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# Investigating the Impact of Outpatient Mental Health Follow-up Care on Continued Adolescent Suicidality: An Evidence-Based Change Project Proposal

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**Investigating the Impact of Outpatient Mental Health Follow-up Care on Continued Adolescent  
Suicidality: An Evidence-Based Change Project Proposal**

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The University of Texas at Tyler, School of Nursing

For NURS 5382: Capstone

Dr. Nelson, PhD, RN, CNE

April 19, 2024

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### **Executive Summary**

The escalating rates of adolescent suicide globally, coupled with the surge in pediatric hospitalization rates, underscore the urgent need for effective intervention strategies. Despite hospitalization, many patients persist in experiencing suicidal ideation and behaviors, often leading to readmissions. A significant portion of these individuals do not receive adequate outpatient mental health follow-up care post-discharge. As a leading pediatric healthcare institution committed to delivering exemplary care, particularly to those struggling with mental health challenges, the organization's commitment demands proactive measures.

### **Objectives and Implementation Plan**

The attached proposal aims to establish an organizational policy to reduce 30-day readmission rates among adolescents with persistent suicidal thoughts and behaviors. Key strategies involve enhancing patient and caregiver education, promoting adherence to post-discharge care plans, and fostering compliance with outpatient mental health follow-up recommendations. Following the Knowledge-to-Action (K2A) model, the project spans four phases over 18 months, with phase one focusing on policy development, stakeholder engagement, and educational material creation. Pilot testing and data analysis occur during phase two, followed by policy revisions during phase three. Phases two and three are iterative, allowing for repeated cycles of implementation and refinement. The final phase includes a sustained implementation period and a comprehensive feasibility and sustainability assessment for future policy roll-out across Katy, Woodlands, and Austin community campuses.

### **Evaluation and Continuous Improvement**

Regular assessment and feedback mechanisms will monitor policy effectiveness. Data collection and analysis will track 30-day readmission rates and employee protocol adherence. Internal stakeholder feedback will be solicited via electronic surveys to assess the policy's impact on workflow and perceived

patient benefits. Continuous quality improvement initiatives will ensure ongoing enhancement of care delivery.

### **Outcomes and Financial Impact**

The proposed policy aims to improve patient outcomes by reducing readmission rates, enhancing patient and caregiver engagement, and promoting seamless continuity of care. The proposed project also offers a compelling cost-benefit proposition, balancing short-term investments with long-term patient outcomes and healthcare efficiency gains. While initial costs will include salary expenses related to policy development, staff training, and material creation, the anticipated reduction in readmission rates and crisis interventions will yield substantial savings over time. Additionally, the intangible benefits, such as improved quality of life for patients and families and the societal impact of preventing adolescent suicides, underscore the value of this initiative.

### **Conclusion**

Establishing an organizational policy to reduce readmission rates for adolescents struggling with suicidal thoughts and behaviors represents a critical step in fulfilling our commitment to excellence in pediatric mental healthcare. Through a strategic focus on education and follow-up care, we aim to empower patients and caregivers, thus diminishing the risk of recurring crises and nurturing a resilient and well-supported community. By uniting in this effort, we can enact meaningful change and serve as a beacon of hope for those navigating mental health challenges. With a steadfast dedication to proactive mental health interventions and the cultivation of a prevention-focused culture, the organization can lead the way in addressing the global crisis of adolescent suicide and setting a gold standard for excellence in pediatric mental healthcare.

## **Investigating the Impact of Outpatient Mental Health Follow-up Care on Continued Adolescent Suicidality: An Evidence-Based Change Project**

Adolescent suicide has emerged as a pressing global crisis, prompting the American Academy of Pediatrics (2021) to declare a national emergency in children's mental health. Within the demographic of children and young adults aged 10-24, suicide now stands as the second leading cause of death, surpassing the toll of any singular medical condition (Asarnow, 2023; CDC, 2023). Notably, post-discharge suicide rates have witnessed an alarming 35% increase, with more than 50% of suicides occurring within seven days of discharge and 25% transpiring before the individual's first follow-up appointment (Bojanić et al., 2020; Vale, 2023).

This paper presents an evidence-based quality improvement project proposal to bridge gaps in patient and caregiver (PAC) knowledge, comprehension, and adherence to obtaining outpatient mental health follow-up care (OMHFC) post-discharge. The overarching goal is to mitigate 30-day readmission rates for continued suicidal thoughts and behaviors (STB) and enhance long-term patient outcomes. Employing a systematic approach, this paper comprehensively investigates critical aspects of improving adolescent mental health outcomes. This proposal encompasses a rationale for the project, a literature synthesis, a brief discussion of key project stakeholders, a detailed implementation plan and timetable, meticulous data collection methods, rigorous evaluation criteria, a comprehensive cost-benefit analysis, and a thorough discussion of anticipated results and suggested recommendations.

### **Rationale for the Project**

The prevalence of mental health issues among adolescents aged 10-19 is striking, affecting one in seven individuals (CDC, 2022). The COVID-19 pandemic has worsened this issue, evidenced by a reported 37% decline in mental health among high school students (WHO, 2021). In the United States, pediatric admission rates for mental health issues have risen by over 50% in the past 15 years, with more than three million patients presenting with severe suicidal ideation during this period (Chen et al.,



2020; NAMI, 2022; Radhakrishnan et al., 2022). Gordon (2022) highlights a concerning 61% surge in psychiatric hospitalization rates for children under 19 years old from 2016 to 2021.

Despite the increased rates of emergency center (EC) visits and psychiatric hospitalizations, post-discharge OMHFC utilization has only experienced a marginal 5% increase, indicating unanticipated barriers to accessing OMHFC services (Gordon, 2022). Many patients face readmission due to persistent STB, with a significant portion failing to secure OMHFC after discharge—a critical factor in improving patient outcomes and ensuring sustained success. This concerning trend underscores the urgent need for comprehensive attention and interventions to address escalating mental health challenges among adolescents. It serves as the inspiration for the following research question: Among adolescents experiencing STB, how does the timely receipt of OMHFC compare to the absence of follow-up care after EC visits or psychiatric hospitalization influence readmission rates and persistent STB, including suicide attempts (SA), suicidal ideation (SI), and self-harming (SH) behavior, within a 30-day timeframe?

Healthcare institutions shoulder a significant responsibility to mitigate adolescent suicide deaths, and frontline healthcare providers occupy a pivotal role in effecting meaningful changes across the healthcare continuum. Through early risk identification and intervention, provision of education and resources, and consistent post-discharge follow-up contact, providers can profoundly impact the accessibility of mental health and suicide prevention services. This proactive approach seeks to enhance adherence to treatment plans, ultimately leading to better patient outcomes, decreased likelihood of readmissions, and mitigation of ongoing STB following discharge.

The organization is committed to enhancing patient outcomes and preventing adolescent suicide. However, the organization currently lacks a policy that outlines the requirements for educating PACs on mental health and suicide prevention, as well as assisting in connecting patients with community resources. While case managers currently conduct post-discharge follow-up calls, the existing policy only mandates contacting patients identified by the electronic medical records (EMR)

system as medium or high-risk for readmission. However, this risk calculation relies solely on data documented within the last 24 hours and excludes crucial psychosocial and suicide-related data, thereby leading to the oversight of critical cases. Furthermore, the current CM call template fails to adequately address suicide prevention and interventions, focusing predominantly on medical concerns and omitting patients discharged or transferred from the EC.

### **Literature Synthesis**

The University of Texas at Tyler online library was used to find relevant literature, and databases searched include CINAHL, PubMed, PsycINFO, and Psychology and Behavioral Sciences Collection. Google Scholar was used to locate open-access articles. The search was limited to scholarly articles using the combination of keywords and phrases: suicide risk, SA or SI or SH, after hospitalization or discharge, outpatient mental health or follow-up care, community-based or school-based and mental health programs, reducing suicide after hospitalization, and mental health or psychiatric and follow-up care.

The initial search produced a total of approximately 4,720 articles. Next, a revised search was done to include “and adolescent or child or teen,” results were filtered to include only peer-reviewed articles published between 2019 and 2023, full-text articles published in English, and qualitative, quantitative, mixed-methods, systematic reviews, and meta-analysis studies. Titles and abstracts of the resulting 138 studies were reviewed to ensure studies were directly linked to OMHFC and its relation to the risk of suicide and ongoing STB among adolescents after hospitalization. Twenty-two articles were initially selected for closer examination using this methodology, and nine articles were removed as they did not pertain directly to the research question. Thirteen articles met the criteria for inclusion and are contained within this paper’s literature review.

