Bree Collaborative | Behavioral Health Early Interventions for Youth
February 14th, 2024| 8-9:30AM
Hybrid

MEMBERS PRESENT VIRTUAL

Terry Lee, MD, CHPW (Chair)
Linda Coombs, MSW, LICSWUHC
Thatcher Felt, DO, YVFWC
Jeffery Greene, MD Seattle Children's
Nicole Hamberger, SWACH
Libby Hein, LMHC, Molina
Kevin Mangat, MHA, Navos
Mckenna Parnes, PhD, University of Washington
Sarah Rafton, MSW, WCAAP
Brittany Weiner, LMFT, CPPS; WSHA
Jennifer Wyatt, LMHC, MAC, SUDP with KingCounty Behavioral Health and Recovery Division

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative

WELCOME

Beth Bojkov, Bree Collaborative, welcomed everyone to the Behavioral Health Early Intervention for Youth and provided an overview of for the meeting.

Motion to approve January meeting minutes: motion approved.

Evaluation Sub-committee
Karie Nicholas, MA, GC reviewed request for 2-5 people to participate in the evaluation sub-committee. The sub-committee we will mee for 45 minutes once a month to help develop the evaluation plan to measure progress for guidelines detailed in this report.

- Sarah Rafton and Libby Hein volunteered

Present & Discuss: Review Charter

Ms. Bojkov reviewed feedback from the Bree members on the charter. The statement from background to focus less on children that are already in crisis in ED and more before crisis was removed from the charter, otherwise approved of aim and purpose.

- Clarification from a member on what is meant by this group when the term behavioral health is used since in their context it typically covers mental health and substance use. Feedback was given that the focus areas leaned towards addressing mental health not substance use.
- Ms. Bojkov recommended the group discuss further to help narrow down the scope of the report and ensure that the term conveys what the group is about. The charter can be updated as needed to reflect the work of the group.

Further clarification question, how upstream do we go to promote prevention while being mindful of the scope of the report?

- The group discussed the role of Bree and common audiences for the report. Ms. Bojkov reviewed the Bree areas of influence and main audiences of reports.

- Comment: There are more resources available in Primary care setting than the BH services
- The group is interested in focusing on either early relational health or adolescent health time limited interventions. The group will further discuss the focus of the report.
- Ms. Nicholas advised that the broader the scope of the guidelines the harder they are to implement.

Ms Bojkov then transitioned the group to discuss the data on previous reports to guide the group's scope.

Previous Report uptake

	Pediatric Psychotropics	Behavioral Health Integration	Telehealth	Suicide Care
Health System				
Health Plans				
FQHC's				
HCA	2.7	3	2.2	2.2
Employer/purchaser				
OSPI	2.5	1	n/a	2.8

Measures
*** included in HCA contracts**

Pediatric Psychotropics	Telehealth	Behavioral Health Integration	Suicide Care
Metabolic monitoring for children and adolescents on antipsychotics (health system)	*Visits, differentiate types of services (in person, audio only, audio visual) (health plan)	NCQA behavioral health treatment within 14 days (health plan)	*Follow-up After Hospitalization for Mental Illness (health system)
Use of multiple concurrent antipsychotics in children and adolescent (health system)	Monitor, report, and act on quality, experience, and adverse outcomes related to vendor care outcomes through existing standard quality monitoring programs (health plan)	NCQA anti-depressant medication management (health plan)	
*Use of first-line psychosocial care for children and adolescents on antipsychotics (health system)		*Depression Screening and Follow up for Adolescents and Adults (DSF-E) (health system)	
*Follow-Up Care for Children Prescribed ADHD Medication (ADD) (health system		*Antidepressant Medication Management (AMM) (health system)	
		*Follow-up After Hospitalization for Mental Illness (health system)	
		30-day Psychiatric Inpatient Readmissions (health system)	

Measures
From previous Bree Reports

- Organization collects data on
  - Race and ethnicity, SOGI, Homelessness, incarceration status, disability status, Food insecurity, transportation insecurity
- Organization uses data for QI work
  - Race and ethnicity, SOGI, Homelessness, incarceration status, disability status, Food insecurity, transportation insecurity
- Organization stratifies specific measures by equity data
  - Bree evaluations do not currently ask if organizations stratify BH metrics by social data

