MEMO TO THE CPMT
May 31, 2019

Information Item I-1: March 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 March 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 March 2019 equal $21.5M for 993 youth. This amount is a decrease from March last year of approximately $1.1M, or 4.86%. Pooled expenditures through March 2018 equal $22.6M for 1,023 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	$3,535,417	$2,417,594	($1,117,823)	-31.62%
Private Day Special Education	$12,424,517	$11,778,129	($646,388)	-5.20%
Non-Residential Foster Home and Community Services	$6,957,764	$6,984,426	$26,663	0.38%
Non-Mandated Services (All)	$237,139	$996,085	$758,946	320.04%
Recoveries	($586,770)	($704,486)	($117,716)	20.06%
Total Expenditures	**$22,568,066**	**$21,471,748**	**($1,096,318)**	**-4.86%**

	Program Year 2018	Program Year 2019	Change Amt	Change %
Residential Treatment and Education	131	97	(34)	-25.95%
Private Day Special Education	301	285	(16)	-5.32%
Non-Residential Foster Home and Community Services	1,007	920	(87)	-8.64%
Non-Mandated Services (All)	90	196	106	117.78%
Total Youth Counts (Unique Count in each category)	**1,529**	**1,498**	**(31)**	**-2.03%**

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 March.

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

ATTACHMENT:
Budget Chart

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

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

Mandated/ Non-Mandat	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%	$746,634	37		0	$746,634
		Group Home	57.64%	$153,793	7		0	$153,793
		Education - for Residential Medicaid Placements	46.11%	$261,860	20	$304,092	4	$565,952
		Education for Residential Non-Medicaid Placements	46.11%	$112,449	10	$755,446	10	$867,895
		Temp Care Facility and Services	57.64%	$83,319	9		0	$83,319
	Residential Total			$1,358,056	83	$1,059,538	14	$2,417,594
	Non Residential	Special Education Private Day	46.11%	$56,041	4	$11,722,088	281	$11,778,129
		Wrap-Around for Students with Disab	46.11%	$179,808	32		0	$179,808
		Treatment Foster Home	46.11%	$2,767,819	106		0	$2,767,819
		Foster Care Mtce	46.11%	$912,239	112		0	$912,239
		Independent Living Stipend	46.11%	$506,763	26		0	$506,763
		Community Based Service	23.06%	$1,840,372	522		0	$1,840,372
		ICC	23.06%	$650,066	116		0	$650,066
		Independent Living Arrangement	46.11%	$34,607	4		0	$34,607
		Psychiatric Hospital/Crisis Stabilization	46.11%	$92,752	2		0	$92,752
	Non Residential Total			$7,040,468	924	$11,722,088	281	$18,762,555
Mandated Total				**$8,398,523**	**1007**	**$12,781,626**	**295**	**$21,180,149**
Non-Mandated	**Residential**	Residential Treatment Facility	57.64%	$51,539	5		0	$51,539
		Temp Care Facility and Services	57.64%	$2,885	1		0	$2,885
	Residential Total			$54,425	6	$0	0	$54,425
	Non Residential	Community Based Service	23.06%	$719,623	152		0	$719,623
		ICC	23.06%	$222,037	38		0	$222,037
	Non Residential Total			$941,660	190	$0	0	$941,660
Non-Mandated Total				**$996,085**	**196**	**$0**	**0**	**$996,085**
Grand Total (with Duplicated Youth Count)				$9,394,608	1203	$12,781,626	295	$22,176,234
Recoveries								-$704,486
Total Net of Recoveries								$21,471,748
Unduplicated child count								993

Key Indicators		
Cost Per Child	**Prog Yr 2018 YTD**	**Prog Yr 2019 YTD**
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$22,061	$21,623
Average Cost Per Child Mandated Residential (unduplicated)	$41,186	$34,051
Average Cost Per Child Mandated Non- Residential (unduplicated)	$20,489	$21,058
Average Cost Mandated Community Based Services Per Child (unduplicated)	$3,057	$3,526
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$13,949	$20,179
Average Cost for Treatment Foster Home	$25,017	$26,111
Average Education Cost for Residential Medicaid Placement (Residential)	$16,202	$23,581
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$47,369	$43,395
Average Special Education Cost for Private Day (Non-Residential)	$41,295	$41,327
Average Cost for Non-Mandated Placement	$2,797	$5,082

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

Category	Program Year 2019 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2019 Allocation	$732,674	$168,737	77%
Non Mandated Program Year 2019	$1,630,458	$863,032	47%
Program Year 2019 Total Allocation	$39,593,010	$21,471,748	46%

MEMO TO THE CPMT

May 31, 2019

Information Item I- 2: Review Residential Site Visit Process and Criteria

ISSUE: That the CSA Management Team have a process and criteria for conducting site visits for current and prospective residential private providers.

BACKGROUND:
The CSA Management Team has been delegated authority to approve Open access (Tier I) and Child Specific Contracts with providers for non-congregate care services located in the State of Virginia. All Out of State Residential Treatment Center and Group Home contracts MUST be approved by the CSA MT and CPMT. Two important legal considerations are relevant for CSA contracting:

1. §2.2-4345.A.14 specifies that under the Virginia Public Procurement Act, public bodies entering into contracts for purchasing services under the Children's Services Act "for goods or personal services for direct use by the recipients of such programs if the procurement is made for an individual recipient" may be considered as exempt from the requirements for competitive sealed bidding or competitive negotiation.

2. The Appropriation Act specifies that state pool funds shall not be spent for any service that can be funded through Medicaid for Medicaid-eligible children except when Medicaid-funded services are unavailable or inappropriate for meeting the needs of the child.

