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

January 29, 2021
Community Policy and Management Team (CPMT)
Agenda

FINAL

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

1. **MINUTES:** Approve minutes of December 4, 2020 meeting

2. **ITEMS:**

- **CSA Administrative Items**
  Item A – 1: Approve Policy on Waiver of Parental Contribution for Family Peer Support Partner (FPSP) Services
  Item A – 2: Endorse CSB Proposal for Mental Health Initiative (MHI) State Funds
  Item A – 3: Approve Policy Change for Approval of Out of State Residential Providers

- **Contracts Items**
  Item C – 1: Child-Specific Contract Requests
  a. Foundations of Pennsylvania
  b. Youth Villages
  c. Springbrook, South Carolina
  d. Devereux, Florida

- **CSA Information Items**
  Item I – 1: FY 21 Budget Report
  Item I – 2: Update on Proposed CSA-Related Legislation
  Item I – 3: Report on Fidelity Monitoring for Intensive Care Coordination

- **HMF Information Item**
  Item I – 4: Children's Behavioral Health Blueprint Quarterly Report
  Item I – 5: Update on Respite Services for Families Impacted by COVID-19

- **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 4, 2020
Community Policy and Management Team (CPMT)
Virtual Meeting due to COVID-19 Emergency Procedures

Meeting Minutes

Attendees: Lesley Abashian (home), Stacy Alexander (home), Robert Bermingham (office), Michelle Boyd (home), Tisha Deeghan (home), Deb Evans (home), Annie Henderson (home), Joe Klemmer (home), Michael Lane (home), Richard Leichtweis (home), Chris Leonard (home), Deborah Scott (office), Jane Strong (home), Nancy Vincent (home), Daryl Washington (home),

Attended but not heard during role call: Jacqueline Benson (home)

Absent: Gloria Addo-Ayensu, Christy Gallagher, Michael Becketts, Rebecca Sharp

HMF Attendees: Jim Gillespie, Desiree Gordon, Peter Steinberg,

CSA Management Team Attendees: Adam Cahuantzi, Patricia Arriaza, Janet Bessmer, Xu Han, Jessica Jackson, Andrew Janos, Kamonya Omatete, Sarah Young, Stephanie Pegues, Mary Jo Davis, Chris Metzbower, Tim Elcesser

Stakeholders and CSA Program Staff Present: Janet Bessmer, Patricia Arriaza, Sarah Young, Samira Hotochin, Lisa Morton, Xu Han, Kristina Kallini, Chris Metzbower, Shana Martins

FOIA Related Motions:

I move that each member's voice may be adequately heard by each other member of this CPMT.
Motion made by Tisha Deeghan; seconded by Bob Bermingham; 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 Zoom conferencing line, and that the public may access this meeting by calling 888-270-9936 Conference code: 562732. It is so moved."
Motion made by Tisha Deeghan; seconded by Lesley Abashian; 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 Tisha Deeghan; seconded by Joe Klemmer; all members agree, motion carries.

1. **MINUTES:** Approve minutes of October 23, 2020 meeting. *Motion made by Chris Leonard; second by*

Rick Leichtweis; approved by all members, motion carries.

2. **ITEMS:**

- **CSA Administrative Items**

Item A – 1: Establish an OCS Triennial Audit Steering Committee – Item presented by Janet Bessmer. Request that the CPMT establish a committee to oversee the upcoming CSA audit. Recommendation is that the CPMT Chair will appoint members to join this committee. Tisha has already selected members to serve on this committee. Members are as follows: Chris Leonard (CPMT Chair- as of next month) Michael Becketts (CSA budget is within DFS), Jane Strong (representing special education), Lesley Abashian (due to extensive knowledge of CSA). Nancy Vincent asked who will be the fiscal agent representative? Janet Bessmer responded that there has been a change in the fiscal agent and Michael Becketts and his staff will be corresponding with the fiscal agent as needed. Motion to approve members selected for the committee. *Motion made by: Rick Leichtweis seconded: Michael Lane. Approved by all members, motion carries.*

Item A – 2: Establish a CPMT workgroup for CPMT Appeals Procedures – Item presented by Janet Bessmer. Short-term workgroup needed to develop recommendations to the CPMT to develop additional policies and procedures for Appeals. Michael Becketts and Jackie Benson have agreed to serve on this workgroup. Annie Henderson has also agreed to join. CSA Staff will also join/assist as needed. If any members are interested in joining please email Janet Bessmer. *Motion made by: Joe Klemmer, seconded by Staci Alexander approve; motion carries.*

- **CSA Discussion Item**

Item D – 1: Discuss JLARC Recommendations (attach HHS fact sheet & paper) – A summary of the report was presented by Janet Bessmer. There may be impact to our local program if these changes are implemented. Adam Cahuantzi (FCPS MAS) stated that less the 1% of special education students are in day school placement, which is less than the benchmark established by the State. This is primarily due to the abundance of services and programs offered in Fairfax County. Across the State there is an increase in Private Day enrollments, but Fairfax County does not have a significant increase in enrollments. Fairfax is preforming well compared to the rest of the state. Tisha Deeghan asked what the likelihood of adopting these recommendations. Jane Strong stated that if the recommendation is adopted it will take some time since the department is not set up to implement these changes (report states July 1, 2022). Deb Evans asked where in the state is the increase in cost so great. Rick Leichtweis responded that the increase in cost is due to the increase in enrollment and type of child and availability of resources within the school jurisdictions.

- **CSA Information Items**

Item I – 1: FY 21 Budget Report – Item presented by Xu Han. Rick Leichtweis asked if we have reached our max budget for the year. Xu Han responded that although it seems that way, there is a delay in paying invoices, so this report does not capture the full picture of what has been spent as of today. This report captures the first quarter.

Item I – 2: Review Annual CSA Parent Satisfaction Survey – Item presented by Janet Bessmer. Surveys were sent out to parents electronically as well as paper copies via mail. We have taken note that there are some concerns regarding time to service, CSA's delayed response time and lack of availability of services/providers. CSA is also distributing surveys to parents after FAPT and Team Based Planning meetings. Rick Leichtweis offered to get private providers to assist with increasing the response rate.

Item I – 3: Review CSA Service Monitoring Plan – Item presented by Patricia Arriaza. CSA was able hire a new position last year to focus on monitoring services. Various strategies of monitoring have been implemented to ensure that services are provided in a proper and timely manner.

Item I – 4: Status update on CPMT workgroup on Magellan's Single Case Agreement – Item presented by Janet Bessmer. Group is planning to gather data for a few new single case agreements moving forward and CSA will reach out to the workgroup if guidance is needed.

Approved:

- **NOVACO – Private Provider Items –** Deb Evans brought up the issue of restraints in residential setting. Janet mentioned that there is a recommendation for that in JLARC. CSA Management Team has been trying to address issues of equity and behavioral health care access. One suggestion was to have that be the theme of the CSA Symposium, which will be a half day virtual training this year. Thank you to Tisha for leading this group. Starting next month Chris Leonard will take over as Chair of the CPMT.
- **CPMT Parent Representative Items –** Jackie Benson mentioned the Family Advisory Board (FAB) were discussing the topic of COVID 19 vaccine and when mental health providers will be able to provide services in the home. Tisha stated that she would share the vaccination plan that was provided by the Health Department. Daryl Washington mentioned that the adult group homes were included in the long-term care group for vaccination.
- **Cities of Fairfax and Falls Church Items –**
- **Public Comment –** no comments

Adjourn 2:35 – *Motion made by Chris Leonard; seconded by Michael Lane. All members approved.*

Next Meeting: January 29, 2021 1:00 – 3:00pm (via Zoom)

Approved:

MEMO TO THE CPMT
January 29, 2021

Administrative Item A - 1: Approve Policy to Waive CSA Parental Contribution for Family Peer Support Partner (FPSP) Services

BACKGROUND:

Using lived experience of successfully advocating for their own child with mental/behavioral health needs, Family Peer Support Partners provide peer support services to families of children with mental/behavioral health needs, including information, resources, training and emotional support with the aim of helping them to successfully navigate services and to learn to play an active role in the delivery of needed services, partnering with both providers and natural supports supporting the family. The provision of information, education and social support along with role modeling and coaching leads to the following outcomes: reduced parental stress; reduced feelings of isolation and helplessness; and a greater capacity to engage in an empowered way to partner with supports and services on behalf of their family. FPSP services are a best practice in children's behavioral health promoted by SAMHSA.

In September 2014 NAMI-Northern Virginia was competitively awarded a contract to provide Family Support Partner services for families involved in ICC, funded through a grant from the Virginia DBHDS. In January of 2017 Fairfax County was awarded a phase two DBHDS grant to provide family support partner services to any family of a child with mental health issues. The grant period was for four years, from October 1, 2016 through September 30, 2020, with an award amount of $405,911 annually. The county was granted a no-cost extension through January 31, 2021 to spend out the budget. Under the DBHDS contract services were provided to families at no cost.

Effective January 2021 PRS, Inc. was competitively awarded a contract to continue providing services, now called Family Peer Support Partner (FPSP) Services, at a cost of approximately $200,000 annually in county funding. Under the new contract services will continue to be provided at no cost to families. To make up the difference between the previous contract of $405,911 and the reduced amount of the new county contract, CSA-eligible families needing FPSP services will access them through CSA purchase of services. The county contract will serve families who are not CSA eligible.

It is requested that FPSP services be exempted from the CSA parental contribution requirement, for three reasons. First, FSPS services differ from traditional mental health treatment, and it would be difficult to convince families to pay for a peer support service they may not initially perceive as essential. Second, with county-funded FPSP services provided at no cost it would not be equitable to charge CSA-eligible families. Third, the fiscal impact will be minimal, since the great majority of CSA-eligible families getting FPSP services will also be getting other CSA services for which they will be paying a fee.

Children's Behavioral Health System of Care Blueprint: This project accomplishes the Blueprint strategy to create a family support partner program, under the goal of developing and expanding youth and parent/family peer support services.

ATTACHMENT:
None

FISCAL IMPACT:
the fiscal impact will be minimal, since the great majority of CSA-eligible families getting FPSP services will also be getting other CSA services for which they will be paying a fee.

FAMILY ADVISORY BOARD REPORT:
The Family Advisory Board believes that waiving the CSA co-pay for Family Peer Support Partner Services would encourage families to engage in this very valuable peer support service.

INTERNAL CONTROL IMPACT:
None

STAFF:
Jim Gillespie, SOC Director

MEMO TO THE CPMT
January 29, 2021

Administrative Item A – 2: Endorse CSB Protocol for Use of Unspent State Mental Health Initiative Funds

ISSUE:
It is requested that the CPMT endorse a CSB protocol for using approximately $1.2 million in unspent prior year state Mental Health Initiative funds to increase purchase of services for children and youth with serious emotional disturbance (SED). On January 25 the CSA Management Team reviewed and endorsed this request.

RECOMMENDATION:
That the CPMT endorse a CSB protocol for using approximately $1.2 million in unspent prior year state Mental Health Initiative funds to increase purchase of services for children and youth with serious emotional disturbance

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. In 2006 the Board of Supervisors appropriated an additional $440,650 in ongoing funding to supplement MHI State funds and CSA in purchasing services for children and youth with behavioral health issues. For the past several years the state MHI allocation has been under-spent, resulting in a current unspent balance of $1,166,321. DBHS requires that be spent for the intended purpose.

The current annual MHI allocation is used to support four Youth and Family Behavioral Health Specialist II positions and to purchase intensive behavioral health treatment for children and youth with more complex needs than can be met through outpatient services. In January 2020 CPMT endorsed and DBHDS approved also funding three Senior Clinician positions to begin spending down the accumulated balance. After the onset of COVID that number was reduced to two, with DBHDS concurrence. The unspent balance was accumulated through periodic vacancies in the MHI-funded positions, which had the added effect of reducing the case management capacity to assist families in accessing MHI-funded intensive behavioral health treatment.

DBHDS MHI Administrative Requirements:

- MHI funds must be used exclusively to serve new, currently unserved children and adolescents or provide additional services to underserved children and adolescents with serious emotional disturbances (SED) and related disorders that are not mandated to receive services under the CSA. Children and adolescents must be under 18 years of age at the time services are initiated.

- 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.
- CSBs must develop referral and access protocols that assure effective linkages with key stakeholders, agencies and entities in the community (e.g., CSA, social services, schools, and juvenile justice services, detention centers).
- Services should be provided in the least restrictive and most appropriate settings, including homes, schools, pre-schools, community centers, group homes, and juvenile detention centers.
- These funds shall be used exclusively for children and adolescents, not mandated for outpatient behavioral health services under the Children's Services Act.
- Each CSB must work collaboratively with its local FAPT(s) and CPMT(s) to establish an 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.

PROPOSED PROTOCOL:

It is proposed that the unspent balance of $1,166,321 be spent to:

1. Continue funding two CSB Youth and Family Senior Clinician positions. These clinicians are trained in and provide evidence-based treatments for children and youth with SED. The clinicians will be trained in the following EBPs:

   - The Core Competency Training (CCT) developed by Dr. Christy Esposito Smithers. CCT is an evidence-based intervention using a manualized transdiagnostic CBT/ DBT treatment protocol. This modular treatment protocol can be used to treat multiple comorbid conditions and high-risk behaviors. Areas to be covered in the 4-day training include treatment of depression, anxiety, disruptive-behavior disorders, suicidality, and non-suicidal self-injury, trauma, substance abuse, and working with the family. Participants learn core CBT/DBT skills to address multiple mental health issues in youth age 12 and up and their families. Participants participate in group supervision, commit to using a very brief evidence-based assessment to track client progress, commit to complete very brief checklists to track use of the treatment protocol.
   - Trauma-Focused Cognitive Behavioral Therapy
   - In addition, the implementation of Parent Child Interaction Therapy will be considered for FY 2022 if treatment capacity exists.
   - MHI funds not expended on Senior Clinicians due to periodic vacancies or other causes will be used for purchase of services, including Multi-Systemic Therapy and Functional Family Therapy from private providers for MHI-eligible children and youth.

2. Increase purchase of service funding by $300,000 annually, targeting youth identified by the school system as having attendance issues and determined to have SED. Such youth will be primarily identified through an interdisciplinary team, including CSB representation,

primarily identified by an interdisciplinary team, with CSB representation, established for that purpose. A secondary target population will be youth 14 and over with SED identified by CSA family assessment and planning teams and multi-disciplinary teams as posing a risk primarily to others. Another target population will be upper elementary and middle school-age children with SED.

This proposed use will meet Appropriations Act requirements and the DBHDS Guidelines for the use of MHI Funds.

Target Population:
Youth with serious emotional disturbance or related disorders who are not eligible for CSA mandated services. Priority access will be given to youth in families with incomes that qualify for subsidy under the CSB sliding fee scale.

Access to Services:
All families may access MHI-funded services through the CSB walk in intake process. Youth identified at family assessment and planning team meetings, family resource meetings, family partnership meetings or ICC youth and family team meetings as needing trauma-focused cognitive behavioral therapy will be prioritized for MHI-funded treatment services.

Individualized Service Planning:
All youth served will have an individualized plan of care compliant with the requirements in the CSA Code, developed through a multi-disciplinary team process.

Services to be Provided:
The primary service to be provided is evidence-based outpatient behavioral health therapy, primarily cognitive behavioral therapy, intensive in-home services, intensive care coordination, MST and FFT. All children and youth served will be living in the community. Funding will not be used for residential care, furniture, supplies or computers.

Review and Reporting:
A report of MHI services and expenditures will be presented to the CPMT on an annual basis.

ATTACHMENT:
None

INTERNAL CONTROL IMPACT:
None

FISCAL IMPACT:

The unspent MHI balance is sufficient to fund two Senior Clinician positions and $300,000 annually in purchase of services through FY 2023.

STAFF:
Jim Gillespie, CSB Youth and Family Services Director

MEMO TO THE CPMT

January 29, 2021

Administrative Item A - 3: Policy Change for Approval Process of Out of State Residential Providers

ISSUE: That current local policy requires CPMT approval for Out of State Residential Treatment Facilities and Group Homes which may result in delays in placement for youth.

BACKGROUND:
CPMT approval of out of state, congregate care providers supported best practice of keeping children as close to their home and community as possible. Proximity permits greater family participation in treatment service and enables regular monitoring by case managers. The Appropriations Act also requires that Medicaid-enrolled providers, generally in-state residential facilities, are utilized unless unavailable or inappropriate.

In recent years, a general state-wide trend has been noted of greater difficulty in gaining admission for some children in-state residential placements. Appropriate in-state facilities are reportedly more difficult to obtain for youth who are on the Autism Spectrum, youth with high levels of aggression, as well as youth with medical/physical health needs and youth with sexual acting out behaviors. In-state facilities have reported accepting up to 30% of youth from other states and indicate that the current Medicaid reimbursement rate is one factor.

The CSA Management Team has delegated authority to approve Open access and Child Specific Contracts with providers for non-congregate care services located in the State of Virginia. All Out of State Residential Treatment Center and Group Home contracts MUST be approved by the CSA MT and CPMT. Delays in placement may occur to finalize approval of the contract by CPMT. The CSA Management Team supports being given the authority to authorize these child specific contracts. The agency director of the case managing agency reviews and approves child-specific contract requests before the CSA Management Team reviews in our current process.

In order to maintain oversight and fulfill duties of the CPMT outlined in the Code of Virginia, the CSA Management Team will ensure that regular reporting to the CPMT about out of state placements and providers is performed. Duties outlined in section 2.2 – 5210. 14 require review and analysis of data in management reports including number of children placed out of state and 17. submission to the Department of Behavioral Health and Developmental Services information on children under the age of 14 and adolescents ages 14 through 17 for whom an admission to an acute care psychiatric or residential treatment facility licensed pursuant to § 37.2-403 et seq., exclusive of group homes, was sought but was unable to be obtained by the reporting entities. Such information shall be gathered from the family assessment and planning teams or participating community agencies authorized in § 2.2-5207;

RECOMMENDATION: That the CPMT approve a policy change permitting the CSA Management Team to approve child-specific, out-of-state placements in Residential Treatment Centers (Psychiatric Residential Treatment Facilities or PRTFs) and Group Homes. The CPMT will receive a quarterly report regarding the number of children in out of state placements, the name and specialty service offered by the provider and reason for placement.

ATTACHMENT: Contract Section HMF Policy Manual - Child Specific Change

INTERNAL CONTROL IMPACT: None

FISCAL IMPACT: None

STAFF:
Janet Bessmer, CSA
Barbara Martinez, DPMM

All Fairfax-Falls Church public child serving agencies purchasing services from public and private providers serving at-risk youth and families under the CSA will utilize standard umbrella agreements for specialized services. These agreements contain general terms and conditions including indemnification language of the County, insurance requirements, process for resolution of disputes and reporting requirements. Providers are required to sign an Agreement for Purchase of Services to do business with the CPMT. The CSA Program Manager has been delegated signature authority for agreements entered into by the CPMT. The CSA Management Team has delegated authority to approve Open access and Child Specific Contracts with providers for non-congregate care services located in the State of VirginiaCSA eligible youth. All Out of State Residential Treatment Center and Group Home contracts MUST be approved by the CSA MT and CPMT.

There are two general types ofis one general Agreements for Purchase of Services, one issued to individual outpatient therapists and the second to, HomeCommunity-Based, Treatment Foster Care, Congregate and Residential Services and Private Day schools. These Agreements serve as the basic agreement between the CPMT and the provider and must be signed by both parties before actual services can be rendered. The providers fall into three categories of System of Care Providers: Tier I(In Network and open access), Tier II (In network but restricted access requiring CSA Manageemeent Team Approval prior to use), and Tier III (Out of Network and New to the System of Care). Such agreements do not represent any specific request for service or guarantee of use. Rather, as each child specific requirement for service arises, an individual Purchase Order is issued pursuant to the Agreement for Purchase of Services specifying the service(s) required, the rate(s) of the services and the unit number of services being contracted for the specific client.

