## Primary Care Clinics serving Pediatric Patients

Checklists: The checklist translates the Bree guidelines into action steps for that sector (i.e., clinician, health delivery site, public health, etc.). The action items have been arranged into levels 1, 2, and 3 to correspond to the difficulty level of implementing the action into the sectors’ setting. Bree staff co-created the checklists with report workgroup members and topic experts.

* Level 1 actions (introductory): activities that provide a starting place to improve care including advancing audience knowledge and self-efficacy in addressing the health topic. These activities may be able to be incorporated into existing workflows.
	+ Note: These actions are to be encouraging for individuals to begin treating the chosen health topic.
* Level 2 actions (intermediate): activities that may require collaboration, new workflows, and resources to accomplish.
* Level 3 actions (advanced): activities that may require higher collaboration, resources, funding, and time to accomplish.

Level 1

#### Education & Capacity Building

1. **Offer teen-friendly and culturally inclusive health information materials on**: (Resource: [Teen Health Hub](https://doh.wa.gov/teenhealthhub))
	* recognizing behavioral health signs and symptoms
	* unhealthy behaviors
	* how to support peers
	* how/where to get help when necessary
2. **Ensure staff know national and local crisis resources, including crisis lines.** (Resource: [Youth Suicide Prevention Resources | Washington State Department of Health](https://doh.wa.gov/you-and-your-family/injury-and-violence-prevention/suicide-prevention/youth-suicide-prevention/youth-resources))
3. **Ensure primary care healthcare workers understand/receive training on the following:**
	* How to discuss family involvement in care with youth
	* Risk, strength and protective factors for youth
	* Signs and symptoms of behavioral health concerns in youth
	* Common co-occurring concerns in youth behavioral health
	* Special considerations for populations at higher risk for BH concerns
	* Bias and stigma towards people with behavioral health concerns (mental health/substance use)
4. **Offer resources to providers** on brief intervention
5. **Establish and train staff on safety protocols for patients at risk of suicide.** Resource: [Bree Collaborative Suicide Care report](https://www.qualityhealth.org/bree/our-guidelines/suicide-care/)
6. Encourage providers to **share their identities** with youth and caregivers as comfortable.
7. **Have a** **directory with provider demographic data** of BH referral sources easily accessible (see Washington’s [Mental Health Referral Services for Children and Teens (MHRS) through](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/mental-health-referral/))

#### Screening, Brief Intervention and Referral to Treatment

1. **Universally screen annually for youth behavioral health concerns for which there is a validated screening instrument** according to most updated evidence-based guidelines ([Bright Futures](https://publications.aap.org/toolkits/resources/15625/Bright-Futures-Toolkit-Links-to-Commonly-Used), [USPSTF-depression](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-children-adolescents)[, USPSTF-anxiety](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-anxiety-children-adolescents))
	* **Depression** (PHQ2, PHQ9, PHQ-A)
	* **Anxiety** (GAD-2, GAD-7)
	* **Alcohol & Other Substances** (CAGE-AID, CRAFFT)
2. **Enter screening results** into the medical record
3. **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 including for common co-occurring conditions**.
	* Systematically include evaluation for other symptoms not included on all validated screening tools, such as social isolation and loneliness.
	* Assess for suicidal ideation, self-harm or substance use that poses immediate danger in confidence without caregiver present (involve caregiver if positive per WA statute). (resource: [Supporting Adolescent Patients in Crisis](https://wcaap.org/wp-content/uploads/2021/10/Crisis-toolkit_final56497.pdf))
	* Use appropriate crisis intervention protocols, including referral to emergency services and/or crisis line if necessary ([**988**](https://www.samhsa.gov/find-help/988)). (Resource: Bree Collaborative’s [Suicide Care](https://www.qualityhealth.org/bree/our-guidelines/suicide-care/) Report)
	* Ask patient for consent to include support system (e.g., caregivers) when discussing screening results.
4. **Use validated tools when assessing for common co-occurring conditions** (E.g., Child Trauma Screen, Connors Rating Scale, Pediatric Symptom Checklist, Strengths and Difficulties Questionnaire)
5. **Consult with behavioral health professionals as needed.** (free insurance-agnostic resource: [Partnership Access Line (PAL)](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/wa-pal/)
6. **Routinely address behavioral health concerns in confidence,** but involve caregivers with permission and per statute
7. **Identify youth and caregivers’ risks, strengths and protective factors** (e.g., social support, coping skills) that can support reaching their treatment goals.
8. **Provide or refer for a brief intervention** tailored to identified concern when indicated. (resources: [FAST](https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/), [Children’s care guides)](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/resources/)
	* See[**First Approach Skills Training (FAST) Program**](https://www.seattlechildrens.org/healthcare-professionals/community-providers/fast/) for evidence-based training and brief intervention resources.
	* Provides may delegate to appropriately trained team member as available (e.g., CHW)
9. **Refer to specialists for evaluation** of co-occurring conditions as necessary
10. **Refer patients and families to behavioral health providers,** especially those who share characteristics (race, ethnicity, sexual orientation) with youth and family as possible.
11. **Ideally, use warm handoffs** when referral is necessary

