Members Present

Hugh Straley, MD (Chair), Bree Collaborative

Kate Comtois,* PhD, MSW, Harborview
    Medical Center

Matthew Layton,* MD, PhD, FACP, DFAPA,
    Washington State University

Karen Hye, PsyD,* CHI Franciscan

Neetha Mony, MSW, Washington State
    Department of Health

Julie Richards, MPH, Kaiser Permanente
    Washington Health Research Institute

Jennifer Stuber, PhD, University of Washington
    School of Social Work

Jeffrey Sung, MD, Washington State Psychiatric
    Association

Staff and Members of the Public

Therese Hansen,* Washington State
    Department of Health

Ginny Weir, MPH, Bree Collaborative

Emily Wittenhagen, Bree Collaborative

* By phone/web conference

WELCOME AND INTRODUCTIONS

Hugh Straley, MD, Bree Collaborative, opened the meeting and those present introduced themselves.

BREE COLLABORATIVE OVERVIEW

Ginny Weir, MPH, Bree Collaborative, presented a background of the Bree Collaborative, how meetings are run, the process of developing recommendations, and how recommendations are disseminated, covering Robert's Rules of Order, House Bill 1311, stakeholders involved, the role of the Health Care Authority, past and current work, the Open Public Meetings Act (OPMA), and the potential language for the aim and charter of the workgroup.

> **Action Item**: Ms. Weir to send the OPMA materials to the group.

PRELIMINARY SCOPE OF WORK

Ms. Weir went over the proposed work plan for the workgroup and the Suicide Prevention Charter and Roster and discussed:
- Ways the Behavioral Health Integration recommendations could serve as a model for the recommendations of this group, including factors like access to psychiatric services, integrated care teams, implementation techniques, and standards/processes that can apply both locally and nationally (locally, taken up by Washington's Accountable Communities of Health, etc).
- How it came about that this topic was chosen, and its relevancy and potential impact.
- How the Medicaid Waiver demonstration project effects (and doesn't effect) this work.
- The Bree's (limited capacity) role following the dissemination of recommendations in monitoring implementation and pushing for legislative change, and how these efforts could potentially be bolstered by others.
- The opportunity to introduce measures into the Common Measure Set.
- Areas outside the clinical space that could be included, like school systems, corrections, VA, etc.

- Considering other individuals and/or organizations to invite to the table.
- Making a distinction between suicide care and suicide prevention, where prevention falls more outside clinical systems, and considering where we can have the greatest impact.
- Opportunities for prevention that do exist in the clinical setting.
- Not wanting to get too diffuse by focusing on several systems.
- Having Therese Hansen, Washington State Department of Health, walk the group through the four areas of the state's suicide prevention plan at the next meeting to avoid duplication.
- The possibility of having the most impact by focusing on clinical systems, where there is more unmet need than the public health realm that includes other systems like schools, etc.
- Potential focuses: primary care, emergency departments, care transitions, behavioral health organizations, specialty care (oncology etc), and even medical schools.
- Potential framework: Identification, risk formulation, management, treatment, and follow up.
- The limitations of risk stratification tools to be clinically relevant, and the challenge of engaging complex, expensive interventions that may not be effective, which has led to a quality chasm.
- The pushback to the zero suicide model, which in some ways is a branding issue.
- Provider limitations in education on the topic and willingness to discuss it, like providers working off outdate contracts and expressing hesitancy to have the conversation with patients due to lack of training or time.
- Psychotherapeutic interventions, collaborative assessment for causality, and other types of management for those identified as at risk for suicidality.
- Barriers to treatment like resources for both systems and patients and gaps in management.
- Integrating gun safety and proper medication storage and other types of preventive efforts into the framework, by proactively building awareness and motivation to take preventive actions.
- Efforts being made by places like WSHA and Seattle Children's, like giving out lock boxes.
- Potentially using motivational interviews by social workers in a healthcare setting.
- Limitations of means assessment, care transitions, and follow up after a suicide attempt (sometimes called tertiary treatment).
- How to be most impactful with screening for suicidality.
- The challenge of fragmented systems, and curiosity about the most common interventions being used among them.
- Identifying those who could benefit from behavioral health treatment that we don't already know, and whether to include someone from the behavioral health space in this group.
- The limitations of the PHQ-9 as a predictor and warning signs that are not covered by this.
- Focusing on primary care, emergency departments, behavioral health, care transitions, and specialty care (such as oncology and opioid treatment programs).
- Using the Zero Suicide Framework for definitions and framework.
- Calling out data separately and in the Charter, including data identifying prevalence of suicide as a top cause of death in youth and middle aged groups. Calling it out as the 10th cause of death is not as impactful as some of the other metrics.

Action Item: Ms. Weir to send the Behavioral Health Integration materials to the group.
Action Item: Ms. Hansen, Washington State Department of Health, to walk the group through the state's suicide prevention plan at the next meeting.

NEXT STEPS AND PUBLIC COMMENTS

Dr. Straley and Ms. Weir thanked all for attending and asked for final comments and public comments. The meeting adjourned.