FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for
AT-RISK CHILDREN, YOUTH & FAMILIES
January 24, 2020
Community Policy and Management Team (CPMT)
GC, Room 232

Agenda

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

1. **MINUTES:** Approve minutes of December 6, 2019 meeting

2. **ITEMS:**

- **CSA Administrative Items**
  Item A – 1: Approve Revisions to the CSA Local Policy and Procedures Manual

- **HMF Administrative Items**
  Item A – 2: Endorse HMF Mid-Year Budget Proposals
  Item A – 3: Endorse CSB Protocol for Use of Unspent Mental Health Initiative Funds

- **CSA Contracts**
  Item C – 1: Child Specific Contract Request for Benedictine School
  Item C – 2: Child Specific Contract Request for Sedona Sky

- **HMF Presentation Item**
  Item P – 1: Update from the Northern Virginia Family Network

- **CSA Information Items**
  Item I – 1: Review Amendments to the CPMT Bylaws (Not in Packet)
  Item I – 2: CPMT Quarterly Data Report
  Item I – 3: Quarterly Residential Entry and UR Report
  Item I – 4: Quarterly Serious Incident Report
  Item I – 5: Review CSA Budget Report (Not in Packet)

- **HMF Information Item**
  Item I – 6: Regional Evidenced Based Practice Learning Collaborative

- **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 Community Policy and Management Team
December 6, 2019

DRAFT

Attendees: Tisha Deeghan**,** Michael Becketts, Jacqueline Benson, Annie Henderson, Teresa Johnson, Joe Klemmer, Chris Leonard, Deborah Scott, Rebecca Sharp, Jane Strong, Michael Lane, Lesley Abashian, Staci Jones Alexander

SOC Attendees: Jim Gillespie, Desiree Gordon, Peter Steinberg

Stakeholders and CSA Program Staff Present: Janet Bessmer, Patricia Arriaza

1. **Approve minutes of October 25, 2019 meeting:**
   - ✓ Motion made by Staci Jones Alexander, seconded by Michael Lane. Motion Approved by all CPMT members.

2. **Items:**

- **CSA Administrative Item:**
  - Item A-1: Endorse Statement of Intent for Evidence-Based Treatments (EBT) Eligible for Title IVE and CSA Funding.
    - ✓ Motion made by Teresa Johnson, seconded by Deb Scott. Motion Approved by all CPMT members.

  Three EBTs have been identified by Virginia Department of Social Services (VDSS); Multisystemic Therapy (MST), Functional Family Therapy (FFT) and Parent Child Interaction Therapy (PCIT). VDSS is planning on using state training funds to train providers in our region on these interventions.

    - Members viewed videos that summarized the approach and use of each of the 3 EBTs
    - Will we have enough trained providers to serve the families that need these services before advertising/recommending the EBTs? VDSS will be making provider selections in Dec/Jan and will begin advertising on their site around Apr/May. We will do our best to ensure availability before promising services to families. Providers in our area seem interested so we are hoping to roll out these services and evaluate capacity.
    - Will the providers have after-school availability when implementing these services? FFT and MST are offered in the home/community so after school hours will be provided. MST has a 24/7 component. PCIT is for children ages 3-7 and is typically done in an office.
    - Estimated cost for services: FFT $55/day; MST $94/day; PCIT $101/hr
    - How will we ensure that the intent of the State at a federal level will be met at the local level? VDSS and Office for Children (OFC) requested local CSAs to endorse/fund these EBT services in the beginning in order to ensure multiple referral sources, and have identified diverse funding streams (i.e.: Title IV-E, Medicaid, etc.) to ensure sustainability.
    - Seems that these EBTs are designed to meet the needs of a particular populations (i.e.: MST is geared towards youth who are involved with JDC and PCIT is effective for younger children. Will there be other resources/EBTs available for kids who do not meet the criteria for the above mentioned services? Through HFM training consortium

Approved:

CSB therapist and other therapist in the community will be trained on many other EBTs (i.e.: DBT). Ultimate goal is to have various resources that will meet the needs of youth and families in the community.

- VDSS will be investing their training funds to get providers started/trained, therefore endorsing these EBTs will not affect local funds. Our locality will need to determine how to secure spots with providers.

- **CSA Contracts:**
  - Item C – 1: Approve New Providers for FY20
    - ✓ Motion made by Michael Lane, seconded by Staci Jones Alexander. Motion Approved by all CPMT members.
      - Tutoring for Success; we typically do not have contracts for tutoring because it is offered by the schools however last year there was an increase in use of CSA funds for tutoring. The CSA Management team agreed that a contract would be beneficial in order to lock in a rate.
      - Equine and Music Therapy; Utilization of these services have increased; therefore, there is a need to add more providers.
  - Item C – 2: Approve Outpatient Service Rates effective January 1, 2020
    - ✓ Motion made by Chris Leonard, seconded by Michael Becketts. Motion Approved by all CPMT members.
      - If approved there will be a $40,000.00 increase/year based on the past three years of utilization.
      - If providers do not accept this rate a child specific contract can be requested.
      - Suggestion was made to analyze rates of other jurisdictions to determine if they are comparable.

- **CSA Information:**
  - Item I – 1: Review CSA Budget Report
    - Reviewed reason for changes in amount spent on RTC Education and non-residential Foster Home and Community Services.
  - Item I – 2: Review Proposed Amendments to the CPMT Bylaws
    - Updated CPMT Bylaws reflect changes in membership/departments, CPMT duties in VA code.
    - County attorneys have reviewed the changes to the CPMT Bylaws and have determined that since there are three jurisdictions served by the Fairfax Falls-Church CPMT, the City of Falls-Church and Fairfax will need to determine if the Bylaws need to be approved by their City Counsels, or if it only needs to be approved by the Fairfax County Board of Supervisors (BOS). Once this is determined the process for approval of the CPMT Bylaws will be incorporated into the revisions and final revisions will be brought to the January 2020 CPMT meeting for approval.
  - Item I – 3: Review Proposed Revisions to the CSA Local Policy and Procedures Manual
    - Most updates are internal administrative changes that reflect current CSA practice. Approval for changes will be requested at the Jan 2020 CPMT meeting.
- **HMF Information item:**
  - Item I – 4: Children's Behavioral Health Blueprint Quarterly Report

- Presentation regarding outcomes/updates of the Short Term Behavioral Health (STBH) program. HMF has hired a consultant to obtain surveys and complete a data analysis of the program.
- Their services are implemented in therapists' office and it was determined that transportation was a barrier for some families that were referred. Chris Leonard has offer to help with transportation support.
- HMF has a survey on their website and is requesting feedback regarding their services. The website also has a list of providers that are trained in REACH.

- **NOVACO – Private Provider Items:** No updates reported
- **CPMT Parent Representative Items:** No updates reported
- **Cities of Fairfax and Falls Church Items:** No updates reported
- **Public Comment:** No updates reported

Motion to adjourn by Chris Leonard, second by Teresa Johnson. All members approve.

NEXT MEETING: January 24, 2020; Government Center Room 232

Approved:

MEMO TO THE CPMT

January 24, 2020

Information Item A - 1: Approve Proposed CSA Policy Manual Revisions

ISSUE:
The Healthy Minds Fairfax/Children's Services Act Policy Manual requires updating and revisions as part of the CSA program's plan to review each section in alternating years.

RECOMMENDATION:
That the CPMT approve the changes proposed to the Healthy Minds Fairfax/Children's Services Act Policy and Procedures manual.

BACKGROUND:
Proposed changes to the manual are needed to reflect current practice, add the Parental Contribution Policy changes that were approved by the CPMT on 7/26/2019 and include disclaimer language that indicates the use of the manual requires comprehensive knowledge of the CSA program, policies and procedures of partner agencies. Individuals interested in receiving CSA funding are advised to seek the assistance of their child's case manager or the CSA office.

ATTACHMENT:
Summary of changes, Proposed policy manual changes

INTERNAL CONTROL IMPACT:
None

FISCAL IMPACT:
None

STAFF:
Patricia E. Arriaza, CSA

Updates to Fairfax-Falls Church Children's Services Act
Policy and Procedures Manual
January 24, 2020

Policy/Procedure/Action	Changes & Comments	Section/Page
Disclaimer	Added disclaimer – use of manual requires comprehensive knowledge of CSA program, individual agency policies, processes, etc. Members in the community should request assistance from case manager or agency staff if looking to reference sections of the manual.	page 2
Authorization of IFSP	Corrected language that indicated FAPTs authorize services.	4.5, page 29
References to CONs	Removed references to required submission Certificates of Need.	5.1, page 41
Non-mandated CHINS	Review non-mandated residential - change "other out of placement procedures" to CHINS; added language about IACCT process to reflect current practice.	page 41
CSA Eligibility	Removed 3rd bullet to reflect completion of task.	5.1, page 47
UR approval procedures	Updated language of 2nd bullet (non-mandated youth) to reflect current practice.	8.1, page 60
Remove "FAPT authorization"	Removed references to FAPT authorizing services.	pages 63, 65, 100, 101
UR approval of CSA Funding	Updated language to reflect current practice - replaced reference to budget analyst with "internal CSA tracking procedures".	8, page 61
Budget Management	Updated language in various sections to reflect current financial practices.	9.3, pages 65, 66 9.4, pages 66, 67 9.5, pages 67, 68
Payment documentation procedures	Deleted reference to CSB cases and transferring via FOCUS.	15.10, page 80
Medical necessity documentation	Added language to reflect need for backup documentation for clinical services (IIS, MHSB, TDT) as required by the State.	15.10, page 80
Medicaid and CSA	Removed bullets 1 & 2 under CSA Case Manager Responsibilities to reflect current practice.	Section 16.5, page 84
Provider responsibilities - SIRS	Updated language of 3rd bullet to reflect current practice - added submission of SIRS to UR manager and removed the contracts supervisor.	17.3, page 87
SIRS reporting	Updated language to reflect current practice - reporting of SIRS to CPMT.	17.7, page 88

Policy/Procedure/Action	Changes & Comments	Section/Page
Parental Contribution	Added updated parental contribution policy language; changed parental contribution agreement to parental contribution assessment where appropriate. Policy changes approved by CPMT at July 26, 2019 meeting.	25, page 92-94
Annual cost allocations	Updated language to reflect current practice.	27, page 99
Contracts Management	Removed requirement that purchase orders must be signed by provider and CPMT designee (CSA Fiscal Manager) to reflect current practice and align process with County policy around purchase orders.	29, page 102

Changes and Updates to Policy and Procedures Manual

Fairfax-Falls Church Children's Services Act

a program of

Healthy Minds Fairfax

December, 2019

Updates to Fairfax-Falls Church Children's Services Act
Policy and Procedures Manual
December 6, 2019

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References to CONs	Removed references to required submission Certificates of Need.	5.1, page 41
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Text to be deleted is stricken through;
corrected/updated text is highlighted in green.

About this Manual

The local policy and procedures manual defines the procedures for case managers and supervisors engaged in direct service delivery and the administrative processes and legal mandates that support or regulate them. Unless otherwise noted, all local policies and procedures, except those specifically designated for the Children's Services Act, also apply to services provided directly or through contract by the Children's Behavioral Health Collaborative Program.

CSA forms may be accessed through the county's FairfaxNET at http://fairfaxnet.fairfaxcounty.gov/Dept/DFS/csa/Pages/default.aspx or by contacting the CSA program office at (703) 324-7938 if you do not have access to FairfaxNET.

Disclaimer

The policies, procedures and practice standard described in this manual are reviewed periodically, in part or as a whole, to ensure that they continue to reflect current thinking and practice as well as changes required by the Virginia Office for Children's Services. Policies and procedures may be modified, amended or terminated at any time based on the review process outlined in this manual (See section below).

This manual is intended for use by public human service agency staff and school personnel who have been trained in policies, procedures and practice standards relevant to the Children's Services Act. County, city and school staff are also responsible for following all relevant agency and organizational requirements that may not be fully specified in this manual but are implied and embedded in the work of staff such as procurement, financial procedures, etc.

Accessing Children's Services Act funding is contingent on the child/youth meeting eligibility criteria and adherence to the Commonwealth and local requirements. Individuals interested in receiving Children's Services Act funding should contact their child's case manager, school social worker or the CSA office for assistance.

Review and Amendment of the Policies and Procedures Manual

These policies and procedures may be amended at any regular meeting of the Community Policy and Management Team (CPMT) by a majority vote of those present and voting. CPMT delegates to the CSA Management Team authority to amend any section of the manual titled "procedures", "methodologies" or "responsibilities" through a majority vote at any regular meeting of the CSA Management Team. The CSA Management Team shall report such amendments at the following regular meeting of the CPMT.

Prior to recommending to CPMT a policy amendment, or to considering amending any section of the manual titled "procedures", "methodologies" or "responsibilities", the CSA Management Team shall evaluate the impact of the proposed amendment on the CSA internal control system, to include providing reasonable assurance that the following objectives are met: assets are safeguarded; reliable information/data; effective and efficient operations; and compliance with applicable laws, regulations, policies, procedures and contracts. A summary of the evaluation shall be submitted to the CPMT for review.

- Closing remarks by Chair, to include when the decision will be rendered and how the parents, case manager, and FAPT/MDT will be notified.
- CSA staff confirms CPMT decision in writing within 5 business days to parents, case manager, and FAPT/MDT leader.

4.5 Individual Family Service Plans (IFSP) /Meeting Action Plans (MAPs)

Individual Family Service Plans (IFSPs) (referred to as Meeting Action Plans (MAPs) in Fairfax-Falls Church CSA) that request CSA funding for services must be developed through a team-based planning process as described in the Team-Based Planning section of this manual (Section 6). The IFSP/MAP is a written assessment of the youth and family's strengths and needs and recommends a plan for the provision of services.

Action plans for community-based services developed through team-based planning processes are submitted for review to the CSA office when CSA pool funds or Mental Health Initiative Funds are needed to purchase services. A Utilization Review analyst will review the action plan and required supporting documentation for consistency with the CSA practice standards and compliance with CPMT policies and state and federal laws and policies. Upon review and approval, the action plan becomes the CSA IFSP/MAP.

Funding for short-term crisis stabilization placements, as well as FPM and ICC services, shall be requested via submission of the IFSP-EZ form and required supporting documentation to the CSA office. ~~These requests will be reviewed by one of the two standing FAPTs to who are responsible for the authorization of such services.~~ These requests will be reviewed by one of the two standing FAPTs prior to being reviewed by a Utilization Review analyst for authorization

When the team-based planning process is unable to develop or to agree upon a safe and effective community-based plan of care, long-term residential or group home treatment may be considered via a referral to the FAPT.

The IFSP/MAP and the Court

In any matter properly before a court for which state pool funds are to be accessed, the court shall, prior to final disposition, and pursuant to COV § 2.2-5209 and 2.2-5212, refer the matter to the Community Policy and Management Team (CPMT) for assessment by a local Family Assessment and Planning Team authorized by policies of the CPMT for assessment to determine the recommended level of treatment and services needed by the child and family. The FAPT making the assessment shall make a report of the case or forward a copy of the Individual Family Services Plan to the court within 30 days of the court's written referral to the CPMT. The court shall consider the recommendations of the FAPT and the CPMT. If, prior to a final disposition by the court, the court is requested to consider a level of service not identified or recommended in the report submitted by the FAPT, the court shall request the CPMT to submit a second report characterizing comparable levels of service to the requested level of service. Notwithstanding the provisions of this subsection, the court may make any disposition as is authorized or required by law. Services ordered pursuant to a disposition rendered by the court pursuant to this section shall qualify for funding as appropriated under this section. (COV § 2.2-5211E) In Fairfax-Falls Church, only plans that were developed by FAPTs or state-approved multi-disciplinary teams with funding subsequently authorized by UR shall be submitted to the court as recommendations of the CPMT.

The target population shall be the following:

1. Children placed for purposes of special education in approved private school education programs, previously funded by the Department of Education through private tuition assistance;
2. Children with disabilities placed by local social services agencies or the Department of Juvenile Justice in private residential facilities or across jurisdictional lines in private, special education day schools, if the individualized education program indicates such school is the appropriate placement while living in foster homes or child-caring facilities, previously funded by the Department of Education through the Interagency Assistance Fund for Non-educational Placements of Handicapped Children;
3. Children and youth for whom foster care services, as defined by COV § 63.2-905, are being provided;
4. Children and youth placed by a juvenile and domestic relations district court, in accordance with the provisions of COV § 16.1-286, in a private or locally operated public facility or nonresidential program; or in a community or facility-based treatment program in accordance with the provisions of subsections B or C of COV § 16.1-284.1; and
5. Children committed to the Department of Juvenile Justice and placed by it in a private home or in a public or private facility in accordance COV § 66-14.

Prioritization of CSA Non-Mandated Services

For access to CSA non-mandated services priority will be given to:

- Children placed by a juvenile and domestic relations district court, in accordance with the provisions of COV § 16.1-286, in a private or locally operated public facility or nonresidential program; or in a community or facility-based treatment program in accordance with the provisions of subsections B or C of COV § 16.1-284.1.

- Children committed to the Department of Juvenile Justice and placed by it in a private home or in a public or private facility in accordance COV § 66-14. COV § 2.2-5211 B.

Non-Mandated Residential and Other Out-Of-Home Placements

Parental Agreement for CHINS and Non-Mandated Placements

When the FAPT and the legal guardian agree on an out-of-home placement that is the most appropriate and least restrictive service, and non-mandated funding is available, the public case management agency, the legal guardian and the CSA Program must enter into a Parental Agreement. This Parental Agreement requires the legal guardian who retains custody to agree to place the child and the CPMT to agree to provide funding in accordance with CPMT policies and procedures. A discharge plan for returning the child home as quickly as appropriate must be included as part of the IFSP/MAP.

Parental Agreements

The Parental Agreement requires the legal guardian who retains custody to agree to place the child and the CPMT to agree to provide funding in accordance with the CPMT's policies and procedures. Per CPMT decision the CSA Program must also be a party to the Parental Agreement. A discharge plan for returning the child home as quickly as appropriate must be included as part of the IFSP/MAP.

The public case management agency designated and the legal guardian shall develop an agreement that provides for:

- Family participation in all aspects of assessment, planning and implementation of services;

will be referred to the Division of Child Support Enforcement (DCSE), as is required of all foster care cases. In addition to a written placement agreement, these non-custodial out-of-home placements require that the initial Foster Care Service Plan be completed within sixty (60) days of placement and adopted by the court. (COV § 16.1-281) The service plan must be in the agency case record.

Non-Mandated Residential and CHINS ~~Other Out-of-Home Placement Procedures~~

When FAPT recommends a placement outside the home and determines that the child meets the eligible population for CSA services, the following process shall be followed:

~~1.~~ After verification of availability of non-mandated funding, UR shall authorize CSA funding for the placement and document eligibility in the electronic record. CSA funding is contingent on receipt of the Parental Contribution Assessment, IFSP/MAP, Medicaid application, and current CANS. ~~and Certificate of Need (if appropriate).~~ If youth has active Medicaid at time of placement, the IACCT process must be completed prior to service authorization.

2. ~~After UR authorization,~~ The case management agency and legal guardian shall develop and sign a Parental Agreement, based on the state model and modified to the requirements of the specific case. The sections in the state model may not be deleted or modified.
3. The CSA Program Manager or designee signs the Parental Agreement confirming that the request is in policy compliance. ~~CSA Utilization Review staff or others may be consulted as appropriate.~~ Parental Agreements are not valid without the signatures of the parent/legal guardian, public agency representative and CSA Program Manager or designee.

~~4.~~ CSA funding for the placement shall not begin prior to UR authorization. ~~and completion of the Parental Agreement.~~

5. The public agency case manager completes a CSA encumbrance form to generate a purchase order, after which placement can be made.

Procedure for Accessing Non-Mandated Funding

The budget analyst will monitor the CSA non-mandated budget and keep the FAPTs and UR staff informed of the availability of funding for new and continuing service authorizations.

Case Management and Case Support Services

All youth served in CSA have an identified Lead Agency Case Manager who has specified duties and responsibilities described in this manual. Youth who are served in more than one agency will have an identified case manager in each agency, with one of them being deemed the “lead CSA case manager” for purposes of CSA functions. The case manager for children in foster care is the foster care specialist assigned to them.

Families who do not have current agency involvement may contact the CSA program directly to self-refer. (See Section 6.3 for more information.) The Team-based Planning Coordinator will accept these self-referrals, obtain a consent to exchange information, screen for CSA eligibility, and gather basic information about the youth’s needs before connecting the family with an appropriate case manager for the initial team-based planning meeting.

Youth are served by whichever entity first identifies the case and brings the youth forward for service funding. The broad access (i.e., no wrong door) approach has been helpful in gaining access for all families but presents challenges regarding the match of case manager skills and system role with youth needs. The state’s funding category of Case Support presents an opportunity to match youth who are served in the CSA system of care who have behavioral health care needs with staff from our public

- When notified by DFS Accounts Receivable that a family's account is delinquent the case manager should then contact the family to discuss barriers to payment, determine if the family may benefit from requesting a reduction or waiver, or contact finance to develop a payment plan.

Service Plan and Family Participation

- Document efforts made to involve family members on the IFSP/MAP. A parent or legal guardian must sign the IFSP/MAP. When present and appropriate, the youth involved will also sign. The IFSP/MAP cannot be implemented without the consenting signature of a custodial parent and/or agency or individual legally serving in the place of the parent, unless otherwise ordered by the court, upheld by the appropriate appeals process, or authorized by law, or where a youth over the age of fourteen (14) exercises his or her right to treatment without parental consent. The lack of a consenting signature of a parent on an IFSP/MAP will not interfere with procedures to provide immediate access to funds for emergency services and shelter care.

Medicaid

- Obtain the DSM diagnosis of a youth in need of RTC or Community-Based Residential Treatment in a group home enrolled with DMAS. If a complete DSM diagnosis is not available, it is the responsibility of the case manager, in consultation with their supervisor and/or program manager to determine whether it should be pursued. A DSM diagnosis should not be pursued solely to ensure eligibility for Medicaid reimbursement for RTC.
- For non-mandated youth, as of July 1, 2015, service requests will be submitted with the specific provider identified. The service authorization will include the provider and allow non-mandated funds to be released subject to availability, in a more timely fashion, resulting in reductions in Time to Service.
- ~~For the first year of implementation of the restructured service authorization process, case managers will be allowed/encouraged to identify the provider before funding request submitted. Training for team-based planning members will include emphasis on review of appropriate provider options in the planning discussion. During the implementation process, the CSA MT will address and resolve any questions or concerns that arise. After the first year, the CSA MT will review this practice change and make a final determination.~~
- Encourage families whose child is placed through an IEP in a Medicaid enrolled residential facility to apply for Medicaid.

Administrative

- Prepare a Children's Services Act Authorization form to encumber funds for payment and submitting it to CSA Finance staff if CSA funds are authorized within five days of the service authorization.
- Complete a Case Status Change form if lead case management changes or there are changes in the child or family's information that need to be entered into the HARMONY information system such as change of address or admission of child into a different residential program.
- Coordinate and monitoring delivery of service.

Foster Care Prevention Services

- Consult with the DFS case manager who has an active case regarding the family, if the Team-based Planning Meeting is considering recommending Foster Care Prevention services. Or, in cases where DFS does not have an active case, contacting the Team-based Planning Coordinator for DFS and requesting that a DFS staff member attend a Team-based Planning Meeting for the

- Contact with the case manager and any other relevant collateral sources to obtain any updates or additional information, as needed, and to discuss questions, issues, and concerns.

3. UR Analysts will have a maximum of five business days to complete the service authorization process. For requests requiring a written Utilization Report, UR Analysts will have a maximum of 10 business days from receipt to complete their review and determination about authorization.

Approval Procedures

1. If the requested services are approved by UR, UR analysts will document in Harmony the service authorization, and send copies of the authorization to the case manager via secure email as well as to the CSA central file. A service authorization consists of a specific start and end date, the name of the approved service type(s), and units of service necessary to generate purchase orders. Approvals will be designated by one of the following statuses:
   a. Status: **Approved**
   b. Status: **Approved with comments/recommendations** – The current request is approved, but in the notes UR staff may offer resources, suggestions and/or consultation about the service request. The comments may include directions that are relevant for any future requests. For example, application for a Medicaid waiver may be a required action step before any additional CSA funded services will be approved.
   c. Status: **Approved with amendments** – UR staff will work collaboratively with the CM and/or supervisor to adjust/refine some aspect of the request such as number of hours, type of service. The decision about the service authorization, however, is made by the UR Analyst and is subject to an administrative appeal based on the criteria below.

~~2.~~ For non-mandated youth, UR Analysts will verify the availability of funding for the services via internal CSA tracking procedures. ~~the Budget Analyst for CSA who maintains and tracks the funding availability.~~

3. If the requested services are not approved based on the information provided, the UR Analyst must respond in a secure email to the case manager and supervisor one of the following statuses:
   a. Status: **Pending** – Ex. if additional information is needed (report, documentation), if the CANS needs to be updated/corrected. Timely response from the case manager/supervisor or other agency designee who can provide the information is necessary for disposition of the request. The case manager will have up to five business days from time of notification to provide the requested information or communicate a plan for getting the information along a different timeline. If the information is not received or the case manager has not communicated in that timeframe, UR will change the determination to "Status: Not approved", and notify the worker and supervisor via secure email that the request is no longer under consideration. The request itself will be securely shredded. The CSA program will not keep copies nor return it to the worker.
   b. Status: **Not approved** – UR staff will document the reasons for not approving the service citing SOC practice standards, level of care, CANS, missing information, etc.
   c. Status: **Not eligible** – For situations where CSA law and/or state and local policy does not allow the service, such as Medicaid reimbursable expenses where no justification or inadequate justification has been provided to support "unavailable" or "inappropriate."

Decision Review Procedures

1. **Parent Notification**: Case managers shall advise all parents/legal guardians of the existing appeal process as well as the administrative reconsideration process and provide them with the written appeal procedure as part of their orientation to CSA, as per current policy.
2. **Administrative Reconsideration**: The UR Analyst will provide the case managers/supervisors with the reason that the service request was "Not approved," "Not eligible" or "Approved with

authorized by the CPMT to approve the payment of foster care maintenance according to local and state CSA policies and procedures.

9.2 Encumbrances

1. Provide to the CSA or FCPS Finance Team a CSA Authorization to Encumber in hard copy or electronically within five business days of the ~~FAPT~~ UR service authorization.
2. For IEP-required services, in lieu of a FAPT review, the FCPS CSA case manager shall enter the state-required data elements into the Management Information System (MIS), provide a current CANS according to the CPMT-approved administration schedule, and a current IEP Services Page and Placement Page documenting the need for a private special education placement.
3. Provide to the FCPS Finance Team a CSA Authorization to Encumber in hard copy or electronically within five business days of completion of an IEP for private special education placement.
4. Report to the CSA Office within five working days the initiation or termination of the following services:
    - residential treatment;
    - group home placement;
    - therapeutic foster care placement;
    - home-based services; and
    - intensive care coordination.

