Transcript: Strategies to Support School-Based Youth Behavioral Health Webinar
June 17, 2025

Kayla: Welcome to the Behavioral Health Substance Use Disorder Integration Technical Assistance webinar, Strategies to Support School-Based Youth Behavioral Health. This webinar is supported by the Bureau of Primary Health Care of the Health Resources and Services Administration. Participants have entered in a listen-only mode. You can submit questions by using the question and answers feature. To open the Q&A, click on the Q&A icon at the bottom of your Zoom window. If you experience any technical issues during the event, please message us through the chat feature or email bphc-ta@bizzellus.com.

This event is being recorded and the slides will be available on the TA portal following the event. We offer behavioral health continuing education units for participation in BHSUD integration technical assistance events. You must attend the event and complete the online Health Center TA Satisfaction Assessment Form after the event. A link with instructions will be provided at the end of the session. CE certificates will be sent within five weeks of the event from the Health Center BHSUD TA team via Smartsheet. I am pleased to introduce you to today's presenters.

Chad Thomas started his teaching career at an alternative school for teens in the Juvenile Justice System in Indiana and was awarded the Wal-Mart Teacher of the Year Award in 2001. After moving to Chicago, he became a nationally board-certified English and reading teacher and one of the founding educators at Talent Development Charter High School in the West Garfield neighborhood. Chad became principal at Sullivan High School in Rogers Park in July of 2013, when its existing school health clinic had just closed. Chad and the Ginn Group Collaborative worked together to reopen the clinic that fall. He is now the Director of School Leader Engagement at Chicago Public Schools.

Mary Crang is the Associate Medical Director for Integrative Behavioral Health Services at the Ginn Group Collaborative. Dr. Crang has practiced in a variety of care settings, including school-based health centers, commercial walk-in clinics, and academic health center and inpatient trauma care. Dr. Crang also serves as the University of Illinois at Chicago Department of Population Health Nursing Science. In this position, she collaborates with the Illinois Health and Family Services Bureau of Behavioral Health to care for Illinois' children with mental illnesses who reside in the residential settings.

Andrew Gluck is the Vice President of Development and Performance Improvement at Ginn Group Collaborative. Mr. Gluck pioneered the application of expected value return on investment in the healthcare field. He has served as a consultant to school-based health clinics in Louisiana, Indiana, Nebraska, New Mexico, and Oregon, to change the conversation from the simple provision of service to the economic benefits of short and long-term health outcomes. It is now my pleasure to turn the webinar over to Mary. Mary, please go ahead.

Mary Crang: Hello, everyone. Kayla, thank you. Let's look at the objectives and course outline for this webinar. The objectives are, to identify the complexity between federal and state laws that pertain to the privacy of data. We'll discuss staffing models to deliver integrated behavioral health care in school-based health settings. Next slide, please. The course outline, we are going to look at creating a safe, supportive school environment by looking at education, medical team alignment. Strategies for hiring database and data privacy or confidentiality.

Staffing for behavioral health services by defining the problem to solve, looking at staffing mix to implement screening and treatment, and what are the considerations for your school-based health center? We'll then hear from our colleagues, your colleagues in the school-based center via a panel. Next slide, please. Let's look at our first polling question. What topic areas does your organization most need support with the delivery integrated behavioral health to youths?

Do you need access to services? Is data privacy or confidentiality needed? Are referrals important and needed? How about staffing? Maybe there's something else, other. Tell us about that in the chat, please. We will open the polling now and give you a minute to answer.

[pause 00:05:01]

Kayla: We'll leave the poll open for just a few more moments.

[pause 00:05:26]

Mary: I hope everyone's had enough time to answer the question or fill in what they think needs to be done. Okay, Kayla, let's go ahead and close the poll. Thank you.

[pause 00:06:06]

Mary: Chad will be our next presenter.

Chad Thomas: Hi, everyone. So excited to be here. I was lucky enough, in 2013, to inherit a school that had a clinic that closed, and we reopened with the Ginn Group and our medical provider. It was a unique opportunity, really, to start to create a safe and supportive in-school environment. The school at the time we inherited it, the previous year had over 500 suspensions and 75 arrests. It was a unique opportunity for us to really marry the ed and the med together. I really saw, as the principal of the school at the time really saw, that the clinic was an asset that we had to leverage to stabilize the environment.

We really brought the-- we had a behavioral health team there. We brought the behavioral health team, and we also brought the clinic staff together and really started to think about, how do we do this together and marry the ed and the med together? We

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had administrators like myself on that team, the clinic staff on that team, the school nurses, counselors, teachers, parents, students. We were all coming together on what it looks like. Obviously, some of the more confidential matters stayed with just the staff in the school, but we also had parents helping us with engagement of getting parents knowledge of what the new clinic would be providing for our students, too.

