Summary of Technical Expert Panel Evaluation of Measures

(Deliverable 4-3)

December 17, 2025

Behavioral Health Measures Development & Inpatient and Outpatient Measures Maintenance Project Team

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Contents

I. Background

The Centers for Medicare & Medicaid Services (CMS) tasked the Mathematica Behavioral Health Measures Development & Inpatient and Outpatient Measures Maintenance (BHIOMM) project team to develop the Post-Discharge Safety and Follow-up Plan for Patients with Suicidal Ideation (Safety and Follow-up Plan) measure under contract 75FCMC18D0032, task order 75FCMC24F0136. The BHIOMM project team conducted a literature review and led interviews with clinicians and individuals with lived experience to inform the initial measure specifications. The BHIOMM project team then convened a technical expert panel (TEP) on December 10, 2025, to review the measure components and assess face validity. The BHIOMM project team will use the feedback from the TEP to refine the measure specifications and inform upcoming testing activities.

II. Responsibilities of the TEP

The BHIOMM project team organized the project TEP to consist of standing members supporting the duration of the five-year project and supplemental members serving a one-year term with expertise specific to the clinical area of new measure development for the year. The TEP includes psychiatrists, psychologists, nurses, and experts in measurement science and data sources. The TEP also includes individuals with behavioral health lived experience who have chosen to remain anonymous and submit feedback separately from group meetings.

The BHIOMM project team convenes the TEP throughout the BHIOMM contract to contribute direction and thoughtful input on Mathematica's work and analysis. The TEP's responsibilities include:

- Providing expert insight to inform measure development
- Reviewing and interpreting findings from measure testing
- Offering feedback to project team on implementation considerations
- Contributing guidance to support ongoing measure maintenance

Table II.1 lists the TEP members invited to the December 10, 2025, meeting and their organizational affiliations.

Table II.1. BHIOMM TEP names, affiliations, and attendance

Name, title	Organization	Attendance
Larry Epp, EdD, LCPC	Sheppard Pratt Health System	Present
Julia Jung, RN	Los Angeles Jewish Health	Absent
Hossam Mahmoud, MD	Carelon Health	Present
Stacy Miller, MS	Mental Health Outcomes	Present
Claire Mireau, PhD, OTR/L, TPS	MN Department of Human Services	Present
Laura Potts, MBA, MHI, BSN, BA, RN-BC	The Ohio State University Wexner Medical Center	Present

Name, title	Organization	Attendance
Linda Riccio, OT/L, FAOTA	TCM Consulting & Management	Absent
Amelia Sattler, MD	Stanford School of Medicine and Standford Health Care	Present
Simon Weisz, JD, HBA	Greenspace Mental Health, Ltd.	Absent
Pallavi Yadav, MBBS, MHA, CQPA	University of Toledo Medical Center	Present
Alisa Busch, MD, MS*	McLean Hospital	Present
Susan Cutillo, LCSW, LADC, MBA*	Griffin Health	Absent
Matthew Davis, MD, DFAPA*	Riverview Psychiatric Center	Present
Frank Ghinassi, PhD, ABPP*	Rutgers Health University Behavioral Health Care	Present
Caitlin Gillooley, MS*	American Hospital Association	Present
Jill Harkavy-Friedman, PhD*	American Foundation for Suicide Prevention	Present
Karen Johnson, MSW*	Universal Health Services, Inc.	Present
Cindy Mataraso, PsyD*	Crestwood Behavioral Health, Inc.	Present
Lisa Patton, PhD*	Customer Value Partners	Present
Pushpa Raja, MD, MSHPM*	VA Greater Los Angeles Health Care System	Absent
Therese Samarco, LMSW*	Henry Ford Health System	Present
Morgan Shields, PhD*	Washington University in St Louis	Present
Sam Stolpe, PharmD, MPH*	Johnson & Johnson	Absent

* Notation indicates supplemental TEP members serving a one-year term.

III. Meeting summary

The BHIOMM project team convened the TEP virtually on December 10, 2025, and 17 out of 23 TEP members were present. Attendance included 7 of the 10 standing TEP members and 10 of the 13 supplemental TEP members.

