



REPORT TO THE LEGISLATURE

Children's Regional Behavioral Health Pilot Program

2020

Authorizing legislation: [RCW 28A.630.500](#)

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Executive Summary

Recommendations from the Children’s Behavioral Health Workgroup established the Children’s Regional Behavioral Health Pilot Project in July 2017. The purpose of the pilot project was to investigate the benefits of an Educational Service District Behavioral Health System Navigator to coordinate between the behavioral health and K–12 education systems to develop strategies to engage in regional partnerships to increase access to care for students who are eligible for Medicaid. The Navigator’s work was built upon four core elements:

1. Coordination of Medicaid billing for schools and school districts in the educational service district (ESD) region.
2. Facilitation of partnerships across systems (state-ESD-district-regional partners).
3. Integration of service models to ensure the adequacy of system level supports for students in need of behavioral healthcare.
4. Collaboration among the two pilots, Office of Superintendent of Public Instruction (OSPI), and other stakeholders.

Prior to this project, the benefits of having a dedicated staff person employed full-time to navigate between the behavioral healthcare and education systems were only assumed. Through this pilot, the benefits have proved tangible and several important discoveries regarding the intersection of behavioral health services and the K–12 education system were made.

The interactions between the Navigator and school districts revealed that the Medicaid system is complex and presents multiple pathways for schools to navigate. Because the education system’s focus is on educating students, having to navigate complex systems to seek care can create barriers that inhibit access to needed behavioral health services for youth. Increasing access to care in the school setting requires collaborative partnerships and support from the entire K–12 system including OSPI, regional ESDs, and local school districts to successfully engage in the publicly funded healthcare system. Establishing a Behavioral Health Systems Navigator role at the ESD level facilitates this process and can increase access to care.

Background

Across the nation, 1 in 5 school-aged children (ages 13–16) are diagnosed with a significant behavioral health problem. Of all lifetime cases of mental health disorders, 50% begin before age 14, while 75% are developed by age 24 (HHS 1999; SAMHSA, 2007; Child Mind Institute, 2016; NAMI, 2017). Additionally, because the average delay between the onset of mental health symptoms and intervention is between 8–10 years (Gall et al., 2000; Kataoka et al., 2002; California Health Interview Survey, 2005; Behrens, 2013), many youth never receive services for these conditions, the most common of which are depression, anxiety, attention-deficit hyperactivity disorder (ADHD), and behavioral or conduct problems (Perou et al., 2013).

All these issues have the potential to negatively affect children’s ability to function in the school, home, and community settings if left unaddressed. However, research has shown that early identification and treatment improves student outcomes. In fact, the provision of comprehensive school-based mental health and substance treatment services has been associated with several positive benefits, including enhanced academic performance, decreased identification of special education services, fewer disciplinary encounters, increased engagement with school, and higher rates of graduation (SAMHSA & CMS, 2019).

While less than 20% of school-aged youth needing mental health services receive them, the majority of those that do obtain services get them through school. Although educating youth and ensuring they have the supports they in need in order to learn is the focus of school districts, increasing the responsibility of meeting all student needs – including mental and behavioral health – are shifting to schools (ASSA, 2019). Unfortunately, schools often lack the capacity to both identify and adequately treat the behavioral health needs of their students.

As identified in *Exploring the Landscape of Mental Health and Wellness in Washington’s K–12 Education System* (Kaiser Permanente, 2017), among school districts in Washington, the most frequently cited unmet need faced by schools centered around students’ mental, emotional, and behavioral health needs. Most specifically, problems associated with increasing rates of depression and anxiety as well as the impacts of unaddressed adverse childhood experiences (ACEs) and trauma were identified. In addition, many informants acknowledged that the education system was, in large part, failing to meet the non-academic needs of students, reporting a lack of resources as well as the limited capacity to meet the multiple physical, social, and emotional needs that students bring with them into the classroom (Kaiser Permanente, 2017).

Delivering behavioral health services to thousands of students each year also puts districts in uncertain financial positions. As school budgets are changing, school districts face a growing

responsibility to meet the needs of the whole child, which includes providing access to behavioral health services with limited dedicated resources to do so. One result has been a growing recognition at the national level of the need for prevention efforts, accessible health insurance, and comprehensive health services for young people. This has resulted in new funding opportunities within the education sector, one of which is Medicaid. But participating in the Medicaid program is not easy and there are many obstacles to obtaining Medicaid reimbursement for school districts (ASSA, 2019).

Nationally, as well as in the State of Washington, students and adults face multiple system barriers that often inhibit access to needed behavioral health services. Most communities and schools lack high-quality, comprehensive treatment for children and adolescents. Other barriers include healthcare and social service workforce shortages, especially in rural areas, treatment deserts (regions in which services do not exist), limited access to a culturally and linguistically appropriate services, and a lack of service coordination and integration across multiple systems (House Bill 1713, 2017). Navigating complex systems while seeking care often presents challenges and creates barriers that inhibit access to needed behavioral health services (SAMHSA & CMS, 2019). The resulting impact of these barriers is lower service utilization. In 2019, 61.7% of youth in Washington with major depression did not receive any mental health treatment, compared to 50% of youth nationwide (Mental Health America, 2019).

In acknowledgement of the growing behavioral health needs of our youth, the Children's Behavioral Health Workgroup (the Workgroup) was formed by the Legislature in 2016. The Workgroup is directed 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. As a result of one of these recommendations, the Children's Regional Behavioral Health Pilot Project was created per Revised Code of Washington (RCW) 28A.630.500 (Appendix A).

Through this legislation, the Office of Superintendent of Public Instruction (OSPI) was charged with implementation and oversight of the pilot project. The purpose of the project was to investigate 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 included the competitive selection of two ESD partners, and was initiated in July 2017, 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.

Introduction

This report outlines the results of the 2-year pilot project (July 2017–June 2019). It begins with an analysis of the systems-level implementation of the pilot activities at both the state and regional levels. Details include the noteworthy impacts related to the Office of Superintendent of Public Instruction’s improved knowledge and understanding of healthcare transformation, as well as its increased capacity to partner with the Health Care Authority (HCA) and to engage with other stakeholders to increase understanding of the publicly-funded behavioral health delivery system. This report also includes a case of study of each educational service district’s (ESD) implementation of the project, viewed through the lens of the initial assumptions (see page 8) that predicated this work. In addition, the report summarizes the successes and challenges of the pilot sites’ ability to increase access to care by exploring school-based Medicaid service delivery in K–12 settings. The report ends with a review of lessons learned and a set of recommendations to the Legislature.

It is important to mention the context of the transitioning publicly-funded behavioral health system in Washington during the time period of this pilot project. Senate Bill 6312 (2014) directed the state to integrate the financing and delivery of physical and behavioral health services by January 2020. This changed the administration of Washington’s publicly-funded behavioral health system from the county-run Behavioral Health Organizations (BHOs) starting in April 2016 (in some regions) to the Managed Care Organizations (MCOs) in all regions by January 2020. This changing landscape illustrates the importance of a linkage existing between the education and healthcare systems when transitions occur.

Terms and Definitions

The following definitions were used to organize the project and should be used to ensure a shared understanding of this report:

- **Access to Care:** accessibility, capacity, and funding in the healthcare and education systems.
 - Accessibility: healthcare plans cover all needed services at multiple locations with the fewest barriers to access.
 - Capacity: providers have a suitable amount of qualified staff that offer fully integrated services at convenient times to all acuity levels.
 - Funding: integrated publicly and privately funded care systems with a single value-based payment contract.

- **Behavioral Health or Behavioral Healthcare:** the prevention, intervention, and treatment of mental health and/or substance use disorders.
- **Behavioral Health System:** the publicly-funded behavioral health system, funded by Medicaid through the state Legislature and matched by the Center for Medicaid Services.
- **Comprehensive School Mental Health:** full array of tiered supports and services that promote positive school climate, social and emotional learning, and mental health and well-being, while reducing the prevalence and severity of mental illness and substance use.
- **Multi-tiered System of Supports:** a framework for enhancing the adoption and implementation of a range of evidence-based instruction and interventions to achieve important outcomes for all students.

The following terms, from the authorizing language in House Bill 1713 (2017), were used to design and organize the pilot project activities and develop the role of the Behavioral Health System Navigator:

- **Coordination** of Medicaid billing for schools and school districts in the ESD region(s).
- **Facilitation** of partnerships across systems (state-ESD-district-regional partners).
- **Integration** of service models and ensure the adequacy of system level supports for students in need of behavioral healthcare.
- **Collaboration** among the two pilots, OSPI, and other stakeholders.

Implementation

Implementation was led by the Office of Superintendent of Public Instruction (OSPI) and included significant partnership-building and cross-systems coordination as well as regional strategies to engage community partners. Strengthening of partnerships between the Health Care Authority (HCA) and OSPI was initiated in 2016 through the development of a multidisciplinary state team participating in the Healthy Students, Promising Futures National Learning Collaborative. The Washington team is comprised of representatives from HCA; the Department of Health (DOH); the Department of Children, Youth, and Families (DCYF); the School-based Health Alliance; and Kaiser Permanente. OSPI leads this team's efforts to increase the capacity for schools to engage in Medicaid reimbursement and expand access to healthcare in schools. Participation in this collaborative while implementing the pilot project significantly improved OSPI's understanding of K–12 Medicaid reimbursement programs; thus,

bolstering the ability to support school districts to engage with healthcare systems and other partners. Engagement in this work strengthened communication, coordination, and problem-solving regarding school-based behavioral health service needs and system gaps among state-level education and healthcare partners.

OSPI's leadership throughout the pilot project also created a formalized internal agency understanding of the complexities of supporting the healthcare and education sectors to increase access to care for behavioral health. As part of the systems-level implementation process, OSPI staff acknowledged the need to broaden their understanding of the project's funding mechanism: a 50/50 match of state general funds and federal Medicaid dollars. This is an innovative approach to leveraging existing funds to increase access to behavioral healthcare services and supports for students and families through strong school-community partnerships and collaboration.

This funding source also created a unique contractual relationship between OSPI and HCA, offering further opportunity for cross-system collaboration and partnership between these two agencies. The new contractual relationship allowed Medicaid funding to partially support a position at OSPI. This position is dedicated to supporting the [Medicaid State Plan](#) by ensuring effective project oversight, guiding implementation, and increasing capacity of OSPI and project stakeholders to engage with the publicly-funded healthcare system. The funding mechanism also outlined allowable project activities at both the state and ESDs that support the Medicaid State Plan (e.g., increasing school district awareness of and participation in Medicaid reimbursement programs; coordinating between HCA, school districts, and behavioral healthcare providers; and leading school districts in developing processes for identifying students in need of behavioral healthcare and linking those students to providers). As such, these funds could not be used to support direct services.

One of the first outcomes of this cross-agency collaboration was the creation of a document that mapped the many ways in which schools can access Medicaid funds (included in Appendix B). This document includes Medicaid program details, eligibility requirements, and allowable services and providers. According to ESD leaders, this was a valuable resource that had not been previously available and has shown the difficult circumstances faced by schools trying to navigate the Medicaid system.

At the ESD level, the core implementation component was the establishment of the Behavioral Health System Navigator (Navigator) position. Once the contractual processes between OSPI and HCA were in place, OSPI, in consultation with the Association of Educational Service Districts, established a competitive process for the ESDs to apply to participate in the pilot project. In the fall of 2017, 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. Subsequently, a Request for Proposals for a consultant to conduct the case study was released in December 2017. Maik & Associates, LLC, was awarded the contract in early 2018.

The primary responsibility of the Navigator is to bridge the gap between the K–12 education and behavioral healthcare systems. The Navigator is **not** a direct service provider. The Navigator is also tasked with coordinating Medicaid billing for schools and school districts, facilitating school-community partnerships, collaborating with state and local partners, and integrating behavioral health systems to increase access to care across the ESD region. These positions have the potential for significant reach, with access to 59 school districts in seven counties in Northeast Washington ESD 101 (NEWESD 101), and 45 school districts in five counties in Capital Region ESD 113 (ESD 113). Through new and existing collaborative relationships, the Navigators are charged with connecting to local, regional, and state K–12 and behavioral health system partners to identify innovative strategies to increase access to behavioral health services for eligible students and their families.

Implementation activities for the Children’s Regional Behavioral Health Pilot Project were guided by the legislation and framed around a set of assumptions about the K–12 education and public healthcare systems. These high-level assumptions were based upon the collective knowledge and experience of partners working within these two systems.

Guiding assumptions were:

1. School-based behavioral health service delivery is effective;
2. ESD regional coordination will increase access and reduce barriers to care for K–12 students and families;
3. Fostering school and community partnerships increases access to care;
4. K–12 schools effectively use Medicaid reimbursement to expand health services to students; and,
5. Medicaid service delivery and billing are accessible for schools.