In addition to these provisions, the criteria used for decision-making about contracting and making placements with a provider include:

- The provider's adoption of System of Care principles and practice standards calling for trauma-informed care, the use of evidence-based interventions, and a commitment to family engagement and participation in service planning and treatment so that youth remain in out of home placements for the minimum time necessary.

Our local SOC policy manual describes our system of categorizing providers in a tiered manner as follows:

"*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 authorization, submitting the Contract Request for Out of Network Provider Form to the CSA Contracts Management Team and submitting encumbrances once approval is given by the CSA Management Team.

These providers:

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

Tier III Providers

Tier III providers are Residential Treatment Center and Group Homes located outside of the State of Virginia. They are not approved as an approved In-Network and Approved Out-of-Network Provider and are not listed on the CSA Provider Directory. These providers do not have a signed contract in place and Contracts & Procurement Management must gather and review all required documentation. CSA Case Managers and Team-Based Planning Teams may access these providers after additional review and approval by the CSA Management Team and CPMT

approval. Case Managers are responsible for acquiring FAPT authorization, submitting the Contract Request for Out-of-Network Provider Form and the RTC or Group Home attachment to the CSA Contracts Management Team and submitting encumbrances once approval is given by the CSA Management Team.

These previously unknown or unapproved providers are:

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

Members of the Family Assessment and Planning Team used a workgroup process to review national best practice from the SAMHSA-endorsed Building Bridges Initiative and prepare a site visit process and criteria for qualitative reviews of current and prospective residential providers. The CSA Management Team approves this process as a means for obtaining information about providers for decision-making and as part of contract monitoring. In addition, it is hoped that as the Commonwealth moves to adopt requirements from the Family First Prevention Services Act for Qualified Residential Treatment Facilities, these efforts will be supported by state-wide standards and quality improvement initiatives.

ATTACHMENTS:
Building Bridges Initiative (BBI) Principles
Overview of the Site Visit Process
RTC/GH Self-Assessment Tool for Site Visits
RTC/GH Site Visit Tool
CSA Site Visit Tool Tip Sheet

STAFF:
Sarah Young, CSA
Jessica Jackson, CSB
Kristina Kallini, CSA

Building Bridges Initiative (BBI) Principles:

- Family Driven and Youth Guided Care
- Cultural and Linguistic Competence
- Clinical Excellence and Quality Standards
- Accessibility and Community Involvement
- Transition Planning and Services (between settings and from Youth to Adulthood)

http://www.buildingbridges4youth.org/sites/default/files/Fiscal%20Strategies%20that%20Support%20the%20BBI%20Principles.pdf

Overview of the Site Visit Process

Preparation to Begin Site Visits:

- Identify purpose
- Determine procedures related to site visits
- Prepare (agency) Self Assessment Tool
- Generate observation guidance tools for team member use on Site Visits

1. Site Self Assessment Tools
2. RTC/GH Site Visit Tool
3. Tip Sheet
4. Environmental Component of Trauma Informed Care (TIC) Checklist

Plan a Specific Site for a Visit:

- Identify specific focus areas (if one exists)
- Coordinate with Contracts and FAPT Coordinator
- FAPT Coordinator notifies FAPT members
- FAPT members respond if interested and available

Inform and Prepare the Selected Site for a Visit:

- Send the (agency) Self Assessment Tool
- State expectation about personnel qualifications to complete the form
- State the preferred response date
- Discuss the site's expectations and the local team's expectations related to the visit

Identify and Prepare the Local Team for a Visit:

- Identify team members
- Provide the site's completed Self-Assessment Tool
- Provide the 3 observation guidance tools to members
- Team organizes travel plans, other necessary visit related details

Visit the Site:

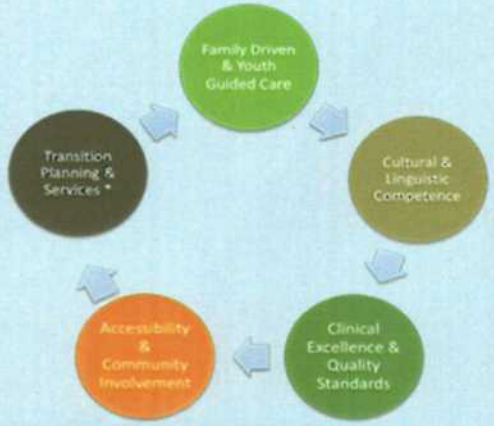
- Use site Self Assessment Tools to guide communications with staff
- Use the 3 observation guidance tools throughout the site visit
- Focus on strengths and needs aligned with BBI and System of Care principles and values

Review and Present a Site Visit Report:

- Team debriefs using the 4 tools identified.
- Team completes the RTC/GH Site Visit Tool.
- Team prepares a report (strengths and needs of the program) with recommendations
- Team decides who will present the report to the CSA Management Team (MT)

Team Document: Report/Presentation with Recommendations

The process identified above is specific to RTCs with existing contracts and RTCs being considered for a contract.



