VERMONT AGENCY OF EDUCATION & AGENCY OF HUMAN SERVICES

JANUARY 15, 2020

REVIEW OF SUCCESS BEYOND SIX; SCHOOL MENTAL HEALTH SERVICES

ACT 72 (2019), SECTION E.314.1.

PREPARED BY THE AGENCY OF HUMAN SERVICES, DEPARTMENT OF MENTAL HEALTH, IN COLLABORATION WITH THE AGENCY OF EDUCATION

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LEGISLATIVE REQUIREMENT

Act 72 (2019) Sec. E.314.1 SUCCESS BEYOND SIX; REVIEW

(a) The Success Beyond Six program is based on agreements between the Designated Agencies and local schools, supervisory unions, or districts. The Agency of Human Services does not play a role in funding decisions; however, the overall program spending is part of the Medicaid program and impacts overall Medicaid spending and the budget neutrality cap.

(b) Given the limited room in the Global Commitment Medicaid budget neutrality cap, the Agency of Human Services (AHS), the Agency of Education (AOE), and Department of Mental Health (DMH) shall assess and determine how to evaluate Success Beyond Six program spending against other competing priorities in the Medicaid program.

(c) AHS, AOE, and DMH shall report to the General Assembly on Success Beyond Six evaluation and oversight not later than January 15, 2020. The report shall include:

(1) an inventory of existing methods for providing school-based mental health services;

(2) analysis of the trend in school-based mental health programming that is funded through the Success Beyond Six program fiscal mechanism;

(3) evaluation of the program attributes;

(4) determination, in partnership with the Designated Agencies, of metrics for evaluating program outcomes; and

(5) a proposal for how AHS, AOE, and DMH should participate in Success Beyond Six spending decisions.

EXECUTIVE SUMMARY

It has been well cited that school-based mental health (SMH) is a key strategy for the promotion of mental health and prevention of mental disorders. A recent Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Medicare and Medicaid Services (CMS) Joint Bulletin[1] noted that schools use multi-disciplinary approaches, often collaborating with community providers to provide needed services, and rely on multiple funding sources to support school mental health, including Medicaid and non-Medicaid authorities.

Success Beyond Six (SB6) was developed with the intent *to ensure partnership between the local school system and community mental health*, recognizing that such a partnership strengthens the ability of both entities to meet the needs of students and families. It is also a means to reduce the cost burden on education by using local education funds as the state match to draw down federal Medicaid for eligible services to eligible children.

Local decision-making has been the primary determinant of how the Designated Agency (DA) and school systems collaborate and the AHS role has been to apply general Medicaid program oversight standards and, specific to this program, standards for covered services and claims payment. Looking to the future, the State seeks to ensure equitable access to both support services and high-quality learning opportunities for all students. This lens is an important consideration as we move forward with designing best practice models statewide. How can we ascertain that all students across Vermont are being well-served and have the same chances for success in their individual educational endeavors?

SB6 has three main components: School-Based Clinical Services, School-Based Behavioral services, and CERT (Certified Educational, Recreational, Therapeutic Schools) with different funding structures within SB6 Medicaid.

KEY FINDINGS

Increasing acuity - While student enrollment numbers have declined across Vermont, the trend for number of students served through SB6 has not changed significantly and the proportion of total student population served through SB6 has remained relatively steady. However, over the past decade SB6 Medicaid total costs of services has increased, especially in the most recent

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/cib20190701.pdf

two fiscal years. The SB6 Medicaid total costs of services trend is influenced by Medicaid rates, available workforce, and student need. Stakeholder input and population level data suggest that the acuity of students has increased significantly in the past 10 years. Schools have expressed concern that their local school budgets bear the burden of school-based mental health as their local match funds have increased with the increasing use of Medicaid.

Identifying costs - The increasing costs of SB6 are driven by student need, availability of workforce, and Medicaid rates including the Federal Medical Assistance Percentage (FMAP) for Vermont. Analysis of SB6 data showed that the average cost per-student is nearly twice as high for CERT therapeutic schools compared to the clinical and behavioral services. CERT programs are highly intensive educational settings for students referred through their school's educational support team. The average SB6 per-student cost for students with Autism Spectrum Disorder (ASD) is nearly 3.5 times higher than for students with Severe Emotional Disturbance (SED). Most students with ASD are served through SB6 behavioral and clinical services in public schools or specialized autism programs. Additionally, most SB6 full -time equivalents (FTEs) are within the Behavioral Intervention services with a Medicaid Fee-for-Service billing mechanism. Behavioral Intervention services are a very intensive level of support within the public school system while also supporting some students in Independent Schools. These three areas contain the highest spending in SB6, with FFS billing at the highest rate of cost growth.

Partnerships and Collaboration - In regions where there was a strong partnership, including regular meetings, between the school leadership and Designated Agencies, clear themes emerged that both entities valued the working partnership with a shared goal to support students and families for success in school. And, there was a shared acknowledgment that even with the current level of partnership and services, it was not enough to meet the needs of students and families in their region. Both entities expressed concern about the budget pressures and desire to have effective and efficient school mental health.

Regional Variation - It is clear that how school mental health is structured varies from region to region and even from school to school within the same district. In general, this was seen as positive such that the local entities craft the services to meet their unique needs given their already existing resources. However, there was some concern expressed that effective practices may not be shared and spread effectively to other regions and there was a desire for more transparency about why differences (in services and rates) exist. In addition, the question of equitable access to high-quality supports for all students is also a concern. If we know that certain service models are working well, are we not bound to share those across the state and do what we can to improve scalability?

Promising models - Collaborative and integrated care approaches are showing promise and should be considered for broader roll-out. These include newer models that incorporate a teamed approach with behavioral consultation, such as the "Pod" model. The approaches being tested through the federally funded Project AWARE initiative to increase awareness of mental health needs of students and strengthen the integration between school mental health and school-wide approaches to address the emotional and behavioral needs of students will also be evaluated for statewide application. This includes the Interconnected Systems Framework for linking school mental health with Positive Behavior Intervention and Support (PBIS). PBIS is a "formal system of positive behavioral supports" to reduce student problematic behavior and ensure they are focused and learning. In schools with PBIS, SB6 school mental health providers are typically members of the PBIS implementation and educational support teams.

Controlling Costs and Meeting Needs - On the heels of the passage of Vermont's Act 264 system of interagency coordination for children, SB6 was began as an effort to help address the concern about the rising cost burden on education by leveraging federal Medicaid and was intentionally expanded over the years. However, the solution to problems of the past has now raised concerns to be addressed, as the trajectory of the Medicaid costs under SB6 is seen as unsustainable. While many aspects of Success Beyond Six are working well, some improvements have been identified, such as strengthening the practice model, ensuring equitable access statewide, and updating the financial structure. The concern of the rising costs amidst still unmet need suggests that the solution(s) must be designed at the state (and national) level, rather than through the individual local partnerships.

RECOMMENDATIONS AND NEXT STEPS

A primary solution for controlling costs while improving service delivery and increasing access is Delivery System and Payment Reform. Moving forward, any efforts by AHS, DMH and AOE to implement reforms will rely on strong partnerships, collaboration and alignment with current initiatives in the state.

Identified next steps and collaborations:

- AHS, DMH and AOE will continue to communicate about changes to SB6 and Special Education restructuring so that the two Agencies can collaboratively develop combined approaches that ensure student needs are met.
- AHS and DMH will prioritize SB6 for potential delivery system and payment reform. The first step will be to conduct an analysis of time and expense for this work.

- AHS and DMH will support identified practice model improvements through collaboration with the DAs/VCP and educators.
- Partners in each region will explore how to implement regular local collaborative meetings if they are not already occurring, composed of LEA representatives and DA school mental health directors and CYFS director.

INTRODUCTION

PROCESS

This report was created through a multi-faceted process including review of prior evaluations of school-based mental health services and programs in Vermont, a review of national standards and publications, a review of Vermont data, and a series of stakeholder input sessions around the State including the following organizations:

1. Vermont Superintendents Association (VSA)
2. Vermont Council of Special Education Administrators
3. Vermont Care Partners (VCP) and Designated Agencies (DA): Child, Youth & Family Directors, School Mental Health Program Directors
4. Regional partnerships of DA and local educational agencies in Rutland, Chittenden, and Washington counties
5. Act 264 Board and the children's State Program Standing Committee
6. Medicaid and Exchange Advisory Board (MEAB)
7. Vermont Federation of Families for Children's Mental Health Board

Stakeholder meeting agendas (included in Appendix A: Stakeholder Meeting Attendees and Agendas) included an overview of the intent of the report, the legislative questions, the context of why this matters, and questions seeking input from the stakeholder group to gain their perspective on each of the five report questions. Additionally, Vermont Care Partners submitted to DMH a written memo with input from the DA network (Appendix B: Summary Vermont Care Partners Memo to DMH).

BACKGROUND

As mentioned in the Executive Summary, Success Beyond Six (SB6) was developed with the intent *to ensure partnership between the local school system and community mental health*, recognizing that such a partnership strengthens the ability of both entities to meet the needs of students and families. It is also a means to reduce the cost burden on education by using local education funds as the state match to draw down federal Medicaid for eligible services to eligible children.

Success Beyond Six is not a statutorily defined program; however, requirements at Title 33, Chapter 43 regarding Children and Adolescents with Severe Emotional Disturbance apply.

Eligible children and youth[2] with assessed need are entitled to medically necessary community mental health services. Success Beyond Six (SB6) is the name of the program to provide these services in schools as contracted between the school and the DA. While not all school mental health services are provided by DAs, DAs are the only qualified entity to provide expanded mental health supports beyond traditional clinical therapies under Medicaid.

Local decision-making has been the primary determinant of how the DA and school systems collaborate and the AHS role has been to apply general Medicaid program oversight standards, and specific to this program, standards for covered services and claims payment. State matching funds for this program are provided by the local communities and certified by the local education agencies. Those matching funds are used by AHS as the source of state share to draw down the federal Medicaid/CHIP match and to reimburse the DA based on the contract for costs and services between the supervisory union/school and the DA. DMH holds funding agreements with each DA to address the programmatic, quality and fiscal requirements of using Success Beyond Six Medicaid for school mental health.

SB6 has three main components: School-Based Clinical Services, School-Based Behavioral services, and CERT (Certified Educational, Recreational, Therapeutic Schools) with different funding structures within SB6 Medicaid.

SECTION 1: AN INVENTORY OF EXISTING METHODS FOR PROVIDING SCHOOL-BASED MENTAL HEALTH SERVICES

This section includes existing systems and practices for providing school-based mental health services for Kindergarten through 12th grade from a national and state perspective:

A. Best practice for school mental health
B. Provided in Vermont through the Success Beyond Six program
C. Provided in Vermont outside of the Success Beyond Six program
D. Examples of methods for providing school-based mental health services outside of Vermont

A. BEST PRACTICES FOR SCHOOL-BASED MENTAL HEALTH SERVICES

It has been well cited that school-based mental health (SMH) is a key strategy for the promotion of mental health and prevention of mental disorders (Academies, 2009)

[2] VT=312% Federal Poverty Level

(CMS/SAMHSA, 2019) (Hoover, 2019). Research demonstrates the value of supporting children and youth who experience significant stresses; teaching all students skills for emotional regulation, social relationships and competencies such as problem-solving, planning and self-awareness; and addressing risk behaviors such as violence, aggression and substance use (Academies, 2009).

"Comprehensive school mental health systems represent a strategic collaboration between school systems and community programs that together provide a full array of evidence-based, tiered services…to promote mental health and reduce the prevalence and severity of mental illness among children and adolescents."

US DEPT OF HEALTH AND HUMAN SERVICES, 2018

At a congressional briefing following the Parkland tragedy in March 2018, Dr. Ron Avi Astor offered two visions for schools: *welcoming, caring, supportive schools* or *restrictive, fortressed schools* (Congressional briefing, March 23, 2018). The case was made that **the primary strategy for school safety is to create *relational safety*** through social emotional learning, school climate and mental health supports. Strategies included Multi-Tiered Systems of Support (such as Positive Behavior Intervention & Supports, PBIS) with a focus on social-emotional learning and connecting with students, and clear pathways to more intensive mental health supports. The National Center for School Mental Health (NCSMH) is promoting the creation of *comprehensive school mental health systems*, recognizing that schools are an essential access point for mental health services. Whereas access to mental health (MH) services through Community MH centers across the country is poor and sees high no-show rates, national data shows that youth are six times more likely to follow through and complete MH treatment in schools than in community MH centers. States across the US, and in other countries, are taking action to create and expand *comprehensive school mental health* (Hoover, 2019).

SAMHSA and CMS issued a Joint Bulletin in July 2019 to provide guidance to states and school systems on addressing mental health and substance use issues in schools (CMS/SAMHSA, 2019). This bulletin recognized the "urgent need" to identify and intervene early to address the mental health needs of students, and that "[s]chools can fill a critical role in both identifying such children and adolescents and connecting them with treatment and other services they need". SAMHSA/CMS noted that schools use multi-disciplinary approaches, often collaborating with community providers "as a strategy to expand needed services".

SAMHSA/CMS cited best practice models for school mental health; the table below shows which of these nationally recognized practices are implemented in Vermont:

Best practice models	***Present in VT***	***Under development in VT***
Multi-Tiered System of Supports:	✓	
o *Positive Behavioral Interventions and Supports*	✓	
o Interconnected Systems Framework		✓
o *Response to Intervention*	✓	
Comprehensive school mental health systems:	✓	
o *Building mental health literacy* (i.e. *Mental Health First Aid and Youth Mental Health First Aid*)	✓	
o *Counseling, psychological, and social services (CPSS) coordinators*		✓
o *School resources officer (SRO) with training in mental health concepts*	✓	
o *Crisis Intervention Teams (CITs)*		✓
o *Behavioral Health Aides and Peer Supporters*	✓	

SAMHSA/CMS concluded that "[n]o single funding source can adequately support all mental health and substance-related prevention and treatment needs of students and their families and caregivers; however, federal, state, and community-level resources can be leveraged with philanthropic and other funding streams to ensure appropriate levels of support." Medicaid authorities for funding school-based mental health includes both the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, and Medicaid demonstrations and waivers (e.g. Section 1115 demonstration projects). Non-Medicaid authorities for school mental health funding include the Individuals with Disabilities Education Act (IDEA) and Title I of the Elementary and Secondary Education Act, as amended by the Every Student Succeeds Act (ESSA). In addition, in some areas, such as Vermont, local Education Fund dollars derived from property tax revenue are used to fund school-based mental health services. The most common Medicaid payment approaches described in the bulletin are: 1. Fee-for-service/claim-based payment and 2. Recognized cost reimbursement (CMS/SAMHSA, 2019).

B. SCHOOL MENTAL HEALTH THROUGH SUCCESS BEYOND SIX MEDICAID

PURPOSE OF THE SUCCESS BEYOND SIX (SB6) MEDICAID PROGRAM

Success Beyond Six was developed with the intent *to ensure partnership between the local school system and community mental health*, recognizing that such a partnership strengthens the ability of both entities to meet the needs of students and families. It also was a means to reduce the cost burden on education by using local education funds as the state match to draw down federal Medicaid for eligible services to eligible children (Vermont Department of Mental Health, 2008).

While not all school mental health services are provided by DAs, DAs are the only qualified entity to provide expanded mental health supports beyond traditional clinical therapies (individual, group, family, and psychiatry) under the Vermont Medicaid program, including supportive counseling, service planning and coordination, and crisis stabilization to name a few. School mental health (SMH) services provided through a DA allows the SMH provider to bring expertise in mental health practice to school-based teams while also providing the additional structure of clinical supervision, administrative support for billing and reporting, ability to link with other DA services, and oversight and accountability to the State.

As indicated in the funding agreements between the Department of Mental Health and the DAs, the goals for the provision of Success Beyond Six Medicaid are to:

- Serve children/youth and families in their school settings.
- Screen, assess, and treat children/youth's mental health needs.
- Provide clinically appropriate services to children/youth and families that result in increased competencies and reduced symptomology.
- Partner with schools to increase awareness, recognition and response to student mental health through promotion, prevention, and intervention activities within the Multi-Tiered Systems of Support (MTSS) framework.

MULTI-TIERED SYSTEMS OF SUPPORT (MTSS) FRAMEWORK

Schools are adopting many paradigms for addressing the complex and more acute needs of our students. An overarching framework for conceptualizing the integration of core academic and social emotional learning for all students is discussed in both Title 16 and the State Board of Education's Education Quality Standards (Vermont State Board of Education Rules Series 2000).

A Multi-Tiered System of Supports (MTSS) is a "framework that unifies educational opportunities and supports to improve outcomes and ensure equity for all students" (AOE MTSS Field Guide, 2019).

Vermont's MTSS Framework:

- Unifies general and special education in intentional, ongoing collaboration;
- Provides a layered continuum of high-quality, evidence-based instruction, intervention and assessment practices matched to student strengths and needs;
- Relies on effective and timely use of meaningful data;
- Helps schools and districts organize resources to accelerate the learning of every student;
- Engages and develops the collective expertise of educators, students, families and community partnerships; and
- Employs a systemic approach to decision-making and continuous improvement that ensures positive outcomes for all students. (AOE MTSS Field Guide, 2019).

Within the wide range of supports LEAs can provide to best meet students' needs, many have opted to incorporate Positive Behavior Intervention and Support (PBIS), whereby schools use a "formal system of positive behavioral supports" to reduce student problematic behavior and ensure they are focused and learning (see https://www.pbisvermont.org/).

Where schools are implementing PBIS (Figure 1), the DA SMH providers are typically members of the school implementation team offering a mental health lens and helping to identify roles within different levels of school-based supports: 1° for all students, 2° for those at risk, and 3° for those with an identified need.

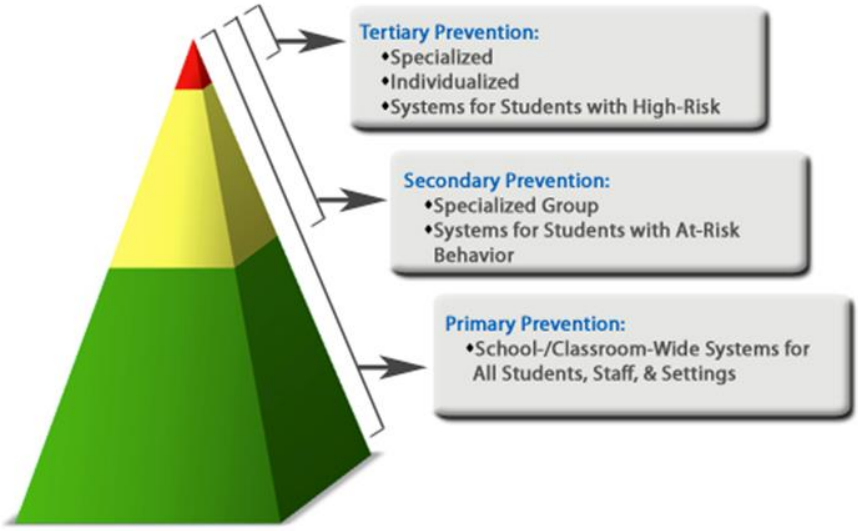


Figure 1 PBIS Model

As of the 2018-2019 school year, 156 (53%) of Vermont schools are implementing PBIS in 92% of Supervisory Unions/Supervisory Districts (SU/SDs)" (UVM Center on Disability and

Community Inclusion, 2019). Half of the PBIS schools have implemented at the Targeted (2°) and about 1/3 have implemented at the Intensive (3°) level. Seventy-seven percent of these schools implemented PBIS with fidelity, up 8% from the previous year (UVM Center on Disability and Community Inclusion, 2019). Fidelity of implementation is an important factor that must be considered to assure success in school mental health services.

SB6 DELIVERY MODEL

School mental health services under Success Beyond Six have three main areas of focus which will be described in greater detail:

- School-Based Clinical Services
- School-Based Behavioral services
- C.E.R.T. Therapeutic Schools

SB6 school mental health services are grounded in trauma-informed practices, evidence-based approaches (e.g. ARC, CBT, DBT, ABA), and provided within a family- and system of care lens to work with students in the context of family and in collaboration with other system partners. Behavioral services are grounded in principles of learning and behavior based on Applied Behavioral Analysis (ABA) in the context of trauma-informed care and clinical mental health approaches.