III.1. Introduction

The BHIOMM project team opened the meeting by welcoming participants and explaining that the purpose of the meeting was to obtain feedback on the Safety and Follow-up Plan measure to inform specification refinement and upcoming testing. We also provided a brief overview of the project, emphasizing the central role of the TEP in offering expert input on new and existing measures under development for potential use in CMS quality reporting programs. We then conducted the roll call and reviewed any conflicts of interest. No TEP members declared conflicts of interest for this meeting; however, some members noted they are employed by inpatient psychiatric facilities (IPFs) that may report on this measure if implemented in the future.

III.2. Measure overview

The BHIOMM project team presented an overview of the Safety and Follow-Up Plan measure. The measure assesses the percentage of qualifying discharges for which there is documentation at admission or during the hospitalization that the patient had suicidal ideation or risk or a suicide attempt and the patient received a copy of a collaboratively developed post-discharge safety plan and follow-up plan at or prior to the time of discharge. Table III.2 contains the measure description the BHIOMM project team presented and discussed with the TEP.

Table III.2. Safety and Follow-up Plan measure component and description

Measure component	Measure description
Denominator	Eligible discharges for which the patient screened positive for suicidal ideation or risk or had suicide attempt documented at the time of admission or during the hospitalization.
Denominator exclusions	Discharges for which the patient: • Died during the hospitalization, or • Was transferred due to an emergent physical health need, or • Was transferred to another inpatient psychiatric facility, or • Was discharged due to elopement or failure to return from unplanned leave
Numerator	Qualifying discharges for which there is documentation of a collaboratively developed post-discharge safety plan and a follow-up plan at or prior to the time of discharge. The post-discharge safety plan collaboratively developed between clinician and patient contains, at a minimum: 1. Warning signs of impending crisis 2. Internal coping strategies to manage impending crisis 3. People, social settings, and activities that help manage impending crisis 4. Assessment of patient's environment and plan for environment devoid of lethal means (environmental safety) 5. Reason for living 6. Contact list for support or help 7. Crisis hotline phone number(s) and other resources The follow-up plan must contain, at a minimum: 1. Documentation of a scheduled mental health appointment including date and provider/clinic name and contact information. 2. Documentation that a clinician sought permission from the patient to provide essential records to the provider at the time of discharge (e.g., a Release of Information), or patient is transferred within the organization where a release of records is not required for clinicians to have access to patient records. 3. Documentation of a plan for the facility to follow-up with the patient, such as phone call.

The BHIOMM project team informed the TEP that this measure is under development for potential inclusion in CMS's Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program and may be considered for inclusion in other CMS programs in the future. Facilities will collect data from the medical record and submit data through a web-based tool. We noted that the measure is currently in the alpha testing phase,

which includes qualitative assessment to refine specifications and determine suitability for continued investment. As part of this phase, we interviewed clinicians and TEP members with lived experience.

The interviews with TEP members with lived experience provided insights into the experience of safety and follow-up planning during and after an IPF stay. Several overarching themes emerged: (1) the importance of using recovery-oriented, non-stigmatizing language in safety and follow-up plans; (2) strong consensus that safety planning should be collaborative, inclusive, and initiated early in the hospitalization; (3) universal agreement that warm handoffs would strengthen continuity of care despite their absence in current practice; (4) shared emphasis on the value of timely, persistent post-discharge follow-up contact; and (5) mixed views on whether the measure accurately reflects care quality. The BHIOMM team shared these themes with the other TEP members to inform discussion during the meeting on December 10.

III.3. Measure rationale

The BHIOMM project team presented to the TEP the rationale for the measure, emphasizing that safety planning[1] serves as a critical component of psychiatric care because it addresses risks such as suicide and self-harm, thereby improving patient outcomes and reducing preventable harm (National Action Alliance for Suicide Prevention, 2019). We underscored evidence demonstrating that the first week following discharge represents the period of highest suicide risk and that timely follow-up can mitigate this risk (Chung et al., 2017; Olfson et al., 2016; Forte et al., 2019). We also outlined existing implementation gaps, noting that among 1,333 Joint Commission–accredited hospitals, only 19.3 percentage included all key components of safety planning and just 4.0 percentage fully implemented recommended suicide prevention activities at discharge (Chitavi et al., 2024).