The heightened vulnerability to suicide post-psychiatric hospitalization underscores the critical role of timely OMHFC in decreasing adolescent suicide rates and the persistence of STB after discharge. Diverse OMHFC settings, such as community-based suicide prevention programs like the Wesley Life

Force (WLF) network and school-based suicide prevention programs, offer interventions encompassing crisis intervention, educational initiatives, risk identification, psychological care, routine psychiatric care, and supportive therapy (Briggs et al., 2019; Morgan et al., 2022; Walsh et al., 2022). Implementation of the WLF network has demonstrated a noteworthy 17% reduction in suicide rates. In comparison, school-based suicide prevention programs have proven effective in decreasing SA and SI by up to 34% and 15%, respectively (Morgan et al., 2022; Walsh et al., 2022).

In the initial 30 days post-discharge, suicide rates surge to levels 100 times higher than the general population, emphasizing the imperative for prompt OMHFC to mitigate suicide and STB risks (Fontanella et al., 2020; Rengasamy & Sparks, 2019). Acknowledging this urgency, The Centers for Medicare & Medicaid Services and the National Committee on Quality Assurance advocate for OMHFC within 30 days post-discharge, with global evidence favoring a narrower window of seven days (Fontanella et al., 2020; Bojanić et al., 2020). Adolescents receiving follow-up care within this timeframe exhibit a 56% reduction in suicide risk, contrasting starkly with the 3.1% suicide rate among those lacking such care (Bojanić et al., 2020; Fontanella et al., 2020). Furthermore, timely OMHFC within seven days correlates with a 40% decline in depressive symptoms and heightened adherence to subsequent OMHFC appointments over six months (Bear et al., 2020; Doupnik et al., 2020; Hoffman et al., 2023). Despite these compelling findings, only half of discharged patients receive OMHFC within the recommended timeframe, resulting in low continuity of care, increased risk of readmission, and elevated suicide risk (Choi et al., 2020; Fontanella et al., 2022; Hoffman et al., 2023).

The recurrence of continued STB leading to patient readmission, coupled with the heightened susceptibility to suicide prior to attending scheduled follow-up appointments, highlights the necessity to identify individuals at elevated suicide risk and employ interventions pre-discharge (Choi et al., 2020; Fontanella et al., 2022). Conducting post-discharge patient follow-ups within a critical window of 72 hours post-hospitalization and engaging in OMHFC within seven days of discharge emerges as pivotal

components in substantially augmenting patient outcomes (Bojanić et al., 2020; Choi et al., 2020; Doupnik et al., 2021; Fontanella et al., 2020). This multifaceted approach is emphasized by its demonstrable effect in mitigating the risk of suicide, fostering elevated confidence in safety planning, enhancing adherence to scheduled OMHFC appointments, and accomplishing a discernible reduction in the rates of re-hospitalization, particularly in cases characterized by persistent STB (Choi et al., 2020; Doupnik et al., 2020; Doupnik et al., 2021; Hoffman et al., 2023; Rengasamy & Sparks, 2019).

Individuals receiving OMHFC within the initial 30 days post-discharge exhibit a noteworthy 26% readmission reduction within the subsequent five days, emphasizing the potential to mitigate adverse outcomes associated with mental health readmissions through the use of timely OMHFC and patient contact post-discharge (Bear et al., 2020; Briggs et al., 2019; Choi et al., 2020; Hoffman et al., 2023). Research demonstrates that patients who receive a sequential series of follow-up telephone calls extending over 90 days, initiated promptly post-discharge, manifest an 11% greater reduction in persistent STB than those who receive a singular call and patients who actively participate in a regimen of high continuity of care after discharge manifest a diminished risk of readmission within the span of one year, in stark contrast to their counterparts who experience low and moderate continuity of care (Choi et al., 2020; Rengasamy & Sparks; 2019). Simultaneously, this 90-day approach generates a notable 22% enhancement in safety planning confidence and proficiency levels, alongside a notable 7% increase in the utilization of OMHFC services after discharge (Gryglewicz et al., 2024; Rengasamy & Sparks, 2019).

However, it is imperative to note that extended and sustained patient contact, while yielding commendable outcomes, is not indispensably requisite for achieving measurable results - even a brief interaction with mental health professionals post-discharge can yield noteworthy benefits. One succinct encounter can facilitate heightened patient engagement, perpetuate discussions about mental health, and aid individuals in the delicate transition from inpatient to outpatient mental health settings

(Doupnik et al., 2020; Watling et al., 2022). A singular post-discharge call, characterized by effective structuring, patient-centeredness, and participatory elements, yields substantive advantages (Doupnik et al., 2020; Rengasamy & Sparks, 2019). Notably, a single post-discharge telephone call can precipitate a nearly 25% increase in compliance with OMHFC, a reduction surpassing 60% in depressive symptoms, and a substantial decrease of up to 84% in the risk of readmission, exceeding the outcomes observed among those devoid of any post-discharge follow-up (Choi et al., 2020; Doupnik et al., 2020; Gryglewicz et al., 2023; Watling et al., 2022). These results underscore the profound impact of targeted and well-conceived post-discharge interventions in mitigating adverse mental health trajectories and promoting a more robust continuum of care.

### **Project Stakeholders**

An integrative and interdisciplinary collaborative strategy is imperative to foster transparent communication and ensure the inclusion of diverse perspectives, thereby cultivating a more comprehensive policy and enhancing staff adherence. This transformative endeavor influences a broad spectrum of stakeholders, encompassing frontline healthcare providers such as social workers (SWs), care managers (CMs), registered nurses (RNs), and medical providers (MDs). Additionally, pivotal contributors to the project's development and execution comprise the Information Technology (IT) and Quality Improvement (QI) departments, the Risk and Compliance Department, and departmental and executive leadership.

The initiative has garnered widespread support, notably from the Vice President of Nursing, who serves as the project's gatekeeper and sponsor. Furthermore, influential project champions among RNs and MDs with robust connections to the behavioral health population will further bolster the project's momentum. Beyond the healthcare professionals directly involved, other stakeholders impacted by this initiative encompass PACs, insurance companies, and the overarching organizational structure.

Navigating the delicate balance between adolescents' desire for medical autonomy and corresponding parental rights poses inherent challenges for clinicians. This complexity is further pronounced when addressing issues related to suicidality among adolescents, as they may exhibit reluctance to seek assistance and resist psychiatric interventions despite a caregiver's inclination towards treatment. Recognizing the significance of incorporating adolescent patient preferences and values into the decision-making and care plan formation process is paramount. This becomes particularly crucial in ensuring sustained adherence to OMHFC following discharge. Adopting a multidisciplinary approach to OMHFC planning emerges as a pivotal strategy, engaging diverse healthcare providers, including MDs, SWs, and CMs. Furthermore, active involvement of both PACs in the planning process is advocated, as this collaborative approach has demonstrated enhanced patient outcomes.

### **Implementation Plan**

The project team will work collaboratively with MDs, SWs, CMs, RNs, the IT and QI departments, the RCD, and departmental and executive leadership to develop and implement a comprehensive policy mandating frontline providers, including SWs, RNs, and MDs, educate PACs on obtaining OMHFC within seven days of discharge. Furthermore, it will require frontline providers to identify and address barriers hindering timely OMHFC access and assist caregivers with referrals before discharge. Additionally, CMs will be required to conduct post-discharge follow-up calls within 72 hours to assess for ongoing STB, medication compliance, and safety plan effectiveness and provide further assistance in connecting with OMHFC providers or resources, if required.

The proposed QI project will be executed in four phases; designed to align with the Knowledge to Action (K2A) framework, the project's framework integrates knowledge with a repeatable and adaptable action cycle to ensure effective adaptation of knowledge and interventions based on barriers identified, outcomes achieved, and feedback received during project evaluation (Corey & Roussel, 2023;

Ham-Boyloyi, 2022). Phase one initiates the project with policy creation, employee education, and stakeholder engagement. This precedes a succinct pilot implementation trial in phase two, concluding with a comprehensive review of data and feedback. Phase three entails policy revision and employee education, and phases two and three may be revisited to apply revised policies for further evaluation and modification until a final policy is developed. Phase four marks the implementation of the finalized policy over an extended six-month period, during which monthly data analysis will be conducted. The feasibility and sustainability of the project will be assessed after the sixth month, with potential consideration for roll-out at community campuses in Katy, the Woodlands, and Austin.

