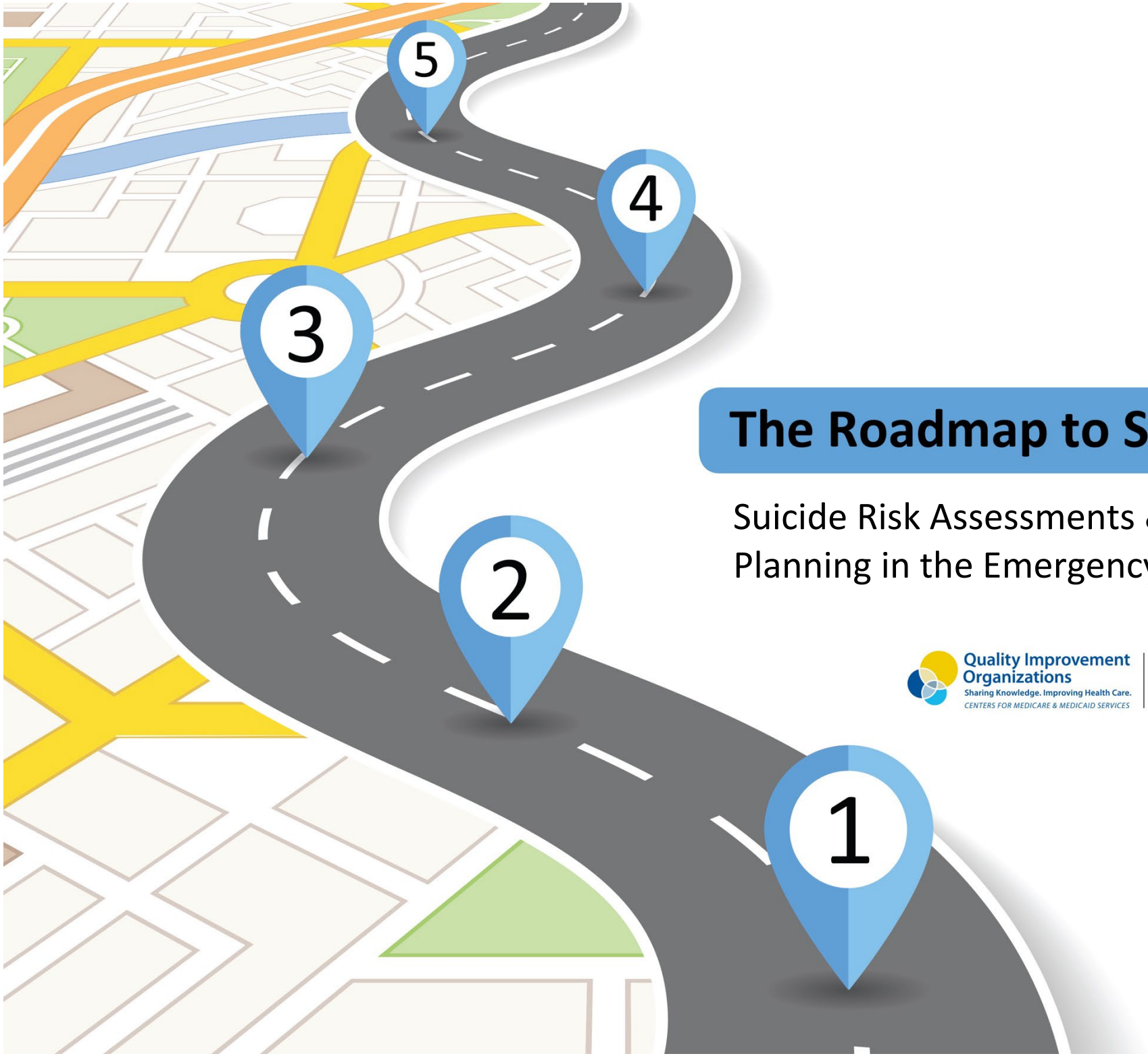


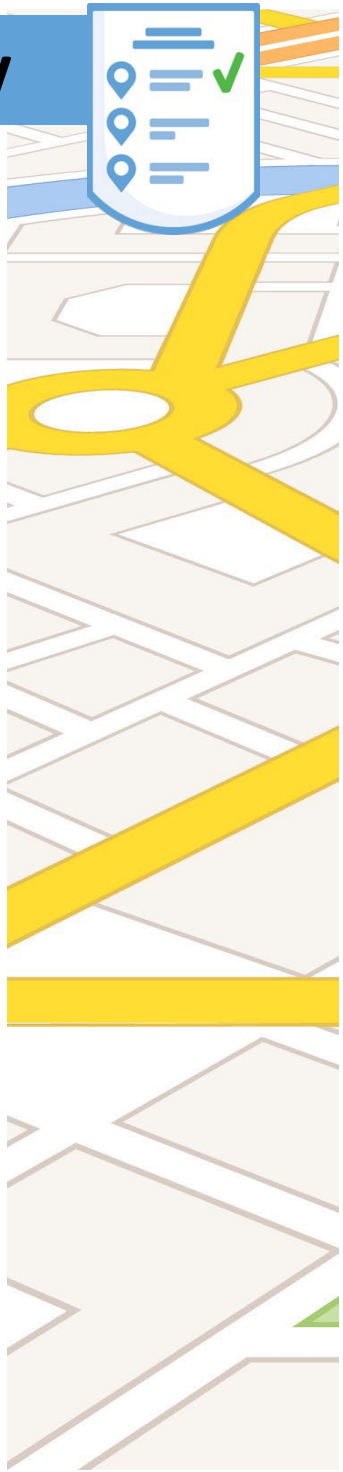
The Roadmap to Success:

Suicide Risk Assessments & Safety Planning in the Emergency Department

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

HSAG HEALTH SERVICES ADVISORY GROUP

Preparing for Your Journey



Any successful journey begins with planning and preparation. Three key areas should be addressed before beginning any quality improvement or patient safety initiative.

Leadership Commitment

The success of a project can be determined by the level of commitment and support from leadership. It is important for hospital leaders to communicate a consistent, frequent message in support of the project. The executive project champion can establish accountability, dedicate resources, and break through barriers.

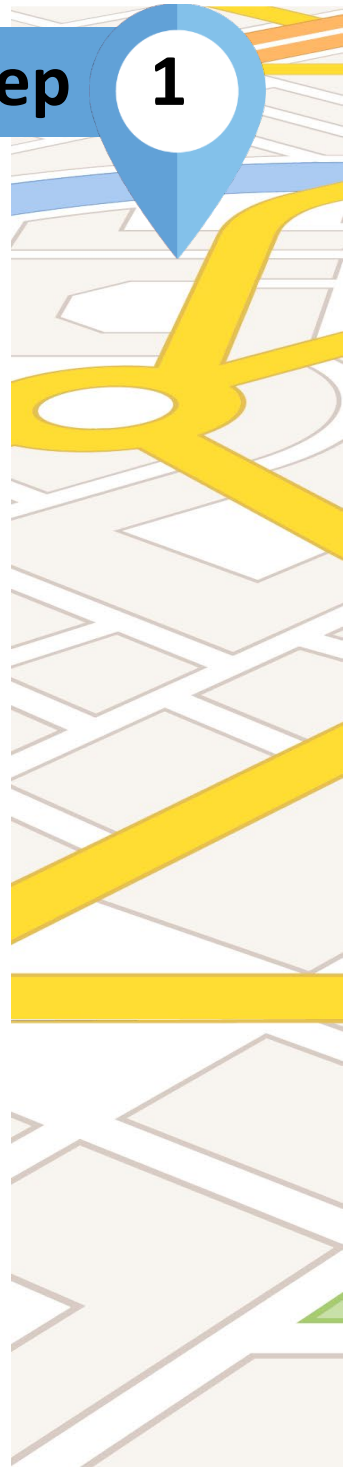
Project Champion

It is important to have a person who is a significant influence with frontline staff, physicians, and other key personnel. Frequently, we think of a physician as a champion because he/she is instrumental in garnering provider buy-in and practice change. However, depending on the project, it can be any key personnel with the authority and skills to influence change, lead by example, and assist in essential goal and vision messaging.

Multidisciplinary Project Team

The project team should consist of key area representatives throughout your facility with the skills, knowledge, and experience in their fields of expertise. A team member should possess strong communication skills, have a collaborative mindset, and show a commitment to change. It is vital to **have representation from frontline staff who will be impacted most by the change**. It also is important to keep the size of your team manageable. Remember, a team can have ad hoc members whose role is to provide expertise in a specific area for a short period of time.