BBI Core Principles

RTC/GH Provider Self-Assessment Tool for Site Visits
Fairfax-Falls Church CSA

RTC/GH Agency: _____

Describe the Program Philosophy of Treatment (Approach/Model) e.g. rewards/consequence/behavioral based, positive peer culture, Sanctuary Model, Collaborative Problem-Solving, etc.: _____

_____

_____

_____

1	2	3	4	5	Don't Know/
Never/ Almost Never	Rarely	Sometimes	Often	Always/ Almost Always	Doesn't Apply

	Family/Youth Guided, Individualized, Strengths Based Care	1	2	3	4	5	DK/DA	Comments
1	Goals are formed by the youth and family (with input from team members), who are able to recall goals when asked (i.e. family/youth words/language, measurable goals)	1	2	3	4	5	DK/DA	
2	Family members are encouraged to select people to participate in family team meetings	1	2	3	4	5	DK/DA	
3	Youth's strengths, interests, talents, passions, and past successes are used to address behaviors of concern	1	2	3	4	5	DK/DA	
4	Youth involved in decision making about their care (e.g. in treatment meetings, voice in decisions of aftercare services, youth advisory council, residents' meeting, helps with recruitment of staff/counselors, meal planning, initiate or give input on youth activities, suggestion box etc.)	1	2	3	4	5	DK/DA	
5	Capacity to ensure verbal and written communication/intervention based on family's language/communication needs. Family choice for cultural and language reflected in staff assignment.	1	2	3	4	5	DK/DA	
6	Accommodations are made for family who want to participate in person for therapy e.g. weekend sessions, outside of work hours, lodging at reduced rates	1	2	3	4	5	DK/DA	
7	Include youth in staff training on use of restraints and seclusion	1	2	3	4	5	DK/DA	
8	Routine opportunity for engagement in ILS and vocational skills (e.g. culinary, horticulture, budgeting, dance/music studies, technology, vehicle maintenance/repair, cosmetology, etc.)	1	2	3	4	5	DK/DA	
9	Family time/visits away from the facility decided as a team and only cancelled when there are safety concerns (not as a consequence)	1	2	3	4	5	DK/DA	
10	Staff routinely seek family advice or participation in daily life and support of child (via email, phone calls, communication during on-site visits)	1	2	3	4	5	DK/DA	
11	RTC fosters and encourages communication with youth and providers via phone and visits e.g. Community providers stay in touch with each other and w/youth throughout treatment	1	2	3	4	5	DK/DA	
12	Flexibility in time youth can talk with family and in family therapy session days/times	1	2	3	4	5	DK/DA	

RTC/GH Provider Self-Assessment Tool for Site Visits
Fairfax-Falls Church CSA

RTC/GH Agency: _____

13	Assistance to family members in spending time with youth (e.g. transportation for family time, reduced cost or free lodging, etc.)							
14	Family members are called about SIRs, possible antecedents and involved in revision of safety plans and adjustment to treatment plans (using incidents to learn more about the youth's needs and adapt intervention as appropriate, partnering with family around planning response to serious incidents)	1	2	3	4	5	DK/DA	

1	2	3	4	5	Don't Know/
Never/ Almost Never	Rarely	Sometimes	Often	Always/ Almost Always	Doesn't Apply

	Staff Development and Evidence and Practice and Trauma Informed Care	**1**	**2**	**3**	**4**	**5**	**DK/DA**	**Comments**
1	Staff are routinely trained in trauma informed care, cultural humility, and youth guided practices	1	2	3	4	5	DK/DA	
2	Ethnicity, culture, language, values, spiritual life, gender, and family traditions reflected and supported in daily experiences (e.g. meals, religious practice opportunities, prayer time, structure for youth being called by their preferred pronoun and name, therapist gender, etc.)	1	2	3	4	5	DK/DA	
3	Ongoing Assessment	1	2	3	4	5	DK/DA	
4	Procedures in place to reduce/eliminate use of physical restraints (trauma informed practice in use, frequency and type of restraints and/or seclusion)	1	2	3	4	5	DK/DA	
5	Evidenced based practices (EPBs) are used (credentialing of therapists as appropriate for certain EBPs)	1	2	3	4	5	DK/DA	
6	Staff are observed talking, engaging, and interacting with youth during the visit (not just providing sight and sound supervision) and avoiding power struggles and triggers using knowledge of youth warning signs	1	2	3	4	5	DK/DA	
7	Physical setting appearance of being trauma informed (*See Trauma Informed Environment Checklist)	1	2	3	4	5	DK/DA	

1	2	3	4	5	Don't Know/
Never/ Almost Never	Rarely	Sometimes	Often	Always/ Almost Always	Doesn't Apply

	Transition/Aftercare Support and Outcomes	**1**	**2**	**3**	**4**	**5**	**DK/DA**	**Comments**
1	At time of admission and throughout barriers to discharge are continuously addressed	1	2	3	4	5	DK/DA	
2	Community providers and RTC staff communicate at least 1x/wk	1	2	3	4	5	DK/DA	

RTC/GH Provider Self-Assessment Tool for Site Visits
Fairfax-Falls Church CSA

RTC/GH Agency: _____

3	Does the provider know who the FCPS/FCCPS representative is who will be involved with aftercare/return to learn education coordination	1	2	3	4	5	DK/DA	
4	Aftercare providers (e.g. counselors, MDs, mentor, etc.) are included in team meetings before youth transitions and there is a treatment team meeting with providers at least 30 days prior to transition	1	2	3	4	5	DK/DA	
5	Transition supports/services offered to youth and/or family following discharge (e.g. care visit within 7 days of return home)	1	2	3	4	5	DK/DA	
6	Outcomes performance data is collected from the youth, parent, and involved community providers, shared with community members (e.g. online, marketing materials, reports), and used for quality improvement	1	2	3	4	5	DK/DA	

Other Information that May Be Useful:

1. The different types of assessments and evaluations the RTC has capacity to complete or routinely completes an information on whether there are any additional costs for such assessments.

_____
_____
_____

Identified areas of growth (scores of 1's and 2's) for the program:

_____
_____
_____
_____

Please provide information on quality improvement plans for addressing identified areas of growth. If there is already a quality improvement action plan in place, please attach it to this document or describe below.