2.1 Categories of Approved Providers

Tier I Providers

Are approved as “open access,” or “In-Network Providers,” are listed on the CSA Provider Directory and are accessible by CSA Case Managers for purchases on behalf of CSA eligible clients. Case Managers are responsible for meeting CSA requirements including but not limited to acquiring authorization, submitting encumbrances, and Utilization Management.

These providers are:

- Located in the State of Virginia or close proximity to the Washington DC Metro area;
- Enrolled with the Department of Medical Assistance Services (DMAS) as a Medicaid Provider, as appropriate per type of service;
- Insured for appropriate limits, per the Office of Risk Management for Fairfax County;
- Licensed for the contracted services by the State of Virginia or their respective jurisdiction for the provider location;
- Willing to accept the SOC Practice Standards;
- In the Virginia State Service Fee Directory (SFD) or willing to enter their organization, services, and current rates, with the exception of individual outpatient therapy providers in the SFD.

Tier II Providers

Are approved as restricted access and are not listed on the CSA Provider Directory. They are accessible on a Child Specific basis. The providers may have a signed contract in place and all required documentation is may already be held current. CSA Case Managers and Team-Based Planning Teams

may access these providers after additional review and approval by the CSA Management Team. Case Managers are responsible for acquiring UR authorization, submitting the Contract Request for Out of Network Provider Form to the CSA Contracts Management Team and submitting encumbrances once approval is given by the CSA Management Team.

These providers:

- May or may not be in the State of Virginia;
- Commit to working with DMAS as a Medicaid Provider for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) as appropriate for the services to be provided;
- Are insured for appropriate limits, per the Office of Risk Management for Fairfax County;
- Licensed for the contracted services by the jurisdiction of their location;
- Accept the SOC Practice Standards;
- Must be listed in the Virginia State Service Fee Directory (SFD) or willing to enter their organization, services, and current rates, with the exception of individual outpatient therapy providers prior to providing services in the SFD;
- Are accredited by Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Virginia Association of Independent Specialized Educational Facilities (VAISEF) when appropriate.

Tier III Providers

~~Tier III providers are Residential Treatment Center and Group Homes located outside of the State of Virginia. They are not approved as an approved In-Network and Approved Out-of-Network Provider and are not listed on the CSA Provider Directory.~~ These providers do not have a signed contract in place ~~and Contracts & Procurement Management must gather and review all required documentation~~and are new to the system of care. These providers can apply during an open application period and be reviewed by the application review team and the CSA Management Team for a contract. CSA Case Managers and Team-Based Planning Teams may access these providers after additional review and approval by the CSA Management Team ~~and CPMT approval~~. CSA Case Managers are responsible for acquiring UR authorization, submitting the Contract Request for Out-of-Network Provider Form and the RTC or Group Home attachment to the CSA Contracts Management Team and submitting encumbrances once approval is given by the CSA Management Team.

These previously unknown and/or unapproved providers are:

- ~~Not located in the State of Virginia;~~
- Willing to commit to working with DMAS as a Medicaid Provider for EPSDT when appropriate;
- Insured for appropriate limits, per the Office of Risk Management for Fairfax County;
- Licensed for the contracted services by the jurisdiction of their location;
- Willing to accept the SOC Practice Standards;
- Accredited by Council on Accreditation (COA), Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), Virginia Association of Independent Specialized Educational Facilities (VAISEF) when appropriate.

2.2 Protocols for Becoming a System of Care Network Provider

Before entering into any agreements with a service provider, the CPMT has tasked the CSA Management Team with screening potential providers and approving appropriate providers for the necessary services. New providers, or new services with existing providers, will be considered during a bi-annual "Open Application Period."

Potential New Providers Applications are evaluated during two two-month periods each calendar year. During these "Open Application Periods," potential providers may submit the Fairfax-Falls Church CSA System of Care Network Application to the CSA Contracts Team with all of the required supporting documentation. Once all required documentation is received, the CSA Contract Analyst for the service category will review the application, documentation, contact references and engage staff from the CSA Work Group or Single Agency Liaison, such as FCPS-MAS and DFS-FC&A, for presentation of the application. ~~During~~ After the two-month application period, potential providers will be contacted if additional documentation is needed. If the provider meets the minimum requirements for the service category, the application will be presented to the CSA Management Team for ~~review and recommendation to the CPMT.~~approval of award of a contract. Once approved by the CSA Management Team, the award of a new provider contract will be presented to the CPMT in the Quarterly Contract Activity Report.

~~Minimum Standards for Tier I System of Care Network Provider enrollment:~~

- ~~Located in the State of Virginia;~~
- ~~Enrolled with the Department of Medical Assistance Services (DMAS) as a Medicaid Provider;~~
- ~~Insured for appropriate limits, per the Office of Risk Management for Fairfax County;~~
- ~~Licensed for the contracted services by the State of Virginia;~~
- ~~Accept the SOC Practice Standards;~~
- ~~Ability to provide services and treatment modalities asserted by the SOC Evidence Based Practice Work Group to be accepted by the SOC and ability to provide verification of certification in requested treatment modalities.~~

2.3 Protocols for Becoming an Out-of-Network Provider

The CSA Management Team has the authority to designate providers as Tier II (Child Specific/Restricted~~Etirected~~ Access) providers due to past performance, concerns over outcomes and child safety. Child Specific agreements can also ~~only~~ be requested by a case manager from a child serving public agency. Case Managers are responsible for acquiring CSA Services Authorization, submitting the Contract Request for Tier II/Out-of-Network Provider Form to the CSA Contracts Management Team and submitting encumbrances once approval is given by the CSA Management Team ~~and CPMT~~.

When a service is needed for a CSA eligible youth that is not currently provided by an In-Network Provider, all Out of State providers of Residential and Group Home Services must be approved by the CSA Management Team ~~CPMT~~ prior to entering into a Child Specific Contract.

Items CSA Management Team may consider in deciding to recommend a contract with a potential provider include:

- Licensing/certification status of the provider (if applicable);
- Medicaid enrollment/application status of the provider (if applicable);

- Reference checks, to include previous employers, colleagues/associates, other jurisdictions, and licensing/certification bodies;
- The ability, capacity and skill of the provider to provide the services required;
- Ability of the provider to provide services promptly, or within the time specified, without delay or interference;
- The character, integrity, reliability, reputation, judgment, experience and efficiency of the provider;
- The quality of performance on previous contracts or services (where applicable);
- The previous and existing compliance by the provider with laws and ordinances relating to the contract or service;
- Sufficiency of the financial resources of the provider to provide the service;
- The quality, availability and adaptability of the services to the particular use required;
- The ability of the provider to provide future services for the use of the subject of the contract;
- Whether the provider is in arrears to the County on a debt or contract or is in default on a surety to the County or whether the provider's County taxes or assessments are delinquent;
- Other information as may be secured by the CPMT or its agent having a bearing on the decision to award a contract.

2.4 Provider Requirements that Must Be Met Before Proceeding with Contracting

1. The provider must be in the Virginia State Service Fee Directory (SFD) or willing to enter their organization, services, and current rates prior to ~~actually~~ providing CSA funded services.
2. The provider must be properly licensed to provide the service(s) offered (if required), must have current insurance that meets the County's insurance requirements, and must provide acceptable documentation of both.

2.5 Certifying Provider Qualifications

Per COV § 2.2-2648, enacted by the 2011 Virginia General Assembly revised the Code of Virginia § 2.2-2648 to read:

> 20. Deny state funding to a locality, in accordance with subdivision 19, where the CPMT fails to provide services that comply with the Children's Services Act (§ 2.2-5200 et seq.), any other state law or policy, or any federal law pertaining to the provision of any service funded in accordance with § 2.2- 5211;

Licensed/Certified Providers

Those providers requiring state licensing need to adhere to established state licensing procedures and have a current state license. Providers need to maintain state established operating standards. The providers must provide the following information in order for the CSA Management Team to consider recommending approval. ~~to the CPMT:~~

- Each potential provider will complete and sign the Agreement for Purchase of Services, pertinent Addenda indicating the specific services provided, and Rate Sheets indicating the breakdown of service costs;

- Each potential provider, where appropriate, will complete and sign information sheets requesting a listing of all degrees, accreditation(s), three references, and insurance coverage;
- Each licensed/ certified provider will provide a current license/certification.

Providers with No Licensing/Certification Requirements

There are providers for which there are no licensing requirements. These providers must provide the following information in order for the CSA Management Team to consider recommending approval to the CPMT:

- Each potential provider will complete and sign the Agreement for Purchase of Services, pertinent Addenda indicating the specific services provided, and Rate Sheets indicating the breakdown of service costs;
- Each provider, where appropriate, will complete and sign an information sheet requesting a listing of all degrees, accreditation, three references, and insurance coverage.

Identifying Providers for Child Specific Needs

Agency case managers will follow the procurement process under the CSA. Such procedures include the purchase of goods and non-specialized services. The local Provider Directory will be updated by CSA Contracts staff as updates occurs. The Provider Directory identifies all Tier I Providers with whom the CPMT has contracted to provide client services.

MEMO TO THE CPMT
January 29, 2021

CONTRACT ITEM C 1a: Child Specific Contract Request for Foundations in PA

ISSUE: The Community Services Board (CSB) requests approval of a child specific Agreement for the Purchase of Services (APOS) with Foundational Behavioral Health for residential treatment in Doylestown, PA for Harmony #162453.

RECOMMENDATION: The CSA Management Team recommends CPMT approval of a child specific APOS with Foundations Behavioral Health for residential treatment in Doylestown, PA for Harmony #162453.

PROVIDER:

Foundations Behavioral Health
833 E Butler Ave
Doylestown PA 18901
Phone: 215-345-7151
https://fbh.com/

MEDICAID ENROLLMENT: Foundations Behavioral Health does not participate with Virginia Medicaid; the youth is eligible for Medicaid.

LICENSE/ACCREDITATION: Foundations Behavioral Health Center is a licensed provider of Children's Behavioral Health by Pennsylvania Department of Human Services.

INSURANCE STATUS: Foundations Behavioral Health Center is appropriately insured in accordance with Fairfax County standards.

PROGRAM DESCRIPTION:

Foundations Behavioral Health is a trauma-informed facility that specializes in complex behavioral and psychiatric diagnoses. The program is primarily geared toward youth with ID and Autism diagnoses. Most of their out-of-state population is comprise of youth on the Autism Spectrum or those with developmental delays. Dependent on the youth's needs, the program uses ABA informed principles, elements of DBT/mindfulness, and/or CBT, as deemed appropriate based on the youth's needs. Foundations' clinical and medical team complete comprehensive assessments to determine intervention plans that are appropriate and realistic for the greatest impact based on the youth's anticipated discharge to the home/community.

OTHER CONTRACTED PROVIDERS CONSIDERED:

All in-state CSA contracted Medicaid enrolled, clinically appropriate residential providers were considered, and none were available or appropriate based on the youth's diagnosis and situation.

Provider Name	Telephone	Packet Sent	Reason for denial or why determined inappropriate	Accepted/ Denied Admission
Fairwinds	☑ Yes	☐ Yes	Program doesn't use communication devices and wouldn't be able to support a youth that is nonverbal.	denied
Grafton	☑ Yes	☑ Yes	Grafton does not have availability, noting the following: "We just do not have any appropriate beds open and no discharges scheduled for the near future." At a minimum, Grafton does not anticipate having bed availability in a month.	No bed availability
UMFS	☑ Yes	☐ Yes	Youth being nonverbal is an exclusionary criteria for their Program.	Denied
Hughes Center	☑ Yes	☐ Yes	The Hughes Center does not have a formalized ABA program, has a 10-12 week waitlist, and has a hold on admissions due to COVID-19 related issues.	No bed availability
Devereux Foundation	☑ Yes	☑ Yes	Per admissions, the nonverbal unit is small and the unit is currently full. It will likely be a few months before a bed becomes available at	No bed availability

FISCAL IMPACT:

Daily Rate - $ 600/day

Daily Rate includes the following:

- Room and board
- 24-hour Supervision
- Evaluations, treatments, and services provided by clinicians including Psychology, Behavioral Specialist, Nursing and Psychiatry
- Laundry Services

Estimated total cost for 4 months of residential service: $72,000

Education- $ 321.36/day

Estimated total cost for 4 months of education:	$26,351.52
Total Estimated Fiscal Impact for 4 months:	$98,351.52

STAFF:
Jessica Jackson
Barbara Martinez

MEMO TO THE CPMT
January 14, 2021

CONTRACT ITEM C-1b: Child Specific Contract Request for Youth Villages in TN

ISSUE: The Juvenile and Domestic Relations District Court (JDRDC) requests approval of a child specific Agreement for the Purchase of Services (APOS) with Youth Villages for residential treatment in Bartlett, TN for Harmony #163603.

RECOMMENDATION: The CSA MT recommend CPMT approval of a child specific APOS with Youth Villages for residential treatment in Barlett, TN for Harmony #163603.

PROVIDER:

Youth Villages, Rose Center for Girls
7386 Memphis Arlington Road
Bartlett, TN 38135
(901) 384-2043
www.youthvillages.org

MEDICAID ENROLLMENT: The provider does not participate with Virginia Medicaid.

LICENSE: The provider is licensed as Children's Residential Treatment Center by the State of Tennessee Department of Mental Health and Substance Abuse Services.

INSURANCE STATUS: Youth Villages is appropriately insured by Fairfax County standards.

PROGRAM DESCRIPTION (from website):

Youth Villages Rose Center for Girls specializes in providing trauma-focused therapy and supervision for girls with higher acuity needs, including history of trauma, suicidal or self-harming conditions, psychotic symptoms, and sexual behavior problems. The facility has a child-to-staff ratio of 3:1 allowing for intensive treatment while maintaining a level of safety that creates an environment of trust. In this environment, girls receive intensive therapy while also readjusting to routine, education, and life in a community setting.

OTHER CONTRACTED PROVIDERS CONSIDERED:

All in-state CSA contracted Medicaid enrolled Residential providers were considered. However, most of them denied admission or were not appropriate/suitable for the child's diagnosis and situation.

Tier 1: Open Contracts Contracted In-State Facilities				
Provider Name	**Telephone Contact Date**	**Application Submitted Date**	**Accepted/ Denied Admission**	**Reason for denial or why determined inappropriate**
Bridges Hospital (Centra Health Systems) *Medicaid Level C*	**N/A**	**N/A**	N/A	Bridges is an unsecure facility. Due to history of AWOL, client requires locked facility
Childhelp USA, Inc *Medicaid Level C*	**N/A**	**N/A**	N/A	Client does not meet age requirement
Fairwinds (Ed Murphy & Assoc.) *Medicaid Level C*	**N/A**	**N/A**	N/A	Client does not meet age requirement
Grafton School *Medicaid Level C*	*11/24/20	**11/24/20**	Denied 12/8/20	Client was denied due to milieu not being appropriate at this time
Hallmark YouthCare Inc. *Medicaid Level C*	**N/A**	**N/A**	N/A	Client was placed at Hallmark from December 2019-August 2020. Client was unsuccessfully discharged after going AWOL.
Jackson Field Homes *Medicaid Level C*	**N/A**	**N/A**	N/A	Client requires a locked facility
Poplar Springs Hospital *Medicaid Level C Female Only*	**9/11/20**	**9/11/20**	Denied 9/11/20	Poplar Springs denied client due to AWOL history, SIR involving riot/destruction of property at Hallmark
Timber Ridge School (Leary Educational Foundation) *Medicaid Level C Male Only*	**N/A**	**N/A**	N/A	Timber Ridge is for males only
Timber Ridge School (Leary Educational Foundation) *NON-Medicaid Male Only*	**N/A**	**N/A**	N/A	Timber Ridge is for males only

* attempted contacts on 11/18, 11/24, 11/30, & 12/2/20

Tier 1: Open Contracts Contracted In-State Facilities				
Provider Name	**Telephone Contact Date**	**Application Submitted Date**	**Accepted/ Denied Admission**	**Reason for denial or why determined inappropriate**
Southstone Behavioral Health *Medicaid Level C*	**11/24/20**	**11/24/20**	Denied 12/7/20	Client was denied due to history of AWOL and aggression and behaviors not suitable for current milieu
Youth for Tomorrow – New Life Center, Inc. *Medicaid Level C*	**N/A**	**N/A**	N/A	Youth for Tomorrow is not appropriate due to severity of youth's needs. It is also an unlocked facility
Youth for Tomorrow – New Life Center, Inc. *NON-Medicaid*	**N/A**	**N/A**	N/A	Same as above
UMFS-United Methodist Family Services *Medicaid Level C*	**N/A**	**N/A**	N/A	UMFS is not appropriate due to severity of youth's needs and youth requires a secure facility.
Elk Hill Farm *Medicaid Level B*	**N/A**	**N/A**	N/A	Elk Hill is for males only
Grace Haven House *Medicaid Level B* *Female Only*	**N/A**	**N/A**	N/A	Facility is not appropriate due to severity of youth's needs and youth requires a locked facility
Intercept Youth Services *Medicaid Level B*	**N/A**	**N/A**	N/A	Facility is not appropriate due to severity of youth's needs and it is not a locked facility
Kids in Focus *Medicaid Level B*	**N/A**	**N/A**	N/A	Facility is for assessment and diagnostic
Outreach Services *Medicaid Level B* *Female Only*	**N/A**	**N/A**	N/A	Facility is not clinically appropriate and not a secure facility
Rest Assured *Medicaid Level B*	**N/A**	**N/A**	N/A	Facility is not clinically appropriate, and youth requires a locked facility
Aurora House (City of Falls Church *Non-Medicaid* *Female Only*	**N/A**	**N/A**	N/A	Facility is not clinically appropriate, and youth requires a locked facility
Discovery School – Boys (Discovery School of VA) *NON-Medicaid* *Male Only*	**N/A**	**N/A**	N/A	Facility is for males only
Discovery School – Girls *NON-Medicaid* *Female Only*	**N/A**	**N/A**	N/A	Facility is not clinically appropriate and youth requires a locked facility
Turning Point *NON-Medicaid* *Male Only*	**N/A**	**N/A**	N/A	Facility is for males only

Tier 2: CPMT Approved Child Specific Contracts The following **Medicaid Enrolled In-State Providers** That REQUIRE A CHILD SPECIFIC CONTRACT REQUEST & APPROVAL BY THE CSA MANAGEMENT TEAM PRIOR TO PLACEMENT WITH CSA FUNDING				
Cumberland Hospital (RTC, Specialized Care & Hospital Program) *Medicaid Level C*	**N/A**	**N/A**	N/A	Facility is not clinically appropriate.
Cumberland Hospital (RTC, Specialized Care & Hospital Program) *Hospital Medicaid*	**N/A**	**N/A**	N/A	Same as above
Harbor Point Behavioral Health Center *Medicaid Level C*	**12/4/20**	**12/4/20**	Denied 12/8/20	Client was denied due to codefendant being a resident and not appropriate for both to be on the same unit.
Hughes Center for Exceptional Children *Medicaid Level C*	**N/A**	**N/A**	N/A	Facility is not clinically appropriate
Kempsville Behavioral Health *Medicaid Level C*	**11/24/20**	**11/24/20**	Denied 12/4/20	Client was denied due to her history of aggression and SIR prompting discharge from Hallmark
Liberty Point Behavioral Health (BOYS ONLY) *Medicaid Level C*	**N/A**	**N/A**	N/A	Facility is for Males only
Newport News Behavioral Health *Medicaid Level C*	**11/25/20**	**11/25/20**	Denied 12/4/20	Client was denied to codefendant being on unit and inability to keep residents separate
North Springs Behavioral Health *Medicaid Level C*	**11/24/20**	**11/24/20**	No response	North Springs was contacted on 4 separate dates and times and there was no response from the Admissions Department

Prior to considering non-contracted providers located outside of Virginia, the following out of state providers that accept Virginia Medicaid were considered.

