Oregon Public Health Division

>> School-Based Health Center Mental Health Expansion Grant

Summary Report

January 1, 2014-June 30th, 2015 Grant Period

Oregon Health Authority

Oregon SBHC School-Based Health Centers

Prepared by the School-Based Health Center Program – May 2016

Contents

Executive Summary

The Mental Health Expansion Grant (MHEG) is an on-going project through the Adolescent and School Health Program in the Public Health Division to expand adolescent mental health services in school-based health centers (SBHCs). As of July 1, 2015, Oregon has 76 certified SBHCs in 24 counties located in elementary, middle, high and combined grade schools. The MHEG was one of nineteen grant-funded Investment Project awards from the Addictions and Mental Health Division to support and enhance Oregon's community mental health system. The first phase of the project was 18 months (January 1, 2014-June 30, 2015).

SBHCs were well-positioned to receive AMH Investment Project funding; SBHCs address many, if not all, barriers to timely mental health care that youth experience due to their robust partnerships, strong system of care, focus on prevention and commitment to serving adolescents regardless of their ability to pay. Anecdotally, SBHC providers have expressed the need for mental health providers in their clinics for years but have been limited by funding. The MHEG strengthened the ability of the participating SBHCs to more effectively meet the needs of the youth they serve and also provided many learnings.

MHEG Outcomes and Lessons

The MHEG provided key lessons and recommendations that can be used by others interested in replicating similar projects. Grant outcomes and lessons included the following:

Integrating behavioral / mental health and primary care

Outcomes

39 state-certified SBHCs received capacity grants for a total of approximately 25 FTE. A little over a third of SBHC grantees had not provided mental health services on-site in the previous school year. All SBHCs that applied for capacity grants were awarded funding, and provided mental health services through a contracted mental health agency, hiring internally, or partnering with the mental health division in their agency.

All grantees were co-located either in an office in the school or in the SBHC with primary care providers. They had varying degrees of shared and separate systems; one third had fully integrated systems, with aligned documenting, billing, and care coordination.

Lessons

Co-locating care comes with physical, logistical, and systemic challenges.

- Sharing physical space and support staff: Many SBHCs are small and not built with a growing clinic in mind. SBHCs needed to determine where the mental health provider would sit, and how that space would be kept confidential. Workflows needed to be adjusted and considerations for sharing the medical / office assistant time.
- Culture shift: There was some lack of understanding and initial discomfort between provider types and agencies who were unused to working together.
- Data and information sharing: Data/information sharing was complicated by different electronic health record systems for physical health and mental health, as well as occasional provider discomfort in sharing information with a different provider type.
- Billing and reimbursement: Grantees were at times constrained by who can bill and receive reimbursement for mental health services in Oregon.

Increasing access to mental health services

Outcomes

The MHEG increased SBHC mental health visits for individual and group counseling, as well as improving the ability of SBHCs to meet the cultural and linguistic needs of clients. SBHCs provided 35,689 mental health visits in 2014-15, a 91% increase over the previous year. Mental health clients increased to 8,426, a 56% increase over the previous year. Fourteen SBHCs expanded services and increased the number of days they were open, and a number of SBHCs were able to provide MH services over the summer for the first time.

MHEG providers held behavioral health, psycho-education, support, and wellness groups for anxiety, depression, grief, and healthy relationships. These groups enabled providers to treat and work with more adolescents, do prevention work, and strengthen partnerships with school and community providers. In addition to providing routine mental health care to adolescents, MH providers helped schools respond to mental health crisis situations by providing immediate intervention, as well as longer term grief and bereavement supports.

Lessons

In order to increase access, grantees needed to hire providers, provide services, and bill and receive reimbursement for those services.

- Staffing challenges: A few sites had significant delays hiring mental health providers due to provider shortage and difficulty hiring in rural areas. Some

grantees had not taken into account the additional support staff time that would be needed to provide service and coordinate care.

- Balancing caseloads: Many mental health providers found their caseloads full within a short period of time and needed to determine a way to triage clients and referrals continued to arrive. Others had difficulty with adolescents not showing up to their appointment, which was frustrating to providers with a full caseload and wait list.
- Billing and reimbursement: Although the MHEG increased the number of visits, SBHCs were not able to maximize billing and reimbursement. Grantees had difficulty billing as many adolescents do not know their insurance information, or the services that SBHCs were providing were not billable, such as mental health promotion activities or care coordination.

Improving quality of care

Outcomes

The MHEG supported quality improvement projects directly—through grant funding—and indirectly, by giving SBHCs flexibility to work outside of revenue-driven care and pursue trainings and projects. Regarding the latter, SBHCs trained mental health providers in trauma-informed care, and treatment frameworks like the Family Check-up and Attachment-Based Family Therapy.

Grant funded projects focused on the adolescent well-visit and equity and cultural competency. Five SBHCs participated in a project to improve the quality of the adolescent well-visit by incorporating depression screening (PHQ-9) and substance abuse screening (SBIRT). This work aligned with state health system transformation efforts, as incentive measures for Oregon Coordinated Care Organizations (CCO) include SBIRT, depression screening, and the adolescent well-visit. This project reinforced that SBHCs can be effective vehicles for meeting the CCO incentive measures.

Equity and cultural competency projects helped SBHC staff work meet the cultural and linguistic needs of their clients and be more responsive to racial inequities, like training staff to become certified medical interpreters for Spanish or embarking on a year-long project exploring oppression and equity in the SBHC.

Lessons

In order to increase quality of care in the SBHCs, partnership development and local context played a key role.

- Challenges with referral entities: SBHCs lacked knowledge of community referral entities and when patients were referred out, there was poor communication back to SBHCs from providers in the community.
- Difficulty with EHR systems: Many SBHCs were unable to track and report steps of screening, brief interventions, and referrals within their system, making quality improvement projects difficult.
- Planning stage is sometimes the most important: Coordination on dates, times, and context for trainings is critical to successful events. Incorporating local context to ensure content relevance enhanced participant satisfaction.

Building networks and partnerships between SBHCs and the community

Outcomes

In an effort to ensure proper identification, referral, treatment and care of adolescent with mental health needs, grantees formed strong relationships with school administration, counselors, nurses, and teachers through outreach and participation on teams that discuss school supports for students who are struggling. SBHC mental health providers trained school staff on mental health topics, improving school knowledge and climate.

As one SBHC mental health provider stated, "parents are partners in treatment". SBHCs reached out to parents during school orientation and community events to let them know of available services. When a young person accessed mental health services, the SBHC involved parents in treatment, when appropriate. The MHEG also allowed SBHCs to form stronger partnerships with community organizations and providers. Strong connections create a stronger safety net for families. Through the MHEG, SBHCs built new partnerships and strengthened existing partnerships with individuals and groups.

Lessons

SBHCs' partnerships can be both essential and challenging.

- Expectations on roles and relationship: Some schools and SBHCs had different ideas of what each would provide in terms of services or information sharing. Similarly, community organizations and providers lacked understanding of what an SBHC does and therefore was unwilling to provide information on a shared client.
- Communication is key: Partnerships were improved through continued and consistent conversations clarifying positions to ensure everyone is on the same page.

- Families face additional barriers to care: Many parents faced challenges in being more involved in their child's care, including work schedules, transportation, or childcare. Some challenges could be mitigated by SBHC flexibility.

Changing social norms related to mental health

Outcomes

By adding mental health providers to SBHCs (which see youth regardless of their ability to pay) the MHEG removed financial barriers to care like insurance status or insufficient funds. Co-location of mental health with primary care in safe, non-stigmatizing SBHCs, created an implicit message that mental health care is as routine as going to the doctor. Mental health providers had seen youth who had been referred by their friends, or who self-referred due to the positive experience their peer had with SBHC mental health services.

Health Service Advocates in Lincoln County SBHCs and Youth Advisory Councils (YACs) in Deschutes, Jackson, and Washington counties helped to connect youth to and provide education about SBHC mental health services. These individuals and groups improved knowledge of services and normalized care. Each YAC conducted a youth participatory action research project (YPAR) around a health care issue. Project topics included: mental health stigma, teen substance use, suicide prevention, sleep, effects of public displays of affection on school climate, self-esteem, stress, and awareness of mental health issues and perceived barriers to accessing care.

Lessons

- Resistance to therapy: Although many SBHCs felt that they were making headway in reducing stigma in youth for mental health services, some SBHCs found families still unwilling to participating in therapy.
- Challenges in youth-adult partnerships: Grantees felt that to be successful, YAC facilitators need to be flexible regarding recruiting, scheduling, and planning due to shifting school and personal schedules.
- Questionable sustainability: Without continued grant funding, YAC sustainability is uncertain. It may be possible with medical sponsor buy-in and financial support.

Improving technical infrastructure

Outcomes

SBHCs implemented projects to improve the technological infrastructure of their clinic or SBHC system. Seven SBHCs purchased electronic health record systems (EHRs) to be able to document encounters electronically and bill for services more efficiently. Some grantees leveraged MHEG funding to pay for personnel time used

for data entry or technical assistance. Multnomah County received a grant to explore the feasibility of implementing information technology solutions to enable interoperability between the physical and mental health systems in SBHCs and other Multnomah County systems broadly.

Two rural SBHCs received grants to implement tele-psychiatry in order to link students to services that was unavailable in their communities. MHEG funds were used to purchase equipment and contract with tele-psychiatry providers.

Lessons

- Expensive and time consuming: Implementing new EHR systems was more time consuming and expensive than anticipated, and required additional staff and staff time. Those needing to modify their existing EHR, found challenges in terms of cost and lack of knowledgeable personnel.
- Concerns on sharing information: Some mental health providers had concerns over who had access to the information they input into the EHR as part of a patient's background or treatment.
- Tele-psychiatry is promising but takes time to build clientele: Projected targets of the numbers of patients per month fell short which may be due to stigma present in the community about accessing mental health services more broadly. Grantees also had difficulty getting meaningful assistance on technical or clinical issues, partly due to the relative newness of the technology.

Conclusion

This School-Based Health Center MHEG Summary Report is intended to be a resource for other communities working to integrate mental and/or behavioral health services into an SBHC. The report presents an overview of the MHEG goals, background and our evaluation process. The report shares the grantees' strategies of integration, outcomes, challenges and lesson learns. SPO hopes that others will apply strategies and lessons learned from MHEG projects to effectively integrate mental and behavioral health services in their SBHC system. The SPO will utilize the information regarding what worked well for SBHCs and what barriers exist, to develop a plan to support SBHCs in providing mental health as part of their core service offering.

>> Introduction

Adolescence is a period of time of rapid development and physical, emotional, mental and social change. It is a key phase of establishing independent identity, making decisions and lifestyle choices, and forming interpersonal relationships. All of these can influence mental health and well-being—in adolescence and later into adulthood.[i] It is a time when protective factors and healthy behaviors can be set and practiced, and also a time when mental health problems first emerge.

Nationally, approximately one in five adolescents has a diagnosable mental health disorder[ii] and almost one in three shows signs of depression[iii]. Studies have shown, however, that most adolescents do not seek out or receive the services they need to treat their mental health disorder due to barriers and stigma.[iv] Barriers to services include: missed prevention and early identification of mental health disorder, poorly coordinated services, lack of health insurance or coverage restrictions, and shortages of providers with expertise in adolescent mental health.[v] Nearly half of adolescents with a psychiatric disorder did not receive any kind of treatment in the past year.[vi] There has been a recurring call for improvements in the mental health system to prevent and treat adolescents with mental health disorders.[vii]

Box 1. Adolescent Mental Health Data

(2013 Oregon Healthy Teens Survey)

- 16.5% of 8th graders and 19.9% of 11th graders felt that their emotional and mental health was fair or poor.
- 14.4% of 8th graders and 15.2% of 11th graders had an unmet emotional or mental health care need.
- 11% of 11th graders missed 3 or more school days because of emotional health reasons.
- 16.1% of 8th graders and 14.5% of 11th graders seriously considered attempting suicide in the previous year.

Oregon-specific data also demonstrated a need for improvement in their adolescent mental health care system; mental health burden and unmet needs are similar to those at a national level. In 2013, almost one in five 11th graders surveyed had fair or poor emotional or mental health, and 16% of 8th graders had seriously considered attempting suicide. (Box 1) These data, coupled with nationwide tragedies like the mass shootings in Newton, Connecticut and at the Clackamas Town Center in Oregon created momentum in the Oregon State Legislature to dramatically boost funding for mental health programs.[viii,ix]

Ultimately, the Oregon State Legislature increased funding by $22 million to the Addictions and Mental Health Division (AMH) 2013–2015 budget to support and enhance children's and adolescents' mental health programs. With the funding appropriated by the Legislature, AMH created the Investment Projects to fund

statewide programs emphasizing prevention, early identification, and intervention, as well as training and technical assistance for providers.[x]

SBHCs in Oregon

School-based health centers (SBHCs) were well-positioned to receive AMH Investment Project funding to support integration of mental and physical health services. SBHCs are committed to serving adolescents regardless of their ability to pay and address many barriers to timely mental health care. SBHCs are medical clinics that offer primary care services either within or on the grounds of a school. Many SBHCs in Oregon also offer mental health and dental services in addition to physical health. Each SBHC is staffed by a primary care provider, as well as other medical, mental, or dental health professionals, and office support staff.

Since 1986, over 409,766 Oregon youth have had 1,384,178.3 visits to SBHCs to have their physical, mental and dental health needs met. As of July 1, 2015, Oregon has 76 certified SBHCs located in elementary, middle, high and combined grade schools.

