School Based Mental Health Program

Budget Note 19, Quarter 2 Report: October 1 - December 31, 2025

Budget Note 19 Transmittal

Quarterly, written reports to the Board of County Commissioners that include qualitative and quantitative metrics on outcomes related to the impact of the program, including details on billing practices, caseload per clinician, and total youth served, disaggregated by school, race and ethnicity.

Introduction

As described in Quarter 1, the School Based Mental Health (SBMH) program is conducting a systematic evaluation with the Health Department's Program Design and Evaluation Services (PDES) team. This evaluation aims to address the Board of County Commissioners' FY 2026 Budget Note 19 request and build evaluation tools that the program can use to monitor outcomes and inform decision-making.

This report is organized using a framework that focuses on three interdependent factors—program outcomes, staffing/resources, and financial sustainability. Data collected in each area will guide decision making in order to measure impact and outcomes, determine staff placement and productivity levels, and create a financially sustainable model.

Quarter 2 Report Objectives

Program Outcomes

- **Measures of Success**: Identify Key Performance Indicators (KPIs) based on evidence-based output and outcome measures included in the logic model.
- **Initial Program Data**: Provide initial program data from the new Epic Electronic Health Record (EHR) and conduct a systematic review of Evolv EHR data over the past 2 years to demonstrate program effectiveness in meeting KPIs.

Staffing and Resources

- **SBMH Ecosystem Assessment Data**: Provide a summary of SBMH Ecosystem Assessment key findings based on interviews with school district leaders and review of complementary resources provided by school districts and other MCHD programs.
- **SBMH District Scorecard**: Present a draft framework for the SBMH District Scorecard, a yearly planning tool that can be used to consolidate essential information, guide SBMH planning and Mental Health Consultant (MHC) placement, and enhance collaboration among all partners within the school ecosystem. This tool includes youth behavioral health outcome data, which will be used to ensure SBMH services are aligned with student needs.

Financial Sustainability

- **Transition to Epic Electronic Health Record (EHR) System**: Describe continued progress on SBMH's transition to the Epic EHR system, including training, staff capacity building, and improving reporting and billing processes to increase billable revenue capture.
- **Initial Financial Data:** Provide initial financial data to demonstrate improvements made to the SBMH program's ability to maximize potential revenue from billable services.
- **Additional Funding Sources**: Provide an update on long term funding sustainability options explored in Quarter 2 and describe the infrastructure, data, and resources that would be needed to complete these initiatives.

Program Outcomes

PDES Evaluators collaborated with the SBMH program to identify meaningful KPIs based on evidence-based output and outcome measures included in the SBMH logic model. Detailed definitions of KPIs in development can be found in Appendix A. This Quarter 2 report also includes initial program data from Epic EHR, as well as the past two years of Evolv EHR data, to demonstrate program effectiveness in meeting KPIs.

KPIs are organized into three groups:

- **Capacity**: Measures of the resources available to the program to support students
- **Encounters**: Numbers of individual services provided to student clients
- **Prevention Services**: Numbers of prevention, education, and outreach events in schools

At the county level, examining the data from year-to-year can help to understand how the total services provided is changing over time, including in the context of what resources were available to deliver those services. Further, as a useful set of KPIs is developed, this can become a

framework for creation of district- and school-level reports that can be shared with school partners to inform ongoing planning, monitoring, and improvement of programs (see SBMH District Scorecard section of this report).

Indicator: Capacity

Type: Process measures

Rationale: These metrics show total resources available for the program, particularly the Mental Health Consultants (MHC) who are working in schools. Capacity indicators provide context for the total number of services that may be provided by the Program.

Sources: All information for capacity measures is collected from SBMH program administrative data, such as budgets, district contracts, and personnel records.

Metric definitions: Appendix A includes a definition of each metric below, as well as the data sources, how numbers are calculated, and any specific guidance related to the interpretation of that information.

- Metric 1: **# of Mental Health Consultants (individuals)**
- Metric 2: **# of Culturally Responsive Mental Health Consultants**
- Metric 3: **FTE for school Mental Health Consultants**
- Metric 4: **District funding contributed**
- Metric 5: **Capacity-building and monitoring (IN DEVELOPMENT)**

Indicator: Client Encounters

Definition: Encounters are mental health services for students (clients) provided by Mental Health Consultants in schools.

Type: Output

Rationale: "Encounters" include any clinical interactions with individual students or groups of students. This can include individual therapy, group therapy, crisis services, and case management.

Source: Client encounter data are reported in Electronic Health Record (EHR) systems by the therapist who provides the services. The SBMH program transitioned from "Evolv" to "Epic" EHR

systems in September 2025. For this reason, there could be changes in how numbers are reported, although billing codes for specific services should not have changed.

Metric definitions:
SBMH **encounters** are counts of individual treatment services or other support. A current list of billing codes included as encounters can be found in Appendix A, in addition to a detailed definition of each metric below, the data sources, how numbers are calculated, and any specific guidance related to the interpretation of that information.

- Billable services are identified based on the EHR code for services provided. These are codes for which it is possible to bill if there is a mechanism in place to do so; if a student does not have health insurance, or if they have a private insurance that does not have a billing agreement in place, then the service will not be able to be billed.

SBMH **clients** are numbers of unique individuals who are engaged in individual level care encounters (one or more encounters from the table).

- Metric 1: **Total number of encounters**
- Metric 2: **Unduplicated count of clients**
- Metric 3: **Clients by age group**
- Metric 4: **Clients by race/ethnicity**
- Metric 5: **Clients by language**
- Metric 6: **Clients by gender**
- Metric 7: **Clients by insurance coverage**
- Metric 8: **Service type (IN DEVELOPMENT)**
- Metric 9: **Billing-related indicator (IN DEVELOPMENT)**

Indicator: Prevention Services

Definition: Number of prevention, education, and outreach (PEO) events.

Type: Output

Rationale: PEO "events" include activities of SBMH providers that support their therapeutic services, such as classroom or school assembly education presentations, family support groups, or consultation with school staff about general or individual student needs. These are activities that are not billable or reported in the EHR, but are important to providing a comprehensive approach to mental health support for youth in schools.

Source: PEO event data are reported by Mental Health Consultants on a monthly basis using a Google Form that asks them to identify the number of events by category, the number of people who were engaged per event, and a description. Completion of monthly reports is monitored by the SBMH program data quality team, and staff are reminded to report if they have not done so.

Metric definitions: All metrics are for the number of **events;** each event is a single count, regardless of the number of people who were involved. Appendix A includes a detailed definition of each metric below, as well as the data sources, how numbers are calculated, and any specific guidance related to the interpretation of that information.

- Metric 1: **Total event count**
- Metric 2: **Consultation - youth**
- Metric 3: **Consultation - non-youth**
- Metric 4: **Presentations - schools, communities**
- Metric 5: **Group - youth education group (non-clinical)**
- Metric 6: **Family support group (non-clinical)**

Key Performance Indicator Table (DRAFT)

Notes about the DRAFT KPI Table below:

- Current numbers for 2025-2026 were updated in early January 2026 to include all of Quarter 2 services through December 2025.
- The first portion of SBMH services for the 2025-26 school year began late (late September 2025) due to the transition in Electronic Health Record (EHR) reporting systems, which required training and delayed the start of referrals and individual services.
    - Although the end of December (end of Quarter 2) is just under half-way through the school year, the current number of services is at 30% of last year's total number of services. Analysis of the prior two years of data suggests that about 40% of the total number of services are typically delivered by this time in the year (by the end of Quarter 2). Service numbers are less during the first half of any year as students are being initially referred to and engaging with the program.
    - Two primary reasons for being slightly behind historical numbers include: the three-week delay in service startup due to the EHR transition means that there were only 14 weeks of SBMH program service in the 17 weeks of school, and 3 out of 24 Mental Health Consultant position vacancies from the start of the year were extended through December due to a hiring freeze.

    - Factoring in these limitations, the number of services projected for the end of Quarter 2, based on FY 2024 performance, would be 1,703. **The actual number of services is 1,753, suggesting that the program is on track or a little ahead of historical performance.**
    - For more information, please see Appendix A, SBMH Projections
- Due to the change in EHR system, from Evolv to Epic in September 2025, some numbers could change because of different reporting procedures.
    - Ethnicity and Race are reported separately beginning with the 2025-26 school year to align with new OHA race/ethnicity standards. The Epic EHR follows this standard.
    - Clients are asked to provide information about race, ethnicity, or gender, but can decline to answer.
    - Procedures for the Epic EHR require information about health insurance to be entered before care can begin.
- Some metrics are still in development (marked as TBD/To Be Determined and ###), and a few were not collected in prior years (marked as n/a for "not available").

Table 1: Key Performance Indicators (KPI) for School-Based Mental Health Program

SBMH Key Performance Indicators (KPI) report	2023-2024 school year	2024-2025 school year	2025-2026 school year (PRELIMINARY to date)
MEASURE: Capacity Source: program records			updated 1/6/26
# of MH consultants (Individual clinicians)	24	24	24*
# of culturally responsive MH consultants	18	18	19
FTE for school MH consultants	19.65	19.65	19.65
District funding contributed	$312,000.00	$312,000.00	$312,000.00
Capacity-building & monitoring (IN DEVELOPMENT)	n/a	n/a	TBD
MEASURE: # Encounters Source: Electronic Health Records (EHR)	*Evolv*	*Evolv*	*Epic*
# Encounters (Multnomah Countywide)			
Total encounters	**6,156**	**5,906**	**1,753**
Unduplicated (unique youth)	737	687	449

# Unique clients (Multnomah Countywide)			
Age group			**
Elementary school (ages 5-11)	107	137	143
Middle school (ages 12-14)	155	224	149
High school (ages 15+)	475	326	167
Race/ethnicity			
African American/Black	103	91	42
American Indian/Alaska Native	24	22	15
Asian	30	24	16
Hispanic	228	243	***
Middle Eastern/North African/SWANA	4	3	0
Native Hawaiian/Pac Islander	10	9	5
White	265	243	231
Other single race	15	11	0
More than one race	0	0	47
Unreported/refused to answer	58	41	93
Ethnicity			***
Cuban			1
Mexican			66
Puerto Rican			1
Other specified Hispanic			85
Hispanic, no specific origin			7
non-Hispanic			184
Unreported/refused to answer			105
Language			
English	550	509	340
Spanish	148	150	98
Other	20	19	11
Unreported/refused to answer	19	9	0
Gender			
Female	419	369	187
Male	272	276	120
Nonbinary/other	41	35	19
Unreported/refused to answer	5	7	123
Insurance coverage			
OHP	295	311	356
Private	18	10	3
Uninsured/self-pay	99	86	40
Unreported/refused to answer	325	280	50

Type of Service: TBD			
TBD	##	##	##
Billing measure: TBD			
TBD	##	##	##
MEASURE: # Prevention Events Source: Event reporting forms	PEO reports	PEO reports	PEO reports
# Events - Prevention, Education, Outreach (PEO), Multnomah County			
Total count	**821**	**1072**	**221**
Consultation - youth	502	407	125
Consultation - non-youth	156	173	67
Presentations - schools, communities	28	36	2
Group - youth education groups (non-clinical)	124	442	25
Group - family support groups (non-clinical)	11	14	2

* There were 3 vacancies in therapist positions at the start of the fiscal year, and hiring was delayed due to County hiring freezes. Mental Health Consultants can begin to see clients after completion of training: 2 new Mental Health Consultants will be able to see clients beginning in February 2026, and 1 new therapist will be able to see clients beginning in March 2026.
** Data on client age for FY 2026 in this table were pulled after other demographic data, and 10 additional youth had been added at that time; for this reason, client age information is for 459 youth.
*** Beginning in FY25, Ethnicity is reported separately from Race, to align with new OHA reporting standards (Epic aligns with these standards).

How The Data Will Be Used

The SBMH program will use the demographic data above to optimize services for marginalized students and increase access to care. Specifically, the program can use a county-wide version (shown above) and district or school-level versions in partnership with school districts, to review capacity and services. Monitoring services for specific populations can help to provide resources that retain Black and Brown students in mental health services and in school. This goal is also supported by diverse SBMH staff who have experience and a track record of achieving positive health outcomes for students experiencing inequities.

This data will also be used to establish productivity and performance standards. This quarter, the program made significant progress in building reporting capacity using the new EHR system, developing reports needed for program operations, and creating new tools that will be used for data-driven planning and decision-making (e.g. KPI matrix shown in Table 1 above and the SBMH District Scorecard). In Quarter 3, the SBMH team will shift its focus from data gathering and tool development to setting performance standards that balance financial sustainability, high-quality clinical services, and positive behavioral health outcomes for youth.

To do this, they will work with the Behavioral Health Division (BHD) and Health Department (HD) leadership to examine the data collected using the new tools. With a clear picture of staff time spent across billable services, PEO activities, and continuing education/administrative tasks, the program will work with BHD and HD leadership to set meaningful productivity levels. This data driven approach will help to determine the optimal blend and balance of staff time spent across activities in order to meet youth behavioral health needs and create positive outcomes.

An additional area of monitoring that is of interest is client outcomes — measures of whether students who engage in care are improving. The SBMH program is implementing a new client outcomes tracking tool during FY 2026, after transition to Epic EHR is complete. Clients will be asked 2-3 questions at the start and end of their therapy sessions, to assess their level of need and whether therapy sessions are meeting their needs. This will help Mental Health Consultants to adapt their ongoing care to best serve individual youth clients; in aggregate, data may be used to see how students in care improve over a school year. Metrics from these data will be developed in Quarter 4, and tested in FY 2027.

Staffing and Resources

In Quarter 2, PDES Evaluators developed a summary of SBMH Ecosystem Assessment key findings based on interviews with school district leaders and review of complementary resources provided by school districts and other MCHD programs. Based on this information, they developed a draft framework for the SBMH District Scorecard, a yearly planning tool that can be used to consolidate essential information, guide SBMH planning and Mental Health Consultant (MHC) placement, and enhance collaboration among all partners within the school ecosystem.

Three components of the SBMH Ecosystem Assessment:

- Key findings from interviews with school district leaders
- Identification of complementary resources provided
    - Within schools and by school districts

    - By other Health Department programs
- Proposed framework for SBMH District Scorecard

Key Findings from School District Interviews

To inform an understanding of SBMH program implementation and perceived effectiveness, PDES Evaluators conducted a series of key informant interviews with external partners who work directly with the program in all Multnomah County school districts, and with staff working in aligned programs in state agencies and in other counties. The interviews sought to gather various perspectives, including those of school district partners, on SBMH program operations in order to identify successes and find opportunities to strengthen implementation and collaboration. PDES Evaluators also sought to understand current and changing capacity of resources that collaborate with the SBMH program to deliver a comprehensive system of mental health support for students. For more detail, see Appendix B.

Interviews were completed with one or more staff from:

- Primary program contacts in the six Multnomah County school districts working with the SBMH program: Centennial, David Douglas, Gresham-Barlow, Parkrose, Portland Public, and Reynolds
- MCHD School-based Health Center (SBHC) program
- Oregon Health Authority (OHA) SBHC program
- Oregon Department of Education (ODE) Student Success Act
- SBMH administrators from Clackamas and Washington Counties

Strengths

Information shared by participants highlights the value of the critical, low-barrier nature of the County's SBMH program, and experienced, stable clinicians and staff.

- **High Satisfaction:** School district leaders report high satisfaction with the SBMH team's responsiveness, multilingual staff capabilities, and immediate site consultation for high-risk situations (e.g., suicide ideation).
- **Provider Stability and Licensure:** Multnomah County SBMH clinicians are highly valued for their stability and licensure, a significant advantage over some private providers who experience higher turnover and may have less experienced staff (working on licensure hours).
- **Culturally Specific Care:** County teams are valued for providing culturally specific and multilingual providers (e.g., Spanish-speaking, Black/African-American) who are essential in diverse or white-minority districts and buildings.

- **Underserved Focus:** The SBMH team's primary focus is students and families who are uninsured or underinsured, often those from the Black, Indigenous, and People of Color (BIPOC) community, who face significant barriers to accessing mental health services elsewhere.
- **Low-Barrier Access:** The core strength of the County model is the flexibility of MHCs, who can establish relationships and be present in schools without the constraint of billing for non-direct service time. This is critical for complex and high-need communities (e.g., Latinx families navigating complex needs, like fear of ICE).
- **SBMH as Specialty Care:** SBMH clinicians fill the critical role of providing full therapeutic services, a function that is explicitly outside the scope of most school staff due to policy and indemnification constraints, and their mandated roles (see separate report section on "complementary resources").

Challenges

Challenges included staffing limitations and funding constraints. Partners expressed support for enhanced data-driven decision-making and sustainable resource allocation to meet escalating student mental health needs.

- **Demand for care is greater than availability**: Mental health services are "generally insufficient" due to high demand and limited resources. Having more requests than capacity to serve all students referred for therapy is common in Centennial, Reynolds, and David Douglas, where providers frequently reach full capacity.
    - The program is currently working on a project to operationalize a “waitlist” function in EPIC which was not possible in the Evolv EHR. Adopting a waitlist process workflow will allow programs to better aggregate the number of clients who need services. To support these waitlisted clients to enter services, the program will examine clinically appropriate guidelines for when clients should be tapered off services to help support openings for an influx of waitlisted clients.
- **Staffing Gaps**: A significant financial and social challenge is the lack of Spanish-speaking clinicians, despite a large Latino student population in some districts.
- **Funding Uncertainty**: Declining enrollment and financial challenges risk further cuts to non-mandated services, like counseling and mental health. The elimination of "wiggle room" funding for private providers' non-billable hours limits their utility in high-need, low-barrier schools.

Opportunities

- **Data Enhancement:** Improving the collection and sharing of referral and service delivery data with school partners across all County SBMH providers is necessary to provide school and district leaders with a holistic view for better resource management and planning.
- **EHR Alignment:** The SBMH team transitioned to the Epic EHR system in September 2025, the same EHR system currently used by the Integrated Clinical Services (ICS) School Based Health Centers (SBHC). Although it is taking some time to identify and integrate procedures that were in place when the two programs had separate EHRs, this new alignment is expected to significantly improve cross-coordination, shared notes, and care management.
- **Model Expansion:** School district leaders all expressed a desire to expand the flexible, low-barrier Multnomah County SBMH model to all schools. Considerations for future resource planning could include finding new ways to coordinate resources.

Complementary Resources

The SBMH Ecosystem Assessment also identified complementary resources for student mental health provided by both School Districts and the Health Department. This information was identified during interviews with partners or aligned programs (see Key Findings from School District Interviews above), and through reviews of Oregon Department of Education (ODE) or School Based Health Center (SBHC) reports. For more detail, see Appendix C.

Two types of relevant resources were identified: school resources and Multnomah County Health Department resources, both of which are described in depth below.

School Resources

These are staff or programs that operate within the school system. Many are school district employees, but some are not. PDES Evaluators identified their primary roles, and also how they support or coordinate with the SBMH program. During key informant interviews, some partners noted that there can be confusion about roles from people who see titles such as “school counselor” or “school psychologist” and assume that these staff could provide mental health therapy. However, **these roles are not duplicative of SBMH —** they have other defined roles to play in the school system, and are not able to provide mental health therapy in the way that SBMH clinicians can. For instance, providers in school psychologist or school counselor roles often provide therapy on a limited basis (e.g., six sessions), while MH Consultants can provide longer-term services. If school psychiatrist and school counselor resources are reduced in a School

District, this can impact SBMH because of the coordinating role (such as providing referrals) that these staff often provide.

Table 1 (below) summarizes these resources, their general function in schools, and how they may coordinate with SBMH program staff.

Table 1. Complementary resources/partners for SBMH programs in schools
Roles in **bold** specifically complement SBMH program staff (details in *italics*)

Resource	**Role in SBMH services**
District Coordinator	Actively support coordination with other resources in the district, plan for SBMH resource deployment in buildings according to need.
District Contract	The financial contribution per district, with details about expectations.
School Administrators	Assure SBMH have private office spaces, actively support coordination with other resources in buildings
School Counselors	Focus on universal Tier 1 and 2 social-emotional learning and instruction. *Provide students referrals to SBMH.* (Their primary role is often managing schedules for 300-500 students each.)
School Psychologists	*Provide student referrals to SBMH.* (Their primary role relates to mandated assessment and diagnosis duties tied to the Individuals with Disabilities Act.)
School Social Workers	Focus on removing barriers to education (e.g., housing, food, healthcare) and community resource connection, not long-term therapy. *Provide complementary support for needs that may be identified during SBMH care; provide student referrals to SBMH.*
School-Based Health Centers	Coordinate physical health care with SBMH; collaborate in "wraparound" care plan meetings with SBMH and others in support of high-need students.
School Nurses	School nursing is a specialized practice of nursing that advances the well-being, academic success, and lifelong achievement and health of students. Generally providing limited healthcare for students, including

Table 1. Complementary resources/partners for SBMH programs in schools Roles in **bold** specifically complement SBMH program staff (details in *italics*)	
Resource	**Role in SBMH services**
	managing and preventing chronic disease needs.
Integrated Clinical Services (ICS) Behavioral Health Consultant	This role provides the primary care model of mental health, which includes *warm handoffs to SBMH, quick check-ins, bridging, and triaging referrals.*
Outpatient Treatment Programs in Schools	Outside private providers (e.g., Trillium) may also provide individual-level student mental health care in schools, *complementing SBMH services (so that SBMH services can be focused on culturally-specific care, and the uninsured, as needed.)*
Prevention Specialists/Other County Staff	Multnomah County has some prevention specialists who may support prevention-related education in classrooms and communities. *May be able to collaborate with SBMH to cover prevention-related needs.*

Table 2 (below) identifies the presence of school-based coordinating resources among Multnomah County's six partner districts. Notably, some districts may be facing future budget reductions that could affect the presence of these resources, and thus affect the SBMH program and provision of a coordinated continuum of care for students.

