Optum

Optum Idaho

A Toolkit for Behavioral and Mental Health Services in Idaho Schools

with the Idaho Behavioral Health Plan (IBHP)

Optum Idaho Mental Health in Schools Email: *mhsidaho@optum.com*
Mailing Address: 322 E Front St, Ste 400, Boise, ID 83702

Table of Contents

Acronyms

Acryonym	Meaning
ADA	Americans with Disabilities Act
ADHD	Attention Deficit Hyperactivity Disorder
ASAM	American Society of Addiction Medicine
BB	Bounce Back
BD	Behavioral Disorder
BIP	Behavioral Intervention Plan
CANS	Child and Adolescent Needs and Strengths Assessment
CBITS	Cognitive Behavioral Intervention for Trauma in Schools
CFTSI	Child/Family traumatic Stress Intervention
CMH	Children's Mental Health
CPSS	Child PTSD Symptom Scale
DBD	Disruptive Behavior Disorder
DBH	Division of Behavioral Health
EBD	Emotional/Behavioral Disturbance
EI	Emotional Impairment
EMR	Electronic Medical Record
FAPE	Free Appropriate Public Education
FBA	Functional Behavioral Assessment
FERPA	Family Educational Rights and Privacy Act
HIPPA	Health Insurance Portability and Accountability Act
IBHP	Idaho Behavioral Health Plan
IDAPA	Idaho Administrative Procedures Act
IDEA	Individuals with Disabilities Education Act
IDHW	Idaho Department of Health and Welfare
IEP	Individual Education Plan
ISF	Interconnected Systems Framework
LOCGs	Level of Care Guidelines

Acryonym	Meaning
LRE	Least Restrictive Environment
MOU	Memorandum of Understanding
MTSS	Multi-tiered System of Support
NAMI	National Alliance on Mental Illness
PBIS	Positive Behavioral Interventions and Supports
PSC	Pediatric Symptoms Checklist
PTS	Post-Traumatic Stress
RFQ	Request for Qualifications
RTI	Response to Intervention
SAMHSA	Substance Abuse and Mental Health Services Administration
SDQ	Strengths and difficulties Questionnaire
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SHAPE	School Health Assessment and Performance Evaluation
SSA	Social Security Act
SSET	Support for Students Exposed to Trauma
STEAM	Science, Technology, Engineering, Arts and Mathematics
STEM	Science, Technology, Engineering and Mathematics
TCC	Targeted Care Coordination
TCIT	Teacher-Child Interaction Training
TST-R	Trauma Systems Therapy for Refugees
YES	Youth Empowerment Services

Purpose

A school-based model for behavioral and mental health service delivery can increase treatment accessibility for youth. This toolkit will review a number of steps for developing a working relationship between a clinical service provider, the school district and the parents of children who need services. It will help identify the requirements to establish collaboration between educators, family members, and mental health professionals in order to provide youth with better access to mental health services.

This document defines “educational need” and “medical necessity” in order to identify appropriate services. The participating systems may have different eligibility requirements to attain services. These requirements should be clearly identified by each of the collaborating partners.

Who Might Use This Toolkit?

The toolkit provides a general guideline for starting a collaborative program and may need to be adapted in situations involving unique considerations based on district or provider requirements. Some requirements (polices, guidelines, rules and laws) may differ between education and mental health agencies.

Network Providers

This Toolkit has been developed to assist Optum Idaho network providers establish services under the Idaho Behavioral Health Plan (IBHP) that can be presented to local school district officials around the State.

Idaho School Districts

School personnel can use this toolkit to help identify their needs and resources to implement these services. In addition, it will assist the effort to create a safe and supportive learning environment.

Background & Rationale

Behavioral and Mental Health in Schools

On average, our youth spend 6-7 hours a day at school. In order to have optimal success, children need to come to school "ready to learn." Readiness includes having adequate rest, proper nutrition, a safe environment, and positive mental health.

Interconnected Systems Framework is an emerging approach for building a single system of social, emotional, and behavioral supports in schools.

The term "Behavioral and Mental Health" represents a continuum of concerns that includes children with anxiety, Attention Deficit Hyperactivity Disorder (ADHD), post-traumatic stress due to trauma, major depression, and more. Federal laws are in place for students who qualify for support to address these concerns. These laws will be explained in detail later in this document.

Social Emotional Learning: A Model for Behavioral and Mental Health

The current effort to establish clinical resources in Idaho schools is one element of a broader national endeavor to create a safer, healthier environment for school children. This initiative began in 1999 when the Safe Schools and Healthy Students program began in response to school-based shootings that were occurring in the U.S.[1] This original program was supported by various federal, state, and private partners throughout the country and continues today.

Core Features: A Comprehensive School Mental Health System

In its recent document detailing the development of mental health resources in schools, the Substance Abuse and Mental Health Services Administration (SAMHSA)[2] supported School Mental Health Work Group describes an overarching structure for a comprehensive school based mental health program.

Initiating such a comprehensive system requires coordination between multiple groups of contributors who include school personnel, (administrators, educators, counselors, social workers and school psychologists), community partners (medical, behavioral health) and family members. All these contributors will need a "roadmap" of how such a system is constructed and what their role might be in participating. The core features of such a plan are detailed below.[2]

Core Features of Roadmap

CLICK HERE TO RETURN TO TABLE OF CONTENTS

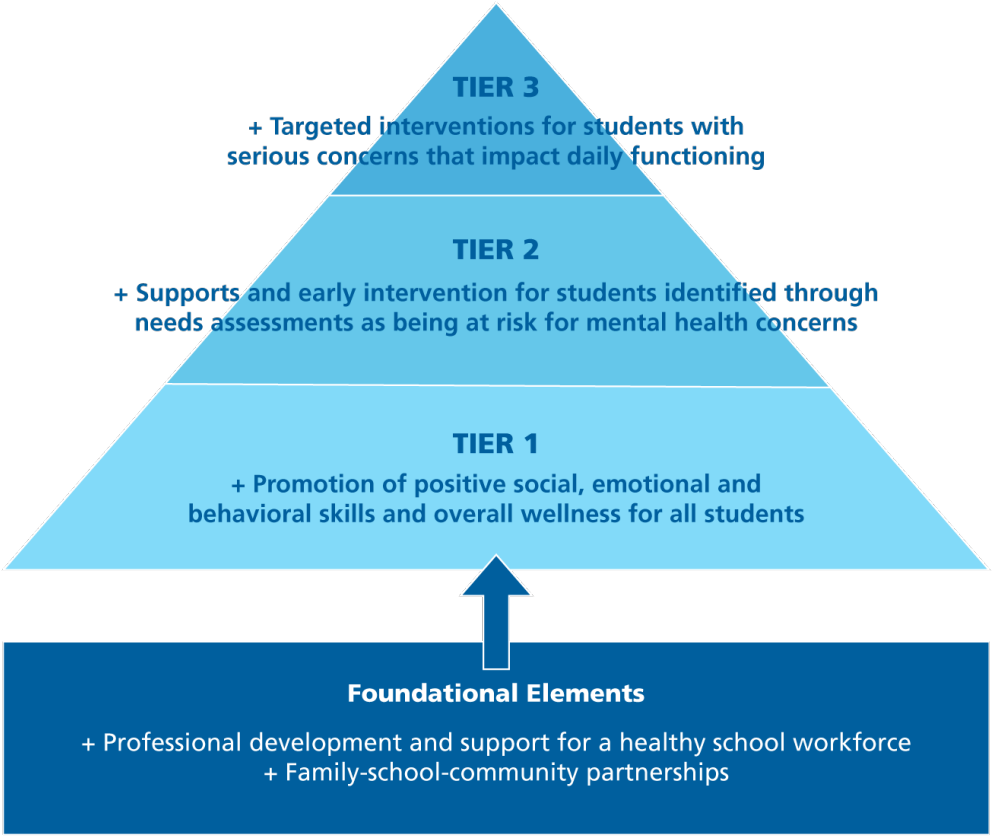
"Many schools deliver instructional or behavioral intervention to students in varying intensities, also known as a multi-tiered system of support (MTSS), to address the academic needs of the larger student body, including (but not limited to) students with identified disabilities. Based on a public health framework, prevention is an underlying principle at all three tiers;

Tier 1 Focusing on promoting mental health and preventing occurrences of problems.

Tier 2 Focusing on preventing risk factors or early-onset problems from progressing.

Tier 3 Focusing on individual student interventions that address more serious concerns and prevent the worsening of symptoms that can impact daily functioning.

Multi-Tiered System of Support



Professional development and support for a healthy school workforce as well as family-school-community partnerships are foundational elements that support these three tiers. Matching the range of academic, behavioral and social needs within a school involves the layering of interventions from universal approaches to targeted programming for students with mild impairment and, for some students, adding on individualized interventions linked to the lower-tiered structures.

The MTSS approach ensures that all students, including those in both general and special education, can access the service array and will have exposure to universal mental health supports. The number of tiers in an MTSS can vary, though many districts employ a three-tiered model."[2]

The effectiveness of school-based efforts is enhanced when emotional and behavioral needs are addressed at the appropriate level. A broadly based and systemic program that addresses prevention activities through intensive approaches is a proven and effective platform to introduce interventions. The Interconnected Systems Framework (ISF) is a specific program that has the endorsement of the SAMSHA[3] and addresses the needs for behavioral health support at more than a single level. The ISF is an emerging approach for building a single system of social, emotional, and behavioral supports in schools.