SBHCs succeed through unique public-private partnerships between the Oregon Public Health Division, school districts, county public health departments, public health and private practitioners, parents, students and community members. Services are available to students regardless of their ability to pay. In some instances, centers provide services to siblings, families and community members as well.

Providing accessible care to young people has always been a hallmark of SBHCs, but the types of services have shifted over time. In the past 15 years, the national SBHC model has evolved from targeted services to comprehensive primary care to integrated mental health and primary care. In 2006, the State Program Office conducted a multi-pronged review of the mental health system in Oregon SBHCs[xi]. At that time, 28 of 42 SBHCs (67%) reported having a mental health provider on-site. Centers both with and without mental health providers noted barriers to mental health services, including: operational costs, inadequate staffing, and lack of community mental health services. Based on the results, the authors recommended an increase in funding for on-site mental health providers, and to address barriers to integrating mental health providers into existing school-based health centers.

Mental Health Expansion Grant (MHEG)

AMH's Investment Projects award in 2013 to SBHCs—the Mental Health Expansion Grant (MHEG)—was an opportunity to finally address the needs outlined in the 2006 SBHC mental health assessment. The goal of the MHEG is to address the mental health care needs of adolescents and to strengthen the mental health care delivery system in Oregon SBHCs. From feedback from AMH and with that goal in mind, the SPO crafted and release two RFQs (aka, request for qualifications) to the SBHC field, one for capacity grants and one for support projects. Appendices A and B outline grant awardees.

The grant awarded SBHCs across the state $3.6 million to add or expand mental health staffing capacity, and $800,000 to support mental health projects (see Box 2 for information on support projects).To coordinate the integration of mental health service provision into SBHCs, the State Program Office created a new position—the School Mental Health Specialist. In addition, this person would be responsible for fostering the adoption of mental health promotion and problem prevention in K-12 public schools in Oregon. Map 1 shows the SBHC grantee counties.

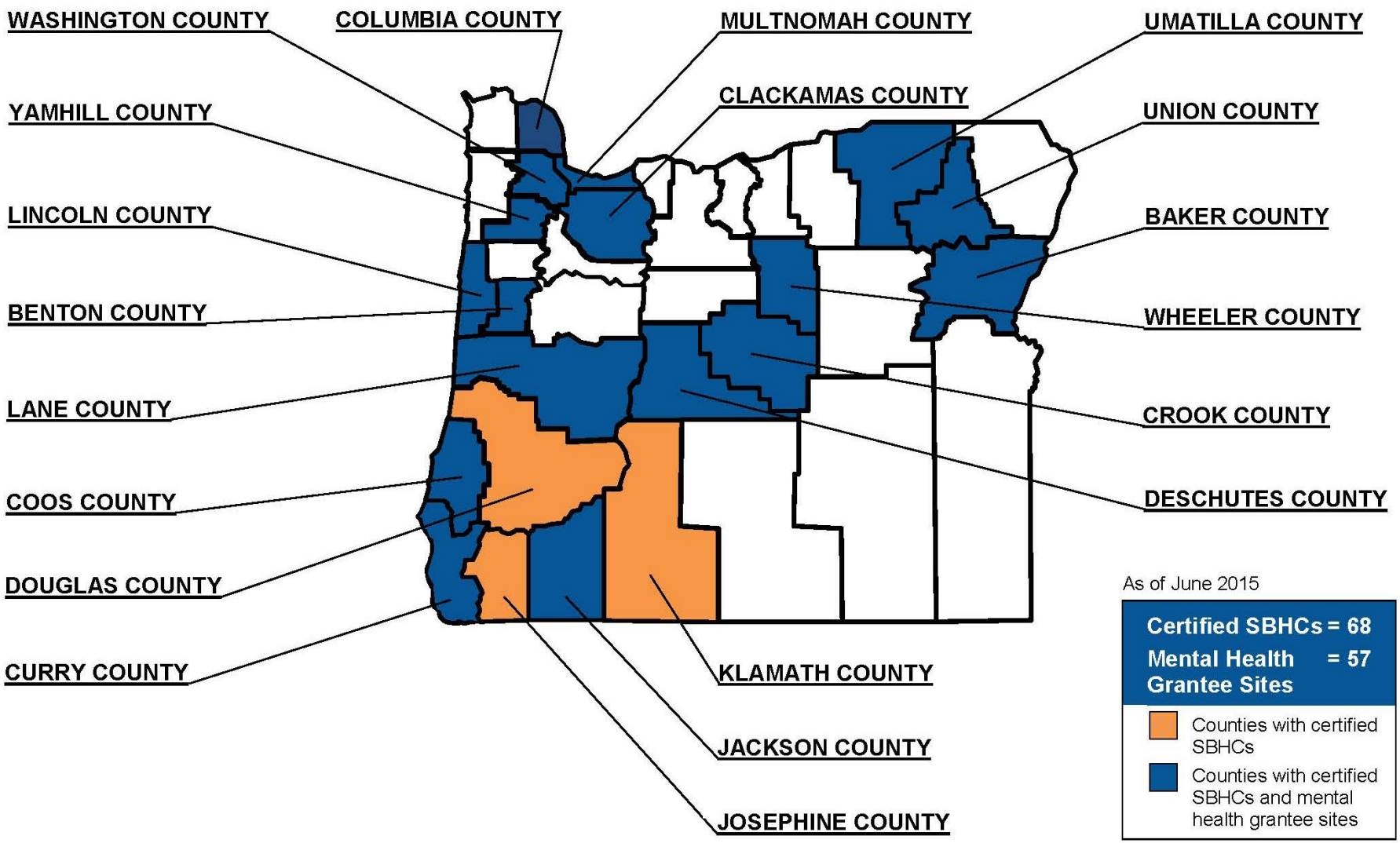
Box 2: MHEG Support Projects

There were 19 support projects awarded in the following categories:

- Mental health screening tool or framework
- Telemental health
- Youth Advisory Committee
- Data capturing system
- Supporting equity and cultural competence

This report uses the term "mental health" to be inclusive of both behavioral health and mental health care. For more information about the distinction made in Oregon between behavioral health and mental health care, see Appendix C.

Map 1: OREGON SBHC Mental Health Grantees 2013-15



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>> Evaluating the Mental Health Expansion Grant

The MHEG involved eight separate projects—capacity grants, support projects, and two additional projects we were able to launch due to additional funds mid-grant. The latter were the Health Service Advocate positions in Lincoln County and Youth-Participatory Action Research training project (see the Changing Social Norms section for descriptions of the projects and lessons learned). A logic model was developed to describe the activities, outputs, and projected outcomes of the MHEG overall. (See Appendix A).

Methods

The goals of the evaluation were:

- To assess impact of MHEG on the identified outcomes
- To set priorities for the subsequent grant period
- To identify technical assistance and training needs
- To provide data to support sustainable funding for mental health services.

There were multiple data sources used for this evaluation, including: SBHC encounter data; grantee progress reports; site visit data; patient satisfaction survey; Adolescent Health Project data (e.g. chart review data, office report tool data); YPAR and YAC project data; and data collected by project implementers specific to their work.

SBHC encounter data

All 68 certified SBHCs in Oregon submitted client visit encounter data to the State Program Office for the2013-14 and 2014-15 school years. Client and visit information is collected on each encounter visit, including basic demographics, provider type, and diagnostic and current procedural terminology (CPT) codes.

Grantee progress reports

Each grantee was required to submit two progress reports and one final report to the SPO. A template was created by the SPO that included questions on implementation of the grant projects in regard to outcome accomplishment, including expanding mental health capacity, building networks, changing social norms, and improving technological infrastructure.

Site visit data

During the 2014-15 SY, the School Mental Health specialist was able to visit 18 SBHC grantee sites, which covered 13 of 20 medical sponsor grantees. At each site visit, the mental health provider, physical health provider(s), grant manager, other staff, school administration, and other school staff that interface with the SBHC (e.g. school counselors) were interviewed.

Patient satisfaction survey

Certified SBHCs administer annual patient satisfaction surveys. Because this survey is for public health evaluation purposes only, no IRB approval is required. Immediately following a visit, the SBHC provider asks a student to fill out the confidential survey. Information is collected on unmet primary care and mental health needs, health education topics covered during visits, and questions regarding patient experience.

Project-specific data

Some grantees received MHEG funding to implement specific technology or quality improvement projects. Grantees were required to collect data on project implementation and outcomes. The projects and their data are outlined in the following outcome chapters, and include projects focusing on screening, cultural competency and equity, youth advisory councils and youth participatory action research to name a few.

Based on the logic model and identified goals and outcomes, quantitative and qualitative data from the above data sources were used to measure success in the following:

- Integrating behavioral / mental health and primary care
- Increasing access to mental health services
- Improving quality of care
- Building networks built between SBHCs and community partners
- Changing social norms related to mental health, and
- Improving technological infrastructure in terms of SBHC ability to provide services to clients and to capture data, provide and bill for services, and increase efficiency.

This report devotes a chapter to each outcome and includes findings and lessons learned.

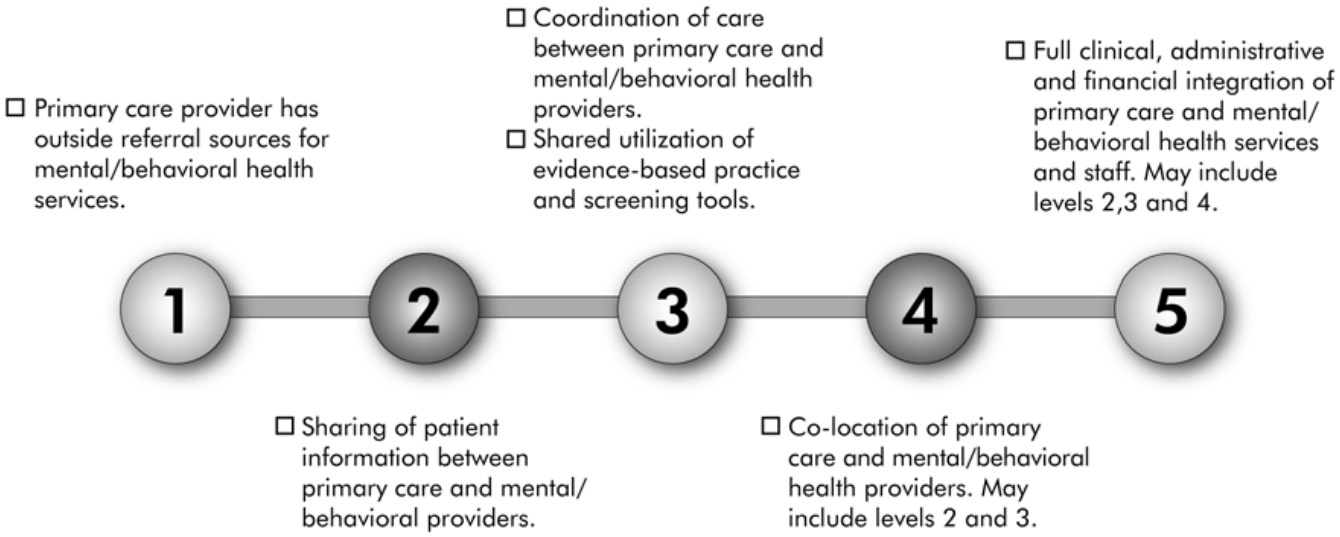
>> Integrating Behavioral / Mental Health and Primary Care

Background

For the past fifteen years, there has been mounting evidence and increased incentives for integration of behavioral/mental health and primary care.[xii] The terms *integration* and *integrated care* is used here to refer broadly to co-located mental health and primary care. In SBHCs, this is done by introducing mental health into primary care, as SBHCs are primary care clinics, first and foremost. The SBHC model is built on the premise of access and convenience; by integrating mental health and primary care, adolescents are able to get all of their health needs met in one location that is convenient for them and their families.[xiii,xiv] A recent study showed that children and adolescents who receive integrated mental health and medical care are 66% more likely to have a good outcome than those who receive more traditional primary care.[xv]