It was really a community effort to create this sort of synergy where our goals in the schools were also the clinic's goals, too. Our goals were their goals and their goals were our goals. We really tried to align and build the trust from there. Next slide. As I mentioned, some of the data points there, we also had a school that only had, it was a high school, we only had about 80% of the students attending school. Just to give you a more raw number, if you think about that, 80% with 180 school days means that a kid on average would miss 36 school days. That's a lot of school days. You add that for four years, you're talking over 140, 150 days of school they're missing.

We really went after the attendance issues and chronically absent students first, and started getting in there and diagnosing the students, what their needs might be through risk assessments. We'll talk a little bit more about that in a minute. The clinic really can help with helping students with the IEPs and 504 plans. They can be present in some of those meetings to make sure that, again, the ed and the med are talking to each other, so we can make sure that the kids are getting all different types of care. From asthma care to whatever medications they might need during the school day.

The clinic also was really, my eyes and my ears on the trends of the school and what was happening, not like on an individual basis, but as an aggregate in groups, either the female students or the male students or a grade level. We were looking at, what are some of the behavioral concerns with this group of students or certain groups of students or populations of students? Then coming up with interventions that would either be school-based interventions, or clinic-based interventions, or community support that we might need, but we wouldn't know that if we didn't talk to each other and find out what was happening with our student population and really thinking about that through data.

We'll go to the next slide, I think. I'm turning it back over, or I'm sorry. My question here is, I think we had a unique model at the school. Just wanted to get an idea here. Does the principal of your school, that you're in, play an integral part of the academic team? I just wanted to take a poll here for a minute, because we were real intentional about the work that we were doing in my administration team. Me being the principal and the clinic staff really coming together and sitting at the table together to really talk about care for students. I know that that's not the case in all schools. This was a pretty short poll. If you could just click yes or no, we could see some of the real. Yes, it's about 60-40 here. That is interesting. Something to consider as you start the next school year and thinking about what that could look like in the summer months as you transition to the start of

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school year and figuring out ways to start to get the school more on board with some of the work that you're doing in your school-based health clinics. Turn it back over to Mary.

Mary: Thank you, Chad, very much. That was very helpful. Glad to get that background. We're going to look at how were we able to get this accomplished, and what can we do? Let's first look at privacy law. Please go to the next. Okay. Excuse me, back up one more. I apologize. I was looking at something else. Honoring data privacy law helps address our need to having a safe, supportive school environment. A school-based health collaborates with school staff. Everyone at the school-based health center needs to understand the data privacy laws that apply to the health information.

Different staff may be subject to different data privacy or disclosed processes. Federal and state laws may vary. Districts also may have policies that interact. The laws frame-- what do they do? How do they help this? They help frame school staff and healthcare providers collaborate with each other along with the students and families. They help shape policies on how to deal with referrals or emergencies. They determine the content of the required patient access forms, and they impact how and where records are stored. How does health information disclosed to the school from a third party provider remain protected or doesn't?

There is a complex interplay of federal and state laws here. From the health information in the student's educational record, FERPA, or Family Education Rights and Privacy Act, applies where HIPAA, or the Health Insurance Portability Accountability Act, does not apply. State laws can apply where neither HIPAA nor FERPA apply. HIPAA generally defers to more protected state laws, and FERPA and state laws can apply at the same time at times. Knowing what the rules apply to whom helps promote a trust, safety, and transparency school-based health clinic. Next slide, please.

Data privacy Health Insurance Portability Act, or HIPAA, generally considers minors, their parents and guardians as their personal representative. However, state laws are an integral part of understanding data privacy. For example, California has passed laws that allow patients to make a request to redirect the explanation of benefits to a location of their choice. Massachusetts has also passed some laws that mandate, like using general terms for explanation of benefits like office visit to describe sensitive services or allowing members to redirect that explanation of benefits to an alternative physical or electronic address.

They may also, and the patient may elect not to receive that explanation of benefit, especially if there's no cost sharing of the visit or the service occurred. Next slide, please. Now, when it comes to staffing, to create an environmental and that aligns with educators, school-based health staff, parents, and students, that also respect data privacy, we must first consider what challenges are the most prevalent, that need to be addressed within your school.

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How is your staff going to address the problem that is trying to be solved? While the data on this graph before you shows national trends on behavioral health as reported from the 2023 HRSA National Survey of Children's Health and Adolescent Mental and Behavioral Health, you will want to look at the data within your community and your school district. It is good for school-based health centers to ensure that the memorandum of understanding with schools allows for non-identifiable sharing of student data. A needs assessment can confirm that you have the right staffing mix to support the behavioral health challenges most prevalent in your community.

The community data should guide the approach to screening and intervention. Next slide, please. How do we tailor behavioral health integration to school needs following your environmental assessment? What does your organization really want to accomplish? For example, based on your assessment of your school community and your current resources, let's say that you believe your behavioral health efforts should be focused on providing in-school services to a small subset of students in crisis. You may wish to provide preventative behavioral health services to a large portion of the student body, thus referring out more intensive interventions.

