FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for AT-RISK CHILDREN, YOUTH & FAMILIES

January 27, 2023
Community Policy and Management Team (CPMT)

Agenda

FINAL

1:00 p.m. -- Convene meeting ~

1. **MINUTES:** Approve minutes of December 9, 2022 meeting

2. **ITEMS:**

- **Administrative Items**
  Item A – 1: Mental Health Initiative- State Transportation Costs
  Item A – 2: Policy for Coverage of Credit Card Service Fee

- **Contract Items**
  Item C – 1: Out of State Contract Approvals

- **Information Items**
  Item I – 1: Budget Report
  Item I – 2: State Reporting of Administrative Costs for CSA Program
  Item I – 3: Fiscal Analysis of Private Day Rate Setting Methodology
  Item I – 4: Overview Children's Behavioral Health Plan

- **NOVACO – Private Provider Items**
- **CPMT Parent Representative Items**
- **Cities of Fairfax and Falls Church Items**
- **Public Comment**

3:00 p.m. – Adjourn

FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for AT-RISK CHILDREN, YOUTH & FAMILIES

December 9, 2022
Community Policy and Management Team (CPMT)
Virtual Meeting due to COVID-19 Emergency Procedures

Meeting Minutes

Attendees: Staci Alexander (Annandale, VA), Michael Axler (Fairfax, VA), Deb Evans (Woodbridge, VA), Annie Henderson (Fairfax, VA), Joe Klemmer (Fairfax, VA), Richard Leichtweis (Fairfax, VA), Chris Leonard (office), Dana Jones (office), Dawn Schaefer (Springfield, VA), Rebecca Sharp (office), Daryl Washington (home)

Attended but not heard during heard during roll call: Matt Thompson, Michael Becketts

Absent: Lesley Abashian, Gloria Addo-Ayensu, Jacqueline Benson, Michelle Boyd, Lloyd Tucker

HMF Attendees: LaVurne Williams, Philethea Duckett,

CSA Management Team Attendees: Barbara Martinez, Jessica Jackson, Kamonya Omatete, Andrew Janos, Kelly Conn-Reda, Tim Elcesser, Desiree Roberts

Stakeholders and CSA Program Staff Present: Janet Bessmer, Kendra Rascoe, Jeanne Veraska, Sarah Young, Samira Hotochin, Lisa Morton, Jesse Ellis, Alicia Gallogly, Amee Vyas

FOIA Related Motions:

I move that each member's voice may be adequately heard by each other member of this CPMT.
Motion made by Chris Leonard; second by Annie Henderson; all members agree, motion carries.

Second, having established that each member's voice may be heard by every other member, we must next establish the nature of the emergency that compels these emergency procedures, the fact that we are meeting electronically, what type of electronic communication is being used, and how we have arranged for public access to this meeting.

State of Emergency caused by the COVID-19 pandemic makes it unsafe for this CPMT to physically assemble and unsafe for the public to physically attend any such meeting, and that as such, FOIA's usual procedures, which require the physical assembly of this CPMT and the physical presence of the public, cannot be implemented safely or practically. I further move that this CPMT may conduct this meeting electronically through a dedicated auto conferencing line, and that the public may access this meeting by calling: 571-429-5982; participant access code: 279 121 98#. It is so moved.
Motion made by Chris Leonard; seconded by Matt Thompson; all members agree, motion carries.

Finally, it is next required that all the matters addressed on today's are statutorily required or necessary to continue operations and the discharge of the CPMT's lawful purposes, duties, and responsibilities.
Motion made by Chris Leonard; seconded by Annie Henderson; all members agree, motion carries.

Approved:

1. **MINUTES:** Approve minutes of September 23, 2022 and October 28, 2022, CPMT meeting. *Motion made by Chris Leonard; seconded by Rick Leichtweis; all members agree, motion carries.*

2. **ITEMS:**

- **Administrative Items:**
- **Item A-1:** Appointment of New Family Assessment and Planning Team (FAPT) Member Appointment of Genette Hopkins as a DFS representation on FAPT – Sarah Young. *Motion made by Deb Evans: Second Rebecca* Sharp; *all members agree, motion carries.*
- **Item A-2:** Update on Policy for Using Expedited FAPT Service Planning for Emergency Access to Primary Substance Use Disorder (SUD) Treatment Services – Janet Bessmer. This was brought to the team in the September 2022 meeting, however, at the time rates were based on estimates. Now that firm rates have been identified this item has been brough back for approval as the rates are significantly higher than original estimate. This process would allow case managers to request intensive SUD treatment and related supports on behalf of a youth/family that meet the criteria. Regular updates regarding utilization of these services will be provided to the CPMT. *Motion made by Rick Leichtweis; Seconded by Joe Klemmer; all members agree, motion carries.*

- **CSA CONTRACT ITEMS:**

  Item C – 1: Out of State Contracts – None
  Item C – 2: Substance Use Disorder Treatment Provider and Rates – Barbara Martinez and LaVurne Williams. DPMM, CSA and CSB have been working on finding a provider that specializes in substance abuse treatment. The only local provider that has been identified is Sandstone Behavioral Health, however their rates are significantly higher than other RTCs. This is being shared with CPMT since the rates are about 400% more than a typical RTC. When youth are placed in one of these facilities CPMT will be notified. LaVurne Williams shared that CSB has had trouble finding resources to assist youth locally. There are very few facilities that provide SUD treatment and accept insurance/Medicaid. The facilities that have been identified are out of state. CSA Management Team will be able to approve these placements. Chris Leonard asked what the normal cost of this treatment would be in comparison to what Sandstone charges. Barbara Martinez commented that it would be difficult to find a good comparison because there are no local facilities that provide the services needed.

- **CSA INFORMATION ITEMS:**

  - **Item I – 1:** October Budget Report & Status Update, Program Year 2023 – Presented by Desiree Roberts.
  - **Item I – 2:** Recommendations from State Workgroup for Special Education Funding – Presented by Janet Bessmer. Final recommendations have been released. The state workgroup recommended moving funding for Special Education from CSA to Department of Education.
  - **Item I – 3:** FY 23 Quarter 1 Residential Entry and FAPT Report – Presented by Jeanne Veraska and Sarah Young. Summary of report was shared with CMPT. No questions/comments regarding the report.
  - **Item I – 4:** Serious Incident Report (SIR), FY23 Quarter 1 – Presented by Jeanne Veraska. Summary of SIRs were provided. CSA made note that some providers sent reports late so there were some discrepancies with the numbers in the report. Details regarding the late reports will be provided in the next report. CSA is working with providers to get reports in a timely manner.
  - **Item I – 5**: Parental Contribution Accounts Service Fee for Credit Card Payments – Presented by Janet Bessmer. Many families have requested to make parental contribution payments via credit

card/medical flexible spending account. If the credit card service fee is covered by CSA program, families will be able to use their flexible spending. Chris Leonard suggested bringing this back to the next meeting for approval once some internal procedures have been discussed.

- **Private Provider Items -** none
- **CPMT Parent Representative Items –** none
- **Cities of Fairfax and Falls Church Items –** Falls Church had a meeting to discuss the opioid funds and how to use those funds.
- **Public Comment –** none

Adjourn 2:22pm: *Motion to adjourn made by Daryl Washington; seconded by Michael Becketts; all members agree, motion carries.*

Next Meeting: January 27, 2022, 1:00 – 3:00pm (location TBD)

Approved:

MEMO TO THE CPMT

January 27, 2023

Administrative Item A -1: Mental Health Initiative- State (MHI-S) Funding Approval for Transportation Services

ISSUE: That DBHDS requires CPMT approval for the planned use of MHI-State funds for youth.

BACKGROUND:
The Mental Health Children and Adolescent Initiative (MHI) is a Virginia Department of Behavioral and Developmental Health (DBHDS) funding allocation to CSBs dedicated to serving children and adolescents with serious emotional disturbance and other disorders who are not mandated to receive services under the Children's Services Act (CSA). The annual MHI allocation to the Fairfax-Falls Church CSB is $515,529.

The current annual MHI allocation is used to support four CSB Behavioral Health Specialist II positions, two Senior Clinician positions and to purchase intensive behavioral health treatment for children and youth with more complex needs than can be met through outpatient services. Currently, guidelines for MHI-State Funds (Exhibit D) permit purchase of services such as in-home therapy, Applied Behavioral Analysis (ABA), Intensive Care Coordination (ICC), and Family Peer Support Partners (FPSP) for CSA non-mandated youth eligible for MHI-State funds as long as these services are linked to an individualized service plan. However, there isn't clear language around the use of funds for transportation costs. CSB staff have engaged in conversations with DBHDS around the use of MHI-State funds for the use of transportation and they are in support of this as long as the existing policies are followed and the local CPMT endorses this expenditure.

RECOMMENDATION: For CPMT members to approve the use of MHI-State funds for transportation costs for eligible youth.

ATTACHMENT: DBHDS Exhibit D

INTERNAL CONTROL IMPACT: Transportation costs would be approved on a child-specific basis in the same manner as all other purchased services.

FISCAL IMPACT: The use of MHI-State funds for transportation costs is not expected to have a major impact on MHI-State expenditures. Only a few children per fiscal year would need the additional service of transportation added to their array of additional services.

STAFF: Jessica Jackson, LCSW, CSB

Exhibit D: Fairfax-Falls Church Community Services Board
Performance Measures for the Mental Health Initiative (MHI) Fund

This Agreement is between the Department of Behavioral Health and Developmental Services ("DBHDS" or "Department") and the **Fairfax-Falls Church Community Services Board** ("CSB" or "Subrecipient"), collectively hereinafter referred to as "the Parties", entered into this Agreement to govern certain activities and responsibilities required for operating or contracting the **Mental Health Initiative (MHI) Fund** (the "Program" or "Service"). This Agreement is attached to and made part of the performance contract by reference.

Purpose: The Mental Health Initiative (MHI) Fund was established by the General Assembly in FY 2000 to create a dedicated source of funding for mental health and substance abuse services for children and adolescents with serious emotional disturbances (SED) who are not mandated for the Children's Services Act (CSA). Specific language from the Appropriation Act states:

> ***"Out of this appropriation $6,148,128 the first year and $6,148,128 the second year from the general fund shall be provided for mental health services for children and adolescents with serious emotional disturbances and related disorders, with priority placed on those children who, absent services, are at-risk for custody relinquishment, as determined by the Family and Assessment Planning Team of the locality. The Department of Behavioral Health and Developmental Services shall provide these funds to Community Services Boards through the annual Performance Contract. These funds shall be used exclusively for children and adolescents, not mandated for services under the Comprehensive Services Act for At-Risk Youth, who are identified and assessed through the Family and Assessment Planning Teams and approved by the Community Policy and Management Teams of the localities. The department shall provide these funds to the Community Services Boards based on an individualized plan of care methodology."***

Term: This Agreement shall govern the performance of the Parties for the period of **July 1, 2021** through **June 30, 2023** ("Period of Performance").

A. The CSB Responsibilities: In order to implement the **Mental Health Initiative (MHI) Fund,** the CSB agrees to comply with the following requirements.

1. MHI funds must be used exclusively to serve currently unserved children and adolescents or provide additional services to underserved children and adolescents with serious emotional disturbances and related disorders that are not mandated to receive services under the Children's Services Act (CSA). Underserved refers to populations which are disadvantaged because of their ability to pay, ability to access care, or other disparities for reasons of race, religion, language group or social status.
2. Children and adolescents must be under 18 years of age at the time services are initiated. MHI funds can be used to bridge the gap between the child and adolescent and adult service systems, if the service was initiated before the adolescent's 18th birthday. MHI funds cannot be used to initiate new services once an adolescent turns 18 years of age.
3. MHI funds must be used to purchase services which will be used to keep the child or adolescent in the least restrictive environment and living in the community.
4. CSBs may use MHI funds to support personnel used to provide services to children and families. For example, the funds may be used to create a position dedicated to serving the non-CSA mandated population of children in the community; each service provided shall should be linked to an individualized service plan for an individual child and reported through the CCC3 by using Consumer Designation Code 915 code.
5. MHI funds should not be used when another payer source is available.
6. Services must be based on the individual needs of the child or adolescent and must be included in an individualized services plan. Services must be child-centered, family focused, and community-based. The participation of families is integral in the planning of these services.
7. CSBs must develop policies and procedures for accessing MHI funds for appropriate children and adolescents The CSBs shall work collaboratively with its local Community Policy Management Teams (CPMTs) to establish a MHI Fund Protocol for how the CSB will expend the MHI funds for the target population, as defined below.
8. Services shall be provided in the least restrictive and most appropriate settings, including homes, schools, and community centers.
9. **<u>Target Population for Mental Health Initiative (MHI) Funds</u>**

a. The target population to be exclusively served with MHI funds is children and adolescents with serious emotional disturbance and related disorders who are not mandated for services under the CSA. Serious emotional disturbance in children is defined as a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

b. Related disorders are not defined in the appropriations act. However, the assumption for the purposes of these guidelines is that the language "related disorders" allows the necessary flexibility to serve children with mental health or co-occurring mental health and substance use problems who may not fit the definition above but who, in the opinion of CSB clinical staff, are in need of services that can only be provided with the use of MHI funding. This shall be documented in the child's file and on the service plan.