### **Implementation Timeline**

The participant cohort for this project initiative will encompass individuals aged six to nineteen who present in acute crisis with STB at the organization's 960-bed acute pediatric hospital in the Houston Medical Center. This targeted demographic enables a focused examination of acute crisis scenarios and provides a nuanced understanding of this critical age group's unique challenges and considerations. The project's execution will unfold through a meticulously structured framework comprising four distinct phases (see Appendix B for the project flowchart).

#### **Phase One: Policy Creation, Education, and Stakeholder Engagement**

Due to its complexity, six months is allotted for the initial phase of this project. Preliminary policy creation, revision, and approval will take three to four months, adhering to the procedural nuances of the organization's policy framework. The policy creation process will involve the collaborative efforts of the project team, complimented by the expertise of SWs, CMs, RNs, MDs, and department leaders, with final approval from executive leadership and the RCD. Drawing upon empirical foundations presented by Bojanić et al. (2020), Fontanella et al. (2020), and Rengasamy and Sparks (2019), the policy will articulate explicit requirements that frontline providers educate PACs on the importance of OMHFC and provide PACs with resources and OMHFC referrals before discharge.

Additionally, the policy will require CMs to complete post-discharge follow-up telephone calls with PACs within 72 hours of discharge. Subsequently, the project team will collaborate with CMs, SW, and educators over the next two months to design and create electronic training modules, printable resources, PAC education materials, and a CM post-discharge call template. Once complete, the IT department will seamlessly integrate these materials into the organization's training platform and the EMR system, and educators and departmental leadership will strategically assign training modules to pertinent staff.

Stakeholder engagement, a critical aspect of phase one, is predicted to be an ongoing process under the oversight of departmental leadership and educators. Internal and external stakeholders will be systematically notified and educated about the upcoming policy alteration. A feedback loop will be established to solicit insights, and potential barriers to implementation will be diligently identified via employee surveys. In tandem with CMs, organizational executives will orchestrate outreach activities directed at external stakeholders. This proactive engagement will acquaint external entities with the impending policy shift, illuminate the significance of OMHFC, and solicit collaborative support in facilitating timely OMHFC for discharged patients. This multifaceted approach ensures a comprehensive and academically grounded foundation for the subsequent phases of the project.

### **Phase Two: Pilot Testing, Data Collection, and Stakeholder Feedback**

Moving into phase two, a two-month pilot testing of the policy is slated for the EC and inpatient units. Frontline providers will record interventions in the EMR system, ensuring meticulous documentation of the implemented measures. Concurrently, the QI department will gather EMR data weekly, while departmental leadership and educators will obtain employee feedback during the final week of phase two. At the conclusion of this pilot testing phase, the QI department and the project team will collaboratively analyze the collected data, culminating in the creation of a comprehensive report, which will be presented for executive leadership review during phase three. This review process



is designed to critically evaluate outcomes to determine if policy adjustments are necessary based on the efficacy and viability of the implemented policy. The academic rigor of this phase is emphasized through the comprehensive integration of empirical evidence and stakeholder perspectives, thereby facilitating evidence-based decision-making to enhance and optimize the implemented policy in phase three.

### **Phase Three: Policy Revision and Staff Education**

In the one-month timeframe of phase three, executive leadership will assist the project team in a rigorous policy revision process, using the insights gained from meticulous data analysis and stakeholder feedback obtained in phase two. Any policy revisions will require RCD approval to uphold compliance with legal, ethical, and regulatory guidelines. Once approved, the revised policy will be seamlessly integrated into the organizational framework through upload to PolicyTech by the IT department. Concurrently, departmental educators will adjust training modules to reflect policy revisions. Department leaders will then disseminate additional training to ensure staff readiness and compliance with the updated policy.

In alignment with the scholarly foundations of this QI project initiative, it is noteworthy that phases two and three are cyclical, and they may be repeated if additional policy refinement and testing are required. This iterative approach draws inspiration from Gilbert's (1999) scholarly work on policy implementation and assessment, establishing an adaptive approach to achieve key measures and benchmarks while allowing for ongoing improvements and adjustments.

### **Phase Four: Sustained Implementation and Evaluation**

Subsequently, during phase four, the operational policy, meticulously crafted, tested, and officially sanctioned, will undergo a sustainable implementation over six months. This implementation phase represents a critical juncture where the policy's effectiveness is subjected to real-world application and scrutiny. During this phase, frontline providers will continue to record interventions

within the EMR for each patient. Additionally, CMs will initiate follow-up telephone calls within 72 hours of discharge, ensuring comprehensive documentation of post-discharge assessments for ongoing STB and OMHFC compliance.

The QI department will conduct monthly data collection and analysis, providing the project team with periodic results for presentation to both departmental and executive leadership. During the sixth month, departmental leaders and educators will obtain employee feedback. The project team will generate a comprehensive report for executive leadership review, combining data and feedback from the six-month implementation period. Aligned with the scholarly principles of evidence-based decision-making, executive leadership will meticulously evaluate the project's efficacy, compliance, and feasibility for sustained application and potential expansion. This evaluative process gauges the project's effectiveness in realizing anticipated outcomes, contributing substantively to organizational policy implementation and QI initiatives.

#### **Data Collection Methods**

Periodic data collection and analysis will be integral throughout the project's implementation, primarily emphasizing evaluating progress toward attaining desired outcomes. This evaluation will systematically compare the collected data against the baseline data, providing a comprehensive assessment of the project's advancement. To ensure adequate data collection, frontline providers will thoroughly and accurately document interventions in the EMR, including education and resources provided, assistance with OMHFC appointments and referrals, and completion of post-discharge follow-up telephone calls. Employee feedback will be collected electronically through a Qualtrics survey consisting of 14 questions (see Appendix C). The survey will utilize Likert scales and include opportunities for qualitative responses. The QI department will utilize the EMR's internal data exploration tool, Slicer-Dicer, to conduct regular extractions from the EMR system, performing weekly extractions during phase two and monthly extractions during phase four. Slicer-Dicer will allow the QI

department to retrieve de-identified patient clinical-epidemiological data from a large population and conduct preliminary data analysis (Saini et al., 2021).

The efficacy of this policy will be validated by demonstrating a 90% adoption and compliance rate, as evidenced by the fact that 90% of frontline healthcare providers have disseminated educational information to PACs. Furthermore, a notable achievement will be observed, with 90% of patients being linked with OMHFC resources before discharge. Lastly, a key metric for success will be the facilitation of post-discharge continuity, with 90% of discharged patients receiving a follow-up telephone call within 72 hours after discharge.

### **Evaluation**

During the preliminary data analysis phase, data will be thoroughly and systematically examined to categorize the dataset and to identify any discernible trends and patterns. This comprehensive process includes exploring participant characteristics, including age, gender, ethnicity, diagnosis, and administered treatments and assessing compliance with OMHFC appointments, frequency of continued STB, and 30-day readmission rates. Moreover, the descriptive analysis will intricately quantify employee adherence to established policies and procedures and assess interventions implemented. Frequencies and percentages will be calculated and presented in tabular and graphical formats to enhance clarity.

The QI department will utilize Stata 14.1 to conduct inferential statistical analyses to investigate relationships and effects within the dataset. Multivariate analyses will be undertaken to determine the effectiveness of interventions in improving OMHFC adherence and reducing 30-day readmission rates. Multiple linear regression analyses will be performed to examine the impact of interventions on the rates of continued STB leading to readmission within the 30-day timeframe. Logistic regression analysis will assess whether pre-discharge interventions influence OMHFC compliance following discharge. Furthermore, the project team will explore associations between categorical variables, such as patient demographics and adherence to OMHFC standards, through Chi-square testing. This methodologically

rigorous approach will provide a comprehensive understanding of the project's impact and effectiveness by systematically evaluating the complex interplay of variables and their influence on OMHFC compliance and readmission rates.

In order to conduct a comprehensive assessment of individual and organizational policy adoption, the QI department will extract employee performance data from the EMR system. Quantitative measures will be employed to evaluate the rate of policy adoption and how clinicians integrate interventions into their day-to-day clinical practices. It is essential to emphasize that this analysis' primary aim is not punitive; instead, it is focused on evaluating adherence metrics and identifying areas for improvement. To uphold confidentiality and protect the privacy of individuals, all collected data will undergo de-identification before being systematically organized in a contingency table. Subsequent analysis will be facilitated through the utilization of Microsoft Excel.

