Harm to Self and Others

January 17th, 2019

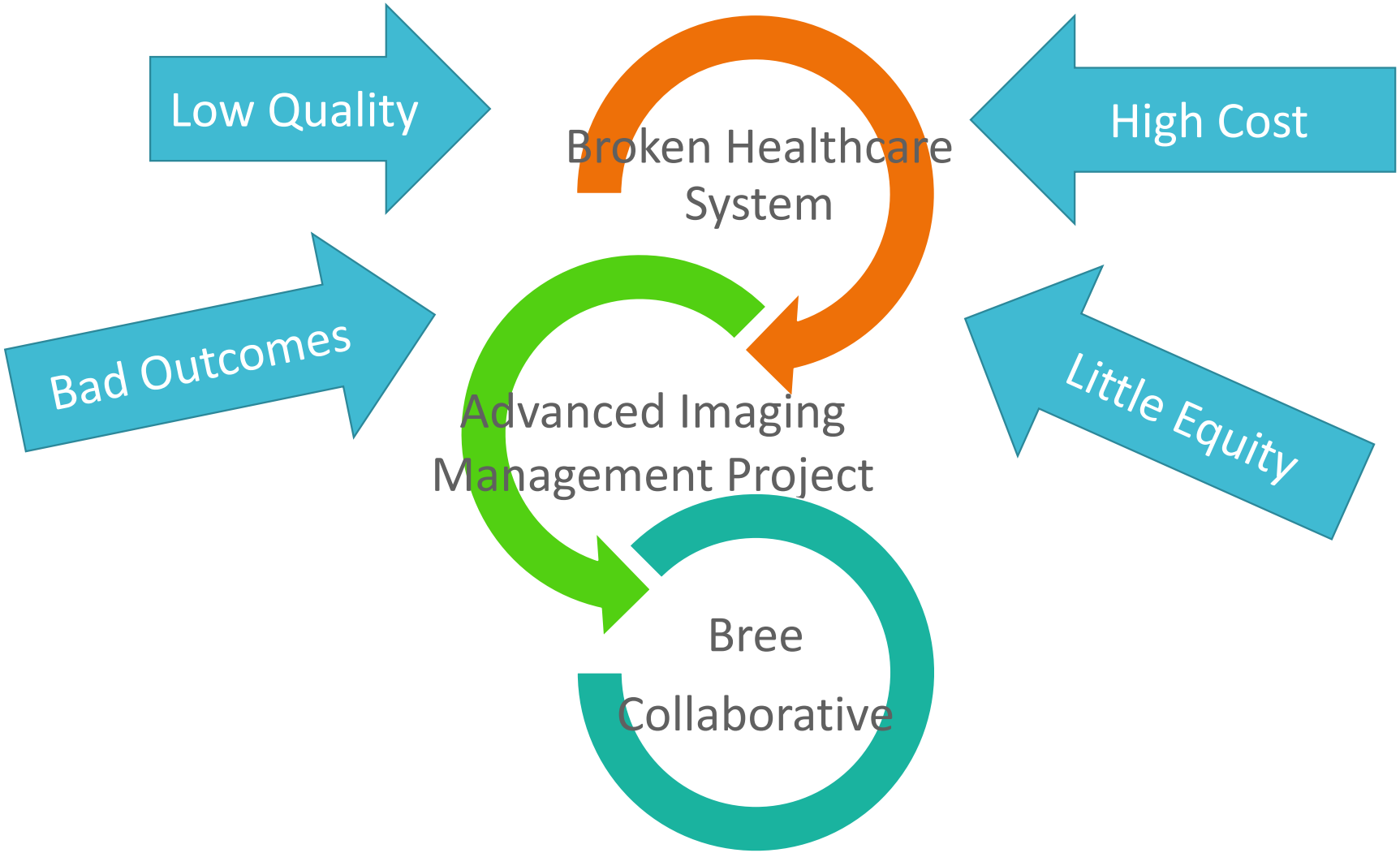
Agenda

- Welcome and Introductions
- Bree Collaborative Overview
  - Background
  - Past Work
  - Implementation
  - Open Public Meetings Act
- Review Volk Decision and Legislative Ask
- Preliminary Scope of Work
  - Previous Suicide Care Recommendations
  - Draft Charter and Roster
- Public Comments/Good of the Order

