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## Dr. Robert Bree Collaborative Background

The Dr. Robert Bree Collaborative was established in 2011 by Washington State House Bill 1311 “...to provide a mechanism through which public and private health care stakeholders can work together to improve quality, health outcomes, and cost effectiveness of care in Washington State.” The Bree Collaborative was modeled after the Washington State Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree, a pioneer in the imaging field and a key member of the AIM project.

Members are appointed by the Washington State Governor and include public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations. The Bree Collaborative is charged with identifying up to three health care services annually that have substantial variation in practice patterns, high utilization trends in Washington State, or patient safety issues. For each health care service, the Bree Collaborative identifies and recommends best-practice, evidence-based approaches that build upon existing efforts and quality improvement activities to decrease variation. In the bill, the legislature does not authorize agreements among competing health care providers or health carriers as to the price or specific level of reimbursement for health care services. Furthermore, it is not the intent of the legislature to mandate payment or coverage decisions by private health care purchasers or carriers.

See **Appendix A** for a list of current Bree Collaborative members.

Recommendations are sent to the Washington State Health Care Authority for review and approval. The Health Care Authority (HCA) oversees Washington State’s largest health care purchasers, Medicaid and the Public Employees Benefits Board Program, as well as other programs. The HCA uses the recommendations to guide state purchasing for these programs. The Bree Collaborative also strives to develop recommendations to improve patient health, health care service quality, and the affordability of health care for the private sector but does not have the authority to mandate implementation of recommendations.

For more information about the Bree Collaborative, please visit: [www.breecollaborative.org](http://www.breecollaborative.org).

Suicide is a leading cause of death nationally with certain minority groups at higher risk. The Bree Collaborative elected to address this topic and a workgroup convened to develop recommendations from February 2018 to X.

See **Appendix B** for the Suicide Prevention and Care workgroup charter and a list of members.

See **Appendix C** for results of the Guideline and Systematic Review Search Results.

## Purpose Statement

Suicide is the second leading cause of death among those aged 15-34 and the fourth leading cause of death among those aged 35-44, resulting in approximately one death every twelve minutes.<sup>1,2</sup> Suicide rates are higher among those who are non-Hispanic American Indian/Alaska Native, middle-aged adults, and veterans and other military personal.<sup>2</sup> Sexual minority youth (i.e., those who identify as lesbian, gay, bisexual, transgender, or queer) show higher rates of suicidal ideation and suicide attempts.<sup>3</sup> The rate of suicide in Washington State is higher than the national average.<sup>4</sup> Suicide is a response to multiple internal (e.g., depression, substance abuse) and external factors (e.g., lack of social support, financial stress) indicating the need to intervene through the health care system.<sup>5</sup>

## Recommendations

For in- and outpatient care including care transitions, behavioral health, and specialty care

- Screening for depression and suicidal ideation and patient risk formulation.
- Suicidal ideation management and treatment to target.
- Follow-up and support after a suicide attempt.
- Implementation pathway(s) with process and patient outcome metrics.
- Identifying other areas of focus or modifying areas, as needed.

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<sup>1</sup> Kochanek KD, Murphy SL, Xu J, Arias E. Mortality in the United States, 2016. NCHS Data Brief No. 293. December 2017. Available: [www.cdc.gov/nchs/data/databriefs/db293.pdf](http://www.cdc.gov/nchs/data/databriefs/db293.pdf)

<sup>2</sup> Murphy SL, Xu J, Kochanek KD, Curtin SC, Arias E.. Deaths: Final Data for 2015. Centers for Disease Control and Prevention. National Vital Statistics Reports. Volume 65, Number 4. June 30, 2016. Available: [www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66\\_06.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_06.pdf).

<sup>3</sup> Stone DM, Luo F, Ouyang L, Lippy C, Hertz MF, Crosby AE. Sexual orientation and suicide ideation, plans, attempts, and medically serious attempts: evidence from local Youth Risk Behavior Surveys, 2001-2009. Am J Public Health. 2014;104(2):262-271.

