MEMO TO THE CPMT

December 7, 2018

Information Item I- 1: OCS Final Audit Findings and Implementation of Quality Improvement Plan (QIP)

ISSUE: That OCS has issued their final audit findings and accepted the Quality Improvement Plan for the program.

BACKGROUND:

During the Self-Assessment Validation Audit, OCS determined that there was one instance of CSA funding authorized without the appropriate documentation of clinical necessity determination. This finding falls within a Level Two category and therefore, is not subject to denial of funds. Future audits where this issue is identified will be subject to funding denial.

The local CSA program submitted a Quality Improvement Plan and has implemented the necessary staff training and policy manual changes.

ATTACHMENT:

OCS Letter to County and City leadership with audit findings
CSA Management Team Memo and attachments

STAFF:

Janet Bessmer, CSA Manager

COMMONWEALTH of VIRGINIA

Scott Reiner, M.S.
Executive Director

OFFICE OF CHILDREN'S SERVICES
Administering the Children's Services Act

November 13, 2018

Bryan Hill, County Executive
Fairfax County, Virginia
12000 Government Center Parkway
Fairfax, Virginia 22035

David Hodgkins, Acting City Manager
Fairfax City, Virginia
City Hall Room 316
10455 Armstrong Street
Fairfax, Virginia 22030

Wyatt Shields, City Manager
City of Falls Church, Virginia
400 North Washington Street, 3rd Floor
Falls Church, Virginia 22046

Re: Fairfax-Falls Church Children's Services Act (CSA) Audit Findings

Dear Mr. Hill, Mr. Hodgkins, and Mr. Shields:

The final report regarding the Fairfax-Falls Church Children's Services Act (CSA) Self-Assessment Validation Audit (Audit Report 39-2018) was issued August 9, 2018. The Fairfax-Falls Church Community Policy and Management Team (CPMT) submitted a Quality Improvement Plan to address the findings of the auditor.

The auditor reported one finding of non-compliance, which resulted in CSA state pool funds being expended in violation of requirements established by the Code of Virginia or other applicable state policy. Specifically:

- Community-based mental health services were funded for a non-Medicaid eligible youth without a properly documented clinical necessity determination as required by State Executive Council for Children's Services (SEC) Policy 6.3. A Quality Improvement Plan has been submitted by the CPMT. This finding falls into Level Two under SEC Policy 4.7 and <u>is not subject to denial of funds</u> in the current audit cycle. Repeat findings on this issue in a future audit would result in a denial of CSA reimbursement per Policy 4.7.

1604 Santa Rosa Road, Suite 137 • Richmond, Virginia 23229-5008 • PHONE: 804-662-9815 • FAX: 804-662-9831 • WEB: www.csa.virginia.gov

OCS Audit staff will monitor implementation of the Quality Improvement Plan by the Fairfax-Falls Church CSA program.

Please accept my appreciation for the cooperation of the Fairfax-Falls Church CPMT Chair and CSA Coordinator throughout this review period. Should you have any questions about this communication, please contact me by phone at 804-662-9082 or via e-mail, scott.reiner@csa.virginia.gov.

Sincerely,

Scott Reiner
Executive Director

cc: Maris Adcock, Business Manager, Office of Children's Services
Tisha Deegan, Fairfax-Falls Church CPMT Chair
Janet Bessmer, Ph.D., Fairfax-Falls Church CSA Coordinator

Memo to CSA Management Team

November 5, 2018

Issue: Quality Improvement Plan for Ensuring Medical Necessity Criteria Met for Specific Medicaid Services

Background: The OCS self-assessment with on-site validation found one instance in which a youth had received CSA funding for a Medicaid-covered service where the record did not contain the required documentation showing that the youth had met the Medicaid criteria to receive the service. CSA cannot fund these Medicaid-defined specific services absent such documentation, even for youth who are not enrolled in Medicaid. If these services are being requested, the youth must be assessed for medical necessity and approved by a licensed clinician (LMHP). This process takes the place of the former VICAP process which may be familiar to many stakeholders. CSA may fund the assessment to determine if the service is appropriate.

To compete the audit process, our local CSA office must submit and implement a Quality Improvement Plan (QIP) to address this area. Our QIP includes two steps: 1) revised sections of the local policy manual to clarify these requirements and 2) complete booster training for UR, FAPT members and ICC providers to ensure that all are aware of this requirement. Because UR authorizes most services except those in the ICC Plan of Care, they can ensure compliance by not approving the three specific services without documentation by a licensed clinician. ICC facilitators must also be trained

The state policy manual sections are included below:

10.1 Medical Necessity for Specific Clinical Services

Criteria defining medical necessity have been identified for specific community-based clinical services which are funded through the state Medicaid program (Department of Medical Assistance Services, DMAS). These specific services are: Intensive In-Home Services, Mental Health Skill Building Services, and Therapeutic Day Treatment. State Executive Council Policy 6.3 requires that when state pool funds are to be utilized (e.g., for non-Medicaid members) for these services, that the FAPT/CPMT ensure that the criteria for medical necessity specified by DMAS for these services is met. The mechanism for making such determination is left to local policy and practice within broad guidelines, including use of an independent clinical assessment. In cases where the medical necessity criteria are not met, FAPT and CPMT should consider alternative services to meet the youth's needs. (page 63, OCS User Manual)

9.4 Medicaid (DMAS)

For intensive in-home therapy, therapeutic day treatment and mental health skill building services, CSA requires a determination of clinical necessity (made by either the FAPT through the concurrence of a Licensed Mental Health Professional (LMHP) or by a contracted evaluation). (page 61, OCS User Manual)

Recommendation: That the CSA Management Team approve changes to the local policy manual to insert these requirements for UR staff and ICC. (See attached).

Attachment: DRAFT changes to local policy manual

Draft Changes to Local Policy Manual

Responsibilities of Utilization Review Staff

1. Review requests for services developed and approved by FAPTs and MDTs and provide service authorizations for those requests that meet state and local funding requirements;
2. Conduct timely utilization reviews according to a schedule in the approved Utilization Management plan;
3. Contact lead case manager to review pertinent case history;
4. Complete the Department of Behavioral Health and Developmental Services' form for youth whose admission to a residential treatment facility was requested but not obtained for 30 days.
5. Conduct necessary record review and attend Team-based Planning Meetings, treatment team meetings, site visits, as needed to collect data and assess the service plan. Contact other agency members and providers for additional information and for coordination of care;
6. Prepare a written report regarding the results of the UR. Distribute the report to the lead agency case manager, ICC facilitator when applicable, the FAPT, and the CSA record;
7. Participate in Contracts' workgroups activities such as meetings, contract renewal discussions, and site visits;
8. Prepare summaries and analyses of utilization for the Management Team and CPMT;
9. Review and render decisions on case-by-case requests for use of non-Medicaid providers for residential and group home services.
10. Review ~~and certify~~ ***documentation*** that the ***medical necessity*** criteria for Intensive In-Home***, therapeutic day treatment, and mental health skill building*** services are met ***before authorization of CSA funding*** for non-Medicaid enrolled youth;
11. Review serious incident reports and follow-up with contracts' staff, lead case manager, providers, and other team members as needed.
12. Provide system feedback through regular communication with teams and through written reports regarding evaluation of the effectiveness and efficiency of purchased treatment services.
13. Evaluate facility and service quality compared to current best practices and licensure standards, encouraging the use of trauma-informed and evidence-based practices in written and verbal reports.
14. Monitor progress of services through comparison of CANS scores over time. Serve as CANS Super Users offering training and support to the system to enhance the reliable and valid use of the state mandatory uniform assessment tool. (page 30)

15.8 Intensive Care Coordination Services and Supports

To facilitate access to enhanced services, supports and treatments to build capacity for access to services in the community, and ultimately to prevent residential and group home placements, the CPMT permits authorization of up to $60,000 over 15 months for a combination of community-based and short term out-of-home (90 days or less) interventions for children and their families entering ICC. Purchase of services under this policy is subject to all existing local policies and procedures.

