Bree Collaborative | Behavioral Health Early Interventions for Youth
June 12th, 2024| 8-9:30AM
Hybrid

MEMBERS PRESENT VIRTUAL

Terry Lee, MD, Community Health Plan of Washington (Chair)
Diana Cockrell, MA, SUDP, HCA
Katie Eilers, MPH, MSN, RN, DOH
Brittany Weiner, MS, LMFT, CPPS, Washington State Hospital Association
Kevin Mangat, LMHC, MHA, Navos
Santi Wibawantini, LMFT, CMHS, Kaiser Permanente (KP)
Sally McDaniel, LMFT, LMHC, SUDP, CMHS, Greater Lakes/MultiCare
Delaney Knottnerus, LICSW SUDP, King County
Angela Cruze, NFYI
Lisa Farvour, ESD 112
McKenna F Parnes , PhD, UW Department of Psychiatry and Behavioral Sciences

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. Minutes were approved at the end of the meeting.

Correction to minutes: name spelling and titles
Motion to approve May meeting minutes: motion approved.

WORKGROUP WORKPLAN

Ms. Bojkov reviewed the workplan for the rest of the workgroup. In June the group will be reviewing the draft guidance for primary care settings implementing screening, brief interventions and referral to treatment. In July, the group will focus on reviewing the evidence-based treatments for common childhood behavioral health concerns and school-based implementation of screening, brief intervention and referral to treatment. In August, the group will discuss YBH metrics, and identify gaps in measurement. The goal will be to have a draft version of the report by October.

Questions

- Diana: want to make sure the goal is for BH integration into primary care, not anything bidirectional?
    - Terry: you bring up a good point that integration goals for the state are bidirectional, but because we are looking at early interventions for behavior, think it makes sense focusing on bringing behavioral health into primary care for this specific report.

- Terry: the school folks will have a chance to present next month, not sure if universal screening in schools is something to aspire to, but not sure if there are issues around that.
- Diana: just thinking about the RCW and work in play, the diversion that went from local juvenile justice settings to school settings and thinking about early intervention for young people who aren't identified as having a behavioral health needs or conditions that the start of that a lot of times is the justice system involvement. This might be a place where individuals get peeled off and served in the justice system not behavioral health system. But I think that's more in the crisis realm not the early intervention realm.
- Emily: With this proposed timeline, we would be voting on a report in January?
    - Beth: we might be done with it earlier than that but yes.

EVIDENCE REVIEW

Ms. Bojkov transitioned the group to review a few pieces of evidence that were included in the evidence table.

- Levy SJ, Williams JF, AAP COMMITTEE ON SUBSTANCE USE AND PREVENTION. Substance Use Screening, Brief Intervention, and Referral to Treatment. Pediatrics. 2016;138(1):e20161211
    - Clinical report providing simplified adolescent SBIRT clinical approach that in combination with accompanying policy statement guides pediatricians in implementing substance use prevention, detection, assessment and intervention practices across varied clinical settings in which adolescents receive health care
    - Emphasized that family-directed therapies are the best validated approach for adolescent SUD
    - Policy piece shares the role of health plans in covering screening and services for SUD at parity to physical health, and ensuring some sort of standardized coverage for confidential follow up for adolescents
    - They highlight the brief interventions for use without disorder (pediatricians to advise to stop, counsel regarding medical harms, and promote strengths) and mild-moderate SUD (brief advice to stop, brief counseling regarding harms, and close patient follow-up, consider referral to SUD treatment).
    - They also highlight several validated screening tools (S2BI, BSTAD, NIAA) and assessment (CRAFFT, GAIN, AUDIT) tools
- Anxiety Disorders in Children and Adolescents - AAFP
    - Clinical recommendations for anxiety in children highlighting
        - CBT as effective for 6-18 y/o with social anxiety disorder, generalized anxiety disorder, separation anxiety disorder, specific phobia or panic disorder (A level evidence)