Different tiers of the care continuum just mentioned may be applicable to your school system. You also want to know what services you want to offer. Are you wanting to offer one-on-one counseling? What about group counseling? How about crisis intervention or acute care? You need to know what resources are available in your school and in your community. Community organizations may already partner with your school and offer services that dovetail with your goals. For example, some organizations may provide translation services for school-based health centers.

Resource options may include post-secondary educational institutions in your area, workforce development boards, and charitable organizations. At this time, we don't have the time to cover the topic of community resources, but we plan to cover this topic in depth in the community of practice session that is coming this fall. We look forward to you attending that. Defining your goal drives staff recruitment and billing strategies. Who can bill for the services you want to offer is a huge question. What expertise is needed for them to bill, and what training is needed? Next slide, please.

As we think through staffing, we're going to talk about behavioral health screening, a common activity that all school-based staff can support that will help your school-based health center meet a variety of goals. Every individual should be screened for substance use, and anyone at the school-based health center can administer the first level of screening. This is from the front desk administration to the counselor. However, there needs to be an appropriate training developed to the individuals doing the screening about the delivery and the interpretation of the results.

A script can help to standardize this overall process. There are several free validated tools of screening for adolescent substance use disorders, and such as screening for

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brief intervention is one of them, and the Brief Screener for Tobacco, Alcohol, and other Drugs. If an initial screening indicates substance use, a second level screen instrument should be used to assess the severity of the use. For example, the Alcohol Use Disorder Identification Test, or AUDIT, or you could use the drug, alcohol screening test, DASH-A for DASH for adolescents.

Finally, consider what happens with the results. How does your school-based health center plan to follow through the results your school-based health center has obtained from the screening? Is there an established community network? Who can deliver an intervention based on the severity? Next slide, please. Once you have defined the services and the expertise needed to support these services, you can begin to consider what staffing mix may be best to support your school.

The right mix is going to depend upon the size of your population that you're covering, particular problems confronting that population, financial status of the school-based health center. Is it an FQHC where they can bill at a higher rate? Outreach workers, do you have them? Medical assistance. Are there other staff that may be supported through like Health Resources and Service Administration or the Bureau of Primary Health Care Funding Award? Building is important consideration for sustainability. The availability of school community resources to augment staffing helps with the sustainability.

In any case, each individual should perform their services at the top of their license to help with sustainability. As you think about staff, you may have to access, consider who can and needs to be involved in the treatment or the referral process. That said, you'll need to staff based on what works best in your setting and aligns with your overall goals. Next slide, please. We have offered a few practical suggestions to help you complete the staffing puzzle. Let's recap.

Using a staffing mix that works for your population, leverage your needs assessment to support making connections with local qualified partners for referral, recruit from the community you serve to best support students and families and foster the connections within the community resources. For degree seeking students, like individuals studying nursing or psychology or pre-med, school-based health centers can serve as practicums and internship sites. The school-based health centers can become approved sites for graduate-level clinicians and help complete their clinical requirements for their schooling. Now let's turn our attention to Andy, who is going to introduce our panelists to us. Andy?

Andrew Gluck: Hi, everybody. Yes. We're thrilled to have two health centers with us to share information about their successes related to delivering behavioral health services. I'm joined by representatives from Project Vida and Partnership Health Center. By the way, as we're going here, please add your questions to the Q&A as you think of them. We've set aside some time at the end to go over some of those questions. In terms of

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our panelists, next slide, please. First, I want to take a few moments to introduce the panelists, and you can see Pamela.

Pamela Ponce is with Campus Care. She's the co-chief. She's also Project Vida Health Center, El Paso, Texas. She helped to create and establish the Campus Care program, which delivers integrated primary and behavioral health services to youth across rural and underserved communities. The program has expanded to 28 campuses under her leadership. It uses an innovative model that includes community health workers to build trust and bridge the gap between healthcare and community served.

You also see there Rebecca. Rebecca Hamler, she's LCPC. That's a licensed behavioral health clinician. She works with the Partnership Health Center in Missoula, Montana. She's based in the Hawthorne Elementary School satellite office. Rebecca has worked with youth and their families at Hawthorne for the past 12 years. She's trained in a variety of therapeutic modalities. She's also a clinical autism support specialist.

Finally, we have with us today Torrye Hart, LCSW, Behavioral Health Associate Director. Also with the Partnership Health Center in Missoula, Montana. She's worked in the mental health field for over 10 years with focus areas in integrated behavioral health, family dynamics, and education. She supervises the school-based behavioral health program at Partnership Health Center in Missoula, Montana. I'd like to begin first both, just to give a little background, Pamela and Torrye, can you share some brief background on your respective school-based health center programs? We can start with Pamela.

