Accountable Communities of Health Evaluation
PROJECT SUMMARY REPORT

Cascade Pacific Action Alliance

Youth Behavioral Health Coordination Pilot Project

Center for Community Health and Evaluation
January 2018

Summary

This report describes the Youth Behavioral Health Coordination Pilot Project of the Cascade Pacific Action Alliance Accountable Community of Health. The project addresses behavioral health issues, including Adverse Childhood Experiences (ACEs), through prevention and mitigation using school-based behavioral health services and referrals.

The pilot is being implemented in primary and secondary schools in Cowlitz, Mason, Thurston, and Wahkiakum counties. Cowlitz implemented the Project in the fall of 2015; Mason, Thurston, and Wahkiakum implemented during the 2016-17 school year. Leadership on the pilot project is being provided by the local Behavioral Health Organizations, schools (local and ESDs), and CPAA. The project is jointly funded by the BHOs (70% of the total) and participating schools (30%). Additional funding is being provided by a grant from the Cambia Health Foundation.

The four school districts implementing the YBHC pilot project are meeting the goals of identifying children with behavioral health challenges as early as possible and connecting them to treatment services. Over 200 students have been referred to the program and 131 received counseling and other behavioral health services.

While quantitative outcome measures are not yet available, interviews with program staff and others identified a number of encouraging initial results, including connection to services, reduced stigma around mental health, clear improvement in selected cases, and an increase in feelings of support for school staff around dealing with behavioral health crises.

Lessons learned include: Engage partners early to ensure a common understanding of vision, roles, and responsibilities; integrate BH providers with the rest of the school; create a comprehensive, integrated system of support; and establish systems for data tracking and evaluation

The program will continue to operate for the foreseeable future with a focus of ongoing project evaluation and refining data analysis and reporting.

Introduction

An Accountable Community of Health (ACH) is a regional organization consisting of representatives from a variety of sectors, working together to improve population health. ACHs were established with funding from a State Innovation Model (SIM) federal grant and now receive funding from multiple sources, including SIM and the state's Medicaid Transformation Demonstration. Nine ACHs have formally organized across Washington as part of the Healthier Washington initiative to strengthen collaboration across a range of sectors, develop and implement regional health improvement efforts, and provide feedback to state agencies about their regions' health needs and priorities.

A key responsibility of the ACHs in Healthier Washington is to facilitate and coordinate projects that bring together multiple sectors to collaboratively address a health priority within their region. In July 2016, all nine ACHs submitted initial SIM project proposals to the Health Care Authority (HCA) and have since moved forward with further planning and project implementation.

This report describes the Youth Behavioral Health Coordination Pilot Project of the Cascade Pacific Action Alliance, including rationale, design, planning, implementation, accomplishments, and outcomes, as well as prospects for project sustainability.

ACH snapshot

Cascade Pacific Action Alliance (CPAA)

Web site	https://www.cpaawa.org/
Geography & population	Cowlitz, Grays Harbor, Lewis, Mason, Pacific, Thurston, and Wahkiakum counties 2017 population: 621,680 (9% of state)

Overview and goals

In January 2015, stakeholders from across the CPAA region identified improved behavioral health care coordination for children as a high need in local schools and undertook an effort to reduce the number of children with unmet behavioral health needs. The result was CPAA's Youth Behavioral Health Coordination Pilot Project.

The project addresses behavioral health issues, including Adverse Childhood Experiences (ACEs), through prevention and mitigation using school-based behavioral health services and referrals. It coordinates with school districts, clinicians, and behavioral health care providers to identify students with behavioral challenges as early as possible and connect the children and their families to community-based interventions and treatment services.

The specific goals of the YBHC project are to:

- Identify children with behavioral health challenges (mental health and substance use disorders) as early as possible in both education and health care settings
- Connect vulnerable children with community-based interventions and treatment services
- Decrease the number of school-aged youth with unmet behavioral and physical health needs through improved care coordination by schools, pediatric primary care physicians, and behavioral health specialists
- Prevent teen suicide and suicide attempts through early intervention and care coordination.

Site selection and funding

The YBHC project partners selected potential sites for implementation by looking at ACEs "hotspot" maps and using the collective knowledge of stakeholders to generate a list of 35 candidate schools. The education service districts (ESDs) and community partners then contacted schools with a structured set of questions to identify schools that were ready and interested in implementing a pilot. The four sites selected included primary and secondary schools in Cowlitz, Mason, Thurston, and Wahkiakum counties. Cowlitz implemented the Project in the fall of 2015; Mason, Thurston, and Wahkiakum implemented during the 2016-17 school year.

