Memo to the CPMT
April 26, 2019

Administrative Item A-3: Appointment of new Family Assessment and Planning Team (FAPT) members

ISSUE:
CPMT approval of the following persons to serve on the FAPT:

JDRDC
- Sean Crimmins

DFS
- Sharah Brame

FCPS
- Laura Thieman

RECOMMENDATION:
Approval of the appointment of the nominees as a FAPT representatives.

BACKGROUND:
Sean, Sharah and Laura have shadowed existing members at FAPT meetings and attended All-FAPT member training. They are prepared to serve as alternates for JDRDC, DFS and FCPS respectively on the FAPT.

FISCAL IMPACT:
None.

STAFF:
Sarah Young, FAPT Coordinator

MEMO TO THE CPMT
April 26, 2019

Administrative Item A-4: Endorse Proposed FY 20 Healthy Minds Fairfax Budget

ISSUE:
The FY 2020 Healthy Minds Fairfax budget is presented for endorsement

RECCOMENDATION
The Children's Behavioral Health Collaborative Management Team (CBHCMT) recommends that the CPMT endorses the budget contingent on Healthy Minds receiving the full amount in the County Executive's proposed FY2020 budget.

BACKGROUND:
In March of 2016 the CPMT approved a multi-year children's behavioral health system of care blueprint for calendar years 2016 through 2019. On April 8, 2019, the CBHCM approved a recommended budget to support continued implementation of Blueprint strategies in FY 2020. The CBHCMT recommends that if the proposed County Executive's budget is passed, all projects should be funded. If the Healthy Minds Fairfax items are not included in the approved budget, then the CBHCMT will review and re-prioritize proposed projects and present a recommendation to CPMT on May 31. As the work on the strategies progresses during the year the amount of funding allocated may shift between projects as necessary.

FY 2020 Projects Previously Endorsed by CPMT:

Evidence-Based Practice Training Consortium:	$150,348 (under contract)
Give an Hour Pro-Bono Outpatient Therapy:	$88,660 (under contract)

FY 2020 Projects in the Proposed County Executives Budget

Multicultural Behavioral Health Services	$130,000
CR 2 Mobile Crisis Response Expansion	$100,000
Psychiatric Consultation for Pediatricians	$100,000

CBHCMT Recommended FY 2020 Projects:

Short Term Behavioral Health Services (STBH)	$167,000
CR 2 Mobile Crisis Response Expansion (additional)	$100,000
REACH Mental Health Training for Pediatricians	$75,645
Psychiatric Consultation for Pediatricians (Additional)	$35,000
Integrating Behavioral Health and Physical Health in CSB	$33,841
CSB Merrifield Crisis Response Center Youth Recovery Group	$28,818
Evaluation of REACH Pediatrician Training	$25,000
Best Practice Trainings for Providers/Families	$15,000
Trainings for Providers/Families: Working with Anosognosia	$15,000
Training Program for Providers/Families – Youth & Family Lens	$10,000
Evidenced Based Training for FCPS Staff	$8,420
Youth Navigator – project will be assigned to HMF Intern	$0

In order to accomplish the Healthy Minds Fairfax vision that all children and youth in the Fairfax Falls Church community are socially, emotionally, mentally, and behaviorally healthy and

resilient, the Children's Behavioral Health System of Care Blueprint addresses five over-arching goals:

- Access to services and supports
- Increasing awareness and reducing stigma
- Coordination and Integration
- Family and youth engagement
- Quality of services and supports of services and systems

The chart below presents the major FY 2020 projects by the goals that they address:

Access

- Short-Term Behavioral Health
- CR2 Mobile Crisis Response
- Psychiatric Consultation for Pediatricians
- Navigation Website
- Give an Hour
- Multicultural Services

Awareness and Stigma

- Training for Providers and Families: Working with Anosognosia

Coordination and Integration

- Integrating behavioral and physical health
- Psychiatric Consultation for Pediatricians
- REACH Pediatrician Training
- CSB Behavioral/Physical Health Integration

Family and Youth Engagement

- CSB Youth Recovery Group
- Youth Navigator
- Parent Support Partners

Quality

- Evidenced based Practice training for FCPS
- Evaluate Reach training
- Reach Pediatrician Training
- Training for Providers and Families: Youth and Family Lens
- Best Practice Trainings for Providers/Families
- Evidence-Based Practice Consortium

ATTACHMENTS:
FY 2020 Funding Proposals Summary
FY 2020 Funding Proposals

STAFF:
Jim Gillespie, HMF Director
Peter Steinberg, CBHC Program Director

Goal: Access

FY 2020 Healthy Minds Fairfax Funding Proposal

The Short Term Behavioral Health Service for Youth: Continuation of Service

This funding request is in the amount of $167,500 to continue the Short Term Behavioral Health (STBH) Service for Youth. This funding request is to pay for services for students who attend 24 Fairfax County Public Schools. These are the same schools that were funded last year.

A. Progress to Date

The Short Term Behavioral Health Service for Youth (STBH) is in the process of completing its third full year of service delivery. STBH is a short-term outpatient psychotherapy intervention, purchased from contracted private providers, for students with depressive and anxiety symptoms or other emerging mental health issues. Youth and their families receive 6-8 sessions of outpatient counseling using an evidence-based approach. In addition to direct treatment, the families will get help with accessing services through their insurance and connecting to other services if necessary after the youth and family completes the Short Term Behavioral Services. Referrals are from school social workers, school psychologists and school counselors. The program is available for students in families with incomes less than 400% of poverty ($98,400 for a family of four) who cannot access timely services through insurance or Medicaid. It addresses Blueprint Strategy 13D.

In FY19 The Short-Term Behavioral Health Program for Youth is projected to serve approximately 250 students from 19 high schools, 14 middles schools and 5 elementary schools. The average number of referrals is expected to be about 5.2 sessions per student. The GAIN Short Screener is administered at the beginning and after 30 days of treatment. To date, of the students that have completed a 1st and 2nd GAIN-SS results indicate that approximately 66.6% of youth served had improved behavioral health symptoms, while 26.6% reported no change and 6.6% saw an increase in behavioral health symptoms. Discharge summaries completed by STBH clinicians indicate that 2% showed deterioration; 14% no change; 14% showed minimal change; 25% showed moderate improvement and 31% showed significant improvement in behavioral health symptoms. Another 14% left treatment too early for their symptoms to be properly assessed.

B. Description of any new project activities

During this year, the leadership at the Fairfax -Falls Church Community Services Board (CSB) funded an expansion of the services. This expansion allowed the program to add 14 schools and opened the program to youth seeking services at the CSB who otherwise were to be placed on a monitoring list or did not meet the CSB's priority population. The CSB fund will

continue to fund this expansion during FY 20. In FY 21, we will be seeking funds to cover this expansion.