SCHOOL-BASED CLINICAL SERVICES

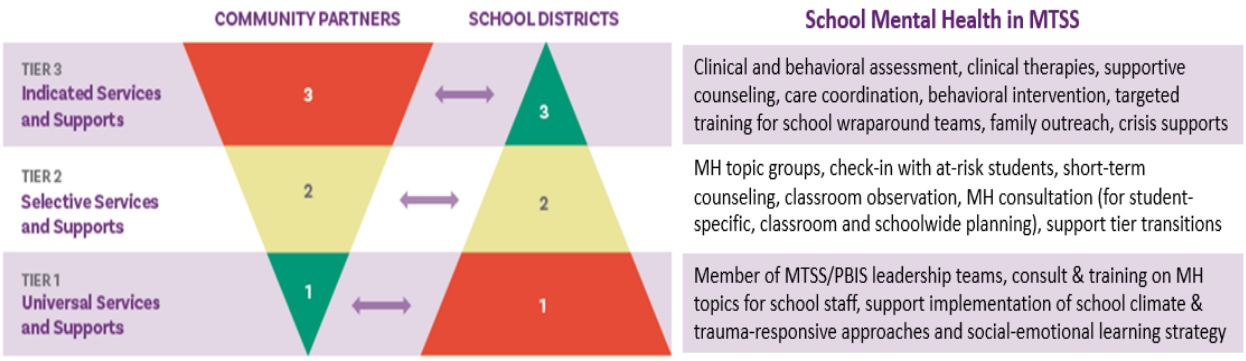
School-based clinical services are performed by a Masters-level or above clinician and may be provided in public elementary, middle and high schools as well as through partnership with Independent Schools. Under the current case rate payment model, SMH clinical services include the following traditional and innovative service delivery options:

- Clinical assessment
- Clinical therapies
- Individual and group supportive counseling and skill development
- Service planning & coordination
- Mental Health consultation (student-specific and system-wide)
- Crisis response
- Family support
- Health and wellness

Where SMH clinicians are embedded in PBIS-participating schools, they can be an active team member at all levels – tiers – of PBIS implementation (Figure 2). At the Universal level (Tier 1), SMH clinicians can participate in school leadership team meetings, provide general consultation

or training on mental health issues, and assist in the implementation of school-wide practices. They can also assist in reviewing and interpreting student data to assist in making decisions on whether Tier II (2°) or Tier III (3°) supports are needed. At the Targeted level (Tier II), they can provide Check-In/Check-Out interventions for students at risk for needing more supports. Some may partner with teachers or guidance counselors on such topics as bullying, relationships, conflict resolution, and other skill building topics. They can participate in student Education Support Team (EST) meetings, offer consultation and clinical expertise regarding students not on the DA caseload, assist in training para-educators and classroom support staff on behavior support plans, and assist teachers in creating classroom-wide behavior support plans. At the Intensive level (Tier III), the more traditional individualized treatment services and family interventions are available, in addition to the supports described at the other tiers.

Figure 2 MTSS/PBIS and SMH model



Adapted from (Hoover, 2019)

Some DA-school partnerships involve a Case Manager instead of a clinician. The school MH Case Manager likely does not have a master's degree and performs only services within the scope of their education and training, typically Service Planning & Coordination and Community Supports. This is one way that the DA meets some of the mental health needs of the school when there are workforce limitations in filling a Master's level position.

Local decision-making has been the primary determinant of how the DA and school systems collaborate, for good reason. However, the state has an obligation to ensure equitable access to both support services and high-quality learning opportunities for all students. This lens should be an important consideration as we move forward with designing best practice models statewide. How can we ascertain that all students across Vermont are being well-served and have the same chances for success in their individual educational endeavors?

Payment structure

Per Member Per Month case rate The State of Vermont uses a case rate reimbursement methodology for school-based clinician services within the SB6 program. The Global Commitment Demonstration provides the flexibility to develop alternative approaches intended to promote access and public health/early intervention strategies to improve care delivery and reduce program costs.

The State developed monthly case rate limits based on historical Fee-For-Service utilization and payment rates, following review of the reasonableness of historic payment rates related to costs. One goal was to ensure that the monthly case rate ceiling is sufficient to cover program costs (salary, benefits and indirect) subject to meeting minimum caseload requirements. The monthly case rate methodology provides reimbursement for the full array of covered services provided by school-based clinicians and provides the flexibility for schools and Designated Agencies to collaborate in order to develop innovative service delivery options.

The Per Member Per Month (PMPM) case rates are established annually for each DA. A case rate is set for PBIS and non-PBIS schools where there are contracts with both. In advance of the new Fiscal Year, each Designated Agencies reports to DMH how many PBIS and Non-PBIS school contracts they will have with the Local Education Agency (LEA) in the upcoming school year. The PMPM is based on the total school-based clinician FTEs and the estimated revenue for each school contract held by the DA. The contract revenue is divided by the number of clinicians assigned to the program, divided by the minimum number of children to be served in a month. Recognizing the value in SMH participation in Positive Behavior Interventions and Supports (PBIS), a higher case rate limit has been established (in other words, the minimum number of students to be served is lower) for clinicians working in Vermont's PBIS-participating schools.

There is an established minimum service threshold per month to bill the monthly case rate for each student. Properly submitted case rate claims are paid until the maximum billing amount is reached. Then DAs continue to submit claims for students who meet the minimum service threshold, even if the maximum billing amount has been reached and no additional payments are made.

See Section 2 for data about students served through this service (Figure 9) and workforce FTEs (Figure 16).

SCHOOL-BASED BEHAVIORAL SERVICES

School-based behavioral services are a collaboration between the DA and local educational program to provide consultation and behavioral intervention with targeted students in a school

setting. The behavioral services use evidence-based and best practice strategies such as Applied Behavior Analysis (ABA) that are individualized to the student's mental health and behavioral needs to help the student access their academics. The Behavioral Services include initial and ongoing assessment by clinical professionals, typically Board-Certified Behavioral Analysts (BCBAs); behavior interventions that are grounded in the assessment and behavior support plan; and clinical training and supervision of the Behavioral Interventionist (BI) as described in the BI Minimum Standards. These services may be provided within a mainstream education program in public elementary, middle and high schools or in an alternative education program through partnership with Independent Schools.

The behavioral services covered by Medicaid include:

- Functional Behavioral Assessment (FBA)
- Behavioral support planning (BSP)
- Community Supports, aka Intensive Behavioral intervention
- Service Planning & Coordination
- Behavioral consultation (student-specific and system-wide)
- Autism-specific programming

Regional Example: Pod Model

The WCMH Pod model uses a team of a Behavioral Consultant, a Case Manager, and up to 8 Behavioral Interventionists to serve up to 14 students. This model allows for more services to be offered to more students at the same cost as serving 8 students through individual contracts. The Pod capability is dynamic and can be structured to each school's need using a point system to establish services based on professional capacity. Capacity includes:

- Behavioral consultation
- Case management
- Behavioral Intervention
- Curriculum consultation
- Para-educator model (training & support)
- Functional Behavioral Assessment

	Traditional BI 2017-2018	Pod Model 2018-2019
Behavioral intervention:	Served **66** students with **66** BIs	Served **98** students with **62** BIs
Consultation:	provided for **9** students through 9 "consult only" contracts	consultation for an additional **13** "unidentified" clients as part of the pod cost
Contracts:	**66** "traditional" individual BI contracts **9** consult-only contracts = **75** contracts	**8** Pod contracts **8** "traditional" individual BI contracts = **16** contracts

Payment structure

Fee-for-service Behavioral Services are billed fee-for-service (FFS) as provided in accordance with the Mental Health provider manual. DMH has established FFS rates that are updated with increases or decreases provided by the Legislature during the annual budget process. FFS rates are the same across DAs.

DAs may enter into contracts with a school for FFS behavioral services for a specific student or for a package of behavioral services (see Regional Example side bar above).

See Section 2 for data about students served through this service (Figure 9) and workforce FTEs (Figure 16).

C.E.R.T. THERAPEUTIC SCHOOLS

Concurrent Education Rehabilitation and Treatment (CERT) school programs provide therapeutic behavior services concurrent to education (community support in a school setting). CERT assists individuals, their families, and educators in planning, developing, choosing, coordinating and monitoring the provision of needed mental health services and supports for a specific individual in conjunction with a structured educational setting. CERT programs are run by a DA and are typically AOE-approved Independent Schools or programs. These supports may include assistance in daily routine, peer engagement and communication skills, supportive counseling, support to participate in curricular activities, behavioral self-control, collateral contacts, and building and sustaining healthy personal, family and community relationships. Children must meet the definition of severe emotional disturbance in order to qualify for CERT services (Vermont Department of Mental Health, 2019).

Payment structure

Per Diem rate DMH sets a daily rate for therapeutic behavior services concurrent to education (community support in a school setting). Medicaid covers the treatment services and educational services are covered by the LEA/AOE. The DA provides DMH a detailed list of staff FTEs, benefits, travel expenses, supplies and notable program changes with the breakout of costs that are attributed to treatment vs education. The budgets are analyzed for significant changes and compared to actual prior year expenses in order to set separate education and mental health service rates.

See Section 2 for data about students served through this service (Figure 9).

C. SCHOOL MENTAL HEALTH PROVIDED IN VERMONT OUTSIDE OF THE SUCCESS BEYOND SIX PROGRAM

Schools may also pursue other strategies for mental health supports and services in their buildings. These include the following:

- School hires and directly funds a mental health provider (e.g. BCBA, licensed social worker, or licensed mental health clinician)
    - school supervises the position and directs their activities
    - sometimes this includes hiring the DA SB6 provider to be employed by the school rather than the DA
- School opens space for private clinician
    - private provider bills DVHA Medicaid or commercial insurers directly
    - limited to clinical services only
- School contracts for other private entities to provide school-wide training on mental health topics (e.g. trauma-responsive schools) or student-specific interventions
    - unable to leverage Medicaid to support the funding of these contracts
    - oversight of quality of service may vary
- Schools takes advantage of federal grant funding, such as the SAMSHA-funded Project AWARE grant, to contract for services, via state Agency partnership and initiative

The Vermont Agency of Education was awarded a 5-year grant (9/30/2018 to 9/29/2023) from SAMHSA for **Project AWARE** (Advancing Wellness and Resilience in Education) State Education Agency. Vermont Project AWARE is a joint effort between the AOE, DMH and three communities to promote: on-going collaboration at the state and local level regarding best practices to increase awareness of mental health issues; enhance wellness and resiliency skills for school age youth; and support system improvements for school based mental health services. The project establishes planning teams with each of three LEAs and their DA partner. Target communities include Orleans Southwest Supervisory Union, partnering with Lamoille County Mental Health; Slate Valley Unified School District and Greater Rutland County Supervisory Union, who will both partner with Rutland County Mental Health Services. Several evidence-based practices will be used, including: Youth Mental Health First Aid®; Umatter® youth suicide prevention activities; Positive Behavioral Interventions and Supports (PBIS); Interconnected Systems Framework (ISF); and Attachment, Regulation, and Competency (ARC) framework for complex trauma. The Governor's office has expressed interest in expanding this program.

D. EXAMPLES OF METHODS FOR PROVIDING SMH SERVICES OUTSIDE OF VERMONT

Vermont is one of forty-five states and the District of Columbia which leverages Medicaid for eligible SMH services. It is noted that mental health services provided in a school setting "are subject to the same federal and state laws and regulations that apply to Medicaid services provided in other settings" (CMS/SAMHSA, 2019).

STATE	Other states' strategies to finance School Mental Health
Alabama	Alabama Departments of Education and Mental Health developed cross system funding to support school-based mental health programming.
Arkansas	Developed administrative procedures to finance a school-based mental health program. Arkansas also formed a state-level collaboration between their Departments of Education, Mental Health/Behavioral Health, and Juvenile Justice for shared funding of school-based services, and a comprehensive manual of Arkansas's approach to school-based mental health within their State is available online.
California	Passed the "Mental Health Services Act," which levies a "1% income tax on personal income in excess of $1 million" to support mental health initiatives, including comprehensive school-based mental health systems.
Florida	Utilized a SAMHSA Project AWARE grant to produce a "Universal Screening Planning Packet," designed to guide schools in implementation of broad-based mental health screening so that students may receive further support and mental health services when indicated.
Louisiana	Used Medicaid state plan authority in LA 15-0019 to cover the services of a licensed nurse in the school setting for Medicaid-eligible students with an "individualized health plan" thereby not limiting the nursing services to services in an Individualized Education Plan (IEP.)
Massachusetts	Amended their Medicaid state plan to cover services within Individual Health Care Plans, Individualized Family Service Plans, Section 504 plans, or services otherwise deemed medically necessary.
Michigan	IDEA revisions expanded counseling sessions for students at elevated risk for mental health concerns (i.e., "Tier 2") and for those with existing mental health needs (i.e., "Tier 3").
Nevada	The governor's state-funded block grant called "Social Workers in Schools" began in the 2015-2016 school year and provides full-time social workers to address mental health/behavioral health issues identified on school climate surveys. Through "Social Workers in Schools," the Department of Education's Office for a Safe and Respectful Learning Environment has placed over 225 social workers in 170 schools over the past two years
South Carolina	Department of Education created a "Psychosocial Behavioral Health Rehabilitative Medicaid Standard" for students in Tiers 2 and 3 to enhance coverage for school-based services. South Carolina also developed a recurring

	line item in the state budget to ensure funding for rural communities to develop school mental health programs.
Tennessee	Johnson City designated school mental health funding for case managers in schools to provide Tier 2 and Tier 3 level services.

(CMS/SAMHSA, 2019)

Michigan's efforts to expand school-based Medicaid, as noted in the State Spotlight, shows that states across the country recognize the value of school mental health and are looking to Medicaid as well as other strategies to fund it. Vermont has had the option for funding school mental health with Medicaid for several decades; we are striving to improve the service and funding model with consideration of equitable access to the service.

SECTION 2: AN ANALYSIS OF THE TREND IN SCHOOL-BASED MENTAL HEALTH PROGRAMMING THAT IS FUNDED THROUGH THE SUCCESS BEYOND SIX PROGRAM FISCAL MECHANISM

This section will review the trends in SB6 spending, students served, workforce FTEs, and student need.

STATE SPOTLIGHT: EXPANDING SCHOOL-BASED MEDICAID IN MICHIGAN

In August 2019, CMS approved Michigan's State Plan Amendment (SPA) to allow districts to seek Medicaid reimbursement for services provided to all Medicaid-enrolled students (not just services included in a student's with IEP/IFSP). In addition, Michigan expanded the types of providers who can be placed on the Medicaid Staff Pool list for reimbursement, as well as the types of Medicaid services in school-based settings (and for all Medicaid-enrolled students) to include: physician's assistants, clinical nurse specialists, nurse practitioners, marriage and family therapists, board certified behavioral health analysts, school social workers, and school psychologists. This expansion represents a significant pathway to increasing access to Medicaid services in Michigan schools—especially access to behavioral health services. This landmark change was the product of years of work by a multi-sectoral group of agency staff, timely movement from the Michigan Legislature, and strong support from school districts.

(Council of Chief State School Officers, 2019)

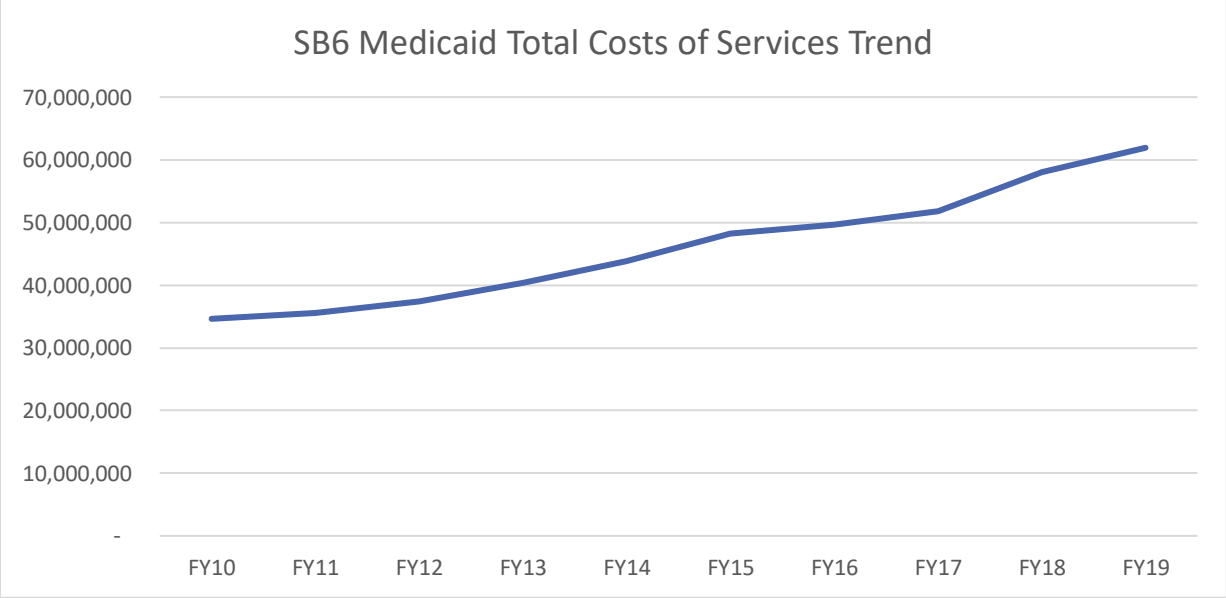
There are LEA/DA contracts for Success Beyond Six funded school mental health in nearly every school district in Vermont and in 13 independent schools, as of December 2019 for state fiscal year 2020.

SFY 2020	Total in VT	With any SB6 # (%)	With School-Based Clinician # (%)
Public Schools	292	201 (69%)	185 (63%)
Supervisory Unions	53	48 (91%)	44 (83%)

SB6 MEDICAID COSTS OF SERVICES TRENDS

For the last 10 years, the Medicaid total costs of services in SB6 has been on the rise, with the greatest increases occurring in the prior two fiscal years (Figure 3). The SB6 Medicaid total costs of services trend is influenced by Medicaid rates, available FTEs, and student need. This section will explore each of those.

Figure 3 SB6 Medicaid Total Costs of Services

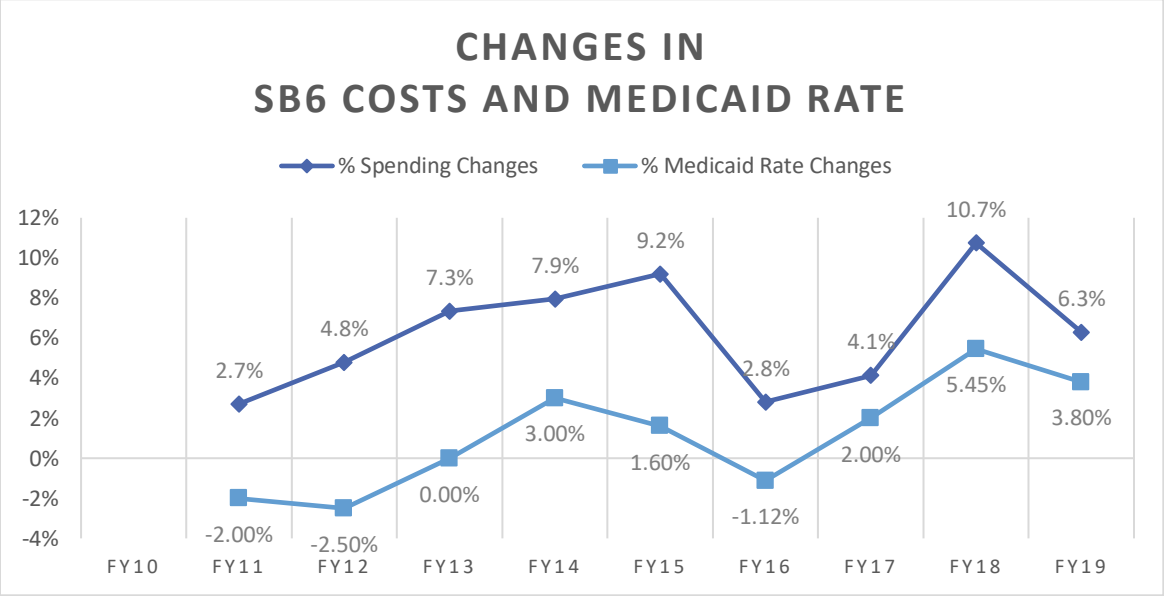


MEDICAID RATE CHANGES

For all SB6 charts in this section it is important to note that legislative Medicaid rate changes occurred across the fiscal years which applied to SB6 and influence the trend lines of total costs, FTEs and students served. Using FY10 as the starting point, we compared the annual changes in Medicaid rate and spending (Figure 4). Some Medicaid rate changes were only applied to a partial fiscal year; therefore, the chart shows the effective, or annualized, rate change. This

comparison shows the impact of the Medicaid rate changes on the spending changes. Once the Medicaid rate change is considered, the remaining amount of spending increase can be attributed to SB6 contract/service changes. While the chart below shows the annual changes, it should be noted that Medicaid rate changes have a cumulative effect. For example, FY20 applied a 1.23% Medicaid rate increase for SB6; when this is added to prior FY Medicaid rate changes, the cumulative 10-year Medicaid rate increase is 11.46%.

Figure 4 Annual Changes



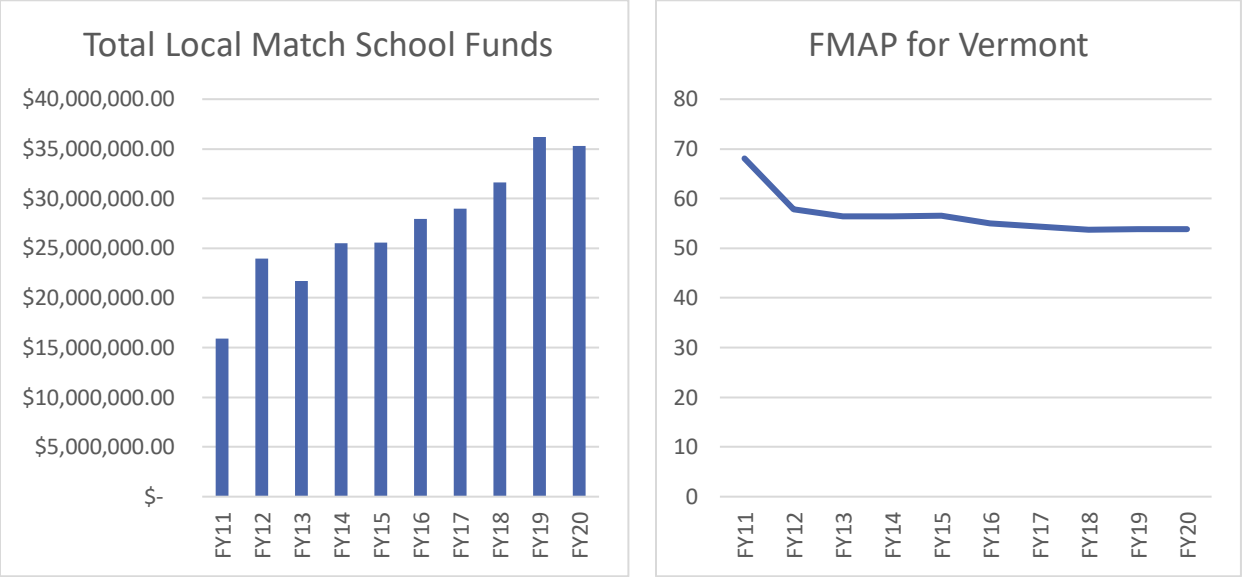
LOCAL SCHOOL MATCH

As previously described, Success Beyond Six is structured to use local educational funds to match, or draw down, the federal Medicaid share. Schools have expressed concern that their local school budgets bear the burden of school-based mental health as these local match funds have increased with the increasing use of Medicaid (Figure 5).

Also impacting the local match funds are any changes in the Federal Medical Assistance Percentage (FMAP) for Vermont. As established under the Social Security Act, the Secretary of Health and Human Services calculates and publishes the FMAPs each year for each state and territory. The FMAP is the percent of federal matching funds; the FMAP cannot go below 50% and has a high of 83%. For Vermont, the current FY20 FMAP is 53.87%. This means that Medicaid matches $0.54 to VT's $0. 46 for every dollar spent through Medicaid. Vermont's FMAP has reduced over the past decade, such that the state match portion has gone up (FY11 FMAP was 68.07%, so VT only paid $0.32 for every Medicaid dollar). This has bearing on the

total local match funds, in addition to the increased service rates, number of contracts and FTEs.

Figure 5 Local School Funds for SB6 & FMAP

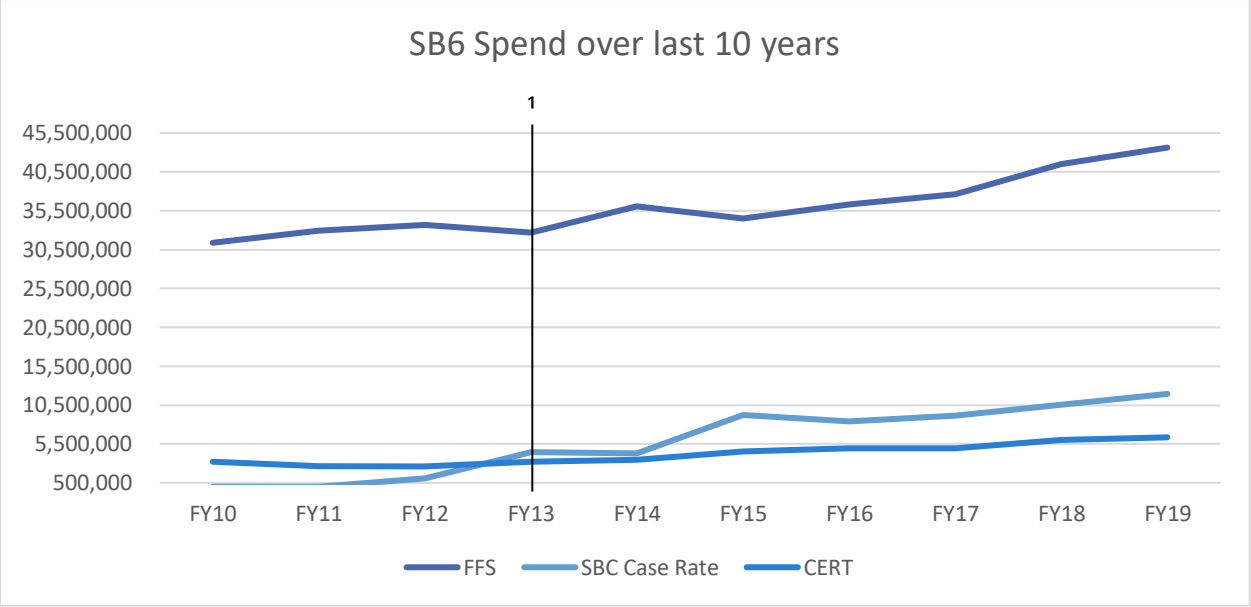


SB6 MEDICAID COSTS OF SERVICES BY TYPE

To understand the distribution of spending across the different SB6 structures, the total Medicaid costs of services was broken down by Medicaid payment mechanism, which is a simplistic way to get at programming: Fee-For-Service (FFS) is generally used for Behavioral Intervention Services, School-Based Clinician (SBC) case rate for clinical services, and CERT case rate for the concurrent education rehabilitation and treatment services that occur in Independent schools (

Figure 6). As would be expected, the most frequently used, moderately intensive level of SB6 services has the highest total cost: fee-for-service behavioral intervention services.

Figure 6 SB6 10-Year Spending Trend



Notes: [1] SB6 Clinician Case Rate went into effect statewide FY13 following regional pilot, shift from FFS.

TRENDS OF STUDENTS SERVED

Agency of Education reports that student enrollment numbers have declined across Vermont (

Figure 7). For the last 10 years, the trend for number of students served through SB6 has not changed significantly and the proportion of total student population served through SB6 has remained relatively steady (ranging from 4.3% - 4.9%). However, stakeholder input and population level data suggest that the acuity of students has increased significantly, as will be discussed in a later section of student needs.

All SB6 student data that follows represents *only open clients of the DA* and do not capture all students who benefit from SB6 supports at the Targeted and Universal levels of MTSS or students who received clinical services below the case rate threshold for billing. Service data are reported by the DAs to DMH through the Monthly Statistical Report (MSR) for all students who receive direct intervention and are open to the DA. Figure 8 shows the statewide total number of students who received direct services under SB6, based on MSR data.

Figure 7 K-12 Enrollment

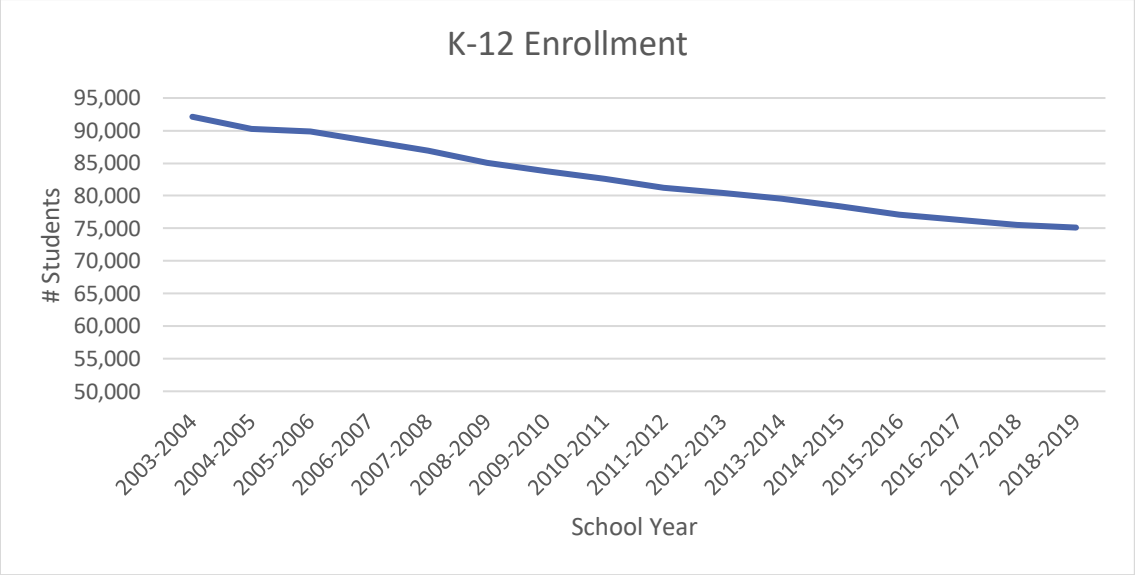
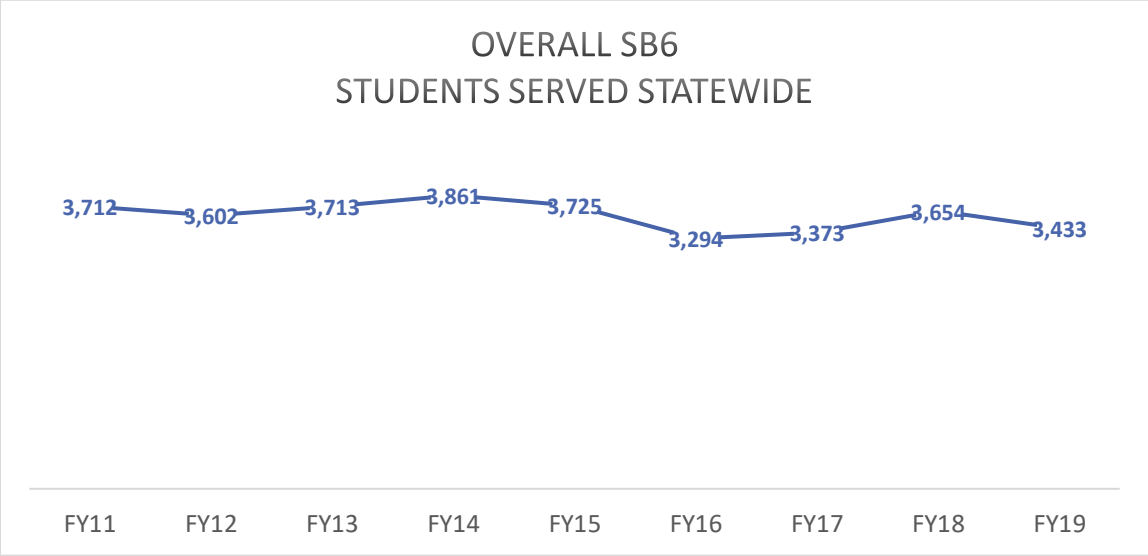


Figure 8 SB6 Students Served Statewide

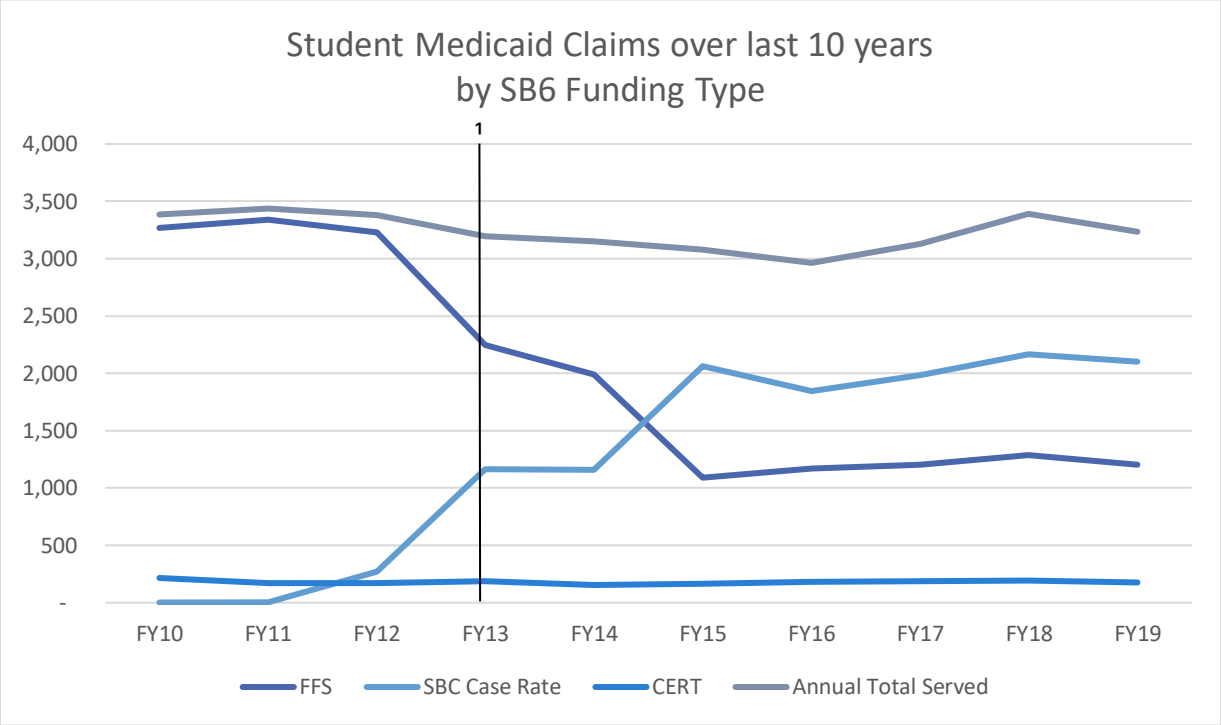


Notes: Data source is DMH Monthly Statistical Report encounter data

STUDENTS SERVED IN SB6 BY PROGRAM TYPE

Figure 9 shows the number students for whom there was a Medicaid claim under SB6. These totals vary slightly from the MSR data above due to noted differences in what data are collected. Under the School-Based Clinician Case Rate, if the clinician provided direct intervention with a student, but did not meet the minimum threshold amount of service in the month, the case rate is not billed for those students and thus does not appear in these MMIS data. The apparent drop in students served through Fee-For-Service and concurrent increase in School-Based Clinician Case Rate reflects the shift of funding structure for clinical services.

Figure 9 Students Served in SB6 Statewide by Program Type



Notes: [1] SB6 Clinician Case Rate went into effect statewide FY13, shift from FFS

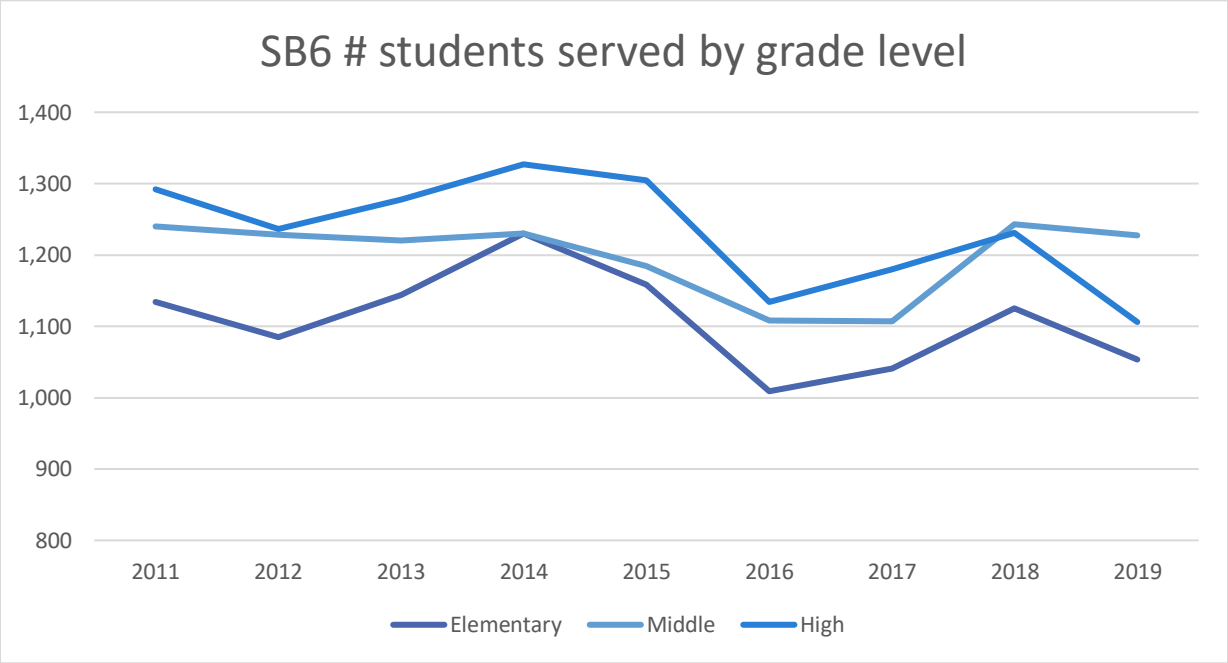
Data source is Medicaid Management Information System (MMIS) paid claims

STUDENTS SERVED IN SB6 BY GRADE LEVEL

Lastly, the trends for students served in SB6 by grade level were reviewed (Figure 10). Since schools across Vermont vary in the breakout of grades across elementary and middle schools, and SB6 service data includes information about the student's age, not grade level, the chart below is a rough estimate. The general age/grade grouping was used as follows:

	Grades	Age
Elementary	K-4	5-9
Middle	5-8	10-13
High	9-12	14-18+

Figure 10 Students Served in SB6 by Grade Level



Note: Data source is DMH Monthly Statistical Report encounter data

It is important to note again this data represents students who are open clients of the DA receiving direct intervention and does not include other students who also benefit from the mental health consultation and school-wide supports provided through SB6 SMH. This is especially true for elementary schools. FY18 also saw increases in residential treatment, crisis stabilization programs, and intensive home and community-based services. Additionally, we have seen an upward trend in Emergency Department claims for children and youth presenting with mental health needs over this time period.

TOTAL SB6 SERVICES TREND

While there has been a 5% reduction in the number of students who received direct services through SB6 from 2009 to 2019, there was a 17% increase in the total number of direct services provided to those students (Figure 11). Since these services must be medically necessary, it indicates support for the assertion that the needs of students have increased. Again, this data

does not capture the additional consultation and school-wide supports offered by the SB6 providers.

Figure 11 SB6 Total Number of Services and Students Served

Children Served by Success Beyond Six
FY2010-FY2019

	Fiscal Year									
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Total SB6 Services	248,197	240,841	220,630	224,311	240,928	254,375	240,805	262,225	322,513	291,017
Total Children Served by SBS	3,687	3,712	3,602	3,713	3,861	3,725	3,294	3,373	3,654	3,519

Analysis is based on Monthly Service Report (MSR) data submitted to DMH by designated community agencies for FY 2010-FY2019 for clients served by the Children's Mental Health Services Program and by the Success Beyond Six Cost Center.

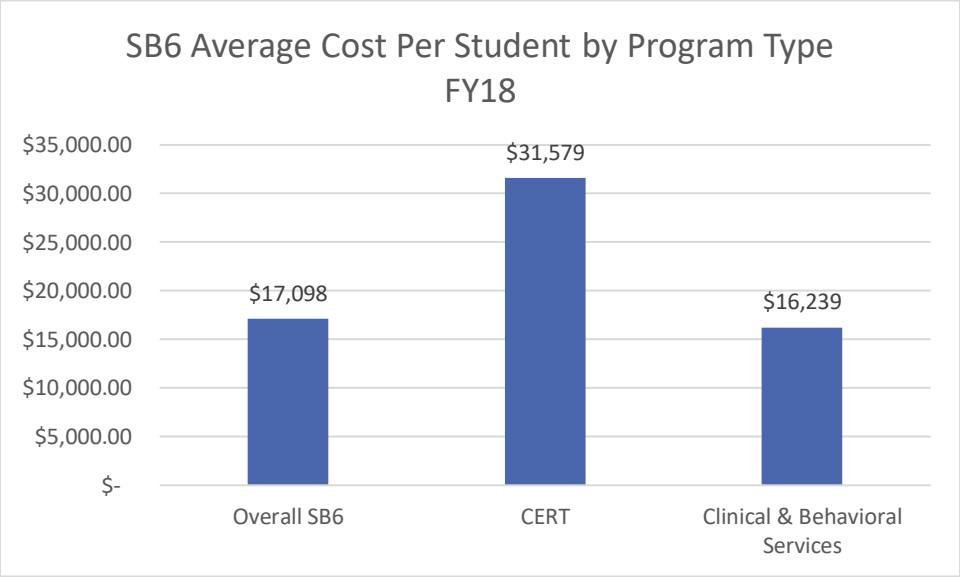
PER STUDENT COSTS

It can be informative to look at the average cost per student based on SB6 program type or students' diagnostic needs. The overall numbers of students served is discussed in the *Trends of Students Served* section above).

BY PROGRAM TYPE

This analysis showed the average cost per student is higher for CERT therapeutic school settings compared to the clinical and behavioral services (Figure 12). CERT programs typically serve students referred through their school's educational support team which determines, typically through the IEP process, that the student's needs are unable to be met at the public school and can be supported in the CERT program. As was noted previously, clinical and behavioral services are typically provided in public schools, but these services are also provided in Independent Schools where most students receive Special Education supports and services.

Figure 12 Average Cost Per Student by SB6 Program



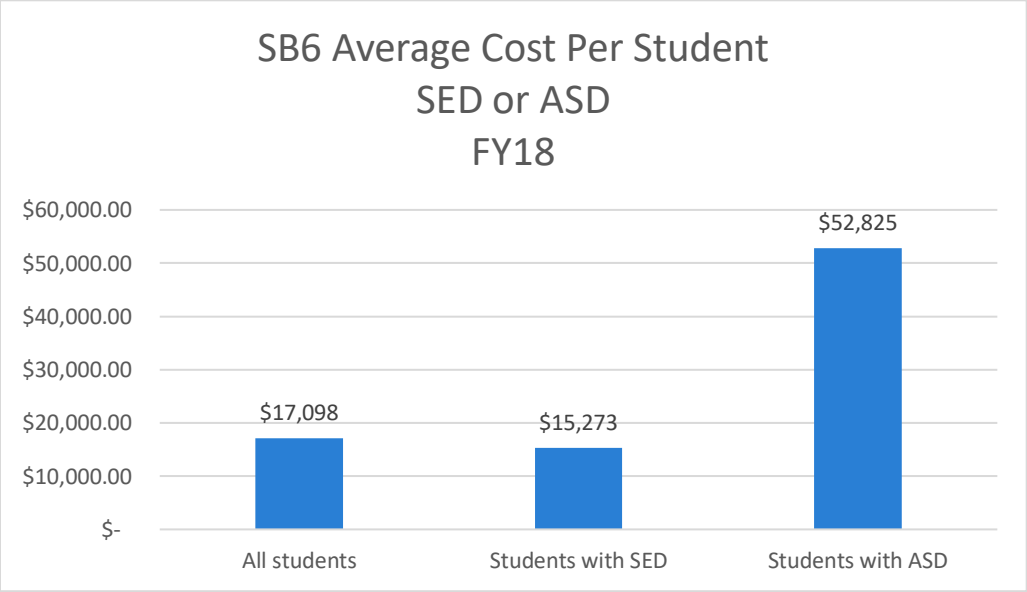
Notes: Data source is Medicaid Management Information System (MMIS) paid claims

BY STUDENT DIAGNOSTIC NEED

As noted in the 2008 legislative report on Success Beyond Six (Vermont Department of Mental Health, 2008), the average per student cost for students with Autism Spectrum Disorder (ASD) and Severe Emotional Disturbance (SED) were significantly different. This trend continues 10 years later (

Figure 13). Typically, students with ASD need more intensive levels of support over a longer period. A very small number of students served in CERT have an Autism Spectrum Disorder (ASD) diagnosis; most students with ASD are served through SB6 school behavioral and clinical services. Some DAs have created specialized Autism collaboratives to serve students with ASD who have significant needs (WCMH, HC, NCSS, CSAC).

Figure 13 Average Cost Per Student with SED and ASD

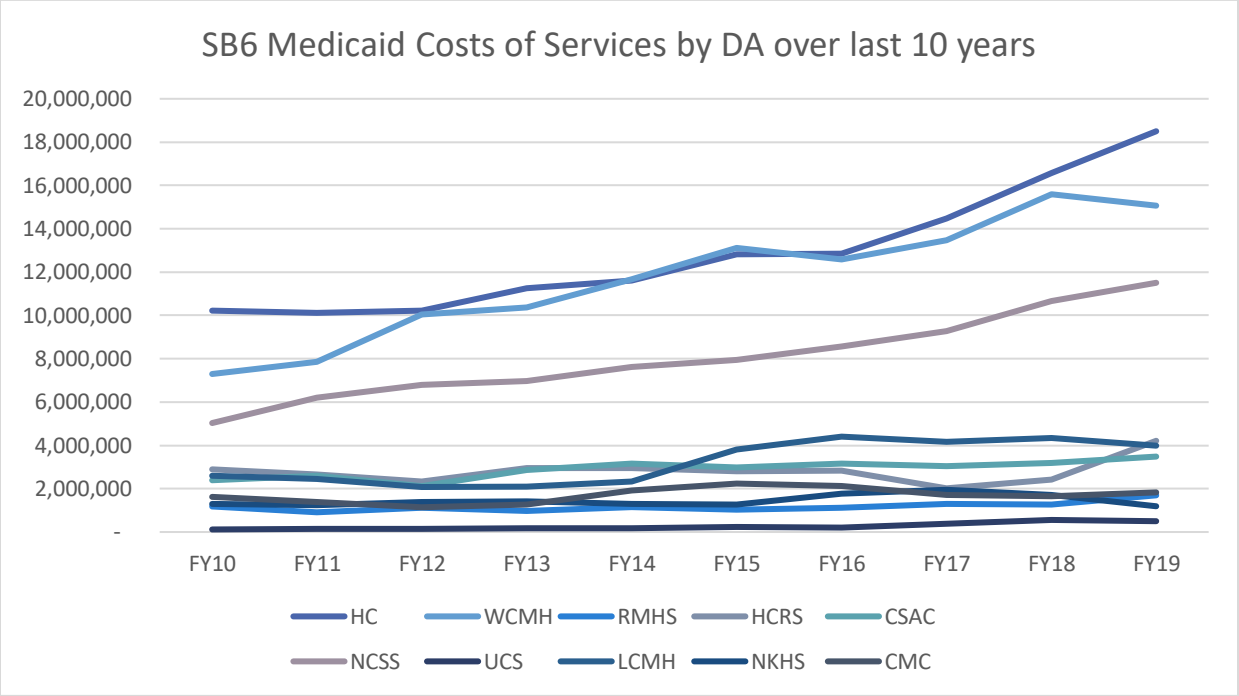


Notes: Data sources are Medicaid Management Information System (MMIS) paid claims and DMH Monthly Statistical Report service data (MSR)

TOTAL MEDICAID COSTS OF SERVICES BY DA

When looking at SB6 total Medicaid costs of services by Designated Agency (Figure 14), the top three DAs (Howard Center, Washington County Mental Health and Northwestern Counseling and Support Services) are the three DAs who were early providers of school mental health and continue to innovate and develop partnerships in their regions. It should be noted that the WCMH data throughout this report include the data for subcontracted school mental health services provided by Laraway Youth & Family Services in Lamoille County.

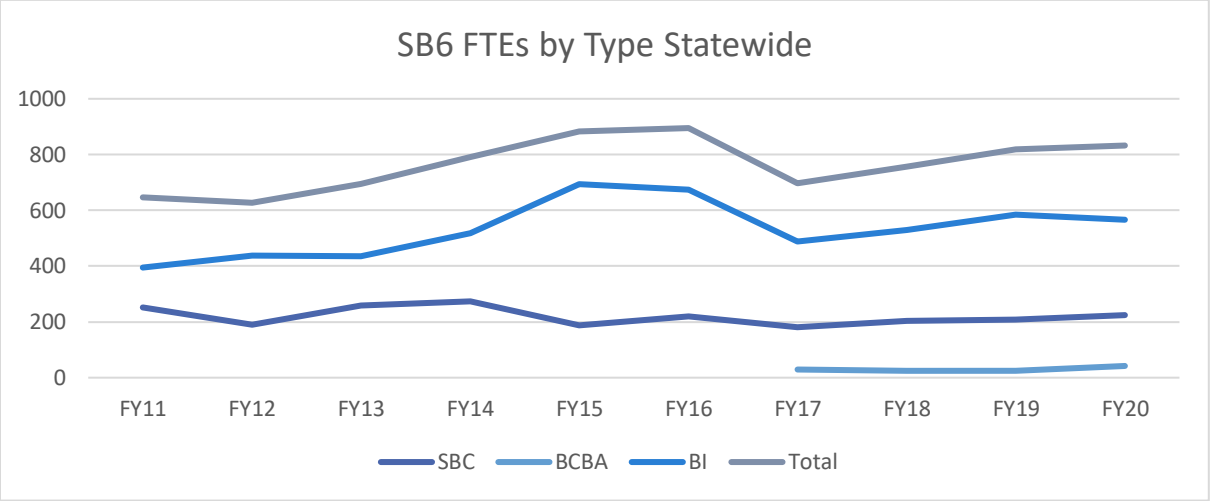
Figure 14 10-year Trend of SB6 Total Medicaid Costs of Services by DA



FTE TRENDS

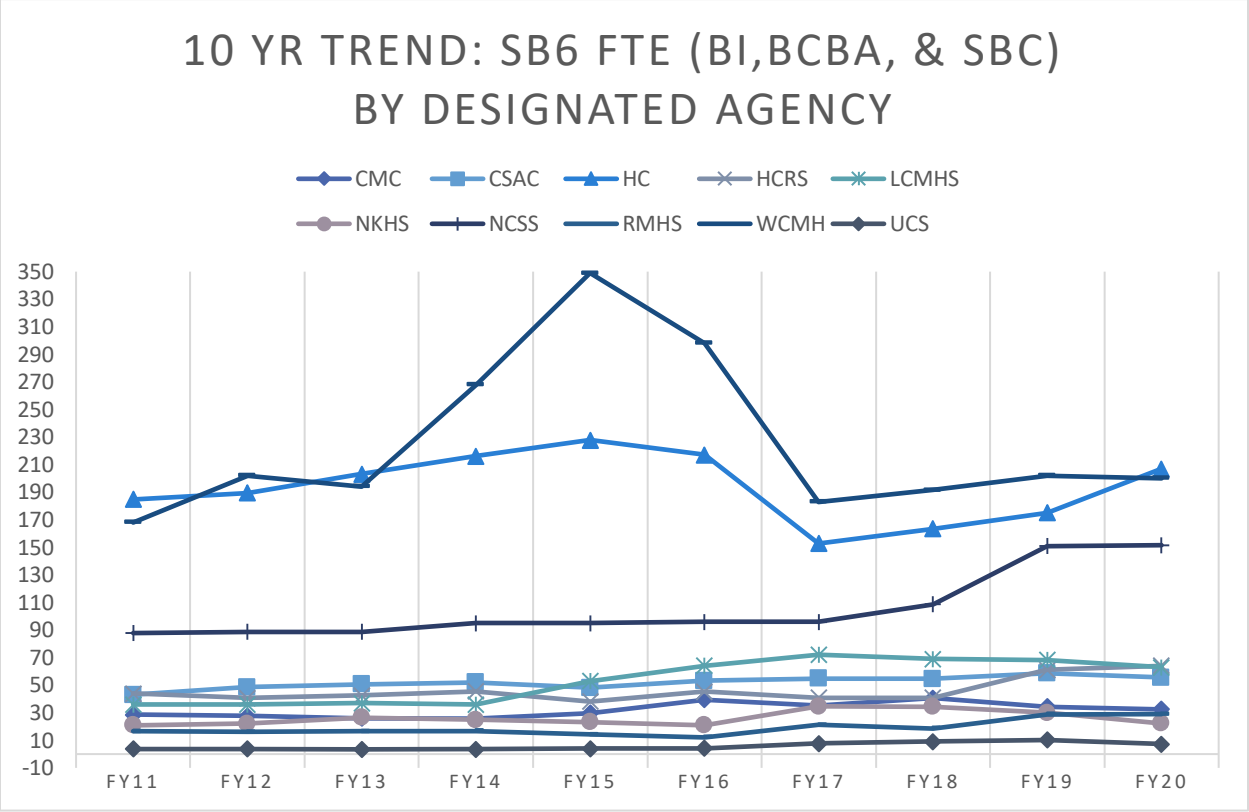
Similar to the spending trends, it is important to look at the staffing trends based on the type of SB6 program. The majority of FTEs are in the Behavioral Intervention services. While some DAs began to train and hire Board Certified Behavioral Analysts (BCBAs) as early as 2007, DMH started to uniformly collect data on BCBAs in FY17. About 10% of the SB6 FTEs are in non-CERT therapeutic Independent Schools. Figure 15 shows the SB6 FTEs for school-based clinical and behavioral services, not CERT programs.

Figure 15 10-year Trend of SB6 FTEs (non-CERT)



The drop from FY16 – FY 17 in FTEs for Behavioral Intervention (BI) services is primarily due to Washington County Mental Health (WCMH) and Howard Center (HC), as can be seen in Figure 16. One reason for this change for WCMH was the initiation of a more efficient "Pod" model, combining behavioral intervention with BCBA consultation to increase the school staff's capacity to respond to students' behaviors and reduce reliance on 1:1 BI services (see Regional Example).

Figure 16 FTEs by DA



STUDENT NEED TRENDS

There is interest in understanding why the SB6 program has grown to its current level of use and how this relates to current student population and need, particularly given declining numbers of student enrollment statewide over time.

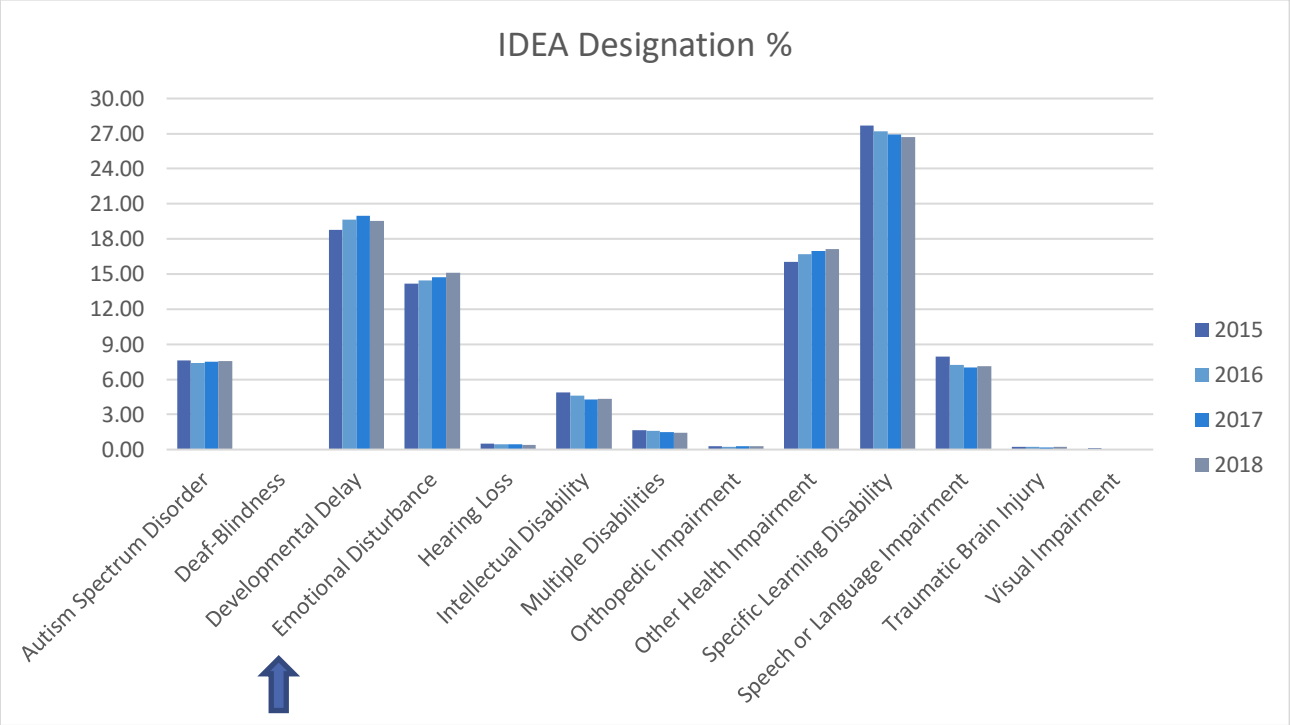
To better understand the broad student population needs around mental health, we looked to several key indicators such as IEP trends, custody rates, and what is known from population-level surveys of how Vermont's children and families are doing.

EDUCATION DATA

Some of the required data for federal IDEA funding indicate that the makeup of our student population with special needs may be changing over time. For instance, as indicated in Figure 17, whereas the percentage of students with an IEP designated as having autism, intellectual disability, multiple disabilities, specific learning disabilities, or speech or language impairment

has declined since 2015, the proportion of qualifying students with emotional disturbance and other health impairment has increased during the same timeframe.

Figure 17 IEP Trends



In addition, Vermont's rates of serious emotional disturbance are very high compared to national estimates. As noted in the State Interagency Team's latest System of Care Plan (VT State Interagency Team, 2019):

> "we have the highest rate of identifying students with emotional disturbance in the country. As a percentage of students (ages 6-21) who received special education services in the 2016- 2017 school year in Vermont, about 14.4 percent were identified with an emotional disturbance, according to federal data [see Report on Act 46 of 2015; Section 49. Coordination of Educational and Social Services.] That is more than twice the national average of 5.4 percent."

The annual MTSS survey conducted by AOE with VT Schools included questions about mental health and social services/supports (Figure 18) as well as new questions about trauma-informed practices (VT Agency of Education, 2019). With 294 schools (100%) reporting, the data show that schools are interested and pursuing training for staff on trauma-informed practices (Figure 19).

Figure 18 Mental Health and Social Services and Supports

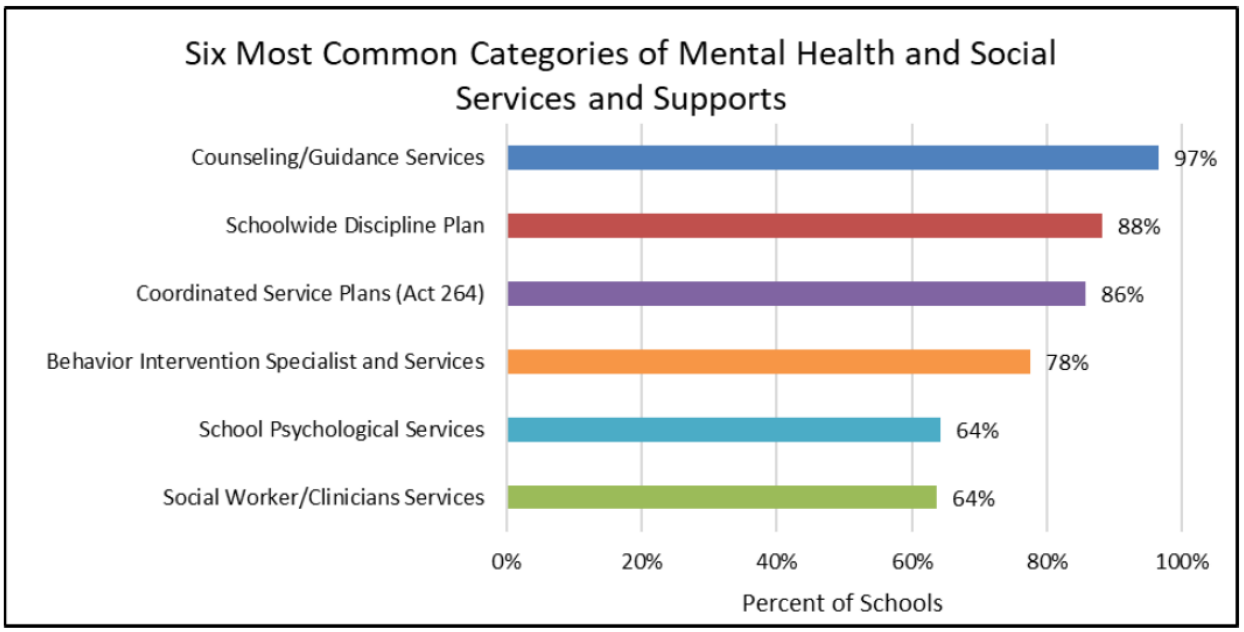
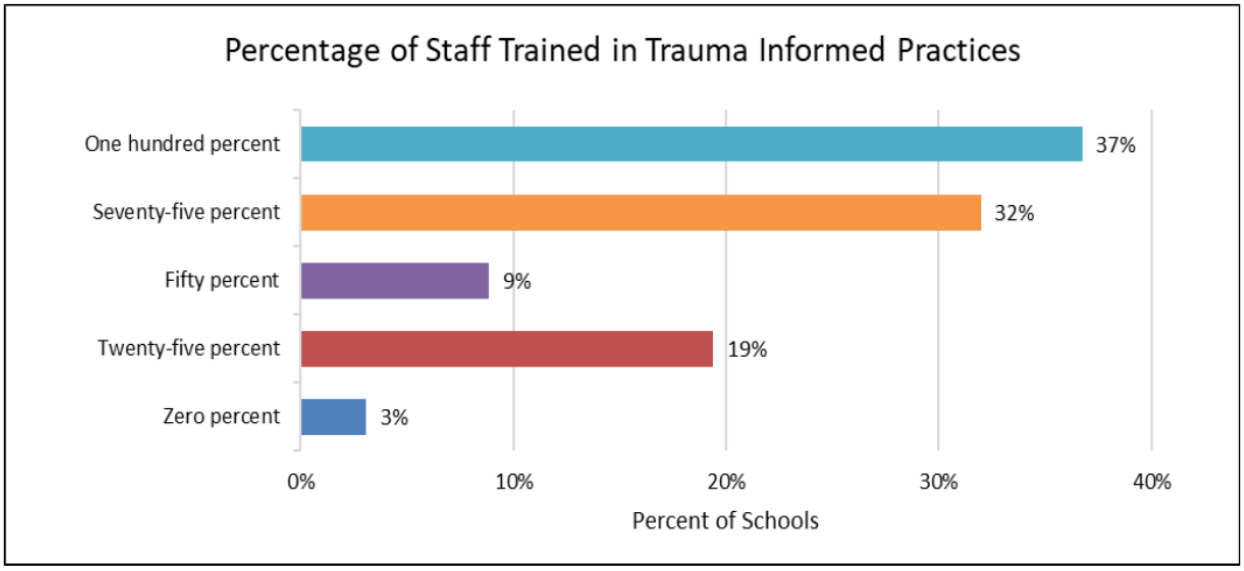


Figure 19 School Staff Trained in Trauma Informed Practices



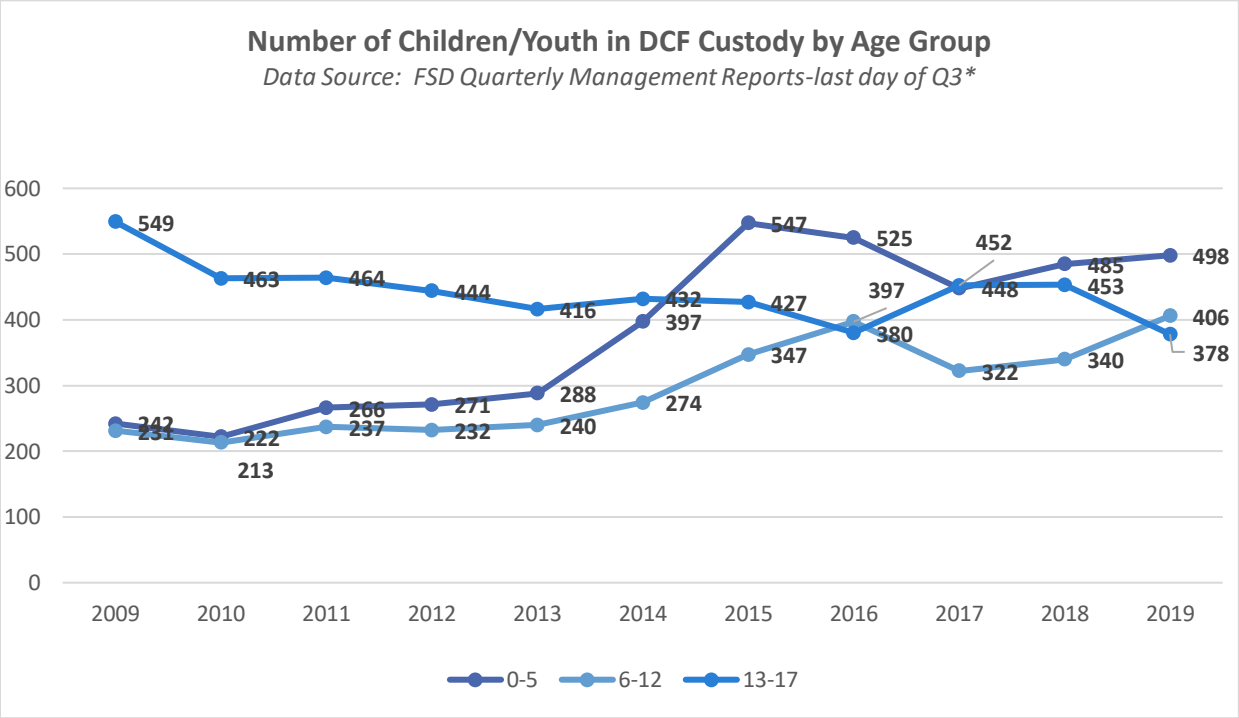
DA School Mental Health Program Directors report that truancy is often a reason for referral to their services. They also noted that the schools where they have SB6 contracts also tend to have high numbers of free and reduced lunches and higher poverty rates among families, indicating that these stressors – social contributors of health – are likely related to the mental health needs of students. On average, the rate of Vermont students who are eligible for free and reduced lunch (FRL) is 36-39%, which is relatively low compared to other states nationally,

but individual school rates vary and some are upwards of 70-80% (VT Agency of Education, 2019).

CUSTODY RATES

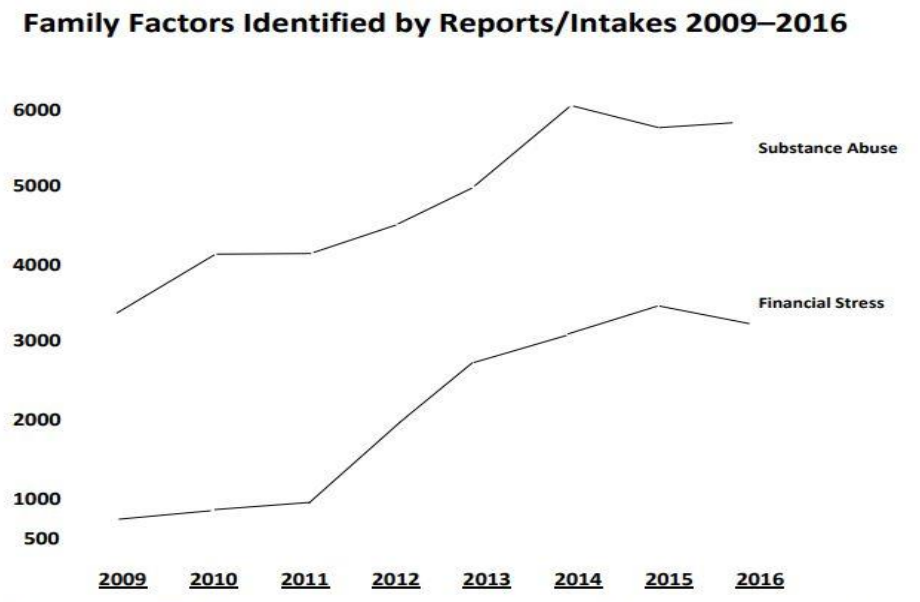
One measure of the wellbeing of our communities and families is the rate of children and youth in the care and custody of the state due to substantiated reports of abuse and neglect. Unfortunately, the overall rate has been increasing and this is seen in both the youngest ages and adolescents (Figure 20). "Increased rates of poverty, substance abuse (particularly opiate use), and family and community violence have been linked to this increase" (VT Department for Children & Families, 2019). As seen in Figure 21, substance use and financial stressors were on the rise from 2013 – 2015; children born during those years are entering school now.

Figure 20 DCF Custody rates by age ranges



Source: VT Department for Children & Families (2019)

Figure 21 Family Factors



Numbers extrapolated from Report on Child Protection in Vermont (years 2009-2016), Vermont Department for Children and Families

POPULATION HEALTH TRENDS

Analyses of the 2016-2018 National Survey of Children's Health (NSCH) multi-year weighted data were conducted by Laurin Kasehagen, MA, PhD, an epidemiology assignee to the Vermont Departments of Health and Mental Health. These analyses provide insight into the population-level characteristics, strengths and needs of Vermont's children, youth and families. We know from the NSCH that parents report **nearly 1 in 6 children in Vermont experience *three or more* types of adversity** (United States Census Bureau, 2016-2018). The most common types of adversity for Vermont children are living in a family who experiences economic or housing difficulties, divorce or separation of parents, and living in a family where there is adult substance use or where there is an adult struggling with severe depression or suicidality. One important take-away from the data is that *children who demonstrate resilience show signs of thriving despite exposure to adversity*. Creating environments that are supportive, welcoming and responsive to a child and family's needs helps to build resilience.

According to parent report in the NSCH, Vermont children have a higher prevalence of Attention Deficit and Hyperactivity Disorder (ADHD) of any sub-type (11.0) compared to the national rate (10.3) (Kasehagen, 2019). The distribution of demographic characteristics of children with ADHD appear to differ from the general Vermont child population. In Vermont,

children with ADHD tended to be younger, male, multi-racial/ethnic, come from households with divorced parents or single woman headed households, and in deep poverty. Comparing VT children with ADHD to all other children, they tend to have other conditions present, such as developmental delays or learning disabilities, behavioral or conduct problems, and depression or anxiety, which can complicate the service and support needs (United States Census Bureau, 2016-2018).

YRBS

The Vermont Youth Risk Behavior Survey is conducted every two years in nearly all public middle and high schools. Through this anonymous survey of students in grades 6-8 and 9-12, we can learn more about the risk and health behaviors of young Vermonters. This can be helpful in identifying trends in resilience factors and the expressed concerns of students. The following information is from the most recent YRBS results (2017; the 2019 survey results are not yet available), with analysis by the CDC epidemiologist assigned to VT Departments of Health and Mental Health (Health, 2019).

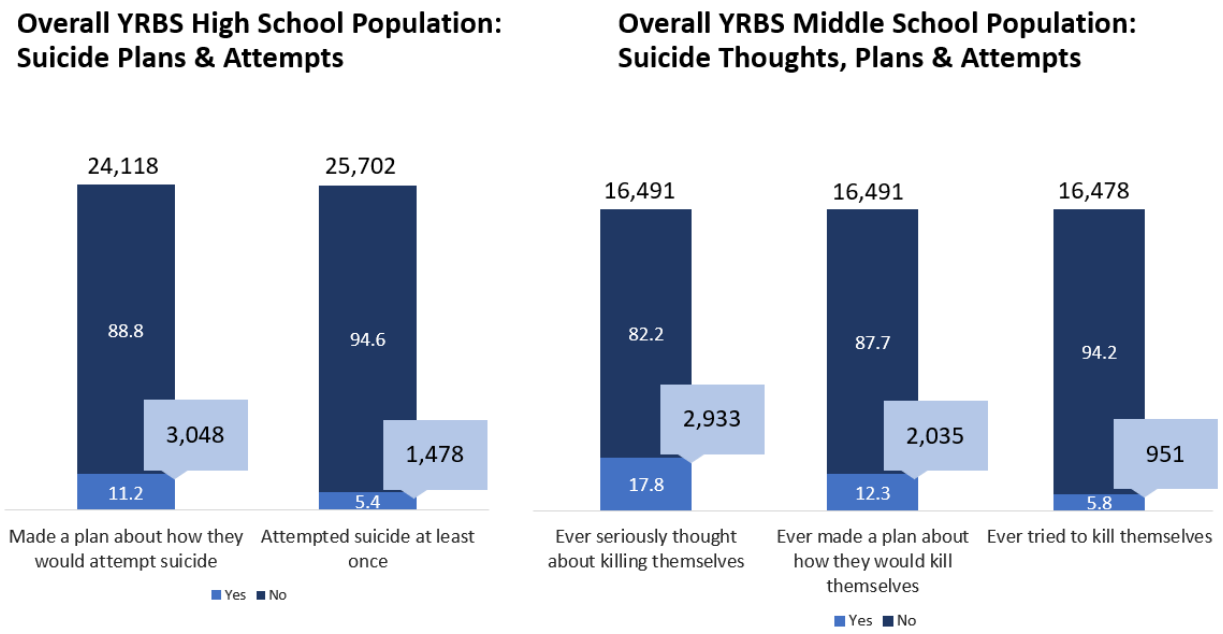
SAD OR HOPELESS

Nearly *1 in 5* Middle School students report feeling sad or hopeless almost every day for at least two weeks during the past year; *1 in 4* among girls. Among High School students, *1 in 4* report feeling sad or hopeless; and this is three times higher for LGBT students. *1 in 6* high school students reported doing something to purposely hurt themselves without wanting to die.

SUICIDAL CONCERNS

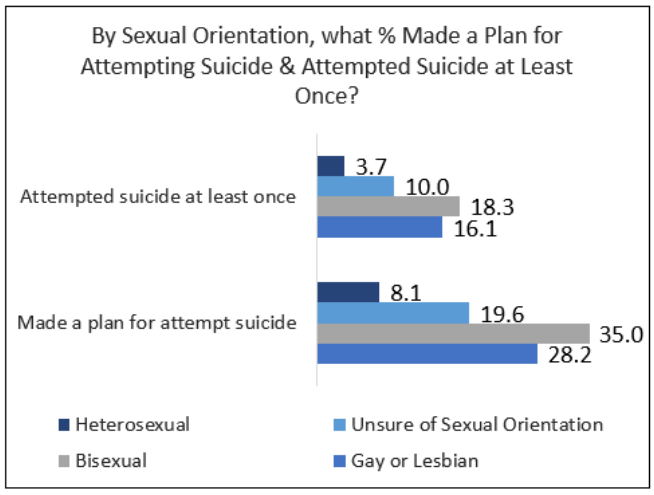
Nearly *1 in 5* middle school students ever thought seriously about killing themselves. About *1 in 10* middle and high school students made a plan about how they would attempt suicide. About *1 in 20* high school students attempted suicide at least once. *This is about 1 student in every classroom.* Twice the number of females than males had suicide thoughts, plans, and attempts. These statistics are alarming and unfortunately are a window into understanding the rate of suicide among young Vermonters as being higher than the national average (2.6 per 10,000 among children under the age of 18; 13.7 per 10,000 among 18-22 year olds) (Vermont Department of Health, 2019).

Figure 22



The greatest concern is with students who identify as lesbian, gay or bisexual (LGB) or whose sense of gender does not correspond with their birth sex. Their reported suicidal concerns are notably higher than the general student population in both middle (Figure 24) and high schools (Figure 23).

Figure 23 Suicide Concerns Among LBGTQ High School Students



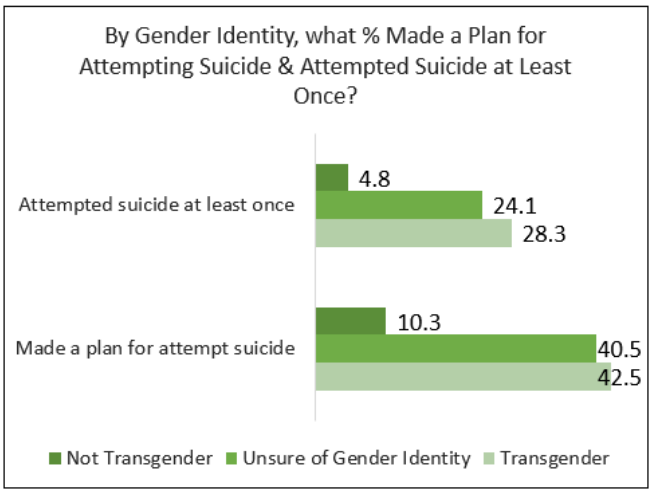
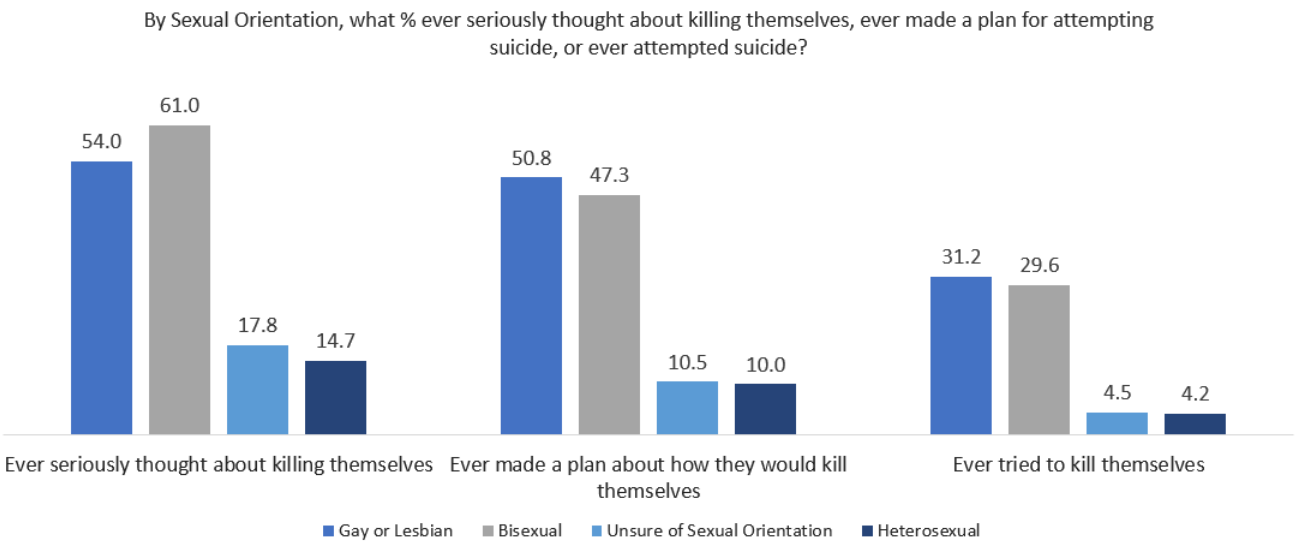


Figure 24 Suicide Concerns Among LGB Middle School Students



SENSE OF SAFETY

For middle school students who identify as LGB or are unsure of their sexual orientation (20% of the student population), about *1 in 5* did not go to school because they felt unsafe at school or on their way to or from school. Of high school students who have a sexual identity other than heterosexual (15% of the student population), *1 in 10* don't go to school for similar safety reasons. Among high school students who do not identify as cisgender, meaning they identify as transgender or are unsure of their gender identity (3% of the student population), *1 out of 5* didn't go to school for similar safety reasons.

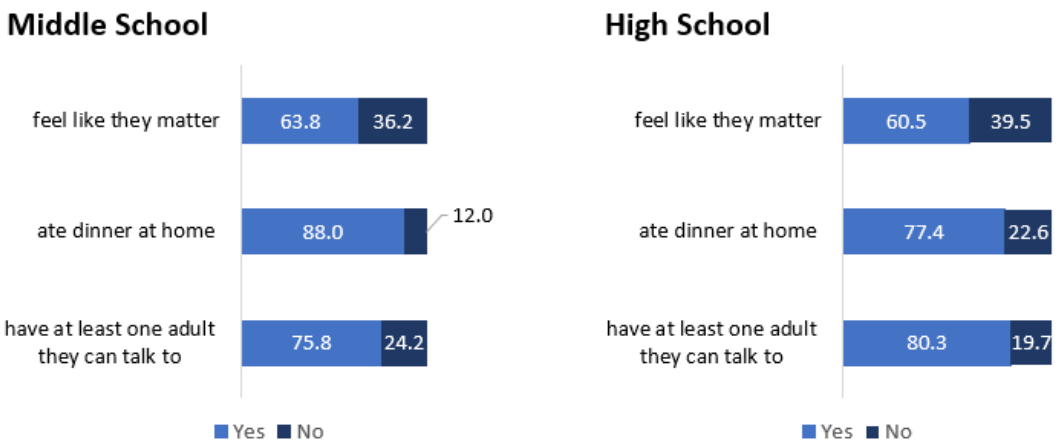
PROTECTIVE FACTORS

The top three highest protective factors for middle and high school students identified in the YRBS were:

1. Feel like they matter to people in their community
2. Eat dinner at home with at least one parent on 4 or more days a week
3. Reported there is at least one teacher or other adult in their school that they can talk to if they have a problem

Figure 25 shows the percentage of middle and high school students who endorsed these factors. However, fewer LGBTQ students in middle and high school identified the presence of a protective factor.

Figure 25 Strong Protective Factors



School mental health can impact students' resilience and flourishing, support them and their families, improve their connection with their schools, and help them develop skills to cope when faced with difficulties at home, school or community. This indicates how important it is to ensure school-wide supports are available to build resilience, such as social-emotional learning and connections with a trusted adult.

HOSPITALIZATION & EMERGENCY DEPARTMENT UTILIZATION

We have seen an increase in the number of children and youth presenting at emergency departments with mental health concerns (Figure 26) and Medicaid claims for children's inpatient psychiatric hospitalizations have also increased over the past 10 years, primarily seen with voluntary admissions (Figure 27).

Figure 26 Pediatric ED Claims by Sex

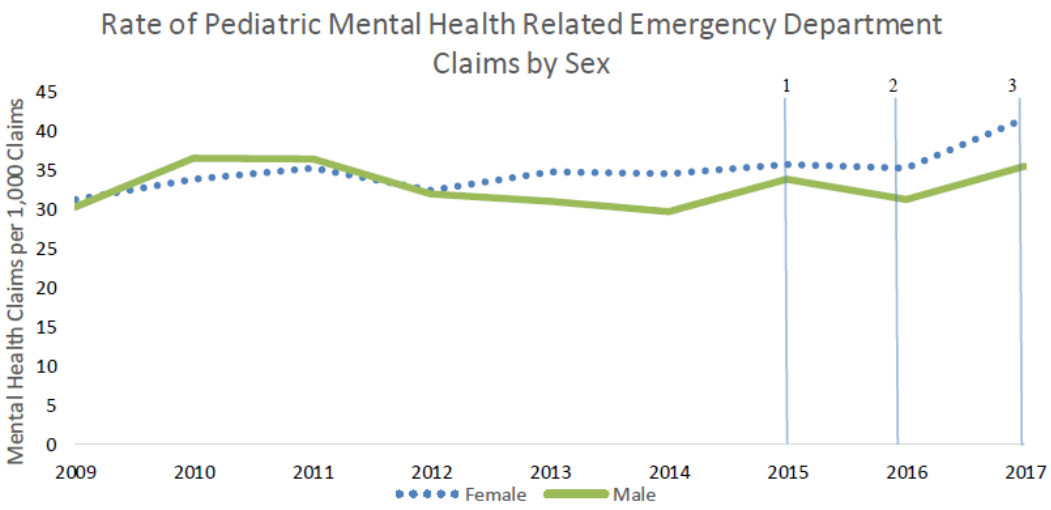
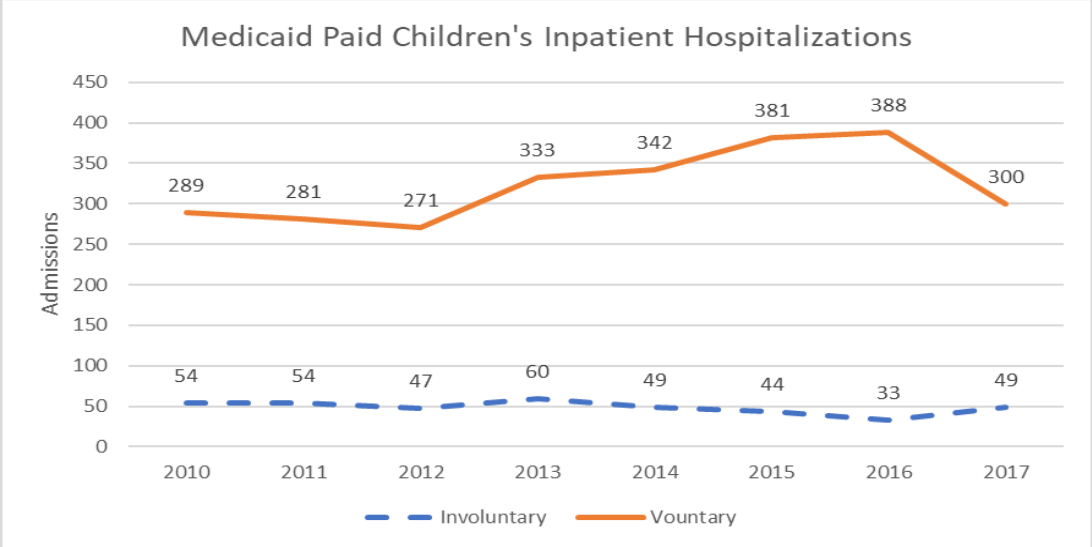


Figure 4: Rate of mental health related claims per 1,000 emergency department claims by sex. Diagnosis fields 1-6 were searched for a mental health related diagnosis code. Claims restricted to Vermont children under the age of 18 that visited an emergency department in Vermont or New Hampshire.

Figure 27 Medicaid Paid Children's Inpatient Hospitalizations



YOUNG VERMONTERS USE OF CRISIS TEXT LINE

Vermont implemented the Crisis Text Line in 2017, which is a national resource that offers free, 24/7 support for people in crisis. An individual can text the crisis line from anywhere and connect with a trained crisis counselor. VT has a unique identifier that allows us to see data specific to those

using the Crisis Text Line in VT. The data shows that this is an important resource for young Vermonters and is another window into their mental health concerns.

Of the young Vermonters who have used Crisis Text Line in the last year, 19% were aged 13 or younger and 81% were aged 14-17; 91% identified as female, 9% male, 3% transgender. Most notably and aligned with what we see in YRBS data, 61% identified as LGBTQ; this was noted as higher than the national average (Crisis Text Line, 2019). Their concerns fell into categories in the following rank order, with school being the most common issue:

Conversations started with "VT" keyword in past year by youth under 18 y.o.

Texters past 365 days	38
Conversations	106

Issues

School ▲	47.00%
Depression/Sadness	40.50%
Anxiety/Stress	36.90%
Suicide	29.80%
Relationship	29.80%
Isolation/Loneliness	17.90%
Self Harm	13.10%
Grief	7.10%
Sexual Assault	4.80%
Finances	4.80%

Gender Sexual Identity ▲	0.048
Abuse, emotional	0.048
Substance Abuse	0.036
Eating Body Image	0.036
Military	0.024
Abuse, physical	0.024
3rd Party	0.024
Social Media	0.012
Bullying	0.012

▲ higher than national average for what Crisis Text Line sees

STAKEHOLDER INPUT ABOUT TRENDS

In the stakeholder meetings, we consistently heard about the significant challenges students and their families are facing and subsequent impacts in the school, leading to the desire for more mental health supports for teachers and students.

Increasing Acuity - Universally, school leadership spoke about seeing younger students with higher needs to a degree they haven't seen before. Educators see student behaviors at more intense levels over the past decade and these concerns are showing up in younger ages than previously. Examples provided by school leaders were students kicking, screaming, highly dysregulated, biting, peeing, smearing feces, running away or bolting, and verbal disrespect of

adults in the school building. Schools value relationships with the DAs to provide services through SB6 but are also concerned they are bearing the burden of mental health costs.

Additionally, among students identified as receiving Special Education (IEPs) or Educational Supports (504 plans), schools report seeing higher levels of acuity and the need for more intensive supports, especially among students with Emotional Disturbance or Autism Spectrum Disorders. They were also concerned about students' reading proficiency being lower; when the students' emotional and behavioral needs are the focus for supports, students may be less able to access instruction for learning to read. (Interestingly, the legislatively commissioned DMG report speaks to this issue by identifying a statewide need to strengthen universal literacy approaches within our education systems, an area that the AOE will be directly addressing in the coming months).

Social Contributor of Health - School leadership and mental health providers expressed concern about the broader context in which their students are struggling, including significant levels of homelessness and unstable housing (e.g. WCMH reported that 2018-2019 school year had the highest ever number of youth experiencing homelessness served through the school SB6 program). Personnel from some regions spoke about the high number of babies born opiate exposed 5-6 years ago who are now entering the school system. Others spoke about the mental health and substance use concerns of parents and involvement with the child welfare (DCF) system. Educators pointed to trends in special education, free & reduced lunch, readiness for Kindergarten and challenges in early education settings. The themes from the stakeholder groups generally echoed patterns in the data.

Evolving Roles of Educators - School leaders spoke about the changing role of teachers, the need to accordingly support and train them in the social-emotional-behavioral needs of students, as well as how to manage classrooms when multiple students are experiencing these difficulties at any point in time. They acknowledged the impact of adversity on a student's working memory and processing; challenges with executive functioning impacts students' ability to attend to the curriculum in a group setting. In addition, needs across the classroom can fluctuate, requiring nimbleness in how a teacher supports each student's presenting needs in the moment. School leaders are concerned about this impact on teachers, as they see many struggling with empathy fatigue overwhelmed with the demands of balancing implementation of proficiency-based academic initiatives and social-emotional initiatives.

Partnerships and Collaboration - In regions where there was a strong partnership, including regular meetings, between the school leadership and Designated Agencies, clear themes emerged that both entities valued the working partnership with a shared goal to support

students and families for success in school. And, there was a shared acknowledgment that even with the current level of partnership and services, it was not enough to meet the needs of students and families in their region. Both entities expressed concern about the budget pressures and desire to have effective and efficient school mental health.

Regional Variation - It is clear that how school mental health is structured varies from region to region and even from school to school within the same district. In general, this was seen as positive such that the local entities craft the services to meet their unique needs given their already existing resources. However, there was some concern expressed that effective practices may not be shared and spread effectively to other regions and there was a desire for more transparency about why differences (in services and rates) exist. In addition, as noted previously, the question of equitable access to high-quality supports for all students is also a concern. If we know that certain service models are working well, are we not bound to share those across the state and do what we can to improve scalability?

ANALYSIS OF TRENDS

There has been interest in understanding why spending for SB6 school mental health has been on the rise, when student population numbers are on the decline. The trends clearly show the increases in spending are related to student need, FTEs, and Medicaid rates. The data trends and stakeholder input about student need points to increasing acuity – high levels of emotional dysregulation, aggression, inattention, and significant safety concerns – and at younger ages. While the proportion of the declining Vermont student population served through SB6 has remained relatively steady (~4-5%), the amount of medically necessary services provided to those students has increased by 17% over the past decade.

SECTION 3: AN EVALUATION OF THE PROGRAM ATTRIBUTES

ORIGINAL INTENT OF SUCCESS BEYOND SIX

The 2008 legislative report on Success Beyond Six for Act 35 provides a detailed history about the origins of this unique partnership and funding mechanism. For many years, Vermont was seen nationally as innovative and ahead of other states in prioritizing resources for mental health in school settings. Excerpts are captured below.

> Success Beyond Six was developed "to help reduce the cost burden to education and the state by tapping into the one significant financial resource mental health possessed: access to federal Medicaid funding to eligible Medicaid-enrolled students for medically necessary services" (Vermont Department of Mental Health, 2008).

Success Beyond Six was officially defined in a December 1992 policy memo by Governor Howard Dean and began official implementation in early 1993. It was "intended to solidify and expand local partnerships among Vermont's 60 supervisory unions, local human service agencies, parents and community members in order to improve learning and behavioral outcomes for students."

Supervisory unions were first authorized to use funds to participate in the Success Beyond Six initiative in Section 166 of Act 60 of 1993, the state appropriations act. That section permitted each supervisory union to use up to $16,000 of funds eligible for matching federal funds or a great amount if agreed to by individual supervisory unions, the commissioner of education, and the secretary of human services. The section also required the services to be provided through a contract with community-based Medicaid providers. The form and substance of the contract was to be established as part of an overall agreement for the implementation of the program and executed between the commissioner of education and the secretary of human services.
The text of the authorization was repeated in each subsequent state budget bill through 1996. Beginning in 1997, the language was changed by removing the $16,600 limit. The language appeared that way in all subsequent budget bills through 2004. Subsequent budget bills have not included language on the subject.

In 1993 the articulated goals of Success Beyond Six were:

1. Enhance the capability of schools and communities to meet the needs of at-risk students. This will ultimately help all students so they can be successful in the regular classroom.
2. Build and solidify a partnership between the local human service system and the 60 supervisory unions, making it easier for human services and school personnel to coordinate resources in better serving children and families.
3. Increase, coordinate, and focus all resources from all sources in order to best meet the prevention and treatment needs of children and families.

The evaluation for Success beyond Six [at that time] was to be based on two outcomes:

- teachers report they are receiving more assistance in addressing the needs of children with behavioral problems in the classroom, and
- evidence indicates that human service providers and schools have developed a better system of care to support children and their families.

Since 1993, the State has evolved in its understanding and implementation of Results Based Accountability and additional work has been undertaken to define outcomes in this area (see next several sections).

CURRENT FINANCIAL MONITORING OF SB6

AHS monitors all Global Commitment to Health waiver expenditures to ensure compliance with Medicaid Budget Neutrality requirements and is monitoring spending trends in all programs, including Success Beyond Six, to ensure adherence. AHS must balance the waiver budget neutrality requirement against federal EPSDT mandates for children, which require the state to meet medically necessary needs of children that can be covered under Title XIX of the Social Security Act, regardless of cost.

In order to ensure that spending under SB6 is within the spending authority approved for this program, DMH conducts several levels of financial monitoring.

Spending trend monitoring is conducted through weekly draws which show the SB6 billings by each individual DA. A summary sheet also depicts monthly spending.

DMH monitors the required Match payments. DA's can choose whether they send Monthly or Quarterly match payments directly to DMH by paper check. Checks are then processed through Accounts Receivable and tracked in both the Children's annual Financial Plan and Medicaid Projections spreadsheets. DAs are asked to submit an estimated 4th quarter match payment no later than June 15th per the contractual agreement.

Annual Medicaid utilization reconciliation is accomplished in late August or early September to allow additional time for DA's to bill any remaining June SB6 claims.

Annual Case rate review is conducted for the CERT program daily rates and School-Based Clinician case rates.

EVALUATION OF FISCAL MECHANISM

Under the traditional fee-for-service mechanism, SB6 providers served only students who were identified clients of the DA and needed to document and bill for each service for each client served, often in 15- to 30-minute increments. With the statewide shift to the SB6 Clinician per-member-per-month (PMPM) Case Rate mechanism in FY13, the new payment structure offered a more flexible approach. By drawing down the case rate through direct intervention to a minimum target caseload, the clinician is able to provide a wider range of school-based

supports, such as consultation to teachers, early intervention and prevention supports to classrooms or groups of children without having to identify each student as a client of the DA.

As noted in Figure 15, the majority of FTEs within the SB6 program are within the Behavioral Intervention services which use the Medicaid Fee-for-Service billing mechanism. This is a very intensive level of support with Board Certified Behavioral Analysts conducting Functional Behavioral Assessments, developing behavioral plans, and supporting the Behavioral Interventionist (BI). The BI typically provides 1:1 intervention with a student. Review of the data suggests the BI Program has the highest number of FTEs (BIs and BCBAs), the FFS spending is at a higher trajectory, and the number of students served is low due to the intensive level of programing. Anecdotally, DAs have also reported difficulties filling positions, including BIs.

EVALUATION OF PROGRAMMING

Designated Agencies submit annual reporting for Success Beyond Six programming in addition to the standard requirements for service and financial reporting under Medicaid. While these metrics, and potential others, are discussed in Section 4: A determination, in partnership with the Designated Agencies, of metrics for evaluating program outcomes, a summary of the results from the 2018-2019 school year are reported here to demonstrate the impact of SB6 programming on students' needs and strengths.

CHILD & ADOLESCENT NEEDS AND STRENGTHS (CANS) MEASUREMENT

The Child and Adolescent Needs and Strengths (CANS) is an "information integration" tool to support the assessment of the child and their caregiving system to inform treatment planning and level of care decisions, measure progress over time, and also provide program-level outcome measurement. Annual training and certification are required for providers who administer the CANS and their supervisors (Praed Foundation, 2019). The SB6 programs are required to use the CANS at the beginning of the school year (or when the student began receiving SB6 services if it was after the start of the school year), and again toward the end of the school year to measure change over time. The following charts show the statewide aggregate data for students with two points in time measurements using the CANS.

The CANS scoring can indicate the level of need or presence of strength for the student. Identifying those students who have a need that "interferes with functioning" (Score = 2) or a need that is "dangerous or disabling" (Score = 3) communicates when action is needed to support the student (a score of 2 requires action or intervention; a score of 3 requires immediate or intensive action). Identifying a student's strengths that may be useful as

protective factors and as a foundation for developing a strengths-based plan; when a strength is absent (Score of 2 or 3), the intervention could focus on building or developing the strength.

Figure 28 illustrates the most prevalent high scoring items on the CANS for students entering a SB6 program in the Fall of FY19, and how those areas were impacted over time (

Figure 29). Strengths are included in these charts, as it is notable that lack of strengths are the top four most prevalent issues, above all other emotional/behavioral or life functioning items. The largest void of strengths fell in the area of Community Connection, which assesses a student's sense of support and belonging in their identified community. This is followed by a lack of Optimism and Resiliency.

Figure 28 Most Prevalent Needs (Including Lack of Strengths)

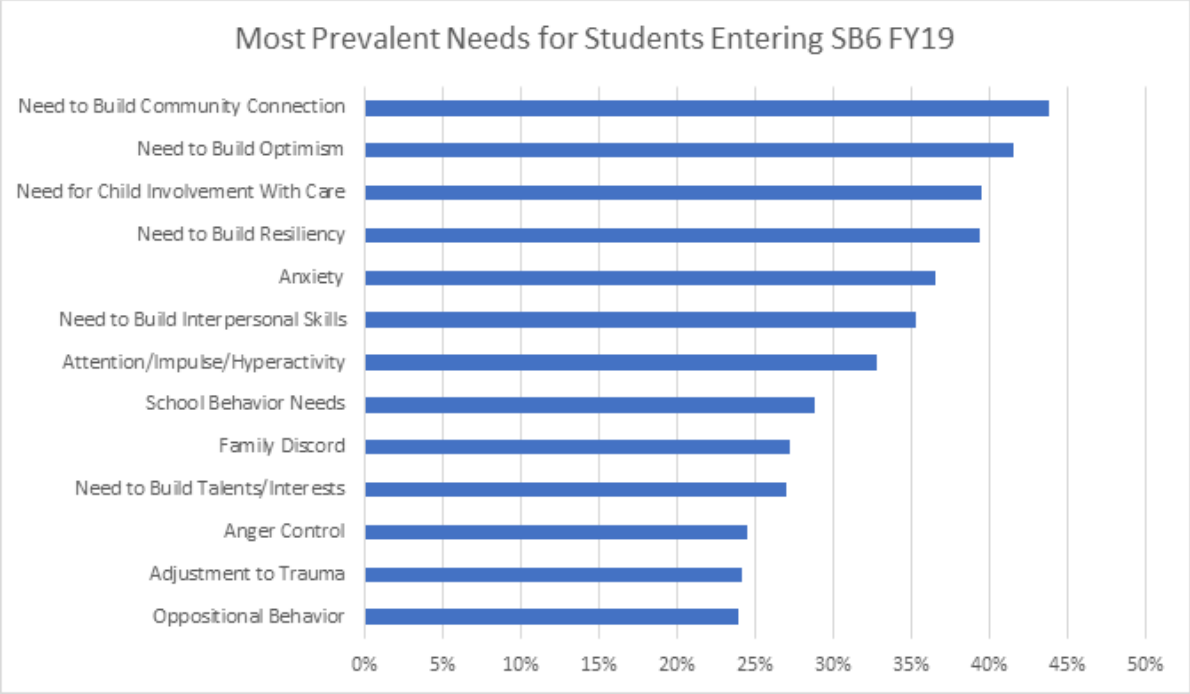
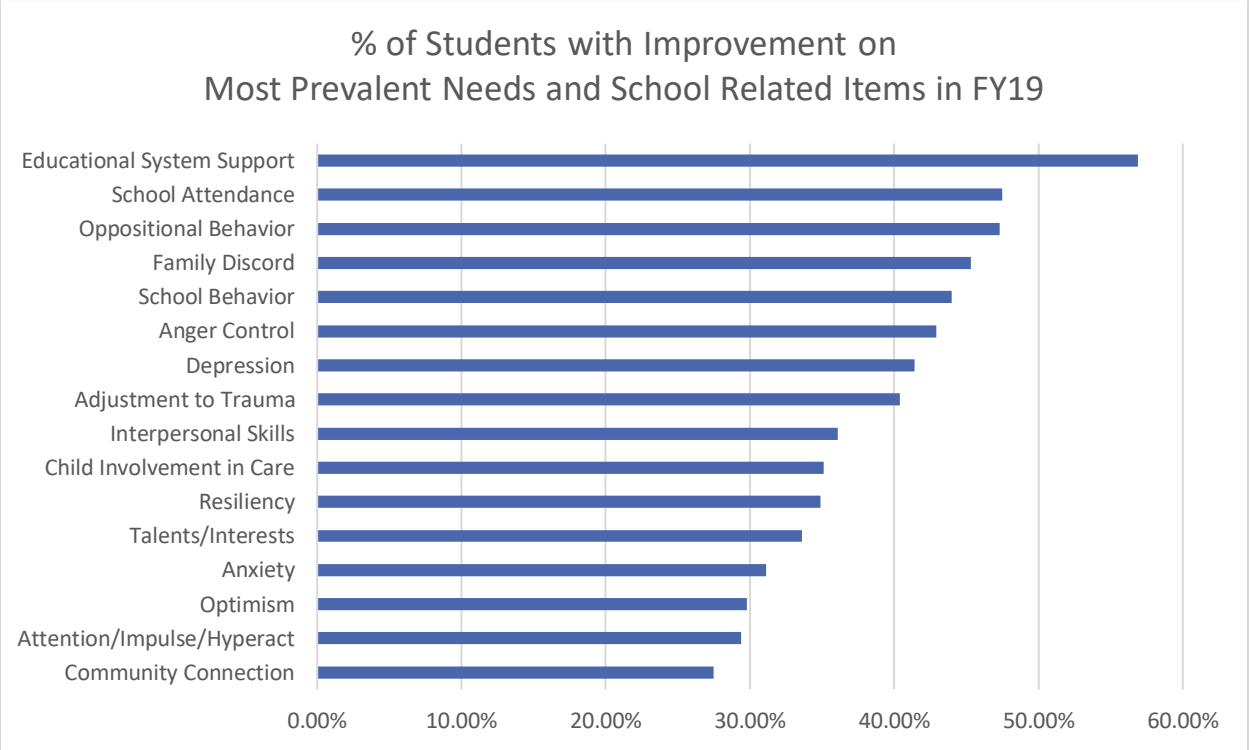
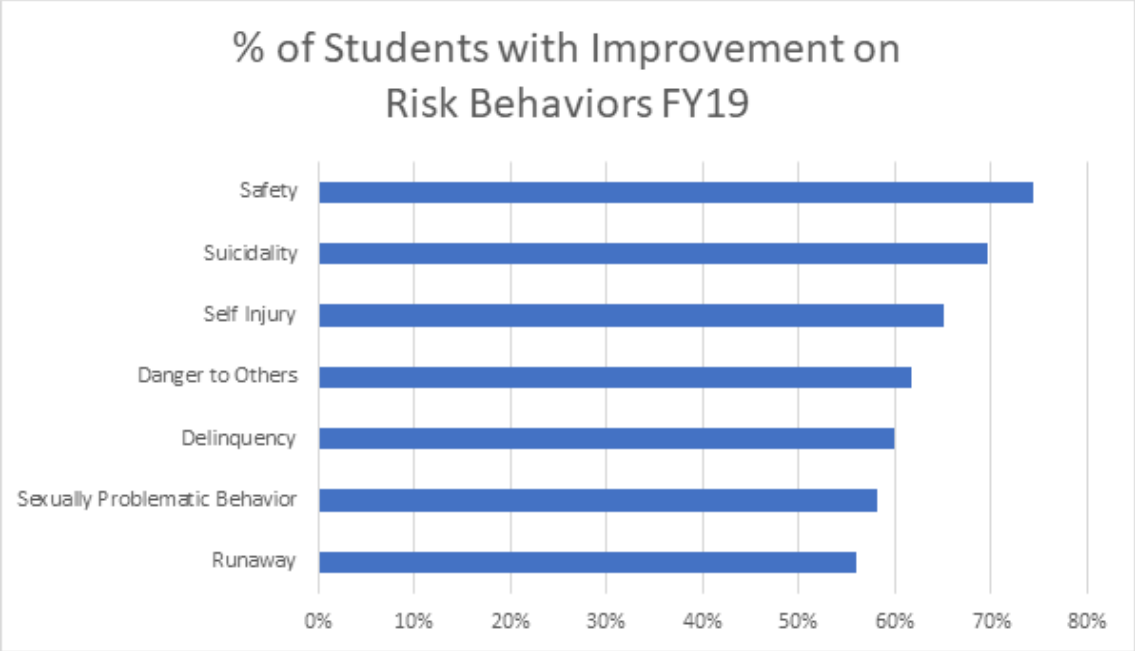


Figure 29 Percent of Students with Improvement on Most Prevalent Needs and School Related Items in FY19



Of those students identified as not having a strength in the beginning of the school year, we can look at those who improved on building a strength by the Spring. A notable finding here is related to students who were assessed as lacking a strength in their Educational System, which assesses the relationship between the student/family and the school, and whether the school can meet the student's needs. Of those who identified this as an area in need of improvement in the fall, 57% had improved by the Spring. Significant improvements were also seen for Resiliency, Interpersonal Skills and Relationship Permanence.

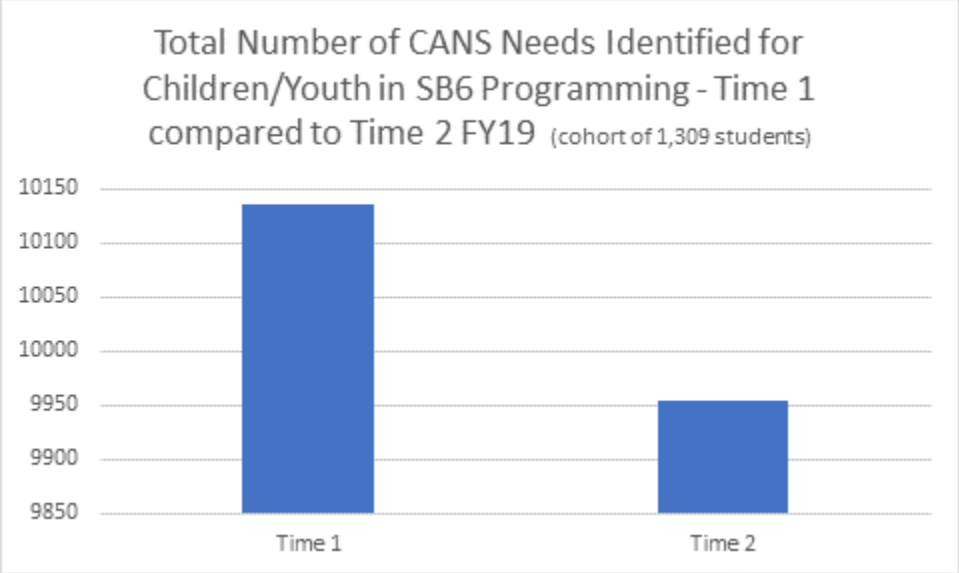
Figure 30 Percent Improvement on a Risk Behavior or Safety Item in FY19



Total number of CANS items identified as needing to be addressed at Time 1 compared to Time 2 for the cohort of 1,309 children and youth with two assessments in the FY19 time period.

Figure 31 illustrates the amount of need that was resolved by the end of the school year for children and youth in SB6 programming.

Figure 31 Total Number of CANS Needs Over Time



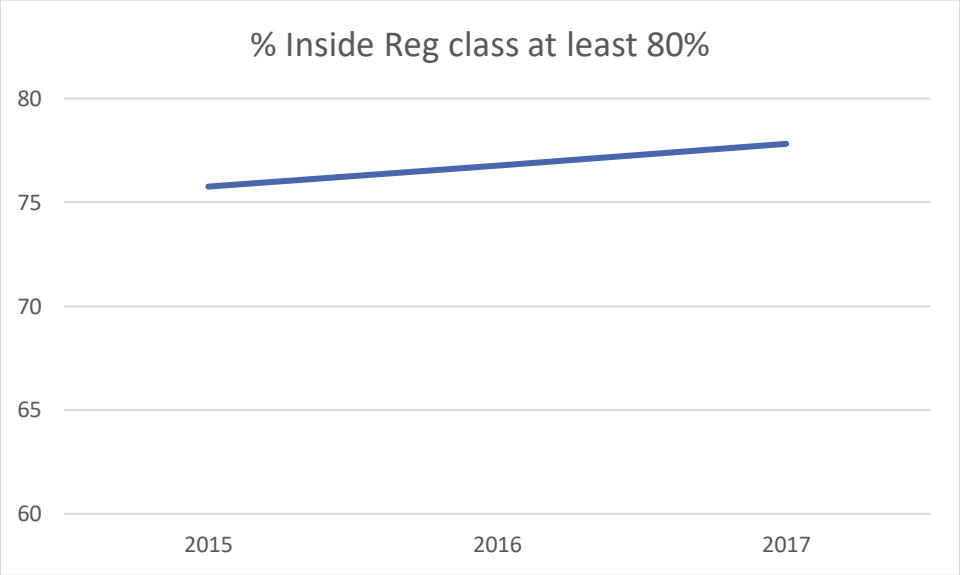
SCHOOL SATISFACTION SURVEY

Each DA conducts a satisfaction survey of SB6 services with participating schools and reports results locally. DMH is working with the DAs to align those questions for future reporting.

AGENCY OF EDUCATION DATA

In addition, some of the recent data obtained from AOE's required federal IDEA reporting materials indicates progress in helping our youth with special needs better access educational opportunities **(VT Agency of Education, 2019)**. As indicated in Figure 32, the proportion of students on IEPs who were in the classroom at least 80% of the time increased from 2015 to 2017.

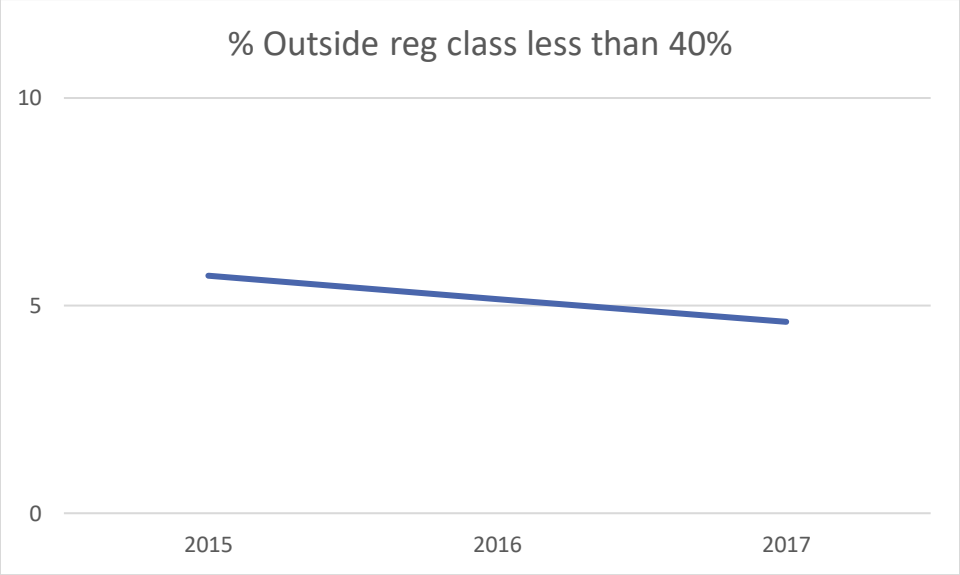
Figure 32: % Inside Regular Class at least 80%



In addition,

Figure 33 shows that the proportion of these students who were outside the classroom more than 40% of the time declined during the same timeframe. Although these trends cannot be attributed solely to SB6 efforts, they are an indication that the work we are collectively doing statewide for students with special needs is successful.

Figure 33: % Outside Regular Class Less than 40%



Interestingly, IDEA-linked external placements have held relatively steady during the same timeframe at 6%. However, AHS-funded placements of children and youth in residential treatment programs has significantly increased over the last 10 years.

SECTION 4: A DETERMINATION, IN PARTNERSHIP WITH THE DESIGNATED AGENCIES, OF METRICS FOR EVALUATING PROGRAM OUTCOMES

CURRENT METRICS

The Department of Mental Health performs oversight of the Success Beyond Six program, including program outcomes and financial monitoring. Monitoring of SB6 services falls under the DMH general Medicaid program oversight standards and, specific to this program, standards for covered services and claims payment.

The Behavioral Intervention Program Minimum Standards (2009) established outcome reporting requirements. The financial agreements between DMH and the DAs for the use of SB6 Medicaid established program and fiscal monitoring and reporting activities. Current Program Performance measures for all SB6 programs include the following Results Based Accountability measures:

How Much:

1. # of Students Served
2. # of FTEs and contracted payment per school

How Well:

3. Results of SB6 School Satisfaction Survey

Is Anyone Better Off:

4. Child and Adolescent Needs and Strengths (CANS) tool data submission:
    a. % of eligible* students who received two CANS in the school year (*eligible = students who were in school based programming for 5 months or more this reporting year)
    b. % of students who improved on an item in the Strengths domain
    c. % of students who improved on a Support Intensity score
    d. % of students who improved on School Behaviors
5. % of program discharges due to youth dropping out of school

Since 2009, DMH completes an annual report of the Behavioral Intervention Programs to summarize performance in meeting the minimum standards. For the 2018-2019 school year, this report was expanded to all SB6 programs to report on the measures identified above.

POTENTIAL ADDITIONAL METRICS

One of the overall purposes of SB6 is that, with appropriate mental health supports, children are available for education and remain in their school and community. Therefore, we believe it is important to continue to explore methods to measure how well the program is meeting this aim. Where possible, we seek alignment of mental health with the multi-tiered systems of support outcomes:

Increased classroom participation
Reduced disciplinary actions
Reduced out-of-home placements

National guidance on comprehensive school mental health recommends measurement of student-level and school-wide outcomes to link SMH to broader student educational outcomes and school climate. "School-level outcomes, such as school climate, teacher retention and discipline practices, may also prove useful in documenting the impact of universal mental health programming. Tracking and monitoring these outcomes at the school and district levels can improve understanding of the system and of student needs, gaps and service utilization patterns" (Hoover, 2019).

While there is sincere interest in looking at a broader set of school-level outcomes, there are potential challenges in immediately doing so. First, any expansion of metrics not explicitly linked to SB6 participation cannot be adequately or accurately interpreted as "evaluative" of the SB6 program. While the broader school-level metrics are clearly impacted by numerous factors, including strategies within the education system (e.g., MTSS, PBIS, Act 173 practice improvements, etc.) and are not solely the result of the SB6 program, school level data can

inform the coordination of educational and mental health. All of these aspects must be weighed when considering the ROI for metric expansion, especially considering the considerable person hours that adopting new metrics may require.

Second, routinely reporting out on discipline referrals and additional relevant information at the classroom level would be currently difficult, if not impossible, for the AOE to carry out successfully. AOE has recently completed the launch of the Statewide Longitudinal Data System (SLDS) and is still working out many glitches in that regard, largely now focused on ensuring an enhanced district capacity for meeting required state and federal data reporting needs. AOE staff anticipate that the ability to adequately report on a more robust set of indicators, beyond those already required for federal funding, will not be realistic for 1-2 more years. AOE is currently ensuring that all required federal reporting is caught up, after experiencing significant reporting delays linked with the SLDS launch.

Potential areas for expanded metrics are listed below. The State would need to evaluate the capacity to collect this data, the source, and the value before moving forward with new metrics.

1. Student specific:
    a. Office Discipline Referrals (ODRs)
    b. Time in classroom
    c. Out-of-School/ Out-of-Home placements
    d. Academic improvement (for CERT and possibly Behavioral Intervention Services)
2. School climate:
    a. School climate survey data
    b. Teacher rating of feeling supported to address mental health needs in classroom
    c. Amount and impact of SMH consultations for school-wide and classroom-specific mental health needs
3. Tie SB6 to Whole population outcomes (Act 186) and AHS indicators
    a. Vermonters are healthy:
        i. Rate of suicide deaths per 100,000 Vermonters
    b. Vermont's families are safe, nurturing, stable, and supported:
        i. Rate of substantiated reports of child abuse and neglect per 1,000 children
        ii. Rate of children and youth in out-of-home care per 1,000 children /youth
    c. Vermont's children and young people achieve their potential:
        i. % of adolescents in grades 9-12 who made a suicide plan
        ii. Children are ready for school.
        iii. Children succeed in school.
        iv. Youths choose healthy behaviors

v. Youths successfully transition to adulthood

SECTION 5: A PROPOSAL FOR HOW AHS, AOE, AND DMH SHOULD PARTICIPATE IN SUCCESS BEYOND SIX SPENDING DECISIONS.

Success Beyond Six is an innovative approach designed to meet the mental health needs of students and their families through partnership between the local school system and mental health agency. Over the years, there have been intentional decisions to expand the access and increase the allocation under SB6 in response to the challenges identified for serving children with severe emotional disturbance, the rising costs of Special Education spending, and the focus on creating school environments that meet the needs of all students (VT Agencies of Education and Human Services, 2015; Vermont Department of Mental Health, 2008; VT Department of Education, 2001).

The continued expansion of SB6, however, has also raised concerns and the trajectory of the Medicaid total costs of services under SB6 is seen as unsustainable. There is confusion about the growth in school mental health spending when the student population has been in decline. Yet schools are concerned about the mental health and behavioral struggles of their students and the impacts on teachers, and feel that the current array of resources is inadequate to meet the needs for all students and teachers in their school buildings.

Finally, schools have taken different approaches to address these needs and thus the nature of partnerships under SB6 vary across the state. When looked at in isolation, it raises questions about why resources are more available in some regions as compared to others.

Due to the complex nature of this programming, financing and the needs of Vermont's children and communities, any proposed solution must also be multi-faceted and must continue the partnership between AHS, DMH and AOE.

Stakeholder input - When asked how the State should participate in SB6 spending decisions, **l**ocal education leaders have asked that the State establish the overall structure and guidelines, while leaving decisions for the details of local partnerships to those local entities. It was also suggested that a core set of mental health supports should be available to all schools – at no cost to the district – allowing the districts to determine and fund their needs beyond the basics.

All groups expressed appreciation for the opportunity to come together with their local partners and the State (DMH, AHS, and AOE) to discuss school mental health issues and their local needs. They encouraged – indeed, requested – to have opportunities for such dialogue on a periodic basis.

If our collective goal is to provide a level foundation of mental health supports available in all schools. Any such changes would need to be entered into with a thoughtful multi-stakeholder process to ensure that all potential resources are explored and potential impacts are considered. As described in the Executive Summary, Delivery System and Payment Reform processes are a natural fit for future exploration of such potential systemic changes.

STRATEGIES

DELIVERY SYSTEM AND PAYMENT REFORM FOR SB6

Delivery system reforms are typically focused on practice model improvements that support best practices in service delivery for individuals currently experiencing need, coupled with the flexibility to provide supports across broader populations, moving more upstream into prevention and wellness promotion. These delivery system improvements are typically supported by payment system reforms that support flexibility in service delivery through more streamlined and population-based payments, coupled with overall spending limits or caps. The addition of service delivery and payment flexibility is additionally supported by accountability to outcomes and other measures of progress and value.

Elements of delivery system and payment reform for Success Beyond Six include expanding access, practice improvement, payment model evolution, cost containment and outcomes measurement.

EXPLORE CORE SET OF SCHOOL MENTAL HEALTH SERVICES ACCESSIBLE IN ALL SCHOOL DISTRICTSS

- AHS, DMH and AOE, with input from stakeholders, could identify what constitutes core mental health services and supports that all school districts could have access to. Funds for the core SMH would need to be added to the AHS/DMH budget to draw down Medicaid, and thus would not require local school match. LEAs could then make decisions to contract above and beyond the core SMH for individualized needs.

  Example- If it were determined that every school district should have access to a to-be-determined minimum capacity of a school-based clinician to provide direct mental health intervention to a minimum caseload as well as consultation for school-wide efforts, then anything above (e.g. intensive BI services) is purchased by the LEA through contract with DA with local school match.

- DMH and AOE could conduct an analysis of the gap between current SBC resources and those needed to attain the identified goal, looking at FTE and fiscal implications. This

likely wouldn't resolve pressure on the Medicaid cap in the short-term but could have longer-term impacts through raising up the capacity to address mental health in all schools. Additionally, lessons learned from the current Project AWARE could inform the implementation of statewide school-based clinical services.

STRENGTHEN SCHOOL MENTAL HEALTH PRACTICE MODEL

Best practice expansion - Ensure that SB6 staff understand concepts of MTSS/PBIS and the link with SMH. Apply lessons learned from early phases of Project AWARE – a federal grant opportunity – to consider scaling up implementation of the Interconnected Systems Framework and related mental health and trauma-responsive trainings and consultation for school teams. Ensure SB6 program leaders and school-based clinicians understand the flexibility under the SBC case rate to provide prevention and mental health consultation for school climate and classrooms to improve the school's capacity to meet needs of students, as well as how this is affected (or not) by recent expansion of flexibility in SPED funding (Act 173). DMH and AOE can provide opportunities for this workforce development.

- Create mechanism for DA SMH leadership to share and spread effective models of school mental health, such as the Pod or PBIS consultant models.
- Develop standards beyond the Behavioral Intervention Services to include CERT and school-based clinical services, including expectations for consultation to expand the school's capacity to respond to mental health needs. Update SB6 contract as necessary, including identification of agreed upon metrics for consultation.

Continuous quality improvement - Work with AOE and local schools to explore potential use of MTSS school data to inform how best to focus MH consultation in each setting.

Recommend each region hold regular local collaborative meetings of LEA representatives and DA school mental health directors and CYFS director (e.g. Washington County's "Governance Board" or the District/Community Leadership Team (DCLT) under the Interconnected Systems Framework).

- Creation and dissemination of information about SB6 school mental health, the process to develop SB6 partnerships, and services and supports available through SB6 with the goal to improve schools' understanding and to create statewide transparency.

Example - See Ohio's toolkit[3]

PAYMENT MODEL EVOLUTION AND CONTROLLING COSTS

Cost analysis - The three primary components of SB6 programming each have unique funding structures that were created over different points in time. With current understanding of the Global Commitment to Health agreement with CMS and recent experiences with mental health payment reform and cost valuation analysis, it is recommended that Success Beyond Six undergo a similar costing analysis.

Move away from FFS - There may be opportunities to explore shifting from the upward trending fee-for-service structure for Behavioral Intervention Services; updating the clinical services case rate methodology; and to consider value-based payment structure that incentivizes – and measures – a blend of direct student intervention and consultation approaches.

Financial Monitoring - With the recent shift from grant to contract agreements between the State and DAs for SB6 Medicaid, there is continued refinement of financial oversight. DMH could conduct annual random sample survey audits of SB6 contracts between the LEA and DA (with additional FTE staff time to conduct this).

DMH will work with DAs to review reporting requirements to identify areas to strengthen while also reducing the burden of reporting.

- *Example*- Shift reporting from school-level to SU/SD level for fiscal reporting to DMH; FTE reporting at SU/SD level for BCBA & BI, retain at school level for SBCs. Would need to continue to know PBIS status of each school for SBC case rate and allows to track where clinicians are across VT (tends to be more static), whereas the BIs/BCBAs tend to be more fluid to respond to where the need is across SU/SD.

Set Spending Allocation for SB6 spending per region - DMH could establish a Medicaid allocation for SB6 spending per region such that the DA and LEA could enter into agreements up to that amount; anything over would necessitate AHS/DMH approval. A clear process would need to be established to determine an equitable baseline and how to manage requests for increases or unused amounts, with consideration of the structure used for the recent mental health payment reform.

[3] http://education.ohio.gov/Topics/Student-Supports/School-Based-Health-Care-Support-Toolkit

Rate Setting - DMH could establish SB6 rate ranges for service types such that Medicaid would only cover up to the established range per FTE/program type to provide transparency for the local contracting process. It would also be important for any toolkit or documentation to note that schools/SUs may purchase services for students who are not Medicaid eligible and those service rates would not include the ability to leverage federal match and thus may be higher.

Implementation – DMH will conduct a review of DA and statewide spending trends against each DA's approved spending authority and report back to DAs how trend compares to anticipated spending for the FY at the DA and statewide. This will occur in January and March of each year as well as ad hoc when there is a request for changes to the approved spending authority.

DELIVERY SYSTEM AND PAYMENT REFORM- EXAMPLE MODEL

REGIONAL GLOBAL BUDGETS

Pulling all of these strategy concepts into a cohesive approach could be our best solution. While not every school or supervisory union/district may have the resources for the full scope of work to address students' mental health needs and respond effectively, taking a more global approach within a region may bring increased flexibility and collaboration. An illustration of this is a model in which each DA region has an allocation for school mental health informed by a combination of factors to be determined, such as student enrollment, current SB6 spending and utilization, etc.

Fiscal Agent and Governance- The regional school mental health budget would be held by the DA (as the Medicaid enrolled provider paid by DMH), but with a clear governance structure for the regional partnerships involving each supervisory union/district in their catchment area such that the DA and SU/SD leaders coordinate together in determining how to apply the resources across the region.

Covered services- The regional partnership would be responsible for the continuum of supports from consultation and education that supports the school-wide population to the direct services for students who need intensive supports.

Practice improvement- Applying practice models that are currently showing promise in some regions would support this new structure for school mental health, including concepts from the Pod model, Interconnected Systems Framework, regional governance teams, lessons from Integrating Family Services and the more recent DMH payment reform, and AOE's census-based funding considerations.

Accountability- Outcome measures would be established that include population-level and student-level measurements.

Local match- SU/SDs contribution into the regional allocation could be based on a per-pupil ratio.

Outcomes- SU/SDs could see benefit of economies of scale for the type of programming that each SU might not be able to provide individually. For example, the region could identify how much need there is for BCBA behavioral services and consultation, clinical service and consultation, and a team of behavioral interventionists and case managers who could more readily respond where the need is identified and shift as needs shift based on collaborative decision-making of the regional partnership and without having to change or create new contracts between a SU/SD and DA for each transition.

Moving in this direction to create a wholly new structure for school mental health would bring us closer to the vision of having an educational system that is responsive to the mental health needs of students and families and of having more equitable access to mental health services and supports. This is a large undertaking which would require thoughtful planning, extensive stakeholder input, coordination across two State agencies, and policy and payment reform. AHS, DMH and AOE would need to be committed to putting resources to support this transition, which would of necessity include engagement of an external consultant to support the process.

ACT 173 IMPLICATIONS

After two legislatively commissioned studies regarding Special Education funding and practice, the General Assembly passed Act 173 in 2018. The purpose of Act 173 is to "enhance the effectiveness, availability, and equity of all services provided to all students who require additional support in Vermont schools." The ultimate goal is to enhance funding flexibility so that all students' needs can be best served.

The State Board of Education, Agency of Education, and a Census-Based Advisory Group to the SBE (CBAG) are currently working through necessary rule changes and administrative guidance documentation for the field. In terms of funding, the prior reimbursement model for special education expenses is now changing to a census block grant model using a new statewide formula (see UVM study for details). In terms of practice, the AOE is providing significant guidance and professional learning opportunities for the field based on four key levers within the SBE's existing Education Quality Standards (EQS; Rule 2x00 series). The four system- and district-level levers are: (1) curriculum design, implementation, and coordination; (2) needs-

based professional learning; (3) local comprehensive assessments; and (4) effective Education Support Teams.

This is a significant piece of legislation within the Education sphere, coming on the tail end of Act 46 (governance consolidation); with successful implementation, it will represent a sea change in practice and funding. The effects on SB6 are unclear at this point, but conversations about improving SB6 practice and associated funding models should occur hand-in-hand with statewide and local decision-making linked to Act 173.

It is not yet known what the potential impacts are – helpful or detrimental – on Success Beyond Six and school mental health. Certainly, the broader intent of Act 173 is aligned with the goals of the Success Beyond Six program. There will likely be opportunities for shared learning. Any action undertaken to improve SB6 needs to be informed by ongoing work under Act 173, including determining potential impacts to independent schools and SB6.

RECOMMENDATIONS

1. AHS, DMH and AOE will continue to communicate about changes to SB6 and Special Education restructuring so that Agencies can collaboratively develop combined approaches that ensure student needs are met. This will occur through the Act 173 Advisory Committee and MEAB, as well as regular meetings between AOE, AHS and DMH executive leadership.
2. AHS and DMH prioritize SB6 for potential delivery system and payment reform. The first step will be to conduct analysis of time and expense for this work.
3. AHS and DMH will support identified practice model improvements through collaboration with the DAs/VCP and educators.
4. Partners in each region will explore how to implement regular local collaborative meetings if they are not already occurring, composed of LEA representatives and DA school mental health directors and CYFS director.

APPENDIX A: STAKEHOLDER MEETING ATTENDEES AND AGENDAS

1. Vermont Superintendents Association (VSA) & Vermont Council of Special Education Administrators representatives (October 15, 2019)
2. Vermont Care Partners (VCP) and Designated Agencies (DA): Child, Youth & Family Directors, School Mental Health Program Directors (October, November, December 2019)
3. Regional partnerships of DA and local educational agencies in:
    a. Rutland (Rutland Mental Health Services and Rutland City SU on November 13, 2019)
        i. Heather Hildebrant, School Based Services Supervisor, RMHS
        ii. Karen Grimm, School Based Services, RMHS
        iii. Loren Pepe, Principal, Rutland Northwest ES
        iv. Sharon Napolitano, Assistant Principal, Rutland MS
        v. Kerry Coarse, Assistant Principal, Rutland Intermediate School
        vi. Pam Reed, Dir. Equity & Inclusion (Sped Ed), Rutland City SU
        vii. Jennifer Wigmore, Associate Principal, Rutland HS
    b. Chittenden (Howard Center and Burlington School District on November 25, 2019)
        i. Cara Gleason Krebs, School Services Director, Howard Center (HC)
        ii. Anne Paradiso, Director of School Programs, HC
        iii. Lisa Bilowith, Program Director, Jean Garvin School, HC
        iv. Julie Smith, Autism Program, HC
        v. Stacie Curtis, Director Early Education, BSD
        vi. Jim Kelly – Principal Hunt MS, BSD
        vii. Shelley Methias – Principal Edmunds, BSD
        viii. Leonard Phelan – Principal CP Smith Elementary, BSD
        ix. Leshawn Whitmore – Principal Flynn Elementary, BSD
    c. Washington (Washington County Mental Health, local SU/SDs on November 15, 2019)
        i. Donna Rae – Dir Student Services Waitsfield
        ii. Stacy Anderson – Co-Director Special Services, Barre UUSD
        iii. Erin Longchamp – Barre DCF Family Services Division
        iv. Michaela Martin – Co-Director of School Transformation, Central VT SU

v. Sabrina Brown – Student Services Director, Caledonia Central SU
vi. Kelly Bouchey, Director of Special Services, Washington Central UUSD
vii. Don McMahon, Co-Director Special Services, Barre UUSD
viii. Tiffiny Moore, Director of School Based Services, WCMH
ix. Lisa Estiville, Director, Adolescent Therapeutic Education & After School Services, WCMH
x. Nicole Grenier, Children, Youth & Family Services Director, WCMH

4. Act 264 Advisory Board and the Children's State Program Standing Committee
5. Medicaid and Exchange Advisory Board (MEAB)
6. Vermont Federation of Families for Children's Mental Health Board

Agenda Template:

Success Beyond Six Stakeholder Input Meeting

Purpose of the Meeting*: To solicit input from key education partners on the provision of Success Beyond Six services in schools to inform the legislative report*

1. **Introductions**
2. **Report Intent and Why this Matters**
    a. DMH/AOE provide high level context
    b. Overview of the questions we are charged with answering
3. **Discussion Questions**
    a. What services do you currently use through SB6 and what is working well in your districts from your perspective?
    b. What are the challenges related to SB6? Related to areas such as funding and access and how services are delivered. What would strengthen the SB6 services?
    c. What other models of school based mental health outside of SB6 do you use? How do you fund it? Who provides it?
    d. What trends are you seeing in your schools related to student needs and populations? Our data indicates more services in the HS level, does this align with what you are seeing?
    e. How are students identified for school based mental health?
    f. What metrics or information do you use to determine the value of SB6 in your school (is it school generated or DA generated)? What ideas do you have about how to capture School mental health work at Tiers 2 and 1 (impact, # kids, how is flexibility being used)? What should be tracked at state level?

g. What are your recommendations for how AHS, AOE & DMH participate in SB6 spending decisions?

h. What additional needs do you see related to social, emotional, behavioral health of children and youth that are not currently being addressed through school based mental health services?

4. Next Steps

APPENDIX B: SUMMARY VERMONT CARE PARTNERS MEMO TO DMH

November 21, 2019

Dear Laurel,

Thank you for the opportunity to provide specific input for the legislative report on Success Beyond Six programming that is due to the Vermont Legislature in January.

Vermont should be very proud of the school-based services we deliver to Vermont's most vulnerable children, youth, and families. By embedding mental health services in schools, we are mitigating the impacts of developmental trauma, supporting students in accessing their education, and preventing the onset of worsened and more costly mental health and substance use disorder conditions later in life. Integration between education and the community-based mental health system maximizes the time and resources available to both children and families to strengthen families, prevent adverse childhood experiences, and address social determinants of health. Determined at a local level, school-based services can be flexible to meet the needs of both specific students and specific school districts.

DMH has been a strong partner in communicating the value of these services over years. We know DMH is well-versed in many of the program methods and attributes. This memo will offer a VCP perspective on #2, #4, and #5 of the legislative report requirements.

Here is a summary of our main points:

- **Vermont children/youth are more stressed than they were ten years ago, as indicated by rates of DCF custody, rates of Opioid Use Disorder among parents, and rates of economic stress.**
- **Mental health data for children/youth in Vermont indicate that the stressors above are causing increased behavioral acuity for children/youth across settings.**

- **Trends in the last four years indicate that, while the number of identified students has stayed relatively stable, Success Beyond Six programs are providing more and more services per student, reflecting the increase in individual need and acuity.**
- **Despite school districts' development of more internal resources to meet the needs of an increasingly acute student population, the demand for DA specialized, integrated, and community-based services is still high. Rather than a more mixed population, we now serve school districts' most acute-needs students, a trend which likely contributes to the increase in DA services per student.**
- **The upward spending trend reflects the increased case intensity as well as the increased cost of providing these highly valued services in response to the presenting need.**
- **The flat trend in 'number of students served' doesn't tell the whole story. Through the School-Based Clinician Case Rate, we are providing interventions that support the social/emotional development of whole classrooms and whole schools.**
- **This Legislative Report is an opportunity to share with a larger audience the extensive data and metrics that DAs currently provide to DMH as part of their Success Beyond Six Contracts.**
- **Spending decisions should continue to be made at the local level while maintaining current AHS, AOE, and DMH oversight. Vermont should be proud of its investment in early interventions.**

In the material that follows, we are offering DMH some data and information to use that can support these key points. The memo is organized around the three bolded elements of the report requirements:

> *(c) AHS, AOE, and DMH shall report to the General Assembly on Success Beyond Six evaluation and oversight not later than January 15, 2020. The report shall include:*
>
> *(1) an inventory of existing methods for providing school-based mental health services;*
>
> ***(2) analysis of the trend in school-based mental health programming that is funded through the Success Beyond Six program fiscal mechanism;***
>
> *(3) evaluation of the program attributes;*

(4) determination, in partnership with the Designated Agencies, of metrics for evaluating program outcomes; and

(5) a proposal for how AHS, AOE, and DMH should participate in Success Beyond Six spending decisions.

Please let us know if we can provide additional resources that may be useful in this effort.

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