By integrating Positive Behavioral Interventions and Supports (PBIS) with school mental health services, the ISF brings community partners and families into a multi-tiered structure. PBIS is a framework that organizes a continuum of evidence-based, system-wide practices to support a rapid response to student needs. Frequent databased monitoring informs decision-making and empowers each student to achieve his or her potential.[3]

Providing an avenue for youth to receive mental health services in school is a component of PBIS. Using "clinical treatment" represents the highest level of support in a three-tiered model for school based mental health.[3, 4] Immediately preceding individual therapy in the schools in the ISF are universal and more selective prevention programs that involve groups of children with similar behavioral and mental health concerns. Evidence-based interventions by licensed mental health clinicians to address a child or youth's needs represent one element of this broader intervention model.

Facts About School-Aged Children and Mental Health

- The National Alliance on Mental Illness (NAMI) reported in 2019 that over one third (37%) of students with a mental health condition age 14-21 and older who are served by special education drop out—the highest dropout rate of any disability group.[5, 6]
- In 2017, a National Academy of Sciences report defined a 28% diminishment of net family income by age 50 for persons having mental health issues as a child.[7]
- It was concluded that effective treatments targeted to children that lower the risk of experiencing these psychological conditions or that mitigate adult psychological and economic consequences are likely to have long-lasting payoffs and to be very cost-effective.[7]
- Twenty percent of children in the U.S. may have a mental health condition, but as few as 21% of those children actually receive treatment.[8]
- A recent report (August 2019) provided by the United States Inspector General reviewed the incident of follow-up behavior therapy for children in Medicaid when they were prescribed medication for ADHD.[9]
  - » The national average of children participating in Medicaid with no follow-up behavior therapy was 45% while the average for children participating in Medicaid in Idaho with no follow-up behavior therapy was 78.4%. (Appendix E)[9]
  - » The national average for no follow-up care within 30 days after hospitalization for ADHD was 35.1% while Idaho's average rate was 80%. (Appendix D)[9]
  - » Youth are 10 times more likely to complete evidence-based treatment when offered in schools than in other community settings.[2]

The national average of children prescribed medication for ADHD was 45%, while the average for children participating in Medicaid in Idaho with no follow-up behavior therapy was 78.4%.

Youth are 10 times more likely to complete evidence-based treatment when offered in schools than in other community settings.

Idaho in an Overview

Children, adolescents and young adults in Idaho represent a unique population of learners with diverse talents and challenges. The 2019 Bluum[10] report detailing Idaho's education environment identified 274,046 attendees of public schools and 65,099 participants in other schools of choice. These individuals represent the majority of students ranging in age from 5-18 years.

Idaho Children with Mental Health Challenges

- A report from the Idaho Department of Health and Welfare (IDHW) suggested that 20% of children have a diagnosable condition while 10% have a serious emotional disturbance (SED) that disrupts their daily functioning.[11]
- More specific information about Idaho children was detailed in the IDHW's Division of Behavioral Health (DBH) mental health public dashboard report for June 2019. This report stated that 1,936 children were provided intakes to Children's Mental Health (CMH) offices across the seven regions for State Fiscal Year (SFY) 2019.[12]
- A total of 2,996 children in the state received services throughout SFY 2019 in DBH offices.[12]

Idaho Children in the Medicaid Plan

- Medicaid members in the IBHP are represented in the IDHW reference to children with SED.
  - » Between April 1, 2018 and April 1, 2019, approximately 66,860 distinct child/youth clinical contacts for outpatient behavioral health services with IBHP providers occurred.[13]
  - » Within that group, the five most prevalent diagnosis groups were:
    - › Depressive Disorders
    - › Anxiety Disorders
    - › Trauma-Stress Related Disorders
    - › Disruptive/Impulse/Control Disorder
    - › Neurodevelopmental Disorders[13]
- These data become more significant when considering the findings in the 2016 Child Mind Institute report about the impact of having a comprehensive mental health resource in the school that show...
  - » "...In fact, young people with access to mental health services in school-based health centers are 10 times more likely to seek care for mental health or substance abuse than those who do not."[14]

A report from the Idaho Department of Health and Welfare (IDHW) suggested that 20% of children have a diagnosable condition while 10% have a serious emotional disturbance (SED) that disrupts their daily functioning.

Considered together, these data points reflect a need for behavioral health resources that address the problems experienced by children in Idaho. Out-of-school time is related to school difficulty and more complex challenges with academic success. This toolkit is designed to support resources in the environment that many Idaho children experience daily. Research shows that students participating in a comprehensive and collaborative school-based mental health program have substantially fewer disciplinary problems, they enjoy improved mental health, and perform better in school (SAMHSA).[15,16]

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Getting Started

Developing a program of "on site" mental health services involves the following considerations and mileposts:

- Planning and timelines for activity and acquisition of personnel
- Clinical agency and provider preparedness
  - » Administrative processes
  - » Billing/Funding sources for services
- School District preparedness
  - » Child referral for services
  - » Parent/Guardian engagement
  - » Youth engagement
- Member eligibility
  - » Education criteria for specialized support
  - » Medicaid criteria for IBHP services
- Outcome metrics and reporting

Idaho has seven health districts, 115 school districts, and 57 charter schools throughout the state. Each brings its specific considerations to developing behavioral health services in the school setting.

Planning and Timelines

Idaho has six educational regions, 115 school districts, and 57 charter schools throughout the state.[10] Each brings its specific considerations to developing behavioral health services in the school setting. The outline below covers many of the elements needed to develop services while allowing adaptations to be added by each district and agency relationship.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

The overall process can occur in phases outlined in elements 1 through 6 below.

1. Establish commitment of participants
2. Establish and maintain operational teams
3. Develop systems of communication and collaboration
    a. School District personnel
    b. Agency and providers
    c. Parents/caregivers/youth
    d. Community stakeholders
4. Clinical intervention – Define operational aspects of how each of the system elements function to bring services to the school-aged student
5. Outcomes
    a. Identify the tools and how they will be used to determine outcomes
    b. Identify who will administer the tool(s)
    c. Determine how the data will be analyzed and reported
6. Satisfaction surveys
    a. Parent/Caregiver
    b. Educator
    c. Child/Youth
    d. Mental Health Provider

Developing these elements will require collaboration and planning among the participants across the timeline depicted below:

12 Months Out

Objectives

- Identify interested participants in the forms of "model" schools, programs or departments within the District.
- Determine how the mental health clinic model can supplement existing District mental health programs and behavioral supports or provide new pieces to the programs which already exist.
- Explore existing "best practices" in other Districts and states.
- Establish potential funding sources and strategies to underwrite programmatic development.

Stakeholders

- District decision makers to include Superintendent, Director of Special Education, and/or Director of Counseling Services.
- School level decision makers to include the Principal, Counselor, Special Educator, and Parent/Teacher organization.
- Identify school level leads who will be points of contact for agency clinician and participating parents.

Activity

- Schedule and begin independent and collaborative meetings in an alternating pattern to complete work items within each area.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

9 Months Out

Objectives

- Develop Request for Qualifications (RFQ) for interested agencies.
- Develop Memorandum of Understanding (MOU) from the school to specify expectations for clinician activity within the building.
- Obtain confirmation from District legal department that RFQ and MOU are ready for distribution to potential candidate agencies and clinicians.
- Publicly announce the presence of the RFQ and provide the parameters for responses from interested agencies and providers.
- Clarify and confirm any additional funding resources that might be available through grants, endowments, and other sources.

Stakeholders

- District and school-level decision makers.
- Agencies and clinicians interested in pursuing the effort described in the MOU.

Activity:

- Complete all project documents to enable process to move forward.

6 Months Out

Objectives

- Review and score RFQ submissions from interested agencies to determine which might be eligible for consideration.
- Complete selection of those agencies and providers who meet the criteria defined in the MOU and confirm their continued interest in the project.
- Announce successful agency and provider identities and provide instructions for subsequent actions to be taken prior to conducting hiring interviews at the school level.
- Provide procedural instructions for candidate interviews at the school level and determine the relative areas of importance to be covered in the interview process:
  - » Determine clinician experience, characteristics and proficiency with evidence-based interventions for school setting.
  - » Interview teams make selection from the candidates interviewed and advise district administrative personnel of the selection.
  - » An administrator and agency director/clinician complete the MOU for operations in the school.

Stakeholders

- Designated team members and agency director/clinician.

Activity

- Clinical agency director to begin considering programs and clinician's activity within the school setting.
- Interviews are completed and clinicians chosen for specific buildings (interviews done in collaboration with school district personnel).

2-3 Months Out

Objectives

- Define team meeting schedule and begin identifying important aspects of collaboration, operations, and work relationship between educators, parents/ caregivers, youth, and clinician.
- Define processes and procedures for referrals, communication, emergencies, workflows, documentation, security, monitoring, outcomes, and discharge.
- Determine the role of broader district programs addressing behavioral health and the uniformity of school level support for evidence-based clinical interventions with students.

Stakeholders

- Building team members, agency director/clinician, parents/caregivers, and other community participants.

Activity

- Construct the processes and operations that will enable a child to receive in-school services and complete a "virtual" walkthrough to identify gaps or challenges.

1-2 Months Out

Objectives

- Identify the "in-school" clinician space, equipment, hardware, phone, storage area, furniture, and supplies needed to provide therapeutic services.
- Determine how the outcome data will be obtained, analyzed and reported to communicate the program's status and effectiveness.