C. Updated Project Budget

Anticipated FY 19 expenditures $134,000
(all direct costs to contracted STBH providers)

Projected FY 19 expenditures $167,500

D. Plan for continued funding after expiration of HMF funding:
Since this initiative serves children and families who cannot immediately access insurance for treatment, it is anticipated that continued HMF funding will be necessary to maintain it.

E. Proposed Outcome Measures

Functional Outcomes

- Participating youth will continue to complete a GAIN Short Screener at STBH service initiation and again 60-90 days after service initiation. Scores will be analyzed to determine the average change in score between the two administrations. The percentage of youth with scores that improved, remained the same and declined will also be reported.
- At discharge the treating clinician will continue to assess the status of addressing target problems on a scale from "deteriorated" to "significant improvement".
- At discharge the parent/guardian will assess the status of addressing target problems on a scale from "deteriorated" to "significant improvement".

Quality outcomes

- Parent/guardians will complete a satisfaction survey.
- Participating youth will complete a satisfaction survey.

Continuum of Care Outcome

- At discharge, the treating clinician will continue to report on the follow-up services to which the youth and/or family were referred, and whether they received the services for which they were referred.

Healthy Minds FAIRFAX
Supporting Emotional Wellness in Youth and Families

Goal: Awareness and Stigma

MEMORANDUM

To: CBHC Management Team

From: SOC Training Committee

Date: March 8, 2019

Issue: FY2020 Children's Behavioral Health Funding Request to Expand the Knowledge and Skills of Systems of Care Workforce and Families

a. Description of the project and how it will accomplish a Blueprint strategy or action step.

The Systems of Care Training Committee recognizes the benefit of effective training for all stakeholders to build and sustain a robust Systems of Care. Outlined below is a training request that contributes to the success of specific Goals and Strategies outlined in the Blueprint.

Training for Providers and Families - Working with Anosognosisa
Training that builds skills in working with and supporting individuals who lack insight into their illness or condition--also known as "anosognosia." Training on this topic is expected to increase engagement and improve outcomes for individuals who are underserved due to this symptom. These training opportunities will be offered to agency staff, medical and behavioral health providers, criminal justice and Diversion staff, peer supporters, and parents/caregivers.

Anosognosia, also called "lack of insight," is a symptom that impairs a person's ability to understand and perceive their illness or condition. It is the single largest reason why people with schizophrenia or bipolar disorder (and other medical conditions) refuse medications or do not seek treatment. Perception can vary over time leading others to misinterpret lack of insight as being "in denial" or stubbornness. According to NAMI, "anosognosia affects 50% of people with schizophrenia, and 40% of people with bipolar disorder. It can also accompany illnesses such as major depression with psychotic features." People with anosognosia are at increased risk of homelessness or arrest. Learning to understand anosognosia and its risks can improve the odds of helping people with this difficult symptom." An example of an existing Evidence-Based Practice training that addresses anosognosia and is available for both providers and family members is LEAP™, developed by a psychiatrist whose brother lived with both schizophrenia and anosognosia.

The training will focus on specific communication skills that supports building trust and meaningful dialog - essential components in both therapeutic and family relationships. These are especially critical when working with individuals experiencing anosognosia. While behavioral health providers may have training in such practices as Motivational Interviewing, providing a training that is effective and accessible to a wide range of providers and other supporters in our community can help build a common language for collaboration and provide a broader understanding of how to support an individual's movement toward treatment and recovery. It is well-recognized in the family community that parents are eager for training that can improve their knowledge and effectiveness when supporting their child, especially those with anosognosia. The skills developed through this training will help providers and families support youth into the future, especially during the critical transition to young adulthood.

b. Description of why current available services in the county cannot meet the need.

Currently, there are no known programs being delivered, consistently and broadly, that address the proposed training program topic.

c. Have other funding sources been explored?

There are currently no known funding sources for launching training on the proposed training topic.

d. How will the program be sustained after the funding?

During the pilot, various funding sources will be explored for sustaining the program.

e. What are the outcome measures including how will the data be collected and reported back to the Children's Behavioral Health Collaborative?

Outcome measures for the proposed trainings for providers and families.

1. Examples of what may be collected and reported:
    a. Numbers of training events and number of participants trained in total and by category.
        - Category examples:
            - **Provider** -Physician, pediatrician, psychiatrist, nurse, social worker, etc. Behavioral health provider or other medical provider
            - **Youth and family** - Parent/caregiver, Youth, Other family member or friend
            - **Other** - Law enforcement/criminal justice
2. Results of participant surveys

Sample questions and rating items might include: Did the training meet the stated objectives? What will you do differently as a result of this training? Other meaningful outcome measures would be developed.

It is expected that at least 90% of participants will state they feel more confident in treatment collaboration.

f. A project budget identifying how county funds will be used and whether a one-time or ongoing expenditure is being proposed.

One-Time Budget Requests for Training	Est. Budget
Training Program for Provider and Families - Working with Anosognosia	$15,000
Total Request	**$15,000**

g. A timeline for when the project will be completed if county funds are approved.

July 1 – August 30, 2019: Planning and marketing of launch training event; development of surveys and other outcome measurement tools and reports for ongoing trainings
Fall 2019: 3-day training event for providers and families with professional trainer

- Day 1: Full-day interactive skills training for large audience
- Day 2: Train the Trainer for Providers

- Day 3: Train the Trainer for Families

December 31, 2019: Complete follow up training and final certification of local trainers

January 1-June 30, 2020: Deliver at least 2 additional trainings to providers and 4 additional trainings to families

Goal: Access

Mobile Crisis Response Expansion Project Proposals

Submitted by the Children's Behavioral Health SOC Integration Workgroup

March 8, 2019

BACKGROUND AND PROPOSALS

On March 23, 2018, Deputy County Executive Tisha Deeghan, after consultation with the CPMT, approved a HMF funding request of $34,000 in FY 2018 and $100,000 in FY 2019 to operate a pilot project to increase the capacity of CR2 mobile crisis response services by 20% from May 2018 through December 2019. Due to the delays involved in coordinating the project with the other Northern Virginia localities, it did not begin until January 2019. The project will operate for six months in FY 2019 at a total cost of approximately $100,000. The County Executive's proposed budget for FY 2020 includes $100,000 for CR2 expansion. It is not definite until the budget is approved on May 7, but it's inclusion is a good sign.

Proposal 1: Expand CR2 services by 10% in FY 2020 at a cost of $100,000, if county budget request is not approved.