_____
_____
_____
_____

Reviewer Name: _____ **Date:** _____
Reviewer Role/Title: _____ **Date:** _____

This form is to be completed by a clinical staff member.

RTC/GH Site Visit Tool
Fairfax-Falls Church CSA

RTC/GH Agency: _____

Describe the Program Philosophy of Treatment (Approach/Model) e.g. rewards/consequence/behavioral based, positive peer culture, Sanctuary Model, Collaborative Problem-Solving, etc.: _____

_____

_____

_____

1	2	3	4	5	Don't Know/
Never/ Almost Never	Rarely	Sometimes	Often	Always/ Almost Always	Doesn't Apply

	Family/Youth Guided, Individualized, Strengths Based Care	1	2	3	4	5	DK/DA	Comments
1	Goals are formed by the youth and family (with input from team members), who are able to recall goals when asked (i.e. family/youth words/language, measurable goals)	1	2	3	4	5	DK/DA	
2	Family members are encouraged to select people to participate in family team meetings	1	2	3	4	5	DK/DA	
3	Youth's strengths, interests, talents, passions, and past successes are used to address behaviors of concern	1	2	3	4	5	DK/DA	
4	Youth involved in decision making about their care (e.g. in treatment meetings, voice in decisions of aftercare services, youth advisory council, residents' meeting, helps with recruitment of staff/counselors, meal planning, initiate or give input on youth activities, suggestion box etc.)	1	2	3	4	5	DK/DA	
5	Capacity to ensure verbal and written communication/intervention based on family's language/communication needs. Family choice for cultural and language reflected in staff assignment.	1	2	3	4	5	DK/DA	
6	Accommodations are made for family who want to participate in person for therapy e.g. weekend sessions, outside of work hours, lodging at reduced rates	1	2	3	4	5	DK/DA	
7	Include youth in staff training on use of restraints and seclusion	1	2	3	4	5	DK/DA	
8	Routine opportunity for engagement in ILS and vocational skills (e.g. culinary, horticulture, budgeting, dance/music studies, technology, vehicle maintenance/repair, cosmetology, etc.)	1	2	3	4	5	DK/DA	
9	Family time/visits away from the facility decided as a team and only cancelled when there are safety concerns (not as a consequence)	1	2	3	4	5	DK/DA	
10	Staff routinely seek family advice or participation in daily life and support of child (via email, phone calls, communication during on-site visits)	1	2	3	4	5	DK/DA	
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RTC/GH Site Visit Tool
Fairfax-Falls Church CSA

RTC/GH Agency: _____

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Never/ Almost Never	Rarely	Sometimes	Often	Always/ Almost Always	Doesn't Apply

	Staff Development and Evidence and Practice and Trauma Informed Care	**1**	**2**	**3**	**4**	**5**	**DK/DA**	**Comments**
1	Staff are routinely trained in trauma informed care, cultural humility, and youth guided practices	1	2	3	4	5	DK/DA	
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3	Ongoing Assessment	1	2	3	4	5	DK/DA	
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Never/ Almost Never	Rarely	Sometimes	Often	Always/ Almost Always	Doesn't Apply

	Transition/Aftercare Support and Outcomes	**1**	**2**	**3**	**4**	**5**	**DK/DA**	**Comments**
1	At time of admission and throughout barriers to discharge are continuously addressed	1	2	3	4	5	DK/DA	
2	Community providers and RTC staff communicate at least 1x/wk	1	2	3	4	5	DK/DA	

RTC/GH Site Visit Tool
Fairfax-Falls Church CSA

RTC/GH Agency: _____

3	Does the provider know who the FCPS/FCCPS representative is who will be involved with aftercare/return to learn education coordination	1	2	3	4	5	DK/DA	
4	Aftercare providers (e.g. counselors, MDs, mentor, etc.) are included in team meetings before youth transitions and there is a treatment team meeting with providers at least 30 days prior to transition	1	2	3	4	5	DK/DA	
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6	Outcomes performance data is collected from the youth, parent, and involved community providers, shared with community members (e.g. online, marketing materials, reports), and used for quality improvement	1	2	3	4	5	DK/DA	

Other Information that May Be Useful:

1. The different types of assessments and evaluations the RTC has capacity to complete or routinely completes an information on whether there are any additional costs for such assessments.

Comments/Recommendations: _____

_____

_____

Would you refer a friend or family member to this program? ***(Circle One)*** Yes No

Reviewer Name: _____ **Date:** _____

CSA Site Visit Tool Tip Sheet

Mission: Aligned with BBI in working to promote best practices, evidenced based and informed practices for positive outcomes for children and families touched by residential programs.

Process: Send the Site Tool to the Provider in advance so they know what is being looked for and ask them to complete a self-assessment tool. For any self-assessed ratings of 1 or 2, ask about their Quality Improvement Plan. If there is no plan, then ask about steps they can take for quality improvement.

Person Conducting Site Visit: Rate the quality of services when on site. Look for specific indicators of quality. Please be sure to add information to the Comments section on the tool to provide information on rates. For example, a provider may do well addressing individual's religious preferences/needs while not having a strong practice in place for addressing youth with gender differences. Below is a list of examples of thinks you may observe, hear, learn about, etc. that may support a higher score. There are also examples of questions you may ask to gather additional information.

Categories:

<u>Family Driven and Youth Guided Care</u>

Person Centered Language: (family and youth narrative of their understanding of the problem) Look for youth and family narrative in the intake assessment, treatment plans, and/or in how staff speak about youth goals

Linguistic competency or sensitivity:

- If a family is not English literate - are treatment plans and other reports translated into the language of the family? Are family narratives of strengths and needs understood by the staff and reflected in the intervention plan.
- Use of a tele-language phone line
- How do staff address language barriers to being heard and understood across of components of the placement? School, residence, admin.