Tier 3: Child Specific (Require CPMT approval of a Child Specific Contract) Out of State—Virginia Medicaid Participants and Non-Medicaid Participants				
Provider Name	**Telephone Contact**	**Application Submitted**	**Accepted/ Denied**	**Admission Reason for denial or why determined inappropriate**
Devereux Foundation	11/24/20	N/A	Denied 11/24/20	Client denied due to history of AWOL
New Hope Treatment Center Carolinas Medicaid Level C	11/24/20	11/24/20	Denied 11/25/20	Client denied due to AWOL, criminal activity and history of aggression
UHS Foundations Pennsylvania	11/12/20	11/12/20	Denied 11/23/20	Client denied due to criminal behaviors and history of aggression

FISCAL IMPACT:

Daily Rate: $650/bed day x 90 days= $58,500

Total approximate cost for 3 months of services: $58,500

Psychotherapy, physician	$22.43
Psychotherapy, clinician	$23.30
Group Psychotherapy, clinician	$15.51
Family Psychotherapy, clinician	$23.26
Intake Assessment	$0.80
Plan Development	$4.72
Other therapy (art, music, equine, etc)	$116.28
Medical Supplies	$2.36
Nursing Services-24 hour	$84.37
Incidentals-Outings/Personal Items	$13.00
Room & Board	$275.00
Additional Daily Supervision	$38.97
Education	$30.00
Total	**$650.00**

STAFF:
Matt Thompson
Barbara Martinez

Memo to the CPMT
January 29, 2021

CONTRACT ITEM C-1c: Child Specific Contract Request for Springbrook Autism Center

ISSUE: CSB Youth & Family Intensive Services requests approval of a child specific Agreement for Purchase of Services (APOS) for residential placement at Springbrook Autism Behavioral Health in Travelers Rest, SC for Harmony #120637.

RECOMMENDATION: CSA Management Team recommends approval of a child specific APOS for residential placement at Springbrook Autism Behavioral Health in Travelers Rest, SC for Harmony #120637.

PROVIDER:

Springbrook Autism Behavioral Health
One Havenwood Lane, Suite B
Travelers Rest, SC 29690
(864) 834-8013
https://springbrookautismbehavioral.com

MEDICAID ENROLLMENT: Springbrook participates in Virginia Medicaid.

LICENSE: Springbrook is a licensed Psychiatric Residential Treatment Center (pending verification).

INSURANCE STATUS: Springbrook is appropriately insured per Fairfax County standards (pending verification).

PROGRAM DESCRIPTION: Springbrook specializes in the treatment of Autism Spectrum Disorder. They provide Applied Behavioral Analysis (ABA) therapy and have a team of Board-Certified Behavioral Analysts (BCBA's) on staff to oversee their programming. ABA therapy is not only provided on an individual level but is built into every aspect of their program from within the educational setting and OT, to their rewards-based system and group recreational therapy.

All front-line staff are trained by the BCBA's for certification as Registered Behavioral Technicians (RBT's). Additionally, what makes them unique and necessary for this youth is their ability to conduct integrative therapy. Given the youth's additional mental health diagnoses of ADHD, ODD, GAD, and DMDD as well as health related concerns, along with ABA he requires medication management, occupational therapy, and nutritional services. He will also benefit greatly from play therapy as well as animal-assisted therapy, given youth's past trauma history, both of which are also offered by Springbrook. Lastly, the clinical team at Dominion believes that having worked with the youth over the past several months, he benefits greatly from routine

and structure and this is something that Springbrook is able to offer the youth, along with helping to promote his independence. Additionally, the youth struggles with teamwork, social skills, and decision making which is an area of focus within their programming.

Springbrook is located in South Carolina and the youth's mother has indicated that along with youth's immediate family engaging in family therapy, there is extended family that resides in the area that will be available to support the youth if he were to receive treatment there.

OTHER CONTRACTED PROVIDERS CONSIDERED:

The parent along with youth's Dominion Hospital therapist had made referrals to several CSA contracted in-state residential treatment facilities as well as out-of-state facilities however youth was either denied from these facilities or they were determined to be clinically inappropriate. The parent with the support of the hospital therapist and Magellan Care Manager contacted Springbrook, a residential treatment facility in South Carolina, that accepted the youth during an interview conducted on 10/21/2020. The facility considered the youth to be a good fit for their program. Dominion Hospital, the Magellan Care Manager, and the parent considered this facility and their programming to be the best fit for the youth based on his diagnoses and treatment needs, and the parent indicated this is the only acceptable option.

(Continued on next page)

Provider Name	Telephone Contact Date	Application Submitted Date	Accepted/ Denied Admission	Reason for denial or why determined inappropriate
Bridges Hospital (Centra Health Systems) *Medicaid Level C*	**N/A**	**N/A**	**N/A**	Inappropriate as it is an unsecured facility
Childhelp USA, Inc *Medicaid Level C*	**N/A**	**N/A**	**N/A**	Age. Exclusionary criteria.
Fairwinds (Ed Murphy & Assoc.) *Medicaid Level C*	**TBD – Referral made by Dominion Hospital**	**TBD – Referral made by Dominion Hospital**	**Denied**	Denied due to age. Exclusionary criteria.
Grafton School *Medicaid Level C*	**TBD – Referral made by Dominion Hospital**	**TBD – Referral made by Dominion Hospital**	**Denied**	Denied due to past history of seizures, lack of participation in treatment, and weight issues
Hallmark YouthCare Inc. *Medicaid Level C*	**TBD – Referral made by Dominion Hospital**	**TBD – Referral made by Dominion Hospital**	**Denied**	ASD diagnosis. Exclusionary criteria.
Jackson Field Homes *Medicaid Level C*	**10/7/20**	**10/7/20**	**Denied**	Denied due to weight/hip problems. Large campus which requires walking to school and for therapies. Youth requires a smaller environment.
Poplar Springs Hospital *Medicaid Level C Female Only*	**N/A**	**N/A**	**N/A**	Inappropriate. Serves females only.
Timber Ridge School (Leary Educational Foundation)	**1/14/21**	**1/14/21**	**Denied**	ASD diagnosis. Exclusionary criteria.
Medicaid Level C Male Only				
Timber Ridge School (Leary Educational Foundation) *NON-Medicaid Male Only*	**See Above**	**See Above**	**Denied**	ASD diagnosis. Exclusionary criteria.

- **Riverside Behavioral Health Center – DENIED**
  10/12/20 – Significant needs not met by our facility

FISCAL IMPACT:

The youth is Medicaid eligible and Springbrook is an in-network Medicaid PRTF provider. The youth has been approved for a residential level of care through the Medicaid IACCT process. There are additional non-Medicaid funded services that require CSA funding. These include the specialized Autism daily supervision and Occupational Therapy. Since these are non-Medicaid

services, the Magellan Care Manager has indicated that they do not negotiate rates for non-Medicaid services.

Medicaid Services for 4 months:

Service	**Unit Cost**	**Total for 4 months**
Room and Board:	$164/bed day	$20,336 .00
Residential Daily Supervision:	$121.30/bed day	$15,041.20
Residential Supplemental Therapies:	$48.50/bed day	$ 6,014.00
Residential Medical Counseling:	$46/bed day	$ 5,704.00
Residential Case Management:	$13.70 bed day	$ 1,698.80
TOTAL		**$48,794.00**

Non-Medicaid Services for 4 months:

Service	**Unit Cost**	**Total for 4 months**
Specialized Autism Daily Supervision (staffing ratio 3:1)	$56/bed day	$6,944.00
Occupational Therapy	$82.50/hour	$1,650.00 (20 hr. est.)
Speech Therapy	$121.25/hour	$2,425 (20 hr. est.)
Residential Special Education	$245/day	$20,580 (84 school days)
TOTAL		**$31,599.00**

STAFF:
Jessica Jackson
Barbara Martinez

Memo to the CPMT
January 29, 2021

CONTRACT ITEM C-1d: Child Specific Contract Request for Devereux Dual Diagnosis Program

ISSUE: CSB Resource Team requests approval of a child specific Agreement for Purchase of Services (APOS) for residential placement at Devereux Advanced Behavioral Health in Melbourne, FL for Harmony #147673.

RECOMMENDATION: CSA Management Team recommends approval of a child specific APOS for residential placement at Devereux Advanced Behavioral Health in Melbourne, FL for Harmony #147673.

PROVIDER:

Devereux Advanced Behavioral Health
8000 Devereux Drive
Melbourne, FL 32941
(321) 775-4975
www.devereux.org

MEDICAID ENROLLMENT: Devereux participates in Virginia Medicaid.

LICENSE: Devereux Viera Campus is a Florida licensed Psychiatric Residential Treatment Center.

INSURANCE STATUS: Devereux is appropriately insured per Fairfax County standards.

PROGRAM DESCRIPTION:

Devereux is a treatment facility with locked and unlocked housing units that specializes in working with youth that display a deficit in adaptive and social functioning. The program uses evidence-based interventions in school, the community and in the housing units. This youth would receive occupational and speech therapy. One of the goals is to increase personal independence in all settings. The youth also will have an opportunity to transition to their Specialized Therapeutic Group Home (STGH).

OTHER CONTRACTED PROVIDERS CONSIDERED:

All clinically appropriate providers currently under open contract were considered and none were available or appropriate based on the youth's diagnosis and situation.

Provider Name	Telephone	Packet Sent	Reason for denial or why determined inappropriate	Accepted/ Denied Admission
CHILD HELP	☒ Yes	☒ Yes	level of aggression, safety for him and others	11/9/2020
DISCOVERY SCHOOL FOR BOYS	☒ Yes	☒ Yes	level of aggression and ASD	11/10/2020
FAIRWINDS	☒ Yes	☒ Yes	Age restriction youth 5 to 12 yrs old	11/23/2020
GRAFTON	☒ Yes	☒ Yes	Deemed not appropriate for milieu	11/27/2020
HALLMARK	☒ Yes	☒ Yes	Diagnosis of ASD disqualifies	11/27/2020
JACKSON-FIELD	☒ Yes	☒ Yes	Diagnosis of ASD disqualifies	12/11/2020
POPULAR SPRINGS	☒ Yes	☒ Yes	Level of aggression, safety	12/7/2020
RIVERSIDE	☒ Yes	☒ Yes	Level of aggression, safety	12/15/2020
SOUTHSTONE BH	☒ Yes	☒ Yes	Deemed not appropriate for milieu	11/24/2020
TIMBER RIDGE	☒ Yes	☒ Yes	Diagnosis of ASD disqualifies	11/9/2020
UMFS	☒ Yes	☒ Yes	level of aggression, safety	11/20/2020
YOUTH FOR TOMMOROW	☒ Yes	☒ Yes	Diagnosis of ASD disqualifies	11/27/2020
DEVEREUX, MASS	☒ Yes	☒ Yes	Deemed not appropriate for milieu	11/4/2020
NEW HOPE	☒ Yes	☒ Yes	Diagnosis of ADS disqualifies	12/7/2020
KIDS PEACE	☒ Yes	☒ Yes	Due to acuity, requires higher level of supervision which program cannot provide.	12/31/2020
KEMPSVILLE CENTER	☒ Yes	☒ Yes	Diagnosis of ASD disqualifies	12/22/2020
BARRY ROBINSON	☒ Yes	☒ Yes	Military families only	11/6/2020
HARBOR POINT	☒ Yes	☒ Yes	safety for milieu and self	11/16/2020
DEVEREUX, FL	☒ Yes	☒ Yes	ACCEPTED (ON WAITING LIST)	1/11/2021

FISCAL IMPACT:

Services for 6 months:

Service	Unit Cost	Total for 6 months
Room and Board:	$298.45/bed day	$53,721.00
Therapeutic Behavioral Supports:	$190.81/bed day	$34,345.80
Residential Daily Supervision:	$27.00/bed day	$ 4,860.00
Residential Special Education:	$155.12/day	$18,614.40 (120 days)
TOTAL		**$111,541.20**

STAFF:
Jessica Jackson
Barbara Martinez

MEMO TO THE CPMT
January 29, 2021

Information Item I-1: December Budget Report & Status Update, Program Year 2021

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 2021 cumulative expenditures through December 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 December 2020 for FY21 equal $11.74M for 751 youths. This amount is a decrease from December last year of approximately $2.9M, or 19.89%. Pooled expenditures through December 2019 for FY20 equal $14.65 M for 860 youths.

	Program Year 2020	Program Year 2021	Change Amt	Change %
Residential Treatment & Education	$1,862,293	$1,602,998	($259,295)	-13.92%
Private Day Special Education	$7,480,122	$6,346,211	($1,133,911)	-15.16%
Non-Residential Foster Home/Other	$3,424,235	$2,408,044	($1,016,191)	-29.68%
Community Services	$1,778,968	$1,405,422	($373,546)	-21.00%
Non-Mandated Services (All)	$419,130	$427,841	$8,711	2.08%
Recoveries	($314,157)	($454,469)	($140,313)	44.66%
Total Expenditures	**$14,650,592**	**$11,736,047**	**($2,914,545)**	**-19.89%**
Residential Treatment & Education	68	68	0	0.00%
Private Day Special Education	274	229	(45)	-16.42%
Non-Residential Foster Home/Other	292	224	(68)	-23.29%
Community Services	512	432	(80)	-15.63%
Non-Mandated Services (All)	103	137	34	33.01%
Unique Count All Categories	**1,249**	**1,090**	**(159)**	**-12.73%**
Unduplicated Youth Count	**860**	**751**	**(109)**	**-12.67%**

Note: The number of youths served is unduplicated within individual categories, but not across categories. Number of youths served is indicative to number of youths who have service invoices paid for by DFS and reported to OCS. Actual youths served may be higher upon receipt of outstanding invoices.

RECOMMENDATION:
For CPMT members to accept the December Program Year 2021 budget report as submitted.

ATTACHMENT:
Budget Chart

STAFF:
Terri Byers, Timothy Elcesser, Xu Han and Usman Saeed (DFS)

NOTE:

There is an overall decrease across all service types with 109 fewer youths served as compare to the same period of last year. Average cost of total expenditure has also decreased by 8%

Residential Treatment & Education decreased by $259k with same number of youths served. Actual RTC open enrollment FY21 is about 2/3 of that in FY20.

There is also a decrease in Private Day Special Education by $1.13M with 45 fewer youths served. This is due to that payment had been withheld to DC and MD providers due to issue of rates above 2% cap. Number will start to pick up when the payment starts.

Non-Residential Foster Home/Other has decreased by $1M with 68 fewer youths served then in same period last year. Average cost per youth is decreased by 8%

Community Services decreased by $373k, Non-Mandated Services expenses have increased by only $8k with 34 more youths served.

Program Year 2021 Year To Date CSA Expenditures and Youth Served (through December 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%	$473,190	28			$473,190
		Group Home	57.64%	$109,618	6			$109,618
		Education - for Residential Medicaid Placements	46.11%	$33,672	4	$477,102	12	$510,774
		Education for Residential Non-Medicaid Placements	46.11%	$29,549	3	$458,023	9	$487,572
		Temp Care Facility and Services	57.64%	$21,844	6			$21,844
	Residential Total			$667,873	47	$935,125	21	$1,602,998
	Non Residential	Special Education Private Day	46.11%	$90,807	4	$6,255,404	225	$6,346,211
		Wrap-Around for Students with Disab	46.11%	$19,172	10			$19,172
		Treatment Foster Home	46.11%	$1,531,340	95			$1,531,340
		Foster Care Mtce	46.11%	$584,364	96			$584,364
		Independent Living Stipend	46.11%	$51,677	12			$51,677
		Community Based Service	23.06%	$1,070,864	343			$1,070,864
		ICC	23.06%	$334,558	89			$334,558
		Independent Living Arrangement	46.11%	$221,490	11			$221,490
	Non Residential Total			$3,904,273	660	$6,255,404	225	$10,159,677
Mandated Total				**$4,572,147**	**707**	**$7,190,528**	**246**	**$11,762,675**
Non-Mandated	**Residential**	Residential Treatment Facility	57.64%	$7,989	2			$7,989
	Residential Total			$7,989	2			$7,989
	Non Residential	Special Education Private Day	46.11%	$5,160	1			$5,160
		Community Based Service	23.06%	$359,579	117			$359,579
		ICC	23.06%	$55,114	17			$55,114
	Non Residential Total			$419,852	135			$419,852
Non-Mandated Total				**$427,841**	**$137**		**0**	**$427,841**
Grand Total (with Duplicated Youth Count)				**$4,999,988**	**844**	**$7,190,528**	**246**	**$12,190,516**

Recoveries	**-$454,469**
Total Net of Recoveries	**$11,736,047**
Unduplicated child count	751

Key Indicators

Cost Per Child	Prog Yr 2020 YTD	Prog Yr 2021 YTD
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$17,036	$15,627
Average Cost Per Child Mandated Residential (unduplicated)	$31,038	$29,145
Average Cost Per Child Mandated Non- Residential (unduplicated)	$16,178	$15,535
Average Cost Mandated Community Based Services Per Child (unduplicated)	$3,230	$3,122
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$26,102	$16,900
Average Cost for Treatment Foster Home	$20,127	$16,119
Average Education Cost for Residential Medicaid Placement (Residential)	$26,620	$31,923
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$48,075	$40,631
Average Special Education Cost for Private Day (Non-Residential)	$27,300	$27,713
Average Cost for Non-Mandated Placement	$4,069	$3,123

Program Year 2021 Year To Date CSA Expenditures and Youth Served (through December Payment)

Category	Program Year 2021 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2021 Allocation	$663,010	$18,221	97%
Non Mandated Program Year 2021	$1,630,458	$394,876	76%
Program Year 2021 Total Allocation	$38,657,566	$11,736,047	70%

MEMO TO THE CPMT

January 29, 2021

Information Item I- 2: Update on CSA-related Legislation

ISSUE: For the CPMT to have information about CSA-related bills under consideration by the General Assembly.

BACKGROUND: The General Assembly is currently reviewing bills with impact to CSA. Most of the bills attempt to address the increase in special education expenditures by changing eligibility requirements to permit CSA funding for services and supports offered in a public school setting. Currently, CSA funding can only be used for private special education services and/or services offered in the home and community. Bills written broadly to expand CSA for public school services cause concern about cost. For example, FCPS has more than 28,000 youth with special education eligibility and only 300 students funded by CSA. If expansions to eligibility were to pass, the increases in the target population could result in significant expenditure increases.

Bills that focus on supporting students in transitioning back to public schools during a 12-month period or that propose a pilot study in up to eight localities are more conservative by offering some parameters for these changes.

Finally, it does appear that the General Assembly will be asked to approve a workgroup to develop implementation plans for moving special education funding to VDOE out of CSA. Some individuals caution about making changes to CSA eligibility during a short session when redesign/reorganization is likely.

ATTACHMENT: Summary of CSA-related Bills

STAFF:
Janet Bessmer, CSA

Attachment: CSA-related Bills 2021 General Assembly

SB 1313 Children's Services Act; funds expended special education programs Mason (companion HB2117)

Children's Services Act; special education programs. Requires that funds expended for special education services under the Children's Services Act only be expended on educational programs that are licensed by the Department of Education. The bill adds children and youth previously placed in approved private school educational programs for at least six months, who will receive transitional services in a public school setting for no longer than 12 months, to the target population for eligibility for the state pool of funds. The bill requires the Secretary of Education, in conjunction with the Office of Children's Services and the Department of Education, to establish a work group (the Work Group) with appropriate stakeholders to develop a detailed plan to direct the transfer of Children's Services Act funds currently reserved for children requiring an educational placement in a private special education day school or residential facility to the Department of Education and to develop a standardized reporting process, template, and reporting requirement for private special education day school tuition rates to ensure that tuition rates can be accurately compared across schools and over time. The bill requires that the Work Group submit its plan and recommendations to the Chairmen of the House Committee on Appropriations and Senate Committee on Finance and Appropriations by November 1, 2021.

