Fairfax County Interagency Youth Behavioral Health Work Group

PHASE TWO IMPLEMENTATION –
Building a Systems of Care approach

Update to Successful Children and Youth Policy Team
May 14, 2014

Assignment to Work Group

- Fairfax County Board of Supervisors directed staff to identify requirements to address ***youth behavioral health services requirements as part of FY 2014 budget guidance***.

- The Successful Child and Youth Policy Team (SCYPT) voted to endorse the proposed recommendations and noted support for $1.0 million for behavioral health direct services in October 2013.

- Presented preliminary recommendations to Board of Supervisors Human Services Committee in November 2013.

- Report on progress to SCYPT - May 2014.

FY 2015 Budget Guidance Included in the FY 2015 Approved Budget

Behavioral Health Services

"The expansion of Behavioral Health services included in the FY 2015 budget is an important step in meeting the critical needs in the community for services to youth and their families. Staff is directed to continue to develop specific implementation policies and programs and report to the Board at the first Human Services Committee in FY 2015. The report should identify opportunities for enhanced collaboration with the Fairfax County Public Schools, a clear explanation of the use of funds approved for the expansion, options for acceleration of future funding, and a report on the demand of services in FCPS and Fairfax County. "

Report On:

- Enhanced Collaboration
- Budget Plan
- Options for acceleration
- Anticipated demand – obtaining baseline

Response to Board Budget Guidance - Summary

➢ **Enhanced Collaboration between Schools and Human Services**

- A recommendation on a common, easy to use screen for use when there are concerns that a child needs behavioral health services.

- A common "intake" procedure for all youth – whether they have access to health insurance coverage – or not – that would assist families in obtaining needed health care for mental health or substance use treatment.

- An initial agreement on the role of the staff in the schools – social workers, psychologists, and in human services – CSB, Juvenile Court and CSA services – and referring agencies (DFS, NCS, Health, community)

- Target "conditions" or needs to access contract funds for treatment: anxiety, depression, conduct issues, substance use treatment, trauma.

Response to Board Budget Guidance - Summary

➢ **Budget Plan**

- Draft scope of services for contracts – Behavioral Health treatment to include Cognitive Behavioral Treatment, Family Therapy, Motivational Interviewing, through individual and group modalities for mental health and substance use needs; and case management/care coordination

- Recommendations on systems outcome measures to be used in an integrated health care Systems of Care framework:
  - commonly used set of measures to include in electronic health records; and
  - system-wide data sharing business process for collection/analysis and reporting.

- An outline of the Systems of Care office and the positions requested for funding (slide 20)

- Training and next steps

Response to Board Budget Guidance - Summary

➢ **Options for acceleration**

- Additional funding for contractual services – to address anticipated demand for services in area of care coordination
- Priority hiring for Systems of Care positions
- Training funds

➢ **Anticipated demand** – obtaining baseline data

- Requires decision on use of data system for shared information and reporting
- Need to identify impact of Affordable Care Act on access to behavioral health services through insurance coverage
- Need to quantify the family supports gaps – particularly for additional family behavioral health supports and other community supports
- Estimate remains at 400-600 families in need of services today