Proposal 2: Expand CR2 services by an additional 10% in FY 2020 at a cost of $100,000, if county budget request is approved.

a. A brief description of the project, including how it will accomplish Blueprint strategies or action steps

Relevant Blueprint Action Step: *Coordinate discharge for youth presenting to emergency departments for substance use or suicidality to indicated follow-up care.*

Need: For a number of years, Virginia has experienced a consistent pattern of the lack of child and adolescent psychiatric inpatient beds due to the demand overshadowing the capacity. This issue generally occurs in late winter through spring and again in late fall. Between September 2017 and February 2018 Inova Fairfax Medical Center's Emergency Department evaluated 176 children and adolescents who presented to the ED due to behavioral health issues. These cases included suicide attempts, overdoses, suicidal ideation with a plan, homicidal ideation, major depression and anxiety. These assessments are conducted by psychiatric liaisons in person or through the use of telemedicine. For those children in need of psychiatric hospitalization, Fairfax County youth are often being placed in psychiatric hospitals outside the Washington area, sometimes several hours away and/or in another state. These hospitals have little or no knowledge of Fairfax area resources making coordination of care and appropriate discharge planning challenging. Further the great distance is an impediment to family participation in treatment, visitation and ability to support their child. During the periods when bed availability is a significant issue, youth may be housed in the Emergency Department(s), in observation beds or admitted to the medical unit often with sitters receiving little or no treatment until a bed becomes available. For some patients, these admissions are not reimbursable due to lack of medical necessity due to a medical condition which places a financial burden on the family and hospital. Knowledgeable staff believe that some of the youth currently being recommended for

an ED evaluation and/or hospitalization may be safely diverted if an intensive community-based intervention were available to connect with the youth and family at the time of assessment in the ED or prior to going to the ED.

In addition, in areas around the country with well-staffed mobile response and stabilizations services, those programs can act as after-hours response for youth in High Fidelity Wraparound, providing a much more intensive and responsive intervention that typical telephone after-hours response.

Proposed Project Description: Mobile response and stabilization services are available in Northern Virginia through the Children's Regional Crisis Response (CR2) program, operated by the National Counseling Group under contract with the Arlington Community Services Board with funding from the Virginia Department of Behavioral and Developmental Services. The purpose and goal of this type of intervention is to provide the child and family intensive in home support by developing safety plans to bridge them through the immediate presenting crisis to a mental health intervention in a less restrictive environment. However, the program has limited capacity and without additional staff unable to expand to serve this group of youths who may be in need of an immediate psychiatric intervention.

It is proposed to expand local crisis response capacity by 20% through the addition of two new counselors for the CR2 program. The is to create a protocol for youth identified by the CSB, High Fidelity Wraparound providers or emergency departments, to be considered for CR2 services and to create capacity to serve approximately forty additional youth per month. Each additional counselor can serve approximately twenty youth per month. CR2 staff would develop referral protocols with the CSB, local emergency departments and high fidelity wraparound providers..

CR2 counselors are available to meet with clients within their homes or any site in the community, including schools, courts and community centers. CR2 collaborates with CSBs, CSA agencies, and other professionals so that every child and family served may benefit from coordinated care and a team approach. The collaboration process is further enhanced through community outreach, awareness campaigns, and training so that every locality may improve its ability to prevent crises and provide a successful response. CR2 serves children age 17 and younger experiencing a psychiatric crisis due to mental health issues that are placing them at risk of psychiatric hospitalization who are experiencing mental health or behavioral challenges. CR2 is provided at no cost to families. Families with commercial insurance may be required, by their insurer, to provide a copay for psychiatric assessment and medication services. Services provided by CR2 include:

- Rapid mobile response
- 24-hour intervention
- Screening and triage
- Clinical assessments, including lethality
- Psychiatric assessment and services
- Medication prescription

- Bilingual counselors
- Case management
- 30-day post discharge support
- Care coordination with community resources and professionals
- Safety planning

b. A brief description of why currently available services in the county can't meet the need

Model changes to CR2 for FY 2019 have increased capacity and the program is now able to respond to nearly all referrals. It remains at least 50% under-staffed compared with best practice programs, however, and is unable to consider enhanced services such as after-hours response for High Fidelity Wraparound. And any increase in publicizing the service would likely overwhelm it with referrals. Same day access at the CSB Merrifield Center is responsive to the needs of some youth identified at the ED, but usually not for those arriving after business hours, or with needs that require more intensive intervention than outpatient services. The CSB has a Mobile Crisis Unit (MCU). This unit serves the entire county and may or may not be available to respond to the ED. Further, these Fairfax County programs do not have the ability to provide intensive in home support immediately and on a daily during the crisis. In addition to the CR2 response to the hospital, these follow up services are at the crux of the collaboration with CR2.

c. A project budget identifying how county funds will be used, and whether a one-time or ongoing expenditure is being proposed:

Proposal 1: $100,000
Proposal 2: $100,000

The proposal is for funding for FY 2020 only, with the possibility of a continuation request for FY 2021. It is possible that additional state funding may become available for FY 2020 or 2021, which may decrease the need for HMF funding.

d. Have other funding sources been explored?

Proposal 1 for $100,000 is in the County Executive's proposed budget for FY 2020.

e. How will the program be sustained after the funding?

It is possible that additional state funding may become available for FY 2020 or 2021, which may decrease the need for HMF funding.

f. A timeline for when the project will be completed if county funds are approved: There may be some delay in implementing the service expansion because the program is being competitively re-bid for FY 2020, and those processes are not always completed on time.

g. Outcome measures and reporting

The CR2 program is currently evaluated as required in the contract between National Counseling Group and Arlington County for mobile response services in Northern Virginia. The current evaluation methodology measures success in hospital diversion, living status at discharge, and

school status at discharge. These measures are consistent with best practice in evaluating mobile response services as identified by SAMHSA. CR2 outcomes on these measures are in line with those of best practice states and localities, with the exception of the many referrals deferred (23%) due to lack of capacity. When the CR2 contract is re-competed it is suggested that measures be added on percentage of calls with a face-to-face response, and percentage of face-to-face responses within 45 or 60 minutes.

Project Implementation Evaluation: The evaluation is designed to be a "proof of concept" that a streamlined process for the ED to access mobile response services will result in more youth being able to remain safely with their families with the support of the mobile response intervention. There are five elements that will need to be implemented:

1. Implement a user-friendly referral process from the Fairfax Hospital ED to CR2.
    a. Measure: Number of referrals from the Fairfax Hospital ED to CR2.

2. CR2 consistently responds to referrals with a timely face-to-face visit at the ED.
    a. Measure: Percentage receiving face-to-face ED visits within 60 minutes of referral.

3. CR2 consistently does a timely face-to-face follow-up visit in the home.
    a. Measure: Percentage of face-to-face follow-up visits within 24 hours of ED visit.

4. CR2 consistently conducts a risk/acuity assessment and develops a plan of care.
    a. Measure: Percentage of referrals with risk/acuity assessment and plan of care

5. CR2 consistently facilitates transition to ongoing services and supports
    a. Measure: Percentage of referrals successfully transitioned to ongoing services and supports.