In developing ICC service plans, informal services and supports should be considered before purchase of services, in order to most efficiently use resources and to link families with resources that will continue after the ICC/CSA intervention terminates. When purchasing services, evidence-based and evidence informed treatments and practices should be utilized when available and appropriate. ICC purchase of out-of-home respite and residential service services must follow existing CSA policies regarding provision of such services using contracted providers.

For intensive in-home therapy, therapeutic day treatment and mental health skill building, state and local CSA policy requires a determination of clinical necessity by a licensed mental health provider (LMHP). CSA funds may be used to purchase an independent clinical assessment for the determination.

(local manual, page 74)

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.
5. 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.
6. 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.
7. 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.

(local manual page 75)

MEMO TO THE CPMT

December 7, 2018

Information Item I- 2: Update on State Private Day Outcome Measures Workgroup and Rate Setting Study

ISSUE: That the CPMT receive updated information about the study for rate setting and other activities regarding provision of Private Day special education services.

BACKGROUND:

Progress on the following two initiatives related to Private Day special education services were reported to the General Assembly's Joint Subcommittee for Health and Human Resources:

1. The Office of Children's Services (OCS) shall coordinate with the Virginia Department of Education (VDOE) to facilitate a work group . . . to identify and define outcome measures to assess students' progress in private day placements that may include assessment scores, attendance, graduation rates, transition statistics, and return to the students' home schools
2. OCS to contract for a study on the current rates paid by localities to special education private day programs licensed by VDOE. – Examine adequacy of current rates – Recommendations for implementing a rate-setting structure – Consider the impacts on local school districts, local government, and public and private educational service providers. • Final report due by July 1, 2019.

ATTACHMENT:

OCS Presentation to Joint Subcommittee for Health and Human Resources Oversight, November 26, 2018

STAFF:

Janet Bessmer, CSA Manager
Adam Cahuantzi, FCPS MAS

Office of Children's Services
Empowering communities to serve youth

Virginia Department of Education

Recommendations for Progress Monitoring of Students in Private Special Education Placements Under the Children's Services Act

Report Pursuant to Chapter 2, Item 282 (O) of the 2018 Appropriation Act

Joint Subcommittee for Health and Human Resources Oversight
November 26, 2018

Scott Reiner, Executive Director, Office of Children's Services

Hank Millward, Director, Office of Specialized Education Facilities and Family Engagement, Virginia Department of Education

Trends in Students with Disabilities and Private Placements

Office of Children's Services

Virginia Department of Education

DOE Data on Private Placements by Disability

December 1 Placement Codes by Disability Category							
DOE Private Day Placement Code 3							
	2013	2014	2015	2016	2017	% of 2017 Total	Change Since 2013
Autism	610	695	792	911	1000	33%	+63.9%
Emotional Disturbance	809	891	900	913	969	32%	+19.8%
Intellectual Disability	159	166	184	193	198	7%	+24.5%
Multiple Disabilities	158	168	186	193	185	6%	+17.0%
Other Health Impairment	372	407	438	458	503	17%	+35.2%
Specific Learning Disability	127	129	131	111	125	4%	-1.5%
State Totals	2235	2482	2655	2802	3004	100%	+34.4%

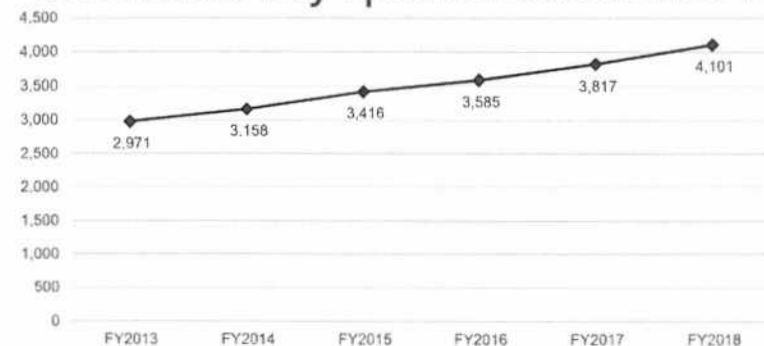
Source: DOE December 1 Special Education Child Count

Note: Totals reflect other disability categories with counts which are suppressed due to being <10.

Office of Children's Services

Virginia Department of Education

Youth Served CSA Private Day Special Education Services

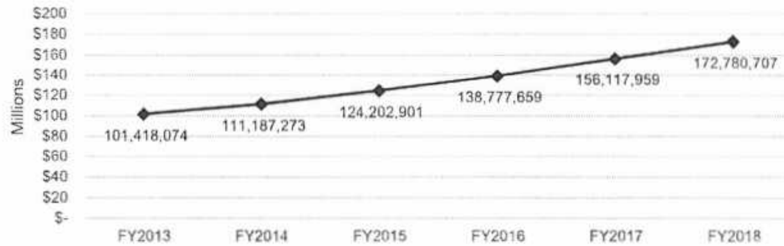


Source: CSA Data Set (pre-2017) and Local Expenditure and Data Reimbursement System (LEDRS)

Office of Children's Services

EDUCATION

Net CSA Expenditures
Private Day Special Education



Source: CSA Data Set (pre-2017) and Local Expenditure and Data Reimbursement System (LEDRS)

Recommended Outcomes for Private Day Special Education Students

Office of Children's Services

EDUCATION

Chapter 2, Item 282 (O)

- The Office of Children's Services (OCS) shall coordinate with the Virginia Department of Education (VDOE) to facilitate a work group . . . to identify and define outcome measures to assess students' progress in private day placements that may include assessment scores, attendance, graduation rates, transition statistics, and return to the students' home schools.

Office of Children's Services

EDUCATION

Process

- A large and diverse workgroup (30+ participants)
  - OCS, VDOE, LEAs, private providers, parents, local government and CSA, other relevant stakeholder groups
- Presentations from VDOE on existing measurements (Special Education Performance Report)
- Presentations from VAISEF on existing data collection efforts
- Discussion and consensus building

Office of Children's Services
Virginia Department of Education

Current VDOE Monitoring Activities

- Results Driven Accountability (RDA) reviews of local educational agencies (LEA) – *Every Student Succeeds Act (ESSA)*
  - Prior to ESSA was based on compliance with *Regulations Governing Special education Programs for Children with Disabilities in Virginia.*
  - Not all LEAs reviewed on yearly basis.
  - Based on rating received on local determination reports to the public.
- Licensure monitoring of private schools for students with disabilities – *Regulations Governing the Operation of Private Schools for Students with Disabilities*
  - Void of language regarding "progress monitoring."
  - Regulations currently speak only to monitoring reviews as part of license renewal.
  - Current practice is that all private schools for students with disabilities are visited as least once per year regardless of licensure status.