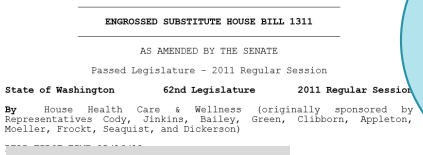
Roberts Rules of Order

- Quorum is 50%+1
  - Need quorum to make decisions
- Decisions made through motions
  - Making a motion
  - Seconding the motion
  - Debate (if needed)
  - Vote
  - Announcing results
- One person: one vote
- Voting limited to members present

Background
2011 Health Care Environment



Background
Members and Topic Selection


ENGROSSED SUBSTITUTE HOUSE BILL 1311

AS AMENDED BY THE SENATE

Passed Legislature - 2011 Regular Session

State of Washington 62nd Legislature 2011 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Cody, Jinkins, Bailey, Green, Clibborn, Appleton, Moeller, Frockt, Seaquist, and Dickerson)

House Bill 1311

QI Organizations

Employers

Hospitals

23 Members

Physicians

Health Plans

Others

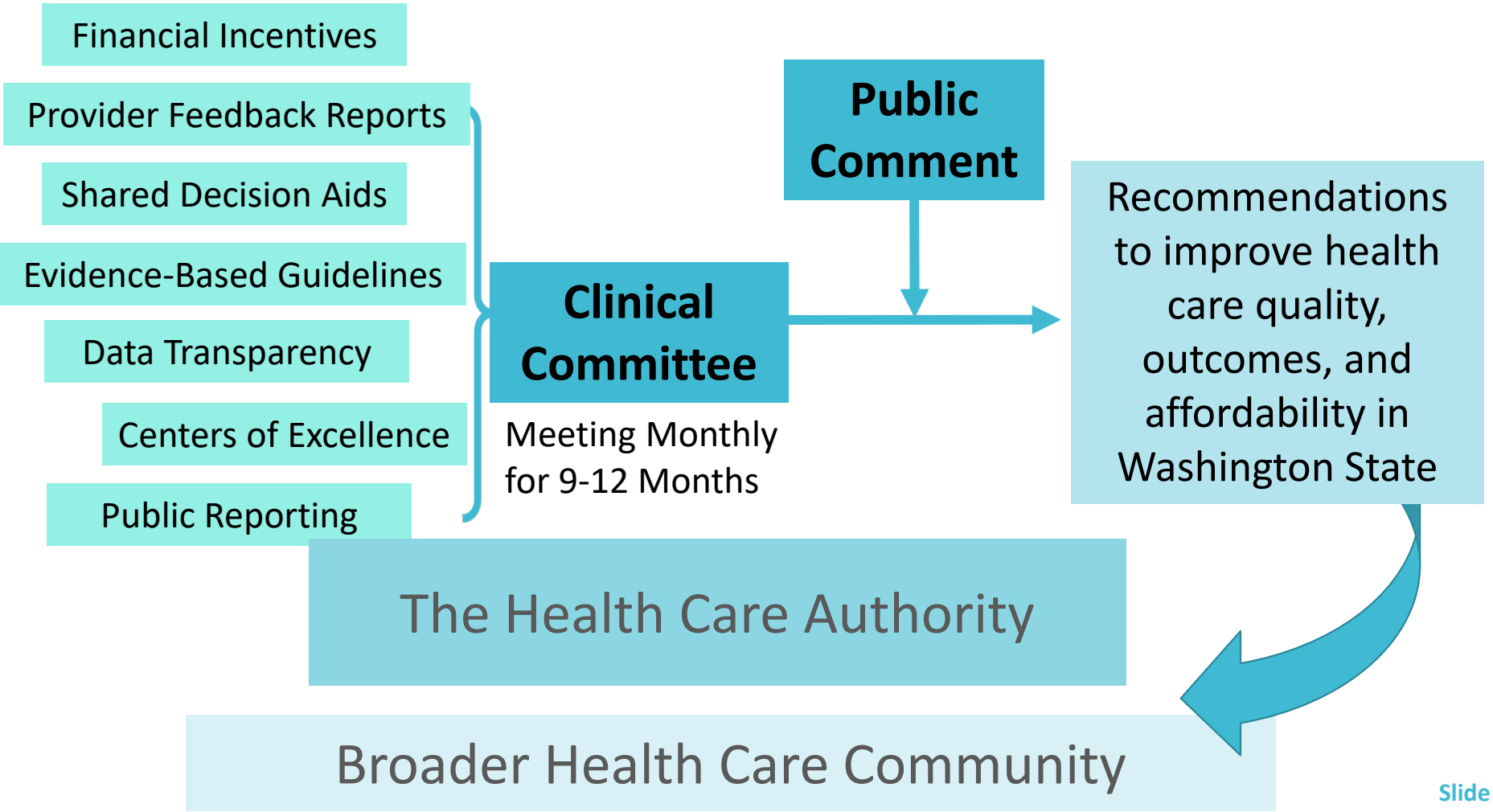
Public Purchasers

Identify health care services with high:

- **Variation**
- **Utilization**

Without producing better outcomes

Recommendations Formed in Clinical Committee



Report and Recommendation Process

Formulation

Select Topics

Bree Collaborative members discuss potential topics with high variation in the way that care is delivered, that are frequently used but do not lead to better care or patient health, or that have patient safety issues. Determination of three new topics by Bree Collaborative member majority vote.