Leadership on the pilot is being provided by the local Behavioral Health Organizations (BHOs), schools (local and ESDs), and CPAA. The project is jointly funded by the BHOs (70% of the total) and participating schools (30%). Additional funding is being provided by the Cambia Foundation.

Service delivery model

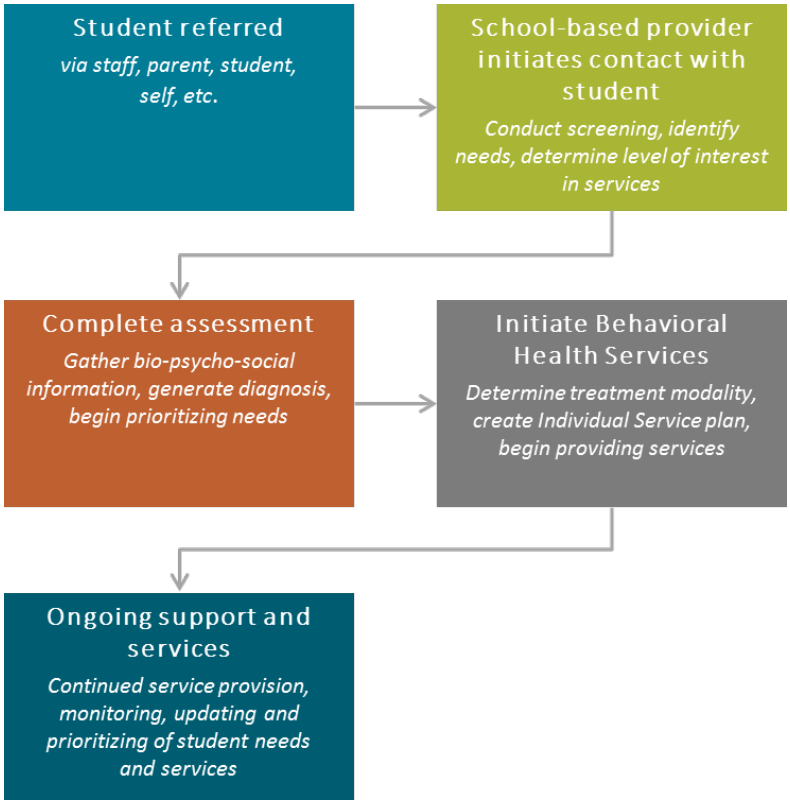
Figure 1 illustrates the service delivery model being implemented across all four sites; details that give a flavor of implementation by site are provided below. Early warning signals (e.g., absenteeism, declining grades, etc.) are used to identify students for referral-based screening. In addition to students self-referring, identification is done by existing interdisciplinary teams that can include the principal, school counselor, school nurse, school psychologist, and teachers.

The school-based behavioral health provider (BH provider) screens students using standard tools such as the Strengths and Difficulties Questionnaire (SDQ), the Global Appraisal of Individual Needs Short Screener (GAINSS), and Pediatric Symptoms Checklist. These tools help identify the types of clinical, behavioral, social/emotional, academic and/or basic supports needed by the student. Based on a student's assessments, the appropriate behavioral health services are provided.

The BH provider also helps coordinate services, working in partnership with school nurses, counselors and other school staff. Their activities can include:

- Attaining confidentiality release forms to share information across systems;
- Identifying and coordinating referrals;
- Serving as the information conduit between all those serving the student and providing feedback loops between educational, clinical, and community settings;
- Helping the student find a health home;
- Notifying provider practices in the area about the pilot and their role as the lead case manager for students attending that school.

Figure 1. YBHC Service Delivery flow chart



There is variation in workflow and services offered across the four sites; the following gives a flavor some of the local features:

Wahkiakum. Students are referred by anyone at the school: principal or teachers, recess aides. The school has a referral form but many of the referrals are made verbally. Criteria used for referral include attendance, behavior and academic performance. The school-based therapist, prevention/intervention specialist, and both principals meet as a group to discuss referrals. As a group, they decide if individual counseling or group counseling is the best fit. Individual counseling services are provided by the school-based therapist and group counseling is provided by the prevention/intervention specialist. The school district is considering adding a case manager to provide additional support.