Office of Children's Services
Virginia Department of Education

Recommended Measures

1. Graduation Rates
2. Attendance
3. Individual Student Progress
4. Standardized Test Scores
5. Return to Public School Setting
6. Post-Secondary Transition
7. Suspension and Expulsion
8. Restraint and Seclusion
9. Parent Satisfaction
10. Student Perspectives

Office of Children's Services
Virginia Department of Education

Additional Issues to Consider

- Progress monitoring of individual students should be seen as a shared responsibility between the LEA and private school.
- Student placements in a private school are made by through the IEP team process following the "full" development of the students individualized education program (IEP).
  - Least restrictive environment (LRE) is last decision made by the IEP team.
- Return to public school is also an IEP team decision.
  - Need parental consent <u>or</u> for the LEA to prevail in a due process hearing to change the LRE.
- Sending LEA still responsible for student's access to a free appropriate public education (FAPE).
  - Current regulations require at minimum an annual review of a students IEP <u>or</u> when there is a demonstrated lack of progress being made by the student.

Office of Children's Services
Virginia Department of Education

Additional Issues to Consider - Continued

- Sensitivity to characteristics of private day students and differing perspectives on how their progress should be measured
- The only student data required to be provided by the *Regulations Governing the Operation of Private Schools for Students with Disabilities* is restraint and seclusion.
  - Beyond that, the only collection and reporting of student progress data by private schools that was identified was that which the Virginia Association of Independent Specialized Education Facilities (VAISEF) demonstrated they collect as part of their accreditation process.
- Nothing in law or regulation which requires a private school to be accredited.
  - Approximately, only half of the VDOE licensed schools are accredited.
- Private schools that are not accredited were not included in workgroup.

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Additional Issues to Consider - Continued

- VDOE agrees to serve as the lead agency in moving forward:
  - Development/refinement of outcome measuring protocols. Tried to utilize existing measures or those "easily" adaptable from existing measures but additional work needed to finalize measurement protocols.
  - Responsibility for the collection of the data.
- To whom and how will the collection of data be reported?
  - LEAs
  - Private Schools
  - Private School Accrediting Agencies
  - OCS
  - VDOE
  - Joint Subcommittee for Health and Human Resources Oversight
  - Public (As done with an LEA s regarding the VDOE Indicators)

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Additional Issues to Consider - Continued

The following items were not discussed during the workgroup discussions. However, they will need to be discussed and evaluated going forward:

- Use of the data
  - Impact on private schools
  - Impact on LEAs
- Fiscal impact
- Staffing impact
- Need to bifurcate, where possible, the data that is being collected by LEAs to measure their performance on the VDOE indicators to reflect students in private schools separate from the total student population.

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Additional Issues to Consider - Continued

- As of yet, there has been no discussion on the need to measure progress of students placed "publicly" or for "non-educational reasons" in residential facilities.
- Explore any necessary statutory or regulatory changes. May need to amend current regulations:
  - *Regulations Governing the Operation of Private Schools for Students with Disabilities*
  - *Regulations Governing Special Education Programs for Children with Disabilities in Virginia*
- Current recommendation is that the collection of data should begin with the 2019-2020 school year. However, given need to further develop/refine outcome measuring protocols; this may need to be delayed.

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VIRGINIA DEPARTMENT OF EDUCATION

Recommendations

- Adopt the identified outcome measures.
- Convene a workgroup, with VDOE as lead agency, to develop/refine outcome measurement protocols.
- Workgroup to be small and include only:
  - Representatives from VDOE
  - Representative from OCS
  - Representative from private school accrediting agencies
  - Representative from private schools that are not accredited
  - Representative of Virginia Council of Administrators of Special Education (VCASE)
  - Representative from Parent Educational Advocacy Training Center (PEATC)

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Recommendations - Continued

- Representative from State Special Education Advisory Committee (SSEAC)
- Representative from the Virginia Board for People with Disabilities (VBPD)
- Representative from Joint Subcommittee for Health and Human Resources Oversight

• Use the regulatory process to move this initiative forward.

Cost and Rate Setting Study for Private Day Special Education Programs

OCS
Office of Children's Services

Chapter 2, Item 282 (M)

- OCS to contract for a study on the current rates paid by localities to special education private day programs licensed by VDOE.
  - Examine adequacy of current rates
  - Recommendations for implementing a rate-setting structure
  - Consider the impacts on local school districts, local government, and public and private educational service providers.
- Final report due by July 1, 2019.

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Cost Study

- Contracted with Public Consulting Group (PCG)
- Phase 1 includes a national scan on how states fund private special education and rate setting models
  - Preliminary report due December 1
  - Conducted initial stakeholders sessions on October 29 – 30 to include public schools, local governments, and private providers
- Phase 2 includes collection of costs, analysis and recommendations on a methodology for possible rate setting

MEMO TO THE CPMT

Item I – 4: October Budget Report & Status Update, Program Year 2019

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

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

The attached chart details Program Year 2019 cumulative expenditures through October for LEDRS categories, with associated Youth counts. IEP-driven expenditures for Schools are separated out. Further information on the attachment provides additional information on recoveries, unduplicated youth count, and:

-Average cost per child for some Mandated categories

-Average costs for key placement types, such as Residential Treatment Facility, Treatment Foster Home, Education placements.

Total Pooled Expenditures: Pooled expenditures through October 2018 equal $5.4M for 735 youth. This amount is a decrease from October last year of approximately $1.4M, or 20.32%. Pooled expenditures through October 2017 equal $6.8M for 658 youth.

General comparisons to the previous year based on LEDRS reporting categories is presented below:

	Program Year 2018	Program Year 2019	Change Amt	Change %
Residential Treatment and Education	$1,073,120	$379,410	($693,710)	-64.64%
Private Day Special Education	$3,701,802	$3,258,467	($443,335)	-11.98%
Non-Residential Foster Home and Community Services	$2,178,483	$1,763,615	($414,868)	-19.04%
Non-Mandated Services (All)	$44,628	$278,659	$234,031	524.40%
Recoveries	($205,733)	($267,958)	($62,225)	30.25%
Total Expenditures	**$6,792,300**	**$5,412,193**	**($1,380,107)**	**-20.32%**

	Program Year 2018	Program Year 2019	Change Amt	Change %
Residential Treatment and Education	70	36	(34)	-48.57%
Private Day Special Education	234	238	4	1.71%
Non-Residential Foster Home and Community Services	550	560	10	1.82%
Non-Mandated Services (All)	30	116	86	286.67%
Total Youth Counts (Unique Count in each category) *	**884**	**950**	**66**	**7.47%**

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

Expenditure claims are submitted to the State Office of Children's Services (OCS) through October.

RECOMMENDATION:
For CPMT members to accept the October Program Year 2019 budget report as submitted.