SB 1133 Children's Services Act; eligibility for state pool of funds, pilot program Suetterlein

Children's Services Act; eligibility for state pool of funds; pilot program related to educational placement transition for certain students with disabilities. Expands eligibility for use of the state pool of funds under the Children's Services Act to services that are provided in a public school setting and requires that private day schools be approved and licensed by the Department of Education or an equivalent out-of-state licensing agency to be eligible for the state pool of funds. The bill requires the Department of Education and relevant local school boards to develop and implement a pilot program for up to four years in two to eight local school divisions in the Commonwealth. In developing the pilot, the Department is required to partner with the appropriate school board employees in each such local school division to (i) identify the resources, services, and supports required by each student who resides in each such local school division and who is educated in a private school setting pursuant to his Individualized Education Program; (ii) study the feasibility of transitioning each such student from his private school setting to an appropriate public school setting in the local school division and providing the identified resources, services, and supports in such public school setting; and (iii) recommend a process for redirecting federal, state, and local funds, including funds provided pursuant to the Children's Services Act, provided for the education of each such student to the local school division for the purpose of providing the identified resources, services, and supports in the appropriate public school setting. The bill requires the Department of Education to make a report to the Governor, the Senate Committees on Education and Health and Finance and Appropriations, and the House Committees on Education and Appropriations on the findings of each pilot program after two and four years.

MEMO TO THE CPMT

January 29, 2021

Information Item 1- 3: High Fidelity Wraparound Overview and Fidelity Monitoring Report

ISSUE: A brief overview of High Fidelity Wraparound and review of the fidelity monitoring report for FY18 through FY20

BACKGROUND:
High Fidelity Wraparound is a structured, team-based process that uses an evidence-based, nationally recognized model that partners with families to use their voice and strengths to develop a family-driven plan that promotes self-advocacy. The High Fidelity Wraparound model follows a structured series of four phases (Engagement and Team Preparation, Planning, Implementation, Transition) with associated activities and hallmarks. Currently, the CSA contracts with two providers for Wraparound, UMFS and Wraparound Fairfax.

To monitor the providers' adherence to the High Fidelity Wraparound model, CSA staff used established assessment tools created by the Wraparound Research and Evaluation Team (WERT) from the University of Washington. Two tools were used:

- The Wraparound Fidelity Index- Short Version (WFI-EZ) is a brief, self-administered survey that measures adherence to the Wraparound principles. This survey allows families the opportunity to share their thoughts on how the Wraparound process is helping their youth and family achieve their goals.
- The Document Assessment and Review Tool (DART) assesses adherence to standards of high-quality Wraparound as noted in youth/family documentation (such as intake and assessment documentation, team meeting notes, plans of care, crisis plans, and other records).

The results of the fidelity monitoring activities done by CSA staff for fiscal years 18 though 20 are in the attached report.

While the number of low responses from the WFI-EZ doesn't allow us to make generalizations about the program, the DART results show that there was improvement in four of the seven areas measured including g Crisis response; Safety planning; Total fidelity; Meeting attendance; and Timely engagement.

Upon review of the achieved results, the following recommendations were suggested:

- Improve the WFI-EZ survey process;
- Improve record documentation;
- Use DART results to inform the adherence to the High Fidelity Wraparound model; and
- Improve the use of natural and community supports.

Fidelity Monitoring activities have been transitioned to the Virginia Wraparound Implementation Center (VWIC). It is suggested that the Wraparound providers consider the above recommendations as they partner with VWIC to establish future fidelity monitoring efforts.

ATTACHMENTS:
Brief Overview of High Fidelity Wraparound
Wraparound Fidelity Monitoring Report, Intensive Care Coordination, FY2018 – FY2020

STAFF:
Patricia E. Arriaza, CSA
Jessica Grimes, UMFS
Doug Healey, Wraparound Fairfax

High Fidelity Wraparound

Presented by:

What is High Fidelity Wraparound?

- An evidenced-based planning process designed to meet a family's needs and vision
- Four Goals of High Fidelity Wraparound (VaSOC)
  1. Meet stated needs prioritized by youth and family
  2. Improve family's ability to manage own services/supports
  3. Develop/Strengthen family's natural support system
  4. Integrate work of services and supports into 1 plan

How does Wraparound work?

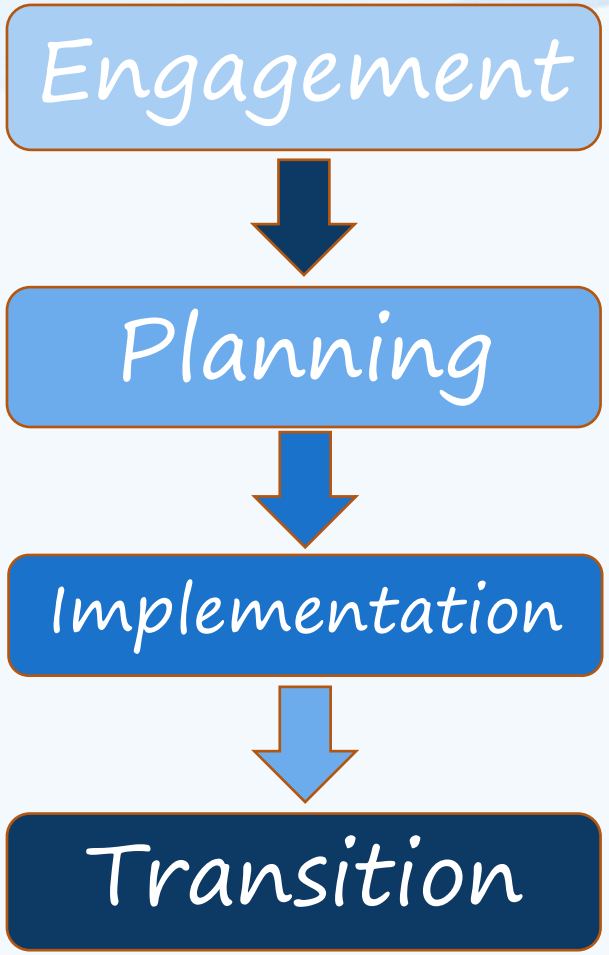
- A facilitator trained in the HFW model is assigned to the family
- The HFW facilitator, with the family's input, develops the HFW team (natural supports, system partners, service providers)
- The HFW facilitator moves the team through the 4 phases of Wraparound, staying focused on the family's needs and vision

The Wraparound Team

- The Youth and Family Team (YFT) includes family members, natural supports, system partners and providers
- Meets monthly to create/adjust the plan of care
- Develops short-term, measurable goals for the team and family
- Models problem-solving techniques, prioritizing needs, short-term goals, task assignments and accountability

Ten Principles of Wraparound

- Family Voice and Choice
- Team Based
- Natural Supports
- Collaboration
- Community Based
- Culturally Competent
- Individualized
- Strengths Based
- Persistance
- Outcome Based



Phases of Wrap

What is required of families?

- Monthly meetings
- Home visits (more in the beginning)
- Input in developing the plan of care, using natural supports and existing functional strengths
- Willingness to try new ways of doing things
- Completion of tasks
- Willingness to eventually lead the YFTs

Roles in Wraparound

- HFW Facilitator
- Case Manager
- Family Support Partners

How can services for families be funded?

- Medicaid
- Private insurance
- CSA
  - Flex funds

CSA is always funder of last resort

Wraparound Fidelity Monitoring Report

INTENSIVE CARE COORDINATION, FY2018 – FY2020

Contents

Background

This report covers the FY2018 to FY2020 fidelity monitoring activities for the Intensive Care Coordination (ICC) services funded through the Children's Services Act. Two ICC programs (Wraparound Fairfax and UMFS) provide services to youth and families using the High Fidelity Wraparound (HFW) model. The Wraparound Fidelity Assessment System (WFAS) tools used to assess fidelity to the HFW model were developed by the Wraparound Evaluation & Research Team at the Department of Psychiatry & Behavioral Sciences, UW School of Medicine.

The Wraparound Fidelity Index-Short Form (WFI-EZ) survey was used to assess family satisfaction, while the Document Assessment and Review Tool (DART) was used to review individual case files to assess adherence to the HFW model. The assessment activities were undertaken by Children's Services Act (CSA) staff and a graduate management intern funded through a grant by the Substance Abuse and Mental Health Services Administration (SAMHSA), with collaboration from both ICC programs.

High Fidelity Wraparound

High Fidelity Wraparound is a team-based, collaborative planning process for developing and implementing individualized care plans for children with behavioral health challenges and their families. It is an evidence-based process driven by 10 principles, grounded in a strengths perspective, and driven by underlying needs.

High Fidelity Wraparound has four goals:

- To meet the stated needs (not services) prioritized by the youth and family;
- To improve the youth/family's ability and confidence to manage their own services and supports;
- To develop or strengthen the youth/family's natural support system over time; and
- To integrate the work of all child serving systems and natural supports into one streamlined plan.

Ten Principles of Wraparound

1. Family voice and choice
2. Team based
3. Natural supports
4. Collaboration
5. Community-based
6. Culturally competent
7. Individualized
8. Strengths based
9. Persistence
10. Outcome based

ICC Stakeholders Committee

The ICC Stakeholders Committee, chaired by staff from the Fairfax-Falls Church Children's Services Act Program, and made up of representatives from the two ICC/HFW providers, Fairfax County Public Schools, Community Services Board, Department of Family Services, Juvenile & Domestic Relations District Court, and one homebased provider in the community, serves in an advisory capacity for the implementation of High Fidelity Wraparound in the community. The ICC Stakeholders Committee meets on a quarterly basis and provided input into the development of the WFI-EZ survey protocol, helping to brainstorm solutions to low response rates outlined in the WFI-EZ section of this report.

Wraparound Fidelity Index Short Form (WFI-EZ)

The Wraparound Fidelity Index Short Form (WFI-EZ) is administered twice a year and measures fidelity information on adherence to wraparound principles and practices. Each cycle the caregiver and facilitator for each eligible youth and family team were invited to complete the survey. Families were considered eligible to be surveyed if they had actively participated in at least three months of wraparound and were still open at the time of the survey period. This report combines data from four cycles, from FY2018 to FY2020 (1 cycle in FY2018, 2 in FY2019 and 1 in FY2020).

Survey Protocol

A local survey protocol was developed based on the Virginia Department of Behavioral Health & Developmental Services' (DBHDS) Wraparound Fidelity Index (Short Form) Survey Protocol. Based on the number of families served by the two Intensive Care Coordination/Wraparound providers in the Fairfax-Falls Church community, a random sampling method would be used to determine the families that would be invited to complete the survey. This method was used for the first three cycles. Due to the low response rates throughout the first three survey cycles, the ICC Stakeholder Committee determined that starting with FY2020 Cycle 1, all eligible families would be invited to participate in the survey. The individual survey cycles are detailed below.

Number of potential families to survey	Number who should be approached to take the WFI-EZ
15 or less	Survey all families
16-50	Randomly select 15 families to be surveyed from this group.
51 or more families	Randomly select 30% of families in from this number to be invited to take the survey

FY2018

For the FY18 survey cycle, 16 families were invited to complete the WFI-EZ online. A personalized link was emailed to each of the eligible families; follow up emails and calls were done to encourage families to complete the WFI-EZ. The survey window for this first cycle was open for two months, allowing time to send the initial invitation, send follow-up emails and do follow up phone calls to families. In the follow up phone calls families were offered the opportunity to complete the survey via the phone. For the FY2018 survey cycle, four responses were received.

FY2019, CYCLES 1 & 2

For the FY2019 cycles, the ICC Stakeholders Committee determined that families should be given an opportunity to complete the survey via a paper form, at the beginning or end of a Youth and Family Team Meeting. Families would be provided with an envelope in which they could place the completed survey, to ensure confidentiality. The sealed WFI-EZ forms were submitted to CSA, where the Graduate Management Intern entered the responses into WrapTrack, WERT's online data entry and reporting system for the Wraparound Fidelity Assessment System (WFAS) tools.

Cycle 1

In FY2019 Cycle 1, youth and families who received services between the months of July 2018 to December 2018 and had been actively engaged in wraparound for at least three months were eligible to be surveyed – 55 families matched the eligibility criteria; 19 (35%) of the families were randomly selected to be surveyed. The survey window ran from May 5th to June 21, 2019. Eleven responses were received.

Cycle 2

In FY2019 Cycle 2, youth and families who received services between the months of January 2019 to June 2019 and had been actively engaged in wraparound for at least three months were eligible to be surveyed – 31 families matched the eligibility criteria; 15 of the families were randomly selected to be surveyed. The survey window ran from October 1 to November 12, 2019. Eight responses were received.

FY2020, CYCLE 1

To address the low response rates from families, the ICC Stakeholders Committee decided that starting with the FY2020 survey cycles, all eligible families would be given the opportunity to respond to the survey during the beginning or end of a Youth and Family Team meeting that fell within the designated survey window.

In FY2020 Cycle 1, youth and families who received services between the months of July 2019 to December 2019 and had been actively engaged in wraparound for at least three months were eligible to be surveyed – 35 families matched the eligibility criteria; all were to be given the opportunity to respond to the survey. The survey window ran from February 15 to March 30, 2020. Fifteen responses were received.

The sealed WFI-EZ forms were submitted to CSA, where the Graduate Management Intern entered the responses into WrapTrack, WERT's online data entry and reporting system for the Wraparound Fidelity Assessment System (WFAS) tools.

WFI-EZ Survey Process Limitations

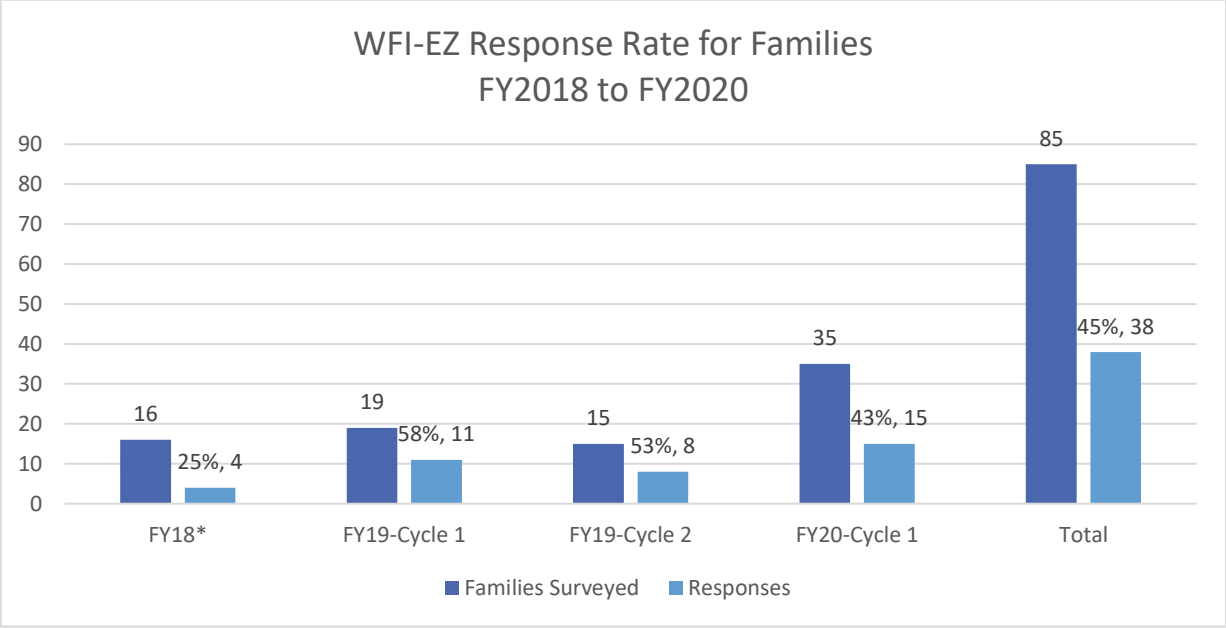
For the FY2018 cycle families were emailed a link to access the WFI-EZ survey online. When follow-up was done via the telephone, one family declined to participate. For the ensuing cycles, staring with FY2019 Cycle 1, families were to be given the WFI-EZ survey in paper format at the beginning or end of a Youth and Family Team during the survey window.

It is unclear how many families decided to not participate in the survey and how many did not receive the survey due to teams running out of time during the Youth and Family Team meetings or the need to take meetings virtual during the FY2020 cycle due to the COVID-19 pandemic. Follow up calls to families were done by CSA staff after the survey windows had closed. Staff reported not being able to leave messages due to voicemail boxes being full, phone calls not answered, and phone numbers being disconnected. Families may be hesitant to answer unknown numbers or return calls from a person with whom they are not familiar. Follow up calls did not significantly increase the number of surveys completed.

Better response rates may be achieved by surveying families throughout the year rather than in two distinct timeframes. Staff resources would need to be considered in making changes to the survey protocol that require greater involvement from CSA staff.

Response Rates

The DBHDS protocol calls for a survey response rate of 75-80% to ensure that the locality has enough results to get an accurate reflection of the quality of High Fidelity Wraparound.



*Survey activities began in the Spring of 2018 therefore only one survey cycle was completed in FY2018.

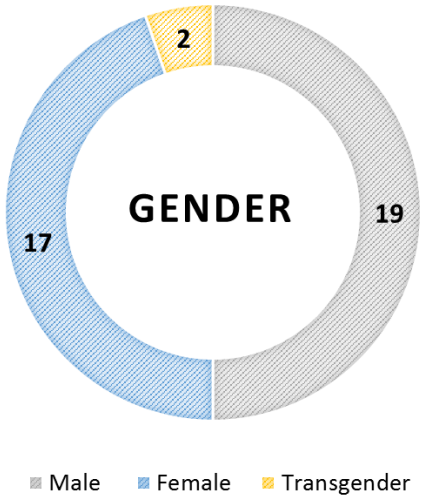
WFI-EZ Survey Results

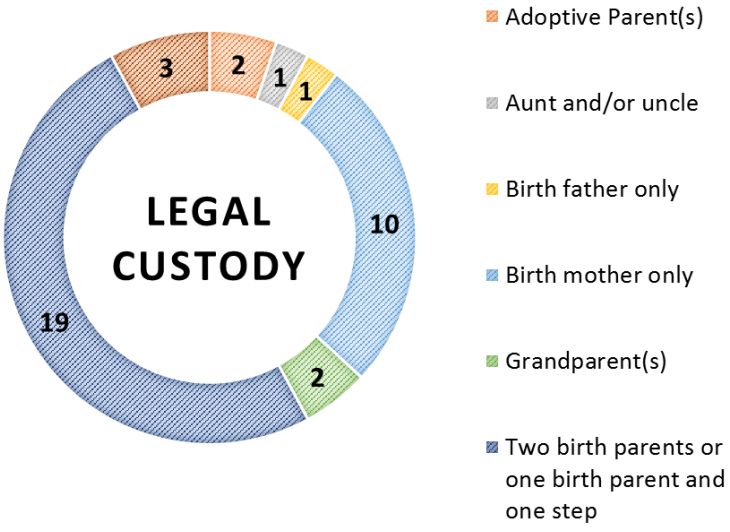
Across the four survey cycles, a total of 85 families were eligible to complete the WFI-EZ survey, with 38 families (45%) responding. While responses from the wraparound facilitators were also gathered, the data shared in pages 6- 8 focuses on the responses from families.

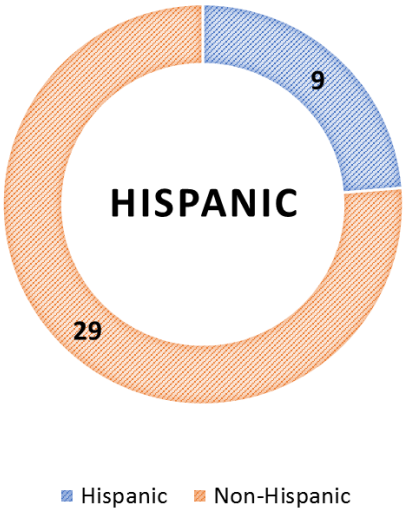
While the low response rate makes it difficult to draw generalizations as to the programs' fidelity to the High Fidelity Wraparound model, the information found in the Strengths and Weaknesses tables on page 8 may be helpful in the development of future Continuous Quality Improvement activities.