In 2018, the Legislature passed House Bill 2779, which directed each pilot ESD to adopt and implement a mental health literacy curriculum in at least one high school involved in the pilot. OSPI will create a detailed summary report upon the completion of the pilot project that will explain the processes involved for a school to adopt a curriculum and successfully implement in the classroom.

Case Study: Navigating the Education and Behavioral Health Systems

To establish a clear and shared understanding of the project and to provide a road map for the implementation of program activities, the Office of Superintendent of Public Instruction (OSPI), the pilot educational service districts (ESDs), and the consultants developed a logic model including project goals and objectives (Appendix C).

This included the development of an overarching goal:

To increase equitable access to care in K–12 settings for students in need of behavioral health supports through cross-system regional and state collaboration between schools and communities.

The group also developed a purpose statement:

To investigate the benefits of having a dedicated full-time staff person for networking with regional healthcare partners and K–12 school districts to coordinate behavioral health service delivery to students and families eligible for Medicaid.

A set of research questions, based on the established assumptions, were created to inform the data collection for the case study (Appendix D).

Collective Activities

To meet the project’s goal and objectives, strategies to engage in regional partnerships for systems level change were established, and built upon the four core elements – coordination, facilitation, integration, and collaboration – as set forth in the legislation. The following provides a summary of the types of key collective activities at the state and regional level to work toward the project goal.

Coordination: At the regional level, the Navigator works within the ESD to build agency capacity to understand the Medicaid payment system and supports the development or expansion of processes that increase both ESD and district ability to access Medicaid funding. The Navigator also coordinates behavioral health resources among schools, districts, and communities. At the state level, OSPI builds capacity to understand the multiple pathways of Medicaid reimbursement and to disseminate these learnings within the ESDs, school districts, and within OSPI.

The Navigator strengthens existing or establishes new relationships with the districts in their service region related to behavioral health needs, gaps, services, and supports. The Navigator is

charged with connecting with each school district to identify a single point of contact. From there, the Navigator, in collaboration with the district, assesses the district's capacity to:

- 1) identify students in need of behavioral health services,
- 2) refer students to needed services,
- 3) deliver evidenced-based services, and
- 4) link students and families to other community-based providers.

As part of this work, the Navigator is also tasked with supporting the development or expansion of processes and procedures that increase the district's capacity to successfully access Medicaid funds through the School-Based Health Care Services program (SBHS) and Medicaid Administrative Claiming (MAC). The Navigator, in collaboration with district or school staff, reviews current practices to better understand how and what service types are delivered, and the district's use of Medicaid reimbursement programs to cover the costs of delivered services (SBHS and MAC). Through this one-on-one process, the Navigator assists districts to navigate the healthcare delivery system and provides technical assistance on Medicaid billing and reimbursement processes.

While conducting Medicaid coordination activities with districts, approximately half (53%) involved district administration, 14% with student support staff, 12% with finance staff, 8% with ESD staff, and 8% with special



Figure 1: Pilot Timeline & Activities.

education staff. Forty-five percent (45%) were made through email, while 40% were conducted in-person between the Navigator and district stakeholders. One activity was conducted through a web-based meeting system and 14% occurred over the phone.

Facilitation: In this role, the Navigator is charged with facilitating partnerships across the multitude of local, regional, and state agencies that play a role in the behavioral health system. Facilitation of systems-wide change can result in reduced systems level barriers, improved direct service delivery models, and increased access to care for children and families. The Navigators routinely engage in collaborative meetings with project partners to better understand and be prepared for the healthcare transformation process.

At the regional level, the Navigator engages with the Accountable Communities of Health (ACH) (see Figure 2), Managed Care Organizations (MCO), Behavioral Health Organizations (BHO), and other behavioral health service providers to participate in regional healthcare initiatives. They build relationships to align service delivery models (school- and community-based), to reduce barriers and increase access to care. 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.

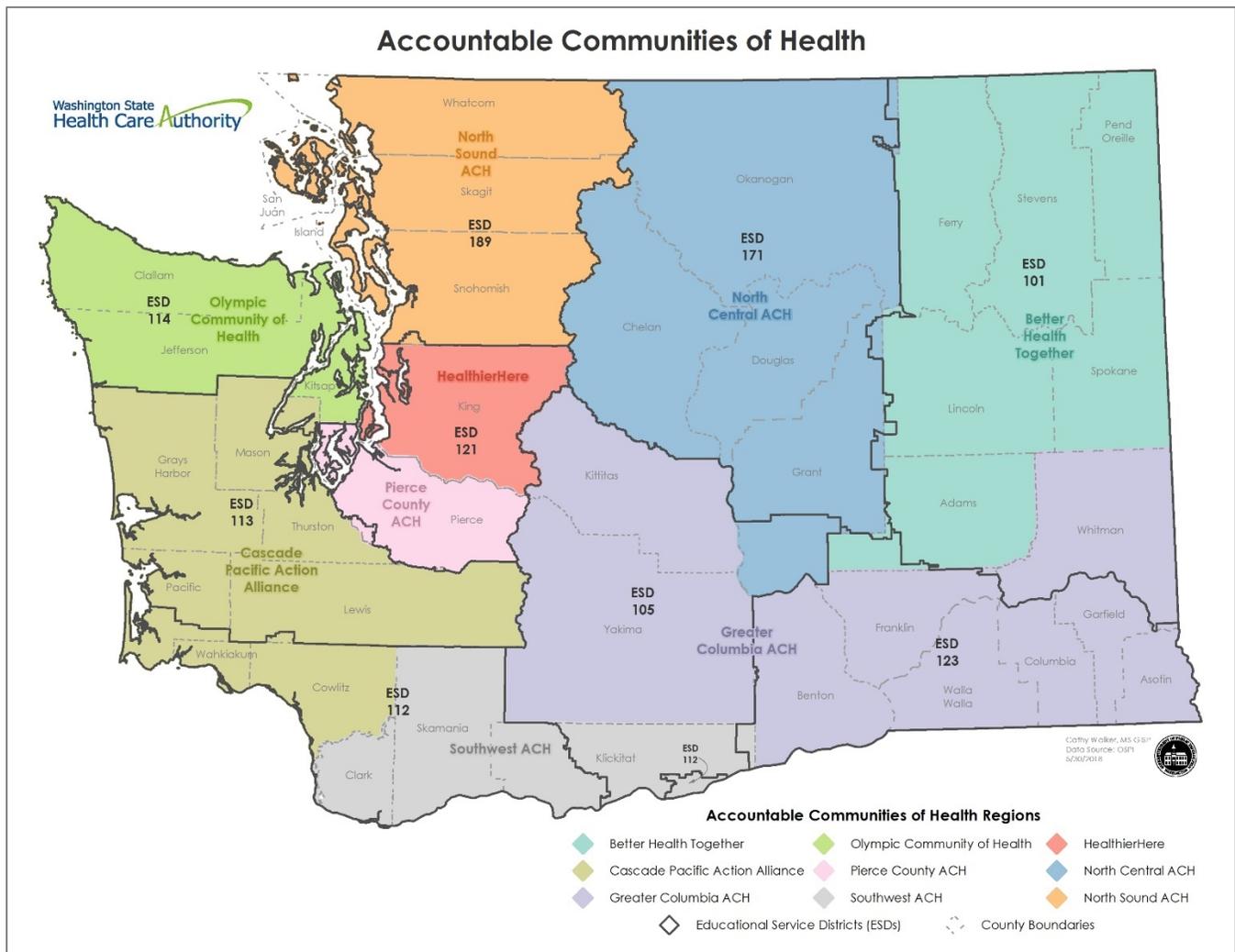


Figure 2: Regional Accountable Communities of Health & Educational Service Districts.

Integration: In their service region, the Navigator strengthens existing and establishes new relationships with school districts. To ensure the adequacy of systems-level supports, Navigators work closely with district- and building-level administrators and student support staff to conduct needs assessments and gaps analysis, and design action steps for the integration of behavioral health service delivery models. During the pilot project, Navigators conducted needs assessment, gap analysis, resource mapping, and fund mapping activities with 88 districts between the two regions.

At the state level, OSPI works to understand healthcare transformation and the integration of behavioral and physical healthcare to inform ESDs on how to approach relationships with the ACH and the MCOs. This includes cross-agency communication to determine how to help the ACHs and schools communicate about shared initiatives that help prevent chronic disease and promote positive health outcomes.

Collaboration: OSPI leads the pilot project by engaging each pilot site and the consultants individually, as well as the project team collectively. Throughout the pilot project, the team has met monthly to review project progress, discuss barriers, identify solutions, and share lessons learned. The collaborative team approach to this project has allowed for OSPI to communicate progress with healthcare and education partners and the Children’s Mental Health Workgroup. Leaders and Navigators at the two pilot ESDs worked collaboratively to learn from each site’s differing experiences engaging in the healthcare system and their various approaches to working toward the shared project goal.

Unique Activities

Guided by the legislation and in adherence with funding parameters, each pilot site approached the identified core elements of the work (i.e., coordination, facilitation, integration, and collaboration) from their own regional context. These custom-fit approaches were based on regional needs and allowed for a rich investigation into how the infusion of a dedicated full-time staff person, whose primary focus to increase access to behavioral healthcare, made a meaningful impact within a short period of time.

Northeast Washington Educational Service District (NEWESD) 101: Building from the Ground Up

Prior to the launch of the pilot project, NEWESD 101 had little to no engagement in the expansion of school-based behavioral healthcare systems and infrastructure. As such, hiring a Navigator who had experienced healthcare transformation in Southwest Washington provided the ESD with a new level of competency to engage in systems level change. In fact, the professional experience that the Navigator brought to the position allowed the ESD to more readily engage with regional partners. This expedited the development of relationships needed to build strong cross-systems collaboration and the implementation of systems level change.

Partnership facilitation is exemplified by NEWESD 101 Navigator’s participation with the Better Health Together Collaborative ACH comprised of more than 60 representatives from Spokane-based community organizations that work with Medicaid eligible clients. As a member agency, the Navigator established the ESD as an important community partner, while also raising partner awareness of the ESD’s role in coordinating and providing supports for school districts. The ACH saw so much value in the Navigator that they awarded funding to NEWESD 101 to build out their behavioral health system (June 2018).

The Navigator also actively participated in other established regional behavioral healthcare initiatives, such as the Family Youth and System Partner Round Tables (FYSPRT). A governance structure used by the Wraparound with Intensive Services Program (WISe), FYSPRT is a regional

forum for families, youth, and systems to address the individual behavioral health needs of children, youth, and families with the goal of integrating systems and addressing access to care for children eligible for Medicaid. The Navigator provided the first opportunity for NEWESD 101 to engage with these types of partners from a systems-level coordination approach, and proved to be extremely valuable, not only to the ESD and their service region, but also to the broader healthcare coalition in the ESD's region.

As one stakeholder noted:

"I do think that it's important to have a Medicaid navigator in each ESD – boots on the ground to know the population, demographics and needs of the region – they can be a great resource to connect district and schools to services/funding – there are lots of groups working on these things with a similar goal but we don't all work together. This role can bring all this work together – connect the work – de-silo it."

In addition to systems integration, the NEWESD 101 Navigator conducted outreach to all 59 school districts, meeting with more than 30 districts to raise awareness of the project and garner buy-in. To that end, the Navigator worked with district teams conducting needs assessments, gap analyses, and resource mapping. The purpose of these activities was to better understand the existing school-based behavioral health services and supports, to provide team members with data to inform decisions about these services, and to determine the most effective course of action to increase access to behavioral health for children in the school setting.

This work has been instrumental in moving districts toward assessing school-based behavioral health systems. For example, the Navigator reported meeting with the Riverside School District's counseling team to review the reports of the completed SHAPE Quality and Sustainability Tool (School Health Assessment and Performance Evaluation System, National Center for School Mental Health). Through this process, the team identified the district's lowest three domain areas (Screening and Data Driven Decision Making, Teaming, and Student Outcomes/Data) and created long-term goals and indicators for success; identified available resources and barriers; and established a district level team to move this work forward.

The Navigator deepened districts' understanding of school-based Medicaid reimbursement programs (SBHS and MAC). This included gathering data from Health Care Authority (HCA) and school districts to determine their use of these programs. Through this effort, the districts had

access to the Navigator, who was able to conduct a deep analysis of Medicaid program usage patterns and identify access barriers. Because of this work, school district participation in SBHS and MAC increased in the region.

For example, the SBHS program allows school districts to receive Medicaid reimbursement for providing certain health related services as outlined in a student's Individualized Education Program (IEP). For HCA to draw down federal matching funds, SBHS requires districts to provide local matching funds per the [Intergovernmental Transfer \(IGT\) Process](#). The match requirement and the Medicaid billing activities may create barriers for school district participation in the program, especially smaller districts.