Systematic Suicide Risk Screening—Step 1

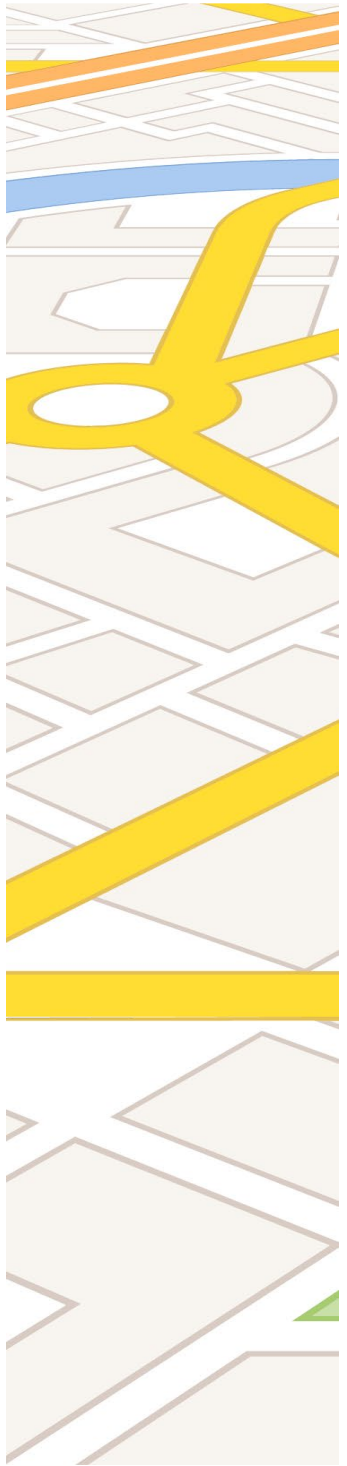


Rationale:
Early identification of patients at risk for suicide allows timely intervention in the emergency department (ED) before crises escalate. Using validated tools ensures consistency and reduces patient risk, improving overall safety.[1]

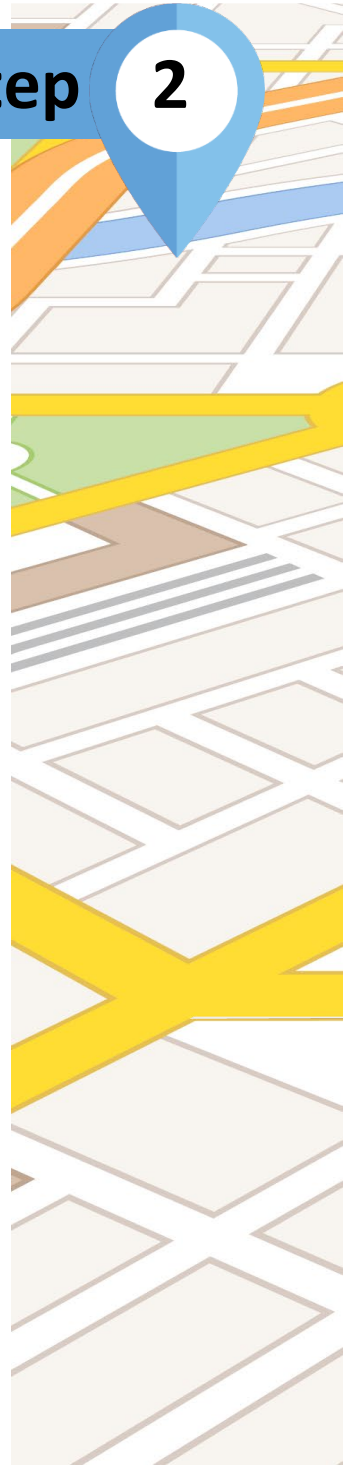
	Strategies to Implement	Tools and Resources
☐	• Develop standardized, evidence-based workflows and decision trees for triage and intake, brief intervention, and referral/disposition to treatment. • Ensure policies and procedures, training, and monitoring systems are in place and are aligned to support clinicians. • Use validated, brief, suicide-risk screening tools (e.g., Ask Suicide-Screening Questions [ASQ], Columbia-Suicide Severity Rating Scale [C-SSRS], Patient Safety Screener [PSS-3]) universally or on those presenting with mental health (MH) concerns or known risk factors (e.g., substance use disorder [SUD], several life stressors). • Involve information technology (IT) to ensure screens/assessments are integrated into the electronic health record (EHR). • Ascertain the severity of suicide ideation to inform safety (e.g., ED-Safe Patient Secondary Screener [ESS-6]).	• National Institute of Mental Health (NIMH). Ask Suicide-Screening Questions Toolkit—https://www.nimh.nih.gov/research/research-conducted-at-nimh/asq-toolkit-materials • Suicide Prevention Resource Center (SPRC). Caring for Adult Patients with Suicide Risk: A Consensus Guide for EDs—https://sprc.org/edguide/ • The Columbia Lighthouse Project. The Columbia Protocol (C-SSRS)—https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/ • SPRC. The Patient Safety Screener: A Brief Tool to Detect Suicide Risk—https://sprc.org/the-patient-safety-screener-a-brief-tool-to-detect-suicide-risk/ • SPRC. ESS-6 and Tip Sheet—https://sprc.org/wp-content/uploads/2022/11/ED-SAFE-Secondary-Screener-and-Tip-Sheet.pdf • Institute for Healthcare Improvement (IHI). White Paper: Improving Behavioral Health Care in the ED and Upstream—https://www.ihi.org/library/white-papers/improving-behavioral-health-care-emergency-department-and-upstream • Greenwald A. National Institute of Health. Trauma-Informed Care in the Emergency Department: Concepts and Recommendations for Integrating Practices into Emergency Medicine—https://pmc.ncbi.nlm.nih.gov/articles/PMC9946309/#:~:text=Defining%20trauma%2Dinformed%20care,against%20re%2Dtraumatization%20%5B5%5D
☐	Create a trauma-informed culture. Educate ED staff and providers regarding: • Trauma-informed care (TIC). • Stigma. • Caring for patients with MH conditions. • Recognizing the warning signs of suicide risk. • De-escalation skills. • Selected prescreening and brief-screening tools. Provide annual, new hire, and as needed MH and TIC	

