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Building Cross-Sector Collaboration to Support School Behavioral Health Services: Washington's Children's Regional Behavioral Health Pilot Program

Overview

The Children's Regional Behavioral Health Pilot launched in July 2017 to develop strategies for increasing access to care, specifically behavioral health services, for Medicaid eligible students in Washington. Across the state, school districts faced challenges with meeting students' mental, emotional and behavioral health needs. The pilot project was launched in response to these needs and centered around having a dedicated full-time education service district (ESD) staff person to network with regional healthcare partners and K-12 school districts to reduce barriers to behavioral healthcare services. Two ESDs participated in the pilot project, which lasted from July 2017 through June 2020.

Core to the success of the pilot project, which was led by the Office of Superintendent of Public Instruction (OSPI), was strong cross-sector collaboration and partnership building as well as regional strategies to engage community partners. A key step toward building and strengthening these partnerships was the participation of key state agencies in the Healthy Students, Promising Futures Learning Collaborative (HSPF). Washington joined HSPF in 2016 with the formation of a cross-sector state team that includes representatives from the Health Care Authority; OSPI; the Department of Health; the Department of Children, Youth and Families; the Washington School-Based Health Alliance; and Kaiser Permanente. The relationships established through the state team's participation in HSPF provided an important foundation for the success of this pilot project.

This case study provides an overview of the pilot project and highlights key lessons learned from this work. As states consider innovative methods for improving cross-sector collaboration, coordination of care and financing for school health services, especially behavioral health services, Washington's model and experience provides valuable insights that can inform future efforts.

This case study draws heavily from OSPI's [report to the state legislature](#), and the HSPF team greatly appreciates the work that went into creating this report and the state's willingness to share the lessons learned from this work.

Background

Mental health problems affect one in five school-aged children (ages 13-16) across the nation. While the needs are significant, less than 20 percent of school-aged children needing mental health services receive them. The majority of students who do obtain services get them through school.¹ Lack of access to mental health services and supports can have a serious and lasting impact across all areas of a child's life. Leaving children without support contributes to school drop-out, unemployment, and involvement with the juvenile or criminal justice system. In addition to loss of short- and long-term opportunities, there is also loss of life with suicide as the second leading cause of death for those ages 10 to 24.²

Unmet student mental health needs are a critical problem in Washington. A report issued by Kaiser Permanente in 2017 determined that among Washington school districts, the most frequently cited unmet needs faced by schools were students' mental, emotional and behavioral health needs.³ Specifically, issues associated with depression, anxiety, adverse childhood experiences (ACEs) and trauma were identified. The report also found that the education system was, in a large part, failing to meet the non-academic needs of students, reporting lack of resources as well as limited capacity to meet the multiple physical, social and emotional needs that students bring with them to school.

While there is increased recognition of the importance of supporting student mental health and wellness and the critical role this plays in ensuring student success, school districts often lack dedicated resources to deliver the necessary services and programs. Accessing Medicaid reimbursement to support the delivery of school health services, including mental health services, presents an important opportunity for school districts to leverage additional funding to meet the mental health needs of students; however, accessing Medicaid funding for school health services is complex and requires engagement and support from multiple parties at the state and local levels.

In recognition of the increasing children's behavioral health needs in Washington, the state legislature formed the Children and Youth Behavioral Health Workgroup in 2016. The group includes representatives from the Office of the Superintendent of Public Instruction (OSPI), Department of Health, Health Care Authority (HCA), State Department of Children, Youth and Families, state legislature, healthcare providers, tribal governments, community health services and other organizations. In addition, the group includes parents of children and youth who have received services. The Children and Youth Behavioral Health Workgroup works to identify barriers to behavioral health services and provide recommendations for improving access to and coordination of behavioral healthcare services in the early learning, K-12 education and healthcare systems.

In 2016, the Children and Youth Behavioral Health Workgroup [issued recommendations to the state legislature](#) based on the group's work. The recommendations included [charging OSPI](#) with the implementation and oversight of the Children's Regional Behavioral Health Pilot Project.

¹ [Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health](#) (Substance Abuse and Mental Health Services Administration, 2019)

² [Leading Causes of Death Reports](#) (Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2017)

³ [Exploring the Landscape of Mental Health and Wellness in Washington's K-12 Education System](#) (Kaiser Permanente, 2017)

Pilot Project Overview

The Children's Regional Behavioral Health Pilot launched in July 2017 with the goal of investigating the benefits of having a dedicated full-time educational service district (ESD) staff person to network with regional healthcare partners and K-12 school districts to reduce barriers to behavioral healthcare services. The pilot started with a specified duration of 24 months. In July 2019, the pilot was extended to June 30, 2020, for a total duration of 36 months. As part of the pilot project, Maiké & Associates, LLC, was awarded the contract to develop and support the pilot project and played a key role in implementation.