10. Appropriate Services to be supported by Mental Health Initiative (MHI) Funds

a. CSBs must follow the DBHDS Core Services Taxonomy categories and subcategories in providing, contracting for, and reporting these services. However, some flexibility exists in consultation with the Office of Child and Family Services (OCFS) to assure that the needs of individual children are met.

b. Types of services that these funds may be used for include: crisis intervention and stabilization, outpatient, intensive in-home, intensive care coordination, case management, Family Support Partners, Parent Child Interaction Therapy (PCIT), Trauma Focused Cognitive Behavioral Therapy (TF-CBT, Multi-systemic Family Therapy (MST), Family Functional Therapy (FFT), therapeutic day treatment, alternative day support (including specialized after school and summer camp, behavior aide, or other wrap-around services), and highly intensive, intensive, supervised family support services.

c. Given the population to be served, children and adolescents with serious emotional disturbances, services need to be appropriately intensive and comprehensive. Prevention and Early Intervention-Part C services are not appropriate uses of these funds.

d. All expenditures shall be linked to an individualized service plan for an individual child. Expenditures may be for something that is needed by more than one child, providing it can be linked to the individualized service plan of each child.

e. CSBs may use MHI funds to support personnel used to provide services to children and families. For example, the funds may be used to create a position dedicated to serving the non-CSA mandated population of children in the community; however, as stated above, each service provided shall should be linked to an individualized service plan for an individual child.

f. CSBs may use up to 5% of the total MHI fund allocation for administrative costs associated with the overall MHI fund management and administration. Administrative costs include non-direct service personnel and supplies.

g. MHI funds may not be used for residential care services, partial or full hospitalizations, or for CSA mandated populations. MHI funding may not be used to purchase vehicles, furniture,computers, or to provide training.

h. The CSB shall work collaboratively with its local Family Assessment and Planning Teams (FAPTs) and/or Community Policy and Management Teams (CPMTs) to establish a MHI Fund Protocol to specifically outline how these funds will be used to serve the non-CSA mandated population in the CSB's catchment areas. The MHI Protocol will be included in the CSB's MHI policies and procedures.The CSB should seek input and guidance in the formulation of the protocol from other FAPT and CPMT member agencies.

   a. The MHI Fund Protocol shall at minimum:
      i. Clearly articulate the target population to be served within the SED, non-CSA mandated population;
      ii. Establish defined protocols and procedures for accessing services, ensuring that all key stakeholder agencies have a method to link into services;
      iii. Clearly articulate the kinds or types of services to be provided; and
      iv. Provide for a mechanism for regular review and reporting of MHI expenditures.

The CSB shall ensure that the CPMT(s) have had the opportunity to give input to and review its protocol for MHI funds. A copy of the plan shall be kept on file at the CSB.

B. The Department Responsibilities: In order to implement the **Mental Health Initiative (MHI) Fund,** the Department agrees to comply with the following requirements.

1. The Department shall distribute the funds in the regular semi-monthly electronic funds transfers, beginning with the July 1 payment of each state fiscal year.
2. The Department shall establish a mechanism for regular review and reporting of MHI Fund expenditures to include a process by the Office of Child and Family Services which may differ from the process of the Office of Management Services.

C. Payment Terms: The Department shall provide the CSB **$515,529**, in Restricted MHI State General Funds in regular, semi-monthly payments. The Department may, at its reasonable discretion, modify payment dates or amounts, or terminate this Agreement and will notify the CSB of any such changes in writing.

D. Limitations on Reimbursements: CSB shall not be reimbursed or otherwise compensated for any expenditures incurred or services provided following the end of the Period of Performance.

E. Use of Funds: The CBS may not use the funds provided under this Agreement for any purpose other than as described herein and allowable to carry out the purposes and activities of the Program. The CSB agrees that if it does not fully implement this program as approved or as subsequently modified by agreement of the Parties, the Department shall be able to recover part or all of the disbursed funds.

F. Performance Outcome Measures: Services shall have the purpose of keeping children in their homes and communities and preserving families whenever possible.

G. Reporting Requirements:

1. All expenditures shall be linked to an individualized service plan for an individual child and reported through the CCC3 by using Consumer Designation Code 915 code. Expenditures may be for something that is needed by more than one child, providing it can be linked to the individualized service plan of each child.

2. The CSB shall provide data reports as required in CCS 3 and finance reports on the funds provided by the Department as required in CARS pursuant to Section 12 Reporting and Data Quality Requirements of the FY 2022 and FY 2023 Community Services Performance Contract.This information will be reported through the CCS3 by using Consumer Designation Code 915 code.

3. The CSB may carry-forward a balance in the MHI fund during the biennium in which the funds were distributed. If the CSB has a balance of 10% or greater, of the current allocation, at the end of the biennium, the CSB shall work with the OCFS to develop a plan to spend the end of the biennium balance.

H. Monitoring, Review, and Audit: The Department may monitor and review use of the funds, performance of the Program, and compliance with this Agreement, which may include onsite visits to assess the CSB's governance, management and operations, and review relevant financial and other records and materials. In addition, the Department may conduct audits, including onsite audits, at any time during the term of this Agreement.

I. Entire Agreement: This Agreement and any additional or supplementary document(s) incorporated herein by specific reference contain all the terms and conditions agreed upon by the Parties hereto, and no other contracts, oral or otherwise, regarding the subject matter of this Agreement or any part thereof shall have any validity or bind any of the Parties hereto.

J. Counterparts and Electronic Signatures: Except as may be prohibited by applicable law or regulation, this Agreement and any amendment may be signed in counterparts, by facsimile, PDF, or other electronic means, each of which will be deemed an original and all of which when taken together will constitute one agreement. Facsimile and electronic signatures will be binding for all purposes.

K. Conflicts: In the event of any conflict between this Agreement (or any portion thereof) and any other agreement now existing or hereafter entered into, the terms of this Agreement shall prevail.

Exhibit D: Fairfax-Falls Church Community Services Board
Performance Measures for the Mental Health Initiative (MHI) Fund

Signatures: In witness thereof, the Department and the CSB have caused this Agreement to be executed by the following duly authorized Parties.

Virginia Department of Behavioral Health and Developmental Services

By: DocuSigned by: Alison Land 648C7B1925394FB...

Name: Alison G. Land, FACHE

Title: Commissioner

Date: 7/30/2021

Office of Child and Family Services

By: DocuSigned by: Nina Marino 1B33E7524C139478...

Name: Nina Marino

Title: Program Director

Date: 7/30/2021

Fairfax-Falls Church Community Services Board

By: DocuSigned by: Garrett Mcguire 558ED1BA378F4D0...

Name: Garrett Mcguire

Title: Chairperson

Date: 7/29/2021

By: DocuSigned by: Daryl Washington 1AFC94B97388437...

Name: Daryl Washington

Title: Executive Director

Date: 7/29/2021

MEMO TO THE CPMT

January 27, 2023

Information Item A - 2: Parental Contribution Accounts Service Fee for Credit Card Payments

ISSUE: That the CPMT approve the method for how service charges for credit cards payments is paid for parental contribution accounts.

BACKGROUND: The CSA program has been working closely with DFS Fiscal staff to manage the parental contribution accounts. One additional improvement to our process requested by families is to permit them to use credit cards and flexible medical spending accounts to pay their monthly invoices. At the present time, parents are only able to send in a check or money order to the county. Credit card payments are not available.

To add the option of credit card payments through an online link, the CSA program and DFS Fiscal will work with staff from the Department of Finance and the Department of Information Technology to set up the process. The credit card processing will require a service fee be charged of 2.35% per transaction. One alternative is for parents to pay the service fee added to their monthly parent contribution amount if they opt to use a credit card. If the service fee is passed on to the parent, then flexible spending account cards cannot be used because the fee is not permitted. The alternative is for the processing fee to be paid out of CSA program support funds. Consistent with other human services programs that support vulnerable populations, the CSA Management Team and CSA program staff recommend that the service fee is covered by the program support budget for any family that choses to pay using a credit card.

RECOMMENDATION: That the CPMT approve payment of the 2.35% service fee from program support funds which allows for families to use their flexible medical spending accounts.

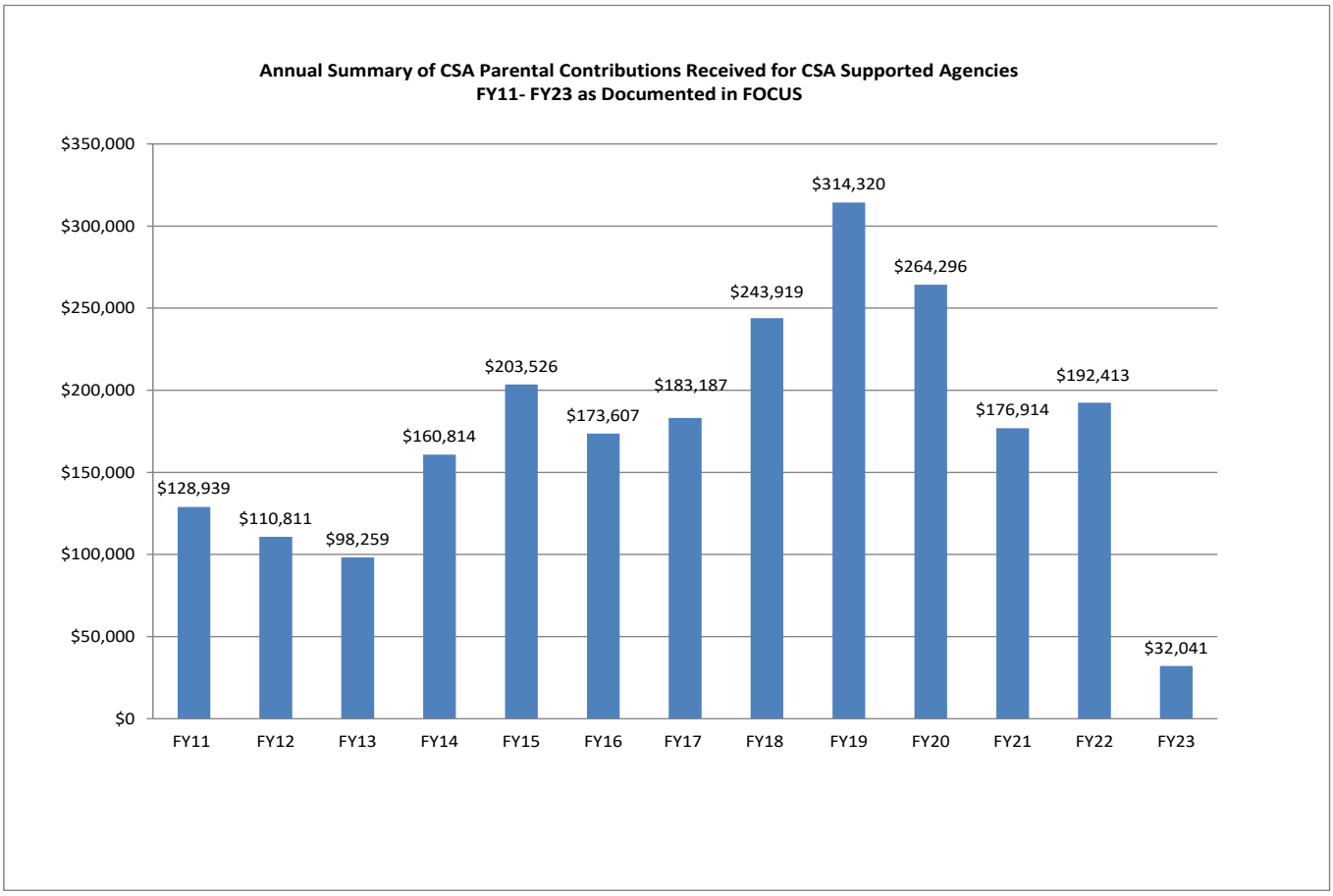
INTERNAL CONTROL IMPACT: None

FISCAL IMPACT: The average annual parent contribution collections for the past five years is $238,372. If the program were to cover the service charge of 2.35% for all payments, it would cost $5,600. The CSA program support budget can cover this amount.