STAFF:
Yin Jia, Xu Han, Terri Byers (DFS)

Program Year 2019 Year To Date CSA Expenditures and Youth Served (through October)

Mandated/ Non-Mand:	Residential/ Non-Residential	Serv Type Descrip	Local Match Rate	County & Foster Care	Youth in Category	Schools (IEP Only)	Youth in Category	Total Expenditures
Mandated	Residential	Residential Treatment Facility	57.64%	$177,420	17		0	$177,420
		Group Home	57.64%	$60,445	5		0	$60,445
		Education - for Residential Medicaid Placements	46.11%	$69,148	8	$9,690	1	$78,838
		Education for Residential Non-Medicaid Placements	46.11%	$7,814	3	$54,892	2	$62,706
	Residential Total			$314,828	33	$64,582	3	$379,410
	Non Residential	Special Education Private Day	46.11%	$12,408	3	$3,246,059	235	$3,258,467
		Wrap-Around for Students with Disab	46.11%	$28,658	10		0	$28,658
		Treatment Foster Home	46.11%	$632,376	69		0	$632,376
		Foster Care Mtce	46.11%	$239,303	79		0	$239,303
		Independent Living Stipend	46.11%	$166,980	24		0	$166,980
		Community Based Service	23.06%	$502,211	307		0	$502,211
		ICC	23.06%	$190,118	69		0	$190,118
		Independent Living Arrangement	46.11%	$3,969	2		0	$3,969
	Non Residential Total			$1,776,023	563	$3,246,059	235	$5,022,082
Mandated Total				**$2,090,851**	**596**	**$3,310,641**	**238**	**$5,401,492**
Not Mandated	Residential	Residential Treatment Facility	57.64%	$44,137	3		0	$44,137
	Residential Total			$44,137	3	$0	0	$44,137
	Non Residential	Community Based Service	23.06%	$163,367	90		0	$163,367
		ICC	23.06%	$71,155	23		0	$71,155
	Non Residential Total			$234,522	113	$0	0	$234,522
Not Mandated Total				**$278,659**	**116**	**$0**	**0**	**$278,659**
Grand Total (with Duplicated Youth Count)				**$2,369,510**	**712**	**$3,310,641**	**238**	**$5,680,151**
Recoveries								**-$267,958**
Total Net of Recoveries								$5,412,193
Unduplicated child count								735

Key Indicators

	Prog Yr 2018 YTD	Prog Yr 2019 YTD
Cost Per Child		
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$10,301	$7,364
Average Cost Per Child Mandated Residential (unduplicated)	$17,083	$12,239
Average Cost Per Child Mandated Non- Residential (unduplicated)	$9,378	$7,762
Average Cost Mandated Community Based Services Per Child (unduplicated)	$2,155	$1,636
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$15,441	$10,436
Average Cost for Treatment Foster Home	$9,815	$9,165
Average Education Cost for Residential Medicaid Placement (Residential)	$9,686	$8,760
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$38,265	$12,541
Average Special Education Cost for Private Day (Non-Residential)	$15,820	$13,691
Average Cost for Non-Mandated Placement	$1,925	$2,402

Program Year 2019 Year To Date CSA Expenditures and Youth Served (through October)

Category	Program Year 2019 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2019 Allocation	$732,674	$23,480	97%
Non Mandated Program Year 2019 (Local Match Rate	$1,630,458	$236,173	86%
Program Year 2019 Total Allocation	$39,593,010	$5,412,193	86%

MEMO TO THE CPMT

December 7, 2018

Information Item I- 5: Healthy Minds Fairfax Blueprint Quarterly Report

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

BACKGROUND:
When CPMT approved the Blueprint in March 2016 it directed that staff provide quarterly progress reports. The full progress report for the period July through September 2018 is attached, with a summary below. One of the identified challenges, the lack of referrals to Give an Hour pro bono therapy, will be addressed at the meeting. CPMT members will be solicited for ideas on how to increase referrals.

Areas of Strategic Focus:

Access

Accomplishments:

- An MOU with Arlington has been finalized to expand the regional mobile stabilization and response service to safely divert youth from hospitalization.
- A contract amendment with Northern Virginia Family Service has been finalized to expand VPIP services for immigrant families with children with or at risk of behavioral health issues.
- The PRS CrisisText Connect program engaged in 1815 text conversations with 1582 unique individuals, a 41% increase over last year.
- The Office for Children has developed a 48-hr. Social-Emotional Competencies certificate program. With funding from HMF, they purchased materials and resources that supported the implementation of the first two workshop series in this certificate program.
- Short-Term Behavioral Health Services has expanded to five additional schools.
- The Given an Hour pro bono therapy service was launched in July.
- DFS has provided foster parents with training in the Reflections curriculum, based on the ARC model (Attachment, Regulation and Competency) that the authors have adapted specifically for use with foster families.

Challenges:

- Give an Hour has had very few referrals to date.

Planned Activities

- The FCPS/CSB school-based substance abuse intervention program is about to launch in the following pyramids: South Lakes, Herndon, Langley, West Potomac, Robinson and Bryant/Mountain View high schools.
- Functional Family Therapy is being considered for youth with chronic school absences related to behavioral concerns. Contracting issues are currently being addressed to support implementation of this intervention.

Awareness and Stigma

Accomplishments:

- HMF was featured on the county blog in July 2018 and the county cable channel in August.
- The Fairfax County Trauma-Informed Community Network has reached over 4000 people with their 90-minute Trauma Awareness 101 Training, which is now available on-demand as a 30-minute webinar.

Challenges: None identified

Planned Activities

- The TICN continues to host full day sessions of their Trauma-Informed Supervisor Training, and have reached hundreds of supervisors from county human services agencies, schools, and non-profit partners.

Coordination and Integration

Accomplishments:

- The Virginia Department of Health has been awarded a federal grant to establish a statewide pediatric mental health access program. Inova Kellar Center is a Northern Virginia partner.
- The CSB has added nursing staff to support its services to children and youth.

Challenges:

- The CSB Resource Team is short-staffed due to turnover, limiting their capacity to provide care coordination. They are working on hiring so that families do not remain on a waitlist.

Planned Activities:

- A new navigation website will be ready this winter for testing by families and other stakeholders.
- In May another cohort of local pediatricians will participate in intensive behavioral health training.

Family Engagement

Accomplishments:

- In November a training session for parents was held on evidence-based treatments.
- NAMI has already provided parent support partners for as many families (55) as in all of FY 18.

Challenges:

- A new youth peer support group began in May 2018 but has had difficulty attracting members. CSB staff will be meeting with the CBHC Management Team on December 17 to problem solve.
- Little progress has been made on including youth and families in the evaluation of services.
- Little progress has been made on regularly gaining feedback and input from youth with lived experience.

Planned Activities

- Short-Term Behavioral Health Services is finalizing a contract with an organization specializing in maximizing the response rate to parent satisfaction surveys.

Quality

Accomplishments:

- In November 2018, 45 clinicians were trained in Trauma-Focused Cognitive Behavioral Therapy. The enrollment requirements for this training included a commitment from accepted clinicians to pursue certification.

Challenges:

- The response rate to surveys assessment the fidelity of intensive care coordination to High Fidelity Wraparound principles has been low. A plan for increasing the response rate will be implemented in January.

Planned Activities

- The Core Competency Training offered this year to approximately 70 clinicians treating adolescents will include a trauma specific session, which will be scheduled for spring of 2019.
- In 2019, approximately 100 clinicians working with children ages 7-12 will receive training in MATCH-ADTC- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems.

System Transformation

Accomplishments: None identified

Challenges: None identified

Planned Activities

- The Transitional Age Youth workgroup will be proposing a policy statement that in summary states that behavioral health providers who work with children and youth are committed to help their clients transition their services from children and youth services to adult services.
- The Department of Neighborhood and Community Services is completing a fiscal mapping of county children's services.
- The Transitional Age Youth workgroup is identifying a model for a drop-in center to keep young adults ages 18-24 engaged in services.

ATTACHMENTS:

Quarterly Report on Blueprint Strategies to the Community Policy and Management Team: 12/7/18
Give an Hour Healthy Minds Fairfax Flyer

STAFF:

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

FREE COUNSELING FOR CHILDREN AND YOUTH

Give an Hour has partnered with Healthy Minds Fairfax (HMF), Fairfax County and the Cities of Fairfax and Falls Church, Virginia to provide no cost, confidential mental health services to income eligible youth and children between the ages of 5 and 21.