The NEWESD 101 Navigator created a process to overcome the barriers by positioning the ESD to cover the required matching funds and coordinate Medicaid billing for 39 school districts who did not previously participate. This problem-solving approach significantly improves the potential for districts to receive reimbursement for services that they are already federally required to provide per the Individuals with Disabilities Education Act (IDEA).

Although the NEWESD 101 Navigator experienced some success in increasing awareness and utilization of the SBHS program, the Navigator encountered resistance from some school districts who were unwilling to re-engage with the MAC program. This resistance, in part, is due to a longstanding legacy among school districts that the MAC program is too risky of an investment to engage in. However, through partnership and support from HCA staff, the Navigator educated districts on the MAC program's redesign and the improvements made to considerably reduce the level of monetary risk districts face. The resulting impact of the Navigator's relationship-building and ability to coordinate between HCA and school districts was an increased number of districts willing to tap into the MAC program.

As one stakeholder summarized:

"Many people believe working with Medicaid is not a good investment, so having the ability to have the [Navigator] walk [districts/schools] through this process...to make direct connections...makes the system more human, more doable, more complete."

The Navigator's role in relationship-building is a necessary component to successful engagement in the regional healthcare network for the K-12 system. In this role, the Navigator pursued facilitating agreements between the ESD and Better Health Together, the ACH, and to contract with the four MCOs serving the region. This effort established a sustainable partner

that schools can work with to increase utilization of the Medicaid system for eligible students and their families.

As reported by the Navigator:

"I met with two representatives from Amerigroup. I provided information regarding HB 1713, the pilot, short and long-term goals, our logic models, and plans for ESD 101 to become a [behavioral health] provider. Amerigroup is interested in learning more about the types of services our students and staff need and would like to work together to identify common goals. Amerigroup has licensed children's mental health first aid trainers and offered this service free of charge for our districts that need it."

The impacts achieved by NEWESD 101 due to the availability of a dedicated staff person knowledgeable about the transformation of the publicly-funded behavioral health system cannot be understated. As this work continues, the Navigator will increase access to behavioral healthcare for all Medicaid eligible students in the region by expanding district-level capacity to engage with the healthcare system. The Navigator, serving all 59 districts, will continue to foster relationships needed to coordinate care, integrate systems, and link students to the network of available providers and services.

Mental Health Literacy Implementation

In the NEWESD 101 region the Mental Health & High School Curriculum Resource training reached 26 staff in 13 districts. The training increases understanding of mental health and mental disorders among both students and teachers. Teachers are trained to be comfortable with their own knowledge of mental health and mental disorders and empowered to share this knowledge with students.

Some school staff shared with the Navigator that having a new curriculum reviewed, approved, and implemented was a lengthy process for most districts. In addition to the Mental Health and High School Curriculum resource, NEWESD 101 was also able to bring the CharacterStrong Advisory and Leadership Curriculum to three high schools reaching 1,650 students. CharacterStrong provides social emotional learning (SEL) and character development. These curricula and trainings are focused on fostering the whole child through SEL competencies of self-awareness, self-management, social awareness, relationship skills, responsible decision-making, and character development.

The Mental Health and High School Curriculum takes a technical approach to mental health information and teaching. NEWESD 101 chose the CharacterStrong curriculum to be an integrated approach embedded into the culture of the high school. They are recommending high schools use both curricula to capture a whole district approach to mental health and social emotional learning.

Capital Region Educational Service District 113: Expanding Regional Integration

The Capital Region Educational Service District (ESD) 113 has been a Washington state licensed outpatient substance use disorder treatment provider since 1998. In 2014, the ESD added mental health treatment services, establishing themselves as a licensed behavioral health agency. As such, the ESD came to the pilot project with experience in providing direct behavioral health services in both the clinical and school settings, as well as existing relationships with school districts and other community partners. This historical knowledge and experience added significant value to the project. ESD 113 staff helped project participants to develop the shared understanding needed to engage in this work.

ESD 113 currently contracts with both regional BHOs and MCOs and participates in the Cascade Pacific Action Alliance (ACH). Starting in January 2020, the agency hopes to be in contract with the other four MCOs operating in the region to increase utilization of the Medicaid system for sustainability.

Because of these existing relationships, the Navigator in ESD 113 approached the work of the pilot through a different lens, placing the emphasis on expanding the ESD's role as a bridge between the K–12 education and behavioral healthcare systems.

Like NEWESD 101, the Navigator in ESD 113 was experienced in working in the behavioral healthcare arena and had years of relationship-building with regional partners. This background allowed for quick start-up and enabled the ESD to continue its engagement with regional and district-level partners. As part of this effort, the Navigator participated in numerous regional collaborative opportunities to increase access to behavioral healthcare. A few examples include the Thurston County Board of Health, the Cascade Pacific Action Alliance's Youth Behavioral Health Coordination Project, and Choice Regional Health Network's Medicaid Transformation Change Plan and Activities.

As summarized by one regional stakeholder:

"The benefit is that [the Navigator] is a resource for the other behavioral health providers. The Navigator is an access point into schools."

In this role, the Navigator also undertook the important work of becoming familiar with the Medicaid State Plan to inform how a school-based multi-tiered system of supports framework aligns with the public health model of universal, selective, and indicated levels of care. This shared model is designed to assist with cross-system coordination efforts by developing a shared language that supports and serves students in the school and community settings.

The Navigator conducted meetings within the ESD with early learning and special education staff to increase collaboration on children's behavioral health services and to better understand these programs' experiences with Medicaid reimbursement. The Navigator reviewed data to explore school districts' use of the Medicaid programs and examined potential barriers that may have prevented schools from maximizing these programs. Because of this work, two important findings were discovered:

- First, schools within the ESD 113 region have a higher rate of use of the Medicaid programs (SBHS and MAC) available to schools than the rest of the state (likely due to their proximity to HCA headquarters, which increases program staff's ability to conduct outreach with local districts).
- Second, disparities exist in reimbursement rates for services provided through the SBHS program as compared to rates for a licensed behavioral health agency.

The second finding is complex, as the program rates are influenced by state and federal guidelines related to where the service is delivered. Investigation into the Medicaid programs available to schools revealed that even when used at their fullest potential, there are limitations. For example, the SBHS program is not the best avenue to provide behavioral health services to Medicaid eligible students. Through this project, the Navigator learned that behavioral health services are not commonly written into Individualized Education Programs, and therefore, school districts are not able to bill for these services through the SBHS program. Moreover, to effectively increase access to care for all Medicaid eligible students, schools would be required to directly contract with MCOs. To do so requires either licensure as a behavioral health agency or for the school to become an allowable Medicaid billing agency. This is an unrealistic option for most school districts, but within the realm of possibility for an ESD.

This increased understanding of access barriers is important for informing potential recommendations of the Children's Mental Health Workgroup. Moreover, these findings have enriched the knowledge of the entire project team and the ability to communicate with partners and stakeholders about specific barriers to these systems that were unknown prior to the pilot project.

As part of a larger model of tiered behavioral health interventions, the Navigator at ESD 113 facilitated conversations with school districts about behavioral health services and the alignment of these services within a continuum of care approach. The Navigator conducted outreach activities with all regional school district superintendents to offer support on conducting needs assessments, gap analysis, and resource mapping as a means of increasing access to behavioral healthcare for students. The Navigator facilitated meetings between behavioral health providers and school districts for the purposes of reducing barriers and increasing access to care.

In reflecting on this work, the Navigator stated:

"I tried to put myself in the shoes of a school counselor or school administrator in a building trying to connect a youth to services in this new system. Schools already find this task challenging, and it will only become more challenging with integration. Currently, referral sources only deal with ONE Medicaid system. However, when transition occurs (in our region) they will be dealing with FOUR Medicaid systems (Amerigroup, Molina, United, and Coordinated Care for foster youth), all of which could end up having different access points and be contracted with a different provider network. Having someone at the ESD level who can help schools understand and navigate this system to connect youth to care is essential."

As illustrated by the work of the ESD 113 Navigator, this role can take on a variety of tasks once the Navigator understands the regional context of healthcare delivery. For example, the Navigator convened a group of stakeholders to work collectively to redesign and update the Child & Adolescent Needs and Strengths (CANS) screening instrument for use in both the school and community-based behavioral health systems.

From both the local and state level, the Navigator positions have shown the benefits of bringing together diverse groups of stakeholders to increase equitable access to care for students in need. These collaborative efforts have helped to inform the process and have contributed to the development of models that can be replicated by other ESDs across the state (See Appendix G, Navigator Playbook).

Conclusion

Prior to this project, the benefits of having a dedicated staff person employed fulltime to navigate between the behavioral healthcare and education systems were only assumed.

Through this pilot, the benefits have proved tangible. For example, Northeast Washington Educational Service District (NEWESD) 101 leadership shared at a team meeting that they are now seen as a regional partner and are included in meetings they were not previously aware of. These stakeholders trust the Navigator can show up to meetings in the healthcare or education sector and advocate for students and discuss solutions because of their valuable understanding of both systems (education and behavioral healthcare).

At the state level, the Office of Superintendent of Public Instruction's (OSPI's) leadership created a more formal agency understanding of the complexities in supporting the healthcare and education sectors to increase access to care. This resulted in ongoing communication between program staff at both Health Care Authority (HCA) and OSPI as well as formal quarterly meetings between the two agencies.

In anticipation of the Navigator role expanding to all nine educational service districts (ESDs), OSPI worked with pilot project participants to create a Playbook to be used as new Navigators begin this work in their respective regions (Appendix G, Navigator Playbook.)

In September 2018, informed by this pilot project, OSPI submitted a 2019–21 funding request to the governor to increase [supports for school safety and mental health](#). The request included a rationale for establishing ongoing funding for Behavioral Health System Navigators at all nine educational service districts to perform regional behavioral health and suicide prevention coordination. [HB 1216 - Concerning non-firearm measures to increase school safety and student well-being](#) reflects many of the components included in OSPI's supports for school safety and mental health budget request.

Although House Bill 1216 (2019) passed the Legislature, funding for expansion of the Navigators at each ESD was not allocated by the legislature. In September 2019, OSPI's 2020 Supplement Budget request for [Fully Funding House Bill 1216](#) provides the detailed information on how the Behavioral Health System Navigator is a critical component of comprehensive school safety and student well-being, which needs to be fully-resourced for the ESDs to be responsive to the districts in their service area.

Lessons Learned

Through the implementation of the Children's Regional Behavioral Health Pilot Project, OSPI and its partners have learned some valuable lessons.

1. The Medicaid system is complex (*Assumption #4: K–12 schools effectively use Medicaid reimbursement to expand health services to students*).

There is significant need for a dedicated staff person working regionally with school districts to navigate the complexities of the Medicaid system, and the healthcare system in general, in order to increase access to care for students eligible for Medicaid.

Schools do not typically use Medicaid reimbursement dollars in an effective way to expand health services to students, but can, if provided the support. Medicaid billing opportunities are accessible for schools, if provided the guidance and support from a dedicated staff person.

The Navigator, working internally at the ESD and externally with school districts and healthcare system partners, has created a way for these social service sectors to collaborate and break down barriers that have traditionally reduced access to care.

2. Medicaid reimbursement programs create multiple pathways to navigate (*Assumption #5: Medicaid billing is accessible for schools*).

In collaboration with HCA, OSPI mapped out the multiple pathways schools may take to seek Medicaid reimbursement for healthcare services provided in the school setting. Pathways are dictated by the types of services or activities provided, provider types, and regional MCO/BHO networks (Appendix J, Medicaid Pathways Grid).

To engage in the current reimbursement programs available, ESDs or schools must hold separate contracts with HCA for the School-Based Healthcare Services (SBHS) program, the Medicaid Administrative Claiming (MAC) Program, and each managed care organization (MCO) to take advantage of the full suite of reimbursement options available to them. Other than SBHS and MAC, schools cannot receive Medicaid reimbursement until they become a licensed behavioral health agency or a licensed medical clinic, which is not their primary purpose.

The SBHS program is limited to students who are eligible for both Medicaid and special education services. In order to be reimbursable, services delivered through this program must be identified in the student's Individualized Education Program (IEP). This program is not a viable pathway for schools to receive full Medicaid reimbursement for behavioral health services for all behavioral health needs.

Engaging in this program is administratively burdensome for some schools. It is funded using a 50/50 federal/non-federal match through an intergovernmental transfer (IGT) process. While federal funds provide 50% of the costs, participating school districts are required to provide 60% (local match) of the non-federal portion, and HCA must provide the remaining 40%. Some school districts reported to the Navigator that the benefits did not outweigh the costs to participate in this program.