#### **Cost/Benefit Analysis**

The primary resource needed for the successful execution of this project is interdepartmental personnel, encompassing IT and QI departments, SWs, CMs, MDs, educators, and departmental leaders. Training materials and patient resources will be formulated and stored electronically to optimize fiscal efficiency, mitigating tangible material costs. Existing organizational platforms, including the EMR system, Microsoft Excel, and Stata, will be utilized for data collection and analysis to minimize software expenditures. Consequently, the financial requisites for this project will be nominal. Preliminary estimates project salary costs to approximate \$250,000 throughout the project's duration, encompassing contributions from all participating departments.

According to McEnany et al. (2020), the average daily hospital cost is approximately \$4,300. Organizational data demonstrates that approximately 200 behavioral health patients seek treatment each month, one-third of whom are discharged home, and the average boarding time while awaiting psychiatric hospital placement is approximately three days. Therefore, assuming two-thirds of patients

require inpatient psychiatric hospital placement and an average daily boarding time of three days, the average monthly caseload is approximately 400 patient days per month. Therefore, current hospital boarding costs are in excess of \$20.6 million per year. Fontanella et al. (2020) accentuate a 60% reduction in readmission rates for continued STB with adherence to recommended OMHFC guidelines. Anticipating equivalent outcomes with extended integration of the new organizational policy, the institution can realize estimated annual savings exceeding \$12.4 million annually, potentially mitigating unreimbursed hospital costs associated with 30-day readmissions. After implementation, the ongoing expenses are anticipated to be minimal, rendering this organizational change highly advantageous for both patients and the institution.

### **Discussion of Results**

This proposal outlines a theoretical project for development and implementation at a leading pediatric hospital in the Texas Medical Center. Due to the organization's intricate policy creation process, demanding a substantial time commitment, implementing this policy within the designated course timeframe was not feasible. Nevertheless, upon the successful implementation of the policy, a projected 25% reduction in 30-day readmission rates for persistent STB is anticipated within six months, supported by Choi et al. (2020). Extended policy adoption may yield a substantial decrease of up to 60% in readmission rates, as evidenced by Fontanella et al. (2020).

Change initiatives face challenges such as conflicting demands, limited resources, staff resistance, and communication gaps. Multiple concurrent improvement projects and conflicting demands can strain resources, underscoring the importance of having a clearly defined project scope and accurate cost assessment before initiation. Operating within the project scope and adhering to budget constraints are pivotal to mitigating the impact of resource limitations. Another hurdle is employee resistance, influenced by perceived loss and inadequate planning. Project transparency, clear and timely communication, and proactive employee engagement and involvement can enhance the

likelihood of successful project implementation, fostering a sense of value and inclusion. (Nilsen et al., 2020).

Leaders must recognize the critical importance of fostering innovation and encouraging team members' creativity, which is often how topics and ideas for change in EBP are identified. Successful EBP implementation relies heavily on creativity and innovation, and leaders must prioritize knowledge transfer and behavior change to effectively implement change while acknowledging that steps in the EBP process may coincide (Melnyk, 2010; Titler, 2008). Innovative thinking and creativity become paramount when existing policies prove unsuitable for modification to align with project requirements.

As Green (2019) highlights, the team leader's role is critical in ensuring project success, necessitating adopting a leadership approach that effectively addresses the diverse motivational factors impacting individuals and teams. A participative leadership style is particularly advantageous, as it fosters interdepartmental collaboration, facilitates shared decision-making, and enhances interpersonal communication within the team. Furthermore, recognizing the pivotal role of end-users in driving successful project design and implementation, the team leader will strategically employ a transformational and democratic leadership style. This approach aims to nurture a culture characterized by trust, support, and the absence of hierarchical barriers, empowering team members and end-users to collaborate, think innovatively, and communicate candidly. By integrating participative, transformational, and democratic leadership styles, the project leader will establish a trusting environment that fosters collaboration, motivating end-users to pursue shared project goals.

### **Conclusion and Recommendations**

The organization is responsible for delivering high-quality care to all patients, especially those struggling with mental health issues. This paper has presented a comprehensive proposal for an 18-month EBP QI initiative to enhance adolescent compliance with the timely receipt of OMHFC services post-discharge. Given the time and interdisciplinary collaboration required for the policy drafting

process, it is recommended that the organization establish a workgroup to commence immediately. This approach will enable phase two to commence during the first month of fiscal year (FY) 2025, with the project potentially concluding by the end of FY 2025.

The primary objectives of this project are to diminish persistent STB, mitigate 30-day readmission rates, and enhance long-term patient success. Adhering to the K2A framework, completing the project's four phases is anticipated to culminate in a policy that provides frontline providers with guidelines for connecting PACs with OMHFC services, providing education and resources, and conducting post-discharge follow-up telephone calls. The escalating global adolescent suicide rate underscores the urgency of such initiatives. By implementing this initiative, patients are expected to experience improved outcomes, with a targeted 25% reduction in 30-day readmission rates for persistent STB within the first six months and a 60% reduction with sustained long-term policy adoption.

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Appendix A

Evidence Table

Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/ Method	Sample/ Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
1. Bear, H.A. et al. (2020). Systematic review and meta-analysis: Outcomes of routine specialist mental health care for young people	Conceptual framework: N/A  Purpose of study: to determine outcomes following TAU by MH specialist services among	MA  Inclusion criteria: • CYP • Using MH services for depression  assessed TAU outcome (specialist MH care)	N=38 (of initial 6,350 studies; published from inception to 01/2019)  Characteristics • 11,739 CYP • Participant size from 6-4,659 • 7-20 yrs old	IV: TAU (eclectic or IDT ITVNs)  DV(1): depression symptom improvement  DV(2): symptom reduction over time (3 mo, 18 mo)	Data extracted using a standardized, pre-piloted extraction table  Multilevel random effects univariate models, consistency (CI), longitudinal trend analysis of	Data analyzed using Stata 14.1  DV(1): pre-post ES using Hedge's g, CI  DV(2): Hedge's g, BIC	DV(1): $g = -0.89$ , 95% CI = -1.04 to -0.73  DV(2): $g = -0.6$ (3 mo) and -1 (18 mo); BIC = -219.5	LOE: I  Strengths: high methodological quality; high interrater agreement; high validity and reliability; thoroughly described process; study replicable  Limitations: poor quality of data due to missing information and lack of detail regarding TAU ITVNs and fidelity, large geographical skew towards North American studies  Bias: funnel plots to assess for sample size and publication bias  Feasibility: applicable to improve timely OMHFC after discharge, to encourage

Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
with depression and/or anxiety.	CYP with depression at individual level	<ul style="list-style-type: none"> <li>• Original research</li> </ul>	<ul style="list-style-type: none"> <li>• M age = 13.8 yrs</li> <li>• 61.65% female</li> <li>• 33 studies used diagnostic or cut-off inclusion criteria</li> <li>• 4 – 196 treatment sessions (M = 26.8)</li> </ul> <p>Databases (3):</p> <ul style="list-style-type: none"> <li>• MEDLINE</li> <li>• Embase</li> <li>• PsycInfo</li> </ul>		standardized change (Hedge’s g) using mixed-effects MR and BIC			<p>continuity of care for a minimum of 3 months after DC.</p> <p>Conclusion: SIG RED in symptoms when receiving TAU in specialist mental health services over time (33-40% showed improvement/recovery); initial large RED within the first 3 months then gradual deceleration thereafter; higher rates of improvement in clinician reporting versus patient reporting</p> <p>Recommendation: further studies to investigate specific and detailed ITVNs to improve recovery rates; patient views need to be considered and incorporated; shared decision-making treatment models necessary</p>

Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

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			Setting: US, UK, Germany, Australia, Canada, Sweden, Denmark, Norway, Finland, New Zealand, Italy, Ireland, and India  Attrition: NR					
2. Bojanić, L., et al.	Conceptual	QUAN; DS	N = 826	IV: DC from IP psychiatric	Count obtained from the	DV(1 & 2):	IV: 26,426 deaths	LOE: VI

Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
(2020). Early post-discharge suicide in mental health patients: Findings from a national clinical survey.	framework: N/A  Purpose of study: to examine factors associated with suicide after DC from psychiatric IP care	Inclusion criteria: • DBS within 1 week of DC from IP psychiatric care • Formal DC & DC date recorded	All ages; England & Wales; 1997-2016  Attrition: NR	hospitalization  DV: after IP psychiatric hospitalization, DBS within  (1) 0-3 days post DC  (2) 4-7 days post DC	NCISH (1997-2016), Office for National Statistics, & clinical data via questionnaires completed by patient's clinician	Descriptive analysis (# and %)  Comparisons (chi-square)	DV(1): 428 (51.8%)  DV(2): 398 (48.2%)  Comparison: $\chi^2=0.18$	Strengths: 20 years of data; diagnosis & most frequently used means to commit suicide identified; increased risks identified among specific populations  Limitations: exploratory & uncontrolled retrospective study; inability to draw etiological conclusions; possible clinician bias; possible missed DBS; inability to confirm patient diagnoses (provided by clinicians); unable to obtain hour of DC & subsequent death  Bias: potential for clinician bias on questionnaires Conclusion: Risk of DBS is SIG INC in the 7 days after DC; safety planning and FU appointments essential to reduce risk of DBS

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								Recommendation: further QUAL and QUAN study into DC planning needed; should focus on specific needs based on diagnosis
3. Briggs, S., et al. (2019). The effectiveness of psychoanalytic/psychodynamic psychotherapy for reducing suicide attempts and self-	Conceptual framework: N/A  Purpose of study: To assess whether PSYAN is more effective than TAU to prevent SA and SH	SR & MA  Inclusion criteria: • RCT • Comparing PSYAN to TAU	N=17 out of 3304 potential studies (1970-2017)  All ages included: • Adult = 9 • < 18 years old =3  Databases (6): • PubMed • PsycINFO	IV: PSYAN  DV(1): occurrence of repeated SA  DV(2): occurrence of repeated SH (incl. SA and self-injury)	Data extracted by 2 authors independently using form adapted from the Cochrane Data Extraction and Assessment Template 2011  Random effects model	Analysis conducted with Stata version 14.2  SR: • Primary outcomes: SA and SH • Secondary outcomes (risk factors): depression,	DV(1): SIG RED at 12 months (OR= 0.469; 95% CI 0.274–0.804; I <sup>2</sup> = 0.0)  DV(2): SIG RED at 6 months (OR= 0.27; 95% CI 0.109–0.668, I <sup>2</sup> = 82.7%)  DV(3): SIG RED at 12 months (SMD= -0.505; 95% CI -0.763- -0.246; I <sup>2</sup> = 0.0%)	LOE: I  Strengths: overall low risk of bias, large participant population included, variety of settings and countries included  Limitations: moderate quality of evidence, limited sample size, diverse ITVNs (intensity, content, duration), majority of studies on adults & results grouped  Bias: possible reporting bias in 9 studies; low risk of selection, performance and detection, and attrition bias

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harm: Systematic review and meta-analysis.			<ul style="list-style-type: none"> <li>Psycharticles</li> <li>CINAHL</li> <li>EMBASE</li> <li>CCRCT</li> </ul> Setting: inpatient, outpatient, community, and emergency, home; USA, UK, Europe, Australia  Attrition: NR	DV(3): number of admissions	for MA with fixed effects model for subgroup comparisons  HGNY (I <sup>2</sup> ) relative importance guided by Cochrane handbook	anxiety, psychosocial functioning, admissions  MA: • DV(1): OR, CI, I <sup>2</sup> • DV(2): OR, CI, I <sup>2</sup> • DV(3): SMD, CI, I <sup>2</sup>		Feasibility: treatment and FU at stated intervals to maximize impact of PSYAN to RED SA and SH  Conclusion: PSYAN shows SIG treatment effect for number of SA, SIG RED of SH, SIG RED of admissions  Recommendation: further study needed with increased sample size; consider specific diagnostic and problem categories for more specialized ITVNs; study longer FU intervals (>12 months) after treatment ends
4. Choi, Y., et al.	Conceptual	Nested CCS	N=18,702  Sample:	IV: continuity of care	Data obtained from	Analysis conducted	DV(1): n = 8,022; 42.9%	LOE: IV

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(2020). Association of continuity of care with readmission, mortality and suicide after hospitalization discharge among psychiatric patients.	framework: N/A  Purpose of study: to identify associations between continuity of OMHFC and readmissions, mortality and suicide	Inclusion criteria: • IP claims 1/1/02 – 12/31/13 • seen primarily for psychiatric disorders • with national health insurance  Exclusion criteria: • without informati	• all ages • IP hospitalization for MH disorders 2002-2012  Setting: • South Korea  Attrition: NR	(OP) visits after DC  DV(1): 1 year readmission rate  DV(2): risk readmission within 1 year for continuity of care index: (a) high (0.75-1) (b) medium (<.75) (c) low (<0.4)	National Health Insurance Service-National Sample Cohort (NHIS-NSC) 2002-2013  Risk-set sampling method; patient-based measurement method; continuity of care index; conditional	using SAS version 9.4  DV(1): n, %  DV(2): (a) AOR (b, c, d): AOR; CI; p  DV(3): n, % (a & b) AOR; CI  DV(4): (a) AOR (b, c, d): AOR; CI; p	DV(2): (a) AOR = 1 (b) AOR = 1.519; 95% CI = 1.250-1.845; p<0.0001 (c) AOR = 1.789; 95% CI = 1.425-2.263; p<0.0001 (d) AOR = 1.116; 95% CI = 0.975-1.278; p=0.112  DV(3): n = 108; 9.1%  DV(4): (a) AOR = 1 (b) AOR = 2.709; 95% CI = 1.168-6.284; p=0.012	Strengths: large sample population with control group; 11 years of data; nationwide study; high validity and reliability; thoroughly described process  Limitations: possibility of coding inaccuracies; some covariates unable to be identified; inconsistent measurement methods for continuity of care; difference in study designs; some small sample sizes  Bias: possible immortal time bias; confounding bias minimized by calculating AOR  Feasibility: feasible for implementation with focus on improving continuity of care

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	within 1 year	on about IP days <ul style="list-style-type: none"> <li>• discharged or admitted in 2013</li> <li>• died in hospital</li> <li>• with medical aid</li> </ul>		(d) no FU visits  DV(3): 1 year rate of DBS  DV(4): risk of DBS within 1 year for continuity of care index: (a) high (0.75-1) (b) medium (<.75) (c) low (<0.4)	logistic regression		(c) AOR = 3.839; 95% CI = 1.351-10.914; p=0.020 (d) AOR =	Conclusion: continuity of OMHFC after DC associated with lower risk of readmission and suicide; medium and low continuity of care associated with high risk of readmission within 1 year of DC; suicide risk for medium and low continuity of care greater than high continuity of care  Recommendation: need efforts to improve continuity of care (improving patient awareness of importance of OMHFC; implement policy to promote continuity)

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				(d) no FU visits				
5. Doupnik, S.K., et al. (2020). Association of suicide prevention interventions with subsequent suicide attempts, linkage to follow-up care, and depression	Conceptual framework: N/A  Purpose of study: to examine the association of brief acute care SI ITVNs with subsequent SA and	SR & MA  Inclusion criteria: • published 01/2000 – 05/2019 • clinical trials of single in-person encounter suicide prevention ITVNs • directly assessed SI risk,	N=14 studies (4270 patients)  Databases (5): • MEDLINE • Scopus • CINAHL • PsychINFO • Embase  Setting: Acute care EDs and MH clinics in USA, UK, Malaysia,	IV: brief suicide prevention ITVNs  DV(1): subsequent SA  DV(2): linkage to FU care	Data extracted and reviewed by 2 study authors independently; PRISMA guidelines  Random-effects models (pooled effect size estimates weighted for inverse variances of	Analysis conducted using Stata version 15  DV(1 & 2): pooled OR (pOR), CI, Hedges g	DV(1): 3.5% RED (pOR = 0.69; [95% CI = 0.55-0.87]; Hedges g = 0.21 [95% CI = 0.08-0.33])  DV(2): 22.5% INC (pOR = 3.04 [95% CI = 1.8-4.17]; Hedges g = 0.55 [95% CI = 0.32-0.78])	LOE: I  Strengths: risk bias assessed/rated for each study to assign bias score; techniques to account for studies with small sample sizes  Limitations: limited to English publications, did not include unpublished findings, small sample size with one study accounting for large proportion of study participants, unable to examine if ITVN ultimately reduced DBS if study did not include death as an outcome  Bias: low risk of bias; bias risk assessed using Cochrane Risk of Bias tool and publication bias assessed using Peter