Determination of workgroup Chair (typically Bree Collaborative member)

Convene Workgroup

Selection and recruitment of workgroup members including from health plans, providers, hospitals, and other relevant stakeholders including at least two members of the specialty or subspecialty society most experienced with the health service

Approval of workgroup charter and roster by Bree Members

Development

Workgroup develops initial scope, problem statement, and focus areas. Also identify barriers, drivers of change, and indicators or proxies for success

Updates at Bree Meetings

- Engagement with expert speakers
- Development of stakeholder-specific recommendations
- Development of implementation strategy and action steps (e.g., financial incentives, data transparency)

Presentation at Bree Meeting for vote for dissemination for public comment

Public Comments

Public comment opportunity including online survey and outreach to specific stakeholder groups.

Workgroup meets to address public comments and make any necessary changes to Report and Recommendations

Presentation at Bree Meeting for final adoption

Implementation

Approval by Director of the Health Care Authority.
"…all state purchased health care programs must implement the evidence-based best practice guidelines or protocols and strategies…"

Dissemination of final approved Reports and Recommendations.

Annual reports to Legislature and Governor's Office.

Working with hospitals, health systems, clinics, health plans, purchasers, patients, quality organizations, the Legislature, and the Health Care Authority to implement recommendations.

Re-review

Reports may be selected for re-review annually or if there is new evidence one year after adoption

Topic Areas

DR. ROBERT BREE COLLABORATIVE

- Obstetrics (2012)
- Cardiology (2012)
- Elective Total Knee and Total Hip Replacement Bundle and Warranty (2013 and 2017)
- Elective Lumbar Fusion Bundle and Warranty (2014 and 2018)
- Elective Coronary Artery Bypass Surgery Bundle and Warranty (2015)
- Bariatric Surgical Bundled Payment Model and Warranty (2016)
- Low Back Pain (2013)
- Spine SCOAP (2013)
- Hospital Readmissions (2014)
- End-of-Life Care (2014)
- Addiction and Dependence Treatment (2015)
- Prostate Cancer Screening (2016)
- Pediatric Psychotropic Drug Use (2016)
- Behavioral Health Integration (2017)
- Guidelines for Prescribing Opioids for Pain (2015-Present)
- Opioid Use Disorder Treatment (2017)
- Alzheimer's Disease and Other Dementias (2017)
- Hysterectomy (2017)
- LGBTQ Health Care (2018)
- Collaborative Care for Chronic Pain (2018)
- Suicide Care (2018)

Areas for 2019

Guidelines for Prescribing Opioids for Pain
Ongoing

Maternity Bundled Payment Model

Palliative Care

Shared Decision Making

Harm to Self and Others

Reports

- What is the problem?
  - Is variation unwarranted?
  - Does it contribute to patient harm?
- What does it look like in Washington State?
- What are solutions within the medical system?
  - Focus areas
  - Stakeholder-specific recommendations
- How do we get there?

Implementation

- **Agency Medical Directors Group** (AMDG) reviews and approves recommendations which are then forwarded to the Director of the Health Care Authority (HCA)
- **HCA Director** reviews and decides whether to apply to state-purchased health care programs
- Legislation does not mandate payment or coverage decisions by private health care purchasers or carriers
  - Delivery systems and providers not required to implement recommendations

Open Public Meetings Act

- Required of Bree Collaborative meetings and workgroup meetings
- Allows the public to view the “decision-making process
- Training

Roster

OPEN GOVERNMENT/RECORDS TRAINING ROSTER

Course Subject(s) (check all that apply):

- ☐ Open Public Records Act Training (RCW 42.56)
- ☐ Open Public Meetings Act Training (RCW 42.30)
- ☐ Records Retention/Management Act Training (RCW 40.14)

Course Title(s):

Organization(s)/agencies providing training:

Trainer(s):

Format (in person, online, webinar, etc.):