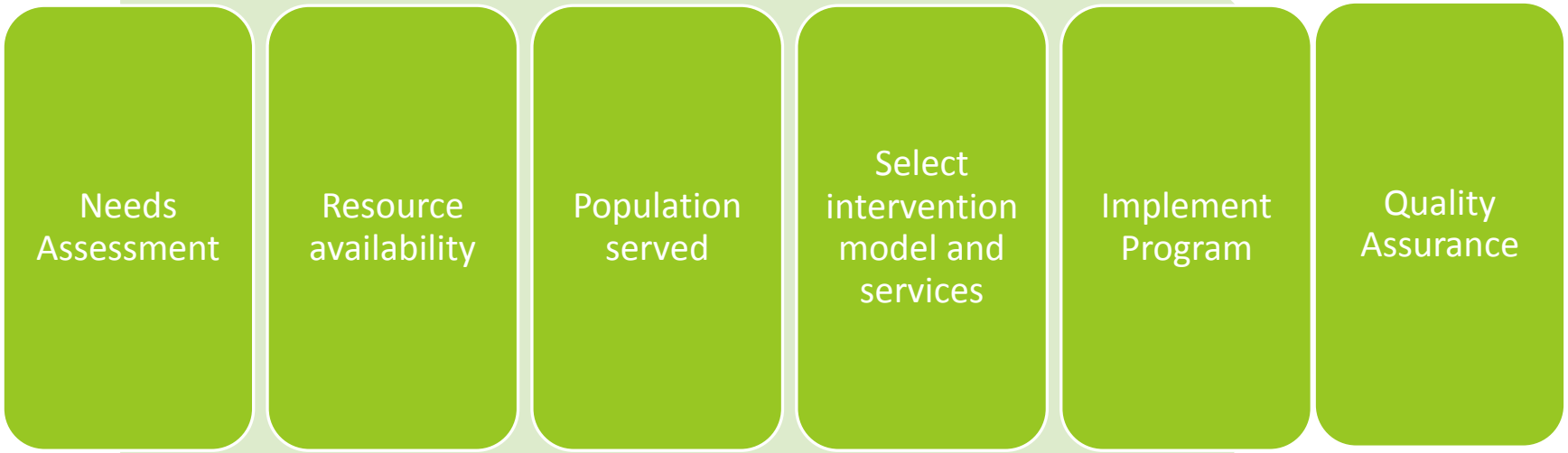
REVIEW- Recommendations from Fall 2013 report

- Interagency Youth Behavioral Health Work Group established a detailed work plan on proposed recommendations with key deliverables and timeframes (and use of $1.2 million in recurring baseline funding) in Fall 2013. Recommendations included the following:
  1. Implement system changes to improve information sharing, best practices, collaboration, and accountability of the system
  2. **Continue implementation of a "Systems of Care" approach: connect the continuum - Across County, School, and Community supports and services**
  3. Develop and implement CSB Youth Services Division Resource Plan
  4. Review needs of youth served in multi-agency and co-located sites, including educational and treatment settings, with goal to best leverage supportive services, treatment and educational services to meet youth needs
  5. Expand the scope of the mental health promotion/wellness priorities within the Prevention Fund
  6. Improve access to behavioral health care for families with insurance and Medicaid
  7. Review policies on use of CSA non-mandated funding

Recommendation 2

Phase II Design Tasks to Address Youth Behavioral Health Gaps in Systems of Care Continuum - youth and families needing treatment services

- Youth with emerging mental health or substance use needs
- Episodic or chronic
- Behavioral health supports needed
- Service plan for mental health substance use treatment required



Gaps identified in Work Group report:
- Behavioral Health Care coordination
- Mental health and Substance Use treatment
- Case management functions
- Youth referral sources: Community providers, Self/family, FCPS, DNCS, Health Dept.

$1.O million requested for FY 2015:
Funding for Systems of Care positions (3)
Contract services for mental health/substance use treatment
Care Coordination: county, FCPS and contracted

6,000 youth accessing services or in need;
400-500 youth needing care coordination

- Intake, assessment, triage, referral,
- Transition across levels of care
- Lead case management assignments
- Team job descriptions
- Select geographic area to test model
- Establish Transition and roll out
- County-wide time table

- Staff training
- Develop service agreements
- Create budget
- Policies & procedures for oversight and management

- System performance measures and outcomes
- Accountability plan
- Consumer engagement strategies

Project Plan

Goal: **Enhance access to behavioral health services and care coordination for "mid-tier" level of care for youth and their families**

Deliverables:

- Refine definition of recommended **target population**
- Child serving points of entry
- Establish **screening, referral, intake** procedures
- Resource recommendations – budget, staffing, contracting
- **Care coordination model** defined
- **Services definitions and treatment** standards completed
- **Quality Assurance** – practice standards and performance measures completed
- **Accountability Plan** – job descriptions and governance
- **Implementation schedule** and key milestones plan document completed