Collaborative Engagement;

- How are family/child/clinical team different perspectives and conflicts related to goals
- How willing/able is clinical staff open to collaborative dialogue – ensuring all voices are heard.

Treatment goals: monitored and communicated?

- Data driven? Family/child input a part of the monitoring process? Formal monitoring process (objective)/informal monitoring process (subjective)?
- Here you may look for in person communication in treatment team meetings, at time of admission to staff working with youth, via email initially and each time a goal is changed.
- How do you develop treatment goals? Here you are looking to see that the youth and parent's input is gathered and used in forming goals.
- Youth input in decision making: What was the last suggestion you and/or your team received from a youth? What was your response to the suggestion? What is the process for youth who have suggestions or feedback on services (youth specific or general)?

Who participates in interviews for staff members?

Family Support and Increasing Family Engagement with the Program and the Youth

- What is your plan/policy for instances in which a family arrives late or after the designated visitation time? Here we would look for some flexibility as the parent/family-child relationships are so important. Score lower if there is no flexibility with visits.

- Are there designated times for family to call in and/or for the youth to call out? Here we would want to see that they can call at all times unless clinically contradicts treatment. It's okay if there is structured time but to know they can call and talk if needed
- In what ways does the provider communicate with families around SIRs?
- In what ways is the family involved in revising safety plans or adjusting interventions
- Does the program provide transportation or other supports for off-campus family activities?

Strengths Based & Individualized/Cultural & Linguistic Competency

Youth/Families are able to provide input on gender preference for therapist

There are opportunities for individuals to practice different forms of religion e.g. able to account for differences in prayer times and/or days of the week and holidays recognized by youth

Adapt meals for individuals with food restrictions by religion or preference

There is a process and/or structure in place for youth to identify their preferred pronouns, name

Staff are able to identify child's strengths and ways that talents, interests, skills, past successes are used to maximize success towards goals

- Assessment of strengths, talents, interests, and past successes of youth and families? Here you are looking for any form of interview/assessment discussion with the youth, possibly a written tool that is used to increased understanding about a child's strengths.
- In what way do you provide ongoing assessment of a child and family's individual strength and needs? Here we look for concrete assessment, changes in information gathered, and ways new information is used to adjust the treatment plan.
- Identify indicators that specific identified strengths are being used to build on successes. For example, if a youth shows leadership skills and struggles in social situations or with self-confidence, the youth may be encouraged and engaged in taking an active role to lead a youth council/residents meeting to practice using this skill in a social setting where the youth can receive positive recognition
- How are improvements in confidence, agency, and engagement used to benefit both the parent-child relationship in the clinical setting, phone contact, and family activities.
- Is homework assigned for time spent with family and is that homework used as part of the on-going treatment? (To include home visits)

Coordination with Youth's Community Team and Other Service Providers

How do you communicate with the community based service providers:

- Safety plans
- Risk assessment: recent challenges /historic challenges
- Homework assignments
- Progress and concerns community providers note during home visits

Staff Training, Evidence and Practice Informed and Consistent with Research on Positive Outcomes:

Goals are SMART: Specific, Measurable, Attainable, Relevant, Time-Bound

What does implementation of the site's identified model of treatment look like in practice?

How is fidelity to the identified model monitored? Are monitoring tools available to the community team?

What are the plans and procedures for workforce development?

What training do staff members (youth counselors/direct care workers, therapists, administrators, administrative support staff) have outside of the state licensing requirements? Here you are

looking to see how the agency invests in staff at all levels through sending to evidenced based training

What assessments and evaluations do you have the capacity to complete or complete routinely? Is there an additional cost for assessments or is it part of your programming?

What evidenced based approaches do you offer? Here you are looking for one or a combination of the following:

- Trauma Focused Cognitive Behavioral Therapy (TF-CBT) – Interventions that address the impact trauma has on domains of function and stages that involve building skill in coping with emotions, working through a trauma narrative
- Cognitive Behavioral Therapy (CBT) – helping individuals make connections between events/situations, feelings, associated thoughts, and behaviors. Here you would look for examples of how providers teach skills on restructuring or replacing negative thoughts/perceptions (thinking errors, cognitive distortions).
- Dialectical Behavioral Therapy (DBT) – typically addresses building skills in mindfulness, affect/emotion regulation, radical acceptance, improving distress tolerance, etc.
- Motivational Interviewing (MI) – typically asking future focused questions related to how things will be for example once a person experiences happiness or no longer feels depressed
- Functional Family Therapy (FFT) – A short term treatment strategy built on respect of individuals, families, and culture. Focus is on motivating individuals and families to become more adaptive and successful in their own lives. FFT is used to save families and prevent crime and victimization in communities.
- Multisystemic Family Therapy (MSFT) - is an intensive family and community-based treatment for serious juvenile offenders with possible substance abuse issues and their families. The primary goals of **MST** are to decrease youth criminal behavior and out-of-home placements.
- Applied Behavioral Analysis (ABA) –is a therapy based on the science of learning and behavior and helps explain: How behavior works, how behavior is affected by the environment. how learning takes place. ABA requires a Functional Behavioral Assessment (FBA). This tool identifies behaviors of concern and the "function" for behaviors e.g. avoidance/escape, to gain attention or another reward or access to a preferred item, etc. It also requires compliance to the approach - through "protocols"- across all settings.
    - Are all staff are trained on for consistent use of behavioral strategies.

What is the model/procedure for crisis intervention?

