Atrium Health Care Pathway Program Summary

Patients are selected for the Atrium Health Zero Suicide Pathway Program based on the results of their Columbia Suicide Severity Rating Scale (C-SSRS) or through direct referrals from the inpatient treatment team.

Patients are enrolled prior to discharge from the inpatient setting, after being assessed by the Pathway team for suicide risk and a review of their safety plan. Clinicians from the Pathway team initially contact the patient virtually or in person while they are on the inpatient unit. This develops rapport and begins the seamless connection and transition to their outpatient care.

The second contact with the patient is made within the first 24 hours after discharge. The clinician continues frequent phone, text, and mail contact with the patient until they are fully engaged in outpatient treatment. This outreach helps support patients through goal setting/treatment plans, medication support, connection to community resources, and safety planning.

Clinicians help patients identify barriers to outpatient follow up and remove the barriers. They also engage the patient's family members and/or emergency contacts to offer further support to the family and to identify any additional constraints that may arise. If a patient endorses any safety concerns, the licensed clinician assesses the patient and either adjusts the safety plan to address current concerns or refers the patient for immediate care. Emergency resources such as mobile crisis or the police will be contacted if indicated.

Usually, clinicians follow up with these patients for about 30-45 days after discharge from the inpatient units. Currently we are only working with adults and primarily referrals from our BH Davidson facility; however we are hoping to expand and work with kids in the near future. We have put in a proposal for a grant to help with this endeavor.