CPG highly across all AGREE II domains, with an overall mean score of 6.5/7. Table 1 shows domain scores, and Figure 1 illustrates the overall agreement. Panel comments noted the guideline’s clarity, feasibility, and alignment with evidence-based recommendations. Stakeholder review with end-users (PCPs and clinical staff) yielded positive feedback, citing improved confidence in addressing suicide risk

and appreciation for integrated EMR prompts. The adoption of this CPG is expected to enhance patient safety, strengthen organizational compliance with The Joint

Commission's 2024 National Patient Safety Goals, and improve provider engagement with suicide prevention.

Limitations included the small pilot sample, potential provider resistance, and the short timeline, which limited long-term outcome data. However, the project's implications extend beyond the local site by providing a scalable, evidence-based model for other primary care settings.

Table 1

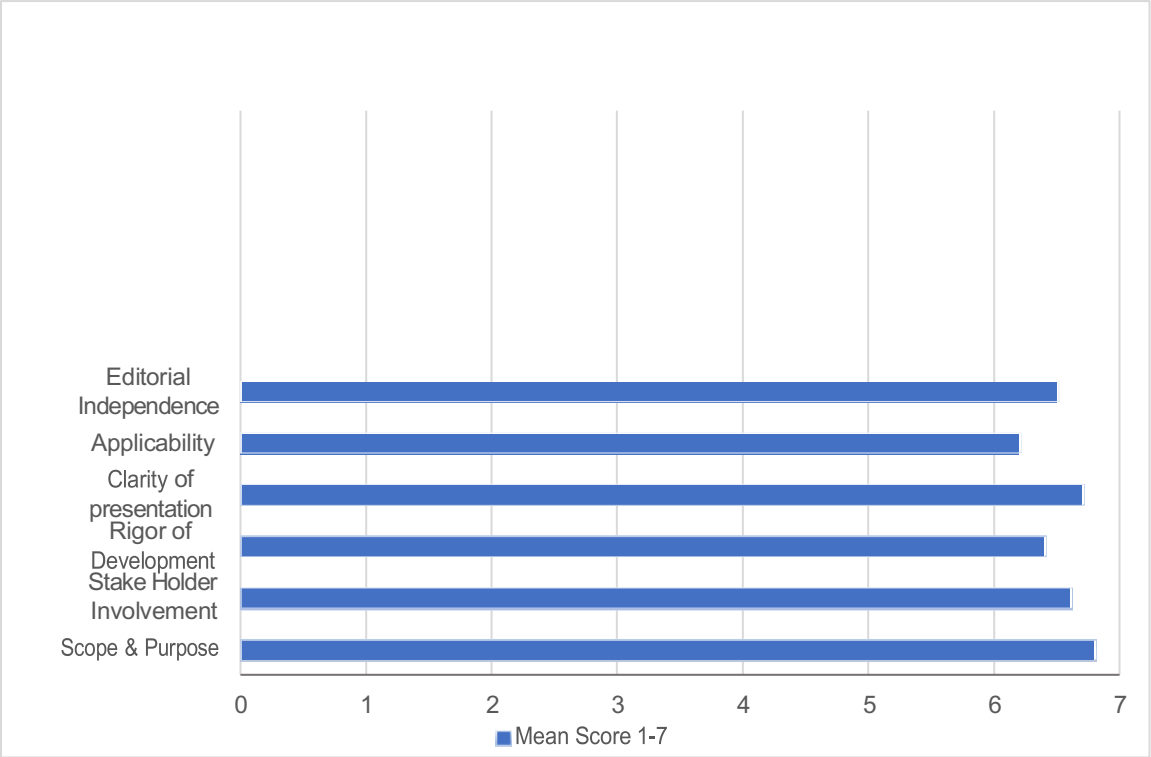
AGREE II Domain Scores

Domain	Mean
Scope & Purpose	6.8
Stakeholder Involvement	6.6
Rigor of Development	6.4
Clarity of Presentation	6.7
Applicability	6.2
Editorial Independence	6.5

Note. Scores are on a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree).

Figure 1

Overall Expert Panel Agreement on CPG Quality.



Note. Scores reflect expert panel ratings of the CPG across AGREE II domains on a 7-point Likert scale (1 = strongly disagree, 7 = strongly agree).

The Guideline

The guideline instructs the use of a centralized suicide risk-assessment tool tab within the EMR (See Table 2). It incorporates two validated tools: the Columbia-Suicide Severity Rating Scale (C-SSRS) for suicide risk screening, and the Safety Planning Intervention (SPI) for brief, collaborative safety planning. Detailed instructions for both tools are embedded directly within each EMR form to support provider ease of use. Staff access the tools through the “Suicide Risk Assessment” tab located in the behavioral

health section of the EMR. Currently, tools are available in English only. Expansion to additional languages will be considered based on population needs.