The BHIOMM project team also presented evidence of the effectiveness of safety planning and follow-up activities, noting that:

- These activities resulted in an approximately 50 percent reduction in the risk of repeat suicide attempts over 18 months post-discharge (Brown et al., 2005).
- They were associated with a 45 percent decrease in suicidal behaviors over six months and a two-fold increase in outpatient engagement compared with usual care (Stanley, 2018).
- Across 26 studies, they contributed to reductions in suicidal ideation, depression, and hopelessness; fewer hospitalizations; and improved treatment engagement (Ferguson, 2022).
- Studies show that higher levels of patient–clinician collaboration reduce suicidal ideation and, in broader implementation studies, reduce emergency department visits and hospital readmissions (Lohani et al., 2024; Cullen, 2024).

[1] According to the Stanley–Brown Safety Planning Intervention, safety planning is a brief, collaborative clinical intervention in which a clinician and an individual develop a written, prioritized list of coping strategies and sources of support aimed to aims to mitigate acute risk. (suicidesafetyplan.com).

The BHIOMM project team separately shared the measure's logic model that maps the inputs, activities, and outputs that contribute to the desired outcomes and impacts of this measure and requested TEP members review the model offline and provide comments via email.

III.4. Discussion of measure components

Denominator

Defining eligible discharges

The BHIOMM project team opened the discussion on the Safety and Follow-up Plan denominator by asking the TEP members to assess whether the denominator, as currently specified, is clinically appropriate.

- One TEP member noted that patients with severe cognitive impairments—such as advanced autism, dementia, or uncontrolled psychosis—may be unable to understand or carry out a safety plan, raising concerns about the appropriateness of including these individuals in the denominator population.
    - Another TEP member cautioned against excluding patients with cognitive impairments or psychosis, noting that doing so could signal that providers need not adapt safety planning for populations they perceive as "difficult" and could introduce bias by allowing facilities to apply the exclusion too broadly.
- Another TEP member emphasized that not everyone with suicidal ideation is clinically appropriate for a full safety plan and noted that tools like the Stanley–Brown Safety Plan specifically focus on people in crisis rather than individuals who report ideation without intent or planning. However, they stressed the broad concept of safety planning remains valuable and relevant for anyone experiencing suicidal thoughts or behavior, particularly when caregivers are involved.
- One TEP member acknowledged that safety planning is appropriate for patients of all ages with the necessary assistance or support provided.
    - Another TEP member suggested aligning the measure with Joint Commission standards by excluding children under age 12 from required suicide screening and risk assessment.
- Five TEP members agreed that patients admitted for aggression or inability to care for themselves also benefit from safety and follow-up planning, as it supports proactive development of self-management strategies.

Operationalizing suicide risk in the denominator

The BHIOMM project team asked the TEP to provide input on how best to define "risk" within the denominator narrative description.

- One TEP member emphasized the need to clearly define how "risk" is determined, noting variability and potential under-reporting in clinical assessments and suggesting that the measure should specify whether minimal, moderate, or higher levels of risk—as identified through tools

like the Columbia-Suicide Severity Rating Scale (C-SSRS) or clinical judgment—should prompt inclusion. The TEP member noted the complexity of defining risk, as clinicians may hesitate to document concerns that could affect discharge decisions.

  - Another TEP member stressed that if the specification uses the term "risk," it must be clearly operationalized—identifying who determines risk and how levels of severity are defined—while noting that clinicians may still determine a patient to be at risk even when the patient denies suicidal thoughts.

  - One TEP member recommended that the measure specifications specify which suicide screening tool to use—given concerns about accuracy and variability of screening tools—and suggested that, rather than leaving "risk" undefined, the measure could stratify patient populations to support consistency and standardization. In post-meeting email follow-up from three clinicians on the TEP, those members stated their facilities use the Columbia-Suicide Severity Rating Sale (C-SSRS), Ask Suicide-Screening Questions (ASQ), and Assessing & Managing Risk Suicide (AMSR) screening tools.

  - Other TEP members supported a broad interpretation of risk and implementation of safety planning. One TEP member argued that the measure should focus on lifetime risk rather than trying to decide current risk, noting that anyone admitted with suicidal ideation or behavior has elevated ongoing vulnerability and would benefit from a discharge safety plan. Another TEP member agreed that all patients in an IPF are at elevated risk for crisis; they noted that safety planning is designed to be flexible and adaptive, as illustrated in crisis-line models where safety planning is often required for everyone, and suggested that a universal approach could both simplify implementation and ensure broader benefit.