How to Access Individual Services

1. Visit bit.ly/GiveanHourHMFairfax

*Please note that the link is case sensitive

2. Check your eligibility
3. Type in your zipcode
4. Call your provider

Questions please contact:
fairfaxcounty@giveanhour.org

Give an Hour Healthy Minds Fairfax

Give an Hour has partnered with Fairfax County and the Cities of Fairfax and Falls Church, Virginia to provide no cost, timely, long-term counseling services to your child. Give an Hour (GAH) is a 501(c)(3) nonprofit that develops national networks of volunteers who are capable and committed to responding to acute needs within our society, beginning with the mental health needs of our military service members, our veterans, their loved ones and their communities. In order to serve those in need, the organization mobilizes a national network of mental health professionals who pledge to "give an hour" of their time each week to support these individuals. In addition to direct counseling, Give an Hour's network of volunteer professionals is working to remove the barriers to mental health care by participating in and leading education, training, and outreach efforts in schools, communities, and on military bases.

Give an Hour services are provided at **no cost** to you or your family, with no charges billed to insurance. In order to access services, visit the Give an Hour Healthy Minds Fairfax webpage at bit.ly/GiveanHourHMFairfax and complete the referral form. Give an Hour's Referral Project Specialist will contact you within 72 hours to connect you with an appropriate provider. Your child's school social worker, psychologist or counselor can also assist in the referral process.

Give an Hour Healthy Minds Fairfax staff can be reached at fairfaxcounty@giveanhour.org and are available to answer any questions you may have about the program.

FAIRFAX-FALLS CHURCH CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE BLUEPRINT FOR 2016-2019

Quarterly Report on Blueprint Strategies to the Community Policy and Management Team
December 7, 2018

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

Governance Structure:

A. *Establish a Children's Behavioral Health System of Care oversight committee as the locus of SOC management and accountability.* Accomplished through designating CPMT as the oversight committee. The fifth CPMT parent representative, Terry Williams, has been appointed.

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

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

D. *Continue to develop partnerships with community organizations and agencies in different sectors for coordination, financing and support of the SOC approach.* Work on this strategy was scheduled to begin in January 2018, but a workgroup has not yet been assembled.

Financing Strategies:

E. *Coordinate county budgeting, including but not limited to Diversion First, to maximize the possibility of high priority children's behavioral health needs being funded.* To complete these strategies a matrix of youth services has been developed and fiscal mapping conducted. This strategy has now been folded into a SCYPT fiscal mapping strategy for children's services. Regarding the action step on identifying alternative methods of budgeting the required local CSA match, it was decided to wait to see if the General Assembly takes action on the issue of rising CSA private special education expenditures. The General Assembly directed that a study be done on the feasibility of state rate setting for private special education services.

Service Quality and Access:

F. *Develop/facilitate trainings and outreach materials that increase awareness and knowledge of systems of care values and creates better informed consumers, providers and county and school system staff.* The Training Committee continues to work on revising and expanding the SOC training. The Committee's training plan was presented to the Children's Behavioral Health Collaborative Management Team meeting on July 29th, and was approved in August. The Committee is moving forward with implementation of the plan: 1. a master calendar for children's behavioral health trainings and events and a children's behavioral health resources page are now live on the Healthy Minds Fairfax public website. For both of these pages, visits and pageviews will be tracked. 2. A training for parents on evidence-based treatments is scheduled for the 2nd quarter, with a presenter having been identified. Staff will work on recording and uploading the PowerPoint presentations that have been completed around the areas of insurance access, CANS & GAINSS, and Intensive Care Coordination and Wraparound.

G.

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

FY 19	FY18	FY17
14	0	0

H. *Collect and regularly report on community outcomes, and assess gaps in the array of services and supports necessary for the success of the SOC in preventing and treating behavioral health issues.* The annual CSA service gap survey has been revised locally and by the state.

I. *Review intake, assessment, triage, referral protocols across all levels of care, and lead case management assignments with the goal of supporting families in accessing both public and community provided resources.* CPMT endorsed use of local funding to expand the regional mobile stabilization and response service; the contract with Arlington to do so is about to be finalized and services will be expanded soon.

GOAL 2: Data Systems
Coordinator: Janet Bessmer

A. *Increase cross-system data sharing.* CSA is represented on the HS IT Advisory Committee that meets monthly and is consulted on various topics such as Document Management, the "Front Door," and the Services taxonomy to ensure that recommendations meet CSA needs. CSA has requested to meet with planning facilitators to review the unique needs of the CSA program as an existing cross-agency collaboration.

B. *Use cross-system data to improve decision-making and resource use.* To begin in CY 2019

GOAL 3: Family and Youth Involvement
Coordinator: Jim Gillespie

A. *Increase the presence and effectiveness of family leadership through a sustained family-run network.* A group of family-led nonprofit organizations that serve families, children and youth in northern Virginia began meeting in fall 2017 and continues to meet periodically in person and virtually. The group includes representatives from about eight organizations who gather to share information about their own programming, and exchange ideas for addressing regional challenges and for leveraging potential collaborations. The group has invited participation of Voices of Virginia's Children to share information on state and regional policy and legislative efforts and their impact on local families and children.

B. *Increase family and youth involvement in system planning and implementation.* In December 2017 CPMT approved revisions to local policies and procedures.

C. *Include youth and family participation in the evaluation of publicly and privately provided services, with prompt action for improvement when necessary.* Parents and youth helped develop new CSA provider evaluation surveys, but implementation has been delayed due to the transition to a new state data and financial reporting system (LEDRS).

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

GOAL 4: Increase Awareness and Reduce Stigma
Coordinator: Jesse Ellis

A. *Implement "gatekeeper trainings" to increase layperson understanding of mental illness, recognition of signs and symptoms of mental illness or emotional crisis, and support of others in accessing help, using a cultural competency lens.* Gatekeeper trainings continue to be provided in a number of ways through Mental Health First Aid and the Kognito suite of online trainings (including a peer training for teens), Signs of Suicide, and Lifelines.

B. *Promote youth-led initiatives to combat stigma associated with mental illness, treatment, and accessing help.* Awareness initiatives to combat stigma and promote help-seeking also continue. The RFP for mini-grants for youth-led projects to address stigma, funded by the regional suicide prevention grant, will be available from the CSB soon. Eleven high schools are currently implementing Our Minds Matter clubs,

developed by the Josh Anderson Foundation, and the Foundation hosted a youth track at the 2018 FCPS Mental Health and Wellness Conference, attended by over 50 students.

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

Number of views of PSAs promoting help-seeking behaviors:

FY19 YTD	FY18	FY17
444	6,597,856	3,298,928

Number of crisis texts and calls:

FY19 YTD	FY18	FY17
378 text conversations/1996 calls	1815/5597	1087/4927

D. *Maintain a speaker's bureau and/or list of approved presenters to school and community groups.* To be completed in FY19.

GOAL 5: Youth and Parent/Family Peer Support

Coordinator: Jim Gillespie

A. *Create a Family Navigator program.* Through the Virginia Department of Behavioral and Developmental Services, the county has been selected as a sub-recipient for a federal SAMHSA grant that will fund family navigator/parent support partner services for the next three years. In October 2017 NAMI Northern Virginia was selected as the provider through September 2020. The goal is to serve approximately 100 youth and families annually.