Time frame: **May 2014 presentation to SCYPT**
Implement Program – July 2015

Deliverables

- **Target population**

Children experiencing:
Anxiety Depression
Conduct concerns
Trauma Substance use

- **Screening**

Assessment interview
and tool:
GAIN-Short Screener

- **Services**

Evidence-Informed
Behavioral Health Services:
Cognitive Behavioral
Treatment
Individual, Group and
Family Therapy
Motivational Interviewing
Service Navigation

Subcommittee One: Entry into Care

Refine definition of recommended target population	Youth with known or emerging mental health or substance use needs Episodic or chronic Behavioral health supports needed Service plan for mental health substance use treatment required
Establish screening, referral, intake procedures	

1. **Best Practice research – other jurisdictions - models like the one we want to build**
2. **What are their strategies for identification of need?**
3. **Recommendations for child serving points of entry?**
4. **Screening tools and intake procedures recommendations**

GAIN-SS http://www.assessments.com/catalog/GAIN_SS.htm

Global Appraisal of Individual Needs - Short Screener

Short screen for general populations to quickly and accurately identify clients who have one or more behavioral health disorders

- Rules out those who do not have behavioral health disorders.
- Easy-to-use, validated tool for use by multiple child-serving disciplines across the system. Requires minimal training or direct supervision to administer.
- Serves as a periodic measure of behavioral health change over time.

EXAMPLES of cases likely to be screened

- Twelve year old child misbehaves on bus; child is upset with family over vacation plans changing. Child has special education services; does not meet eligibility for CSA funding for BH needs; conduct issues include biting, spitting, hitting adults/verbal abuse.

- Fourteen year old lives part time with each parent; older 17 yr. old sibling with conduct concerns in one home; hitting younger sibling, being abusive to parents. A third sibling is truant and repeatedly runs away from home.

- Blended family with five stepchildren; conduct concerns with three children; history of domestic violence in family, verbal abuse, physical altercations among some siblings. Two siblings with known marijuana use.

- Eleven year old child with anxiety resulting from family situation; (mother depressed; no medication.)

- Twelve year old boy seen in the community beating younger 6 year old brother; CPS and police called.

- Fifteen year old youth running away, school attendance ok, living in shelter housing for temporary stay; extensive family conflict present.

- Fourteen year old argues with parent regarding use of computer. Situation escalates and child refuses to go to school. Child reports being depressed, has no friends.

  Sixteen year old child transferred to new high school because of attendance and behavior issues. Student lost a parent in previous year. Parent discovers child is stealing; not using substances; family has insurance.

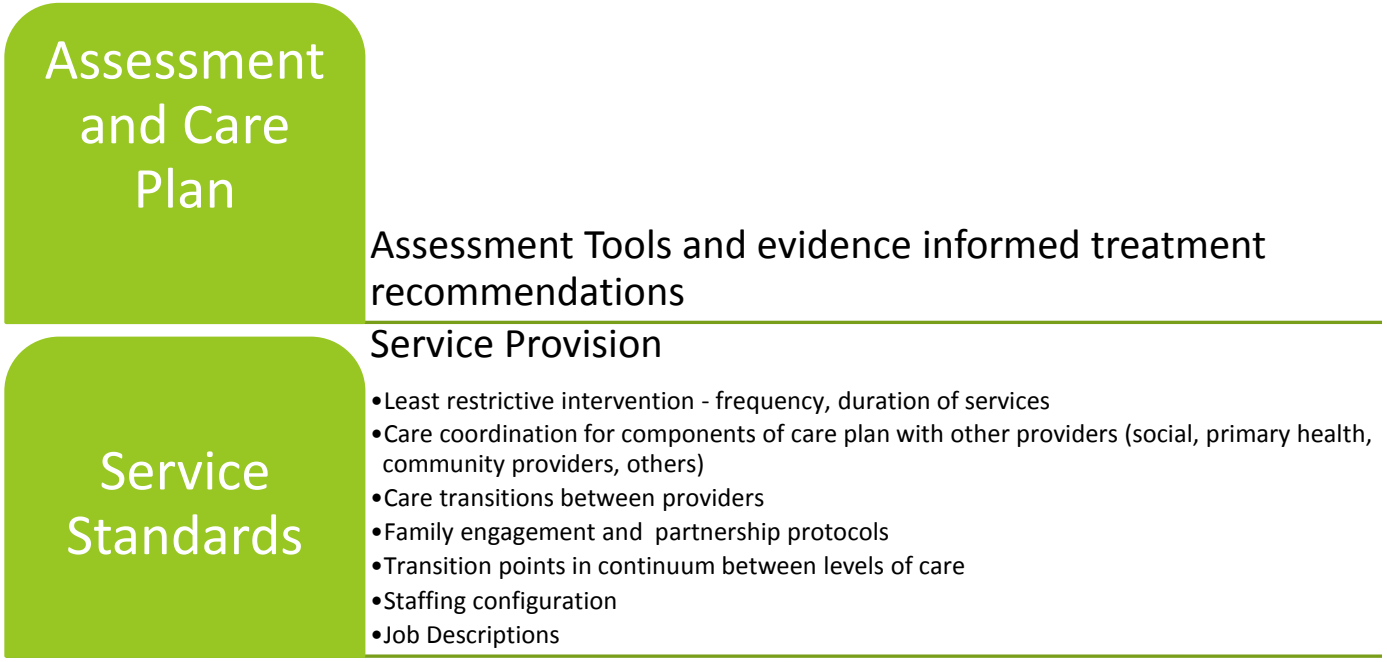
  Youth is depressed and anxious. Parent's insurance is limited in choice of providers, not taking new patients. Parents need to participate in family support services to deal with healthy communications and establishing boundaries.