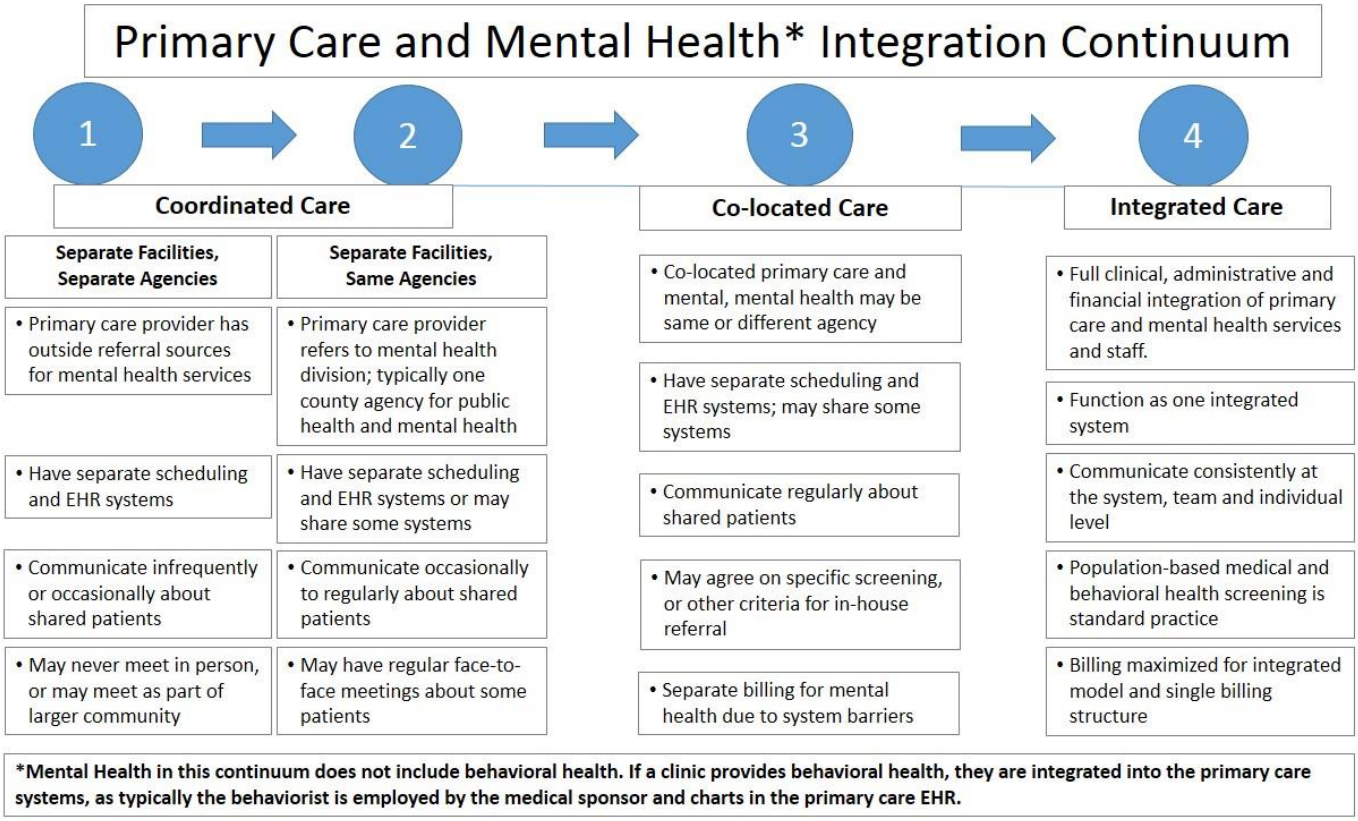
There have been many groups who have attempted to define what components are essential to integration, as a way of making a distinction between that and merely co-locating. The SPO created a continuum of SBHC integration of mental health into primary care as part of the 2006 assessment (See Figure 1). This model was created to describe SBHCs in 2006.

Figure 1. 2006 Primary Care and Mental Health Integration Model



Since then, due to the MHEG and work occurring nationally and in Oregon for integration of mental health and primary care, we have gained insight into specific characteristics that clinics may exhibit at different points in the continuum. Our new continuum is shown in Figure 2.

Figure 2. New Primary Care and Mental Health Integration Continuum



Outcome Highlights

Capacity grant funds were designed to cover the salary of a QMHP for the SBHC and any necessary capacity/infrastructure to collect and report on the mental health encounter visits as defined by the SPO. Out of 69 SBHCs[1], 39 were funded capacity grants for a total of approximately 25 FTE. (See Appendix B for a list capacity grantees.) MHEG grantees were primarily FQHCs and high school SBHCs. All SBHCs that applied for capacity grants were awarded funding, and provided mental health services in one of three different ways: 1) In 41% of awarded SBHCs, SBHC medical sponsor or county public health contracted with a mental health agency to provide services in the SBHC, 2) In 36% of awarded SBHCs, SBHC medical sponsor hired mental health providers to work for their organization, or 3) In 23% of awarded SBHCs, SBHC medical sponsor partnered with the mental health division in their agency. The latter was more common for health department sponsors. A little over a third of SBHC grantees had not provided mental health services on-site in the

[1] There were 68 certified SBHCs for the SY 14-15. We included data from the one SBHC that lost certification at the end of the 2013-2014 school year. We continued to fund their capacity grant for the remainder of the grant period, and those MH services were provided at the school instead of in the SBHC.

previous school year. Grantee characteristics, including manner of mental health service provision is in Table 1.

Table 1. Characteristics of MHEG Capacity Grantees

Capacity Grantee Characteristics	Awarded SBHCs
SBHCs awarded	39 SBHCs
Medical Sponsors	
FQHC	22
County Public Health (non-FQHC)	8
Other	9
Employers of mental health providers	
Medical sponsor	14 (36%)
Mental health division within medical sponsor agency	9 (23%)
Contracted mental health agency	16 (41%)
Had a mental health provider prior to MHEG	14 (36%)
School type	
High school	23 (59%)
Middle school	2 (5%)
Elementary school	6 (15%)
Combined grade	8 (21%)
Integration Level for Mental Health and Primary Care	
Coordinated Care (Separate Facilities and Agencies)	0
Coordinated Care (Separate Facilities and Same Agency)	2 (5%)
Co-located Care	25 (64%)
Integrated Care	12 (31%)

Primary Care and Mental Health Integration Continuum

The SPO was interested in exploring the level of integration in MHEG SBHCs and to learn about the challenges faced by clinics newly co-locating services. For those newly co-located, there were a number of things to figure out, including data sharing, billing, workflows, policies, and procedures. Some grantees partnerships were more streamlined—for example, if the SBHC medical sponsor was also the employer of the mental health provider, or if the partnership was between different divisions within one agency.

SBHCs were categorized along the New Primary Care and Mental Health Integration Continuum (Table 1). The majority (64%) were co-located and had varying degrees of

shared and separate systems. Almost a third were integrated, and had aligned documenting, billing, and care coordination. It is important to note that though a fully integrated SBHC system may seem ideal, "the 'best' place on the continuum may differ for each center, depending on its particular population and community makeup. The goal should be to develop the capacity to address youth physical and mental health concerns comprehensively; some centers may be quite successful at this task without full integration. As each center addresses its own barriers and limitations, it can then determine its capacity to integrate mental health services into the SBHC according to need rather than resources/funding." (2006 SPO Assessment) For many, the barriers regarding mental health agency eligibility, provider eligibility, and reporting requirements are seemingly insurmountable to achieving full integration for their SBHC. It is anticipated that as MHEG continues into the future, some SBHCs will remain co-located until these barriers have been removed or eased.

Box 4. Integration Experiences

Medical sponsor employs mental health provider

"Starting this school year the SBHC counselors were relocated from the school counseling office into the SBHC office. With this location change there has been increased coordination of care between physical and mental health services. Through co-location providers are able to discuss shared cases and make warm-hand off referrals. Also starting this school year the mental health providers were added into the SBHC EHR system that the primary care providers use. This integration allowed for providers to better identify if a student was shared amongst providers. Both of these changes, office location and EHR, were made possible because of the MHEG. These two key changes have significantly helped to coordinate care within SBHC.

As there have been several new providers and staff members starting with SBHC, we started holding weekly team meetings. This is a time where shared cases are discussed, referrals can be made, and most importantly team rapport is built. Through increased awareness and knowledge of each other providers are more willing to make referrals." – SBHC Coordinator

The SPO asked MHEG grantees to speak to their level of integration; highlighted responses are shown in Box 4, 5 and 6. Most positive accounts mentioned referrals and warm-handoffs, frequent meetings between providers, coordination and consultation, and shared-client record or sharing information via releases of information. Some MHEG grantees gave specific examples of how the clinicians were able to work together in order to get to the root of patient problems, when ailments were presenting in a physical or psychological way, such as this example about a mental health issue presenting as a physical ailment:

> *We had a girl come to us for chronic abdominal pain and recurrent episodes of shortness of breath. Our Family Nurse Practitioner (FNP) recognized symptoms of anxiety and referred her to our mental health provider. She was later prescribed anti-anxiety meds from our FNP and regularly sees our MH provider. She reports that the abdominal pain and shortness of breath has dissipated.*

Along and Outside the Continuum: Mental Health and Behavioral Health in SBHCs

A few SBHCs employ licensed providers who can bill both behavioral and mental health codes, thus functioning as both a behaviorist and a mental health provider. As a result of the grant, a few systems are leveraging grant funding to move to a hybrid model of service provision. In this scenario, both behaviorists and mental health providers work within the SBHC. Two systems have primary care and mental health operating within their SBHC, and are adding behaviorists to their clinic. One system has behaviorists, and are adding a contracted mental health provider. Due to the different requirements in the provision of mental health versus behavioral health, some SBHCs feel that having both allows for them to better meet student needs. Behaviorists can take warm handoffs and meet with students who may not meet the criteria for a mental health diagnosis, which is essential in beginning mental health treatment. The intent is that the enhanced delivery model will have a mental health provider for higher acuity needs and the behaviorist for in-the-moment consultative treatment, to reach all levels of need in mental health. Deschutes County—SBHCs sponsored by St. Charles and Mosiac Medical, one Multnomah County SBHC, and Outside In's SBHC at Milwaukie High School are piloting this model in the 2015-2016 school year.

Box 5. Integration Experiences

Medical sponsor partners with mental health division within their agency

"The combination of co-location and an integrated health record already provides an enhanced environment for behavioral health integration efforts. Currently both primary care and behavioral health providers have complete access to the client's record. They share office space and have frequent huddles and meetings to staff patients and consult about client needs.

Behaviorists are demonstrating an increased awareness of the impact of physical health upon behavioral health and primary care providers are demonstrating increased understanding of the processes used by behavioral health clinicians. As time goes on each type of provider is increasingly more cognizant of the interplay between their interventions and there is evidence to suggest that plans for treatment and service are reflective of that understanding.

Both types of providers are also increasingly more comfortable with the language that each discipline uses and this comfort is seen in the use of the language across disciplines. Primary care show increasing awareness of the impact of social and economic difficulties and the behaviorists appear more comfortable discussing the impact on such issues as high blood sugar and hypertension." –SBHC Coordinator

Challenges and Lessons Learned

Though there are demonstrated benefits, co-location and integration can be mired with challenges due to existing partnerships and infrastructure. Some challenges that grantees faced during the grant period and their lessons learned are listed below.

Co-location issues

Many SBHCs were not originally designed with co-location in mind, thus one initial problem was finding adequate, confidential space for the mental health provider. Some grantees used excess MHEG funds to reinforce walls, or modify the space to better suit all providers. A few grantees had to place their mental health provider outside of the SBHC in a nearby location within the school, because the SBHC was at maximum capacity. Having the MH provider outside the SBHC creates difficulties in integrating the provider into the SBHC workflows. To get around that, SBHCs have reported that, "sites where the clinician is not physically located in the clinic have worked out agreements with medical sponsors to assist clients with checking in to see their clinician."

Other challenges involved the time-consuming nature of integrating MH into the existing services, systems, and practice time. SBHCs reported that this work requires more staff development and planning time than they anticipated. Due to this, grantees were able to use MHEG funds to increase clerical, technical or accounting support.

Box 6. Integration Experiences

Medical sponsor partners with mental health agency

"Integration of services between primary care and behavioral health have increased as a direct result of this grant. Due to being located in the same area as the community's pediatrician and school RN, accessing information has been accomplished easily. With the appropriate releases of information, the mental health provider and pediatrician have been able to better serve clients using shared information pertinent to treatment. Often, the primary care provider is better aware of family history and can provide insight not given by the family themselves. This information is useful in the treatment process and allows the mental health provider to address needs of the client and family as a whole. In addition, as the primary care physician meets with patients, the mental health therapist has been able to provide onsite consultations, and meet with patients considering services at the time of the appointment to begin the process of treatment services." –SBHC Coordinator

Building rapport between different agencies

New partnerships can be difficult. For those who were partnering with a different agency to provide mental health services, each agency may have different expectations on roles and responsibilities, as well as a lack of understanding of what the other organization provides. In some circumstances, the rapport within the clinic—staffed by providers from different agencies—is better than the relationships between their employers.

As one grantee noted:

> *The biggest challenge has been integration on the oversight level. The SBHC is not currently managed by a sole entity that provides ultimate oversight of the financial and administrative aspects, and focuses on efforts toward alliance with the other SBHCs in our county.*

Building rapport within the SBHC

For many years physical health and mental health were seen as unrelated, and the care and services were developed separately. Because of that, many primary care and mental health providers lack understanding of the processes used by the other modality. One grantee noted that primary care provider stigma continues to be a problem, perceiving that some providers are uneasy working with mental health clients who may behave differently from other people. Another mentioned that primary care providers did not understand the role of a behaviorist in comparison to a traditional mental health provider.

Time, training, and proximity were mentioned as helping the providers become more knowledgeable and comfortable with each other.

Data sharing between primary care and mental health

One particular challenge has been the segregation of primary care and mental health data through disparate electronic health record (EHR) technologies. Reasons for this include:

- Mental health provider contracting agency uses a different EHR system.
- Primary care EHR does not offer appropriate mental health functionality, leading to:
  - Selection of a different EHR system; or
  - Return to paper charts for mental health visits.

The lack of EHR integration means primary care providers do not always have a full picture of the concerns facing the young people they are serving. Conversely, mental health providers may not be able to access the full health history of their clients.

One example of this was in Lane County:

> *Being two separate institutions, sometimes medical records from PCP's (primary care providers) are sent directly to Lane County Behavioral Health (LCBH) rather than the SBHC, where they are needed to track key performance measures*[xvi]*. We are solving for this by having our SBHC support staff member fax releases directly from the SBHC. Also… our LCBH therapists are not accustomed to tracking physical health data (the key performance measures) so we are trialing a new tracking tool to help with this.*

SBHCs have found ways of sharing information, like printing out a chart and scanning it into another system or giving the other provider "see only" access to the EHR system.