9.3 Budget Management

Budget Analyst Responsibilities

1. Monitor and report CSA Pool fund expenditures to the CPMT (or its designee) at regularly scheduled meetings ~~on a monthly basis~~. Report additional data as requested by the CPMT and FAPTs on expenditures and encumbrances.
2. Ensure the availability of CSA State Pool funds for monthly reimbursement.
3. Prepare the CSA Pool Reimbursement Request report on a monthly basis for the local CPMT Fiscal Agent's review and final submission to the State. In addition to preparing expenditures by required categories, include expenditure refunds by the amount and type of service expenditure credited.
4. ~~Report to the state CSA Fiscal Agent the expenditure refunds on the Pool Reimbursement Request form by the amount and type of service expenditure credited;~~
5. Provide expenditure and encumbrance data to the ~~Prioritization Committee~~ UR Manager for Non-Mandated cases on a weekly basis, giving the unencumbered balance.
6. Serve as the principal liaison to the local Fiscal Agent on the annual Pool Allocation Plan (budget) and expenditure issues.
7. As needed, and after consulting with the CSA Program Manager, prepare the Supplemental Allocation request for signoff by the CPMT Chair and approval by the Fiscal Agent. Report this request to the CPMT at the next regularly scheduled meeting. ~~and coordinate the process for obtaining CPMT approval of Supplemental State Pool funds.~~
8. Communicate to the CSA Program Manager and DFS Finance Manager the State approval of supplemental requests and new appropriations.
9. ~~Prepare the CPMT approved Administrative Funds Budget Plan for the state's share of the Administrative Funds allocation. The sheet is then reviewed and submitted to the State CSA Fiscal Agent by the local CPMT Fiscal Agent.~~ Ensure submission of Administrative Funds Budget Plan by the CSA Manager to the CPMT Chair, with final approval by the Fiscal Agent. State administrative

funding shall be used to support the cost of a local CSA Program Manager and other staff to administer the CSA program as necessary.

~~9.~~

10. Ensure ~~that all~~ the separation of Administrative Funds and CSA Pool funds ~~expenditures are tracked so they are clearly identifiable~~ in the County's financial system.

~~11. Ensure that CSA Pool funds are not used for administrative expenses that may be incurred for support services to the CPMT and the FAPTs.~~

Financial Management

The Finance Teams are the CPMT's or its designee's liaison with service providers regarding invoices and payments. Team members are assigned to support specific program units in the human service agencies in the local CSA structure to ensure consistency and familiarity with each unit's case manager and consumer's particular needs. In addition, FCPS has its own team of staff dedicated to processing FCPS case-managed cases.

- Fairfax County Department of Family Services (DFS) and Fairfax County Public Schools (FCPS) both maintain a Finance Team to process encumbrances, issue purchase orders (PO), and set up ~~process~~ invoices for payment.
- CSA cases that are case managed by FCPS school case managers have their encumbrances and payments processed by the FCPS Finance Team.
- FCPS Finance PO's are reviewed and mailed by the Fairfax County DFS Finance Team to ensure the PO has been properly created.
- ~~Fairfax County Finance Team issues all payments for CSA.~~
- FCPS Finance payment batches are reviewed by Fairfax County Finance Team when check runs are set up to ensure the payments are correct and proper.
- The Fairfax County Department of Finance issues all payments for CSA.

9.4 CSA & FCPS Finance Teams Responsibilities

The CSA Finance Teams will:

1. Maintain financial records related to CSA reimbursable expenditures.
2. Receive from the CSA case manager requests to encumber funds and verify that the encumbrance complies with CSA policy and procedures.
3. Encumber funds and process invoices for ~~authorized~~ contracted providers for services delivered to children and their families who are eligible to receive services funded from CSA Pool funds.
4. Within five business days of receipt of a complete and accurate encumbrance request with all required case documentation, create a Purchase Order (PO) containing appropriate codes to allow for the service to be tracked to the correct funding category for reporting purposes and send it to the identified service provider. If the encumbrance request is not complete and accurate, or does not nor include all required case documentation, inform the case manager within three business days of receipt.
5. At the time of PO creation, also create an enrollment for all CSA-funded services, not including those listed as exceptions to the requirement for an IFSP/MAP developed through a team-based planning process in the Team-Based Planning section of this manual. Treatment foster care and respite services are also to be enrolled.
6. Receive invoices from the service providers for services authorized by the case managers. Invoices for FCPS clients are transferred electronically by the CSA Finance Team to the FCPS Finance Team for payment.

7. Respond to provider questions about payment of invoices, verifying ~~FAPT~~ UR authorization of the service and current contract with the provider for the service.
8. Terminate purchase orders throughout the fiscal year upon the request of a case manager indicating that services are completed to release unused encumbered funds.
9. Terminate all previous year purchase orders (POs) by November ~~1st~~ 15th. Note: Previous year's expenses cannot be paid after September 30th.
10. ~~Work~~ Collaborate with case managers, assigned workers, supervisors, and CSA Contracts staff and CSA staff to support efficient access to services.
11. CSA Finance Team only: Verify with Self-Sufficiency staff that purchase orders for IV-E services are eligible for IV-E reimbursement. Verify ~~with the FRU unit staff youth~~ potential eligibility for Medicaid reimbursement by reviewing the Management Information System Federal Reimbursement Unit (FRU) notes.

CSA Finance Manager or Designee Responsibilities

1. Oversee all CSA financial management ~~activities~~ payments.
2. Ensure that the local CSA payment data interfaces with the County's financial system within the established accounting structure.
3. Serve as the principal liaison to independent auditors.
4. Serve as primary liaison to FCPS Finance Team.

CSA Program Manager Responsibilities

1. Ensure that CSA Pool funds are not used to supplant federal or state funds supporting existing programs.
2. Authorizes use of CSA administrative expenses for program use.

Local CPMT Fiscal Agent or Designee Responsibilities

1. The local representative (for Fairfax/Falls Church, it is the Deputy Director of the Department of Finance) is assigned by the CPMT to be locality's fiscal agent.
2. Serve as the CPMT liaison with the State CSA Fiscal Agent on the annual Pool Allocation Plan (budget) and expenditure issues.
3. Approve and file the monthly CSA Pool Reimbursement Request as well as any Supplemental Allocation requests and the Administrative Funds Budget Plan to the State Fiscal Agent.

9.5 Policy for Use of Administrative Funds

~~The CPMT will make decisions on specific uses of Administrative Funds available to the CPMT for the added costs incurred by the CPMT in implementing the CSA. An Administrative Funds Budget Plan will be prepared in accordance with CPMT decisions. State administrative funding shall be used to support the cost of a local CSA Program Manager and other staff to administer the CSA program as necessary.~~

Procedures for Recovery of Funds from Other Sources

1. The CPMT designates DFS to receive and disburse funds recovered and paid to the CSA Pool for individual clients.
2. The Special Welfare Fund ledger is the designated control ledger for all funds recovered and paid to the pool for individual client accounts i.e., Social Security, Supplemental Security Income, Veterans Administration benefits, client trusts (child support), and other funds collected for specific CSA eligible children.

3. Accounting Team Supervisor and Accounting Staff enter the receipt of funds from other sources for a CSA-eligible child in Harmony and reconcile details on the child, CSA-eligible category, funding source, and anticipated duration of funding and confirm with CSA case managers.
4. CSA case manager requests that benefits and support payments be made payable to Fairfax County.
5. ~~CSA forms and billing direct checks and money orders to be mailed to Fairfax County Department of Family Services, P.O. Box 3406, Fairfax, Virginia 22035.~~ All payments are received by ACH direct deposit.
6. Funds are deposited into the Special Welfare Fund per the County's Accounting Technical Bulletin on cash/check handling.

Responsibilities of Accounting Staff for Special Welfare Fund

1. Establish a special welfare account, unless an account already exists, in the name of the CSA eligible child for whom funds were deposited. The child-specific account is the ledger sheet on which all receipts and disbursement are recorded. Disbursement of funds from other sources (i.e. Social Security~~, SSI, Veterans Administration~~ benefits, ~~client trusts~~ child support) are expenditure refunds in the CSA Pool Funds reporting and are in accordance with existing State policy and are tracked in the County's financial information system. These expenditure refunds and a breakdown of their sources must be reported on the Reimbursement Request form.
2. Determine what funds from other sources can be refunded to ~~the CPMT cost center~~ CSA Pool funds for expenditures made on behalf of the CSA eligible child.
3. Refund ~~the CPMT cost center~~ CSA Pool funds for expenditures made on behalf of children in foster care in accordance with State Policy Manual Volume VII, Section III, Chapter B, 14 a-f, pp. 403-41.
4. Refund ~~the CPMT cost center~~ CSA Pool funds for expenditures made on behalf of children placed by the Juvenile and Domestic Relations District Court or the State Division of Youth and Family Services.
5. ~~Special welfare account balances are disbursed after the child leaves foster care custody. An accumulated special welfare account balance is disbursed to the parent, guardian or foster child at age of maturity when the child leaves foster care custody.~~ Social Security and SSI funds must be applied to current services that a child is receiving. In the case where a child leaves CSA services for a home trial period or permanent placement, the Accounting Staff will forward any Social Security or SSI funds received by the County to the parent or guardian. When a child reaches the age of maturity, the Accounting Staff will return any child-specific Social Security or SSI and related interest earned to the Social Security Administration.
6. ~~If, after due diligence, DAHS staff cannot locate the responsible parent, guardian or foster child at age of maturity, return the child-specific SSA/SSI savings or other investments and interest earned on the funds to the Social Security Administration. The LDSS must seek written approval from the SSA to disburse these funds to a new payee rather than returning it to SSA. Disburse the remaining special welfare account balance to the State Treasurer in accordance with "The Uniform Disposition of Unclaimed Property Act", Title 55, Chapter 11.1, Sections 55-210.2.10, Code of Virginia.~~

9.6 Restrictions on Use of Pool Funding

Non-Duplication of Case Management Services

Medicaid prohibits concurrent funding of more than one case management service, regardless of funding source. Therefore, a child may not receive more than one purchased case management service at a time.

The relevant case management services include:

15.9 Reporting Requirements

1. The Crisis "Bandaid" plan is due to the case manager within 14 days after initial face to face contact with the family.
2. The Plan of Care is due to case manager within 45 days after initiation of ICC.
3. The Individualized Care Plan and the Safety Stabilization Plan are due to case manager within 45 days after initiation of ICC.
4. The Plan of Care shall be updated monthly and shared with the Lead Case Manager, including a summary of services provided.
5. Serious Incident Reports shall be reported as per the provisions in the CSA Agreement for Purchase of Services.

Note: Date of initiation of ICC is defined as the date ICC provider assigns the youth/family to an IC facilitator.

15.10 Finance and Payment Documentation Procedures

1. The initial encumbrance form shall be completed by the CSA case manager and includes ICC services beginning with the date ICC was initiated and continuing for up to six months thereafter.
2. Upon receipt of the encumbrance form, Finance staff will create POs and corresponding invoices and send them to the provider. ~~For CSB cases, CSB Finance will complete the invoices (based on the CSB billing system) and send them to Finance, which will initiate a Transfer Voucher in FOCUS.~~
3. The beginning and final month of ICC is paid on a pro-rated amount. The PO amount shall not exceed the contracted rate for a six-month period.
4. Community-based and short term out-of-home (90 days or less) interventions may be accessed by the intensive care coordinator through the approved encumbrance process. Total expenditures for such services shall not exceed $25,000 in the first six months of the ICC intervention.
5. If the Plan of Care includes specific community-based clinical services with Medicaid medical necessity criteria, the team will ensure that an independent clinical assessment by a licensed clinician documents that the criteria are met prior to accessing CSA funds. These specific services are Intensive In-Home, Therapeutic Day Treatment, and Mental Health Skill Building. The record must contain documentation that the Medicaid criteria were met even for youth who are not enrolled in Medicaid.
6. If ICC is approved for continuation beyond the first six months, expenditures for community-based and short-term out-of-home interventions shall not exceed $25,000 for the subsequent six-month period and $10,000 for the final three months. The total ICC intervention shall not exceed 15 months.
7. Total expenditures during ICC shall not exceed $60,000. If the youth requires an out-of-home service during the ICC intervention, the expenditure is deducted from the overall ICC budget.
8. Over the 15-month intervention, the types and amounts of services that may be selected by the ICC Youth and Family Team and encumbered by the CSA case manager include:
   - In-home and out of home respite for caregivers–up to $18,000.
   - In-home and residential crisis intervention/stabilization in a short-term program with a planned length of stay of 90 days or less–up to $20,000.
   - Flexible funds–up to $5,000.
   - Community-based Interventions (e.g., home-based services, ABA, mentoring, interpretation, psychiatric services, transportation, recreation) up to $38,000.
9. CSA Management Team approval is required to authorize expenditures in excess of the limits for each subcategory above and for extensions of ICC services beyond the 15 months. ICC shall present a written request for signed approval by the CSA Management Team.

submitting the documentation to the designated Department of Medical Assistance Services (DMAS) subcontractor for the utilization review or, in the case of CBRT, maintaining the case file documents required for Medicaid coverage. For RTC and TFC claims submitted by the provider, the DMAS subcontractor will advise the provider as to whether the child is eligible to receive services through Medicaid. Failure by the provider to submit Medicaid paperwork according to the APOS guidelines may result in CSA non-payment for Medicaid eligible services.

The provider is asked to notify the FRU directly of the status of Medicaid approvals and denials, and to fax or send by secure email a copy of the written communications from Magellan regarding the status. A facsimile (fax) line is designated to receive information from providers regarding Medicaid status. The FRU maintains data regarding the submission of all documentation of youth to providers for RTC, CBRT and TFC Medicaid services while the case is open to CSA funded services. When the case is closed, the FRU will forward the documents to CSA staff for integration in the CSA file. The FRU provides reports to CSA and Finance staff regarding Medicaid submissions, approvals and denials.

Department of Medical Assistance Services

DMAS will reimburse providers for the covered services for RTC, CBRT and TFC for each eligible child at a daily rate agreed upon between the CPMT and the provider. This negotiated rate cannot exceed a maximum established by DMAS for these services. For TFC and CBRT services, Medicaid reimburses only for case management. For RTC services, Medicaid provides a per diem rate for residential treatment. The per diem rate should include room and board and combined residential, however, if the youth is Title IV-E eligible and the RTC placement is Title IV-E reimbursable, then room and board is not included in the Medicaid per diem rate.

The education expenses may be paid by CSA pool funds. The psychiatric, professional, and pharmacy, as well as the occupational therapy, physical therapy, and speech and language therapy services provided by an outside agency may all be billed to Medicaid separately by the enrolled provider. Reimbursement for RTC will be at the rate agreed upon between the CPMT and the RTC provider, subject to an upper limit set by the Medicaid agency.

CSA Contracts Management Staff Responsibilities

1. Negotiate rates with providers, including the agreed upon rate for Medicaid reimbursement, and obtain CPMT approval of all contracts.
2. Maintain a listing of Medicaid enrolled providers who have a current, approved contract with the CPMT. The information is included in the local CSA Provider Manual Medicaid Directory which is maintained electronically on County FairfaxNET.

CSA Case Manager Responsibilities

The CSA Case Manager will:

~~1. Complete and submit to CSA a Certificate of Need (CON) and include supporting documents necessary for submission for Medicaid reimbursement.~~
~~2. Coordinate obtaining the signature of a physician to review and sign the CON for new placements in Medicaid enrolled residential and group home placements.~~
1. Notify the FRU Medicaid Analyst of TFC placement changes including moves between foster homes and admissions to residential and group home placements.
2. Case managers are not responsible for obtaining rate certification letters /documentation for or submitting them to providers.

- Abuse or neglect;
- Criminal behavior;
- Death;
- Emergency treatment;
- Facility related issues such as fires, flood, destruction of property;
- Food borne diseases;
- Serious illnesses (communicable diseases such as such as TB, meningitis, influenza, etc.);
- Serious injury (accident or otherwise);
- Sexual misconduct/assault;
- Substance abuse;
- Suicide attempt; and
- Other incidents which jeopardize the health, safety, and well-being of the youth.

17.3 Provider Responsibilities

1. Shall notify the proper authorities, consistent with state regulation, and take appropriate action to re-establish the health, safety, and well-being of the youth.
2. Report the incident, within 24 hours of the incident, via telephone, to the case manager of the placing agency of each youth involved.
3. Complete and submit within 48 hours of the incident, a written report, for each youth involved, to the case manager of the placing agency and CSA Utilization Review Manager. ~~and effective July 1, 2006, to the local CSA Contracts Supervisor~~. The written report should give a factual, concise account of the incident and include, minimally, the following information:
   - Name of facility;
   - Name of person completing form;
   - Date and time of incident;
   - Date of this report;
   - Youth's name, age, gender, race, reason for placement, disability;
   - Placing agency;
   - Placing agency Case Manager's name;
   - Where the incident occurred;
   - Description of incident (including what happened immediately before, during and after the incident);
   - Names of witnesses;
   - Action taken by staff in response to incident;
   - Names and agency of others notified (family, legal guardian, child protective services, medical facility, police);
   - Resolution of incident;
   - Signature of person completing report; and
   - Facility director's signature and date.
4. Separate reports should be completed and submitted for each youth involved. The Provider should not disclose the identity of other persons involved in the incident in each individual report.

17.4 Case Manager of Placing Agency Responsibilities

1. Assess the risk to the child within 24 hours of receiving a verbal serious incident report, and take appropriate action to ensure the child's health, safety, and well-being. Consult with UR and Contracts' staff if unable to ensure health, safety, and well-being of the child;

2. Follow the placing agency's internal serious incident reporting guidelines.
3. Notify CSA Utilization Review staff of any serious incidents that may meet criteria for CSA Management Team review.

17.5 CSA UR Manager or Designee Responsibilities

In concert with the CSA Contracts Manager or designee, monitor all serious incident reports and follow the Administrative Response Protocol (see Section 17.1).

17.6 UR Staff Responsibilities

1. Review content of SIR. Check compliance of required elements as stated in the APOS. Consider quality of response and follow-up with provider in UR review.
2. If contract requirements have been followed, and there are no concerns about quality or response to incident, the UR Analyst will initial SIR document and submit for filing. No further action is needed.
3. If follow-up is required, the UR Analyst will attach documentation regarding actions taken (e.g., email, log of correspondence with dates/points of contact/nature of follow-up, etc.). If resolved, UR Analyst will initial SIR document and submit all documentation for filing.
4. For issues around quality, the UR Analyst will take the lead. For issues regarding contract violations, Contracts staff will take the lead.
5. If concerns remain unresolved, the UR Analyst will staff the SIR with the UR Manager.
6. The UR Manager will consult with Contracts Manager and bring to CSA Management Team for further direction.
7. The UR Manager and Contracts Manager present SIRs report to CPMT quarterly.

17.7 CSA Contracts Staff Responsibilities

1. Follow Administrative Response Protocol (see Section 17.1).
2. ~~Collect, collate, and~~ Monitor serious incidents occurring at each facility and utilize this data, as well as reports from state licensing agencies when processing provider contracts for renewal.
3. ~~The Contract workgroup will periodically review serious incident reporting with the CSA Management Team and/or the CPMT.~~ The Contract manager along with the UR manager will summarize serious incident reporting and prepare a report for the CPMT quarterly.

18. Management of Records and Data Security

1. CSA client records (physical or electronic) shall be retained for three years after CSA case closure. These include but are not limited to the documents listed on the Virginia Office of Children's Services CSA Uniform Documentation Inventory Form. Child specific team documents are also included in this requirement.
2. CSA client records shall be destroyed with six months of the end of the above three-year period, according to the process set forth in COV § 42.1-86.1, Disposition of public records.
3. CSA contract records shall be retained according to the GS-2 fiscal schedule for five years after contract expiration or until audit, whichever is longer, and then destroyed within six months according to the process set forth in COV § 42.1-86.1.

8. For documents that need to be shared within specific county regions, the S: or I: Drives are additional locations to save them, provided confidential files are password protected.
9. To save a database containing confidential information, it has to be password protected or placed in restricted folder on the L: Drive.
10. Confidential data MUST be password protected on the shared network drives.
11. The document should be placed in a password or active directory protected network folder when possible. These can be set up by your program area's Security officer.
12. In addition to not being secure, Information stored on the C: Drive is not automatically backed up as in the case of the network drives and will be lost in case of a computer hardware failure.

25. Parental Contribution Policy

Pursuant to Va. Code Ann. §2.2-5206 (3) of the Children's Services Act and Va. Code Ann. §16.1-286, the CPMT has approved procedures for the active involvement of parents or other legally responsible parties in the planning, delivery, and financing of services for their children. Virginia law requires parents to participate in treatment and services recommended for their child and to contribute financially to the cost of those services based on their ability to pay.

All families accessing CSA pool funds shall be assessed a parental contribution (co-payment) for services using a CPMT-approved sliding fee scale, with the following exceptions:

- Children who are in foster care with the Department of Family Services;
- Children who are receiving only the specific educational services designated by the child's IEP for residential or private day placement
- Children referred by DFS Protection and Preservation Services and Child Protective Services for CSA-funded community-based foster care prevention services may be considered for a time-limited waiver when necessary for the safety of the child.
- CSA-eligible youth who are aged 18 or older.

The Parental Financial Contribution is determined based on the total gross annual income of the household (IRS Form 1040, Line 6). The household is defined as including one or more adults who are acting in a caregiving capacity and dependent children residing in the same home. If a parent is absent from the home but retains custody rights, his/her income shall also be included in the determination of the parental financial contribution unless the parent who is absent from the home is providing child support payments. If the household includes adults who are not acting in a caregiving capacity (e.g. a young adult child living with parents, an aged parent living with adult child), these adults will not be included when determining household income. The income of kin and fictive-kin who are caretakers is not counted when determining the parental financial contribution for *community-based services only*. The income of live-in significant others is not included in the parental contribution assessment.

The household income is used to determine the parental contribution for community-based and residential services.

The table below details the incomes that will be considered when determining the household income.

Household Income Determination*		
Person	Community-Based Services	Residential Services
Parent(s) (including stepparent and adoptive parent(s))	Yes	Yes
Divorced Parent 1. Joint custody 2. Paying child support	1. Both incomes used in calculation 2. Income of custodial parent considered	1. Both incomes used in calculation 2. Income of custodial parent considered
Kin/Fictive Kin	No	Yes
*In cases of questions or appeals, CSA may request additional financial information to resolve the matter. As appropriate, individuals are encouraged to utilize the administrative reconsideration process prior to making an appeal. The appeal process is outlined in section 4.4, page 26 of this manual.		

In assessing a parental contribution (co-payment), the household income will be adjusted by the number of dependent children in the home. To determine Adjusted Household Income

When a family's assessed ability to pay exceeds the average monthly cost of services, the family will be responsible for paying the service providers directly. These families may receive agency case management (not including case support) for assistance with activities such as service planning and provider identification without charge. For residential care, the cost of the service to be covered by the family presumes use of Medicaid and excludes CSA-eligible education costs.

25.1 Parental Contribution Fee Scale

The parental contribution fee is based upon charging the family a percentage of their monthly Adjusted Household Income (AHI) from 1.65% to 10% for community-based services and 3.33% to 20% for residential services.

Tier	Adjusted Household Income (AHI)	Community-Based Services	RTC / Group Home
1	$48,599 - And Below	$0	$0
2	$48,600 - $55,599	$67	$135
3	$55,600 - $62,599	$77	$154
4	$62,600 - $69,599	$86	$174
5	$69,600 - $76,599	$96	$193
6	$76,600 - $83,599	$106	$213
7	$83,600 - $93,599	$203	$361
8	$93,600 - $103,599	$228	$405
9	$103,600 - $113,599	$252	$448
10	$113,600 - $123,599	$276	$491
11	$123,600 - $133,599	$301	$534
12	$133,600 - $143,599	$325	$578
13	$143,600 - $158,599	$454	$799
14	$158,600 - $173,599	$501	$882

15	$173,600 - $188,599	$548	$966
16	$188,600 - $203,599	$596	$1,049
17	$203,600 - $218,599	$643	$1,133
18	$218,600 - $233,599	$691	$1,216
19	$233,600 - $324,999	5% of AHI ÷ 12	10% of AHI ÷ 12
20	$325,000 - $374,999	8% of AHI ÷ 12	15% of AHI ÷ 12
21	$375,000 - and Above	10% of AHI ÷12	20% of AHI ÷ 12

25.2 Parental Contribution Fee Waiver/Reduction

The CSA Program Manager or designee may waive or reduce the parental contribution (co-payment) amount based upon documentation of financial hardship. In the absence of such a waiver or reduction, parents/legal guardians are required to pay the assessed parental contribution (co-payment) amount for their children to receive CSA-funded services.

If the parents' income level qualifies the family or child for income-based benefits such as Medicaid, SNAP, TANF, and Free or Reduced school lunches, the family may submit proof of the benefit in lieu of submitting income verification. The CSA Program may verify benefits and eligibility through intra-agency data sharing with DFS Self-Sufficiency or other human services agencies with proper consent. The school social worker may verify eligibility for federal school lunch benefits by signing the Parental Contribution Assessment. Eligibility for qualifying income-based benefits must be confirmed annually when the Parental Contribution Assessment is renewed.

When families have incomes within Tiers 19 – 21 on the Parental Contribution Scale and request a reduction or waiver of the parental contribution, they must provide the two most recent paystubs together with a copy of their most recent tax return. Families requesting a waiver or reduction must also provide documentation regarding their assets including investments, property ownership, and business holdings. The CSA program may consult with the County Attorney's Office and the tax administration to determine "ability to pay" in situations where families have extensive assets in addition to high income.

25.3 Assessing Parental Contribution when Multiple Children in the Family are Receiving CSA Services

When a family has more than one child receiving CSA funded services that require a parental contribution (co-payment), the parental contribution shall be assessed for the child subject to the highest contribution unless the family is granted a Parental Contribution Waiver based on the above-listed exceptions. The parental contribution may be waived for the other children receiving CSA funded services. If services are discontinued for the child for whom the parental contribution (co-payment) is assessed, then the contribution shall be charged for the sibling receiving CSA services.

25.4 Changes to Parent Income or Household Size

Parents are responsible for promptly reporting to the case manager changes in income or household size, which shall be used to re-assess the parental contribution (co-payment) amount by completing and submitting a new Parental Contribution Assessment to the CSA office. The parental contribution (co-

- a data field indicating the circumstances under which the child ends each service; and
- a data field indicating the circumstances under which the child exits the Children's Services Act program.

The current requirements can be found at https://www.csa.virginia.gov/html/pdf/LEDRS.xlsx.

In addition to the requirements above, the following are also new requirements:

- PO details including service and provider details;
- Recoveries, refunds, SSI, SSA, parental contributions, etc.;
- State Student Testing Identifier.