Pamela Ponce: Thank you. Thank you, everybody. Hello. Yes, Project Vida Health Center is an FQHC. We started the Campus Care program around eight years ago. We started with behavioral health service in one of these campuses as a pilot. At that time, the school district we were partnering with had a lot of issues and it really had a mental health crisis with some completed suicides. They were really desperate for wanting that support. It went very well. These students that were part of that pilot saw improvement, administration saw improvement, teachers saw improvement, their parents saw improvement in these students, so we kept it going.

Essentially, we grew to what we are now, which is 28 campuses across six different school districts. We have around 45 employees right now. We have now integrated primary care services into some of these campuses as well. Our model is composed of an interdisciplinary team. It includes community health workers working very closely with providers and providing these services inside the campuses. I'll talk more about those positions in a little bit, but we have identified barriers to accessing care. So, that model focuses on addressing those barriers. This last year, we served around 3,000 students. That's a little bit about the program, but again, I'll go more into detail in a bit.

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Andrew: Torrye, would you like to give a little bit of your background?

Torrye Hart: Yes, absolutely. I also work for an FQHC, running a school-based health program in Missoula, Montana. Our program started in one school, around five years ago, and then slowly built to two schools. In the past few years, our health center and the school district have really worked together to just keep expanding that program. Out of 16 public schools in Missoula, we currently have embedded BH services in six of them, and two more will join our program in August. Right now we have a team of nine, and with that team, we're seeing about 300 unique patients per school year for about 4,000 visits per school year.

In our program, really, we focus on behavioral health care in school, but we also prioritize supporting a range of health needs with the help of our community health worker and just referrals back and forth with our primary clinic for medical and dental services as well.

Andrew: That's terrific. Thank you so much. Yes. Let me follow up a little bit, Torrye, with you and Rebecca. You've indicated that having a dedicated community health worker available full-time has improved your relationship with the schools and enabled your behavioral health clinicians to expand access to more patients. Can you tell us a little bit more about your care team model and how the CHW role in particular has impacted your program?

Rebecca Hamler: Yes, I'll jump on. Thanks for having us again here today. Having a community health care worker really helps become the bridge between our main clinic for our primary care of dental, medical, social work back into the school with our integrated behavioral health. Our biggest piece, when we look at us following the survey, looking at access and staffing and really working on some of those mental health needs in the area of anxiety and that behavioral and conduct challenges, we get to focus on that in the school, and really be the clinical lead.

Our community health worker is so strategic in stabilizing the model so that if we need a connection back to a med provider or to a pharmacy, maybe a student is, their insurance has lapsed and they still need to get access to their medication, we can hand that off to our community health worker, and she can help work with the family and the community to help bridge them back to the medical clinic.

I liked how Chad said the ed and the med marry together so that these populations that are coming in with complex mental health needs are not only getting clinical treatment on site at school, they're also accessing this whole body model of getting back to the primary care and dental if that's maybe something that hasn't been treated because they haven't had that bridge to get back to that care model because the mental health was the primary facing issue. We always try to package back to what referrals the family or the student might need to better access their health.

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Andrew: Thank you so much. That was great. Good explanation of your care team model. While I've got you, if you can stay on here, I got another question for the two of you. If you can tell us a little bit-- share some of your lessons learned about finding school-based substance use services. Going from the model to a condition in particular. Yes.

Torrye: I can jump in there first [crosstalk].

Andrew: Yes, Torrye, go right ahead. Yes, please do. Yes, jump in.

Torrye: Really, what we've learned is, is there's no one-size-fits-all. Substance use services, like our other BH services, are really most effective as part of individual treatment planning and really examining a wide range of factors that might influence a student's use. Two main areas we're working with in our program right now are prevention and evidence-based treatment. For prevention, we're really zeroing in on psychoeducation around substance use. Not only risks, but also what could lead to an urge to use, and how do we navigate both of those things together?

Also, our clinicians, as well as our CHW, are trying so hard to amplify protective factors with our students. We're really building that social circle, we're really helping students create or amplify meaningful activities they already have, create or build a better plan and hopes for their future. Just all of those pieces that we know help curb some more of those impulsive use decisions. When it does come time, we're working with evidence-based treatment for all of these things, especially with substance use. We're looking at motivational interviewing around current use, maybe future hopes for their use.

We're working with CBT and DBT. All of this is really wrapped into, again, that whole person care. We're looking at medical, we're looking at other health needs that are impacting this youth. We're starting something new with our youth court in this year, thinking about a diversion program. Instead of receiving a first ticket for use, students engage in some of these psychoeducation preventative and treatment methods to see if that will help them shape their use more how they would like it to be so they can function in their life in a more meaningful way.