COMMON FACTORS:

Not emergencies (yet) BUT acute care need exists

A service gap exists for providing urgent care

Needs require immediate attention and entry into care



1. **Best Practice research – for target population, what treatment is needed?**

Care Coordination Model - Proposed Client Flow – Youth Behavioral Health

Youth exhibits behaviors that cause concern for their well-being

Anxiety Depression Conduct Substance Use Trauma

Administer Screening Instrument

GAIN Short Screener

Who should be trained to use?

Community youth providers
(Nonprofit and faith)
CrisisLink
FCPS School Counselors
DNCS Teen Center/Youth staff
Health Dept. Nurses in Schools
DFS Social Workers
JDRDC intake staff
FCPD School Resource officers
HCD Resource staff

Determination of need

FCPS Psychologists /Social Workers
CSB Youth Outpatient staff
Contract providers

Further assessment for Anxiety, Depression,
ODD, Trauma

ASSESSMENT INSTRUMENTS

Clinical interviews
Examples of assessments might include: Achenbach Child Behavioral Checklist
Connors Comprehensive Rating Scale
Behavior Assessment System for Children (BASC-2)

TIER III

Needs higher level services

CSA eligible
Referral to Family Assessment Planning Team and intensive care coordination when indicated
EXISTING SERVICE ARRAY

SERVICE NAVIGATION

Determination of insurance
Medicaid eligibility
CSA
County funded

PROVIDER SELECTION

Specialty care needed
language, disability, SMI complexity, availability

CARE COORDINATION SERVICES

Service plan creation
Family concurrence on plan
Services order(s) initiated
Electronic Health Record created

CASE MANAGEMENT SERVICES

CANS Administered at 3 week
treatment for youth
with behavioral health treatment needs or at time
of assessment if not meeting BH needs criteria
Referral for additional services/wrap around
Initiate group peer family services

Insurance or Self pay?

Community Health providers Pediatricians Primary Care providers Private practice clinicians

Medicaid?
No Insurance?
Access Barrier?(language, cultural, disparities)

Referral to Utilization Management Systems of Care Office

treatment plan and determine level of services required
Youth and Family assessments shared

TIER II Services NEW SERVICE ARRAY

Assessment indicates Treatment Needs in one or more of following:

Outpatient Services and Medication

Anxiety: Behavioral and Cognitive Behavioral Therapy
Depression: combined medication (SSRI) and CBT treatment
Conduct Concerns:

- Parent management training programs
- Cognitive Behavioral Treatment

Trauma: Trauma-Focused Cognitive Behavioral (TF-CBT).
Substance Use: CBT, MI,12 Step AA/NA, Family TX
Typical timeframe: 10-16 week individual/90 day group