In consultation with the HCA, OSPI found that to increase Medicaid reimbursement for districts, which in turn may increase access to care for all students, would require working with the MCOs. To work with the MCOs will likely require the ESD and/or school district to become a licensed behavioral health agency or licensed medical clinic. Licensure requires educational agencies to engage heavily in the healthcare system. It is not realistic to expect school districts to learn the complexities of what it takes to coordinate services for students with varying levels of eligibility, coverage, and medical necessity.

We can change the number of schools that are better able to access MAC and SBHS funding; but that does not guarantee an increase in the number of children that access behavioral healthcare under the current Medicaid State Plan.

3. State-level coordination and leadership is important (*Assumption #2: ESD regional coordination will increase access and reduce barriers to care for K–12 students and families*).

Engaging in state, regional, and local level behavioral health systems-level work requires OSPI and ESD leadership buy-in and investment.

The scope of this project required gaining a conceptual understanding of large systems-level healthcare service delivery and payment models. Without a regional staff person to develop the readiness at an ESD and build capacity within the ESD itself, it would be nearly impossible to create measurable change. A system change initiative requires time, expertise, knowledge, and strategic planning to develop internal agency engagement and buy-in as well as external community and school-based partnerships. This required significant education and investment of the Navigator's time to ensure the ESD fully participated.

Cross-agency coordination between OSPI and HCA has significantly improved the ability to do this work, which has benefited the ESDs at the regional level. HCA also acknowledges the value of this formalized relationship. OSPI's leadership of the state's Healthy Students Promising Futures National Learning Collaborative team considerably improved the agency's ability to support local education agencies' engagement with healthcare systems and partners. This state team strengthened communication, coordination, and problem-solving regarding school-based behavioral health service needs and reduced systems gaps among state-level education and healthcare partners.

4. The education and healthcare sectors have different cultures and conflicting values. (*Assumption #2: ESD regional coordination will increase access and reduce barriers to care for K–12 students and families*).

In an era of equity in education, the values of the educator can be challenged by the healthcare system and eligibility requirements. In the school setting, educators can struggle to navigate a fragmented healthcare system that includes variable rates of coverage and payment complexities which make it difficult to provide equal access to care for all students within the healthcare system. Educators find that navigating eligibility standards can be challenging and discouraging.

According to the Washington State Constitution:

"It is the paramount duty of the state to make ample provision for the education of all children residing within its borders, without distinction or preference on account of race, color, caste, or sex." –Article IX, Section 1.

Increasing access to care in the school setting requires collaborative partnerships and support from the entire K–12 system infrastructure including OSPI, regional ESDs, and local school districts to successfully engage in the publicly-funded healthcare system.

"Educating children is the main focus of school districts – not managing health care billing systems – and the challenge of balancing both is intensifying." – AASA, 2019

5. Mandating curriculum is complex in implementation.

In year two, The Navigator for both ESDs approached multiple school districts about implementing the required mental health literacy curriculum added to the Navigator's scope of work in 2018 (House Bill 2779). Multiple barriers to successful implementation included a time-intensive, school-board driven curriculum adoption process, challenges related to a pre-planned academic calendar, and resistance from districts to another unfunded mandate (regardless of potential benefits). Mental health curriculum will be most successfully delivered within an established infrastructure of a multi-tiered system of supports framework. To achieve the most desirable results for students, the Navigator should provide consultation to districts on selecting curriculum as part of a comprehensive school-based behavioral health system rather than a standalone legislative mandate.

Recommendations

This report offers the following recommendations for next steps to build upon the successes of the pilot project.

1. Fund a full-time dedicated Behavioral Health Systems Navigator at each of the nine educational service districts. The work of the Behavioral Health Systems Navigator should focus solely on engaging with school districts and the health care provider community to navigate system barriers and increase access to behavioral healthcare in the school setting for eligible students.
2. Provide support for ongoing OSPI leadership for the ESD Behavioral Health Systems Navigators.
 - a. To support successful systemic change at the state level, a dedicated role at OSPI is needed to sustain this work.
 - b. Funding for a system-utilization study that investigates the maximization the resources available for a comprehensive school-based behavioral health system (e.g.: SBHS, MAC, public and private health reimbursement, school-based health centers, care coordination, etc.) that serves all students regardless of their insurance coverage.
3. Direct OSPI and HCA to continue to partner to improve understanding of each sector's priorities, and to work to reduce the access barriers to behavioral healthcare for K–12 students. This should include exploring additional state-level partnerships to increase access to care for students who are not eligible for Medicaid.

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- Andrew Bingham, Behavioral Health Systems Navigator, Student Support Services, Northeast Washington ESD 101
- Grace Burkhart, Behavioral Health Systems Navigator, Capital Region ESD 113

- Mike Hickman, Assistant Superintendent of Student Support, Capital Region ESD 113
- Mick Miller, Assistant Superintendent, Northeast Washington ESD 101
- Andrew Eyres, Assistant Superintendent of Teaching and Learning, Capital Region ESD 113
- Erin Wick, Senior Director of Behavioral Health and Integrated Student Supports, Capital Region ESD 113
- Ramona Griffin, Director of Student Support Services, Northeast Washington ESD 101
- Todd Johnson, Program Director, Center for Research and Data Analysis, Capital Region ESD 113
- Sara Ellsworth, Regional Administrator for Behavioral Health & Integrated Student Support, Capital Region ESD 113

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- Todd Slettvet, Section Manager, Medicaid Program Operations and Integrity, Health Care Authority

References

- Avenevoli, S., Baio, J., Bitsko, R. H., Blumberg, S. J., Brody, D. J., Crosby, A., ... & Huang, L. N. (2013). Mental Health Surveillance Among Children in the United States, 2005-2011.
- Behrens, D., Lear, J.G., & Price, O.A. (2013). Improving Access to Children's Mental Health Care: Lessons from a Study of Eleven States. The George Washington University: Washington, D.C. http://www.healthinschools.org/wp-content/uploads/2016/10/March2013-StatePrograms_d5_color_FINAL.pdf
- California Health Interview Survey. (2005). Los Angeles, CA: UCLA Center for Health Policy Research.
- Child Mind Institute. (2016). 2016 Children's Mental Health Report. <https://childmind.org/report/2016-childrens-mental-health-report/>
- Gall, G., Pagano, M.E., Desmond, M.S., Perrin, J.M., & Murphy, J.M. (2000). Utility of psychosocial screening at a school-based health center. *The Journal of School Health* 70(7), 292-298.
- Kataoka, S.H., Zhang, L., & Wells, K.B. (2002). Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *American Journal of Psychiatry*, 159(9), 1548-55.
- Maibe, M. M., Osborne, B. M., Fox, T., Scarano, D. (2017). Exploring the Landscape of Mental Health and Wellness In Washington's K-12 Education System. https://docs.wixstatic.com/ugd/100032_27d153a54c854d37ac38c0cb75943737.pdf
- Mental Health America, Annual Report (2019). Retrieved from: <https://mhanational.org/sites/default/files/201909/2019%20MH%20in%20America%20Final.pdf>
- National Alliance on Mental Illness. (2017). Mental Health Facts: Children and Teens. <https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers>
- Substance Abuse and Mental Health Administration (2015). Accessing Medicaid Funds for School-Based Mental Health Services. Retrieved from: <http://www.fredla.org/wp-content/uploads/2015/09/Medicaid-for-School-Based-MH-Services.pdf>
- Substance Abuse and Mental Health Administration, Centers for Medicare and Medicaid (2019). Guidance to States and School Systems on Addressing Mental Health and Substance

Use Issues in Schools. Retrieved from: <https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf>

Substance Abuse and Mental Health Services Administration, Center for Mental Health Services. (2007). Promotion and Prevention in Mental Health: Strengthening Parenting and Enhancing Child Resilience, DHHS Publication No. CMHS-SVP-0175. Rockville, MD.

The School Superintendents Association (2019). Structural Inefficiencies in the School-Based Medicaid Program Disadvantage Small and Rural Districts and Students. Retrieved from: [http://www.aasa.org/uploadedFiles/Policy_and_Advocacy/Resources/AASA Medicaid Report FINAL.pdf](http://www.aasa.org/uploadedFiles/Policy_and_Advocacy/Resources/AASA_Medicaid_Report_FINAL.pdf)

U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health. Retrieved from <http://profiles.nlm.nih.gov/ps/access/NNBBJC.pdf>

APPENDICES

Appendix A: RCW 28A.630.500, Children's mental health and substance use disorder services—Pilot sites—Report. (Expires January 1, 2020.)

(1) Subject to the availability of amounts appropriated for this specific purpose, the office of the superintendent of public instruction shall establish a competitive application process to designate two educational service districts in which to pilot one lead staff person for children's mental health and substance use disorder services.

(2) The office must select two educational service districts as pilot sites by October 1, 2017. When selecting the pilot sites, the office must endeavor to achieve a balanced geographic distribution of sites east of the crest of the Cascade mountains and west of the crest of the Cascade mountains.

(3) The lead staff person for each pilot site must have the primary responsibility for:

(a) Coordinating Medicaid billing for schools and school districts in the educational service district;

(b) Facilitating partnerships with community mental health agencies, providers of substance use disorder treatment, and other providers;

(c) Sharing service models;

(d) Seeking public and private grant funding;

(e) Ensuring the adequacy of other system level supports for students with mental health and substance use disorder treatment needs;

(f) Collaborating with the other selected project and with the office of the superintendent of public instruction; and

(g) Delivering a mental health literacy curriculum, mental health literacy curriculum resource, or comprehensive instruction to students in one high school in each pilot site that:

(i) Improves mental health literacy in students;

(ii) Is designed to support teachers; and

(iii) Aligns with the state health and physical education K–12 learning standards as they existed on January 1, 2018.

(4) The office of the superintendent of public instruction must report on the results of the two pilot projects to the governor and the appropriate committees of the legislature in accordance with RCW 43.01.036 by December 1, 2019. The report must also include:

(a) A case study of an educational service district that is successfully delivering and coordinating children's mental health activities and services. Activities and services may include but are not limited to Medicaid billing, facilitating partnerships with community mental health agencies, and seeking and securing public and private funding; and

(b) Recommendations regarding whether to continue or make permanent the pilot projects and how the projects might be replicated in other educational service districts.

(5) This section expires January 1, 2020.

Appendix B: Medicaid Pathways Grid

	School-based Health Care Services (SBHS)	Medicaid Administrative Claiming (MAC)	Managed Care Organizations (MCO)	Behavioral Health Organizations (BHO)	Integrated Managed Care (IMC)	Fee-for-Service (FFS)
Service Area	All counties	All counties	<p>Currently, physical health is managed by MCOs* and behavioral health is managed by BHOs in the following counties: Mason, Thurston, Grays Harbor, Pacific, Lewis, Wahkiakum, Cowlitz, Clallam, Jefferson, and Kitsap.</p> <p>By 2020, all physical and behavioral health will be covered through integrated managed care (IMC), managed by the MCOs.</p> <p>*Coordinated Care is the statewide MCO responsible for the Apple Health Integrated Foster Care Program for children and youth in foster care, adoption support, and young adult alumni.</p>		<p>Apple Health offers integrated managed care in all counties except for Mason, Thurston, Grays Harbor, Pacific, Lewis, Wahkiakum, Cowlitz, Clallam, Jefferson and Kitsap.</p> <p>By 2020, all physical and behavioral health will be covered through integrated managed care (IMC), managed by the MCOs.</p>	All counties
What does/could the Medicaid program do?	Reimburses contracted ESDs, SDs, charter, and tribal schools for Medicaid-covered special education and early intervention related health care services.	Provides partial reimbursement to contracted ESDs, SDs, charter, and tribal schools for staff time spent performing Medicaid administrative activities.	Reimburses ESDs and SDs for Medicaid-covered physical health services and low-level behavioral health services.	Reimburses contracted ESDs and SDs for providing Medicaid-covered behavioral health services.	Reimburses contracted ESDs and SDs for providing Medicaid-covered physical & behavioral health services.	Reimburses ESDs and SDs for Medicaid-covered physical & behavioral health services.
Who is eligible?	Title XIX Medicaid eligible students (0-20) with an	All students (not just those that are Medicaid-	Medicaid eligible students enrolled in an Apple Health	Medicaid eligible students enrolled in Apple Health and	Medicaid eligible students enrolled in an Apple Health managed care	Medicaid eligible students not enrolled in an