	Strategies to Implement	Tools and Resources
	education to staff and providers (e.g., Zero Suicide: Suicide Care Training Options) using teach-back and scenario-based training.	• Oregon Health and Science University (OHSU). Sample Suicide Risk-Safety Interventions ED Policy—https://www.ohsu.edu/sites/default/files/2020-01/OHSU-Policy-HC-PC-450-POL-Suicide-Risk-Safety-Interventions.pdf • SPRC. Suicide Care Management Plans—https://sprc.org/wp-content/uploads/2022/11/Suicide-Care-Management-Plans.pdf • The Joint Commission. National Patient Safety Goal for Suicide Risk Reduction—https://www.jointcommission.org/en-us/knowledge-library/suicide-prevention?rfkid_7:content_filters= • Zero Suicide. Suicide Care Training Options—https://zerosuicide.edc.org/sites/default/files/2020-11/2020.11.18%20Suicide%20Care%20Training%20Options_0.pdf
☐	Monitor/audit and report the percentage of screening processes observed and performed as per training standards. Review monthly, during the quality assurance meeting, using suggested dashboard metrics that are reported monthly to executive leadership: • Suicide screening rate (percent of documented screenings for eligible ED patients). • Average daily duration (in minutes) ED patients are in restraints. • Percentage of agitated patient codes in the ED that resulted in restraint use. • Average rating of ED staff confidence in use of de-escalation techniques and procedures. • Total number of patient-to-staff assaults in the ED. • BH patient experience of ED care (1–5 scale).	

[1] The Joint Commission. Detecting and treating suicide ideation in all settings. *Sentinel Event Alert*. 2016 (updated 2021); Issue 56. https://www.preventsuicidect.org/wp-content/uploads/2021/05/SEA_suicide_TJC_requirements.pdf