Data

- Opioid ED Visits
  - Counties with increasing opioid ED visit for ages 11-17 Benton-Franklin, Chelan-Douglas, Clallam, Greys Harbor, Jefferson, Lewis, Okanogan,
  - Children ages 11-17 also have the highest rates of ED visits for opioids in Mason, Snohomish, Clark, Grant, Island, Kitsap, Kittitas, Pierce, and Skagit counties, however rates there are not increasing
- Statewide, hospitalizations for drug and opioid use is second highest among those ages 10-17
- In 2018/2019 3.2% of teens ages 12-17 reported needing but not receiving treatment for illicit drug Use, higher than the national average of 3%
- In 2019 the suicide rate for children ages 10-19 was 7.2 per 100,000 and highest among those over 18 with no high school diploma
- Washington State Treatment Penetration Rates for 2019 was 55%

Ms. Nicholas provided overview of Bree evaluation plan and work done to review previous report uptake. The slides above were presented as some of the information our staff has gathered as part of the previous evaluations.

- Workgroup Comment: penetration rate is a flawed measure.
  - Ms. Nicholas acknowledged the comment and recommended that a measure should be tied to what the goal of the report is. The workgroup was reminded that they can recommend adjustments to measures as necessary.

- Group members raised the issue that the state doesn't really measure BH outcomes like we do Blood pressure. If youth are having a problem, we want to know if it is getting better, however that is not baked into the state and practice.
  Action: discussion on measures will continue in the data evaluation sub-committee.

PRESENT& DISCUSS: PRELIMINARY EVIDENCE REVIEW

Ms. Bojkov presented findings from preliminary evidence reviewed for the report. Resources reviewed: AHRQ, UPSTF, CDC Resources, Bright Futures, AAP, Systems of Care Framework.

DISCUSSION: DRAFT FOCUS AREAS

Ms. Bojkov transitioned the group to discuss focus areas for the report and how to narrow the scope of the report.
The group appreciated the review of evidence. Group member requested to connect with Schools.

What are the biggest barriers for youth accessing treatment early?

- Comment: for rural communities, access to Behavioral health. When we identify youth as having a need to access BH, they are unable to access care and timely counseling. If there is BH staff, they feel overwhelmed by the high number of clients.
- Comment: How do we engage with youth differently? Adolescents are engaged through social media and there are unique ways to engage them. Also mental and behavioral health providers are not routinely engaging families in treatment, which is a gap for young children.
  - **Action:** get copy of CoLab report on individual therapy for young children
  - **Action:** define age of youth at next workgroup
- Comment: Practitioners need to engage families in the treatment of the youth. Best practices to engage families in the care of the youth, especially with younger children.

- Comment: How to engage and train medical residents and primary care doctors on behavioral health to feel comfortable to make that next step to assist patients. They are doing well at screening and initiating treatment, but there is limited data on the impact. Getting primary care pediatricians to be comfortable prescribing for behavioral health is also a gap. Primary care providers should be able to bridge kids between visits if they do not have a therapy appointment.
- Comment: Primary care prescribing of buprenorphine is important for youth with substance use

What are some potential strategies to overcome those barriers?

- Comment: FAST first approach skills training is for BH specialists and shows that the training helps children receive care that work.
- Comment: Combination therapy (medication and CBT)
- Comment: Seattle Children's Partnership Access Line program can provide 24/7 access for primary care providers
- Comment: when an Educational service district is a legal behavioral health provider – breaks down barriers to providing behavioral healthcare in schools.

Proposed scope:

- Integrated Pediatric Behavioral Health into Primary Care
    - Schools?
    - Family based approaches to care.
- Coordination between Primary Care and Schools—group will discuss further
    - SBHC
    - School Nurses
    - Direct BH care at the school
    - Review models for school based BH care

Other suggestion

- Connection to schools
    - How to identify in schools
    - School Based Mental Health programs
- Training to clinicians on prescribe buprenorphine for youth.

Group reviewed potential audiences.

- Patients and Families
- **Clinicians and Healthcare Professionals**
- **Primary Care Settings**
- **Health Plans**
- **Purchasers**
- Department of Health, Public Health Agencies
- School based health centers/Schools billing Medicaid, School nurses
- DSHS
- DCYF

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. At the next workgroup meeting, the group will continue the review of evidence and discussion on focus of the report.

The workgroup's next meeting will be on **Wednesday, March 13th from 8-9:30PM**.