Rochester. School counselors or school staff refer students to the BH provider via the Child Assistance Team (CAT team). Parents also request services and some of the children walk in on their own. The BH provider contacts the family soon after the referral to get consent; if the child is over 13 years old they check with the student to determine whether to contact family. The BH provider has not referred students out for additional services thus far but could if more intensive services are needed.

Pioneer. Discipline, attendance and academic problems go to a "child study team" made up of principal, counselor, teachers, special education teachers. Once referred to the BH provider, they do an intake assessment and determine appropriate next steps; in almost all cases so far the next step has been to begin counseling with the child. Before counseling can begin, the family must approve. The school counselor most often is the one who contacts the family because they know them and are more likely to have a trusting relationship. The BH provider then sees the child, adjusting the intensity of services as appropriate so that they maintain enough overall capacity to see all children in need.

Monticello. Referrals come from a variety of sources: teachers and staff, parents calling into the school about problems, or students walking in themselves. The BH provider is invited to meetings at the school where student cases are being discussed which can be another source of referrals. The primary role of the project is providing BH services to all students, along with additional wrap-around services that were previously only provided to children with Medicaid. These services might include food and housing assistance or general assistance navigating the social service system.

In addition to self-referrals, referrals come from the principal or teachers based on a discipline and attendance report (Homeroom Report). Additional youth may be referred due to behavior, attendance, or families in crises. The goal of this initiative is to provide early, comprehensive and effective outpatient behavioral health care and ensure primary health care needs are being met. A Care Coordination Team (CCT) assists in the coordination of that care to meet the needs of the youth and family. This core team consists of a behavioral health professional, and a community health worker from Columbia Wellness, however the individual service plan is developed in collaboration with Monticello School staff. Additional wrap-around services are provided including food and housing assistance or general assistance navigating the social service system.

Service utilization

Table 1 lists participating schools and shows the number of students referred to the project, screened, and receiving behavioral health counseling and other services during the 2016-2017 school year. A total of 215 students were referred to the program across all four sites and 131 received or are currently receiving services.

Table 1. Staffing and services, 2016-2017

County	Cowlitz	Mason	Thurston	Wahkiakum	Total
District	Longview School District	Pioneer School District	Rochester School District	Wahkiakum School District	
Schools	Monticello Middle School	Pioneer Primary, Middle School	Rochester Primary School, Grand Mound Elementary, Rochester Middle School	J.A. Wendt Elementary, John C. Thomas Middle School, Wahkiakum High School	
Student population	552	761	1,581	455	3,349
Referrals to project	39	29	75	72	215
Receiving BH services	37	12	40	42	131
Completed referrals to other services	9	0	0	12	21

Referrals to project: Number of students referred to the school-based behavioral health provider – either by school staff/teachers or self-referred

Receiving BH services: Number of students with at least one counseling visit with the school-based behavioral health provider

Completed referrals to other services: Number of students completing referrals to other outside services – Primary medical care, behavioral health, social services, and other

Outcomes

If successful, the YBHC project will result in improvements in a number of outcomes that can be captured by existing school data sources, including: number of absences, number of discipline incidents, and measures of individual academic achievement. As yet, these data have not been collected in a way that permits assessing changes over time that are attributable to the program.

While quantitative outcome measures are not yet available, interviews with program staff and others identified a number of encouraging initial results. Early data from Monticello Middle School in Cowlitz County during the 2015-16 school year suggest the project contributed to improvements in attendance and discipline. Other results reported qualitatively by project stakeholders are described below. The text in italics gives examples of some success stories recounted by BH providers.

Immediate access to behavioral health services. Prior to the pilot, school staff had to refer most patients to outside services, and there often barriers to the children following up to actually receive counseling or other services. As one school staff member said "For families of kids with mental health issues in the past it was hard to find services within a reasonable driving distance who would take their insurance. Great to have someone in the building!"

During summer school a student who was receiving services brought in another student who was sad and lonely, and who also accepted services. The friend who brought them in felt strongly, based on their experience with the BH provider, that counseling could help. The referring student continues to receive services as well and both are making progress.