The pilot project leveraged the existing structure and strength of Washington's ESDs to better coordinate the delivery of behavioral healthcare services to students. An ESD is a regional education unit in Washington that services dozens of school districts. ESDs were established in Washington more than 40 years ago to allow school districts to work, plan, and buy equipment collectively and provide intermediary services between OSPI and local school districts. There are nine ESDs across the state. Capital Region Educational Service District 113 (ESD 113), located in Olympia, and Northeast Washington Educational Service District 101 (NEWESD 101), located in Spokane, were selected as the pilot sites through a competitive process. NEWESD 101 includes 59 school districts in seven counties, and ESD 113 includes 45 school districts in five counties.

Central to the pilot project was the development of Behavioral Health System Navigator (Navigator) positions for ESD 113 and NEWESD 101. The Navigator's primary role was to connect the K-12 education and behavioral healthcare systems. The Navigator is not a direct service provider and instead focused their work on improving Medicaid claiming for school districts and schools within their ESD, catalyzing school-community partnerships, strengthening collaboration with state and local partners and ensuring schools were recognized as a critical component of the region's behavioral health care system.

The launch of the pilot project and creation of the ESD Navigator position was in response to recommendations included in the Children and Youth Behavioral Health Workgroup's 2016 [report to the state legislature](#). The report highlighted the significant need for increased access to and resources for school behavioral health services and also called attention to challenges related to delivering these services in schools including accessing Medicaid reimbursement, supporting care coordination, increasing collaboration between the education and healthcare systems and ensuring investment in prevention and intervention services. The report underscored the importance of funding a full-time mental health lead at each of the nine ESDs as well as a coordinator in OSPI and recommended the creation of a pilot project to validate this strategy.

Implementation of Pilot Project in NEWESD 101 and ESD 113

While the overall structure and requirements for each pilot project site were the same, each site implemented the project activities in a way that was reflective of the unique needs and assets of their ESD.

Northeast Washington Educational Service District (NEWESD) 101

The NEWESD 101 Navigator played a critical role in supporting school districts and schools in expanding their school-based behavioral healthcare systems and infrastructure, something that had not been prioritized by the ESD prior to the arrival of the Navigator. The Navigator conducted outreach to all 59 school districts to generate buy-in for the project and work with districts to conduct needs assessments, gap analyses and resource mapping (see page 42 of the [full legislative report](#) for additional details). These activities were key to identifying their unique needs and determining action steps to expand access to behavioral health services in the school setting. The ESD used the [School Health Assessment and Performance Evaluation \(SHAPE\) System](#) developed by the National Center for School Mental Health to conduct their needs assessment.

The Navigator worked with school districts to increase awareness and utilization of opportunities for accessing Medicaid reimbursement for eligible health services delivered in schools. Washington's school-based health services program (SBHS) allows school districts to receive Medicaid reimbursement for eligible services included in students' Individualized Education Program (IEP). School districts can also access Medicaid Administrative Claiming (MAC) funds to cover the costs of administrative activities, such as outreach and enrollment, conducted in the school setting. The Navigator worked with the HCA (the state Medicaid agency) to understand the extent to which districts in the ESD were accessing Medicaid funding and to identify related barriers. The Navigator was then able to work with school districts and the ESD to develop and implement strategies to overcome these barriers and ultimately increase school district participation in both the SBHS and MAC programs.

For example, a key barrier identified by the Navigator was that the state's SBHS program requires school districts to provide a local match in order to draw down federal matching funds. In Washington, this is done through an [Intergovernmental Transfer Process](#). It is common practice in states to require school districts to provide the local match in order to receive the federal matching funds. However, this can create a barrier to school districts participating in school Medicaid programs if they are unable to provide the matching funds, particularly for small school districts. The NEWESD 101 Navigator was able to address this barrier by positioning the ESD to cover the required matching funds and coordinate Medicaid billing for 39 school districts who did not previously participate in the SBHS program. Centralizing the administration of the SBHS program at the ESD level is an excellent strategy for administering the program.

The Navigator also provided training to staff in 13 districts on mental health literacy. This was a legislative requirement of the Navigator's work with the ESD. The training focused on increasing understanding of mental health and mental health issues among students and teachers.