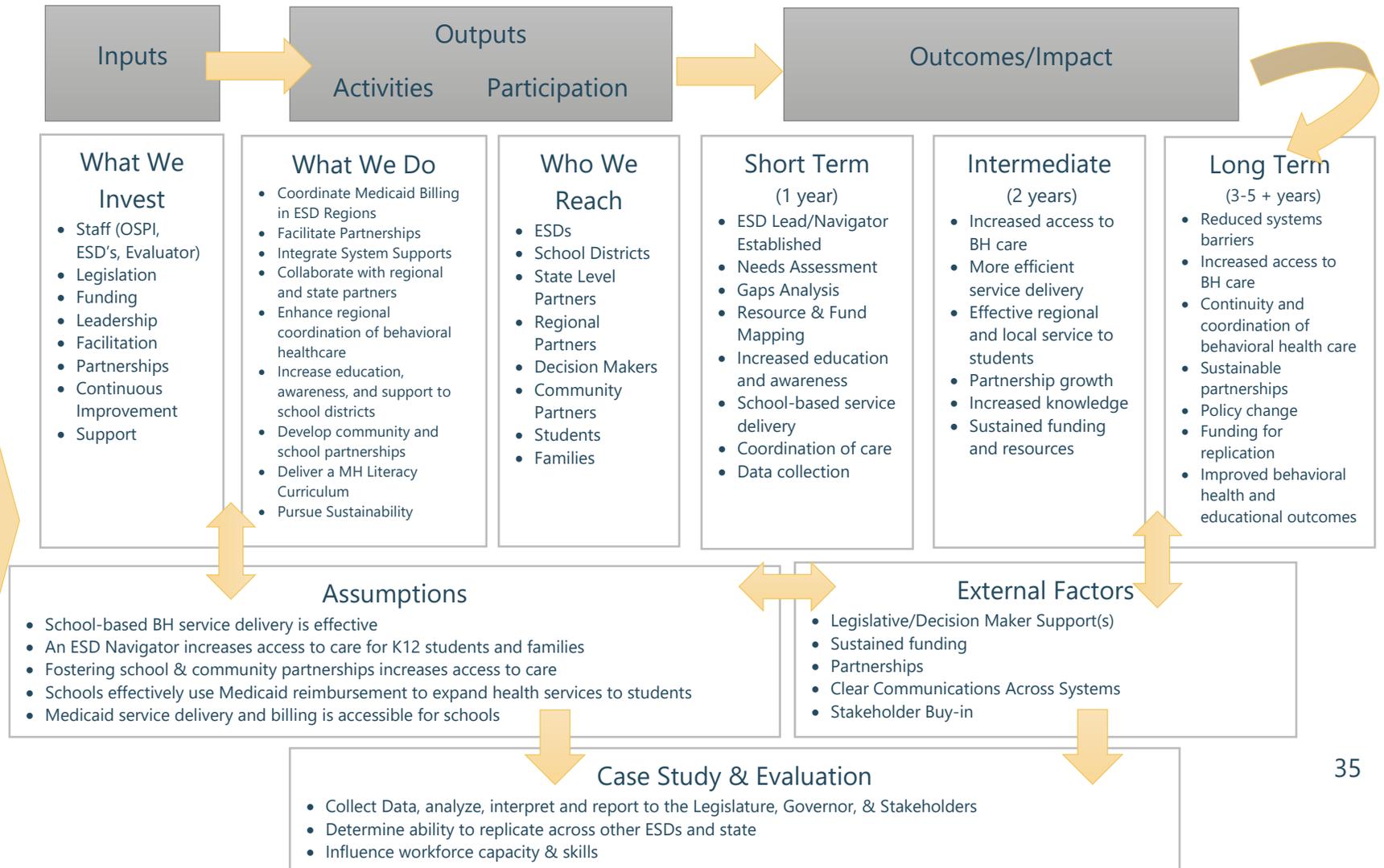
	School-based Health Care Services (SBHS)	Medicaid Administrative Claiming (MAC)	Managed Care Organizations (MCO)	Behavioral Health Organizations (BHO)	Integrated Managed Care (IMC)	Fee-for-Service (FFS)
	individualized education program (IEP) or individualized family service plan (IFSP).	eligible) can be the recipient of MAC reimbursable activities. The application of a Medicaid Eligibility Rate (MER) determines the reimbursement amount to just those Medicaid eligible children.	MCO and who reside in non-integrated managed care regions, which includes: Mason, Thurston, Grays Harbor, Pacific, Lewis, Wahkiakum, Cowlitz, Clallam, Jefferson, and Kitsap.	who reside in non-integrated managed care regions, which includes: Mason, Thurston, Grays Harbor, Pacific, Lewis, Wahkiakum, Cowlitz, Clallam, Jefferson, and Kitsap.	plan and who reside in integrated managed care regions .	Apple Health MCO. Examples of students who may be FFS: American Indian/Alaska Native Dual-eligible—Medicare/Medicaid Individuals who meet certain criteria.
How is eligibility determined?	Students must meet the definition of a child with a disability per the Individuals with Disabilities Education Act (IDEA) and must have an IEP or IFSP. Referral by a physician or other Department of Health (DOH) licensed provider of the healing arts within the	All students (not just those that are Medicaid-eligible) can be the recipient of MAC reimbursable activities. The application of a Medicaid Eligibility Rate (MER) determines the reimbursement amount to just those Medicaid eligible children.	Medical necessity as determined by a physician or other qualified provider within the provider’s scope of practice. ESDs and SDs must contact the student’s MCO to determine which services are available and to determine eligibility criteria. Some services may require prior authorization (PA).	Medical necessity as determined by a physician or a behavioral health professional within their scope of practice. Meets access to care standards and/or American Society of Addiction Medicine (ASAM) criteria for substance use. ESDs and SDs must contact the student’s MCO and/or BHO to determine which services are available	Medical necessity as determined by a physician or other qualified provider within the provider’s scope of practice, including behavioral health professionals. ESDs and SDs must contact the student’s MCO to determine which services are available and to determine eligibility criteria. Some services may require prior authorization (PA).	Medical necessity determined by a physician or other qualified provider within the provider’s scope of practice. ESDs and SDs must review HCA’s Provider Billing Guides for detailed billing instructions. Some services may require prior authorization (PA).

	School-based Health Care Services (SBHS)	Medicaid Administrative Claiming (MAC)	Managed Care Organizations (MCO)	Behavioral Health Organizations (BHO)	Integrated Managed Care (IMC)	Fee-for-Service (FFS)
	provider's scope of practice.			and to determine eligibility criteria. Some services may require prior authorization (PA).		
What Medicaid services may be reimbursable?	Direct health-care services provided to Medicaid eligible students where the service is identified in the student's IEP and/or IFSP limited to: Audiology services, Counseling services, Occupational therapy (OT), Physical therapy (PT), Speech language pathology (SLP) services, Nursing services, Psychological assessments and services.	Administrative activities provided to Medicaid eligible students such as: Medicaid outreach, Medicaid application assistance, referrals for and coordination of Medicaid-covered services, coordination of Medicaid transportation, coordination of Medicaid translation/interpretation, Medicaid program planning, training related to the delivery	Preventive and wellness services including: ABA therapy, chronic disease management, asthma and diabetes care, vision/hearing screenings, acute/emergency care, low level behavioral health services as determined by the MCO, immunizations, OT, PT, SLP services provided to general ed. and students with a 504 accommodation.	Behavioral health services including substance use disorder treatment for students who meet access to care standards or ASAM criteria.	Physical and behavioral health services including substance use disorder services.	Preventive and wellness services including: ABA therapy, chronic disease management, asthma and diabetes care, vision/hearing screenings, acute/emergency care, behavioral health services, immunizations, OT, PT, SLP services provided to general ed. and students with a 504 accommodation.

	School-based Health Care Services (SBHS)	Medicaid Administrative Claiming (MAC)	Managed Care Organizations (MCO)	Behavioral Health Organizations (BHO)	Integrated Managed Care (IMC)	Fee-for-Service (FFS)
		of Medicaid-covered services.				
Who may provide the service(s)?	ESD or SD staff who hold licensure with Department of Health (DOH), and DOH-licensed contracted providers. For a list of SBHS approved providers, visit WAC 182-537-0350.	ESD or SD staff whose salary/benefits are not fully federally funded, not paid through the district's Indirect Cost Rate, or part of an ineligible job description. Eligible staff must participate in the Random Moment Time Study (RMTS).	Qualified providers as determined by the Health Care Authority (WAC 182-502-0002) and each MCO. Direct services provided by RNs or LPNs are not reimbursable unless under the direct supervision of a qualified provider (WAC 182-502).	Qualified providers as determined by HCA and each BHO.	Qualified providers as determined by the Health Care Authority (WAC 182-502-0002 and each IMC MCO). Direct services provided by RNs or LPNs are not reimbursable unless under the direct supervision of a qualified provider (WAC 182-502).	Qualified providers as determined by the Health Care Authority (WAC 182-502-0002).
How are ESDs and school districts reimbursed?	ESD or SD contracts with SBHS program; ESD/SD enters claims directly into ProviderOne system. Reimbursement rates are based on the SBHS fee schedule. Amount of claims the ESD/SD submits	ESD or SD contracts with MAC program ESD/SD staff participate in RMTS Results of RMTS determine reimbursement amount ESD/SD submits local match through Certified Public	ESD or SD contracts with each MCO in their region . Reimbursement rate for services provided is based on a negotiated contract between the ESD or SD and each MCO.	ESD or SD contracts with BHO to receive reimbursement.	ESD or SD contracts with IMC MCOs in their region. Reimbursement rate is based on a negotiated contract between the ESD or SD and the IMC MCO.	ESD or SD enrolls as a billing provider with the Health Care Authority (HCA). ESD/SD enters claims directly into ProviderOne system. Reimbursement rates are based on HCA's fee schedules.

	School-based Health Care Services (SBHS)	Medicaid Administrative Claiming (MAC)	Managed Care Organizations (MCO)	Behavioral Health Organizations (BHO)	Integrated Managed Care (IMC)	Fee-for-Service (FFS)
	determines local match required. ESD/SD receives invoice from HCA; ESD/SD submits local match through Intergovernmental Transfer (IGT) process; ESD/SD receives reimbursement via check or electronic fund transfer (EFT).	Expenditure (CPE) process ESD/SD receives reimbursement via check or EFT				
Where can ESDs and LEAs find more information?	SBHS webpage Contact Shanna Muirhead, SBHS program manager at shanna.muirhead@hca.wa.gov	MAC webpage Contact Jonathan Rush, MAC program specialist at jonathan.rush@hca.wa.gov	HCA website Contact MCO program specialists at hcamcprograms@hca.wa.gov	hcamcprograms@hca.wa.gov	hcamcprograms@hca.wa.gov	Contact HCA Provider Enrollment at providerenrollment@hca.wa.gov or 800-562-3022 ext. 16137.

Appendix C: Project Logic Model



Appendix D: Guiding Questions

The research questions used to develop data collection tools and shape the case study focused on systems integration, access to care, and project sustainability.

Systems Integration

1. Is the ESD regional coordination model an effective and efficient strategy to increase access to behavioral health services for students and families?
2. Did collaboration, coordination, facilitation, and integration improve across systems (State-ESD-District-Regional Partners)?

Access to Care

1. Does the implementation of a regional service delivery model increase access to clinical behavioral healthcare for Medicaid eligible students?
2. Is accessibility similar across program sites? Does access differ by participant type (e.g. Medicaid eligible, non-Medicaid eligible)?
3. Does the implementation of a regional service delivery model reduce access barriers?

Sustainability

1. Does the implementation of a regional coordination model increase the access to Medicaid funds by schools/districts for behavioral health services?

Appendix E: Identified Barriers with The School-based Health Services Program

What we are Learning about System Barriers

In the school setting, the School-Based Healthcare Services Program (SBHS), administered by the Health Care Authority, is an optional fee-for-service Medicaid program that reimburses contracted local education agencies, ESDs, and, charter schools for providing medically necessary services to eligible students. This program is limited to students who are eligible for both Medicaid and special education services. Services delivered through this program must be identified in the student's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). In many cases, behavioral health services are not delivered through this program.

School-Based Healthcare Services Program Limitations

Not all school districts participate in the SBHS program. Of the students eligible for the program, approximately 3.91% of students eligible for Medicaid received services from this program in 2017. The program has limitations on the allowable service providers and services in the school setting. Providers must be licensed health care providers with the Department of Health. Eligible services are limited to those outlined in the SBHS billing guide. If services do not meet all requirements, schools are denied reimbursement.

Funding is Complicated for Schools to Navigate

The SBHS program is funded using a 50/50 federal/non-federal match. In order to draw down the federal funds from the Center Medicare and Medicaid Services, the state must provide 50% of the reimbursement. Participating school districts are required to provide 60% (local match) of the non-federal split and HCA must provide the remaining 40%. The reimbursement provided to the school district includes the return of the local match, the state matching funds, and the federal funds. This process is called the Intergovernmental Transfer Process.

For example: A district submits a claim in the amount of \$1,000. The district is responsible for providing \$300, HCA provides \$200, and CMS provides \$500. Once HCA receives the match from the district, the district will receive a check for the total amount of the claim (\$1,000).