Table 2. Number of complementary resources/partners, by School District (School year 2024-2025)						
School District (# of students) **Resource**	Centennial (5,352)	David Douglas (8,686)	Gresham-Barlow (11,370)	Parkrose (2,711)	Portland Public (42,785)	Reynolds (9,656)
School administrators	23	40	45	12	190	52
School counselors	15	25	40	8	155	36

Table 2. Number of complementary resources/partners, by School District
(School year 2024-2025)

School District (# of students) / **Resource**	Centennial (5,352)	David Douglas (8,686)	Gresham-Barlow (11,370)	Parkrose (2,711)	Portland Public (42,785)	Reynolds (9,656)
School psychologists	6	4	6	2	65	9
School social workers	0	3	1	0	49	14
School-Based Health Centers	1	1	1	1	5	1
School nurses	5	7	8	2	43	10
Integrated Client Services (ICS) BH Consultant	1	1	0	1	3	1
Outpatient treatment programs in schools*	Trillium; and four other contracted providers so can have 2 per school	Trillium; REAP	Trillum; Life Stance; Stronger Oregon; Eastside Family Therapy; Care Solace	Trillium; Stronger Oregon; and Latino Network for cm services	Trillium; Sankofa; LifeWorks; and other contracted providers	Trillium; Stronger Oregon; Northwest Family; Sankofa

Data sources: 2024-25 ODE profiles; SBHC reports

*specific treatment providers were mentioned during interviews - this may not be a complete list

Multnomah County Health Department Resources

The Multnomah County Health Department has at least two programs with prevention staff who can do work in school settings, although they do so at the request of schools and are not dedicated to specific schools or to a specific amount of time in school-based work. Although limited, these staff may be a resource for prevention, education, and outreach (PEO) activities of the SBMH staff. While they do not have sufficient capacity to work in all schools, these prevention

specialists could support the SBMH team with general content, materials, or technical support for PEO activities, and SBMH staff could also facilitate relationships between school systems and prevention specialists.

Behavioral Health Division: Wellness and Prevention Program

The Behavioral Health Division Wellness and Prevention team focuses on primary prevention among youth and young adults. They can provide training, technical assistance, and resources for classroom or larger setting health education related to prevention of mental health harm, substance use, or gambling. This team also provides support to schools after a youth suicide, as well as general training, such as Mental Health First Aid and Applied Suicide Intervention Skills Training, which could complement services provided by SBMH clinicians .

Public Health Division: Prevention and Health Promotion, Community and Adolescent Health Programs

The Community and Adolescent Health (CAH) team conducts prevention activities focused on shared risk and protective factors, including various trainings for teachers and school staff (e.g., Youth Mental Health, Substance Use Prevention, Being an "Askable Adult," Coaching Youth Into Adults, and Understanding Violence as a Public Health Issue). They also involve youth in health promotion projects, such as Crime Prevention Through Environmental Design (CPTED), and sponsor two annual youth summits (one for LGBTQ+ youth and one for violence prevention).

SBMH District Scorecard (DRAFT Framework)

The purpose of a school- or district-based SBMH District Scorecard is to systematically provide consolidated information that is relevant to ongoing SBMH planning, monitoring, and improvement. Having information in a simple format could also facilitate collaboration among partners within the school ecosystem.

The current draft of this Scorecard has two parts – the Annual Summary and Quarterly Report, which are both detailed below. For more detail, see Appendix D.

Annual Summary

- **School Context:** This section includes identified school factors that can inform needs for mental health support among students, including potential need for culturally-specific support, such as student population demographics, community need measures, and student mental health measures.

    - See Appendix E for more detailed Youth Behavioral Health Outcome data; indicators from this appendix will be included in the Scorecard as Mental Health measures.
- **SBMH Services:** This section summarizes SBMH services from the prior year, including detailed types of services delivered.

Quarterly Report

- **SBMH Activities:** This report is designed to provide a high-level summary of the current year's activities. It will also provide District-level data that can be used to look at how the program is addressing or meeting needs of the student population.

DRAFT SBMH District Scorecard Framework

The Draft SBMH school- and district-level "Scorecards" below are ***currently in development*** and are intended to provide general awareness of the content in consideration. Final versions of Scorecards for school districts and buildings will be informed by the current examination of SBMH program indicators and population-based youth mental health outcomes.

Annual Summary		
School Context		
Identified school factors that can inform needs for mental health support (NOTE: In this Draft SBMH District Scorecard, County-level data is used, but data will be specific to school or district, as appropriate.)		
Student Population	**Status/Data**	**Date/Source**
Student population K-12	80,230	2024-25 NCES Common Core
Race/ethnicity composition	American Indian/Alaska Native: 6% (483) Asian: 7% (5,746) Black/African American: 9% (7,143) Latino: 26% (21,067) Multiracial: 10% (8,337) Native Hawaiian/PI: 2% (1,314) White: 45% (36,149)	2023 ACS 5 year Estimates

Community Needs	**Status/ Data**	**Date / Source**
Free/reduced lunch	73% (58,707)	2024-25 NCES Common Core
Child poverty	14% (15,163 children ages 5-17)	2023 ACS 5-year estimates
Mental Health measures from student surveys and other population data (NOTE: Final Report format may include additional measures) **See Appendix E: Youth BH Outcome Data for more detail**		
Percentage of students who self-report **good or better mental health**	6th grade: 70% 8th grade: 62% 11th grade: 51%	2024 SHS
Estimated number of students with **fair or poor mental health**	Grades 4-6: 4,900 Grades 7-9: 6,600 Grades 10-12: 9,600 More than 21,000 students grades 4-12 combined	2024 SHS data, applied to student enrollment data
Percentage of all students who self-report **feeling sad or hopeless for 2+ weeks such that they stopped usual activities (depression)**	6th grade: 27% 8th grade: 30% 11th grade: 37%	2024 SHS
Estimated number of students **experiencing depression**	Grades 4-6: 5,100 Grades 7-9: 5,700 Grades 10-12: 7,800 More than 18,000 students grades 4-12 combined	2024 SHS data, applied to student enrollment data
Percentage of all students who self-report **unmet mental**	6th grade: not asked 8th grade: 21%	2024 SHS

health needs	11th grade: 25%	
Estimated number of students with **unmet mental health needs**	Grades 7-9: 4,000 Grades 10-12: 5,000 About 9,000 students grades 7-12 combined	2024 SHS data, applied to student enrollment data
Prior Year School-Based Mental Health (SBMH) Services - from FY25 **See Table 1: Key Performance Indicators data table for more detail**		
Information about prior year SBMH program activities in the school/district (NOTE: In this Draft SBMH District Scorecard, County-level data is provided, but data will be specific to school or district, as appropriate.)		
Staff capacity Prior year		
24 MH Consultants	19 delivering culturally- and linguistically-responsive care	Serving 6 districts
Prior year SBMH Activities	**# of Encounters**	**Date / Source**
Total # of encounters	5,906	FY25 EHR data
Total youth clients served	687	FY25 EHR data
Prevention Education Outreach (PEO) Events provided	1,072	FY25 PEO report

Quarterly Report (revision date) **NOTE: This table is for example purposes only. Data will be provided for Quarter 3 in the next report.**					
Current Year School-Based Mental Health (SBMH) Activities					
	Q1 July-Sept	Q2 Oct-Dec	Q3 Jan-Mar	Q4 Apr-Jun	Cumulative total
Capacity					
# of clinicians					

Total FTE clinicians					
Services					
Total # encounters					
# clients total and for priority populations (determine with school partners)					
Total # PEO events					

How The Data Will Be Used

The SBMH District Scorecard will provide a comprehensive and consolidated tool that can be used to look at the student population as a whole, including demographic characteristics, social determinants of health indicators such as housing and poverty levels, as well as the overall state of youth behavioral health. This comprehensive data will then be used to evaluate services that are provided by the SBMH program to determine whether what's being provided meets student needs, and where adjustments should be made.

By tracking year-over-year trends in encounters, staff capacity and retention, and behavioral health outcomes such as population-wide student depression and unmet mental health needs, the program will be able to provide schools with meaningful, shared data to inform service decisions. It will also be useful for SBMH Supervisors to coach, guide, and train clinicians, focusing on site-specific issues or needs of the student population (reports will be provided in this format for districts and schools).

This data enables the SBMH program to tailor services to emerging student needs in specific schools and districts, and ensures that clinician training is relevant and responsive to achieve positive behavioral health outcomes, such as overall good emotional and mental health, and school connection indicating that a teacher or adult cares (see Appendix E: Youth BH Outcomes). In addition to this data, the SBMH team is operationalizing a quality improvement process to implement the use of an evidence-based Feedback Informed Treatment (FIT) model. This model ensures clients are receiving quality and appropriate care. FIT tools are short questionnaires that gather real-time client feedback around client's overall wellbeing and how the therapeutic

relationship is going, allowing Mental Health Consultants to make real time adjustments to improve treatment effectiveness and reduce dropout rates.

Direct Clinical Services (DCS) is currently part of a larger Feedback Informed Treatment (FIT) Quality Improvement project in partnership with CareOregon. The aim of this project is to help strengthen the Culture of Feedback within DCS and ensure client voice guides service delivery. Through this quality improvement process it was identified that a new FIT tool, that is more culturally responsive and more client friendly would better center the client's voice in treatment. The Outcome Rating Scale (ORS) and Session Rating Scale (SRS) are the evidence-based practice tools that the program will be working toward implementing. These tools help support quality care through real time client feedback so that staff can make shifts in service planning to meet the immediate needs of the clients (rather than getting feedback in an exit survey once the client has already been discharged). The ORS/SRS tools have been shown to improve retention in therapy and treatment outcomes. The ORS/SRS information can also be utilized in supervision and peer consultations as a means to collectively address barriers to care.

Direct Clinical Services has begun piloting the ORS/SRS tools with smaller teams who were transitioning to Epic EHR after SBMH. All Supervisors have been trained on FIT as a model as well as how to utilize the tools in supervision. In order to maintain the integrity of the tools, it is important that the information gleaned be used for professional consultation to improve client outcomes rather than as a punitive measure. Once learnings/findings are analyzed from the smaller teams' implementation of the FIT tools, SBMH will create a plan to integrate them into team practices.

Financial Sustainability

In Quarter 2, the SBMH team continued its transition to the Epic EHR, focusing on training, staff capacity building, and improving reporting and billing processes to increase billable revenue capture. Significant improvements were made in Quarter 2 to the revenue cycle and billing process, and the BHD Billing team is able to provide initial financial data to demonstrate the effectiveness of these quality improvement efforts in maximizing potential revenue from billable services. The SBMH team also continued to explore longer-term funding sustainability options and the infrastructure, data, and resources that would be needed to complete these initiatives.

Epic Transition and Near-term Quality Improvements

Revenue Cycle and Billing Process Improvements

The SBMH team went live in Epic on September 16, 2025. While the Epic EHR system has been more challenging to implement than initially expected, SBMH clinicians and BHD Billing and Reporting teams are becoming more comfortable and proficient using the platform. Furthermore, the transition has led to significant improvements in the revenue cycle process, as there is now proper infrastructure to adequately support billable services in Epic EHR. The BHD Billing team now receives support from the Health Department Accounts Receivable (AR) team, which is helping to maximize billable revenue. The AR team is able to provide a high level of scrutiny to ensure submission of the cleanest possible claims to payers.

During the initial months of the Epic EHR transition, the BHD Billing team is reviewing every SBMH service claim to check for errors and increased revenue opportunities. The AR team then completes a final review before claims are submitted. This rigorous, multi-step process ensures claims are accurate and likely to be paid. It has also helped the BHD Billing team and SBMH program identify areas for quality improvement, such as documentation training or Epic template updates. As more BHD Direct Clinical Services (DCS) programs transition to Epic, the BHD Billing team will continue to monitor a certain percentage of all claims, as well as any claims that the EHR flags for errors, on an ongoing basis.

Reduced Claim Denials

With funds allocated by the Board in FY 2026, the BHD Billing team was able to hire a new team member. The new Compliance and Billing Program Specialist Senior is completing chart reviews and helping to provide 1:1 support to clinicians to assist with their clinical workflows, documentation, and billing needs. This has provided crucial support to clinicians, which has allowed the rest of the BHD Billing team time to focus on charge reviews.

As a result, the BHD Billing team now has sufficient staffing to investigate any denied claims during the initial months of SBMH's transition to Epic EHR, ensuring maximum revenue is received. As of December 17, 2025, the only denials received for SBMH services are due to an administrative error that is pending resolution by Epic. The BHD Billing team anticipates that all of those denied claims will be approved and paid by January 31, 2026.

This represents a significant improvement from previous years. For comparison, SBMH recorded 162 denials in calendar year 2024 and 219 denials from January to August 2025, prior to the

transition to Epic EHR. While it is anticipated that some claims may be denied going forward, the new infrastructure and training are proving highly effective in reducing denials for the SBMH program.

Initial Claims/Revenue Data

Following the SBMH team's Epic launch on September 16, 2025, the first claims were submitted to insurance payers in mid-October 2025. This timing reflects the standard, necessary process for all EHR transitions, where all claims are held for additional review to ensure maximum billable revenue. The BHD Billing team and Health Department AR team are diligently working through the initial backlog, successfully processing and submitting claims as they are deemed payable.

As of early December 2025, the SBMH team has received payment for 6% of their billed services. The remaining 94% of charges are either pending payment with the insurance provider or pending review from the BHD Billing or Health Department AR team. Due to the overall EHR transition and rigorous review process currently in place, there is a lag between when services are entered into Epic and when payment is received; so the financial data is not fully reflective of the team's full billable potential.

Claims/Revenue Data: September 16 - December 31, 2025

- Total claim amount entered by SBMH clinicians from 9/16/25-12/31/25: **$800,957**
    - Last year, this total number ($489,540) appears lower for this same time period because SBMH's former EHR, Evolv, had a rate setup associated with the actual reimbursement rates for each insurance provider. The amount received for each claim was very similar to the amount billed out due to this rate setup.
    - This year, this amount is substantially higher because all charges in Epic bill at the highest possible rate, and industry standard is to be reimbursed 30-60% of that total amount.
    - Yearly projections based on the total amount billed through December 31, 2025
        - Average billed per month: **$266, 986**
        - Projected billed by 6/30/2026 (9 months): **$2,402,871**

- Billable revenue received from insurance providers: **$25,124 (as of 1/12/26)**
    - Revenue generated from claims billed by (SBMH) for the first half of the current fiscal year (July 1, 2025–December 31, 2025) constitutes approximately 6% of the total claims volume. The current payment cycle exhibits a 60–90 day delay, which aligns with industry standards and is primarily attributed to the necessary internal

review process preceding final claim submission. Additionally, the HD's Accounts Receivable team has been operating with half its staff for the past month, which has slowed the claims submission process.

- A comparative analysis against the same period last year (July 1, 2024–December 31, 2024) shows SBMH received $280,754 in revenue, with a claim payment rate of 71.2%. Projecting this year's performance based on a presumed payment rate of around 72% for the current period would result in an estimated revenue of $301,488 thus far. This forecast indicates a projected year-over-year revenue increase from last year's $280,754 for the first half of the school year.

- Claim amount currently being reviewed by insurance providers: **$137,941 (as of 1/14/26)**
  - CareOregon recently let us know that they are currently experiencing significant delays in reviewing claims data. However, they have reported that they anticipate being able to increase their claims review processing speed soon. We also have yet to receive any payments from DMAP and Trillium, two of our three main insurance providers. Insurance providers are actively reviewing claims and will continue to approve claims on a rolling basis.

- Additional claims being reviewed by HD AR before submission to insurance providers: **$646,872**, of this amount:
  - Non-reimbursable claim amount: **$116,872 (as of 12/31/25)**
    - This amount represents services provided to clients who are uninsured, underinsured, or have private insurance (add link to Private Insurance section below)
      - This represents SBMH's commitment to serving youth in need, regardless of their insurance status. Recent data indicates that only 3 enrolled SBMH clients reported to have private insurance, and the amount of students with active Medicaid has increased since last year.
  - Potentially reimbursable claim amount: **$530,000 (as of 1/13/26)**
    - Because medical billing protocols require providers to bill out at the highest possible rate, the standard reimbursement rate ranges from 30-60% of the rate billed. Thus far, SBMH claims are averaging a reimbursement rate of around **39%**, which is within the range of industry standards.
    - Projecting actual reimbursement rates based on the projected billed by 6/30/2026 (9 months): **$2,402,871**

- Projected reimbursement revenue at 30%: **$720,861**
- Projected reimbursement revenue at 39%: **$937,120**
- Projected reimbursement revenue at 45%: **$1,081,292**
- Projected reimbursement revenue at 60%: **$1,441,723**

The program has implemented a rigorous claim review process that involves every service/claim being reviewed by a certified medical coder to ensure it meets compliance standards. This thorough review process provides clinicians with real time corrections to ensure their notes are accurate and in compliance. Because of this new procedure, the program aims to produce the highest quality of claims and as few denials as possible, but this thorough process has delayed submission. Additionally, since staff are still new to the Epic EHR system, their corrections take more time than they would in Evolv since they are still learning how to navigate the system. The review and submission process will be faster going forward as the transition progresses, and there is more data on claims paid. We expect to have more data for comparison in Quarter 3.

Increased Reporting Capacity

The BHD Billing and SBMH teams are working together to increase reporting capacity in the new Epic EHR. They have collaboratively identified both a short- and long-term solution to meet current program data needs, and have identified opportunities to learn from other programs in the Health Department that also use Epic EHR.

For the short term, the ICS Billing team is reviewing old Evolv reports to determine data requirements and providing the SBMH team with a list of existing Epic reports and instructions for immediate data access. Concurrently, the BHD Billing team is developing long-term custom reporting capacity for the four key report needs and scheduling regular weekly meetings with SBMH staff. This approach aims to address immediate data needs while building a sustainable system that reduces manual work and filtering.

Also, given the very different reporting functionalities in the Evolv and Epic EHR systems, the SBMH team reached out to other Health Department programs that recently transitioned to Epic. The SBMH team is consulting with three Public Health programs to learn how they built team capacity for reporting and managed the change process.

Increased Billing Capacity and Revenue

Billing and coding knowledge among SBMH clinicians has increased following training sessions on September 30 and December 9, 2025. These trainings, along with support from the BHD billing

team, are expected to boost billable revenue as SBMH clinicians have demonstrated increased knowledge of billing services. The SBMH program will continue to collaborate with the BHD Billing team on quality improvement for billing compliance and documentation.

Process improvements implemented focus on workflow, clinical documentation and efficiency. Program workflows have also been streamlined to improve the outreach-to-enrollment process, which is expected to result in more billable services as clients move from outreach/engagement to enrollment more quickly. Recognizing that many factors, such as cultural considerations and mental health stigma, may make a slower approach clinically necessary, the SBMH program continues to provide culturally responsive support to staff on how to best approach service enrollment with their clients to help mitigate any potential barriers.

Furthermore, the SBMH team completed training on the Collaborative Assessment and Management of Suicidality (CAMS) framework. CAMS is a patient-centered, suicide-focused clinical philosophy of care based on empathy, honesty, and trust, equipping providers with the skills to effectively reduce suffering and treat suicidal risk. Epic allows for seamless integration of this evidence-based clinical tool, a process that would have required in-house development in Evolv. The ability to easily integrate quality tools like CAMS through the new Epic EHR ensures clinicians are able to offer the best care to our clients.

Additional Funding/Billing Revenue

In Quarter 2, the SBMH program finalized a group therapy protocol to allow group therapy sessions to be billable. The program is currently piloting and refining the process; staff have been trained in the new protocol and they have begun billing for group therapy sessions. The Evolv EHR was not set up to bill for these services so this will be a new billable service opportunity for the program.