Number of families served by parent support partners:

FY19 year to date	FY18	FY17
55	55	32

B. *Expand evidence-based peer to peer groups, family/community networks.* In March HMF funding was approved for The Merrifield Crisis Response Center Peer Recovery Staff to implement a weekly Peer Group for teens who've been served by Emergency Services. The group began in May 2018 but has had difficulty attracting members. CSB staff will be meeting with the CBHC Management Team on December 17 to problem solve.

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

FY19 year to date	FY18	FY17
0	2	0

GOAL 6: System Navigation

Coordinator: Peter Steinberg

A. *Develop an accurate, accessible and real time database of behavioral health care providers that includes information on if they are accepting new clients, if they accept insurance, and their areas of expertise, with*

functionality to assist families in understanding behavioral health issues and in navigating the system to access services.
The work of development of the database has been "pushed out" to January of 2019 to allow for a focus on the development of the clearinghouse for children's behavioral health information below. Work has begun, however, in compiling the lists of training participants from the most recent offerings by the Fairfax Consortium for Evidence Based Practice.

Number of "hits" on new on-line navigation tool:

FY19 (YTD)	FY18	FY17
Begins in FY 19	0	0

Percentage of users satisfied with on-line navigation tool:

FY19 (YTD)	FY18	FY17
Begins in FY 19	N/A	N/A

B. *Create a clearing house for information on children's behavioral health issues and resources.*
"Content gathering" is underway for the clearing house of children's behavioral health information to be added to our current Healthy Minds Fairfax website. In consultation with the CSB's web developer, Lara Larson, it appears possible for us to simply incorporate a design remodel within our existing web address and drop our new content there. This work of content development will probably continue through December and will include review by members of the original work group and a "testing" process by consumers.

GOAL 7: Care Coordination and Integration
Coordinator: Jim Gillespie

A. *Provide behavioral health consultation to primary care providers and patients.*
The Virginia Department of Health has been awarded a federal grant to establish a statewide pediatric mental health access program, to include behavioral health consultation. Inova Kellar Center is a Northern Virginia partner.

B. *Promote resources to implement tiered levels of integration based on capacity and readiness.*
The county partnered with Inova to provide intensive behavioral health training to 65 pediatricians in October and December 2017. An inter-agency workgroup headed by Dr. Gloria Addo-Ayensu developed a community plan to implement integration, including but not limited to consultation, facilitated referral, co-location and full integration, which was endorsed by CPMT in June. The workgroup also developed a project to safely divert youth from hospitalization when appropriate through expansion of CR2 mobile crisis response services, which was approved for HMF funding in March.

Number of pediatric primary care psychiatric consults:

FY19 year to date	FY18	FY17
0	0	0

C. *Increase the appropriate implementation of behavioral health screenings and referrals in primary care settings.* The workgroup will be recommending screening tools for use in primary pediatric care, probably based on the recommendations of the REACH staff who presented the intensive behavioral health training for pediatricians.

GOAL 8: Equity/Disparities
Coordinator: Peter Steinberg

A. *Promote the adoption of culturally and Linguistically Appropriate Services (CLAS) Standards among BH providers.* The CPMT adopted the Culturally and Linguistically Appropriate Services (CLAS) Standards at

its February 24, 2017 meeting. The Fairfax Consortium for Evidence Based Practice's training on LGBT Best Practices and the ongoing work of the Underserved Populations workgroup discussed elsewhere is a reflection of these standards. There are no additional updates at this time.

B. *Increase access and availability to behavioral health services for underserved populations.* The Underserved Populations workgroup has completed its report and presented it to the CBHC Management Team on 7/30/18. With the support of the CBHC Management Team, the original work group is willing to continue its work to implement recommendations and explore the viability of recommendations that warrant more research. Funding from the CSB has made it possible to provide Youth Mental Health First Aid training to more Faith/Youth leaders in houses of worship where underserved youth live than originally anticipated. With the recent funding of Northern Virginia Family Service's VPIP program, exploration will begin to see how Healthy Minds Fairfax can help to expand multicultural mental health services by one position to serve more Latino youth in our underserved communities.

C. *Require training in cultural competence and advancing equity in alignment with One Fairfax for County, FCPS, and County-contracted behavioral health service providers.* At the March CSA conference, 62 participants attended a workshop called "In Their Shoes", working from a strength based approach to cultural competency. Participants reported overwhelmingly that the presentation was helpful and content clear. The SOC Training Committee is currently reviewing a "one and done" training option vs. a longer training experience for staff and community partners. DFS staff shared their training approach for consideration and other trainers are being explored as well. It is anticipated that an early winter training will be offered to meet this need.

D. *Implement support structures for LGBTQ youth.* The Fairfax Training Consortium for Evidence Based Practice anticipates offering a second training focusing on the specific clinical skills therapists can use in their practice to help address the unique needs of this population this Fall. An additional research based educational approach called the Family Acceptance Project is also being reviewed for a possible training option through the Consortium.

GOAL 9: Reduce Incidence of Youth Suicide in our Community
Coordinator: Jesse Ellis

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

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

C. *Develop a common and coordinated approach to youth suicide postvention.* A resource for community organizations on implementing suicide postvention will be published on the redesigned website. An extension of the committee has begun meeting to discuss opportunities for coordinated community postvention outreach and services.

D. *Continue to make available and promote the suicide prevention hotline, including textline.* In FY2018, PRS CrisisLink answered 5,597 calls, a 14% increase over last year. Of these calls, 196 were from youth under 18, and 298 were from individuals 18 to 24; this represented a 42% increase in calls from these age groups. First quarter data indicate even higher call volume in FY19. The PRS CrisisText Connect program engaged in 1815 text conversations with 1582 unique individuals, a 41% increase over last year.

E. *Train behavioral health providers in evidence-based practices specific to the treatment of youth with suicidal ideation and behavior.* The Fairfax Training Consortium for Evidence Based Practice will offer a

three-part training on Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC), beginning in February. To date this year, they have offered their Core Competencies training and a training on Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).

Number of BH providers trained in evidence-based suicide prevention treatment:

FY19 year to date	FY18	FY17
70	178	0

GOAL 10: Evidence-Based and Informed Practices

Coordinator: Peter Steinberg

A. *Develop definitions and criteria for evidence-based and evidence-informed practice in prevention and intervention/treatment.* Content for this information is in development at present with a final review anticipated by October '18.
B. *Establish a set of core competencies based on service type for all public & contracted provider staff.* Content for this information is in development at present with a final review anticipated by October '18.
C. *Train County, school staff and providers on EBPs, including how and when to use them. Include a review of practices that are harmful.* Curriculum still needs to be developed or compiled from other sources in order to be ready to present to this audience. This work has been moved forward again to be addressed this next quarter.
D. *Incentivize the use of EBPs among providers.*
The significant energy involved to launch the above-mentioned trainings and focus groups have delayed a full discussion of incentivizing the use of EBPS among providers. A preliminary discussion has begun with one initial idea of allowing County contracted private providers who have attended specific training offerings may be invited to propose a higher individual rate based on their training participation. More ideas will be provided in the next quarter.