    - In a post-meeting email follow-up, a TEP member stated, "In an ideal world, all patients could benefit from a safety plan, since everyone could potentially be at risk for a mental health crisis or suicidality. But what we are measuring is the use of a best practice in the subset of patients who by professional consensus need it - those who are recently or imminently at risk of suicide."

- One TEP member cautioned that identifying when past suicidal thoughts or behaviors occurred is impractical without an electronic health record and argued for making safety planning a universal process, noting that selective application leads to missed opportunities and undermines the goal of supporting all patients during the high-risk post-discharge period.

Defining timeframe for past suicidal behavior

The BHIOMM project team asked the TEP whether the denominator should define a timeframe for suicide attempt and, specifically, whether a patient who attempted suicide years earlier—but facilities admit for a different reason—should receive a safety plan.

- One TEP member recommended narrowing the denominator to patients admitted specifically with suicidal ideation or attempt, emphasizing that a tightly defined timeframe is necessary to

preserve measurement integrity and avoid inconsistent interpretations by facilities of who should receive a safety plan.

Considerations for multiple encounters during the measurement period

The BHIOMM project team asked the TEP to comment on how facilities should manage repeat discharges—specifically, whether a returning patient who again screens positive for suicidal ideation receives a new or revised safety plan and how such instances would typically appear in the medical record.

- Six TEP members noted that their IPFs complete a new safety plan for each admission, even if only a brief time has passed, reassessing what was effective or ineffective. These TEP members confirmed the measure should require a safety plan for each eligible discharge.

Denominator exclusions

Appropriateness of current denominator exclusions

The BHIOMM project team opened the discussion on denominator exclusions by asking the TEP members to discuss the appropriateness of the exclusions.

- One TEP member supported the proposed exclusions and cautioned that allowing "patient refusal" as an exclusion could invite bias, misapplication, and reduce provider accountability for engaging patients in safety planning, even as they acknowledged the importance of respecting patient autonomy.
    - Another TEP member asked if patient "sign-off" would mitigate concerns of patient autonomy. The TEP member responded that informed consent, such as having patients formally acknowledge and sign off if they decline to participate in safety planning, could help address concerns related to patient autonomy and refusal. However, the member cautioned that this approach would introduce additional documentation burden.
- One TEP member highlighted consideration for the "transferred due to an emergent physical health need" exclusion that although patients may have physical health needs upon admission, physical health needs should not overshadow the importance of completing a safety plan, emphasizing the challenge of managing complex comorbidities and the need for stronger cross-unit collaboration to support safe discharge planning.
    - The BHIOMM project team responded that clinicians had identified scenarios in which an emergent physical health crisis leads to a patient being moved out of the IPF before a standard discharge process can occur, explaining that the exclusion was intended to capture these situations where completing a safety plan would not be feasible.

Considerations of Against Medical Advice (AMA) discharges as a denominator exclusion

The BHIOMM project team asked whether the AMA discharge process in an IPF differs from that of a general inpatient hospital, specifically questioning whether IPFs are more likely to complete the discharge process—including a safety plan—for patients who request to leave AMA.

- Four TEP members agreed with each other that AMA discharges are complex due to wide variation in state laws and discharge notice requirements.
- One TEP member recommended aligning exclusions with existing IPF quality measures disposition categories that exclude AMA discharges and medical transfers because these encounters typically lack complete transition records (referring to the Transition Record measure in the IPFQR Program) and may not complete a standard discharge process. The TEP member cautioned against creating additional dispositional categories that increase reporting burden.
- One TEP member noted the dilemma of AMA discharges, explaining that although facilities should be accountable, patients who choose to leave may do so amid strained therapeutic relationships, making it challenging to determine whether a safety plan can be completed collaboratively and with patient consent.

Additional considerations for the denominator exclusions

The BHIOMM project team asked the TEP whether the measure should exclude any additional scenarios or whether the current list captures all situations in which completing a safety plan or follow-up plan would not be feasible.