Stakeholders

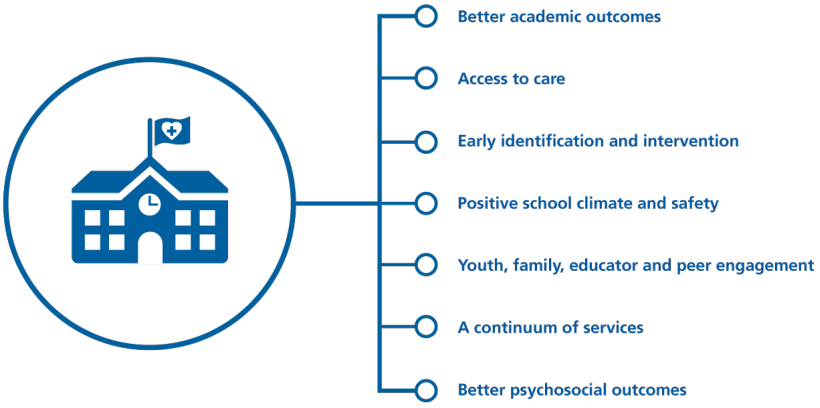
- Building administrator, team members, and clinician

Activity

- Establish where the services will be provided and ensure that equipment needs are met.
- Provide in-service training (as needed and provided by school district) for outside provider team members.

There are clearly identified "positive outcomes" evidenced in the status of children and adolescents who have participated in a comprehensive school mental health system.[2] These outcomes span a spectrum of experiences that result in improvement of not just a child's mental health, but also a child's ability to successfully manage the challenges of emotional and physical development. These areas are featured in the figure below:

The questions and information developed through the different levels of collaboration with project partners are represented in the following table. This table details a variety of considerations that might be expected in the planning but may not completely address the unique attributes of individual districts and mental health agencies that can only be defined at the local level.



Agency/School Readiness for Implementation

Personnel

Agency/Clinician

- **Who will be the point of contact in the agency for school staff and parents specific to the program in the school?**
- How familiar is the clinical agency and clinician with required educational operations involving…
  - » Federal requirements for the Individuals with Disabilities Education Act (IDEA) and the implications for ensuring a Free Appropriate Public Education (FAPE)?
  - » Additional elements of IDEA that include learning in a Least Restrictive Environment (LRE) and how the concept of "Inclusion" is related to the student's learning plan?
  - » The relationship of "Response to Intervention (RTI) and other levels of intervention support in the educational setting.
  - » The basic concepts behind an Individual Education Plan (IEP) and a 504 Plan for learning?
  - » The Family Educational Rights and Privacy Act (FERPA) and how it might relate to clinical practice in the school setting?
  - » The essential criteria of an Emotional/Behavioral Disturbance (EBD) designation and the implications for educational planning and clinical treatment?
  - » The elements of a "Functional Behavior Assessment (FBA) and its utilization with students under consideration for support via an IEP?
  - » The consideration for a positive Behavior Intervention Plan (BIP) as it supports the therapeutic work being done in treatment at school?
  - » The distinction between "educational needs and goals" and "medically necessary" treatment and its relationship in the school to clinical treatment?

School

- **Who will be the point of contact for agency, clinician and parent communication?**
  - » District level (i.e., Special Services Director)
  - » Building level (i.e., School Counselor, Social Worker, Principal, Vice Principal, Special Education representative)
- **What elements should be included in the District's (RFQ) notice?**
  - » Are there minimum thresholds for a clinician's experience and credentials?
  - » Are these services intended for only enrolled students? (See Appendix A)
- What are the criteria to be used to score the template for the different agency responses to the RFQ?
- Will the MOU be uniform across the district or individualized for each school setting?
  - » Reporting to the school
  - » Crisis response
  - » Clinician communication with parents (See Appendix C)
- What are the elements of concern to be addressed in the interview process with prospective agencies and ultimately the clinicians to be selected
  - » Level of clinician participation with school activity
  - » Number of clinical contacts per day, (See Appendix E)

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Operations

Agency/Clinician

- Does the clinician know about school policies and expectations of staff for clinician engagement?
- Has there been an identified method for charting all clinical contact in the school?
  - » Electronic Medical Record (EMR)
  - » Telephonic dictation
  - » Paper chart note, etc.
- **What procedures are needed by the agency and clinician to ensure compliance with the IBHP protocol for treating children within the Youth Empowerment Services (YES) system of care?**
  - » Child and Adolescents Needs and Strengths (CANS) Assessment administration
  - » Independent Assessment with Liberty Healthcare for eligibility considerations
  - » Targeted Care Coordination (TCC)
- What steps will be taken by the agency and/or clinician to maintain appropriate communication with the school team members about the student's treatment status and participation in the program?
  - » Weekly updates regarding clinical contact
  - » New referrals
  - » Referrals that have stalled

School

- What steps are needed to ensure that staff and parents understand the role of the clinician?
- How many buildings will be participating in the project?
- **When will the program begin?**
  - » Beginning of school year
  - » Semester
  - » Quarter
- How many referrals are anticipated for participating schools?
- What types of referrals will be admitted to care in the building or are all referrals considered for intake?
- To avert risks of duplication of services, are there needed guidelines for those students having other Federal program supports?
  - » IEP
  - » 504 Plan
  - » RTI
- What contingencies are needed for summer support of students receiving treatment?

Scope of Program

Agency/Clinician

- Is the clinician's role clarified within the school team?
- Has this information been shared across the school team?
- What are the agency expectations for client contact vs. staff consults?
- What is the clinician's role in ensuring a high level of transparency in the process of initiating treatment and keeping the student's parents informed about treatment progress?
- Are there identified child study team meetings wherein the provider should expect to take part?

- Does the provider have an adequate relationship with the educational staff to effect good communication and awareness of the problems encountered in the school or classroom?

School

- Who are the building project team members and support personnel for the program?
- Have roles been identified and clarified between all team members? What roles do the "in-house" mental health professionals have in the program?
  - Counselor
  - School psychologist
  - Social worker
- **What is the referral process within the school?**
  - How is the student identified for participation?
  - Can the student self-refer to the program and if so, which school personnel should help assist with that referral?
  - What are the mechanisms and operations for reaching out to parents re: a student's perceived need for services?
  - Which school team member is recognized as the point of contact for parent communication re: service referral, service status updates and required permissions for this school activity?
  - Who is responsible for supporting the general education teacher about behavioral health needs for a particular student?

Methodology

Agency/Clinician

- Does the clinician have multiple skill sets for appropriate treatment using evidence-based therapies?
  - Individual
  - Family
  - Family groups
  - Peer group
- Are there specific, brief and trauma focused methodologies for treatment that would be appropriate in this type of consultation and treatment?
  - Teacher-Child Interaction Training (TCIT)
  - Positive Behavioral Interventions and Supports (PBIS)
  - Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
  - Bounce Back (BB)
  - Child/Family Traumatic Stress Intervention (CFTSI)
  - Trauma Systems Therapy for Refugees (TST-R)
- What is the optimal frequency of meetings addressing the development of this collaboration between the mental health agency and the school?

School

- Has the school staff been trained in the intended model for school wide intervention? (i.e., PBIS)
- What is the appropriate level of "situational awareness" for student participation and clinician activity on a daily, weekly or monthly basis?
- How are students transitioned from care as their condition improves?
- What school setting will the behavioral health clinician be in?
  - High School
  - Junior High
  - Elementary
  - Preschool
- What are the expectations of the district/school in a crisis situation with a student in the program?

  - How is a crisis defined within this school, for this age group?
  - What is the pattern of communication and who would typically be advised of the situation?

Permissions

Agency/Clinician

- Does the agency have an administrative packet to be completed by the student's parent or guardian after referral for services, but prior to initiating treatment?
  - Consent to Treat
  - Informed Consent
  - Release of Information forms
  - Reimbursement Agreements
  - Health Insurance Portability Accountability Act (HIPAA) information
- Are all of the consents and authorizations needed to begin working in the school environment and share information with the appropriate team members in place?

School

- Are all of the education-based consents and authorizations needed to collaborate and share information with the identified clinician?
- Have confidentiality considerations for HIPAA and FERPA been addressed?

Data Collection

Agency/Clinician

- Has a "needs assessment" for clinical services with the school team been completed? Has the type of data that will be tracked been discussed?

School

- Has a "needs assessment" with the consulting clinician been discussed? What data will be used to assist in tracking progress?

Evaluation

Agency/Clinician

- Has the agency discussed an approach to measuring the outcome of therapeutic work and the effectiveness of clinician support?
- How is the agency using the Wellness Assessment, or an equivalent measure of emotional/behavioral change to demonstrate treatment effectiveness?
- What are the identified intervals for assessing the child's response to treatment and how are findings reported to parent/guardians and other team members?

CLICK HERE TO RETURN TO TABLE OF CONTENTS

School

- How will you evaluate your program effectiveness using a mental health clinician in your school?
- What elements of student status will be monitored?
- What types of indices does the school use to monitor in-school operations?
  - » Absences
  - » Truancy
  - » Office referrals
  - » Nurse referral
  - » Behavioral incidents
- Informal surveys of student's well-being
- Does the school already have an adopted philosophy model?
  - » Compassionate School Model
  - » Community School Model
  - » Science Technology, Engineering and Mathematics (STEM)
  - » Science, Technology, Engineering, Arts and Mathematics (STEAM)
  - » Trauma-Informed School Model

Collaboration

Agency/Clinician

- Is there a consistent schedule and method for communication with:
  - » School team
  - » Families
  - » Youth

School

- Is there a consistent schedule and method for communication with:
  - » Consulting agency and clinician
  - » Families
  - » Youth

Space and Materials

Agency/Clinician

- Has an identified space been approved and needed materials acquired to begin program?