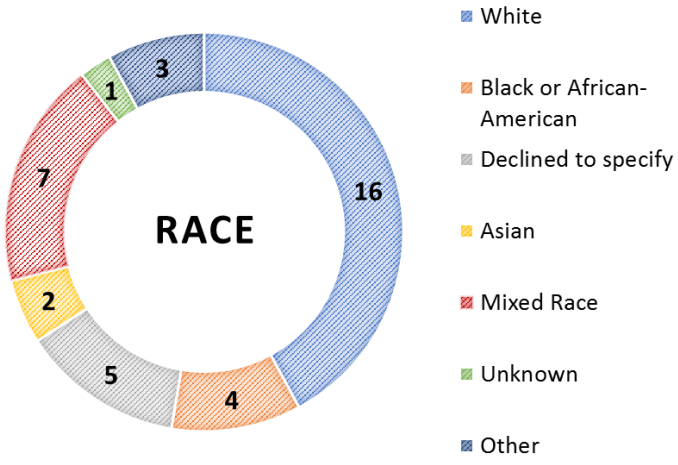
Youth Characteristics

Note: Based on overall responses = 38 families









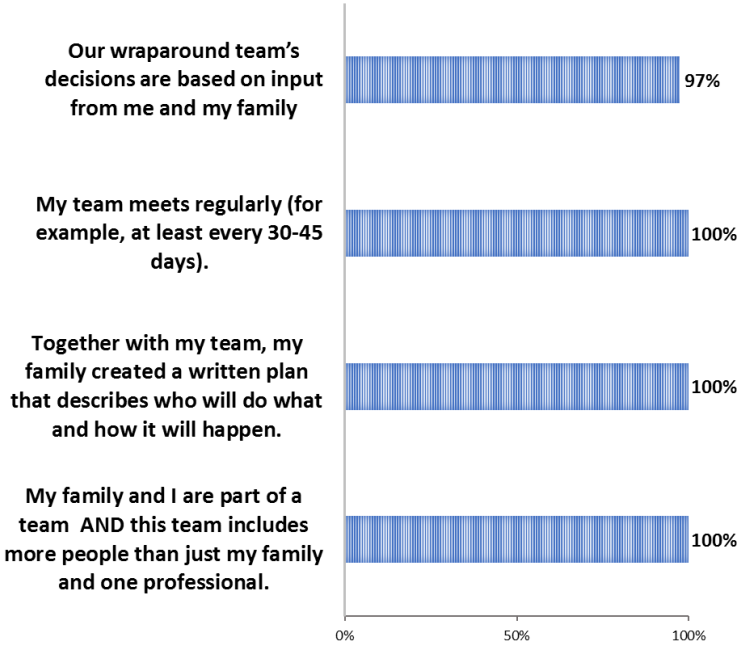
WFI-EZ Results

Sample size: **85**

Response Rate (38/85): **45%**

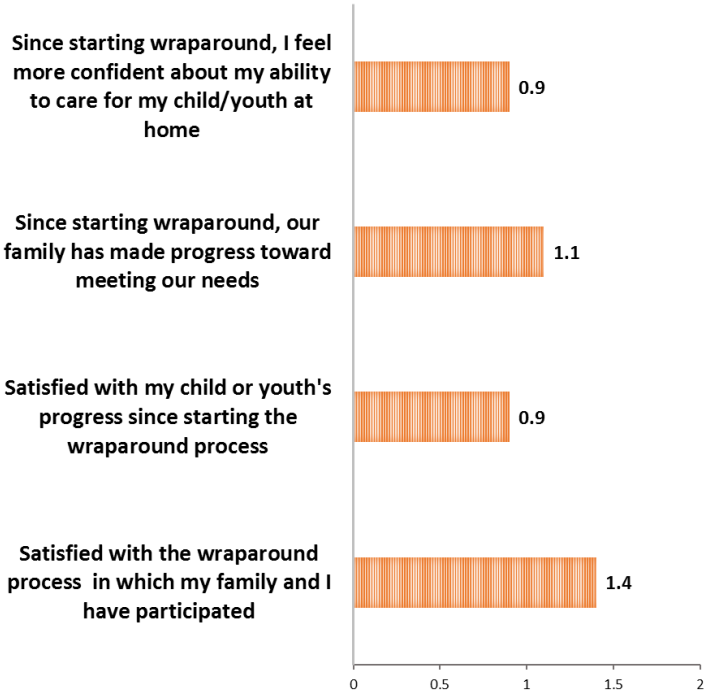
BASIC INFORMATION

Percent of families who said YES



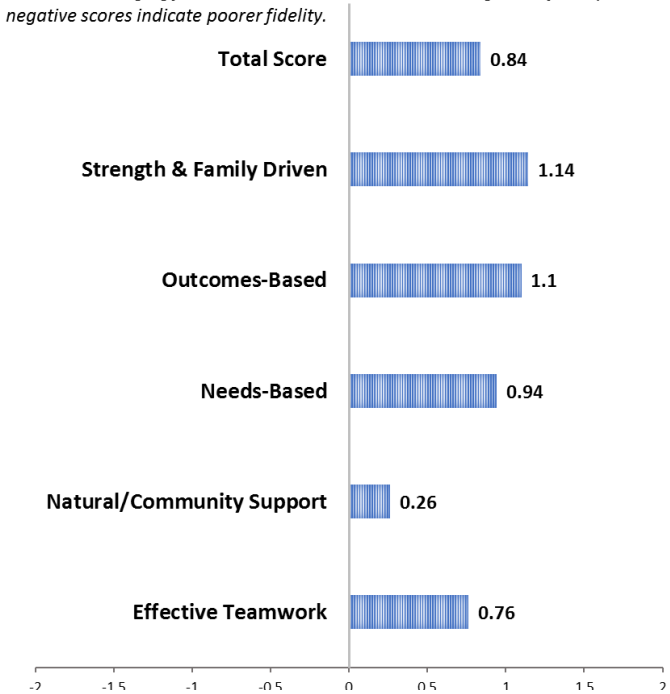
SATISFACTION

Mean score ranging from 0-2, higher scores indicate greater satisfaction.



WRAPAROUND EXPERIENCES

Mean score ranging from -2 to +2. Positive scores indicate greater fidelity and negative scores indicate poorer fidelity.



A NOTE ABOUT THE RELIABILITY OF THE WFI-EZ DATA

With only a 45% response rate, this WFI-EZ data is not a true representative sample of the population served by the ICC/Wraparound providers. To be able to make generalizations about a served population, the WERT researchers suggest at least a 75% response rate[1]. Despite the low response rate, the data may be useful in developing future Continuous Quality Improvement tasks.

[1] Making the Most of Your Wraparound Fidelity Data: How to Interpret WFI-EZ Results and Put Them to Use
Eric J. Bruns, PhD & Spencer Hensley, University of Washington
Wraparound Evaluation & Research Team (WERT)

Areas of Strengths and Improvement

Scores range from-2 to +2, improvements and strengths are recommended by Wraptrack by comparing scores to the national mean.

STRENGTHS	SCORE	NAT'L. MEAN
There are people providing services to my child and family who are not involved in my wraparound team.	**-0.06**	**-0.28**
Our wraparound plan includes strategies that address the needs of other family members, in addition to my child.	**1.24**	**1.12**
At every team meeting, my wraparound team reviews progress that has been made toward meeting our needs.	**1.54**	**1.33**
At each team meeting, our wraparound team celebrates at least one success or positive event.	**1.57**	**1.17**
With help from our wraparound team, we have been able to get community support and services that meet our needs.	**1.16**	**1.04**
National mean scores were established in March 2016.		

AREAS OF IMPROVEMENT	SCORE	NAT'L. MEAN
My family and I had a major role in choosing the people on our wraparound team.	**0.7**	**1.11**
My wraparound team came up with creative ideas for our plan that were different from anything that had been tried before.	**0.92**	**1.13**
Being involved in wraparound has increased the support my child and family get from friends and family.	**0.68**	**0.91**
Our wraparound team does not include any friends, neighbors, or extended family members.	**-0.94**	**0.12**
Our wraparound team includes people who are not paid to be there (e.g., friends, family, faith).	**-0.33**	**0.47**
Our wraparound plan includes strategies that do not involve professional services (things our family can do ourselves or with help from friends, family, and community).	**0.43**	**0.55**
I am confident that our wraparound team can find services or strategies to keep my child in the community over the long term.	**1.11**	**1.19**
At each team meeting, my family and I give feedback on how well the wraparound process is working for us.	**1**	**1.15**
I worry that the wraparound process will end before our needs have been met.	**-0.47**	**0**
Participating in wraparound has given me confidence that I can manage future problems.	**0.86**	**1.04**
National mean scores were established in March 2016.		

Document Assessment and Review Tool (DART)

Reviewing family care records is a rich source of information about how Wraparound services are being implemented. The Document Assessment and Review Tool (DART) assesses critical elements in documentation that match fidelity standards as defined by the National Wraparound Initiative. It consists of 50 items, 31 of which are scores on a scale of 0 – 2, with 0 being no evidence of the item, and 2 being clear evidence of the item being present in the record; 18 of which are scored either 'Yes', 'No', or for some items, 'N/A' or 'Miss'. DART ratings are translated into a total fidelity score.

DART Review Protocol

The DART is used annually to review case files using the providers' paper or electronic records. Reviewers were required to be trained in the use of the DART and be familiar with the DART manual prior to conducting any reviews; the DART training and manual were developed by the Wraparound Evaluation and Research Team (WERT). The results from FY2018 and FY2019 are included in this report. Records were randomly selected from youth and families that had received ICC/Wraparound services in the corresponding fiscal year. A list of the records to be reviewed was given to each ICC/Wraparound provider prior to the review period. A DART form was used for each record reviewed to capture information in the case file. Scores from the paper forms were then transferred to the Scoring Spreadsheet developed by researchers from WERT.

DART Review Limitations

Completing a single DART review can take 1-2 hours depending on the length of ICC/Wraparound services per youth. For each DART cycle done for this reporting period, reviewers scored one file together to ensure that there was agreement in the methodology. WERT recommends that for each round of DARTS two reviewers score a certain number of the same files to ensure interrater reliability. For the number of files reviewed for this report, that would mean scoring 30% (7 files) of the records. This would pose a strain on CSA staff, for whom fidelity monitoring is only a portion of their overall job responsibilities.

Additionally, because the DART focuses on the content found in the case record, variations in record keeping across facilitators and programs can impact the results. The DART scores may be helpful to program managers as they consider how to train facilitators in documenting their wraparound efforts.

So, what DART score indicates "High Fidelity?"

100%

(but no site is realistically going to receive this score)

Fairfax County Results PowerPoint prepared by WERT staff, 2018

Annual DART Review Results

FY2018

For this review, twenty-two records were selected: twelve from Wraparound Fairfax and ten from UMFS. Case records were deemed eligible for review if the youth and family had received ICC/Wraparound services between July 1, 2017 through June 30, 2018 and at least two Youth and Family Team meetings had been held. Paper records were used to conduct these file reviews.

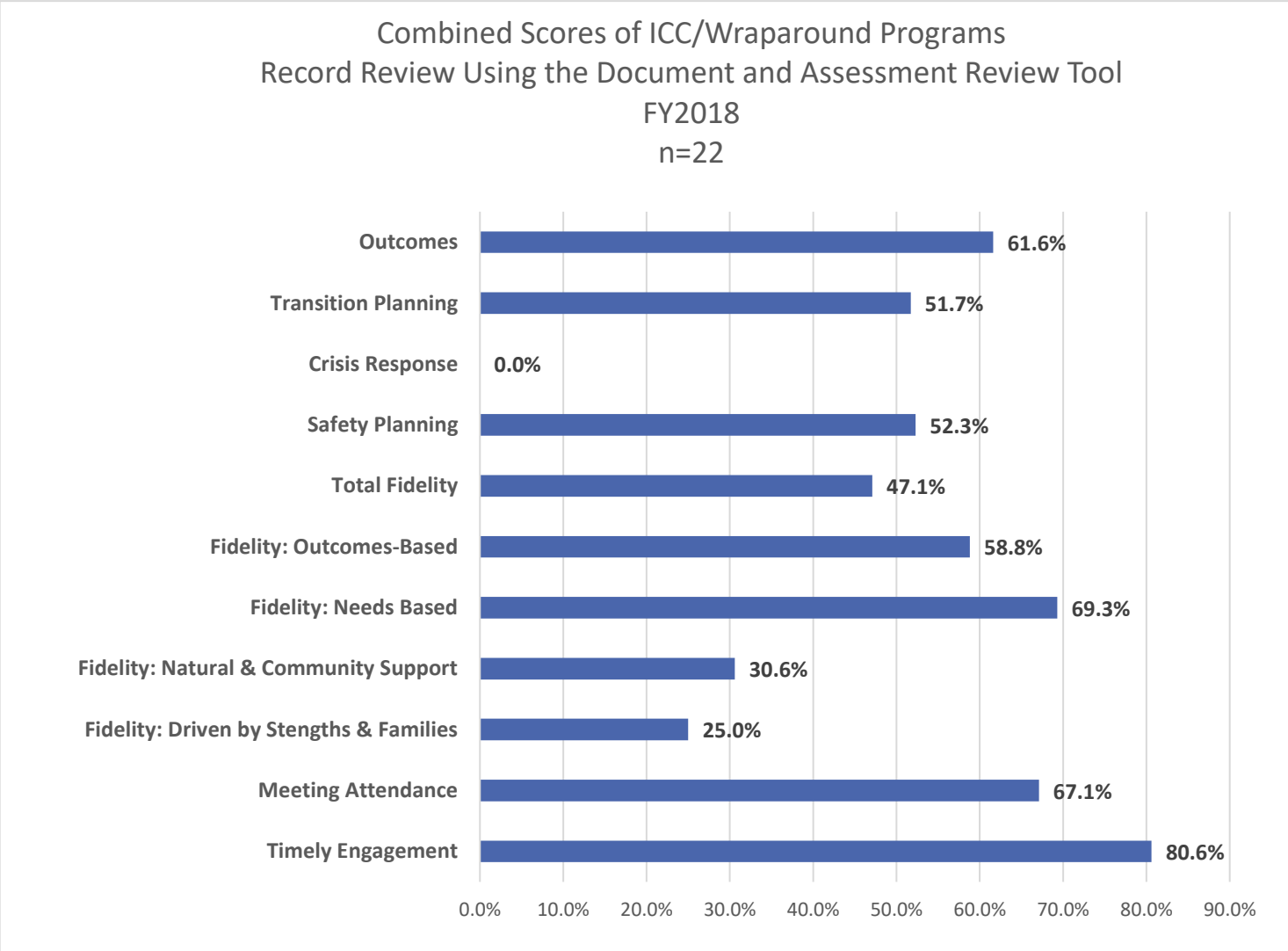


Figure 1 – FY2018 Combined DART

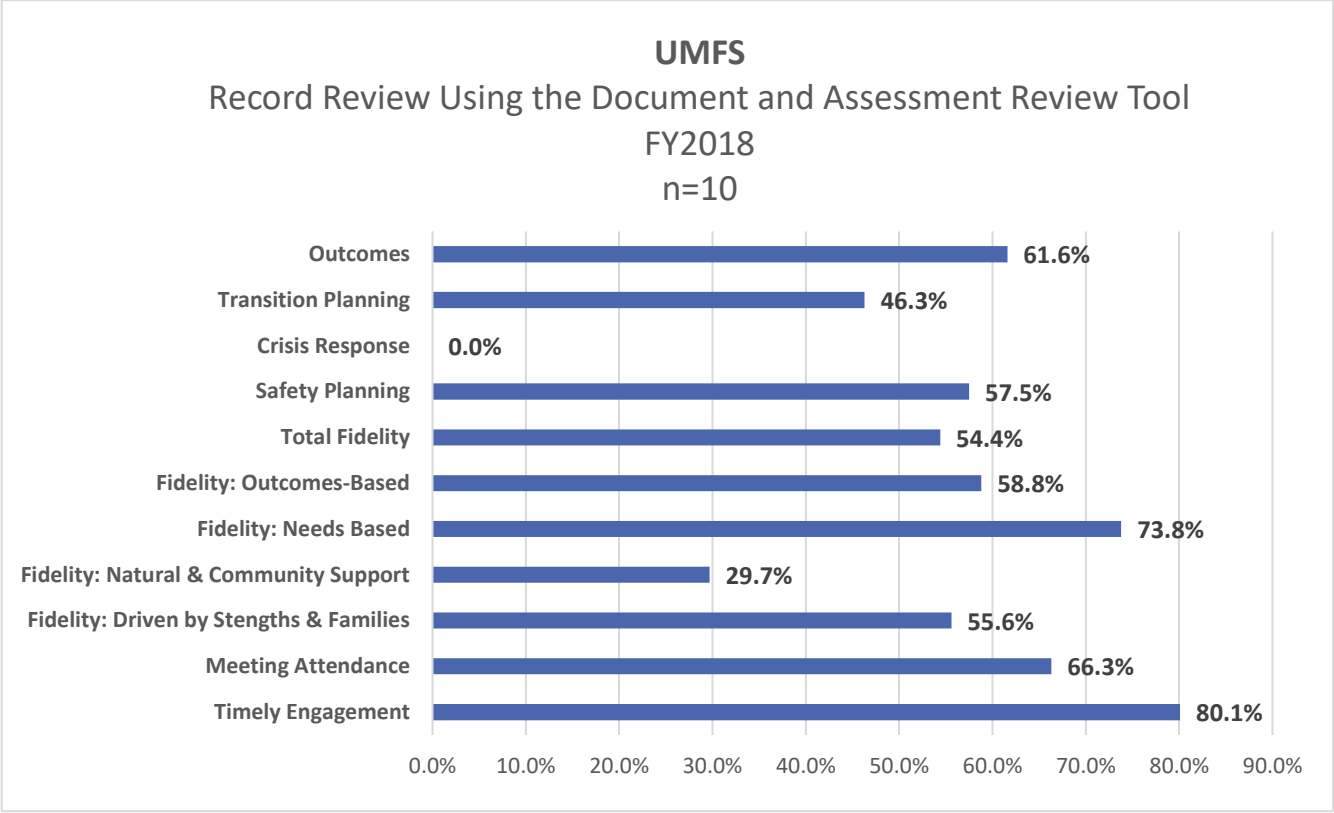


Figure 3 – FY2018 UMFS DART

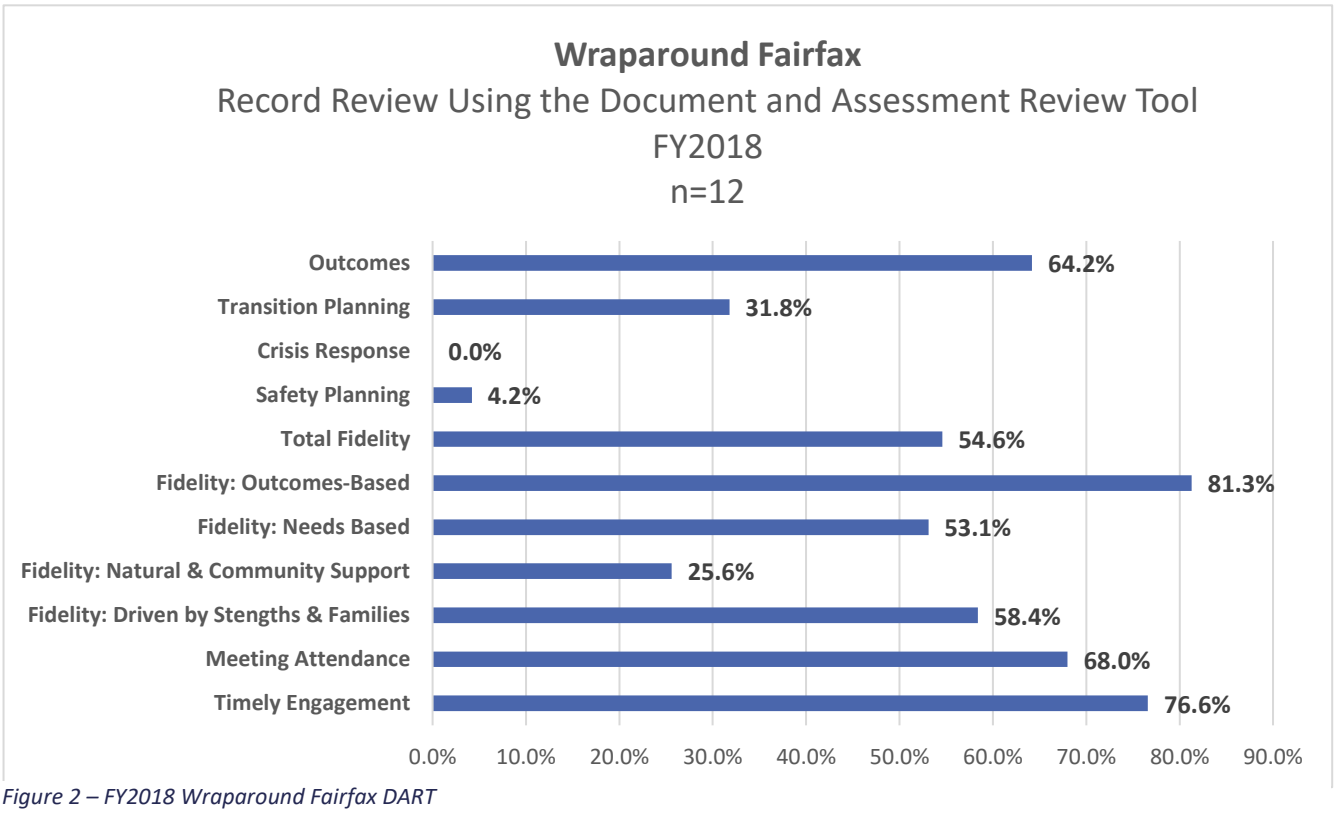


Figure 2 – FY2018 Wraparound Fairfax DART

FY2019

For this review, twenty-four records were selected: twelve from each Intensive Care Coordination/Wraparound provider. Case records were deemed eligible for review if the youth and family had received ICC/Wraparound services between July 1, 2018 through June 30, 2019 and at least two Youth and Family Team meetings had been held. Reviewers were given access to the providers' electronic records.