- TEP members noted that completing a safety plan and/or follow-up may not be feasible when facilities discharge patients to settings such as a carceral setting, court, residential treatment, or partial hospitalization, suggesting these scenarios may warrant consideration as additional exclusions.
- One TEP member recommended revisiting the exclusion list to make sure it covers scenarios in which the follow-up requirements of the numerator may also not be complete as those reasons may be different from the safety plan. That is, in addition to thinking about scenarios in which a safety plan may be infeasible to complete, consider whether there are additional scenarios in which follow-up is unable to be completed and also exclude those discharges.

The BHIOMM project team asked TEP members whether safety planning could still be appropriate when patients are discharged to another level of care.

- One TEP member explained that when their facility discharges patients to other levels of care, their facility still completes a safety plan tailored to the referral destination and clinical presentation, indicating that the measure should not necessarily exclude such discharges.

Numerator: Safety plan component

Appropriateness of safety plan elements

The BHIOMM project team asked whether the measure should require all seven safety plan elements for numerator credit and how the measure should define "collaboratively developed" for measurement purposes.

- One TEP member supported the measure's intent to be flexible and allow adaptation of safety plan language to patients' developmental, cultural, and cognitive needs to ensure meaningful engagement.
    - Another TEP member recommended providing examples of adapted safety plans in the measure guidance to help facilities apply the measure across diverse populations—including those with cognitive impairment, psychosis, or substance use—and suggested that broader terminology such as "coping plan" might further support guidance.
- One TEP member emphasized that all required safety plan elements should be evidence-based and ideally derived from validated tools, questioning the inclusion of items—such as "reasons for living"—that may not have established validation within the Safety-Brown safety plan. They recommended modeling the approach after Joint Commission standards by allowing facilities to use either a validated tool or a validated protocol and providing clear guidance on acceptable tools for both EHR and non-EHR settings.
    - The BHIOMM project team clarified that "reasons for living," while not part of the original Stanley-Brown tool, comes from adaptations used in settings such as the Veteran Affairs (VA) and some clinicians already incorporate this element.
- Multiple TEP members recommended explicitly including significant others or caregivers in the definition of a collaboratively developed safety plan, noting that involvement of those engaged in the patient's care is often clinically important and suggested clearer terminology such as "people identified as supports" to capture those who meaningfully participate in the patient's safety planning.
    - One TEP member cautioned that the term "supports" is too vague and suggested using more specific language—such as "caregivers" or individuals actively engaged in the patient's care—since clinicians cannot realistically identify or contact all potential "supports," but can collaborate with designated caregivers.
    - Another TEP member emphasized the need to balance clarity with patient autonomy when describing involvement of others in safety planning, noting discomfort with language implying that family members are "responsible" for the plan since caregiving relationships vary widely and may not be appropriate or desired for all patients.

Validation of collaboration in the numerator criteria

The BHIOMM project team asked the TEP to identify what types of documentation the measure should allow—such as free-text notes, clinician and patient signatures, or other indicators—to validate in the medical record that a safety plan was "collaboratively developed."

- One TEP member noted that free-text documentation is not feasible for IPFs without electronic health records and suggested that, for measurement purposes, a patient signature accompanied by at least one additional indicator should be sufficient evidence that the facility collaboratively developed a safety plan.

- Another TEP member agreed but noted that patients often feel pressured to "perform" to secure discharge, raising concerns about the validity of signature-based verification.
- One TEP member suggested using language from the Transition Record with Specified Elements Received by Discharged Patients measure, noting that it provides structured options—such as whether the record was discussed with the patient or caregiver, or not discussed due to instability or inability to comprehend—that could be adapted to document when and why collaborative safety planning did or did not occur.

Numerator: Follow-up component

Appropriateness of follow-up components

The BHIOMM project team asked TEP members to share their initial thoughts on the follow-up plan requirements.

