Bree Collaborative | Behavioral Health Early Interventions for Youth
September 11th 2024| 8-9:30AM
Hybrid

MEMBERS PRESENT VIRTUAL

Terry Lee, MD, Community Health Plan of Washington (Chair)
Diana Cockrell, MA, SUDP, HCA
Brittany Weiner, MS, LMFT, CPPS, Washington State Hospital Association
McKenna F Parnes, PhD, UW Department of Psychiatry and Behavioral Sciences
Thatcher Felt, MD, Seattle Children's
Lisa Farvour, ESD 112 (proxy for Denise D)
Libby Hein, LMHC, Molina
Delaney Knottnerus, King County SBIRT
Angela Cruze, National Foster Youth Institute

STAFF AND MEMBERS OF THE PUBLIC

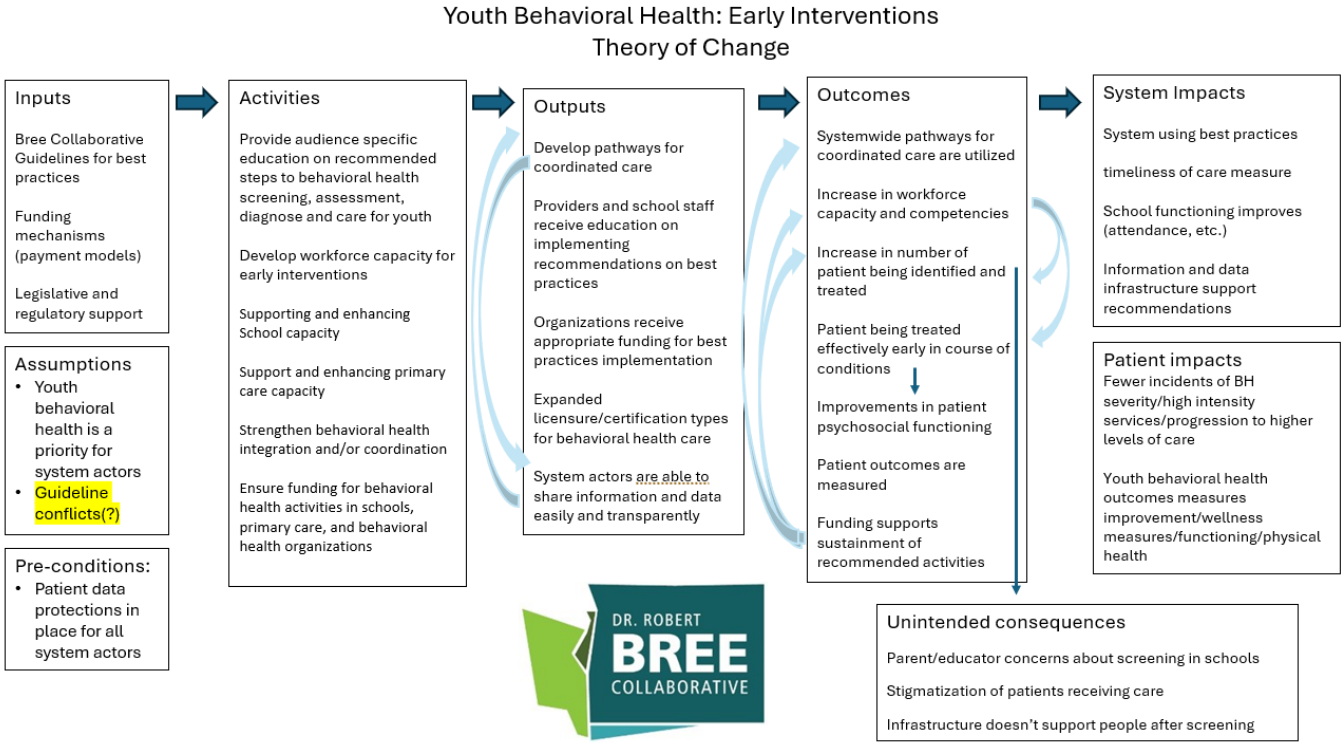
Beth Bojkov, MPH, RN, Bree Collaborative
Emily Nudelman, DNP, RN, Bree Collaborative
Karie Nicholas, MA, GC, Bree Collaborative
Gina Cabiddu