ATTACHMENT: Chart of Annual Parent Contribution Collections

STAFF:
Janet Bessmer, CSA
Alicia Gallogly, DFS Fiscal

Chart: Parental Contributions FY 11 – FY23 YTD



MEMO TO THE CPMT
October 28, 2022

CPMT Contract Information Item C-1: Out of State Residential Child Specific Contract Activity

ISSUE: That the CPMT receive regular reports on the CSA Management Team approvals of placements in out of state residential facilities. Since the last CPMT meeting, DPMM processed one (1) Child Specific Contract Requests for out of state residential facilities.

Date Received by DPMM	Provider	Location	Medicaid Participating/ Single Case Agreement	Requesting Department	Barrier to Contract Pool of Providers	CSA MT Approval Date
1/20/2023	Hazelden Betty Ford	Plymouth, MN	No	CSB	Opiate involved SUD needing detox	1/23/2023

BACKGROUND:

As of January 29, 2021, the CPMT has delegated authority for the approval of out of state residential placements for youth to the CSA Management Team. For each month in which a contract is approved, a report of the contract activity is required by the CPMT to identify both new child specific contract placements and any existing child specific contracts that remain active. In the consideration of each contract placement request, all clinically appropriate Medicaid providers located in Virginia under Agreement for Purchase of Services (APOS) with the County were considered and were determined not appropriate due to the individual needs of the youth.

CURRENT SITUATION:

Since the last CPMT, there were one (1) new child specific contracts approved by the CSA Management Team as noted above. In addition to the newly approved Child Specific Contract, there were a total of ten (10) active Child Specific Contracts for youth with out of state facilities as detailed below:

Provider	Location	Case Managing Agency	Barrier to Contract Pool of Providers	Date of Approval[1]
Devereaux - CIDDS (Kanner)	Pennsylvania	FCPS-MAS	IEP for Residential School under the category of Multiple Disabilities with physical aggression	5/1/2015 (CPMT)
Devereux-Brandywine	Pennsylvania	FCPS-MAS	IEP for residential School Setting. ASD and aggression	4/19/2020 (CPMT)
Benedictine School	Maryland	FCPS-MAS	IEP for Residential School Setting	1/24/2020 (CPMT)

1 Child Specific Contracts approved by the CPMT, prior to the delegation to the CSA Management Team, are noted accordingly.

Maplebrook School	Armenia, New York	FCPS-MAS	Parental Placement of student with IEP for Private Day School Setting. Contract for Education costs only.	9/09/2021
Latham Centers	Brewster, Massachusetts	FCPS-MAS	Prader-Willi Syndrome with severe aggression and other complicating medical issues.	9/20/2021
Judge Rotenberg Center	Canton, MA	DFS-FC&A	Include Intellectual Disability, Autism, ODD, ADHD, and a seizure disorder with a history of physical aggression towards others, property destruction, self-injury and elopement. Seven month stay at Commonwealth Center for Children and Adolescents.	2/14/2022
Sandy Pines Residential Treatment Center	Jupiter, Florida	DFS-FC&A	Young age, level of criminal offenses, and aggression	5/20/2022
Millcreek of Pontotoc Treatment Center	Pontotoc, MS	DFS-FC&A	Borderline IQ, run risk, self-injurious	6/13/2022
Millcreek Behavioral Health	Fordyce, AR	DFS-FC&A	Borderline IQ, run risk, self-injurious	10/10/2022
Sandy Pines Residential Treatment Center	Jupiter, FL	DFS-FC&A	IQ of 68, history of fire setting.	10/24/2022

ATTACHMENT: None

STAFF:
Barbara Martinez, DPMM

MEMO TO THE CPMT
January 5, 2023

Information Item I-1: November Budget Report & Status Update, Program Year 2023

ISSUE:
CPMT members monitor CSA expenditures to review trends and provide budget oversight.

BACKGROUND:
The Budget Report to the CPMT has been organized for consistency with LEDRS reporting categories and Service Placement types.

The attached chart details Program Year 2023 cumulative expenditures through November for LEDRS categories, with associated Youth counts. IEP-driven expenditures for Schools are separated out. Further information on the attachment provides additional information on recoveries, unduplicated youth count, and:

-Average cost per child for some Mandated categories
-Average costs for key placement types, such as Residential Treatment Facility, Treatment Foster Home, Education placements.

Total Pooled Expenditures: Pooled expenditures through November 2022 for FY23 equal $7.9M for 682 youths. This amount is a decrease from last year by approximately $411K, or 4.94%. YTD Pooled expenditures for FY22 equaled $8.3M for 643 youths.

	Program Year 2022	Program Year 2023	Change Amt	Change %
Residential Treatment & Education	$967,190	$1,338,927	$371,736	38.43%
Private Day Special Education	$4,856,808	$3,997,609	($859,199)	-17.69%
Non-Residential Foster Home/Other	$1,690,489	$2,265,573	$575,084	34.02%
Community Services	$1,158,233	$505,429	($652,805)	-56.36%
Non-Mandated Services (All)	$132,806	$190,881	$58,075	43.73%
Recoveries	($466,545)	($371,005)	$95,539	-20.48%
Total Expenditures	**$8,338,982**	**$7,927,412**	**($411,570)**	**-4.94%**
Residential Treatment & Education	48	42	(6)	-12.50%
Private Day Special Education	225	190	(35)	-15.56%
Non-Residential Foster Home/Other	216	219	3	1.39%
Community Services	443	366	(77)	-17.38%
Non-Mandated Services (All)	67	108	41	61.19%
Unique Count All Categories	**999**	**925**	**(74)**	**-7.41%**
Unduplicated Youth Count	**643**	**682**	**39**	**6.07%**

Note: The number of youths served is unduplicated within individual categories, but not across categories.

Expenditure claims have been submitted to the State Office of Children's Services (OCS) through November 2022.

RECOMMENDATION:
For CPMT members to accept the November Program Year 2023 budget report as submitted.

ATTACHMENT:
Budget Chart

STAFF:
Timothy Elcesser and Desiree Roberts

NOTE:

Residential Treatment & Education increased by $371k with 6 less youths served. Most of the increased cost is due to increases for the education for residential Medicaid and non-Medicaid placements.

Private day special education costs paid YTD have decreased by $3.9M with 35 fewer youths served.

Non-Residential Foster Home/Other has increased by 575k with 3 more youths served than FY22.

Community Services decreased by $652k with 77 less youth served in FY23.

Program Year 2023 Year To Date CSA Expenditures and Youth Served (through November Payment)

Trans Descrip	Payment

Mandated/ Non-Manda	Residential/ Non-Residential	Serv Type Descrip	Local Match Rate	County & Foster Care	Youth in Category	Schools (IEP Only)	Youth in Category	Total Expenditures
Mandated	**Residential**	Residential Treatment Facility	57.64%	$425,976	22			$425,976
		Group Home	57.64%	$47,336	2			$47,336
		Education - for Residential Medicaid Placements	46.11%	$35,690	3	$547,654	8	$583,344
		Education for Residential Non-Medicaid Placements	46.11%	$62,685	2	$219,586	5	$282,271
	Residential Total			$571,687	29	$767,239	13	$1,338,927
	Non Residential	Special Education Private Day	46.11%	$130,263	5	$3,867,346	185	$3,997,609
		Wrap-Around for Students with Disab	46.11%	$65,329	38			$65,329
		Treatment Foster Home	46.11%	$1,124,691	75			$1,124,691
		Foster Care Mtce	46.11%	$355,776	69			$355,776
		Independent Living Stipend	46.11%	$84,039	18			$84,039
		Community Based Service	23.06%	$630,694	277			$630,694
		ICC	23.06%	$165,162	89			$165,162
		Independent Living Arrangement	46.11%	$340,266	18			$340,266
		Psychiatric Hospital/Crisis Stabilization	46.11%	$5,044	1			$5,044
	Non Residential Total			$2,901,264	590	$3,867,346	185	$6,768,610
Mandated Total				**$3,472,952**	**619**	**$4,634,585**	**198**	**$8,107,537**
Non-Mandated	**Non Residential**	Community Based Service	23.06%	$153,074	62			$153,074
		ICC	23.06%	$37,807	46			$37,807
	Non Residential Total			$190,881	108			$190,881
Non-Mandated Total				**$190,881**	**108**			**$190,881**
Grand Total (with Duplicated Youth Count)				**$3,663,832**	**727**		**198**	**$8,298,417**

Recoveries	**-$371,005**
Total Net of Recoveries	**$7,927,412**
Unduplicated child count	682

Key Indicators

	Cost Per Child	**Prog Yr 2022 YTD**	**Prog Yr 2023 YTD**
	Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$8,642	$11,624
	Average Cost Per Child Mandated Residential (unduplicated)	$17,799	$33,473
	Average Cost Per Child Mandated Non- Residential (unduplicated)	$8,952	$11,300
	Average Cost Mandated Community Based Services Per Child (unduplicated)	$2,400	$2,174
	Average costs for key placement types		
	Average Cost for Residential Treatment Facility (Non-IEP)	$10,610	$19,363
	Average Cost for Treatment Foster Home	$9,130	$14,996
	Average Education Cost for Residential Medicaid Placement (Residential)	$24,357	$53,031
	Average Education Cost for Residential Non-Medicaid Placement (Residential)	$33,192	$40,324
	Average Special Education Cost for Private Day (Non-Residential)	$15,864	$21,040
	Average Cost for Non-Mandated Placement	$1,578	$1,767

Category	Program Year 2023 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2023 Allocation	$694,188	$57,083	92%
Non Mandated Program Year 2023	$1,630,458	$170,435	90%
Program Year 2023 Total Allocation	$35,416,365	$7,927,412	78%

MEMO TO THE CPMT

1/27/2023

Information Item I- 2: State Reporting of Administrative Costs for CSA Program

ISSUE:
That the Office of Children's Services (OCS) requires an annual report on administrative costs required to support the local CSA program**.**

BACKGROUND:

All localities were required to report the administrative costs to support the local CSA program that exceed the annual state administrative allocation. The annual administrative allocation for Fairfax-Falls Church is $99,512 with state and local shares of $53,623 an $45,889 respectively.

The DFS Fiscal Management team aggregated personnel costs for the various administrative staff who support CSA across the county and schools.

CSA Annual Cost FY2023				
Area	Gross Amount		Amount Supported by GF	
Finance Team Support	$	1,663,300.03	$	902,795.09
Legal Support	$	5,779.79	$	5,779.79
DPMM Support	$	404,260.15	$	320,680.35
FRU Team	$	367,458.31	$	252,153.06
CSA Management	$	766,670.84	$	766,670.84
UR Team	$	715,261.77	$	715,261.77
School Support	$	359,413.13	$	262,931.64
Grand Total	$	4,282,144.01	$	3,226,272.54

Prepared by: Sandra Rojas and Desiree Roberts - sent 12/27/22

The CSA functions require 22 full-time staff and 11 staff who support CSA with a portion of their time.

Column1	100%	75%	50%	25%
DFS Finance	8	3	0	4
Legal	0	0	0	1
DPMM	1	1	1	0
CSA Program	6	0	0	0
UR Team	5	0	0	0
FCPS Finance	2	0	0	1
Total	22	4	1	6

Personnel costs and the cost of the contract with the Federal Reimbursement Unit staff greatly exceed the annual administrative allocation. Additional local costs include staff time for the CSA Management Team and CPMT meetings. These costs were not provided to OCS.