<sup>4</sup> American Association of Suicidology. USA Suicide 2016; Final Data File. Accessed: February 2018. Available: [www.suicidology.org/Portals/14/docs/Resources/FactSheets/2016/2016datapgsv1b.pdf?ver=2018-01-15-211057-387](http://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2016/2016datapgsv1b.pdf?ver=2018-01-15-211057-387)

<sup>5</sup> Stone D, Holland K, Bartholow B, Crosby A, Davis S, Wilkins N. Preventing Suicide: A Technical Package of Policy, Programs, and Practices. 2017. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. Available: [www.cdc.gov/violenceprevention/pdf/suicidetchnicalpackage.pdf](http://www.cdc.gov/violenceprevention/pdf/suicidetchnicalpackage.pdf).

**Example: Table 1: Specifications for Integrated Care**

	Element	Specifications	Patient Perspective	Operational Details for Integrating Behavioral Health Care into Primary Care
1	<b>Integrated Care Team</b>	Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, understand their roles and participate in typical practice activities in-person or virtually such as team meetings, daily huddles, pre-visit planning, and quality improvement.	<i>I can see how my care team takes my concerns into consideration when making treatment decisions and can talk to members of my integrated care team about any of my concerns, including feeling low or depressed, or concerns about my drinking. The team will be able to answer my questions and help me get treatment if I choose to.</i>	<p><b>Usual Care:</b> Behavioral health support is provided by the primary care provider, who may not feel adequately supported or adequately trained in managing all behavioral health conditions in his/her patient panel.</p> <p><b>Steps Toward Integration:</b> Behavioral health professionals are onsite or available remotely but do not participate in clinic-level workflows and are not part of the usual patient care. Behavioral health may closely coordinate and follow up with the primary care provider on all patients that are referred to them for treatment.</p> <p><b>Integrated Care:</b> Practices are committed to developing and maintaining a culture of integration and teamwork including both engaging providers in integrated approaches to care proven to help patients get better and achieve their treatment goals and cross-training providers on behavioral health and primary care. The integrated care team utilizes shared workflows to systematically screen and treat common behavioral health conditions and uses measurement-based behavioral health scales and tools to screen and track patient progress toward treatment goals. Behavioral health professionals participate in primary care workflows. Behavioral health professionals may be practice-based, (i.e., located in the same physical space as the integrated care team) or telemedicine-based (i.e., available to the practice onsite on a regular but not daily basis and available by phone, pager or videoconference) to assist primary care providers and patients during practice hours when they are not onsite.</p>

### Example from Behavioral Health Integration

#### *Patients and Family Members*

- Review **Table 1: Roadmap to Integrated Care**. You should be receiving care that addresses both physical and behavioral health needs. Read through the patient perspective on the eight elements.
- Talk to your primary care provider or other care team members about any concerns including feeling low or depressed, feeling anxious, concerns about drinking or drug use, or any other concerns about behavioral health.
- Ask to see your care plan if you would like.
- Talk to your providers about your concerns with accessing the type of care that you need.
- Track progress on treatment for behavioral health diagnosis in the same way that you would track something like blood pressure.
- Ask your care team about the reasons or evidence for the types of treatments that you receive.
- Give your feedback about your experience at the practice.

#### *Primary Care Practices and Systems (including Primary Care and Behavioral Health Care Providers)*

Review **Table 1: Roadmap to Integrated Care**. The following list includes key action items from the Roadmap.