Date:	**Location:**	**Length of time:**
Trainee Name:	**Trainee Signature:**	

Conflict of Interest Form

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www.breecollaborative.org

Participant Conflict Disclosure

Permanent and ad hoc members of the collaborative or any of its committees may not have personal financial *conflicts of interest that could substantially influence or bias their participation. If a collaborative or committee member has a personal financial conflict of interest with respect to a particular health care service being addressed by the collaborative, he or she shall disclose such an interest. The collaborative must determine whether the member should be recused from any deliberations or decisions related to that service.*

Conflict of Interest decisions must be disclosed and balanced to ensure the integrity of Bree Collaborative decisions while acknowledging the reality that interests, and sometimes even conflicting interests, do exist. Individuals that stand to gain or lose financially or professionally, or have a strong intellectual bias need to disclose such conflicts.

Example: The fact that a member is a health care provider that may provide a service under review creates a potential conflict. However, clinical and practical knowledge about a service is also useful, and may be needed in decision making.

Procedure
Members must sign a conflict of interest form. The Bree Collaborative Chair and/or Bree Collaborative Steering Committee shall make a decision as to whether a conflict of interest rises to the level that participation by the conflicted member could result in a loss of public trust or would significantly damage the integrity of the decision.

The Health Care Authority (HCA) defines conflict of interest as any situation in which a voting member has a relationship with a manufacturer of any commercial products and/or provider of services discussed or voted on during the meeting. Relationship extends to include immediate family member(s).

A relationship is considered as:

1. Receipt or potential receipt of anything of monetary value, including but not limited to, salary or other payments for services such as consulting fees or honoraria in excess of $10,000.
2. Equ… 5%
   ow…
3. Sta… tion
   rep…

Proposed Work Plan

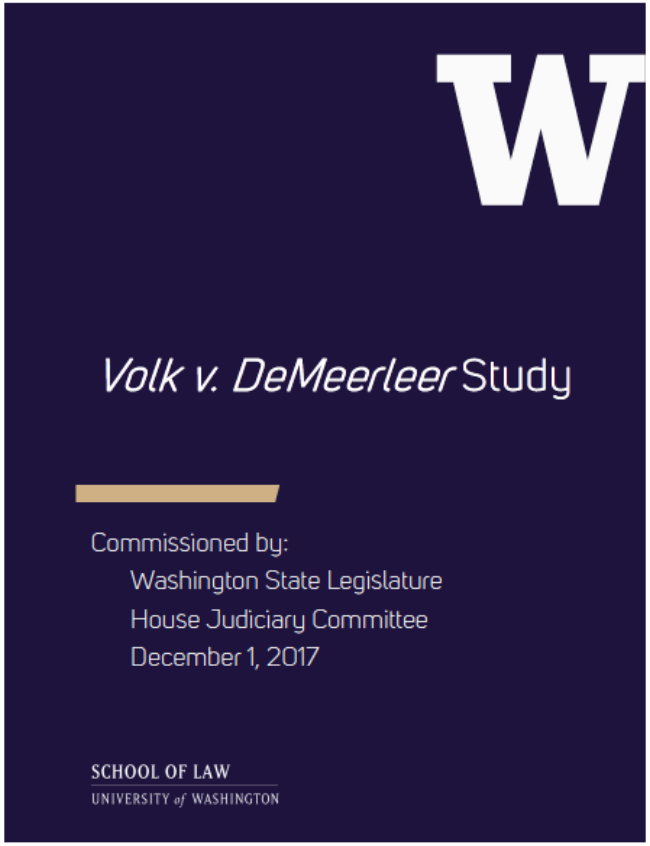
- Monthly meetings starting in January 2019
- Present Roster and Charter January 2019
- Engage experts, talk through barriers
- Final product Fall 2019

Volk v. DeMeerleer
187 Wn.2d 241, 386 P.3d 254

- 2016 Washington State Supreme Court decision
- *"Alters the scope of the 'duty to warn or protect' in at least three critical ways:*
  - *1. It brings into question the groups of health care professionals who are subject to the duty to warn or protect in the voluntary inpatient and outpatient setting.*
  - *2. The duty now clearly applies in the voluntary inpatient and outpatient setting.*
  - *3. Most importantly, outside of the context of an involuntary commitment proceeding, the scope of persons to warn or protect now includes those that are 'foreseeable' victims, not reasonably identifiable victims subject to an actual threat*." Source: www.phyins.com/uploads/file/Volk%20recs-FINAL.PDF

UW Law School Study

- UW Law School prepared extensive study of the case at the request of the House Judiciary Committee



