Bringing Care to the Classroom

SCHOOL-CLINIC TELEPSYCHIATRY CASE STUDY AND TOOLS
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**Introduction**

Schools can be a safe, reliable point of access for Michigan kids in need of behavioral health treatment. The Michigan Health Endowment Fund supports a range of school-based behavioral health initiatives, and we’ve seen particular promise in collaborations that use telehealth solutions. As virtual visits become ever more common, established community healthcare clinics and schools can partner to use technology to help more students get the care they need.

One example of a successful telehealth model is the Family Medical Center of Michigan’s (FMC) partnership with rural schools. FMC, a Federally Qualified Health Center (FQHC), partners with area schools lacking access to community behavioral health services to provide telepsychiatry to students alongside in-person, social-worker-led therapy. This program proved to be financially sustainable, scalable, potentially replicable, and is especially relevant for rural communities or other regions with few practicing psychiatrists or therapists.

This case study profiles what FMC did and what they learned. We’ve also included some templates and documents that we think might be helpful in designing similar programs. The Health Fund hopes this serves as an inspiration, a starting point, and a useful set of tools for other FQHCs and education professionals to learn from and adapt this important work.

This project grew from the strategic goal of FMC’s CEO Ed Larkins and its Board of Director to provide services in rural schools via telehealth. Based on this strategic goal, Audrey Smith, COO, and Jessica Parsil, Director of Behavioral Health Services, developed and implemented FMC’s school-based telehealth project focusing on behavioral health services. Thank you for leading the way in this important project.

This project and case study were created prior to the COVID-19 pandemic. The closure of schools, along with policy changes related to telehealth, spurred FMC to quickly adapt, and they began providing these behavioral health services exclusively via telehealth. While remote treatment plays an undeniably essential role in delivering behavioral healthcare, students will continue to benefit from services that can be provided onsite, during a school day, when schools reopen.
**INTRODUCTION**

**MICHIGAN HEALTH ENDOWMENT FUND**

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**SCHOOLS ADDED IN 2018/19**

- **24 Students Served**
  - Detroit Public School Community District
  - Carstens Academy of Aquatic Science

- **39 Students Served**
  - Detroit Public School Community District
  - Durfee Elementary Middle School

- **60 Students Served**
  - Monroe School District
  - Custer Elementary School

- **83 Students Served to Date**
  - Elementary/Middle/High School Campus
  - Madison School District

- **17, 113, 51 Students Served to Date**
  - Elementary/Middle/High School Campus
  - Morenci Area Schools

**ORIGINAL FUNDED SCHOOLS**

- **Arborwood Elementary School**
  - 82 Students Served to Date
  - Elementary/High School Campus

- **Britton School**
  - 23 Students Served to Date
  - Elementary/High School Campus

- **Deerfield School**
  - 6 Students Served to Date
  - Elementary/Middle School Campus

- **Dundee Community Schools**
  - 97 Students Served to Date
  - Elementary/Middle/High School Campus

- **Madison School District**
  - 83 Students Served
to Date
  - Elementary/Middle/High School Campus

- **Morenci Area Schools**
  - 27 Students Served to Date
  - Elementary/Middle/High School Campus

- **Sterling Elementary, Wagar Middle, and Airport High School**
  - 17, 113, 51 Students Served to Date
  - Airport Community Schools

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**SCHOOLS ADDED IN 2019/2020**

- **15 Students Served**
  - Bedford Public Schools
  - Bedford Middle/High School

- **12 Students Served**
  - Airport Community Schools
  - Neidermeier Elementary School

- **23 Students**
  - Airport Community Schools
  - Ritter Elementary School

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**FMC PRESENCE IN SOUTHEAST MICHIGAN**

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**MICHIGAN HEALTH ENDOWMENT FUND**

**INTRODUCTION** 04
Project Overview

The Family Medical Center of Michigan (FMC) is a Federally Qualified Health Center providing primary care, behavioral health, OB/GYN, physical therapy, pharmacy, and dental services in southeast Michigan. Through this project, FMC wanted to improve access to behavioral health services for school-aged children in rural southeastern Michigan. Specifically, they aimed to address attention deficit hyperactivity disorder, depression, anxiety, trauma, and substance use disorders and improve school culture around behavioral health services. With the grant from the Michigan Health Endowment Fund, FMC implemented a combination of onsite and telehealth behavioral health services in several schools, including elementary, middle, and high schools across its service area.