Project Outcome Evaluation: The desired outcome is for more youth coming to the ED to be assessed for hospitalization to be able to remain safely with their families.

1. Measure: Percentage of youth referred by the ED to CR2 who are able to go home with the support of CR2.

2. Measure: The number of youth hospitalized from the Fairfax Hospital ED during the project period.

3. Measure: The number of youth boarded at Fairfax Hospital during the project period.

Baseline Data: Compiling baseline data for the implementation measures and outcome measure #1 will be difficult because CR2 has been recording referral sources via a text box. It may be possible to identify Fairfax Hospital referrals through a content analysis of the text box data, and from there obtain the other measures. For this project the referral source will need to be collected via drop-down box. Baseline data for outcome measures 2 and 3 is available from Inova and will be collected for the same six-month project period, in the prior year.

Goal: Access and Coordination and Integration

FY 2019 Healthy Minds Fairfax Psychiatric Services Funding Proposal

Submitted by the Children's Behavioral Health SOC Integration Workgroup

March 8, 2019

BACKGROUND AND PROPOSALS

The Fairfax County Executive's proposed budget for FY 2020 includes $100,000 for psychiatric consultation for pediatricians. It is not definite until the budget is approved on May 7, but the fact that it's in the proposed budget is a very good sign. The most efficient use of this funding may be to support implementation of the Virginia Mental Health Access Program (VMAP) in Northern Virginia. VMAP will provide pediatricians with psychiatric consultation and help with connecting young patients with services. It is a new state initiative being partially funded by a small federal grant, supplemented by some state money recently appropriated to DBHDS by the General Assembly. But it's not nearly enough for statewide implementation. Here in Northern Virginia only $35,000 annually is allocated for psychiatric consultation, which will purchase only two half-days a week of consultation from Children's Hospital. So $100,000 would quadruple the amount of consultation time.

Proposal 1: $100,000 to purchase approximately six half-days a week of telephone psychiatric consultation if the county budget request is not approved.

Proposal 2: $35,000 to purchase an additional two half-days a week of telephone consultation, for a total of five full days (10 half-days), if the county budget request is approved.

a. A brief description of the project, including how it will accomplish Blueprint strategies or action steps

This request is to provide telephone psychiatric consultation for pediatricians and other primary care providers serving for children and youth in need of psychiatric services but unable to access them due to the severe shortage of child psychiatrists in Northern Virginia who accept Medicaid and/or private insurance. Psychiatric consultation is telephone contact between a pediatrician and a child psychiatrist to assist the pediatrician in accurate diagnosis and appropriate use of medication. This request supports the following strategy in the Children's Behavioral Health System of Care Blueprint:

• *Provide behavioral health consultation to primary care providers and patients.*

b. A brief description of why currently available services in the county can't meet the need

The 2013 Youth Behavioral Health Services Report identified approximately 6,000 Fairfax children and youth lacking needed behavioral health services and a 2015 community self-

assessment conducted by the Georgetown University Technical Assistance Center for Children's Mental Health identified a local lack of psychiatric consultation and telepsychiatry. The 2016 Fairfax-Fall Church Children's Behavioral Health System of Care Blueprint identified implementing these services as a high priority. The 2018 HMF Behavioral Health Integration Plan calls for implementing psychiatric consultation. Studies indicate numerous barriers to accessing in-person services for youth presenting with mental health concerns, including: significant wait times for evaluation and appropriate treatment; early discharge without being seen by a mental health professional or developing an appropriate treatment plan; unnecessary admission while waiting for evaluation or treatment; high volume of requests for off-site mental health providers; travel time and costs for mental health providers, and families; time taken from school and employment; and potential stigma associated with accessing mental health services.

Numerous studies show that psychiatric and other telehealth health services and consultations break these barriers so that children and youth can access timely and appropriate mental health services, resulting in reduced need for hospitalization and reduced length of hospital stays. The elimination of travel time and cost also enables providers to see more clients more quickly. Telepsychiatry and psychiatric consultation services are feasible, acceptable, and effective for evaluating and treating youth presenting with various mental health concerns and can be delivered across developmental status.

c. A project budget identifying how county funds will be used, and whether a one-time or ongoing expenditure is being proposed: $52,000 for FY 2019.

Proposal 1: $100,000

Proposal 2: $35,000

The proposals are for funding for FY 2020 only, with the possibility of a continuation request for FY 2021. Additional state funding for VMAP may become available for FY 2021, which would decrease the need for HMF funding.

The funding is to purchase telephone psychiatric consultation through a contract between the Virginia Department of Behavioral and Developmental Services and Children's Hospital at a cost of approximately $35,000 per year for a full day per week.

d. Have other funding sources been explored?

The Virginia Department of Health received a five year, $500,000/year federal grant for VMAP implementation, and the 2019 General Assembly appropriated $1.2 million annually. That is far less than the estimated $5 million annual cost for full statewide implementation.

e. How will the program be sustained after the funding?

In most states, pediatric mental health access programs are funded by the state. Continuing efforts will be made to increase state funding for VMAP.

Goal: Access and Coordination and Integration

f. Outcome measures and reporting:

VMAP PCP to Child Psychiatrist Consult Program Evaluation (for federal grant)

Both qualitative and quantitative data will be used to evaluate the project. Quantitative data will be used to identify the numbers and percentages as they apply to patients, providers and sites. For instance, the project manager will track the number and percent of patients from minority or disadvantaged backgrounds. Quantitative data will also address factors such as number and frequency of encounters, type of encounters, referrals, and consultations. Performance scores in standardized patient encounters. Qualitative interviews of providers, patient/families, and other stakeholders in regional sites will be conducted to identify concerns and solicit recommendations for program improvement. This data will be compiled and reviewed monthly during the VMAP Leadership Team meeting. Feedback to the providers and stakeholders in the regional sites will be provided quarterly and as needed for information that is more urgent. This will occur during the monthly scheduled meeting with the VMAP Leadership Team. The Rapid Cycle Quality Improvement (RCQI) approach will be utilized to address findings in a timely manner. Once a problem or concern is identified, those that are involved will develop a plan to address the concern, and then reevaluate the outcomes to make sure the new approach was effective.

Performance Reporting Plan. The Program and Data Managers, under the guidance of the Project Director, will have the lead role in tracking patient encounters and outcomes as well as the project activities related to the Performance data. The Data Manager will enter the patients and providers participating in the project into a database developed in REDCap. This database will enable the Data and Program Managers to track the patients based on their demographics such as age, gender, race, from disadvantaged/underrepresented backgrounds, from rural or underserved locations, or HPSA or MUAs.