Billing and reimbursement

The MHEG allowed SBHCs to provide mental health services without needing to worry about billing in the short-term because the provider salary was covered by the grant. Some of the SBHCs newly providing mental health services did not bill, and took the first grant period as an opportunity to fully integrate their mental health provider into their workflows and systems, including shared charting. With the uncertainty of continuation of grant funds, the SPO encouraged grantees to begin billing for services provided, when able. Moving towards billing has been more challenging than some SBHCs had expected, especially those who were partnering with an outside agency that employed their mental health provider. Typically the outside agency has a different EHR system, and the mental health provider is only able to bill when charting in the other system.

It has been necessary for SBHC partners to meet and discuss how the partnership will change in the event that the mental health provider will bill. Considerations have been: expectation of the number or percentage of billed encounters for the mental health provider, information sharing, workflows, and how much of the reimbursement for mental health services will be returned to the SBHC. One site has decided to move forward with their mental health provider charting and billing through the mental health agency partner, while the other has decided not to bill for the time being. The latter site wants there to be a shared chart at the SBHC, but the mental health provider is unable to bill unless charting in her agency's EHR.

Fragmented and inadequate care system

Though SBHCs can operate as medical homes for their clients, some adolescents receive care from the SBHC but have a community primary care provider (PCP) that has been designated to them. Many SBHCs find that information sharing between community providers is often not reciprocated, and that requesting and receiving information can be time-consuming and not fruitful. One SBHC noted that while integration within their SBHC is relatively seamless, providing coordinated care for patients who have "outside" PCPs is difficult.

>> Increasing Access to Mental Health Services

Background

AMH Investment Projects were created to help Oregon communities meet the unmet mental health needs of adolescents. For decades, SBHCs play an important role in the health care system because they meet young people where they spend a large portion of their time—in school. For rural areas, the location can be a critical benefit, as services are spread out if they exist at all.

The majority of the MHEG funding went to supporting mental health positions in SBHC; 88% of SBHCs now provide MH services, as compared to 36% before the grant. As a result, SBHCs have provided new or expanded mental health services. This additional staffing resulted in increases in direct clinical care as well as mental health promotion activities and problem prevention. A few SBHCs leveraged grant funds to hire MH providers that meet specific cultural and linguistic needs of the community. In addition, some SBHCs are helping to build the future adolescent mental health workforce by acting as preceptors for mental health students.

Outcome Highlights

SBHCs provided mental health treatment and prevention to individuals, families, and groups. Many MHEG grantees feel that having MH available in a convenient location at school attracts adolescents who have barriers accessing community clinics. One SBHC stated that,

> *The mental health therapists see students at the schools that never come into the (county mental health) agency's headquarters-- who have huge mental health issues and many times lack parental support.*

> *"Already I can see that students, teachers, and administration recognize the need for mental health services. I have been able to assist with several students who were feeling overwhelmed or in crisis. Staff is able to bring students directly to my office and I can quickly be available to offer support, assessment, and a safe place to explore their choices. I've met with students who were having suicidal thoughts, and helped them make a plan for safety and connect with outside support for the summer. Other students have said that being able to have a place to talk and share has helped them to feel less stressed and more hopeful about their futures... Being in the school is a great way to meet the students where they are and offer services to kids who might otherwise not have access."*
>
> --SBHC mental health provider

Through the MHEG, SBHCs in Oregon are better poised to serve youth—successes in clinical care improvements are described below.

Clinical Care

With the additional mental health staff, SBHCs provided 35,689 mental health visits in 2014-15, a 91% increase over the previous year (Figure 3); a mental health visit is one in which the client was given a mental health diagnosis, regardless of provider type. Clients with a mental health diagnosis also increased to 8,426, a 56% increase over the previous year (Figure 4). Fourteen SBHCs expanded services and were able to increase the number of days they were open, and a number of SBHCs were able to provide MH services over the summer for the first time.

Figure 3. SBHC Mental Health Visits (any provider)

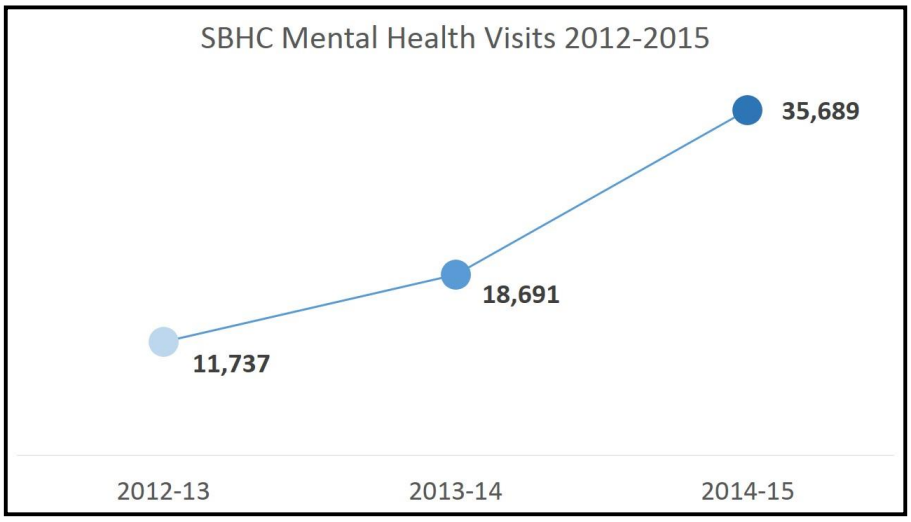
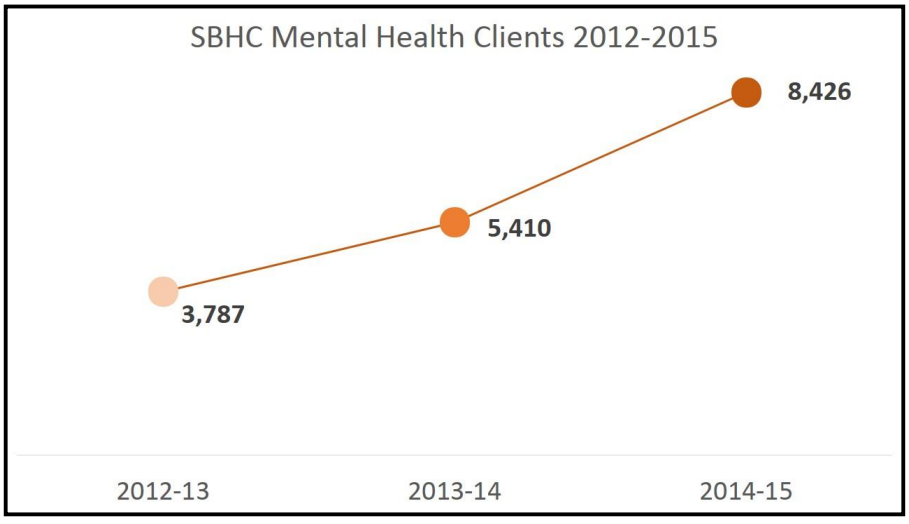


Figure 4. SBHC Clients with Mental Health Diagnosis



In SY 2014-15, 2,949 SBHC clients were seen by a mental health provider, for a total of 22,310 visits. The demographics of clients seen by an SBHC mental health provider are shown in Table 2. There were more female clients (59%) than male clients (41%). Most clients had Medicaid (49%) for their insurance and were between the ages of 14-17 (60%).

Table 2. SBHC Mental Health Provider Client Characteristics

Characteristics of Clients Seen by an SBHC Mental Health Provider	
Gender	
Female	58.5%
Male	41.4%
Transgender-Female to Male	0.1%
Ethnicity	
Hispanic	19.5%
Non-Hispanic	74.3%
Unknown/Refused	6.1%
Race	
White	81.1%
Black	2.8%
Asian	1.1%
Native American	4.1%
Native Hawaiian or Other Pacific Islander	0.5%
Unknown/Refused	12.0%
Insurance Status	
Medicaid	48.5%
Unknown	29.5%
Private	12.3%
None	9.5%
Other Public	0.1%
Age at first visit	
5-9	14.9%
10-13	17.8%
14-17	60.2%
18-21	7.0%

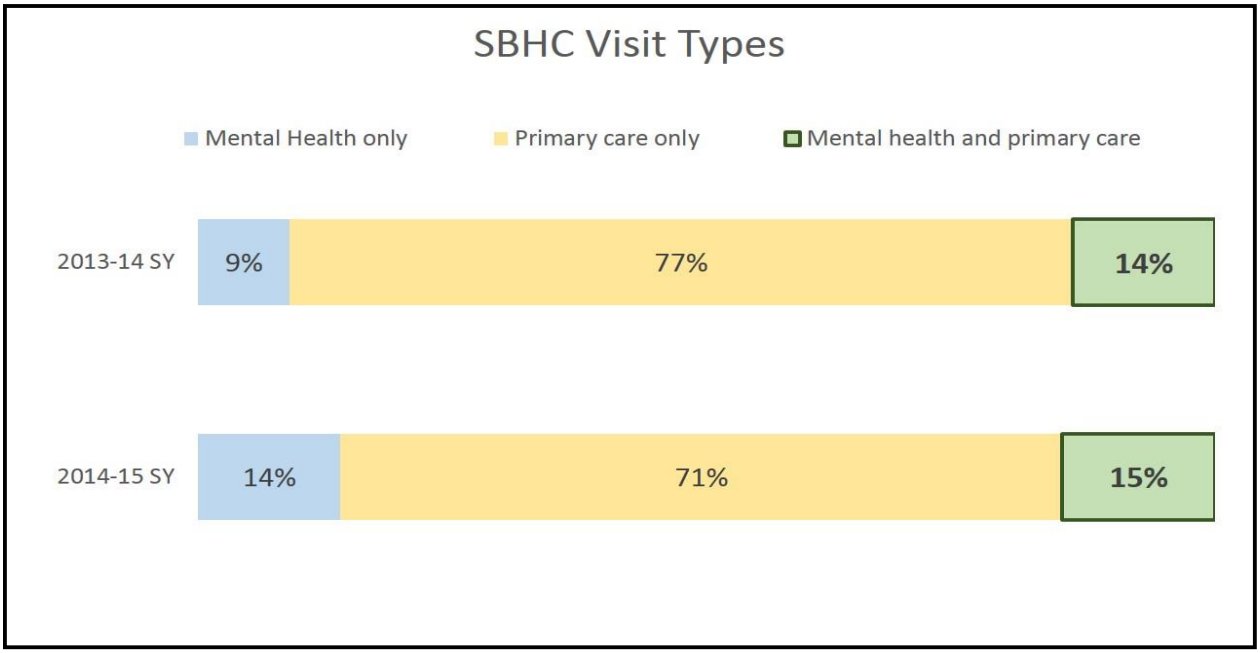
The top procedures and diagnoses have remained the same over the past 4 school years from 2011-2015, as shown in Box 4, and include depression/dysthymia, anxiety, attention deficit disorders, and adjustment disorders. This is consistent with recent national prevalence data; in 2008, the most common disorders among adolescents nationally were depression, anxiety disorders, attention deficit/hyperactivity disorder, and substance use disorder. [viii]

Box 4. Top Mental Health Diagnoses and ICD-9 Codes, 2011-2015

1. Adjustment Disorders (309)
2. Anxiety Disorders (300-300.22)
3. Depressive Disorder (311)
4. Attention Deficit Disorders (314)
5. Dysthymia (300.4)

Most adolescents who accessed an SBHC did so for primary care. In SY 2014-15, 14% of visits were for clients who only accessed mental health, 71% of visits were for clients who only accessed primary care, and 15% of visits were for those who accessed both mental health and primary care (Figure 5). Mental health professionals provided 26% of all visits. While it is possible that those who accessed only mental health have a primary care provider in the community, MHEG grantees are strongly encouraged to work collaboratively with SBHC primary care providers to ensure that all adolescents are receiving age-appropriate physical health services such as well-visits and risk assessments.

Figure 5. SBHC Visit Types



Groups: Treatment, Prevention and Promotion

MHEG grant funded providers held behavioral health, psycho-education, support and wellness groups. In addition to meeting the needs of the students, groups were also ways that providers could treat and work with more adolescents, which was helpful for those who quickly filled their caseload. Groups gave MH providers the opportunity to do prevention work through support or wellness groups. Co-leading groups with community and school partners also enabled MH providers to strengthen partnerships.

SBHCs frequently mentioned having groups for anxiety, depression, grief, and healthy relationships. Groups for specific populations were also common, such as groups for girls or LGBTQ-identifying adolescents. Some groups were formed because the MH provider was seeing a number of adolescents with similar issues that they thought would benefit from a group setting, while others may have started groups and then transitioned those in the group into individual or family therapy.

Culturally Specific Needs

A few SBHCs leveraged MHEG funding to hire mental health providers that had specific cultural and/or linguistic skills and experience, primarily to meet the needs of their community's Latino population. Having a clinician that is capable of communicating in the patient's primary language, and who has a personal understanding of the patient's culture has been helpful in reaching underserved populations, including undocumented Latino children.

Workforce Development

Bethel SBHC in Lane County was part of a program to supervise and mentor Masters of Social Work (MSW) interns from Portland State University. Due to the MHEG, the SBHC had sufficient mental health provider staff time to be able to supervise two MSW interns for the 2014-15 school year. In addition to providing services at the SBHC, the interns provided targeted outreach to two school communities that were identified as high need for mental health services because of reduced resources for counseling. The SBHC felt that the experience was positive due to the expanded services that the interns provided, as well as the opportunity to give MSWs early in their career experience within an SBHC. The only drawback was that the staff supervision and training were time intensive. Bethel will continue supervising interns again during the 2015-16 SY, and another SBHC is planning on supervising a MH intern during that school year, as well.