Number of BH providers trained in trauma evidence-based treatment:

FY19 year to date	FY18	FY17
(begins FY19)	0	0

Number of BH providers trained in evidence-based suicide prevention treatment:

FY19	FY18	FY17
0	178	0

GOAL 11: Trauma Informed Care

Coordinator: Jesse Ellis

A. *Ensure there is sufficient clinical capacity to meet the needs for trauma-specific, evidence-based interventions.* In the spring of 2018, the Fairfax Consortium for Evidence-Based Practice trained over 100 clinicians in the Family Intervention for Suicide Prevention (FISP), which is a trauma-informed treatment protocol for suicidal ideation. In November 2018, 45 clinicians were trained in Trauma-Focused Cognitive Behavioral Therapy. The enrollment requirements for this training included a commitment from accepted clinicians to pursue certification. The Core Competency Training offered this year to approximately 70 clinicians treating adolescents will include a trauma specific session, which will be scheduled for spring of 2019. Also in 2019, approximately 100 clinicians working with children ages 7-12 will receive training in MATCH-ADTC- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems. The offerings of the consortium should make a significant contribution to increasing the clinical capacity of the local provider community to provide evidence-based trauma specific treatment, which has most certainly ben a gap up to this point in time.

B. *Train non-clinical staff in community-based organizations, schools, and county agencies to implement trauma-informed practices.* The Fairfax County Trauma-Informed Community Network has reached over 4000 people with their 90-minute Trauma Awareness 101 Training, which is now available on-demand as a 30-minute webinar. The TICN continues to host full day sessions of their Trauma-Informed Supervisor Training, and have reached hundreds of supervisors from county human services agencies, schools, and non-profit partners. The TICN training subcommittee also developed a training on Secondary Traumatic Stress in the workforce 9The Cost of Caring) that is now available regularly. Trainings and resources on developing trauma-informed spaces are also currently available.

The TICN worked to increase community awareness of trauma and its impact by developing and publishing a Trauma Awareness Fact Sheet that has been widely distributed, and supported mass printing of a trauma infographic poster from the National Council for Behavioral Health that was also widely distributed. The TICN now owns a copy of (and license to screen) the documentary *Resilience*, and the film is regularly loaned out for additional staff and community screenings, and has reached over 6,000 people to date. In addition, the TICN has developed a "Guide to Educating Children, Youth and Families about Trauma & Resilience" to prepare the human services workforce to provide psychoeducation to kids and families. The guide has already been widely distributed to a variety of audiences across the child and youth serving system.

C. *Inform the community at large on the prevalence and impacts of trauma.* The Trauma Informed Community Network continues to host and sponsor screenings of the documentary *Resilience*. Led by the TICN's representative from the Fairfax County Council of PTAs, the Network presented a new version of Trauma 101, specifically for parents, at the FCCPTA Family Engagement Conference in October; they have been invited to also present it at the Virginia statewide PTA conference in early 2019.

D. *Develop shared screening and referral process for individuals impacted by trauma for school and human services agency staff using nationally recognized screening tool.* This is in development.

E. *Human service agency leaders will integrate the concepts of trauma-informed care into their organizational culture.* County Health and Human Services agencies are each implementing plans to ensure their organizations are trauma-informed. An update was provided in the May CPMT packet.

GOAL 12: Behavioral Health Intervention

Coordinator: Peter Steinberg

A. *Develop empirically validated cross system human services and schools screening process available to determine needs, resources, & desirable outcomes.* This work group's report has been shared with the HMF Director with recommendations for a cross system screening process and anticipate its review by the CBHC Management Team and CPMT early Fall '18.

Number of BH screenings (semi-annual measure):

FY19 (YTD)	FY18	FY17
14	88	108

B. *Create capacity to address behavioral health needs of children 0-7.* The Office for Children has developed a 48-hr. Social-Emotional Competencies certificate program. With funding from HMF, they purchased materials and resources that supported the implementation of the first two workshop series in this certificate program. OFC continues to seek funding to establish an early childhood mental health consultation system that will build the capacity of programs and

strengthen the competencies of early childhood educators to promote children's successful social and emotional development.

C. *Establish a training consortium in partnership with university and private provider partners (ex: GMU, INOVA) for ongoing training for staff and service providers.* The Training Consortium for Evidence Based Practice presented its second training on Family Intervention for Suicide Prevention on June 4, 2018 with 66 mental health clinicians in attendance. The first Core Competency 3-day training for mental health clinicians will begin on August 31, 2018 into September. Final arrangements are underway for the scheduling of a nationally certified trainer to train in Trauma Focused CBT in early November. In addition, the first training for clinicians focused on younger children is tentatively scheduled for January 2019. It is also anticipated that a consultant will be hired with expertise in federal and state funding in dissemination and implementation of evidence-based practices for youth and families and grant proposals which will head us to potential grant/foundation applications for funding to address sustainability of the consortium.

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.*
Despite not receiving additional funding for the Short Term Behavioral Health Service for Youth in the most recent budget, we will expand to 5 additional schools this year including Glasgow, Holmes and Poe Middle schools and, for the first time, serve two elementary schools, Annandale Terrace and Herndon. As a reminder, this service continues to link income eligible youth and families from select school communities to timely and available short term mental health counseling (up to 8 sessions), funded by Healthy Minds Fairfax. School referrals totaled 173 this past school year, far surpassing last year's total of 75.

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

FY19 year to date	FY18	FY17
19	130	57

Give an Hour, the pro bono therapy initiative for children, youth and families in Fairfax County and their website went live on July 9, 2018. The Board of Supervisors offered a resolution at their July 10, 2018 meeting recognizing the launch of the Give An Hour campaign in Fairfax County for our at risk youth. A community launch is scheduled for September 20, 2018 with a film screening of *Into the Light* which highlights the impact of trauma on a young veteran and the role Give an Hour played in his life. A panel discussion will follow. We anticipate increased use as school starts and more community awareness events are scheduled.

Number of youth served through pro-bono outpatient therapy services:

FY19 year to date	FY18	FY17
0	0	0

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

F. *Reduce youth substance abuse and use.* With the assistance of a HD epidemiologist and a review of data from youth survey, discipline, AOD intervention seminars for both high school and middle schools and a ranking of the pyramids from greatest to least risk of expanding opioid concerns, along with a zip code review of where overdoses occurred, school pyramids were chosen. The FCPS school-based substance abuse intervention program is "under construction" with the imminent hiring of a part time FCPS clinical supervisor and the subsequent hiring of six FCPS staff to serve the following pyramids: South Lakes,

Herndon, Langley, West Potomac, Robinson and Bryant/Mountain View high schools. This program will work collaboratively with CSB staff for initial trainings and throughout the year in other professional development activities.

GOAL 13: Service Network for High Risk Youth
Coordinator: Janet Bessmer

A. *Increase availability/capacity of provider community to offer trauma assessments and evidence-based trauma treatment; trauma services shall be offered in languages and in locations that are accessible to families.* This goal overlaps with roles of TICN and the Training Consortium. Private providers who offer trauma assessments and treatments are identified in the CSA provider directory. There continues to be a need for providers to offer evidence-based trauma assessments and treatment. TFCBT training was offered by the consortium, supplemented by CSA funding, for 44 clinicians in November, 2018.

B. *Identify and implement an evidence-based parenting program designed for parents of adolescents (12+); language capacity and location/accessibility shall meet the needs of families.* The project is now being coordinated by Bob Bermingham along with FCPS leadership. Both FFT and MST are under consideration for two different populations. In addition, Diversion First funding was earmarked that can be used for this project, provided the target population has a criminal justice connection as befitting the goals of Diversion First. Functional Family Therapy is being considered for youth with chronic school absences related to behavioral concerns. Contracting issues are currently being addressed to support implementation of this intervention.