Measured Outcomes. The evaluation process will address the collection of data required for the annual progress report. Specifically, data will be collected by the Data and the Program Managers through spreadsheets and surveys. Data will be assembled annually. Performance measures will include: 1) consultations & referrals (provider type, mechanism, number of encounters, reason), 2) number and type providers involved with a mental health team, 3) reason for encounter with mental health provider and how delivered, 6) providers seeking care coordination (number, type, and reason). Outcome measures will include: 1) number and type referral for children identified with behavioral disorders, 2) number children that were seen by providers that consulted with mental health teams, and 3) number children from rural and underserved areas that had pediatric providers that consulted with mental health providers.

g. A timeline for when the project will be completed if county funds are approved.

Since Virginia DBHDS already has a contract with Children's Hospital for psychiatric consultation, and it is a large teaching hospital with many psychiatric residents, The expanded consultation hours could begin on July 1, 2019 and run through June 30, 2020.

Goal: Coordination and Integration

Healthy Minds Fairfax Proposal – "BeWell" (Behavioral health and Primary Care integration)

We would like to request funding from Healthy Minds Fairfax to support the following Blueprint goals:

Goal 7: Improve *care coordination and promote Integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care

1. **A description of the project and how the project will project accomplish a Blueprint strategy or action step**?

   The "BeWell" project is designed to support the integration and care coordination of behavioral and physical health activities to meet the whole health needs of clients receiving services from the CSB. An existing, similar pilot project has been undertaken with the adult SMI population via SAMHSA grant funds, with which positive outcomes have begun to be observed. Utilizing peer recovery specialists in a wellness and health coaching role, improvements have been noted in a number of clients' health indicators around obesity, diabetes and blood pressure, in addition to self-reported measures around daily functioning and overall health (see infographic attached). We would like to develop peer wellness support services to youth and families receiving services from the CSB to enhance the integrated coordination of care. We propose that provision of such services will help meet some of the specific identified challenges around *time constraints* and *communication* and information sharing as outlined in the Behavioral Health Integration Plan needs statement. Peer wellness specialists are able to help bridge the *communication* gap between behavioral health and primary care providers by participating in interdisciplinary *case review* meetings and supporting *care coordination* between CSB behavioral health and primary care providers, to support the youth and family's understanding and follow-up with treatment recommendations. These activities would be consistent with the Blueprint strategies and Action Step #4: *Access to Care coordination and case review meetings.*

2. **A description of why current available services in the county cannot meet the need.**
   BeWell is leading the integration and care coordination efforts for the CSB's priority population. In an effort to demonstrate intentional programming, streamline processes and prevent duplication of services the CSB Children's Behavioral Health Services (specifically outpatient and resource which serves the most vulnerable population) would like to increase partnership with BeWell regarding integration and care coordination efforts. Doing so also promotes focused, specialized programming while eliminating the development of additional, costly services.

   The *Healthy Minds Fairfax Behavioral Health Integration Plan* needs statement clearly identifies the gaps and challenges around lack of coordinated and integrated services. The current provision of the CSB Children's Behavior Health services has been limited in the level of primary and behavioral health care integration due to the funding challenges associated with recruiting and sustaining pertinent clinical, professional and para professional positions on the multidisciplinary team. The difficulties particularly related to the recruitment and retention of nurses and Sr. Clinicians has exacerbated the resource and funding issue.

3. **Have other funding sources been explored?**
   Other funding sources are currently being considered under the state's Department of Behavioral Health and Developmental Services (DBHDS) STEP VA initiative (*System Transformation, Excellence and Performance*) a national best practice model designed to reform

and improve the quality and accessibility of comprehensive behavioral health care system across Virginia, including bidirectional behavioral health and primary care integration. The current priority this year for STEP VA that is relevant to this proposal surrounds the roll out of primary care coordination and physical health screening to all CSB clients receiving case management services aged 3 and over. The availability and amount of such funds may not be known until FY2020. In the interim Youth and Family services have not yet accomplished the level of primary care screening and integration that some of the other CSB departments have to date and so represent a significant need. Stagnation in this effort is due to the need for human capitol retention, particularly nursing positions. Recruitment efforts, particularly for nurse has been difficult throughout the industry.

4. **How will the program be sustained after the funding**?
   We hope the implementation funds will help launch the services over the initial 12-24month period, by which time we hope to demonstrate an effective peer support program that supports billing and a reimbursement structure for peer support services.

5. **What are the outcome measures including how will the data be collected and reported back to the Children's Behavioral Health Collaborative?**
   The primary outcome measures will include the number of CSB clients reviewed in care coordination meetings and followed-up by peer wellness support services and activities/events. Secondary outcomes may include health and wellness indicators: e.g. BMI and blood pressure, metabolic screen indicators (lipids, A1C etc) and other BH outcomes tied to individualized treatment goals.

6. **A project budget identifying how county funds will be used and whether a one-time or ongoing expenditure is being proposed.**
   Available county funds will be used to cover provision of **peer wellness/health coaching/care coordination services** and **care coordination training** for multi-disciplinary staff (from Behavioral Health and Primary Care). An estimate is provided in the table below:

Title/Grade	Midpt + FB	# of pos	Total
Peer Specialist /S15 - Non Merit Benefit Eligible)*	29,090	2	58,181
Training			4,500
Admin cost (copying, printing, etc.)			5,000
Total Proposal Cost			67,681

*Assumptions:
Used midpoint hrly rate of $24.6553
Used 20 hours/week; 1040 hours/annual
Apply Non-Merit Benefit Eligible FB rate of 13.45%

Goal: Coordination and Integration

7. **A timeline for when the project will be completed if county funds are approved.**
"Project completion", defined by the implementation and pilot of peer wellness support services is anticipated to be in effect with a successful pilot period within 12-24 months.

Proposal prepared and submit by Shana Grady (shana.grady@fairfaxcounty.gov)

Please submit your proposal to peter.steinberg@fairfaxcounty.gov by **Friday March 8**.

Goal: Coordination and Integration and Quality

FY 2020 Healthy Minds Fairfax Funding Proposal Request
Project: REACH Primary Pediatric Psychopharmacology (PPP) Training

1. **A description of the project and how the project will project accomplish a Blueprint strategy or action step?**

Background

On April 28, 2017, the CPMT approved a recommendation to fund the REACH Mental Health Training for Pediatricians in FY 2018 and 2019. The county then partnered with INOVA to provide intensive behavioral health training to a total of 65 pediatricians in October and December 2017. In the fall of 2018, INOVA training additional 30 pedestrians from Northern Virginia. In May 2019, the partnership continues and the county will train 25 pediatricians and INOVA will sponsor an additional 15 pedestrians at the training. If funded, the county will sponsor a REACH session in Spring 2020 for approximately 25 Fairfax-based pediatricians and family doctors while INOVA will sponsor an additional 15 doctors.