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symptoms for acute care settings: A systematic review and meta-analysis.	linkage to FU care	promoted continued MH care, or both <ul style="list-style-type: none"> <li>included comparison group</li> <li>measured patient outcomes</li> <li>available in English</li> </ul> Exclusion criteria: <ul style="list-style-type: none"> <li>ITVN consisting only of 1</li> </ul>	and US military installations  Attrition: NR		individual effects)			regression tests and contour-enhanced funnel plots  Feasibility: implement brief suicide ITVNs to reduce future SA and improve OMHFC compliance  Conclusion: Brief suicide prevention ITVNs RED subsequent SA; prevention ITVNs delivered in single encounter RED SA and ensure engagement in OMHFC  Recommendation: integrate brief suicide prevention ITVNs into acute care encounters; identify at-risk patients; test ITVN implementation strategies; identify barriers to improve the continuity of OMHFC

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		brief FU contact						
6. Doupnik, S.K., et al. (2021). Mental health service use before and after a suicidal crisis among children and adolescents	Conceptual framework: N/A  Purpose of study: to examine the impact receiving ambulatory MH care or general healthcare in the 30 days	Retrospective CS	N=92,451  Included: • 6-17 yrs old (M=15 yrs) • 54% female • diagnosis of SI (38%) or SA (62%) • treat-and-release ED visits (67%) or ED-to-hospital admissions (33%)	IV(1): ambulatory MH care encounter in 30 days preceding ED visit  IV(2): ambulatory general healthcare visit in 30 days preceding ED visit  DV(1): likelihood	Data extracted from Medicaid Analytic EXtract dataset  DV(1 & 2): AOR & CI (prediction of completion)	Analyses conducted at level of individual ED visit  Predictions determined using mixed-effects logistic regression model	Analysis conducted in SAS version 9.4 (dataset mgmt.), Stata 16 (models), GraphPad Prism 8 and R version 3 (figures)  DV(1a): AOR = 11.01; 95% CI = 9.82-12.35  DV(1b): AOR = 4.6; 95% CI = 3.16-6.68  DV(2a): AOR = 1.17; 95% CI = 1.09-1.24	LOE: IV  Strengths: high probability and statistical significance, large sample size, methods clearly described for replication in future studies  Limitations: study utilized administrative claims data; may have missed services provided for which MCD was not billed; unable to adjust for possible contributing clinical factors; 2009-2012 data may not reflect more recent data  Bias: Possible sampling bias; attempted to limit by sampling from states with highest quality MCD data

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in a United States national Medicaid sample.	before an ED visit for SI/SA has on the likelihood of completing OMHFC visit after DC		between 2009-12  Excluded: • <6 yrs old • adults 18+ • those not eligible for MCD in 3 months before and 1 month after ED visit  Data sources: • Medicaid claims identified by specified	of obtaining OMHFC after DC (a) ED treat and release (b) ED to hospital  DV(2): likelihood of obtaining OMHFC after DC (a) ED treat and release (b) ED to hospital			DV(2b): AOR = 1.25; 95% CI = 1.17-1.34	Feasibility: relevant and applicable to practice; need to identify barriers to obtaining OMHFC  Conclusion: ambulatory MH visit within 30 days before MH ED visit strongest predictor of 30-day post-DC OMHFC compliance; 80% with pre-ED MH visit compliant with OMHFC versus 44% of those without; those with accessibility to OMHFC demonstrate higher rate/compliance with OMHFC after DC for SI/SA; on 25% of those without MH visit 30 days before ED visit had OMHFC after DC  Recommendation: investigate barriers/accessibility to obtaining timely/regular OMHFC; focus on increasing continuity of MH care after

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			(N=20) diagnosis codes  Setting: • 29 states • EDs at US acute care hospitals  Attrition: NR					DC; assist with/coordinate OMHFC if no previously established MH care
7. Fontanella, C.A., et al. (2020). Association of timely outpatient mental	Conceptual framework: N/A  Purpose of study: to determine effect	QUAN; Population based, retrospective, longitudinal CS	N = 139,694 • 10-18 • 51.9% female • Hospitalized for STB 2009 - 2013 • Medicaid data from	IV: receiving MH FU within 7 days of DC  DV: odds of suicide for 8-180 days post DC	Suicide within 8-180 days post-DC measured using the International Statistical Classification of Diseases and Related	Poisson regression, ARR, 95% CI, P values	IV: 56.5% received FU  DV: lower odds of suicide: ARR = 0.44; 95% CI= 0.83; p=0.01	LOE: IV  Strengths: assessed and identified specific factors that DEC/INC risk/timeliness of OMHFC compliance  Limitations: focus on Medicaid-enrolled youths (excluded uninsured/private insured); possibly excluded ITVN/factors affecting receipt of

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health services for youths after psychiatric hospitalization with risk of death by suicide.	of OMHFC within 7 days of hospital DC on suicide risk and continued STB		33 states linked with National Death Index data  Attrition: NR		Health Problems, Tenth Revision codes X60 to X84, Y87.0, and U03 as primary cause of death			OMHFC, did not assess/consider availability/adequacy/effectiveness of OMHFC services; limited statistical power  Bias: possible selection bias  Conclusion: OMHFC within 7 days of DC SIG DEC risk of DBS/SI/SA during first 6 months post-DC  Recommendation: ensure receipt/scheduling of OMHFC within 7 days of DC; facilitate/improve transitional ITVNs (IP to OP); identify patients at INC risk of not receiving FU care
8. Gryglewicz, K., et al.	Conceptual framework: N/A	QUAN; QE; Longitudinal	N=460  10-17 yo; 75% F,	IV: LINC ITVN	Coordinators contacted participants by phone at	Stata SE 15.1 used for data analysis	DV: (1) increased from 79% to 86% at 90 days; p<0.05	LOE: III

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(2023). Caring transition—A care coordination intervention to reduce suicide risk among youth discharged from inpatient psychiatric hospitalization.	Purpose of study: to evaluate utility and potential effectiveness of the LINC in IP settings providing care to suicidal youth		82.5% heterosexual, 80% non-hispanic; >86% with mood d/o  Setting: IP psychiatric hospital & OP settings (after d/c)	DV1 – OP service usage  DV2 - 90 day readmission rate  DV3 – depressive symptoms  DV4 – continued SI	30, 60, and 90 days post-DC  DV1 – measured using LINC Care Coordination Monitoring Form (yes/no)  DV2 – rate obtained via agency records  DV3 – measured by PHQ9; M, SD	DV1&2 – descriptive statistics, X2 tests, t-tests  DV3&4 – mixed effects linear regression	(2) 84% not readmitted  (3) M=5.88; SD=5.43; DEC by 65% from baseline  (4) M=0.42; SD=1.06; DEC by 86% from baseline	Strengths: low cost, easily replicable, testing used has high reliability and validity  Limitations: absence of comparison group, low participation rate from initial group  Bias: participation bias  Feasibility: relevant and sustainable findings but need to investigate reasons for non-participation and expand focus on cultural groups  Conclusion: LINC ITVN DEC risk of suicide/depression and INC engagement/use of OP services post-DC; highlights importance of immediate and intensive OMHFC after DC

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					DV4 – measured by C-SSRS; M, SD			Recommendation: examine adaptations to delivery mode and length of services (e.g. telehealth & longer FU periods); explore impact of ITVNs on diverse cultural groups/settings
9. Hoffman, J.A., et al. (2023). Follow-up after pediatric mental health emergency visits.	Conceptual framework: health equity framework  Purpose of study: to evaluate the association	Retrospective CS  Included: • enrolled in MCD • at least 1 MH ED visits 01/2018-06/2019  Excluded: • no MH coverage	N=28,551  Characteristics • 6-11 yrs (24.5%) • 12-17 yrs (75.5%) • 51.6% female • 57% non-Hispanic White; 31.7% non-	IV: timely OMHFC (within 5 days) after ED DC  DV: risk of return for acute MH care encounter (ED or hospitalization)	Cox proportional hazards multivariable models, adjusted for socioeconomic and clinical characteristics (determined using $\chi^2$ tests), and empirically	DV: % risk reduction, HR, CI	Analyses performed using SAS 9.4  DV: 27% DEC risk of return; HR=0.74; CI=0.63-0.91	LOE: IV  Strengths: clearly stated objectives and hypothesis; significant and valid results applicable to the population; results comparable to previously completed studies with comparisons provided  Limitations: data only from 11 US regions; may not be generalizable to all states; limited continuous MCD enrollment period (6 months) after ED DC, unable to determine which OP MH visits were scheduled specifically in response to the ED visit (versus