The guideline was implemented through a pilot phase that included training sessions for clinical staff and primary care providers. The implementation of the guidelines followed a structured pilot phase utilizing an evidence-based training approach to ensure fidelity and sustainability. Five clinical staff members participated in the intervention, including the primary care provider, a nurse, two medical assistants, and front-desk staff engaged in screening workflows. Training was delivered through two structured sessions, each lasting approximately 30 minutes, over two weeks, to facilitate repetition, skill reinforcement, and integration into routine practice. Current best practices in depression screening inform the curriculum. It included an overview of evidence-based screening guidelines and the rationale for early detection to improve population health outcomes. Instruction emphasized the correct administration and scoring of standardized tools, including the PHQ-9 and Columbia Suicide Severity Rating Scale, followed by role-playing exercises designed to enhance clinical communication skills and confidence when addressing positive screens.

Additional components focused on documentation and referral workflows within the electronic health record, risk stratification, and escalation protocols, including guidance on when to involve the covering psychiatrist or activate emergency procedures. Training also reinforced confidentiality, informed consent, and patient-centered communication principles to promote ethical and culturally sensitive care. To evaluate learning outcomes, participants completed a brief post-training knowledge assessment. They engaged in a structured feedback session, which informed iterative refinements to the workflow before full-scale implementation.

To determine adherence, a chart of audits of 50 patient records was conducted. Results showed an 83% compliance rate, indicating high early adoption and usability among staff. Most non-compliant cases reflected incomplete documentation rather than omission of screening. Staff document all assessment results, safety plans, and referrals directly in the EMR. Providers are instructed to follow up with patients within 24 hours if a risk is identified or if any part of the safety plan requires timely intervention. EMR prompts to support this workflow by flagging follow-up tasks in the provider's dashboard. This structured process ensures consistent, timely screening and follow-up for suicide risk, and empowers staff with tools that are both evidence-based and practical within primary care

Table 2

Guideline Components

Component	Details
Target	Adult 18+ in Primary Care
Objective	Standardized suicide risk screening, assessment and safety training
Tools Used	PHQ-9 (depression + suicide ideation) C-SSRS (severity), SPI (planning)
Workflow Steps	Annual PHQ-9 → C-SSRS if indicated → SPI → Electronic Medical Record (EMR) documentation → referrals as appropriate.
Follow-up Timing	High-risk: within 1 week; Moderate-risk: within 2–4 weeks.
Cultural Competence	Emphasizes linguistically and culturally tailored services for underserved populations.
Review Cycle	Reviewed every 3 years or as new evidence emerges.

Conclusions

This project positively impacts organizational priorities by improving suicide risk detection and safety planning in primary care. Recommendations include ongoing staff training, periodic audits, and EMR integration enhancements. Potential implications for nursing practice include advancing evidence-based, patient-centered care, fostering DEI by addressing disparities in mental health care access, and promoting positive social

change by reducing stigma and preventable deaths. Evaluation methods such as AGREE II reviews and longitudinal tracking of outcomes will support sustainability and continuous improvement. The use of a standardized CPG provides a framework for nurses and other healthcare providers to consistently assess and manage suicide risk, ultimately improving patient outcomes and contributing to a safer healthcare environment.

References

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The Joint Commission. (2024). National patient safety goals, effective January 2024, for the hospital program. https://www.jointcommission.org/standards/national-patient-safety-goals/

Adult Suicide Prevention Guideline for Primary Care Settings

This clinical practice guideline (CPG) provides evidence-based recommendations for the screening, risk assessment, and safety planning of adult patients at risk for suicide in primary care settings. The CPG is intended for use by primary care providers (PCPs), registered nurses, and clinical support staff.

Target Population: Adults (18 years and older) presenting in primary care settings.

Objective: To improve the detection and management of suicide risk among adults in primary care, standardize care practices, and enhance patient safety.

Recommended Tools:

Patient Health Questionnaire-9 (PHQ-9): Administered to all adult patients at intake or annual visits to screen for depression and assess item 9 for suicidal ideation.

Columbia-Suicide Severity Rating Scale (C-SSRS): Used for patients with positive PHQ-9 item 9 response or other identified risk factors to assess severity and immediacy of risk.

Safety Planning Intervention (SPI): Completed collaboratively with patients identified at moderate or high risk to reduce immediate danger and provide coping strategies and crisis contacts.

Workflow Summary:

1. Screen all adult patients annually using PHQ-9.
2. If PHQ-9 item 9 is positive (score ≥1) or if risk factors/concerns arise, administer C-SSRS.
3. If C-SSRS identifies moderate/high risk, complete SPI and discuss follow-up plan.
4. Document all findings, risk level, and safety plan in the electronic medical record (EMR).
5. Provide crisis resources and referrals as needed.

Follow-up: Schedule follow-up within 1 week for high-risk patients and within 2–4 weeks for moderate-risk patients. Ensure warm hand-offs to behavioral health when appropriate.

Cultural Competence: Providers should incorporate culturally and linguistically appropriate services, recognizing disparities in suicide risk and access to care among minority and underserved populations.

Periodic Review: This guideline should be reviewed and updated every 3 years or as new evidence and guidelines emerge.

For more information, refer to the American Psychiatric Association Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors (APA, 2023) and the National Guidelines for Behavioral Health Crisis Care from SAMHSA (2020).