- One TEP member noted challenges with the follow-up plan requirement, explaining that some outpatient clinics do not schedule appointments during inpatient discharge planning and instead return calls later, while some patients with existing provider relationships prefer to arrange their own appointments—both of which complicate documentation of a scheduled follow-up visit.
- One TEP member expressed concern that although documentation of a plan for the facility to follow-up with the patient is clinically valuable, insurers do not reimburse documentation of a plan to follow up with patients, such as through a phone call.
- TEP members voiced concerns that the follow-up component may be duplicative, noting that IPFs already report similar information on an existing measure—Transition Record with Specified Elements Received by Discharged Patients—which captures discharge and care transition information.
- TEP members asked whether the measure intends to align the follow-up component with caring contacts, noting that these brief, structured, non-clinical outreach touches reduce suicide risk and improve follow-up with care. They also questioned what forms of outreach would meet the intent, including whether a "caring card" could satisfy the requirement given that phone calls for every discharged patient may not be feasible.
    - The BHIOMM project team responded that we considered including a formal caring-contact plan with ongoing outreach in the follow-up component, but we removed it in response to clinician feedback, leading to the more limited specification currently proposed.

III.5. Face validity

The BHIOMM project team polled the TEP members on the face validity of the Safety and Follow-up Plan measure as currently specified. The goal in conducting this poll on the currently specified measure, before revising based on the TEP discussion, is for the BHIOMM project team to get a baseline of face validity. The BHIOMM project team asked TEP members to respond on a scale of strongly agree to strongly

disagree on two statements and provide a free text rationale for their vote. In response to questions from the TEP, the BHIOMM project team provided clarification that if TEP members think specific changes discussed today, such as modifying the numerator or exclusions, are needed to achieve face validity, then the TEP member should disagree with the statements and provide their rationale for doing so. Table III.2 shows the responses to the questions that used response scales.

Table III.2. Face validity polling results

Category	The measure accurately reflects quality of care. Number of experts (percentage)	The measure distinguishes between good and poor quality of care. Number of experts (percentage)
Strongly agree	1/12 (8.3%)	1/13 (7.7%)
Agree	4/12 (33.3%)	5/13 (38.4%)
Disagree	6/12 (50%)	7/13 (53.8%)
Strongly disagree	1/12 (8.3%)	0/13 (0%)

For the measure, about 42 percent of TEP members (5 of 12 voting) agreed or strongly agreed that the measure accurately reflects quality, and about 46 percent (6 of 13 voting) agreed or strongly agreed that the measure can be used to distinguish between good and poor quality of care.

TEP members who provided open-ended responses emphasized that that safety planning and follow-up are distinct clinical activities and should not be combined in a single metric, noting that safety planning is strong while the follow-up component as written "needs work". Members also questioned whether the measure could meaningfully distinguish quality across IPFs given the system's broader structural challenges, such as availability and capacity of outpatient mental health providers and lack of insurance reimbursement for follow-up plan documentation that may impact measure performance for an IPF and not capture true differences in care quality.

The BHIOMM project team will revisit face validity of the revised measure specifications in a future TEP meeting.

III.6. Key takeaways

The following key takeaways summarize the major themes and points of consensus that emerged from the TEP discussion.

- TEP members discussed that **documentation of suicide risk differs across IPFs and it is difficult to standardize across IPFs**, with some TEP members concerned that including the term "suicide risk" in defining the denominator population in the specification without clear operational criteria defining "suicide risk" is untenable for measurement.

- TEP members agreed that patients in an IPF experience some level of elevated risk, and safety planning is adaptable and beneficial across the IPF patient population; however, some members emphasized that there should be a **clearly defined, narrow denominator** tied to patients that presented on admission with suicide-related thoughts or behaviors to preserve focus.
- TEP members **supported the safety plan elements** outlined in the measure and appreciated that the intent is not to assess strict adherence to any single safety planning template. They emphasized valuing the measure's flexibility, which allows clinicians to **adapt the safety plan to patient needs** while still covering the core evidence-based components, and recommended CMS make this flexibility clear in the measure.
- TEP members **supported post-discharge follow-up as an best practice** but highlighted several practical issues, such as difficulties scheduling outpatient appointments and insurers not reimbursing documentation of a follow-up plan, as well as potential overlap with other quality measures.

IV. Next Steps

The BHIOMM project team explained that they will refine the measure specifications based on TEP feedback and public comments, reconcile input through December and early January, and then move into testing the draft specifications with selected IPFs by reviewing medical records and calculating preliminary results. The BHIOMM project team will reconvene the TEP in early spring 2026 to review findings and discuss next steps.

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