ATTACHMENT:
None

STAFF:
Janet Bessmer, CSA Director

MEMO TO THE CPMT

1/27/2023

Information Item I- 3: Fiscal Analysis of Private Day Rate Setting Methodology

ISSUE:

The Appropriations Act directs the Office of Children's' Services (OCS) to implement a rate setting methodology for Private Day School services funded through CSA beginning July 1, 2023 (FY 2024). DFS Budget staff conducted a fiscal analysis to determine the estimated local impact. On January 27, 2023, OCS has released their state level fiscal analysis for local review. The Budget does not currently contain appropriations to support implementation and a budget bill has been submitted to eliminate rate setting for FY 24.

BACKGROUND:

OCS engaged a private consultant to analyze Private Day rates and develop a methodology for rate setting. The consultant recommended implementing a tiered system for standardized levels of service in Private Day schools located in Virginia. The proposed structure has nine tiers in Northern Virginia with associated rates and nine tiers for other regions. Out of state programs used by Fairfax and other NOVA jurisdictions, such as those in Maryland and DC where rate setting is already in place, are coded separately and not subject to the Virginia rate setting model. The process outlined by OCS requires that the Private Day providers inform the local school division what level or tier the youth will require to meet the IEP. The local school division is then responsible for confirming the appropriate tier and monitoring that the service level is being implemented.

The state has established a rate for each tier that would be applied beginning FY 2024. The rates only apply to the daily tuition and not to any ancillary services such as physical therapy, occupational therapy, speech/language therapy, and counseling. In FY 2023, the providers were required to identify the tier for the current students so that the locality could report it to OCS for their fiscal analysis. The proposed rates, however, were not applied to the tier structure in FY 2023 to permit time for the analysis. Our local data system allows us to evaluate our current rates (using existing local contracting process) compared to the FY 2024 state proposed rates for each student based on the tier classification provided.

Estimated Local Fiscal Impact:

DFS Fiscal staff evaluated projected costs for private day placements if the rate setting methodology is implemented in FY 2024. The fiscal impact analysis includes students who are enrolled in Virginia schools only, not those in Maryland or DC placements. The analysis determined that the average daily tuition would increase by 11.47% or $43 per day for an

average annual cost increase of $9,872.65 per student. The increase to CSA local expenditures at our 46.11% match rate would be $4,552 per student annually.

Table 1 below compares projected annualized costs for FY 2023 using current rates with projected annualized costs in FY 2024 using the tiered system and state rates proposed per tier for FY 2024. Currently there are 180 youth served in in-state programs. The model considers three different numbers of youth served, allowing for growth in enrollment. Based on the data, it is projected that the new rate structure will increase our local CSA expenditures by an estimated $1.7 million more in FY 2024, assuming similar service/tier levels as FY 2023. Additional estimates are shown below for different enrollment.

Table 1. Projected Total CSA Expenditures for In-State Private Day Schools in FY 2023 and FY 2024

Projected Youth (Full Year)	**Additional CSA Cost**	**Projected FY 2023 Total Expenditures**	**Projected FY 2024 Total Expenditures**
180 Youth	$1,777,076.88	$15,486,350.16	$17,263,427.04
200 Youth	1,974,529.87	17,207,055.73	19,181,585.60
220 Youth	2,171,982.85	18,927,761.31	21,099,744.16

The local match rate for IEP services is 46.11%. As shown in Table 2, the local portion of the increase is $819,410 for the 180 youth currently enrolled.

Table 2. Projected Cost to Fairfax Applying Local CSA Match Rate

Projected Youth (Full Year)	**Additional CSA Local Share**	**Projected FY 2023 Local Expenditures**	**Projected FY 2024 Local Expenditures**
180 Youth	$819,410.15	$7,140,756.06	$7,960,166.21
200 Youth	910,455.72	7,934,173.40	8,844,629.12
220 Youth	1,001,501.29	8,727,590.74	9,729,092.03

Comparing FY 2023 vs. FY 2024 rates for individual youth, daily tuition for 92 youth will increase by an average of $108.52 per day and daily tuition rates for 88 youth will decrease by $41.43. While there is a net cost increase for the new rate structure, an additional problem has been identified for those students whose current tuition cost is above the FY 2024 rate.

If OCS does not permit local CSAs to pay more than the state's rate per tier, FCPS and FCCPS may be required to pay the difference out of non-CSA funds. Alternatively, Private Day schools can be asked to accept the state's tiered rate, the children can be moved to a higher tier, or moved to another school that will accept the state's tiered rate. For the 88 youth whose current rate is higher than what the state proposes for FY 2024, if the school divisions were

required to supplement the CSA payment, the estimated costs to local school divisions are outlined below:

Table 3. Projected FY 2024 Non-CSA Costs to Supplement CSA Allowable Daily Tuition		
Projected Youth (Full Year)	Projected FCPS 2024 (Rates that fall below Rate Setting Amount)	Falls Church (Rates that fall below Rate Setting Amount)
180 Youth	**$679,752.36**	**$35,107.56**
200 Youth	755,280.40	39,008.40
220 Youth	830,808.44	42,909.24

The overall projected fiscal impact to our system is noted in Table 4. For the current 180 youth, additional costs to the CSA budget plus supplemental payments made by the schools will result in total additional costs of $2.5 million. The net impact to Fairfax County is $1.5 million considering only the local match for CSA and the additional local-only cost to FCPS.

Table 4. Fiscal Impact Including Non-CSA Supplement to CSA Allowable Daily Tuition		
Projected Youth (Full Year)	Total CSA + FCPS Cost + Falls Church Cost	Total Cost to FFX (Local Match + FCPS)
180 Youth	**$2,491,936.80**	**$1,499,162.51**
200 Youth	2,768,818.67	1,665,736.12
220 Youth	3,045,700.53	1,832,309.73

Key Considerations/Options:

A. The rates per tier provided by OCS for FY 2024 were increased by 10% from prior proposed rates. The 10% increase is not connected to any additional performance expectations, and it is not clear that providers will apply the additional funding to employee wages or quality programming. It is also likely that providers will ask for the maximum 10% given that the state has made it an option. The rate setting methodology only applies to tuition and therefore, the rates for ancillary services may also be more expensive. Those costs are not built into the model.

B. Our 5-year average contract rate increase for Private Day programs is 2.46% not 10%. We do not know what providers would request in this pandemic recovery environment for FY 2024 if rate setting is not approved for implementation.

C. The rate setting methodology may have an impact on sum sufficiency. Approximately half of the students would have a daily tuition rate lower than what we currently pay. Providers may be unwilling or unable to accept the state's lower rate. CSA would be limited to the tier rate and the difference would need to be paid by another funding source such as the schools.

D. There is also concern that identifying the correct tier may not be based on objective criteria. A school may determine the tier based on the most favorable rate and/or service level may vary depending on the student's needs so one static tier may just not fit the dynamic nature of the educational environment. FCPS and FCCPS personnel will need to monitor that services are delivered as described by that tier. OCS and VDOE do not appear to have any role in monitoring service delivery or the tier system.

E. In future years, it is not clear how rate increases would be determined. OCS does not currently have a role in negotiating provider contracts and therefore, the percentage may not be based on CPI or some other standard commonly used by localities. Our local contracting process typically approves a range of rate increase requests and not across the board increases for every provider every year. The state rate setting methodology eliminates local choice and local management of the contracting process.

F. The state fiscal analysis indicates that the proposed rate setting methodology will increase the overall cost to the Commonwealth as summarized below:

Difference in Daily Rate Per Child Analysis	
Difference in Daily Cost per Child	$38.07
Percent Difference in Cost per Child per Day	12%
FY22 Total CSA Spending for Private Day Special Education (less ancillary service costs)[1]	$170,533,327
12% Projected Increase to Total FY22 Spending (Total Fiscal Impact)	$20,463,999
State CSA Share of Impact (66%)	$13,506,240
Local CSA Share of Impact (34%)	$6,957,759

Conclusion: The state's proposed tier rate setting structure has not been tested. The state fiscal impact confirms the local analysis that costs will increase collectively by 12%. Local data on 180 youth currently being served in Virginia-based Private Day schools comparing FY 2023 rates to proposed FY 2024 rates indicates a net expenditure increase to the CSA budget of $0.8 million. Total cost to the county if FCPS is required to supplement CSA funding to some of the providers would add an additional $0.7 million or $1.5 million to the County's expenditures due to the new structure.

ATTACHMENT:

Language from SB800 285 #2s

RD686 (2021) Cost Study of Private Day Special Education Programs.

STAFF:

Janet Bessmer, CSA
Tim Elcesser, DFS Fiscal
Kelly Conn-Reda, FCPS

Budget Amendments - SB800 (Member Request)

By Member » Item 285 #2s

Chief Patron: Mason
Modify Private Day School Rate Setting (language only)

Item 285 #2s

Health and Human Resources

Children's Services Act
Language

Page 332, line 35, after "B.", strike the remainder of the line.

Page 332, strike lines 36 through 41, and insert:

"Out of this appropriation, $100,000 the second year from the general fund shall be provided to the Office of Children's Services (OCS) to provide technical assistance for localities with private day placements above the statewide average. OCS shall work with the Virginia Department of Education's Office of Special Education to conduct a review of private day placement decisions in those localities with higher than average placements and make recommendations to the local education agency."

Explanation

(This amendment eliminates language implementing private day special education rate setting on July 1, 2023, and redirects the existing funding for the Office of Children's Services to technical assistance for localities with private day placements above the statewide average.)

CSA Private Day Special Education Rate Fiscal Impact Study 2022

Commonwealth of Virginia

Office of Children's Services

January 2023

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Public Consulting Group LLC (PCG) was contracted by the Commonwealth of Virginia Office of Children's Services (OCS) to study the current rates paid by localities to private day special education programs licensed by the Virginia Department of Education (DOE) and to develop findings and recommendations based on the analysis of these rates.

In November 2021, PCG proposed a tiered rate model for private day special education programs based on a cost study. The 2022 Virginia General Assembly directed the Office of Children's Services to implement the rate setting effective July 1, 2023 and to develop, a fiscal impact estimate of the rate changes (Chapter 2, Item 285.B. (2022 Special Session 1). To understand the potential fiscal impact of the proposed rates, PCG was provided actual program expenditure information from the OCS LEDRS system submitted for August 2022 through November 2022 for comparison to the 2021 cost study proposed rates (with inflation-adjusted rates, see below under description of tier model). Data was collected by OCS and consolidated into one file for ease of review, quality assurance, and analysis. For analysis, private day special education programs that have multiple locations were grouped together and analyzed both individually and as one entity.

The fiscal impact analysis estimates an overall spending increase of 12%, based on data available for review as of December 1, 2022. This extrapolates to a $20.5 million increase in annual spending (from FY2022) for this service if the proposed tiered rates are implemented.

Three Key Fiscal Impact Analysis Takeaways **If the proposed tiered rates are implemented…**	
	**The average daily rate per child would increase from $316.15 to $354.17 (12%), extrapolating to a $20.5 million increase in overall spending.**
	**75% of individual private day school programs would experience a daily rate increase at an average of $74 per child.** **25% of individual private day school programs would experience a daily rate decrease at an average of -$49 per child.**
	**The fiscal impact is primarily driven by the proposed tiered rates for children receiving 1:1 support.**

I. PROJECT GOALS

This project was authorized to conduct a fiscal impact analysis study of the current rates paid by localities to private day special education programs licensed by the Virginia Department of Education (DOE) and funded through the Children's Services Act (CSA) in comparison with the proposed rates from the 2021 rate study. Specific goals included:

- Overall comparison between the proposed tiered rates and the current paid rates across all schools to understand the fiscal impact to the state, and
- Analysis of the impact of the proposed tiered rates on individual schools.

II. STAKEHOLDER MEETINGS

PCG invited all private day school providers, public school special education administrators (VCASE), and local CSA leaders to participate in focus groups and training sessions to discuss the proposed rate changes and process for collecting fiscal impact data. **Table 1** below lists all such meetings.