Finally, the Navigator participated in multiple regional behavioral health care collaboratives and initiatives to raise awareness about the role schools can play in ensuring Medicaid eligible children have access to care. For example, the Navigator participated in the Better Health Together Collaborative Accountable Community of Health which included over 60 representatives from community organizations based in the area that work with Medicaid eligible clients. The Navigator's participation in this collaborative established the ESD as a key partner in the delivery of health services to Medicaid enrolled children and also increased awareness among other collaborative members of the ESD's role in supporting the delivery and coordination of health services. As a result

of the Navigator's participation in this collaborative and the overall awareness it raised about the important role schools play in delivering health services, the ACH awarded funding to NEWESD 101 to build out their behavioral health system.

Capital Region Educational Service District (ESD) 113

ESD 113 has a long history of providing behavioral health services in both the clinical and school settings and existing, strong relationships with school districts and community partners. For example, since 1998 ESD 113 has been a Washington state licensed outpatient substance use disorder treatment provider. In 2014, ESD 113 added mental health treatment services, establishing themselves as a licensed behavioral health agency.

As a result of this existing foundation, the ESD 113 Navigator focused on expanding the ESD's role as a bridge between the K-12 education and behavioral health care systems. For example, the Navigator participated in regional collaboratives to increase access to behavioral healthcare. As a part of this work, the Navigator worked to better understand how the school-based multi-tiered systems of support framework used by school districts in Washington aligns with the public health model of universal, selected and indicated levels of care.

In addition, as with NEWESD 101, the ESD 113 Navigator reviewed existing data to better understand school district utilization of the SBHS and MAC programs and identify barriers to school districts accessing Medicaid funding for eligible services. Key findings included the following:

- Schools within ESD 113 have a higher rate of use of the SBHS and MAC programs than the rest of the state. This is likely due to the ESD's proximity to the Washington Healthcare Authority's headquarters which makes it easier for the agency to conduct direct outreach to school districts.
- There are disparities in reimbursement rates for services provided through the SBHS program when compared to rates for a licensed behavioral health agency.
- Behavioral health services are not commonly written into students' IEPs and therefore schools are not able to bill for many of the behavioral health services delivered in schools.
- As the program is currently structured, expanding access to care for all Medicaid eligible students (not just those with IEPs) would require school districts to directly contract with MCOs which would require either licensure as a behavioral health agency or medical clinic. This would present too many barriers for a school district but might be possible for an ESD.

These findings were shared with the Children's Mental Health Workgroup and have important implications for informing future work around expanding the state's SBHS program.

Additional activities carried out by the ESD 113 Navigator included facilitating conversations between school districts and behavioral health providers and supporting needs assessments, gap analyses and resource mapping at the district level.

Behavioral Health System Navigator: Overview of Responsibilities

Additional activities carried out by the ESD 113 Navigator included facilitating conversations between school districts and behavioral health providers and supporting needs assessments, gap analyses and resource mapping at the district level.

Coordination of Medicaid Billing

A core function of the Navigator was working with the ESD to build the capacity of the ESD, school districts and schools to navigate the Medicaid system and leverage Medicaid funding to support the delivery of school health services. This work was complimented by efforts led by OSPI to support ESDs and school districts in understanding the opportunities for Medicaid reimbursement and sharing key findings. The Navigator worked with district and school staff to review current practices for accessing Medicaid funding through the state's SBHS and MAC programs and was then able to provide technical assistance on the Medicaid reimbursement process.

Facilitation of Partnerships

The Navigator played a key role in building partnerships with local, regional and state agencies positioned to support the delivery of children's behavioral health services. This includes regularly participating in meetings of key partners to ensure K-12 education is included within broader conversations about transformation of the state's healthcare system and building relationships with these groups. Key partners Navigators worked with included Accountable Communities of Health (ACH), Managed Care Organizations (MCO), Behavioral Health Organizations (BHO) and other behavioral health services providers.

At the state level, OSPI builds relationships and communicates with state agency partners around identified barriers and solutions for increasing access to care. Over a 12-month period, the Navigators participated in 217 regional stakeholder meetings across an even distribution of education and healthcare partners required for engaging in meaningful cross-sector work.

Identification of Needs and Assets

The Navigators played an important role in working with school districts and schools to better understand their needs and assets and develop appropriate plans based on the findings. During the pilot project, Navigators conducted needs assessments, gap analysis, resource mapping and funding mapping activities with 88 districts between the two ESDs. This work helped the state, ESDs, districts and schools better understand additional supports that were needed to ensure students were receiving necessary services. While these analyses were taking place, OSPI worked to understand the impact of the state's healthcare transformation on the delivery of school health services and how best to support ESDs in establishing relationships with MCOs and ACHs. This included working across state agencies to ensure ACHs and schools were able to communicate about shared initiatives to support the health and wellness of children in the state.