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Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
	between timely OMHFC after ED DC and risk of return for MH acute care within 6 months	<ul style="list-style-type: none"> <li>• CHD without continuous MCD enrollment for 6 months after ED visit</li> <li>• CHD with only MH ED visits that resulted in admission</li> </ul>	Hispanic Black <ul style="list-style-type: none"> <li>• MH diagnoses:</li> <li>• depression-related (39.1%)</li> <li>• disruption, impulsivity, conduct related (25%)</li> <li>• trauma, stressor-related (14.2%)</li> </ul> Databases: <ul style="list-style-type: none"> <li>• IBM Watson</li> </ul>		stratified into 2 groups			previously scheduled), unable to assess quality of OMHFC (only attendance)  Bias: possible selection bias (only 11 US regions included); possible assumption bias (assumed visits with ED claims within 24 hours represented transfers to acute psychiatric hospitals and were excluded)  Feasibility: information can help identify patients with increased risk of not receiving OMHFC after DC: remove barriers to access, provide resources, provide education  Conclusion: FU within 7 days of DC increases length of continued OMHFC for 6 months; connection to OP care within 30 days of DC DEC the risk of repeat ED visits or admission in the 5

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Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
			MarketScan MCD database  Setting: 11 dispersed and deidentified US states  Attrition: NR					days after DC followed by increase thereafter – highlights need for OMHFC within 5 days of D/C; those with previous MH care visits in year prior to the ED visit more likely to FU OP after DC; non-Hispanic Black CHD less likely than White CHD to receive timely OMHFC  Recommendation: further research needed: investigate how OMHFC use after DC varies based on predisposing factors, enabling factors, and need for ongoing MH care; assess how type/quality of OMHFC influences returns/readmissions; assess if specific ITVNs to promote OMHFC and reduce readmission
10. Morgan, A.J., et al.	Conceptual	QUAN  CS; CLS	N=60 WLF networks &	IV: WLF network	Count obtained from the	MELM for count data model.	DV:	LOE: IV

Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
(2022). The effectiveness of an Australian community suicide prevention networks program in preventing suicide: A controlled longitudinal study.	framework: none  Purpose of study: to examine the effect of WLF network establishment on ADOL suicide rates	Exclusion criteria: networks established before 2001 or after 2017	60 control areas  50% regional, 30% in major cities, 20% in remote areas  Attrition: NR	implemented  DV: changes in ADOL suicide rates after WLF established	National Coronial Information System (2001-2017); mapped using Geographic Information System	Counts modelled as a Poisson distribution.  Linear & quadratic models to determine trend  DV: Post WLF IRR	Post WLF IRR = 0.93 (p=0.025) (7% decrease)  Peak in 3rd quarter: IRR = 0.86 (p=0.030) (17% decrease)	Strengths: 17 years of suicide data, multiple community suicide networks (120 total communities included), analysis of a suicide prevention program with evidence of success and a whole-of-community approach  Limitations: Inability to include the most recent data or account for impact of alternative suicide prevention program use; program analyses lacked uniform structure; reliability and validity not discussed  Conclusion: WLF shows decrease in suicide rates with implementation  Recommendation: further research needed to evaluate utilization of alternative programs within

Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

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								communities that may influence the RED of suicide rates
11. Rengasamy, M. & Sparks, G. (2019). Reduction of postdischarge suicidal behavior among adolescents through a telephone-based intervention.	Conceptual framework: N/A Purpose of study: to determine effectiveness of FU phone calls after DC to reduce STB and increase	QUAN; QE Inclusion Criteria: • ADOL • Hospitalized for SI & SA Exclusion criteria: • DC to long-term care facility • Transferred	N = 142 • 12-18; 2017-2018 • Pittsburg metro area • 70% female • 74% white, 22% black, 13% Asian, 1% Native American Attrition: NR	IV(1): SCI at 90 days post DC IV(2): MCI (6 calls) at 1, 7, 14, 30, 60, and 90 days post DC DV(1): Rate of continued STB DV(2): confidence in safety	Identified by medical record census or notification of IP staff; quasi-randomized design into IV groups on day of DC Participant assignment stratified by reason of admission & ITVN recipient	Basic linear regression analysis, linear and logistic regression, Kaplan-Meier, IRR, log-rank (LR). Wilcoxon (W) tests DV(1): OR, CI, p, IRR, LR-X <sup>2</sup> , W-X <sup>2</sup> DV(2): β, CI, p	DV(1): IV2/MCI (6%) versus IV1/SCI (17%); (OR=0.28, 95% CI = 0.09-0.93, p=0.037) & Kaplan-Meier IV1/SCI higher risk of STB than IV2/MCI (IRR = 3.73, LR-X <sup>2</sup> = 4.4, p=0.036; W-X <sup>2</sup> = 4.32, p=0.038) DV(2): IV2/MCI (95.4%) versus IV1/SCI (73.6%); (β = 21.81, 95% CI = 9-34.6, p = 0.001)	LOE: III  Strengths: sample size strongly representative of target population, used electronic medical records with access to multiple health systems, no differences in suicide risk factors among sample, cost effective ITVN  Limitations: limited sample size, unable to contact all families/patients, did not use true randomization schema, no baseline suicide severity for most sampled  Bias: low likelihood of assignment bias  Feasibility: FU telephone calls after DC feasible in adolescent population

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Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
	confidence in safety plan	<ul style="list-style-type: none"> <li>Placed in CPS care</li> <li>Readmitted within 12 hours of DC</li> <li>No FU contact info</li> </ul>		plan at 90 days	(parent or parent & CHD)			<p>Conclusion: MCI more effective than SCI in reducing continued STB and increasing confidence in safety plan (11% reduction in MCI versus SCI); MCI increases confidence in safety plan versus SCI (20% higher confidence)</p> <p>Recommendation: initiate MCI early post DC from IP psychiatric hospitalization; include discussions about continued STB and review safety plans; further determine effectiveness and cost on larger scale</p>
12. Walsh, E.H., et al. (2022). Research review:	Conceptual framework: N/A Purpose of study:	MA & MR Inclusion criteria: • CRT studies	N=12 out of 1425 potential studies (database inception to Jan 2021)	IV: PSSP DV(1): SA DV(2): SI	ORs, sampling variances using trial proportions, corresponding p-values if	Data organized by PICO, ITVN, and contextual factors; analyzed	DV(1): AOR = 0.72 [95% CI: 0.59, 0.87], p = .49 (28% lower odds) DV(2):	LOE: I  Strengths: diverse participant pool (50% in North America, others from Europe, Australia, Asia), equally distributed between male & female (M=49% male)

Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

Citation: (i.e., author(s), date of publication, & title)	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
The effect of school-based suicide prevention on suicidal ideation and suicide attempts and the role of intervention and contextual factors among adolescents: A	to estimate the population effect for PSSP ITVNs on ADOL SA & SI and explore how ITVNs effects vary based on ITVN and contextual moderators	<ul style="list-style-type: none"> <li>• 11-19 years old</li> <li>• ITVN in PPSS</li> </ul>	Database (6): <ul style="list-style-type: none"> <li>• PsycINFO</li> <li>• Medline</li> <li>• Education Source</li> <li>• ERIC</li> <li>• Web of Science</li> <li>• CCRCT</li> </ul> Setting: <ul style="list-style-type: none"> <li>• 10 school</li> <li>• 2 class</li> </ul> Attrition: NR		no trial proportions  MA: Multilevel random effects univariate models, consistency (CI), HGNY (I <sup>2</sup> statistic), Forest plots  MR: Univariate meta-regression	with R statistical packages metaphor and meta  DV 1 & 2: OR, CI, p	AOR =0.85 [95% CI: 0.75, 0.95], p = .93 (15% lower odds)	Limitations: possible increased sampling error in regression weights, underreported school characteristics across CRTs (increased variability), moderator exclusions  Bias: 6 studies low risk & 4 studies high risk of bias (based on CCRBT), no publication bias (Egger’s Regression Test), selection bias limited  Feasibility: PSSP viable ITVN to DEC SA and SI in CYP  Conclusion: PSSP ITVN SIG RED SA (28%) and SI (15%) in CYP with larger SA odds RED with 12 month FU and multi-stakeholder delivery

Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

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meta-analysis and meta-regression.								Recommendation: further studies to determine how to maximize distribution of PSSP (scale, adoption, implementation, sustainability) & include a minimum of 1 year FU for SA
13. Watling, D.P., et al. (2022). Developing a post-discharge suicide prevention intervention for children	Conceptual framework: N/A  Purpose of study: to integrate lived-experiences into the design of a suicide	QUAL  Inclusion Criteria: • lived-experience with suicidality • limited to consumer advisory groups and Acute	N=18  Characteristics • 5 patients; 17-21 yrs (M=19.2); 3 male • 3 female parents • 10 ED MH clinicians (6 female) - 5 RNs, 3 social workers, 2	IV: post-discharge FU phone call  DV: important foundational themes	Focus groups (10 participants per group across 6-10 focus groups); led by female clinical psychologist with >15 yrs experience in CYP MH and STB	Phenomenological analysis using Colaizzi's 7 steps and Nvivo 12  DV: foundational themes	DV: person-centered and participatory in nature (being heard, understood, and active in ITVN process), phone call/FU service dynamics (relationship and rapport building, developing connection), and phone call	LOE: VI  Strengths: small sample for best thematic analysis, number of focus groups held based on research data for best results, study well-defined and well-described to be adequately replicated,  Limitations: short-term study, small participant pool may not reflect overall population, older aged young people, participants may not have been forthcoming in expressing true opinions, sample weighted towards

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and young people: A qualitative study of integrating the lived-experience of young people, their carers, and mental health clinicians.	prevention ITVN delivered by phone after DC from an ED for STB	Response Team • 17-25 yr old (patients), caregivers, and ED MH clinicians	psychologists • Clinician experience: 6-20 yrs (M=11.75)  Setting: Queensland Children’s Hospital, Brisbane, Australia; April-May, 2019  Attrition: NR		Semi-structured recorded interviews Recordings transcribed by Pacific Transcriptions with participant de-identification  QUAL analysis; phenomenological analysis; deductive content analysis		purpose (clear understanding and appropriate support provided)	clinicians, semi-structured format may have indirectly influenced the discussion  Bias: possible sampling bias  Feasibility: Post-DC FU phone calls are a feasible way to continue MH discussions with patients experiencing STB and help transition of care (IP to OP)  Conclusion: Post-DC phone calls effective for FU re: OMHFC compliance, continue MH care discussions, continued symptoms/STB  Recommendation: need to test in specific settings and on larger scale with higher % of patients (vs clinicians); calls should be responsive to

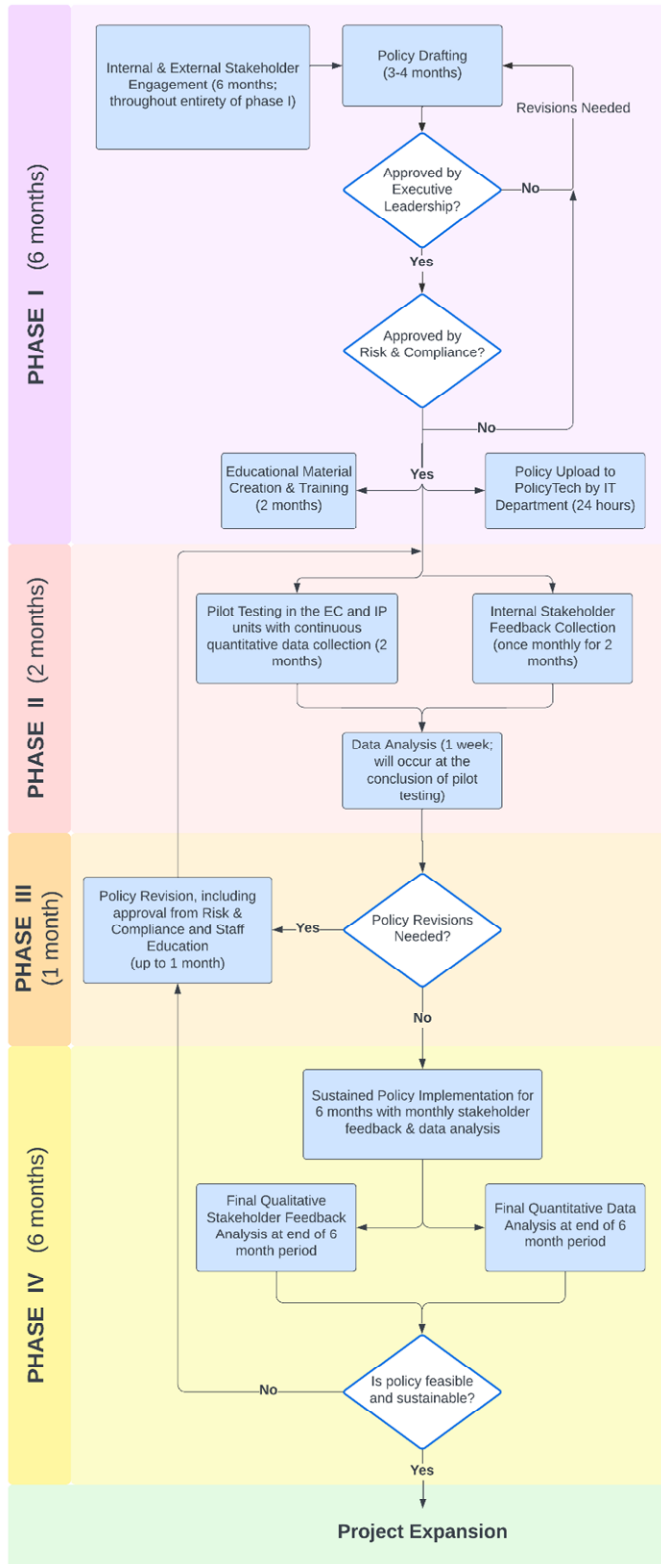
Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

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								person/situation; structured, have clear purpose, recognize individual needs, provide tailored support/guidance

Legend: ADOL = adolescents; AOR = adjusted odds ratio; ARR = adjusted relative risk; ASU = acute services use; BIC = Bayesian Information Criterion; CCRBT = Cochrane Collaboration Risk of Bias Tool; CCS = case-control study; CHD = child/children; CI = confidence interval; CLS = controlled longitudinal study; CRT = cluster randomized trial; CS = cohort study; CYP = children and young people; DBS = death by suicide; DC = discharge; DEC = decrease; DS = descriptive study; ED = emergency department; FU = follow-up; HGNY = heterogeneity; HR = hazard ratio; IDT = interdisciplinary team; INC = increase; IP = inpatient; IRR = incidence rate ratios; ITVN = intervention; LINC = Linking Individuals Needing Care; LOE = level of evidence; M = mean; MA = meta-analysis; MCD = Medicaid; MELM = mixed effects longitudinal models; MH = mental health; MM = mixed methods; MR = meta-regression; NR = none reported; OMHFC = outpatient mental health follow-up care; OP = outpatient; OR = odds ratio; PHP = partial hospitalization program; PSSP = post-primary school-based suicide prevention; PPSS = post-primary school setting; PSYAN = psychoanalytic psychotherapy; QE = quasi-experimental; QUAL = qualitative; QUAN = quantitative; RCI = reliable change index; RCT = randomized control trials; RED = reduced/reduction; SA = suicide attempt; SD = standard deviation; SH = self-harm; SI = suicidal ideation; SIG = significant; SR = systematic review; STB = suicidal thoughts and behaviors, including SI and SA; TAU = treatment as usual; WLF = Wesley LifeForce

Appendix B

Flowchart



**Appendix C**

**Employee Feedback Survey**

The organization values your insight and feedback. Please complete the attached survey in response to the organization’s new policy for patients presenting with suicidal thoughts or behaviors.

Thinking about the new policy, please answer the following...	Not at all	1	2	A little	3	4	Very Well	5
1. I understand the purpose of the new policy.	1	2	3	4	5			
2. I understand and feel prepared to perform my responsibilities.	1	2	3	4	5			
3. Interdepartmental communication and collaboration have improved.	1	2	3	4	5			
4. I am satisfied with the efficiency of the new policy.	1	2	3	4	5			
5. I feel the new policy adequately addresses the needs of our patients.	1	2	3	4	5			
6. I feel the new processes are helping improve our patient outcomes.	1	2	3	4	5			
7. I feel the policy provides adequate patient resources and education.	1	2	3	4	5			

8. Did you receive education about the policy before the go-live date? Y / N

9. Has the new policy negatively affected your productivity or daily routine? Y / N

If yes, please explain.

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10. Do you feel there are any bottlenecks or unnecessary steps in the new workflow? Y / N

If yes, please explain.

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11. Are there any areas in which you feel that you would benefit from more training? Y / N

If yes, please explain.

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12. Would you be willing to provide additional information detailing your experiences with the implementation of the new policy? Y / N

13. In the future, would you be willing to participate in organizational process improvement initiatives to improve processes and workflows? Y / N

14. Please provide any additional feedback in the space below.