TABLE 1: STAKEHOLDER MEETINGS

Meeting Date	Engagement Type	Summary
January 21, 2022	Focus Group with private schools	Focus group held to gather information on implementation needs and challenges.
January 27, 2022	Focus Group with private schools	Focus group held to gather information on implementation needs and challenges.
January 27, 2022	Focus Group with CSA	Focus group held to gather information on implementation needs and challenges.
January 28, 2022	Focus Group with VCASE	Focus group held to gather information on implementation needs and challenges.
April 21, 2022	Focus Group with CSA and VAISEF Advisory Committee	Reviewed the draft guidance training information.
June 17, 2022	Stakeholder Training	Training provided on new rate tools and information shared on upcoming fiscal impact analysis.
June 29, 2022	Stakeholder Training	*Second training option.* Training provided on new rate tools and information shared on upcoming fiscal impact analysis.
August 30, 2022	Provider Meeting	Discussed specialized services challenges.
September 12, 2022	Provider Meeting	*Second provider meeting option*. Discussed specialized services challenges.
Ongoing	Consultation and Technical Assistance	Ongoing consultation and technical assistance were available by request via email between July-December 2022 to address questions about data collection for the fiscal impact analysis.

Below is a summary of recurring themes gathered during stakeholder sessions.

- For schools with specialized services for Autism, the cost of the Board Certified Behavior Analyst (BCBA) positions were significantly higher than a teacher's salary position, therefore increasing cost.
- Due to inflation and other factors (such as specialized services), overall proposed rates may not meet the program cost needs.
- Typically, budgeting is based on a program as opposed to the number of students; however, staffing levels are considered as part of budgeting for a program.

In response to the feedback received, adjustments were adopted by the Office of Children's Services to allow flexibility in billing for BCBA services directly delivered to students, as well as an inflation adjustment for the 2022-2023 proposed tier rates. Additional information on the inflation adjustment can be found under the description of the tier model section below.

III. METHODOLOGY AND LIMITATIONS

DATA COLLECTION PROCESS

PCG sent letters to all DOE-licensed private day special education programs, which included the expectations and plan for the fiscal impact analysis. PCG provided all schools with the data collection tool and instructions for how to provide the requested information on June 17, 2022. Virtual training sessions were held on June 17, 2022, and June 29, 2022, to review how to complete the data collection tool. Schools were "walked through" the instructions and the PCG team answered questions. The training was recorded, and the recording was provided to schools along with written instructions for how to complete the data collection tool. Schools were able to submit questions to the PCG team by email throughout the data collection period.

FISCAL IMPACT ANALYSIS

Schools submitted the data collection tool to OCS, including information under which of the proposed rate tiers their current students (in the 2022–2023 school year) would be served, if the new rate structure were in effect. OCS consolidated the data into one file for PCG to analyze. PCG conducted quality assurance of the data set before analyzing it. In consultation with OCS, PCG removed duplicates, grouped the different programs by school, filtered out July dates (for previous school year data), and identified and removed erroneous data and outliers.

To perform a fiscal impact analysis on this data set, PCG considered the overall cost of implementation of the proposed rates, including the number of students within each rate, the average, minimum, and maximum rates paid currently, the difference in cost under the new rate system for students, and the number of programs and groups with a negative fiscal impact and the number of students in these programs.

LIMITATIONS

PCG and OCS cited the following limitations in our fiscal impact analysis:

- There were more than 3,800 students served by private day special education programs last year (FY2022), but this study only received information for 1,569 students. This is a result of the cut-off for data collection being December 1, 2022. The fiscal impact estimate assumes that the larger population of students is similar to the sampled population of students.
- Some providers with multiple locations recorded multiple programs under the same name, resulting in creating groups of programs to capture the costs across the entire organization.
- The analysis is based on the data collected, which relied on the schools to self-report the tiers in which children were served.
- The analysis is based on current rates and does not consider any external factors that may affect the fiscal impact, including additional rate increases granted to schools going forward.

IV. DESCRIPTION OF THE TIER MODEL

In the 2021 cost study, PCG proposed nine (9) base rate models using three different teacher-to-student ratios, each with three different teacher aide-to-student ratios. These models allow for a range of programs to meet student needs and mirror the programs currently being utilized. A 23% salary add-on is proposed for programs in northern Virginia to account for a higher cost of living in those areas. The Northern Virginia (NOVA) geographic area was identified using the geographic area and pay band differential guidance issued by the Virginia Department of Human Resource Management for Northern Virginia.

In the 2021 *Cost Study of Private Day Special Education Programs Report*, a projected inflation factor of 7% was applied to adjust the rates upward for implementation, however based on U.S. Bureau of Labor Statistics, inflation had increased to 10.85%. An adjustment was made to increase the proposed rates by an additional 3.85% to account for the actual inflation impact.

From the 2021 Cost Study of Private Day Special Education Programs Report:

> *"Programmatic costs were collected from schools to reflect the expenses incurred during the FY19 school year. Since budget models were created to reflect costs in 2022, a cost adjustment factor was calculated. The cost adjustment factor (CAF) was determined using the most recent Consumer Price Index (CPI) data published for Virginia and the surrounding area by the U.S. Bureau of Labor Statistics. CPI data for all items was used for the CAF data. The percent difference in the costs in 2019 compared to 2022 was calculated to be about 6.85%. Therefore, an additional 7% of all budget costs was added into the daily rates for the cost adjustments that occurred between 2019 – 2022".*

Below, Table 2 shows the recommended rates from the 2021 Cost Study of Private Day Special Education Programs Report with the additional 3.85% adjustment.

TABLE 2: COST STUDY PROPOSED RATES

Model	Teacher-to-Student Ratio	Support Staff to Student Ratio	Base Rate	Northern Virginia (NOVA) Rate
1	1:3	1:1	$522.49	$623.17
2	1:3	1:2 – 1:3	$354.86	$420.10
3	1:3	1:4+	$312.94	$369.33
4	1:4 – 1:7	1:1	$466.00	$554.67
5	1:4 – 1:7	1:2 – 1:3	$298.35	$351.59
6	1:4 – 1:7	1:4+	$256.46	$300.84
7	1:8+	1:1	$434.21	$516.12
8	1:8+	1:2 – 1:3	$266.58	$313.07
9	1:8+	1:4+	$224.67	$262.29
*North Virginia (NOVA) geographic add-on (23% increase based on staff costs) was calculated for schools in the counties of Fairfax, Arlington, Prince William, and Loudoun and the cities of Alexandria, Fairfax, Falls Church, Manassas, and Manassas Park				

V. FISCAL IMPACT FINDINGS

The fiscal impact analysis focuses on two aspects of the implementation of the proposed tiered rates: the overall cost of implementation and the financial impact to the schools.

RATE ANALYSIS

PCG analyzed CSA expenditure data (daily tuition rate) for **1,566** students attending a special education private day school in the state of Virginia during the months of August through November 2022. Figure 1 shows how these students would be distributed across the proposed tiered rates if the rates were in effect. The tier with the highest number of students was **tier 6** with **337 students**. The lowest number of students was in **tier 8 NOVA** with **5** students. **Tier 3 NOVA** had no students recorded in the tier.

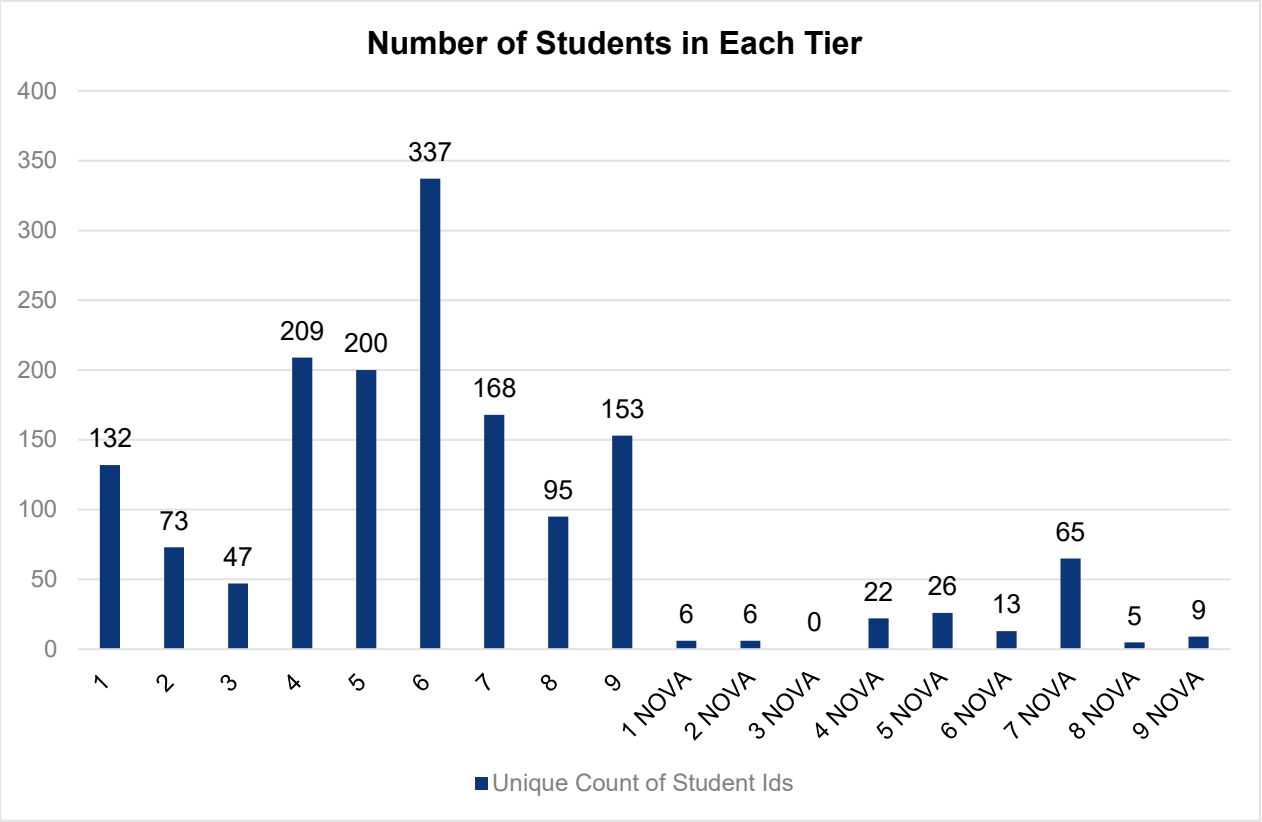


FIGURE 1: STUDENT DISTRIBUTION ACROSS THE PROPOSED RATE TIERS

In Table 3 the "Current Average Daily Rate" column shows the average rate charged for students within each proposed tier under the existing model of billing. Some of these averages are lower than the proposed tiered rates, indicating that the state is paying less on average for these tiers than the rate study rate recommended. For example, in model tier 1, the average rate is **$294.84,** which is significantly lower than the proposed rate of **$522.49.** The data showed the model tiers with the highest daily differences are tiers 1, 4, 1 NOVA, 4 NOVA, and 7 NOVA. In these tiers, the proposed rates are higher than the average rates currently paid. The daily difference was calculated by multiplying the number of students within each model tier by the proposed rates and comparing that to the sum of purchase orders submitted by schools for those students. The tiers that have a higher proposed rate than the current average paid rates have the biggest fiscal impact even if the tier does not have a lot of students. For example, tier 1 shows the largest daily difference of **$29,970.57,** although only 132 students were identified in that tier. The cells highlighted in red represent tiers that would experience a negative fiscal impact to the CSA under the proposed tiered rates, with the negative impact ranging from under $200 per day to roughly $4,500 per day.