Collaboration between ESDs, OSPI and Others

As the pilot project lead, OSPI ensured that all members of the team were kept up to date on progress, barriers encountered and lessons learned. Core to this work was ensuring both education

and healthcare partners, as well as members of the Children’s Mental Health Workgroup, were informed about the project’s progress. ESD leaders and the Navigators from the two pilot sites worked closely as well to share lessons learned and overall progress.

Implementation of Mental Health Literacy Curriculum

The Navigator was also responsible for working to implement a mental health literacy curriculum in at least one high school in the ESD in year two of the pilot project. While both Navigators approached multiple school districts about implementing the required mental health literacy curriculum, implementation proved to be challenging. The Navigators encountered pushback from school districts who saw the curriculum as another unfunded mandate and were also faced with navigating a school-board driven curriculum adoption process. Ultimately, it was determined that integrating the mental health curriculum as part of a district’s existing comprehensive school-based behavioral health system was the most successful strategy for promoting adoption.

Pilot Project Year Three

While originally intended to be a two year pilot project, in July 2019, the pilot project was extended to June 30, 2020. During the third year of the pilot, project partners were able to collaborate to develop an interview protocol and conduct interviews with 85 districts across the two pilot ESDs. The intent of the interview was to better understand the behavioral health systems in place in school districts, the extent to which these systems were effective, and in what ways these might be improved. These interviews also played an important role in identifying next steps for each ESD to move the work initiated through the pilot project forward.

The results of the district interviews are summarized in the [Children’s Regional Behavioral Health Pilot School Districts Speak to Need for Regional Behavioral Health Coordination Full District Interview Report](#) prepared by Maike & Associates in collaboration with ESD 113 and NEWESD 101.

Key findings from these interviews included the following:

- A majority (77%) of districts interviewed have some form of school-based behavioral health services. However, access to services varied greatly; not only in terms of availability of services, but also regarding service eligibility.
- Most districts (93%) also acknowledged their current system was not sufficient to meet the behavioral health needs of their students.
- Transportation, funding, and parental engagement/family issues were the three most frequently cited barriers or gaps to addressing the behavioral healthcare needs of students in their districts.
- Among the 66 districts with access to school-based behavioral health services, 88% had licensed providers delivering services to youth. In general, the way services were provided fell into three broad buckets: non-licensed school staff, licensed clinic-based school staff, licensed school-based staff.
- Funding for behavioral health services fell into two broad categories

- District support through multiple, braided funding streams. Funding streams were typically used to support behavioral health services included general funds, levy dollars, Title 1 and Learning Assistance Program (LAP) funding, general education dollars, Impact Aid, MFLAX (Military Family Support), Special Services funding, grant funding, Small Rural School Achievement Program (SERSAP), Medicaid billing, School Board commitment, Title 4, Part A funding, and timber dollars.
- In-kind contributions only (no out of pocket district costs were required). In this case, community-based providers delivering services in the school setting would directly bill Medicaid and private insurance for services.
- Among the 25 districts who reported participating in the SBHS Program, three indicated that they were receiving SBHS reimbursement for behavioral health services. Among the 15 districts that participate in the MAC Program two indicated that this program was used to support behavioral health services. their district.
- Overall, 82% of districts reported making referrals to community-based providers for behavioral health services.
- Most districts (59%) indicated that they had a suicide prevention plan/protocol in place. This was much more common for larger districts as compared to smaller districts (88% vs. 51%, respectively).
- Approximately one third (36%) of districts stated they had a mental health literacy curriculum in place.
- Over half (54%) of districts reported that the district/school staff received training on mental health literacy (i.e. mental health literacy for adults in the school system). In addition, larger districts were much more likely to report the availability of these types of staff trainings than smaller districts (76% vs. 48%, respectively).

At the end of the interview, the Navigators asked each district about the types of resources needed to help support their school based behavioral health care systems. Overwhelmingly, districts were interested in learning more about a suicide prevention protocol (78%), screening and assessment tools (65%), and a behavioral health curriculum (65%). As a result of the overwhelming request for additional resources from their districts, the Navigators are compiling a “Resource Guide” for schools and districts to help provide support in the above-mentioned areas.

In addition, given the expansion of the Navigator role to all nine ESDs, OSPI worked with pilot project participants to create the [Educational Service District Behavioral Health System Navigator Playbook](#). The playbook will be used as new Navigators begin this work in their respective regions.

Lessons Learned

Washington's efforts to expand school behavioral health services and ensure funding for this work provide valuable lessons learned for other states to consider. Key lessons learned from this work included the following:

Supporting schools in accessing Medicaid reimbursement to expand the delivery of school health services is complex.

