Bree Collaborative | Behavioral Health Early Interventions for Youth
March 13th, 2024| 8-9:30AM
Hybrid

MEMBERS PRESENT VIRTUAL

Terry Lee, MD, CHPW (Chair)
Thatcher Felt, DO, YVFWC
Jeffery Greene, MD Seattle Children's
Libby Hein, LMHC, Molina
Kevin Mangat, MHA, Navos
Mckenna Parnes, PhD, University of Washington
Sarah Rafton, MSW, WCAAP
Brittney Weiner, LMFT, CPPS; WSHA
Denise Dishongh, ESD 112
Erin Wick, ESD 113
Delaney Knottnerus, King County BH and Recovery Division
Katie Eilers, DOH
Santi Wibawantini, KP
Angela Cruze, Boldt System, I AM Foster
Sally McDaniel, Greater Lakes/Multicare
Diana Cockrell, HCA

STAFF AND MEMBERS OF THE PUBLIC

Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Ginny Weir, MPH, Foundation for Health Care Quality CEO
Amna Masic, HCA

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 February meeting minutes: motion approved.

Present & Discuss: Bree Collaborative Area of Influence

Ms. Bojkov reviewed the different audiences in which the Bree Collaborative reports commonly develop guidelines for:

- Clinicians/Healthcare Professionals
- Healthcare Delivery Systems (e.g., pediatric primary care, hospitals, etc)
    - School-based health clinics
    - Home-based services
- Health Plans
- Purchasers
- HCA

Beth reminded the group that the Bree's main line of influence is through contracting with the Health Care Authority, meaning that we influence the people that get, give and pay for healthcare in our state.

Present & Discuss: Level of Prevention & Early Intervention

Group transitioned the conversation to discuss level of preventions. Ms. Bojkov present a diagram by Colizzi, M. et al. (2020) that summarizes risk factors and pluripotent pathological trajectory for mental disorders encompassing the youth prevention and early intervention.

The group discussed the focus of the group to focus on levels of prevention. Our scope is within indicated prevention and secondary prevention, including individuals at high risk for development of mental disorders who are functionally impaired and no longer asymptomatic, including both those with and without a diagnosis.

- Comment from group: helpful to see that we are focusing in between health promotion and care for severe mental health conditions, as that helps narrow the scope in the context of lots of work being done at the Washington HCA
- Question and observation: functionally impaired sounds serious, so hopefully we are going more upstream then that. Ther term functionally impaired covers a wide range of impairment. Terry clarified that this means that we know there is something wrong, we don’t want to take this to mean that just because someone is behaving differently they need intervention; We want to take this to mean that someone, whether it be youth parent teacher etc
    - Chat Comment: I read "functionally impaired" as experiencing symptoms creating a barrier or challenge in at least one domain of life
    - **Action:** put our areas of focus into more plain language for communicating with general public

Group review defined levels of prevention and provided commentary.

- Provide information/language on our agreed upon focal frame.
- The current level of prevention definitions appears to be very clinical; we may want to review to develop verbiage in more plain language.
- Clarification on definition of functionally impaired. This term can encompass a wide range of impairments and the group suggested narrowing the scope to look more upstream. The group discussed a functionally impaired as a problem/concern has been identified that indicates the person may need an intervention (e.g., medication is needed).
    - “functionally impaired” as experiencing symptoms creating a barrier or challenge in at least one domain of life
- Prevention is a key action to mitigate an a more severe health condition.
- Consider moving forward that we want to focus on supporting kids and families. The family component is a very big deal. Recommend exploring opportunities to engage and educate families will be important for this work.
- Comment: it would be beneficial to see a prevention piece to avoid multiple diagnoses, is there a better model to encourage prevention activities rather than clinician adding diagnoses. It tends to be medicalized unfortunately.
- **Question**: Clarification on the lens we are looking at this work: Are we only looking into how the medical system engages? Or also how the schools engage on this topic?
    - For schools, indicated prevention is significant in schools, finding that there are gaps in the being able to bill for services for kids that have symptoms but are not being diagnosed with major depressive disorder.
    - Dr. Lee provided response that Schools and Primary Care are the two areas our group would like to focus the report on.
- Question on How SBIRT in schools is reimbursed?

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    - In King County, locally funded through local taxes for students in middle and high school (ages 10-24). The student needs to be enrolled in a school participating.
- Group member also advocated that school based behavioral health services is an area of expansion currently.
- **Action:** Diana (group member) going to seek out information around what can be done for school based services billed for Medicaid, schools using Medicaid to provide mental and behavioral health services and bring info back to this group
    - CMS guidance came out on how Medicaid can expand access in schools, currently applying for that.