- How many restraints do you estimate per month? What is your policy on restraints?
- What program of behavioral support and safety is used to train staff expected to use restraint? What are the credentials for those allowed to restrain?
- Number of seclusion rooms (if any). Note if there are windows to any seclusion rooms and/or any locks on doors.
- Number of staff at a time that restrain youth
- Frequency of restraints over the past quarter/year/month
- What is the monitoring and evaluation process use of restraint?
    - Is there a formal debriefing with the youth and an administrator/clinical staff and/or involved staff following use of restraint?

- Is a medical assessment of the youth by a nursing staff required? (e.g. checking vitals at minimum).
- If the incident involved multiple peers in aggression/conflict, how were the youth and peer(s) reintegrated to ensure safety (e.g. revision of safety plans, peer mediation if appropriate)
- What are proactive and prevention strategies used before using a restraint (as they are to be used as a last resort)?
- Possible interventions: looking for warnings signs as noted in the youth's treatment plan, verbal de-escalation, inviting to process, encouraging child to take a break, inviting the youth to engage in an alternative activity or to go to a different location, removing the audience through instructing others away from the peer, reminding of alternative options, encouraging use of youth identified coping skills, etc.

Is there a sensory comfort room? What does this look like? Here you would focus on calming colors, safe objects that could be calming to the senses (e.g. stress balls, stuffed animals, fidgets, yoga ball, pillow, etc.)

For additional items, see SAMHSA Checklist https://www.integration.samhsa.gov/about-us/TIC_Environmental_Scan.pdf

Ask about the agency's strategic plan of service delivery development over the next 3 years

Transition/Aftercare:

What is the forum for addressing barriers to discharge/transition from the program?

Do you know Patricia Coleman (School Social Worker Representative who coordinates school returns/transitions from RTCs)

Is there a meeting with aftercare providers at least 30 days prior to the youth's transition home?

What is the timeframe for any transition therapy sessions?

Does your agency offer home based counseling services? Follow up phone calls and/or visits to youth and/or families? Follow up with the youth and family team?

AGENCY
ENVIRONMENTAL COMPONENTS FOR TRAUMA INFORMED CARE

Name of Agency: _____

Reviewers: _____

Date of Assessment: _____

Organizational Assessment

Positive Trauma Informed Care Environment

	YES	NO	DID NOT OBSERVE
Welcome Sign Posted	☐	☐	☐
Initial greeting at agency was welcoming	☐	☐	☐
Staff is friendly/respectful/caring/welcoming/calm	☐	☐	☐
Staff offices are welcoming/engaging	☐	☐	☐
Comfort/Healing/Meditation room(s) or comfort, privacy, quiet areas	☐	☐	☐
Space to make private phone calls	☐	☐	☐
Manipulatives and/or soothing kits (play dough, crayons, washcloths, heated blankets, etc.) are available	☐	☐	☐
Age appropriate toys and materials available	☐	☐	☐
Fish tanks	☐	☐	☐
Pet therapy option/opportunity to have pet interaction	☐	☐	☐
Waterfall/fountains	☐	☐	☐
Plants	☐	☐	☐
Comforting music	☐	☐	☐
Soothing smells	☐	☐	☐
Paint colors soothing/calming	☐	☐	☐
Carpet/flooring - safe & non-institutional	☐	☐	☐

	YES	NO	DID NOT OBSERVE
Lighting is soothing/calming (non-institutional/not fluorescent lighting)	☐	☐	☐
Natural lighting	☐	☐	☐
Operating hours are consumer-friendly	☐	☐	☐
Artwork is:			
Empowering, hopeful, recovery-focused	☐	☐	☐
Culturally diverse	☐	☐	☐
Done by consumers	☐	☐	☐
Soothing/calming	☐	☐	☐
Consumer accomplishments posted/celebrated	☐	☐	☐
Clear, concise, positive signage			
Spanish signage	☐	☐	☐
Consumers screened/assessed for trauma	☐	☐	☐
Consumer referred to trauma services/referral	☐	☐	☐
"Consumer Rights" (includes 'Trauma Rights) are posted several places, clearly visible and consumers are informed of their rights	☐	☐	☐
Consumers/Families are educated about treatment and diagnosis	☐	☐	☐
Consumers are kept informed about any changes in the day's agenda	☐	☐	☐
Trauma/Stress Reduction/Wellness/Recovery materials available	☐	☐	☐
English/Spanish reading materials available in reception area	☐	☐	☐
Veteran Program materials in reception area	☐	☐	☐
Gender specific reading materials are available	☐	☐	☐
Conference rooms/offices are sound proof for confidentiality	☐	☐	☐

	YES	NO	DID NOT OBSERVE
Assistance to complete paperwork and/or surveys is provided if needed (reading level, audio tapes)	☐	☐	☐
Consumers are encouraged to provide feedback (or surveys) on services/experiences, Grievance Policy is explained	☐	☐	☐
Consumers are encouraged to provide immediate feedback	☐	☐	☐
Seating allows for personal space	☐	☐	☐
Opportunity for consumers to complete forms ahead of appointment/forms available on-line	☐	☐	☐
If there is a smoking area, it is safe and 15- 20 feet away from the building	☐	☐	☐
Non-caffeine drinks or water offered to consumers	☐	☐	☐
Physical environment shows evidence of on-going attention to safe practices	☐	☐	☐
Designated/adequate consumer parking	☐	☐	☐
Parking lot is safe with lights	☐	☐	☐
Bike racks available	☐	☐	☐
Office location is safe	☐	☐	☐
Agency Employed Peer Support and Wellness Specialist	☐	☐	☐
Age appropriate recreational games, crafts, sports equipment, leisure activities available	☐	☐	☐
On-going staff Trauma Informed Care training is offered (including re-traumatization)	☐	☐	☐