- Clearly define roles for integrated care team members, including primary care and behavioral health clinicians and staff.
- Structure typical practice activities to facilitate involvement by all members of the integrated care team (e.g., team meetings, daily huddles, pre-visit planning, quality improvement meetings).
- Facilitate patient access to behavioral health and primary care services on the same day as much as feasible.
- At a minimum, ensure that for each patient with an identified behavioral health need, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.
- Ensure that the integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care.
- Ensure that clinicians work together via regularly scheduled consultation and coordination to jointly address the patient's shared care plan.
- Facilitate access to psychiatric consultation services in a systematic manner to assist the care team in developing a treatment plan and adjusting treatments for patients who are not improving as expected under their current plan.
- Coordinate specialty behavioral health services for patients with more severe or complex symptoms and diagnoses.
- Proactively identify and stratify patients for targeted conditions.
- Use systematic clinical protocols based on screening results and other patient data, like ER use, that help to characterize patient risk and complexity of needs.
- Track patients with target conditions to make sure patient is engaged and treated-to-target/remission and have a proactive follow-up plan to assess improvement and adapt treatment accordingly.

- Use age-appropriate measurement-based interventions for physical and behavioral health interventions that are adapted to the specific needs of the practice setting.
- Use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether patients are improving.
- Include appropriate self-management support in care.
- Use patient goals to inform the care plan.
- Communicate effectively with the patient about treatment options and include patient goals, perspectives, and informed treatment decisions into treatment plans.
- Track system-level data regarding access to behavioral care, the patients' experience, and patient outcomes. If system goals are not met, use quality improvement efforts to achieve patient access goals and outcome standards.

### **Health Plans**

Partially adapted from SAMHSA's *ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers*<sup>1</sup>

- Reimburse for Medicare primary care providers participating in a collaborative care program or receiving other integrated behavioral health services as outlined in CMS Federal Register Final Rule for Docket Number CMS-1654-F (e.g., G0502, G0503, G0504).
- Work with health care purchasers to identify and provide data on outcome measurements relevant to their population to better ensure treatment efficacy and patient access (e.g., NCQA behavioral health treatment within 14 days, NCAQ anti-depressant medication management).
- Develop and maintain strong, respectful relationships with practices including sharing information, decision making, costs, and savings as appropriate.
- Work with the Accountable Communities of Health to measure quality and outcomes including traditional clinical measures but also data beyond care delivery and claims: arrests/recidivism, housing status, employment, if possible.

### **Employers**

- When designing benefits, work to eliminate inadvertent barriers to behavioral health care services and integrating care for employees including equalizing benefit structures for behavioral health and physical health care.
- If an employee assistance program is offered, promote employee understanding of behavioral health benefits.
- Include behavioral health-related components in employee wellness programs (e.g., stress and anxiety reduction, interventions around alcohol consumption).

### **Washington State Health Care Authority**

- Certify patient decision aids around treatment options for common behavioral health conditions (e.g., depression, anxiety, alcohol use, substance abuse).

### *Behavioral Health Integration Recommendations (March 2017)*

This Report and Recommendations is focused on integrating behavioral health care services into primary care for those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate. Our workgroup found it important to define integrated behavioral health care in order to create a common vocabulary and focused on using available evidence and existing models to develop eight common elements that outline a minimum standard of integrated care. These eight elements are meant to bridge the different models used throughout Washington State and across the country and include:

- Integrated Care Team
  - Each member of the integrated care team has clearly defined roles for both physical and behavioral health services. Team members, including clinicians and non-licensed staff, understand their roles and participate in typical practice activities in-person or virtually such as team meetings, daily huddles, pre-visit planning, and quality improvement.
- Patient Access to Behavioral Health as a Routine Part of Care
  - Access to behavioral health and primary care services are available on the same day as much as feasible. At a minimum, a plan is developed on the same day that includes continuous patient engagement in ways that are convenient for patients, in person or by phone or videoconferencing.
- Accessibility and Sharing of Patient Information
  - The integrated care team has access to actionable medical and behavioral health information via a shared care plan at the point of care. Clinicians work together via regularly scheduled consultation and coordination to jointly address the patient's shared care plan.
- Practice Access to Psychiatric Services
  - Access to psychiatric consultation services is available in a systematic manner to assist the care team in developing a treatment plan and adjusting treatments for patients who are not improving as expected under their current plan. For patients with more severe or complex symptoms and diagnoses, specialty behavioral health services are readily available and are well coordinated with primary care.
- Operational Systems and Workflows to Support Population-Based Care
  - A structured method is in place for proactive identification and stratification of patients for targeted conditions. The practice uses systematic clinical protocols based on screening results and other patient data, like emergency room use, that help to characterize patient risk and complexity of needs. Practices track patients with target conditions to make sure patient is engaged and treated-to-target/remission and have a proactive follow-up plan to assess improvement and adapt treatment accordingly.
- Evidence-Based Treatments
  - Age language, culturally, and religiously-appropriate measurement-based interventions for physical and behavioral health interventions are adapted to the specific needs of the practice setting. Integrated practice teams use behavioral health symptom rating scales in a systematic and quantifiable way to determine whether their patients are improving. The goal of treatment is to provide strategies that include the patient's goals of care and appropriate self-management support.
- Patient Involvement in Care