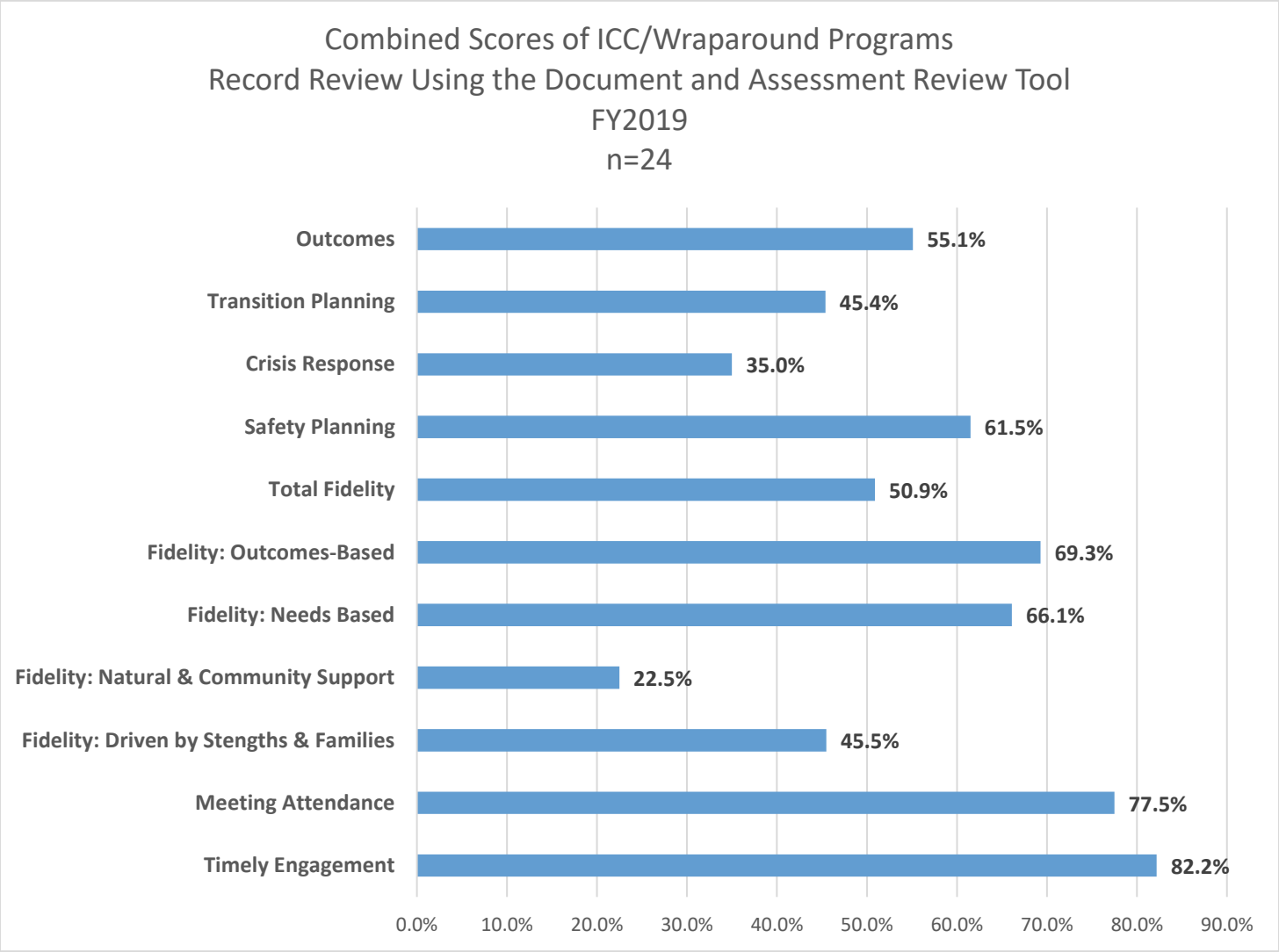


Figure 4 – FY2019 Combined DART

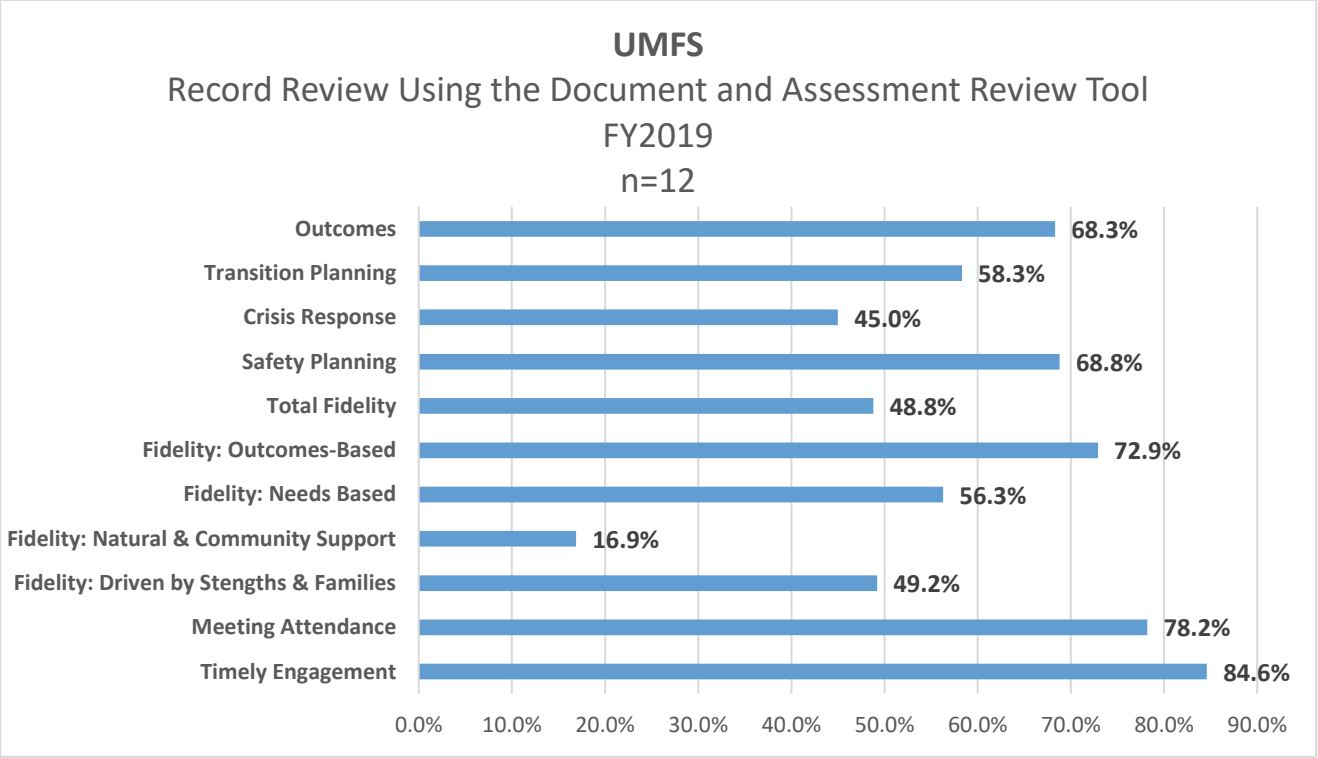


Figure 5 – FY2019 UMFS DART

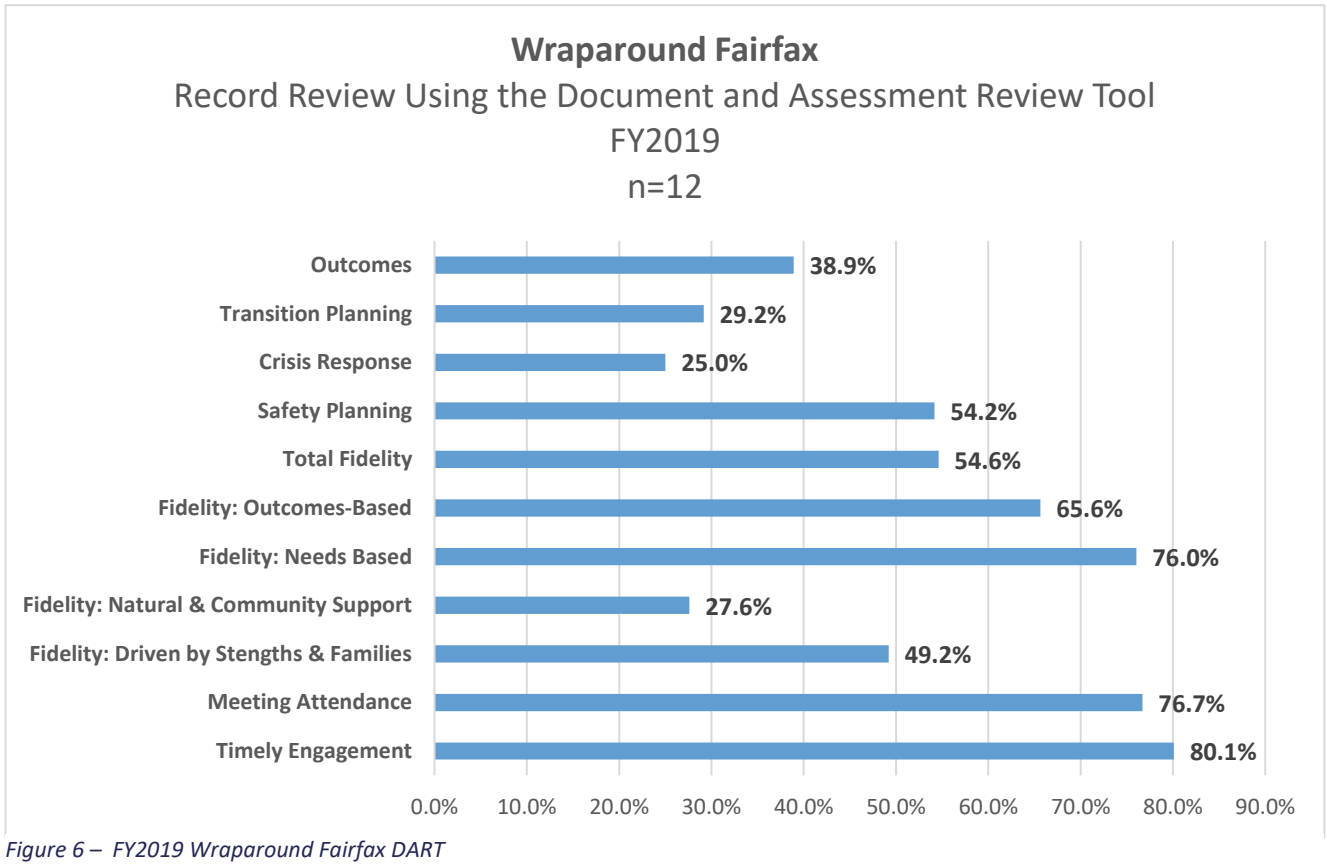


Figure 6 – FY2019 Wraparound Fairfax DART

Improve the WFI-EZ Survey Process

As noted above in the report, the low response rate to the WFI-EZ will continue to pose a problem in trying to understand the ICC/Wraparound programs' fidelity to the Wraparound model. Providing the survey to all eligible families was a first attempt at solving that problem. An additional step may be to provide the surveys throughout the year instead of just twice a year. Youth and Family Teams should be made aware of the survey process early in the start of ICC/Wraparound services to build buy-in and support. Making time at a Youth and Family Team meeting to complete the survey could be built into the process, normalizing the experience. Participating in the survey is, of course, a voluntary process; however, as noted in the report, it is unclear how many families elected to not participate versus how many did not receive the survey at all. Better tracking is needed by both the ICC/Wraparound programs and the staff managing the survey process.

Improve Record Documentation

The DART examines evidence of the adherence to key elements of the Wraparound process and practice expected to be captured in routine documentation. Because the DART focuses on the content found in the case record, variations in record keeping across facilitators and programs can impact the results. The DART review results may be helpful to program managers as they consider how to train facilitators in documenting their wraparound efforts.

Use DART Results to Improve Adherence to the High Fidelity Wraparound Model

Reviewing the individual key elements in the areas of "Transition Planning", "Crisis Response" and "Driven by Strengths and Families" may help the ICC/Wraparound programs develop a plan for program improvement. The individual key elements can drill down into the specific areas where tasks and activities in the Wraparound phases are not being completed, e.g., holding graduation celebrations, completing the post-Wraparound crisis management plan, and updating list of strengths for the youth, team and family on a quarterly basis, etc.

Identify and Engage Natural and Community Supports

Although the WFI-EZ data presented in this report is not generalizable to the population served, one area in the responses received coincides with a low score in the DART reviews – low engagement of community and natural supports. This would indicate that this is indeed an area that could be focused on in future trainings and coaching. Continuing efforts like the recent three-part training series by John VanDerBerg and The Open Table on how to grow natural supports would be beneficial. Coaching efforts could focus on how to talk to families about their support networks and helping the Youth and Family Team understand how to continuously try to engage natural supports.

MEMO TO THE CPMT

January 29, 2021

Information Item 1- 4: Healthy Minds Fairfax Blueprint Quarterly Report July 2020 – December 2020

ISSUE: CPMT review of the quarterly progress report on implementation of strategies in the Children's Behavioral Health System of Care Blueprint

BACKGROUND:
When CPMT approved the Children Behavioral Health Blueprint in March 2016 it directed that staff provide quarterly progress reports. The full quarterly progress report for July 2020 through December 2020 is attached.

Accomplishments during the quarter:

- Healthy Minds Fairfax Short-Term Behavioral Health Services (STBH) is available to children and youth who attend any of the 44 designated Fairfax County Public Schools and all middle school and high school Comprehensive Services Sites. During this 3rd quarter of FY 2021, STBH services are being expanded to include the middle and high school that is part of Falls Church City Public Schools.
- A Children's Mental Health Flyer was developed to be distributed to the community to help parents identify and respond to a possible mental health concern.
- The HMF partnership with NAMI for the provision of Family Peer Support Partner services has been transitioned to PRS.
- The HMF partnership with Formed Families Forward for the provision of the Respite to Recharge program that was a response to the COVID-19 crisis has been extended into the 3rd quarter of FY 2021.

ATTACHMENT:
Quarterly Report on Blueprint Strategies, July 2020 – December 2020
Does My Child Have A Mental Health Concern flyer?

STAFF:
Jim Gillespie, Healthy Minds Fairfax Director
Janet Bessmer, CSA Manager
Peter Steinberg, Children's Behavioral Health Collaborative Manager
Jesse Ellis, NCS Prevention Manager

GOAL 1: Deepen the Community "System of Care" Approach
Coordinator: Jim Gillespie

Governance Structure:

A. *Establish a Children's Behavioral Health System of Care oversight committee as the locus of SOC management and accountability.* Accomplished through designating CPMT as the oversight committee.

B. *Establish cross-system behavioral health system of care practice standards, policies and procedures.* Revised system of care principles and practice standards have been approved by the CPMT. In December 2017 CPMT approved revisions to local policies and procedures, based on the revised practice standards, and these have been incorporated in the SOC training curriculum.

Generate support for the SOC approach among the general public and policy makers and administrators at the state and local levels. Results Based Accountability (RBA) measures were developed for the BHSOC Blueprint, approved by CPMT in September 2017 and quarterly reports have been presented to since February 2018. In 2017 the system of care initiative was re-named Healthy Minds Fairfax (HMF).

C. *Continue to develop partnerships with community organizations and agencies in different sectors for coordination, financing and support of the SOC approach.*
HMF is partnering with the Northern Virginia Family Network, a network of more than 10 regional family- and children-focused nonprofit organizations.

Financing Strategies:

D. *Coordinate county budgeting, including but not limited to Diversion First, to maximize the possibility of high priority children's behavioral health needs being funded.* To complete these strategies a matrix of youth services has been developed and fiscal mapping conducted. This strategy has now been folded into a fiscal mapping strategy for children's services. It was presented to SCYPT in April 2019 and also to DMB leadership in June. Both groups received the fiscal map and its process quite well and gave approval to proceed with fine-tuning the data.

Service Quality and Access:

E. *Develop/facilitate trainings and outreach materials that increase awareness and knowledge of systems of care values and creates better informed consumers, providers and county and school system staff. Develop/facilitate trainings and outreach materials that increase awareness and knowledge of systems of care values and creates better informed consumers, providers and county and school system staff.* A master calendar for children's behavioral health trainings and events and a children's behavioral health resources page were added to the Healthy Minds Fairfax public website in August of 2018. In the first two quarters of FY21, the training events calendar and the community resources website pages received the following visits:

Number of visits/page views for training events calendar website page:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19
15/16	24/28	N/A	N/A	39/44	124/162	89/119

Number of visits/page views for community resources website page:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19
92/119	81/115	N/A	N/A	173/234	265/347	166/272

Due to COVID-19, trainings continued to be held using a virtual platform. In the 1st and 2nd Quarters of FY21, 12 trainings were held with a combined total of 864 participants. Trainings for case managers included Introduction to System of Care, introductions to several Evidence-Based Treatments such as Multisystemic Therapy, Functional Family Therapy and Parent Child Interaction. Case managers, Wraparound facilitators and family support partners were also provided a three-part training series to help them identify and work with natural supports for families. An introduction to EBTs was also held for families. The EBT trainings were recorded and are available online as resources for staff and families.