Non-Trauma Informed Care Environment ("No's" are a positive observation)

	YES	NO	DID NOT OBSERVE
Staff using first/last names to identify consumers	☐	☐	☐
Staff dress (uniforms, identification)	☐	☐	☐
Staff not welcoming/friendly	☐	☐	☐
Security guards and procedures	☐	☐	☐
Special staff parking	☐	☐	☐
Staff talk with consumers behind a desk and/or completing paperwork on computer without facing consumers	☐	☐	☐
Consumers kept waiting	☐	☐	☐
Signage (list of do's, don'ts, no's, rules, language of oppression, we/they language)	☐	☐	☐
Glass bubble/wall/glass separating consumers from registration/admission area	☐	☐	☐
Uncomfortable furniture	☐	☐	☐
Chairs or couches that don't allow for personal space (group rooms are crowded)	☐	☐	☐
Chairs with arms only	☐	☐	☐
Paneled wood	☐	☐	☐
Separate bathrooms for staff and consumers	☐	☐	☐
Smoking area located right outside the entrance door	☐	☐	☐
Noisy/chaotic environment	☐	☐	☐
Damaged walls	☐	☐	☐
Dirty facility	☐	☐	☐
Slamming doors	☐	☐	☐
Loud intercom systems	☐	☐	☐
Offices are not inviting/closed doors	☐	☐	☐
Cubicles	☐	☐	☐

	YES	NO	DID NOT OBSERVE
Religious materials available in reception area	☐	☐	☐
Religious themes in offices	☐	☐	☐

Other: _____

_____

Overall Comments:

What you liked about the environment?

_____

_____

What you didn't like about the environment?

_____

_____

Date: _____ Exit interview completed with _____
(Agency Staff)

Please provide Agency Staff with a copy of the Trauma Informed Environmental Scan.

Residential Settings (Please also complete this portion if facility is a Residential Setting)

	YES	NO	DID NOT OBSERVE
Staff and consumers are interactive (not separated)	☐	☐	☐
Space available for staff and consumers to talk privately	☐	☐	☐
Staff/consumer name tags are similar	☐	☐	☐
Consumers are welcoming and friendly	☐	☐	☐
Rules are rigid and not age appropriate	☐	☐	☐
Accessibility for privacy	☐	☐	☐
Seclusion and restraint practices	☐	☐	☐
Clear boundaries between men and women (if mixed gender program)	☐	☐	☐
Ability to move bed where it feels safe	☐	☐	☐
Consumers can personalize their rooms (photographs of loved ones)	☐	☐	☐
Consumers are given considerations to feel safe, (e.g. CD player for calming music, reading light after lights out, etc.)	☐	☐	☐
If smoke free campus - (smoking cessation, patches offered)	☐	☐	☐
Outside seating available	☐	☐	☐
Accessibility to nature (green spaces, flower/vegetable garden, trees, birdbath, bird feeders, fish pond)	☐	☐	☐
Medication given privately	☐	☐	☐
Dining areas are comfortable (not cafeteria style)	☐	☐	☐
Consumers are actively involved in menu planning	☐	☐	☐
Options available for healthy meals and snacks	☐	☐	☐
Snacks, coffee, drinks accessible to consumers and visitors	☐	☐	☐
Age appropriate leisure activities, arts, entertainment, etc.	☐	☐	☐

	YES	NO	DID NOT OBSERVE
Exercise room/equipment available	☐	☐	☐
Labyrinth	☐	☐	☐
Spaces for family visits	☐	☐	☐

Other: _____

_____

_____

Follow-up items needed from Environmental Scan:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

MEMO TO THE CPMT

May 31, 2019

Information Item I- 3: Healthy Minds Fairfax and CSA Items in County FY 2020 Budget

ISSUE:
Several Healthy Minds Fairfax and CSA items are in the FY 2020 Budget approved by the Board of Supervisors.

BACKGROUND:
The following items are in the FY 2020 county budget.

Multicultural Mental Health Services $130,000
An increase of $130,000 is included to expand contracted multicultural mental health services for youth. These services provide outpatient therapy in a flexible combination of office-based, telehealth, and home-based options to address barriers to services such as language and transportation that make it difficult for underserved populations in the County to access services. This funding is part of the Healthy Minds Fairfax initiative aimed at improving access to behavioral health services for children, youth and families.

Mental Health Crisis Response Services for Youth $100,000
An increase of $100,000 is included to expand contracted mental health crisis response services in order to increase the number of youth served. Services, which include 24-hour intervention; screening and triage; clinical assessments; and psychiatric assessments and services, provide children age 17 and younger with intensive mental health support to bridge them through an immediate presenting crisis to an eventual psychiatric intervention in a less restrictive environment. This funding is part of the Healthy Minds Fairfax initiative aimed at improving access to behavioral health services for children, youth and families.

Psychiatric Consultation Program $100,000
An increase of $100,000 is included to implement a contracted Psychiatric Consultation Program for pediatricians and family doctors who treat children with behavioral health issues and are in need of psychiatric services, in order to assist the physicians with making accurate diagnoses and appropriate use of medications. This funding is part of the Healthy Minds Fairfax initiative aimed at improving access to behavioral health services for children, youth and families.

Children's Services Act (CSA) Service Quality Monitoring $83,936
An increase of $83,936 and 1/1.0 FTE position is included to support the CSA provider evaluation process and enhance the ability to monitor the quality and effectiveness of purchased behavioral health services. The position will monitor contract compliance, evaluate provider outcomes, and promote quality service delivery through oversight activities. It should be noted that $39,373 in Fringe Benefits funding is included in Agency 89, Employee Benefits.