Crisis Response

In addition to providing routine mental health care to adolescents, MH providers fill acute needs of the community. MH providers can help schools respond to crisis situations by providing immediate intervention, as well as longer term grief and bereavement supports. Unfortunately, quite a few SBHC communities experienced deaths of youth or well-known community members during the grant period. MH providers provided grief counseling, as well as immediate and long-term support to students touched by a loss.

One example was in La Pine, where a student committed suicide before the 2014-15 SY. The La Pine SBHC MH clinician,

> *…provided over 40 hours of direct crisis response, and allowed for unique integration rapport building with the high school principal and school counselor, along with the local hub clinical team. The development of those bonds created strong cross-disciplinary appreciation and awareness which continue to directly impact the quality of services being provided at this site.*

Mental Health Screening Project: Increasing Access to Care through Early Identification in Umatilla County

Through partnership with the Intermountain Educational Service District therapist and the SBHC, a project was created to implement a universal mental health screening of sixth grade students at Sunridge Middle School. Administration at the school was in full support of the project. Through passive mail-home consent, sixth grade students completed two screening questionnaires in November 2014. One was a social and emotional health survey entitled "Me and My School". The second screening tool was the "BASC-2 Behavior and Emotional Screening System (BESS)". Additional culture and bullying questions were added at the request of the school administration. Data collected from the two surveys were sent to Dr. Furlong at University of California Santa Barbara for analysis.

Combining data from the two surveys showed the intersection of strengths and clinical concerns. A total of fifteen students were identified in the high risk tier. The principal of Sunridge Middle School stated that he was surprised by nine of the fifteen names on the list of the high risk students. All the high risk students were individually interviewed, assessed, and referred for services. After the process, the principal was incredibly thankful for the implementation of this universal screening because it helped him and other staff to identify students whose story would otherwise have gone unknown.

School administration is in full support making this an annual project and increasing the number of class grades that are screened each year. The goal moving forward is to create a group that specifically monitors the group level data for trends and respond with evidence based school-wide interventions that build students' strengths. Ultimately, we hope to see a decrease in the number of students identified in both the high risk and languishing groups.

Another example was a car accident in Jackson County, which took the lives of a parent and child, and seriously injured other children in the family. The Rogue Community Health clinician relayed her experience:

> *I coordinated with SBHC staff and school administrators for a discussion of the community's needs. Afterwards, each of the elementary school teachers provided time and space for me to speak to their classrooms. I talked and played with the preschoolers; I spoke in each of the older classrooms and offered honesty and resources for support. The school provided space in the library where I offered drop-in counseling and crisis support. There the students created beautiful letters and artwork to send to the children in the hospital, and wrote down their thoughts, prayers, and wishes on poster board.*
>
> *I came bearing resources for family and community members as well, and the school and SBHC coordinated quickly by distributing materials that day to families on how to support children through loss. Information on children's bereavement summer camps and support groups were displayed on campus, and a list of sliding-scale grief counselors was given to front office staff to hand out to parents upon request.*
>
> *Over the course of a week, the teachers, school staff, and SBHC staff grew more confident in their efforts to support the community and school. By the end of the week my role was simply to lend an ear and provide occasional feedback and guidance to staff as they continued efforts to memorialize the family and support their students.*

Challenges and Lessons Learned

Applying and receiving the grants was not the only challenge that grantees faced. Once the grants were awarded they needed to hire providers, receive referrals (from the community, schools, families, or youth themselves), provide services, and bill and get reimbursed for those services. SBHCs faced problems with each of these steps, as outlined below.

Staffing

Delayed hiring

A variety of reasons for hiring delays included the timing of the grant application, bureaucratic processes, and lack of qualified personnel to recruit. . A few SBHCs noted that there has been a workforce shortage across the state, especially for social workers. At one rural SBHC site, it took eight months to hire a mental health provider.

Support staff

Many SBHCs used MHEG funds to increase support staff time. Office, administrative and medical assistants are essential in running a successful clinic—in SBHCs they help support patient screening, charting, setting appointments, and billing for services. Some SBHCs found that with the increased number of patients

accessing services, that they did not have enough support staff to handle the administrative needs.

Receiving referrals

Increasing awareness of services

For SBHCs that were providing MH services for the first time, some experienced a slow uptake of services. Many took time to build relationships with the school to advertise the new or expanded services with teachers, administration, and students. Others attended school registration night and other events hosted by the school for the community and students.

> *"I have appreciated the ability to talk with someone almost instantly when a crisis has developed with a student. Having access to a mental health professional for questions, brainstorming and more is invaluable and very difficult to make happen though an outside agency. Schools do not operate like the outside world. For a student or parent to leave a message with an agency hoping to get an appointment is stressful. "In house" access moves the crisis to manageable almost instantly which is reassuring to the student, their family and their school counselor."*
>
> --School Counselor at Bethel schools

Providing services

Full caseloads

While some SBHCs experienced slow growth of their MH program, other SBHCs reported that their MH provider had a full caseload within the first few months of school. Of those, some modified their schedule to accommodate more students by beginning group therapy. Some had initial conflict with primary care, who wanted to refer to their MH provider, but were frustrated to find that their caseload was full. As a result, a few began a rigorous prioritization of clients and initiated times that were "open hours" for walk-ins or warm handoffs from primary care.

Conflicting priorities

Oregon schools are experiencing high rates of student chronic absenteeism. To combat this, many have instituted policies encouraging kids to come to school and class; some of these policies also penalize class absenteeism. One SBHC faced issues providing services to students when their administration changed policies related to missing class. The new policy was that mental health and physical health appointments would "count against" students' attendance. The SBHC noted that they are dealing with the issue in the following ways:

> *We continue to make sure that students check in with their teachers so they know where students are versus coming to the Health Center between classes and returning late or partway into the class period. We continue to write 'excused passes' so the student can account to teachers and administration for time spent in the Health Center. We write appointment cards in advance as*

often as possible so students can pre-arrange their absence with the teacher. We continue to communicate with administration and attendance staff to make the process as smooth as possible. It is expected that students will ask us for specific dates and times of their appointment…The Principal has indicated that attendance will be handled on a case-by-case basis and he will be sympathetic of Mental and Physical Health situations. He is well aware of students' needs to have easy access to physical and mental health services.

Eventually the principal changed the policy so that health appointments were not counted against a student's attendance record.

Other issues regarding conflicting priorities expressed by grantees are that of prevention versus treatment. Some SBHC MH providers mentioned that they would like more time to do prevention work but for various reasons they are unable to add that into their schedule, e.g. their employer has quotas they need to reach on clients per day, or they have a full caseload and a waitlist of referrals they need to see.

No shows

A few grantees mentioned that students not showing for appointments was a real challenge, especially for sustainability. After scheduling a number of students and having them skip the appointment, the SBHC found that some of the referrals from the school staff were inappropriate in that the students referred were uninterested in meeting with the MH provider. As a result, the provider modified their practice by meeting with the student briefly to discuss how therapy works and assessing the student's readiness to participate *before* scheduling an appointment. This increased student buy-in and reduced no shows.

Psychiatric Care

For those who may need treatment that involves psychotropic medication, it is sometimes difficult to access a prescriber, especially a psychiatrist. One SBHC mentioned that the wait time to for a child psychiatrist in their county was over two months. For patients who are in acute need of medication, this can be an unreasonable wait. Due to the lack of prescribers, some have considered telepsychiatry as an option (For more, see section on *Improving Technological Infrastructure*).

Billing and reimbursement

Insurance information and reimbursement

Many students do not have insurance information at point of service. This is not a MHEG issue, per se, but an SBHC issue. Grantees have found that this has not hindered program implementation, there is extra work involved for the school and clinic staff to remind the student to bring in that information. In addition, securing reimbursement from private insurance continues to be a challenge for some grantees.

Lack of reimbursement for mental health prevention and promotion

With an increase in hours, more MH providers are able to provide mental health prevention work in the school and community. Examples of this include classroom presentations or wellness groups. Frequently, prevention work is not reimbursed by payors, although some SBHCs bill using Prevention, Education, and Outreach (PEO) codes for these activities. Those that bill PEO codes mention that they are not reimbursed at a high rate, but that "receiving any payment is better than no payment".

>> Improving Quality of Care

Background

Quality of care can be defined in many ways. For SBHCs, adult-centered definitions are not suitable; children are not simply "little adults". As outlined by Leatherman and McCarthy in 2004, health and health care are different for children and adolescents than for adults, principally:

- Children's demographics are different than adults, which accentuates socioeconomic, racial, and ethnic disparities in health care.
- Children undergo rapid and continuous developmental change such that health issues and appropriate services change with age and general developmental stage.
- Children have different disease patterns and manifestations.
- Children are dependent on their parents or other caregivers to foster a safe and healthy home environment and to obtain health care.[xvii]

For our purposes, high quality care improves health status, is responsive to patient needs, is evidence based, and addresses cultural, linguistic, and socioeconomic factors.[xviii]

Outcome Highlights

The MHEG directly and indirectly funded SBHC projects that focused on quality improvement. Directly, grant projects included participation in the START project focusing on depression and substance abuse screening, and community directed cultural competency and equity projects. Indirectly, the MHEG funding gave clinics flexibility in pursuing training and projects for their mental health providers, as they did not need to be so tightly focused on maximum revenue generation from service provision.

START (Screening Tools and Referral Training) Project

The Adolescent Health Project is a performance improvement project that focused on increasing alcohol abuse and depression screening within the context of the adolescent well-visit. The project began in the fall of 2013, and three SBHC systems (i.e. Baker County, Deschutes County, and Jackson County-La Clinica del Valle) were able to join as part of the first cohort that also included four family practices from around Oregon. The Adolescent Health Project is jointly funded by the Public Health and Addictions and Mental Health Divisions of the Oregon Health Authority. Partners include the Oregon Pediatric Society Screening Tools and Referral Training (OPS-START) Program and the Oregon Pediatric Improvement Partnership (OPIP).

Participants were trained in the Spring/Summer of 2014 on the use of the Screening, Brief Intervention and Referral to Treatment (SBIRT) framework and using the CRAFFT screening tool for adolescents, as well as the PHQ-2 and PHQ-9 for depression screening. The project consisted of one full-day training for providers and clinic staff as well as technical assistance through learning communities where sites could share challenges and successes. Most sites implemented SBIRT and depression screening by the winter of 2015.

In addition to improving the quality of an adolescent well-visit, the project also moved SBHCs closer to Oregon's health system transformation efforts. SBIRT, depression screening, and the adolescent well-visit are incentive measures for Coordinated Care Organizations. This past year, the targeted age for the SBIRT incentive measure was lowered to include adolescents 12 years and older. The project highlighted how SBHCs can be effective vehicles for meeting those incentive measures. (CCO Metrics: http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx)

Cultural Competency and Equity Projects

Spanish language interpretation

Jackson County- La Clinica enrolled staff in an 8 month certified medical interpreter training program for Spanish, to better meet the needs of their Latino clientele. In Jackson County, 10% of the population is Latino; 18% of La Clinica clientele are Latino. During the grant period, 8 out of 10 therapists at La Clinica were non-Spanish speaking, and the need for therapy for Spanish-speaking families far exceeded the community resources. The training program increased the capacity to serve Latino clients in Jackson County, and has influenced other local organizations—including County Public Health and local hospitals—to explore utilizing a similar program for their staff.

Race and Privilege training

Lane County implemented a year-long program focused on race, disparities, and privilege. The training program consisted of a series of short (2 – 3 hours) and long (6 hours) cultural competency trainings held throughout the school year involving the three Lane County SBHC clinical, medical, administrative and management staff. Safety, trust and space was established for the more difficult conversations of race, ethnicity, sexuality, gender, poverty and privilege specific to the schools and health settings. These conversations were facilitated by Kim Feicke and Carmen Urbina from Oregon Center for Educational Equity. The format was conversational, and allowed participants to share personal experiences as well as discuss issues in treating clientele at SBHCs. The goal of the training series was for the three sites to grow together as a team and learn to incorporate cultural sensitivity and awareness into professional practice. The attendees were able to get 26 hours of CEUs from the National Association of Social Workers.

Participants reported personal and professional learnings from the project. Many stated that they feel comfortable being proactive about race and trauma in their practice.

> *"We treat the person not the behavior. The trainings reinforced me to slow down and look deeper, look internally and now talk about these topics. I will push myself—I leave exhausted, recuperated and inspired. I appreciate what we do."*
>
> *"Pleased and thankful to be in this group, I will ask more questions, be an ally for differences."*
>
> *"Motivated and encouraged to be more proactive. It is conceptually helpful to look at the intersection of race and trauma. There is lots of potential to integrate these subjects in our practices."*

Incorporating cultural competency

Washington County—LifeWorks NW, conducted a series of trainings on mental health topics that incorporated cultural issues relevant to the populations the SBHC serves. Topics included Mental Health First Aid for Youth; Gambling Prevention, Screening, and Referral for Youth; ADHD Screening, Treatment, and Referral for Youth; and a training on HIPAA/FERPA for SBHCs. The trainings had anywhere from 13-71 participants. It was unclear, however, how cultural issues were woven into the trainings as the State Program Office did not see any of the training materials.

Incorporation of evidence-based practices

A number of SBHCs trained their mental health staff on techniques and frameworks that are recognized as evidence-based or evidence-informed practices.