        - SSRIs should be offered 6-18 y/o with social anxiety disorder, generalized anxiety disorder, separation anxiety disorder, specific phobia or panic disorder (A level evidence)
        - Combination therapy (CBT + SSRI) could be offered preferentially over CBT or SSRI alone to 6-8/yo diagnosed with social anxiety disorder, generalized anxiety disorder, separation anxiety disorder, specific phobia or panic disorder (B level evidence)
        - Drew from American Academy of Child and Adolescent Psychiatry guidelines
    - Parthasarathy, S., Kline-Simon, A. H., Jones, A., Hartman, L., Saba, K., Weisner, C., & Sterling, S. (2021). Three-Year Outcomes After Brief Treatment of Substance Use and Mood Symptoms. Pediatrics, 147(1), e2020009191. https://doi.org/10.1542/peds.2020-009191
        - Clustered randomized trial for SBIRT versus usual care in large integrated health system.
        - Followed a subset of adolescents with substance use and mood disorders, and followed them for 3 years after brief intervention. Odds were lower of a depression diagnosis at 1 year (OR = 0.31) and 3 years (OR = 0.51). At 3 years, odds of substance use diagnosis were lower (OR = 0.46) and had fewer ED visits (rate ratio 0.65)
        - Suggests longevity of the impact of SBIRT in primary care setting
    - Gryczynski, J., Monico, L. B., Garrison, K., Dusek, K., Oros, M., Hosler, C., Brown, B. S., Schwartz, R. P., O'Grady, K. E., Kirk, A., & Mitchell, S. G. (2023). Sustainability of Adolescent Screening and Brief Intervention Services in Primary Care After Removal of Implementation Supports. Journal of studies on alcohol and drugs, 84(1), 103–108. https://doi.org/10.15288/jsad.21-00324
        - Seven PCP clinics participated in an implementation study of screening and brief intervention for adolescent patients, all sites delivered screening/brief advice for low-risk use using a uniform protocol. Clinics randomized to delivery BI using generalist (PCP delivered) or specialist (behavioral health clinician delivered) model.
        - Penetration of screening was slow, but slowly increased across implementation to sustainability phases (62% vs 70%). No significant decrease in service provision during the sustainability phase.
        - Overall delivery was significantly higher in generalist model, sustainability did not differ between generalist and specialist models.
        - Implementation supports included clinic leadership engagement, screening and reporting integrated into HER, staff training for specific personnel functions, branded materials to raise awareness, quarterly booster trainings, bimonthly written feedback on screening for MA,s and delivery for providers.

- Barbosa, C., Cowell, A., Dunlap, L., Wedehase, B., Dušek, K., Schwartz, R. P., Gryczynski, J., Barnosky, A., Kirk, A. S., Oros, M., Hosler-Moore, C., O'Grady, K. E., Brown, B. S., & Mitchell, S. G. (2022). Costs and Implementation Effectiveness of Generalist Versus Specialist Models for Adolescent Screening and Brief Intervention in Primary Care. Journal of studies on alcohol and drugs, 83(2), 231–238. https://doi.org/10.15288/jsad.2022.83.231
    - Complementary cost analysis to the above study
    - Marginal cost of SBIRT per patient with positive screen ($6.72 in specialist model, 6.05 in generalist model) program costs for 1 year per site was $13,548 in specialist site versus $12,081 in generalist model.
    - Generalist model was more effective in implementing brief intervention and less expensive than the specialist model.
- Thoele K, Moffat L, Konicek S, Lam-Chi M, Newkirk E, Fulton J, Newhouse R. Strategies to promote the implementation of Screening, Brief Intervention, and Referral to Treatment (SBIRT) in healthcare settings: a scoping review. Subst Abuse Treat Prev Policy. 2021 May 11;16(1):42. doi: 10.1186/s13011-021-00380-z. PMID: 33975614; PMCID: PMC8111985.
    - Scoping review identifying strategies to promote these protocols in healthcare settings
    - Most common interventions include training, educating stakeholders, developing relationships. Only a few involved engaging patients or consumers in the implementation process. Implementation often resulted in an increase in screening, but evidence regarding brief intervention is less clear. Most studies did not assess the reach or adoption of the referral to treat portion.
    - Implementation supported embedding reminders or shifting tasks to other roles in the team to support clinicians in implementation.
- Telehealth for rural diverse populations: telebehavioral and cultural competencies, clinical outcomes and administrative approaches - PMC (nih.gov)
    - This systematic review focused on identifying the components of culturally competent, telepsychiatric care and what approaches clinicians and systems take to implement and evaluate it.
    - The authors found there are no specific competencies that integrate telepsychiatry or telebehavioral health within culture, existing competencies include cultural component including use of interpreters and language matters.
    - Can’t complete cultural competency like a checklist item; needs to be embedded as part of the overall system.