Improvements in student attendance. School and program staff reported that improvements in attendance are some of the first outcomes that can be seen once students engage in the program. One program lead said: "We see kids that aren't coming at all switch over to mostly coming. Or reductions in tardiness." (Wahkiakum) In addition, a middle school counselor reported that "there was a 75% increase in attendance for [middle school] kids in their school who were seen by the program."

A student was referred to the program for failing grades, symptoms of depression, and suicidal thoughts. The student learned healthy coping strategies from the BH provider, who also coordinated with school staff, the student's primary care doctor, and their family. The student eventually reached their treatment goals and was successfully exited from services. They no longer report having thoughts of self-harm and are passing their classes in school.

Connection to resources. Many families are unaware of the resources available to them when their children are struggling. The program provides a way to connect to those resources; for example: "The biggest thing is that it's helped with connecting kids to resources that they didn't know existed. We're a small community with limited resources, education about what exists in the community. Hidden before."

Reduced stigma, recognition of importance of mental health. Treatment for mental health services is often stigmatized, particularly in rural communities. As more children took advantage of the YHBC services they began to recognize the value of services and as the word spread the stigma was reduced: "As program grew, kids took in interest making others aware of the resources that exist. We had a "mental health week" to raise awareness of the resources and have kids better access those and know what they are. Maybe the biggest change is the shifted perspective in the school and more comfort talking about these issues."

An 8th grader came in and reported suicidal ideation and self-harm and was reaching out for help. A crisis plan was prepared and crisis-line phone numbers were included; limits of confidentiality were explained and student agreed for the BH provider to contact her parent. The student enrolled in services and has decreased her suicidal ideation to less than once per 60 days and has not self-harmed in 12 months.

Clear improvements in a number of documented individual cases. The examples of success stories in italics represent only a few of the successful outcomes observed by the BH providers.

A student walked into my office requesting help. She was dealing with moderate anxiety and had no idea where to turn besides her school counselor. She began treatment right away (as she was 14 and could consent on her own). She graduated from services during summer school.

Feeling of support for school staff. School staff mentioned the sense of relief at no longer having to deal with serious cases on their own, without support from providers with more training and experience: "The biggest impact may be sense of calm brought to school administrators – knowing that they have mental health resources. No more feeling of despair that there's nothing they can do."

Lessons learned

YHBC partners identified a number of lessons learned in the process of implementing the project that may be helpful for others doing similar work:

Engage partners early to ensure a common understanding of vision, roles, and responsibilities. The project relies on leadership from and effective collaboration of two complex systems—behavior al health care and education. Challenges related to workflow, referral, communication and information exchange had to be overcome. Attention to planning helped strengthen those partnerships.

Integrate BH providers with the rest of the school. As one school partner reported: "The school body is seeing her as a resource, and we make sure she's out and about—don't want kids to see her as a separate entity, but as part of our school. That's critical to success over time."

Create a comprehensive, integrated system of support. The program was most effective when care coordinators had the resources available to address all of students' needs at the lowest level appropriate, whether it was through direct services or referral and connection to additional supports.

Establish systems for data tracking and evaluation. As one stakeholder said: "The greatest need is for robust evaluation – the behavioral health organizations and schools have supported the provider FTE, but there is no additional money for evaluation."

Support from CPAA helped make connections among the various players. A staff member from one school said: "We're very thankful that (CPAA) came down to participate in the kick-off meeting. Nice to have him sitting at the table as well to be a messenger around what we're trying to do. Meet the players in the program as well."

Conclusions and Next Steps

The four school districts implementing the YBHC pilot are meeting the goals of identifying children with behavioral health challenges as early as possible and connecting them to treatment services. Over 200 students have been referred to the program and 131 have begun receiving counseling and other behavioral health services.

While quantitative outcome measures are not yet available, interviews with program staff and others identified a number of encouraging initial results, including connection to services, reduced stigma around mental health, clear improvement in selected cases, and an increase in feelings of support for school staff around dealing with behavioral health crises.

The program will continue to operate for the foreseeable future. CPAA will work with project partners to build on lessons learned, conduct ongoing project evaluation, and improve data analysis and reporting. Further developing data reporting capabilities to show improvements in outcome metrics over time is of particular interest. Outcome metrics currently being discussed pertain to behavioral health treatment and school-based metrics such as attendance, discipline, and academic achievement.

There may be opportunities to link this project to the Medicaid Transformation projects being implemented through 2020, specifically for behavioral health integration. CPAA will work with project partners to identify these cross-cutting opportunities.