Both Navigators identified multiple barriers limiting school districts' ability to leverage Medicaid reimbursement to expand access to services for students. While these barriers are complex, there was tremendous value in having the Navigator identify these barriers and work with the school districts and ESD to identify potential solutions.

In addition to maximizing the SBHS and MAC programs, there are opportunities to increase Medicaid revenue for school based health services to include services beyond those in students' IEPs. For example, school districts would be able to bill for services not included in students' IEPs if they work with MCOs. However, as is described above, this is complex and would require districts to become a licensed behavioral health agency or licensed medical clinic. Additional support, including technical assistance for school districts, and resources are needed if school districts are to successfully establish these partnerships.

In order to support schools in navigating the opportunities available for accessing Medicaid reimbursement for healthcare services, OSPI, in collaboration with HCA, mapped out the multiple pathways schools may take to seek Medicaid reimbursement for healthcare services provided in the school setting. This information is included in [Appendix J of the state legislative report](#) and is a valuable tool other states might benefit from replicating. State developed tools, such as this chart, play an important role in supporting school districts in navigating the complexities of Medicaid.

Dedicated staff at the state and regional levels to support the school Medicaid program.

Having dedicated staff at both the state and regional levels supports school districts and schools in successfully navigating the school Medicaid program and maximizing Medicaid reimbursement.

The pilot project highlighted the need to have a dedicated staff person at the ESD level working with school districts to support their efforts to navigate the Medicaid system. While there are up front costs with establishing this position, the potential return on investment is significant.

At the state level, staff working with OSPI and HCA play essential roles in supporting ESDs and school districts in accessing Medicaid reimbursement for school health services. This includes providing direct technical assistance and outreach to ESDs and school districts, ensuring policies and procedures are up to date and align with the state's broader health care transformation, and identifying and implementing strategies at the state level to support the expansion of the SBHS and MAC programs.

Cross-sector coordination and leadership is critical to increasing access to school health services.

The strong relationship between OSPI and HCA supported the success of this effort, ensured the participating ESDs received help where needed and created a mechanism for sharing key lessons learned and informing future work. OSPI and HCA's participation in the Healthy Students, Promising Futures Learning Collaborative created a strong foundation for this partnership and improved OSPI's ability to support school districts' engagement with healthcare systems and partners. The close collaboration of OSPI, HCA and other state agencies models the collaboration needed at the regional level to expand access to school health services.

In addition, the Navigator in each ESD was instrumental in building cross-sector partnerships at the regional level to support the expansion of behavioral health services in schools. Through participating in regional collaboratives, conducting needs assessments and gap analyses and developing internal buy-in at the district and ESD levels, the Navigators were instrumental to the success of this project.

Needs assessments, gap analyses and resource mapping can be a key resource in guiding efforts to expand access to health services in the school setting.

A key role each Navigator played was conducting needs assessments, gap analyses and resource mapping in each ESD to better understand the ESD's needs and determine action steps to expand access to behavioral health services in the school setting.

During the third year of the project, OPSI worked with Maiké & Associates to develop an interview protocol to guide these needs assessments and gap analyses at the regional level. The interview protocol, developed by Maiké & Associates in partnership with the two pilot ESDs, is included on page 28 of this [follow-up report](#). Key topics addressed in the interview protocol include access to school-based behavioral health services, referrals to community-based providers for behavioral health services for students, participation in the state's school Medicaid program and policies and programs related to mental health awareness and prevention.

The values and language of the education and healthcare systems often do not align.

The education and healthcare systems often use different language and frameworks to describe their work which can make it challenging to establish cross-sector partnerships. In addition, the healthcare system's eligibility requirements, differing coverage rates, licensing requirements and other complexities can be challenging for educators to navigate.

Establishing a common language and building cross-sector partnerships is key to addressing these challenges. For example, a continued partnership between OSPI and HCA will help ensure each sector is aware of one another's priorities and can support the collaboration needed to reduce barriers to accessing behavioral health care for K-12 students.

Conclusion

Overall, the pilot project highlighted the value of having a dedicated staff person employed full time at the ESD level to navigate between behavioral health care and education systems. While each Navigator took on different activities within their ESD, the overall impact they each had on supporting school districts in maximizing Medicaid reimbursement for eligible school health services, building partnerships between school districts and community based providers and elevating the role school systems can play in delivering behavioral health services to children was tremendous.

As states consider innovative methods for improving cross-sector collaboration, coordination of care and financing for school health services, especially behavioral health services, Washington's model and experience provides valuable insights that can inform future efforts.