Over the 2016–17 and 2017–18 school years, this FMC initiative provided behavioral health services to 381 students across seven locations. Following the grant period, FMC doubled its reach and expanded to urban settings as well. To date, FMC has worked with more than 1,131 students across 30 locations, providing 11,288 therapy sessions and 2,240 telepsychiatry appointments. By providing these services in schools, FMC minimized access barriers and decreased the amount of time students spent out of the classroom. The project successfully improved and, in many cases, created access to necessary behavioral healthcare, including therapeutic treatment, psychiatry, and medication management.

Importantly, the response from school officials, teachers, parents, and students was overwhelmingly positive. The project not only provided vital services to students in need; it also strengthened community collaboration and enhanced teacher knowledge of and access to services for students, all while creating a sustainable and replicable model for partnerships between FQHCs and schools.
Before Implementing this project, FMC had to:

- Secure Board approval
- Select schools for service delivery
- Obtain approval from the U.S. Health Resources and Services Administration (HRSA) to deliver services in school locations
- Determine staffing structure and needs and impanel newly hired staff with insurers
- Set up the necessary technology (e.g. secure internet, web-enabled camera)
- Identify measures and formalize data collection to evaluate progress

Securing Board Approval

Like many health clinics, FMC relies on its board of directors to approve and ultimately champion new initiatives and programs. FMC staff used district and socioeconomic data to present the stark realities of the lack of local behavioral healthcare options for students in rural settings. Faced with the disparity in access to care for these children, Board members were quick to approve the idea for a hybrid in-person/virtual approach and became advocates and essential partners in the project.

Following the grant period, FMC went back to its board seeking approval to expand to urban school settings as well. This time around, FMC staff focused on the socioeconomic determinants of health that prevented many students from seeking behavioral healthcare outside of the school setting. Making the case for this expansion required board members to understand that while urban settings may be home to more behavioral health providers, students from schools with high rates of free and reduced lunch eligibility, lower academic achievement, and racial health disparities could also benefit immensely from onsite services.

"The school-based behavior program is vital to the students and families we serve. So many students lack support for the negative behaviors they feel unable to control, let alone understand. Parents are frustrated, teachers often feel their hands are tied, and many times students do not feel that they are truly being heard. This program has the great opportunity to offer our schools, families, and students a safe place, a listening ear, and at least glimmers, if not rays, of hope!"

ELAINE ROBSON
Retired Educator
Board Member, Family Medical Center
SELECTING SCHOOLS

At the onset of the project, FMC talked to intermediate school districts (ISDs) to help identify the best schools and usher FMC into the school district. This early support and coordination ensured that the school district did not see FMC as a competing organization for the support the ISD already provided for children on Individualized Education Plans and 504s. FMC provided services to fill a gap in what was available, as an added local mental health provider for general education students.

FMC initially selected schools based on the percentage of students who qualify for free and reduced lunch. After reaching out to two ISDs, the ISD superintendents helped FMC identify schools with limited student support services, sufficient capacity to engage with a new program, and a large enough student population to warrant onsite services.