DISCUSSION: SCOPE

Ms. Bojkov transitioned the group to discuss focus areas for the report and how to narrow the scope of the report. Ms. Bojkov reviewed areas we may need to discuss are settings, age, and primary diagnoses. Information was provided to the group on current data and the recommended age groups for different screening tools.

Group confirmed main focuses for settings.

- Primary Care
- School Based Settings
- Community & Home based settings
- Commentary:
    - Question on how the previous draft has community home, no longer there. If this is no longer included, then are we saying we are looking into the family/parent engagement as it relates to the primary care setting and the school-based setting.
        - Clarification given that family/parent engagement will be included within the primary care setting and school-based setting.
        - However, parents and families need to be able to contact help directly, and in that way community settings are a necessary setting to touch on
    - Comment: would love to see more peer support in this role, but those with lived experience are not healing in this space. Group member shared there are not as many individuals engage in peer support. Clinician stigma around peer support workers is very present, but barriers are broken down better when peer support is included.
        - Another reason to put community back into the settings. Want families to feel comfortable to reach out for help.
    - **Action:** add community/home back into the settings to cover parent/family engagement and peer support.
    - **Clarification:** early intervention means stepping in before disease attachment
    - Parents and families are an important group, but they are not an audience of this document

Group discussed ages

- Group members shared their primary focus on middle school and expanded to high school since it was needed. Additionally, the work mainly focuses in middle school with hope that they are preventing more acute mental health concerns in high school
- Grade is easier to use than age for school-based setting as ages vary in grades.
- However, in medical settings we do have interventions for younger people such as 10-year-olds, especially validated screening tools.

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- Unresolved trauma from parents and the impact on young children can greatly influence them as they grow. The earlier we work for parents to help support their children the sooner the child receives assistance. Repairing attachment significantly helps parents and children and provides significant improvement in behavioral health symptoms.
    - Comment: as we talk about how we define our scope, where does this conversation fits into the scope? In our last draft that was the word document we had community and home called out as a setting, are we thinking about family engagement & involvement as it relates to primary and school-based care or do community/home-based settings need their own call out?

Proposed age range: Middle school-high school age range (10-18). The group will continue to review and refine at a future meeting.

Group review primary diagnoses. Initial primary diagnoses included depression, anxiety, trauma/PTSD, substance use, disruptive behavior

- Would adjustment disorder be appropriate to add? The group agreed this would be an appropriate addition.
    - Adjustment disorder is vital as an early diagnosis to catch kids before they have enough symptoms to diagnose depression/anxiety etc and get kids into treatment or support
    - Adjustment – something happened recently and you are struggling with it, for example transitions from elementary to middle and middle to high school, divorce, someone passing, etc
        - Used as a catch all because it's something that can be billed for
- Group members asked if eating disorders would be appropriate to include. Ms. Bojkov clarified that this topic may be a better fit as a specific Bree report rather than included in this report. However, we may be able to add information to this report as deemed appropriate. As a potential example, eating disorder as it may related to lack of attachment in early childhood.
    - Group members support eating disorders as a potential area.
- Autism spectrum disorder to be included within this report? Group clarified that this guidelines for this specific population is out of scope for this report as the intention of the group is focus on a wide range of children and young people.

The group will plan to further review diagnoses at a future meeting through the review of focus areas.

DISCUSSION: SCOPE

Ms. Bojkov transitioned the group to a conversation around focus areas. The proposed focus areas include:

- Patient Education/Provider Training and Capacity Building – this focus area was identified as being too broad.
    - **Action:** to update Patient education to be Patient/Caregiver Education
    - **Action:** Add another focus area as Health Care Professional Training & Capacity Building.
- Identification and assessment
- Treatment and Management
    - Comment: add progress and monitoring to this section -> it was already there
- Coordination & Communication
    - Can we clarify what we mean by this?
        - Communication and coordination between providers and between systems
    - Action: Update to Interdisciplinary Coordination

- Vulnerable Populations
    - Of the populations listed, wanted to add race-BIPOC as groups that experience this very differently
- Financial Strategies

The group advised focusing on finding evidence for **"Identification and Assessment"** focus area for next month and look into how vulnerable population may be impacted in this area as well.

As new group members attended a meeting today. Karie Nicholas invited others to join the Evaluation sub-committee.

PUBLIC COMMENT AND GOOD OF THE ORDER

Ms. Bojkov invited final comments or public comments.

A comment was provided as a request to revisit the eating disorder space and how it may relate to this report as this is greatly impacting our youth.

Ms. Bojkov thanked all for attending. At the next workgroup meeting, the group will continue to discuss the scope of the report as it relates to age/grade range, diagnoses and report focus areas. The group will also begin to work to review evidence on identification and assessment.

The workgroup's next meeting will be on **Wednesday, April 10th from 8-9:30AM**.

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