TABLE 3: TIER PRICE COMPARISON

Model Tier	Proposed Tiered Rates	Current Average Daily Rate	Unique Count of Student Ids	Current Cost per Day (actual PO)	Proposed Tiered Rates Cost per Day	Daily Difference
1	$522.49	$ 294.84	132	$38,998.11	$68,968.68	$29,970.57
2	$354.86	$ 316.63	73	$23,114.32	$25,904.78	$2,790.46
3	$312.94	$ 324.85	47	$15,268.10	$14,708.18	-$559.92
4	$466.00	$ 356.55	209	$73,909.79	$97,394.00	$23,484.21
5	$298.35	$ 317.26	200	$63,451.23	$59,670.00	-$3,781.23
6	$256.46	$ 263.34	337	$88,757.11	$86,427.02	-$2,330.09
7	$434.21	$ 400.21	168	$67,635.01	$72,947.28	$5,312.27
8	$266.58	$ 313.63	95	$29,794.80	$25,325.10	-$4,469.70
9	$224.67	$ 244.28	153	$37,374.29	$34,374.51	-$2,999.78
1 NOVA	$623.17	$ 436.93	6	$2,621.55	$3,739.02	$1,117.47
2 NOVA	$420.10	$ 383.25	6	$2,299.50	$2,520.60	$221.10
3 NOVA	$369.33	$ 0.00	0	$0.00	$0.00	$0.00
4 NOVA	$554.67	$ 366.81	22	$8,069.90	$12,202.74	$4,132.84
5 NOVA	$351.59	$ 365.29	26	$9,497.60	$9,141.34	-$356.26
6 NOVA	$300.84	$ 353.59	13	$4,596.64	$3,910.92	-$685.72
7 NOVA	$516.12	$ 387.08	65	$24,773.06	$33,547.80	$8,774.74
8 NOVA	$313.07	$ 350.99	5	$1,754.95	$1,565.35	-$189.60
9 NOVA	$262.29	$ 352.67	9	$3,174.04	$2,360.61	-$813.43
Total			**1,566**	**$495,090.00**	**$554,707.93**	**$59,617.93**

Table 4 shows the number of students in each tier that currently receive a rate that is higher than the proposed rate.

TABLE 4: STUDENTS AND RATES

Model Tier	Unique Count of Student Ids	Count of Students Currently Receiving a Rate Higher than the Proposed Rate	Percent of Students Receiving a Higher Rate than the Proposed Rates
1	132	4	3.03%
2	73	17	23.29%
3	47	28	59.57%
4	209	1	0.48%
5	200	130	65.00%
6	337	143	42.43%
7	169	43	25.44%
8	95	74	77.89%
9	153	66	43.14%
1	6	0	0.00%
2	6	0	0.00%
3	0	0	N/A
4	22	0	0.00%
5	26	24	92.31%
6	13	12	92.31%
7	64	5	7.81%
8	5	4	80.00%
9	9	9	100.00%
TOTAL	**1,566**	**560**	**35.76%**

The rate analysis revealed that if the new rate model were implemented, it would result in an increase of **$59,618** a day (**$38/child**). When extrapolated against the number of students served in FY2022, this would result in a **$20.5 million increase in total spending overall** (**12%** increase).

TABLE 5: FISCAL IMPACT

Difference in Daily Rate Per Child Analysis	
Difference in Daily Cost per Child	$38.07
Percent Difference in Cost per Child per Day	12%
FY22 Total CSA Spending for Private Day Special Education (less ancillary service costs)[1]	$170,533,327
12% Projected Increase to Total FY22 Spending (Total Fiscal Impact)	$20,463,999
State CSA Share of Impact (66%)	$13,506,240
Local CSA Share of Impact (34%)	$6,957,759

PROGRAM/PROVIDER ANALYSIS

The data was analyzed to determine the overall fiscal impact of the new rates on individual providers. This was done by comparing the actual purchase order (PO) payments under the existing rates to the payments that would be made under the proposed tiered rates, as well as by identifying the number of programs and groups with a negative fiscal impact (proposed rates would be less than existing rates) and the number of students in these groups. There were 219 programs (listed in the CSA billing data) and 41 groups included in this analysis.

TABLE 6: PROGRAM IMPACT

Impact Information	
Number of Individual Programs	219
Number of Provider Groups	41
# of Programs with Negative Fiscal Impact	56 (26%)
# of Groups with Negative Fiscal Impact	10 (24%)
# of Students in Groups with Negative Fiscal Impact	331 (36%)

There are some programs and groups that would be negatively impacted by the proposed rates. There were ten (10) groups (with a total of 56 programs) with a negative fiscal impact, serving 331 students. The chart below shows how these 331 students are distributed by model tier. The tiers with the most students impacted is tier 5 which is the 3rd highest number of students, and tier 8 with the second lowest tier model rate.

[1] Ancillary services include specific interventions included in a student's IEP (e.g., speech/language therapy, physical therapy, applied behavior analysis) that when delivered directly to the student, are billed separately and apart for the daily rate addressed in the fiscal impact study.

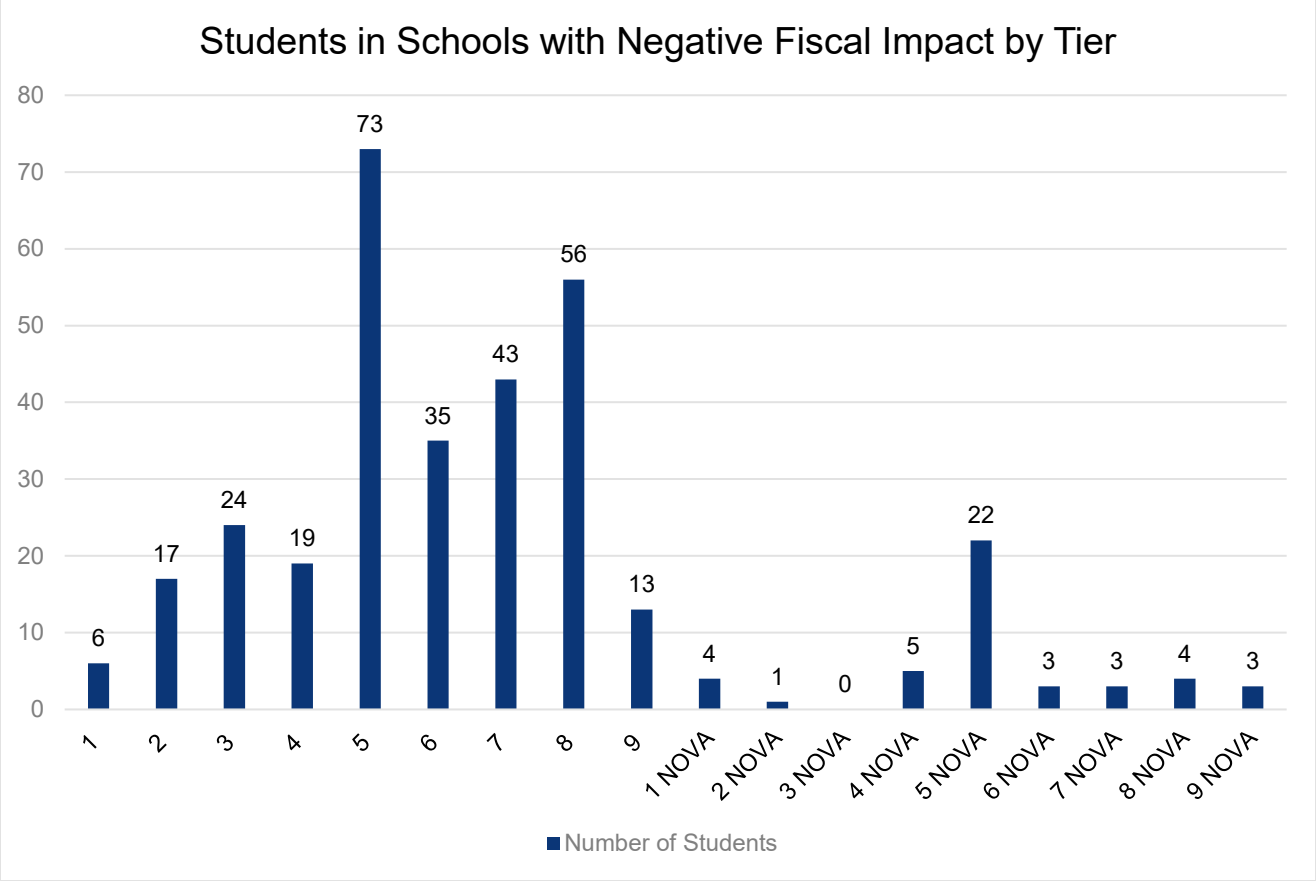


FIGURE 2: STUDENTS IN SCHOOLS WITH NEGATIVE IMPACT

MEMO TO THE CPMT

January 27, 2023

Information Item I- 4: Overview of the Children's Behavioral Health Plan

ISSUE: The Healthy Minds team will present the new Fairfax-Falls Church Community Children's Behavioral Health Plan.

BACKGROUND: In March 2016 the CPMT approved the Fairfax-Falls Church Blueprint for Children's Behavioral Health, 2016-2021. The Blueprint served as the strategic plan for Healthy Minds Fairfax (HMF) to improve access to and the quality of children's behavioral health services. In early 2022, Healthy Minds Fairfax began work on the 2023-2027 version of the Fairfax-Falls Church Children's Behavioral Health Plan. Like the previous Blueprint, it includes goals, strategies, and action steps to ensure that children, youth, and their families can access behavioral health services and supports. To develop the plan, the county engaged in an intensive data- and information-gathering process to understand more about community members' experiences with behavioral health services, including what is working and what needs to be improved.

The Children's Behavioral Health Plan is divided into four key areas: Prevention/Education, Access to Services, Navigation of Services, and System Level. Each key area has at least one goal with key objectives and action steps. These objectives and action steps will help achieve each goal. This Plan will help guide the development of children's behavioral health services for the next five years.

ATTACHMENT: The Fairfax-Falls Church Community Children's Behavioral Health Plan

STAFF:
Peter Steinberg, Program Manager, Healthy Minds Fairfax
LaVurne Williams, Director of CSB Youth and Family Services Director and Healthy Minds Fairfax

FAIRFAX-FALLS CHURCH COMMUNITY CHILDREN'S BEHAVIORAL HEALTH PLAN 2023-2027

Healthy Minds FAIRFAX
Supporting Emotional Wellness in Youth and Families

HEALTHY MINDS FAIRFAX
NOVEMBER 2022

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Background And Approach

In 2001, the Fairfax-Falls Church Community Policy and Management Team (CPMT) launched a System of Care initiative (renamed "Healthy Minds Fairfax" in 2017) to enhance the community's ability to serve youth and families with the most complex mental health and substance use needs. In 2015, the Fairfax County Board of Supervisors approved an expansion of the initiative to a larger population, with the goal of increasing equitable access to quality behavioral health services for children, youth, and their families in the county.

As part of that expansion, a 30-member planning team was convened, comprising county human service staff, school staff, nonprofit representatives, family organizations, family members, and George Mason University faculty. The team was charged with developing a vision and mission for the initiative and establishing goals, strategies, action steps, and a timetable for implementation. They identified fifteen goals that made up the 2016-2020 Healthy Minds Fairfax Blueprint, the framework for the Fairfax-Falls Church System of Care for children, youth, and families.

In early 2022, Healthy Minds Fairfax began work on the 2023-2027 version of the Fairfax-Falls Church Children's Behavioral Health Plan. Like the previous Blueprint, it includes goals, strategies, and action steps to ensure that children, youth, and their families can access behavioral health services and supports. To develop the Plan, the county engaged in an intensive data- and information-gathering process to understand more about community members' experiences with behavioral health services, including what is working and what needs to be improved.

Findings from these data collection efforts informed identification of key issues and strategies to include in the new Plan, which will continue to provide the framework for implementation of the county's efforts to ensure children, youth, and families have needed behavioral health services and supports.

The 2023-2027 Children's Behavioral Health Plan

The Children's Behavioral Health Plan (also known as "the Plan") is divided into four key areas: Prevention/Education, Access to Services, Navigation of Services, and System Level. Each key area has at least one goal with key objectives and action steps. These objectives and action steps will help achieve each goal. This Plan will help guide the development of children's behavioral health services for the next five years.

Vision, Mission, and Values

To have a range of coordinated community-based behavioral health services and supports across the continuum of care for children, youth, and their families to ensure a healthy, equitable, and resilient community.

To ensure that all children, youth, and their families have equitable access to a continuum of quality, integrated and/or coordinated services, supports, and opportunities to allow them to thrive socially, emotionally, and behaviorally.