FMC then worked with each district’s superintendent to develop a memorandum of understanding (MOU) and a business associate agreement (BAA). The MOU and BAA described the services FMC would provide, outline the school’s and FMC’s responsibilities, and allowed these entities to share student information. Working with the superintendents and school administrators to select the institutions and discuss service delivery early on were key to building buy-in for the program among other school staff.
SECURING EXTERNAL APPROVALS

FMC worked with the Health Resources and Services Administration (HRSA) to add each of the school locations to FMC’s scope of work, which ensured onsite services provided by credentialed FMC clinicians would be reimbursable by Medicaid and other insurers, and that project staff would be covered by FMC’s malpractice insurance. The HRSA approval process included:

- Documentation on how FMC would deliver behavioral health services and support access to physical health services at each school
- The estimated number of students to be served
- Where services would be delivered
- Copies of the MOU and BAA

The HRSA approval process took 30–60 days for each site and required behavioral health service delivery to begin within 120 days of approval. Adding to the implementation timeframe, FMC’s board of directors only met once a month and had to approve expansion into each school. In addition to the HRSA and board approval processes, FMC had to panel its newly hired clinicians with insurers to bill for delivered services, which can take between 30 and 90 days.

Maintaining adequate staffing proved challenging throughout implementation.
See the Delivering Services section for more.

STAFFING UP

A medical support coordinator, a social worker, and a remote psychiatrist provided FMC services at each participating school site. Each position brought specific skills to the project and contributed to the success of FMC’s experience. Future implementers of this model should uniquely tailor these roles to the needs of the community it serves.

The medical support coordinator calls parents to schedule and remind them of appointments; facilitates follow-up appointments and prescriptions; provides basic medical examinations prior to psychiatry telehealth visits; and, perhaps most importantly, coordinates with school staff. The importance of this role cannot be overstated—the coordinators are responsible for day-to-day communication with front office staff, teachers, administrators, and the students. To make the counseling as nonintrusive to academic learning as possible, the medical support coordinator works closely with school staff, the social workers, and teachers to identify when it would be best to remove students from the classroom.

FMC carefully modified this position throughout the grant period and beyond to make sure it met the needs of the program. Originally a non-clinical position, the role was changed so that the medical support coordinator could conduct general health screenings and provide student vital information during psychiatry appointments.
The social worker conducts onsite therapy and facilitates the telepsychiatry appointments, which are delivered by the FMC’s onsite psychiatrist. FMC chose to hire masters-level social workers in order to provide tailored and more comprehensive services to students. In addition to the direct care provided to students, the social workers often communicate directly with parents to share progress and ensure lines of communication remain open. While FMC relied on licensed social workers for this position, other behavioral health clinicians can fulfill these roles if appropriate.

Both the medical support coordinators and social workers were assigned to several schools and districts, often traveling between locations throughout the week. Managing and coordinating these schedules is important to ensure students receive services regularly and staff are comfortable with the travel requirements.

In addition to the onsite staff involved in care, FMC also relied on non-clinical staff, including the chief operating officer (COO), who took on the role as project manager, behavioral health director, and the vice president of quality. The COO had experience in school-based health which was instrumental in identifying models of care and was essential to project implementation. The behavioral health director led clinical staff recruitment and training and working together with the chief operating officer, adjusted the model to ensure that the right staff were interjected to meet the different needs of service. The COO and the director of behavioral health also managed the relationships with the superintendents of the school districts; the COO served as the key and the periodic contact person and the director of behavioral health as the contact for the ongoing operations and new services for the schools. The vice president of quality led data collection, review, and analysis and was key to measuring the outcomes related to the change in service model. While FMC relied on senior-level staff, these roles could be fulfilled by anyone in the organization prepared to learn about the challenges unique to providing services in a school setting.
TECH PREP AND SET-UP

FMC worked with school staff to determine the best location for the in-school clinic, in a part of each school building that would allow for two separate, but closely connected areas. One space was needed for the medical support coordinator to call parents to schedule appointments, send appointment reminders, facilitate prescriptions, and coordinate with school staff. A separate space was needed for the social worker to conduct in-person therapy and to connect with the psychiatrist using telehealth equipment.

Several rural school districts housed elementary, middle, and high schools on a single campus or in a shared building. This unique set-up allowed FMC to use one set of equipment to serve a broad range of students.

