Element 4b: School Based Health and Behavioral Health Services

Overview: School based health and behavioral health services are available in different LEAs with varied levels of availability and types of services and are provided to students through a number of different mechanisms. Coordination of school–based health and behavioral health services in a manner that meets the needs of students reduces barriers to learning and improves the health and educational outcomes of students.

Full Commission Element: Screen, identify, and treat the behavioral health needs of students in a coordinated and trauma informed manner.

Full Commission Element: Identify the needs and increase capacity of local education agencies, local health departments, and community–based entities to establish and expand access to health services through School Based Health Centers to meet the comprehensive primary and preventative care needs of students in a coordinated and community focused manner

Background School Based Behavioral Health Services

SB 1265 Expanded Task: As the Commission on Innovation and Excellence in Public continues its work on a final report, the Commission should continue to evaluate the need for additional student behavioral health and other wraparound services. The Commission also should consider and include recommendations in the final report regarding the need for additional behavioral health and wraparound services in local school systems and whether and how funding should be provided to local school systems to support and expand access to these services.

Background – School Based–Health Centers

A School–Based Health Center (SBHC) is approved by MDH and MSDE, is located on school grounds, provides on-site comprehensive primary and preventative health care, referrals and follow-services, and may provide on-site dental care or behavioral health care, referrals and follow-up services (COMAR 10.09.76.01). In fiscal year 2019, there are 83 school based health centers located in 12 local education agencies with total funding of $6.3m from all sources excluding Medicaid and commercial insurance reimbursement. The funding sources for the $6.3m consist of 42% in State funds, 39% local funds, 8% donations, 1% federal, and 10% in other funding.

The average funding reported to MSDE for the 83 SBHCs is $75,239. Funding sources for the average SBHC includes 38% State funds, 44% local funds, 8% donations, 1% federal funds and 10% other funding. "In kind contributions" is listed for many sites, but without

a dollar amount equivalent. It should be noted that some staffing is likely accounted for in base and compensatory education weights.

MSDE defines three levels of SBHCs:

Level I – Core SBHC: must have a minimum of eight hours per week with a licensed medical clinician present and be open a minimum of two days per week when school is open. Level I staff must include a licensed medical clinician and administrative support staff. There may be additional clinical support such as an RN, LPN, or CNA and the licensed medical clinician may not replace the school nurse.

Level II – Expanded SBHC: Must be operational with an advance practice provider on site a minimum of 12 hours per week, available for three to five days when school is in session. Mental health services must be available on site for a minimum of three days and a minimum of 12 hours per week. The SBHC staff must include a licensed medical clinician, a behavioral health professional, clinical support staff (RN, LPN, CAN) and administrative support staff.

Level III – Comprehensive School–Based Health Center: Medical services must be available a minimum of 5 days and 20 hours per week. The availability of full time services should be commensurate with the number of students enrolled at the school. The SBHC may rely on community providers for 24 hour coverages. Level III SBHC services are available for limited hours for defined services for students enrolled in summer hours. The SBHC is open before, during and after school hourse. Level III SBHC staff must include a licensed medical clinician, a mental health professional, clinical support staff (RN, LPN, CAN), administrative support staff, and at least one additional service provider including a general or pediatric dentist, dental hygenist, nutritionist, or health educator for a minimum of 4 hours per month.

Design Assumptions:

1. Dedicated staff at MSDE responsible for close collaboration with other youth–serving agencies to establish shared goals, processes to collect and share data and to identify ways to leverage and blend funding to support school behavioral health in schools. Dedicated staff at MSDE to coordinate with school behavioral health coordinator and staff in LEAs.
2. Each LEA shall have at least one licensed behavioral health coordinator dedicated to support school behavioral health with a Master's Degree and behavioral health training and experience in schools (mental health coordinator in each LEA required under SB 1265 of the 2018 Session).
3. Staff in all schools will be trained to recognize student behavioral health issues, as well as students experiencing trauma or violence outside of school and how to

refer students to behavioral health services. School staff will also be trained in protocols for how to support any student receiving these services while he/she is enrolled in school.

4. Schools to develop and implement systematic screening to identify students with behavioral health needs using an evidence–based measurement approach.
5. Scaling of school behavioral health service availability to ensure that all students have some exposure and access to behavioral health programming and services and to ensure that schools without behavioral health services will organize response plans to connect all students to community–partnered school–based or community behavioral health and other services, as needed.
6. Schools will be required to develop partnerships with available community resources and experts in order to develop an active and comprehensive referral network for community–partnered school based or community behavioral health services.
7. SBHCs should be established or enhanced in schools with high population of students with significant unmet health and behavioral health needs.
8. Where SBHCs exist, additional behavioral health services or community–partnered behavioral health services should be coordinated and potentially co–located with the SBHC where feasible.
9. The initial late 1990's State commitment of $6 million for expansion of SBHCs should be met and adjusted for inflation to approximately $9 million beginning in FY2021.
10. A statewide needs assessment of all LEAs should be completed by December 30, 2019 (appropriate entity? MSDE, MDH, Council on the Advancement of School Based Health Care?) to determine the need and prioritize the expansion and establishment of new SBHCs in each LEA at schools with a high population of students with significant unmet health, dental health, and behavioral health needs.

Implementation Considerations:

1. Complexity of funding streams that currently exist for behavioral health services and SBHC's through federal grants, state grants, local dollars, nonprofit grants and support, commercial insurance reimbursement and Medicaid reimbursement
2. Current funding streams viewed as inadequate.
3. Lack of data on funding streams and appropriate funding levels including value of in–kind contributions. Current data and survey information is difficult to access, unavailable or incomplete.
4. Many behavioral health and school–based health services that are needed include activities that cannot be billed to commercial insurance or Medicaid including, administrative support, prevention, training, case management, somatic and behavioral health promotion, teacher consultation and team meetings.
5. Current lack of capacity and access in many communities to health and behavioral health services and health and behavioral health providers.

6. Need to identify adequate staffing ratios to support student behavioral health including staffing of psychologists, social workers, professional counselors, occupational therapists
7. Need to identify adequate staffing ratios, service hours, and appropriate levels of medical licensure for SBHCs to increase availability and access.
8. Evaluation of staffing ratios for both health and behavioral health services should include an evaluation of how telehealth can be better utilized to provide quality care while increasing access and capacity.
9. The need to expand capacity of existing SBHC's and to establish new SBHC's is not fully known at this time and will be based on a statewide needs assessment. The assessment will determine the optimal expansion through existing SBHCs and creation of new SBHCs and the amount of funding necessary to address the identified expansion needs.
10. Processes for establishing SBHCs are complicated and apparent regulatory barriers exist to expanding sponsorship of SBHCs (currently COMAR 10.09.76.03 lists only local health departments, FQHCs, and certain general clinics).
11. To maximize the establishment new SBHCs and enhancement of existing SBHCs, technical assistance will be needed for: initial start–up; identifying financing mechanisms; expanding service capacity (telehealth, etc.) ; Medicaid and insurance billing complexities; quality assurance, and collection of data.
12. Parent/guardian engagement necessary to maximize access for students to health and behavioral services, reduce stigma, support students outside of the school environment, enhance parenting skills and improve social, emotional and educational outcomes for students.