Family Check-Up

In the fall 2014, Bethel Health Center (BHC) expanded on a past partnership between University of Oregon Child and Family Center (CFC) and Cascade Middle School to secure training and materials to implement the Family Check Up model at their SBHC. In October 2014, Dr. Kevin Moore from the CFC provided a two hour training to 15 staff members, including Bethel School District school counselors, nurses, homeless liaison and family resource center staff, and BHC staff. BHC offered this intervention to families throughout the 2014-15 school year and facilitated 46 Family Check-Up visits to 13 families. This service has allowed for both diversifying our approaches and assessment strategies as well as enhancing collaboration with families and schools to better meet the needs of youth. Families overwhelmingly reported improvement in parenting, their relationship with their child, and reducing family conflict as well as high levels of satisfaction with the services provided. BHC plans to train any new staff and interns on the FCU model in order to continue this valuable intervention.

Trauma-informed care

Multnomah County provides on-going training to their clinicians as part of continuing education for their staff. In the 2014-15 school year, they placed an emphasis on trauma-informed care; trainings included trauma-informed cognitive behavioral therapy (TF-CBT) and understanding "zero tolerance" through an equity and trauma lens. TF-CBT is a 12- to 16-session psychotherapeutic treatment that focuses on behavioral and mental challenges related to trauma, such as PTSD, depression and anxiety for students.

Attachment-Based Family Therapy

In Crook County, the mental health services are provided by Lutheran Community Services, which has taken steps to ensure that the sole mental health provider at the SBHC has had adequate training to meet the needs of a variety of mental health issues. The grant has allowed for the therapist to attend multiple trainings to better serve the youth in the community. For example, the therapist was able to receive intensive Attachment-Based Family Therapy (ABFT) training and is working towards becoming a certified ABFT therapist. SAMHSA describes ABFT as:

> *ABFT is a treatment for adolescents ages 12-18 that is designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety. The model is based on an interpersonal theory of depression, which proposes that the quality of family relationships may precipitate, exacerbate, or prevent depression and suicidal ideation. ABFT aims to strengthen or repair parent-adolescent attachment bonds and improve family communication…parents then become a resource to help the adolescent cope with stress, experience competency, and explore autonomy.*

Challenges and Lessons Learned

START project

The START project helped the state program office understand the challenges faced by SBHCs in implementing a new quality improvement project. Most of the practices (SBHC or non-SBHC) did not have standardized, universal screening procedures for substance abuse or depression. The reasons for not screening were: lack of time, training or knowledge of community referral entities. When providers had identified an adolescent who needed treatment elsewhere and referred that patient out, there was inconsistent and untimely communication between providers; many SBHC providers never received any information from referral entities. Many SBHCs had difficulty with their EHR systems in terms of tracking and reporting the steps of screening to referrals. Finally, the staffing at SBHCs may limit their ability to do and get paid for SBIRT screening, as at the time of the training, there were regulations on the type of provider that is able to be reimbursed. These regulations may be loosened, which would enable RNs to be reimbursed for their part in the screening.

Cultural competence and equity

Overarching lessons learned for cultural competency and equity projects had to do with the planning process. Those who conducted training programs said that it was important to begin the process with meetings that include all partners in deciding on training topics and date scheduling. The Washington County project was hindered by not having all partners at the table early, and it was not until more than halfway through the grant period that partners were able to meet. At that time it became apparent that there were few dates that the medical sponsor would allow staff to attend trainings, and that the training topics that the medical sponsor was interested in were not directly focused on cultural issues. The mental health agency assured the SPO that all of their trainings are geared towards meeting the needs of the county population, which has as large proportion of Latino clientele. In addition to including partners and starting early, grantees felt that the local context was important to increasing the relevance of their training program. Using data and real-life examples enhanced content and participant satisfaction.

Incorporation of evidence-based practices

The MHEG did not directly support incorporation of evidence-based practices with funding, though we know that the funding allowed for training flexibility. It is also possible that there were more practices than those listed above; this information was gleaned from grantee progress reports. In the next grant period, the SPO hopes to provide more training opportunities for SBHC mental health clinicians on evidence-based or emerging practices.

>> Building networks

Background

SBHCs succeed through unique public-private partnerships between the Oregon Public Health Division, school districts, county public health departments, mental health agencies, public and private practitioners, parents, students and community members. The strength of these partnerships between SBHCs and outside entities varies by location and community. Grantees were encouraged to explore new partnerships and to strengthen pre-existing ones.

> *"Health begins in the community."*
>
> --Benton County SBHC Mental Health

Outcome Highlights

Many grantees forged new partnerships with the community or strengthened existing partnerships, like those with school staff. Groups that MHEG grantees mentioned partnering with are described below.

Schools

SBHCs are located on school grounds. Each school is set up differently in terms of personnel, but there are typically individuals at each school that are interact with students that have behavioral issues, including school administration like principals or vice principals, school counselors, or school nurses. At times, there are also teachers who have good rapport with students, and whom students trust and seek advice from. Many SBHC mental health providers outreach to school staff members to be sure that they understand the scope of the services provided at the SBHC and know how to make referrals. Outreach could include presenting at orientation and staff meetings, emails to schools, and meeting with school administrators who can share information with their staff. MHEG grantees mentioned specifically connecting and collaborating with school counselors to identify students who need mental health supports.

> *"Already I can see that students, teachers and administration recognize the need for mental health services … students have said that being able to have a place to talk and share has helped them to feel less stress and more hopeful about their futures."*
>
> --SBHC mental health provider

Additionally, mental health providers may participate on school committees and teams, a couple grantees mentioned that their provider is a part of their school's Special Services Team (SST), which discusses students who are struggling and creates

a plan of support. Others have provided trainings for school staff in a broad array of topics, including grief, self-injury/harm, depression, safety planning, medication, anxiety, suicide prevention, community mental health resources, Mental Health First Aid, and ASIST. Umatilla SBHCs partnered with the school psychologist at Sunridge Middle School to implement a strengths based mental health screening program with 6th graders. The screening helps to identify students who are at risk and those students are then seen by the SBHC mental health provider. Partnerships with school help to increase mental health skills of the school staff, strengthen referral relationships between the school and SBHC, and improve supports for students.

> *"Meeting with school district administration and internal prevention specialists help(s) to increase awareness about SBHC resources while gaining awareness of additional available resources for clients."*
> *--Deschutes County SBHC Behavioral Health Manager*

Parents and Families

Parents play an important role in and adolescent's life, and can be crucial partners to mental health providers. Families may first be introduced to SBHC mental health providers at their school orientation, where they get an overview of the clinic and the services SBHCs provide. Once an adolescent seeks care at an SBHC, the mental health providers involve parents in their child's treatment whenever possible. Some clinicians provide family therapy, and others hold weekly parents groups. As one grantee mentioned, "parents are (our) partners in treatment."

Community Agencies

Schools and SBHCS exist and function as a part of larger communities, each with their own unique needs. Community systems and agencies that are natural touch points for SBHCs include child welfare, youth homeless shelters, young parent programs, family practices and pediatricians, hospitals, mental health agencies, other SBHCs, coordinated care organizations (CCOs), and juvenile probation. Depending on the community, some of these groups may already be collaborating—in Clackamas County, a Youth Services Provider Network comprised of community-based organizations focused on youth has been meeting regularly. The SBHC mental health provider felt that the network helped expand their list of resources and referral resources. Community members and groups may also benefit from trainings by SBHC mental health providers; one grantee mentioned holding trainings on autism awareness, trauma-informed care, and collaborative problem solving.

SBHC mental health providers routinely coordinate care with other medical and mental health providers in the community. MHEG grantees are involved in prevention programs like suicide and substance abuse prevention at a local level. CCOs collaborate with MHEG grantees and grantees participate on the CCO's Community Advisory Council (CAC), helping to inform the CAC on adolescent mental health needs in their community. SBHCs are a part of the complete system of care to support children with special health care needs.

"One student was originally referred by the Superintendent to seek mental health counseling services for his angry outbursts with teachers and in the classroom. He was on his last chance to stay in school and not be expelled. After the Mental Health Provider worked with this student in counseling for several sessions, teachers and the student were able to report that his angry outbursts in class had stopped. Student was able to control his anger through using distress tolerance skills that they worked on in during our counseling sessions. The client was able to control his anger and found success with the completion of the school year."

--Baker HS SBHC mental health provider

Challenges and Lessons Learned

Partnerships are essential to SBHCs, but that does not mean that they are always easy. Misunderstandings, as well as conflicting goals and motivations, can create barriers to partnership.

Working within the school system

As many schools in Oregon are understaffed with school counselors, schools sometimes conflate mental health providers with school counselors. The two roles can be complementary—especially as many providers receive referrals from school counselors—but they are also very different, and have different goals, ways of working, and responsibilities. In addition, schools typically respond in a way to emotional/behavioral problems with a disciplinary approach, which can conflict with the interventionist approach of a mental health provider.

Partnering with parents and families

Connecting to parents can be challenging for SBHCs. Depending on the age of the patient, and school and SBHC policies, the SBHC may need to connect with the parent to complete documentation necessary to begin providing mental health services (that is, a consent to treatment). For some patients, considerable work is done by the medical or office assistant to get in touch with parents before treatment even begins. Once treatment has begun, the mental health provider may want the parent to participate in the therapy. Many parents who are willing to participate in therapy face challenges due to work schedules, transportation, or childcare. SBHCs try to mitigate this by having extended hours, so that parents can come before or after work.

>> Changing social norms related to mental health

Background

Beliefs, norms, values, and language are all important elements in how individuals and communities perceive and experience mental health conditions. All of these influence whether or not individuals seek help, what type of help they seek, what coping styles and support they have, and what treatments may work for them.[xix] Beliefs and norms can create stigma, which can be defined as the prejudice, rejection and discrimination directed at people believed to have a disorder or trait perceived to be undesirable.[xx] Mental illness stigma can interfere with prevention and treatment efforts, thus, combatting stigma is a public health priority.[xxi]

Studies have shown that most adolescents do not seek out or receive the services they need to treat their mental health disorder due to barriers and stigma.[xxii] Corrigan et al. identified two types of barriers related to stigma that may undermine care seeking and participation in treatment programs: person-level barriers and provider and system-level barriers.[xxiii] Person-level barriers are "attitudes and behaviors that affect health decisions, including stigma leading to avoiding treatment, poor mental health literacy, and lack of support network that promotes care seeking", to name a few. Provider and system-level barriers include lack of insurance, financial constraints, staff cultural incompetence, and workforce limitations.

> *"[Because of MHEG], SBHCs are more prepared to address the whole health, mind, and body of the students."*
>
> –SBHC coordinator

Outcome Highlights

The MHEG supported work to change social norms related to mental health and reduce mental illness stigma. The grant enabled SBHCs to provide mental health services to those who would otherwise not have access because of lack of insurance or sufficient money to pay for services elsewhere. In addition, much of the work already described helped to remove person and system-level barriers to care: improving cultural competency and supporting equity through community-driven projects, providing funding for mental health positions that meet cultural and linguistic needs of the community, as well as partnering and educating community partners about mental health and illness. MHEG also funded Health Service Advocates in Lincoln County SBHCs, Youth Advisory Councils in three counties, and Youth Participatory Action Research projects with SBHCs and other youth-serving

organizations, all which help to connect people to services and serve to educate the community and patient about mental health and illness.

Reframing perceptions of health and health care

Routine and for everyone

Availability of mental health services alongside primary care within the SBHC has shifted some students' perception of those services; they now see mental health services as routine instead of out of the ordinary. MHEG grantees also mentioned that prevention and mental health promotion groups that they hold help to reduce stigma. In Benton County SBHCs, the groups' content are typically related to positive behavior choices, social group challenges, self-esteem and other issues that do not require that a child be diagnosed or have an assessment prior to participating in the group. Flyers are produced describing the groups and youth can sign up in much the same way as they can sign up for a field trip. The intent is that these groups might create an environment that supports preventative services and encourages the pursuit of good mental health as a normal and healthy activity. The Benton County SBHC behaviorist met with teachers to explain the benefit of the groups and helped teachers recognize that the pursuit of good mental health is an activity for everyone—not just young people with behavior issues.

> *"The work being done by the YACs is having an important impact on changing school norms around mental health…there were no student deaths by suicide in the district this school year, (this was) in part to the work done by the YACs in reducing stigma around accessing mental health services."*
>
> --School counselor in Deschutes County

Substance abuse as a health issue

A web-based national survey in 2013 compared attitudes about stigma in regard to drug addiction and mental illness and found that respondents held more negative views towards persons with substance abuse issues. Many people believed that substance abuse was a moral failing rather than a treatable medical condition.[xxiv] One MHEG grantee felt that SBIRT implementation helps reframe substance use as a health issue and not a moral issue, by universally and routinely screening patients.

Offering safe and non-stigmatizing environment

The SBHC is seen by many community members as a safe and non-stigmatizing environment. Crook Elementary SBHC reported that clients and parents have expressed their preference to attend therapy sessions at the SBHC rather than at the main mental health agency office. Providing a non-stigmatized environment for those seeking mental health services allows for a higher level of comfort for kids and families. Wheeler SBHC mentioned that providing mental health services in

conjunction with the school helps to reduce stigma, because the school and school officials are trusted by the community members.

Many SBHCs mentioned that positive experiences from clients has helped to reduce stigma and encourage others to come in for care. Word of mouth is powerful; it was common for self-referring clients to say that their friend had a good experience accessing mental health care at the SBHC and that was why they had decided to come in.