As mentioned in the Quarter 1 report, the program continues to benefit from a $175,000 grant from the state to support integrated mental health services. The program also maintained Tier 1 Medicaid status since more than 50% of billable service revenue comes from Medicaid. This Tier 1 status allows the program to bill claims at a higher rate.

Long Term Funding Sustainability Options Explored

The SBMH team and the BHD Billing team have done some preliminary investigation into two potential avenues for increased funding but have determined that more infrastructure, data and resources would be needed to effectively complete these initiatives.

Enhanced Payment Rate for Culturally and Linguistically Specific Services

As stated in the SBMH Quarter 1 report, the program has been in communication with Oregon Health Authority (OHA) around their Culturally and Linguistically Specific Enhanced Rate program which provides a higher billing rate for providers of culturally and linguistically tailored services. Over 75% of SBMH staff currently provide culturally and linguistically specific services, and in Quarter 2, the program explored what it would take to apply to receive this designation from the State and be reimbursed at this higher rate of 22% over the base rate.

After consulting with OHA, we learned that providing these services per OHA's guidelines would require significant administrative support. We would need to create a whole new program as a subset of SBMH Services that would cater to a specific cultural group. This would take a significant amount of resources to initiate and would not guarantee an approval from OHA to receive the higher reimbursement rate. The SBMH program is considering waiting until after the end of this school year to further investigate this option and continue to focus instead on improving the billable services that are currently being provided to youth and families.

Billing Private Insurance Providers

Billing private insurance providers would allow for some additional revenue, although the majority of students served do have Medicaid/OHP insurance, which the program is currently credentialed and set up to bill. Expanding into private insurance billing would require a significant administrative effort, including negotiating individual contracts with each provider. Furthermore, an in-depth conversation is necessary to address confidentiality concerns, ensuring that clients do not receive insurance statements or notices and that their services remain private.

Our most recent data (see KPI data in Table 1) indicated that of the 399 SBMH clients currently enrolled or in pre-enrollment, 356 of them have active Medicaid/OHP, 3 are reported to have private insurance (2 Blue Cross, 1 Kaiser). For FY 2026, the percentage of clients with unreported insurance is 11% (50 records), a significant drop from 41-44% in prior years. Additionally, clients listed as "uninsured" or "self-pay" represent 9% (40 records) of current clients, compared to 13% in the last two years.

Based on this data, SBMH will do a cost benefit analysis to determine whether the operational lift of setting up private insurance billing would financially be worth the time investment. SBMH will determine the infrastructure and staffing supports needed to create, maintain and monitor insurance credentialing and troubleshoot potential claim denials. They will then estimate the potential revenue generated from private insurance to see if the cost of implementation would be

offset by revenue gained or not. SBMH also plans to learn from ICS partners on their experience with insurance credentialing and the implications for client care. SBMH has reached out to ICS BH partners to learn more about their insurance credentialing process. ICS BH shared that one critical piece of their workflow is that they have a credentialing team to support their providers with the many required steps that enable providers to bill different private insurers.

Next Steps for Quarter 3

With the expanded data available, as well as a defined agreement on the tools and structures that will be used to analyze SBMH data, the team will convene with BH/HD leadership to determine how we will use data to:

- Set benchmarks for expectations about how SBMH staff time is allocated among different kinds of services. The leadership team will partner with SBMH to:
    - Examine current distributions of different service activity types per district, age group, and staff member FTE
    - Develop meaningful groupings of service activity types per billing code (see proposed groupings of codes in Appendix A)
    - Examine literature and consult with other programs in Oregon (e.g., school-based health centers, other county SBMH programs) about their specific benchmarks or expectations for staff time use and how those are measured, monitored, and used
    - Develop recommendations for SBMH program-specific benchmarks, and their ongoing measurement, monitoring and use, in consultation with SBMH program school district partners
    - Identify steps needed to implement for ongoing use (e.g., updating position descriptions, established reporting tools, procedures for review and ongoing quality improvement).
- Set benchmarks for billing, revenue, claims, and related processes.

An update on these next steps and SBMH's activities and outcomes will be provided in the Quarter 3 report.

Appendix A: SBMH Key Performance Indicators (KPI)

This document provides the methods for how numbers are reported and may be used for three sets of SBMH Key Performance Indicators:

- Capacity
- Client Encounters
- Prevention Service Events

Other Metrics in Consideration

The following have been discussed, and could be defined as KPI metrics in the future:

- Encounters by district and school, including for district and school-specific reports to those partners.
- Encounters by student sexual orientation, disability status; these characteristics may be associated with increased mental health needs.
- The quality of information to assure billing is processed could be another KPI.
- It can take 3-6 weeks to move from referrals to enrollment for services; tracking the time this process takes may be helpful as a future KPI.

Metric Limitations

- The quality of EHR information for Client Encounters could vary by individual staff, including during the EHR system transition in the 2025-26 school year; completeness of documentation is monitored routinely with followup for staff who may not be applying coding systematically.
- In an effort to improve billing, procedures may have changed to require more up-front completion of enrollment forms prior to providing services for youth. If there is difficulty completing forms, this could affect the characteristics of students who are receiving services, including from specific population groups. Examining student characteristics and enrollment process data during 2025-2026 will be important to determine if changing enrollment procedures affects engagement.
- Availability of complementary services can play a role in performance. For example, some high-needs students should be referred to other services, but if those high-needs services are not available, the SBMH therapists may provide intensive care (multiple times per week) until those other services are available. This reduces time available to see students with less acute need.

- EHR encounter data do not help to understand the outcomes for students. In the future, implementation of individual self-assessments, or linkage to student attendance or performance data could help to assess how students are benefitting from mental health support.

Indicator: **Capacity**

Definition: SBMH resources available to provide services

Type: Process measures

Rationale: These metrics show total resources available for the program, particularly the Mental Health Consultants who are working in schools. Capacity indicators provide context for the total number of services that may be provided by the SBMH program.

Sources: All information for capacity measures is collected from SBMH program administrative data, such as budgets, district contracts, and personnel records.

Metric definitions: For each metric below, we indicate the sources, how numbers are calculated, and any specific guidance related to the interpretation of that information.

- Metric 1: **# of Mental Health Consultants (MHC) (individuals)**
  Why it matters – MHC's are either licensed (LCSW, LPC, LMFT) or are Qualified Mental Health Professionals (QMHP); both are board approved mental health providers. They can serve the whole range of services needed for those in their care. The SBMH program focuses on engaging and retaining a highly qualified and experienced team of MHCs with skills to deliver support for youth in school settings. Retention of high quality staff is a focus, both to assure continuity of relationships and knowledge about specific school settings and to avoid having to fill positions when there is a shortage of well-trained behavioral health providers in Oregon. Staff members often split their time among more than one school, to maximize the number of schools that have coverage.
    - Number of MHCs employed by SBMH, either full-time or part-time, to provide therapeutic services in Multnomah County schools.
- Metric 2: **# of Culturally Responsive Mental Health Consultants**

Why it matters – The SBMH program prioritizes capacity for delivery of services in communities that may have less access to healthcare, including by developing a team of staff who represent those populations.

  - This is the number of individual therapists who have capability for delivering culturally-specific services (e.g., Black, Latinx, or speaking a language other than English). This is defined based on a formally designated Knowledge, Skills, and Abilities (KSA) position, or ability to provide such services although not in a formally designated position.

- Metric 3: **FTE for school Mental Health Consultants**
  Why it matters – Time available is a critical factor in the number of services that can be provided. A number of staff work part-time in different buildings. Understanding the availability per site is key to considering how many clients can be served.
  - This is the total full-time equivalency (FTE) for Mental Health Consultants working in schools. FTE is calculated based on what is written in school district contracts – the actual FTE for 10 months of each year (as schools are in session, and services delivered, for only 10 months).
- Metric 4: **District funding contributed**
  Why it matters – District funding supports an average of about 9% on average of the total costs for therapists in each district. Contributions by districts are established on a year-to-year basis, and could change based on fund availability.
  - Total funding provided by Multnomah County school districts to support therapists, as documented in contracts with each district.
- Metric 5: **Capacity-building and monitoring (IN DEVELOPMENT)**
  Why it matters – Therapists in schools may be asked to support youth in many ways; having clear expectations for use of time can help staff to manage requests. Benchmarks could be set for % time spent, for example, expectations could be that 50% of available time is used for billable services, 25-30% for prevention, education, and outreach, and 20-25% for clinical supervision, admin and documentation, required continuing education and professional development.
  - The number of hours that are required for coordination, reporting, and training may fluctuate year to year. In 2025-26, significant hours were required for training in the new Epic Electronic Health Record (EHR) system. Estimated hours per month for capacity-building in 2025-26 have been documented and tracked.
  - Time is needed for documentation, meetings, training, time to obtain elementary/middle school (ES/MS) student parent consent, consultation meetings, coordination with others (case management); the percentage of students who do not show for their appointments may be variable for different schools as well.

- POTENTIAL DEFINITION: The number of hours per month (or percentage of available hours per month) that Mental Health Consultants are expected to provide individual (billable) services. Targets could be set, taking into account time for other required activities.

Indicator: **Client Encounters**

Definition: Encounters are mental health services for students (clients) provided by SBMH therapists in schools.

Type: Output

Rationale: "Encounters" include any clinical interactions with individual students or groups of students. This can include individual therapy, group therapy, crisis services, and case management.

Source: Client encounter data are reported in Electronic Health Record (EHR) systems by the therapist who provides the services. The SBMH program transitioned from Evolv to Epic EHR systems in September 2025. For this reason, there could be changes in how numbers are reported, although billing codes for specific services should not have changed.

- Developmental Documentation: List specific reports where data are obtained (or if obtained in Epic workbench). Example: SBMH_Referral_and_Enrollment_Data_0229_03 report)

Metric definitions:
SBMH **encounters** are counts of individual treatment services or other support. A current list of billing codes included as encounters is shown in the table below.

- Billable services are identified based on the EHR code for services provided. These are codes for which it is possible to bill if there is a mechanism in place to do so; if a student does not have health insurance, or if they have a private insurer that does not have a billing agreement in place, then the service will not be able to be billed.

SBMH **clients** are numbers of unique individuals who are engaged in individual level care encounters (one or more encounters from the table).

Table: PRELIMINARY DATA on EHR Codes included for SBMH "encounters"

Billing Code	Description	Unit	Provider	Mode[1]	# encounters 9/16/25-1/6/26
Assessment & Plan					
T1023[2]	Screening	PER SVS	QMHP, QMHA	IP, TH, AO*	170
90791	Mental Health Assessment final visit	PER SVS	QMHP	IP, TH, AO*	353
H0032	Service Plan	PER SVS	QMHP	IP, TH, AO*	208
Individual Therapy					
H0004	8-15 min BH Counseling or if no video (AO)	8-15 MIN	QMHP	IP, TH, AO	19
90832[3]	Psychotherapy, 30 minutes with patient	16-37 MIN	QMHP	IP, TH, AO*	285
90834	Psychotherapy, 45 minutes with patient	38-52 MIN	QMHP	IP, TH, AO*	222
90837	Psychotherapy, 60 minutes with patient	53 + MIN	QMHP	IP, TH, AO*	298
Family Therapy					
90882[4]	Environmental intervention (recs to parent w/o client by phone)	PER SVS	QMHP, QMHA	IP, TH, AO	7
90846	Family Psychotherapy (w/o client)	26 + MIN	QMHP	IP, TH, AO	21
90832[3]	Individual therapy w/ client & Family member	8-25 min	QMHP	IP, TH, AO*	See "individual therapy"
90847	Family Psychotherapy (w/ client)	26 + MIN	QMHP	IP, TH, AO	20
Crisis Services					
H2011	Crisis Intervention Services, per 15 min	8-30 MIN	QMHP, QMHA, MH Interns	IP, TH, AO	14
90839	Psychotherapy for crisis, first 60 minutes	30-74 MIN	QMHP	IP, TH, AO*	38
+ 90840	add-on to 90839 for ea. + 30 min > 60 min	75+ MIN	QMHP	IP, TH, AO*	5
Case Management & Environmental Intervention (Can Add code if documented in note)					
90882[4]	Environmental intervention Providing Clinical recommendation to impact the environment to support cl MH	PER SVS	QMHP, QMHA	IP, TH, AO	See "family therapy"
T1016	Case management Linking to service to support MH	/15 MIN	QMHP, QMHA	IP, TH, AO	21
Groups					
90853	Group psychotherapy	PER SVS	QMHP	IP, TH, AO*	8
90849	Multiple-family group psychotherapy	PER SVS	QMHP	IP, TH, AO*	0
H2014[5]	Group Skills Training (Non-QMHP)	PER SVS	QMHP, QMHA	IP, TH, AO	0
Skills & Activity (Not to be used by QMHP)					

Billing Code	Description	Unit	Provider	Mode[1]	# encounters 9/16/25-1/6/26
H2014[5]	Skills training (Non QMHP)	/15 MIN	QMHP, QMHA, Certified Peer	IP, TH, AO	0
G0176	Activity therapy 45 min + (Non QMHP)	45 MIN+	QMHP, QMHA	IP, TH	0
H2032	Activity therapy (Non QMHP)	/15 MIN	QMHP, QMHA	IP, TH	0

1. Mode coding: IP= In-Person; TH=Telehealth (virtual, computer with video); AO=Audio Only (telephone or computer tele visit with client video off). *indicates when AO is not billable.
2. If screening occurs over 2 visits, only the second (completing) visit is billed.
3. Code 90832 may be for individual therapy or family therapy, depending on context.
4. Code 90882 may be for family therapy or case management, depending on context.
5. Code H2014 may be for groups or skill-building, depending on context.

- Metric 1: **Total number of encounters**
    - Total count of all encounters for included services. Duplicate services provided to individuals are counted.
    - Unless otherwise specified, all other numbers examined are total counts (not unduplicated counts), because this represents how available resources are used in schools.
- Metric 2: **Unduplicated count of clients**
  Why it matters – Unduplicated counts may be greater when students have less severe needs; in settings where students have severe needs, the number of unique individuals who can receive care may be less.
    - This is the number of unique youth who receive any kind of services (whether only on one occasion or multiple occasions).
- Metric 3: **Clients by age group**
  Why it matters – The number and type of services provided may be different in different age groups due to variation in need. Another relevant factor is that students ages 14+ can consent to services without parent consent (although every attempt is made to engage parents when this does not introduce risk to the child).
    - Total count of encounters grouped by age of the client at the first contact – Elementary age (5-11), middle school (ages 12-14) and high school (ages 15 or older)
- Metric 4: **Clients by race/ethnicity**
  Why it matters – Providing services to specific groups who may have less access to healthcare is an important program goal; understanding the proportion of services that are

provided by race and ethnicity can help to understand whether that goal is being achieved. Importantly, the school must help to determine what specific populations are a priority, based on their knowledge of their student populations.

  - Total count of encounters by the client's race/ethnicity.
  - Race/ethnicity are self-identified by the client at the time services begin. Clients are assigned only one race/ethnicity code.
  - NOTE: For data in the new Epic EHR, we will separate race and ethnicity counts; in the prior Evolv EHR, race and ethnicity are reported in combination (with Hispanic ethnicity counted regardless of race; all other race groups are non-Hispanic)

- Metric 5: **Clients by language**
  Why it matters – Providing services to specific groups who do not have access to other care, including non-English speaking populations, is a goal of the program. Monitoring services provided by language can help to understand whether the program is achieving its goal.
  - Total count of encounters by the client's language (the language in which care is provided).
- Metric 6: **Clients by gender**
  Why it matters – Student health survey data show that there are important differences in mental health by student gender. Monitoring how program services reach youth by gender may help to understand whether the program is reaching goals of supporting students with the greatest need.
  - Total count of encounters by client (student) self-identified gender (female, male, nonbinary or other gender).
- Metric 7: **Clients by insurance coverage**
  Why it matters – Insurance coverage is documented at enrollment. Students receive services regardless of their coverage, but when coverage is available, the SBMH program can bill for services to the Oregon Health Plan (OHP) or private insurers (if agreements for billable services are in place). Also, if students do not have insurance, families can be supported to enroll in OHP. Understanding insurance coverage of clients can help to know whether the program is reaching its goals of supporting the students who may have less access to healthcare.
  - Total count of encounters by insurance coverage of the client.

- Metric 8: **Service type IN DEVELOPMENT**
  Why it matters – Effective combinations of services delivered by staff may vary based on need, such as for elementary schools vs. high schools. Understanding more about the specific services provided may be helpful in planning how to place staff, considering their skills with different kinds of services and different age groups.

    - POTENTIAL DEFINITION: We may group encounters as shown in the EHR table, or by "tier" of care. Examples of "tier" of care include –
        - Tier 1: Universal services (all students). Most of the effort in this category is likely to be documented separately in Prevention, Education, and Outreach (PEO) reports, rather than in an EHR.
        - Tier 2: Targeted services (e.g., students at-risk, such as those receiving screening or clinical support group services)
        - Tier 3: Individual therapeutic support

- Metric 9: **Billing-related indicator IN DEVELOPMENT**
  Why it matters – Billable services provide revenue that reduces costs to operate the program. Some services are potentially billable, but do not have an entity to bill to. For example, if a client is uninsured, there is no payer. Or if a client has private insurance, but there is no agreement in place for billing, that payer cannot be charged.
    - Potential definition: # (or percentage) of services where it is possible to bill, meaning that there is a payer available such as OHP; # (or percentage) of services where payments have been received.

Indicator: **Prevention Services**

Definition: Number of prevention, education, and outreach (PEO) events.

Type: Output

Rationale: PEO "events" include activities of SBMH providers that support their therapeutic services, such as classroom or school assembly education presentations, family support groups, or consultation with school staff about general or individual student needs. These are activities that are not billable or reported in the EHR, but are important to providing a comprehensive approach to mental health support for youth in schools.

Source: PEO event data are reported by SBMH Mental Health Consultants on a monthly basis using a Google Form that asks them to identify the number of events by category, the number of people who were engaged per event, and a description. Completion of monthly reports is monitored by the SBMH program leadership, and staff are reminded to report if they have not done so.

Metric definitions:
All metrics are for the # of **events;** each event is a single count, regardless of the number of people who were involved.

Why these matter – SBMH staff in schools can provide important school system support in a variety of ways, not all of which are billable as clinical services to an individual student. These kinds of activities contribute to a comprehensive school environment, including by raising awareness about mental health and therapist availability for staff and families, providing skill-building and coaching to school staff and student families, or providing consultation about management about issues faced by specific students or the need for a school-wide response (e.g., supporting response if there is a significant mental health incident, such as a self-harm event, in the school community).

- Metric 1: **Total event count**
  - Total number of all events.
- Metric 2: **Consultation - youth**
  - Total number of informal consultations with individual youth; this could be part of the early process for engaging a youth client to enroll for care.
- Metric 3: **Consultation - non-youth**
  - Total number of informal consultations with school staff.
- Metric 4: **Presentations - schools, communities**
  - Total number of presentations, which could be school assemblies, community events, or classroom presentations, to raise awareness.
- Metric 5: **Group - youth education group (non-clinical)**
  - Total number of groups with youth, such as discussions in a classroom with students experiencing conflict.
- Metric 6: **Family support group (non-clinical)**
  - Total number of groups with families, which could include coaching or skill-building for families with children in clinical care.

School-based Mental Health (SBMH) Projections

Purpose:

- Provide clarity about how projections for services are determined
- Justify statements about program progress to meeting projected targets

	FY24	FY25	FY26 (Q1+Q2, as of 1/8/26)
Records (EHR)			
# Encounters (Multnomah Countywide)			
Total encounters	**6,156**	**5,906**	**1,753**
Unduplicated (unique youth)	737	687	449
# Unique clients (Multnomah			

Justification for SBMH Q2 report statement that FY26 services are "on track".

- Numbers to date for FY26 from the SBMH report to commissioners indicate 1,753 total services provided in Q1+Q2
    - 40% of total annual services are typically provided in Q1+Q2, because the program does not operate during summer, and as students are referred to services after school starts it takes time for referrals, completing enrollment, and obtaining parent consent (see historical data below)
    - In FY25, a total of 5,906 services were provided. If performing at the same rate, we would expect 40% of 5,906 = 2,362 services by the end of Q2
- FY26 Q1+Q2 were reduced in comparison to historical numbers because
    - 3 weeks delay in start of services due to Epic EHR transition/training (14 of 17 school weeks providing services). This means 82.4% of usual time was available.
    - 3 of 24 Mental Health Consultant (therapist) positions were vacant for all of Q1 and Q2 due to hiring freezes. This means 87.5% of staff capacity in comparison to historical.
    - Applying both of these limitations to Q1+Q2: 2,362 expected services x 82.4% of usual time available x 87.5% of staff available = 1,703 services would be expected in Q1+Q2 of FY26. Actual services provided are 1,753, suggesting that the program is performing on-track or slightly ahead of expected.