Number of Staff, providers & families trained on community resources, insurance access, evidence-based/informed practices, & High-Fidelity Wraparound:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY 18
732	58	N/A	N/A		304	206	0

F. *Collect and regularly report on community outcomes and assess gaps in the array of services and supports necessary for the success of the SOC in preventing and treating behavioral health issues.* An inter-agency workgroup issued a Population Level Data Report on Youth Behavioral Health Needs in the Fairfax-Falls Church Community in February 2020. Presentation to the CPMT was delayed due to COVID and will be done when in-person meetings resume. The annual Office of Children's Services Gaps and Needs Survey was suspended this year in response to COVID. The SOC Training Committee has promoted the implementation of an array of evidence-based interventions that are now available in our community such as MST, FFT, PCIT and TFCBT.

G. *Review intake, assessment, triage, referral protocols across all levels of care, and lead case management assignments with the goal of supporting families in accessing both public and community provided resources.* In FY 20 HMF funding expanded the regional mobile stabilization and response service by 15%. A significant increase in DBHDS funding support has resulted in eight more crisis counselors being hired and eliminated the need for county funding in FY 21.

GOAL 2: Data Systems

Coordinator: Jim Gillespie

A. *Increase cross-system data sharing.* The HS IT Advisory Committee is consulted on various topics such as Document Management, the "Front Door," and the Services taxonomy to ensure that recommendations meet CSA needs. CSA is presently implementing OpenText document management and is working with DFS Finance about how records might be integrated. In addition, CSA has participated in the DFS process to define requirements for replacing or upgrading our management information system which has cross-agency case management functionality.

B. *Use cross-system data to improve decision-making and resource use*. The FY20 Data Analytics Fellowship Academy (DAFA) evaluated CSA data on the effectiveness of Foster Care Prevention Services as provided across our system of care service agencies. The results were presented to the CPMT. In addition, the George Mason Psychology Department has provided free consultation on the statistical analyses of CSA data to include client demographics, service utilization and CANS ratings. It is planned for these results to be shared with the CSA Management Team and CPMT in the future.

GOAL 3: Family and Youth Involvement

Coordinator: Jim Gillespie

A. *Increase the presence and effectiveness of family leadership through a sustained family-run network*
The Northern Virginia Family Network, a network of more than 10 regional family- and children-focused nonprofit organizations meets quarterly to collaboratively address its mission of 'elevating the voices of families to improve outcomes for children, youth and young adults across systems of care'. In May 2020 the Network became a member of the newly formed HMF Family Advisory Board.

B. *Increase family and youth involvement in system planning and implementation.*
In February 2202 the CPMT parent representatives, FAPT parent representatives and representatives from NAMI-NOVA, the Autism Society of Northern Virginia and the Northern Virginia Family Network met to plan the establishment of a HMF Family Advisory Board (FAB). In May 2020 CPMT endorsed the establishment of the FAB as the family advisory board for CSA and Healthy Minds Fairfax, and in July the FAB established an FY 21 monthly meeting schedule.

C. *Include youth and family participation in the evaluation of publicly and privately provided services, with prompt action for improvement when necessary.* In FY21 Q2, the CSA Monitoring and QA Plan was shared with providers and the Family Advisory Board for comments; it was presented to the CPMT at the December, 2020 meeting. Implementation of the Monitoring and QA plan are underway, with CSA staff reviewing and tracking SIRs and monthly progress reports, as well as ensuring that CSA funds are not being used to purchase Medicaid eligible services without the required documentation. In FY21 Q3, a survey company, Crossroads, Inc., will be on board to survey family satisfaction on provider services; the company will survey a pool of families on a monthly basis. This is a change from the previous survey process that was done on an annual basis. The change in the survey protocol will hopefully lead to a higher response rate. Concerns from families will also be able to be dealt with on a more timely basis as the Crossroads will forward any family concerns that need to be addressed on a monthly basis. CSA staff will provide the data necessary for Crossroads to fulfill the established Scope of Work. A report of the survey efforts will be complied after the 4th Quarter of FY21.

D. *Expand evidence-based peer to peer groups, family/community networks*. See Goal 5, Strategy B.

GOAL 4: Increase Awareness and Reduce Stigma

Coordinator: Jesse Ellis

A. *Implement "gatekeeper trainings" to increase layperson understanding of mental illness, recognition of signs and symptoms of mental illness or emotional crisis, and support of others in*

accessing help, using a cultural competency lens. Gatekeeper trainings continue to be provided in a number of ways through Mental Health First Aid, and the Kognito suite of online trainings (including a peer training for teens), and Signs of Suicide. Eleven Kognito modules are now available, including early childhood, military families, postvention, and trauma-informed schools modules. HMF funding has helped expand the implementation of Signs of Suicide to cover all FCPS middle and high schools. The Eric Monday Foundation is finalizing a web-based training specifically for youth sports coaches; FCPS and multiple youth sports organizations have committed to implementing the training with their coaches. The CSB is now offering Mental Health First Aid and QPR suicide prevention trainings virtually. An overview of gatekeeper trainings available through the county and elsewhere is available online.

B. *Promote youth-led initiatives to combat stigma associated with mental illness, treatment, and accessing help.* The CSB awarded nine mini-grants for youth-led projects to address stigma, funded by the regional suicide prevention grant, for FY20. An RFP for FY21 mini-grants will be released shortly. Twenty-three high schools in Fairfax County are currently implementing Our Minds Matter clubs, developed by Our Minds Matter (formerly the Josh Anderson Foundation), and more are planning to do so.

C. *Increase public awareness of issues surrounding mental illness and behavioral health care.* The public service announcements developed by the Health Department have been running in theaters since June 2016. The contract for television and online placement ended in June 2018, so current data is based only on YouTube views.

While the number of texts received by PRS CrisisLink continues a slowly declining trend, the number of calls to the crisisline is significantly higher through the first quarter of FY21; the majority of calls came in through CrisisLink's local number and were not routed through the national number.

Number of views of PSAs promoting help-seeking behaviors:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
132	174	N/A	N/A	306	270	619	6,597,856	3,298,928

Number of crisis texts/calls:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
381/ 4500	*	N/A	N/A	381/ 4500	1638/8289	1675/7780	1815/5597	1087/4927

*Information is unavailable at this time and will be updated on the next quarterly report**.**

D. *Maintain a speaker's bureau and/or list of approved presenters to school and community groups.* To be completed in CY21.

GOAL 5: Youth and Parent/Family Peer Support

Coordinator: Jim Gillespie

A. *Create a Family Support Partner program.* Through the Virginia Department of Behavioral and Developmental Services, the county was selected as a sub-recipient for a federal SAMHSA grant that funds family support partner services for three years. Since October 2017 NAMI Northern Virginia has been the provider. The SAMHSA grant ends January 2021 and effective February 2021 PRS, Inc. will become the provider through a county contract.

Number of families served by family support partners (unduplicated by FY):

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY 18
38	22	N/A	N/A	45	155	160	55

B. *Expand evidence-based peer to peer groups, family/community networks.*
In February 2019 the CSB launched "Heads Up" and "Talk It Out", resource groups for parents and teens (ages 14-17). The groups are available in weekly concurrent sessions. Teens talk about successful, sustainable recovery and resilience through mental health or substance use challenges. Parents acquire resources and discuss ideas on how to help their teen live their healthiest, fullest lives in the aftermath of trauma or through times of emotional distress. The groups became inactive in April 2020 due to COVID but re-opened virtually later in the quarter.

Number participating in expanded parent/family peer support service programming:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY 18
10 parents, 4 youth	9 parents, 5 youth	N/A	N/A	19 parents, 9 youth	91 parents, 72 youth	22 parents, 20 youth	0

GOAL 6: System Navigation

Coordinator: Tracy Davis

A. *Develop an accurate, accessible and real time database of behavioral health care providers that includes information on if they are accepting new clients, if they accept insurance, and their areas of expertise, with functionality to assist families in understanding behavioral health issues and in navigating the system to access services.* A listing of the REACH training pediatricians has been added to the redesigned Healthy Minds Fairfax website. The listing is maintained and updated on a regular basis and it has just been updated to add the November 2019, June 2020 and November 2020 REACH training participants.

Total Number of Visits for All Visitors to HMF Website:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
4,613	4,442	N/A	N/A	9,055	14,811	8,649	2,848	0

Number of Visits for Returning Visitors:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
2,412	2,247	N/A	N/A	4,659	8,062	5,968	1,994	0

Number of Visits for New Visitors:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
2,201	2,195	N/A	N/A	4,396	6,749	2,681	854	0

FY21 (1st& 2ndQtrs. combined) Top Content Viewed by Number of Visits:

Content	Visits
Children's Services Act Forms and Resources	2,076
Healthy Minds Fairfax Homepage	1,470
Children's Services Act	1,084
COVID-19 Mental Health Resources	468
What is a Family Partnership Meeting or Family Resource Meeting?	328
Evidence-Based Treatments and Interventions	278
Get Help In an Emergency	226
Family Assessment and Planning Team	207
About Healthy Minds Fairfax	201
Children's Services Act Staff Roster	190
Children's Services Act Case Management	185
Children's Behavioral Health Community Resources	173
CSA Training Materials	169
Community Policy and Management Team	148
Family Support Services	142
For Providers	130
Healthy Minds Fairfax Directory of REACH-Trained Pediatricians	129
CSA COVID-19 Information	118
How Do I Pay for Services	117
CSA Symposium	117
Finding Supportive Services	109

B. *Create a clearing house for information on children's behavioral health issues and resources.* Current work on the website includes a feedback survey, a weblink policy and adding additional resources for the mental health screening tool. In addition, COVID-19 Mental Health Resources have been added to the website along with CSA COVID-19 Information.

GOAL 7: Care Coordination and Integration

Coordinator: Jim Gillespie

A. *Provide behavioral health consultation to primary care providers and patients.*
The Virginia Mental Health Access Program (VMAP) has launched, making psychiatric consultation and other resources available to pediatricians all over the state of Virginia. More information can be found at: http://www.virginiapediatrics.org/vmap/ By mid FY 21 the pediatricians will also have the support of a care navigator. Through HMF funding a George Mason University 3 psychology residents are currently placed in a local pediatric primary care office to provide behavioral health services.

B. *Promote resources to implement tiered levels of integration based on capacity and readiness.*
HMF is co-sponsoring a REACH behavioral health training for pediatricians to be held virtually in early June. 111 Fairfax-Falls Church are enrolled in the Virginia Mental Health Access Program, through which they have access to telephonic consultation. Psychiatric consultations for Fairfax pediatricians skyrocketed to 40 in the period October – December 2020. In 2018 an inter-agency workgroup headed by Dr. Gloria Addo-Ayensu developed a community plan to implement integration, including but not limited to consultation, facilitated referral, co-location and full integration, which was endorsed by CPMT in June 2018. The workgroup also developed a project to safely divert youth from hospitalization when appropriate through expansion of CR2 mobile crisis response services.

Number of pediatric primary care psychiatric consults:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY 18
15	40	N/A	N/A	55	64	0	0

C. *Increase the appropriate implementation of behavioral health screenings and referrals in primary care settings.* The workgroup recommended screening tools for use in primary pediatric care, based on the recommendations of the American Academy of Pediatrics and the REACH curriculum.

GOAL 8: Equity/Disparities

Coordinator: Peter Steinberg

A. *Promote the adoption of culturally and Linguistically Appropriate Services (CLAS) Standards among BH providers.* This strategy has been achieved.

B. *Increase access and availability to behavioral health services for underserved populations.*
Healthy Minds Fairfax continues to support the Northern Virginia Family Service Violence Prevention Intervention Program (VPIP). During the first two quarters of this year, the VPIP program has served 32 youth and family members. A 100% of those served were Hispanic and 64% of the youth were male while 36% were female.

Require training in cultural competence and advancing equity in alignment with One Fairfax for County, FCPS, and County-contracted behavioral health service providers. Two online half-day trainings for County-contracted behavioral health service providers are planned in the 3rd Quarter. The annual CSA symposium, which will be a half-day virtual event due to COVID-19, will focus its presentations on equity in behavioral health. The symposium is scheduled for March 10th.

C. *Implement support structures for LGBTQ youth.* The Underserved Populations workgroup as identified this as a priority.

GOAL 9: Reduce Incidence of Youth Suicide in our Community

Coordinator: Jesse Ellis

A. *Identify universal suicide and/or depression screening tool(s) for use by the community.* The team developing guidance and protocols for suicide/depression screening by community organizations has finalized a toolkit for publication; it has been incorporated into the new website.

B. *Develop and publish guidelines for service providers on the availability and effective use of crisis services.* The CSB has published information (including printable fliers) on accessing the Mobile Crisis Unit and on Involuntary Psychiatric Hospitalization of Minors.

C. *Develop a common and coordinated approach to youth suicide postvention.* A resource for community organizations and families on implementing suicide postvention has been published on the redesigned website. An extension of the committee has begun meeting to discuss opportunities for coordinated community postvention outreach and services. A new Kognito module on postvention is now available. The Conner Strong Foundation developed "Help is at Hand," a booklet with guidance and supports for survivors; plans for widespread availability and dissemination are in development.

D. *Continue to make available and promote the suicide prevention hotline, including text line.* The PRS CrisisText Connect program engaged in 1638 text conversations with 1389 unique individuals in FY20. This represents a slight decrease from FY19. However, the number of hotline calls answered continued to significantly increase. In FY20, PRS CrisisLink answered 8289 calls, a 7% increase over FY19, after huge increases in FY18 and FY17. Of these calls, 465 (an 43% increase over FY19) were from youth under 18, and 524 were from individuals 18 to 24. These trends continued through the first quarter of FY21, as PRSCrisisLink engaged in 381 text conversations with 359 unique individuals, and answered 4500 calls.

E. *Train behavioral health providers in evidence-based practices specific to the treatment of youth with suicidal ideation and behavior.* The Core Competency Training that is now offered regularly includes a section that is specific to the treatment of youth with suicide behavior. Training on Family Intervention for Suicide Prevention (FISP) is also regularly provided through the Training Consortium.

GOAL 10: Evidence-Based and Informed Practices

Coordinator: Peter Steinberg

A. *Develop definitions and criteria for evidence-based and evidence-informed practice in prevention and intervention/treatment.*

This strategy has been met.

B. *Establish a set of core competencies based on service type for all public & contracted provider staff.*

This strategy has been met.

C. *Train County, school staff and providers on EBPs, including how and when to use them. Include a review of practices that are harmful.* The Fairfax Evidenced Based Training Consortium, which is overseen by the Evidenced-Based Workgroup in partnership between Fairfax County and George Mason University, delivered a training to CSA case managers on evidenced based practices. Several trainings are planned for the 3rd and 4th quarter of this fiscal year. The consortium will be offering trainings in TF-CBT, Family Intervention for Suicide Prevention (FISP), and a refresher course in the Core Competencies. This refresher course will allow participants to become certified in the Core Competencies.

D. *Incentivize the use of EBPs among providers.* All participants who become certified in the core competencies will be placed on a list of provides that will be housed on the Healthy Minds Fairfax website.

GOAL 11: Trauma Informed Care

Coordinator: Chrissy Cunningham and Jesse Ellis

A. *Ensure there is sufficient clinical capacity to meet the needs for trauma-specific, evidence-based interventions.* In the spring of 2018, the Fairfax Consortium for Evidence-Based Practice trained over 100 clinicians in the Family Intervention for Suicide Prevention (FISP), which is a trauma-informed treatment protocol for suicidal ideation. An additional 50 clinicians will be trained in January 2021.

In November 2018, 45 clinicians were trained in Trauma-Focused Cognitive Behavioral Therapy. The enrollment requirements for that training included a commitment from accepted clinicians to pursue certification. To date, 4 clinicians have completed the certification process, and at least several others are scheduled to take the exam. The consortium team continues to explore strategies to encourage and incentivize clinicians to complete the certification process. In the spring of 2020, an additional 24 clinicians attended TF-CBT training, which was provided virtually. In January 2021, an additional 30 clinicians are scheduled to attend virtual TF-CBT training. All of these clinicians will be encouraged to follow-through with certification once they complete the requirements over the year following their training.

In 2019, 51 clinicians working with children ages 7-12 were trained in MATCH-ADTC- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems. An additional 39 clinicians were trained in MATCH-ADTC using a virtual format this spring.

As evidence-based treatment models become more broadly available in our community, efforts have been made to familiarize staff in case management roles with the different treatment models and with how to connect their clients to providers who can offer them. Increasing demand for these evidence-based treatments from our system and our partners is an important part of incentivizing clinicians to participate in training, to follow-through with certification, and to use treatment practices with proven outcomes.

B. *Train non-clinical staff in community-based organizations, schools, and county agencies to implement trauma-informed practices.* The Fairfax County Trauma-Informed Community

Network has reached over 7000 people with their 90-minute Trauma Awareness 101 Training, which is also available on-demand as a 30-minute webinar. The TICN continues to offer full day sessions of their Trauma-Informed Supervisor Training and has reached over 600 supervisors from county human services agencies, schools, and non-profit partners. Additionally, the TICN offers a full day training on Secondary Traumatic Stress (STS) in the workforce (The Cost of Caring), and a 2 hour Secondary-Traumatic-Stress and Self-Care Basics workshop, both of which have reached 500+ staff from county human services agencies and non-profit partners. A special version of STS training focused on navigating the pandemic has been delivered to almost 200 people to date. Additional trainings and resources are available on the TICN website, and include a mini-grant opportunity to fund small space improvement projects. Space improvement projects were completed this spring at the Health Department, Domestic & Sexual Violence Services, Juvenile & Domestic Relations District Court, Department of Family Services and at the Community Services Board. An additional project is underway at the Department of Housing & Community Development. Funds for small projects at community-based organizations will be made available this year through grant funding from the Family & Children's Trust Fund of Virginia (FACT). Awards for those projects, along with additional projects in county spaces, will be announced in January 2021.

This spring, the TICN added to their list of publications, which previously included a "Guide to Educating Children, Youth and Families about Trauma & Resilience" booklet for staff providing psychoeducation to kids and families. The new resource for professionals is entitled "A Guide to Trauma-Informed Approaches for Service Providers," and is available in both booklet and poster format, and is intended for staff in case management and care coordination roles. These resources have been widely distributed, as have two COVID-19 specific publications entitled, "Trauma-Informed Strategies for Working with Youth and Families During the COVID-19 Pandemic" and "Trauma-Informed Strategies for Working with Youth and Families When Out-of-School Time Centers Reopen and Programs Resume."

Inform the community at large on the prevalence and impacts of trauma. In February of 2019, a team of four TICN members from Fairfax-two from the CSBs Wellness, Health Promotion & Prevention Team, one from the NCS prevention team, and one from FCPS Social Work Services-attended an intensive 2-day course to become Master Trainers in the ACE Interface curriculum, an evidence-based program that the VA Department of Behavioral Health and Developmental Services has a license for, and is rolling out across the state to raise awareness in the community about the impact of Adverse Childhood Experiences, and the science of neurobiology, epigenetics and resilience. With support from DBHDS, the Fairfax Master Trainer Team convened the first ACE Interface presenter cohort in the state in April 2019, where 30 people from county HHS agencies, FCPS, non-profit, and family/parent organizations were trained to deliver the curriculum. ACE Interface Presentations- titled Building Resilient Communities and Understanding Adverse Childhood Experiences- have been delivered to over 1,000 people so far, and are currently available in a virtual format, which have drawn larger audiences than pre-pandemic in-person presentations. Recruitment for a second presenter cohort is currently underway, with training scheduled for late February. Thanks to grant funding from FACT, presenters from community, faith or parent organizations will have access to a stipend each time they complete a presentation. In partnership with DBHDS and other ACE Interface Master Trainer Teams from across the state, plans are currently underway for a PSA related to the messages in the ACE Interface presentation, and for additional coordination of this work at the state a regional levels.

C. *Develop shared screening and referral process for individuals impacted by trauma for school and human services agency staff using nationally recognized screening tool.* One county HHS agency is currently screening clients using a validated trauma screening tool. Juvenile & Domestic Relations District Court began piloting the STRESS (Structured Trauma Related Experiences Symptom Screener) in select work units in 2016 and scaled to agencywide implementation in July 2019. Through technical assistance from the RFK National Resource Center for Juvenile Justice, JDRDC is currently working on refining workflow and referral processes to respond to the results of the screening. Expanding the capacity of the provider community to offer evidence-based treatments for trauma, the work of the training consortium, is a key component of ensuring that all of the necessary resources to effectively respond to trauma screening are in place.