Health Service Advocates

Lincoln County SBHCs utilized Health Service Advocates (HSAs) to act as a liaison between the student, home, school, SBHC, and community resources. HSAs assist students and families to access a wide variety of essential physical, mental health, and social services. As a Lincoln County School District employee and a member of the SBHC team, HSAs are well-positioned to identify students in need of mental health services and facilitate a smooth transition into care, by forming relationships with students and families. This innovative and collaborative partnership has proven to be effective in quickly and efficiently linking students, in need of physical or mental health assessment and follow-up, to the appropriate service. Warm handoffs by HSAs to mental health helped students feel more at ease and improved the likelihood of following through. With an HSA at each SBHC who was available to students whenever the school is open, Lincoln County had a greater capacity to coordinate the ever-increasing demand for mental health services both at the SBHC and in the community.

Youth Advisory Councils and Youth Participatory Action Research

Deschutes County, Jackson County-La Clinica del Valle, and Washington County-Virginia Garcia SBHC systems were awarded funding for the implementation and support of Youth Advisory Councils (YACs). There were a total of eight SBHCs participating in the project (three in Deschutes County, four in Washington County, and one in Jackson County). YAC facilitators were hired in the spring of 2014 and began recruiting for students to participate in the YACs in the beginning of the 2014-2015 school year. As part of their grant requirements, the YACs were required to conduct an action research project on a mental health topic of their choice.

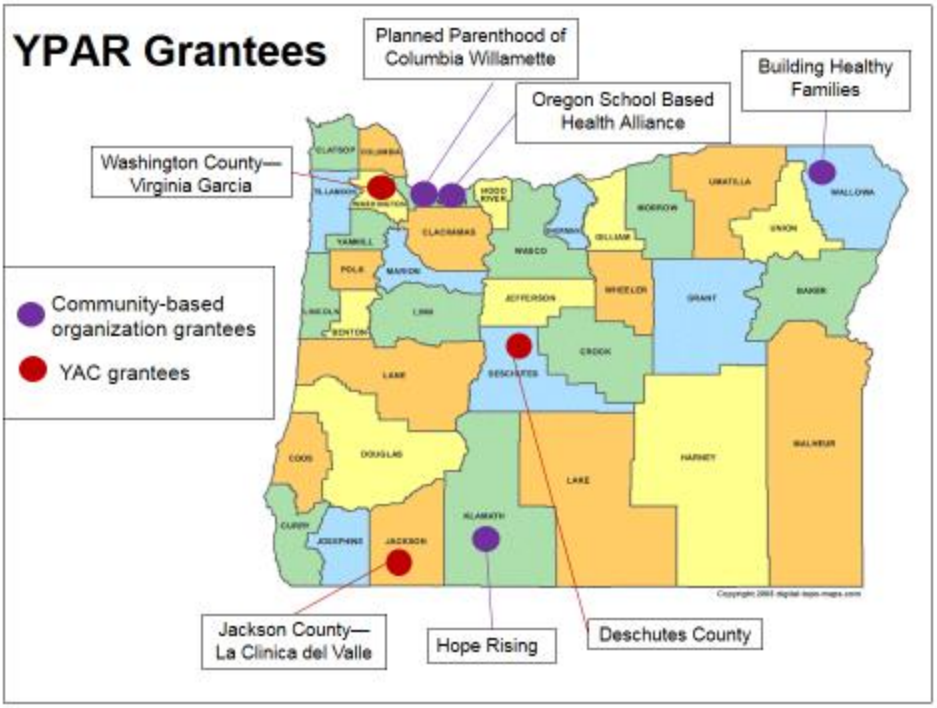
Youth Participatory Action Research (YPAR) Projects

Concurrent to the beginning of YAC activities, our program finalized a Youth Participatory Action Research (YPAR) curriculum that had been in development for a couple of years. Youth Participatory Action Research (YPAR) is an evidence-based strategy to authentically engage youth in programs and policies that impact their lives, providing opportunities for youth to build skills in research, team work, and civic engagement, while promoting strong youth-adult partnerships. The Institute for

Community Research's (ICR's) *Participatory Action Research Curriculum for Empowering Youth* (2004) was identified as a model evidence-based curriculum, and the Adolescent and School Health Program (A&SH) partnered with the ICR to adapt their curriculum for use in Oregon and to use their expertise in youth engagement to develop and conduct a training program on Oregon's YPAR curriculum. Through extra funding, the MHEG was able to support four community-based organizations that work with youth to attend the training as well: Building Healthy Families (Enterprise, Oregon), Hope Rising (Klamath Falls, Oregon), Oregon School Based Health Alliance (statewide organization based in Portland, Oregon), and Planned Parenthood of the Columbia Willamette (Portland metro area). The map in Figure 6 shows all YPAR grantees and their locations. The training program was conducted from January-June 2015 and included a two-day workshop and technical assistance for the 6 months of YPAR project implementation.

ICR conducted an evaluation of the training program in order to 1) assess whether and to what degree the combination of training approaches (curriculum, trainings and technical assistance) strengthened the capacity of facilitators from grantee organizations to implement YPAR with their youth groups effectively, and 2) elicit lessons learned from the processes that could enhance future training efforts to build capacity of new grantees to implement YPAR.

Figure 6. YPAR Grantees, Spring 2015



Results from their evaluation indicate that overall the support and technical assistance provided by ICR and A&SH program were helpful to most facilitators. All facilitators were able to implement the major steps in the YPAR curriculum--choosing a topic, modeling the influencing factors on the issue, developing a hypothesis, choosing research methods to gather more information, implementing research methods, and compiling and analyzing results. Project topics included: mental health stigma, teen substance use, suicide prevention, sleep, effects of public displays of affection on school climate, self-esteem, stress, and awareness of mental health issues and perceived barriers to accessing care.

"YAC members were genuine and sincere in their presentations to my health classes. They held very productive and powerful discussions about mental health, while modeling the importance of breaking mental health stigmas and giving a voice to student concerns that are normally kept silent. I value this program and know that it is positively affecting the environment of our school by giving students permission to talk about these most important issues."

--Health teacher in school with YAC grant

Most groups were able to achieve YPAR results and share those results with important community partners despite the short period of time that was available for the YPAR program in spring 2015. Some examples of "action" post-research include:

- SISTERS HIGH SCHOOL (DESCHUTES COUNTY): As a result of the data collected in their survey on mental health stigma, the Sisters YAC planned a Mental Health Awareness Week. Their plans included a "What's in Your Mental Health First Aid Kit" activity during lunch, handing out mental health promotion wristbands they designed (photo included in attachments), wearing turquoise/purple for suicide prevention awareness, giving presentations about their survey findings and available mental health resources in health classes, and hosting a station where students could make their own stress ball.
- MERLO STATION HIGH SCHOOL (WASHINGTON COUNTY): Merlo Station HS conducted surveys on stress at their school. The YAC students analyzed data from the survey and sought approval for a Stress Awareness Week at the end of May. They planned on having some teachers have aroma therapy in their classes and talk about the benefits of surrounding yourself with calm. Also, they contacted a couple of service animal places to see if they could have a few well-trained pups come to the school during lunch to talk about the stress relief that pets and animals can bring. We purchased aroma strips that the students are going to write the stats of their survey on and hand them out during the school day. This will create not only awareness about their study but awareness of the YAC itself. In the end, approval was difficult to attain, as it was in the middle of state testing and towards the end of the school year. The YAC students were able to demonstrate their findings to students over the course of three days during lunches and handed out aroma strips and tootsie pops that had facts about stress relief written on them. The information was well received from students at large, and the YAC students found it helpful to have some direct contact with both the Community School and School of Science and Technology (two schools on their campus).

Findings from ICR's evaluation and final reports from YAC grantees suggested that the YPAR curriculum for Oregon can and should be adapted and utilized in multiple youth sites and settings across the state.

Challenges and Lessons Learned

Reframing perceptions of health

While there may be a culture shift around access to mental health services for youth, many families are still resistant to participating in the therapy, even if the issue seems to be family dynamics.

Youth Advisory Councils

YAC grantees felt that coordinators need to be flexible regarding recruiting, scheduling, and planning, and should start early, at the beginning of the school year, to allow time to work around stumbling blocks. YAC facilitators noted that all schools operate differently, and it is important for facilitators to make relationships with school administration and staff early in order to be most effective. Getting buy-in from administration for the YAC and YAC activities is critical and sometimes unexpectedly challenging. Administration and school staff should be brought into discussions and planning early; it is important to establish positive relationships in order to move the work forward.

Recruiting at some schools took more time than originally planned, or was underwhelming. Some schools have many club options for students, and students feel busy and over-scheduled. Tactics for recruiting more students included asking YAC members to bring a friend to the next meeting, making presentations at school meetings and in classrooms, and advertising that there was free food at meetings.

Scheduling meeting times that work for all YAC members can be difficult due to class schedules, short lunch breaks, and after school conflicts. YAC facilitators were creative in reminding students to come and in scheduling a few longer periods of time on the weekend or after school in order to accomplish YAC goals.

> *"YPAR definitely gave us a strong sense of purpose and the students really enjoyed being in charge of their own topic and participating in the investigation of the subjects. They were also engaged in helping to create awareness to the schools as a whole."*
>
> --Washington County YAC facilitator

While youth and SBHCs feel that YACs bring benefits to youth and their communities, there is a lack of sustainability broadly, such that without grant funds, many YACs whither and fade. Facilitating YACs takes dedicated staff time, and many medical sponsors are not willing or able to fully fund those positions. Exploring YAC sustainability will be a goal in the next grant cycle.

Youth Participatory Action Research

YACs are able to accomplish a lot in a short period of time; it was possible for them to work through the major pieces of the YPAR process in four months. In order to accomplish this, student groups already had steady and frequent participation and were bought-in to the project. Feedback indicated that projects could be more robust and less stressful if the timeframe was increased. Based on the information collected as part of the evaluations, the YPAR curriculum should be modified to include a rough timeline so that facilitators can plan the major steps over the duration of their program.

In-person, hands-on training was beneficial for facilitators, and for the few youth YPAR participants who were able to attend. It is a goal to include more youth in future trainings, but funding and logistics may be barriers. Training could be improved by offering additional webinars and individual site consultations in research ethics, instrument development, and data analysis. Most groups conducted surveys due to familiarity and the short timeline. Further training on different data collection methods would be beneficial.

>> Improving technological infrastructure

Background

There have been many recent technological advances in health care to increase client services and the ability to capture data to track, report, and bill. Electronic health records, telemedicine, and efforts to create interoperable systems are some MHEG projects to improve technological infrastructure.

SBHCs, like many other health care clinics, managed their clients almost exclusively through paper charts for many years. However, with the advent of improved health care technology, and the increased reporting and tracking requirements placed on providers by payers and other entities, SBHCs are quickly moving toward full adoption of EHRs. SBHCs with access to greater levels of infrastructure, administrative support, and financial resources (often, those sponsored by FQHCs) are generally in the best position to adapt to and integrate EHR use into their clinic workflow. Smaller SBHCs and those without such support have historically not had the funding or capacity to use EHRs.

While many clinics and SBHCs are moving towards or have implemented EHRs in recent years, fragmented care and documentation remains an issue. There exist many

types and brands of EHRs, and there have historically been different EHRs for physical and mental health. The majority are not interoperable, and information sharing between providers—even in the same clinic—is challenging and difficult.

Telemental health (or telebehavioral health) is the use of telecommunications technology to provide behavioral health services, typically by using live, interactive videoconferencing. In Oregon, this service can be extremely helpful in rural areas, where there are limited professionals, distances are far between communities, and there is a struggle to recruit and retain mental health specialists.

Outcome Highlights

SBHCs were able to apply for MHEG funds to implement projects to improve the technological infrastructure of their clinic or SBHC system, including, but not limited to, EHRs. Some were able to leverage unused MHEG funding to help pay for personnel time to help with data entry, capturing, or technical assistance.

Data capturing system

Seven SBHC systems were awarded grants to implement electronic health record systems (EHRs) or explore functionality. Some sites implemented EHRs for the first time, moving from paper charts. The majority of grantees moved forward in signing a contract with OCHIN Epic, some for their primary care EHR, and others for mental health EHR along with primary care. In addition to increasing the ease of data capturing and reporting, EHRs help SBHCs bill more efficiently. For many, OCHIN Epic handles the billing for a fee, which can dramatically increase revenue for sites who were previously billing for few services.

Some sites used MHEG funds to add mental health providers to their primary care EHR. As both will be charting within the same system, this will increase communication and care coordination. Not all primary care EHRs have appropriate functionality for mental health, as there are certain data elements that need to be collected for mental health reporting. OCHIN Epic recently developed a behavioral health module called the Behavioral Health Navigator. The Navigator was created to encompass all reporting elements for mental health within Oregon, and will allow mental and behavioral health providers to chart within the Epic along with primary care. A few sites adopted the Navigator this grant period.

Multnomah County used the funding to explore the feasibility of implementing IT solutions to enable integrated physical and mental health care at SBHCs and interoperability between the systems. Currently, SBHC primary care staff chart in Epic, a physical health EHR, and mental health consultants chart in myEvolv, a mental health EHR. Two separate and distinct records are maintained for the clients who receive care from both provider-types within an SBHC. The current arrangement

has a number of drawbacks, including posing potential safety issues, hampering coordination of care, causing inadvertent duplication of services, and contributing to a less than optimal patient experience. The assessment determined that the best way forward would be to utilize the direct clinical messaging functionality within the two EHR systems while working towards creating a central data repository system for high-level information from a number of Multnomah County systems, including primary care and mental health. The results of the assessment came at a time that explorations into other systems at Multnomah County beyond SBHCs were occurring, so there is a natural groundswell and interest in moving forward with the more long-term option.