Comprehensive Suicide Risk Assessment—Step 2

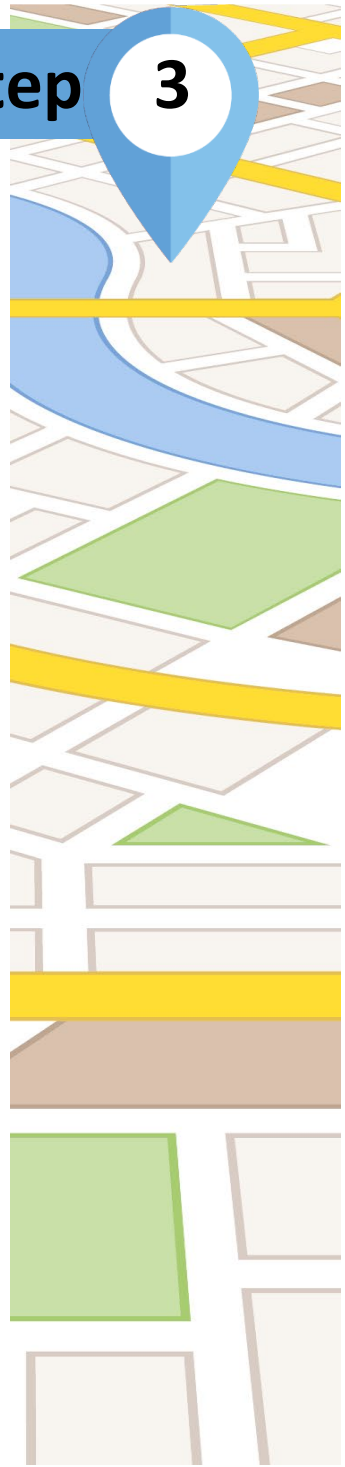


Rationale:
A thorough assessment helps clinicians understand the severity of risk, identify protective factors, and tailor interventions appropriately, which improves patient outcomes.[2]

	Strategies to Implement	Tools and Resources
☐	For patients who screen positively, conduct in-depth risk assessments by MH clinicians or trained ED staff with evidence-based tools (e.g., Suicide Assessment Five Step Evaluation and Triage [SAFE-T], C-SSRS).	• Substance Abuse and Mental Health Services Administration (SAMHSA). SAFE-T Suicide Assessment: Five-Step Evaluation and Triage—https://library.samhsa.gov/sites/default/files/safet-flyer-pep24-01-036.pdf • The Columbia Lighthouse Project. C-SSRS—https://cssrs.columbia.edu/the-columbia-scale-c-ssrs/about-the-scale/ • SPRC. Caring for Adult Patients with Suicide Risk: A Consensus Guide for EDs—https://sprc.org/edguide/ • National Action Alliance for Suicide Prevention (NAASP). Recommended Standard Care for People with Suicide Risk—https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf • SPRC. Suicide Care Management Plans—https://sprc.org/wp-content/uploads/2022/11/Suicide-Care-Management-Plans.pdf • Zero Suicide. Data Elements Worksheet—https://zerosuicide.edc.org/resources/resource-database/zero-suicide-data-elements-worksheet
☐	Evaluate patients for: • Risk factors, noting what can be modified to reduce risk. • Protective factors, noting those that can be enhanced. • Lethal means access. • Severity of ideation, plans, behaviors, and intent.	
☐	Allocate staff resources (e.g., ED clinicians, BH staff, social workers, telehealth professionals) for thorough screening of patients with a positive pre-screen.	
☐	Determine patient suicide risk level and make a level-of-care determination. • The patient may be a danger to self or others.	
☐	Audit and report monthly the number of completed suicide risk assessments and include in your quality improvement (QI) dashboard metrics the number of: • Assessments that occurred. • Patients who screened positive for suicide risk. • Patients who required psychiatric consultation. • Patients who required inpatient psychiatric admissions.	

[2] American Psychiatric Association. *Practice Guideline for the Assessment and Treatment.* 2010. Provide ED-based suicide prevention interventions (e.g., providing a safe environment, brief patient education, explaining next steps). Provide immediate evaluation and environment of safety for those deemed *of Patients with Suicidal Behaviors, https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/suicide.pdf*.