Andrew: That's fascinating. That's great. I know that Chad, at his school at Sullivan, in Chicago, did very similar work. Maybe we'll get some questions about that in the chat. I'm going to turn my attention now to Pamela Ponce, over at Project Vida Campus Care. Pamela, you were able to increase your behavioral health encounters by over 50% compared to the previous year. Please share your key recommendations for increasing and reporting student mental health visits.

Pamela: Sure. We definitely expanded our sites that offer behavioral health services using the model that I talked about earlier, with the community health workers, like my peers here, and the providers, of course. When we expand to a new site, we have a

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person, a position that's called an operation specialist. Their main job duties are to essentially be that public relations/outreach/logistics person who does that work inside the school. One of their main tasks is to ensure that they have the HIPAA compliance basis set up, but also train everybody.

Part of what we do when we start a new site is be very intentional about having trainings. One of the trainings that we have is with school administration. We really need to get their buy-in and their support since the beginning. We have the school administration, principals, assistant principals at the table, and we have a meeting with them where we outline the program, where we can let them know what they can expect from us, but also what we expect from them, to have a successful collaboration. It's a formal space, and we also establish to have these meetings four times a year, every quarter.

In these meetings, we touch base again and we bring our team. We have a report on the referrals, encounters, troubleshoot issues, and highlight successes. Operation specialists also take time to train school staff during staff development weeks after intersessions and vacations. We make sure that all staff, from teachers, to attendance clerks, to librarians, even cafeteria employees, everybody, knows about the program and knows how to access services. We also train our school counselors. In our MOUs with the different school districts, our school counselors are the only ones that can refer to our program. This is just to keep a clean flow of referrals, and so we can track them back.

Our school counselors are a huge champion. We also take the time to have a very formal training with school counselors and let them know how to refer and what is the workflow. Going back to the community health worker, community health workers are essential in our program because they are the ones who usually are members of the community, and they know the needs of the community. It's easy for them to have that trust with the parent or the guardian once they receive that referral. Many times when a referral lands into our office, parents have a lot of questions about what is this service, sometimes stigma, sometimes they're hesitant about signing their students up for the service.

So, the navigator or the community health worker takes the time to really pause and answer these questions, connect with these parents and these guardians, and walk them through the process. I know that in the communities we work in, some are very rural areas and there's not a lot of health literacy. They take the time to really walk the patient or the family member through this process. Register them for insurance if they need to, connect them to any external services they might need, anything. We also have parent presentations that our operational specialists do, where we focus on educating parents and, again, reducing that stigma.

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We have found that the only way to reduce stigma is with education. We ask our stakeholders, "What are some topics that you think our parents can benefit from?" They have given us topics, things such as substance use awareness, just mental health basics, parenting. Some of our peers in our Project Vida programs do parenting classes, and so it's connecting them to those resources so they can see Project Vida as somebody they can trust. We also have had pretty good retention, our mental health providers. Being that some of these schools have already been open for many years, we have gained the community's trust, and them trusting our providers and knowing them.

Over time, really, our program has become pretty established in most of these sites. So, school counselors just refer based on that trust, but also community. Community members start seeing improvement in their neighbors, their peers, their friends' kids, and so they start asking, "What's going on? How can I also have this service?" At this time, we have not really had an issue when it comes to mental health referrals. If anything, it's the opposite. I think we've come into the issue of capacity, and everybody is at capacity.

We need more providers, we need more space for more clients. Really, this interdisciplinary team working together and reducing these barriers has been what I think has helped this program increase the behavioral health encounters so significantly from this last year to this one.

Andrew: Wow. That's a lot. [laughs] Thank you very much. That's incredible. You've also had success, as you mentioned before, recruiting and retaining this interdisciplinary care team. By that, I'm talking about the navigators, pediatric nurse practitioner, physician assistant, all of whom play their own special role and are very important in providing the services. That team allows for effective service coordination. We talked about before, this whole important idea of the ed, med handshake. Communication with school staff and parents, also extremely important.

You've done a little bit already, but I'm going to ask you to share some of your main lessons learned in developing the care team itself and also in maintaining the effective communication with the school staff.

Pamela: Yes, sure. I think it's probably something that a lot of us can relate in community health, right? Recruiting and retention of especially providers can be really difficult. It's something that this program has definitely seen and experienced. I think we have found something that definitely works as far as retention and recruiting. One key thing that I can think of is we have implemented a special calendar for our staff. It's the first time our agency approved this, but due to the nature of the work that we do, it's something that we were able to get approved. Our providers follow the teacher's calendar.

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In our school districts, it's 187 days. Our providers know that they are off when the kids are off, which means we follow a year-round calendar. Every nine weeks, they have two weeks off. Summer, it's like a month and a half off. Every holiday. This is very attractive for providers. It's not something that is really offered much here in our city, at least El Paso. That has been something that has helped a lot. We cannot offer the exact same calendar for our support staff, but we do offer a similar calendar. They follow one of the school counselor's calendar. They work a 2-12 day.