FMC initially worked with a technology vendor who handled all FMC services. In 2017, FMC hired an in-house technology team to help conceptualize a telepsychiatry space in each school and install the necessary software and equipment. This consisted of:

- A mobile cart that held a computer for telepsychiatry
- A combination printer/scanner
- A web-enabled video camera and speakers
- A wireless router connected directly to the FMC network to protect client privacy and avoid using the school’s internet network
- A video conferencing software system. FMC used Lifesize, a system that ensures confidential provider-client communication
EVALUATION AND DATA COLLECTION

FMC staff determined what data would be most important to collect to track progress over time and informed the schools about the needed data at the beginning of the grant. While school staff and administrators seemed able and eager to share data on student attendance and behavior, FMC experienced challenges with obtaining the data from some schools, likely due to timing with the end of the school year.

While one school shared a significant amount of baseline data, FMC staff is working to develop a simplified process and reporting tool for collecting student data from schools on an annual basis using a combination of FMC’s electronic health record and Google Drive. Staff also switched from using paper forms to capture satisfaction survey data to using SurveyMonkey, an online survey tool.

LESSONS LEARNED

- Partner with school superintendents and administrators early to build buy-in. Their support ensures teachers and school social workers are more open and willing to work with FQHC staff.

- Consider each school’s size to ensure there is a large enough student population to generate referrals to warrant the number of days per week staff are in each school.

- Consider implementation timelines carefully, including hiring, credentialing, FQHC board meeting dates, and the HRSA approval process.

- Standardize evaluation metrics, data collection requirements, and data submission process with schools early on.

SAMPLE TOOLS

- FQHC and School MOU
- Job description for behavioral health medical support coordinator
LESSONS LEARNED

- Attended parent-teacher conferences with a resource table and staff to discuss the services provided.
- Held several training and educational sessions for teachers and parents to help them understand the services that would be available.
- Created informational content for school newsletters and sent letters to student homes.

In addition, FMC staff met frequently with school leaders to fine tune the process for student referrals, as well as gather feedback from staff. Throughout the year, FMC staff attended professional development sessions and teacher staff meetings. They also provided classroom presentations on coping with anxiety and managing inattention and described how to access additional support through the school behavioral health clinic.

FMC staff found that the timing and frequency of the information sharing was very important for staff and parent education to ensure appropriate referrals and engagement. In the first year, FMC missed the start of school when orientations and staff professional development took place, missing key opportunities to introduce the new program to staff and parents. But in the second year, FMC was able to be part of Kindergarten Round-up and school open houses to share information about the availability of school-based behavioral health services.

SAMPLE TOOLS

- Flyer to parents about school-based program
- Program handout for parent-teacher conferences
- Presentation to school staff on behavioral health services
- Description of intervention implementation plan
- Presentation for parents on the screening and intervention
OBTAINING AND TRACKING REFERRALS

Referrals were made by counselors, teachers, parents, and principals on an individual basis as students with potential needs were identified. FMC staff conducted in-services with teachers and staff to share “red flags” that might alert them to a potential mental health need. The goal was to get students who exhibit one or more “red flags” to the on-site social worker for screening.

The number of referrals from each school varied, ranging from 30 to 81. An estimated 75–80% of those referred scheduled appointments. Some students didn’t end up with appointments because they declined services or simply did not return FMC communications.

FMC initially began by using paper referrals, which school staff sent to the medical support coordinator. But the paper format created communication challenges: the support coordinator didn’t receive referrals until they were physically present at the school, and there was no system to communicate with schools regarding referral status in the enrollment process, nor a way to share what communication took place with families.

FMC and the schools worked together to develop an online referral system using Google Forms, and to track referrals using Google Docs. With this approach, the support coordinator could see a referral as soon as it came into the system, and all authorized staff could see the status of each referral including actual and attempted communications with families. In order for Google Docs to be HIPAA compliant, stored data must be encrypted, including during uploading and downloading.