WELCOME

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

DRAFT THEORY OF CHANGE

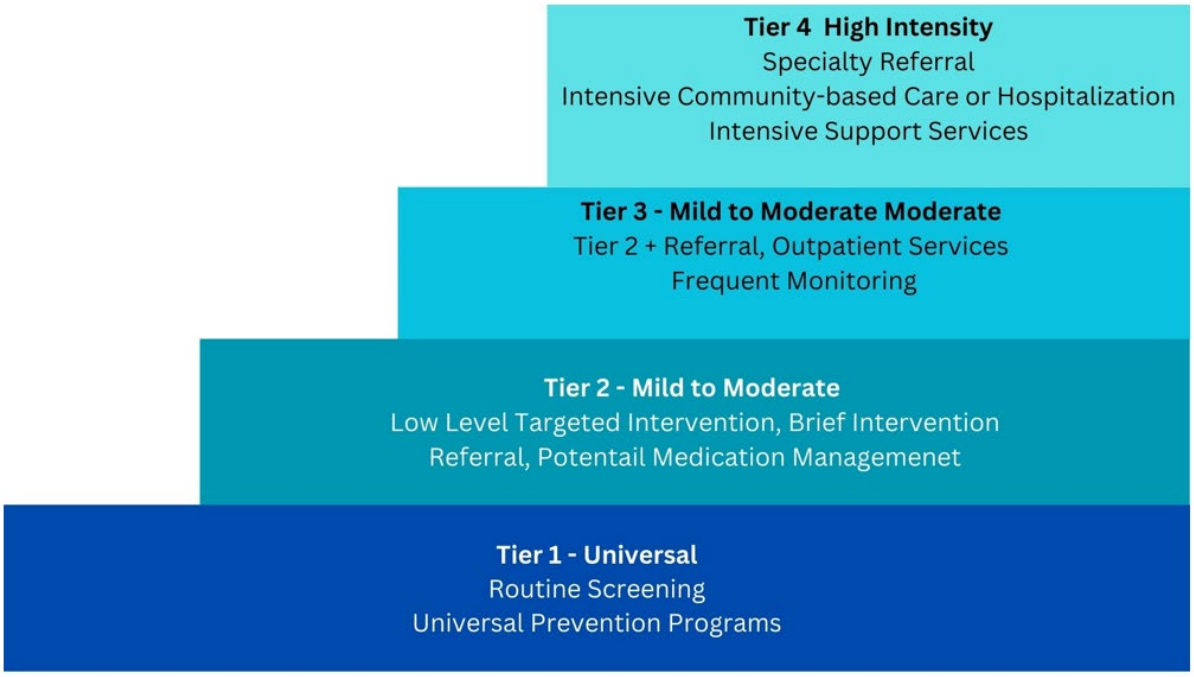
Beth then transitioned the group to discussing the Draft Theory of Change. The theory of change is how we imagine things are going to change based on our guidelines and what happens once the guidelines are published.



- Diana: are we thinking about how this will work with strategic plan efforts that are underway at the P25 layer? Is the theory of change setting specific, such as it will work in some settings but not others?
    - Karie: the lens is through the whole system, so it is system wide
        - Diana: hope that we can leverage learnings in both spaces, may not always directly connect but think it makes sense
- Diana: we also have feedback groups for youth and family voice in the strategic plan, so might be good to get looped in to that
- Thatcher: want to ensure we're developing a model that includes sustainability, and continuum of care
    - Terry: we have a statement on funding supports sustainment of recommended activities
- Libby: missing involvement of families, sort of runs that gamit of categories here
    - Delaney: what about family skill level or knowledge to access systems when things come up and comfort accessing those systems?
- Beth: we don't have a ton right now on how caregivers can support themselves, and think that is an important piece
    - Diana: dropped in peers parent support solution
- Diana: surgeon general's report on loneliness and power of community and belonging, want to keep that in mind when we're thinking about this report. Our payment structure is built on the individual, which is sort of anti what we know helps people actually heal.

REVIEW DRAFT GUIDELINES

Beth transitioned the group to begin reviewing the draft guideline document. Beth transitioned the group to look at the tier system diagram.



- Terry: We had discussed that public health uses a tiered system, but were not sure if we should break out tier 2 into more branches. We've had lots of discussion about using traditionally nonclinical staff and non-licensed staff, so any feedback would be great.

- Thatcher: would cut out potential medication management and put medication management in tier 3
- Delaney: wondering if there may be a cross walk between this and MTSS, would make sense to think about how that relates to the this tiered system.
- Libby: think tier 2 is more mild, tier 3 is moderate.
- Diana: there are three other models I'm seeing in other places that I'll send over really quick so you can look at them. One of them is from ASAM standards coming out with version 4 for adolescent young adult. It's much more detailed than this, but think it might be helpful context. Then the Strategic plan workgroup has a couple visuals that the feedback groups are working on to have a visual aid to how the systems work. The goal is a bit different but also might be helpful context. Cross-walking MTSS with this when this model is more of a clinical stratification which schools don't have doesn't seem right.
- Delaney: for schools it would be confusing to have something that's four tiers instead of three because the MTSS has three, and the graphic I dropped in is three-dimensional which shows a continuation of services from levels 1-3, we don't want services to stop between the levels. It shows the movement from 1 space to the other.