School

- Has an identified space been approved and needed materials acquired to begin program?
- Have building access hours to provide services been determined?
- Have the following elements of clinical practice been determined?
  - » Play therapy tools
  - » Art materials
  - » Musical instruments
  - » Clinical records
  - » Furniture
  - » Phone
  - » Computer

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Eligibility Criteria

When education and mental health resources are combined, clear eligibility criteria for participation must be developed.

- Each participant has a responsibility to ensure that duplication of services does not occur.
- Guidelines should be used to ensure the goals are clearly identified and services are differentiated from one another

Education Criteria for Specialized Support

Clinicians need to understand the different elements of support and eligibility for students to receive services when they work in the educational setting. This enables clinicians to establish boundaries between what is needed educationally and what might be a medically necessary intervention.

Driving all considerations in the educational setting are two Federal Laws. The Individuals with Disabilities Education Act (IDEA, 2004)16 provides funding and guidelines for special education programs and services. IDEA supports children ages 3-21 in all schools receiving federal monies and who meet eligibility requirements for "special education and related services designed to meet their unique needs". Idaho outlines how IDEA interfaces through the state and local agencies' rules and regulations.

The second law under IDEA is the requirement for a Free and Appropriate Education (FAPE). Because of FAPE, a student is entitled to a "free and appropriate education" at no cost to the parent AND to an education that is specifically designed to meet his or her unique needs.

When education and mental health resources are combined, clear eligibility criteria for participation must be developed.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

FAPE
Free: No cost to parents.
Appropriate: Program is tailored and planned to reasonably meet the child's unique needs.
Public: Public schools are responsible for designing and implementing the Individualized Education Program (IEP) which includes preschool, elementary school or secondary school in each state.
Education: Specially designed instruction and related services as outlined in the IEP.

Children having mental health and/or behavioral disorders may be identified for special education services under a federal category of Emotional Disturbance. This category may have different names between states such as emotional and behavioral disorder (EBD), emotional impairment (EI) or behavior disorder (BD). By definition this means the child has "a condition with one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:"[17]

Emotional and Behavioral Disorder (EBD)

- An inability to learn that cannot be explained by intellectual, sensory, or health factors.
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
- Inappropriate types of behavior or feelings under normal circumstances.
- A general pervasive mood of unhappiness or depression.
- A tendency to develop physical symptoms or fears associated with personal or school problems.

Eligibility for support may be identified through a variety of tools including formal assessments, using tests and measures, classroom/school observations, and clinical diagnosis provided by a child's physician or psychologist. All children identified with disabilities fall under FAPE act.[17]

A variety of "related services" that meet the goals of IDEA and FAPE are also defined in this federal law. These related services include the following:[17]

Related Services as Defined in IDEA
Early identification and assessment
Counseling services
Orientation and mobility services
Psychological services
Physical and occupational therapy
Medical services to diagnose or evaluate for a disability
Parent counseling and training
Recreation
School health services
Social work services in schools
Speech-language pathology and audiology services
Transportation services

Sometimes a child who has a mental health diagnosis may not qualify for special education. In these instances, the team can look for service options and accommodations under the Federal Law, Section 504 of the 1973 Rehabilitation Act.

Section 504 of the 1973 Rehabilitation Act is a civil rights law protecting the rights of individuals with disabilities in programs that receive federal financial assistance from the Department of Education and sets the stage for enactment of the Americans with Disabilities Act (ADA).

This act states that a qualified person meeting the definition of a disability under Section 504 is experiencing "a physical or mental impairment that substantially limits a major life activity."[17] These Major Life Activities (for Section 504) are further defined by the following: walking, seeing, hearing, speaking, breathing, sleeping, standing, sitting, lifting, learning, reading, writing, concentrating, thinking, communicating, performing math calculations, working, eating, bending, operation of bodily function, caring for oneself, and performing manual tasks.

The phrase "substantially limits" is the most critical part of the Section 504 eligibility process and the most easily misunderstood. The presence of an identified disability is not sufficient to qualify a student for protection under Section 504. There must be clear evidence of a "substantial limitation of a major life activity."

The term "substantially limits" means

1. The student is "unable to perform" (this means they can't do it at all) a major life activity that the average student of approximately the same age can perform,

OR

2. The student is "significantly restricted" (this means they can perform the task but have problems doing so) as to the condition, manner or duration under which a particular major life activity is performed as compared to the average student of approximately the same age.

Provider requirements for delivery of services in the school are the same as those for a private agency and must meet the audit standards described in the provider agreement with Optum.

Medicaid Criteria for IBHP Services

IBHP network providers are under contract with Optum Idaho. Providers working within a Medicaid environment are required to adhere to federal and state
administrative guidelines that require a medically necessary treatment for a given condition.

Provider requirements for delivery of services in the school are the same as those for a private agency and must meet the audit standards described in the provider agreement with Optum.

For children participating in the IBHP, the definition of medical necessity is as follows and is found in the Idaho Administrative Procedures Act (IDAPA) reference listed on the next page.[18]

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Medical Necessity Defined
Medically necessary services for eligible Medicaid participants under the age of twenty-one (21) are health-care, diagnostic services, treatment, and other measures described in Section 1905(a) of the Social Security Act (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan.
Services must be considered safe, effective, and meet acceptable standards of medical practice.
Location of definition: IDAPA 16.03.09.880

The guidelines for IBHP practitioners are contained within the documents used by Optum for utilization management that include Level of Care Guidelines (LOCGs) for each service, and in the case of substance use disorders the American Society of Addiction Medicine (ASAM) criteria. Optum core clinical criteria and guidelines were developed by nationally recognized experts and organizations and have been adopted to provide objective and evidence-based admission and continuing stay criteria.

When developing and updating the clinical criteria and guidelines, Optum solicits input from members and their families as applicable, as well as practitioners in specialties affected by the guidelines. Community-based treatment centers and practitioners in Optum regions are also asked to provide input.[19]

The LOCGs are based on the following principles:[20]

- ***Care Should Promote Recovery & Resiliency***: Members have the right to be treated with respect and recognition of their dignity, strengths, preferences, right to privacy, and unique path to recovery. Members also have the right to information that aides in decision making, promotes participation in treatment, enhances self-management, and supports broader recovery/resiliency goals.
- ***Care Should be Effective***: There must be a reasonable expectation that evidence-based treatment delivered in the appropriate level of care improves the member's presenting problems within a reasonable period of time. Effectiveness is measured by the improvement in treatment and the risk of the member's condition likely deteriorating if treatment were discontinued. Improvement must be understood within a recovery/resiliency framework where services support movement toward a full life in the community. Specific measures of effectiveness and progress should be documented in the member's chart and upon any submission of a pre-service request.
- ***Care Should be Accessible***: Ideal clinical outcomes happen when access to the most appropriate and available level of care is facilitated upon admission to care and when transitioning between levels of care. A member's transition between levels of care should be timely and occur in a safe manner, and pertinent clinical information should be communicated to the provider at the next level of care.
- ***Care Should be Appropriate***: Optimal clinical outcomes result when evidence-based treatment is provided in an appropriate level of care that is available, structured and intensive enough to adequately treat the member's presenting problem and support the member's recovery/resiliency. Evidence-based treatments are interventions that have been shown to be safe and effective, not been deemed experimental or investigative, and are appropriate for the treatment of the member's current condition.

Care Should:

Promote the Member's Recovery/Resiliency.

Be Effective.

Be Accessible.

Be Appropriate.

Children using IBHP services must have functional ability measured to continue care. As a result of the Jeff D. Lawsuit settlement, the YES Program requires all children to have a CANS assessment. This functional assessment is required by the State of Idaho and providers must be certified to use the tool.[21]

Clinical Therapies

Children being served with clinical interventions within the school setting in Tier 3 are known to struggle with a variety of emotional and behavioral health concerns. Addressing these clinical problems with evidence-based interventions that support parent, teacher and student participation is essential.

Optum Idaho has partnered with the REACH Institute to develop a series of training modules designed to assist with children who display disruptive behavioral disorder (DBD) symptoms. These modules provide strategies and guidance to address a continuum of concerns for clinicians, mental health paraprofessionals, educators, and parents. Descriptions of each module's content are provided in Appendix I of this document.

Also included in a group of therapies are at least three other interventions that are known to be evidence-based and effective in the school setting.

- Cognitive Behavioral Intervention for Trauma in Schools (CBITS)
- Support for Students Exposed to Trauma (SSET)
- Bounce Back: An Elementary School Intervention for Childhood Trauma

Collectively, these methods for clinical support and change cover a variety of ages and target behaviors. These therapies are described in Appendix I.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Outcomes and Reporting

The following are educational and clinical indices that can be used to measure the program's effectiveness. A "base rate" should be established before the program begins for each student.

Important indicators could include a variety of measures that suggest the student's success within the classroom.

School District Indicators
Grades
Assignment completion
Truancy
Absences (excused)
Referrals to the nurse
Referrals to the office
Aggression (physical and verbal)
Classroom participation
IEP goals/objectives
504 Accommodation Plans

Clinical metrics usually include completion of a pre-measure that is followed at the end of the intervention with a post-measure.