This has been a tool that has helped a lot, because our salaries are competitive, but they're not the best when compared to private practice or to other places. Really having this as a selling point when recruiting staff members has helped a lot. However, this means that we need to be very on top of productivity. Since we only have our providers certain days and they don't work during the summer, we need to be on top of what they produce. We have had to establish a very clear formula of how many encounters are needed for our teams to be sustainable, especially during this time that we need to be weary or mindful of grants and make sure that we're not just sustaining ourselves on grants.

We need to be sustainable through our reimbursements. It's meant that we've had to really be intentional about monitoring productivity. We have weekly management meetings, where we review productivity for every team. We discuss where every team is at and what we need to do to work with them closely if they are falling behind, or the ones that are doing really well, what are they doing and how can we make that a best practice to the rest of the teams? We also have monthly meetings with every frontline team, where we discuss the previous month, we highlight successes, we look at, did they meet their goals? Did they not?

If not, what happened? How can we support you? Again, highlight any best practices so that we can replicate with other teams. We have also started something new this year, where it's a bonus structure and additional earnings. We have found, what is the formula needed, or what's the number that we would need for teams to hit so they can be considered for the bonus structure? This is a structure that rewards employees for exceeding that encounter expectation. We pay out by cluster, so this cluster is done quarterly. This last cluster, for example, is the first time that we did it, and we had 14 of our staff members qualify for the bonus.

It was something that we really wanted to do because we were not able to increase salaries this year, but we said if our teams generate more, then we can give them a little more. So, it has been, again, the first time that we do this, and it's come with a mix of reviews, but I think most employees have shown increased motivation and increased encounters. This is also something that I think has helped with that. Going back to your question on how do we maintain effective communication with the school, again, that one position that we have, we have five of them, operation specialists.

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They don't work directly with the patients, but they're the individuals who are the liaison between the school and our agency. They earn a little bit more than the other support staff members, because with them there's a lot of interdisciplinary skills that are needed. They're like a public relations individual, and so that's their main duty, relationships. Making sure that they are that person that is that link between our program and the school staff. They are everywhere.

They are assigned five, six schools each, and that's their primary role. Just making sure the program runs smoothly, that everybody is in communication, that everybody has what they need, the school and us, and just answer any questions that anybody might have. This is what has worked for us. I don't know, I'm open to any other questions at the Q&A section.

Andrew: Yes, that's incredibly innovative. I have to say, we've been at this for over 10 years ourselves. That's a new one for me, and I appreciate hearing that myself. Thank you very much. The folks in the audience, I think there are about 250 of you out there. We're getting a few questions in the chat. Should we move over to Q&A? If we're all ready for that, please? I have a question I'm seeing in the chat right now. The first question, from Berta Rodriguez, and this is to anyone. She says to hosts and panelists, so no one in particular, so jump in.

Okay. The question pertains to how to incorporate non-specialists like CHWs into the delivery of care. I think you've spoken a lot about that. Berta, if you want to expand upon your question in particular, go right ahead. We're looking at the chat right now, but if anybody wants to jump on that, please do.

Torrye: A really simple answer for partnership, and we can expand more if folks want, is truly anything that a licensed clinician doesn't need to be doing, our CHW takes that task, to support the clinician being able to see more patients or see the same patients at a higher quality. That's really, that's our simple principle. If we don't need a licensed clinician to do it, the CHW can probably support that patient with that task.

Andrew: I heard a lot about trust, engendering trust. If the CHWs are members of the community, and they're people that the community members know, I would think that would go a long way towards engendering the trust that you need, right? Yes. Are there opportunities for student-- I know in one of our schools there are opportunities for students to actually, and maybe Chad can speak to this. They have an idea that they might be going into the behavioral health profession.

In fact, I know that there are some courses for students to get involved, in one way or another. Anything like that happen in your areas? Chad, if you want to jump on that. [silence] All right. I'm not hearing too much of a response. I do see though in the chat window.

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Rebecca: I can.

Andrew: Yes, go ahead.

Rebecca: I'll jump on to that one.

Andrew: Go ahead. Jump on that.

Rebecca: I'll answer two questions for one.

Andrew: Okay.

Rebecca: I work in the pediatric population. I'll answer Kelsey's question over in the chat. For children under 12 years, recommendations for obtaining consent for behavioral health services, data privacy is always that most important step that we're protecting data privacy of clients, families, especially minors. We're always working with the parents. Again, it comes back to that trust and collaboration. I've been at my school site for 13 years. Families are really familiar with me. My principal is key to helping those families feel safe and comfortable talking with our mental health team.