Collaborative Safety Planning—Step 3

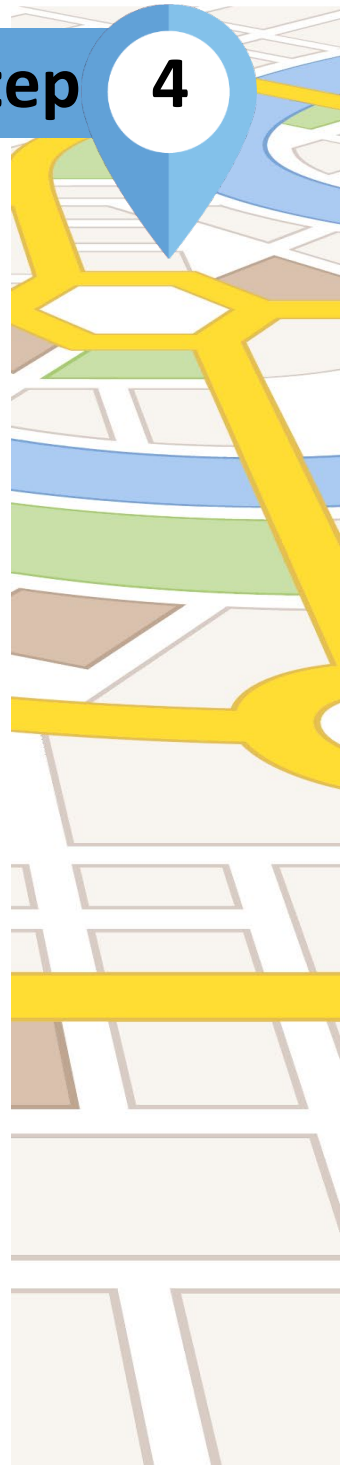


Rationale:
Engaging patients in creating a personalized safety plan increases their sense of control and commitment to staying safe during high-risk periods.[3]

	Strategies to Implement	Tools and Resources
☐	Develop individualized safety plans collaboratively with the patient, including identifying coping strategies and sources of support.	• NAASP. Recommended Standard Care for People with Suicide Risk—https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf • Betz ME, Boudreaux ED. Managing Suicidal Patients in the Emergency Department. *Annals of Emergency Medicine*. 2016—https://pmc.ncbi.nlm.nih.gov/articles/PMC4724471/ • SAMHSA. Safety Plan—https://www.samhsa.gov/sites/default/files/988-safety-plan.pdf • Each Mind Matters: California's Mental Health Movement. My3 App for Safety Planning—https://www.samhsa.gov/sites/default/files/988-safety-plan.pdf • SPRC. Suicide Care Management Plans—https://sprc.org/wp-content/uploads/2022/11/Suicide-Care-Management-Plans.pdf • Zero Suicide. Data Elements Worksheet—https://zerosuicide.edc.org/resources/resource-database/zero-suicide-data-elements-worksheet
☐	Counsel patients and families on reducing access to lethal means (e.g., firearms, medications) during periods of high risk.	
☐	Provide patients with a written safety plan to take home.	
☐	Audit and report monthly the number of completed safety plans and include in the QI dashboard metrics the number of patients: • With a safety plan developed. • Determined to be at elevated risk of suicide who received lethal-means counseling. • Determined to be at elevated risk of suicide.	

[3] Stanley B, Brown GK. Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice*. 2012. 19(2); 256–264. Available at https://psycnet.apa.org/record/2012-07473-004. Accessed on October 17, 2025.

Warm Hand-Off and Linkage to Follow-Up Care—Step 4

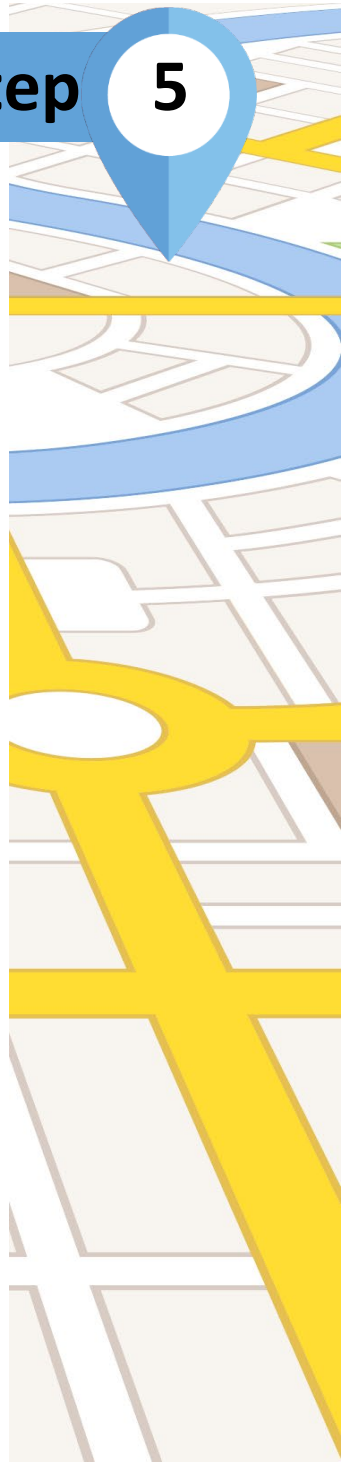


Rationale:
Direct communication between the ED and outpatient providers enhances continuity of care and reduces the chance of patients "falling through the cracks" post discharge.[4]

