Youth Behavioral Health Coordination Project Work Group

Meeting Summary, 5/12/2015

I. Workflow Analysis

The team created an in-depth flowchart for how the pilot would ideally operate, including key steps, who would be responsible for what, the type of screening tools used, etc. Below is a summary of this workflow analysis.

For youth identified in schools:

Step 1: **Identify students for additional, referral-based screening** based on applying universal criteria across *all* students, such as early warning signals, absenteeism, grades, etc.

WHO: Individual school staff and/or existing interdisciplinary team(s) that typically include the principal, school counselor, school nurse, school psychologist, teacher and/or staff member.

Step 2: **Screen students using recommended screening tools & interpret results** (SDQ, GAINSS, and Pediatric Symptoms Checklist, with the possible addition of other questions/tools if needed)

Identify the types of clinical, behavioral, social/emotional, academic and/or basic supports a student needs

WHO: School counselor, school nurse, school psychologist, student assistant professional or social worker (specific person will depend on school; whoever it is must have the expertise to interpret screening tool results)

Step 3: **Identify one case manager per student to coordinate services**. This person would be located at or affiliated with the school, and would be responsible for linking all 5 areas the pilot is interested in coordinating: clinical care, behavioral health, social/emotional, academic and/or basic supports. This person's activities would include but not limited to:

- Attaining confidentiality release forms to share information across systems
- Identifying and coordinating referrals
- Serving as the information conduit between all those serving the student (e.g., feedback loop between education, clinical and community settings)
- Helping the student find a health home
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- Notifying provider practices in the selected area about the pilot and his/her role as the lead case manager for students attending that school

WHO: The exact person will depend on which schools are selected and their current staffing capacity.

Additional notes on this role:

- One potential benefit of the pilot would be to find ways to increase case management capacity at the pilot school (e.g., having multiple ACH partners help fund a case manager)
- The team agreed that ideally this case manager would be based at the school. Other potential options might include a care coordinator located in a provider's office, a community health worker, an existing community organization, and/or an existing MCO care coordinator. That said, the team's preference was to have a school-based case manager, at least for this pilot phase.

For youth identified in clinical settings:

Step 1: **Identify youth for additional, referral-based screening** based on applying universal criteria common in clinical settings (e.g., preventative care, well child visits, other visits)

WHO: Provider, sometimes social worker in various clinical settings (e.g., Community Health Center, pediatrician's office, family practice clinic, tribal health clinic)

Step 2: **Screen students using screening tools typically used in clinical settings & interpret results** (e.g., SCARED, GAD7, PHQ9, CRAFT)

Identify the types of clinical, behavioral, social/emotional, academic and/or basic supports a student needs

WHO: Provider, nurse

Additional notes on this step:

- Unlike in the school setting above, the team decided *not* to recommend specific screening tools for providers. As part of the pilot, however, the Bright Futures resource could be offered to providers in a pilot community, which includes various screening resources.

Step 3: **Identify one case manager per student to coordinate services**, again across all 5 areas: clinical care, behavioral health, social/emotional, academic and/or basic supports.

WHO: Provider, nurse and/or medical assistant would ideally refer ongoing case management back to school-based case manager (step #3 above).

Additional team notes on this step:

- The type of case management and the person responsible for it will depend in part on the pilot sites selected, the provider office's capacity, and the type of insurance a youth has. For this reason, the team discussed that care coordination/case management for youth identified in clinical settings might best be done by the school-based case manager (step #3 above), particularly for the pilot phase.
- Some provider practices may have a care coordinator that can take responsibility for that student.
- At a minimum, there's a need to give providers a place to direct inquiries about clinical, behavioral health, social/emotional, academic and basic need resources available in that community.

Value Add of Pilot:

As the team created this workflow design, it identified several value-adds of the pilot (i.e., what the pilot can offer that is above and beyond current practices; how it can provide value to schools and communities):

- By focusing on case management across all 5 areas: clinical care, behavioral health, social/emotional, academic and/or basic supports (equally important and integrated)
- By providing information, education and training on current best practices for case management
- By serving as a knowledge hub and providing an inventory of all the available resources and options to those serving youth (e.g., to clinicians, social service providers, caregivers, family members, school staff, etc.)

II. Pilot Sites

Lynn Nelson updated the team her outreach with the initial list of schools identified. Based on this information and the team's feedback, the list of potential pilot sites was narrowed down to those schools that have either expressed interest in participating in the pilot and others that still need additional follow-up.

Interested:

- Ocosta Elementary, Middle and High School (Grays Harbor)
- Rochester Primary School and Grand Mound Elementary School (Thurston)
- Tumwater Black Lake Elementary School (Thurston)

- Pioneer Elementary and Middle School (Mason)

Additional Follow-up Needed:

- Tumwater Middle School (Thurston; Megan to follow-up)
- Wahkiakum Elementary, Middle and High Schools (Wahkiakum; Julia)
- Kelso Elementary, Middle and High Schools (Cowlitz; Julia)
- South Bend Elementary, Middle and High Schools (Pacific; Lynn)

In the event that we lack urban options, the team discussed revisiting North Thurston or Longview schools.

III. Screening Tools

As mentioned above, the team discussed various screening tools at length during the workflow analysis. **It decided to recommend three potential tools with school partners**: SDQ, GAINSS, Pediatric Symptoms Checklist, with the possibility of adding other questions or tools if needed. These would be recommendations only; the decision on which screening tool a school selects will be done in collaboration with pilot sites.

IV. Summary and Next Steps

Our next team meeting is **May 22 from 2-3pm** via conference call.

Dial-in: **1-860-970-0300; 8945714#**

Assignments:

- Megan, Julia and Lynn to follow-up with additional schools listed above to gauge their interest & current landscape (see above)
- CHOICE team to update the pilot site matrix (including criteria-specific detail) based on information gathered through our initial school outreach & today's meeting