I talk with my principal, my school counselor, every single day. I'm very visible, families know who I am. I always go back to reaching out to parents, use our community health care workers, if they need to go off-site to meet with that parent. Say that parent doesn't have transportation, or they're in a housing shelter, our community health worker can just go to them and help fill out that paperwork. The secondary question was for opportunities for youth to get to be interested or focused in the behavioral health sphere. We have a model called Leader in Me, and all of Missoula County Public Schools is integrated into the Leader in Me curriculum.

It's based on the seven habits of highly successful people. Every kid has a job or a leadership role. In my school, through my clinical client caseload, I have about 32 kids I work with. My older kids are the mentors to the younger students. They get to be the counselor after I teach them the curriculum. Superflex or cognitive behavioral therapy triads. They learn it, and then they help me run a group with the younger students. We're also going to be running a teen dialectic behavioral therapy group.

I'd love to see how we can get that outreached into the community, for some of these teens, to come back into our school setting and maybe be like a junior counselor, or share some advocacy on their part. Whether it's tabling in the community, or like helping bridge back to, "Hey, I did this DBT group, I'm a teen in the community, this is how it worked for me." Like Pamela said, just really being visible and empowering communities to have the voice and being seen as the expert, not us as the expert, but the community and the client to get to say, "Here's what we want to do." Those are two main things that I've seen success here in Montana.

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Andrew: That's great. Jenny, do you want to vet a few of the other questions?

Jenny: I think you're doing a great job, Andy. You can go ahead and keep going.

Andrew: [laughs] Okay. Yes, there are a few other ones here with billings. By the way, I've got an MBA and I'm the business guy in our group, so this goes to my particular interest. Are you able to bill all insurances for SBH services? We've been researching and found that Medicaid has coverage, but have seen that commercial payers will not pay for these services. Would you be able to confirm? Anybody want to jump on that one?

Mary: I was just going to [crosstalk]-

Andrew: I was going to put you on the spot, Mary, because I know you know. Go ahead.

Mary: For billing purposes for myself, I need to have my name be placed on the panel for that insurance company. That meaning Blue Cross Blue Shield or whatever. Then on top of it, for those individuals that are on the Medicare ones or Medicaid ones also. Maybe that's the issue more than anything, is making sure that you are on their panel to allow for billing.

Andrew: Great. That's great. On the business side, one more business question. We'll get back to the other. I'm seeing in here, talking about productivity, how do you measure that? What is the productivity requirement? Tell us your number of encounters for productivity. We're not, by the way, this is just one lens to look through. We're not all about just numbers, but if we don't have the resources to serve our children, then we're not doing them a service either. Question about productivity. Who wants to jump on that one?

Pamela: I can discuss what it looks like for us, particularly. I'm trying my best to answer questions on my end through the Q&A chat, but the productivity one, as far as behavioral health goes, we do need five encounters a day for our behavioral health providers. It comes out to 25 encounters a week. Our teams are expected to have minimum 30 patients on their caseload, at any given time. As far as the medical goes, we need a minimum of eight encounters a day for our physician assistant or nurse practitioner to see. This formula basically is what can sustain the salaries of both individuals and supplies and licenses for the EMR and everything that we need to run the program.

Andrew: Right. Necessary evil. We got to do it. Got to have the productivity. Yes, pay attention to the business side just a bit. While we have you up there, what were the agenda items listed when meeting with school admin?

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Pamela: Oh, yes. I was working on [crosstalk]-

Andrew: I didn't catch all of them. Encounters, what were the others? Yes, go ahead.

Pamela: Yes. For the initial meeting, when we start a new site, we have a meeting with the administration team, the principal, assistant principal. We usually ask for the principal to assign a point of contact, because principals are really busy, and sometimes they can't be the point of contact, so we ask them to identify either an AP, assistant principal, or a school counselor, somebody who will be that person who will make decisions for us. We establish that in the meeting. We discuss infrastructure needs and office spaces such as internet, phone line, office keys, et cetera.

We discuss what they can expect for our program and what we need from them as far as, for example, I was mentioning the quarterly meetings. We let them know, per the MOU, it's important that we meet once a quarter, it's important that we have that key stakeholder there, and that we have somebody from the counseling team in these meetings. We bring our teams to those meetings as well, so we can answer questions. Sometimes our therapists or our provider like to provide success stories.

We cannot discuss individual names or individual details, but success stories or trends that we're observing in their schools, so that they know. Sometimes stakeholders have used this information to launch campaigns or educate these students on these needs. That's usually what we discuss in these meetings.

Andrew: Okay, hopefully that answers. I know you're typing furiously, trying to answer some of these other questions. I'll let you know if I see another one for you. Well, it can be for anybody. Tandy Miles says, "How do you bill for groups? This has been an issue for us." I assume in different payers and in different states, it may differ. Again, I see Mary's nodding her head. Mary, do you want to jump in on that one, again, billing?