All client-specific information shall remain confidential and only non-identifying aggregate demographic, service, and expenditure information shall be made available to the public;" COV§2.2-2648 D. 16.

27. Annual Cost Allocation Plan and Management of the Interagency Budget

The cost allocation plan amount to be allocated to Fairfax-Falls Church is defined by the total Medicaid target and the total non-Medicaid pool allocation as specified in the Appropriations Act. Effective July 1, 2000, the state pool funds for the Medicaid target and non-Medicaid allocations are distributed to Fairfax-Falls Church based on the greater of Fairfax's percentage of actual 1997 CSA program expenditures to total 1997 program expenditures or the latest three-year average of program expenditures.

The base year for CSA expenditures is 1997 actual program year expenditures and therefore, the local match for the base year funding consisting of the actual aggregate local match rate based on actual total 1997 program expenditures for the "Children's Services Act for At-Risk Youth and Families." (2003 Appropriations Act, Item 935, Item 299, section D2). The funds used for local match must be "cash" (i.e., in-kind resources cannot be used). Matching funds may be from any source other than state or federal funds received under the CSA, unless otherwise prohibited. Local match for Medicaid eligible expenditures is based on the aggregate local match rate based on 1997 program year expenditures.

This match rate will be applied to the gross service expenditure less the federal Medicaid participation amount. The CPMT has centralized the CSA Pool fund budget, financial management and reporting functions in the Department of Family Services. Expenditures and encumbrances of CSA Pool funds for individual eligible children are to be maintained by DFS through combined utilization of the County's CSA information and financial management systems.

~~Supplemental Requests for CSA State Pool Funds for the unanticipated costs of the mandated/targeted populations will be prepared by the Budget Analyst and subsequently submitted through the Local CPMT Fiscal Agent to the State Fiscal agent after receiving CPMT approval.~~ Supplemental Requests for CSA State Pool Funds for the unanticipated costs of the mandated/targeted populations will be prepared by the Budget Analyst, reviewed by the CSA Manager and approved by the Fiscal Agent. The submission of the Supplemental Request will be done via the CSA Local Government Reporting application, available online.

into three categories of System of Care Providers: Tier I, Tier II, and Tier III. 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. ~~The purchase order must be signed by both the provider and the CPMT designee. The CPMT signature authority on the purchase order is delegated to the CSA Fiscal Administrator or designee.~~

29.1 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 have a signed contract in place and all required documentation is 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 ~~FAPT~~ 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;

MEMO TO THE CPMT
January 24, 2020

Administrative Item A - 2: Endorse Funding Proposals for FY 2019 Healthy Minds Fairfax Budget (Revised)

ISSUE:

A revised FY 2020 Healthy Minds Fairfax project budget is presented for endorsement.

BACKGROUND

On April 26, 2019, the CPMT approved a project budget of $1,068,800 for FY 20. At the mid-point of this fiscal year, we have determined that we will have a budget surplus of approximately $183,000. The surplus is due to projects scheduled to begin at the beginning of FY 2020 did not begin until later in the fiscal year or in some instances will not take place. Additionally, our final budget was more than we projected. The Children's Behavioral Health Collaborative Management Team (CBHCMT) approved the additional projects to support the continued implementation of the Blueprint strategies in FY 2020.

FY 2020 Projects Previously Endorsed by CPMT:

Evidence-Based Practice Training Consortium:	$150,348 (under contract)
Give an Hour Pro-Bono Outpatient Therapy:	$14,777 (under contract)
Multicultural Behavioral Health Services	$130,000
CR 2 Mobile Crisis Response Expansion	$100,000
Psychiatric Consultation for Pediatricians	$100,000
Short Term Behavioral Health Services (STBH)	$167,000
CR 2 Mobile Crisis Response Expansion (additional)	$100,000
REACH Mental Health Training for Pediatricians	$75,645
Psychiatric Consultation for Pediatricians (Additional)	$35,000
Integrating Behavioral Health and Physical Health in CSB	$33,841 (will not occur)
CSB Merrifield Crisis Response Center Youth Recovery Group	$28,818
Evaluation of REACH Pediatrician Training	$25,000
Best Practice Trainings for Providers/Families	$15,000
Trainings for Providers/Families: Working with Anosognosia	$15,000 (will not occur)
Training Program for Providers/Families – Youth & Family Lens	$10,000 (will not occur)
Evidenced Based Training for FCPS Staff	$8,420
Making Good Work	$59,950

CBHCMT Endorsed Mid-Year FY 20 Additional Projects

Increase Funding for Contract for Evidenced Based Training Consortium	$8,5000
Additional funding for STBH	$15,000
Talk It Out	$1,200
Pyramid Model Equity Coaching Guide	$14,809

Youth Fest	$1,000
Behavioral Health Clinicians in FCPS Community Schools	$44,880
Developing Trauma Sensitive Spaces at Burke School	$20,000
Vaporizing Vapes	$38,250
Evaluation of Additional Projects	$6,125

ATTACHMENTS:
FY 2020 Mid-Year Funding Proposals Summary
FY 2020 Mid-Year Funding Proposals

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

CBHC MT - Approved Mid-Year Proposals.

Proposal Number	Agency/Workgroup	Name of Proposal	Brief Description	Amount
1	Evidence-Based Workgroup	Increased funding for contract with George Mason University	The Evidenced-Based Workgroup is seeking an increase in the of the contract with George Mason University. A new requirement for providers to participated in the trainings offered through the Fairfax Consortium for Evidenced-Based Practice is to participate in supervision twice a month for 6 months. In order to accommodate all of the participants and an additional supervisor is needed.	$8,500
2	Short Term Behavioral Health Services	Amend the STBH Funding Proposal	In school year 2019-2020, we have an increase of 18% in referrals over the same period in school year 2018-2019. In order to meet the needs of the youth who are referred, additional funds are needed to pay for the cost of treatment.	$15,000
3	Community Services Board	Talk It Out	Staff of the Northwest Center in Reston, VA would like to start a once a week parent support group called, "**Talk It Out.**" This group would be open to parents and guardians of existing clients and non-clients of the Communit Services Board. There will be no charge for participating in this group. The group would support caretakers of children and teenagers that are struggling with issues addressed by the mission of the Community Services Board.	$1,200
4	Office for Children	The Pyramid Model Equity Coaching Guide	The Office for Children proposes to develop and implement a coordinated series of professional learning opportunities to build capacity of early childhood specialists to advance equity; promote social and emotional skills of children through the use of culturally responsive practices; and prevent suspension, expulsion, and disciplinary disparities in early programs. The professionals learning series will use the Pyramid Model Equity Coaching Guide and facilitated discussions on understanding the impact of race and implicit bias.	$14,809
5	NAMI Northern Virginia	Youth Fest	This event brings together teens, young adults, and families for one day of seasonal fun, great food, and positive conversations around mental health. After hearing hopeful stories of living with a mental health condition, there are two breakout sessions. Teens and young adults complete a craft while having a conversation on mental health. Adult family members meet to hold a discussion facilitated by one of our family support group program leaders.	$1,000

Proposal Number	Agency/Workgroup	Name of Proposal	Brief Description	Amount
6	Fairfax County Public Schools	Behavioral Health Clinicians in FCPS's Community Schools	The behavioral health clinicians will be able to see students for up to 20 hours per week during academic year 2019-20 at FCPS' three existing community schools: Glasgow MS, Whitman MS, and Mt. Vernon Woods. Behavioral health clinicians will be hired at these schools having experience in Cognitive Behavioral Therapy (DBT) and Dialectical Behavioral Therapy (DBT) which are empirically supported treatments for children and youth who exhibit difficulty regulating their emotions effectively. Data will be collected from the behavioral health clinicians similarly as to the short-term behavioral health (STBH) providers.	$44,880
7	Fairfax County Public Schools	Developing Trauma-Sensitive Spaces at Burke School	Trauma-sensitive spaces at Burke School will provide escalating students a proactive opportunity to access de-escalation and self regulatory techniques in a safe and sanctioned setting, addressing barriers which interfere with reaching their full potential. Through intentional modifications to the physical space, students will have new opportunities to use trauma-sensitive spaces as they develop self-awareness and regulation skills.	$20,000
8	Fairfax County Health Department	Vaporizing Vapes: Using Mobile Cessation Technology to Reduce Youth Vaping in Fairfax County	The Fairfax County Health Department, in Partnership with Fairfax County Schools seeks to customize and implement the Truth Initiative's **This is Quitting** mobile cessation program to reduce vaping use among adolescents and young adults in Fairfax County. This program offers text messags for teens and young adults that provide support to users throughtout the quit process. It gives users the option to set a quite date and provides up to 12 weeks of tailored text messages. This program provides users with on-demand support for cravings, sress, relapse, or desire for more messages.	$38,250
9	Fairfax County Public Schools	Mentor Progam at Mountain View Alternative School	The Mountain View in-house Mentor/Mentee Program is seeking funds to promote healthy eating habits. During their monthly social gatherings are used as incentive celebrations draw in more of the school population into the program. Mountain View has rolling admissions each semester so they are acquiring new students each semester so these gathers are also used to entice new students to participate in the Mentor Program. While they asked for $5000, they stated that they will be pleased with any amount of money that is granted to them.	$2,500
CBHC also approved allowing HMF to spend 5% of the approved on evaluation. This comes to be $6,125 (we subtracted out the amount from STBH and Trainining Consortium because the evaulation is funded.				$6,125
			Total of all Mid-Year Proposals including funding for Evaluation	$152,264

HEALTHY MINDS PROPOSAL 1

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

To: CHBC Management Team
From: Healthy Minds Fairfax Evidenced Based Practice Workgroup
Date: January 10, 2020
Re: Request to $8,500 to GMU Contract

We are requesting to add $8,500 to the FY20 contract with George Mason University (GMU) to ensure that all training participants receive supervision to ensure that they are keeping to the fidelity of the evidenced based model that they received training in. The requirement that all participants receive supervision was recently added and GMU must add a second supervisor to provide supervision to the next cohort of participants in the Match ADTC training.

Healthy Minds Fairfax
12011 Government Center Parkway
Suite 404
Fairfax, Virginia 22035
Phone: 703-324-5535, FAX: 703-653-7052; TTY 711
www.fairfaxcounty.gov

Amendment to the FY 2020 Healthy Minds Fairfax Funding Proposal

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

This proposed amendment is to seek an additional $15,000 to the original request of $167,500 for a total of $182,500 total of to continue the Short Term Behavioral Health (STBH) Service for Youth. This funding request is to pay for services for students who attend 38 Fairfax County Public Schools. At the end of December 2019, 18% more youth have been referred to the program during the school year 2019-2020 as compared to same period in school year 2018-2019. This could be due to the increase number of schools that have been designated as STBH schools.

A. Progress to Date

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

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

B. Description of any new project activities

During this year, the leadership at the Fairfax -Falls Church Community Services Board (CSB) funded an expansion of the services. This expansion allowed the program to add 14 schools

and opened the program to youth seeking services at the CSB who otherwise were to be placed on a monitoring list or did not meet the CSB's priority population. The CSB fund will continue to fund this expansion during FY 20. In FY 21, we will be seeking funds to cover this expansion.

C. Updated Project Budget

Projected FY 20 expenditures: $182,000 ((all direct costs to contracted STBH providers)

D. Plan for continued funding after expiration of HMF funding:

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

E. Proposed Outcome Measures

Functional Outcomes

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

Quality outcomes

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

Continuum of Care Outcome

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

HEALTHY MINDS FAIRFAX PROPOSAL 3

DATE: January 8, 2020

Healthy Minds Fairfax FY 2020 Request

Parent Support Group – Talk It Out

Staff of the Northwest Center in Reston, VA would like to start a once a week parent support group called, "**Talk It Out**." This group would be open to parents and guardians of existing clients and non-clients in Fairfax County. There would be no charge for participation in the group. The group would support caretakers of children and teenagers that are struggling with issues addressed by the mission of the CSB.

The group will be modeled after the Juvenile Court **Family Services Group** run at Fairfax County Court and **Heads Up** group at Merrifield. The group will be a non-billable support group for parents and care givers. It would give emotional support to parents going through a difficult time with their child. Group facilitators will help parents access the appropriate services in the county; including in the private sector. This may include parents seeking services for their children and teenagers at the CSB.

The group will be open format without a curriculum and as the group forms topics and curriculum will be developed from participants. The group will initially be staffed by existing CSB staff (David Edelman) with the hope of adding another facilitator in the near future, either another clinician or Peer Recovery Specialist. Juvenile Court Staff have recommended getting parent volunteers who have been through County Government Services in the past. This could be from Court, CSB, DFS, Special Education in School, etc. These volunteers would need to be vetted by VIVA.

Blueprint Goal Addressed:
Goal 5: Youth and Parent/Family Peer Support
Develop and expand youth and parent/family peer support services.
The creation of a Family Navigator program to assist families in "navigating the system" and expansion of evidence-based peer to peer groups round
out the strategies of this goal.

Strategy B in Goal 5 states: "Expand peer support services for Youth and Families"
By expanding available family support to Reston this will meet the need for expansion of Goal 5. The need for this type of group in the north county area is high. It would provide emotional support to parents struggling through a difficult time with their child. The group would support caretakers of children and teenagers that are struggling with behavioral health issues and help parents access the appropriate services in the county; including those within the private sector.

Northwest Center
1850 Cameron Glen Drive, Suite 600
Reston, VA 20190
703-481-4100, Fax 703-435-1961, TTY 711
www.fairfaxcounty.gov/csb

Due to staffing patterns and space availability at the Northwest Site there is no current plan to start a concurrent adolescent group, such as **Talk It Out**, at Merrifield. There are already several groups being offered at the NWC site, including: SUD Group, Trauma Group for Girls, and upcoming a MATCH group for younger children.

How requested funds will be used by June 30, 2020:
$1200 is being requested at this time to purchase METRO bus tokens for families in need and for group start-up materials such as resource books, paper, pens, brochures, cups, plates and light refreshments such as coffee, tea and snacks.

Juvenile Court **Family Services Group** provides bus tokens to families in need who attend.

How will the program be sustained after the funding?
The group will be run by CSB staff and may eventually be supported by Peer Recovery Specialists and parent volunteers vetted by CSB VIVA

Have other funding sources been explored?
No other funding sources have been explored at this time.

What is the recent data indicating extent of need (if available) for the proposed project?
From September 2019 to December 2019, the supervisors from the CSB at the North County, conducted outreach & engagement to many stakeholders in the North County area. This included schools, PTA's, courts, DFS and other community programs. During this outreach/engagement, many of the stakeholders were inquiring about a resource were parents could come to and get support and system navigation.

What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?
The hope is that, based on the feedback the North County supervisors received from the stakeholders, the program will bring in the targeted population and have positive outcomes. They will be keeping track of satisfaction, available support, marketing/outreach efforts, attendance and referral sources.

What are the outcome measures including how will the data be collected and reported back to the CBHC?

Northwest Center staff will be using the outcome measures provided by Lisa Lunghofer, Ph.D., owner of Making Good Work, LLC. The instruments include the *Satisfaction with Services Scale EBP*; the PROMIS measure of *Informational Support* and the PROMIS measure of *Emotional Support*. These scales will be offered at group start, six-week interval and at conclusion of group participation.

HEALTHY MINDS FAIRFAX PROPOSAL 4

- A brief description of the project and how the project will accomplish a Blueprint goal, strategy or action step?

The Office for Children proposes to develop and implement a coordinated series of professional learning opportunities to build the capacity of early childhood specialists to advance equity; promote social and emotional skills of children through the use of culturally responsive practices; and prevent suspension, expulsion and disciplinary disparities in early learning programs. OFC staff who support early childhood educators in centers and family child care homes throughout the county will participate. These OFC specialists provide coaching and mentoring to early childhood educators in the community and will be supporting the county's new Early Childhood Mental Health Consultation System. (Goal 8: Equity/Disparities; Strategy 6). The professional learning series 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.

The Pyramid Model Equity Coaching Guide provides the classroom coach with a reflection tool to examine the implementation of Pyramid Model practices through the lens of culturally responsive practices and identification of implicit bias
The facilitated discussions will incorporate current best practices around applying an equity lens and building on children's diverse knowledge and abilities to empower them to achieve their full potential. This will be informed by work being done at the Children's Equity Project (CEP), a multi-university initiative focused on promoting equity from the early years through the early grades. The CEP is housed at Arizona State University and includes multiple partners such as Bank Street College and Georgetown University.

- Please describe how you will use the funds by June 30, 2020

We are requesting $14,089. Funding will be used to contract with two facilitators, provide a video conference to follow-up and the resources needed to support the work for 40 participants in each of the facilitated sessions.

Implementation Plan:

1. Use The Pyramid Model Equity Coaching Guide to guide the conversation http://challengingbehavior.cbcs.usf.edu/Implementation/Equity/Guide/index.html
- Invite Dr. Rob Corso , the Executive Director of the Pyramid Model Consortium and Senior Research Associate at Vanderbilt University, to conduct a train the trainer session on the Pyramid Model Equity Coaching Guide
  Speaker fee: $1500
  Travel expense: $1000

Coaching Guide: $15 per guide ($15 x 40 =$600)

- Each participant will complete the online module Culturally Responsive Practices to Reduce Implicit Bias (https://pyramid.litmos.com/self-signup/register/66520?type=2):
  $29 per participant ($29 x 40 = $1160)

- Follow up video conference with Dr. Corso: $300

Total: **$4,560**

2. Facilitated Community of Practice

- Invite Lisa Gordon, Project Director of School Systems Partnerships and Programs, Bank Street College of Education; Developer of webinar series for mental health consultants in collaboration with Georgetown University and the "Children's Equity Project," Arizona State University, to facilitate
  Facilitator fee for virtual and face to face
  sessions: $5,000
- Resources:
  Each and Every Child: Teaching Preschool with an Equity Lens
  $28 per book ($28 X 40 = $1,120)

  Spotlight on Young Children: Equity and Diversity (NAEYC book)
  $25.00 per/book ($25 x 40 = $1,000)

Total Cost: **$7,120**

Additional Resources for #1 and #2:

Loose Parts 3: Inspiring Culturally Sustainable Environments
$32.95 per/book ($32.95 x 40 = $1,318)

Standing Up for Something Everyday by Beatrice S. Fennimore
$19.77 per/book ($19.77 x 40 = $790.80/$791)

NAEYC Position Statement: "Advancing Equity in Early Childhood Education"
Printing: 24 pages @ $.15 per page (24 x $.15 x 40 = $144)

"Leading with Equity, Early Childhood Educators Make it Personal": Summary of the Leading and Working Toward Equity Leadership Summit, March 2019
Printing: 26 pages @ $.15 per page (26 x $.15 x 40 = $156)

Total Cost: **$2,409**

References:

HEALTHY MINDS FAIRFAX PROPOSAL 4

Fairfax County Equitable School Readiness Strategic Plan, Birth-8 (https://www.fairfaxcounty.gov/office-for-children/sites/office-for-children/files/assets/school-readiness/pdfs/fairfax-county-equitable-school-readiness-strategic-plan.pdf)

One Fairfax: (https://www.fairfaxcounty.gov/topics/one-fairfax)

School Readiness Resources Panel Presentation: (https://www.fairfaxcounty.gov/boardofsupervisors/sites/boardofsupervisors/files/assets/meeting-materials/2019/sept17-health-housing-human-services-revised-school-readiness-resource-panel-recommendations.pdf)

Using the Equity Coaching Guide to Address Culturally Responsive Practices, November 7, 2018 (http://challengingbehavior.cbcs.usf.edu/Training/Webinar/archive/2018/11-07/2018-11-07_Using-the-EquityCoaching-Guide.html)

"Achieving Quality With Equity: Recognizing and Supporting High-Quality Practices and Professionals in Low-Resource Communities", Nov 19, 2019 by Junlei Li (https://www.zerotothree.org/resources/3008-achieving-quality-with-equity-recognizing-and-supporting-high-quality-practices-and-professionals-in-low-resource-communities)

"How Can Teachers Use CLASS to Build Equity": Webinar https://info.teachstone.com/webinar/teachers-class-equity?hsCtaTracking=0c6f2809-ecee-4b2f-8fcf-4818604f4937%7C11e585ad-99e8-4bde-94b7-d4a2a1239b02

Moving Beyond Multicultural Education: Promoting Equity in Early Childhood Education, by Jen Neitzel and Ebonyse Mead (https://www.earlychildhoodwebinars.com/webinars/moving-beyond-multicultural-education-promoting-equity-in-early-childhood-education-by-jen-neitzel-and-ebonyse-mead/?fbclid=IwAR1sf9IgGdD0xdRiB1PuFtPUUqINXR85ju-kUhb5KZpVkui1pFH34e8QAis)

The Children's Equity Project (CEP) (https://www.iecmhc.org/about/partners/childrens-equity-project-cep/)

Creating Welcoming and Inclusive Environments for Lesbian, Gay, Bisexual, and Transgender (LGBT) Families in Early Childhood
Settings (https://search.proquest.com/openview/59a65fcf7af396c9ed274e5997f0bbe8/1?pq-origsite=gscholar&cbl=27755)

HEALTHY MINDS FAIRFAX PROPOSAL 4

Creating a Welcoming Early Childhood Program for LGBT-Headed Families: Resources about Diverse Family Structures (https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/lgbt-resources.pdf)

Handouts from Diversity Toolkit:

Sexual Orientation and Gender Identity (http://www.nea.org/tools/30411.htm)
Gender http://www.nea.org/tools/30408.htm

LGBTQ Lives in Selected Children's and Young Adult Books © 2009 Cooperative Children's Book Center; updated annually (http://ccbc.education.wisc.edu/books/detailListBooks.asp?idBookLists=446)

Creating Gender Safe Spaces (https://www.virtuallabschool.org/focused-topics/gender-safe)

- How will the program be sustained after the funding?

New employees will be offered the opportunity to attend sessions twice a year facilitated by staff who have participated in the learning experience.

- Have other funding sources been explored?

NA

- What is the recent data indicating extent of need (if available) for the proposed project?

Knowledge and strategies of equitable decision making and implementation are needed for responding to early childhood educators throughout the county who are mentored and educated and supported by OFC staff

- What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?

OFC has a history of positive outcomes for early childhood educators and the children they support when professional learning opportunities are followed with on-site mentoring and technical assistance. These proposed professional learning sessions will provide OFC staff who provide mentoring and technical assistance with knowledge and strategies to build the capacity of community early childhood educators to support children's social and emotional competencies and promote equity.

- What are the outcome measures including how will the data be collected and reported back to the CBHC?

Participants will be asked to attend a series of sessions that will include reflection and documentation of strategies implemented in their work with community early childhood educators.

HEALTHY MINDS FAIRFAX PROPOSAL 5

Mid-Year Funding Proposal
Healthy Minds Fairfax, Children's Behavioral Health Collaborative

A brief description of the project and how the project will accomplish a Blueprint goal, strategy or action step?

NAMI Northern Virginia's YouthFest event brings together teens, young adults, and families for a day of seasonal fun, great food, and positive conversations around mental health. Everyone gathers for food while a couple teen and young adult presenters share their hopeful story of living with a mental health condition. Following this, there are two breakout group sessions. Teens and young adults complete a craft while having a conversation on mental health. In the past, this group has discussed topics such as coping strategies or ways to combat stigma. Adult family members meet to hold a discussion facilitated by one of our family support group program leaders. After these groups, everyone comes together for a seasonal activity such as wagon rides in the fall or pot planting in the summer. Throughout the event, we have a resource table available with information on local mental health resources for all age groups. The event is no cost to participants and is open to anyone. The goal of this event is to create a sense of community, remind participants that they are not alone, encourage positive conversations around mental health, share information on local mental health resources, and bring people together for a day of fun. We are requesting $1000 for this event.

Please describe how you will use the funds by June 30, 2020

We will be hosting our 2020 SummerFest event in mid-June. We will be booking a venue, likely a recreation center in Fairfax. We will be getting the event catered and will also bring some snacks and drinks ourselves. Funds will also be needed to gather materials for activities (craft supplies), promote the event by creating and distributing flyers, and provide stipends to presenters.

How will the program be sustained after the funding?

Our NAMI Northern Virginia Youth Leadership Council—the group of teenagers assisting in planning and executing the YouthFest events—is planning to host some fundraising efforts this year to raise funds for events such as YouthFest. As our organization fundraising increases as well, we will have room to expand the budget for youth programs and events.

Have other funding sources been explored?

We often leave room in the budget for two YouthFest events each year. We hope, however, to be able to expand on our youth and family programs and events, using the budget for other needed programs such as Ending the Silence (youth presentation program) or family support programs.

HEALTHY MINDS FAIRFAX PROPOSAL 5

What is the recent data indicating extent of need (if available) for the proposed project?

The following statistics were pulled from NAMI.org. The data are from studies conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), and the U.S. Department of Justice.

50% of all lifetime mental illness begins by age 14 and 75% by age 24, but only about 50% of youth ages 6-17 with mental health conditions receive treatment. The biggest reason for this is stigma.

There can be serious consequences of untreated mental health conditions in teens and young adults. High school students with significant symptoms of depression are more than 2x as likely to drop out of school than peers. About 70% of youth in juvenile justice system have a diagnosed mental health condition. Suicide is 2nd leading cause of death among people ages 10-34 in the US.

Parents and caregivers are also severely impacted by this. At least 8.4 million people in the US provide care to an adult with a mental or emotional health issue. Caregivers of adults with mental or emotional health issues spend on average 32 hours per week providing unpaid care showing the need for teens and young adults to get support before adulthood.

These statistics indicate the need for support and conversation among teens, young adults, and family members to reduce stigma, increase awareness, and encourage those struggling to reach out for help. YouthFest does this by directly bringing these populations into positive hopeful conversations about mental health in a safe, friendly environment.

What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?

At the most recent YouthFest—FallFest 2019--we had 17 teens and young adults, 12 adults, and 5 young children attend. Of them, 17 completed the post-event evaluation. 88% agreed that they felt more comfortable talking to their peers about mental health. 82% agreed that they had learned about at least one new mental health related community resource. 50% said that the most meaningful part of the event was the discussion groups. Others listed the youth speakers as the most meaningful part or did not answer the question. About 70% of the survey respondents said they were very likely to attend another YouthFest event.

At a previous event, SummerFest of 2018, we also had 34 attendees (20 teens and young adults, 14 adults). 22 people responded to the survey, of which 77% agreed that they felt more comfortable talking to their peers about mental health and 77% agreed that they learned about at least one new mental health related community resource. 72% said they were very likely to attend another YouthFest event.

What are the outcome measures including how will the data be collected and reported back to the CBHC?

At the end of each YouthFest event, we hand out an event evaluation for attendees to fill out. I have attached the evaluation from our 2019 FallFest event. We will collect these

evaluations at the end of the next YouthFest event and can send the data collected to CBHC in a summary. The survey includes questions on demographics, what was meaningful about the event, and whether participants feel more knowledgeable and more comfortable talking about mental health with their peers.