The Values of Children's Behavioral Health Services in Fairfax/Falls Church

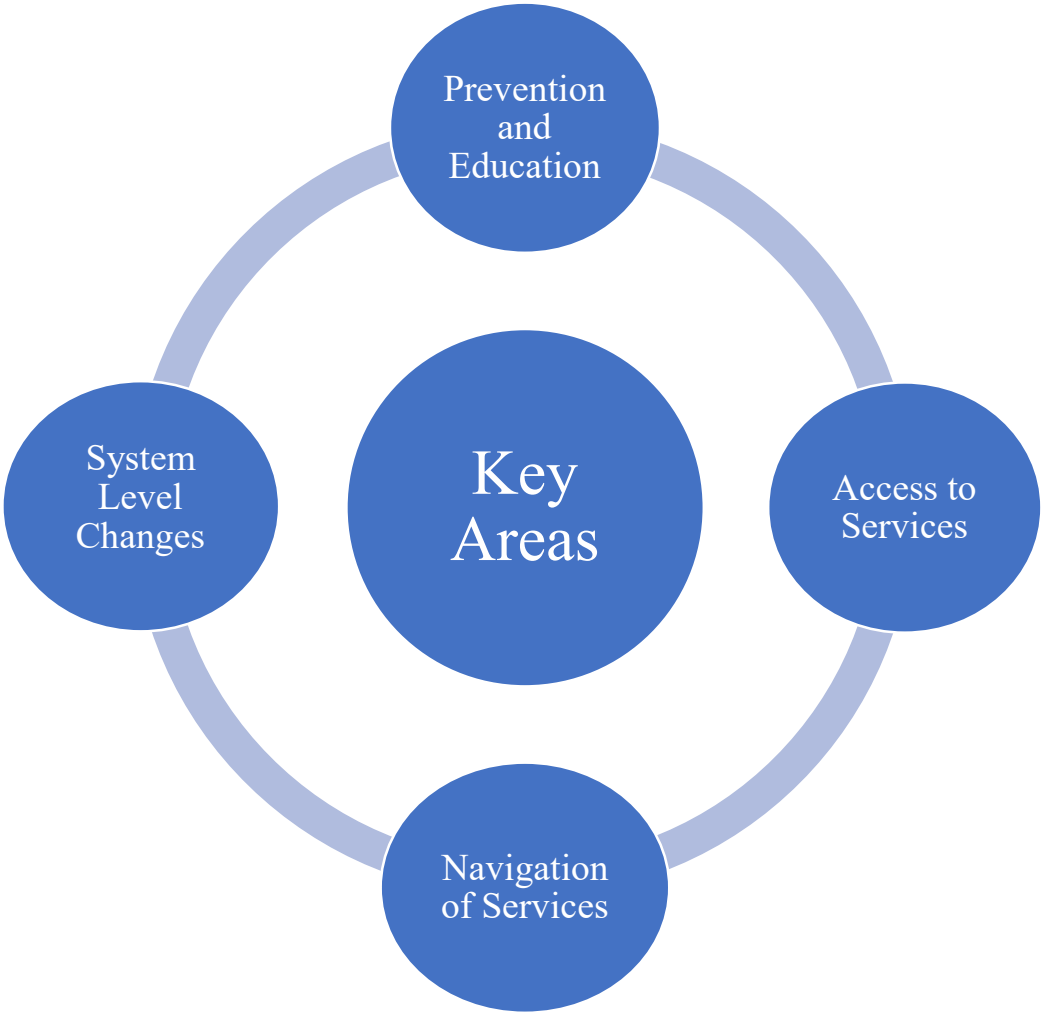
- All services will be family-driven, youth-guided, strength-based, and individualized.
- All children will have access to quality and affordable behavioral health services.
- All services will be culturally and linguistically competent and reflect the cultural, racial, ethnic, and linguistic characteristics of the populations we serve.
- All services will support the physical and psychological safety of the child.
- All services will be delivered in the community when possible.
- All services will be integrated between all public and private child serving agencies including the school system.
- All services will include family's natural support system (e.g., relatives, faith community, friends, etc.).
- All services will be guided by data at the program level.

The Equity Principles in Behavioral Health Services in Fairfax/Falls Church

The Children's Behavioral Health Plan builds on Fairfax County's One Fairfax policy. One Fairfax is a joint racial and social equity policy of the Fairfax County Board of Supervisors and School Board. It commits the county and schools to intentionally consider equity when making policies or delivering programs and services. The One Fairfax policy is a declaration that all residents deserve an equitable opportunity to succeed — regardless of their race, color, sex, nationality, sexual orientation, religion, disability, income or where they live.

The Children's Behavioral Health Plan works to ensure that all children and youth have equal access to a range of high-quality behavioral health services. To accomplish this, the Plan works to reduce existing disparities in access to care and in behavioral health outcomes. Consistent with the One Fairfax policy, the Plan is informed by the theory of Targeted Universalism, which acknowledges that targeted strategies may be needed to move different populations or communities towards a universal goal.

Key Areas, Goals, Objectives, and Action Steps



Key Areas and Goals
Key Area: Prevention and Education: To raise awareness of behavioral health, reduce the stigma that is associated with behavioral health, and to promote the development of protective factors.
Goal 1: Fostering connection and belonging among children and youth.
Goal 2: Equipping trusted adults to build social-emotional skills in the children and youth they work with.
Goal 3: Raising awareness of mental health and substance use.
Key Area: Access to Behavioral Health Services: To utilize a family-centered approach to connect children, youth, and their families to a complete range of behavioral health services that are equitable and affordable.
Goal: Expanding access to quality family-centered behavioral health services across the continuum of services.
Key Area: Navigation of Children's Behavioral Health Services: To reduce barriers and length of time to receive services by developing strategies to connect children, youth, and their families to appropriate levels of behavioral health services.
Goal: Developing an easier way for youth, their family members, and community members to navigate the children's behavioral health system.
Key Area: System Level Changes: To infuse equity and **trauma-focused** care throughout the behavioral health system for children, youth, and their families.
Goal 1: Ensuring that children's behavioral health services is seen through an equity lens.
Goal 2: Continuing to integrate trauma-informed practice into all public and private child serving agencies.

Key Area: Prevention and Education: To raise awareness of behavioral health, reduce the stigma that is associated with behavioral health, and to foster the development of protective factors.	
Goal 1: Fostering connection & belonging among children and youth.	
Key Objective	Key Action
1. Reduce social isolation & loneliness and increase social connectedness among children and youth.	1A. Implement strategies to increase inclusion and belonging among participants in youth programs and services. 1B. Promote and support the development of trauma-informed spaces and culturally relevant strategies. 1C. Address root causes, including difficulties communicating and interacting with others, stigma and discrimination, physical and mental health that limit mobility and social interaction, and traumatic life transitions.
2. Encourage adult family and community members to talk to youth about mental health and substance use.	2. Equip and empower adult family and community members to serve as trusted adults to youth. Specific attention should be given to language & culture to meet the needs of at-risk Hispanic youth.
3. Increase opportunities for children and youth to get involved in their communities and activities (interests, community contributions, sense of place and belonging).	3A. Increase equitable utilization of after-school and summer youth programing (academic enrichment, recreation, athletics, etc.).

	3B. Improve the availability and utilization of youth programming options in targeted communities (including communities with high levels of child poverty, limited English proficiency, at-risk populations, and transportation barriers). Specific attention should be given to language & culture to meet the needs of at-risk Hispanic youth.
4. Increase the sense of acceptance and safety for LGBTQ+ youth.	4. Identify and endorse a professional model for creating safe spaces for LGBTQ+ youth that can be broadly used across the youth behavioral health system.
Goal 2: Equipping trusted adults to build social-emotional skills in the children and youth they work with.	
Key Objective	Key Action
1. Train people who work with children and youth in out-of-school settings to develop social-emotional skills (e.g., refusal and problem-solving skills, emotional regulation) among their participants. Develop a train the trainer sessions to work on various skills with children (e.g., denial & problem-solving skills.	1A. Identify key learning objectives for an easily implementable strategies to incorporate social emotional learning into everyday programing and interactions. 1B. Draft a curriculum and develop implementation strategies for a train the trainer module for trusted adults.

2. Ensure a consistent approach to Tier 1 Social Emotional Learning (SEL) across all FCPS schools.	2. Identify standard objectives and strategies to be implemented across all schools to promote social emotional learning.
Goal 3: Raising awareness of mental health and substance use.	
Key Objective	Key Action
1. Increase awareness and knowledge of issues relating to substance use to promote informed decision-making among children and youth.	1A. Identify and implement interventions that are timely and relevant to current trends in prevalence, morbidity, and mortality. This includes public health engagement, communications work, social media, peer to peer learning, and culturally and linguistically appropriate interventions. 1B. Target specific programs and interventions to groups at elevated risk. 1C. Develop and implement messaging campaigns (broad campaigns, but also components to be delivered in-person at schools, youth programs, etc.) that emphasize key facts families and youth need to know, to be delivered through a standardized process. Consider SAMHSA's "Talk. They Hear You" media campaign.

2. Increase awareness and knowledge of issues related to mental health to promote effective help-seeking behaviors and reduce stigma and increase acceptance.	2A. Identify and implement an awareness campaign to provide consistent messaging. 2B. Promote and ensure access to gatekeeper trainings that promote awareness and encourage help-seeking behaviors tailored to specific populations. 2C. Continue to implement and support youth led initiatives to raise awareness and address stigma.

<u>Key Area: Access to Behavioral Health Services:</u> To utilize a family-centered approach to connect children, youth, and their families to a complete range of behavioral health services that are equitable and affordable.	
Goal: Expanding access to quality family-centered behavioral health services across the continuum of services.	
Key Objectives	Key Action
1. Address the urgent needs of youth entering the behavioral health system.	1A. Work with public and private child serving agencies, family organizations, caregivers, and youth to explore innovative approaches to meet the current trend in children and youth behavioral health. 1B. Support the work of the Behavioral Health Workgroup, a regional consortium focused on workforce issues. Liaise with the County's Social Isolation/Stigma Committee to explore mental health wellness programs for the workforce. 1C. Identify and recommend legislative priorities for submission to the appropriate agency legislative affairs committee, the Board of Supervisors, the Fairfax County School Board, or the Falls Church City School Board.

2. Increase resources for youth who have a substance use disorder.	2A. Coordinate with the Children's Services Act, the Community Services Board, Fairfax County Public Schools, and the Opioid and Substance Use Task Force on efforts to increase services to youth who have suffered a non-fatal overdose on opioids or diagnosed with a substance use disorder. Specifically, increase the number of placement options for youth detoxification, residential services, and medication and assisted treatment services. 2B. Review services that are currently available to identify gaps and create strategies to fill those gaps. 2C. Increase staff recruitment and retention efforts for youth substance use disorder services.
3. Continue to develop partnerships with families and educate parents and caregivers on evidence-based practices to empower and equip them to make decisions that best meet their child's needs.	3A. Develop and sustain trainings for public and private child serving agencies staff in promoting a family-centered approach. 3B. Develop opportunities for family members to learn about evidence-based practices and how to connect their child to practices that fits their child's needs.

4. Increase access and availability to behavioral health services for underserved populations.	4A. Review the recommendations in the Innovative Behavioral Health Strategies for Underserved Populations report (2018). 4B. Review current programs, services, and interventions to determine what has increased access and can be scaled up. 4C. Determine what additional services, interventions, and policies are needed to continue to expand access to services for underserved populations.
5. Strengthen the current Family Peer Support Partner Program.	5A. Work with current Family Peer Support Partners providers, stakeholders, and caregivers to promote and expand the services to families and the community. 5B. Explore how Family Peer Support Partners can be utilized during times of mental health crises.
6. Expand the use of peer support models for children, youth, and their families.	6. Explore peer support models for children and youth and identify effective models to implement in Fairfax.