	Strategies to Implement	Tools and Resources
☐	Prepare and provide staff with an active list of community MH treatment providers who have established relationships with your hospital to include inpatient, outpatient, and 24-hour crisis centers. Review the list at least quarterly to update.	• Centers for Disease Control and Prevention (CDC). Suicide Prevention: Resource for Action—https://www.cdc.gov/suicide/pdf/preventionresource.pdf • IHI. White Paper: Improving Behavioral Health Care in the ED and Upstream—https://www.ihi.org/library/white-papers/improving-behavioral-health-care-emergency-department-and-upstream • SAMHSA. Systems-Level Implementation of Screening, Brief Intervention, and Referral to Treatment—https://library.samhsa.gov/sites/default/files/sma13-4741.pdf • NAASP. Best Practices for Individuals with Suicide Risk—https://theactionalliance.org/resource/best-practices-care-transitions-individuals-suicide-risk-inpatient-care-outpatient-care
☐	Arrange immediate follow-up appointments with mental health providers before discharge.	
☐	Facilitate direct communication ("warm hand-off") between ED staff and outpatient clinicians or crisis teams.	
☐	Create a process with community MH partners for executing referrals and warm handoffs after hours and on weekends.	
☐	Collaborate with MH partners to provide a monthly report of successful attendance to referred treatment.	
☐	Observe/audit warm hand-off process monitoring for effective patient education and engagement. Perform a monthly audit of warm hand-offs and include these data in the QI dashboard metrics: • Completion of warm hand-off (percent successfully connected with MH provider prior to discharge). • Percentage of patients discharged with a scheduled follow-up appointment within 24–72 hours.	

[4] NAASP. Best Practices in Care Transitions for Individuals with Suicide Risk: Inpatient Care to Outpatient Care. 2018. Available at https://theactionalliance.org/resource/best-practices-care-transitions-individuals-suicide-risk-inpatient-care-outpatient-care. Accessed on October 17, 2025.

Post-Discharge Follow-Up: Caring Contacts —Step 5



Rationale:
Early follow-up contacts help identify new or persisting risks, reinforce safety plans, and connect patients to needed support, reducing rehospitalization and suicide risk.[5]

	Strategies to Implement	Tools and Resources
☐	Complete caring contacts check-in with patient in the mode preferred by the patient (by phone, text, or email) within 24–72 hours post-discharge. Consider performing the first contact within 24 hours of discharge and the second contact within 7 days of discharge.	• SPRC. Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments—https://sprc.org/edguide/ • NAASP. Recommended Standard Care for People with Suicide Risk—https://theactionalliance.org/sites/default/files/action_alliance_recommended_standard_care_final.pdf • IHI. White Paper: Improving Behavioral Health Care in the ED and Upstream—https://www.ihi.org/library/white-papers/improving-behavioral-health-care-emergency-department-and-upstream • Zero Suicide. Data Dashboard—https://zerosuicide.edc.org/resources/key-resources/data-dashboard
☐	Consider establishing an agreement with a local crisis center that allows its staff to make caring contacts with recently discharged patients.	
☐	Observe/audit caring contacts process monitoring for effective patient engagement and follow through. Perform a monthly audit and report monthly: • Percentage of patients discharged with suicide risk who receive a contact attempt within 24–72 hours. • Percentage of patients successfully reached on first follow-up attempt. • Percentage of follow-up contacts that included reassessment of risk and reinforcement of the patient's safety plan. • 30-day repeat ED visits or psychiatric hospitalizations.	

[5] Motto JA, Bostrom AG. A randomized controlled trial of postcrisis suicide prevention. *Psychiatric Services*. 2001. *52*(6); 828–833. Available at https://pubmed.ncbi.nlm.nih.gov/11376235/. Accessed on October 17, 2025.

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