Discussion about progress for "total students served"

- It is unclear how the delay in startup of the program due to EHR transition and training will affect total numbers of students served, but possibly it will only delay their engagement and limit the number of services provided per student, rather than having a major impact on the number of students.
- However, the staff vacancies in FY26 will affect the number of students served because there are schools that do not yet have coverage and there will be less than half of a year to engage and serve students. Applying an annualized estimation of 93.8% of staff capacity for

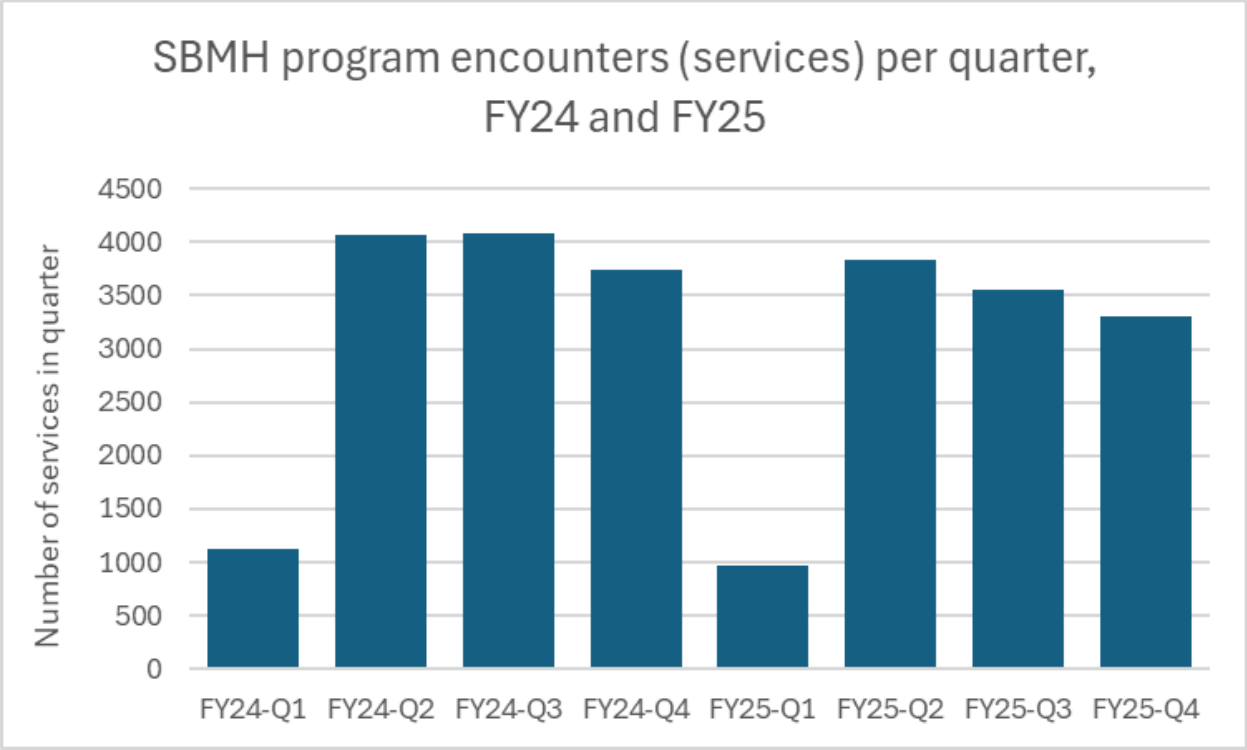
the year (87.5% during Q1/Q2 per above, and 100% for Q3/Q4) to the FY25 total of 687 students served in FY25, this suggests that the program may serve 644 students in the FY26 year. If so, the current service of 449 students is 69.7% of the projected 644 for the year, suggesting that the program is making good progress to meet expected numbers for the year.

REFERENCE for statement that 40% of annual services are provided in Q1+Q2

The number of client encounters (or services) varies during the school year (see below).

- Q1 includes summer months, when the program does not provide services
- After school starts, it can take some time to engage students in care at the start of the school year, including gaining parent approvals for younger students

In each of the past 2 years about 40% of all encounters/services in the total year were delivered during Q1+Q2, and 60% of all encounters/services were delivered in Q3+Q4.



Appendix B: School-Based Mental Health (SBMH) Ecosystem Assessment

PART 1: Findings from Key Informant Interviews

Summary

To inform understanding about School Based Mental Health (SBMH) program implementation and perceived effectiveness, we conducted a series of key informant interviews with external partners who work directly with the program in all Multnomah County school districts, and with staff working in aligned programs in state agencies and in other counties. The purpose of the interviews was to learn how the SBMH program operates from different perspectives (including school district partners), what is working well, and if there are opportunities to strengthen implementation or collaboration. We also wanted to learn about the current and changing capacity of resources that collaborate with the SBMH program to deliver a comprehensive system of mental health support for students.

Information shared by participants highlights their value of the critical, low-barrier nature of the County's SBMH program, and experienced, stable therapist staff. Challenges included staffing limitations and funding constraints. Partners expressed support for enhanced data-driven decision-making and sustainable resource allocation to meet student mental health needs.

Some opportunities for improvement may be provision of systematic reports about services provided, and other data (such as school survey data, demographic data) that could inform program resource planning and monitoring. SBMH adopting the Epic EHR system, which is also used by the Health Department's School-based Health Centers (SBHC), is taking some time but with long-term benefits for both SBMH and SBHCs. Now that both programs are using the same EHR, coordination between the teams will be easier and more efficient.

Methods

Key informant interviews were conducted via videoconference during September-November 2025. Interview transcriptions were recorded (with participant permission) to support analysis and identification of themes. Interviews took between 30-60 minutes.

Interviews were completed with one or more staff from:

- Primary program contacts in the six Multnomah County school districts working with the Health Department's SBMH program: Centennial, David Douglas, Gresham-Barlow, Parkrose, Portland Public Schools (PPS), and Reynolds
- Multnomah County Health Department's School-based Health Center (SBHC) program
- Oregon Health Authority (OHA) SBHC program
- Oregon Department of Education (ODE) Student Success Act
- SBMH administrators from Clackamas and Washington Counties

Guiding Questions

Questions below were designed to meet the interview goals. Questions were shared with participants ahead of time and used to guide conversation, but the conversation was kept somewhat informal. Priority was given to the questions shown in bold text, and potential followup questions identified as sub-points below.

- **How do you know what to ask for and how to place Multnomah County SBMH program counselors in your district?** We understand that plans are made per school year for SBMH counselors in your district (which schools, how to spread FTE).
    - Who provides information to inform your requests? Do you engage with community or others? (e.g., the ODE Aligning for Student Success Integrated Guidance on community engagement)
    - How do you know which schools?
    - How do you know how much FTE per school?
- **Do you have specific populations that you need to prioritize supporting with SBMH?**
- **Has the county been responsive to your needs?**
    - Have you had sufficient SBMH help in the past 2 years?
    - What were the remaining gaps?
- **Could you please tell us about the specific kinds of resources you have in your district that work together with SBMH?**
- **What is the status of these different resources for *this year*?**
    - Has this changed from resources over the past 2 years?
    - Do you anticipate anything changing in the next 2 years? (We know many things are uncertain, just offer your best guess.)
- **Is there anything else you'd like to say about School Based Mental Health programs, and how we can improve them in the future?**
    - What do you see as the most important priorities for implementing SBMH programs when funding is constrained?

- (For interviewees external to SBMH staff): **How do you know whether your mental health program is successful?**
    - What kinds of data do you look at? How do you share data with partners?
    - Do you have examples of reports or data that you could share?
    - Do you have any recommendations for stronger integration between SBMH and related programs or resources?

I. School District Partners

A. Resource Allocation and Determination of Need

SBMH school district partners talked about how they make decisions about where to place the SBMH Mental Health Consultants.

- **Collaborative Placement Model:** Allocation of the SBMH Mental Health Consultants, decisions about how much FTE and in which schools is primarily driven by a close, long-standing partnership between School District Leaders (SDLs) and SBMH supervisors. Most SDLs rely on the SBMH team's expertise for Mental Health Consultant placement, though services are sometimes adjusted based on data indicators.
- **Provider Stability:** Multnomah County SBMH Therapists are highly valued for their stability and licensure, a significant advantage over some private providers who experience higher turnover and may have less experienced staff (working on licensure hours). Some partners mentioned a desire to keep individual SBMH Therapists in place in schools as much as possible, because of the relationships that have been established between individuals on school teams and the SBMH therapists.
- **Data Indicators:** Need is sometimes formally determined using a mix of data points, including racial and linguistic demographics, Title I qualification, referrals and waitlist data, and staff-reported anecdotal information.

B. Population Prioritization

School district staff talked about the students who need care most, and how they identify these priority populations.

- **Culturally Specific Care:** County teams are valued for providing culturally specific and multilingual providers (e.g., Spanish-speaking, Black/African-American) who are essential in diverse or white-minority districts and buildings.
- **Underserved Focus:** The SBMH team's primary focus is students and families who are

uninsured or underinsured, disproportionately including those from Black, Indigenous, and People of Color (BIPOC) communities, who may face significant barriers to accessing mental health services elsewhere.

- **Low-Barrier Access:** A core strength of the County's SBMH model is the flexibility of MHCs, who can establish relationships and be present in schools without the constraint of billing for non-direct service time. This is critical for complex and high-need communities (e.g., Latinx families navigating complex needs, like fear of ICE).
- **Billing Barriers:** Agencies reliant solely on insurance billing struggle to gain traction and maintain presence in schools, creating unmet needs in several middle schools and underscoring the need to expand the flexible, Multnomah County SBMH model.

C. Program Responsiveness and Reporting

- **High Satisfaction:** School district leaders report high satisfaction with the SBMH team's responsiveness, stability, multilingual staff capabilities, and immediate site consultation for high-risk situations (e.g., suicide ideation).
- **Referral Pathways:** Referrals are channeled primarily through multi-tiered systems of support (Tier 2 teams) and school counselors, with high school students having the option to self-refer.
- **Reporting Disparity:** When schools work with other contracted agencies (e.g., Trillium) for therapeutic services, those agencies provide monthly reports about their activities in direct clinical time and prevention/collaboration time. Some districts contribute funds to County SBMH services, but in general detailed reporting like contracted agencies provide, including about billable vs. non-billable services, has not consistently been provided to school and district leaders. There was interest in receiving more detailed reporting about activities.

D. Complementary Mental Health Resources

- **SBMH as Specialty Care:** SBMH Therapists fill the critical role of providing full therapeutic services, a function that is explicitly outside the scope of most school staff due to policy and indemnification constraints, and their mandated roles. (See separate report section on "complementary resources".)

II. Integrated Services and Cross-County Context

A. School-Based Health Centers (SBHCs)

- **Integrated Care Structure:** SBHCs offer short-term (1-6 visits) integrated behavioral health services, focused on crisis and immediate support with a goal of transferring patients to community mental health for long-term issues. Each SBHC has at least one behavioral health provider. SBHCs consider SBMH Therapists to be part of a team to provide coordinated care for youth.
- **EHR Alignment:** The SBMH team transitioned to the Epic Electronic Health Record (EHR) in September 2025. The MultCo SBHC Integrated Clinical Services (ICS) was previously using Epic. Although it is taking some time to identify and integrate procedures that were in place when the two programs had separate EHRs, this new alignment is expected to significantly improve coordination of care through shared notes about needs and progress and care management.
- **Operational Challenge:** A key ongoing challenge is reconciling the medical-centric (quantity/billing) and mental health (therapeutic focus) systems, specifically in clarifying roles for patient follow-up and high-risk protocols.

B. Neighboring County Models

Perceived success of neighboring county SBMH programs was mentioned during FY 2026 dialogue with Multnomah County's Board of Commissioners about the MultCo program. We investigated these counties to understand their models and their goals.

- **Washington County:** Does not directly employ school mental health providers due to cost. Instead, they channel funding through community partners and focus on suicide prevention/training. They maintain a small, non-Medicaid billing SBMH service in two rural districts.
- **Clackamas County:** Utilizes an embedded, dual-role model within SBHCs, including Specialty Mental Health Therapists who provide full therapy and Behavioral Health Consultants (BHCs) for primary care mental health (triage, warm handoffs, quick check-ins). The program operates as "insurance blind", meaning that all students receive services, and the program bills any identified insurer (mostly the Oregon Health Plan, but also private insurers) as much as possible. This model ensures continuous capacity to address student needs, avoiding waitlists or unmet needs.

C. State Agency Perspectives

- Oregon Department of Education Student Success Act: ODE provides funding to all Oregon school districts by legislative requirement. Districts are required to develop a 2-year plan each biennium, including through a process of community engagement and review of data. Funds can be spent on school-based mental health support, if identified as a priority in their plans.
- Oregon Health Authority's School-Based Health Center (SBHC) program collects data from all participating counties about student services, including about behavioral health services provided through SBHCs. Reports are available by county, and include behavioral health services. Different counties apply different models for the coordination of SBHCs and SBMH programs or services, depending on their local context. OHA has not developed "benchmark" metrics for the portion of time or client load for for individual therapy or treatment, but noted that the client load for school-based therapists is lower than observed in dedicated clinical care entities (e.g., for-profit outpatient care providers) because of the time needed to participate in care coordination among school partners and to support non-billable prevention, outreach, and education activities.

III. Challenges and Policy Implications

- **High Demand and Waitlists:** Mental health services are "generally insufficient" due to high demand and limited resources. Waitlists for therapy are common in Centennial, Reynolds, and David Douglas, where providers frequently reach full capacity.
- **Staffing Gaps:** A significant financial and social challenge is the lack of Spanish-speaking therapists, despite a large Latino student population in some districts.
- **Funding Uncertainty:** Declining enrollment and financial challenges risk further cuts to non-mandated services, like counseling and mental health. The elimination of "wiggle room" funding for private providers' non-billable hours limits their utility in high-need, low-barrier schools.
- **Recommendation for Data Enhancement:** Improving the collection and consolidation of referral and service delivery data across all SBMH providers is necessary to provide school and district leaders with a holistic view for better resource management and planning.
- **Recommendation for Model Expansion:** School district leaders all expressed a desire to expand the flexible, low-barrier Multnomah County SBMH model to all schools. Considerations for future resource planning could include finding new ways to coordinate resources (e.g. looking at the dual-role model that Clackamas county uses).

Appendix C: School-Based Mental Health (SBMH) Ecosystem Assessment

PART 2: Complementary Resources

Summary

This report describes the presence and roles of aligned programs or resources for supporting mental health among students in schools. Information was identified during interviews with partners or aligned programs (see separate report section on key informant interviews), and through reviews of Oregon Department of Education (ODE) reports or School-based Health Center (SBHC) reports.

Two types of relevant resources were identified:

- **School-based resources** – These are staff or programs that operate within the school system. Many are school district employees, but some are not. We identified their primary roles, and also how they support the SBMH program. During key informant interviews, some partners noted that there can be confusion about roles from people who see titles such as "school counselor" or "school psychologist" and assume that these staff could provide mental health therapy; however, they have other defined roles to play in the school system, and do not have the training to provide mental health therapy as the SBMH staff do.
- **Multnomah County Health Department resources** – MCHD has at least two programs with prevention staff who can do work in school settings, although they do so at the request of schools and are not dedicated to specific schools or to a specific amount of time in school-based work. These staff may be a resource for prevention, education, and outreach (PEO) activities of the SBMH staff – although they do not have sufficient capacity to work in all schools, these prevention specialists could support the SBMH team with general content, materials, or technical support for PEO activities, and SBMH staff could also facilitate relationships between school systems and prevention specialists.

School-Based Resources

There are many resources present in schools that can complement SBMH programs. The program team, including clinicians who are placed in school buildings, frequently coordinate through systematic meetings or established communication channels.

Notably, complementary resources are *not duplicative* of SBMH resources. However, changes in these resources can affect the SBMH program, for example by interrupting usual practices in referring students for care.

Table 1 summarizes these resources, their general function in schools, and how they may coordinate with SBMH program staff.

Table 1. Complementary resources/partners for SBMH programs in schools
Roles in bold specifically complement SBMH program staff (details in *italics*)

Resource	**Role in SBMH services**
District coordinator	Actively support coordination with other resources in the district, plan for SBMH resource deployment in buildings according to need.
District contract	The financial contribution per district, with details about expectations.
School administrators	Assure SBMH have private office spaces, actively support coordination with other resources in buildings
School counselors	Focus on universal Tier 1 and 2 social-emotional learning and instruction.*Identify students for referral to SBMH* (their primary role is often managing schedules for 300-500 students each).
School psychologists	*Provide student referrals.* Primarily dedicated to mandated assessment and diagnosis duties tied to the Individuals with Disabilities Act (IDA).
School social workers	Focus on removing barriers to education (e.g., housing, food, healthcare) and community resource connection, not long-term therapy. *Provide complementary support for needs that may be identified during SMBH care; provide student referrals to SBMH.*
School-based Health Centers	Coordinate physical health care with SMBH; collaborate in "wraparound" care plan meetings with SBMH and others in support of high-need students.
School nurses	School nursing is a specialized practice of nursing that advances the well-being, academic success, and lifelong achievement and health of students. Generally providing limited healthcare for students, including managing and preventing chronic disease needs.
Integrated Client	This role provides the primary care model of mental health, which

Table 1. Complementary resources/partners for SBMH programs in schools Roles in bold specifically complement SBMH program staff (details in *italics*)	
Resource	**Role in SBMH services**
Services (ICS) Behavioral Health Consultant	includes *warm handoffs to SBMH, quick check-ins, bridging, and triaging referrals.*
Outpatient treatment programs in schools	Outside private providers (for example, Trillium) may also provide individual-level student mental health care in schools, *complementing SBMH services (so that SBMH services can be focused on culturally-specific care, and the uninsured, as needed.)*
Prevention specialists/other County staff	Multnomah County has some prevention specialists who may support prevention-related education in classrooms and communities. *May be able to collaborate with SBMH to cover prevention-related needs.*

Table 2 identifies the presence of school-based coordinating resources among MultCo's six partner districts. Notably, some districts may be facing future budget reductions that could affect the presence of these resources, and thus affect the SBMH and provision of a coordinated continuum of care for students.

Table 2. Number of complementary resources/partners, by School District (School year 2024-2025)						
School District (# of students) **Resource**	Centennial (5,352)	David Douglas (8,686)	Gresham-Barlow (11,370)	Parkrose (2,711)	Portland Public (42,785)	Reynolds (9,656)
School administrators	23	40	45	12	190	52
School counselors	15	25	40	8	155	36
School psychologists	6	4	6	2	65	9
School social	0	3	1	0	49	14

Table 2. Number of complementary resources/partners, by School District (School year 2024-2025)						
School District (# of students)	Centennial (5,352)	David Douglas (8,686)	Gresham-Barlow (11,370)	Parkrose (2,711)	Portland Public (42,785)	Reynolds (9,656)
Resource						
workers						
School-Based Health Centers	1	1	1	1	5	1
School nurses	5	7	8	2	43	10
Integrated Client Services (ICS) BH Consultant	1	1	0	1	3	1
Outpatient treatment programs in schools*	Trillium; and four other contracted providers so can have 2 per school	Trillium; REAP	Trillum; Life Stance; Stronger Oregon; Eastside Family Therapy; Care Solace	Trillium; Stronger Oregon; and Latino Network for cm services	Trillium; Sankofa; LifeWorks; and other contracted providers	Trillium; Stronger Oregon; Northwest Family; Sankofa

Data sources: 2024-25 ODE profiles; SBHC reports

*These are outpatient treatment providers mentioned in interviews – may not be complete or most current.

Multnomah County Health Department Resources

The Multnomah County Health Department has at least two programs with prevention staff who can do work in school settings, although they do so at the request of schools and are not dedicated to specific schools or to a specific amount of time in school-based work. These staff may be a resource for prevention, education, and outreach (PEO) activities of the SBMH staff - although they do not have sufficient capacity to work in all schools, these preventionists could support the SBMH team with general content, materials, or technical support for PEO activities, and SBMH staff could also facilitate relationships between school systems and prevention specialists.

Behavioral Health Division: Wellness and Prevention Program

The Behavioral Health Division Wellness and Prevention team focuses on primary prevention among youth and young adults. They can provide training, technical assistance, and resources for classroom or larger setting health education related to prevention of mental health harm, substance use, or gambling. This team also provides support to schools after a youth suicide, as well as general training, such as Mental Health First Aid and Applied Suicide Intervention Skills Training, which could complement services provided by SBMH Mental Health Consultants.

Public Health Division: Prevention and Health Promotion, Community and Adolescent Health Programs

The Community and Adolescent Health (CAH) team conducts prevention activities focused on shared risk and protective factors, including various trainings for teachers and school staff (e.g., Youth Mental Health, Substance Use Prevention, Being an "Askable Adult," Coaching Youth Into Adults, Understanding Violence as a Public Health Issue). The CAH team engages youth in health promotion projects, such as Crime Prevention Through Environmental Design (CPTED), across priority school districts (although they are not assigned to any particular school). They also support two annual youth summits, one focused on LGBTQ+ youth and the other on violence prevention.