C. *Identify and implement an evidence-based parenting program designed for parents of children (<12); language capacity and location/accessibility shall meet the needs of families.* DFS has provided foster parents with training in the Reflections curriculum, based on the ARC model (Attachment, Regulation and Competency) that the authors have adapted specifically for use with foster families. This curriculum has been well-received by foster families and DFS has plans to expand the training for other caregivers, including birth parents and kinship families. The contract for the ARC Reflections Train-the-trainer is pending. The CSA Management Team has also considered the need to adopt an evidence-based model for supervised visitation services.

D. *Monitor utilization of ICC and Case Support and increase capacity/staffing so that youth with identified behavioral health care needs receive appropriate case management services.* UMFS and Wrap Ffx are fully staff with ICC facilitators. UMFS has 4 with a supervisor who will carry cases part-time. Wrap FFX has 7 facilitators. The CSB Resource Team has had some staff turnover due to promotions. They are working on hiring so that cases do not remain on a waitlist.

E. *Improve the utilization of the annual gaps survey of youth and parents in CSA-SOC to identify needed interventions.* The state OCS survey has been utilized to evaluate needs; however, it may not be sufficiently sensitive to the level of work being conducted in the County at this time. Other community needs assessments should be evaluated to determine if gaps and needs are identified through other efforts such as the Under-Served Populations workgroup.

F. *Develop communication plan to share information about the services and care coordination offered through the SOC process with the broader provider community.* As part of the county's new website design, CSA and HMF have new pages on the county's public website. In addition, CSA has begun producing its monthly newsletter again that contains training announcements and other information pertinent for system partners.

G. *Build system capacity to monitor fidelity to EBT models and conduct outcome evaluation for purchased services.* In the fourth quarter of FY18, CSA staff began implementation of the WFI-EZ survey protocol. Fifty-two families were found to meet the survey criteria; based on the survey guidance from the Office for Children's Services, 30% of those families (n=16) were randomly selected to receive the WFI-EZ survey.

The caregivers, lead case managers, and care coordinators were contacted via email to respond to the survey. This work continued into the first quarter of FY19, with CSA staff following up via email and phone calls to families, facilitators and case managers to encourage completion of the WFI-EZ survey. According to the Wraparound Evaluation and Research Team (WERT), completion of the WFI-EZ tends to be low; the response rate for the first round of the Fairfax evaluation followed tris trend, with less than half of caregivers, facilitators and case managers responding to the survey. The ICC Stakeholder Committee, which is comprised of staff from the CSA, ICC providers, NAMI, and referring agencies (DFS, JDRDC, FCPS), has developed a plan to address the low response rate in the second round which will be implemented in the 3rd quarter of FY19.

H. *Provide IT infrastructure to support data collection for fidelity monitoring and outcome evaluation along with electronic records management.* CSA is a participant on the Health and Human Services Integrative System Implementation Advisory workgroup which is overseeing a multi-year project that supports data analytics, electronic records management, and other functions utilized in CSA. CSA is working with DFS IT staff to discuss efficiency and streamlining through existing technology for incoming documentation and file maintenance. Current work is focused on reviewing options for portals for non-County entities including providers and schools as well as electronic workflows.

I. *Explore opportunities for expanding available financial resources to serve youth on diversion or probation who need intensive behavioral health services.* CSA staff have met with court staff to review the requirements for CSA-funded services and train staff to access these funds. Court staff have been active participants in recent CSA training and supervisory booster sessions. These discussions are ongoing.

J. *Increase family and provider membership on the CPMT.* Our CPMT parent representative positions and our vacancy on FAPT have now been filled.

GOAL 14: DD/Autism Services
Coordinator: Tracy Davis

Develop expanded continuum of care of services for youth with DD/autism. The interagency workgroup convened on 7/23/18, 8/27/18, & 11/1/18. The next meeting is scheduled for 12/13/18. The workgroup is working on refining the direction of the work on this goal. Two main deliverables have been identified:

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

Deliverable #2: DD/Autism Services Case Management Proposal with a Statement of Need to CBHC & CPMT

Updates on each blueprint strategy are addressed below:

A. *Conduct needs assessment and service inventory of the existing continuum of services and supports and identify critical service gaps for youth with DD/Autism.* Status: No further action is required on Strategy A. For Action Steps 1- 4: The workgroup had consensus that the urgent need is to serve the 1,000 youth that are on the DD waiver waitlist and that the largest service gap is for case management along with the need for behavioral supports, respite, crisis supports (such as Reach), transportation and attendant care giver support. The workgroup determined that there is no further needs assessment and inventory needed however consolidating the inventory information and possibly reexamining the needs could be addressed with the development of the subsequent blueprint following the completion of the current blueprint that ends in 2019.

B. *Utilize results of needs assessment and gap analysis to develop a plan to address critical service gaps.* Status: No further action is required on Strategy B. For Action Steps 1- 5: The workgroup determined that there may be a need for focus groups/discussion with service providers such as Grafton, Jill's House and/or other homebased/ABA providers. Jill's House or Autism Society can bring together families to be sure the plan is addressing their needs. The Welcoming Inclusion Network (WIN) and CSB Supported

Employment should be included in all future discussions to address critical gaps. The workgroup determined that these tasks may be completed in conjunction with priority strategy areas E, F & G and therefore there is no further work required for this strategy. Reassessment of utilizing the results of the needs and service gaps should be addressed with the development of the subsequent blueprint following the completion of the current blueprint.

C. *Ensure that DD/Autism BH services are included in System Navigation.* Status: Strategy C may be combined with D in the revised version of this blueprint goal. Strategy C was identified as low priority area; the workgroup has determined that the timelines need to be adjusted.

D. *Develop outreach and social messaging campaign to promote earlier identification of youth with DD/Autism who would qualify for and benefit from referral to services.* Status: Strategy D may be combined with C in the revised version of this blueprint goal. Strategy D was identified as low priority area; the workgroup has determined that the dates will not be adjusted as they track to the completion of the current blueprint that ends in 2019.

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

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

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

Status of Strategy E, F and G: Strategy E, F & G were identified as high priority areas. The objective for the workgroup is to address Blueprint Strategy E, F & G by obtaining project funding to take the CSA process that currently exists to accurately assess children for appropriate supports to prevent crisis. This funding will address the need/gap in services (insufficient case management staff, crisis services for younger children). The timelines will need to be adjusted.

H. *Strategy H - Develop community awareness campaign regarding special needs of youth with DD/Autism.* Status: This strategy was identified as low priority area; the workgroup has determined that the timelines will need to be adjusted. With regards to H.1., it was determined that no further action is required, however providing additional training could be addressed with the development of the subsequent blueprint following the completion of the current blueprint than ends in 2019.

GOAL 15: Transition Age Youth

Coordinator: Peter Steinberg

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

The Transitional Age Youth workgroup has proposed a policy statement that in summary states that behavioral health providers who work with children and youth are committed to help their clients transition their services from children and youth services to adult services. Based on both national and international models to keep youth ages 18-24 engaged in services and to engage those who are not in services, we determined that drop-in centers are needed in Fairfax County specifically for this population. To attract this population, the drop-in center needs to have computers, charging stations and food. Additionally, the center needs to offer vocational/employment assistance, independent living skills, and someone to encourage the person to remain or engage in services. Physical health screenings will also need to be offered. The workgroup is currently working on what this model would look like and the best part of the county to begin to offer this type of services.