TIER II Services EXISTING SERVICE ARRAY
(but continued gap in availability)

Assessment indicates Family Supports Needed

Assessment indicates Family Supports Needed;
Behavioral health
treatment f
or youth not indicated AND referrals
for early
intervention service array for families is needed – parent education, Head Start, kinship supports

Operational Measures:

- # SCREENINGS DONE (by referral source)
- # Families referred for behavioral
- health services
- # ASSESSMENTS
- # families/individuals eligible for
- services
- # families receiving
- financial assistance for services
- #families declining at
- assessment phase
- Cost

System Measures: see chart

Areas for additional procedures/policy discussion with community treatment providers and vendors:

- NEED DETERMINATION re level of service between tier II family supports and behavioral health treatment
- Participation - what happens
- Treatment plan documentation and reporting –integration of system with overall County primary care/behavioral health integration strategies.

System Outcomes	Measures of success Implementation strategy Reporting mechanisms and accountability
Clinical Outcomes	Service Provision Outcomes • Individual and team • Record Keeping – Case notes • Data tracking • Accountability strategy to families and youth – how will clients measure progress and evaluate interventions with staff/program?

1. **Who is responsible for success of proposed model?**
2. **What reporting mechanisms need to be in place?**
3. **What is the systems planning process/resourcing and budgeting mechanism?**

DRAFT Proposed System Measures – dependent upon: data systems, common data definitions, and collection practices		
System/ Payer	**1. Access**	Percentage of the referrals that: • Utilize community behavioral support services •Attendance rates for services included in family plan
	2. Utilization	Rates and percentages for: • Outpatient services • Participation in ongoing community peer and family programs • Percentage referred for services through Family Assessment and Planning Teams
	3. Cost	Cost of care • Expenditures per family – year one
Provider	**4. Practice**	Key practices relevant for youth with behavioral health conditions • Percentage of referred youth reporting on their health status • Youth and family engagement/involvement/voice and choice • Medication usage, delivery and adherence • Side-effects • Medication management • Follow-up after prescribing of behavioral health related medication
Youth/ Family Functioning	**5. Living Environment**	• Child later enters residential services • Child later enters foster care
	6. Behavioral Health and Physical Health	Behavioral health factors: • Clinical assessment and level of functioning • Caregiver strengths/risks • Symptom severity/reduction/management • Youth daily living skills General physical health measures • Weight and nutrition, Body Mass Index (BMI) screening • Management of chronic conditions • Assessment of potential physical effects of behavioral health medications • Dental care

DRAFT Proposed System Measures - dependent upon: data systems, common data definitions, and collection practices		
Youth/ Family Functioning	**7. Employment, Education and Other Responsibilities**	• School placement, attendance, achievement • Employment • Volunteer activities
	8. Family and Community	Measures of social supports and community engagement • Community/neighborhood strengths/weaknesses • Justice involvement • Social relations • Parental rights
Experience of Care	**9. Experience of Care**	Opinions about the care and the supports received and satisfaction with services, transitions and outcomes; reports of services received
Adapted for community based services from proposed systems measures for residential care from National Building Bridges Initiative (BBI): "Building Consensus on Residential Measures: Recommendations for Outcome and Performance Measures".		

Next Steps

Communications

1. Availability of GAIN SS tool
2. Online training
3. Development of Job Aid on resources – how to refer to community health care resources for insured population
4. Tracking protocols (referrals/where)
5. Access to “tier two” assessment and outpatient care
6. Parent permission protocols

Staff Procedures

1. Department protocols for use of screen
2. Training on assessment strategies for referrals
3. Intake personnel at CSB, FCPS – how to access services
4. Assessment teams – FCPS psychologists, social workers, CSB Youth Division, contractors
5. Referral process for DFS, DNCS, Health Department, community youth providers

Systems of Care office

1. Hiring of Systems of Care staff positions
2. Decision on electronic health record and data exchange of information

Systems of Care –Filling Gaps in Services

Systems of Care

3 positions

- System Director: plan and coordinate resources across agencies for the continuum of care, manages funds, establishes system-wide plan
- Service Utilization Specialist – authorize level of services
- Clinician: coordinates care with school and county staff