Appendix D: SBMH District Scorecard DRAFT

Summary

The purpose of a school- or district-based scorecard is to systematically provide consolidated information that is relevant to ongoing SBMH planning, monitoring, and improvement. Having information in a simple format could also facilitate collaboration among partners within the school ecosystem.

Scorecard content is still in development, and will be informed by the development of SBMH program-wide indicator reports and population-based youth mental health outcomes (see separate sections of this report).

The current draft of this Scorecard has two parts:

Annual summary:

- **School context.** This section includes identified school factors that can inform needs for mental health support among students, including potential need for culturally-specific support, such as student population descriptions, community need measures, and student mental health measures.
- **SBMH Services.** This section summarizes SBMH services from the prior year, including detailed types of services delivered.

Quarterly report:

- **SBMH Activities.** This report could provide a high-level summary of the current year's activities.

DRAFT SBMH District Scorecard Tool

The following are drafts of the content for SBMH school- and district-level "Scorecards".

CURRENT DRAFTS ARE IN DEVELOPMENT, and intended to provide general awareness of the content in consideration. Final versions of Scorecards for school districts and buildings will be informed by the current examination of SBMH program indicators and population-based youth mental health outcomes. (See other sections of this report.).

Annual Summary		
School Context		
Identified school factors that can inform needs for mental health support		
Student Population	**Status / Data**	**Date / Source**
Student population	# per school	
Race/ethnicity composition	# / % per school	
ESL students	# per school	
Community Needs	**Status/ Data**	**Date / Source**
Free/reduced lunch	#/% per school or community	
Child poverty	% per school	
SUN school measures	Per school	
Mental Health measures from student surveys and other population data		
Measure xxx	% per grade	2024 SHS
Measure xxx	% per grade	
Measure xxx	% per grade	SEED
Prior Year School-Based Mental Health (SBMH) Services		
Information about prior year SBMH program activities in the school/district		
Staff capacity		
# of individual therapists	Total FTE of therapists	# of therapists with KSA
Prior year SBMH Activities	**# of Encounters**	**Date / Source**
Total # of encounters		EHR report
Assessment & Plan		EHR report
Individual Therapy		EHR report
Family Therapy		EHR report
Crisis Services		EHR report

Case Management/Environment		EHR report
Groups		EHR report
Prevention Education Outreach (PEO) Events		PEO report

Quarterly Report (revision date)					
Current Year School-Based Mental Health (SBMH) Activities					
	July-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Cumulative total
Capacity					
# of therapists					
Total FTE therapists					
Services					
Total # encounters					
# encounters for priority population					
Total # PEO events					

Appendix E: Youth Behavioral Health in Multnomah County

This report summarizes some key indicators of mental health among youth in Multnomah County. The purpose of this report is to inform planning for programs that support mental health and well-being among Multnomah County youth.

Key Findings

School-based surveys in Multnomah County are an important tool for understanding and monitoring youth mental health and well-being. This report shares findings from more than 2,400 6th grade students, 2,600 8th grade students, and 1,500 11th grade students who completed Oregon's Student Health Survey (SHS) in Fall 2024.

Outcomes examined

- **General mental health:** About 70% of 6th grade, 62% of 8th grade, and 51% of 11th grade students reported that their mental health is "good" or better. Translated to real numbers, more than 21,000 students in Multnomah (an estimated 4,900 in grades 4-6, 6,600 in grades 7-9, and 10,200 in grades 10-12) said that their mental health was "fair or poor" - this suggests many young people may need support. Measures of self-efficacy ("I can do things if I try") and resilience ("I can work out my problems") are similar across grades.
- **Depression and self-harm:** About 27% of 6th grade, 30% of 8th grade, and 37% of 11th grade students reported depression in the past year. Translated to real numbers, more than 18,000 students in Multnomah (an estimated 5,100 in grades 4-6, 5,700 in grades 7-9, and 7,800 in grades 10-12) reported experiencing depression. Slightly more than one in ten students in each survey grade said that they had done something to purposely hurt themselves, without wanting to die; a similar percentage said they had seriously considered attempting suicide. Between 2-4% of students in each survey grade said that they had attempted suicide.
- **Access to care:** Approximately one in five 8th-grade and one in four 11th grade students reported having unmet emotional or mental health care needs in the past year. Translated to real numbers, this suggests that about 4,000 students in grades 7-9 and 5,000 students in grades 10-12 had unmet mental health needs. At least three in four students in all grades said that they had visited a doctor/nurse for a check-up when not sick in the past year.

- **Social determinants of health:** About 1 in 7 Multnomah County students reported being hungry at some point in the past month due to not having enough food; this prevalence was similar across grades. Sleeping in places other than a family or guardian's home was reported by one in ten 6th grade students and fewer than one in twenty 8th and 11th grade students. The prevalence of perfect attendance in the past month decreased from about half in 6th grade to one in three for 11th grade.
- **School environments:** Most students (about nine out of ten in all grades) said that a teacher or adult at their school really cared about them. Slightly more 6th grade than 8th or 11th grade students said that they were happy to be at school (84% for 6th vs. 73% for 11th grade), and feel safe at school (87% for 6th vs. 78% for 11th grade). Slightly fewer 8th graders said that it is easy to talk with teachers and other adults at their school than other grades (73% for 8th grade vs. 81% for both 6th and 11th grade).

Trend themes

Prior to 2024, the most recent SHS survey was given in 2022. Findings for Multnomah County schools that participated in both the 2022 and 2024 surveys were compared for a limited set of measures.

- The prevalence of good mental health in 2024 was similar to 2022 for 6th and 8th grade students, but improved slightly among 11th grade students (from 45% in 2022).
- Similarly, measures of depression improved modestly for 6th and 8th grade students, and markedly (from 50% to 37%) among 11th grade students.
- Having unmet mental health needs increased slightly among 8th grade students, but decreased among 11th grade students (from 32% to 24%).
- The prevalence of hunger due to limited food decreased in all grades.

Priority population group themes

For each set of measures, we explored responses by student demographic group for one indicator. Some themes arose across different sets of measures.

- **Gender and sexual orientation:** Prevalence of good mental health was highest among male students who identified only as straight, followed by female students who identified only as straight. Good mental health was similar for male and female students who identified sexual orientation other than straight, and lower than among straight-only identifying males and females. Good mental health was lowest among nonbinary students, with 40% among 6th grade and 25% among 8th grade reporting their mental health was good. Depression was higher among non-straight than straight males and females, and highest among nonbinary students. Reported unmet mental health health needs were

highest among nonbinary and female non-straight students. The prevalence of hunger was greater among nonbinary and male non-straight students than other grounds; these hunger disparities were markedly more prevalent among 6th grade students.

- **Race and ethnicity:** Prevalence of good mental health varied by race and grade, although patterns were not consistent. Prevalence of good mental health was consistently lowest among American Indian/Alaska Native students, and depression was relatively high, at all grade levels. Having unmet mental health needs was also highest among American Indian/Alaska Native students in both 8th and 11th grades, but at least one in five 11th grade students reported having unmet mental health needs in all racial/ethnic groups. The prevalence of hunger due to limited food varied by group, but was generally higher among students identifying as American Indian/Alaska Native and Native Hawaiian/Pacific Islander; hunger was generally lowest among students identifying as White.

METHODS

Data source

The data are from the Oregon Student Health Survey (SHS). This survey is given to youth in 6th, 8th, and 11th grades in Oregon schools.

The most recent survey was conducted in Fall 2024. Data were collected from more than 2,400 6th grade, 2,600 8th grade, and 1,500 11th grade students (see Appendix for participation detail).

Outcomes

We are examining several key indicators:

- Section 1: General mental health
- Section 2: Depression and self-harm (e.g., cutting), suicide ideation
- Section 3: Access to healthcare – including unmet emotional/mental health needs in past year
- Section 4: Social determinants of health – including hunger, housing
- Section 5: School environments - including connectedness to school and bullying

Analysis

Indicators are reported in sets. For all indicators in each set, we describe the current prevalence among students. When possible, we frame these in a positive or strengths-based direction (e.g., the percentage of students with good mental health). However, for some measures it makes more

sense to report the presence of a clear risk factor (e.g., reporting the percentage of youth with depression, not the percentage without depression).

For some "key" indicators, typically one per set of measures, we will also describe:

- Trends
- Different prevalence by student characteristics (race, gender, sexual orientation, social determinants of health)
- A range of estimates by school district

In each figure, confidence intervals are shown as "whisker bars". These show the relative precision of any of the survey estimates - when confidence intervals are larger, the survey estimate is less precise, sometimes because of smaller numbers of people who answered specific questions. Caution should be used when interpreting different estimates as "different" (e.g., higher or lower than one another) - a good rule of thumb is to not assume estimates are truly different from one another unless the confidence intervals do not overlap.

For key indicators, we also calculated the estimated number of youth who may need support. For these estimates, we used the percentage of youth "in need", and multiplied by the total number of students in surrounding grade groups:

- The percentage in need reported by 6th grade students on SHS was applied to student counts for grades 4-6
- Percentages in need reported by 8th grade students on the SHS was applied to student populations in grades 7-9
- Percentages in need reported by 11th grade students on the SHS was applied to student populations in grades 10-12

Estimates were rounded to the nearest hundred for grade estimates, and the nearest thousand for countywide estimates, to acknowledge that these are approximate numbers.

For example, for "need mental health support":

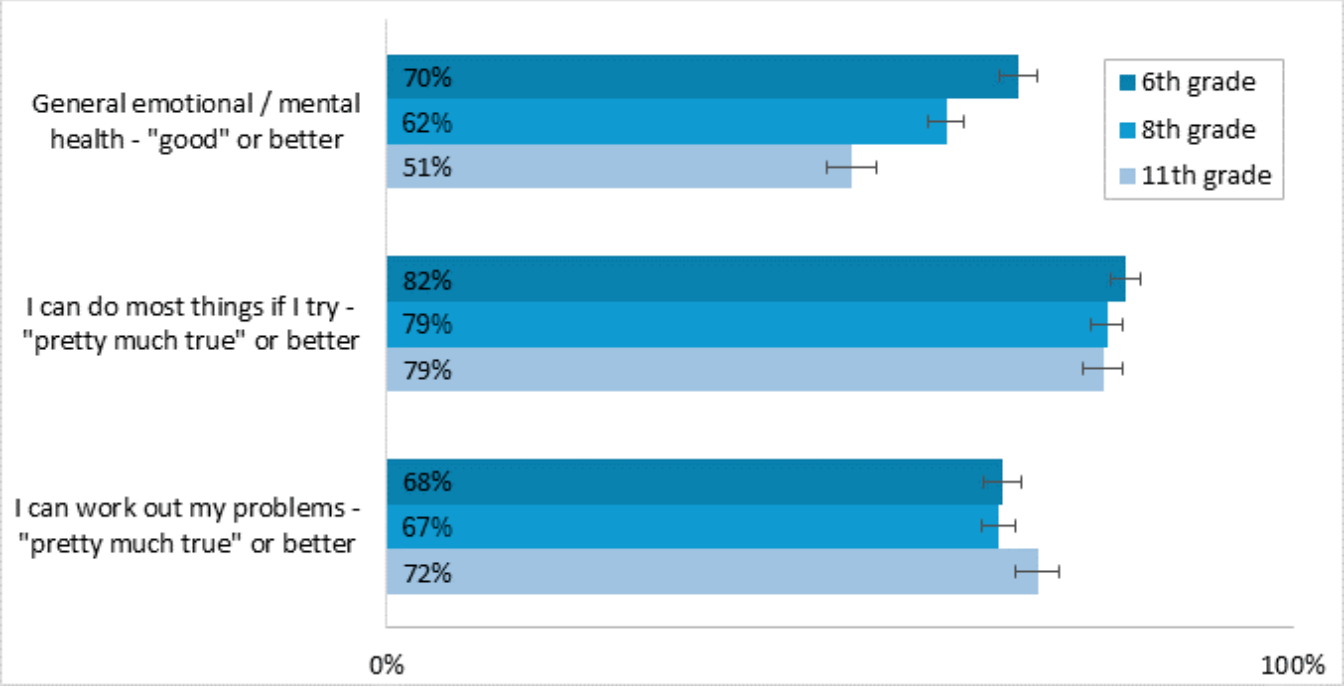
- 47.4% of 11th grade students reported having poor mental health in the 2024 SHS. This does not include students who said "not sure", only those who definitively reported poor mental health.
- 20,354 10-12th grade students were enrolled in Multnomah County, as reported in School Year 2024-25 Fall Membership Report at: https://www.oregon.gov/ode/reports-and-data/students/pages/student-enrollment-reports.aspx

- The estimated number of students in need was calculated as 47.4% x 20,354 = 9,638. To acknowledge that this is an estimate, we report the number rounded to the nearest hundred: in this case, about 9,600 students may need help with mental health.

Section 1. General Mental Health

Support for generally good mental health and self-efficacy (resilience, or the ability to be successful and handle problems) is a foundational aim for programs that support young people, including the school-based mental health program.

Figure 1. *General mental health indicators, Multnomah County students, by grade, 2024.*

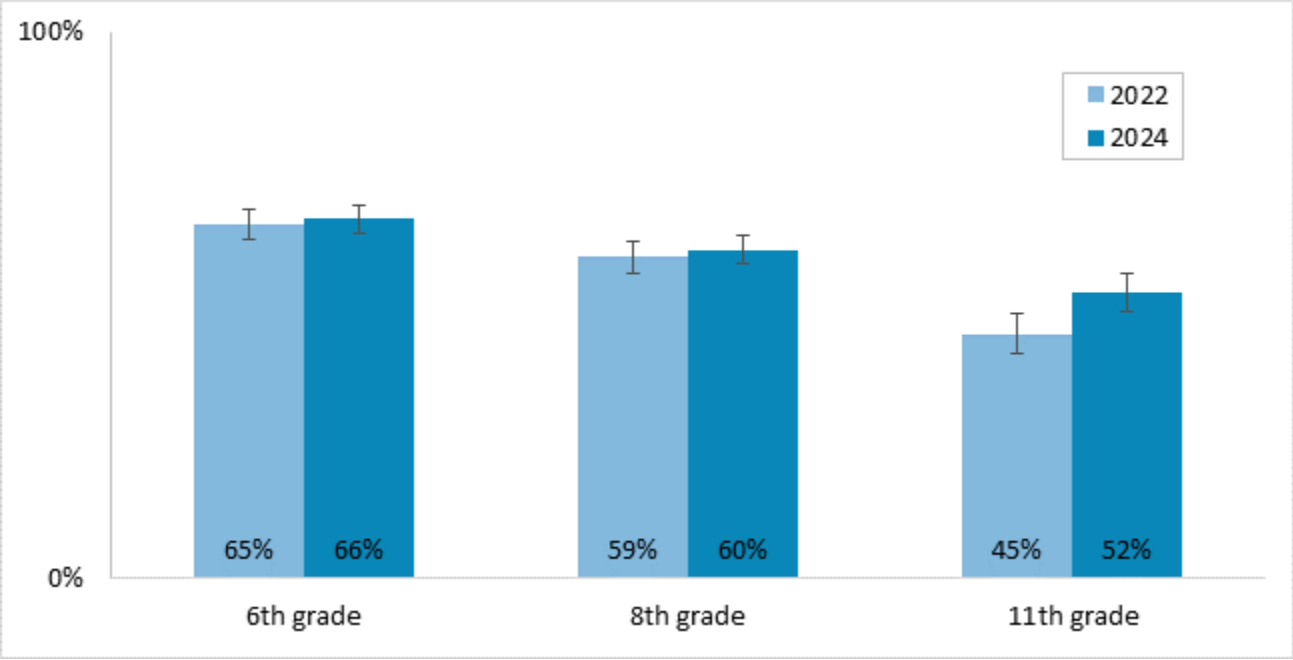


Source: Oregon Student Health Survey, 2024.
Denominators for all metrics include responses of "I am not sure."

- In all grades surveyed in 2024, a majority of Multnomah County students reported their emotional and mental health as "good" or better; percentages were higher for younger grades.
    - Translated to real numbers, more than 21,000 students in Multnomah (an estimated 4,900 in grades 4-6, 6,600 in grades 7-9, and 10,200 in grades 10-12) said that their mental health was "fair" or "poor".
- Prevalence of "good" mental health varied by Multnomah County's six participating school districts: 6th grade (64% - 73%), 8th grade (56% - 64%), and 11th grade (47% - 61%). (Data not shown - district-specific data are not reported to protect confidentiality).

- Approximately 4 in 5 students responded it was at least "pretty much true" they could do most things if they tried. Percentages were similar across grades, although slightly lower among 11th grade than 6th grade students.
- Approximately 7 in 10 students responded it was at least "pretty much true" they could work out their problems. Measures of self-efficacy show greater resilience among students in 11th grade compared to 6th and 8th grades.

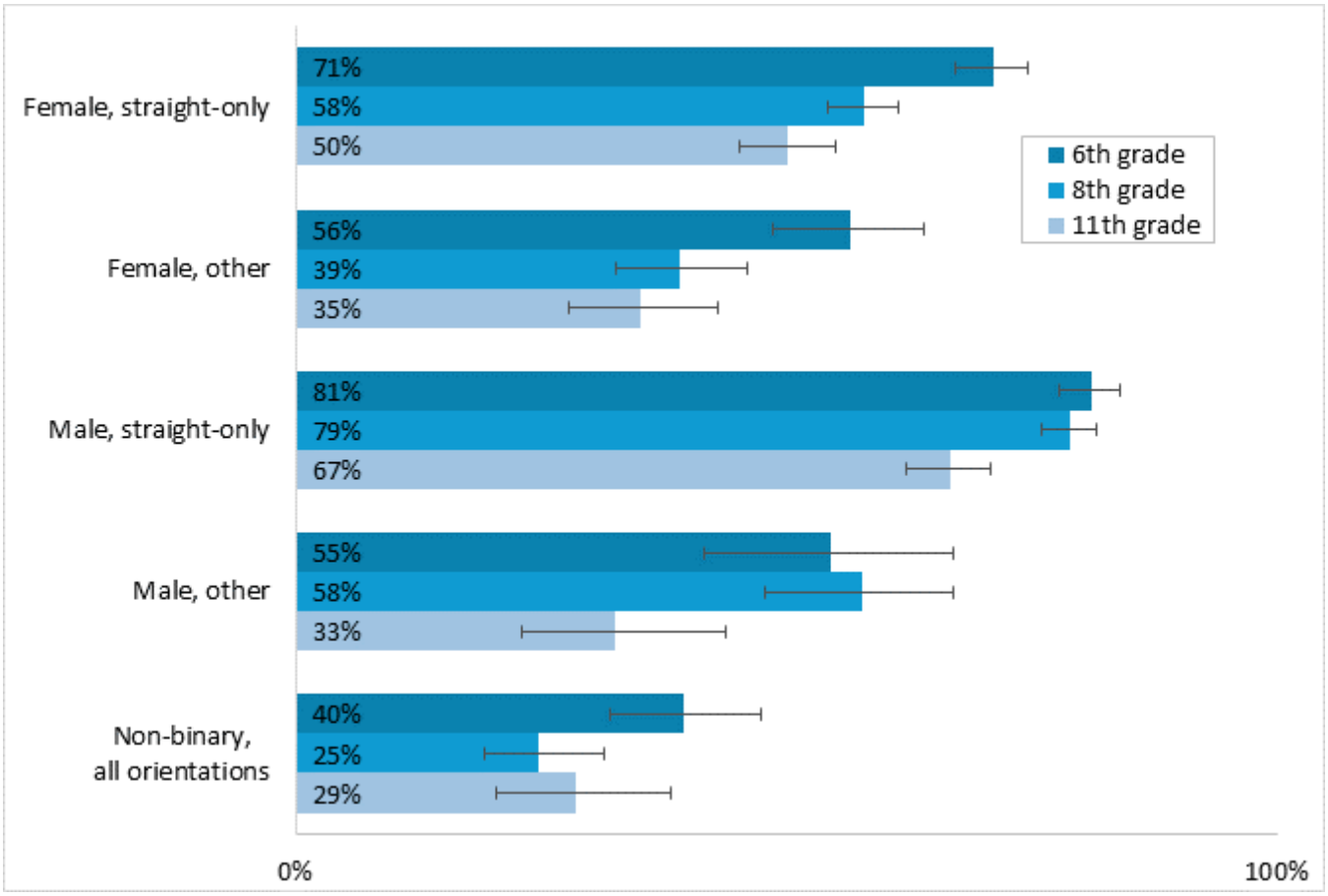
Figure 2. *Good emotional and mental health, Multnomah County students in select schools, by grade and survey year, 2022-2024.*



Source: Oregon Student Health Survey, 2022 and 2024, among schools that participated in both years.
Numbers may not match exactly to countywide estimates, because they are limited to these schools that participated in both years.
Note: SHS percentages include responses of "I'm not sure" in denominator.