Healthy Minds Fairfax Funding Proposal

Supporting Behavioral Health in FCPS Community Schools

Fairfax County Public Schools (FCPS) Department of Intervention and Prevention Services is submitting a request for funding in the amount of $44,880 to provide mental health services through dedicated behavioral health clinicians in Fairfax County Public Community Schools. This request is being submitted for the 2019-20 academic year. The behavioral health clinicians will be able to see students for up to 20 hours per week at FCPS' three existing community schools; Glasgow MS, Whitman MS, and Mt. Vernon Woods ES. A percentage of the youth enrolled in public school settings have difficulty with emotional regulation, which leads to problems with disruptive behavior, impulse control, avoidance behaviors, and conflict with teachers and peers. Behavioral health clinicians will be hired at these school sites having experience with Cognitive Behavioral Therapy (CBT) and Dialectical Behavioral Therapy (DBT) which are empirically supported treatments for children and youth who exhibit difficulty regulating their emotions effectively. Long-term outcomes will include improved mental wellness, increase school attendance and educational success, as measured by academic progress.

Criteria for service

- 400 percent poverty line
- Recommendation of clinical team

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

The project aims to provide mental health services in our three existing community schools, Whitman MS, Glasgow MS and Mt. Vernon Woods ES. The proposed behavioral health clinicians will be available to provide mental health services for up to 20 hours per school site. A community school is a public school that effectively benefits from partnerships with community resources and leverages these resources in the school community. Its integrated focus on academics, health, social services, mental wellness, youth and community development and community engagement leads to improvements in student learning, stronger families, and healthier communities. Behavioral Health Clinicians at FCPS community schools would remove an access barrier by providing services in schools.

This project will primarily work toward Blueprint Goals 8 and 12

Goal 8: Equity/Disparities: *Implement targeted strategies to address disparities in outcomes and access based on race, ethnicity, sexual orientation, socio-economic status, geography, and other factors.*

> **Strategy B**-Increase access and availability to behavioral health services for underserved populations. Strategies are to be developed and implemented in a culturally competent manner and in partnership with communities to be served.

Goal 12: Behavioral Health Intervention: *Address the needs of children with emerging behavioral health issues who have not been able to access appropriate, timely, and matching treatment services in the community.*

> **Strategy 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.

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

Research indicates that one in five school-age students exhibit signs and symptoms of a diagnosable mental health condition. Only 20 percent of these students actually receive any mental health services, and the majority of them receive those services in a school setting. Research increasingly suggests that schools function as the de facto mental health service provider for children and adolescents.

The mental health challenges that students experience adversely affect school engagement and academic performance. Many students are not able to access community providers, due to various access barriers for mental health services. Access is limited due to financial resources, medical insurance coverage and limited availability of mental health providers accepting insurance for services, transportation, and long waitlists. Having behavioral health clinicians in the three existing community schools will benefit students who need mental health services and reduce the barriers to accessing these services for students.

Have other funding sources been explored?

No. Hourly professional positions are approved in our budget to hire behind existing employed contracted positions and no growth positions are available in 2019-2020 budget.

How will the program be sustained after funding?

When hourly behavioral health clinicians are hired future funding might be requested until growth budgeted positions are made available.

What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?

FCPS had a VDOE grant that utilized Behavioral Health Clinicians at five high schools during the duration of the VTSS VDOE grant. In review of the Behavioral Health Clinician services data in these five high schools during 2017-18 and 2018-19, although the sample size was small, there were positive outcomes for the students with promotion/graduation rates and increase in attendance outcomes. Although, there is not a direct correlation between the

services and the data, it is of note that there was overall improvement for the students in these areas.

For the chronic absenteeism rates (absent all day 10 percent of the time or more), 54 students, who received services in 2016-17 returned to the same school for the current school year. Overall, the chronic absentee rate fell from 31.5 percent last year to 22.2 percent by February 2019 for the 54 students who returned to the same school where they received services during the 2017-18 school year. For 79 of the students, the promotion/graduation rates from 2017-18 were as follows:

Falls Church HS (n=15): 86.7 percent
Centreville HS (n=16): 100.0 percent
Fairfax HS (n=24): 95.8 percent
South Lakes HS (n=15): 86.7 percent
West Potomac HS (n=9): 88.9 percent

Outcomes with effective therapeutic services to include, CBT and DBT treatment, through behavioral health clinicians, will support access and effective mental health services to students in our community schools. CBT and DBT have been described as the "gold standard" for mental health treatment. Evidence has shown these treatment approaches effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, eating disorders, and severe mental illness. Numerous research studies suggest that CBT leads to significant improvement in functioning and quality of life. In many studies, CBT has been demonstrated to be as effective as, or more effective than, other forms of psychological therapy or psychiatric medications. There is substantial support for CBT as an effective and appropriate first-line treatment for youth with depression and anxiety.

As a comprehensive treatment for pervasive emotional difficulties, DBT has gained empirical support for its effectiveness from research with adults and adolescents. Several randomized clinical trials have demonstrated the efficacy of DBT for reducing self-harm and suicide attempts in adolescents. Given that evidence on effective treatment for adolescents who engage in suicidal and self-harm behaviors is limited, it is especially noteworthy that DBT is a well-established, empirically-supported treatment for decreasing repeated suicide attempts and self-harm in youth.

CBT and DBT have also been shown to reduce office referrals and disciplinary actions in schools, thereby saving valuable school resources. Because CBT and DBT teach effective skills for emotion management, problem solving, interpersonal effectiveness, and decision making, students who acquire these skills are less likely to be suspended or require specialized placements due to emotional and behavioral challenges. This serves the dual purpose of saving school districts money and improving school attendance, academic and social progress of students involved in the therapeutic intervention.

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

Data will be collected from the behavioral health clinicians similarly as to the short-term behavioral health (STBH) providers. Access to GAINS assessment through collaboration with Healthy Minds Fairfax would be requested and aggregated, behavioral health clinicians would also request completion of the parent surveys and student satisfaction surveys from participants and parents or guardians. Collection of attendance data will be gathered from students accessing behavioral health clinicians and their mental health services duration.

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

A total of $44,880 is requested for hiring behavioral health clinicians for academic 2019-20 school year. Ongoing expenditure is being proposed for future years until other secured positions and/or funding are procured.

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

The behavioral health clinicians will be hired by January 2020 and will remain in the three Community Schools until the end of academic school year 2019-2020. If continued funding is procured ongoing behavioral health clinicians will continued in further academic school years.

Healthy Minds Fairfax Funding Proposal January 3, 2020

Develop Trauma-Informed Spaces at Burke School in Support of SocialEmotional Student Wellness Utilizing Evidence-Based Practices

Fairfax County Public Schools (FCPS) Department of Intervention and Prevention Services is submitting a request for funding in the amount of $ 20,000 in support of developing trauma-sensitive spaces at Burke School, focusing on two outside school courtyards and four designated interior spaces. These spaces, remodeled with core tenets of trauma-sensitive research in mind, will be used by students as they access strategies to assist with self-regulation, returning to a mindset wherein they are able to learn.

FCPS has identified supporting trauma-sensitive schools as a priority in the district's equity plan and many of the special education students served at Burke are dealing with complex emotional, behavioral and family system challenges, including trauma exposures. Burke School's administration and staff have made tremendous strides in strengthening their trauma-sensitive framework in support of both staff and students. They provide ongoing trauma-sensitive professional development to address secondary traumatization. They have also strengthened their school's approach to meeting students' needs, using a trauma-informed Multi-Tiered Systems of Support framework that includes social-emotional learning at all levels. Both clinical and instructional staff are trained in this framework and collaborate to support students whose needs vary in intensity.

This project supports emotional well-being, resilience, and goal directed attributes, which are critical to FCPS's Portrait of a Graduate vision for each and every student. Trauma-sensitive spaces at Burke will provide escalating students a proactive opportunity to access de-escalation and self-regulatory techniques in a safe and sanctioned setting, addressing barriers which interfere with reaching their full potential. These new spaces and the interventions to be used therein live on a continuum of services, which include direct clinical support for students with highly significant needs. With training, we anticipate that non-clinical staff will build the capacity to support students in using these spaces in purposeful ways, thereby allowing the clinical staff to redouble their services for students with higher level needs. Through intentional modifications to the physical space, students will have new opportunities to use trauma-sensitive spaces as they develop self-awareness and regulation skills.

Available data suggests that Burke students currently demonstrate more significant behaviors of concern and discipline referrals than their same aged counterparts in the county, as well as a significant need to spend time out of learning accessing clinical and other staff. If funded, this project will decrease behavioral referrals and increase time in the classroom.

Questions to be addressed:

- ***A brief description of the project and how the project will accomplish a Blueprint goal, strategy or action step?***

This project will primarily work toward Blueprint Goals 11, Strategy A and B:

- **Goal 11: TRAUMA-INFORMED CARE COMMUNITY,** *Enhance the community's ability to effectively identify and respond to children and families who have been exposed to trauma.*
    - **Strategy A, Action Step 1:** Identify core competencies for providers of trauma-informed treatment strategies, based on national and local best practices.
    - **Strategy B:** Train non-clinical staff in community -based organizations, schools, and county agencies to implement trauma-informed practices.

This project aims to strengthen and create trauma-sensitive environments in outdoor and indoor spaces by providing self-regulation strategies and targeted sensory experiences in a safe, sanctioned setting. The project will build on Burke School's existing continuum of social-emotional instruction and intervention, providing a location wherein students may proactively use self-regulatory tools. By doing so, students will reduce their likelihood of entering a crisis state and requiring directed clinical support as well as enhance their availability to return to learning. Incorporating staff and student voice and ownership is key to the implementation of the project; stakeholders from Burke School administration and clinical staff consulted on this proposal and will ultimately facilitate inclusion of student voice and implementation of final plans.

Space Considerations:
When students experience trauma, they experience an overwhelming loss of safety and control. Being able to exercise choice and contribute to their school community in meaningful ways helps to restore a sense of safety and control. For example, the rock pavers pathway, intentionally patterned to allow for student creation in courtyard one, would support movement opportunities and also a chance to practice a mindful moment. Mindful practice is evidence-based and supports all students, but especially students impacted by trauma. The non-climbable art display trellis in courtyard two would allow students' work to be showcased and celebrated, communicating a powerful message to students of their value and competence. Both of these changes to the environment contribute to project based learning ideas which also support access to the curriculum for students. The goal is to build environments of safety, avoid re-traumatization and promote a sense of tranquility and calm.

The manager of Burke Garden Centre, Mr. Fred Dickinson, has worked with Burke's principal, Ms. Debbie Strayhorne to supply plants in the past. He has generously provided a rough quote for the outdoor spaces project for this proposal. He will incorporate discounts and can develop this community / school partnership moving forward. In addition, he has a staff person who may be able to mentor students.

Interventions to Support Self-Regulation and De-Escalation:
As part of their MTSS framework and continuum of supports, Burke School Staff were trained in defusing challenging student behavior using the Crisis Cycle model. This model teaches behavioral and environmental responses to stressors children experience. When students become triggered in their classroom, they may benefit from the proactive use of trauma-informed spaces to support return to baseline functioning. When students are in the same physical space yet in different places on the crisis cycle, they can escalate one another. Identifying an area to quietly practice mindfulness and selfregulatory strategies is best practice to support emotion regulation.

Burke School is also utilizing Zones of Regulation as a school-wide intervention to support the teaching of social-emotional learning, including emotion-identification skills and self-regulatory strategies. This

evidence-based program is being used school-wide at the Tier 1 level in a direct instruction model, wherein all students participate in regular lessons designed to enhance their social-emotional competencies and ultimately reduce disciplinary and attendance concerns while enhancing time spent in the classroom. At the Tier 2 and Tier 3 level, students are able to participate in small group and individualized counseling wherein Zones of Regulation content, language, and strategies are reinforced and/or modeled as needed. Burke School collects pre/post data regarding the utility of this intervention, as well as tracks its impact on the aforementioned school level variables.

Students will be prompted or request to use one of the trauma-sensitive spaces immediately before or after reaching the peak of their crisis cycle. The work done via Zones of Regulation instruction and the Crisis Cycle will assist them and adult staff in identifying their own emotions and when such an intervention may be required. When a student uses one of the (reflection rooms) redesigned traumasensitive spaces, they will be invited into a safe setting and prompted to use one or more self-regulatory strategies to promote de-escalation. The school team will develop training materials for instructional staff to support them as they guide students in how to access the room, available strategies, as well as supervisory and documentation procedures. The team will also lead development of progress monitoring and data tracking sheets, gathering information regarding the immediate utility of the space and strategies for supporting de-escalation.

- ***Have other funding sources been explored?***

The FCPS Office of Intervention and Prevention services has been working with the FCPS grants office to understand what potential trauma-informed grant opportunities exist and there has not yet been a match for this need. In addition, the recent Trauma-Informed Spaces Community Based grant was considered but not open to schools. Most of the recent grants have been service driven, not environmentally driven.

The school social worker at Burke in conjunction with the clinical team is exploring partnerships with the Eagle Scouts, Mentor Works and the Gang Prevention Taskforce. These linkages could help to support relationship-based protective factors for students as well as opportunities for students and mentors to cultivate the outdoor space throughout the school year. In addition, this current proposal could help lay the groundwork for future collaboration and funding partnerships with organizations such as Home Depot and Merrifield Gardens.

- ***What is the recent data indicating extent of need (if available) for the proposed project?***

Higher rates of suspension, expulsion, and increased utilization of community funding sources at Burke School are indicative of the intensity of student needs. As many of these students are eligible for Special Education services under the classification of Emotional Disability, it stands to reason that services in the educational setting must address underlying social-emotional challenges, among other needs.

In the 2017-2018 school year, 77% of students at Burke School had at least one disruptive behavior incident as recorded by the Caring Culture goal of the public equity profile. This is in stark comparison to the division as a whole, which recorded 4% of students who were recorded with disruptive behavior.

Moreover, Time Out of Learning Data from Burke School indicates that students spent 6,306.9 total hours out of learning accessing clinical or behavioral supports due to intensive needs during the 20182019 school year.

➢ ***What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?***

Space Considerations:
This project aligns with the research, training and information provided through the Trauma-Informed Community Network on trauma-informed environments. According to the national best practice resources, a trauma-sensitive school environment contributes to predictable and safe routines, overall wellbeing and is a critical ingredient in supporting self-regulation. Designing environments which are welcoming, engaging, have aesthetic materials on the walls, doors and other surfaces take intentionality. These may include the use of certain colors, arts, plants, fish and turtle ponds, posters and other sensory input. They also incorporate appropriate adult support and supervision.

The changes to the environment and the materials for the indoor and outdoor spaces will be supported through purposeful training of non-clinical staff to understand how to best utilize the space to address the student's specific need. Currently, students who are in need of a break and leave the classroom may take a long time to deescalate and return to the classroom. This points to the need for more intentional and targeted use of existing indoor and outdoor calming spaces with the goal of helping the students to return to learning more quickly. The goal here is to build the capacity of non-clinical staff to help support structured calming opportunities for students to help them return to the learning environment.

Interventions to Support Self-Regulation and De-Escalation:
As previously noted, the Burke School team supports the development of social-emotional learning (SEL) and related skills across all levels using an MTSS framework. This effort is supported by schoolwide implementation of the Zones of Regulation Curriculum. This curriculum addresses several empirically recognized SEL competencies, including identification of emotions, self-awareness, self-regulation, and development of age appropriate social and coping skills. According to research by CASEL, students who participate in SEL initiatives demonstrate improvement in social emotional skills, attitudes about self, others and school, positive attitudes towards school, and improvement in academic functioning. Students also demonstrate fewer conduct problems, less emotional stress, and less drug use (*Source: Durlak, J.A., Weissberg, R.P., Dymnicki, A.B., Taylor, R.D., & Schellinger, K. (2011) The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. Child Development: 82 (1), 405-432.)*

➢ ***What are the outcome measures including how will the data be collected and reported back to the CBHC?***

As a result of using of the remodeled trauma-sensitive spaces and practicing self-regulatory and deescalation skills, aggregate data will show a decrease in time out of learning and discipline referrals, an increase in attendance, and an increase in the use of targeted self-regulation strategies for students making use of the space.

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Data to be collected and reported includes:

- Comparative data examining rates of the following before and after completion and use of the new space:
  - Time out of Learning- This data is already collected by Burke School staff as part of their daily practice.
  - Disciplinary Rates- This data is available from Burke School as well as on the FCPS Equity Profile
  - Chronic Attendance Rates- This data is available from Burke School as well as on the FCPS Equity Profile.
  - Skill-based data- Clinical staff will develop a mechanism to document the effectiveness of skills utilized for students accessing the space.

A total of $ 20,000 is requested for modifications to the two outdoor courtyards and the four interior reflection rooms. The breakdown of the total funding cost is below.

Two Outdoor Courtyards	$ 8, 500 to include a combination of landscaping and hardscaping
Four reflection rooms	$11, 500
Total Costs	**$20, 000**

★ Please note these costs are estimates and recommendations and include rough approximations from nearby Burke Nursery Services provided on 1/2/2019 by Manager, Fred Dickinson

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Outside courtyard #1

Outside courtyard # 2

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Reflection room, example #1

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Reflection room, example #2

Primary References

"Calming Box": A Strategy for Supporting Challenging Students
https://www.youtube.com/watch?v=eEQwSSNUqWU from Dr. Rappaport's Behavior Code Sensory examples:
Touch (weighted blanket, putty, fidget toys, yoga cards, stuffed animals, puppets)
Taste (peppermint candies)
Smell (scented lotion)
Hearing (headphones)

National Center on Safe Supportive Learning Enviornments
https://safesupportivelearning.ed.gov/trauma-recovery Wisconsin Trauma-Sensitive Schools Fidelity Tool, School Environment Section https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/tsfidelitytool.pdf

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SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach
https://store.samhsa.gov/system/files/sma14-4884.pdf

***Recommendation for Courtyards*:**

Courtyard 1 (red eared slider turtle pond)

- Organize existing structures to be more inviting and usable
- Add more individual seating options, for example, cut and sealed tree trunk sections, squared stone
- Add several large rocks at pond edge and in courtyard
- Add frogs and minnows to pond – variety of wildlife to observe
- Add perennial plants and food source plants for turtles
- Add perennial flower bed along sun predominant wall
- Add small meditative patterned paver (made by students) path with a larger rock in the center

(example of type of patterned paver design)

Courtyard 2 (two raised bed gardens and koi pond)

- Cleanup, organize and plant annual and perennial species appropriate to the space (including more flowers and colorful patterned plants)
- More individual seating options placed throughout the courtyard
- Student made round pavers placed in spiral patterns within the grassy spaces over a sand base
- Add more colorful koi for visual stimulation and mental relaxation
- Garden tool rack and tools mounted under metal awning
- 10’ x 8’ Non-climbable art display trellis (using one inch opening chain link fence and brackets lag bolted to brick wall) against courtyard wall to display outdoor art
- Cover the small greenhouse structure for plant starts to go into garden and source starter trays, seeds and tools

Reflection Rooms Line Items*

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Item	**Unit Cost**	**Total**
Paint	$ 130/unit x 2	$ 260
Welded Storage Cabinet	$ 725/unit x 4	$ 2,900
Monitors Computer Cabling & Accessories	$ 200/unit x 4 $ 2000 $ 550	$ 800 $ 2,000 $ 550
Beanbag Chairs	$ 57.88/unit x 8	$ 464
Sensory Fidget Toy Set	$ 18.55/unit x 4	$ 75
Sensory Weighted Lap Pad	$ 44.99/unit x 4	$ 180
Aroma Putty	$ 19.03/unit x 4	$ 77
Hand Puppets	$ 23.99/unit x 4	$ 96
Scented Lotion	$ 17.95/unit x 2	$ 36
Yoga Cards	$ 13.29/unit x 4	$ 54
Wall Scenery Prints	$ 66.24/unit x 4	$ 265
Oval Rug	$ 199/unit x 4	$ 796
Light Covers	$ 34.99/unit x 4	$ 140
Sensory Paths (2)	$ 159.99 $ 159.99	$ 320
Labor (painting, etc.)	$ 1442	$ 1,442
10% shipping		$ 1,045

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TOTAL		$11,500

*rounded up to the next dollar

Detailed Line Items for 4 Reflection Rooms:

Light Blue Paint
5-gallon for two rooms (blue) at $ 130.00
https://www.homedepot.com/p/BEHR-PREMIUM-PLUS-5-gal-540A-3-Blue-Feather-Eggshell-EnamelLow-Odor-Interior-Paint-and-Primer-in-One-205005/204883245

5-gallon for two rooms (green) at $ 130.00
https://www.homedepot.com/p/BEHR-PREMIUM-PLUS-5-gal-P410-1-Pondscape-Eggshell-Enamel-LowOdor-Interior-Paint-and-Primer-in-One-205005/205261853

Welded Storage Cabinet, one per room at $ 725 each to total $ 2,900
www.uline.com

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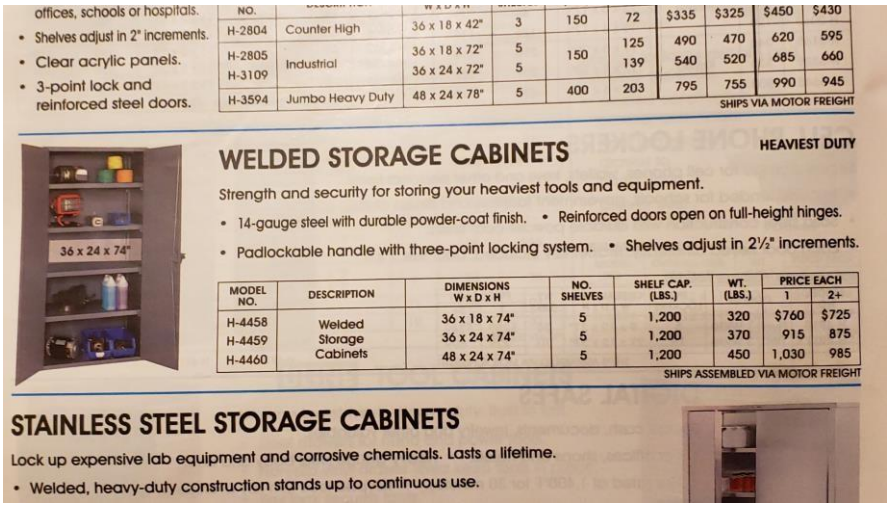

offices, schools or hospitals.
- Shelves adjust in 2" increments.
- Clear acrylic panels.
- 3-point lock and reinforced steel doors.

NO.									
H-2804	Counter High	36 x 18 x 42"	3	150	72	$335	$325	$450	$430
H-2805	Industrial	36 x 18 x 72"	5	150	125	490	470	620	595
H-3109		36 x 24 x 72"	5		139	540	520	685	660
H-3594	Jumbo Heavy Duty	48 x 24 x 78"	5	400	203	795	755	990	945

SHIPS VIA MOTOR FREIGHT

36 x 24 x 74"

WELDED STORAGE CABINETS — HEAVIEST DUTY

Strength and security for storing your heaviest tools and equipment.
- 14-gauge steel with durable powder-coat finish.
- Reinforced doors open on full-height hinges.
- Padlockable handle with three-point locking system.
- Shelves adjust in 2½" increments.

MODEL NO.	DESCRIPTION	DIMENSIONS W x D x H	NO. SHELVES	SHELF CAP. (LBS.)	WT. (LBS.)	PRICE EACH 1	PRICE EACH 2+
H-4458	Welded Storage Cabinets	36 x 18 x 74"	5	1,200	320	$760	$725
H-4459		36 x 24 x 74"	5	1,200	370	915	875
H-4460		48 x 24 x 74"	5	1,200	450	1,030	985

SHIPS ASSEMBLED VIA MOTOR FREIGHT

STAINLESS STEEL STORAGE CABINETS

Lock up expensive lab equipment and corrosive chemicals. Lasts a lifetime.
- Welded, heavy-duty construction stands up to continuous use.