7. Explore the use of non-traditional services.	7. Work with community and family organizations to explore alternatives to traditional therapy such as support groups and use of mental health apps.
8. Create innovative ways to pay for services to increase access and affordability.	8A. Ensure that all children and youth who are eligible are enrolled in health insurance. 8B. Explore innovative ways to incentivize mental health providers to accept health insurance. 8C. Promote, support, and incentivize providers to provide free counseling services, counseling services with a sliding scale, and other free or low-cost services.
9. Continue to promote quality behavioral health services.	9. Continue to support the use of Evidence-Based treatment through provider trainings and supports and caregiver education.

Key Area: Navigation of Children's Behavioral Health Services: To reduce barriers and time to service by developing strategies for service navigation to connect children, youth and their families to appropriate levels of behavioral health services.	
Goal: Developing an easier way for youth, their family members, and community members to navigate the children's behavioral health system.	
Key Objectives	Key Action
1. Map out current behavioral health services including location of services.	1A. Identify behavioral health services that are available to children, youth, and their families inlcuding location of services. 1B. Work closely with youth, families, organizations that support families to help identify gaps in behavioral health services. 1C. Create strategies to fill gaps of services including any service deserts.

2. Establish a navigation system, to include phone and in-person support, for navigating the children and youth's behavioral health system.	2A. Create and implement an in-person/phone support to help the community navigate the childrens/youth behavioral health system. 2B. Create a clearinghouse of information and resources. This system must be connected to existing local services including Coordinated Services Planning, 2-1-1 Virginia, and the 988 Suicide and Crisis Lifeline. 2C. Partner with caregivers to ensure the end product is user friendly.
3. Develop an online navigation system that includes information on local resources, service providers and general information on children and youth's behavioral health issues.	3A. Create and implement an online service navigation system that includes information on local resources, service providers, childrens and youth's behaviorial health information, and service navigation support. This system must be connected to other online systems. 3B. Develop a plan for ongoing support. 3C. Partner with caregivers to ensure the end product is user friendly.

4. Partner with youth and caregivers to develop implementation strategies for new navigation tools. This may include a communication plan, trainings, and social media promotion.	4. Create a platform for youth and caregivers to provide input on the new navigation tools along the way.

Key Area: System Level Changes: To infuse equity and trauma-focused care through the behavioral health system for children, youth, and their families.	
Goal 1: Ensuring that children's behavioral health services is seen through an equity lens.	
Key Objective	Key Action
1. Use data to drive decisions on children's behavioral health care. This includes attaining data required to monitor the status of known vulnerable populations.	1A. Review all items in this plan to determine where we are missing supporting data. 1B. Review all the organizations and programs that need to contribute data to get a complete understanding of "the system." Explore using Memorandum of Understandings with public and private child serving agencies and Fairfax County Public Schools and Falls Church City Public Schools so data can be shared. 1C. Attain data disaggregated by population and place in order to inform future equity conversations.
2. Ensure that people from diverse cultural, ethnic, racial backgrounds and those from the LGBTQ+ community, are included as stakeholders in strategic planning and policy development on children's behavioral health.	2A. Identify and connect with key public, non-profit and private organizations representing diverse cultural, ethnic, and LGBTQ+ community, to bring expertise and input to the children's behavioral health. 2B. Ensure appropriate representation on policy, management, and advisory teams and committees.

3. Use affirming and inclusive language when talking or communicating about children's behavioral health.	3A. Review policies, practices, procedures, and programs to include affirming and inclusive language. 3B. Educate the workforce in equity and the use of affirming language across systems in behavioral health.
4. Explore the use of a wide range of social media options to communicate on children's behavioral health issues and services.	4. Use relevant social media platforms that are widely/commonly used by children and youth to spread relevant information on behavioral health issues and services.

Goal 2: Continuing to integrate trauma-informed practice into all public and private child serving agencies.	
Key Objective	Key Action
1. Support a resilient workforce that is well equipped to respond to the needs of children, youth and their families who have experienced trauma.	1A. Identify and address current workforce challenges in the behavioral health field that impact the wellbeing of its workers. 1B. Offer self-care and resiliency trainings/sharing sessions and initiatives for behavioral health workers (e.g., increase awareness about secondary trauma and foster self-care).
2. Promote trauma-informed policies, procedures, and practices within organizations.	2. Share and review trauma-informed approach in policies, procedures and/or practices among behavioral health organizations and foster implementation.
3. Continue to train non-clinical staff in trauma-informed practices.	3. Identify trainings and offer them to non-clinical staff that interact with behavioral health clients.

Appendix: Historical and Ongoing Work

The Children's Behavioral Health Plan builds on previous and ongoing improvement efforts. These efforts include, but are not limited to, the following:

Key Area: Prevention and Education

- Creating a system for prevention-focused early childhood mental health consultation services to support children's successful participation in early childhood education programs and eliminate expulsion and suspension practices (Fairfax County Equitable School Readiness Strategic Plan).
- Implementing awareness efforts to reduce stigma around behavioral health issues (Community Health Improvement Plan).

Key Area: Access to Behavioral Health Services

- Providing equitable access to affordable healthcare and healthy living opportunities; supporting all residents in attaining their full health potential (Fairfax County Strategic Plan).
- Ongoing efforts to eliminate gaps in opportunity, access, and achievement for Fairfax County Public School Students (Equity and Cultural Responsiveness | Fairfax County Public Schools).
- Increasing the use of health, mental health, and developmental screenings to identify opportunities for early intervention (Fairfax County Equitable School Readiness Strategic Plan).

- Increasing access to timely and appropriate services and supports to individuals and families (CSB Strategic Plan).
- Working to ensure that all students have access to mental health resources (Fairfax County Student Human Rights Commission)
- Utilizing a national framework to adapt youth mental health strategies and shape school mental health services in Fairfax County Public Schools. FCPS uses a similar framework to ASPIRE (ASPIRE).

Key Area: Navigation of Children's Behavioral Health Services

- Working to reduce the challenges in navigating the complex system of services (Community Health Improvement Plan).
- Continue to promote the ability of families, youth, and professionals to obtain services and navigate the behaviorial health system (Fairfax-Falls Church Children's Behavioral Health System of Care Blueprint for 2016-2020).

Key Area: System Level Changes

- Ongoing equity work at the Fairfax-Falls Church Community Service Board. The agency's equity lead is currently conducting a GARE survey (Local and Regional Government Alliance on Race & Equity).
- Striving for racial and social equity in access to and delivery of behavioral health services (Fairfax-Falls Church Children's Behavioral Health System of Care Blueprint for 2016-2020).

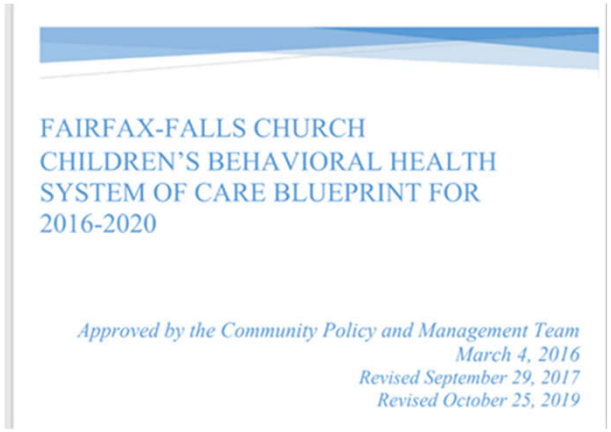
FAIRFAX - FALLS CHURCH
Community Services Board

Healthy Minds FAIRFAX
Supporting Emotional Wellness in Youth and Families

Children's Behavioral Health Plan

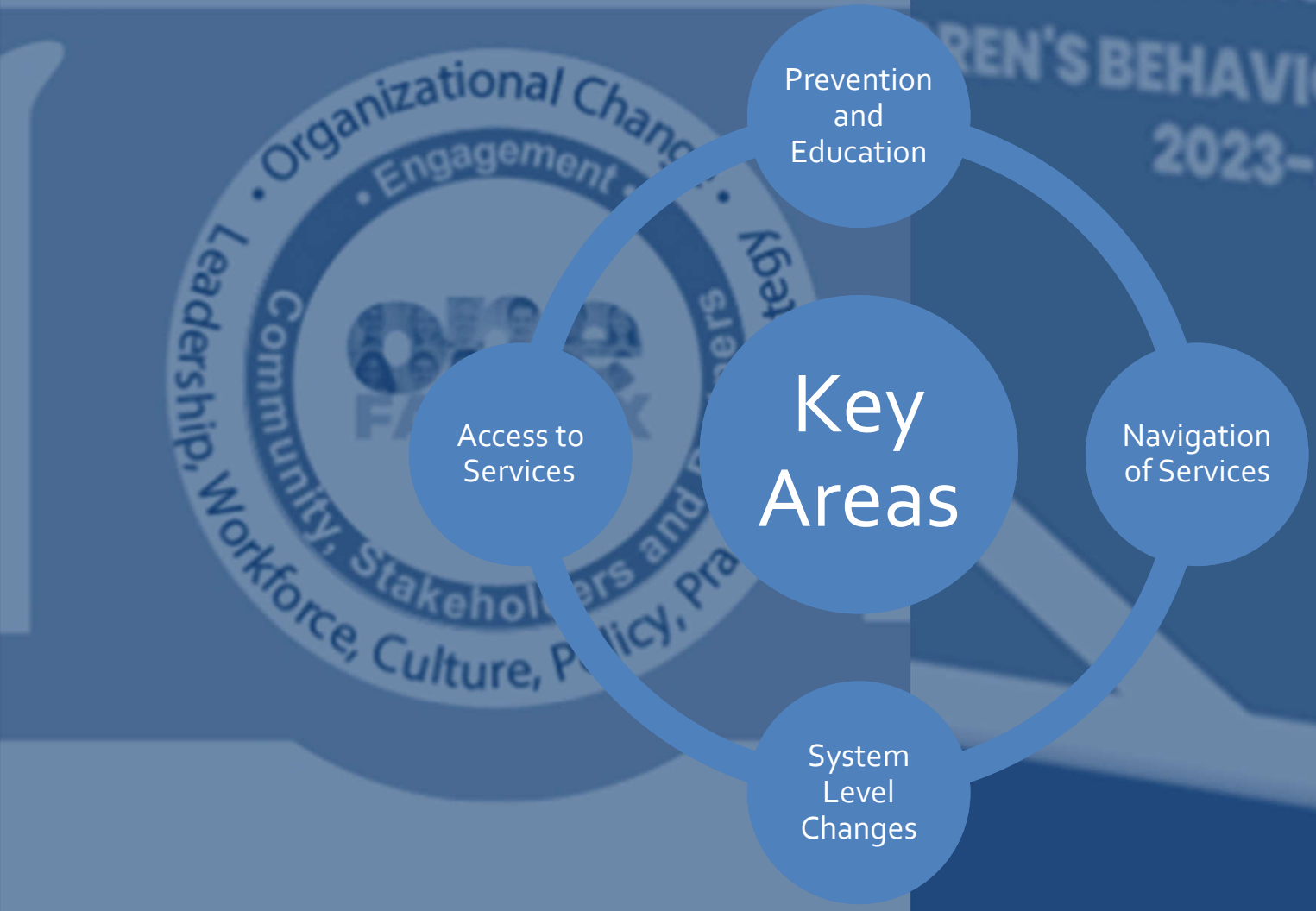
Presentation to the Community Policy and Management Team

January 27, 2023



FROM BLUEPRINT TO THE PLAN

OVERVIEW OF THE CHILDREN'S BEHAVIORAL HEALTH PLAN



PLAN IN ACTION

Mental Health and Substance Use Disorder

Key Area: Prevention & Education

- Expanding distribution of Narcan & Continuing to hold Revive Trainings
- Expanding Public Service Campaign
- Facilitating Caregiver & Youth Groups

Key Area: Access to Services

- Addressing GAPS in Youth Services
- Contracting with service providers
- Expanding Medication Assisted Treatment (MAT) to youth
- Partnering with Northern Virginia Family Service
- Hiring Youth Peer Support

PLAN IN ACTION

Key Area: Navigation of Services

- Developing Work Groups
- Mapping Services

Key Area: System Level Changes

- Working with members of the Healthy Minds Fairfax Collaborative on how to share data
- Partnering with Trauma-Informed Community Network

NEXT STEPS

IDENTIFY CHAMPIONS

QUARTERLY REVIEWS

REVIEW SUCCESS

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Thank you for your time