- Twenty Multnomah County schools participated in the Student Health Survey for both 2022 and 2024.
- Among these schools, good mental health prevalence was stable between 2022 and 2024 for 6th- and 8th-grade students, while increasing for 11th-grade students.

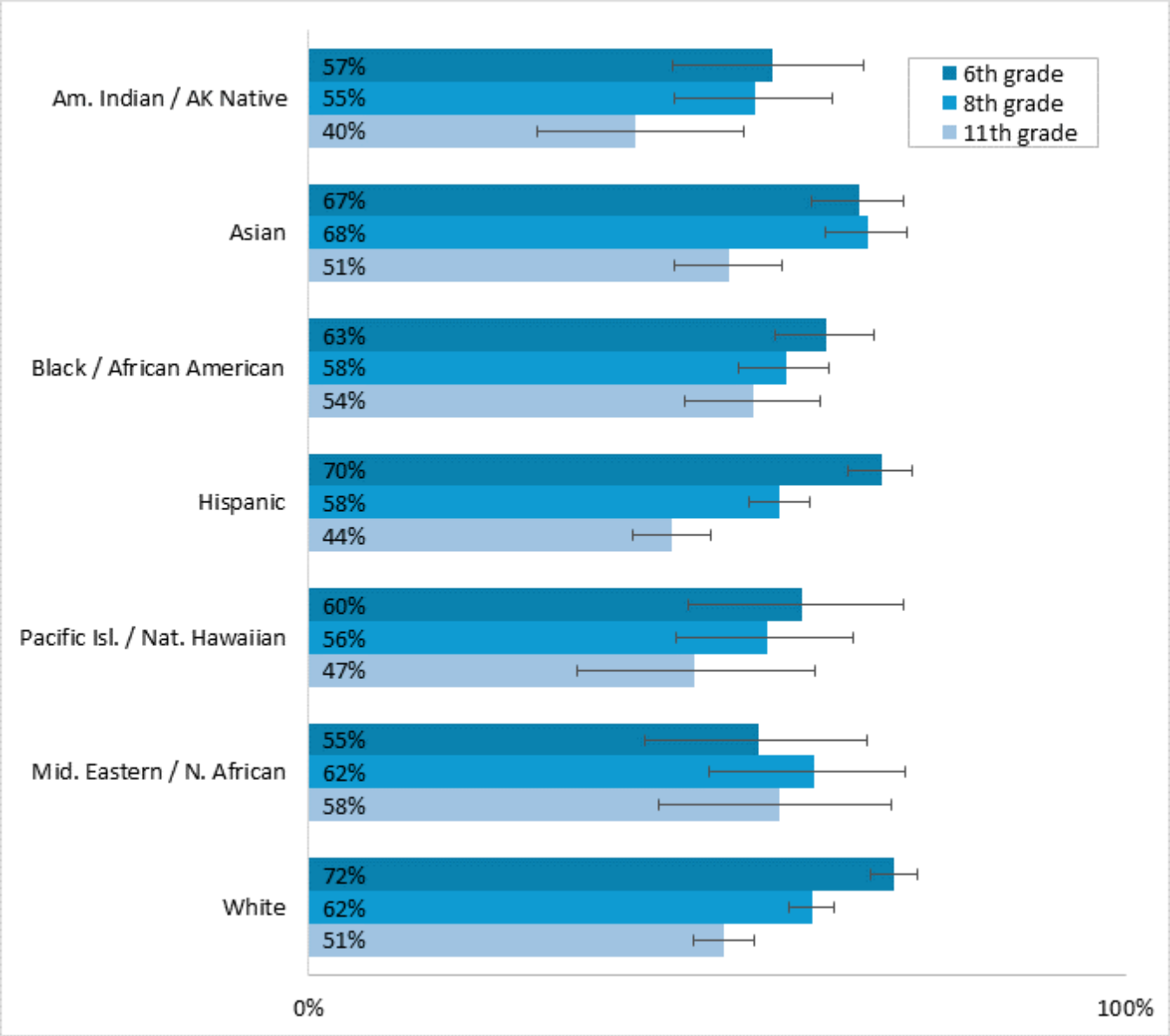
Figure 3. *Good emotional and mental health, Multnomah County students, by gender identification, sexual orientation, and grade, 2024.*



Source: Oregon Student Health Survey, 2024.
Denominator includes responses of "I am not sure."

- Self-reported "good" or better mental health varied considerably by students' identified gender and sexual orientation.
- Prevalence was generally higher among students who identified as male (vs. female or non-binary) and among students who identified only as straight (vs. one or more other sexual orientations).
- Non-binary students reported worse mental health than either male- or female-identified students, regardless of sexual orientation.

Figure 4. *Good emotional and mental health, Multnomah County students, by race/ethnicity and grade, 2024.*



Source: Oregon Student Health Survey, 2024.
Denominator includes responses of "I am not sure."

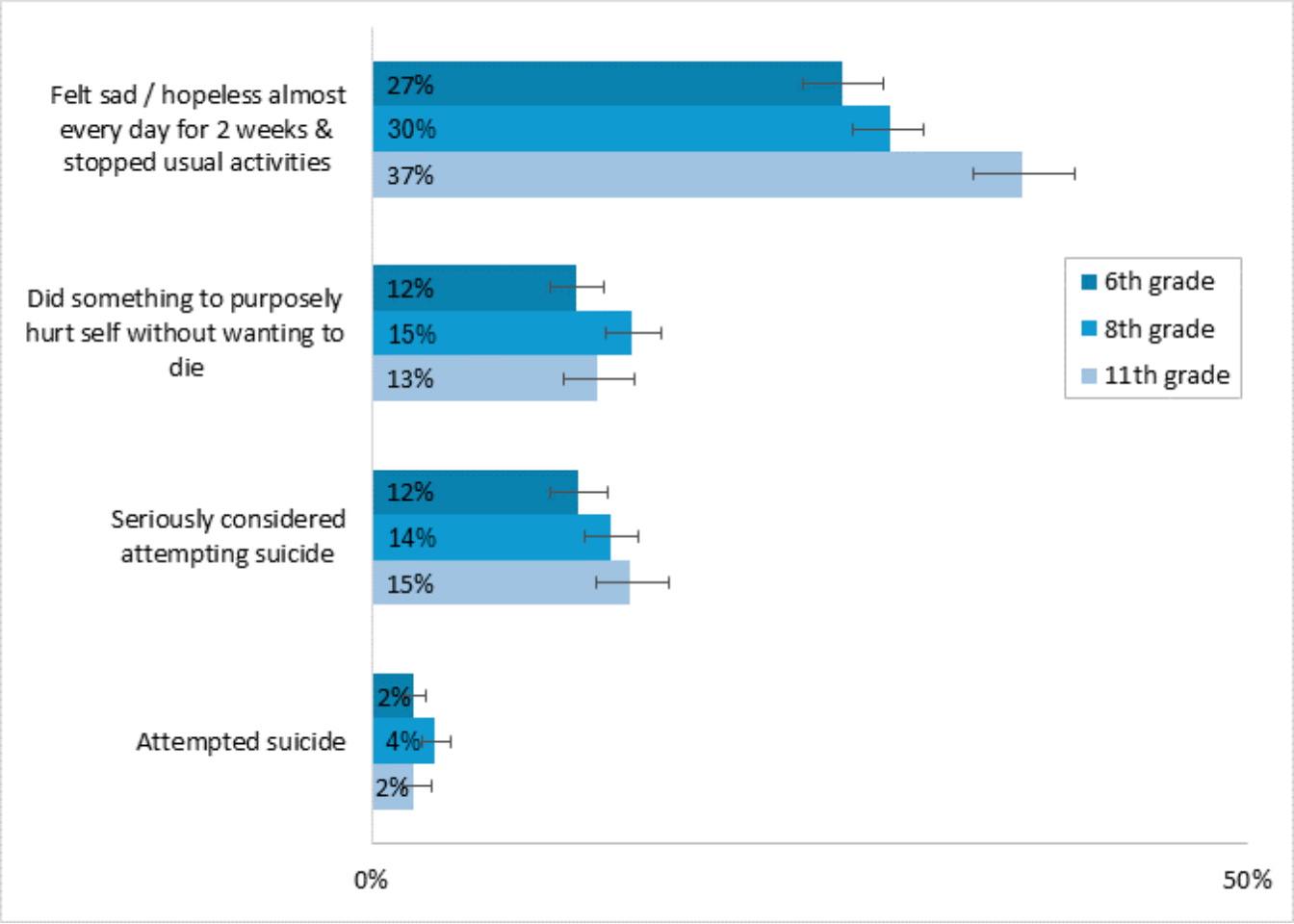
- Self-reported "good" mental health prevalence was generally lower as grade increased, but this pattern varied by student race/ethnicity.
- Among Multnomah County 6th grade students, good mental health prevalence was highest among those identifying as White, Hispanic, and/or Asian. Prevalence was lowest among American Indian/Alaska Native and Middle Eastern/ North African students.

- Among 11th grade grade students, prevalence was highest among Middle Eastern / North African and Black / African American students. Prevalence was lowest among American Indian/Alaska Native, Native Hawaiian/Pacific Islander, and Hispanic students.

Section 2. Depression and Self-harm

Students with poor mental health may develop depression (defined as feeling sad or hopeless every day for at least 2 weeks, such that youth stop doing usual activities). Some students experiencing depression can also engage in self-harm behaviors (like "cutting") or consider suicide.

Figure 5. *Depression and self-harm indicators for past year, Multnomah County students, by grade, 2024*



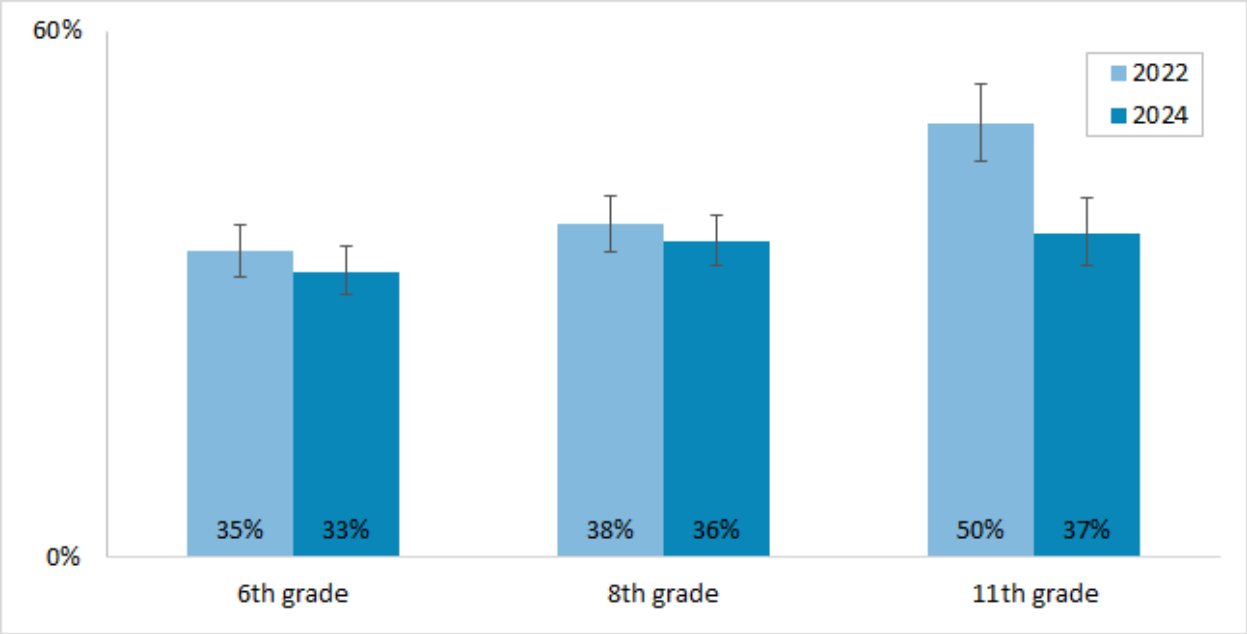
Source: Oregon Student Health Survey, 2024.

- Approximately 1 in 4 Multnomah County 6th-grade students reported experiencing depression in the past year, with this percentage increasing for higher grades.

  - Translated to real numbers, more than 18,000 students in Multnomah (an estimated 5,100 in grades 4-6, 5,700 in grades 7-9, and 7,800 in grades 10-12) reported experiencing depression.

- Depression prevalence varied by school district, in 6th grade (27% - 37%), 8th grade (25% - 44%), and 11th grade (31% - 46%).
- Across all grades, 12%-15% of students reported purposely harming themselves without wanting to die; percentages were similar for seriously considering suicide.
- 2% of 6th- and 11th-graders, and 4% of 8th-graders reported attempting suicide in the past year.

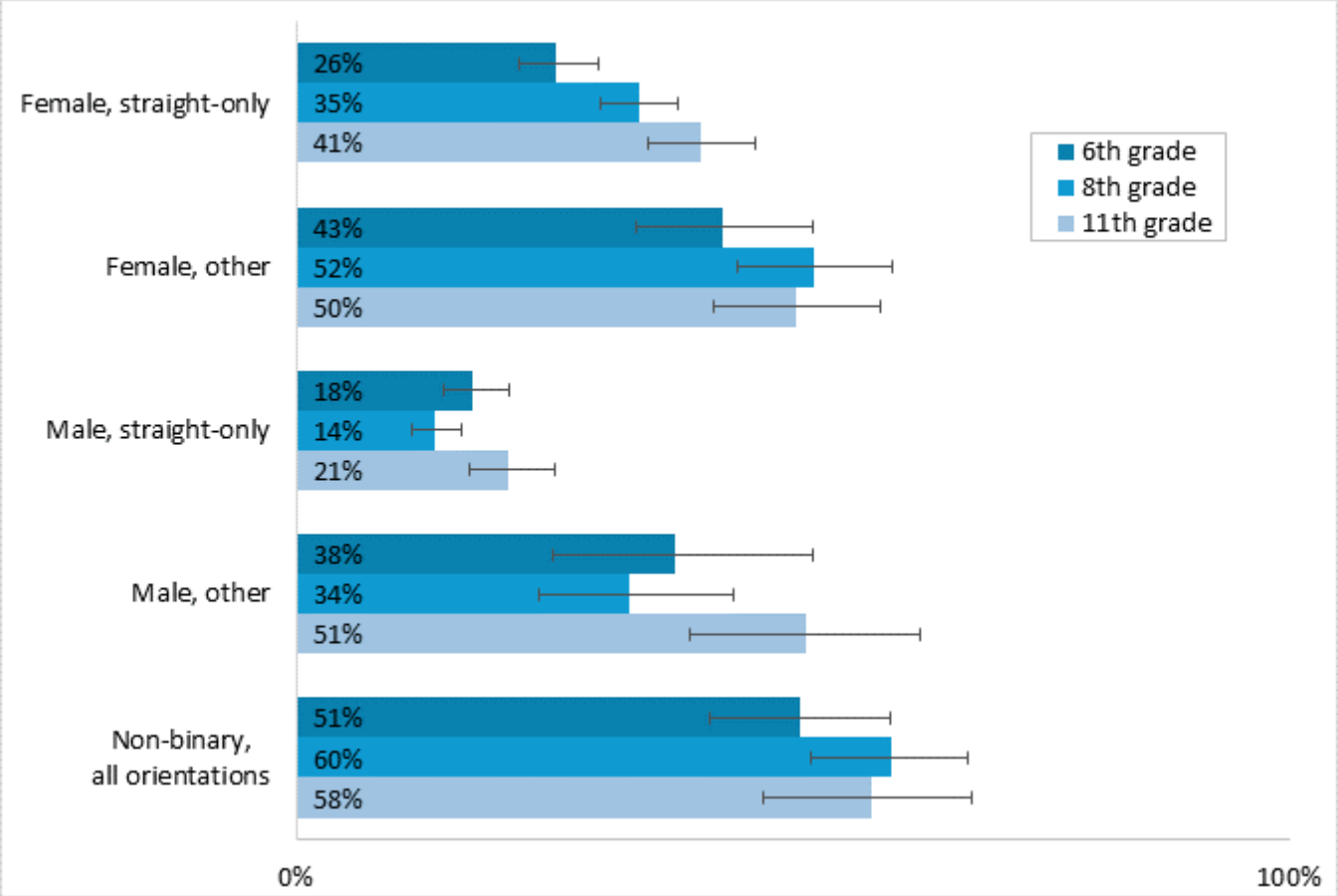
Figure 6. *Depression in past year, Multnomah County students in select schools, by grade and survey year, 2022-2024.*



Source: Oregon Student Health Survey, 2022 and 2024, among schools that participated in both years.
Numbers may not match exactly to countywide estimates, because they are limited to these schools that participated in both years.
Question text: "During the past year, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"

- Among schools participating in both surveys, the prevalence of students reporting depression decreased in all grades between 2022 and 2024.

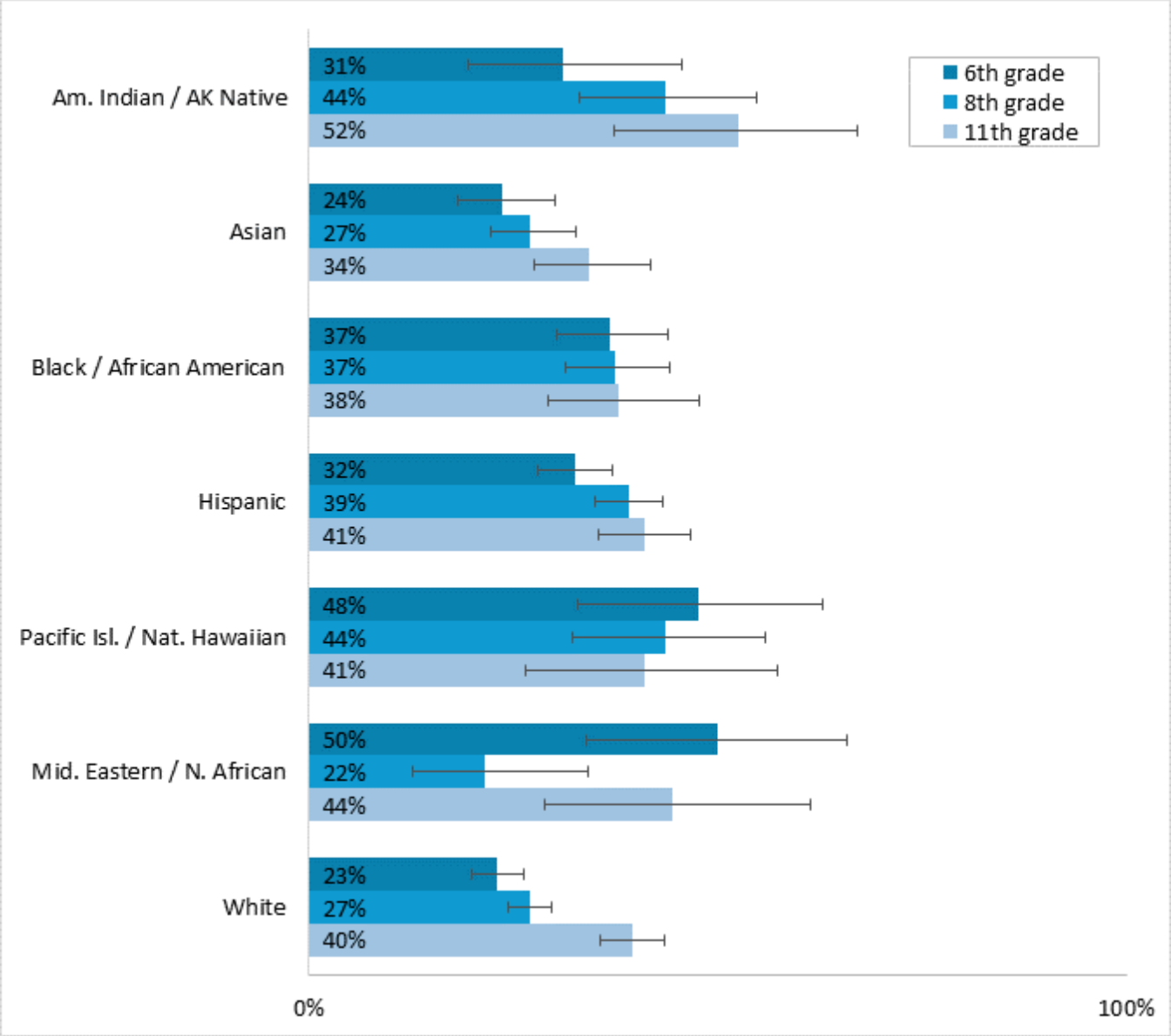
Figure 7. *Depression in past year, Multnomah County students, by gender identification, sexual orientation, and grade, 2024.*



Source: Oregon Student Health Survey, 2024.
Question text: "During the past year, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"

- Depression prevalence was highest among non-binary students for each grade.
- Non-straight females and males had higher prevalence of depression than their straight counterparts.
- Students identifying as female and straight reported higher rates of depression than male and straight students.