IBHP Sources

- Youth Wellness Assessment
- Children/Adolescent Needs and Strengths (CANS)

Clinical Practice Tools

- Child PTSD Symptoms Scale (CPSS)
- Pediatric Symptoms Checklist (PSC)
- Strengths and Difficulties Questionnaire (SDQ)

School districts and individual schools that are working with national "technical centers" may have access to a variety of clinical tools that could be used for no charge as a component of their participation with the research center.

Technical Centers
One center is the University of Maryland's National Center for School Mental Health's (NCSMH) program referenced as the School Health Assessment and Performance Evaluation (SHAPE).[22]
The University of California at Los Angeles (UCLA) has the Center for Mental Health in Schools & Student/ Learning Supports at UCLA, wherein school districts and school administrators may utilize data sources, presentations and a variety of resources to lay the foundation for implementing mental health services within their schools.[23]
Finally, SAMSHA operates a number of relevant websites, programs and technical assistance centers that can assist in the process of developing a mental health in the schools program.[24]

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Billing for Services in the IBHP

All Optum Idaho providers will use the following codes when submitting claims for services rendered in the school.

CPT Code	Place of Service Code	Description	Unit
90791	03	Psychiatric Diagnostic Evaluation; Comprehensive Diagnostic Assessment; used for diagnostic assessment or reassessment, if required.	1 unit = 1 visit
90832	03	Psychotherapy, 30 minutes with patient and/or family member	1 unit = 30 min
90834	03	Psychotherapy, 45 minutes with patient and/or family member	1 unit = 45 min
90837	03	Psychotherapy, 60 minutes with patient and/or family member	1 unit = 60 min
90846	03	Family Psychotherapy, without patient present	1 unit = 1 visit
90847	03	Family Psychotherapy, (conjoint psychotherapy) with patient present	1 unit = 1 visit
90853	03	Group Psychotherapy, other than multiple-family group	1 unit = 1 visit
H2027	03	Family Psychoeducation	1 unit = 15 min
T2002	03	Transportation and mileage reimbursement only available in conjunction with the first member seen on the day of school-based services when receiving the following services: 90847; 90832; 90834; 90837.	1 unit = 1 trip to the school-based service site for that day.

Summary

A school-based model for behavioral and mental health service delivery can increase treatment accessibility for youth. This document reviewed a number of steps for developing a working relationship between a clinical service provider, the school district, and the parents of children needing services.

The growth of programs like this has increased significantly throughout the United States since 1999. A variety of resources to support providers, schools, and parents has also grown.

- Major public funding via government grants, foundation endowments, and professional association grants are available to school districts and community stakeholders to help establish a program like this. (***http://smhp.psych.ucla.edu/pdfdocs/fundfish.pdf***)
- Additionally, SAMSHA funds technical assistance centers in ten regions throughout the U.S. These centers provide materials, research data and recommendations for mental health service delivery in the school setting. (***https://www.samhsa.gov/programs***)

Agencies and providers within the Optum Idaho network also have regional and local resources available to help them build a relationship with schools to provide school-based services.

- Optum's Clinical Training team can assist with technical and administrative information covered in the toolkit.
- If you are a mental health provider and are interested in working within a school setting, please contact Optum's Clinical Training team at *mhsidaho@optum.com*.
- If you are a school or a school district interested in finding a mental health provider to work with your students/families on site, please contact Optum's Clinical Training team at *mhsidaho@optum.com*.
- If you are interested in technical assistance or training to components in the toolkit, please contact Optum's Clinical Training team at *mhsidaho@optum.com*.
- Optum's Provider Relations Advocates and Field Care Coordinators will be available and assigned to connect with each provider and/or school/district for local support once specific questions have been identified through the *mhsidaho@optum.com* process.

References

1. Substance Abuse and Mental Health Services Administration, The Safe Schools/Healthy Students Initiative: A Legacy of Success. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. ***https://store.samhsa.gov/sites/default/files/d7/priv/sma13-4798.pdf***

2. Hoover, S., Lever, N., Sachdev, N., Bravo, N., Schlitt, J., Acosta Price, 0.Sheriff, L. & Cashman, J.(2019). Advancing Comprehensive School Mental Health: Guidance From the Field. Baltimore, MD: National Center for School Mental Health. University of Maryland School of Medicine. ***https://www.schoolmentalhealth.org/Resources/Foundations-of-School-Mental-Health/Advancing-Comprehensive-School-Mental-Health-Systems--Guidance-from-the-Field/***

3. Barrett, S., Eber, L., & Weist, M. (Eds.). (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Eugene, OR: OSEP Center for Positive Behavioral Interventions and Supports. Retrieved from ***https://www.sdcoe.net/student-services/student-support/Documents/School%20Mental%20Health%20and%20School%20Wide%20PBIS.pdf***

4. Krista Kutash, Albert J. Duchnowski, and Nancy Lynn; School-Based Mental Health: An Empirical Guide for Decision-Makers; April 2006, The Research & Training Center for Children's Mental Health, Florida Mental Health Institute University of South Florida: ***http://rtckids.fmhi.usf.edu/rtcpubs/study04/default.cfm***

5. Mental Health Facts; National Alliance on Mental Illness (NAMI); statistics provided by the National Institute of Mental Health. ***www.nimh.nih.gov; https://www.nami.org/nami/media/nami-media/infographics/generalmhfacts.pdf***

6. U.S. Department of Education. (2014).35th Annual Report to Congress on the Implementation of the Individuals with Disabilities Education Act, 2013. Washington, DC: U.S. Department of Education. Retrieved January 16, 2015, from ***http://www2.ed.gov/about/reports/annual/osep/2013/parts-b-c/35th-idea-arc.pdf***

7. Goodman A, Joyce R, Smith JP. The long shadow cast by childhood physical and mental problems on adult life. Proc Natl Acad Sci U.S.A. 2011;108(15):6032-6037.

8. Kristine Goodwin and Jennifer B. Saunders; Improving Children's Mental Health; National Conference of State Legislatures (NCSL), Vol. 22, No. 2 / January 2014; ***http://www.ncsl.org/research/health/improving-children-s-mental-health.aspx***

9. U.S. Department of Health and Human Services; Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Follow-up Care, Office of Inspector General; August, 2019

10. Facts About Public Education in Idaho; Bluum Parents Guide ***https://www.bluum.org/parents-guide/facts-public-education-idaho/***

11. Idaho Children and Adolescents; Chapter VII, Health Systems Research Inc.; IDHW, ***https://healthandwelfare.idaho.gov/services-programs/behavioral-health/about-childrens-behavioral-health***

12. Idaho Department of Health (IDHW) and Welfare Division of Behavioral Health Mental (DBH); Health Public Dashboard for June, 2019; ***https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=3672&dbid=0&repo=PUBLIC-DOCUMENTS***

13. Child and Youth Utilization Information for Selected Quarters of 2018-2019 within the Idaho Behavioral Health Plan; Optum Idaho, August 2019

14. Kaplan D.W., Calonge B.N., Guernsey B.P., Hanrahan M.B. (1998). Child-Mind Managed care and school-based health centers: Use of health services. Archives of Pediatrics and Adolescent Medicine. 152: 25–33.

15. Substance Abuse and Mental Health Services Administration. (2009). Working Together to Help Youth Thrive in Schools and Communities. Washington, DC: U.S. Department of Health and Human Services.

16. School and Campus Health; Substance Abuse and Mental Health Services Administration (SAMSHA); ***https://www.samhsa.gov/school-campus-health***

CLICK HERE TO RETURN TO TABLE OF CONTENTS

17. Children's Mental Health and Emotional or Behavioral Disorders Project; Inspiring Opportunities; Parents Advocacy Center for Educational Rights (PACER); ***https://www.pacer.org/cmh/learning-center/education/introduction.asp***; 2019

18. Optum Idaho Provider Manual; pp. 19; June, 2019 Edition

19. Optum Idaho Provider Manual; pp. 74; June, 2019 Edition

20. Optum Idaho Provider Manual; pp. 75-76; June, 2019 Edition

21. Optum Idaho Provider Manual; pp. 39; June, 2019 Edition

22. National Center for School Mental Health (NCSMH); About The SHAPE System, ***https://www.schoolmentalhealth.org/SHAPE/***

23. Center for MH in Schools & Student/Learning Supports ***http://smhp.psych.ucla.edu/websrch.htm#search***

24. National School Mental Health Projects: Mental Health Technology Transfer Center Network; Substance Abuse and Mental Health Services Administration (SAMHSA); ***https://mhttcnetwork.org/centers/mhttc-network-coordinating-office/national-school-mental-health-projects***

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Appendices

Appendix A – Request for Qualifications for Onsite Mental and Behavioral Health

1. Description of Services

The School District of _____ (the district) is requesting qualifications from mental health providers to work with District students and their families within school buildings, to increase student access to services for mental health and behavioral health counseling. One or more providers will be selected to provide services at school sites throughout the District. The District will enter into a Memorandum of Understanding (MOU) with the provider and the provider's agency. No financial reward will be made with the selection of these providers.

2. General Information

To be considered for participation in this program, the written qualifications must be submitted by mail or hand delivered and received by the District administrative office no later than Month,Day, Year at, Time of Day, and Time Zone. Responses received by facsimile or electronic mail are not acceptable.

Questions regarding services may be directed to District Administrator's Name, Name of District, District Office's address and zip code. All questions must be in written format.