FMC initially tried to have parents complete registration and consent forms in advance of their child’s first appointment, but the response rate was low. Ultimately, they found that having parents complete the forms onsite at the time of the first appointment was the best method for obtaining consent. The form covered future visits, so parents did not have to be present beyond the first meeting.

**HIPAA stands for the Health Insurance Portability and Accountability Act of 1996. As part of the legislation, the U.S. Department of Health and Human Services issued a Privacy Rule, which regulates what and how medical information can be shared. In short, the rule protects patient privacy and prevents providers, businesses, and other entities from sharing personal or identifying information.**
LESSONS LEARNED

- Create a parental consent form that covers participation for the whole year, which minimizes participation barriers by requiring parents to only attend the first intake meeting.

- Address referral issues early and work with partners to develop joint solutions. Ensure there are regular opportunities to discuss referrals with school staff, including information about the referral process, who to refer, and where to refer students if not eligible for care through the school-based program.

- Design a HIPAA-compliant online referral system that allows participating staff to access information remotely and in real-time.

SAMPLE TOOLS

- Referral form for school based behavioral health services
- Parental consent and registration form, completed with staff
- Parental consent form for controlled substances
Setting the Schedule

To ensure high quality care was delivered, FMC conducts a bi-monthly peer review process. This process allows FMC to review complex cases, evaluate adherence to treatment plans, and ensure that all therapeutic options are considered, especially in cases where the psychiatrist prescribed medication. Peer consultation and review are important components of any clinical practice for both the clinicians and clients. FMC incorporates regular opportunities for case discussion and treatment review to both support the staff and to make sure the needs of students are met.

Regular Reviews

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Summer Services

To maintain continuity of care through the summer months, FMC staff continued to provide services at the schools that remained open during the summer. The primary variable for summer services was the availability of the school building, a factor that was often outside of FMC’s control. For some districts, FMC clinic sites and virtual services were available to continue services for students if the parent made the effort to ensure the child continued. In other areas, the district provided a safe location independent of the district so that students and FMC staff had a physical location for therapy services during summer shut down, breaks, and inclement weather days. They also offered to meet students at FMC offices near the schools, though this did not result in many appointments. Participation during the summer months decreased drastically, in part due to a lack of parental engagement and transportation. While some students were transported to the schools and offices by family members, and others received transportation services through their Medicaid insurance plans, others went without care. FMC continues to modify and adapt summer programming to meet the needs of students even when school is out of session.

Growing Services and Staff

Over the course of the three-year grant project, staff treated 381 students and conducted 3,103 appointments. 13%, or 300, of those appointments were telepsychiatry visits. FMC employed two medical support coordinators and five social workers to meet this need. Following the grant period, FMC expanded services and staffing to reach additional schools in both the rural and urban setting. To date, the team consists of nine socials workers and three medical support coordinators.
One of the biggest challenges FMC faced in project implementation was maintaining a sufficient level of staff. Two social workers and a medical support coordinator hired for the project left in the first few years of the program. Covering such a large geographic area required significant travel for staff, which contributed to “compassion fatigue”, burnout, and decreased job satisfaction. To address this, FMC increased salaries and began reimbursing for mileage for traveling between school sites. FMC also prioritized self-care and support for their social workers and medical support coordinators by having regular conversations about their needs and implementing benefits like flexible hours to support staff wellbeing.

Many of the school-based staff describe the strong relationships they have developed as one of the reasons for wanting to stay in the position. A common theme among the school-based staff is that they are passionate about the work they do and genuinely strive to make a difference in the lives of the children and families they work with. This is something important to look for when bringing on new team members to the program.

**LESSONS LEARNED**

- Make specific plans for continued care during the summer months to overcome barriers related to parental and student engagement and transportation.

- Plan for a flexible and fluid appointment schedule during the school day. The medical support coordinator and the social worker often shifted appointment times to account for academic demands and students’ needs.