Figure 8. *Depression in past year, Multnomah County students, by race/ethnicity and grade, 2024.*



Source: Oregon Student Health Survey, 2024.
Question text: "During the past year, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?"

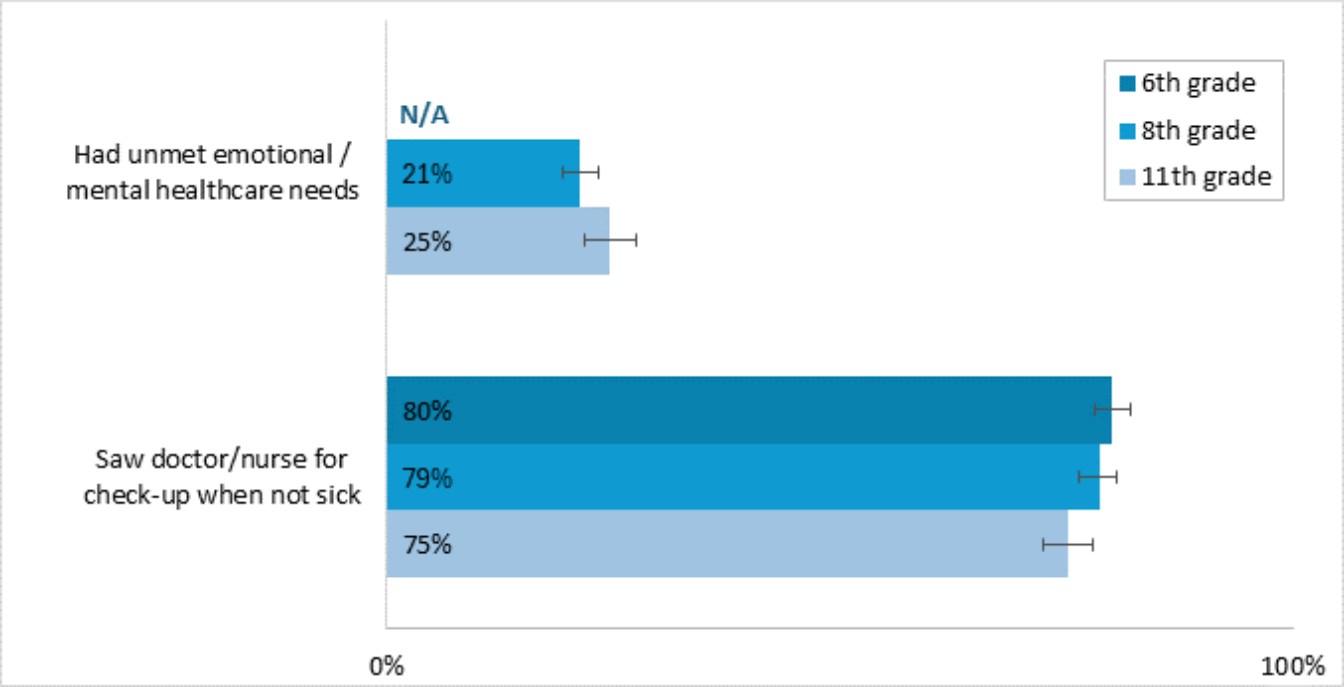
- Depression prevalence among Multnomah County students varied by students' racial/ethnic groups.
- Among 6th grade students, the prevalence of depression was highest among Middle Eastern/North African and Native Hawaiian/Pacific Islander students.

- Among 11th grade students, the prevalence of depression was highest among American Indian/Alaska Native and Middle Eastern/North African students; rates among other groups were fairly similar.

Section 3. Access to Care

Youth should have access to mental and physical health support when they need it. Lack of access to needed support may be reported if programs or services do not exist, if youth do not know about them, or if the systems and people who provide that support are not "accessible", meaning that there are structural or social barriers to youth connecting to those services.

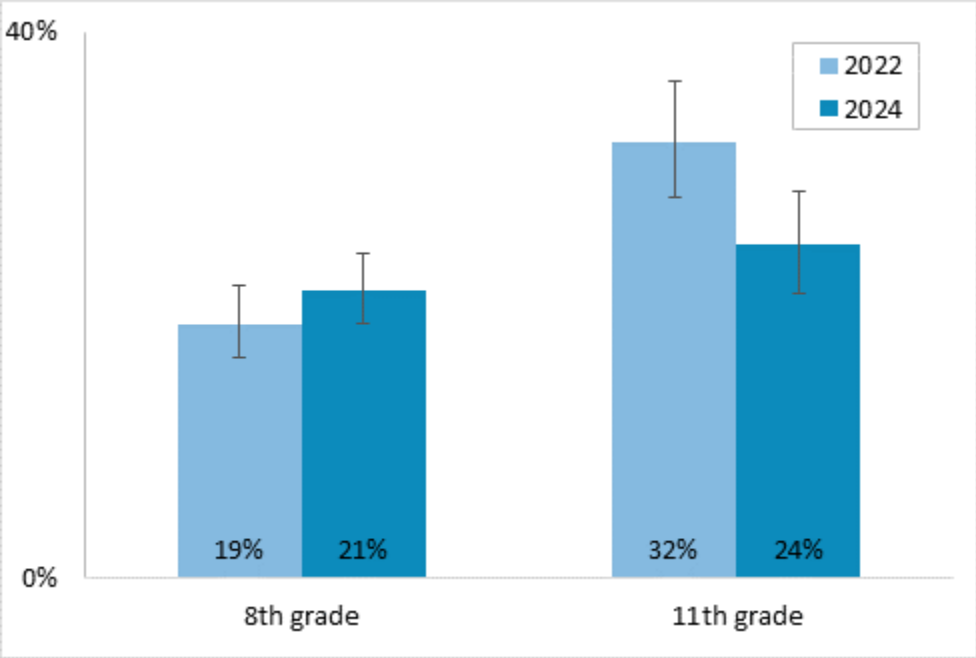
Figure 9. *Health care access indicators for past year, Multnomah County students, by grade, 2024.*



Source: Oregon Student Health Survey, 2024.

- Approximately one in five 8th-grade and one in four 11th grade students reported having unmet emotional or mental health care needs in the past year.
    - Translated to real numbers, this suggests that about 4,000 students in grades 7-9 and 5,000 students in grades 10-12 had unmet mental health needs.
- Unmet need prevalence varied substantially by school district, in both 8th grade (19% - 28%) and 11th grade (18% - 30%).
- At least three-quarters of students in all grades surveyed reported having a check-up with a doctor or nurse when not sick in the past year, suggesting that most– but not all – students have access to physical health care.

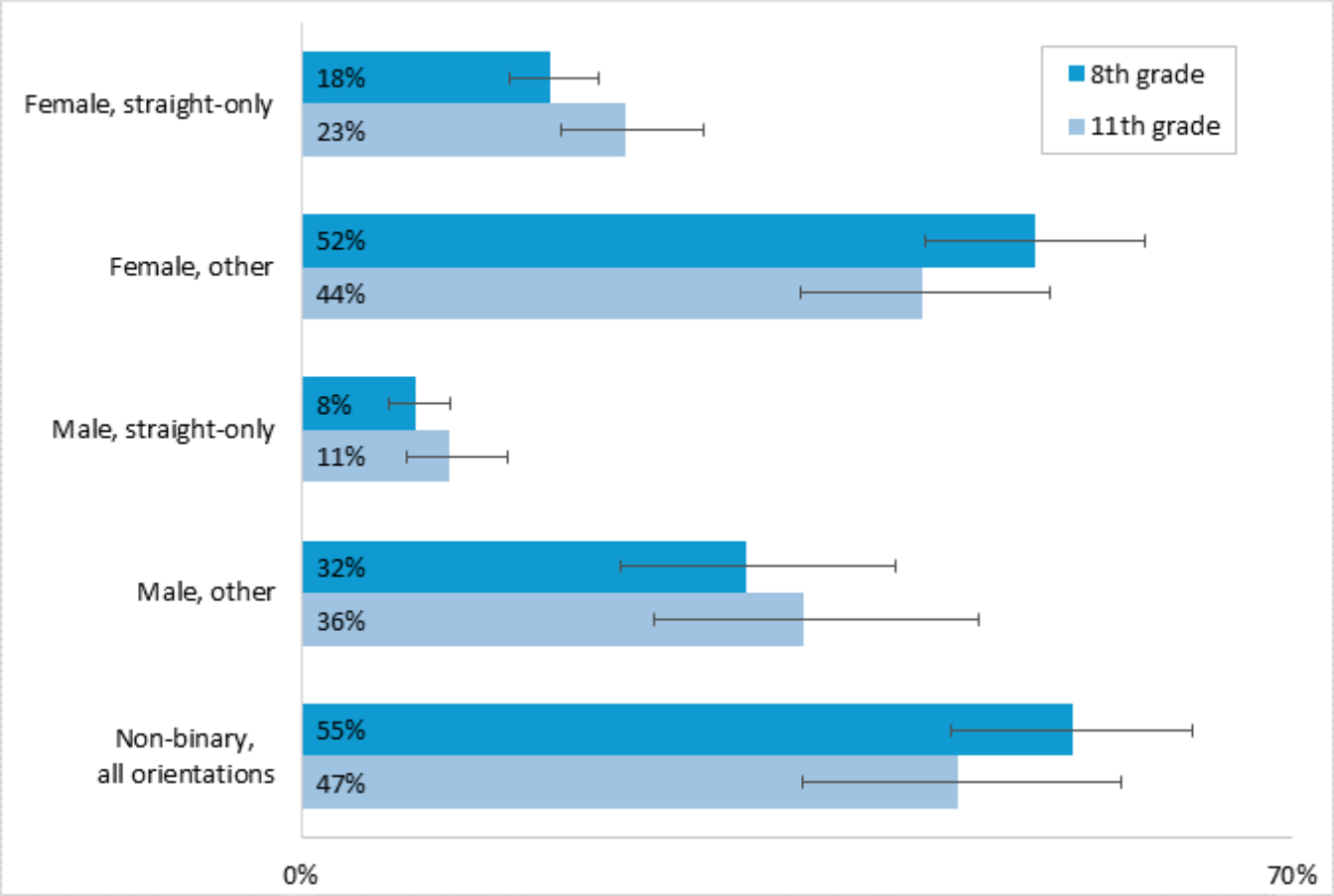
Figure 10. *Unmet emotional or mental health care needs in past year, Multnomah County students in select schools, by grade and survey year, 2022-2024.*



Source: Oregon Student Health Survey, 2022 and 2024, among schools that participated in both years. *Numbers may not match exactly to countywide estimates, because they are limited to these schools that participated in both years.*

- Having unmet emotional or mental health care needs decreased from 2022 to 2024 among Multnomah County 11th-grade students in schools participating in both survey years.
- The prevalence of unmet mental health needs increased slightly for 8th grade students between 2022 and 2024.

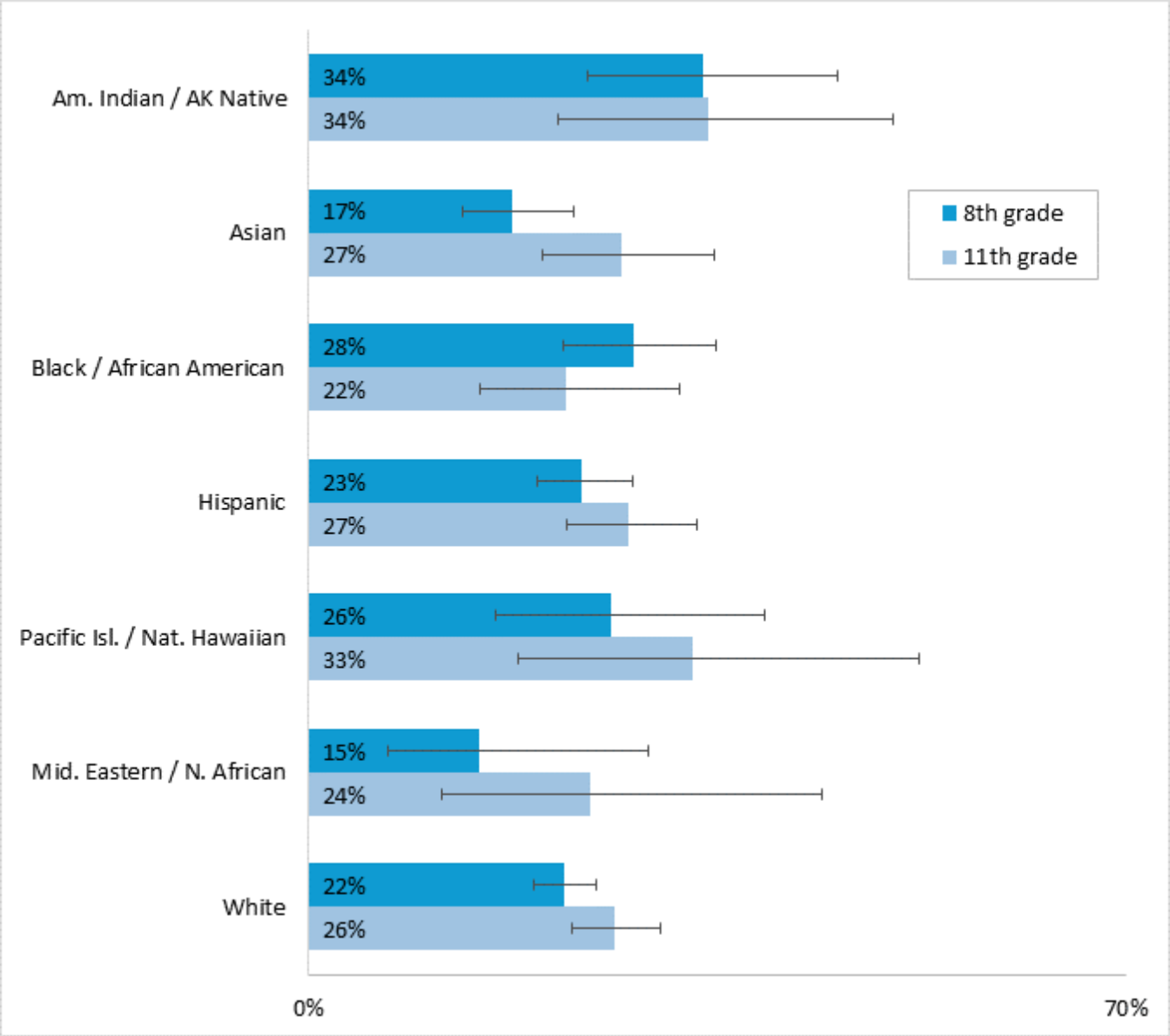
Figure 11. *Unmet emotional or mental health care needs in past year, Multnomah County students, by gender identification, sexual orientation, and grade, 2024.*



Source: Oregon Student Health Survey, 2024.

- Reported unmet emotional or mental health care needs were highest among non-binary students and female students with a non-straight orientation.
- There was no consistent pattern by grade across gender and sexual orientation categories.

Figure 12. *Unmet emotional or mental health care needs in past year, Multnomah County students, by race/ethnicity and grade, 2024.*



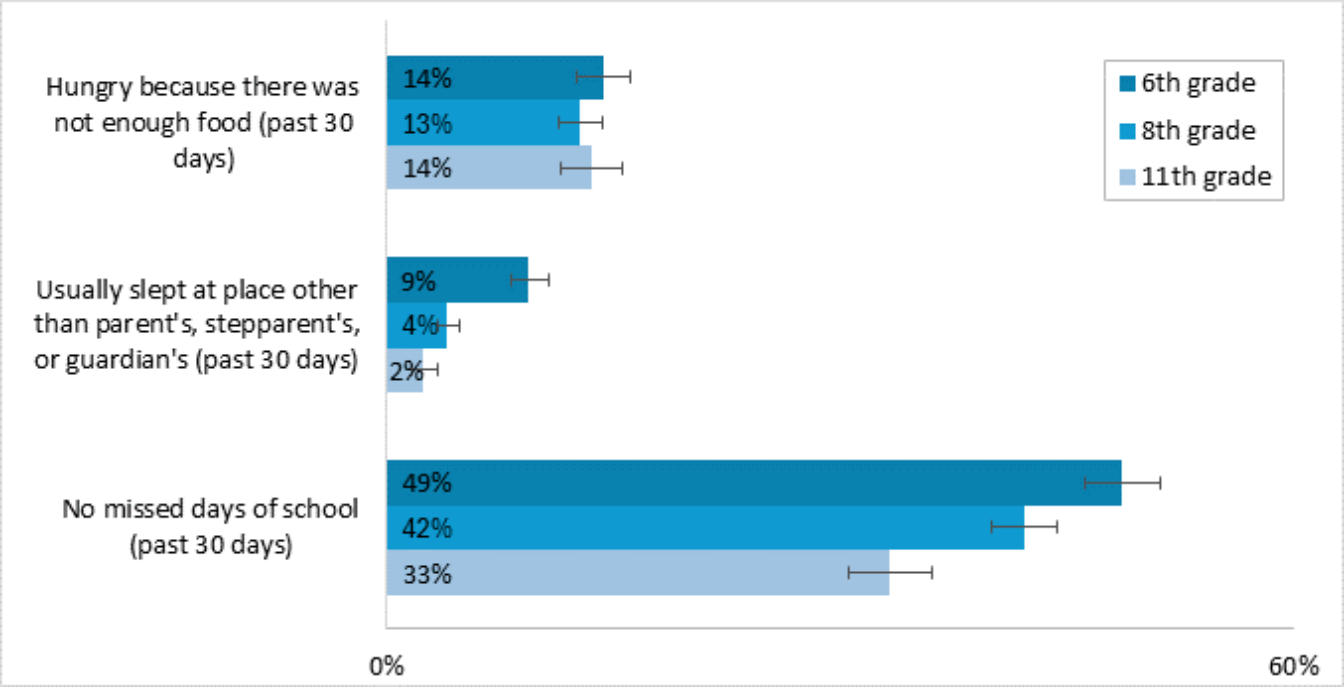
Source: Oregon Student Health Survey, 2024.

- Reported unmet emotional or health care needs were highest among students identifying as American Indian / Alaska Native.
- At least one in five 11th-grade students reported unmet needs among most racial/ethnic categories.

Section 4. Social Determinants of Health

Underlying social needs - such as stable food and housing - can harm youth well-being, causing distress and poor mental health. These are also factors that can harm academic success. Programs that seek to support youth mental health can also identify where basic needs exist and help to connect families to support.

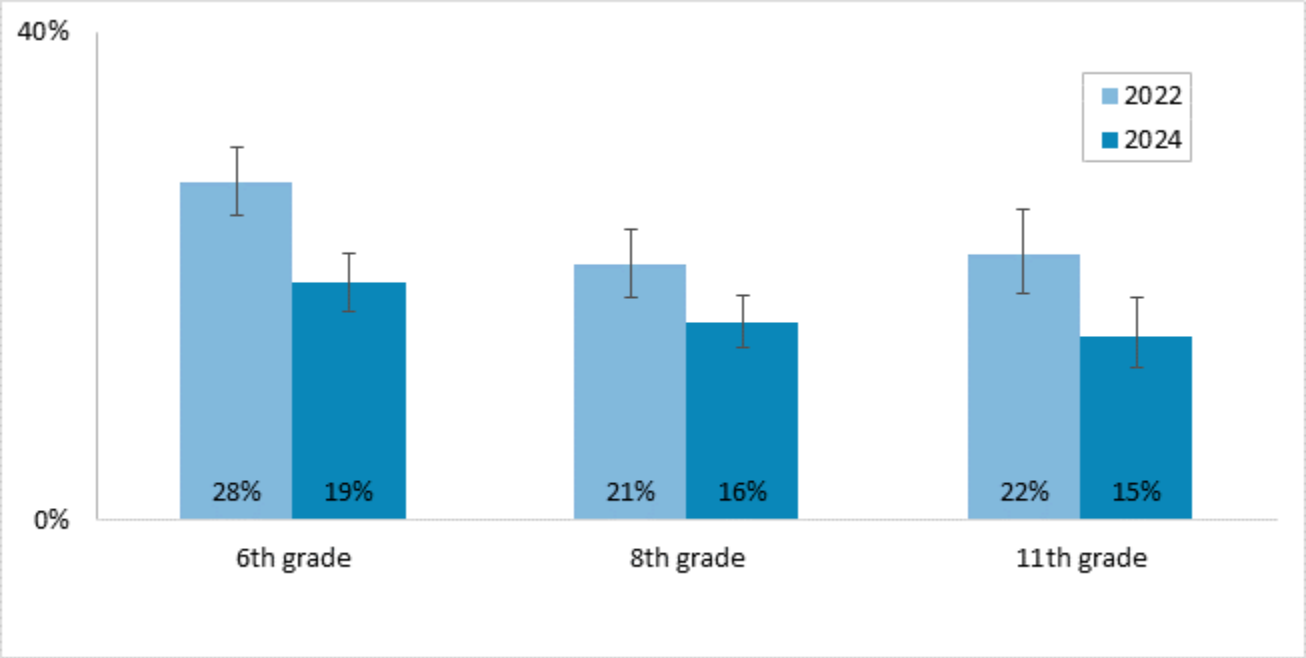
Figure 13. *Social determinant indicators, Multnomah County students, by grade, 2024.*



Source: Oregon Student Health Survey, 2024.