SCREENING, BRIEF INTERVENTION AND REFERRAL TO TREATMENT IN PRIMARY CARE SETTINGS

Ms. Bojkov transitioned the group to reviewing the key barriers for screening, brief intervention and referral to treatment in primary care settings. The group wanted to highlight barriers as they related to the school setting as well. The following changes (in red) were made to the list:

- **Measurement**: underdeveloped measurement for behavioral health treatment outcomes, underutilization of current tools to measure progress during treatment
- **Supply**: of PCPs, community behavioral health, school behavioral health personnel to meet needs of families and patients; lack of availability of place to send patients creates screening hesitancy
- **Time**: lack of time to provide screening and brief intervention in clinical visits and schools
- **Staffing Infrastructure**: health centers/behavioral health providers contracting or integrated with schools
- **Documentation System:** Documentation barriers, inability of electronic systems to systematically document screening, results, diagnosis and referrals, and aggregate trends for quality improvement at both provider and organizational level; access to different documentation systems (between clinicians, schools and providers, etc)
- **Comfortability/Competency**: Providers feeling uncomfortable with identifying/intervening/managing behavioral health concerns in their patients; schools not comfortable screening and brief intervention, not seeing as their core function.
- **Financial:** Medical necessity required to bill for screening and brief intervention in schools – limits the population of youth they can serve, complexity of billing (bigger for schools); insurance company empanelment limits; licensure or training required to submit to bill for SBIRT codes and broader screening and assessment codes; sustainable funding for school based health centers. Adequate reimbursement for screening.
- **Rural**: transportation, broadband internet, access to psych consultation
- **Family Supports**: family capacity for involvement (time, engagement, childcare, work, medical conditions),

Comments

- Brittany: only reimbursement available for brief intervention portion of SBIRT, and rate from HCA billing codes is $26 for 15 min or less, ~$50 for 16-30 minutes. Other thing to consider is to bill for SBIRT in Washington, unless addiction medicine professional or someone with an SUDP, you have to complete a training and submit proof of that training to the HCA to be able to bill – effects sustainability and incentive for billing, for primary care.
- There's a CPT code for screening, not sure where it's reimbursable by our system, but something that could be a recommendation if it's not currently reimbursed.

- Brittany: want to make sure that we clarify what are SBIRT codes, which are screening, intervention and referral to treatment codes which are a specific modality that could be done to fidelity.
    - Terry: we want to take a more general approach, could take the component parts of SBIRT and build those separately and as far as fidelity, some of the studies Beth showed they are testing the component parts of SBIRT without using the SBIRT code.
    - Brittany: want to make sure in our report we're being very clear that SBIRT is a specific modality and screening, brief interventions and referral are separate component parts that could be applied more broadly. Don't want to confuse people thinking they can bill for SBIRT codes when they can't.
- Karie: is having health centers associated with schools a high level infrastructure barrier? Something important to measure?
    - Terry: We would want to look at behavioral health providers as well if they're employed by the school or contracted with them. Break down infrastructure barrier into several different categories.
    - Diana: we want to make clear lines for what part of the school piece we mean or don't mean, because many schools in Washington don't even have a nurse full time, much less medical connection or behavioral health connection or access figured out. There are some educational service districts as licensed BHAs. Spokane is a mental health provider. There's school based health centers and FHCQs that are in partnership with schools that aren't part of the actually school based health center structure. CCBHC is also coming online, not quite sure how all these things work out.
        - Looking at the workplan, in August, September and October, perhaps there's a way to focus on primary care and ways that we can see that working in school settings with certain kinds of structure that are in play and track how much of that gets built out in the future as a support.
- Santi: family supports is also a key barrier, lots of families experience time or work or medical conditions, etc that interfere with ability to support their child.

Beth then transitioned the group to look at the drafted guidelines for primary care settings including some for all systems. These draw from the systems of care framework the group identified as being important to the overall framing of our guidelines. Changes were made in the red:

- **Family & Youth Driven**: Engage families and youth as active partners in decision-making whenever possible. Seek community feedback on changes in service delivery and payment.
- **Home- and Community-based**: Services are provided in the least-restrictive setting, such as the home, school primary care clinic or other community based setting
- **Culturally and linguistically inclusive**: Prioritize adapting agencies, services, and supports to the cultural, racial, ethnic, and linguistic diversity of the young people and families they serve to

provide care that meets individual needs, including those shaped by culture and language, and to ensure equity in access, quality, and effectiveness of services. (e.g., using linguistically appropriate screening tools for families who do not speak English)

- Diana: linked the Washington CBH principles, these closely align.

Beth then transitioned the group to reviewing the drafted guidelines for primary care settings. Changes were made in red. Comments underneath.

1. **Prepare primary care practices to implement screening, brief intervention and referral to treatment protocols.**
    a. Train staff and providers on screening, brief intervention and referral to resources protocols. Example protocol for depression here.
    ~~b.~~ Develop pathway for accessible behavioral health and psychiatric consultation for primary care providers**. ~~Team-based management with onsite behavioral health providers and psychiatric consultation is ideal,~~** ~~but if not feasible consider alternative methods.~~
        i. Tram-based management with onsite behavioral health providers and psychiatric consultation
        ii. Teleconsultation services can be as effective and face-to-face (e.g., PALS)[i]
    c. Define roles of the team in the workflow, including individual responsible for each step along the screening, brief intervention and referral to resources workflow.