Need

Mental health disorders, including attention-deficit/hyperactivity disorder (ADHD), depression, anxiety disorder, and bipolar disorder, are increasingly common among the pediatric and adolescent populations. However, data from the Centers for Disease Control and Prevention's National Health and Nutrition Examination survey (NHANES) reveal that only approximately 50% of pediatric patients with mental disorders received treatment within the past year. Outcomes of undiagnosed, untreated, or poorly managed mental disorders among pediatric and adolescent populations include increased health care costs, hospitalizations, and use of specialty mental health services, as well as inappropriate prescribing practices and increased medication costs.

The majority of these patients are treated in the primary care setting; however, primary care clinicians and pediatricians receive little training related to assessing, identifying, and treating mental disorders in this population during medical school, residency and beyond. In addition, the armamentarium of treatments for pediatric mental disorders is constantly growing resulting in continually evolving evidence-based treatment approaches. However, clinicians are often hard-pressed to find the time to remain abreast of the latest clinical trial data and new drug approvals. Therefore, physician education in the diagnosis and treatment of mental illness in children and adolescents is needed in order to better serve this patient population.

More than ever before, healthcare systems are tasked with providing patients with comprehensive, quality health care while controlling healthcare-related costs. With the increases in child and adolescent mental health disorders and the oftentimes lack of specialized pediatric mental health services, healthcare systems must find alternative ways to better serve and care for this patient population. As primary care clinicians and pediatricians are at the forefront of caring for children, they are in an ideal position to assess, diagnose, and manage pediatric and adolescent patients with mental health disorders. However, many primary care physicians and pediatricians may not be adequately trained to handle these patients.

By providing disease-specific and evidence-based training to these clinicians, healthcare systems can take advantage of and improve upon the primary care resources they currently have available within their system. Improving the confidence and competence of primary care physicians and pediatricians in the treatment of mental health disorders in the pediatric patient population may also help to relieve the burden experienced by specialty mental health services by reducing the number of patients with mild-to-moderate mental health disorders referred to specialty services. The REACH Institute PPP Mini Fellowship is an

evidence-based educational training program that can not only provide primary care clinicians and pediatricians with the knowledge and skills they need to identify and treat children and adolescents with mental health disorders, but it can also provide a cost-effective solution to assist healthcare systems achieve their goal of having a fully-integrated, efficient patient-centered medical home model.

For the needs assessment specifically related to Fairfax County, refer to the Needs Statement on page 4 of the Behavioral Health Integration Plan that was endorsed by the Fairfax-Falls Church Community Policy and Management Team on June 22, 2018. See below for the Needs Statement excerpt:

NEEDS STATEMENT

This community plan for supporting and promoting integration is in support of the Fairfax-Falls Church Children's Behavioral Health Blueprint goal #7: *Improve care coordination and promote integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care.*

While a fully integrated primary care practice is an ideal method for families and youth to access a comprehensive array of high quality services and supports, there are several other options for primary care providers and behavioral health clinicians to increase their level of collaboration and improve care for their patients. Some practices, agencies, and organizations may benefit from support at the level of integration they currently are at or wish to achieve in the near term.

In order to understand the barriers for primary care practices and behavioral health agencies to achieving a higher level of integration, the Integration Committee conducted two focus groups: one with behavioral health clinicians who serve children and families and the other with pediatricians. Group participants were from across Fairfax County and represented a diverse array of practices and agencies. While the views presented were not necessarily representative of all providers in the community, the focus groups highlighted challenges that practices currently face and the need for an array of strategies to support or promote integration.

Below is a summary of challenges highlighted by community pediatricians and behavioral health clinicians:
Limited Knowledge of Available Resources. The primary care providers and behavioral health clinicians represented in the focus groups share the challenge of not knowing what resources exist for their patients throughout the county. Providers want to have a readily accessible and regularly updated directory of primary care and behavioral health providers who are comfortable providing different levels of behavioral health care, including current insurance information. Providers also want more information on available behavioral health training.

> *"A lot of psychiatrists won't take insurance anymore. I'm referring them and [psychiatrists] said 'we don't take it anymore.' I think, 'oh my god, how is my client ever going to afford this.' They don't have that kind of money."*
> *– Behavioral Health Clinician*

Limited Knowledge, Experience, or Comfort with Interdisciplinary Care. A strong theme that emerged during the focus groups was that primary care providers are hindered by a limited knowledge of behavioral health care, difficulty identifying or distinguishing a behavioral health issue from a medical issue, and being unfamiliar or uncomfortable with medication side effects. Discomfort with medication side effects contributes to concerns about liability. Behavioral health clinicians similarly expressed that their patients

often have co-occurring medical conditions, for which they desire more understanding on how to integrate medical considerations into behavioral health treatment.

> *"What stands out to me is that in the nine years that I practiced prior to this[], I probably missed a whole slew of children that presented as headaches and abdominal pain. And where did those kids go? I'm not sure. So, now [that I've been trained] I feel a little bit more comfortable managing that." – Primary Care Provider*

Cost and Availability of Training. Primary care providers expressed that the cost of behavioral health training and the secondary cost of the primary care provider being taken away from patient care is a barrier for providers getting the training they need to provide quality behavioral health care. Nurse practitioners expressed that there are limited training or fellowship opportunities for those who want to manage behavioral health care in their practice.

Time Constraints. Primary care providers noted that they are concerned about dedicating the time needed to address patients' behavioral health issues and expressed concerns for losing that time when patients are unable to show for their appointments. A few primary care providers have developed effective internal processes for managing appointment schedules and waitlists, highlighting that the perceived time constraints may be addressed by sharing best practices.

Insurance and Billing. Providers from both groups acknowledged that insurance is a major barrier – both for families accessing behavioral health care and for pediatric providers and behavioral health clinicians trying to provide services. While there are higher-level policy concerns affecting clinicians' ability to accept insurance, there are also knowledge barriers among individuals and practices. Primary care providers expressed that they would be able to better manage behavioral health care if they were equipped with information on how to effectively bill insurance for their time.

Access to Behavioral Health Clinicians. The main concerns that emerged from the focus groups regarding the ability to coordinate or collaborate with behavioral health clinicians are the limited availability of behavioral health providers who accept insurance and/or have available openings in all areas of the county, as well as a limited number of affordable child psychiatrists.

> *"That's the first question I always ask when they want the [psychiatric] referral. 'How much do you want to pay? How quickly do you want to be seen? I can find you somebody who can see you today if you have $400, but if you want to use your insurance, it's a whole different story.'"*
> *– Behavioral Health Clinician*

Communication. All providers involved in the focus group discussions conveyed that current interdisciplinary communication is very poor. The combination of varied office schedules, confidentiality considerations, and the lack of a streamlined information sharing process is both discouraging to

providers and a hindrance to providing collaborative, quality behavioral health care.