Prevention Services

Neighborhood and Community Services

Fairfax County Public Schools

Health Department

Early intervention Services

Dept. Family Services

Fairfax County Public Schools

Fairfax-Falls Church Community Services Board

Health Department

Family and Community Support Services

Care coordination

Access to treatment

Support services

FY 2015: $600K contract mental health/behavioral health services and case coordination for eligible youth

Office of Comprehensive Services

Appendix – Existing Resources and Service Capacity for Youth Behavioral Health Services

Public Schools

- Wellness/prevention services
- Suicide Risk and Threat Assessments
- Mental health services and treatment
  - Group and individual counseling –general population and target populations (alternative schools)
  - Crisis intervention/stabilization in school settings
  - Parent clinic and consultation
  - Referrals for community/public behavioral health treatment
  - Case management services for CSA enrolled youth
  - Psychological Evaluations

Community Services Board

- Wellness/prevention services
- Medicaid managed care eligibility determination (VICAP)
- Mental health and substance services and treatment
  - Psychiatric evaluations
  - Court ordered psychological evaluations
  - Individual, group and family treatment
- Residential services
- Outpatient and day treatment
- Intensive Care Coordination Services
- Targeted Case Management for SED and at risk youth
- Psych. Hospital Discharge Planning
- Emergency Services

Community Providers

Private (insurance and families)

Nonprofit/faith and community

County funded – contract providers

- Contract oversight in CSA Program office (96 businesses; 39 private therapists – as of 5/14)
- Contract oversight for youth crisis care in CSB (1 provider)
- Community provided (CCFP funded)

Appendix - Existing Services
Human Services and Schools Programs for Youth with Behavioral Health Needs

Prevention

General population – monitor student functioning with short term intervention as needed

Mental wellness and substance abuse awareness

PROGRAMS/SERVICES (examples)

- Wellness programs; depression & suicide awareness i.e. SOS, Response, ASIST, Active Minds chapters
- Positive Behavior Intervention Support (PBIS)
- Mental Health First Aid
- "Three to Succeed" strategies
- Health curriculum
- Resiliency Project
- Partnerships with community coalitions and providers for education, public awareness, & events

Early Intervention

Targeted family and youth interventions

Situational crisis management

Short term social/emotional skill development (anger management, emotional regulation, coping skills)

Group Counseling

Parent consultations

PROGRAMS/SERVICES (examples)

- Family Protection and Preservation Services
- Healthy Families Fairfax
- Nurse Family Partnership
- Maternal Child Health
- Community-School Care Coordination
- AOD and Restorative Behavior Intervention Seminars
- Parent Clinic

Intervention

Targeted family and youth interventions

Continuum of services for life stressors, substance abuse and mental illness

- **Short-term & longer term services for both gen ed. and special ed. populations**
- **Intensive clinical support in public day school, selected school sites and day treatment settings**
- **Targeted Case Management**
- **Outpatient care**
- **Psychiatric evaluations, treatment and medication**
- **Day treatment**
- **Emergency services**
- **Hospitalization**
- **Residential**
- **In-home services**

Emerging need

- Appears as non-emergency
- May be acute or chronic (impacts school performance, social and family life); or
- Long term support needed but managed with appropriate medication and therapeutic care; and
- May be receiving some services

Known need, but may not access treatment and supports

- Youth involved in substance abuse
- Youth or caregiver has suffered trauma (family domestic violence, war, refugee crisis, sexual exploitation or trafficking)
- Youth has committed a crime

Emergency/Crisis

SERVICES (examples)

- CSB emergency services
- Private therapy
- Hospitalization

Stabilization/ After Care/Transition

SERVICES (examples)