The qualifications forms and any enclosed pages requiring signatures or other requested information shall be submitted to the District as a sealed proposal to:

Mr. First /Last Name
Purchasing Office
School District Name
Street Address
City, State Zip

Sealed responses must be received and date stamped by the District's Administrative Offices located at School District's Business office address, state, zip no later than month, day and year by the time noted above.

3. Schedule of Activities

Acryonym	Meaning
Request for Qualifications (RFQ) Issued	Month, Day, Year
Advertisement of RFQ in Local Newspaper	Month, Day, Year
Deadline for Questions	Month, Day, Year by Time of Day, City
Time Submission Deadline (due date)	Month, Day, Year by Time of Day, City
Notification to Approved Providers	Month, Day, Year

Any RFQ received after the date and hour specified above will not be accepted under any circumstances and will be returned to the proposer unopened. Responses must be submitted by mail or hand delivered in person.

4. Minimum Provider Qualifications

Providers must demonstrate the ability to:

A. Provide masters level clinical staff (Licensed Mental Health Providers) for onsite behavioral and mental health services for students and parents/guardians who are Medicaid eligible (providers must be fully credentialed in Optum Idaho Behavioral Health Plan network). Providers may also treat students using private pay or those covered by commercial health insurance.

B. Provide evidence-based behavioral and mental health treatment in individual, group and family modalities for students and their families within the school setting based upon the student's identified medical need for out patient behavioral health services.

C. Screen, evaluate and provide clinical intake for students and families to determine appropriateness for treatment services.

D. Provide language translation for student's family's native language or provide interpreter services.

E. Attend meetings with school personnel as needed, to provide appropriate services for students. Provider will ensure that all appropriate and necessary releases of information and permission documents are signed by a parent or guardian and are in the student's file.

F. Abide by the District's protocol for entry and exit of the school premises and safety procedures, including:

   1. Signing in and out of buildings and wearing a school visitor's badge at all times.

   2. Escorting students and families to and from the main office to the assigned office for treatment.

   3. Providing school administrative staff with the identified clinician's name and contact information and notify the schools' administrative staff of any changes in personnel.

   4. Learning and demonstrating knowledge of school building procedures for safety, lock-down and emergency situations.

G. Abide by the District's protocol for providers of onsite behavioral and mental health services to students, including but not limited to:

   1. Completing an orientation to the building as determined by the school principal.

   2. Maintaining student/family confidentiality in compliance with all state and federal laws and ethical practice guidelines.

   3. Informing the appropriate school staff of the student's name, date of birth, the time of onsite services and the name of the service provider.

   4. Appropriately maintaining District resources and facilities used during the provision of onsite services.

   5. Maintaining an accurate log of dates and times of school-based service and providing a weekly update to the identified administrative school staff.

   6. Maintaining all clinical documentation of clinician/student/family contact in accordance with standards of professional practice and compliance with appropriate rules provided in (HIPAA).

H. Provide the District a signed parent/guardian release of information allowing provider and the District to share student information about educational and clinical concerns.

I. Provide the District a signed parent/guardian consent to treat form for each child/youth that is participating in this school-based outpatient treatment program.

J. Provide the District a signed parent/guardian Informed Consent to Treat detailing the treatment for each child/youth that is participating in this school-based outpatient treatment program.

K. Establish and maintain effective, professional and respectful work relationships with school staff, counselors, social workers and students, and demonstrate professional conduct while on school premises.

L. Manage billing of Medicaid, private pay and commercial insurance independently.

M. Those providers treating children enrolled in Idaho Medicaid and the Idaho Behavioral Health Plan (IBHP) will be fully credentialed through the appropriate Network resources of Optum Idaho and will comply with the following for member treatment:

   1. All children participating under the IBHP will have parental completion of the Wellness Assessment regarding their child's status using the same timeline described in the provider handbook for Optum Idaho.

   2. All children participating in this program will have a completed Child and Adolescent Needs Survey (CANS) that has been administered either through an identified Independent Assessor or a certified Optum Idaho network provider.

N. If selected, provider agrees that during school hours behavioral and mental health care (i.e. psychotherapy) will only be provided at the school site for students or families enrolled at the school site where service is provided.

5. Evaluation Criteria

Awarding of a contract will be premised upon a qualifications-based selection process. A Qualification Review Group will read, review and evaluate each proposal and selection will be made on the basis of the criteria listed below:

A. Agency profile, provider demonstrated clinical proficiency, practice experience and competence in the State of Idaho.

B. Understanding of task and requirements as depicted in the RFQ.

C. Credentials of Idaho mental health professionals proposed to perform services (i.e.) resumes of mental health professionals who will be responsible for providing professional services to the District's students. Provider must commit that staff identified in its proposal will actually perform the assigned work. Any staff changes must have prior approval from the District.

D. Overall quality and completeness of proposal.

E. The clinician's experience and success in providing behavioral and mental health services to children and their families for at least five (5) years as a licensed clinician.

6. Evaluation Process

Each member of the Qualifications Review Group will independently read and rate each submission and complete a qualification evaluation matrix form. A composite evaluation rating will be developed, which indicates the group's collective ranking of the approved providers in descending order. Successful candidates will be notified of their selection in writing.

7. Content and Form Qualifications

Interested mental health providers and provider agencies are directed to provide in their qualifications as much detail as possible pertaining to their capabilities, experience and approach to the services outlined in the RFQ.

AT A MINIMUM, EACH PROPOSAL MUST ADDRESS EACH OF THE FOLLOWING AREAS. PLEASE IDENTIFY ANY INFORMATION DEEMED CONFIDENTIAL TO YOUR COMPANY.

A. Profile of your organization including background and full legal name, address, telephone number and email address of the agency submitting the proposal.

B. A summary of how your organization satisfies the minimum provider qualifications of the Request for Qualification.

C. A description of the organization's capabilities and years of experience delivering the required services, including onsite school building services. Include with this description the trauma-informed and evidence-based brief therapy protocols that your organization is currently utilizing with children and adolescents.

D. A statement of experience and professional capability for each person who will be assigned to provide services. Include resumes for the named staff, including information on the individual's particular skills related to this project, education, experience, significant accomplishments and any other pertinent information.

E. A description of the experience of provider's mental health professionals working with schools, children, adolescents and their families.

F. Describe your organization's prior projects, programmatic developments and collaboration with community partners and children/family mental health stakeholders.

G. A copy of your organization's most recent financial audit or a statement from your financial institution indicating solvency.

H. A statement summarizing your organization's capacity to provide and previous experience providing language translation in a family's native language, or interpreters.

I. A description of your work plan of how your organization will envision providing site-based school services. Include tasks, working collaboratively with educational and family/child service teams, collaborative problem-solving strategies, services and activities.

J. Documentation of liability coverage of no less than $1,000,000 per occurrence for acts and omissions of your employees and organization.

K. A list of names, addresses, telephone numbers and email addresses of three (3) business references. Do not include current or former staff as references.

L. Provide evidence of criminal background checks for mental health professionals.

8. Submittal of Qualifications

Each provider must submit seven (7) copies of your proposal.

Appendix B – School-Based Mental Health RFQ Scoring Template

Clinician Candidate Name: _____

Date: _____ Agency: _____

Reviewer Name: _____ Reviewer Title: _____

Proposal Rating Sheet – Score 1 to 5: 1 = Not met; 3 = Partially met; 5 = Fully met

Criteria	Score
Provide masters level clinical staff with at least XX years of clinical experience.	
Provide treatment in individual, group and family in support of the student.	
Screen, evaluate and provide intake for students at the school.	
For students participating in the Medicaid IBHP, the clinician will ensure that the CANS and a Comprehensive Diagnostic Assessment is completed through the auspices of the Agency or an Independent assessor.	
Provide services in student's native language or arrange for interpretive services to facilitate therapy and parent communication.	
Attend school meetings upon request.	
Abide by district's protocol for entry and exit of school premises and safety procedures.	
Abide by district's protocol for providers of onsite behavioral and mental health services to students. See criteria #2	
Provide District Name a signed parent/guardian "Release of Information" allowing provider and District Name to exchange information regarding educational and clinical care considerations.	
Provide District Name a signed parent/guardian "Informed Consent to Treat" detailing cost, payment, HIPAA guidelines and clinician contact information associated with anticipated treatment.	
Establish and maintain effective professional and respectful work relationships with parents, school staff, counselors and students and demonstrate professional conduct while on school premises.	
Manage private billing and/or Medicaid Reimbursement.	
If selected, agree that behavioral and mental health care will only be provided onsite for students or families enrolled at the school site where service is provided.	
TOTAL SCORE:	

Appendix C – Memorandum of Understanding

School District Name: _____

Protocol for Agency/Clinician Provider of Onsite Services to Students

The School District Name invites qualified Agencies and licensed mental health clinicians to work with students needing medically necessary care within school buildings. Prior to serving students onsite, professionals must be approved; they must have an authorized and active agreement with the School District Name and be fully credentialed in the Optum Idaho network for the provision of services under the Idaho Behavioral Health Plan (IBHP). In addition, all participating Agencies and clinical professionals must review and agree to the following protocols:

1. **Orientation**: Provider must complete an orientation to the building and agree to protocols described herein prior to serving students onsite.

2. **Confidentiality**: The School District Name, and more specifically the building staff at Name of School must be informed of where enrolled students are at all times.

   2.1 The participating Agency and/or clinician must provide the student name, date of birth, when they received onsite services, what the duration was and by whom (name and contact information of licensed clinician) it was provided on a weekly basis.