#### Coordinated Management

1. **If indicated, consider pharmacological management for depression, anxiety, ADHD or substance use disorders** based on most updated clinical practice guidelines. (Resource: [Washington Care Guides – Seattle Children’s](https://www.seattlechildrens.org/healthcare-professionals/community-providers/pal/resources/))
	* Medications for Opioid Use Disorder (MOUD) is effective to reduce risk of overdose and death for patients under 18. (Resource **Bree Collaborative’s Treatment for Opioid Use Disorder Guidelines** ), [learnabouttreatment.org.](https://www.learnabouttreatment.org/for-professionals/youth-treatment/), and Adolescent Learning Collaborative
2. **Follow up at a time that is appropriate to the acuity of the need.** (e.g.,youth with suicidal ideation may need to be held for evaluation and potential escalation of care – [Supporting Adolescent Patients in Crisis](https://wcaap.org/wp-content/uploads/2021/10/Crisis-toolkit_final56497.pdf))
3. **Develop a treatment plan** in partnership with patients, caregivers, and behavioral health professionals
4. **Follow patient medication management** closely(e.g., every 3 months)
5. **At follow-ups, use repeated screening with validated tools to measure progress toward symptom reduction**
6. **Use repeated screening results to inform treatment plan adjustments**

#### Data & Measurement

1. **Integrate behavioral health screening tools into the EHR when able**
	* Screening can be performed by any qualified member of the care team or completed online ahead of the appointment. (screening tool for SODH example [here](https://prapare.org/what-is-prapare/))

Level 2

#### Education & Capacity Building

1. **Incorporate telehealth/telemedicine capabilities for visits.**
2. **Build partnerships with community-based organizations (CBOs)** that provide support for social drivers of health, including parent support groups.

#### Coordinated Management

1. **With consent, share relevant treatment plan information** with the patient’s school support system directly as able.
2. **Share care plans** with professionals involved in youth and their support system’s care.

#### Data & Measurement

1. **Use a registry to track patients** with a history of a positive screen.
2. **Flag patients for follow-up** from a predetermined care team member
3. **Stratify registry** by race, ethnicity, language, sexual orientation and gender identity data, and other relevant factors to identify and address inequities
4. Provide electronic referrals **interoperable language**

Level 3

#### Education & Capacity Building

1. **Ideally, have dedicated staff person** to manage referral process
2. **Hire and retain providers and staff** that identify with the communities they serve.
3. **Hire** [**community health workers**](https://www.hca.wa.gov/billers-providers-partners/prior-authorization-claims-and-billing/provider-billing-guides-and-fee-schedules)**/promotoras, peer support workers,** and others with lived experience as part of the multidisciplinary team.

#### Coordinated Management

1. **Offer group psychotherapy onsite** if behavioral health integrated

#### Data & Measurement

1. **Identify gaps in care** (e.g., missed appointments) and reach out
2. When able, **incorporate EHR functionalities that can confirm closed loop referrals** to external providers and CBOs and receive information back.

The workgroup recommends primary care settings implement a tiered approachto behavioral health concerns for children and youth that seeks to provide the appropriate level of support and intervention based on screening results, assessment and individualized patient and caregiver preferences and goals. *These settings include pediatric primary care offices, family medicine offices, and other outpatient clinics settings where children and adolescents receive primary care.*

#### Education & Capacity Building

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12. **Build partnerships with community-based organizations (CBOs)** that provide support for social drivers of health, including parent support groups.

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