MONITORS and Computer for displaying looped relaxation streamed nature videos, such as scenes from jellyfish, ocean and marine life totalling $ 3, 350

$200 / monitor x 4 = $800

$2000 for computer with interlaced graphic card capable of driving four monitors

$550 for cabling and accessories

Beanbag chairs two per room at $ 57.88 to total $ 463.04 https://www.walmart.com/ip/Big-Joe-LuminBean-Bag-Chair-Available-in-Multiple-Colors/30161646

Sensory Fidget Toy Set, one per room at $ 18.55 per set to total $74.20
https://www.amazon.com/Fidget-Sensory-Anti-Anxiety-SqueezeSoybean/dp/B07F7KJNKK#customerReviews

Sensory Weighted Lap Pad, one per room at $ 44.99 to total $ 179.96
https://www.amazon.com/Sensory-Weighted-Lap-Pad-Kids/dp/B01LX9D33Y/ref=pd_bxgy_201_2/1402282071-5951356?_encoding=UTF8&pd_rd_i=B01LX9D33Y&pd_rd_r=383e4944-a323-490c-8bc0-3822d1c19cbe&pd_rd_w=OdgBa&pd_rd_wg=6ToVm&pf_rd_p=09627863-9889-4290-b90a5e9f86682449&pf_rd_r=F60NH6207K0G93T6P37X&psc=1&refRID=F60NH6207K0G93T6P37X

Crayola Aroma Putty, one per room at $ 19.03 per set to total $ 76.12
https://www.amazon.com/Crayola-Aroma-Reviving-Collection-6Count/dp/B07NLXJ5M7/ref=sr_1_fkmr1_2?keywords=scented+sensory+lotions&qid=1578013614&s=office-products&sr=8-2-fkmr1

Hand Puppets, one per room at $ 23.99 per set to total $ 95.96

https://www.amazon.com/dp/B075KRKPQ7/ref=s9_acsd_omg_hd_bw_bBFvKl_c2_x_0_i?pf_rd_m=ATV

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PDKIKX0DER&pf_rd_s=merchandised-search-10&pf_rd_r=Z18RQ8802QVNFH4ZKTXH&pf_rd_t=101&pf_rd_p=14c4b5e3-c840-4adf-a7b9b1933740087a&pf_rd_i=166335011

Dr. Teal's Body Lotion, 2 sets at $ 17.95 to total $ 35.90

https://www.amazon.com/dp/B07CJ8KG41/ref=sspa_dk_detail_1?psc=1&pd_rd_i=B07CJ8KG41&pd_rd_w=pBNEW&pf_rd_p=45a72588-80f7-4414-9851-786f6c16d42b&pd_rd_wg=EdBo9&pf_rd_r=2WKCTD6SET0HDNSKMY1H&pd_rd_r=552698d0-2d4f-4529-a3d9-ab1dac42bd98&spLa=ZW5jcnlwdGVkUXVhbGlmaWVyPUFORk9QQzNITDZUTkwmZW5jcnlwdGVkSWQ9QTAyOTE4MDIzNjlaQjFKTENNQVNSJmVuY3J5cHRlZEFkSWQ9QTA3NTg3NjQxUVBCUFVJWU41R0VTJndpZGdldE5hbWU9c3BfZGV0YWlsJmFjdGlvbj1jbGlja1JlZGlyZWN0JmRvTm90TG9nQ2xpY2s9dHJ1ZQ==

Yoga Cards, one per room at $ 13.29 to total $ 53.16 https://www.amazon.com/Yoga-Pretzels-Cards-TaraGuber/dp/1905236042/ref=asc_df_1905236042/?tag=hyprod-20&linkCode=df0&hvadid=312678886999&hvpos=1o3&hvnetw=g&hvrand=7119300195437435263&hvpone=&hvptwo=&hvqmt=&hvdev=c&hvdvcmdl=&hvlocint=&hvlocphy=1027067&hvtargid=pla-378801164059&psc=1

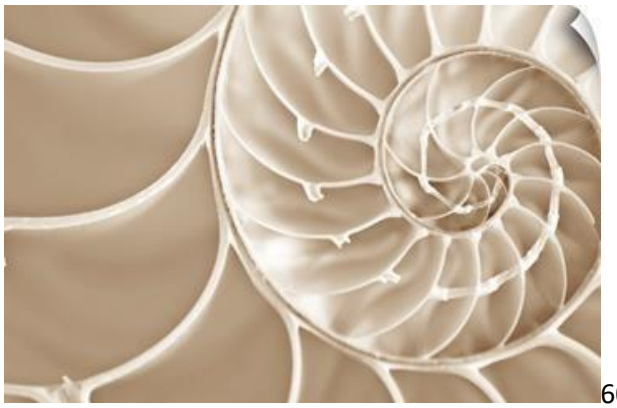
Wall Scenery Rolled/Peel Prints (a few examples below) one for each room avg. cost $ 66.24 to total $264.96

https://www.greatbigcanvas.com/view/wildflowers-at-mendenhall,aks0060146/?product=14&s=sJ68XiDlHMJ1MhmAAci9jKOT14NheDYM5xR9QBdgt441QNuyRKygOtTecEK5bDzD


60 x 40 sale price at $ 69.99

HEALTHY MINDS FAIRFAX PROPOSAL 7


60 x 40 sale price at $ 72.49


60 x 40 sale price at $ 72.49


60 x 40 sale price $ 49.99

Blue Oval Braided Rug, one per room at $ 199.00 to total $ 796.00

https://www.llbean.com/llb/shop/506691?originalProduct=77558&productId=1278092&attrValue_0=Blue%20Multi&pla1=0&mr%3AtrackingCode=31C3C402-BFE7-E511-80ED-00505694403D&mr%3AreferralID=NA&mr%3Adevice=c&mr%3AadType=plaonline&qs=3136886&gclid=EAIaIQobChMI0fOf-bjw5gIVGmyGCh2pyAUJEAkYASABEgKy0fD_BwE&gclsrc=aw.ds

Light Cover, one per room at $ 34.99 to total $ 140.00 https://www.amazon.com/Cloud-Flexible-Fluorescent-Light-

Cover/dp/B01MSGE3X4/ref=sxbs_sxwdsstvp?cv_ct_cx=light+covers+to+dim+the+fluorescent+lights&keywords=light+covers+to+dim+the+fluore scent+lights&pd_rd_i=B01MSGE3X4&pd_rd_r=e2ca45bb-30ff-42c7-a5e1-666fd96ab527&pd_rd_w=v3gfG&pd_rd_wg=AKbHv&pf_rd_p=a6d018ad-f20b-46c9-8920433972c7d9b7&pf_rd_r=XJ3341DTFEJ2TEAY9M72&psc=1&qid=1578364884&s=office-products

School and Classroom Sensory Paths at $ 159.99 https://www.amazon.com/Deluxe-School-Classroom-SensoryPath/dp/B07YBVGN8H/ref=asc_df_B07YBVGN8H/?tag=hyprod-20&linkCode=df0&hvadid=385121612859&hvpos=1o1&hvnetw=g&hvrand=5489419940995787045&hvpone=&hvptwo=&hvqmt=&hvdev=c&hvdvcmdl=&hvlocint=&hvlocphy=1027067&hvtargid=pla-824787737976&psc=1&tag=&ref=&adgrpid=80205191442&hvpone=&hvptwo=&hvadid=385121612859&hvpos=1o1&hvnetw=g&hvrand=5489419940995787045&hvqmt=&hvdev=c&hvdvcmdl=&hvlocint=&hvlocphy=1027067&hvtargid=pla-824787737976

Sensory Path Decals for Floor and Wall at $ 159.99 https://www.amazon.com/Midlee-Sensory-Decals-FloorDesigns/dp/B07X74G8YY/ref=pd_bxgy_229_img_2/131-9797700-2559512?_encoding=UTF8&pd_rd_i=B07X74G8YY&pd_rd_r=fb951978-ba6a-40d7-bdac9aca977a9883&pd_rd_w=DMFZF&pd_rd_wg=ZAbcN&pf_rd_p=09627863-9889-4290-b90a5e9f86682449&pf_rd_r=EA00X3YKV7G1FRT1KTV2&psc=1&refRID=EA00X3YKV7G1FRT1KTV2

Fairfax County Health Department/Community Health Development
Healthy Minds Fairfax Grant Submission

Vaporizing Vapes: Using Mobile Cessation Technology to Reduce Youth Vaping in Fairfax County

A brief description of the project and how the project will accomplish a Blueprint goal, strategy or action step?

The Fairfax County Health Department (FCHD), in partnership with Fairfax County Public Schools (FCPS), seeks **$38,250** to customize and implement the Truth Initiative's **This is Quitting** mobile cessation program to reduce vaping use among adolescents and young adults in Fairfax County.

This is Quitting is a teen and young adult-focused vaping cessation text messaging program developed and maintained by Truth Initiative. It builds on the best scientific evidence from the combusted tobacco cessation literature, input from the Mayo Clinic Nicotine Dependence Center, and formative research with young adult current and former vapers. This first-of-its-kind program has delivered treatment to more than 30,000 young people within the first 3 months of its launch.

This is Quitting offers vaping cessation text messages for teens and young adults that provide support to users throughout the quit process. It gives users the option to set a quit date and provides up to 12 weeks of tailored daily text messages. The program also provides users with on-demand support for cravings, stress, relapse, or desire for more messages.

This is Quitting will address two *Blueprint* action steps: **Goal 12** Address the needs of children and youth with emerging behavioral health issues who have not been able to access appropriate, timely and matching treatment services in the community/**Strategy F** Reduce youth substance abuse and use/**Action Step 4** Implement service enhancements based upon gap analysis AND **Goal 8** Implement target strategies to address disparities in outcomes and access based on race, ethnicity, sexual orientation, socio-economic status, geography, and other factors/**Strategy B** Increase access and availability to behavioral health services for underserved populations. Strategies are to be developed in a culturally competent manner and in partnership with the communities to be served/**Action Step 3(b)** Develop and implement strategies to address identified barriers, which may include expanded access to and use of telepsychiatry, mobile apps, and other technologies.

This is Quitting is freely available on any mobile device to users aged 13 and older per Terms of Service. Users subscribe by texting a designated keyword to the dedicated shortcode, and receive an initial message asking their age to route them into the correct version of the program. Upon responding, users receive interactive daily text messages tailored to their sign-up date or their quit date, should the user choose to set one. Users can set, change, or clear their quit date at any time. Messages include encouragement, motivation, skill and self-efficacy building exercises, coping strategies, and information about the risks of vaping and benefits of quitting. Keywords "COPE," "STRESS," "SLIP," or "MORE" provide on-demand support for cravings, stress and relapse. Many of the messages in this program have been written and submitted by prior users, and users have the option to submit messages to add to the program.

Messages are available for at least four weeks if a user does not have a quit date set; if a user sets a quit date, he/she receive messages for at least one-week pre-quit date and at least eight weeks post-quit date.

Please describe how you will use the funds by June 30, 2020.

Funding in the amount of **$38,250** is requested from Healthy Minds Fairfax to license This is Quitting. Funding will be obligated to the Truth Initiative upon contract signing.

- The Truth Initiative's partnership fee to customize the mobile app to include one keyword and 10 messages and provide service to 5,000 youth is **$15,000**.
- The cost to receive the quarterly data report package is **$12,000**; outcome measures include This is Quitting enrollment among 13-17 year old adolescents and 18-24 year-old young adults; percentage who set a quit date; the percentage who used a keyword; the average number of messages sent to enrollees; and percentage who abstain at 7, 14, 30, and 60 days.
- The cost to develop and produce co-branded materials that will be distributed among FCPS' middle, secondary, and high school communities is **$11,250** and includes digital promotional messages (e.g., tweets, Facebook posts) including Fairfax's brand tag, 4 customized flyers (8.5"x11") featuring selected Fairfax logo, and 2 wallet cards (4"x6") featuring selected Fairfax logo. The Fairfax brand tag will be featured on all materials in addition to the Truth logo and the This Is Quitting logo.

How will the program be sustained after the funding?

On December 3, 2019, the Fairfax County Board of Supervisors tasked County staff, with FCHD as the lead agency, to develop a plan to address youth vaping. In addition to taxation and zoning policies, the BOS directed county staff to work with FCPS "to develop additional public information campaigns directed to inform our students of the dangers of vaping." Additional options and recommendations to address the rise in youth vaping have also been requested and must be submitted within 120 days. A placeholder to fund This is Quitting at the conclusion of the Healthy Minds grant cycle is included in the draft response to the BOS. Likewise, FCHD, vis-à-vis the Office of the County Executive, is working with the Office of the Governor, the Virginia Department of Health and the General Assembly to secure additional funding to prevent and reduce vaping among youth and young adults. If the This Is Quitting pilot is shown to be successful, FCHD will seek to leverage funding from the state and county to continue the program and extend its reach, as part of a comprehensive, coordinated campaign with FCPS, human services agencies, parents and other key stakeholders.

Have other funding sources been explored?

The FCHD will leverage additional funding, in partnership with Fairfax County Neighborhood and Community Services (NCS) to develop a digital marketing campaign to include targeted advertisements on youth-preferred platforms (e.g., You Tube, Snapchat, Instagram) to increase program enrollment and connect youth with services.

What is the recent data indicating extent of need (if available) for the proposed project?

According to data and reports from the National Youth Tobacco Survey and the Surgeon General, vaping rates among youth have surged dramatically over the past three years, increasing 78% among high school students between the years of 2017 (11.7%) and 2018 (20.8%). Data from the 2019 National Youth Tobacco Survey show these rates have continued to increase: the vaping rate among high school students nationally is 27.5%. Moreover, the Surgeon General recently stated that vaping among youth is an epidemic.

FCPS evaluates risky health behaviors among 8th, 10th, and 12th graders annually through the Fairfax County Youth Survey. In 2018-2019, the survey included additional questions that assessed vaping rates in addition to e-cigarette and traditional tobacco use. The 2018-2019 results show that 25% of high school students (n= 6,377 of 32,904 students) reported vaping in the last 30 days. This rate is similar, but slightly below the national rate of 27.5% of high school students reporting vaping. However, among 12th graders who report vaping in their lifetime, Fairfax County is above the national average (30% vs 26.7%).

Further data analysis shows a disproportionate association of vaping by race and ethnicity, particularly among Whites and Hispanic students.

Youth survey results clearly show that Fairfax County is not immune to the national vaping epidemic, and in some instances is seeing even higher rates of use than the national average, resulting in an immediate need for effective cessation services. The existing free cessation services available to youth in the county include the state quit line (Quit Now Virginia) and the Community Services Board substance dependency outpatient services for youth and their families. According to the 2017-2018 Virginia Quitline Stakeholder Report, less than 1% of quitline users are youth, and the text2quit services that are provided through the quitline are not available to those under the age of 18. The state quitline has a 21% quit rate after seven months for adults; quit rates for youth are unavailable. The Community Services Board's support groups are in-person, but, to date, have not received any youth vaping referrals. The data suggest a need to invest in effective youth-focused vaping cessation services to address these gaps in service delivery.

What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?

In January of 2019 the Truth Initiative, a nonprofit public health foundation dedicated to tobacco control, developed a vaping cessation program (This Is Quitting) in response to surging vaping rates among high school students. The program is intended to act as an easily accessible and scalable program to help youth and young adults quit vaping.

The National Institute of Health classifies text messaging as a proven treatment modality for cessation. This is Quitting uses evidence-based methods, including the UK National Institute for Health Research's tobacco cessation interventions for young people, the US Department of Health and Human Services' treating tobacco use and dependence guidelines, and the Mayo Clinic's 5-E Model of Wellness Coaching. Qualitative research and social media observations of young e-cigarette users were also used to develop the program. This innovative program explores why the user is quitting, fosters

connectedness and normativity, and engages youth by using supportive, nonjudgmental messages written in first person or as quotes from other users.

This Is Quitting offers up to 12 weeks of tailored daily vaping cessation text messages. In June 2019, the Truth Initiative published a report on the initial cohort of 27,000 users of the This is Quitting program, 13,421 of whom were youth.

- Fourteen days after program initiation, 46.5% of youth (n=6,241) reported they were vaping less.
- Fourteen days after program initiation, 12.3% of youth (n=1,651) reported they had stopped vaping completely.
- Thirty days after program initiation, the 7-day point prevalence abstinence (ppa) rate was 15.8% for youth, and at 90 days the youth ppa rate was 23.8%.

Since publishing, 22,899 teens have enrolled in the program (January 18,2018 – October 6, 2019), with 100 – 150 young people enrolling each day (ages 13-24). Of this new cohort, 46.6% of teens say they vape less two weeks after enrollment; and 16% say they don't vape at all.

What are the outcome measures including how will the data be collected and reported back to the CBHC?

As stated in the budget justification, reports will be delivered quarterly, provided at least 10 individuals are enrolled in the program. Contracted outcome measures include enrollment among 13-17 year old adolescents and 18-24 year-old young adults; percentage who set a quit date; the percentage who use a keyword; the average number of messages sent to enrollees; and the percentage who abstain at 7, 14, 30, and 60 days. This is Quitting Reports will be sent to two individuals – one representative from FCHD and one representative from FCPS. Staff will present data from these reports, along with data analytic measures of message saturation from the digital marketing campaign (e.g., number of followers, reactions, comments, shares, reposts, total page likes, average likes per day, audience demographics, reach and number of impressions) to Healthy Minds Fairfax at the mid- and end-of-grant year funding cycle. Additionally, FCHD's Division of Population Health and Epidemiology will design a local strategy using the custom app message feature, to further surveillance on youth vaping in Fairfax County.

If your workgroup has a project or services that can be implemented this fiscal year, please submit a proposal to peter.steinberg@fairfaxcounty.gov (703-324-5535) by COB on Tuesday January 7, 2020. To be considered your proposal must answer the following questions:

- **A brief description of the project and how the project will accomplish a Blueprint goal, strategy or action step?**

Mountain View High School is a small alternative high school in Fairfax County Public Schools that serves at risk and disadvantaged students working toward graduation. Our students (roughly 300 students) come from the Herndon, Reston, Oakton, Vienna, Falls Church, Chantilly, Fairfax and Centreville area to receive comprehensive and individualized education as well as resources that promote academic success. Mountain View prides itself on our highly successful in-house Mentor Program which has been in place for at least 25 years. In fact, 85% of our graduating class in 2019 had a mentor. We have two graduations a year, one in February and one in June. We are at least looking to sustain our current program but also want to grow it school wide to celebrate school/student successes. Our goal for this year is to add two celebratory carnivals, one for each semester to celebrate student/school successes. In addition we are inviting student families to participate in our annual Holiday Potluck Celebration to help increase our parental involvement.

Our goal is to focus on identifying emerging at-risk behaviors within our student population so we can intervene and provide supportive resources. Our goal is for our students to reach academic success, overcoming barriers of justice involvement and poverty, building stronger self-esteem and a higher on time graduation rate and. This year we have been afforded a Community Services Board Counselor, a substance abuse prevention Counselor and a therapeutic day treatment Counselor in our school to help streamline identification of behavioral health issues/substance abuse issues and treatment opportunities for our students. Students able to access services outside of school are often referred to Short-Term Behavioral Health (STBH) services as available. At this time, our school is allotted only a part time social worker and psychologist. All evidence, anecdotal and data-based indicate that our students require more resources and services. At Mountain View we want to create an environment of Family, Love and Respect (our school motto) to help create a trusting and nurturing environment for our students and families in order to promote more favorable outcomes for our students.

After reviewing your Blueprint we have identified the following areas of focus for this school year:

Goal 12.
Address the needs of children and youth with emerging behavioral health issues who have not been able to access appropriate, timely and matching treatment services in the community. Intervening early when children and youth present with emerging behavioral health issues can reduce the intensity of the symptoms and duration of treatment. These strategies tend to creating capacity to address the behavioral health needs of children from 0-7;

developing/identifying a validated cross-system screening process to determine the needs, resources and desirable outcomes; creating a training consortium in partnership with a University and private provider partners; and expanding a current pilot initiative of providing timely and available behavioral health services to school age children and youth with emerging behavioral health issues who have not been able to access services. In addition, there is a need to expand the Diversion First initiative to include youth who come in contact with the criminal justice system and reduce youth substance use and abuse.

Goal 12 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.

D. 1. Continue to increase the capacity of Short-Term Behavioral Health Service for Youth to all FCPS 's middle school and high schools.
D.4 Expand FCPS based behavioral health services through the Virginia Tiered System of Support Model, Multi-Tiered System of Support (MTSS).

Goal 12 F. Reduce youth substance abuse and use.

5. Continue to refine substance abuse strategies if needed based upon current Youth Survey data and best practice information.

- **Please describe how you will use the funds by June 30, 2020**

As part of our in-house Mentor/Mentee Program, we host monthly Mentor Lunch Socials to promote our mission of Family, Love and Respect. Mountain View staff members and students are encouraged to identify students who benefit from a mentor/mentee relationship and have them complete an application. Ideally our goal is 100% participation. Mentors meet *at least* monthly with their mentees to foster and grow the relationship and identify areas of assistance needed. The monthly social gatherings are additional incentive celebrations to draw in more of our population to the program. Mountain View also has rolling admissions each semester so we are acquiring new students throughout the year. The socials help to entice new students to participate in the program as well.

Our population is over 70% free and reduced lunch eligible so we promote healthy eating habits as part of our monthly socials as nothing says family more than sharing a meal. In the past FCPS has provided funding for these Mentor Socials but can no longer due to State of Virginia regulations. Currently, our own staff fund and/or provide meals for these events. Here is our current agenda for the school year.

DATE	EVENT	LEAD PERSON	SPONSOR
1st semester			
September 6th	Mentor Picnic	Tina	School Lunch
October 4th	Virtual Meeting	Mentors	Bring Your Own
October 25th	Fall Festival	Michelle & Shunnie	CPC Pizza & Staff
November 20th	Thanksgiving Lunch	Tina/Garvey/Gaston/Houde	FCPS School Lunch
December 20th	Pot luck	Pete/Jackie	Staff/Families

January 24th	Winter Carnival	Committee	? (New Concept)
2nd Semester			
February 28th	?	Pete/Jackie	?
March 27th	March Madness	Lynn/Mike	CPC Pizza & Staff
April 24th	Environmental Club	Culik & Club	?
May 22	Mentor Picnic	Tina	FCPS School Lunch
June	Spring Carnival	Committee	? (New Concept)

- **How will the program be sustained after the funding?**

The Mountain View Mentor Program has been in existence for 20+ years. We have established and nurtured relationships with community businesses and restaurants who have assisted us in the past with reduced-cost or in-kind donations. Will continue to tap into community partnerships and ask for donations from local businesses. The funding we are requesting will sustain or help our program grow by purchasing needed supplies, provide food for our celebrations and support program objectives. We will continue to approach community resources and vendors to help fund our mentor program as well as research other available grants. Finally, we can redesign the program and the events needed to maintain our mission of Family, Love and Respect with our student population that do not require funding as in the past.

As stated in the Congressional Research Service report in July 2019
"According to the Contemporary mentoring programs seek to improve outcomes and reduce risks among vulnerable youth by providing positive role models who regularly meet with the youth in community or school settings. Some programs have broad youth development goals, while others focus more narrowly on a particular outcome. Evaluations of the BBBS program and studies of other mentoring programs demonstrate an association between mentoring and some positive outcomes…."

Recommendations for Success from the Congressional Research Service from July 2019 also state the following criteria;

"Elements of Effective Practice for Mentoring, were developed by researchers and practitioners and draw from peer-reviewed research about mentoring interventions. The standards are in their 4th edition, and are summarized in Table 1 below."

13 Standard	*Description*
1. Recruitment	*Recruit appropriate mentors and mentees by realistically describing the program's aims and expected outcomes.*
2. Screening	*Screen prospective mentors to determine whether they have the time, commitment, and personal qualities to be a safe and effective mentor and screen prospective mentees, and their*

	parents or guardians, about whether they have the time, commitment, and desire to be effectively mentored.
3. Training	*Train prospective mentors, mentees, and mentees' parents (or legal guardians or responsible adult) in the basic knowledge, attitudes, and skills needed to build an effective and safe mentoring relationship using culturally appropriate language and tools.*
4. Matching and Initiation	*Match mentors and mentees, and initiate the mentoring relationship using strategies likely to increase the odds that mentoring relationships will endure and be effective.*
5. *Monitoring and Support*	*Monitor mentoring relationship milestones and child safety; and support matches through providing ongoing advice, problem-solving, training, and access to resources for the duration of each relationship.*
6. Closure	*Facilitate bringing the match to closure in a way that affirms the contributions of the mentor and mentee, and offers them the opportunity to prepare for the closure and assess the experience.*

Source: MENTOR: The National Mentoring Partnership, Elements of Effective Practice for Mentoring, 4th ed., 2015.

Fernandez-Alcantara, Adrienne. "Vulnerable Youth: Federal mentoring Programs and Issues." Congressional Research Service. 2019. Retrieved from https://fas.org/sgp/crs/misc/RL34306.pdf

Our Mountain View Mentor Program utilizes these recommendations along with receives guidance for the FCPS MentorWorks Program. https://www.fcps.edu/blog/mentorworks

- **Have other funding sources been explored?**

We have applied for donations through Wegmans (received $150.00) and Harris Teeter (pending) as well as work with other community partners to help support our mentor program. Centreville Presbyterian Church provides pizza for two luncheons a year for which we are grateful, the staff supplements the pizza with beverages and treats. We also work with Food For Others to receive weekend/evening survival packaged food kits for students. Panera in South Riding also donates day-end baked goods on Wednesday evenings, which the staff picks up at 10pm and sets out the next morning for breakfast. We also have a Mountain View Community Garden which provides home grown vegetables for our students to take home that they started from seed by our science classes.

- **What is the recent data indicating extent of need (if available) for the proposed project? What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?**

The goal is to provide mentoring services to address the academic and social needs of students such as on-time graduation rates, chronic absenteeism, poor academic achievement, problem solving situations, learning about available resources, postsecondary planning as well as addressing family issues or concerns.

According to the Youth Mentor Program:
"Nationally, one in four public school children drop out before they finish high school. For African-American and Hispanic students, the challenge is more severe with the likelihood of graduating on time from high school only 65%. Many of these students don't have access to positive role models, cannot envision a career, and don't feel connected to their communities. It is tragic that young people who drop out are much more likely to be unemployed, incarcerated or live in poverty."

- Students who meet regularly with their mentors are **52% less likely** than their peers to skip a day of school and **37% less likely** to skip a class.
- Youth who meet regularly with their mentors are **46% less likely** than their peers to start using illegal drugs and **27% less likely** to start drinking.
- **Seventy-six percent** at-risk young adults who had a mentor aspire to enroll in and graduate from college versus half of at-risk young adults who had no mentor. They are also more likely to be enrolled in college.
- Mentoring reduces "depression symptoms" and increases "social acceptance, academic attitudes and grades."

"The Stats." *Youth Mentor*, https://www.youthmentor.org/thestats.

According to the FCPS Mentor Works Program;
The Power of Mentoring

- Youth who are mentored believe that they matter.
- They are 80% more likely to seek guidance from an adult when they need it.
- They are 55% more likely to go to college.
- ***Bonus:*** 75% of youth who are mentored describe themselves as being "happy!"

A mentor helps connect youth with resources, safe places, and structured activities. Mentors provide a positive role model, assistance in obtaining a marketable skill through the support of education, and an opportunity to give back through community service.
All of the following are important activities that mentors provide in the lives of their students:

- Academic Support - Encouraging students to reach academic success by showing the benefits of staying in school and evaluating educational choices.

- Role Modeling - Helping students see and strive for broader horizons and possibilities than they may see in their present environments.
- Attention and Support - Mentors provide dependable and consistent attention and support through listening, guiding, and encouraging students to reach their full potential.

("MentorWorks | Fairfax County Public Schools")

- **What are the outcome measures including how will the data be collected and reported back to the CBHC?**
  - Youth Survey Data
  - Mentor Application Data
  - Graduation Statistics
  - School Attendance Statistics
  - Grade Statistics
  - Resource Program Referral Statistics

MEMO TO THE CPMT
January 24, 2020

Administrative Item A - 3: 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 $1.1 million in unspent prior year state Mental Health Initiative funds to increase outpatient services capacity in order to implement evidence-based practices. On January 13 the CSA Management Team reviewed and endorsed this request.

RECOMMENDATION:
That the CPMT endorse a CSB protocol for using approximately $1.1 million in unspent prior year state Mental Health Initiative funds to increase outpatient services capacity in order to implement evidence-based practices.

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 for CSB 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 $1,100,839. It must either be spent or returned to DBHDS.

The current annual MHI allocation is used to support four Youth and Family Behavioral Health II positions and to purchase intensive behavioral health treatment for children and youth with more complex needs than can be met through outpatient services. 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, who are identified and assessed through the Family and Assessment Planning Teams and approved by the Community Policy and Management Teams of the localities.
- 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 $1,100,839 be spent to create three new CSB Youth and Family Senior Clinician positions and fund them through FY 2022. These three clinicians will be trained in and provide evidence-based treatments for children and youth with SED. Using the balance to fund three Senior Clinician positions will provide the additional treatment capacity necessary for Youth and Family Outpatient Services to transition to use of evidence-based practices (EBPs), which often require more frequent sessions and greater pre-session preparation than traditional outpatient therapy. Over time implementation of EBPs may increase capacity, since they are of shorter duration and more effective than traditional services. During the implementation period, however, additional capacity will be required. 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 2021 if treatment capacity exists.
- MHI funds not expended on Senior Clinicians due to periodic vacancies or other causes will be used to purchase Multi-Systemic Therapy and Functional Family Therapy from private providers for MHI-eligible children and youth.