   2.2 All considerations for student confidentiality will be adhered to by the licensed clinician in accordance with ethical, HIPAA and FERPA guidelines.

3. **Facilities**: The School District Name will only offer onsite services when appropriate facilities can be designated. The building principal will identify and designate space. The building principal will provide access to facilities at agreed upon times.

4. **Safety**: All school safety procedures must be followed.

   4.1 The licensed clinician will sign in at the building office and wear an approved School District Name visitor badge.

   4.2 The licensed clinician will escort students and families to and from main office to their identified service area.

   4.3 The Agency/clinician will notify the identified school administrator when services will not be provided (e.g. clinician is absent).

   4.4 The licensed clinician will be familiar with, and follow, all building procedures (e.g. emergency and lock down procedures, sign in and out procedures, etc.).

5. **Authorization**: Appropriate authorizations for clinical/educational practices must be completed with parent/guardian signatures prior to serving students onsite.

   5.1 Release of Information between School District Name and licensed clinician is signed by parent/guardian.

   5.2 An Informed Consent to Treat will be completed, and on file in the building, with appropriate parent/guardian signatures prior to beginning treatment with the identified licensed clinician.

   5.3 In accordance with Idaho State Statute, if the student is of at least XX years of age or older, he/she may authorize the Release of Information.

6. **Communication**: The building principal and licensed clinician will complete and maintain the partner contact sheet. This contact sheet will support ongoing communication between the school and Agency/clinician regarding those students who were seen. The licensed clinician agrees to:

   6.1 Share strategies and resources with building principal that may support student success.

6.2 Resolve conflicts and concerns by participating in direct dialogue. If the provider has a concern, he or she must first report the concern to the building principal or their designee. For example, if the clinician has a concern, they will communicate as follows:

6.2.1 Level 1 - contact principal designee. If unable to resolve, notify level 2.

6.2.2 Level 2 - contact principal. If unable to resolve, notify level 3.

6.2.3 Level 3 – contact First Name, Last Name, Director of Student Services. If unable to resolve, notify level 4.

6.2.4 Level 4 - contact the Special Education Director.

6.3 Coordinate with school counselor and ensure that student referral forms, parental authorizations and informed consent documents are completed, on file and managed as follows:

6.3.1 Obtain parent/guardian permission for observation and survey completion to assist with any outcome measures.

6.3.2 Provide parent/guardian a copy of agreed upon outcome measure for completion and inclusion with treatment data.

6.3.3 Provide teacher a copy of the agreed upon outcome measure for completion and inclusion with treatment data.

6.3.4 Insure that completed outcome measures are returned to school counselor.

7. **Crisis Procedure**. School principal and licensed clinician agree on how to respond when a Student is in crisis.

7.1 A written plan to manage crisis situations will be on file in the school counselor's office and contained within the clinician's health chart.

7.1.1 This plan will be signed by the student's parent/guardian, the appropriate school building representative (i.e., school counselor, social worker, administrator, etc.) and the licensed clinician.

7.1.2 The approved plan will be reviewed by all appropriate participants working on the school management team, to ensure consistency and the effectiveness of the plan.

7.1.3 In the event a student needing crisis support is not currently receiving treatment, the appropriate school personnel (i.e., school counselor, social worker, administrator, etc.) may obtain permission for clinical support via telephone in emergency situations.

We have read and agree to follow the protocols described above for onsite clinical service delivery.

School Principal	Date
Licensed Clinician	Date
Agency Representative	Date

Appendix D – Authorization for Use/Disclosure of Mental Health Information

Authorization for Use/Disclosure of Information: I voluntarily consent to authorize my child's mental health care provider _____ (insert name) to use or disclose my child's mental health information during the term of this Authorization to the recipient(s) that I have identified below.

Recipient: I authorize my child's mental health care information to be released to the following recipient(s):

Name: _____

Address: _____

Purpose: I authorize the release of my child's mental health information for the following specific purpose: _____

_____

(Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization.)

Information to be disclosed: I authorize the release of the following mental health information (check the applicable box below):

☐ All of my child's mental health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by my child.

☐ Only the following records or types of mental health information: _____

_____.

Term: I understand that this Authorization will remain in effect:

☐ From the date of this Authorization until the ____ day of _____ , 20_____

☐ Until the Provider fulfills this request.

☐ Until the following event occurs: _____

Redisclosure: I understand that my child's mental health care provider cannot guarantee that the recipient will not re-disclose that mental health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my child's treatment at their school. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the identified provider of my child's mental health services. The revocation will be effective immediately upon my child's mental health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my child's mental health care provider in reliance on this Authorization before receipt of my written notice of revocation.

Questions: I may contact the provider of my child's mental health services for answers to my questions about the privacy of my health information at (Provider Agency Name, address and telephone number).

_____	_____	_____
Signature	Date	Signature of Witness

If Individual is unable to sign this Authorization, please complete the information below:

_____	_____	_____
Name of Guardian / Representative	Legal Relationship	Date

_____	_____
Witness	Date

Appendix E – Clinician Interview Questions

School: _____ Date: _____

Applicant's Name: _____

1. Tell us about your organization.

2. What populations do you serve? Do you specialize in any particular therapy?

3. Do you have experience in the educational setting?

4. How would you prepare a student to go back to class? What would you do if they were escalated and you had another appointment?

5. Describe the support you could/would provide for the teacher of the student.

6. Do you see yourself helping in a crisis situation? What would the help look like?

7. Do you have experience with working with multidisciplinary teams and sharing information with those teams?

8. How soon can you have staff on site at the school should you be selected?

9. Describe your plan for engaging families after referral.

10. What process do you use for intake and what documents do you require parents to complete?

Appendix F – Parental Consent to Treat an Unaccompanied Minor at School

[SCHOOL NAME]

I, [First, Last Name], am a licensed clinician in Idaho and employed with [Agency Name] at [Agency Address] and will be conducting individual and group therapies with students at [Name of School] this year. I support these students with social, emotional, and/or behavioral concerns at school or at home. I am available during my daytime office hours to meet with parents and caregivers to support and problem-solve any concerns you might have. Your signature below will enable me to provide these services for your child when you can't be at the school with them. Please feel free to contact me at [Email Address] or at [Phone Number] any time.

Therapy groups and individual therapy session topics include friendships, anxiety, self-esteem, grief, divorce, anger, conflict resolution, bullying, and more. I meet with students on a short-term basis in which their therapy needs and progress will be constantly accessed. The therapy sessions will occur during the school day at an agreed upon time with the classroom teacher. I usually do not meet with students during important academic instruction or assessment. With your permission (on a separate authorization form) I will also collaborate with classroom, special education, reading and specials teachers to help the students learn at their personal academics and social/emotional abilities.

All information is confidential and is disclosed with written permission except when the student is dangerous to themselves, others and/or is otherwise required by law. Please note, that I will do my best to contact you when therapy sessions are scheduled. However, at times, immediate therapy support is needed and will take place at the school as required by the situation. You are always welcome to call or email me at any time. I am at [School Name] on [Days] or I can be reached at my agency office [Agency phone number]. Feel free to set up an appointment anytime during the school year when I'm here at [Name of School].

Sincerely,

First, Last Name

Licensed [Type of license; i.e. LCSW, LCPC, etc.]

[Clinician's email]

Yes ____ I give permission for my child, _____ to participate in individual or group therapy when I am not able to be on site.

No ____ I do NOT give permission for my child, _____ to participate in individual or group therapy.

Student's Name: _____

Student's Date of Birth: _____

_____ _____ _____

Parent/Guardian Name Parent/Guardian Signature Date

_____ _____

Parent/Guardian Email Daytime Phone Number

Appendix G – Request Permission for Outcome Measure Completion

[SCHOOL DISTRICT NAME]

Student: _____ D.O.B.: _____

School: _____ Grade: _____

Parent/Guardian: _____

Address: _____

Home/Cell Phone: _____ Work Phone: _____

Date this form was mailed or delivered to the parent/guardian: _____

Notice of Outcome Measure Completion: As you know, your child has been referred for consideration of treatment by a private Behavioral Health clinician housed at your child's school. This request for completion of an outcome measure is a way to help us understand if the treatment is helping. The overall effort is a partnership between Optum Idaho and the SCHOOL DISTRICT NAME to provide access for Behavioral Health services in our school buildings.

In order to provide successful treatment, we are asking you and your child's teacher to complete the attached outcome measure based upon your perceptions today and over the past 4-6 weeks.

Permission to Complete Outcome Measure Form: In addition to reviewing the information provided by you, we would like your permission to have your child's teacher fill out the same outcome form.

I give my permission for the proposed completion of this outcome measure.

_____ _____

Parent/Guardian Signature Date

Appendix H – HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability/Accountability Act, 45 C.F.R. Parts 160 and 164)

*1. ***Authorization*** – I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

*2. ***Effective Period*** – This authorization for release of information covers the period of healthcare from:

a. _____ to _____ .

*OR

b. ☐ All past, present, and future periods.

*3. ***Extent of Authorization***

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

*OR

b. I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____

Signature of patient or personal representative

_____

Printed name of patient or personal representative and relationship to patient

_____

Date

Appendix I – REACH Modules

Optum Idaho partnered with the REACH Institute to develop a course composed of a series of training modules designed to assist with children who display disruptive behavioral disorder symptoms. These seven modules within this course provide strategies and guidance to address a continuum of concerns for clinicians, mental health paraprofessionals, educators and parents.