- Patient goals inform the care plan. The practice communicates effectively with the patient about their treatment options and asks for patient input and feedback into care planning. Patient activation and self-care is supported and promoted.
- Data for Quality Improvement
  - System-level data regarding access to behavioral care, the patients' experience, and patient outcomes is tracked. If system goals are not met, quality improvement efforts are employed to achieve patient access goals and outcome standards.

## Measurement

### [Healthy People 2020<sup>2</sup>](#)

- **MHMD-1: Reduce the suicide rate**
  - Baseline: 11.3 suicides per 100,000 population occurred in 2007 (age adjusted to the year 2000 standard population)
  - Target: 10.2 suicides per 100,000 population
  - Target-Setting Method: 10 percent improvement
- **MHMD-2: Reduce suicide attempts by adolescents**
  - Baseline: 1.9 suicide attempts per 100 population occurred in 2009
  - Target: 1.7 suicide attempts per 100 population
  - Target-Setting Method: 10 percent improvement
- **MHMD-4: Reduce the proportion of persons who experience major depressive episodes (MDEs)**
  - MHMD-4.1: Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)
    - Baseline: 8.3 percent of adolescents aged 12 to 17 years experienced a major depressive episode in 2008
    - Target: 7.5 percent
    - Target-Setting Method: 10 percent improvement
  - MHMD-4.2: Reduce the proportion of adults aged 18 years and older who experience major depressive episodes (MDEs)
    - Baseline: 6.5 percent of adults aged 18 years and over experienced a major depressive episode in 2008
    - Target: 5.8 percent
    - Target-Setting Method: 10 percent improvement
- **MHMD-5: Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral**
  - Baseline: 79.0 percent of primary care facilities provided mental health treatment onsite or by paid referral in 2006
  - Target: 87.0 percent
  - Target-Setting Method: 10 percent improvement
- **MHMD-6: Increase the proportion of children with mental health problems who receive treatment**
  - Baseline: 68.9 percent of children with mental health problems received treatment in 2008
  - Target: 75.8 percent
  - Target-Setting Method: 10 percent improvement



## Appendix C: Guideline and Systematic Review Search Results

Source	Guidelines or Systematic Reviews
AHRQ: Research Findings and Reports	
Cochrane Collection	
Specialty Society Guidelines (via Guideline Clearinghouse including Choosing Wisely)	
Health Technology Assessment Program	
Centers for Disease Control and Prevention	
Institute for Clinical and Economic Review	
BMJ Clinical Evidence Systematic Overview	
Veterans Administration Evidence-based Synthesis Program	

## References

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<sup>1</sup> Association for Community Affiliated Plans. ACAP Fact Sheet Safety Net Health Plan Efforts to Integrate Physical and Behavioral Health at Community Health Centers. September 2014. Accessed: December 2016.

[www.integration.samhsa.gov/integrated-care-models/Integrated Health Fact Sheet ACAP.pdf](http://www.integration.samhsa.gov/integrated-care-models/Integrated_Health_Fact_Sheet_ACAP.pdf)

<sup>2</sup> <https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives>