NEVADA SCHOOL-BASED BEHAVIORAL HEALTH

Toolkit

Nevada Department of Health and Human Services

DIVISION OF CHILD AND FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY

Nevada Department of Education

Nevada Ready!

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INTRODUCTION

Nevada children face increasing behavioral health challenges and limited access to care. These difficulties affect their ability to engage in the academic and social tasks at school, and create increasing burdens on classroom teachers to stabilize and intervene with challenging behavior or emotional needs. The vision of this toolkit is to help districts and schools establish avenues to behavioral health services that resolve barriers to learning.

Creating a solid system of clinical behavioral health services available to children in their neighborhood schools allows them to receive help before problems escalate to a crisis. Additionally, utilizing Medicaid for school-based services builds a funding stream to recruit and retain the Specialized Instructional Support Personnel workforce, including clinical behavioral health providers, that are first responders when children face behavioral health challenges that affect their learning.

Through the resources in this toolkit, we aim to help districts and schools utilize the structure of a Multi-Tiered System of Supports to incorporate a comprehensive School-Based Behavioral Health System into schools using an Interconnected System Framework.

Each district will have unique needs, so each system will have factors that align with the characteristics of the local children, schools, and community. However, this toolkit identifies common factors that will help school leaders build a sustainable pathway prioritizing student wellbeing that directly influences and supports attendance, engagement, and academic success.

WHO IS THIS GUIDE FOR?

This guide is designed to support everyone working to expand access to School Behavioral Health Services that are paid through Medicaid, including state and Local Education Agency staff, state Medicaid agencies, school health providers, public health professionals, and advocates. All of these stakeholders share a common goal: improve student health and educational outcomes.

The Interconnected System Framework *is an approach for building a single system of supports in schools. Integrating Positive Behavioral Interventions and Supports and school mental health, the Interconnected System Framework also brings community partners and families into one multi-tiered structure.*

SHARED MISSION & VISION

In March of 2021, the Centers for Disease Control and Prevention Health Schools established the Whole School, Whole Community, Whole Child Model. This toolkit is a collective impact project and a collaboration between the Nevada Department of Education, Department of Health and Human Services, Nevada Medicaid, and local education agencies. The primary mission of this collaboration is to strengthen policies, programs, and legislation regarding in-school behavioral health to improve learning and promote success for Nevada's youth. Using the Whole School, Whole Community, Whole Child Model, Nevada can integrate academic outcomes and student health using the whole-child approach to teach, support, and nurture all areas of child and youth development and learning, including social-emotional and cognitive skills.

The collaboration has overarching goals: **3**

GOAL 1.

Advance high-quality, sustainable, comprehensive school behavioral health systems in Nevada schools.

GOAL 2.

Research and evaluate behavioral health promotion, prevention, and interventions in schools, including all aspects of procedures including planning, delivery, and continuous quality improvement of high-quality, sustainable, comprehensive school behavioral health systems.

GOAL 3.

Train and support diverse stakeholders and a multidisciplinary workforce in understanding, promoting, and advancing the behavioral health and wellbeing of children and youth.

HOW TO USE THIS GUIDE

Your district or school does not have to complete each section of this toolkit in any particular order. Please select the section that best fits where your school needs to start with implementation of School-Based Behavioral Health Services.

This toolkit will help to establish School-Based Behavioral Health in schools and align services to the Medicaid Services Manual Chapter 2800 MSM 2800 03-01-20 (nv.gov) and MSM Chapter 400 MSM Chapter 400 9/28/22 (nv.gov). It will create the connection between clinical behavioral health services and the educational system by establishing a common language. The guide will help to align Clinical Behavioral Health Services, The Collaborative for Academic, Social, and Emotional Learning, and the Multi-Tiered Systems of Support frameworks. The establishment of a standardized referral process including guidelines for eligibility, assessment, interventions as established in the Plan of Care, community referrals, a continuation of care, and termination of services provided by a Clinical Social Worker or other behavioral health providers, and the school-based teams.

Think about how school and community partnerships, your school's culture and environment, and district policies impact behavioral health.

OVERVIEW OF SCHOOL-BASED BEHAVIORAL HEALTH

School-Based Behavioral Health is heavily aligned with other school and healthcare initiatives happening across the state of Nevada, including:

- Multi-Tiered System of Supports
- Positive Behavior Interventions and Supports
- Social and Emotional and Academic Development
- Trauma-informed classrooms and practices
- Suicide prevention policies in schools
- Restorative justice

Why "Behavioral Health" and Not Mental Health?

Behavioral health is more than just mental health; it includes a continuum from prevention and promoting resilience, as well as the treatment of mental and substance use disorders so that children can thrive. Behavioral health focuses on the whole child with a goal of wellbeing for all students. In this document "behavioral health" will be used to address this continuum. However, some linked resources use the terminology "mental health."

RESOURCES ON THE NEED FOR SCHOOL-BASED BEHAVIORAL HEALTH

Nevada has been ranked 51st in the Nation over the past five years for behavioral health services. This brief two-page factsheet developed by Department of Health and Human Service summarizes behavioral health's impact on students, why School-Based Behavioral Health is essential, and some guiding best practices.

Quick Reference for School-Based Behavioral Health Initiatives (Nevada Department of Education and Department of Human & Health Services) A shortlist of definitions and additional resources to help understand other school-based initiatives intersect with school behavioral health.

Every Young Heart and Mind: Schools as Centers of Wellness, Draft Report (behavioral health Services Oversight and Accountability Commission) – a report from the Subcommittee on Schools and behavioral health that reviews the need for School-Based Behavioral Health and provides state recommendations to improve behavioral health access and outcomes and increase academic success.

PART I.

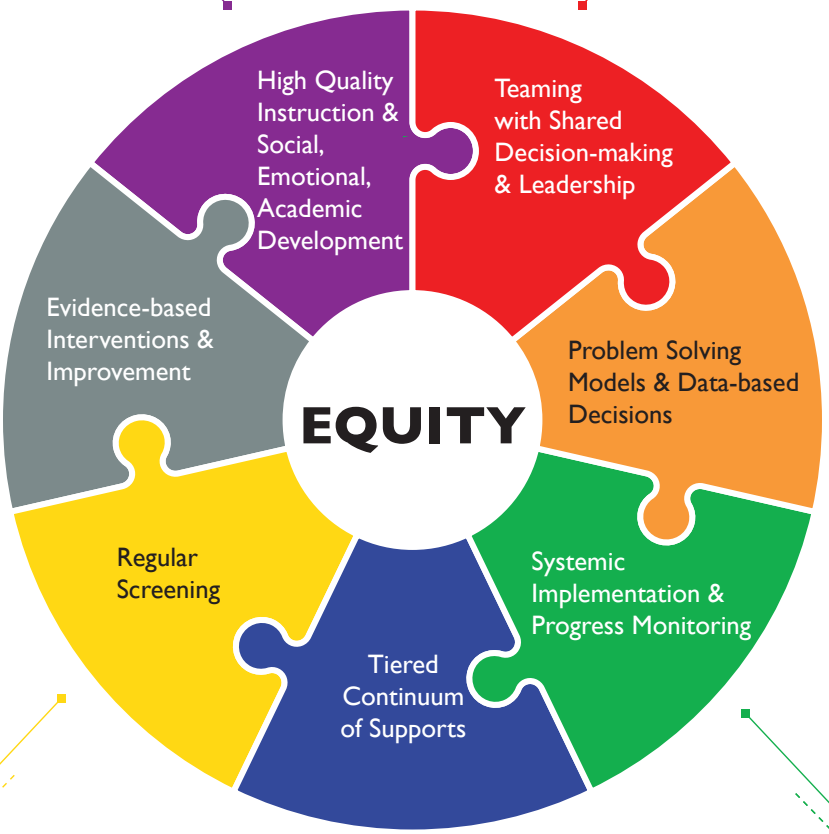
EXPLORATION: SETTING UP YOUR SYSTEM

For schools and districts exploring who are preparing to set up School-Based Behavioral Health systems, this section will help you identify action steps to ensure that you have a strategy, an action plan, adequate staffing, and funding streams to roll out services and supports for your students. Using a Multi-Tiered System of Support framework is one way to ensure that you have set up a comprehensive system of services that meet student needs and available resources.

What is a Multi-Tiered System of Supports Framework?

Multi-Tiered System of Supports is a delivery framework for how a school health system can provide interventions and support to students. It encompasses seven core elements working in concert to ensure equity and student development. Multi-Tiered System of Supports is foundational to building an integrated system across the education environment with collaboration and integration of community and school resources.

MTSS Core Elements



Includes high-quality curricula, differentiated and culturally responsive teaching practices, ongoing professional development, and inclusive learning environments

Strategic grouping people or groups who meet regularly with shared goals, that allow for the design, maintenance, and continual improvement of Multi-Tiered System of Supports

Data sources are traingulated to select contextually relevant interventions based on student need

Processes that allow stakeholders to collect and analyze data, measure fidelity, monitor impact to identify problems, and modify practices in response

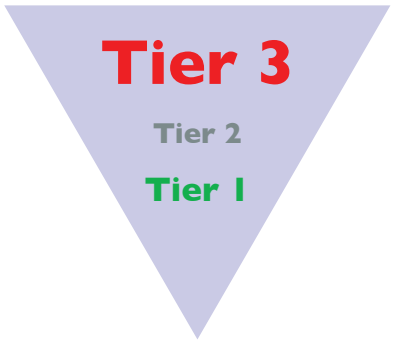
Identifies Tier I instructional needs which may prevent barriers before they arise, as well as a data source for advanced tier supports

Using implementation science to establish a sustainable infrastructure that allows stakeholders across systems to gather academic and behavioral data over time to meet the needs of students (i.e., policies, programs, practices that are coordinated)

Protective and responsive support designed to match all learners needs

WHY USE AN MULTI-TIERED SYSTEM OF SUPPORTS FRAMEWORK FOR SCHOOL-BASED HEALTH SERVICES?

One of the biggest challenges facing schools is the sheer quantity and intensity of needs our students and families face. Frequently, Specialized Instructional Support Personnel like school social workers, school counselors, school psychologists, and school nurses spend the majority of their time troubleshooting problems including stabilizing crises. When they are working in this scenario, they may not have time to implement interventions with fidelity or consistency over time, they feel burned out and stressed at work; concerned that someone may be falling through the cracks.



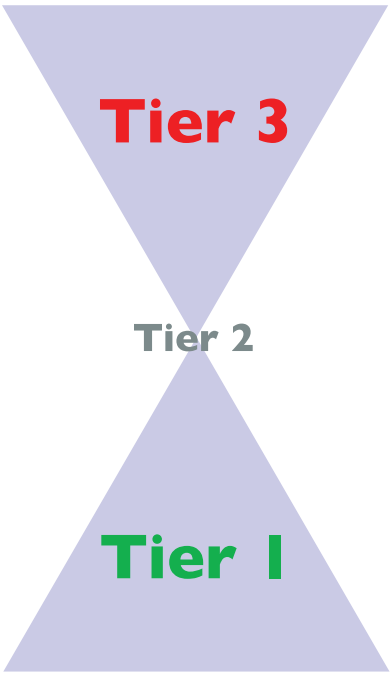
Multi-Tiered System of Supports Reduces Strain on Resources

Many schools are operating in a crisis mode, providing Tier 3 services to as many as 30-50% of the school's student population. Without implementing effective Multi-Tiered System of Supports, it is unsustainable for our existing Specialized Instructional Support Personnel and administrators to continue operating in crisis mode and move towards providing a full spectrum of evidence-based prevention, interventions, and supports. When Multi-Tiered System of Supports is working effectively at Tier 1, Tier 2 can support about 15-20% and, Tier 3 should support 3-5%.

When this is happening, the triangle of where student needs fall in the system looks more like the graphic to the left, with the majority of staff energy spent on an overwhelming number of individualized needs.

Initiation of Multi-Tiered System of Supports: Tier 1

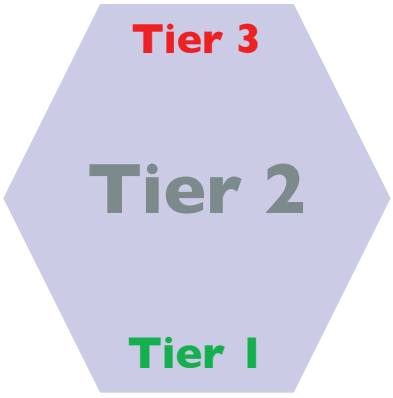
Multi-Tiered System of Supports can increase the efficiency and efficacy of School-Based Behavioral Health services, beginning with Tier 1 supports, which are simultaneously implemented with addressing existing Tier 3 needs, such as conflict resolution and crisis intervention. Without Tier 1 in place, Tier 3 needs are greater, quickly becoming overwhelming, because students lacking in social emotional skills or those unaware of school routines are often referred to one-on-one support from a Specialized Instructional Support Personnel.



While building Tier 1, school staff will still manage the crises that arise, but over time the kinds of crises they see will be less frequent and less severe. When children practice and use their social, communication, and coping skills, fewer conflicts need to be mediated. This starts to free up staff time to implement services at higher tiers. When this happens, the distribution of tiered support needs in a school may start to look more like an hourglass.

School-Based Behavioral Health Considerations at Tier 1

- Continue to implement evidence-based prevention programming at Tier 1
- Identify areas of duplication to streamline and prioritize evidence-based programs and practices
- Increase fidelity of current, evidence-based practices for stronger outcomes
- When adding a new practice, choose one intentionally that addresses prevention of a commonly occurring need at higher tiers among your students
- Select screening tools that will capture targeted areas for your student body to enable staff to intervene before problems become crises
- Data sources include school climate, office referrals, and universal screeners



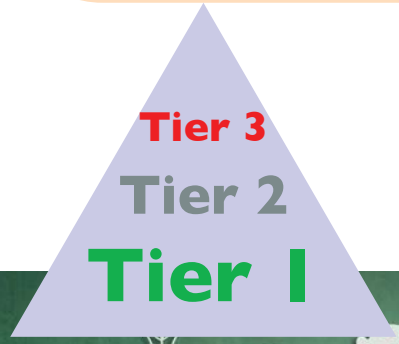
Building Out the System: Implementing Tier 2

As you consider bringing in some Tier 2 services for small group or less intensive settings, continue to maintain and improve Tiers 1 and 3. By including Tier 2 services, Specialized Instructional Support Personnel can serve some of those former Tier 3 needs at this lower level of intervention. This means that as Tier 2 resources become available, and referrals start to be made to Tier 2 programs, we will see our system start to look a little heavy around the middle.

At this stage, the entire school is implementing Tier 1, Specialized Instructional Support Personnel continue to respond to crises, and may be able to start to do more targeted treatment for Tier 3 needs.

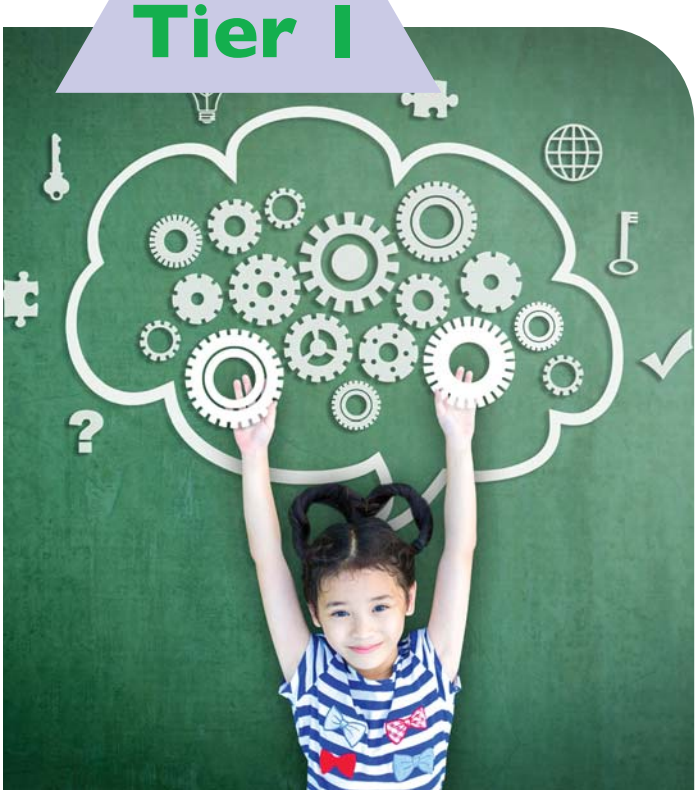
School-Based Behavioral Health Considerations at Tier 2

- Identify commonly arising needs and assess work as a team to identify Tier 2 supports that can be implemented with multiple students, such as evidence-based programs for small group work
- When starting to offer Tier 2 services, choose one intervention, with entry and exit criteria clearly defined to pilot at a time that matches the needs of your population
- Start with Tier 2 interventions and supports that intervene earlier in areas of common crisis scenarios. For example, suppose your Specialized Instructional Support Personnel spend a lot of time intervening with conflict. In that case, Tier 2 groups focusing on proactive communication and cooperation skills will reduce the number of conflict intervention services needed and free your Specialized Instructional Support Personnel to provide more comprehensive services at Tier 3.
- Data sources include targeted screeners and review of student outcomes (behavior, attendance, grades). Progress monitor interventions delivered at Tier 2



Established Multi-Tiered System of Supports with Fidelity

When your Multi-Tiered System of Supports system is established with fidelity, Tier 3 case planning becomes much more feasible. At this point, an established system for deciding when a youth's needs rise to the level of necessitating intervention is in place, and data tools for when they have reached their goals are also established. This is when the distribution resembles the familiar Multi-Tiered System of Supports triangle.



School-Based Behavioral Health Considerations at Tier 3

- Continue implementing Tier 3 services, like crisis responding, conflict resolution, restorative justice conferencing, and incidental brief counseling services
- For students presenting with serious concerns or who are not responding at Tier 2, seek parent and caregiver permission to assess and refer to clinical intervention and treatment
- Data sources include individualized assessments, repeated screeners, and student outcomes (behavior, attendance, grades). Use data decision rules to determine when interventions and services are appropriate.
- Progress monitor interventions at Tier 3

Resources for Multi-Tiered System of Supports

In Nevada, we are fortunate to have access to many resources to set up and maintain a good Multi-Tiered System of Supports.

UNR's PBIS Technical Assistance Center: Offers training and technical assistance to Local Education Agencies interested in implementing or improving their Multi-Tiered System of Supports system.

PBIS.org: Center on Positive Behavioral Interventions and Supports.

National Center for School Mental Health: Online resources for educators and Specialized Instructional Support Personnel to navigate through descriptions and resource samples across the eight domains of the school mental health quality assessment that align with the national Mental Health Technology Transfer Center Curriculum (SHAPE System).

Initiative Inventory: Creating a continuum of services and supports.

Pacific Southwest Behavioral Health Technology Transfer Center: Research, coaching, and technical assistance.

High Leverage Practices. Resource for practices and interventions that are easily implemented and quickly resolve challenges.

EQUITY IN SCHOOL-BASED BEHAVIORAL HEALTH

QUICK TIP

*When you set up your behavioral health framework, ensure equity so that **all** students can thrive!*

Work with your team to answer these questions:

- When there is a behavior concern with a student, have you considered whether health, disability, or behavioral health concerns are underlying the concern?
- Have you ensured that School-Based Behavioral Health resources are **not** used in a punitive fashion? An equitable approach relies on teaming, data-based decision making and a clear referral pathway.
- Are your services strengths-based and focused on increasing coping skills and reteaching Social-Emotional Learning Competencies?
- What additional instruction does the student need to increase desired behaviors?
- Have you ensured that the School-Based Behavioral Health resources are culturally and linguistically diverse to provide equitable services to all students and families?
- Have you considered environmental factors that could negatively impact a student's behavioral health?
- Do you have culturally responsive Tier I services school-wide and embedded in social-emotional learning in all classrooms?

Resources for Equity in School Behavioral Health

DEVELOPING A CLINICAL WORKFORCE FOR SCHOOL HEALTH SERVICES

Schools as a Unique Environment for Clinical Services

School-Based Behavioral Health service delivery within a school environment has different logistics than services in an outpatient or hospital setting. As a result, School-Based Behavioral Health providers may need specific training to provide them with the ability to be "flexible with fidelity" (Kendall, 2008).

Flexibility with Fidelity

Research has shown that it is difficult for clinical behavioral health providers to deliver clinical services in schools with fidelity when the school environment is complex and fluid, so a clear structure and system are important to successfully implement School-Based Behavioral Health programs and interventions (Kendall, 2008).

Flexibility with fidelity refers to addressing the differences found in schools, such as scheduling. For example, a school day may be broken into 40 minute periods, making 45-50 minute one-on-one sessions difficult to structure. The School-Based Behavioral Health provider will need to be flexible and possibly adjust the one-on-one time with the student to 30 minutes. In addition, the clinician will need to consider the student's schedule and grades to ensure they are not pulling the student from the classroom on the same day and time each week, or pulling students repeatedly from classes where the child is struggling academically and will have difficulty catching up. Testing schedules as well as holiday and seasonal breaks affect continuity and opportunity for sessions as well.

Training of Professionals

Training qualified behavioral health providers and Specialized Instructional Support Personnel will help address issues before they arise and allow the provider to be flexible and provide services with fidelity. Training should be divided into two areas, preservice and onboarding training, and postservice training.

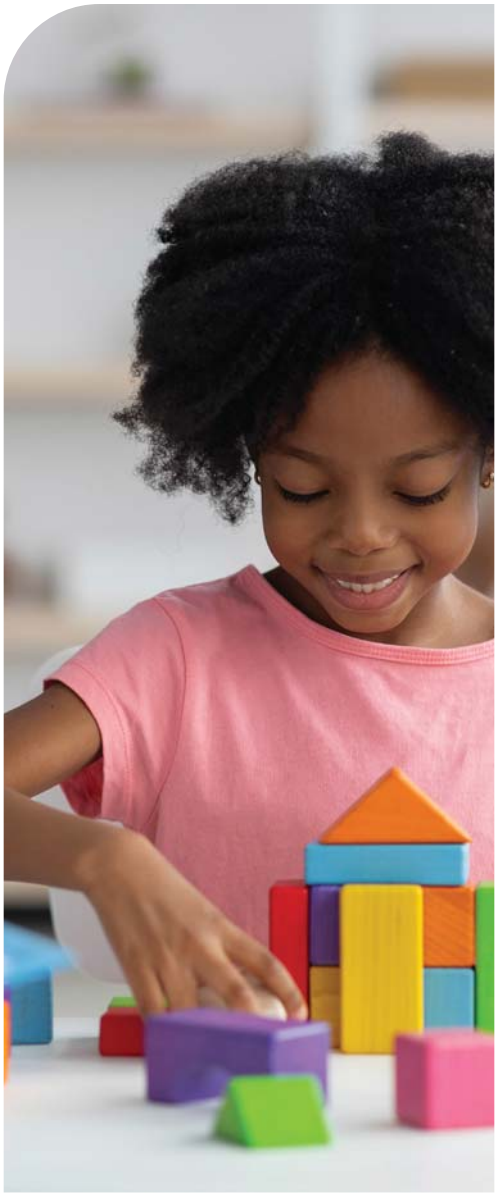
Who are Specialized Instructional Support Personnel?

Specialized Instructional Support Personnel include non-classroom educators: school nurses, school psychologists, school counselors, school social workers, speech pathologists, library media specialists, occupational therapists, physical therapists, and others such as clinical mental health professionals. Many of these professionals are nationally board-certified public school employees in their respective fields. The term was selected to indicate personnel who have specialized training to support the instructional process, resulting in academic and social emotional success for students (National Education Association).

Pre-Service and Onboarding Training

Providing training in school behavioral health services and systems for newly hired mental professionals can help providers understand the differences between school and community health services. For example, the National Association of School Psychologists has developed ten appropriate competency domains to integrate School-Based Behavioral Health services. These competencies include:

- Data-based decision making
- Consultation and collaboration
- Academic interventions and instructional supports
- Mental and behavioral health services and interventions
- School-wide practices to promote learning
- 6Services to promote safe and supportive schools
- Family, school, and community collaboration
- Equitable practices for diverse student populations
- Research and evidence-based practice
- Legal, ethical, and professional practices



Post-Service Training

Clinicians working in schools need support understanding the unique setting that differs from outpatient and hospital therapy settings. Learning the way a school system works and how School-Based Behavioral Health integrates with Multi-Tiered System of Supports will help support School-Based Behavioral Health providers. Local Education Agencies benefit from providing training to clinical staff in the following areas:

- Multi-Tiered System of Supports frameworks
- Collaborating with professionals across disciplines
- School schedule constraints
- Academic considerations
- Interconnected systems

Identifying Training Opportunities

Districts/Schools can work with Division of Child & Family Services/ Nevada Department of Education to access region-wide training opportunities on School-Based Behavioral Health related topics. Providing the training to the behavioral health professionals will also be a shared responsibility with the districts and schools. To ensure the highest level of training, the following is recommended:

- Embed professional development paired with ongoing community networks and allowing School-Based Behavioral Health professionals to attend training during the school day
- Develop professional learning communities that School-Based Behavioral Health professionals can join
- Align training with local goals and standards
- Structure mentor or coaching components during early implementation and provide ongoing support

Ongoing professional development opportunities for your school-based health services workforce is best practice for ensuring staff, student, and system wellbeing.

Invite Community-Based Professionals

It is important to remember that community-based behavioral health professionals (i.e., contracted with an Memoranda of Understanding from community organizations) who deliver services in a school setting will require similar background information and training opportunities for school-based services. Consider inviting community partners to your district- or school-hosted professional development activities.

Workspace Considerations for School Health Services

Careful consideration needs to be given to where School-Based Behavioral Health services will be provided in schools. The facilities and private space must be provided at schools. Some Tier 2 and 3 clinical behavioral health interventions in the school need confidential areas for services and record-keeping (no shared office space). Districts and schools need to consider licensing and certification requirements for Nevada Medicaid reimbursement.

RESOURCES FOR TRAINING

- Center for Application of Substance Abuse Technologies
- Nevada Department of Education Professional Development Catalog
- NDE Office for Safe and Respectful Learning Environments Training

COMMUNITY PARTNERSHIPS

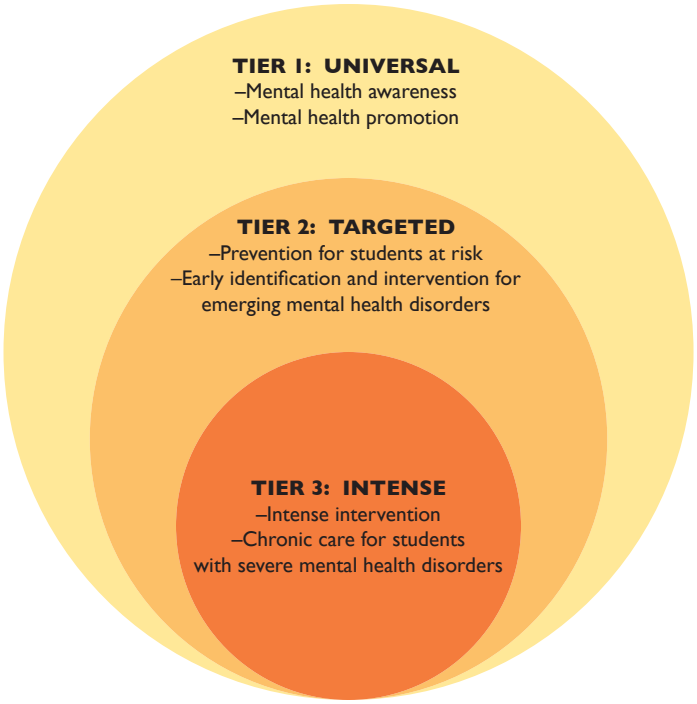
As you identify the gaps in the services available within the school building, consider the ways you can incorporate local community partners to integrate services.

No single entity (school, district, community, county, or state) can provide comprehensive behavioral health services for all students. Partnerships and community buy-in will help bring together resources for the comprehensive School-Based Behavioral Healthcare that is needed.

Interconnected Systems Framework

Working fluidly in an interconnected partnership between educators, Specialized Instructional Support Personnel providing School-Based Behavioral Health, and community partners filling in the gaps is an integrated system. Create a plan for how each resource and provider will plug in, using data as your guide.

Here is an example of how School-Based Behavioral Health services can integrate with an Multi-Tiered System of Supports framework. This circle figure describes how the student receives universal support, and subsets of students will also receive targeted and intensive support. These services are used to restore behavioral health to optimal functioning across the domains of the child's life (school, community, self).



Memoranda of Understanding

A memorandum of understanding is a written document outlining the roles and responsibilities in an agreement with a community partner. It details what the school or district assures will happen and what the community provider assures will happen. This way, you can plan in advance how resource providers will complement each other's work. A Memoranda of Understanding should include discussion of how and when data will be shared, participation in collaborative meetings, and other specifics related to the service and need.

The following figure outlines the features of a Memoranda of Understanding, to assist you in building one that meets your local needs:

Purpose of agreement

Explain what the MOU is for and any definitions of programs or services.

Fiscal & resource agreement

Detail payment exchanged, if applicable. Detail resources or other non-financial sources of support that will be exchanged (e.g., delivery of professional development). MOUs are very helpful for any kind of shared agreement, whether or not payment is exchanged.

Duration & termination

Outline how long the MOU is valid for and procedures for requesting termination by either party.

Memorandum of Understanding Between Appleville School District and Hope Child and Family Services

Purpose of agreement: The purpose of this agreement is to establish roles and responsibilities of the Parties to develop and implement a comprehensive school mental health system that utilizes the strengths and expertise of school and community-partnered professionals.

Roles and responsibilities of each party: The Parties agree to the following roles and responsibilities.

a. Responsibilities of Hope Child and Family Services (HCFS)
   i. Actively participate in school mental health team(s)...
   ii. Provide mental health services, to include...
b. Responsibilities of Appleville School District
   i. Identify school(s) that demonstrate readiness...
   ii. Provide confidential space in school(s) that includes...
   iii. Facilitate inclusion and active participation of community partners...
   iv. Create data-based decision models and referral processes that promote...

Fiscal and resource agreement

a. Appleville School District will pay HCFS the total sum of XX...
b. Payments will be made in a...

Liability release as an independent contractor

a. In providing services to Appleville School District students, HCFS shall at all times operate as an independent contractor and shall have no authority to make any arrangements or incur any liabilities on behalf of the Board.

Duration and termination

a. This Agreement is for the period beginning Month/Day/Year to Month/Day/Year...

Insurance and indemnification

a. [Program Name Here] shall purchase and maintain during the term of any resulting agreement...

Roles and responsibilities of each party

Outline what activities the school district and community partners are expected to participate in. Examples include prevention, promotion, and intervention services, attendance at team meetings, training or professional development provided and/or attended, space and resources for activities and collaboration, data reporting and use guidelines, and guidelines related to student and family confidentiality.

Liability release as an independent contractor

Detail limits to liability for both/either parties here.

Insurance & indemnification

List the types of insurance that the community provider will purchase and maintain, including general liability, professional liability, and worker's compensation, as applicable.

BREAKING THE SILOS: COORDINATION & COLLABORATION

To support student behavioral health, a collaboration between student supports, including partner agencies, and school administration and staff is vital. Included in this section are resources to support coordination efforts.

Coordination, collaboration, and breaking down of silos among staff and stakeholders in education and behavioral health fields are necessary to increase student access to behavioral health. For efforts to be sustainable, there needs to be collaboration and buy-in at every leadership level, including state leaders, district leaders, school leaders, team leads, Specialized Instructional Support Personnel, and community partners. This can be challenging. For example, leadership, staff, and providers can often have different points of view and priorities. However, working together across systems is essential and requires patience, flexibility, and creativity.

Collaboration occurs across different levels of implementation, in a district level team, a site level team, and a student level team (for Tier 3 care plans). Consider ways to utilize your Multi-Tiered System of Supports system and teaming structure for these activities.

District Team

The district team oversees the Local Education Agency's system including writing and strengthening policy, seeking approval from the board of trustees, ensuring legal and liability considerations are made, and reviewing system level data. The district team should include district level administrators, site level administrators, Specialized Instructional Support Personnel, community and tribal partners, and student and family representation.

Site Team

The site team coordinates the intervention and services array, reviews school, group, and student data, manages referrals, and ensures fidelity of implementation within the system. The site level team should include the responsible site administrator, Specialized Instructional Support Personnel, teachers and paraprofessionals responsible for implementing universal supports and conducting screening and data reviews.

For example, a high number of referrals for freshman girls experiencing anxiety during the first six months of school could lead to creating support groups and curricula implemented across a class that all freshmen are taking.

Activities for this team include tracking student data and outcomes of referrals and services, screening students for behavioral health risks, and allocating early intervention and prevention services.

Student Team

The student level team oversees the referrals and implementation of care plans for specific students receiving Tier 3 services. Members of this team include the Specialized Instructional Support Personnel working with the student, community partners working with the student, parents, and the student to the extent they are able to participate in their care planning. This team should have regularly scheduled meetings to discuss student progress, review data, and create and update the Plan of Care documents. The team may also invite other school staff at times to discuss how supports can be integrated into the classroom and home environments. These meetings allow the team to share data (while ensuring confidentiality) to ensure that the student is accessing the needed services to resolve the areas of concern.

FUNDING & SUSTAINABILITY

One of the chief barriers to creating comprehensive School-Based Behavioral Health systems is identifying funding streams that support interventions throughout the three tiers of intervention — from school-wide support to intensive treatment services. Districts and schools need to plan for sustainability when receiving funding for the School-Based Behavioral Health program. A fantastic program is often implemented, only to end once the time-limited grant has run out.

Currently, there is no national or state model for funding these services. While available funding is mainly federal and state, many decisions about using funding and what services to prioritize will happen at the Local Education Agency level. So, there may be examples of how different counties and school districts across Nevada sustain behavioral health services; however, there is no one "best" way to maintain these services.

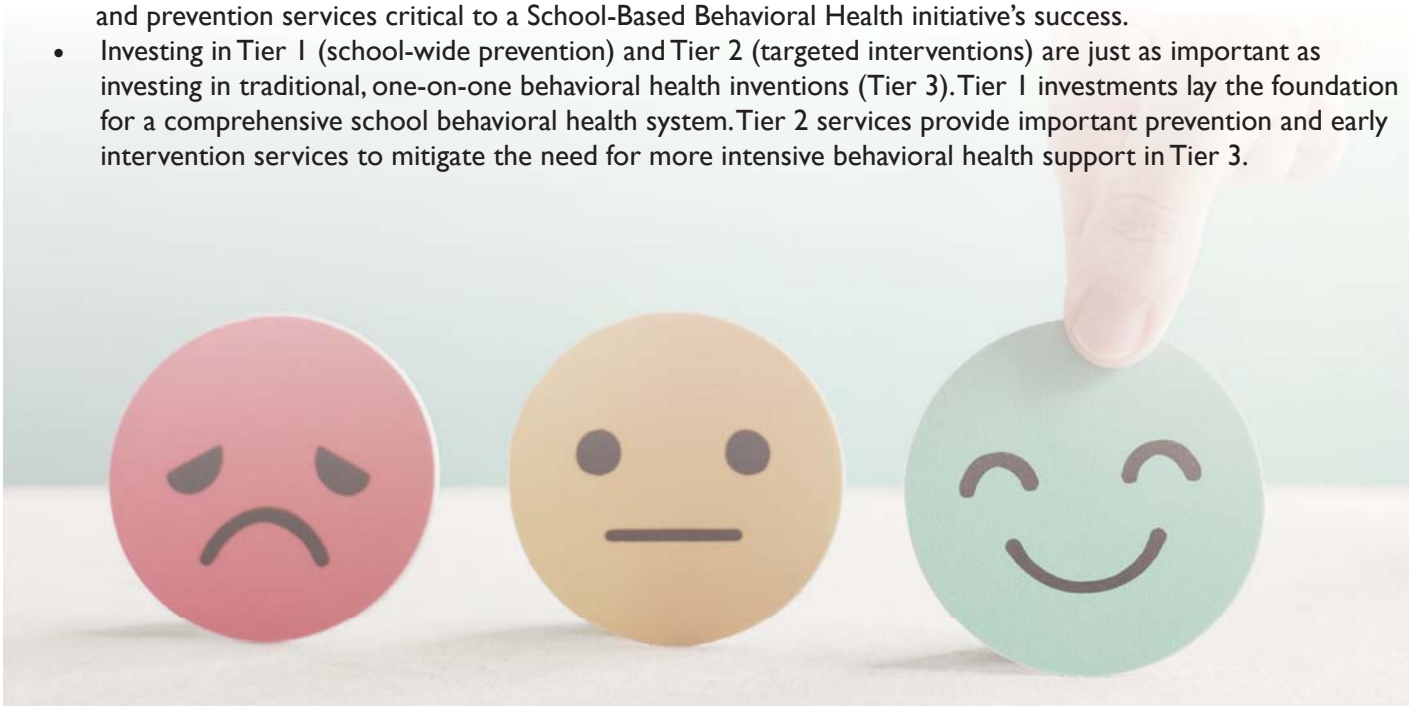
The resources in this section will help you (1) learn about the available funding streams to sustain school behavioral health services and (2) learn about what others have done to sustain school behavioral health programs. Remember, what works in one place may not work in another. However, there are innovative and varying sustainability strategies to garner inspiration from.

Things to consider while identifying your sustainability plan:

- Investing funding and resources that create the critical infrastructure and leverage outside resources. This can sometimes appear to counter the immense need we see in schools for direct services for students. When schools invest in this infrastructure, they can be better positioned to navigate various community providers who may be able to draw down additional funding.
- Utilize flexible funding streams to fill in the gaps between services sustained by more restrictive funding sources. There are funding streams that are more restrictive (i.e., they can only be used for specific services provided by select providers for a particular group of students). There are also funding streams that are more flexible. For example, you may choose to utilize flexible funding for non-NV Medicaid students, staff training and prevention services critical to a School-Based Behavioral Health initiative's success.
- Investing in Tier 1 (school-wide prevention) and Tier 2 (targeted interventions) are just as important as investing in traditional, one-on-one behavioral health inventions (Tier 3). Tier 1 investments lay the foundation for a comprehensive school behavioral health system. Tier 2 services provide important prevention and early intervention services to mitigate the need for more intensive behavioral health support in Tier 3.

QUICK TIP

Suppose you benefit from a grant to build out your School-Based Behavioral Health initiative; use that time-limited grant to create a "runway" to sustainability. Use funding to support your services and staff as you identify and address billing and reimbursement challenges while seeking new partners or additional funding avenues.



Resources for Funding and Sustainability

How to Start Billing Medicaid for SHS Onboarding Guide (NV Medicaid) – A resource that outlines and explains the public behavioral health funding streams (on the education side and healthcare side) in Nevada that can support the entire continuum of School-Based Behavioral Health.

State Funding for Student Behavioral Health in Schools (Education Commission of the States) – A policy brief to help support State Educational Agency, Local Education Agency, and schools to locate common funding from federal and state sources.

QUICK TIP

This toolkit is not intended to outline a linear process. Many schools have found success with action items in many different areas of their system as they build their plan for an effective continuum of services and supports.

School Behavioral Health Financing (Behavioral Health Technology Transfer Center Network) – This resource highlights school behavioral health financing, including infographics, and free webinars for financing school behavioral health services.

NV Medicaid School-Based Health (NV Division of Healthcare Financing and Policy) – This website gives access to the clinical policy team that oversees School-Based Behavioral Health services in Nevada.

PLAN INTENTIONALLY WITH A NEEDS ASSESSMENT

Schools have not traditionally provided School-Based Behavioral Health so you may not be sure where to start. In order to support these children so they can learn in school, consider the available resources and the opportunities for growth. Conducting a needs assessment will help guide your district and schools in choosing a starting point and planning action steps as you identify, prioritize, and address the gaps in school-based behavioral health services.

Resources for Needs Assessment

How to Start and Sustain a School Health Initiative (Alameda County Center for Healthy Schools and Communities) – A step-by-step guide through the stages it takes to implement an initiative, specifically, gathering a team of champions and understanding assets and needs.

Chapter 2: Community Planning, Vision to Reality (California School-Based Health Alliance) – A guide for collecting needs assessment data, including sample surveys and focus group questions, and a process for creating and maintaining youth engagement within the planning process.

School-Based Behavioral Health Assessment (Alameda County Center for Healthy Schools and Communities) – A guide on types of data to gather and how to conduct an assessment on behavioral health needs to develop a plan for increasing behavioral health services.

Youth Engaged in Leadership and Learning: A Handbook for Program Staff, Teachers, and Community Leaders (John W. Gardner Center for Youth and Their Communities, Stanford University) – A comprehensive handbook for guiding youth advocates and the adults who work with them on engaging young people in participatory research, analysis, and planning

School-Based Behavioral Health: Conditions for Success School Sites – A checklist of school site conditions for success, specifically when integrating a community-based behavioral health provider within the school campus.

School-Based Behavioral Health Conditions for Success for Districts – A checklist for Districts to ensure success in implementation.

Assessment Tools:

SHAPE System (National Center for School Behavioral Health) – An online tool to assess the existing structure and operations of school behavioral health systems.

ISF District/Community Leadership Team Installation Guide – A guide used by facilitators and coaches to support district/community leadership teams in installing infrastructures for an interconnected system framework.

PART 2.
IMPLEMENTING SCHOOL-BASED BEHAVIORAL HEALTH

DEVELOP A REFERRAL PATHWAY

To implement School-Based Behavioral Health you need a systematic way of identifying and allocating resources. It is essential for Specialized Instructional Support Personnel and school-based qualified behavioral health professionals to use their skills collaboratively to implement the necessary universal and tiered supports. This clear process is called a "referral pathway".

WHO ARE SPECIALIZED INSTRUCTIONAL SUPPORT PERSONNEL?	WHO ARE QUALIFIED BEHAVIORAL HEALTH PROFESSIONALS?
School Counselors School Psychologists School Social Workers School Nurses	Licensed Clinical Social Workers Licensed Marriage and Family Therapists Licensed Professional Counselors Clinical Interns **Including community providers contracted with the district or school*

School-based qualified behavioral health professionals must plan services based on:

- Student diagnosis
- Need
- Available interventions and services at their site

The Multi-Tiered System of Supports team will work together with the clinical provider to ensure the student's needs are addressed. A referral pathway will give you the structure to fluidly and flexibly plan needed services to specific student needs. Successful integration of School-Based Behavioral Health services requires a genuine commitment and ongoing support from all stakeholders, so building the referral pathway as a team will be the most effective approach.

You will find an example of how to develop a referral pathway here.

The referral pathway assists the school behavioral health service providers to correctly identify, plan and deliver interventions aligned with the student's progress goals. When planning a referral pathway process, consider the ways it aligns with existing tiered programs and interventions already provided at the school site.

Substance Abuse and Mental Health Services has developed a Referral Pathways Toolkit that can help set a protocol for referrals in your education environment.

MAKING REFERRALS

School-Based Behavioral Health services are not the same as private community counseling or non-clinical behavioral health services provided in the schools. School-Based Behavioral Health uses the whole school, whole community, and whole child strengths-based framework to evaluate and assess at-risk students for Tier 3 services.

QUICK TIP

Use multiple sources of data when determining appropriate support and interventions for a student. This will help you ensure that the services provided are matched with the student's presenting needs.

School-Based Behavioral Health services may be needed when a child is facing an acute need, even if they haven't moved up through the lower tiers, so referral pathways must account for different referral sources (e.g. lack of response to intervention, parent referral, acute life events). These needs are determined based on data and evidence, to ensure equity.

Tier 3 clinical assessment should be considered when a student's educational success is moderately to severely impacted by the students internalizing or externalizing behaviors, or their symptoms are escalating, despite early intervention through Multi-Tiered System of Supports.

In addition to establishing a referral pathway, districts/schools will need to develop referral documents.

Here are some examples of referral forms to consider:

- Sample Staff Referral
- Sample Parent or Guardian Referral
- Sample Referral Form: Self or Peer

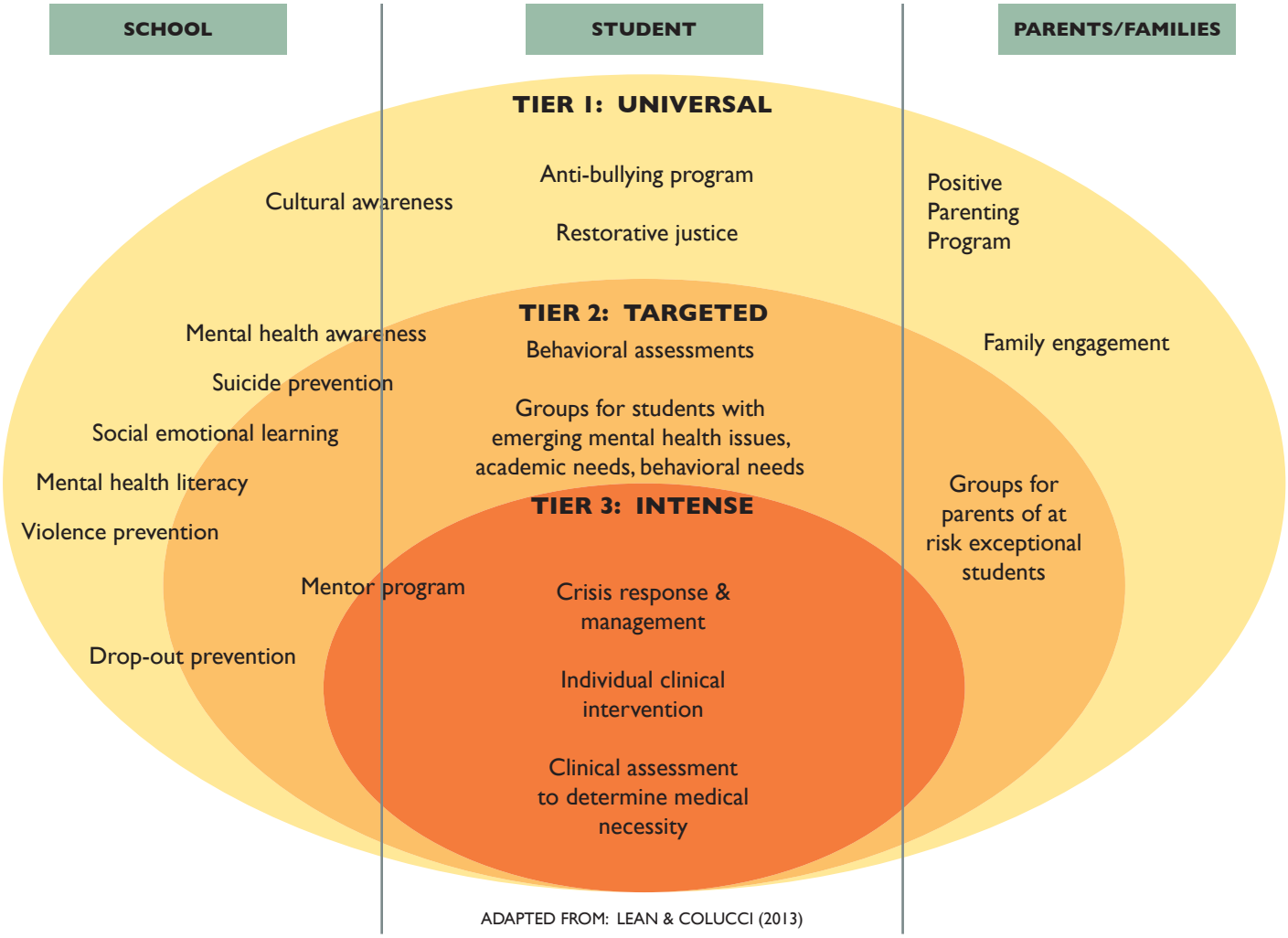
DEVELOP A SERVICE ARRAY & CONTINUUM OF SUPPORTS

The figure on page 17 shows examples of interventions that teams can use to support students, school staff, parents, and families at all three Multi-Tiered System of Supports tier levels.

To build a service array and continuum of supports, inventory existing services

1. Who provides the service (Example of interventions & service provider)
2. When?
3. How is it measured?
4. What are the entry & exit criteria for students to receive this service or support?

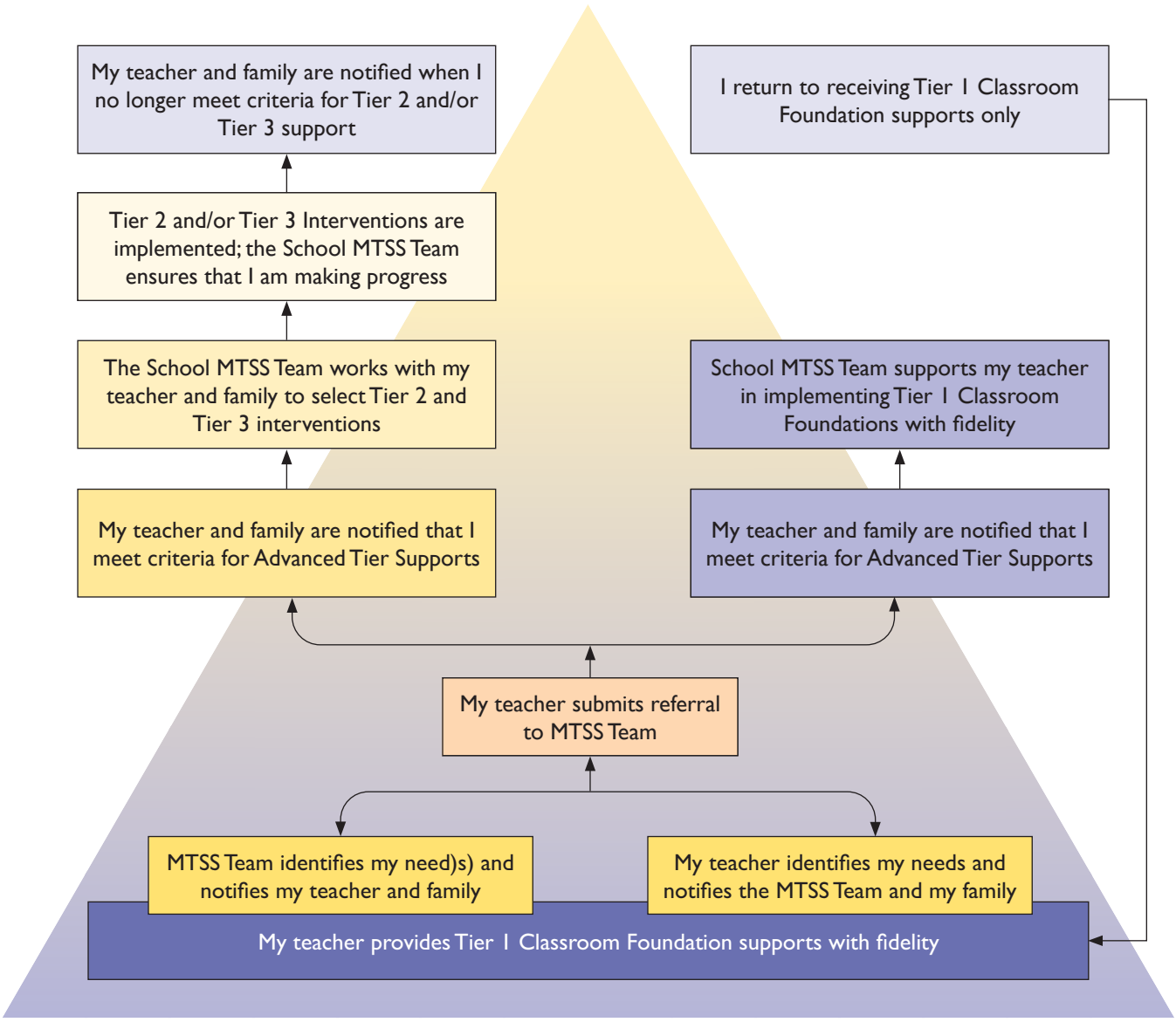
Note this is not an exhaustive list but an example of interventions that schools can use. Districts/schools should complete resource mapping to determine the resources available in your community and at your school site. Here is an example your team can use for resource mapping.



ADAPTED FROM: LEAN & COLUCCI (2013)

Student Example: Data collected on Sam shows that he requires individual Tier 3 interventions for his difficulty paying attention in class. Data taken on the whole class showed that Sam also needs Tier 2 intervention in a small group to help him develop more appropriate social skills. The data also showed that the majority of children in Sam's grade would benefit from revisiting the whole-school Tier 1 intervention for bullying prevention.

MTSS Flowchart: Student Experience



Remember, services are tiered, not students!
A child may be enrolled in a Tier 3 intervention, but the child is not a "Tier 3 Kid".

IDENTIFY ENTRANCE & EXIT CRITERIA

Districts and/or schools should clearly define the service entrance and exit criteria for Tier 2 and 3 services. Developing a rubric will help ensure equity, and aligns with data-based decision making, and is appropriately matched to student needs and specific concerns. Here is an example of entrance and exit criteria.

STUDENT ELIGIBILITY & REQUIREMENTS

For a student to be eligible for School-Based Behavioral Health services, the student must meet the following criteria:

1. Enrolled in public school or a participating district or state charter
2. Under the age of 21
3. Meets the criteria for medical necessity
4. A referral has been made for School-Based Behavioral Health according to the referral pathway established by the district

All students who meet the above requirements can be provided School-Based Behavioral Health services free of charge, regardless of whether they are enrolled in Nevada Medicaid. Schools will provide the same services and documentation to all students who qualify as medical necessity and would benefit from School-Based Behavioral Health services.

Nevada Medicaid will reimburse districts if the student is enrolled in Medicaid at the time of service. If a district has an electronic health record system, the system will track eligibility and bill when applicable. Schools do not need to verify Medicaid eligibility, and individual school providers do not need to know a student's insurance status if they are using an electronic health record to document behavioral health services in.

SCREENING

It can be hard to help students if you do not know who needs the extra support. Screening for and early identification of potential problems are crucial first steps in promoting behavioral health. The gold standard is to screen ALL students for behavioral health concerns and ensure educators and staff know how to recognize early signs and symptoms of behavioral health concerns (Anderson et et., 2019; Naser et al., 2018).

Multi-Tiered System of Supports includes universal screening as one of the core features at Tier 1. Screeners are one source of data to determine if a student warrants a higher level of support or further assessment.

Universal Screening

Universal screening conducted at Tier 1 identifies students who have additional risk factors. The students identified in these screenings can then access greater support at Tier 2 and Tier 3.

It should NEVER be the case that a single individual is responsible for managing all School-Based Behavioral Health tasks.

Considerations for Universal Screening

- Should academic and behavioral screening be integrated?
- Capacity to address student needs identified by a screener? (includes referral network)
- Personnel to coordinate screening, interpret results and make service recommendations?
- Will school board approval be required?
- How to communicate with families about the screening? parent-teacher association/parent-teacher organization groups?
- Will family consent be required?
- Which grade levels will be included? All? Just transition grades (e.g., 6, 9)?
- How will schools share data with districts? How will districts share data with the county?
- What training will be provided to staff?
- In an emergent behavioral health situation, ensure your school has a crisis protocol to respond to student

Selecting a Screening Instrument

- Is it valid, adequately normed, reliable, and culturally responsive?
- Does the screener cover the desired content areas?
- Is the developmental level appropriate?

Resources for Universal Screeners

- Comprehensive, Integrated, 3-Tiered Model of Prevention: Systematic Screening
  Includes resources related to the free Student Risk Screening Scale – Internalizing and Externalizing
- Indiana Department of Education Universal Screening Toolkit
- From pbis.org: Communicating with your community about systematic screening
- From the Substance Abuse and Mental Health Services Administration: Ready, Set, Go, Review: Screening for Behavioral Health Risk in Schools Includes a comparative review in the Appendix III
- National Center for School Mental Health Quality Guide: Screening
- Missouri School-wide Positive Behavior Support: Tier 2 Workbook and Resources
  –The Student Identification Process chapter is particularly helpful

Targeted Screening

Targeted screeners are used to screen individuals or cohorts of students who have behavior, data, or referrals (such as a parent request for help) indicating concerns are present.

Targeted screeners, such as the Behavioral Health Screening and Level of Care Utilization System/Child and Adolescent Service Intensity Instrument are more than an information gathering process. The screening and assessment are the first steps in building a trusting and therapeutic relationship between student and clinician. It is also an important beginning point of understanding and appreciating who the student is and the interrelationship between the student's symptoms/behaviors and the student as a whole person.

A LOCUS/CASII score is required to seek reimbursement through Medicaid Services Manual 2800/Provider Type 60.

Resources for Screening, Identifying, and Referring Students

For regional or county teams:
How to Start and Sustain a School Health Initiative – A step-by-step guide through the stages it takes to implement an initiative. Specifically, this includes creating a plan, formalizing agreements through contracts, and creating high-level strategies.

For school district or school site teams:
School Behavioral Health Quality Guide: Teaming (National Center for School Behavioral Health) – A guide with background information on teaming, best practices, possible action steps, examples from the field, and resources.

Advancing Education Effectiveness: Interconnecting School Behavioral Health and School-wide Positive Behavior Support (Center on Positive Behavior Interventions and Supports) – This guide provides a framework to connect school behavioral health services with Positive Behavior Interventions and Supports. It includes many resources and tools for developing the systems, collaborations, and practices to do this work. Some helpful tools for partnerships include:

- Appendix B, Building an Inclusive Community of Practice – Four Simple Questions (page 144)
- Appendix E, Implementation Guide: District and Community Cross Systems Team (page 150)

Active Implementation Hub (National Implementation Research Network) – An online learning environment for use by any stakeholder involved in active implementation and scaling up of programs and innovation. Some specific tools:
Module 3: Implementation Teams

Example of team agendas:
Monterey County's ISF Leadership Team Calendar – An example of the discussion topics and content covered at monthly leadership team meetings. This is a helpful resource for considering how to onboard members and build a monthly calendar of coordination meetings.

Sample of School-Based Behavioral Health Referrals:
Sample Staff Referral
Sample Parent or Guardian Referral
Sample Referral Form: Self or Peer

Clinical assessments:
School Wellness Clinical Assessment
Children's Uniform Behavioral Health Assessment
Children & Adolescent Service Intensity Instrument
CASII Dimensions Score Sheet
CASII Scoring Sheet PDF

Establish a Referral Pathway Cheat Sheet – A cheat sheet was developed to help districts and schools to establish referral pathways for School-Based Behavioral Health Services. Includes sample referral forms, sample Plan of Care, sample Data Assessment Plan progress notes, and sample consent for services and consent to bill for Medicaid services.

PARENTAL CONSENT

You will need parent/guardian consent to provide targeted screeners, assess a student, or plan care.

Informed Consent

Informed consent lays the foundation for the psychotherapy relationship and treatment to come in respecting the client's legal rights and offering her or him the opportunity to make an informed decision about participating in the treatment to be offered.

- It is a collaborative process that sets the tone for the psychotherapy relationship, promoting an enhanced therapeutic alliance
- It promotes shared decision-making power in the relationship
- It promotes the client's autonomy and empowers the client to play an active role in her or his treatment
- It minimizes the risk of exploitation of, and harm to, the client through this information sharing and collaborative decision-making process

Consent to Assess

Targeted screeners and clinical assessments require informed consent from the parent before being conducted.

Consent to Seek Reimbursement

Ensure you have the correct release of information forms under the Health Insurance Portability and Accountability Act of 1996 or the Family Educational Rights and Privacy Act to seek reimbursement for School-Based Behavioral Health services from Medicaid.

- Consent to bill for Medicaid services is a Family Educational Rights and Privacy Act regulation (Consent to bill for Medicaid Spanish form)
- Consent to work with outside community agencies is Health Insurance Portability and Accountability Act of 1996 and Family Educational Rights and Privacy Act

Consent to Treat

Ensure you have consent to treatment forms signed by the parent to deliver School-Based Behavioral Health services.

- Sample 1 Consent for School-Based Behavioral Health Services
- Sample 2 Consent for Therapeutic Services
- Sample 3 Consent.docx – Google Docs

PROTECTING PRIVACY

Health information is regulated by different federal and state laws, depending on the source of the information and the entity entrusted with the information. The Family Educational Rights and Privacy Act and the Health Insurance Portability and Accountability Act of 1996 are two examples of federal laws that regulate privacy and the exchange of specific types of information. The work of healthcare providers, school personnel, and others interacts with Family Educational Rights and Privacy Act and Health Insurance Portability and Accountability Act of 1996 frequently, which is why it is important to understand these laws and know when they apply.

Health Insurance Portability and Accountability Act of 1996 vs Family Educational Rights and Privacy Act infographic 2018 (cdc.gov)

Health Insurance Portability and Accountability Act of 1996 or Family Educational Rights and Privacy Act? A Primer on School Health Information Sharing in California (National Center for Youth Law) – A printable guide, similar to the web resource above, that helps navigate the complex interactions of Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act in School Health Services programs, including School-Based Behavioral Health, school-based mental health programs, school nursing services, and other types of health services delivered on school campuses.

ASSESSMENT

The Comprehensive Biopsychosocial Assessment is required for School-Based Behavioral Health, and must be completed in one session and contain:

I. School-based qualified behavioral health professional, when to break student confidentiality

A. Exceptions
   1. School-Based Behavioral Health professional must report if the student is going to harm themselves or someone else follow District protocol for suicidal ideation and crisis intervention
   2. Someone is hurting the student
   3. The student is going to gravely hurt someone else
   4. The student gives you permission to share with others
   5. Mandated reporting requirements for child and elder abuse/neglect

B. Complies with both requirements of Family Educational Rights and Privacy Act & Health Insurance Portability and Accountability Act of 1996

II. Documentation of informed consents obtained

A. Documentation that clinician has informed the student of the risks and benefits to psychotherapy
   1. Your symptoms may improve
   2. Your symptoms may stay the same or may intensify
   3. Your viewpoints may change
   4. Your relationships may change

B. Documentation of discussion of the extent of professional boundaries
   1. Therapeutic relationship is not a friendship; it is a professional relationship established to achieve specific treatment goals

C. Documentation that the clinician has managed student expectations regarding the inherent time-limited nature of therapy

III. Comprehensive psychosocial assessment content

A. Presenting problems and relevant conditions affecting physical and mental health status (e.g., living situation, daily activities, social support, cultural and linguistic factors, and history of trauma or exposure to trauma)

B. Mental health history, previous treatment dates, providers, therapeutic interventions and responses, sources of clinical data, relevant family information, lab tests, and consultation reports, and

C. Physical health conditions reported by the student (must be prominently identified and updated)
   1. Name and contact information for primary care physician
   2. Medications, dosages, dates of initial prescription and refills, if possible
   3. Past and present use of tobacco, alcohol, and caffeine, as well as illicit, prescribed, and over-the-counter drugs
   4. Students' substance use or abuse history including family history

D. Special status situations and risks to student or others (e.g., emancipated minor student; fall/seizure precautions; threats made to others);

IV. Full diagnosis consistent with the presenting problems, history, mental status examination, and/or other clinical data, and;

V. For children and adolescents, prenatal events, and complete developmental history

A. Any complications or health conditions during pregnancy/gestational period?

B. Natural birth, c-section?
   1. Any birth trauma?

C. Were developmental milestones within the normal range? Any developmental milestone that was not within normal range? (Use District approved psychosocial assessment and health screening)

D. Results of any previously-completed psychological/developmental/neurological assessments

VI. Student strengths in achieving goals

Examples of Clinical Assessments

School Wellness Clinical Assessment
Children's Uniform Behavioral Health Assessment

Medical Necessity

From Assessment to Discharge – all services must be based on medical necessity. This means that every service provided to the student/family is medically necessary to support the student/family in their path to recovery and restoration of functioning.

This principle underscores the importance of good clinical documentation and why simply providing incidental "emotional support" to the student is not enough.

When considering a student's need for treatment, consider the following:

LIFE FUNCTIONING	IMPAIRMENT CRITERIA	INTERVENTION-RELATED CRITERIA
During the assessment process, the clinician should identify and document the student's areas of life functioning impacted by their behavioral health such as: • Problems with primary relationship group • Problems related to the social environment • Educational problems • Occupational problems • Housing problems • Economic problems	**The student must have at least one of the following as a result of the mental disorder identified in the diagnostic criteria:** • A significant impairment in an important area of life functioning, or • A probability of significant deterioration in an important area of life functioning, or • Children also qualify if there is a probability the child will not progress developmentally as individually appropriate.	**All three criteria below must be met:** • The focus of the proposed intervention is to address the condition identified in impairment criteria and; • It is expected the proposed intervention will benefit the student by significantly diminishing the impairment, or preventing significant deterioration in an important area of life functioning; and/or for children it is probably the child will be enabled to progress developmentally as individually appropriate, and; • The condition would not be responsive to physical healthcare treatment.

Medical necessity is established through the clinician's thorough analysis and documentation of the Behavioral Assessment, Biopsychosocial Assessment, LOCUS/CASII assessment, and is presented in the Plan of Care. In order for the results of the three assessments to indicate medical necessity for treatment, three criteria must be established and documented: deficiencies in areas of student life functioning, impairment criteria, and intervention-related criteria.

Diagnosis

Included in professional licensing standards, school-based qualified school behavior health professionals are expected to be competent in clinical assessment and diagnosis. Clinical assessment and mental health diagnoses serve several practical purposes. They can help clinicians:

- Coordinate care with other professions;
- Decide how best to keep students and the public safe
- Determine the need for referrals and additional services, and
- Help identify potential courses of treatment

Diagnostic language provides a relatively simple way for a wide range of medical and mental health professionals to serve the same student. In addition, certain diagnoses are known to be correlated with specific crisis issues, such as depression and suicide and self-harm; as such, diagnosis can help clinicians remember to screen for potential crisis and enable them to more effectively assist students seeking additional resources. Furthermore, certain diagnoses have a well-established research base that helps the clinician identify a preferred treatment method, such as behavioral interventions for phobias.

The clinician should be sure to utilize DSM-5/ICD-10 diagnostic codes, as some insurance companies may not reimburse for services documented using the previous DSM-IV/ICD-9 codes.

PLAN OF CARE

School-Based Behavioral Health require a treatment plan, called a Plan of Care. Plans of Care must be *reviewed* at least every 90 days. For children and adolescents, plans of care must be *updated* every year at a minimum or when indicated by student progress or lack thereof; students age 19-21 treatment plans must be *updated* every two (2) years at a minimum, or when indicated by student progress or lack thereof.

Components of the Plan of Care

The Plan of Care contains the following components, which reflect the elements and processes required to fulfill regulatory requirements as well as to facilitate best clinical practice.

- Medical necessity (DSM Diagnosis/Health Condition)
- Start and end dates (duration)
- Plan of Care is written for no longer than one year
- Plan of Care can be reviewed and renewed annual or more often as is medically necessary
- Frequency (How long and how often will you meet with the student) Start and end times
- Type of treatment (services/interventions)
- Who will provide services/interventions within their scope of practice (QMHP/QMHA/QBA)
- Goals (Include long-term goals and short-term benchmarks/objectives)
- Progress evaluation over time (monitor improvement toward goal per session/group)
- Strengths
- Obstacles/weaknesses
- Discharge plan

Student's signature

Parent/guardian signature

Clinician signature, with license

Clinician supervisor signature

Qualities of an Effective Plan of Care

CULTURALLY RELEVANT: The plan should take into consideration all types of cultural issues to arrive at a meaningful understanding of the student's world view. These considerations include ethnicity but are expanded to include family of origin, traditions and holidays, religion/spiritually, education, work ethic, etc.

CLIENT-CENTERED: The plan should be written in a way that is culturally-sensitive and personally relevant. The plan is developed in collaboration with the student and uses language that is understandable and is acceptable to the student.

STRENGTHS-BASED: The plan identifies strengths of the student and utilizes student strengths to reduce barriers. The plan focused on the student's competencies as well as what the person needs to do to overcome impairments.

REALISTIC: An effective treatment plan reflects "where the student is at." For example, if a student is in the early stages of change, the objectives should be reasonable and consistent with the student's willingness and ability to accomplish them within a 90-day period.

Sample Plan of Care

A sample of a Plan of Care can be found here and https://doe.nv.gov/SafeRespectfulLearning/School_Based_Behavioral_Health_Toolkit/.

GOLDEN THREAD

The Golden Thread is the consistent presentation of relevant clinical information throughout all documentation for a client. The Golden Thread begins with an intake assessment that clearly identifies an appropriate clinical problem and corresponding diagnosis. Next, the Plan of Care should reflect a clear series of goals for helping the student/client through the identified problem. Each goal should have specific interventions prescribed that reflect best practices and evidenced-based treatments to help guide the student/client along the path to recovery. Finally, the Golden Thread includes progress notes that demonstrate that the services you deliver match what was prescribed in the Plan of Care. Each note should lead into the next, creating a comprehensive story of the client's progress through treatment.

The Golden Thread is not only important for compliance and reimbursement, but it can also be an important tool for delivering quality care.

INTERVENTIONS

Tier 2 Interventions

Tier 2 interventions and supports are lower intensity, or group-based services that are selected as part of the Plan of Care to resolve challenges related to a student's diagnosis.

Tier 2 Intervention Example: A child with ADHD may have difficulties waiting for attention from adults, taking turns, or listening to the perspectives of their peers. Through a basic skills training group the child can learn and practice skills live with other children.

Evidence-based Tier 2 interventions include a skill-based learning component and a measurement component, and follow the golden thread aligning diagnosis criteria with treatment planning, intervention delivery, and measurement of growth.

These services may be delivered individually or in a small group setting with others who have similar intervention needs, and when group dynamics or social skills development are critical features of the intervention and the child's presenting needs.

QUICK TIP

Which interventions you choose to add to your Tier 2 continuum of services will depend on our staff, their scope of work, and the types of services they can confidently and competently delivery.

Tier 2 Clinical Intervention Modalities

The following are examples of some of the possible clinical Tier 2 intervention options.

Mindfulness-Based Cognitive Therapy

Mindfulness-Based Cognitive Therapy is a manualized, group program for treating mood disorders, stress related disorders, and bipolar disorder using cognitive-behavioral techniques and mindfulness skills, helping participants identify false beliefs or unhelpful thought patterns and engage with mindfulness behaviors instead.

Mindfulness-based Stress Reduction

Mindfulness-based Stress Reduction is a manualized, group program for treating anxiety, depression, stress, eating disorders, PTSD and chronic pain using a combination of mindfulness activities and yoga.

Multidimensional Family Therapy

Multidimensional Family Therapy is a manualized, family-based treatment and substance abuse prevention program developed for adolescents with drug and behavior problems and delinquency. It is typically delivered in an outpatient setting, though it can also be used in inpatient settings.

Skill Development Group Sessions

The goal of social skills group therapy is for children to gain skills in social interaction, joint attention, having fun together with others, problem solving together, and learning to handle the challenges of social situations at school, extracurricular activities and at home. Social skills groups may be used to treat symptoms and concerns arising from diagnoses like ADHD, Autism, ODD, depression and anxiety. For example, social skills groups may address communication skills needs, self-regulation needs, social-awareness and empathy, impulsivity, or other targeted needs. Social skills groups enable role playing and practice in a semi-structured setting with real peers.

Skill Development individual Sessions

Low intensity concerns that have potential to increase in intensity may respond to short-term, focused skill development sessions as an early intervention. Skills deficits that resolve student distress related to a life event, peer conflict, or other concerns can be addressed through services delivered by a trained individual implementing a program, such as a workbook or scripted skills sessions to build skills and resolve distress. These may fall under Tier 2 as they are low intensity, short-term, and focus on quickly resolving a need.

Targeted Case Management

Targeted Case Management is to address children's mental, physical, and behavioral health needs by advocating for children and families' rights and needs, Linking children and their families to community resources and services as needed, increasing natural support systems, coordinating with other providers using a team approach to monitor ongoing needs and progress, helping to make positive changes in family functioning for all participating family members, provide supported referrals to community resources, assist in finding financial resources to help meet the safety needs of children and their families.

Targeted, Short-Term Therapeutic Support Groups

Short-term groups that meet acute or incidental needs such as a loss, death or traumatic event in a community. For example, a grief support group offers a different quality of support and connection that comes from being with people who have also recently experienced a loss. Grief support groups provide emotional support, validation, and education about grief. The type and focus of short-term support groups should be undertaken only by staff with training and a scope of work encompassing the topic of the therapy group.

Evidence-Based, Tier 2 Non-Clinical Interventions and Supports

Some examples of evidence-based Tier 2 psychoeducational support that complement therapeutic activities may include some of these options (*remember to tailor your offerings to the needs of your students and the competencies of your Specialized Instructional Support Personnel workforce*).

Check In/Check Out

Check In/Check Out is a highly effective research-based, non-clinical intervention and can be changed and adapted to suit any school or situation. The program consists of students daily checking in with an adult at the start of school to retrieve a goal sheet and encouragement, teachers provide feedback on the sheet throughout the day, students check out at the end of the day with an adult, and the student takes the sheet home to be signed, returning it the following morning at check in. Check In/Check Out is a non-clinical intervention, but the data derived from Check In/Check Out can be used to demonstrate whether skills learned in therapy are generalizing out through behavior and self-management improvements in the classroom.

Flexible Seating/Workspace

Children with sensory needs or difficulty focusing may benefit from flexible seating or soft spaces in the classroom where they can engage in classroom activities from a more comfortable or quiet setting. Having an area where children can opt to move for a time away break, or access movement opportunities can support participation in the classroom, especially for children with dysregulated moods, Autism, or ADHD.

Friendship Groups

Friendship groups are semi-structured, open-ended social opportunities that help children who have difficulty making and keeping friends, joining peer interactions, or experiencing loneliness. Informal group supports like friendship groups create safe spaces where children can start to build and increase social connections to peers, which predicts better learning outcomes, cognitive skills, and openness to experience.

Mind-Body Integration & Movement-Based Activities

Children with behavioral health needs often benefit from activities that incorporate mental focus with physical movements. For example, yoga and dance utilize concentration, posture, and muscle tension and relaxation, with increasing demands on physical and mental focus over time. Music, such as wind instruments and choir, incorporate targeted breath work, counting, emotional expression, and sound vibration. Physical sports also work on breathing, physical stamina, and focus. Participation in co-curricular activities that build physical, mental, and emotional skills may complement cognitive- and mindfulness-based clinical interventions.

Parenting Classes

Parent education programs focus on enhancing parenting practices and behaviors, such as developing and practicing positive discipline techniques, learning age-appropriate child development skills and milestones, promoting positive play and interaction between parents and children, and locating and accessing community services and supports.

Pre-teach/Reteach Expectations

For children with difficulties like poor emotion regulation or limited self management skills, as well as those who struggle with impulsivity and lack of focus, additional repetitions of desired and appropriate day-to-day school behaviors can complement a treatment Plan of Care. Non-clinical staff may reteach and help practice psycho-educational and social skills, or skills practiced in therapy to increase repetitions, role play in multiple examples, or practice together in real life school settings.

Structured Recess or Lunch

Structured recess teaches children who show aggressive behavior to play safely in the supportive environment of a small group setting. A staff member takes a group of up to six children assigned to structured recess during the time they would typically have recess. During recess, they spend approximately half of their time discussing the aggressive behavior that took place and why, followed by practice with the specific skill they are trying to build. The other part of the time is spent playing cooperative games where they are given directions and feedback on how to play together safely.

Tier 3 Interventions

Tier 3 interventions and supports are higher intensity, individualized services that are typically delivered in an individual setting over a period of 4-16 weeks. In many cases, Tier 3 individualized services may be combined with Tier 2 services as part of a comprehensive Plan of Care.

Evidence-based Tier 3 interventions include a skill-based learning component and a measurement component, and follow the Golden Thread aligning diagnosis criteria with treatment planning, intervention delivery, and measurement of growth.

Tier 3 Intervention Example: A child with major depressive disorder may benefit from a targeted therapy plan that practices emotion regulation skills through cognitive behavioral therapy.

- *The emotion regulation skills allow the child to function in their activities of daily living as well as their academic and social tasks at school*
- *The intervention selected should be one that is evidence-based to treat the presenting diagnosis, is appropriate for the child's age, developmental skills, and cognitive ability to participate, and utilizes progress monitoring to ensure that treatment is effective*
- *If the child is not making progress, the Plan of Care should be reviewed and modified, including considering modifying aspects of the intervention selected, frequency, duration, or intensity of therapy*

Tier 3 Clinical Intervention Modalities

QUICK TIP

Which interventions you choose to add to your Tier 3 continuum of services will depend on your staff, their scope of work, and the types of services they can confidently and competently deliver.

Acceptance and Commitment Therapy

Acceptance and Commitment Therapy is a mindfulness-based, individualized therapy that teaches people to accept positive and negative experiences as an expected part of the human life, and practices skills to build psychological flexibility, a hallmark of mental health. It is evidence-based for treating anxiety, obsessive compulsive disorder, and mood disorders in a wide variety of populations.

Cognitive Behavioral Therapy

Cognitive Behavioral Therapy is a form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, eating disorders, and severe mental illness. Cognitive Behavioral Therapy helps individuals identify unhelpful behaviors and thinking patterns and learn new skillful ways of responding.

Dialectical Behavior Therapy

Dialectical Behavior Therapy is a behavioral treatment that was developed to treat complex and difficult problems of mental illness, including suicidal behavior and treatment resistant conditions. It is frequently used to treat the emotional dysregulation and inappropriate coping skills seen in non-suicidal self injury, bipolar disorder, and borderline personality disorder. It utilizes elements of other therapies, including acceptance and mindfulness, exposure-based programs, cognitive techniques, behavioral contingencies and problem solving skills.

Exposure and Response Prevention

Exposure and Response Prevention is a robust cognitive therapy approach to obsessive, repetitive, or intrusive thoughts and resulting avoidance behaviors, such as in conditions like Obsessive Compulsive Disorder, phobias, or certain traumatic experiences. The therapist facilitates the person in learning to not respond to the obsessions with the usual compulsive or avoidant behaviors, to tolerate settings that would normally trigger these thoughts, and to reduce distress.

Family Therapy

Family therapy is a type of treatment designed to help with issues that specifically affect families' mental health and functioning. It can help individual family members build stronger relationships, improve communication, and manage conflicts within the family system. Some of the primary goals of family therapy are to create a better home environment, solve family issues, and understand the unique issues that a family might face.

Intensive Behavioral Therapy: Tolerance and Delay Training

Tolerance and delay training is a targeted treatment for severe or dangerous problem behaviors occurring in young children. It is a systematic teaching protocol for helping children transition to less-preferred tasks and to use communication skills to access preferred tasks and helps the treating provider identify behavioral attempts at communication quickly before they escalate into dangerous behaviors.

Motivational Interviewing

Motivational interviewing is a collaborative conversation to learn about and strengthen an individual's motivation for changing behavior. Its principles and strategies may be used to enhance relationships and create client directed change for challenging issues. This technique focuses on the individual's personal strengths and encourages them to make decisions that will help them achieve their goals.

Parent-Child Interaction Therapy

Parent-Child Interaction Therapy is an evidence-based treatment for young children with behavioral disorders. It is a combination of play therapy and behavioral therapy for young children and their parents or caregivers. The adults learn and practice new skills and techniques for relating to children with emotional or behavior problems, language issues, developmental disabilities, or mental health disorders.

Parent Training Sessions

When parents become trained in behavior therapy, they learn skills and strategies to help their child succeed at school, at home, and in relationships. Learning and practicing behavior therapy requires time and effort, but it has lasting benefits for the child and the family. Parent training is beneficial for children with challenging behaviors including those related to Autism, ADHD, ODD.

Solution-Focused Brief Therapy

Solution-Focused Brief Therapy is a strength-based approach to psychotherapy based on solution-building rather than problem-solving. Unlike other forms of psychotherapy that focus on present problems and past causes, Solution-Focused Brief Therapy concentrates on the person's current circumstances and future hopes. Through a collaborative approach, the therapist facilitates the person identifying goals and actions to reach them. It may be beneficial when working with addiction, counterproductive habits or behaviors, and relationship skills.

Evidence-Based, Tier 3 Non-clinical Interventions and Supports

These are some examples of effective, non-clinical tools that can support children in maintaining emotional or behavioral self-management. They are individualized to the student, based on need, and complement and support clinical therapeutic interventions as part of a child's plan.

Behavior Contracts

Behavior contracts are a written plan between a child or youth and a staff member. They outline what is expected and what outcomes will happen. In behavior contracting, it is important to focus on strengths and ensure that consequences are followed through. Behavior contracts can be effective when students are willing to work through a written plan and adults are committed to supporting the student in receiving the desired outcomes.

Behavior Intervention Plan

Behavior Intervention Plan are clear written plans for how to modify an environment to support a child's needs. These include prevention strategies, teaching new functional skills to replace a problem behavior, and identifying meaningful ways to acknowledge and reward the child when they make prosocial choices and demonstrate they are acquiring new skills. A Behavior Intervention Plan gives all school staff the same plan for responding to a child's difficult behavior, in ways that align with and support a clinical therapy program.

Check and Connect

Check and Connect is a dropout prevention program for high school students with learning, emotional, and/or behavioral disabilities. Students typically enter the program in 9th grade, and are assigned a monitor (e.g., a graduate student, special education teacher, or community member with experience in human services), who works with them year-round as a mentor, advisor, and service coordinator. The program is overseen at the school level by a program coordinator (e.g., special education coordinator or school psychologist), who provides monitors with regular advice and feedback.

Crisis Intervention Plan

Crisis Intervention Plan are detailed plans that identify each stage of a crisis escalation for a particular child. These plans help school staff identify what each stage of escalation looks like, and how staff should respond at that stage to successfully deescalate the crisis.

Modified Passing Period Schedule

For students with difficulty maintaining behavior during passing periods or high traffic areas with peers, a modified passing period schedule for that student can ensure that the student maintains safe and pro-social behavior. In a modified schedule, the student will transition between classes either right before or right after the rest of the student body. Often, fights or peer problems can derail progress, so a modified passing schedule may help a student build confidence that they can have good days without problem behaviors. This helps stabilize behavior while the student is learning new functional skills in therapy. Once functional skills are in place, the student rejoins the typical passing times.

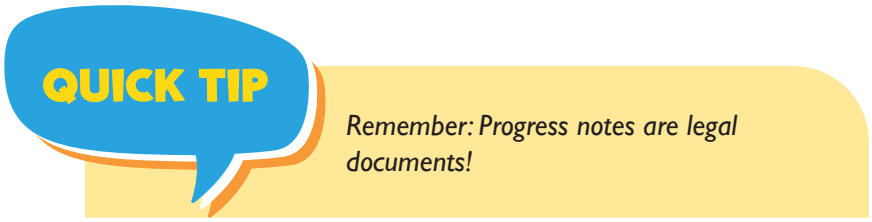
CLINICAL DOCUMENTATION

It is important to carefully document all care provided, including the following items, using the Golden Thread to tie together all aspects of care. Always include these components:

1. Evidence of consents to assess, treat, and seek reimbursement for services
2. The **Behavioral Screening** and **Comprehensive Biopsychosocial Assessment** are the first steps toward establishing medical necessity and provides the foundation for the start of services
3. The **Diagnosis** records the areas of need and supports medical necessity
4. The Behavioral Screening and Comprehensive Biopsychosocial Assessment support clinicians in developing a **Case Conceptualization** that informs the treatment planning process
5. The **Treatment Plan** creates a framework for the services we provide. Together with students, we develop goals and planned interventions that support the student in their recovery.
6. Each **Service** provided links back to an issue identified on a Treatment Plan through the Assessment. Documentation of services includes progress notes and data.

Progress Monitoring

Progress notes must be entered into the care coordination software system within 24 hours of service delivery. Limit the use of abbreviations; when using abbreviations, ensure they are approved and standardized.



What Progress Notes MUST include:

To meet regulatory, compliance, and best practice standards, progress notes MUST:

1. Be related to the student's progress in treatment/treatment plan
2. Provide timely documentation of relevant aspects of care
3. Document
   a. Consumer encounters
      i. Appointments – dates of session and session start/stop times
      ii. Phone calls
      iii. Written correspondence
   b. Interventions
      i. This includes initiation of Mental Health Crisis Holds (formerly known as Legal 2000's)
   c. Follow-up care
   d. Clinical decisions
   e. Consumer response to interventions
   f. New assessment information
      i. New or updated LOCUS/CASII
      ii. Suicide Risk Assessment
      iii. Initial and updated Biopsychosocial Assessments
   g. Referrals to community resources
   h. Signature of the clinician providing the service, including professional degree, licensure and/or job title
   i. Location where services were provided
   j. Clinical supervision and/or consultation received
      i. This documentation should include the student issues that were staffed/consulted upon in supervision and/or consultation
      Example: *"Staffed case with clinical supervisor regarding best practices/evidence-based treatment for student's long-term exposure to traumatic experiences; discussed TF-CBT as a treatment modality and explored referrals to adjunctive therapies in the community, such as eye movement desensitization and reprocessing and neurotherapy."*
   k. If service is provided in a language other than English, state the language used. If an interpreter is used, include the name of the interpreter in the progress note.

Progress Note Format:
The Data Assessment Plan format is considered best practice and meets regulatory compliance guidelines. This format helps to ensure that all of the requirements of the note are met in an efficient manner aimed at the inclusion of *maximum essential content* with *minimum investment of valuable clinician time*. This format also enables clinicians to utilize progress notes as a communication tool that will provide a clear picture of student services, and status for continuity of care and establishment of medical necessity.

D = DATA What does the student present with this session?

A= ASSESSMENT What did you, the clinician, do this session to address the student's presenting problem/symptoms? How did the student (and others present) respond to your interventions this session?

P = PLAN As the clinician directing treatment, what is your plan going forward and how does that relate to the presenting problem/symptoms/treatment plan goals?

COORDINATION OF CARE

Coordination of care is a systematic approach to case management using a team-based approach. Well-coordinated care ensures services are extended to students using a system of care framework that meets the child's presenting needs and aligns with the child and family's values and goals. Additionally, care coordination ensures there is no duplication of services or activities but rather a collaboration between School-Based Behavioral Health and community-based behavioral health services when both are in place.

Targeted case management is a way of ensuring the implementation and fidelity of School-Based Behavioral Health systems, including Tier 2 and 3 interventions as well as classroom or school supports. For example, in a coordinated system, a student needing extra time to self-regulate can be provided space and opportunity within the classroom environment. This enables them to practice skills learned in a skill-based training group or individual therapy in a true to life environment.

EXITING A PLAN OF CARE

The student's treatment plan must include criteria for their eventual exit. Articulate how the clinician and the youth, or their legal guardian(s) will know when treatment objectives have been achieved and termination of the treatment relationship is indicated.

Discharge Plan

A "Discharge Plan" is part of the treatment plan and describes how services will be ended. This is completed at the beginning of treatment, and is different than the "Discharge Summary" completed at the conclusion of treatment and notated in the progress notes.

Even though the beginning of treatment may seem too soon to be thinking about the end, all treatment plans must contain a plan for the student's eventual exit.

The Plan Must Contain:

- Anticipated duration of overall services
- Discharge criteria
- Required aftercare services and plan for accessing those services
- Agencies/providers expected to be involved

Discharge Summary

The discharge summary is the exit summary completed at the end of services. It must include the following:

- The last service contact with youth
- An explanation of reasons for exit, current level of functioning, and recommendations for further treatment (aftercare)
- Documentation of the youth's diagnosis at admission and termination
- A summary statement that described the effectiveness of treatment modalities, as defined by progress towards treatment goals and objectives

Completion of Plan of Care

When exiting a student from services, there is demonstration that they have returned to baseline levels of functioning. Sometimes, this means interventions and supports have been scaffolded, moving the child systematically from more intense, higher tiered services to lower tiered services and finally restored to independent functioning.

RECOMMENDATIONS FOR SCHOOL-BASED CARE COORDINATION SOFTWARE

All of the components outlined within this toolkit are easily accessible within a comprehensive school-based care coordination platform.

When considering purchasing a district software platform consider the systems capacity for the following:

Technical Requirements

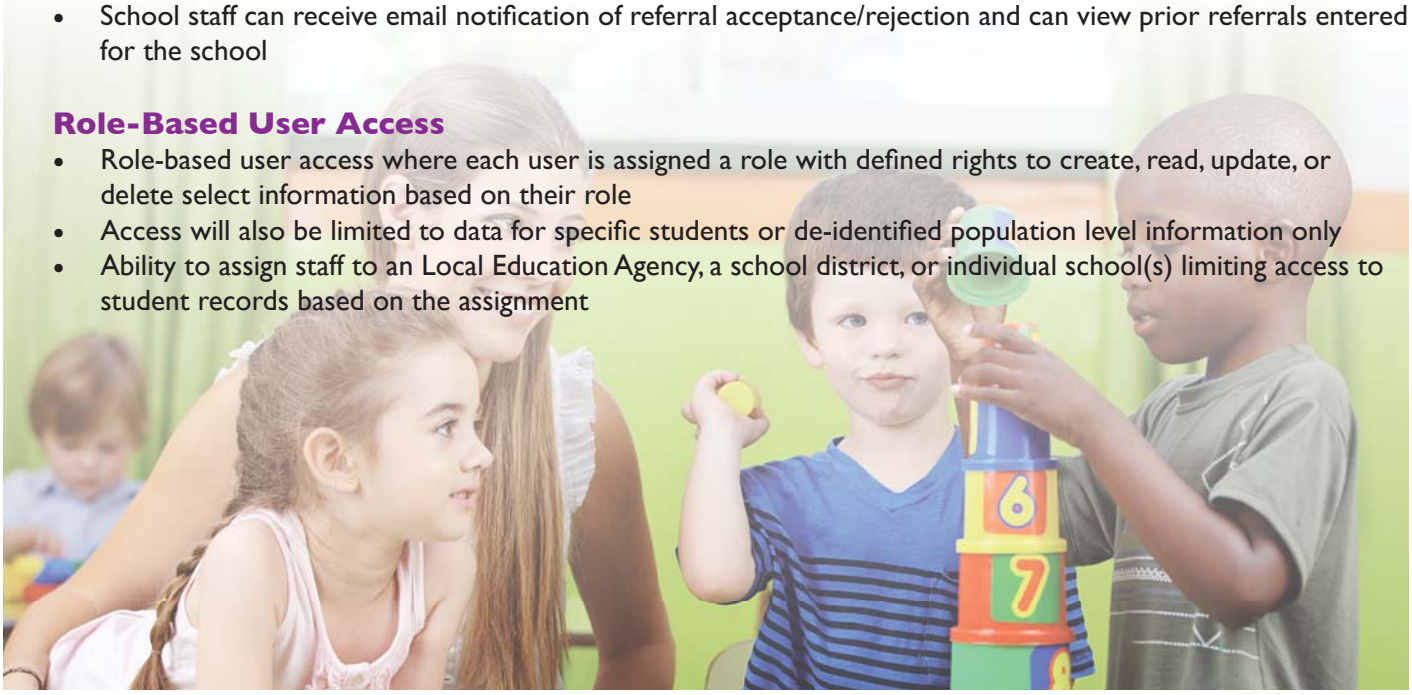
System maintains either a FedRAMP authorization or an annual SSAE 18 SOC 2 Type II audit based on State of Nevada required NIST Special Publication 800-53 MOD Controls using identified controls and minimum values as established in applicable State PSPs.

Referral

- Allow school staff, Local Education Agency professionals, case managers, care coordinators, and other service providers to generate behavioral health referrals on behalf of students
- The referring party will see that the referral was received (acknowledged) by the Local Education Agency, or if the Local Education Agency decides not to proceed with the student
- The system should be able to search existing participant records to minimize duplication of records prior to creating a referral
- Include a searchable referral directory for both internal and external providers with configurable search criteria, including insurance accepted, specializations, location, etc.
- Referral directory should display providers based on proximity to the student's home address, school address, or other address
- Support a specific workflow where referrals can be made directly in the platform by school staff (teachers, administrators, counselors) to Local Education Agency professionals when there is indicated need. Role-based access should prohibit school staff from accessing information about the student's care following the referral.
- Allow Local Education Agency staff to directly enter referrals to the Local Education Agency on behalf of school staff.
- Automatically assign referrals to designated Local Education Agency staff for review
- Provide email notifications to designated Local Education Agency staff when a new referral is entered into the system
- Local Education Agency staff can review and accept referral, initiating Local Education Agency intake process
- Local Education Agency staff can reject a referral and enter a reason for rejection
- School staff can receive email notification of referral acceptance/rejection and can view prior referrals entered for the school

Role-Based User Access

- Role-based user access where each user is assigned a role with defined rights to create, read, update, or delete select information based on their role
- Access will also be limited to data for specific students or de-identified population level information only
- Ability to assign staff to an Local Education Agency, a school district, or individual school(s) limiting access to student records based on the assignment



Assessment

- Offer a standard intake process for each program offered through the Local Education Agency and/or state and local agencies, including eligibility screening and applicable consents
- Ability for a student to be enrolled in more than one program
- Support Local Education Agency-specific intake, follow up, and discharge processes
- Scheduling and management of individual tasks within each process based on program-specific or standard templates
- Host a standardized approach to behavioral health assessment that may be completed by student self-report, staff interview, or by a parent/caregiver
- Ability to deliver assessments and other forms to students/parents/caregivers to complete remotely or in person using streamlined workflow, including via email, text, or scanned QR code. Offer a variety of validated behavioral health assessment tools, including broad-based and single-domain tools.
- Ability to provide assessments and other forms in multiple languages
- Offer automatic scoring and clinical significance of scores of assessment tools, sending an electronic report to an approved provider in real-time
- Offer student trends report for longitudinal assessments using standard measures
- Ability to provide organization or program-specific forms and assessments
- Include the ability for parent and student consents, including authorization to bill, consent to participate, and consent to share information to be completed and managed within the platform. Ability to capture student, parent/caregiver, and staff electronic signatures on consents, care plans, case notes, and other electronic documents.
- Staff forms can be signed by a supervisor if a staff user has insufficient credentials
- Integrate with Nevada Student Information System (Infinite Campus) and Medicaid billing systems
- Provide an information/data summary that can be shared with parents/caregivers

Care Planning and Management

- Schedule, assign, and monitor tasks for all care team members involved with student care plan
- Include clinical notes functionality for tracking services and billable events, including status, duration, encounter setting, and notes related to encounter
- Allow care team members to share notes, upload client documents, establish, track, and document customizable goals for students, obtain and record consent, and track and report individual progress towards the goals
- Provide ability to conduct virtual visits with students via a built-in, Health Insurance Portability and Accountability Act of 1996/Family Educational Rights and Privacy Act compliant, secure telehealth platform

Data Analytics and Reporting

- Real-time dashboard(s) and reports, including both standard and program- and organization-specific reports
- Ability to export data at state level, district level, and school level. Dashboard access should be assignable at the staff user level
- Ability to export data in CSV format
- Reports to include services provided, billing reports, task completion rates, length of time to complete tasks, and referral outcomes

Data Security and User Access

- Ability to provide user authentication (i.e., password requirements, password update frequency, password encryption, number of failed login attempts allowed, etc.) that complies with state IT standards
- Provide for "role-based" security maintained by the application administrators
- User session management that complies with state IT standards, e.g., automatic logout of users after a defined period of activity
- System hosted, including data backup and disaster recovery sites, within the continental United States

DATA COLLECTION & OUTCOMES

School resources are limited, schools implementing School-Based Behavioral Health programs will eventually want to know that the school behavioral health investment is a good value. Data collection demonstrates not only that individual students have been restored to typical functioning, but also that the system itself is demonstrating effective outcomes.

Some outcomes that are likely to be essential to track from the school's perspective include:

- Improved academic performance
- Improved student behavior
- Improved school climate
- Increased teacher satisfaction and reduced turnover
- Increased parent participation in school activities
- Increased parent and student satisfaction
- Increased attendance
- Graduation rates
- Decreased suspensions and expulsions

Some outcomes that will be important to track from the behavioral health perspective include:

- Improved student behavioral health outcomes such as reduced rates of students reporting depression and anxiety
- Increased student report of knowing how to access services if they have a behavioral health need
- Increased teacher report of knowing how to access services and support for their students
- Increased rates of students identifying a supportive relationship with an adult on campus
- Decreased student report of loneliness
- Reduced rates of students experiencing suicidal ideation

ADDITIONAL RESOURCES

Common Language: Terms and Definitions

In order to integrate systems, it's important that terms are used in the same ways in schools, across agencies and embedded within training activities. The following terms have been outlined to meet the requirements of school behavioral and academic intervention services, Medicaid billing requirements, and Multi-Tiered System of Supports training and technical assistance programming.

Accommodation

- Accommodation involves adapting instructional strategies and/or the classroom environment for students with special needs. Classroom accommodations can be made across educational settings
- Any individualized plan may include accommodations:
  – Legally enforceable within a 504/IEP plan
  – 504/IEP accommodation plan may act as a Plan of Care and an additional plan is not required if they meet all requirements of a Plan of Care and document medical necessity of the services being provided
  – Not all plans of care are required to be IEP/504 accommodation plans, as Local Education Agencies/State Educational Agencies may have the need for shorter and less formal plans for lower acuity health conditions

Assessment

- Use of a validated tool or method to measure level of functioning: academic, behavioral, psychosocial, physical, domains of functioning, areas of rehabilitative need to drive an individualized plan
- Assessment is conducted by a qualified professional within their identified scope of practice
- Used to develop an individualized plan including but not limited to a Plan of Care, healthcare plan, individualized education plan (IEP), 504 accommodation plan, Behavior Intervention Plan, academic intervention plan

Data-Based Decision Making

- Occurs at all levels of Multi-Tiered System of Supports implementation, from individual students to the district level
- Teams use screening, diagnostic, progress monitoring, classroom assessment, and fidelity data to make decisions about instruction, movement within the system, intensification of instruction and support, and identification of students with disabilities (in accordance with state and local policies)

Interventions
- Based on data demonstrating need (Tier 2: data, screeners; Tier 3: individual assessment)
- Instruction to develop skills
- Medical necessity
- Evidence-based
- Implemented by a trained professional within their scope of practice
- Progress monitoring with regular review

Plan of Care
- Plan of Care is defined as a medical document developed after an assessment by a qualified health professional acting within their scope of practice
- Serves as documentation of medical necessity for all services being provided to the student
- Must include all elements outlined in MSM 2803.1D(5)

Screener
- A tool or method that efficiently identifies risk for poor outcomes including academic, behavioral, social, emotional, school completion, college/career readiness or identifies current and emerging health needs
- Use of data connected to valid and reliable indicators of the desired outcome
- Determine need for further evaluation, treatment or support
- May be part of an assessment
- May be universal for all students or targeted for a specified need
- May be used to progress monitor or as one of multiple data sources that consider whether students meet entry or exit criteria for tiered interventions and support

Specialized Instructional Support Personnel
- Specialized Instructional Support Personnel—also known as non-classroom educators—work with teachers, school support staff, parents, community members, and other education stakeholders to help students remove learning barriers while examining their individual strengths and talents, interests, and insecurities
- They include professionals such as school counselors, psychologists, social workers, occupational therapists, library media specialists, speech language pathologists, school nurses, and others. Many of these professionals are nationally board certified public school employees in their respective fields

Tier 1 Interventions
- School-wide data collection, practices, and systems for prevention
- Universal, preventative, proactive, or responsive intervention applicable or useful for everyone in the general population
- Tier 1 interventions practices are determined by federal, state, and local policy and local population data
- Additional Tier 1 practices should be determined by a site-based team that reviews school-wide data

Tier 2 Interventions
- Selective, preventative, and supplemental interventions targeted at groups whose risks of developing academic, behavioral, or social-emotional concerns are higher than average
- Identified by data decision rules and referral pathways

Tier 3 Interventions
- Individualized and intensive interventions based on assessments and support plans matched to a specific student's identified needs
- Identified by data decision rules and referral pathways

CONTRIBUTORS

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DIVISION OF CHILD AND FAMILY SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY

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https://doe.nv.gov/SafeRespectfulLearning/School_Based_Behavioral_Health_Toolkit/