Ongoing Gaps in Behavioral Health Services for Students¹

¹ Schools/Districts/ESDs may be contracting with providers who are billing Behavioral Health Organizations, Managed Care Organizations, funding providers through general funds, or

Even with full use of the SBHS program, schools will still be left to find ways to meet the behavioral health needs of all students. The SBHS program is intended to serve students with special education needs.

Medicaid only covers approximately 42% of the public-school population. Schools must navigate the private healthcare system for the remaining 58 percent of students. This requires significant resources. There are 1,115,000 students in Washington’s public schools, of which 473,000 students are eligible for Medicaid, of which only 66,700 are eligible for the SBHS program. Schools are tasked with locating other healthcare programs and funding for the remaining 406,300 student’s ineligible for the SBHS program. For the 642,000 students covered by non-Medicaid insurance sources more coordination and services are required. Each of which comes with its own set of eligibility criteria.

Use of the SBHS Program	Current State 2017	Projected Potential Statewide Implementation
Contracted & billing LEAs & ESDs	135 school districts, one ESD	All local education agencies, nine ESDs
Number of students receiving healthcare services	18,500	66,700
Reimbursement	\$10,604,859	\$38,200,000

Next Steps

Students who are eligible for Medicaid and do not receive special education services can be supported by the Navigators who are connecting with the Managed Care Health Plans in their respective regions and working to develop pathways for services. Educational Service Districts and school districts continue to seek resources and connection for students who are not eligible for Medicaid.

OSPI, ESD 101, and ESD 113 will continue to work through June 30, 2019 on the pilot project. They are working with districts to further investigate barriers and gain a deeper understanding of school district utilization of Medicaid programs and reimbursement funds. A case study will be submitted to the Legislature on December 1, 2019.

providing services and not billing the SBHS. OSPI does not have access to this data. This data is limited those currently contracted and billing the SBHS program and does not account for all schools statewide.

Appendix F: Behavioral Health System Navigator Playbook

Educational Service District Behavioral Health System Navigator Playbook

A Guide for Linking Regional Education and Healthcare
Systems



BACKGROUND AND INTRODUCTION

The Children’s Behavioral Health Workgroup, formed in 2016 by the legislature, was tasked with identifying barriers to children’s behavioral health services. Their recommendations to the legislature included strategies for improving access and coordination in early learning, K–12 education, and health care systems. One of the workgroup’s recommendations created the OSPI Children’s Regional Behavioral Health Pilot Project authorized by [RCW 28A.630.500](#).

Project Goal: To increase equitable access to behavioral healthcare and services for students in need through state and regional cross-system collaboration with schools and communities.

Project Purpose: To investigate the benefits of a dedicated staff person networking with regional partners and K–12 school districts for the coordination of behavioral health services to students and families who are eligible for Medicaid.

Background: In 2017, House Bill 1713 directed the Office of Superintendent of Public Instruction (OSPI) to provide leadership in supporting two Educational Service Districts (ESD) to hire a dedicated staff person as a Behavioral Health Systems Navigator (Navigator). The role of the Navigator is to increase access to behavioral health services and supports for students and families by piloting regional cross-system coordination.

The primary responsibility of the Navigator is to bridge the gap between the education and behavioral health systems. In the fall of 2017, Northeast Washington ESD 101 (serving 59 districts in 7 counties) and Capital Region ESD 113 (serving 45 districts in 5 counties) were selected as the two sites to pilot this concept.

The Navigator supports the development and expansion of processes and procedures that increase the school district capacity to successfully connect students to care by liaising between community-based providers as well as providing school districts with information on the available Medicaid programs to help schools maximize their use of currently available resources.

PURPOSE

The purpose of this playbook is to provide a roadmap for an ESD Behavioral Health Systems Navigator to engage in regional K–12 and healthcare partnerships through relationships and collaboration activities that will ultimately increase access to care. Each region has a unique makeup of school districts and healthcare systems. The Navigator can help determine the best approach for the ESD as they learn the healthcare and education landscape in their respective region. This playbook draws upon the learning and experiences of the two ESD Navigators from Capital Region ESD 113 (CR ESD113) and Northeast Washington ESD 101 (NEWESD101)

and OSPI's Behavioral Health and Suicide Prevention Program Supervisor during the ESD Regional Behavioral Health Pilot Project. The Navigator is **not** a direct service provider, rather the Navigator designs their approach to the work using the following guiding principles:

- Coordination of behavioral health resources, supports, service providers, schools, school districts, and communities in the ESD region.
- Facilitation of partnerships across the multiple systems of behavioral healthcare services and supports for children and families.
- Ensuring the adequacy of systems level supports for students in need of behavioral health services through the integration of various service delivery models appropriate for the school setting.
- Collaboration with ESDs, OSPI, districts, schools, community partners, and other stakeholders to increase access to behavioral healthcare services and supports.

The Navigator performs activities that support the guiding principles such as:

- Conducting outreach to school districts in the ESD region to provide technical assistance and training for expanding Medicaid services and billing.
- Conduct an inventory of the current behavioral health providers in the region to help schools make connections (e.g.: Federally Qualified Health Centers, Community-based Clinics, School-based Health Centers, ESD licensed behavioral health providers, etc.).
- Working with schools to coordinate behavioral health service delivery by assisting in needs assessments, gaps analysis, and resource mapping.
- Investigating and documenting barriers to behavioral health services for students and creating resource materials that assist schools in connecting students to services.
- Collecting data from school districts on their experience with collaborating with community-based providers and identifying opportunities to support with collaboration strategies.
- Surveying school district completion of their Plan for Recognizing and Responding to Emotional or Behavioral Distress authorized by RCW 28A.320.127. Navigators provide technical assistance and support to districts on plan development and implementation.
- Conducting an inventory of appropriate ESD programs and resources and linking school districts to them when requested or when interested.

The Navigator participates in a learning community of their peers to work together on shared initiatives and gather information from lessons learned. This peer network is critical to the Navigator's work because each region's unique circumstances offer perspectives that

expand the Navigator's knowledge as well as challenge the group to create innovative solutions.

NAVIGATOR ACTIVITIES

The Pilot Project participants recommend each ESD Navigator to spend the first six months engaging in an active assessment of the unique conditions in the region related to the ESD, school districts, and the behavioral health system.

Needs Assessment, Gaps Analysis, and Resource Mapping

An important lesson during the pilot phases of the Navigator work was the value of internal agency communication, strengthened by the establishment of the Navigator position. Because this is new work for the agency, it is important to assess how the Navigator will intersect with other ESD programming. Once identified, the Navigator should provide ongoing briefings to agency staff on the progress of the work and identify opportunities for collaboration.

When working with districts to increase access to care to behavioral healthcare services, the Navigator can use tools to help districts conduct an initial needs assessment and gaps analysis to understand their current systems and identify where to start. A useful tool for the Navigator is the School Health Assessment and Performance Evaluation System (SHAPE). The Navigator can use this tool to assist schools/districts to determine steps for increasing access to care. Additionally, the Navigator should create an inventory of regional service providers available for referral services, care coordination, or the provision of co-located services.

Recommended Activities within the ESD:

1. Make connections, get introductions to program directors, build relationships, and conduct an analysis of agency work that intersects with the Navigator role (e.g.: Nursing, Counseling, Special Education, Threat Assessment, School Safety, etc.).
2. Set up one-on-one meetings and learn about program administration and activities and how the Navigator can partner to ensure ongoing communication and program cross-collaboration.
3. Brief agency partners on the Navigator role and responsibilities and identify opportunities for partnership and collaboration.
4. Consider presenting to agency leadership and/or the board annually on the Navigator activities, progress, and plans.

Recommended Activities with Districts:

1. Outreach to all districts with a focus on readiness to benefit.
2. Establish a point of contact for behavioral health at each school district.

3. Share details of the Navigator role and generate interest.
4. Assist districts in conducting a needs assessment, gaps analysis, and resource mapping.
5. Identify next steps for increasing access to care.

Identifying and Engaging Regional Healthcare Partners:

The Health Care Authority's (HCA) Healthier Washington initiative aims to build healthier communities through a collaborative regional approach involving the Accountable Communities of Health (ACH). The Healthier Washington approach includes goals that all people with physical and behavioral health comorbidities will receive high quality care and that Washington's annual health care cost growth will be 2% less than the national health expenditure trend.



Figure 3: Regional ACHs and ESDs.

The nine ACH's (see Figure 4) bring together leaders from multiple health sectors with a common interest in improving health and health equity. As ACHs better align resources and activities, they support wellness and a system that delivers care for the whole person. Their boundaries are similar (although not exact) to the ESD regional boundaries.

Health system transformation depends on coordination and integration with community services, social services and public health. ACHs provide the necessary links and supportive environments to address the needs of the whole person.

ESDs can be important partners in this regional approach to a healthier population by participating with their regional ACH. Like ESDs, each ACH's body of work is unique to the region's needs. A Navigator begins building relationships with the region's healthcare leaders

and spends time learning about their ACH's goals, programs, and initiatives by attending public meetings.

The Health Care Authority recommends that ESD Navigators take the following steps to begin fostering relationships with the ACHs:

1. Reach out their ACH's Executive Director to set a meeting where the ESD can share about their role in the region and learn about the ACHs current work in the region with the population they share (children and youth).
 - a. Explain that the Navigator role is new, authorized by legislation, and charged with increasing access to behavioral health care in the region.
 - b. Share how the ESD is assessing how they can engage in regional partnerships creating awareness of bidirectional referral relationships.
 - c. Learn about the ACH Board makeup, governance structure, standing and ad-hoc committees, and public meeting schedules; explore if there is a place for the Navigator.
 - d. Learn about the ACH's identified goals, objectives, and outcome measures, specifically for interventions on social determinants of health related to children and youth.
2. Explore opportunities to partner in potential future proposal opportunities (e.g.: care coordination programs, create/build awareness about the region's strategies for integrated managed care, early and periodic screening, diagnostic and treatment (EPSDT), nursing services, etc.).
3. Find out how the ESD and ACH can partner on ensuring schools have a current understanding of the referral resources available in the region so that the right student is referred to the right care at the right time.
4. Attend the ACH's public meetings to learn more about current initiatives and ongoing plans for transforming healthcare.

MEDICAID PROGRAMS AVAILABLE TO SERVE STUDENTS IN SCHOOL DISTRICTS

There are multiple ways in which the State Medicaid Plan administers behavioral health to children and youth in the state. On average, 42% of a school district's population is eligible for Medicaid in Washington. The Navigator can help schools maximize the resources available to them by leveraging available Medicaid resources.

Medicaid Administrative Claiming – MAC

MAC is an optional Medicaid program that allows school districts and ESDs to receive federal reimbursement for administrative activities (performed by school staff) that support the goals of the Medicaid State Plan. Examples of eligible activities include outreach to provide information about Medicaid programs and covered services to students and families; assisting individuals in applying for or accessing Medicaid covered services; and, referring students and families to health providers. School District (SD) staff participate in a Random Moment Time Study (RMTS) to determine what percentage of their time is spent performing reimbursable activities such as outreach, application assistance, and referring students/families to needed healthcare services.

Participation process

- Participating SDs use a web-based random moment time study/claiming system.
- Selected SD staff receive an email which requires them to describe a 1-minute interval (moment) of a specified workday.
- This moment consists of four short questions with pre-defined answers followed by an open-ended question to detail the specifics of the activity.
- Typically, the RMTS takes 1-2 minutes to complete.

Recommended Activities:

1. Visit the [MAC Website](#) for current program information.
2. Connect with HCA Program Manager for information and training.
3. Request information from HCA regarding districts currently participating in the program.
4. Explore the option of participating in MAC at the ESD (if not already using the program).
5. Share details and generate interest with districts in the region.
6. Connect districts with the MAC Program Specialist at HCA.

School-Based Health Care Services – SBHS

The Washington State School-Based Health Care Services (SBHS) program is an optional Medicaid program administered by the Health Care Authority (HCA). The SBHS program provides partial reimbursement to contracted school districts, educational service districts, and charter and tribal schools for Medicaid covered health-related services provided to Medicaid eligible students. In order to receive Medicaid reimbursement through this program, services must be included in the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP). School-based IEP/IFSP health-related services are carved out of Medicaid Managed Care Organizations (MCOs) and are reimbursed fee-for-service by the HCA.

Covered Services

To receive reimbursement, covered services must be referred or prescribed by a physician or licensed practitioner of the healing arts, provided by Department of Health (DOH) licensed providers, must be written in the child's IEP or IFSP, and must be provided in a school setting or via telemedicine.

Recommended Activities:

1. Visit the [SBHS Website](#) for current program information.
2. Connect with HCA Program Manager for information and training.
3. Request information from HCA on Districts using the program.
4. Discuss with ESD leadership if the agency might want to act as the coordinating organization for smaller districts.
5. Share details and generate interest with districts in the region.
6. Connect districts with the SBHS Program Specialist at HCA.