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. CSB will obtain parental consent to contact the CSA Program to verify that the youth is 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 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, along with two evidence-based in-home interventions, MST and FFT, when funding permits. 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:
DBHDS Guidelines for Mental Health Children and Adolescent Initiative (MHI) Funds

INTERNAL CONTROL IMPACT:
None

FISCAL IMPACT:

The unspent MHI balance is sufficient to fund three Senior Clinician positions through FY 2022. If the project is successful in meeting the behavioral health needs of the children and youth served, and current staffing is insufficient to meet the demand for outpatient services, an FY 2023 county budget request to continue the three positions will be considered.

STAFF:
Jim Gillespie, CSB Child, Youth and Family Services Director

GUIDELINES FOR THE USE OF MENTAL HEALTH CHILDREN AND ADOLESCENT INITIATIVE (MHI) FUNDS

I. Background

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

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

This document is intended to provide clarity for localities on the intent of the funds and guidance regarding their appropriate use. Although these funds are designed to address some of the gaps in funding for services for non-CSA mandated children and adolescents, in addition to this dedicated source of funding, a collaborative, interagency approach with creative and innovative treatment strategies will be necessary to serve this challenging population of children and families in need.

II. Principles for The Use of Mental Health Initiative Funds

The following are principles to consider when determining the appropriate use of MHI funds. These principles should be reflected in Community Services Board (CSB) policies and procedures governing the use of MHI funds. The principles are designed to facilitate the consistent use and management of these funds across Virginia.

- 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 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 stakeholder

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.

III. Target Population for Mental Health Initiative Funds

The target population to be exclusively served with MHI funds is children and adolescents with serious emotional disturbance and related disorders who are not mandated for services under the CSA. Serious emotional disturbance in children is defined as:

(1) A defined serious mental health problem that can be diagnosed under DSM-IV and/or all of the following:
(2) Problems in personality development and social functioning that have been exhibited over at least one year's time; and
(3) Problems which are significantly disabling based upon the social functioning of most youngsters their age; and
(4) Problems that have become more disabling over time; and
(5) Service needs that require significant intervention by more than one agency.

Related disorders are not defined in the appropriations act language. However, the assumption for the purposes of these guidelines is that the language "related disorders" allows the necessary flexibility to serve children with mental health or co-occurring mental health and substance abuse problems who may not fit the definition above but who, in the opinion of Community Services Board clinical staff, are in need of services that can only be provided with the use of MHI funding.

IV. Appropriate Services to be Supported by Mental Health Initiative Funds

- CSBs must follow the DBHDS Core Services Taxonomy categories and subcategories in providing, contracting for, and reporting these services. However, some flexibility exists in consultation with the OCFS to assure that the needs of individual children are met.
- Services that are most appropriate for use of these funds include: emergency, local inpatient, outpatient, intensive in-home, therapeutic day treatment, alternative day support (including specialized after school and summer camp, behavior aide, or other wrap-around services), and highly intensive, intensive, supervised family support services (including therapeutic foster care or residential respite care).
- Given the population to be served, children and adolescents with serious emotional disturbances, services need to be appropriately intensive and comprehensive. Prevention and early intervention services are not appropriate uses of these funds.
- In general, services should have the purpose of keeping children in their homes and communities and preserving families whenever possible.
- All expenditures should be linked to an individualized service plan for an individual child. Expenditures may be for something that is needed by more than one child, providing it can be linked to the individualized service plan of each child.
- CSBs may use MHI funds to support personnel used to provide services to children and families. For example, the funds may be used to create a position dedicated to serving the non-CSA mandated population of children in the community; however, as stated above, each service

provided should be linked to an individualized service plan for an individual child.

- **MHI funds may not be used for residential care services or for CSA-mandated populations. In addition, MHI funding may not be used to purchase furniture, supplies or computers.**

V. Funding Allocation Procedures

DBHDS will provide the MHI funds to CSBs through the community services performance contract process. The funds are restricted; CSBs must account for and report the receipt and expenditure of these funds separately. CSBs will report on the use of these funds through performance contract reports and the Community Consumer Submission, adhering to the current Core Services Taxonomy descriptions and classifications of services.

DBHDS will distribute the funds in the regular semi-monthly electronic funds transfers, beginning with the July 1 payment of each state fiscal year. CSBs will take all necessary actions to ensure the complete use of their allocations of these funds.

Each CSB allocation consists of amounts identified for each city or county, these allocations represent pools of funds that CSBs may use across their service areas to provide services. If a CSB wishes to retain any current funding protocol that reserves or allocates amounts of funds to individual localities, the protocol must contain guidelines for tracking utilization of dollars and re-allocating those funds if expenditure patterns result in projected balances. A CSB can use funds in its allocation to serve any non-mandated child or adolescent in its service area, as long as the preceding requirements are satisfied.

VI. Mental Health Initiative Fund Protocol

Because flexibility and interagency collaboration are necessary when using these funds, each CSB must work collaboratively with its local FAPT(s) and CPMT(s) to establish a MHI Fund Protocol to specifically outline how these funds will be used to serve the non-CSA mandated population in the CSB's catchment areas. The CSB shall seek input and guidance in the formulation of the protocol from other CSA member agencies.

The MHI Fund Protocol shall at minimum:

1) Clearly articulate the target population to be served within the SED, non-CSA mandated population;
2) Establish defined protocols and procedures for accessing services, ensuring that all key stakeholder agencies have a method to link into services;
3) Clearly articulate the kinds or types of services to be provided; and
4) Provide for a mechanism for regular review and reporting of MHI expenditures.

Although MHI funds are provided to local CSBs for services, each CSB must ensure that the FAPT(s) and CPMT(s) have had the opportunity to give input to and review its protocol for MHI funds. A copy of the plan should be kept on file at the CSB.

VII. Accountability and Reporting Requirements for Mental Health Initiative Funds

- The CSB will maintain an open/enrolled case and case record on all children receiving MHI-funded services.
- DBHDS will establish a mechanism for regular review and reporting of MHI expenditures.

This information will be reported through the Community Consumer Submission (CCS) by designating the child with a 915 code.

CSBs should ensure that all funds are obligated by June 30th of each year.

Memo to the CPMT
January 24, 2020

CONTRACT ITEM C-1 Child Specific Contract Request for Benedictine School

ISSUE: FCPS Multi-Agency Services requests approval of a child specific Agreement for the Purchase of Services (APOS) with Benedictine School for Harmony # 125215.

RECOMMENDATION: The CSA Management Team recommends the approval of a child specific APOS with Benedictine School in Ridgely, Maryland.

PROVIDER:

Benedictine School
14299 Benedictine Lane
Ridgely, MD 21660
(410) 634-2112

MEDICAID ENROLLMENT : Benedictine School is not enrolled as a Virginia Medicaid provider.

LICENSE: Benedictine School is licensed by the State of Maryland Department of Human Resources Office of Licensing and Monitoring to provide a residential childcare program.

INSURANCE: This provider is appropriately licensed and insured by Fairfax County standards.

PROGRAM DESCRIPTION (from the website):

The Benedictine School is a year-round co-ed day and residential school for individuals ages 5-21 with intellectual disabilities, multiple disabilities, and autism. They are certified by the Maryland State Department of Education (MSDE) for their day program and The Department of Human Resources (DHR) which certifies their school residential program.

The Mission of The Benedictine School is to assist individuals with disabilities in becoming as independent or semi-independent as possible; to make wise use of leisure time; and to live and work in a community setting.

The program offers extensive and intensive services in the areas of functional academics, life skills, communication, and vocational/transition skills. The Benedictine L.I.F.E. Skills Program is an intensive, functional life skills development program. Its structure provides each student with an intensive, fully integrated curriculum which provides instruction and training in those most necessary of life skills including but not limited to: effective communication, vocational preparation, activities of daily living, health and fitness, leisure and recreation, social skills and functional academics/community experiences.

OTHER CONTRACTED PROVIDERS CONSIDERED:

All appropriate residential education providers under open contract were considered. None were clinically and educational appropriate settings for this student and those that were clinically and educationally appropriate did not accept the student.

FISCAL IMPACT:

One year due to the standard IEP Period, based on the two rates below will cost: $160,517.20

IEP Residential School Room & Board (IEP-MTCE)	$234.92 per bed day	$85,745.80
Residential Education - Special Education (IEP-Edu-Sped)	$339.87 per day	$74,771.40

The costs of this program are similar to a Medicaid in-state program at $393.50 per day plus education such as Grafton. As a Medicaid participating provider, Grafton accepts the $393.50 per day for room & board and combined services plus a residential education rate of $255.00 per day. The average costs on a student without Medicaid would be a total of $194,627.50 based on $143,627.50 for their room & board and combined services and another $51,000 for residential education.

STAFF:
Adam Cahuantzi, FCPS Multiagency Services
Barbara Martinez, DPMM

Memo to the CPMT
January 24, 2020

CONTRACT ITEM C-2 Child Specific Contract Request for Sedona Sky

ISSUE: Fairfax County Public Schools-Multiagency Services (FCPS-MAS) requests approval of a child specific Agreement for Purchase of Services (APOS) with Sedona Sky Residential Treatment Facility in Arizona for the youth with Harmony #161340 retroactive to September 19, 2019 for educational costs only.

RECOMMENDATION: FCPS-MAS recommends CPMT approval of a child specific APOS with Sedona Sky Residential Treatment Facility in Arizona for the youth with Harmony #161340 retroactive to September 19, 2019 for educational costs only.

PROVIDER:

Sedona Sky
3090 E. Coronado Trail
Rimrock, AZ 86335
(855) 879-4786
www.sedonasky.com

MEDICAID ENROLLMENT: Sedona Sky does not participate with Virginia Medicaid.

LICENSE: Sedona Sky is licensed by the Arizona Department of Health Services to operate as a Behavioral Health Residential Facility. They are also accredited by the Joint Commission for Accreditation and the National Independent Private Schools Association.

INSURANCE STATUS: Sedona Sky is licensed per Fairfax County standards.

PROGRAM DESCRIPTION: (Provided by the requestor)

"Sedona Sky Academy is a specialized school exclusively for struggling girls. Sedona Sky is unique by offering the best of therapeutic boarding schools (warm environment, strong academics) and residential treatment centers (clinical sophistication, high staff to student ratios) Sedona Sky Academy is a safe place of healing, hope, and trust where young women heal and family relationships are restored. Families trust our experienced, exemplary staff and rely on the clinically sophisticated therapy we offer. Because we're specialized in trauma, anxiety, and depression-related symptoms specifically for girls, we produce better outcomes than other more generalized residential treatment centers for girls."

OTHER CONTRACTED PROVIDERS CONSIDERED:

This student has an IEP for a Private Day School setting. The student was enrolled in Phillips in Annandale prior to the parental placement at Sedona Sky prior to request for education costs at Sedona Sky.

Attached is a guidance document from the Office for Children's Services showing that CSA is responsible for the education costs when a student has an IEP.

FISCAL IMPACT:

Education Costs $4200/month

Request is for 12 to 18 months: $50,400 to $75,600

The cost for the private day placement at Phillips Day School would be $50,952.60 based on 180 days at $283.07 per day or $ 5,095.26 a month.

ATTACHMENT: OCS Residential Placement of Students with Disabilities

STAFF:
Adam Cahuantzi, FCPS Multiagency Services
Barbara Martinez, DPMM

Office of Comprehensive Services
Empowering communities to serve youth

Residential Placement of Students with Disabilities

	CSA Placement	Parental Placement
Educational Purpose	**1** IEP identifies residential placement as Least Restrictive Environment	**3** Parent makes unilateral placement to meet student's educational needs
Non-Educational Purpose	**2** IFSP identifies need for residential placement	**4** Parent makes placement for treatment purposes

NOTES: *A placement made through a signed Parental Agreement with a public child-serving agency is a CSA placement. A placement made through Adoption Assistance is a parental placement.*

1 IEP identifies private residential placement as LRE

- §2.2-5211.B1 – "Special Education Mandate" - CSA pays for IEP services. When child is Medicaid eligible and meets medical necessity criteria for residential treatment, Medicaid funds may be used for placement. (Medicaid does not fund the educational portion of services.)
- School division remains responsible for FAPE (IEP, re-evaluation, progress reporting).

2 IFSP developed by the FAPT identifies need for residential placement

- §2.2-5211.B2 – "Special Education Mandate" - CSA pays for all services. When child is Medicaid eligible and meets medical necessity criteria for residential treatment, Medicaid funds may be used for residential treatment services. (Medicaid does not fund the educational portion of services.)
- School division of child's residence remains responsible for FAPE (IEP, re-evaluation, progress reporting).

3 Parent makes unilateral educational placement

- Child gives up right to FAPE, i.e., child does not have access to public school services. Parent holds fiscal and oversight responsibilities for all services including educational services. (8 VAC 20-81-150.C.7.c.)

4 Parent makes placement for treatment purposes

- Child maintains right to FAPE – school division of child's residence is responsible to ensure student has services necessary to benefit from the residential facility's educational program.
- School division identifies appropriate services in the IEP and how they will be delivered, e.g., may provide direct services, arrange with another school division to provide services, or negotiate with provider for purchase of appropriate services. See VDOE: SESS FAQ 014-11 for more information. Link: http://www.doe.virginia.gov/special_ed/regulations/state/faq_implementing_regulations/2011/014-11_parent_placement_of_student_residential.shtml.
- If the least restrictive environment identified in the IEP is private day school, it is appropriate to utilize CSA funds for the services necessary to ensure the child's access to FAPE if such services are to be purchased from a private provider.

NORTHERN VIRGINIA FAMILY NETWORK

Tips For Engaging Families in Mental Health and Disability Services

Suggestions For Agencies Across Systems of Care

1 Acknowledge Families As The Experts

- Take time to listen to and gather information from families
- Utilize family members' expertise to form goals and action plans, emphasizing strengths over deficits
- Treat families as partners in implementing common goals

Make Participation Easy 2

- Provide opportunities and appropriate spaces for families to safely share their perspectives
- Be clear about meeting goals in advance
- Value transparency; make all relevant information accessible to families
- Anticipate and carefully address any potentially triggering information that needs to be shared

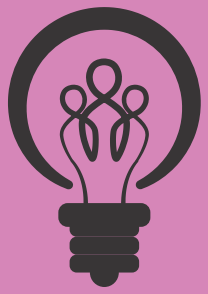
3 Recognize The Positives

- Acknowledge all contributions to the conversation and give credit where it is due
- Celebrate successes; confidence increases when families know they've made progress
- Recognize diversity as a strength

Honor Each Family's Culture 4

- Recognize personal assumptions before meeting with a family; encourage families to share about their culture and how it impacts service needs
- Inquire about the cultural needs of the family, including document translation and interpreters
- Allow the youth to help define who is 'family', encouraging family members in all roles to engage

5 Offer Additional Support



- Offer respite and child care for meetings
- Honor family contributions of time and talent; recognize volunteers
- Share information, resources and services with families to build skills and increase engagement
- Create procedures to limit the need for family members to retell potentially traumatizing information about their situation

Looking to increase family voice and participation? NVFN is your first stop for connecting to families, children and youth impacted by disabilities, mental health conditions and other unique needs.

Contact us at NVFNetwork@gmail.com to learn how we can help you!

NORTHERN VIRGINIA FAMILY NETWORK

NVFN is a network of nonprofit organizations serving Northern Virginia families and children. Our mission is to elevate the voices of families to improve outcomes for children, youth and young adults across systems of care.

The Arc promotes and protects the human rights of people with intellectual and developmental disabilities and actively supports their full inclusion and participation in the community throughout their lifetimes.	thearcofnova.org
The Autism Society of Northern Virginia (ASNV) builds community for over 5,000 individuals and families affected by autism through education, advocacy and support.	asnv.org
CHADD is a nonprofit organization that provides information and support to parents of children with attention deficit disorders, adults with attention deficit disorders, and others dealing with people affected by attention deficit disorders.	meetup.com/novachadd
The mission of this organization shall be to ensure that all individuals with Down syndrome and their families receive the support necessary to participate in, contribute to and achieve fulfillment of life in their community.	dsanv.org
Formed Families Forward is a resource center focused on supporting foster, kinship, and adoptive families of children and youth with disabilities and other special needs.	formedfamiliesforward.org
NAMI Northern Virginia and its volunteers work together to raise awareness and provide education, advocacy, and support programs for people living with mental illness, families, students, educators, law enforcement, and the public throughout our neighborhoods.	nami-northernvirginia.org
Parents Of Autistic Children of Northern Virginia (POAC-NoVA) and its predecessor organization has worked for more than two decades to improve the quality and quantity of education for students with autism in Northern Virginia.	poac-nova.org
PEATC is Virginia's Parent Training and Information Center serving families of children with disabilities or suspected disabilities from birth through age 26 and the processionals who work with them.	peatc.org
The Regratifying Foundation's mission is to encourage foster care youth to continue their education, learn about and consider professional careers and to set future personal and career goals before they age out or emancipate from foster care.	regratifyingfoundation.org

MEMO TO THE CPMT

January 24, 2020

Information Item I - 1: Review Proposed CPMT Bylaw Changes

ISSUE: That the CPMT bylaws be updated periodically to reflect current Code sections and membership with recommended language from Office of County Attorney.

BACKGROUND:
The CPMT Bylaws may be amended at any regular meeting of the CPMT by a two-thirds (2/3) vote of those present and voting, provided, however, that notice of the proposed changes have been submitted to the members of the CPMT thirty (30) days prior to the meeting. These bylaws may also be amended at any time without advance notice by unanimous vote of all members of the CPMT.

Proposed changes include:

- Updating the code sections referenced in Article I
- Adding duties to Article IV to reflect the Code
- Moving local government elected official or designee to Section 2: state mandated members
- Revise/remove Director of Department of Administration for Human Services from Section 3
- Optional members: Correct/amend number of private service providers from 2 to 1
- Adding sections related requirements for public meetings such as FOIA, record retention and notices
- (New) Roles of City Councils, removal of optional members

DISCUSSION:

The county attorneys who reviewed and proposed amendments to the Bylaws requested the following issues be discussed and decided by the CPMT:

Va. Code Ann §2.2-5204 states that the cities and counties who come together to create a CPMT shall JOINTLY establish the team; it is this office's advice that the 3 jurisdictions of the CPMT, Fairfax County BOS, City of Fairfax and City of Falls Church Councils must adopt by-law changes but *that the cities are not required* to approve certain CPMT actions.

- Under Article V, Section 1 Memberships, Section 3 Locally Mandated Members and Section 4, Optional Members, and Section 5, Appointments and Terms, the City Councils *are not included* in the approval process.
- Article 13, Removal: We *have not* included the City Councils in this. The FCBOS was left in the Absences section since that only involves notice.

- Article XV, Amendments: We included all 3 jurisdictions in approval of any amendments to CPMT By Laws based on the §2.2-5204 language.

ATTACHMENT: Additional proposed revisions to CPMT bylaws

STAFF:
Janet Bessmer, CSA Program Manager
Deborah Laird, Assistant County Attorney
Martin Desjardins, Assistant County Attorney

RBA

Results-Based Accountability
Performance Plan
FY 2020, Quarter 2 Report to CPMT

SUMMARY	
Name of Work	**Children's Services Act (CSA) for At-Risk Youth – Systems of Care**
Agency	Human Services within the Department of Family Services (DFS)
Contact (Name, Phone, Email)	Patricia E. Arriaza, Management Analyst III, 703-324-8241, patricia.arriaza@fairfaxcounty.gov
Purpose	The Children's Services Act (CSA) for At-Risk Youth and Families is a law enacted in 1993 that establishes a single state pool of funds to purchase services for at- risk youth and their families. The state funds, combined with local community funds, are managed by local interagency teams who plan and oversee services to youth. The mission of the CSA is to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youth and their families in the Commonwealth.
Customers	At-risk youth between the ages of 0 to 21 and their families as defined by VA § 2.2-5212
Total Customers	Youth served: FY19:1,252; FY18: 1,311 ; FY17: 1,428 ; FY16: 1,494; FY15: 1,343; FY14: 1,200
Total Staff Year Equivalents (SYE)	FY2019: 11 FY2018: 10; FY2017: 10; FY2016: 10; FY2015: 10; FY2014: 10
Total Budget	FY2019: $38.3 million for CSA pooled funding; $1,068,171 for program administration FY2018: $38.6 million for CSA pooled funding; $1,053,393 for program administration FY2017: $40.8 million for CSA pooled funding; $1,057,286 for program administration FY2016: $41.9 million for CSA pooled funding; $988,075 for program administration FY2015: $39.8 million for CSA pooled funding; $947,889 for program administration FY2014: $38.0 million for CSA pooled funding; $909,356 for program administration

Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

Summary of Annual and Quarterly[1] Performance Measures	
How Much Was Done?	
1.1	Total Youth Served Annually
1.2.1	Annual CSA Pool-fund Expenditures
1.2.2	Annual CSA Expenditures by Service Type
How Well Was It Done?	
2.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of youth participating in CSA who live in family settings.**
2.1.1	Number of youth in a long-term congregate care setting
2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services
2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**
2.2.1	Average number of days (length of stay) CSA participating children live in congregate care – measured in current setting and at post-discharge
2.2.2	Number of youth entering long-term congregate care settings
2.2.3	Number of youth exiting long-term congregate care settings
2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services
2.3	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment**
2.3.1	JDRDC and DFS data on Relief of Custody Petitions: # ROC petitions filed/# children entering foster care from ROC petitions
2.3.2	Number of children entering foster care from CHINS petitions

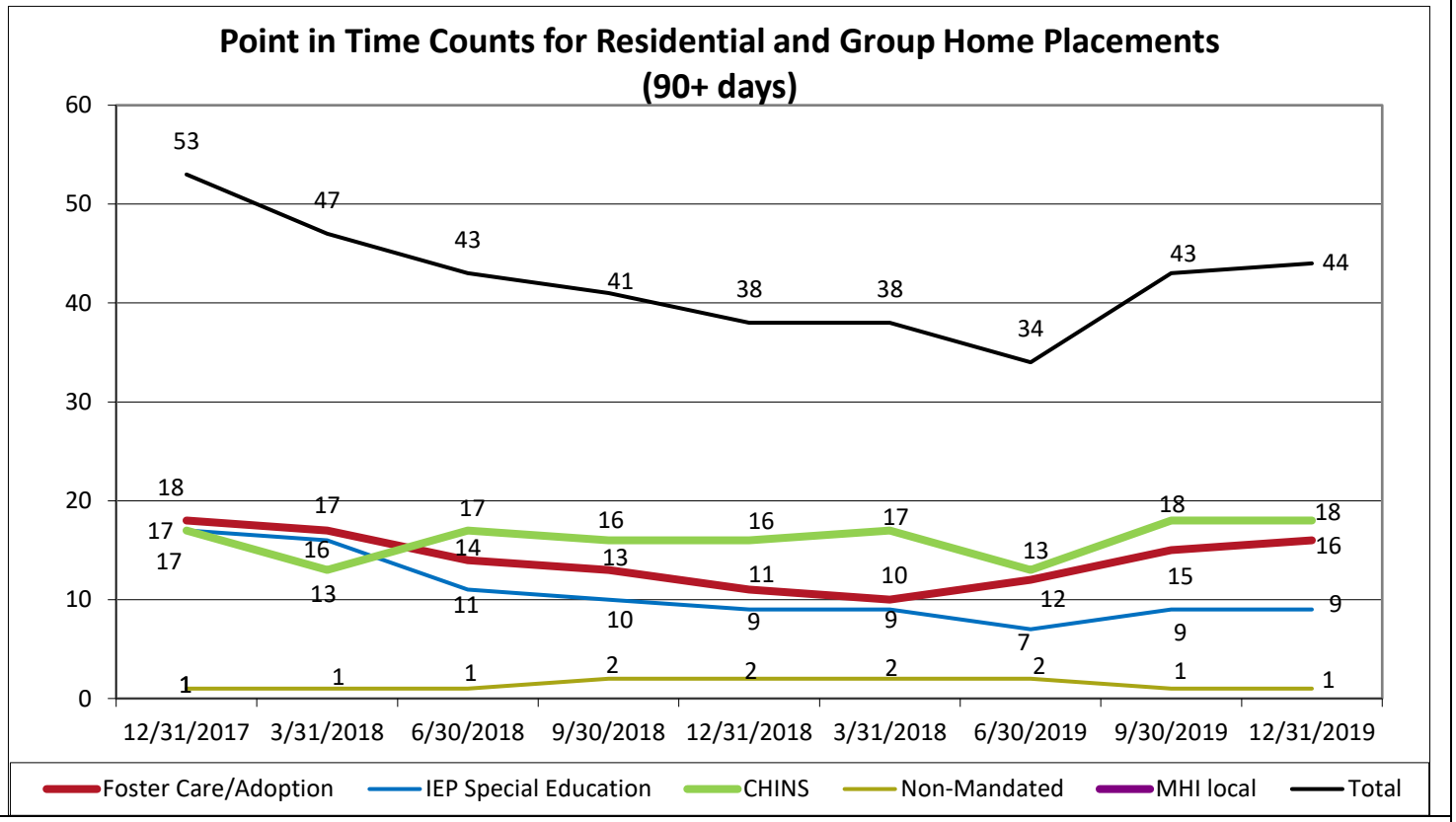
[1] Quarterly performance measures highlighted in blue.