Some grantees used the opportunity to begin tracking services that were not "encounterable", like prevention services and care coordination (e.g. "warm handoffs"). With this information, the SBHC SPO has a more complete picture of the array of services that are being provided at SBHCs.

Telemental health

Two SBHC systems in rural areas—Curry and Wheeler Counties—received funding for telemental health projects. Telemental health (or telemental health) is the use of telecommunications technology to provide mental health services. This service can be helpful in meeting the needs of communities where there are limited professionals and distances are far. The bulk of awarded funding was used for the purchase of equipment, as well as contracts with service providers. Both telemental health projects have contracts with the OHSU Department of Psychiatry to provide telemedicine.

Challenges and Lessons Learned

Data capturing

Time-consuming whether new or old

Implementing new data systems is time consuming. Sites who were interested in adopting a new EHR system found that the timeline was much longer than anticipated; the time between contract signing and implementation can be very long (over 6 months). There were bureaucratic delays in having some contracts signed.

Operating existing data systems can be time consuming and require additional staff and staff time. One example from Clackamas County highlights challenges:

> *The electronic behavioral health record, Cerner (formerly Anasazi), is complicated to learn and time consuming to use. In an effort to ease the burden for the front office staff at our clinic, an extern was utilized for a three month trial to register students and enter insurance information. It was determined that there was a low return on investment to spend hours training a limited term extern. Instead, the clinic receptionist entered the patients'*

demographics, and then sent students' insurance information to an office specialist at Clackamas County's Behavior Health Clinic to enter information.

Modification, interoperability, and training are costly

Required reporting for mental health services in Oregon is complex and may take time to build into existing EHRs. Oregon's Addictions and Mental Health Division revamped their data collection system at the beginning of the grant implementation. All clinics enrolling clients in the mental health system were required to enter data into this system, called MOTS (Measures and Outcomes Tracking System)[xxv]. This added an unexpected requirement on grantees that was time consuming and costly. Additionally, there have been quality improvement projects that would be more effective if workflows and data elements could be built into the EHR. For many sites, modifying their EHR is an impossibility due to cost and lack of knowledgeable personnel.

The ideal solution to the Multnomah County issue of creating data sharing and interoperable systems was estimated to be expensive. The county decided to go with the short-term, less-costly option for the time being, while trying to leverage movement and interest to secure funds for a longer term solution.

Confidentiality

While many systems are interested in EHR interoperability, there have been anecdotal reports of concerns by mental health providers around sharing information with primary care providers. The reports indicate that some mental health providers feel that not all of the information they would input into an EHR should be shared. Some sites are exploring different ways that information can be kept separate, while others feel that there needs to be a change in the clinic culture such that mental health providers and primary care providers can understand privacy laws and trust each other.

Telemental health

SBHCs initially projected to see 2-3 patients per month for telepsychiatry, but have fallen under this initial estimate. Wheeler County increased their outreach to the community to increase awareness that this service is now available. They believe there is still substantial stigma attached to receiving mental health and substance abuse services in their small, rural community. Additionally, as telemedicine is relatively new in Oregon, both grantees found it difficult to get meaningful assistance or clarity on issues that they faced, including reimbursement.

>> Looking Forward: Sustainability

Billing and reimbursement of mental and behavioral health

As we look towards sustainability for SBHCs in general and for mental health services within SBHCs, it is necessary to examine billing and reimbursement. In Oregon, billing and reimbursement for mental health is complicated by the fact that there is a distinction between behavioral health and mental health (See Appendix D for more information). Behavioral health bills through primary care, while mental health bills through the mental health system. Some SBHCs provide behavioral health services, some provide mental health services, and some provide both types of services. In regards to billing, for behavioral health, the provider must be licensed and credentialed to bill and receive reimbursement. For mental health, the medical sponsoring agency billing the codes needs to be certified to provide mental health by the county mental health authority. The requirement for agency certification may be difficult or impossible for some SBHC medical sponsors. Even if the SBHC partners with a certified mental health agency to provide mental health services, the SBHC and agency must determine a reimbursement mechanism for billing such that the SBHC receives the funds. Some SBHCs are unable to bill Medicaid because they do not have a contract with their Coordinated Care Organization. Of the sites that we have billing data for, 38 SBHCs (out of 52) billed Medicaid for mental health services provided to Medicaid patients in SY 2013-2014.

Additional challenges include the large number of non-billable services done by SBHC mental health providers and staff in order to engage youth and their families, like outreach, care coordination, and health education. These services help youth and families access services and receive better care, and for communities to have a better understanding of mental wellness.

In the 2015-2017 grant cycle the State Program Office will focus on SBHC mental health sustainability by examining the current payor relationships, current challenges to billing and reimbursement, and explore ways to support SBHCs in providing mental health services as a core part of their work.

Appendix A: Logic Model

Mental Health Expansion Grant						Goal
Inputs	Activities	Outputs	Short Term Outcomes (3 months to 1 year)	Mid Term Outcomes (1-2 years)	Long Term Outcomes—(2+ years)	
•AMH staff •AMH resources •Funding •Technical Assistance (TA) •SBIRT / Depression project •SPO staff •SPO resources •SBIRT / Depression project •Expertise in YPAR, adolescent health, SBHCs, data and evaluation •Encounter data •SBHC and county staff •SBHC experience and resources •Data capture systems	Provide funding for: Capacity Grants (39 SBHCs) Implement projects: • Telemental health (2 SBHCs) • SBIRT and Depression Screening (9 SBHCs) • Cultural Competency (13 SBHCs) • YAC (8 SBHCs) • YPAR (8 SBHCs and 4 community partners) • Data system (7 systems)	•Funding to SBHCs Capacity and Integration: •# MH staff hired •# and type of MH services provided (including telemental health) Quality of care: *Screening* •# SBHCs in Learning Collaborative •# providers charting SBIRT and depression screening *Cultural Competency* •# staff trained •Project specific outputs Youth Engagement: *YAC* •# facilitators hired •# youth recruited •Topics chosen •YPAR project results *YPAR* •# trained •# YPAR projects completed •Project specific outputs Data Systems: •# Contracts with EHR provider •# SBHCs using MH EHRs	Capacity and Integration •SBHCs have MH provider on-site •SBHCs capable of providing telepsychiatric services Quality of Care: •SBHCs (and their providers) participating in project gain skills and knowledge about SBIRT and depression screening •SBHC staff will increase knowledge and skills on topics incorporating cultural competency Youth Engagement: •Youth learn about mental health issues that are pertinent to them and their community •Youth will learn how to conduct and lead research projects Data Systems: •SBHCs acquire and begin charting mental health and primary care data	SBHCs able to provide MH services on-site and coordinate care with primary care provider Increase in # of youth receiving services and in # services Improved screening on substance abuse and mental health topics SBHC staff improvement in ability to meet language and cultural needs of clients Youth engaged in mental health promotion and prevention Increased efficiency, care coordination, and billing due to EHR	Integration of behavioral health and primary care Increased mental health capacity and access to services Improved quality of care Networks built between SBHCs and community partners Improved SBHC ability to capture data, provide and bill for services, and increase efficiency Changed social norms related to mental health	Mental health needs of adolescents met by Oregon SBHCs

Appendix B: Capacity Grantees

County	Medical Sponsor	Mental Health Provider Agency	SBHCs	Had mental health in prior school year (Y/N)
Baker	Baker County Health Department	New Directions	Baker HS	N
Benton	Benton Community Health Center	Benton Community Health Center	Lincoln ES	N
			Monroe ES/MS	N
Clackamas	Clackamas County Health Department	Clackamas County Health Department	Oregon City HS	Y
			Sandy HS	N
Columbia	Public Health Foundation of Columbia County		Rainier Jr/Sr HS	Y
			Sacagawea ES	Y
			Vernonia K-12	Y
Coos	Waterfall Clinic	Waterfall Clinic	Marshfield HS	N
			Powers K-12	N
Crook	Mosaic Medical	Lutheran Family Services	Crooked River ES	Y
Deschutes	LaPine Community Health	Deschutes County Mental Health	LaPine HS	Y
	Mosaic Medical		Ensworth ES	Y
			Lynch ES	Y
	St. Charles		Redmond HS	N
			Sisters HS	N
Jackson	La Clinica	La Clinica	Crater HS	Y
			Jewett ES	Y
	Rogue Community Health	Rogue Community Health	Ashland HS	Y
			Butte Falls	N
			Eagle Point	N
Lane	Peace Health	Peace Health	Cascade MS	Y
	Lane 4J	Lane County Behavioral Health	Churchill HS	Y
			North Eugene HS	Y

County	Medical Sponsor	Mental Health Provider Agency	SBHCs	Had mental health in prior school year (Y/N)
Multnomah	Multnomah County Health Department	Multnomah County Health Department	Centennial HS	N/A (first year)
			Cleveland HS	Y
			David Douglas HS	Y
			Grant HS	Y
			Madison HS	Y
			Parkrose HS	Y
			Roosevelt HS	Y
Umatilla	Umatilla County Health Department	Umatilla County Health Department	Pendleton HS	Y
			Sunridge MS	Y
Union	Center for Human Development	Center for Human Development	La Grande HS	N
			Union K-12	N
Washington	OHSU	Lifeworks NW	Merlo Station HS	Y
Wheeler	Asher CHC	Community Counseling S	Mitchell K-12	Y
Yamhill	Virginia Garcia	Yamhill Health Department	Willamina HS	N
	Willamette Heart		Yamhill-Carlton HS	Y

Appendix C: Support Projects

County	SBHC	Project Type(s)
Baker	Baker HS	Screening (START project) Data system
Clackamas	Milwaukie HS	Data system
Curry	Brookings Harbor	Telemental health
Deschutes	La Pine HS	Screening (START project) Youth Advisory Council (YAC) Data system
	Redmond HS	Screening (START project) Youth Advisory Council (YAC) Data system
	Sisters HS	Screening (START project) Youth Advisory Council (YAC) Data system
Jackson	All La Clinica SBHCs	Cultural competency and supporting equity
	Crater	Screening (START project) Youth Advisory Council (YAC)
Lane	4J / Bethel	Data system Cultural competency and supporting equity
Multnomah	All schools	Data system
Union	La Grande / Union	Data system
Washington	Merlo Station	Data system
	Merlo/VGMHC Schools	Screening / Framework Implementation Youth Advisory Council (YAC) Cultural competency and supporting equity
Wheeler	Mitchell	Telemental health

>> Appendix D: Behavioral and Mental Health Care in Oregon

In Oregon, a distinction is made between behavioral health care and mental health care. The grant requirements did not specify what model of care that SBHCs provide (i.e. mental health, mental health and behavioral health hybrid, or behavioral health), as long as the provider was a Qualified Mental Health Provider (QMHP). Depending on preexisting partnerships in combination with community and client needs, SBHC grantees chose a model of mental or behavioral health care, or built upon their established model.

Mental health can be known as "traditional mental health", "specialty mental health", or "mental health". This type of care is typically used for acute symptoms associated with mental health diagnosis. Patients undergo a formal intake process that includes an assessment (with information laid out by Oregon Administrative Rules (OARs) 309-039-0540) and creation of a treatment plan based on the assessment. The mental health provider bills standard mental health codes for reimbursement. In Oregon, to provide mental health services and be eligible for reimbursement from Medicaid, the mental health provider must be employed by a certified Medicaid biller by their community mental health program, which is operated by the local mental health authority[xxvi]. Some counties operate this program directly with county employees, through contract(s) with local non-profit organization(s), or a combination of county-operated and contracted services.[xxvii] Mental health providers employed by the community mental health program are paid for services rendered, as a result, having a full caseload is incentivized[xxviii]. There is no need for a patient to be referred to mental health by a primary care provider.

Overview of Mental Health and Behavioral Health Differences	
Mental Health • Longer sessions • Greater frequency of sessions • Bill mental health codes • No need for referral • Focus on improving mental health • Diagnostic assessment, psychotherapy and psychopharmacological, individual or group, recovery-oriented care. Broad scope that varies by diagnosis	**Behavioral Health** • Short sessions • Greater time between sessions • Bill medical codes • Need primary care provider referral • Focus on improving health outcomes • Problem-focused, solution oriented, functional assessment. Focused on primary care provider concern and enhancing primary care plan. Population health model (Dundon M, 2011)

Behavioral health focuses on the psychological and social determinants that affect overall health[xxix]. In June 2014, a workgroup (the Integrated Behavioral Health Alliance of Oregon) was created to define the scope and standards of behavioral health provision. Through their work, Senate Bill 832 passed in June 2015 that defines the practice of integrated primary care, defines "Behavioral Health Homes" and "Behavioral Health Clinicians" for the first time[xxx]. Behavioral health providers are known by many names, including "behaviorists", "behavioralists", or "behavioral health consultants". In order to see a behavioral health provider, a patient needs to be referred by the medical provider. The behavioral health provider will use the diagnosis from the medical provider referral to provide treatment and bill for the services they provide. The codes used for billing behavioral health services are health and behavior codes, not mental health codes. Behaviorists are typically LCSWs and have the ability to provide specialty mental health services if employed by an agency that is a certified Medicaid biller for their county. Thus, behaviorists may provide both mental health and behavioral health care, depending on the needs of the client.

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