BUILD BRIDGES BETWEEN SCHOOL DISTRICTS AND LICENSED BEHAVIORAL HEALTH PROVIDERS

The Navigator will need to build relationships with providers who contract with Managed Care. The five Managed Care Organizations (MCOs) collectively cover all students participating in Apple Health, WA's Medicaid Program. MCO coverage varies by region, and not all five MCOs cover all regions. The Navigator will need to establish relationships with the MCOs to fully understand the regional provider network and determine opportunities for partnerships.

Recommended Activities

1. Identify the [managed care organizations](#) that cover students in your ESD region.
**All regions will need to work with Coordinated Care for foster students.
2. Reach out and set up a meeting.
3. Determine opportunities for partnerships (e.g.: care coordination, bidirectional referral relationships, etc.).

SUSTAINABILITY PLANNING

The Navigator will work in their region to engage in the healthcare systems. Sustainability for each ESD will vary depending on the role in which they play. This may include:

- Plans for reaching all districts in the region.
- Steps for comprehensive mental health in schools using a Multi-Tiered System of Supports (MTSS) framework.
- Diversified funding resources to increase access for all students.
- Ongoing relationships with community partnerships.
- Ongoing relationships and coordination with the MCOs and ACHs to determine strategies for combatting the social determinants of health that have an impact on children and youth.

RESOURCES AND REFERENCES

More resources to use when developing plans with schools:

[Interconnected Systems Framework, Mental Health Integration Tools](#)

[The Center for Health and Health Care in Schools: School Mental Health](#)

[Ohio Dept of Ed Tier II & III BH Supports](#)

[Ohio Dept of Ed School-based health Care Support Toolkit](#)

[Canada's School Mental Health-Assist](#)

DEFINITIONS AND ACRONYMS

For the purposes of this project, the following terms, definitions, and acronyms will be used:

ACCOUNTABLE COMMUNITY OF HEALTH (ACH)

Regional Medicaid delivery systems to bring together leaders from multiple health sectors with a common interest in improving health and health equity.

AMERICANS WITH DISABILITIES ACT (ADA)

The ADA is a civil rights law that prohibits discrimination against individuals with disabilities in all areas of public life, including jobs, schools, transportation, and all public and private places

that are open to the general public. The purpose of the law is to make sure that people with disabilities have the same rights and opportunities as everyone else.

APPLE HEALTH

Washington's Medicaid program.

BEHAVIORAL HEALTH

Includes not only ways of promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also to prevent or intervene in substance abuse or other addiction disorders.

BEHAVIORAL HEALTH AGENCY (BHA)

A licensed and certified agency providing mental health and/or substance use disorder treatment services.

BEHAVIORAL HEALTH – ADMINISTRATIVE SERVICES ONLY (BH-ASO)

These organizations administer services such as 24/7 regional crisis hotline for mental health and substance use disorder crises, mobile crisis outreach teams, short-term substance use disorder crisis services for individuals who are intoxicated or incapacitated in public, application of behavioral health involuntary commitment statutes, available 24/7 to conduct Involuntary Treatment Act (ITA) assessments and file detention petitions, and regional ombuds.

BEHAVIORAL HEALTH ORGANIZATION (BHO)

The Health Care Authority manages contracts with Behavioral Health Organizations for mental health and substance use disorder (SUD) treatment services in regions that have not yet implemented Integrated Managed Care. As Apple Health continues to implement Integrated Managed Care across the state, responsibility for behavioral health coverage transfers to integrated managed care plans. This transition will be complete by January 1, 2020. The only current BHO's include Great Rivers, Thurston-Mason, and Salish.

BEHAVIORAL HEALTH SERVICES ONLY (BHSO)

Apple Health offers Behavioral Health Services Only (BHSO) plans in all regions with integrated managed care. These plans are for clients who are eligible for Apple Health, but not eligible for managed care enrollment. The Behavioral Health Services Only plans are offered by the same health plans administering Integrated Managed Care.

DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)

The lead agency for state-funded services that support children and families to build resilience and health, and to improve educational outcomes.

DEPARTMENT OF HEALTH (DOH)

The lead agency for state-funded public health programs and services.

ELECTRONIC HEALTH/MEDICAL RECORD (EHR/EMR)

Electronically-stored patient health information that can be shared across different health care settings.

EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

Child health component of Medicaid. Federal statutes and regulations state that children under age 21 who are enrolled in Medicaid are entitled to EPSDT benefits and that States must cover a broad array of preventive and treatment services. Service(s) identified through EPSDT become medically necessary service(s).

FEE FOR SERVICE (FFS)

Payment for services delivered on an encounter basis. Procedure codes, units, and reimbursement rates.

HEALTHCARE AUTHORITY (HCA)

Washington’s state Medicaid agency. Receives funding from the Center for Medicaid and Medicare Services (CMS).

INDIVIDUALIZED EDUCATION PROGRAM (IEP)

A document that is developed for each public school child (ages 3-21 years) who needs special education. The IEP is created through a team effort and reviewed periodically.

INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

A plan for special services for young children (0-3 years) with developmental delays. An IFSP only applies to children from birth to three years of age.

INTEGRATED MANAGED CARE

An initiative under Healthier Washington to bring together the payment and delivery of physical and behavioral health services for people enrolled in Medicaid, through managed care.

INTERGOVERNMENTAL TRANSFER (IGT)

Match and funds transfer process for the School-based Health Services Program, contracted with HCA.

MANAGED CARE ORGANIZATION (MCO)

Most Apple Health clients have managed care, where Apple Health pays a health plan a monthly premium for each enrollee's coverage. This includes preventive, primary, specialty, and other health services. Clients in managed care must see only providers who are in their plan's provider network, unless prior authorized or to treat urgent or emergent care. In Washington, there are five managed care plans: Coordinated Care, Community Health Plan of WA, Molina, Amerigroup, and United Healthcare, although every plan is not available in all parts of the state.

MEDICAID

A joint government (federal and state) insurance program that helps with medical costs for persons of all ages whose income and resources are insufficient to pay for health care. In Washington, Medicaid is termed Apple Health.

MEDICAID ADMINISTRATIVE CLAIMING (MAC)

An optional Medicaid program that allows school districts and ESDs to receive federal reimbursement for administrative activities performed by school staff that support the goals of the Medicaid State Plan. Examples of eligible activities include outreach and providing information about Medicaid programs and covered services to students and families, assisting individuals in applying for or accessing Medicaid covered services, and referring students and families to health providers. School staff participate in an electronically administered time study and the results of the time study, along with the school population's Medicaid eligibility rate determine the funds received by the school.

MEDICAID STATE PLAN

The State Plan is the officially recognized statement describing the nature and scope of Washington State's Medicaid Program. A State Plan is required to qualify for federal funding for providing Medicaid services.

MENTAL HEALTH TREATMENT

Treatment choices for mental health conditions will vary from person to person. Treatments range from evidence-based medications, therapy and psychosocial services such as psychiatric rehabilitation, housing, employment and peer supports.

MULTI-TIERED SYSTEM OF SUPPORT (MTSS)

A framework for enhancing the adoption and implementation of a continuum of evidence-based instruction and interventions to achieve important outcomes for all students.

RANDOM MOMENT TIME STUDY (RMTS)

Web-based system for claiming/reimbursement through the Medicaid Administrative Claiming Program. Operated by the University of Massachusetts Medical School.

SCHOOL BASED HEALTH CENTER

School-based health centers generally operate as a partnership between the school district and a community health organization, such as a community health center, hospital, or the local health department and can provide a combination of primary care, mental health care, substance abuse counseling, case management, dental health, nutrition education, health education, and health promotion.

SCHOOL BASED HEALTH CARE SERVICES (SBHS)

An optional Medicaid program administered by the Health Care Authority. The SBHS program reimburses contracted school districts, educational service districts, and charter and tribal schools for Medicaid covered health related services provided to Medicaid eligible students. In order to receive Medicaid reimbursement through this program, services must be included in the child's Individualized Education Program or Individualized Family Service Plan. School-based IEP/IFSP health related services are carved out of Medicaid Managed Care Organizations and are reimbursed fee-for-service.

SUBSTANCE USE DISORDER TREATMENT

Treatments that usually involve planning for specific ways to avoid the addictive stimulus, and therapeutic interventions intended to help a client learn healthier ways to find satisfaction.

VALUE-BASED PAYMENT

Also termed pay-for-performance, is shifting health care reimbursement strategies away from a system that pays for volume of service (fee-for-service) to one that rewards quality and outcomes.

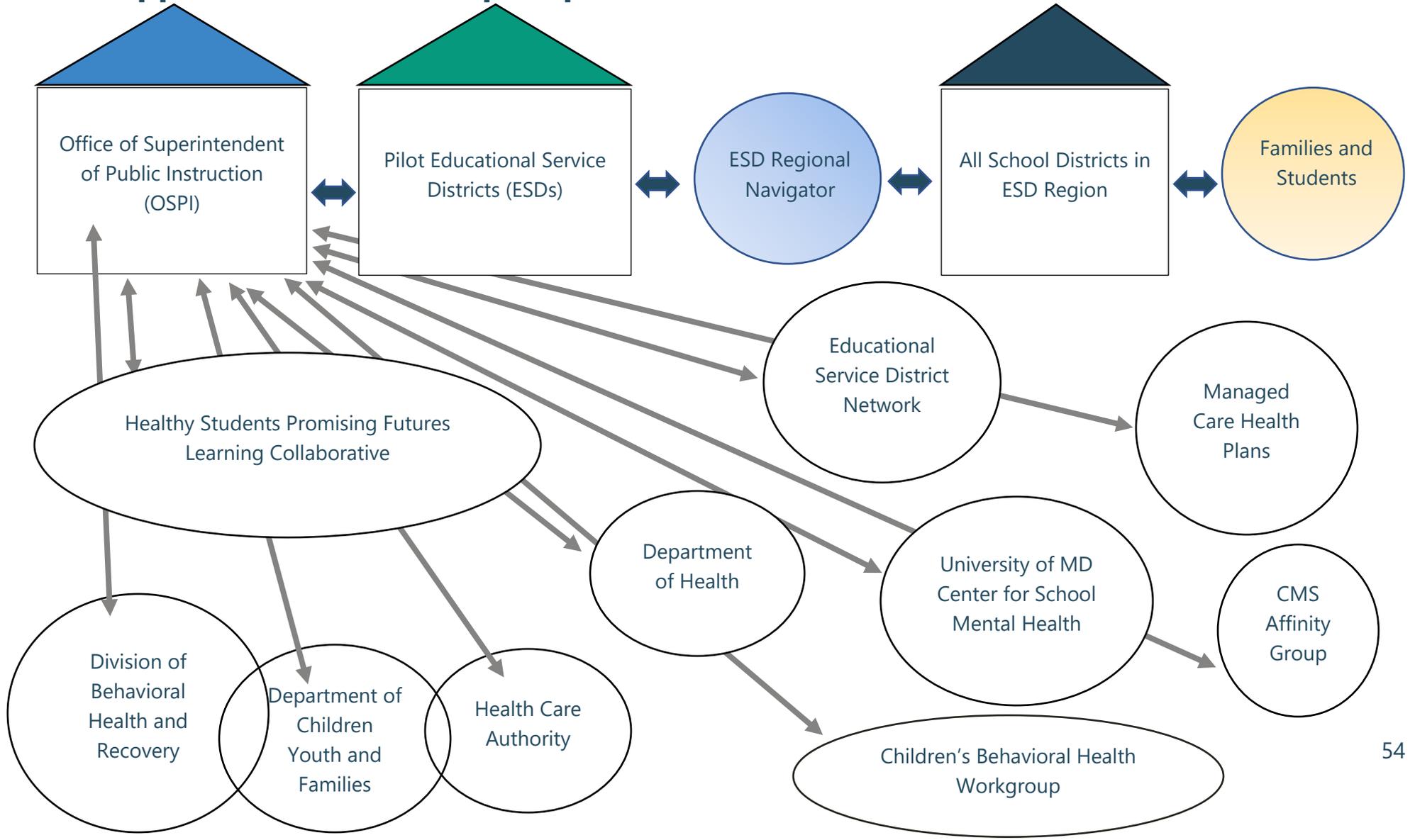
Navigator Job Activity Examples:

- Attending School Based Health Care Services (SBHS), and Medicaid Administrative Claiming (MAC) webinars and trainings.