D. *Human service agency leaders will integrate the concepts of trauma-informed care into their organizational culture.* County Health and Human Services agencies continue to implement plans to ensure their organizations are trauma informed. Evidence of lessons learned by agency leadership from across HHS in the Taking the Lead: Training for Leaders in High Stress, Trauma-Exposed Workplaces (training that was sponsored by the TICN in 2016) have been apparent throughout the response to the pandemic, and the TICN has received multiple requests for review of those training materials during this time.

GOAL 12: Behavioral Health Intervention

Coordinator: Peter Steinberg

A. *Develop empirically validated cross system human services and schools screening process available to determine needs, resources, & desirable outcomes.* The Brief Screening for Adolescent Depression (BSAD) is available for families and youth on the Healthy Minds Fairfax Website as well as the website for the Falls Church-Fairfax County Community Services Board. Healthy Minds Fairfax staff continues to work with human services to develop a protocol for screening tools.

Number of BH screenings

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
15	15	N/A	N/A	30	50	89	88	108

B. *Create capacity to address behavioral health needs of children 0-7.* Office for Children staff who support early childhood educators in centers and family childcare homes throughout the county participated in a professional learning series that will use The Pyramid Model Equity Coaching Guide and facilitated discussions on understanding the impact of race and implicit bias. The Pyramid Model for Social Emotional Competence in Infants and Young Children (formerly known as SEFEL – the Social Emotional Foundations for Early Learning) applies coaching and mentoring through an equity lens. The Pyramid Model is a multi-tiered framework of evidence-based teaching practices that promote social and emotional skills of all children, prevent challenging behaviors and provide individualized interventions for children with persistent challenging behavior.

C. *Establish a training consortium in partnership with university and private provider partners (ex: GMU, INOVA) for ongoing training for staff and service providers.* The Fairfax Consortium on

Evidenced Based Practice has entered its fourth year and we are in the early planning stages for the next year. All trainings that recently took place were delivered online. The consortium will be offering 3 trainings in the 3rd and 4th quarter. The trainings are in TF-CBT, Family Intervention for Suicide Prevention, and a refresher course in the Core Competencies.

D. *Expand access to timely and available behavioral health services for school age children and youth with emerging behavioral health issues who have not been able to access such services.* Healthy Minds Fairfax Short-Term Behavioral Health Services (STBH) is available to children and youth who attend any of the 44 designated Fairfax County Public Schools and all middle school and high school Comprehensive Services Sites. During the 3rd quarter, STBH services will expand to include the middle and high school that is part of Falls Church City Public Schools. Children and youth who must wait for services at the Falls Church-Fairfax Community Services Board will be screened for STBH services. As a reminder, this service continues to link income eligible youth and families from select school communities to timely and available short-term mental health counseling (up to 8 sessions), funded by Healthy Minds Fairfax. During this quarter, all services were provided via telehealth.

Number of youth served through Short-Term Behavioral Health Services:

FY21 (1st Qtr)	FY21 (2nd Qtr)	FY21 (3rd Qtr)	FY21 (4th Qtr)	FY21 TOTAL	FY20	FY19	FY18	FY17
20	67	N/A	N/A	87	205	215	126	57

E. *Develop recommendations for the Board of Supervisors Public Safety Committee that reflect Diversion First initiatives needed for youth who come in contact with the criminal justice system.* CSB and JDRDC staff continue to meet to address the behavioral health needs of the court that can be provided by the CSB.

- *Reduce youth substance abuse and use.* Substance Abuse Prevention Services (SAP) are available in all Fairfax County School pyramids including alternative schools. During this school year, 5 youth have been referred to the CSB for SAP services.

GOAL 13: Service Network for High Risk Youth

Coordinator: Janet Bessmer

A. *Increase availability/capacity of provider community to offer trauma assessments and evidence-based trauma treatment; trauma services shall be offered in languages and in locations that are accessible to families.* This goal overlaps with roles of TICN and the Training Consortium. Private providers who offer trauma assessments and treatments are identified in the CSA provider directory. There continues to be a need for providers to offer evidence-based trauma assessments and treatment. TFCBT training was offered by the consortium, supplemented by CSA funding, for 44 clinicians in November 2018 and were offered again in Spring 2020. Additional training dates are set for the Fall, 2020. The Training Consortium is strategizing how to increase the number of clinicians who complete the certification process. Links to listing of certified therapists will be provided.

B. *Identify and implement an evidence-based parenting program designed for parents of adolescents (12+); language capacity and location/accessibility shall meet the needs of families.* Three providers are currently under contract to provide Functional Family Therapy.

C. *Identify and implement an evidence-based parenting program designed for parents of children (<12); language capacity and location/accessibility shall meet the needs of families.* Parent Child Interaction Therapy (PCIT) is currently being offered by one provider in our region.

D. *Monitor utilization of ICC and Case Support and increase capacity/staffing so that youth with identified behavioral health care needs receive appropriate case management services.* UMFS and Wraparound Fairfax are fully staffed. There appears to be adequate capacity at this time.

E. *Improve the utilization of the annual gaps survey of youth and parents in CSA-SOC to identify needed interventions.* The annual state OCS survey was suspended for FY20.

F. *Develop communication plan to share information about the services and care coordination offered through the SOC process with the broader provider community.* CSA produces a bi-monthly newsletter that contains training announcements and other information pertinent for system partners. See social marketing goals for more information about outreach efforts. DFS has been facilitating a quarterly home-based provider meeting to share information about FFPSA implementation. Two information sessions about EBTs were provided to nearly 300 county and school staff during the summer. CSA has also developed a specific page on their public and internal website with information and job aides regarding new services.

G. *Build system capacity to monitor fidelity to EBT models and conduct outcome evaluation for purchased services*. Fidelity monitoring efforts have been moved to the Virginia Wraparound Implementation Center, which is funded through a federal grant. Both Wraparound providers, UMFS and Wraparound Fairfax, have entered into MOUs with VWIC. As VWIC collects data on family satisfaction through the WFI-EZ survey and compliance of the model through file reviews using the DART, data will be entered into an online information system. CSA staff will have access to this data. A report out on the WFI-EZ and DART data collected from FY18 through FY20 was provided to the CSA Management Team and the ICC Stakeholders Workgroup.

H. *Provide IT infrastructure to support data collection for fidelity monitoring and outcome evaluation along with electronic records management.* CSA has implemented an electronic document management system, OpenText, and has been able to work remotely. Serious Incident Reports and other data are tracked and collected electronically.

I. *Explore opportunities for expanding available financial resources to serve youth on diversion or probation who need intensive behavioral health services.* CSA staff continue to collaborate with juvenile court leadership to make the CSA process accessible to probation officers. Training about MST and FFT have been provided to court staff.

J. *Increase family and provider membership on the CPMT.* FAPT parent representative positions have been filled. All vacant CPMT positions were filled as of September 24, 2019. The Family Advisory Board was established.

GOAL 14: **DD/Autism Services**
Coordinator: Tracy Davis

Develop expanded continuum of care of services for youth with DD/autism. The workgroup has refined the direction of the work on this goal. Two main deliverables were identified:

Deliverable #1: Revised SOC Blueprint Goal 14, DD/Autism Services, with updated action steps and dates

Deliverable #2: DD/Autism Services Case Management Recommendations with a Statement of Need

The two deliverables for Goal 14 stated above have been accomplished.

Updates on each blueprint strategy are addressed below:

A. *Conduct needs assessment and service inventory of the existing continuum of services and supports and identify critical service gaps for youth with DD/Autism.* Status: No further action is required on Strategy A. For Action Steps 1- 4: The workgroup had consensus that the urgent need is to serve the 1,000 youth that are on the DD waiver waitlist and that the largest service gap is for case management along with the need for behavioral supports, respite, crisis supports (such as Reach), transportation and attendant care giver support. The workgroup determined that there is no further needs assessment and inventory needed however consolidating the inventory information and possibly reexamining the needs could be addressed with the development of the subsequent blueprint following the completion of the current blueprint.

B. *Utilize results of needs assessment and gap analysis to develop a plan to address critical service gaps.* Status: No further action is required on Strategy B. For Action Steps 1- 5: The workgroup determined that there may be a need for focus groups/discussion with service providers such as Grafton, Jill's House and/or other homebased/ABA providers. Jill's House or Autism Society can bring together families to be sure the plan is addressing their needs. The Welcoming Inclusion Network (WIN) and CSB Supported Employment should be included in all future discussions to address critical gaps. The workgroup determined that these tasks may be completed in conjunction with priority strategy areas D, E, & F and therefore there is no further work required for this strategy. Reassessment of utilizing the results of the needs and service gaps should be addressed with the development of the subsequent blueprint following the completion of the current blueprint.

C. *Develop a system navigation, community awareness & outreach campaign to promote early identification of youth with DD/Autism who would benefit from referral to services.* Status: No further action is required on Strategy C. For Action Steps 1 – 7: The workgroup indicated that current efforts by CSB, FCPS, and family organizations are ongoing. Each organization will assume responsibility going forward for implementing the current efforts. Reexamining the needs and the services with regards to system navigation, community awareness & outreach to promote early identification could be addressed with the development of the subsequent blueprint following the completion of the current blueprint.

D. *Improve transition planning for children with intellectual disabilities or chronic residential needs.*

E. *Ensure access to crisis stabilization services designed for youth with DD/Autism with providers trained to serve this population*

F. *Increase case management and care coordination capacity for children and youth with DD, particularly for younger children.*

Status of Strategy E, F and G: Strategy E, F & G were identified as high priority areas. The objective for the workgroup is to address Blueprint Strategy E, F & G. The DD/Autism services workgroup presented a recommendation to take the CSA process that currently exists to accurately assess children for appropriate supports to prevent crisis and applying it to 347 of the more than 1,300 youth who have open cases with the CSB Developmental Disabilities Services Unit. On November 7, 2019, the recommendations were presented to the CSB DD Support Services leadership team. The CSB will assume responsibility going forward for implementing the recommendations that they determine to be most beneficial. Obtaining additional positions to serve in a case management role appears to be the next area to be addressed.

GOAL 15: Transition Age Youth

Coordinator: Peter Steinberg

Provide coordinated services and supports for youth and young adults of transition age, both those still in school and those who have left school. Reduce the number of youth of transition age who are living with unidentified and untreated serious mental illness who have signs and/or symptoms of a serious mental health condition that emerged before they transition out of youth serving systems/programs.

A. Health Minds Fairfax plans to reward a contract to a private agency to offer case management services to transition age youth.

Does my child have a mental health concern?

Healthy Minds FAIRFAX
Supporting Emotional Wellness in Youth and Families

Have a talk with your child to find out how they are doing. Give them your full attention. Listen carefully, repeat what you heard and ask if you got it right. When they feel heard and understood, they're more likely to share with you.

Notice what is going on with your child. You know your child best.

Here are some things to look for:

- Becoming more irritable, hyperactive, energetic, fidgety, or aggressive.
- Excessive sadness, fears or worries.
- A steep drop in grades, getting into trouble at school or not attending school.
- Loss of appetite, significant weight gain or loss, lack of sleep or too much sleep.
- Withdrawal from activities, family, or friends.
- Alcohol or drug use.
- **Thoughts of suicide or harming themselves or others – Do not be afraid to ask your child if they are having these thoughts.** Your asking will not put those thoughts in their head. Rather, it tells them you care and that you will help keep them safe.

How to get help:

Below are several options for you to speak with a mental health professional. Do not worry about making the wrong choice. Every number leads to someone who can help.

- Contact your child's pediatrician.
- Call your health insurance company or visit their website to search for a behavioral/mental health provider.
- Contact the Fairfax-Falls Church Community Services Board (CSB) at 703-383-8500, weekdays from 9 a.m. to 5 p.m.
- Walk into the CSB's Merrifield Center (8221 Willow Oaks Corporate Drive, Fairfax, VA 22031) weekdays from 9 a.m. to 5 p.m.
- Contact your child's school counselor, school public health nurse, social worker, or psychologist.
- Take a free, confidential online mental health screening (bit.ly/TestYourMood) and practice talking with your child about mental health concerns by taking a free, online Kognito training (kognito.com/fairfax). [Though these courses are designed for educators, parents can use the same skills in talking with their own children.]
- Visit fairfaxcounty.gov/healthymindsfairfax or fairfaxcounty.gov/csb to get mental health information and local resources.

If your child is having a mental health crisis, these services are available 24/7:

Below are several options for you to speak with a mental health professional. Do not worry about making the wrong choice. Every number leads to someone who can help.

- Call the CrisisLink hotline at 703-527-4077, 1-800-273-8255 or text "CONNECT" to 855-11.
- Call Children's Regional Crisis Response (CR2) at 571-364-7390.
- Call CSB Emergency Services at 703-573-5679.
- Bring your child to the CSB's Merrifield Crisis Response Center, 8221 Willow Oaks Corporate Drive, Fairfax, VA 22031.
- **Call 911 if it is a life-threatening emergency. Make sure to notify the operator that it is a psychiatric emergency and ask for an officer trained in crisis intervention or trained to assist people experiencing a psychiatric emergency.**

www.fairfaxcounty.gov/healthymindsfairfax
www.fairfaxcounty.gov/csb

FAIRFAX - FALLS CHURCH
Community Services Board

Dec. 2020

MEMO TO THE CPMT

January 29, 2021

Information Item 1-5: Update on Respite Services for Families Impacted by COVID-19.

ISSUE: Healthy Minds Fairfax staff will provide an update on the Formed Families Forward Respite to Recharge Program. This was a respite program for kinship families who met the referral criteria and was funded by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. CARES Act funding ended on December 30, 2020. This program will continue using local funds and will be opened to all families who meet the admission criteria.

BACKGROUND:
Healthy Minds Fairfax received funds through the CARES Act to sponsor the Formed Families Forward Respite to Recharge Services. This service was open to kinship families whose income was up to 300% of the poverty level and is raising a child(ren) who has a behavioral health need. Kinship families who qualified for the services were eligible to receive up to 10 hours of respite for 8 weeks. Families were able to use their own care provider whose background was checked by Formed Families Forward. Twenty-five families received a total of 1504.25 hours of respite. Due to the low demand from kinship families, families who already received services were given the opportunity to received additional hours of respite. Overall, families were very appreciative of the service.

Beginning in late January 2021, Formed Families Forward will offer free respite to 27 low-income families who reside in Fairfax County or the cities of Fairfax and Fall Church. Families will receive up to 15 hours of respite over a period of 8 weeks. Families must meet the following criteria to qualify for services: family income is 300% or below of the poverty level, the family was directly impacted by COVID-19, and are raising children and youth who have behavioral health needs.

FISCAL IMPACT:
The cost of this is extension of the respite program is $75,000.

ATTACHMENT:
Final Report on Implementation of Respite to Recharge

STAFF:
Peter Steinberg, Program Manager, Children's Behavioral Health Collaborative
Tracy Davis, Management Analyst

Final Report on Implementation of *Respite to Recharge*

To: Healthy Minds Fairfax, Fairfax County

From: Formed Families Forward

Contact: Kelly Henderson, Executive Director, Formed Families Forward, Kelly.Henderson@FormedFamiliesForward.org; 703-539-2904

Submitted: December 29, 2020

Reporting Dates: May 18 to December 30, 2020

Quantitative Update:

	Total for program
Number of background checks for providers	16
Number families (service slots) in the program	25
Number of hours of used	1504.25

Kinship Families

Number of Unique (nonduplicated) Interest Forms Completed by Family Members:

38

Number of Kinship Caregiver Families (by service slot) who Received Services:

25

Race/ethnicity and Kinship Relationship of the Families who Received Services:

(Numbers provided for the 10 Unique Families using the 25 service slots; self-identified descriptors) Race/ethnicity: African American/Black - 7 Caucasian/White - 1 Hispanic/Latino - 2 Caregiver relationship to child/children: Grandparent - 7 Aunt - 3

Respite Providers

Number of Unique (nonduplicated) Applications Completed by Respite Provider Candidates:

31

Number with Completed Background Checks and Paperwork, ready to serve as Respite Providers:

16 (includes those who withdrew from availability after approval)

Narrative:

What worked well?

Kinship families who utilized the program were very satisfied and appreciative of the opportunity for respite. Due to COVID-19, families with their own care providers were more likely to enroll and use the program.

Due to low enrollment, we employed a three-phase approach to service delivery. The ten unique kinship families who were eligible and approved for the program and who followed through to identify a childcare provider of their choosing were initially enrolled in slots for 10 hours of childcare for a period of 8 weeks. Following discussion with Healthy Minds Fairfax leaders, given the low demand by kinship families, we offered previous Respite to Recharge recipients an opportunity to enroll for an additional 8-week slot. Six families took advantage of this. Finally, again following discussion with HMF staff in mid-November, we offered each

enrolled kinship family an opportunity for a slot of up to an additional 20 hours per week from November 21 through December 18. All but one enrolled family used those hours. The additional slots and hours of paid childcare were enthusiastically received and afforded kinship families significant respite during the holiday season. Due to resurging COVID numbers, some families whose children with special needs were attending school in person part time had to return to full time virtual learning, increasing demands on kinship caregivers and making respite even more critical.

Another strength of the program was our ability to be nimble and responsive to the needs of the community. Beth Spivack served as a consistent primary contact for the families for most of the program implementation period; this trustful relationship benefited kinship families who in past have struggled to connect positively with public assistance and supports. We made referrals to HMF website and to other local programs for both the kinship families eligible for the *Respite to Recharge* program as well as families who applied but did not meet the criteria (e.g., birth families; adoptive and foster families raising children with significant mental health needs).

We contracted with a native Spanish speaker who works for FCPS as a special education instructional aide and who is familiar with the sometimes-intensive needs of nontraditional families. She has assisted five candidate families with translating materials, explaining the program and facilitating application and implementation once the families are approved. She also explained that no data on immigration status will be reported by FFF to any agency.

Challenges faced and approaches implemented?

Reaching eligible kinship families was a major challenge in implementing the program as designed. Despite dedicating resources to robust marketing and working with HMF, FCPS, NCS and other County agencies and offices to promote the program, we were not successful in reaching the thousands of kinship care families in our County who have incomes at 300% of poverty and below. Our implementation of a similar program of free childcare to Prince William county families raising children with disabilities was much more successful in reaching eligible families; the active engagement and support of County school division and agency leaders in promoting and making warm referrals was critical to the success of that program.

Based on conversations with ineligible applicants as well as applicants who were eligible, and who started but did not complete the application/enrollment process, we believe several factors account for the underusage of the program.

First, “kinship” and “respite” are generally unfamiliar terms and concepts. When referrals were made by professional partners such as school social workers, parent liaisons, family service workers, and staff at non-profit organizations, they often connected ineligible families, mostly low income/high need birth families. Second, physical health concerns related to COVID limited families’ willingness to work with unfamiliar childcare/respite provider candidates. Families who did participate in the program used extended family, previous childcare providers, or other

known persons. As a result, childcare providers tended to drop off the list because they are not utilized.

Funding Update

Healthy Minds Fairfax funding for the kinship *Respite to Recharge* program was authorized through Purchase Orders 8500435549 ending June 30, 2020, and 8500438007 ending December 31, 2020. Respectively, the scopes of work for these two phases of *Respite to Recharge* targeted delivery of respite services to 15 and 25 families.

FFF has invoiced, received and spent all funds under the first PO 8500435549 for $30,050. Under the second PO (8500438007 for $43,730) we have invoiced and received $14,578 which has been expended to administer, promote and manage the program and pay childcare providers for the most recent of the 25 family slots served to date. Given the inability to serve the fully proposed 40 family slots by end of December 2020, FFF will not invoice for the remaining funds authorized under PO 8500438007.