The modules cover a variety of topics, including:

Understanding Disruptive Behavior Disorders in Children and Adolescents

This module is designed for both Master-level clinicians and certified paraprofessionals, teaming together to work within the family system. The goal of this module is **to increase your understanding** of disruptive behavior disorders in children and adolescents. By the end of this module, you will know the key symptoms of common disruptive behavior disorders; identify conditions comorbid with disruptive behavior disorders; and understand the risk factors associated with disruptive behavior disorders.

Supporting Students with Disruptive Behavior Disorders

This moduleis designed for Master level clinicians, certified paraprofessionals and Educators, has the goal of increasing your understanding of disruptive behavior disorders and your comfort in helping students with these disorders. By the end of this module, you will be able to identify common disruptive behavior disorders, understand the key features of, and your role in **effective intervention**, and recognize the value to successful intervention of building relationships with educators and parents.

Assessing Disruptive Behavior Disorders in Children and Adolescents

This module is designed for both Master-level clinicians and certified paraprofessionals, teaming together to work within the family system. The goal of this module is to increase your understanding of the **assessment** of disruptive behavior disorders in children and adolescents. By the end of this module, you will understand best practices for the assessment of disruptive behavior disorders and be able to use standardized disruptive behavior assessment measures.

Teaching Skills to Support Adolescents with Disruptive Behavior Disorders

This module is designed for both Master-level clinicians and certified paraprofessionals teaming, together to work with Educators and within the family system. The goal of this module is to increase your understanding of the skills clinicians and paraprofessionals can teach adolescents with disruptive behavior disorders. By the end of this module, you will be able to understand adolescence as a critical period of development and learn how to build a strong foundation for successful interventions with disruptive adolescents. You will identify the key skills to support adolescents with disruptive behavior disorders and learn **strategies for teaming** to support adolescents with disruptive behavior disorders.

CLICK HERE TO RETURN TO TABLE OF CONTENTS

Teaching Skills to Support Children with Disruptive Behavior Disorders

This module is designed for both Master-level clinicians and certified paraprofessionals teaming together to work with Educators and within the family system. The goal of this module is to increase your understanding of skills clinicians and paraprofessionals can teach children with disruptive behavior disorders. By the end of this module, you will be able to **differentiate between skill and performance deficits in children**, and you will learn key skills to support children with disruptive behavior disorders.

Teaching Skills to Support Parents with Disruptive Adolescents

This module is designed for both Master-level clinicians and certified paraprofessionals teaming, together to work with parents within the family system. The goal of this module is to increase your understanding of the skills clinicians and paraprofessionals can teach parents of adolescents with disruptive behavior disorders. By the end of this module, you will understand the implications of adolescence as a critical period in disruptive behavior disorders; learn **guidelines for communicating with parents of adolescents;** identify and employ the key principles underlying parent support; learn key skills that parents can use to modify the behavior of disruptive adolescents; and learn how to work as a clinician-paraprofessional team to support parents with disruptive adolescents.

Teaching Skills to Support Parents with Disruptive Children

This module is designed for both Master-level clinicians and certified paraprofessionals teaming, together to work with parents within the family system. The goal of this module is to increase your understanding of the skills clinicians and paraprofessionals can teach parents of children with disruptive behavior disorders. By the end of this module, you will learn guidelines for communicating with parents; identify and employ the key principles underlying parent support; **understand the ABC Model** and its practical application in skills building; and learn to work as a clinician/ paraprofessional team to support parents with disruptive children.

The seven REACH Modules are now available, at no cost, for professional development through the Idaho AWARE Project's Information Portal: ***idahoschoolmentalhealth.org/idaho-aware-project***. If you have access to a RELIAS account, you may also access the seven REACH Modules there at no cost.

Additional therapeutic approaches have been developed to address a broad range of concerns secondary to childhood and adolescent behavioral health concerns. These therapeutic treatments are evidence-based and demonstrated to be effective with symptoms of stress related to trauma, depression, anxiety, school violence, neglect and physical abuse. Examples of individual and group treatment have been demonstrated to be effective in multiple cultural settings and across the age continuum seen in the school setting.

Specific information about target populations, essential components, research and outcomes can be accessed online at the National Child Traumatic Stress Network (***www.NCTSN.org***).

Cognitive Behavioral Intervention for Trauma in Schools (CBITS)

https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions

"CBITS is an ideal trauma intervention for underserved ethnic minority students who frequently do not receive services due to a whole host of barriers to traditional mental health services. This school-based program is designed to be delivered in school settings, whether it is in an urban or midwestern public school serving a diverse student body or a religious private school providing outreach to an immigrant community. CBITS has been successfully used in a wide variety of communities because it can be flexibly implemented and addresses barriers such as transportation, language and stigma.

During the CBITS training and ongoing consultation with sites, we have specifically included in our training ways to implement this program to address cultural competency. We encourage sites to use culturally appropriate examples

during the treatment, and we discuss the cultural issues pertinent to each trainee's site. Although there are examples for each of the exercises in the manual, clinicians are encouraged to substitute these for culturally salient ones. For example, in working with immigrant populations, we focused some of the parent sessions on separation and loss issues that so many had experienced during the migration process. When we've worked in Catholic schools, faith-based clinicians openly discussed the students' examples of coping through prayer and complementing this with CBIT skills.

In addition, CBITS has also addressed the barrier of parent and family involvement that can be so common in many communities. We have used a community-based participatory partnership model of including ethnic minority parents from the community being served along with community leaders, clinicians and researchers to design the implementation plan so that the program is presented in a relevant and culturally congruent way."

Support for Students Exposed to Trauma (SSET): School support for Childhood Trauma

https://www.nctsn.org/treatments-and-practices/trauma-treatments/interventions?page=2

"Designed for implementation by school teachers or counselors, Support for Students Exposed to Trauma (SSET) is a cognitive-behavioral, skills-based support group aimed at relieving symptoms of child traumatic stress, anxiety, depression and functional impairment among middle school children (ages 10-16) who have been exposed to traumatic events. It is used most commonly for children who have experienced or witnessed community, family or school violence, or who have been involved in natural disasters, accidents, physical abuse or neglect. It includes 10 lessons in which children learn about common reactions to trauma, practice relaxation, identify maladaptive thinking and learn ways to challenge those thoughts, learn problem solving skills, build social support and process the traumatic event. Between sessions, children practice the skills they have learned."

Developed as an adaptation of the Cognitive-Behavioral Intervention for Trauma in Schools program (CBITS; Stein et al., 2003; Kataoka et al., 2003; Jaycox et al., 2010), SSET contains many of the same therapeutic elements but is designed to be implemented by school staff members without clinical training, with the back-up of a clinician who can help with clinical decision-making related to screening and intervention, provide emergency back-up and advise on high-risk students. The SSET adaptation of CBITS does not include individual or group imaginal exposure to the traumatic event and is designed to be more like a school lesson, written in lesson plan format.

Schools are one of the natural environments that can support health and mental health. Delivery of mental health programs through schools can overcome logistical barriers (transportation, scheduling, etc.) as well as reduce stigma.

SSET is designed for children in late elementary school through early high school (ages 10-16) who have experienced events such as witnessing or being a victim of family, school or community violence; being in a natural or man-made disaster; being in an accident or fire; or being physically abused or injured; and who are experiencing moderate to severe levels of post-traumatic stress symptoms. SSET was developed and tested in middle schools serving diverse, multicultural and multilingual students—predominantly Latino, African American, Caucasian and Asian. It is designed to be used in schools with children from a variety of ethnic and socio-economic backgrounds and acculturation levels."

Bounce Back: An Elementary School Intervention for Childhood Trauma

https://www.nctsn.org/interventions/bounce-back-elementary-school-intervention-childhood-trauma

"Bounce Back is a cognitive-behavioral, skills-based group intervention aimed at relieving symptoms of child traumatic stress, anxiety, depression and functional impairment among elementary school children (ages 5-11) who have been exposed to traumatic events. Bounce Back is used most commonly for children who have experienced or witnessed community, family, or school violence, or who have been involved in natural disasters, accidents, physical abuse,

CLICK HERE TO RETURN TO TABLE OF CONTENTS

neglect or traumatic separation from a loved one due to death, incarceration, deportation or child welfare detainment. The clinician-led intervention includes 10 group sessions where children learn and practice feelings identification, relaxation, courage thoughts, problem solving and conflict resolution and build positive activities and social support. It also includes two to three individual sessions in which children complete a trauma narrative to process their traumatic memory and grief and share it with a parent/caregiver. Between sessions, children practice the skills they have learned. Bounce Back also includes materials for parent education sessions.

Developed as an adaptation for elementary aged students of the Cognitive-Behavioral Intervention for Trauma in Schools (CBITS) program, Bounce Back contains many of the same therapeutic elements but is designed with added elements and engagement activities and more parental involvement to be developmentally appropriate for children ages 5-11.

Bounce Back is designed to be implemented in schools for children in elementary school grades kindergarten through fifth grade (ages 5-11) who have experienced events such as witnessing or being a victim of family, school or community violence; being in a natural or man-made disaster; being in an accident or fire; or being physically abused or injured; and who are experiencing moderate to severe levels of PTSD symptoms.

Bounce Back was developed and implemented in schools serving diverse, multicultural and multilingual students—predominantly Latino, African American, Caucasian, and Asian. It is designed to be used in schools with children from a variety of ethnic and socio-economic backgrounds and acculturation levels."