"Some parents don't want to sign a release form. There's all these things on the list - this one, that one - they just say 'no, no.' So, for whatever reason, that becomes an issue because without the release you cannot [share] it with anyone else." – Behavioral Health Clinician

"[There is] a lot of pushback around, 'sign this consent or go to this specialist, or go here and go there.' Those are insurmountable recommendations for our families... The perception that we're creating more business for the family to deal with, [is] a lot of times where that push back happens." – Behavioral Health Clinician

"We have so much diversity in our area and there's a lot of cultural factors that play into the consent and privacy. The fact that, for some families, they even sought out mental health treatment already is a stigma. So, to let the school know that their child is in mental health treatment - that's huge."
– Behavioral Health Clinician

Cost to Bring on Interdisciplinary Providers. While behavioral health clinicians in the focus group expressed a desire to have a psychiatric nurse available to them at the agencies and practices to reduce the demand for child psychiatrists, some identified the cost of bringing on additional staff as a barrier.

Limited Space for Integrated Staff. Most primary care providers represented in the focus groups expressed that physical space for added services in their offices/clinics is limited. Many expressed a high need for tele-mental health services so that patients can access behavioral health services from either the pediatrician's office or other community access points.

Limitations of Treatment in Integrated Facilities. At least one participant pointed out that, even in fully integrated facilities, providers are limited in the level of behavioral health care they can provide. In these settings, there is still the need to refer particularly challenging clients or clients with specialized needs.

The Blueprint Strategy that will be addressed:

Blueprint, Goal 7: Care Coordination and Integration – Improve care coordination and promote integration among schools, primary care providers and mental health providers, including the integration of primary and behavioral health care. Specifically, Strategy B: Promote resources to implement tiered levels of integration based on capacity and readiness to include information sharing, co-location, full integration, behavioral health homes and telemedicine.

Integration Plan, Strategies to Expand Behavioral Health Clinicians' and Primary Care Providers' Access to Resources and Training, Strategy 2: Expand REACH training.

Description of the project:

The REACH Institute training on Primary Pediatric Psychopharmacology (PPP) has been addressing the need outlined above for nearly 8 years. The training program consists of a 3-day live educational program followed by 6 months of distance learning/coaching. The REACH program goes beyond the simple didactic lectures and case-study presentations typical of traditional continuing medical education (CME) programs through the integration of hands-on training related to the incorporation and use of mental health screening tools, peer-to-peer learning to improve clinician-patient communications through the use of role-playing exercises, problem-solving related to implementing behavioral healthcare strategies into practice through small group roundtable discussions, and ongoing bi-weekly teleconference coaching to

promote continued learning and incorporation of evidence-based care in their practice. The training is led by 4 nationally recognized key opinion leaders in child psychiatry, pediatrics, and primary care, and is intended to promote not only increases in knowledge, skills, and attitudes, but also practice change and improved patient management.

Specially, this REACH pediatrician training is to improve their ability to:

- Correctly identify and differentiate among pediatric behavioral health problems childhood depression, ADHD, bipolar disorder, anxiety states, oppositional and conduct disorders, and psychosis.
- Effectively manage psychopharmacology: selecting medications, initiating and tapering dosages, monitoring improvements, and identifying and minimizing medication side effects.
- Create and implement a treatment plan by mobilizing existing resources like family members, school personnel and other professional caregivers.

2. A description of why current available services in the county cannot meet the need.

This is the only training program that provides a comprehensive mental health and psychopharmacology training with an extensive follow along to assist participants in the integration of the new skills in to the pediatricians' practices that will come to our community and provide continuing medical education credits for participants and provide long term clinical support via ongoing conference calls.

The REACH Institute is the only vendor that offers such a course and will bring it to our locality and train 30 or more pediatricians at a time.

3. Have other funding sources been explored?

The total project cost to the county for 25 participants is $75,645, and that amount is broken down as follows:

3-day Training Workshops (Fees for 4 trainers):	$11,250
12 Consultation Calls (2 consultants + call fees for two call groups):	$8,496
Materials:	$5,600
Travel:	$9,975
REACH Personnel:	$13,725
Indirect Costs:	$11,599
Food for physicians and trainers	$15,000

Additional costs and in-kind resources not covered by the county:

Site for 3-day training	In-kind
Food for the additional physicians and trainers	$10,000+
15 additional participants	$33,000

Other resources were confirmed to share the cost of the project:

INOVA: Site for 3-day training; In-kind resource (confirmed)
INOVA: Food; $10,000+ (confirmed)
INOVA: Additional participant training; $33,000

4. How will the program be sustained after the funding?

This is a one-time only expense for training the pediatricians and therefore ongoing funding is not necessary to sustain the project. Future funding will only be necessary in order to expand the project to additional pedestrians in need of training.

Goal: Coordination and Integration and Quality

5. **What are the outcome measures including how will the data be collected and reported back to the Children's Behavioral Health Collaborative?**

Outcome measurement plan

Following the training, all participants will be asked to attend case-based, 1-hour long conference calls two times a month for six months. Calls for four groups composed of 12-15 participants each will be scheduled for a total of 24 calls (12 per group). A REACH pediatric faculty member and psychiatry faculty member will lead each call.

REACH will collect the following evaluation data from training participants:

1. Daily Unit Questionnaire - assesses each participant's perception of the presentation quality, content quality, and practice relevance of each unit of the training workshop.
2. Overall Questionnaire - satisfaction with the overall training.
3. Knowledge and Comfort Questionnaire - assesses participant's knowledge and comfort with assessing, diagnosing, and treating child mental health problems. Completed pre-training workshop, post-training workshop, and at the conclusion of the 12 conference calls.

Previous training data

Feedback from participants who have completed the REACH training program reveals increased confidence in the assessment, diagnosis, and treatment of pediatric patients with mental disorders. The pre and post data from the December 2017 training is as follows:

Assessment and Diagnosis:

	Knowledge (n=26)		Comfort (n=26)	
	Pre	**Post**	**Pre**	**Post**
ADHD	3.19	3.73	3.08	3.85
Anxiety Disorder	2.50	3.35	2.15	3.31
Major Depressive Disorder	2.54	3.38	2.04	3.35
Bipolar Disorder	1.73	2.77	1.46	2.46
Conduct Disorder	2.08	3.00	1.77	2.73
Autism and Autism Spectrum	2.65	2.88	2.36	2.76
Suicide Risk	2.85	3.20	2.44	3.08
Aggression	2.15	3.15	1.73	2.92
Co morbid Psychiatric Disorders	1.92	2.88	1.56	2.69
Not at all (1), Small Amount (2), Moderate Amounts (3), Great Deal (4)				

Treatment:

	Knowledge (n=26)		Comfort (n=26)	
	Pre	**Post**	**Pre**	**Post**
ADHD	2.92	3.85	3.08	3.73
Anxiety Disorder	2.15	3.38	1.88	3.19
Major Depressive Disorder	2.00	3.35	1.84	3.15

Goal: Coordination and Integration and Quality

Bipolar Disorder	1.54	2.65	1.32	2.12
Conduct Disorder	1.58	2.69	1.28	2.50
Autism and Autism Spectrum	2.12	2.50	1.81	2.52
Suicide Risk	2.19	3.04	1.92	2.92
Aggression	1.65	2.88	1.38	2.65
Co morbid Psychiatric Disorders	1.54	2.81	1.31	2.54
Not at all (1), Small Amount (2), Moderate Amounts (3), Great Deal (4)				

6. **A project budget identifying how county funds will be used and whether a one-time or ongoing expenditure is being proposed.**

   See # 3 and #4 above.