- Approximately 1 in 7 Multnomah County students reported being hungry at some point in the past 30 days due to not having enough food; this prevalence was similar across grades.
- Hunger prevalence varied by Multnomah County school district, particularly in 6th grade (11% - 24%) but also in 8th grade (10% - 19%) and 11th grade (13% - 18%).
- About 1 in ten 6th grade students reported usually sleeping some place other than their family or guardian's home; instability was lower for higher grades.
- Approximately half of 6th grade students reported perfect attendance over the past 30 days; attendance decreased for higher grades.

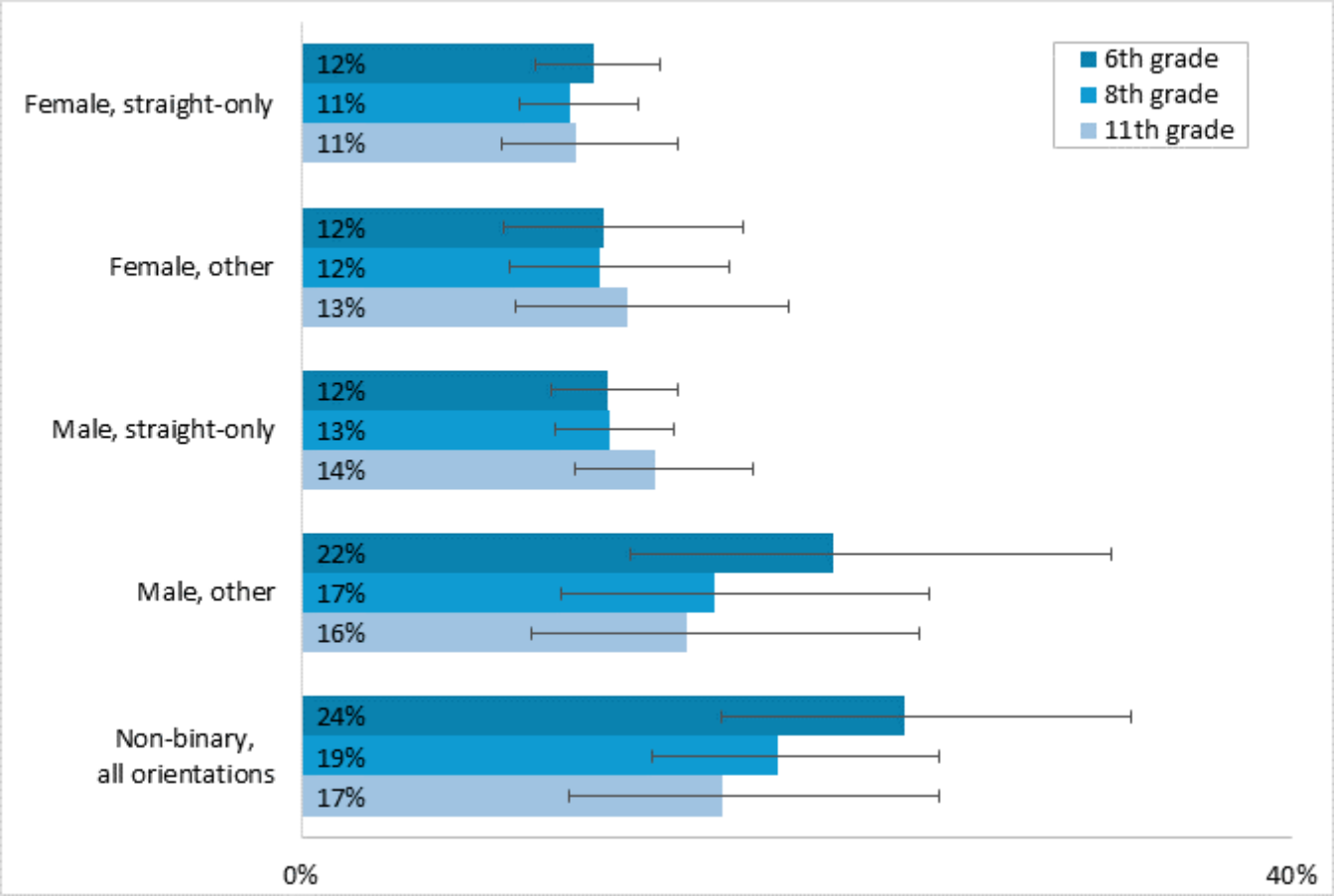
Figure 14. *Hunger due to limited food in the past 30 days, Multnomah County students in select schools, by grade and survey year, 2022-2024.*



Source: Oregon Student Health Survey, 2022 and 2024, among schools that participated in both years. *Numbers may not match exactly to countywide estimates, because they are limited to these schools that participated in both years.*

- Among the 20 Multnomah County schools participating in both survey years, reported hunger decreased from 2022 to 2024 for all grades.

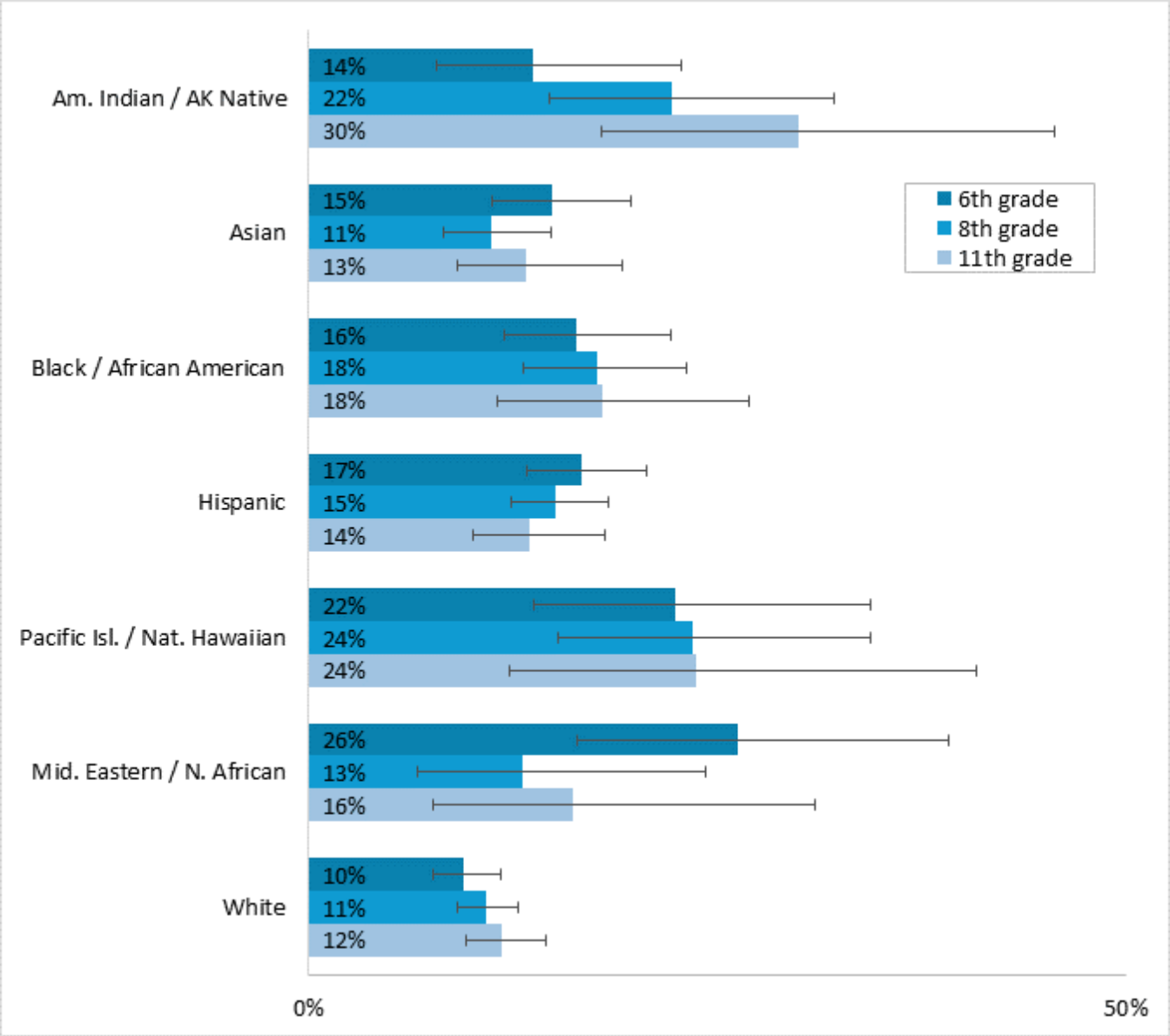
Figure 15. *Hunger due to limited food in past 30 days, Multnomah County students, by gender identification, sexual orientation, and grade, 2024.*



Source: Oregon Student Health Survey, 2024.

- Past-month hunger prevalence was highest among students who identified as non-binary, or as male with a sexual orientation other than straight.
- Hunger in these groups was highest among 6th-graders, while hunger was more consistent across grades for other gender+orientation groups.

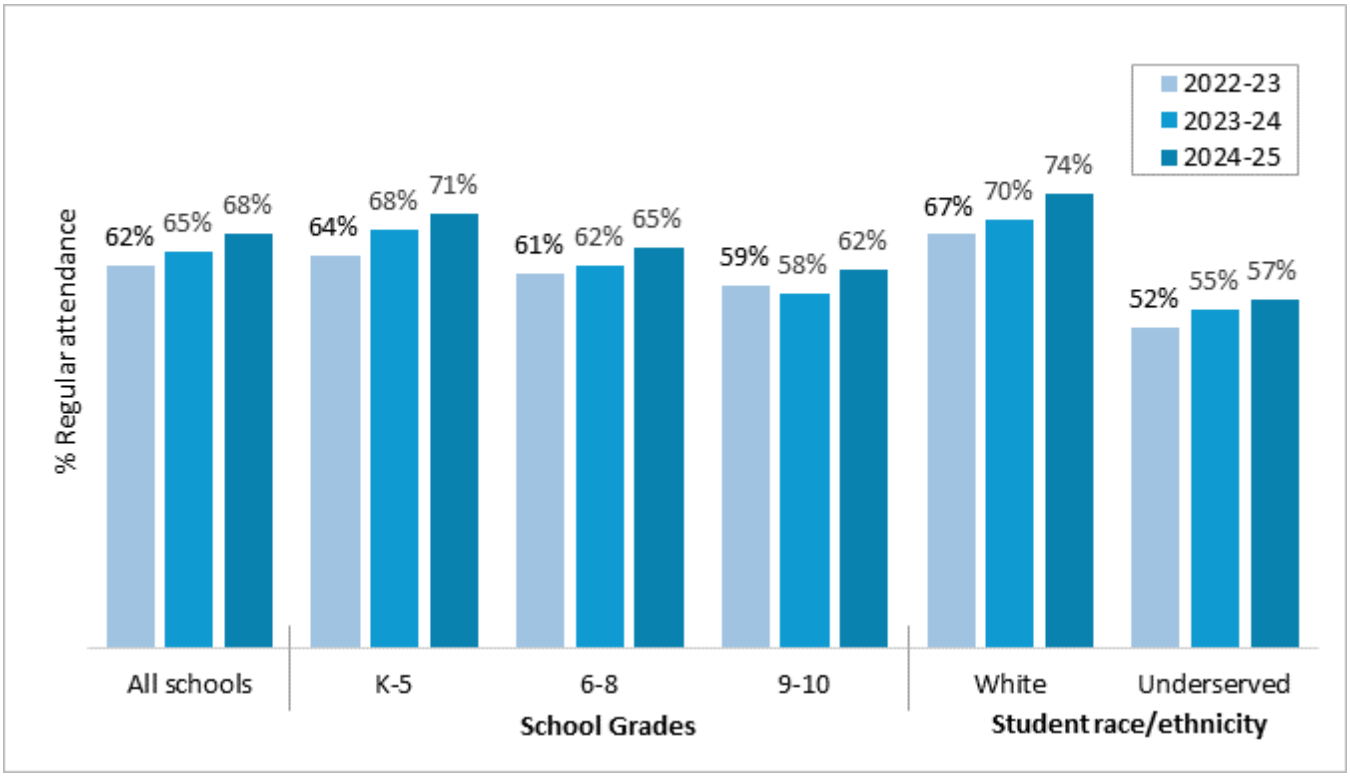
Figure 16. *Hunger due to limited food in the past 30 days, Multnomah County students, by race/ethnicity and grade, 2024.*



Source: Oregon Student Health Survey, 2024.

- Past-month hunger prevalence in Multnomah County varied substantially by students' racial/ethnic group.
- While several race/ethnicity groups had limited survey samples and large corresponding confidence intervals, hunger was generally highest among students identifying as American Indian / Alaska Native or Pacific Islander / Native Hawaiian.
- Across all grades, hunger was lowest among students identifying as White.

Figure 17. *School Attendance on 90% of enrolled days, Multnomah County grades K-10, by subpopulation and school year.*



Source: Oregon Department of Education Accountability Measures, School Year 2024-2025 file.

- Among Multnomah County students in grades K-10, regular attendance (90% of enrolled days) has increased the past two school years.
- Regular attendance was higher among K-5 students than for older grades.
- Regular attendance for underserved race/ethnicity groups (American Indian/Alaska Native, Black/African American, Hispanic/Latino, and Native Hawaiian/Pacific Islander) was increasing but lower than that for White students across all years.

Section 5. School environments

This section provides grade-specific results for additional measures that may be relevant to mental health support. Specifically, they may help to understand how well students are connecting with their school community, and whether they are experiencing bullying at school.

Figure 18. *School-related attitudes, Multnomah County students, by grade, SHS 2024.*

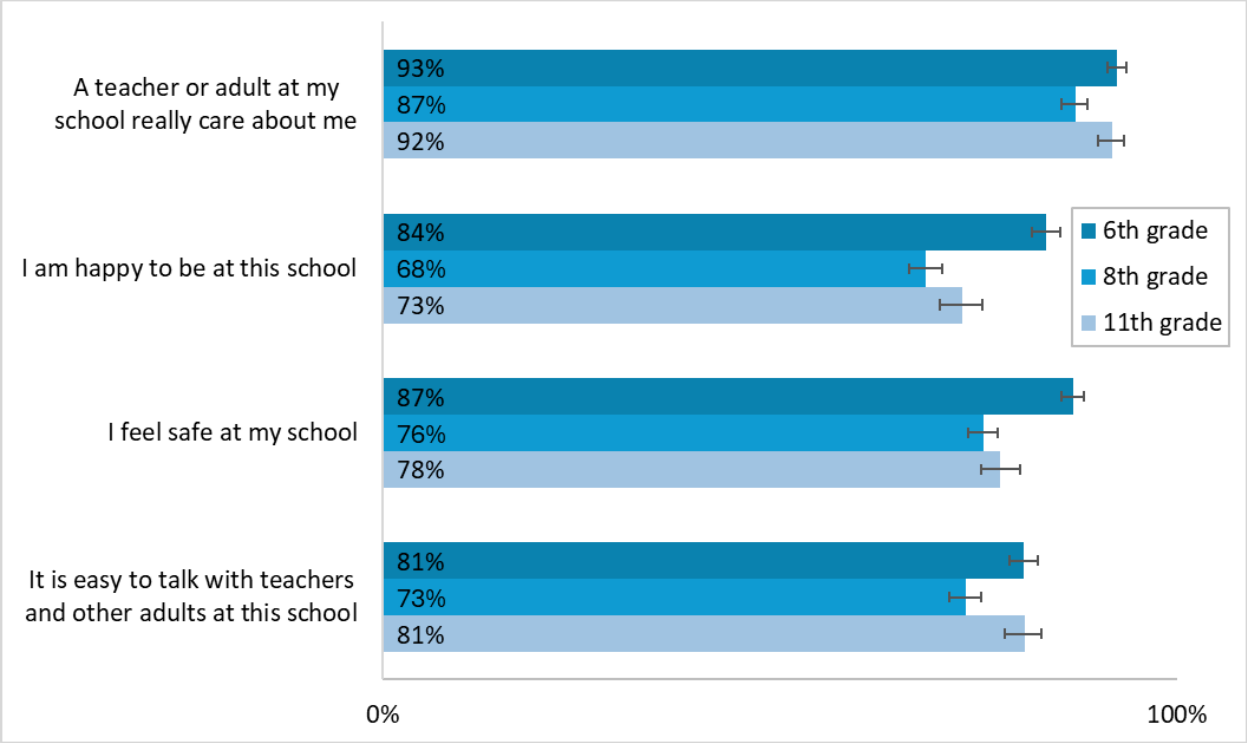
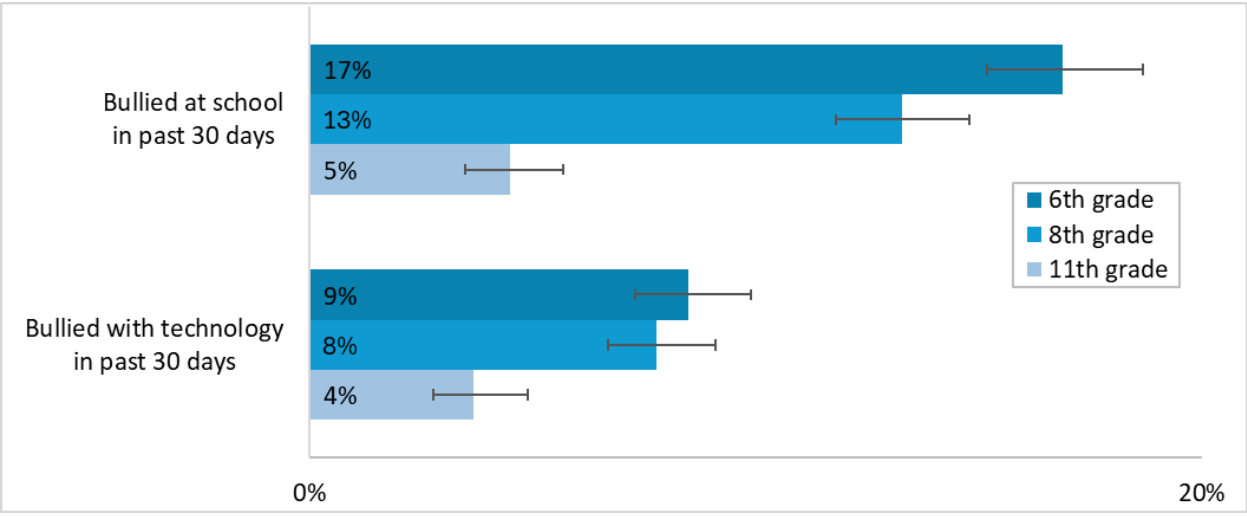


Figure 19. *Experiencing bullying in the past year, Multnomah County students, by grade, SHS 2024.*



Appendix: Participation in SHS

Tables below show the number of Multnomah County students who participated in the Student Health Survey (SHS) in 2024. Understanding levels of participation can help to understand what populations of students are represented, and the size of specific groups of students who may need support.

Table A-1. *Oregon SHS participation by gender, sexual orientation, and grade, Multnomah County students, 2024*

	6th grade	8th Grade	11th Grade
Female Straight sexual orientation (only)	804	915	506
Female Non-straight sexual orientation (lesbian, bisexual, queer, etc.)	232	246	201
Male Straight sexual orientation (only)	1,027	1,093	585
Male Non-straight sexual orientation (gay, bisexual, queer, etc.)	97	126	98
Non-binary gender (any sexual orientation)	280	234	126

Note: Students could select multiple sexual orientation groups. Categories in this table were assigned so that they are mutually exclusive.

Table 2: Oregon SHS participation by race/ethnicity and grade, Multnomah County students, 2024

	6th grade	8th Grade	11th Grade
American Indian / Alaska Native	127	126	73
Asian	398	416	273
Black / African American	326	363	170
Hispanic	748	813	504
Native Hawaiian / Pacific Islander	113	97	56
Middle Eastern / North African	82	74	55

White	1,326	1,490	897

Note: Students can identify as having more than one race or ethnicity. Categories in this table are not mutually exclusive; therefore, totals in this table add to more than the total number of students who participated in SHS.