Action item: Beth to revise the tiered system graphic based on feedback

Beth then transitioned the group to reviewing the focus areas again. The group discussed what should be considered under a financial focus area.

- Diana: suggesting early intervention fore folks before they reach level of diagnosis and needing treatment
    - Terry: we would use the word preclinical or subclinical, criteria for diagnosis is not met but there are symptoms that need to be addressed
- Thatcher: need to establish importance of paying for screening in the clinical setting, some of that's a legislative issue
- Libby: funding to support home programs, home and community based programs, aligns with early intervention and preclinical syntax. There are a lot of families that won't go to schools or clinics, so it makes sense to expand into home.
- Beth: curious about any thoughts on value based purchasing aspect?
    - Libby: we have evidence-based practices being tracked, there's a lot of work to do in that space, but think there's a lot of opportunity to attach value-based contracting to evidence-based practices which we might want to consider
        - Diana: what comes to mind for EBPs is that we have a system that has built in disparities, so want to leave room for practice based evidence. Maybe a financial request for what is practice-based evidence investments look like and what we can learn from other cultures, other interventions etc
        - Karie: think the bullet on value-based purchasing and practice based evidence we need more information in order to operationalize that and select outcome metrics as the subgroup has talked about numerous times
- Terry: for the last bullet on practice based evidence, think funding itself could be something we track. Is this being funded by the legislature?
    - Gina: I work with nonprofits and have a background in fundraising, so oen of the metrics could be looking at # of minority led organizations that get funding, # of applicants increased, dollar amounts to those organizations, etc; helpful to look at what is a quantifiable metric that has an equity lens and light on system barriers in pale for the need of those organizations to plug gaps.

- Terry: returning to VBP, there are other measures like healthcare utilization and cost that can be evaluated, many BH conditions result in healthcare cost productions
    - Libby: almost don't want to attach anything in particular but we want to drive as a system of care towards people getting good outcomes, whether through evidence-informed praties or reduction in PHQ-9 scores, don't want to get too prescriptive but that is the direction we need to go. Could change the statement to value based purchasing for outcome based care
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Beth transitioned the group to looking through the health plan guidelines, and reviewed them in detail with the group. Following suggestions were made:

- Libby: clarify that expanding the types of professionals that can be reimbursed for screening, assessment and brief intervention, the assessment needs to be done by a licensed professional who can appropriately perform the assessment
- Beth: is there a specific timeframe to follow up after a positive screen?
    - Libby: depends on severity, if it's severe, it should be immediate. Don't know if we could outline that here, it would be based on severity
- Gina: there might be an opportunity to move screening upstream or use tools that don't require a ton of clinical expertise and qualification since the provider workforce is short and those tools are not going to be accessible. Consider getting these screening tools into the hands of more professionals upstream.
- Brittany: Think it will be super important to have some language here around explicitly calling out that the system needs to account for youth privacy, especially folks who are in family systems where maybe they don't get a ton of support for behavioral health concerns
- Angela from chat: 100% support the nondiagnosis route for youth, youth may need alternative support specially with coming from systems to prevent the multitude of diagnoses by the time they turn 18, although advocate for real lived experience experts like peer support and that's something we currently don't have in this section
    - Thatcher: one of the great things about peer support is it's very financially effective and the cost of services is very high potential for improving outcomes is actually quite good
- Karie: in reference to the HEDIS measures, the goal is to move from depression screening measure to depression remission over time
- Thatcher: think we should call out coverage needs to occur across state lines as well, helps to build adequacy and maintain relationships with providers from other states
    - Karie: health plans are differently regulated at the state level, one place that might be possible is with FQHCs and there are some that work across state lines, but not sure doing this in Medicaid would be possible; other thought is that Washington, Oregon and California have discussed making a shared health plan but don't think anything has really happened there
        - Terry: under certain conditions it is allowed, part of it depends on the state and part depends on the treatment
        - Karie: so maybe a guideline on figuring out where the gaps are and how to close those gaps

PUBLIC COMMENT AND GOOD OF THE ORDER

Beth invited final comments or public comments, then thanked all for attending. Beth welcomed a moment to approve the minutes from July.

Motion to approve July meeting minutes: motion approved.

At the next workgroup, the group will hear from our school partners on their student assistance professional program to expand access to behavioral healthcare services in school settings.

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