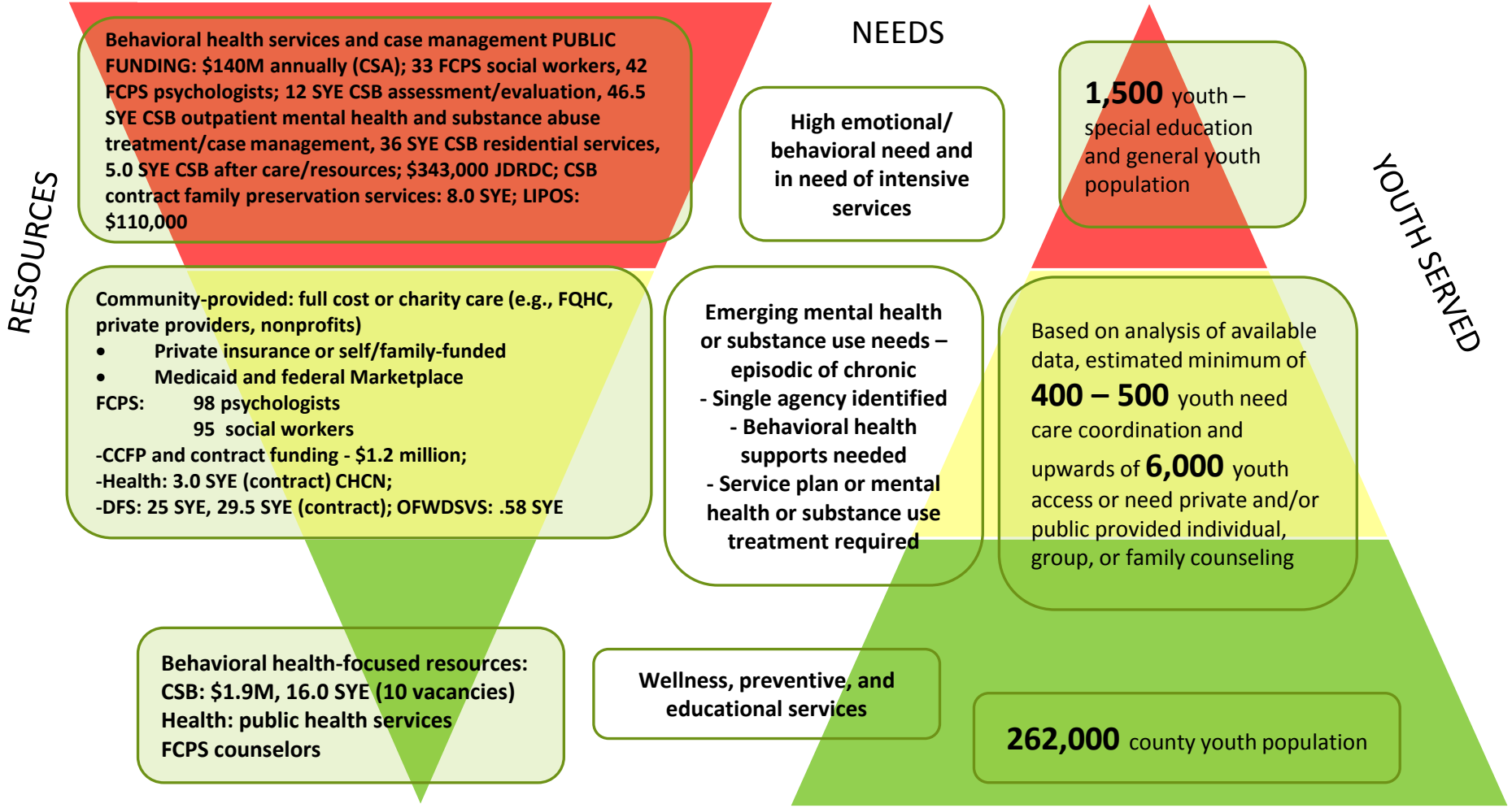
- Intensive Care Coordination
- Discharge planning

PROGRAMS/SERVICES (examples)

- Behavioral techniques training (respect, responsibility, resiliency, coping)
- Outpatient services – individual, family and group counseling
- Residential services
- Intensive in-home services

Appendix - Public youth behavioral health funding is concentrated at high emotional and behavioral need population – smallest percentage of all youth

- Reinvest any savings into "mid-tier" targeted interventions
- Bring prevention strategies to scale county wide



Note: As youth present mental health and substance abuse needs, stabilize or move into crisis, the resources following them may serve them or may be absent, depending upon the family/youth eligibility for specific funding and programs.