Legislative Ask

- *"Identify best practices for mental health services regarding patient mental health treatment and patient management.*
- *The workgroup shall identify best practices on:*
  - *patient confidentiality,*
  - *discharging patients,*
  - *treating patients with homicide ideation and suicide ideation,*
  - *record-keeping to decrease variation in practice patterns in these areas, and*
  - *other areas as defined by the workgroup.*
- *The workgroup shall be comprised of:*
  - *clinical and administrative experts including psychologists,*
  - *psychiatrists,*
  - *advanced practice psychiatric nurses,*
  - *social workers,*
  - *marriage and family therapists,*
  - *certified counselors, and*
  - *mental health counselors."*

Suicide Care Recommendations
Adopted September 2018
Six Focus Areas

I. Identification of Suicide Risk
II. Assessment of Suicide Risk
III. Suicide Risk Management
IV. Suicide Risk Treatment
V. Follow-up and Support After a Suicide Attempt
VI. Follow-up and Support After a Suicide Death

Identification of Suicide Risk

Screen all patients over 13 annually for behavioral health conditions (i.e., mental health, substance use), associated with increased suicide risk using a validated instrument(s), including:

- Depression
- Suicidality (i.e., suicidal ideation, current plans, past attempts)
- Alcohol misuse
- Anxiety
- Drug use

Assessment of Suicide Risk

- Based on results from identification above, further assess risk of suicide with a validated instrument such as the full C-SSRS and assess additional risk factors including:
  - Mental illness diagnosis
  - Substance use disorder(s)
  - Stressful life event
- Other relevant psychiatric symptoms or warning signs (at clinician's discretion)

Suicidal Risk Management

- Ensure individuals at risk of suicide have pathway to timely and adequate care (e.g. follow-up contact same day or later as indicated by suicide risk assessment).
- Keep patients in an acute suicidal crisis in an observed, safe environment.
- Address lethal means safety.
- Engage patients in collaborative safety planning.
- If possible, involve family members or other key support people in suicide risk management.

Collaborative Safety Planning

Key components should include:

- Recognition of warning signs of a suicidal crisis
- Addressing lethal means safety(e.g. safe firearm and medication storage)
- Internal coping strategies
- Socialization strategies for distraction and support
- Contact numbers for friends and family members to ask for help
- Professionals/agencies to contact during crisis, including Suicide Prevention Lifeline 1-800-273-TALK (8255) and local crisis numbers

Source: Stanley B, Brown GK. Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. Cognitive and Behavioral Practice. 2012 May;19(2):256-264.

Suicide Risk Treatment

- Use effective evidence-based treatments provided onsite that directly target suicidal thoughts and behaviors (rather than focusing primarily on specific mental health diagnoses) through integrated behavioral health or off-site with a supported referral. The interventions with the most robust evidence include:
  - Following-up with a patient by initiating a non-demand caring contact
  - Dialectical behavior therapy
  - Suicide-specific cognitive behavioral therapy
  - Collaborative assessment and management of suicidality
- Document patient information related to suicide care and referrals.

Sources: Luxton DD, June JD, Comtois KA. Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. Crisis. 2013 Jan 1;34(1):32-41. Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, et al. Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. Arch Gen Psychiatry. 2006 Jul;63(7):757-66. Brown GK, Ten Have T, Henriques GR, Xie SX, Hollander JE, Beck AT. Cognitive therapy for the prevention of suicide attempts: a randomized controlled trial. JAMA. 2005 Aug 3;294(5):563-70. Stanley B, Brown G, Brent D, et al. Cognitive Behavior Therapy for Suicide Prevention (CBT-SP): Treatment Model, Feasibility and Acceptability. Journal of the American Academy of Child and Adolescent Psychiatry. 2009;48(10):1005-1013. Comtois KA, Jobes DA, S O'Connor S, Atkins DC, Janis K, E Chessen C, et al. Collaborative assessment and management of suicidality (CAMS): feasibility trial for next-day appointment services. Depress Anxiety. 2011 Nov;28(11):963-72. CAMS.care. What is the "Collaborative Assessment and Management of Suicidality" (CAMS)? Accessed: June 2018. Available: https://cams-care.com/about-cams/.

Follow-up and Support After a Suicide Attempt

- Provide contact and support during transition from inpatient to outpatient sites and from out-patient to no behavioral health.
- Ensure supported pathway to adequate and timely care, as outlined above (e.g., collaborative safety planning, onsite or referral to offsite behavioral health)

Follow-up and Support After a Suicide Death

- Follow-up and support for family members, friends, and for providers involved in care including screening for depression, suicidality, anxiety, alcohol misuse, and drug use.