Mary: Yes, groups can be an issue as far as that goes. You bill for them, there is a group code that you can use to bill for. That's what I normally do. Unfortunately, the reimbursement rate is low, but when you have multiple individuals in that group, you can bill for each one of them in that group. That does make it-- you have to really decide, that's where that play comes in. Are you going to want to do-- can you afford to do group counseling, or do you think you can't? Need to do one-on-one? How much one-on-one do you need to do compared to the group counseling that you can get done?

You have to weigh out the cost benefits analysis on what is that going to be. If you have a really big problem, and you want to deal with that as a group, the group may be the only thing to be able to handle it. You may be not making out the costs that you want to make for seeing it, but it might be helping your overall program. Analyzing what your situation is, what your problem is, what you want to get out of that, and why you want to do that is important.

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Andrew: Yes, it goes back to your original point at the very beginning, which is, what problem are you trying to solve? Each school may be just a little bit different. It depends upon the age range of the kids that you're working with as well, I'm sure. I think you've answered a lot. Ashley, you ask, how many BHCS are on staff? I'll be honest, I don't-- behavioral health-- what's a BHCS? Alphabets-

Torrye: Behavioral health clinician. [laughs]

Andrew: Oh, just clinicians. That's simple. That was easy enough.

Torrye: I bet you would have made it there.

Andrew: Oh, yes, eventually.

Torrye: Yes. We currently have six. We'll have eight next year. Just one for each school in our smaller programs and smaller sites.

Andrew: Okay.

Pamela: As far as Project Vida, we have 12. We have 12 therapists and 1 therapist coordinator. She's an LPCS, but our staff isn't divided one per campus, it depends on the school size. If it's a high school, like 3,000 students, then it'll be a team per site. If it's a middle school or an elementary school where it's smaller population, we divide the teams in two or three schools, but the most we do is three schools per team.

Andrew: Do we have time for any more questions? How are we doing on time here? We're getting towards-

Jenny: We could do one very quick one.

Andrew: Okay, I see. I'm going to go to my friend, Chad. Chad, I have a question for you. I know that at Sullivan, this goes to the ed, med handshake. What kind of regular meetings did you have between what staff at the school level? Can you talk a little bit about how you integrated school staff with the behavioral clinic staff?

Chad: Yes, every school is going to be a little unique. When we first started at the school, we had a care team that morphed into a behavior health team, and a member of the clinic would join that team. That was the one. Now, some schools have culture and climate teams. That would be an entry point for a clinic to maybe think about integrating into the school's culture. An attendance team, because a lot of times attendance is sort of so you have to be a little bit creative based on the org chart of the school, especially if you're a new clinic starting out, figuring out where you might fit in and start to get into that mold. Then I would also recommend having your clinic give you data.

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How many encounters have you had? In at least a quarterly or a semester basis. That was something I was always looking at. I was like, "How many kids are we seeing a day?" On good days, we would see 40 to 45 kids in the clinic. We only had 650 to 750 kids in my 10 years as a principal. On a good day, we would hit 35 to 45, and for all different types of reasons. That would be what we were looking for, and really to drive our metrics. It worked. When we came into the clinic, we had 80% attendance. By the end of year two, we had 90% attendance.

Andrew: Wow.

Chad: It jumped 10%. It worked and it definitely also reduced those suspensions. We went from 500 suspensions in year one, to 120 in year two. Still 120, but that was year two. We got down to, at the end of my time there, 15 suspensions total. From 500 to 15. When you start taking care of the whole child, the whole child sort of starts to show up differently, and our school started to change.

Andrew: The referrals flowed both ways, right? From the clinic to the social workers and to administrators, teachers, and back the other way as well.

Chad: Yes. We gave our clinic staff the access to the Google Doc where the referrals lived, so they could see the referrals in real time just as much as the behavioral health teams. It was a joint effort there with the referrals.

Andrew: Okay. I think it's time to wrap up. That was educational for all of us. For me included. I'm going to turn this back over to the Bizzell team.

Kayla: Access more behavioral health substance use disorder integration technical assistance opportunities by emailing the team, visiting the TA portal, and scanning the QR code, subscribe to Hub in Focus. If you are interested in joining deeper into the behavioral health integration in a school-based health center setting, we have a community of practice on this topic resuming in August. Registration opens next week, so please subscribe to the Hub in Focus, or send us an email if you're interested in joining or learning more.

Our next webinar on medications for opioid use disorder in primary care is on Thursday, June 26th, from 2:00 to 3:00 PM. We'll drop the registration link in chat if you haven't already signed up. Please share your feedback on today's session. You must complete the assessment if you plan to claim continuing education credits. We appreciate your time to tell us about your experience today, and the assessment will automatically open when you close the meeting, and is also in the chat.

The slides will be posted to the TA portal. These resources and references are included for further reading. Thank you for your attendance and this does conclude today's webinar. You may now disconnect.

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