2.3.3	Number of children entering foster care from delinquency petitions	
2.4	**Fiscal Accountability Outcome Goal 1: Fairfax-Falls Church CSA leverages state and local fiscal resources to serve youth and families efficiently**	
2.4.1	Per capita cost per youth receiving CSA services	
2.4.2	Per capita cost per youth receiving residential/ group home services	
2.4.3	Annual per-child unit cost of residential/group home services	
2.5	**Fiscal Accountability Outcome Goal 2: Fairfax-Falls Church is making maximum use of Medicaid as an alternative to CSA or locality funding**	
2.5.1	Percentage of placements in Medicaid-enrolled facilities	
2.5.2	Percentage of Medicaid placements receiving Medicaid reimbursement	
2.6	**Parent Satisfaction Survey**	
2.6.1	Percent of parent survey respondents who are satisfied with CSA services	
	Is Anyone Better Off?	**Headline Measure (HM)**
3.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of children participating in CSA who live in family settings.**	
3.1.1	Percentage of CSA youth who received only community-based services	
3.2	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment.**	
3.2.1	Percentage of children receiving CSA-funded services through the foster care prevention mandate who are successfully prevented from entering foster care	
3.2.2	Percentage of children with families participating in CSA-funded family partnership meetings through the foster care prevention mandate who are successfully prevented from entering foster care after the family partnership meeting	

3.3	**Functional Outcome Goals: Child and Adolescent Needs and Strengths (CANS) outcomes improve for children served by the CSA system of care from initial assessment to second assessment.**	
3.3.1	Percent of positive change in CANS outcomes by domain level of need	
3.4	**Functional Outcome Goal 1: Children participating in CSA-funded services will experience a decline in behaviors that place themselves or others at risk.**	
3.4.1	Percent of positive change in Child Risk Behavior by actionable rating	
3.5	**Functional Outcome Goal 2: Children participating in CSA-funded services will experience a decline in behavioral or emotional symptoms that cause severe/dangerous problems.**	
3.5.1	Percent of positive change in Behavioral/Emotional Needs by actionable rating	
3.6	**Functional Outcome Goal 3: Children participating in CSA-funded services will experience an increase in identified strengths that are useful in addressing their needs and developing resiliency.**	
3.6.1	Percent of positive change in Strength Domain by actionable strength	
3.7	**Functional Outcome Goal 4: Needs and issues of parents/caregivers of children participating in CSA-funded services that negatively impact their care-giving capacity will be reduced.**	
3.7.1	Percent of positive change in Planned Permanency Caregiver functioning by actionable need	

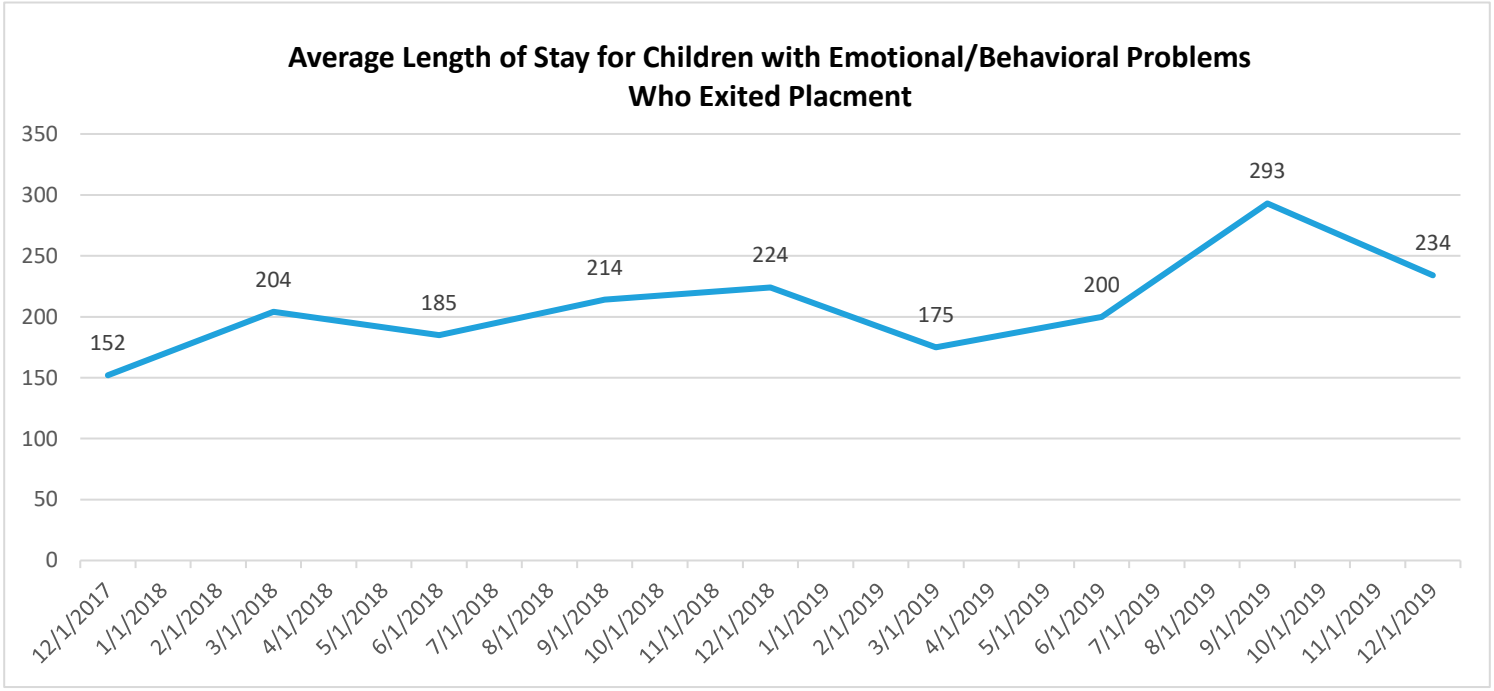
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q2			
How Well Measure	**Number**	**Title**	**Value**
	2.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of children participating in CSA who live in non-residential settings.**	
	2.1.1	Number of youth placed in a long-term congregate care setting	44
Graphs/Charts			
Notes	**Analysis**: The total point in time count saw an increase in the first quarter, mirroring the increase in Foster Care/Adoption placements. The PIT count increased by 1 from Q1 to Q2. **Planned Action:** Continue to monitor.		

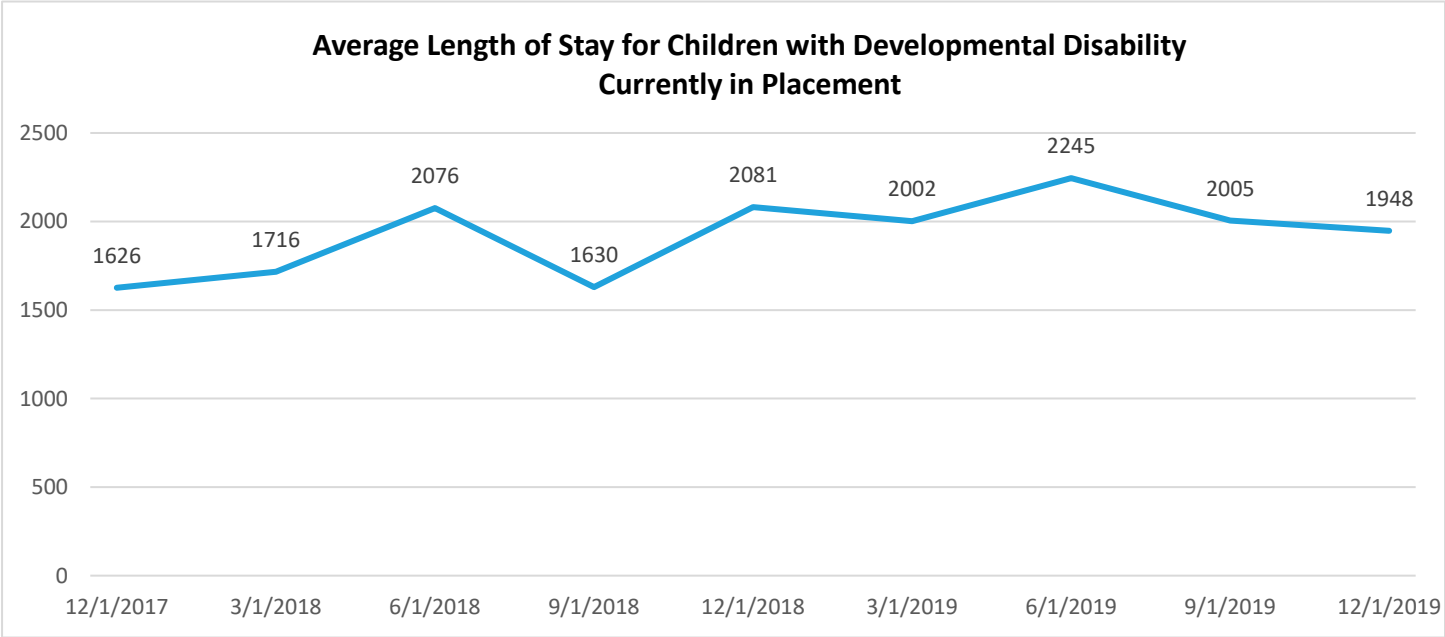
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q2			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.1	Number of days CSA participating children live in congregate care before being returned to a family setting	234 days for youth with emotional /behavioral disabilities
Graphs/Charts			
Notes	**Analysis:** Best practice indicates that youth with emotional/behavioral problems should be returned to a family setting within 6-9 months [180-270 days]. The length of stay for youth with primarily emotional/behavioral problems exiting placement (n=16) was 234 days at the end of the 2nd quarter (LOS ranged from 27 to 825 days). Ages ranged from 14 to 18, with average age being 16 years. Of the 16 exits, 4 were from Foster Care and Adoption, 8 from the Community Services Board, 1 from Falls Church District Court and 3 from Fairfax County Juvenile and Domestic Court. **Planned Action:** Continue to monitor.		

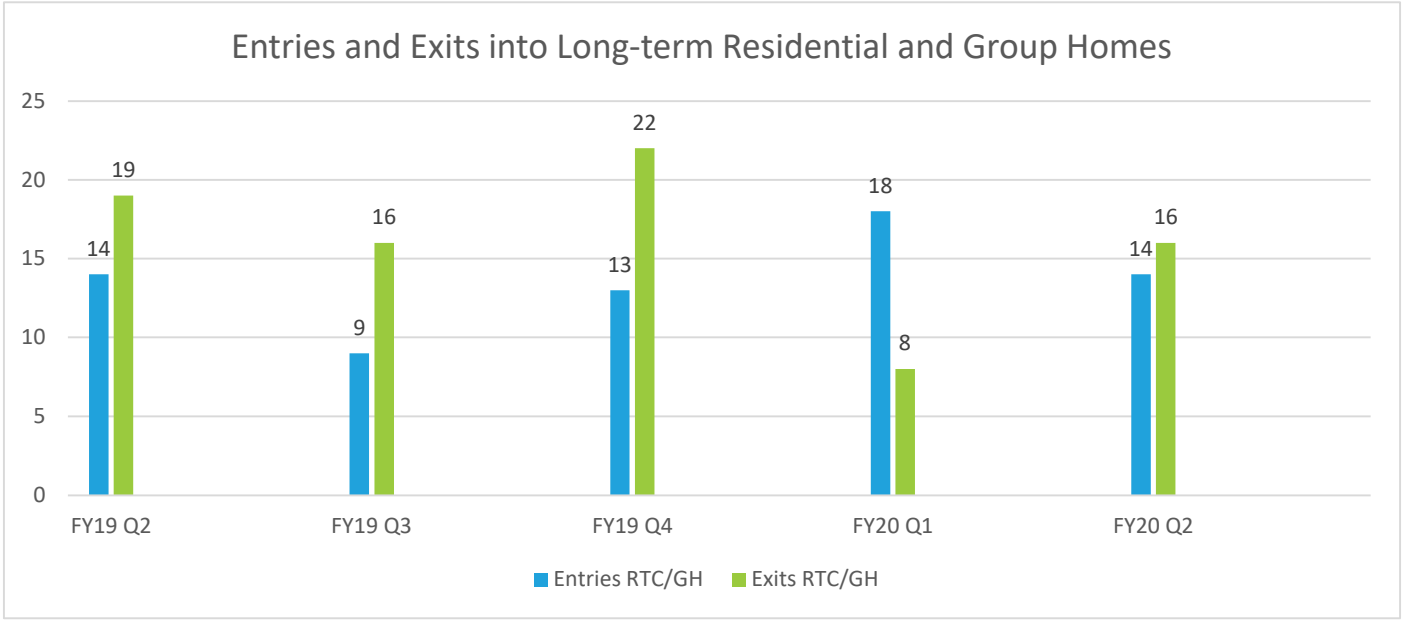
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q2			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.1	Number of days CSA participating children live in congregate care before being returned to a family setting	1948 days for youth with developmental disabilities
Graphs/Charts			
Notes	**Analysis:** The length of stay for youth with primary needs from developmental disabilities (n=6) was 1948 days, range of LOS is 106 to 3,766 days. Five (5) placements are from Fairfax County Public Schools and 1 is from Foster Care and Adoption; 1 is at Benedictine, 2 at Grafton, 1 at Devereux, 1 at Discovery School of VA and 1 at UHS of Doylestown (Foundations Behavioral Health). The ages range from 14 to 22, with the average age being 19. **Planned Action:** Continue to monitor.		

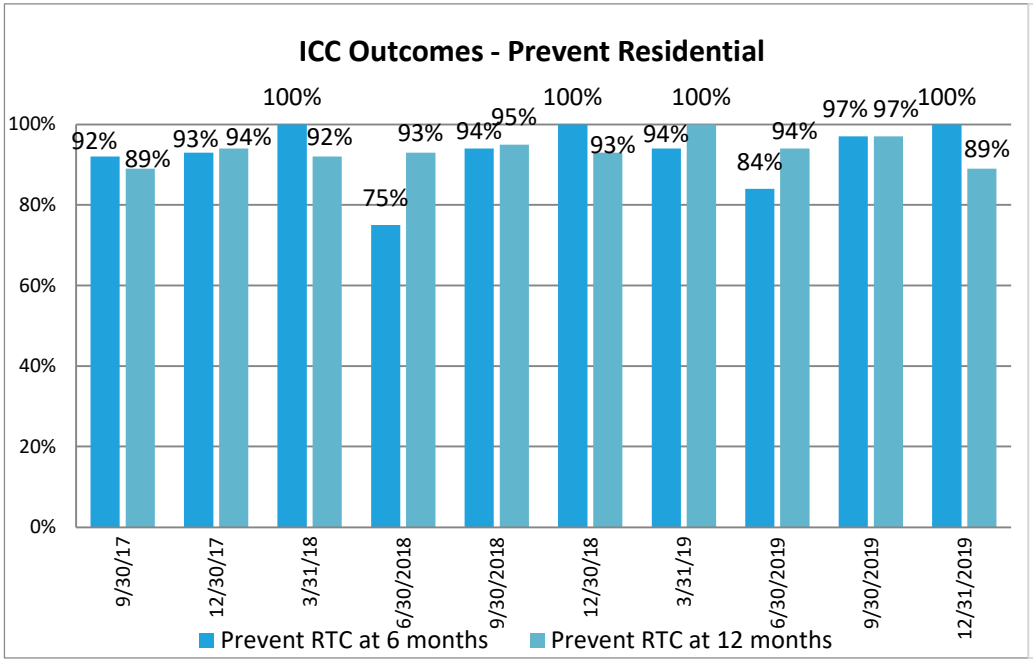
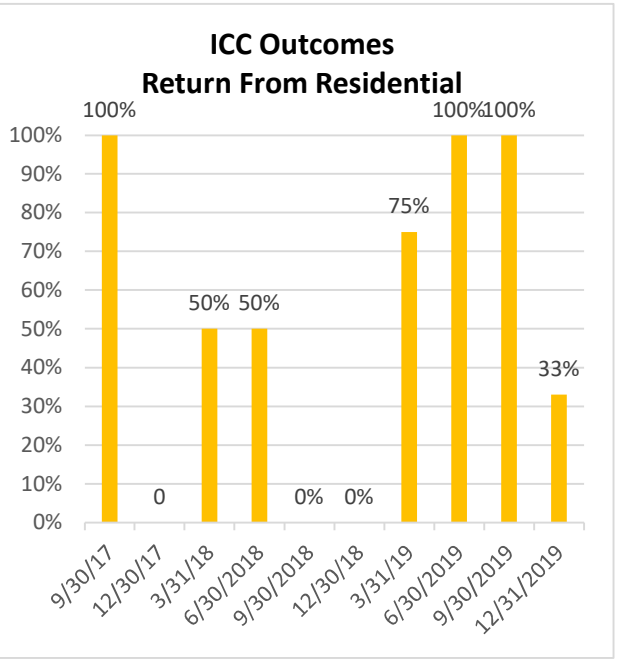
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q2			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.2	Number of youth entering long-term congregate care settings	14
	2.2.3	Number of youth exiting long-term congregate care settings	16
Graphs/Charts			
Notes	**Analysis:** There were 14 entries and 16 exits this quarter. **Planned Action:** Utilize ICC as a resource for youth to support successful return to a community/family-based setting. Utilize Leland House and crisis stabilization services to meet youth with intensive needs in the community, even during a crisis.		

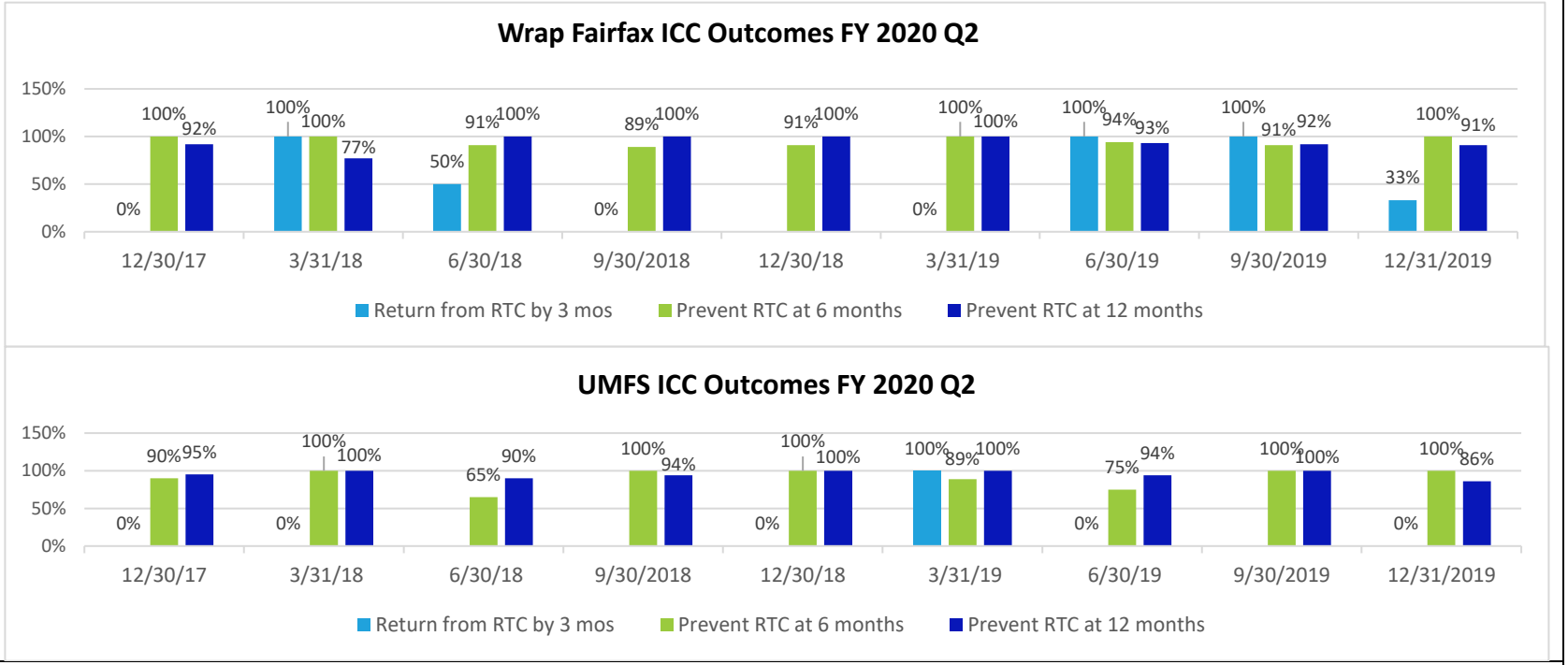
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q2			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services	100% / 89%
	2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services	33%
Graphs/ Charts	 		
Notes	**Analysis:** 100% (n=23) of youth were maintained in the community 6 months after initiation of ICC services. 89% (39 of 44) of youth remained in the community 12 months after the initiation of ICC services. 33% (1 of 3) youth returned from residential within three months of initiation of ICC. **Planned Action:** Use fidelity monitoring tools developed by the Wraparound Evaluation & Research Team (WERT) to monitor the providers' fidelity to the Wraparound model. The ICC Stakeholder group continues to meet quarterly to address system implementation issues as needed.		

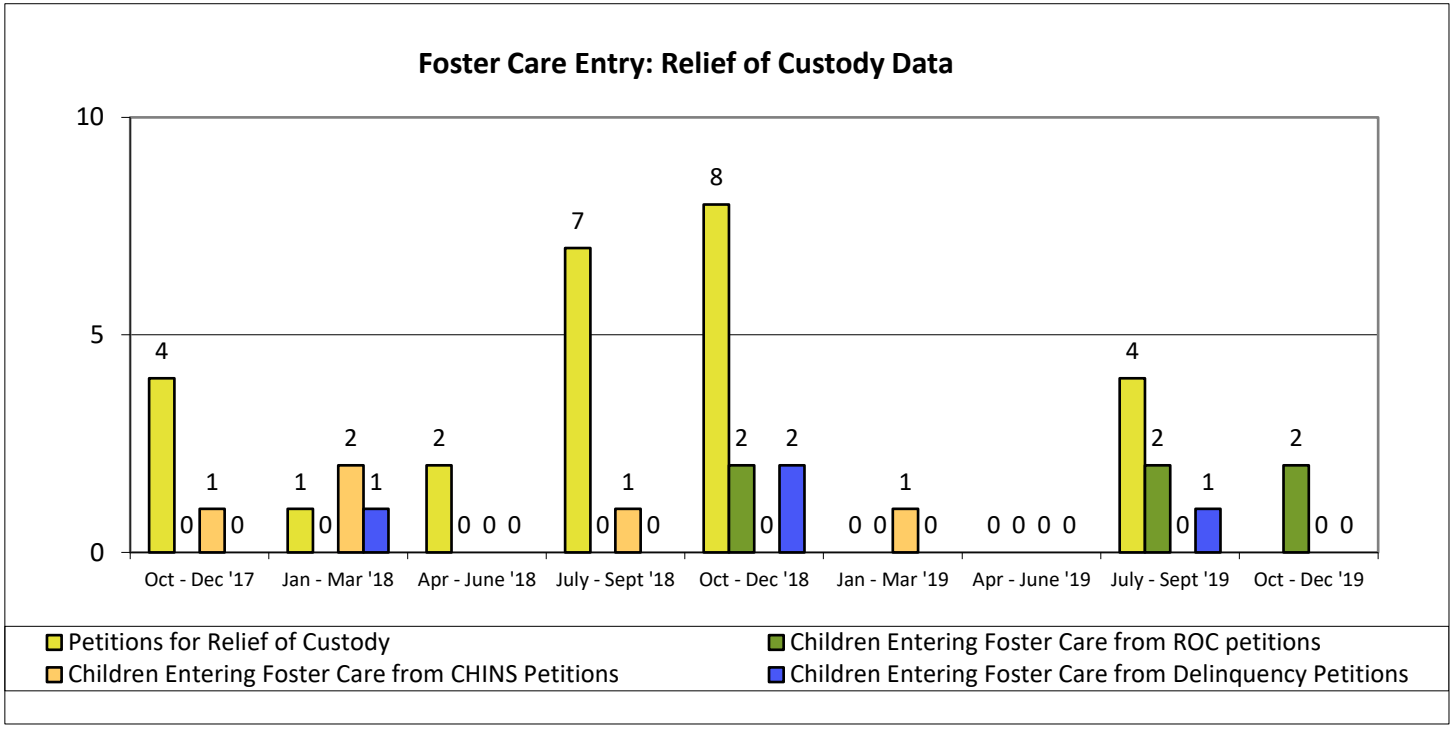
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q2			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services	Wrap Fairfax 100%/91% UMFS 100%/86%
	2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services	Wrap Fairfax 33% UMFS --%
Graphs/ Charts			
Notes	**Analysis: Wraparound Fairfax:** 100% (n=13) of youth were maintained in the community 6 months after initiation of ICC services. 91% (21 of 23) of youth remained in the community 12 months after the initiation of ICC services. 33% (1 of 3) youth referred while in RTC returned home within 3 months of initiation of ICC. **UMFS:** 100% (n=10) of youth were maintained in the community 6 months after initiation of ICC services. 86% (18 of 21) of youth remained in the community 12 months after the initiation of ICC services. No youth were referred to UMFS while in residential care.		

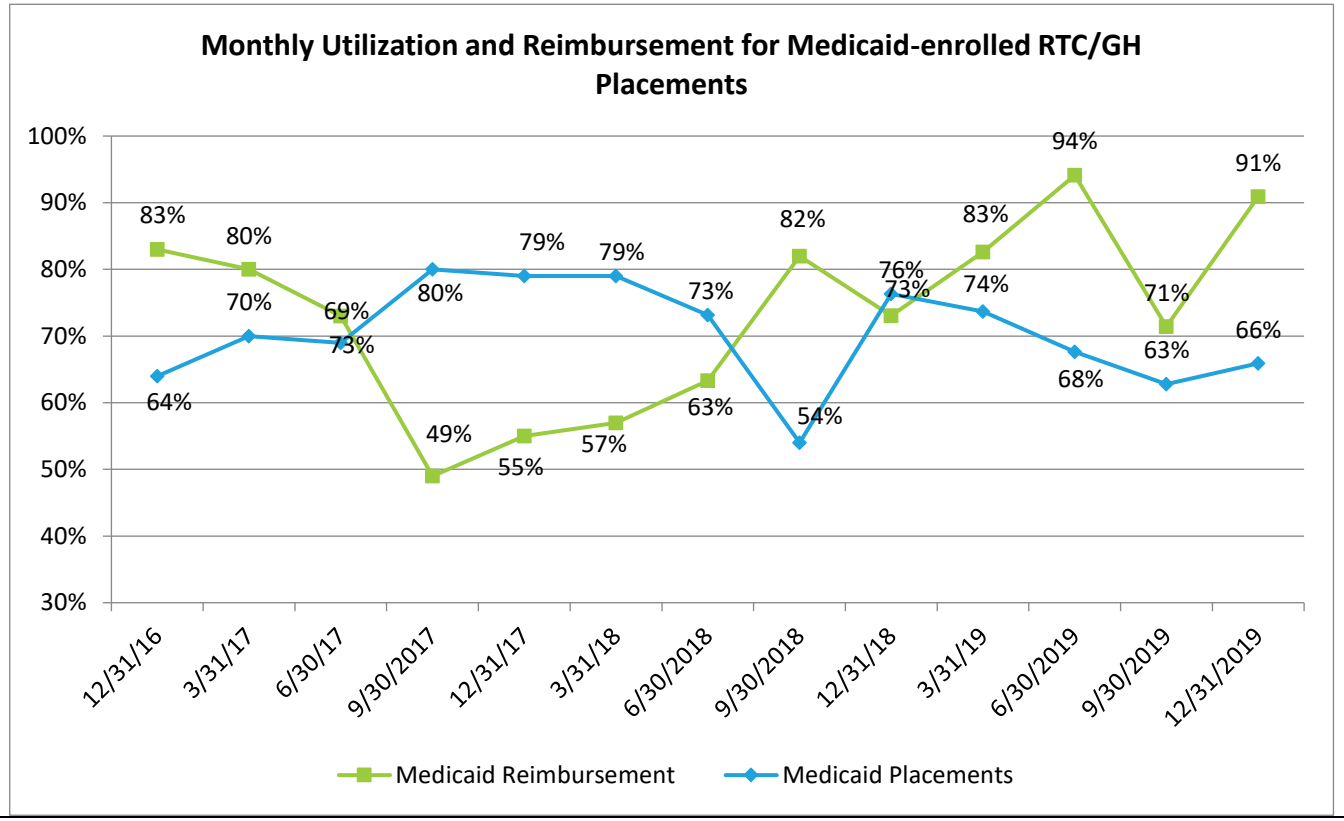
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2019 Q2			
How Well Measure	**Number**	**Title**	**Value**
	2.3	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment**	
	2.3.1	JDRDC and DFS data on Relief of Custody Petitions: # ROC petitions filed/# children entering foster care from ROC petitions	ROC filed / 2 entries
	2.3.2	Number of children entering foster care from CHINS petitions	0
	2.3.3	Number of children entering foster care from delinquency petitions	0
Graphs/ Charts			
Notes	**Analysis**: 2 children entered foster care from relief of custody petitions. **Planned Action**: Continue to monitor.		

Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

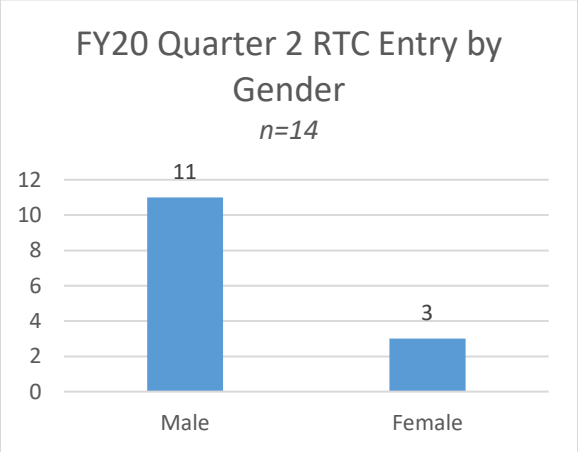
FY 2019 Q2			
How Well Measure	**Number**	**Title**	**Value**
	2.5	**Fiscal Accountability Outcome Goal: Fairfax-Falls Church CSA leverages state and local fiscal resources to serve youth and families efficiently**	
	2.5.1	Percentage of placements in Medicaid-enrolled facilities	66%
	2.5.2	Percentage of Medicaid placements receiving Medicaid reimbursement	91%
Graphs/Charts			
Notes	**Analysis**: The number of youth placed with Medicaid providers this quarter is 66% (29 of 44). Youth placed with non-Medicaid providers is 15 (34%). Of the Medicaid placements, the potential for Medicaid reimbursement (Medicaid eligible youth admitted to Medicaid providers) is 23 (52%). Of those 23 placements, 20 (87%) were approved for Medicaid; 1 (4%) was denied and 2 (5%) are pending.		

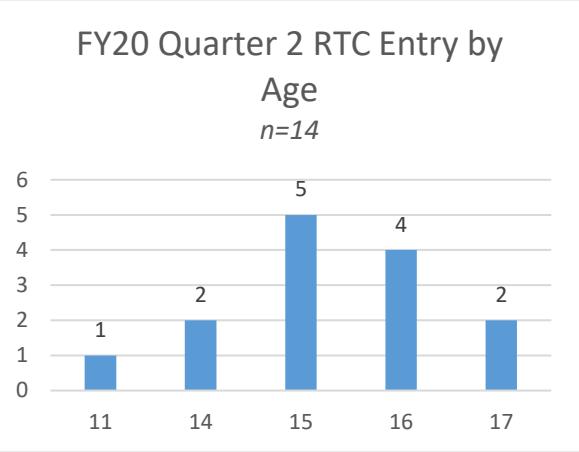
QUARTERLY RESIDENTIAL ENTRY AND FAPT REPORT

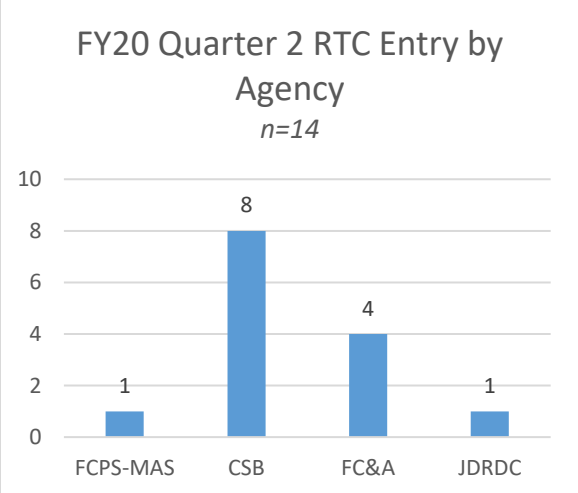
Residential Entry Report

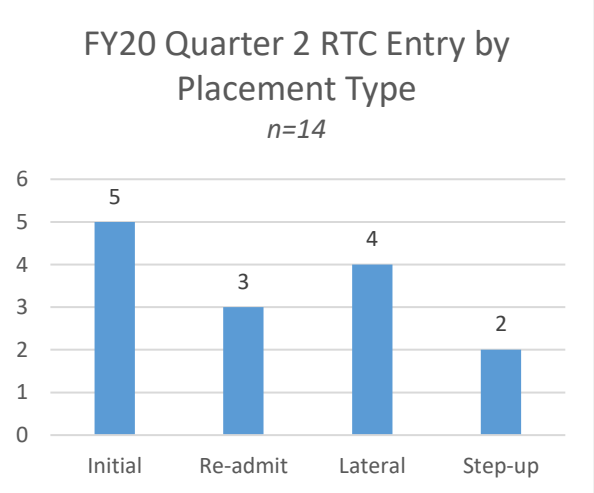
As stated in the local CSA policy manual under Section 4.4 Multi-Disciplinary Teams and Family Assessment and Planning Teams, *prior to the residential placement of a child across jurisdictional lines, the FAPT shall (i) explore all appropriate community services for the child, (ii) document that no appropriate placement is available in the locality, and (iii) report the rationale for the placement decision to the CSA Program Manager who shall inform the CPMT at its next scheduled meeting.*

Fourteen youth entered long-term residential settings FY20 Quarter 2, Oct (4), Nov (7), and Dec (3).









CANS: Actionable Needs

Across the 14 youth, the most frequently identified "Actionable" needs on the CANS were as follows:

- Depression-10
- Opposional-9
- Anxiety-9
- Adjustment to Trauma-8
- Runaway-7
- Anger Control-6
- Danger to Others-7

Patterns, Trends, and Service Gaps

- There were three youth with actionable scores in substance use. This is an increase in previous quarters over the past two fiscal years, however, it may be a result of an overall higher number of youth in long-term residential placements.
- There were two youth placed in RTC by their families prior to coming to FAPT.
- Increasingly, cases are returning to FAPT after FAPT has recommended transitional services to be started while youth is in a residential placement. However, there is a trend of case managers not following through with getting supportive, transitional services in place. In some cases, youth's behaviors and symptoms worsen as keeping youth in placements longer than necessary often leads to regression.
- There are more youth who are returning to FAPT after several months of returning home from prior placements. It appears that the more youth bounce in and out of different placements, the harder it is for them to achieve sustained stability. Further, the treatments both in the community and the residential placements are largely not evidence-based practices. As our capacity for linkage to evidence-based treatments grow, it is expected that there will be a reduced need for out-of-home placements, as well as sustained progress following discharge from out-of-home placements.
- For youth with significant trauma symptoms and behaviors, there remains a lack of evidence-based trauma treatment in our community. Often, it is less important the level of care, but more important is the ability to match the youth and family with an appropriate provider competent to provide an EBT model of care in a safe environment.

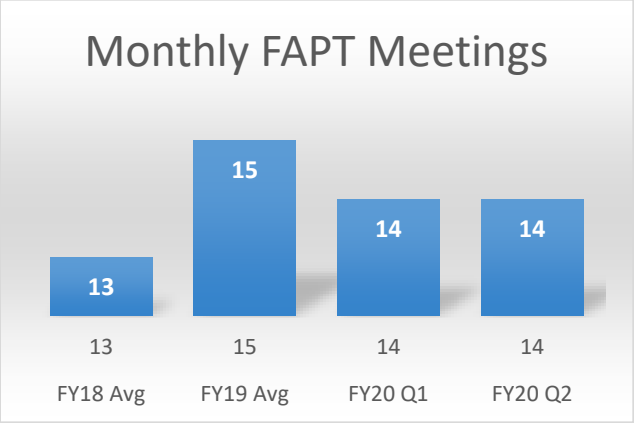
FAPT Report

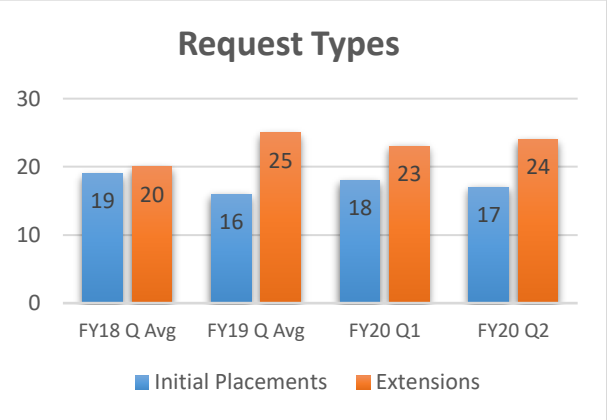
For the second quarter of FY20 (Oct 2019-Dec 2019):

- **41** meetings were held
- **17 (41%)** were new requests for placement:
    - 1 youth was deferred and rescheduled for the following week, as the team was unable to develop a plan

- 3 of these youth had a community-based plans developed in lieu of a plan for placement out of the home; the rest developed plans for RTC or GH placement
- 2 youth had been placed prior to the FAPT meeting; 1 was placed by FC&A and 1 was a parent placement
- 7 of these youth were actively receiving community-based services at the time of the FAPT referral, including 5 who were active with ICC

- **24 (59%)** were requests for extensions of existing placements, all of whom received an extension of anywhere from 3 weeks to 3 months
- No FAPT appeals were requested or heard during this quarter
- For this quarter the average time it took from receipt of a complete FAPT request in the CSA office to the actual FAPT meeting date was **13.5** calendar days





Issues and Trends:

- Acuity of youth needs
  - Extreme Aggression – young children, youth with Autism/DD
  - Sibling abuse
  - Older teens in care
- Families whose capacity to meet the needs of the youth is limited
  - Parental mental health needs
  - Physical health needs
  - Burn-out, hopelessness
- Disrupted adoption (private and public adoptions)
  - Family engagement and continued commitment to youth
- Families with private resources coming to CSA/FAPT after exhausting other resources
  - Educational advocates at FAPT
  - Recommendations for long-term residential by their own private clinical supports
  - Recommendations for non-contracted, non-Medicaid RTCs such as Wilderness programs and therapeutic boarding schools out-of-state

Relevant Practice Standard:

Care coordination and a team-based planning process will be offered to all youth with significant behavioral or emotional challenges and who require services/resources that necessitate collaboration among multiple agencies/systems and/or coordinated interventions by multiple agencies and programs.

a. Care Coordination, system navigation, support in accessing services
b. Awareness of county resources
c. Connection to evidence-based interventions and our continuum of care

Myth/perception*: *Families must use their private resources before coming to CSA. Why does this myth exist? Because case managers equate CSA with funding and not with our System of Care values of coordination and navigation. Yes, families do need to use their insurance when available but we can still offer case management and help families identify services that match the youth's needs.

Are our public agency/school resources for carrying CSA cases sufficient to meet the needs of families who have private/non-CSA funding sources?

Respectfully submitted by *Kim Jensen, UR Manager and Sarah Young, FAPT Coordinator*

MEMO TO THE CPMT
January 24, 2020

Information Item I-4: Serious Incident Report, FY20 Quarter 2

ISSUE: That the CPMT receive information about the disposition of reports of serious incidents that impact youth and families receiving services within the system of care as they relate to contractual requirements and service delivery.

BACKGROUND: Our contract (Agreement for Purchase of Services) specifies provider requirements for reporting serious incidents to both the case managing agency and to the CSA program. Our current CSA policy manual contains procedures describing staff responsibilities in the event of serious incidents for youth receiving CSA funded services.

When serious incidents occur, contracted providers are required to give verbal or email notification of the incident to the case manager and guardian within 24 hours and a written report to the CSA Utilization Review Manager within 72 hours of the incident. This centralized reporting enables the CSA Program to review and collate reports by both the individual youth and facility.

On June 24, 2016, the CPMT directed the CSA Management Team to develop proposed policy and procedures to ensure centralized reporting of serious incidents to include criteria for reporting to the CPMT about the disposition of incidents. A determination was made that the CPMT would be made aware of adverse incidents for youth receiving CSA-funded services that have the potential to impact the safety/well-being of youth due to allegations of:

- Alleged criminal activity by the provider to include abuse/neglect of clients
- Legal/Risk Management issues to include unsafe conditions
- Ethical/Licensure issues to include boundary and dual relationships
- Contractual violations/fiscal issues to include failure to report SIRs and billing misconduct

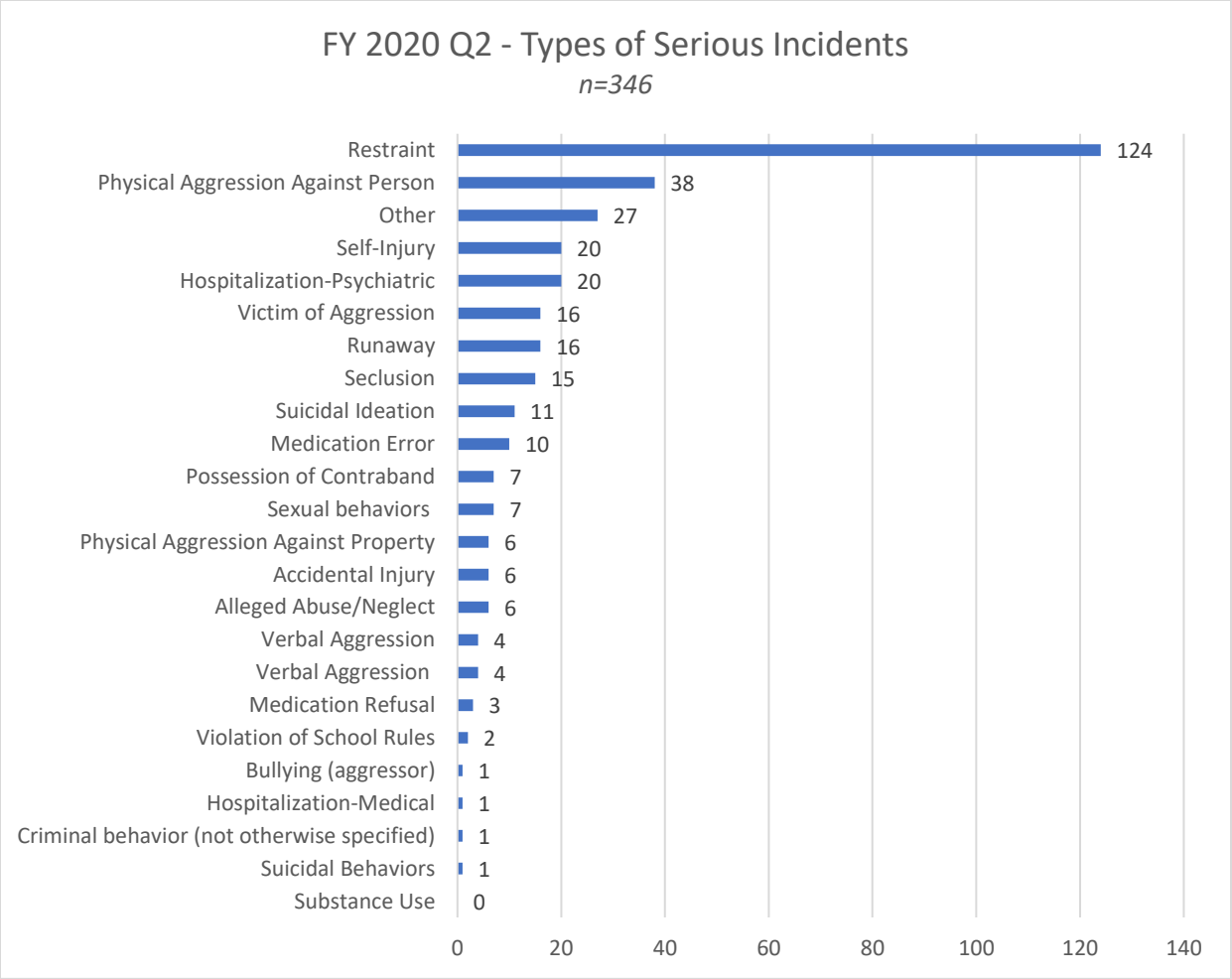
When the incident meets the criteria stated above, the CSA UR Manager and the CSA Contracts Coordinator review the details and decide if immediate action is needed to ensure the safety of the involved youth and other youth in the program/facility. During periods of investigation, contracts are "frozen" and removed from the local CSA Provider Directory and notifications are made to case managers of youth served by the provider. The CSA MT is briefed at the next meeting and subsequently makes a decision regarding future referrals and contracts. The CSA UR Manager and the CSA Contracts Coordinator notify the CSA Program Manager who informs appropriate Human Services Leadership when a situation requires such escalation. When necessary, case managers, CSA staff and contracts analyst make sight visits to assess the facility and any continued risk to the youth receiving services funded by the County.

SERIOUS INCIDENT REPORT: During the second quarter of FY20, there was one new SIR that required CSA Management Team involvement, and one SIR from the first quarter that required additional action from the CSA Management Team:

- CSA received a letter of complaint from a parent about a 90-day assessment and diagnostic program. In response, the CSA Management Team requested feedback from case managers about their experiences with this program. The compiled concerns included the following:
    - Lack of consistent participation in meetings by treating therapists or case managers

    - Staff not being physically present with youth during meetings/participating from a different location than where the youth is at that time
    - Loss of phone service at the facility which lasted more than 24 hours, without an alternate means of contact provided to parents or County case managers.
    - Lack of timely submission of reports
    - Clinical staff using language around autism being able to go into "remission" like cancer
    - Lack of structured activities throughout the day that result in extended time spent watching tv
    - Lack of security at the facility, allowing for visitors to enter and interact with youth without having to show identification or be otherwise checked in and monitored
    - Failure to report SIRs to CSA
    - The decision of the CSA Management Team was to send a letter to the program outlining the concerns and informing the program that any future requests for placement with the program will be considered on a child specific basis.
- In follow-up from the FY20 Q1 SIR report, a home-based provider submitted a Corrective Action Plan (CAP) upon the request of CSA Management Team. The CAP failed to address the specific issues regarding discrepancies in billing where the County paid for sessions that the family reported did not take place. A meeting was held with the provider on December 12, 2019, to further discuss these concerns. The provider submitted additional documentation to update the CAP that was accepted by CSA Management Team on 1/13/20, the provider terminated the employment of the home-based counselor, and the provider has agreed to refund the County for sessions that cannot be confirmed. The provider remains on probation and billing practices are being monitored more closely.

VOLUME OF SIRS: The volume of SIRS increased from 267 total incidents in FY20 Q1 to 346 in FY20 Q2, an increase of 23%. Most of this increase is found in the number of restraints that went up from 78 in FY20 Q1 to 124 in FY20 Q2, an increase of 37%. There were 134 unduplicated youth who received SIRS in Q2, but only 40 unduplicated youth with SIRS of restraints. Of the 40 unduplicated youth who were restrained, 5 youth made up 60% (n=74) of the total number of restraints. Of note, there were three private day schools that represented nearly half of all SIRS (47%; n= 162). Of these, 58% were for physical restraints. However, although one private day school had more SIRS than any other provider (n=65), only 6 of these were for physical restraints. This may suggest that while private day schools may be experiencing similar behaviors from youth across the board, at least one day school has been able to manage the behaviors without an excessive use of restraints. UR staff continue to follow-up with providers and case managers when there are questions or safety concerns. UR follow-up is documented and filed in the youth's CSA chart.



STAFF:

Kim Jensen, Children's Services Act Utilization Review Manager

MEMO TO THE CPMT

January 24, 2020

Information Item I - 6: Regional Evidenced Practice (EBP) Learning Collaborative

ISSUE: Fairfax County along with other localities in Virginia has been invited to form a team of representatives from child serving agencies and family organizations to participate in the Evidenced Based Practice Learning Collaborative.

BACKGROUND:
Representatives of the Commonwealth's child serving agencies are planning a series of free regional EBP Learning Collaboratives which will be facilitated by the National Implementation Research Network. The purpose of these learning collaboratives is to bring together local teams to build leadership capacity, learn about evidenced-based practices and current initiatives in Virginia, and to begin/continue local level planning for successful EBP implementation and sustainability. The Fairfax County team will consist of Healthy Minds Fairfax staff (Janet Bessmer and Peter Steinberg) as well as a representative from the Northern Virginia Family Network, Community Services Board, Department of Family Services, and the Juvenile and Domestic Relations District Court. Team members for the Fairfax team will be selected by the Healthy Minds Fairfax Evidenced-based Workgroup with input from senior leadership from the child serving agencies.

Members of the Healthy Minds Evidenced-based Practice Workgroup form child serving agencies are:

Community Services Board: Patricia Sloate, LaVurne Williams, Marilyn Liciaga, and Treca Stark
Department of Family Services: Brittany Curtis-Cathcart
Fairfax County Public Schools: Jennifer Spears
Child Services Act: Janet Bessmer and Kim Jensen
Healthy Minds Fairfax: Peter Steinberg

ATTACHMENT:

Copy of Flyer for Evidenced-Based Practice Learning Collaborative.

STAFF:

Janet Bessmer, CSA Manager
Peter Steinberg, Children's Behavioral Health Collaborative Manager

Evidence-Based Practice in Virginia:

Are you ready to turn data into wisdom?

As we prepare to move into the next decade, Virginia's child and family serving systems are undergoing dramatic change. Do these phrases ring a bell?

- The Family First Prevention Services Act
- Behavioral Health Redesign
- Juvenile Justice Transformation
- Virginia Tiered Systems of Support
- High Fidelity Wraparound
- System Transformation Excellence and Performance (**STEP-VA**)

Embracing schools, social services, juvenile justice, behavioral health and CSA systems, all of these initiatives involve the identification and installation of evidence-based practices (EBP) – a wide set of interventions that have established effectiveness in improving outcomes for children, families, and communities.

Becoming a more evidence-based system doesn't "just happen" and will require extensive partnerships and lots of work. If you ever look into the heart of "collaboration" you'll find the word "labor." In the public sector, state agencies and local partners will need to learn together and work together to realize the potential benefits of these changes and to assure they are installed with sensitivity to local and individual youth and family needs.

In recognition of this, representatives of the Commonwealth's child-serving agencies and their local partners (Children's Services Act, Education, Social Services, Juvenile Justice, Behavioral Health and Developmental Services, Medical Assistance Services (Medicaid)) are planning a series of **FREE** Regional EBP Learning Collaboratives facilitated by the National Implementation Research Network. The purpose of these events is:

> To bring together local teams in the children's services system(s) to build leadership capacity, learn about evidence-based practices (EBP), current Virginia EBP initiatives, and to begin/continue local level planning for successful EBP implementation and sustainability.

These events will not focus on specific EBPs, but about getting ready to think about and implement a variety of new practices with youth and families at the locality level.

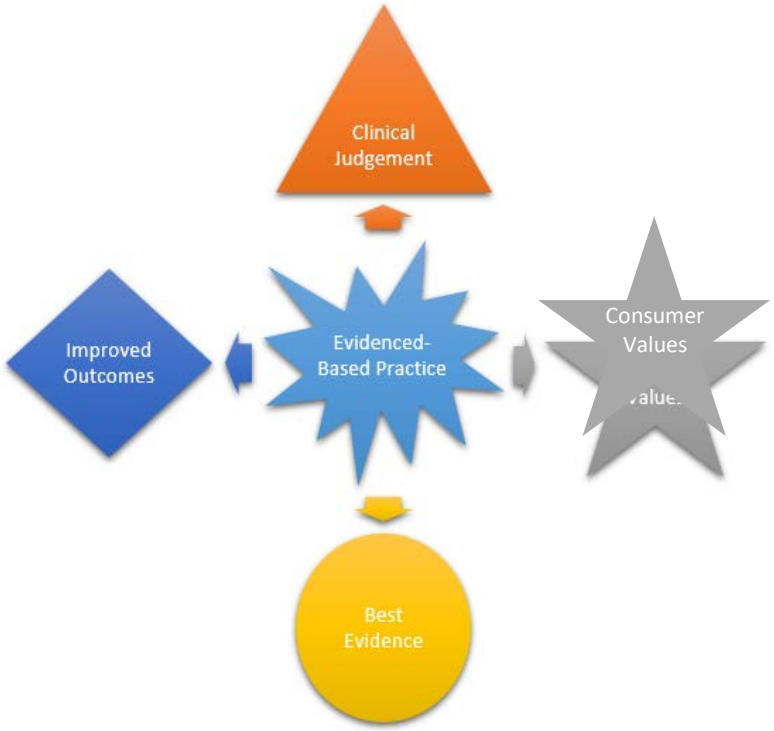
Localities, or if more practical and appropriate, regional teams of representatives from the child-serving systems (think about for example, the agencies on your CSA teams or who might be a local "agent of change") are invited to come together for a day of learning, self-reflection, team building, and planning to enhance your local/regional readiness for the adoption, implementation and long-term sustainability of the new and excited approaches.

Locality teams would include a single jurisdiction and are most appropriate for larger jurisdictions where agencies only "cover" that locality (e.g., the CSB and the CSU serve only that locality). Regional teams might be most appropriate for a group of smaller or more rural localities, those where the CSU and the CSB are multi-jurisdictional, or regions where several smaller localities might work with a larger locality in a collaborative approach. Regional teams need not adhere to traditional regional boundaries such as planning districts, DSS region, etc., but rather, should reflect the reality of services on the ground. It may be, for example, that a jurisdiction in one planning district/CSB catchment area is actually closer to and have a history of access to a different jurisdiction/district for the types of services and service providers most relevant to their population.

This free training is open to all localities and will take place in April 2020 in a variety of locations throughout the Commonwealth:

- Northern Virginia – April 15
- Richmond – April 16
- Abingdon – April 23
- Lynchburg – April 24
- Tidewater – April 30

Local or regional teams should identify their team members and submit the application no later than February 14, 2020. Local/regional teams will receive confirmation of attendance on or before March 13, 2020.



This is a FREE Regional EBP Learning Collaborative facilitated by the National Implementation Research Network!

NIRN NATIONAL IMPLEMENTATION RESEARCH NETWORK
FRANK PORTER GRAHAM CHILD DEVELOPMENT INSTITUTE

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE
OCS Office of Children's Services Empowering communities to serve youth
Virginia Department of Behavioral Health & Developmental Services
VIRGINIA DEPARTMENT OF SOCIAL SERVICES
Virginia Tiered Systems of Supports VTSS
FAMILY FIRST VIRGINIA