- Anticipate the unique stresses and associated needs with staff working on this program, such as regular daily travel, navigating a new model of care, and secondary trauma. In the program design, shape the position and benefits to mitigate these pressure points, and plan for interim assessments of staff roles, expectations, and satisfaction. Be prepared to adjust as needed.
Tracked individual health progress: While this data wasn’t enough to be statistically significant during the grant period, FMC continues to gather and analyze health outcomes over a longer time.

Focused on access to services: In a pilot, the most important questions might be about the program itself: Did it function as expected? What unexpected challenges came up? Did it provide access to more students? Is it sustainable? The answers to these questions can be found throughout this toolkit, and can substantially help FMC and others with the next steps.

Evaluated management of behavioral health conditions: FMC might not yet have the full picture of its long-term impact on students, but they can see how their program helped students address behavioral health needs that otherwise might go untreated.

Emphasized qualitative data: Feedback from students, families, school professionals, and program staff were key to understanding the program’s impact and how it can be improved.

**SAMPLE TOOLS**

- Depression Assessment: PHQ-9
- Anxiety Assessment: GAD-7
I have seen major improvements in mental health stability with clients after working together for some time. Some of these students require higher levels of care than others, so progress always looks different. I have one student who comes to mind that made significant progress after years of being in therapy with other agencies. He was seeing myself and the psychiatrist. He hated school, was defiant in school and at home, and had extreme aggressive behaviors.

We worked through his resistance of treatment and developing a positive therapeutic relationship. His medication was changed as well by the psychiatrist he sees at FMC via telehealth appointments while at school. He then began to come to sessions, eager to talk about his experiences, wanting to make positive changes in his life at school and at home. He shared that he wanted to be able to change his reputation at school from that of the bully, to one that people looked up to and wanted to be his friend. Through this program he was able to achieve these goals.

FMC SOCIAL WORKER

30 Schools and Counting
1,131 Students Served
11,288 Total Appointments
2,240 Telepsychiatry Appointments
FUNDING & SUSTAINABILITY

By receiving federal approval to add each school as a service site, FMC was able to bill Medicaid for services delivered and receive an enhanced wraparound payment as an FQHC. They also ensured that all staff were credentialed with all of the Medicaid health plans in the counties of operation as well as commercial insurers. For the schools, partnering with an established healthcare provider eliminated the need for district staff to learn the details and requirements of insurance billing, making an FQHC a low-risk, high-reward partnership.

FMC used a sliding fee scale for families without insurance or with high deductibles and did not turn any student away due to an inability to pay. For students without health coverage, FMC staff assisted the family with signing up for affordable insurance.

With a sustainable and scalable funding model, FMC is maintaining and expanding services now that the grant period has ended. For example, FMC is:

- Continuing to provide services in all of these schools
- Increasing the number of days social workers are present at two school sites
- Expanding services to five schools in currently served districts and to five schools in two new districts, including three schools in Detroit Public Schools Community District. They are also looking to expand into schools in Wayne County and Toledo, Ohio.

Beyond FMC’s plans for expanding their program, the project serves as a proof of concept for other FQHCs and school partnerships. FMC demonstrated that a provider can successfully base behavioral health services, including tele-psychiatry, in schools, and that this model is effective for reaching students and eliminating barriers to care. The work is unequivocally replicable and adaptable for communities across not only Michigan, but the entire country.

LESSONS LEARNED

- Ensure that all requirements to bill Medicaid and other insurers for services are addressed and that there is a clear understanding of billable services.
Tools

Here is a compiled list of resources that relate to the Michigan Health Endowment Fund Telehealth Implementation Case Study:

- FQHC and School MOU
- Job description for behavioral health medical support coordinator
- Flyer to parents about school-based program
- Program handout for parent-teacher conferences
- Presentation to school staff on behavioral health services
- Description of intervention implementation plan
- Presentation for parents on the screening and intervention
- Referral form for school-based behavioral health services
- Parental consent and registration form, completed with staff
- Parental consent form for controlled substances
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