7. **A timeline for when the project will be completed if county funds are approved.**

   This training will be completed by June 30, 2020.

Goal: Family and Youth Engagement

Description

In 2017 the peer recovery specialists of the Merrifield Crisis Response Center worked with nearly 972 youth, of that number approximately 640 were not connected to needed behavioral health services. In the early spring of 2018 Healthy Minds Fairfax awarded funding for the provision of a youth drop-in peer group which was named Meraki.

The first meeting of Meraki was held in June of 2018. Two young people attended the group with support from their parents and social service workers respectively. They stopped attendance due to transportation difficulties after two meetings. Consultations were sought with fellow youth partners and representatives of Healthy Minds Fairfax and a new collaboration was born.

It was determined that transportation to Merrifield Center without support of adult care givers would make participation in the programming difficult. Through collaboration and with support of CSB Youth Services Management LaVurne Williams and Birgit Snellenburg, an adult drop-in group was also formed. The two groups were renamed **Heads Up (Youth group)** and **Talk It Out (Parent group)**. Advertisements and web postings about the newly branded groups were placed on county social media platforms beginning January 18, 2019 and an open house was hosted on February 5, 2019.

Service targets and timeline

The relaunched groups are held on the third floor of the Merrifield Center, utilizing the space vacated by the youth day treatment programming. The two groups meet the **Blueprint Strategy Goal 5: Youth and Parent/Family Peer Support to develop and expand youth and parent/family peer support services.** These groups will help expand evidence based peer to peer groups/family and community networks.

The average youth and parents attending Peer Recovery sessions is estimated at 4 – 6 sessions. The budget is focused on $30 per person, per session. 960 hours/2 = 480 youth hours and 480 parent hours. This translates to 1 youth attending 1 evening and 1 parent attending 1 evening. If every youth and parent attends an average of 4 times, that would be 120 unduplicated youth and parents attending sessions.

Since the inception of the **Heads Up Talk It Out** groups on February 7, 2019 five separate parents have attended the weekly parent peer support group. No youth have attended the youth peer support group to date. Groups have been launched on previous Healthy Minds Fairfax funding so timeline of project if ongoing expanded funding is approved will run until end of FY 2020.

In 2018 there were 580 youth who utilized the services of the Merrifield Crisis Response Center. Engagement of these Youth in services is critical to reduce their use of Crisis Services.

Goal: Family and Youth Engagement

CSB Youth and Emergency Services are working with stakeholders, Walk-In Assessment, Fairfax County Schools SAP programming and Juvenile and Domestic Relations Court Central Intake to increase awareness of groups and potential referral sources.

The mission of these groups continues to be to help these youths and their families to manage stress and decrease use of Acute Care services though development of recovery skills in collaboration with Peer Recovery Support.

Lack of current available services

Currently there are no other CSB sponsored recovery support groups for youth and their adult supports. In addition, there are no other drop-in / engagement groups for youth facilitated by peer recovery specialists. Due to the age group of this population transportation is a tremendous barrier.

Funding Sources

In the previous year funding was secured through Healthy Minds Fairfax. Peer Recovery funding is also being sought through CSB Executive Leadership and Internal Department of Behavioral Health and Developmental Services funding sources.

Program Sustainment

Future funding will continue to be explored through the aforementioned portals, as well as the Department of Behavioral Health and Developmental Services Funding.

Budget FY 2020

Category	1 position (midpt/hr)	Cost +FB @ 13.45%	# of pos	Total
Peer Recovery Specialist (S-15)	24.6553	7,272.57	3	21,817.72
Snacks/games/engagement activities				4,000.00
Admin Costs (copying, printing, marketing etc.)				3,000.00
Total				**28,817.72**

Notes:
Peer Specialist at S15 midpt
hourly rate
5 hours/week for FY 2020
13.45% non-merit benefit eligible
FB rate is applied

Goal: Family and Youth Engagement

The groups target youth aged 14-17 y/o and their adult supporters. They are staffed by existing CSB personnel and MCRC Peer Recovery Staff.

Group: **Heads Up** & **Talk It Out**
MCRC Youth Drop-in Recovery Group
90 minutes

The focus of **Heads Up** is to provide education to teens about the elements of successful, sustainable, recovery and help them to develop their own successful plans for recovery through exposure and collaboration with Peer Recovery support staff. The groups provide teens psychoeducational information provided by Peers to help these individuals integrate behavioral tools to manage stress and weather crisis.

Group Topics:
SAMSHA Eight Dimensions of Wellness
(for 4 weeks)
Week 1: Occupational and Financial
Week 2: Emotional and Physical
Week 3: Intellectual and Social
Week 4: Spiritual and Environmental

Second Block:
(for 4 weeks)
Wellness and Recovery Action Plan
Week 1: WRAP Overview
Week 2: Discovery and Development of Wellness Tools
Week 3: Crisis Plan
Week 4: Post Crisis Planning

Third Block:
(for 8 weeks)
Whole Health Action Management
Week 1: WHAM Overview
Week 2-8: Wellness Strategies, Stress Management and Peer Support

If on-going funds are awarded, the group will run continuously through the end of the fiscal year. Data will be reported quarterly.

Outcome measures that will be used are:

- Full participation in 4 week cycles
- Participation and completion of subsequent 4 week groups
- Decreased number of visits to MCRC requiring inpatient hospitalization
- Increased number of youth connected to services

Goal: Family and Youth Engagement

Programming for the **Talk It Out** adult supporters group includes connection to fellow adults with shared experiences, guest speakers from CSB behavioral health treatment staff, psychiatry to discuss medications, court services central intake to explain juvenile court processes. They have already begun development of resources for system navigation.

Currently this group is being generously supported by CSB Behavioral Health staff but this group would benefit from a Certified Peer Recovery Staff skilled in family peer support services to augment service provision. The goal is to have Parent and Peer Support staff eventually take over hosting the groups and championing ongoing provision of Family navigation and Peer Support.