- Communicating with SBHS, and MAC Program Specialists with the Health Care Authority.
- Collaborating with internal ESD departments (e.g. Prevention Programs, Special Education, School Fiscal Services, Nursing Corps, etc.) on Medicaid billing.
- Attending ACH Medicaid Transformation Collaboratives.
- Meeting with regional Amerigroup Washington (AMG), Coordinated Care of Washington (CCW), Community Health Plan of Washington (CHPW), Molina Healthcare of Washington (MHW), and UnitedHealthcare Community Plan (UHC), to discuss partnerships.
- Meeting with school district superintendents, administrators, and counseling staff to discuss SBHS, MAC, and Medicaid integration.
- Attend the Annual Conference on Advancing School Mental Health to learn about national behavioral health efforts.
- Exploring Electronic Health Records (EHR) systems and options for Medicaid billing.
- Exploring IT Technology systems and options to support Medicaid billing.
- Exploring 3rd party contracting, credentialing, and claims management services.
- Communicating with Washington School Information Processing Cooperative (WSIPC) regarding IEPOne and Medicaid billing technology.
- Communicating with Public Consulting Group (PCG) regarding IEPOne partnership, and EasyTrac system.
- Monthly learning community meetings.
- Data collection and reporting.
- Present process and outcomes with peers.
- Identify and build relationship with school and community-based providers.
- Map providers and services available for schools to use for referral and decision making.
- Facilitate relationships between providers and schools.
- Provide education and awareness on Medicaid billing options available to schools.
- Provide support to schools interested in participating in Medicaid billing options by connecting them with HCA and/or MCO-contracted providers.
- Active participation representing K–12 voice among regional healthcare system partners: Accountable Communities of Health, Family Youth and System Partner Round Tables, Behavioral Health Providers.
- Serves as a conduit of information and resources bi-directionally between schools and the BH system.
- Explore funding opportunities to fill gaps that cannot be met by insurance reimbursement (infrastructure building, care coordination, services for non-insured).
- Collect data from districts on current system to deliver/coordinate/fund BH services.
- Explore if school Medicaid reimbursement recovers the cost of services; learn how reimbursement funds are used, identify barriers for participating in available Medicaid programs.
- Inform ESD Network on lessons learned and recommendations for approaching the work.
- Implement a mental health literacy curriculum in at least one high school, document curriculum adoption process to inform case study.

- Contact each Superintendent in the region and establish a point of contact at each school district in the region.
- Establish relationships with Managed Care Organizations to increase access to care and coordinate care.

Appendix G: Partnership Map



Appendix H: Interim Report

(placeholder, communications has this report in word)

Appendix I: Key Stakeholder Interview Summary

CHILDREN'S BEHAVIORAL HEALTH REGIONAL PILOT PROJECT

STAKEHOLDER INTERVIEW SUMMARY

January 2019

INTRODUCTION AND METHODOLOGY

As part of the pilot project, Maike & Associates, LLC is tasked with the conduct of a case study to investigate the benefits of a dedicated staff person networking with regional partners and K–12 school districts for the coordination of behavioral health services to students and families who are eligible for Medicaid. This includes interviews with key stakeholders.

In November 2018, the Behavioral Health Systems Navigators (Navigator), assigned to the two-pilot study Educational Service Districts (ESD) – Northeast Washington ESD 101 and Capital Region ESD 113 – identified three to four key stakeholders at both the school/district and community/regional levels as well as ESD and state-level partners knowledgeable about the pilot project. Identified participants were contacted via email with a brief explanation of the project and a request for an interview. Nine (9) stakeholders were contacted and all agreed to be interviewed. Interviews were conducted over a three-week period in late November and mid-December 2018. Each participant answered questions from their own perspective, drawing from their own experience and expertise. As such, not all respondents answered all questions and not all questions were asked of all respondents. The purpose of the interview was to obtain a deeper understanding from stakeholders' perspective of the pilot project, the role of the Navigator, and potential benefits or value-added from this role.

The brief 20-30-minute interview was structured around four main questions (See Appendix A). The first asked participants about how the Navigator had engaged them (district, school, agency) in the pilot project. The second question sought information about if engagement with the Navigator had increased participants' knowledge and/or awareness of the behavioral health system, with this specific to Medicaid eligible students and families. Question three asked interviewees if working with the Navigator had increased access or reduced barriers to behavioral health services, with the final question seeking participants' perspectives about project benefits experienced to date. Potential reflections on information to share with legislative or other decision makers was also discussed. The following information provides a broad overview, by topic, of participant responses. Direct quotes are included to contextualize findings.

ENGAGEMENT

Engagement, or interactions, with the Navigator varied by interviewee role (i.e., education or community partner) as well as by ESD site. At both the district and regional levels, activities conducted have resulted in actions in some form. These include conducting or facilitating the SHAPE assessment tool, coaching building school-level MTSS/PBIS teams, or fostering relationships with entities across systems to make connections to increase access to direct services. Generally, school/district level interactions occurred in-person, by phone, and via email. One district level informant in ESD 101 noted, “Andrew met with the leadership team and presented SHAPE outcomes. He was there to get principal buy-in and he got it!”

At the regional/community level, as well as with State level stakeholders, interactions with Navigators were more formalized around collaboratives and/or existing stakeholder meeting/activities, often occurring in person on a monthly or quarterly basis. These activities were more systems level work, including partnership at regional healthcare meetings, and regular contact with BHOs and MCO partner agencies to ensure that the “education voice” was present and heard at these various convenings.

KNOWLEDGE AND AWARENESS

All interviewees agreed that the role of the Navigator increased knowledge and awareness, of both the K-12 education system and the behavioral health system related to Medicaid eligible youth. Participants commented on the importance of having a single point of contact with knowledge of both systems as well as the region in which these schools and community partners served. Moreover, that the Navigator served as a critical link between education, healthcare and families. One education partner reflected, “Many people believe working with Medicaid is not a good investment, so having the ability to have the [Navigator] walk [districts/schools] through this process...to make direct connections...makes the system more human, more doable, more complete.” A state-level participant indicated, “What I like about the Navigator, is having someone know specifically what’s happening in the region – knows each district – it’s helpful to have someone local at the site.”

Community partners were grateful for a point of contact that was able to answer questions about the education system, while also having knowledge about the inner workings of the healthcare system. As noted by this community partner, “When questions come up, the [Navigator] can answer those questions about the education system, in a room of mostly behavioral health people, so it helps to have [someone with] knowledge on both sides of the spectrum.”

At the district/school level, activities conducted were credited with improving knowledge and awareness among school staff, from school counselors to building principals. In fact, this

district-level informant noted, "I think probably the SHAPE team itself – counselors, mental health staff, teachers, - their knowledge has increased so that has impacted their day-to-day with kids and families. [And,] increased knowledge with principals of these systems."

INCREASED ACCESS AND REDUCED BARRIERS

A key outcome of the regional pilot project is to increase access and reduce barriers to behavioral health for Medicaid eligible children and families within the ESD sites. Collaborating with district/school personnel and community stakeholders to identify and dismantle systems level barriers are critical components of this work. Informants acknowledged that this position has resulted in connecting students and families to services, unifying partners, and integrating systems. One community partner noted, "I think students wouldn't be getting the services they are getting if it wasn't for that connection. If you think of a school building, they are focused on education, that's their mandate. It's not mental health. Having that relationship is really connecting those schools and students to services that they otherwise wouldn't get."

Again, participants noted the importance of having a single person dedicated to do this work that not only connects the dots between the systems but is the access point (for those outside of the education system) to the school. For example, in one district, although mental health services had previously existed, because of the Navigator, service providers and school staff were more unified and better coordinated resulting in increased access. Specifically, the district informant stated, "The [Navigator] has helped coalesce the team and partners."

VALUE-ADDED

We were also interested in knowing what, if any benefit, or value-added, participants perceived as a result of launching of the pilot project and the work of the Navigators in their respective regions. By and large, informants perceived several benefits because of the pilot project with these falling across four broad categories: coordination, collaboration, facilitation, and integration. For example, this respondent noted the benefit of having a regional expert available to assist schools to better understand the Medicaid system, specifically reimbursement, "[The pilot project] has increased visibility of current Medicaid funding for SBHS and MAC – one of the benefits is having someone on the ground, sharing this information, reengaging districts in this option..."

Another participant indicated, "I do think that it's important to have a Medicaid navigator in each ESD – boots on the ground to know the population, demographics and needs of the region. [Navigators] can be a great resource to connect district and schools to services/funding – lots of groups working on these things with a similar goal but we don't all work together. This role can bring all this work together, connect the work, and de-silo it." From a district-level perspective, this participant felt that the most important benefits were "... Bringing the

knowledge and experience of a framework that we can use that is scalable – a holistic long-term approach. To use that framework to build teamwork – a collaborative approach...to teach us about a systems approach...and to facilitate that process.”

Several participants also noted the benefit of having a dedicated person working to integrate the education and health care systems. This stakeholder commented on how the Navigator can “Merge the two worlds – healthcare and school – and continues the conversation [outside of meetings], bridging the work that is already happening – putting it together into one big picture.” In a nutshell, making sure that partners are “working from the same sheet of music.” While this stakeholder indicated, “The benefit is that [the Navigator] is a resource for the other behavioral health providers. The Navigator is an access point into schools.”

Coordination of resources, partners, and processes were also identified as particular benefits of the regional pilot project. One participant stated, “She provides a direct conduit to services available...finding resources...making all of the connections.” This was echoed by another participant that saw the role of the Navigator as aiding in connecting across systems, reducing siloes, and increasing access to whole person care. Navigators can aid this process, “by being the one with the knowledge of all services/resources and hopefully have the ability to help provide direct links to services, with follow-up to ensure engagement in those services.”

SUMMARY AND CONCLUSIONS

Navigators engaged stakeholder partners through a variety of means, with educator interactions mainly related to building knowledge and awareness and increasing capacity to serve Medicaid eligible children and families. At the community-level, engagement typically centered around establishing new or strengthening existing relationships. The intent of these interactions was to enhance awareness of the pilot study and to facilitate the integration of the education and health care systems.

As noted, without exception stakeholders acknowledged the value of the pilot project and most specifically the role of the Behavioral Health Systems Navigator. From district personnel to state-level stakeholders, each recognized the importance of having a dedicated staff member whose sole responsibility was to assist schools, students and families to navigate through the education and health care systems. However, regional differences were identified in how stakeholders recognized the work of the Navigator. For example, prior to the launch of the pilot project, the ESD 101 region did not have the capacity to support or perform these types of activities, therefore, stakeholders were able to easily identify when the Navigator role was established and the positive impacts as a result of this work. Comparatively, ESD 113 has been a leader in the advancement of school-based behavioral health services, is a licensed behavioral health provider, and has long history of leveraging partnerships and collaborating

across systems. As such, stakeholders were less likely to identify a distinct difference in the Navigator's role as part of the pilot, rather perceived this as an extension of the regional coordination and systems level work undertaken by the ESD.

APPENDIX A

CHILDREN'S BEHAVIORAL HEALTH REGIONAL PILOT PROJECT: INTERVIEW FORMAT

Background: In 2017, the Legislature passed House Bill 1713 establishing the Children's Regional Behavioral Health Pilot Project. This measure directed the Office of Superintendent of Public Instruction (OSPI) to provide leadership in supporting two Educational Service Districts (ESD) to hire a dedicated staff person to serve as a behavioral health systems navigator. The role of these staff members is to bridge the gap between the K-12 and publicly funded behavioral health systems with the goal to increase access to services and supports for students and families. In your region, this work is being piloted through NEWESD 101.

A major component of this project is a case study being conducted to investigate the benefits of having a dedicated staff person that is partnering and coordinating with regional healthcare and education partners. This includes interviews with key stakeholders. You have been identified as a key stakeholder in the NEWESD 101 region, in which Andrew Bingham acts as the Behavioral Health Systems Navigator.

Project services were implemented in early 2018. Since then, what types of interactions have you had with the Behavioral Health Systems Navigator (BHSN) assigned to serve your region? (Some of these activities might have included meetings, phone calls, letters, agreements, etc.).

Who else was engaged in these activities; other community members/providers/partners)?

What actions, if any, resulted from these activities?

Has working with the BHSN improved your knowledge and/or awareness of the K-12 education system and how students and families access behavioral health services? If so, how? If not, why not?

What do you or your agency see as the value-add (if any) by having the BHSN participate in regional healthcare activities? Are the needs of students/children well-represented among regional healthcare initiatives? Is there someone other than the ESD advocating exclusively for students/children in regional healthcare initiatives?

Has working with the BHSN increased access and/or reduced barriers to behavioral health services for Medicaid eligible students and families in your region? If so, how?

If not, in your opinion, what support could the BHSN provide to reduce access barriers?

What have you found to be the benefits of having the BHSN serving your region and/or school district?

Finally, reflecting on your experience with the Children’s Regional Behavioral Health Pilot Project in your region and/or school district, what do you think is important to share with the legislature or other decision makers about this project?

As we finish this interview, are there any questions or thoughts about the project and the work being done?



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