II. **Universally screen annually for common childhood behavioral health concerns** (anxiety, depression, ADHD, trauma, substance use) according to most updated clinical guidelines (Bright Futures, AAP) using a validated instrument(s) including:
    a. Depression (e.g., PHQ-2, PHQ-3 and/or PHQ-9)
    b. Anxiety (e.g., GAD-2, GAD-7)
    c. ADHD (e.g.,
    d. Trauma (e.g., Child Trauma Screen, ACES screening)
    e. Disruptive Behavior (e.g., Pediatric Symptom Checklist, Strengths and Difficulties Questionnaire)
    f. Substance Use (e.g., CAGE AID, CRAFFT)
    g. Strengths and resilience factors
    h. Consider using screening instruments validated in specific populations (e.g…)

III. **For youth with a positive screening result, presenting with a behavioral health related complaint, or for which there is strong clinical suspicion of a behavioral health concern despite a negative screen, perform a comprehensive assessment**.[ii]
    a. Assess for comorbid behavioral health concerns (e.g., co-occuring anxiety and depression, ADHD and behavioral concerns, history of trauma and substance use, etc)
    b. Consider other symptoms not included on all validated screening tools, such as social isolation and loneliness, when assessing behavioral health concerns. These symptoms are not always recognized using validated instruments which can contribute to underdiagnosis.

c. Assess for functioning in key areas (home, school, peers, etc) and use functioning and quality of life to guide treatment planning.

IV. **At a minimum, provide evidence-based brief intervention for patients (and family) with mild-moderate symptoms**.

a. **First Approach Skills Training (FAST) Program** provides evidence-based training and resources for children, families and providers for common behavioral health concerns in children.

b. If a patient is identified with substance use, brief interventions should include motivational interviewing,

- Terry: team-based management is not going to be feasible for all clinics. We might want to remove that language, as there are a range of solutions and its up to each clinic and school to decide what is best for them. I think it would be best to offer a range of options then that might be more acceptable in terms of different stakeholders.
    - Diana: think it would be good to have levels of sophistication so there's options in menus for people to see how to grow or how to think strategically about what could be next for whatever it is they're doing in that menu of options. COPE serves all family caregivers with peer support regardless of insurance status, not limited by funding.
- Brittany: support idea of highlighting different culturally validated/tailored screening tools
- Katie: is there any screening that clinicians use for strengths and resilience alongside sort of deficit or risk screening? Is there a role for that?
    - Terry: don't think it's general practice, just from what I've seen, but certainly part of the solution to leverage whatever supports and strengths there are. There are scales but not widely used. We're a long ways from systematically measuring something like that.
- Delaney: are we still thinking in the primary care based clinic, or school space? I do see some nuance. At King County, we developed a tool that has a lot of the validated screening tools embedded, so it has PHQ-2 and GAD and CRAFFT embedded, also use SB2I and we included one with strengths and resiliency factors. It includes parents as well. Just want to note there is nuance, if a primary care provider or behavioral health provider in a clinic you can easily switch between screening tools in the EHR, but can't do that in schools. Children aren't coming in annually to primary care right now, but schools can't handle doing annual screening for everyone, they can only do one grade level. To some extent a lot of school districts develop a blanket needs assessment that can range from something that's done by an organization to a school counselor, they are just doing what they can.
    - Beth: we'll revisit school based screening in July

ACTION ITEMS

- Workgroup members: review and comment on the pediatric primary care guidelines and

PUBLIC COMMENT AND GOOD OF THE ORDER

Ms. Bojkov invited final comments or public comments, then thanked all for attending. At the next workgroup, the group will review school-based SBIRT and evidence-based therapies for youth with the scoped behavioral health concerns.

Good of the Order:

- **Propose a Bree Topic for 2025:** The Bree Collaborative will accept submissions for 2025 topics until **Monday, July 8th, 2024,** at Midnight. Please contact Beth at ebojkov@qualityhealth.org with questions.

The workgroup's next meeting will be on **Wednesday, July 10th, 2024 from 8-9:30AM**.

[i] Carrillo de Albornoz S, Sia KL, Harris A. The effectiveness of teleconsultations in primary care: systematic review. Fam Pract. 2022 Jan 19;39(1):168-182. doi: 10.1093/fampra/cmab077. PMID: 34278421; PMCID: PMC8344904.

[ii] Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Part I. Practice Preparation, Identification, Assessment, and Initial Management ; 2018