ATTACHMENT: None

STAFF:
Jim Gillespie, HMF Director; Janet Bessmer, CSA Manager: Peter Steinberg, CBHC Manager

MEMO TO THE CPMT

May 31, 2019

Information Item I- 4: 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 January through March 2019 is attached, with a summary below.

Areas of Strategic Focus:

Access

Accomplishments:

- As of March 31, Short-Term Behavioral Health Services (STBHS) has already served 156 youth, compared to 130 for all of last year.
- STBHS has been expanded to 15 additional schools and now accepts referrals from the CSB.
- The PRS CrisisText Connect program engaged in 1815 text conversations with 1582 unique individuals in FY18, a 41% increase over the prior year.

Challenges:

- The Give an Hour pro-bono therapy service does not have enough clinicians to serve referrals.

Planned Activities:

- Funding was approved in the county and HMF budgets for FY 2020 to expand CRS mobile response services by 20%.
- Healthy Minds Fairfax received an additional $130,00 in the County budget to expand multicultural mental health services to youth. The Underserved Population workgroup is looking at proposals to expand services and will present these proposals for approval in the Summer 2019.

Awareness and Stigma

Accomplishments:

- On February 2 HMF had a table at the Mount Vernon Town Hall Meeting, attended by 300; On January 24 at Woodson High School for the showing of Angst; On February 20 at Fairfax High School for the showing of Angst; on February 25 at the Athletic Mental Health Conference; and On April 5 at the Fairfax County Public Schools Special Education Conference, attended by over 1,000 family members, youth and FCPS staff.
- The CSB awarded seven mini-grants for youth-led projects to address stigma, funded by the regional suicide prevention grant.
- The Health Department and the Department of Housing and Community Development are among agencies whose staff are all being provided the TICN's Trauma 101 training.

Challenges: None identified

Planned Activities

- New funding allocated by HMF will expand the implementation of Signs of Suicide to cover all FCPS middle and high schools.
- The Eric Monday Foundation is developing a web-based training specifically for youth sports coaches; FCPS and multiple youth sports organizations have committed to implementing the training with their coaches.
- In May and June, the Trauma Informed Community Network (TICN) will host screenings of *Broken Places*, which addresses community trauma.

Coordination and Integration

Accomplishments:

- In May 35 local pediatricians participates in intensive behavioral health training.

Challenges: None identified

Planned Activities:

- A new navigation website is being tested by families and other stakeholders.
- Through HMF funding a George Mason University psychology resident will be placed in a local pediatric primary care office to provide behavioral health services.
- Beginning in the fall of 2019 psychiatric consultation will be available to Northern Virginia pediatricians, and later in the year they will have access to a care navigator.

Family Engagement

Accomplishments:

- Three quarters through the fiscal year 116% more families (119 versus 55) have been served with Parent Support Partners than in all of FY18.
- Short-Term Behavioral Health Services purchased the services of an organization specializing in maximizing the response rate to parent satisfaction surveys, and thus far 15 surveys have been completed, mostly by Spanish-speaking families.
- A new youth peer support group was started in February 2019 with a broadened target population and an accompanying parent support group.
- After meeting periodically since 2017, a Northern Virginia Family Network was officially formed in March 2019. An intensive day long planning meeting, facilitated by an expert consultant from FREDLA (supported by HMF funds), resulted in consensus around formalized procedures and plan of action. A network of more than 10 regional family- and children-focused nonprofit organizations will meet quarterly to collaboratively address its mission of 'elevating the voices of families to improve outcomes for children, youth and young adults across systems of care'.
- At the March 2019 CSA Symposium, approximately 200 participants attended a workshop titled, "Respectful Curiosity: The Art of Engagement" which covered topics related to cultural competence, exploring one's own biases and how to meet the client where they're at.

Challenges:

- 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

- The Transition Age Workgroup plans to survey transitional youth (ages 16-24) and parents of transitional youth to find out what their needs are and what services they that they need.

Quality

Accomplishments:

- A "Guide to Evidence-Based Treatment" workshop was held during the March 13 CSA Symposium - approximately 180 people participated in the training, most of them Fairfax staff.
- Fifty providers were trained on Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) in February.

Challenges:

- The response rate to surveys assessing the fidelity of intensive care coordination to High Fidelity Wraparound principles has been low.

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.
- A provider directory of clinicians trained in evidenced-based practices is being developed and will be available during the Summer 2019.
- The WFI-EZ is used to determine fidelity to the High Fidelity Wraparound model by capturing the family and facilitator satisfaction with the wraparound process. The next round of WFI-EZ surveys will be completed in FY19's fourth quarter. The annual file review, which uses the DART (Document Review Assessment Tool), will begin in May 2019.
- an ICC/Wraparound training for case managers will be held in June 2019.

System Transformation

Accomplishments:

- The Department of Neighborhood and Community Services completed a fiscal mapping of county children's services and presented it to the Successful Children and Youth Policy Team.

Challenges: None identified

Planned Activities

- The Transitional Age Youth Workgroup is working on adding a SOC Principle stating that transitional age youth face unique needs and that our Systems of Care will work to ensure that the transitional age youth successfully transitions to adulthood.

- This workgroup continues to plan to develop resources and programs for transitional age youth to include a drop-in center.

ATTACHMENTS:
Quarterly Report on Blueprint Strategies to the Community Policy and Management Team: 5/31/19

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

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
May 31, 2019

Healthy Minds FAIRFAX
Supporting Emotional Wellness in Youth and Families

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

Governance Structure:

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

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

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. On February 2 HMF had a table at the Mount Vernon Town Hall Meeting, attended by 300; On January 24 at Woodson High School for the showing of *Angst;* On February 20 at Fairfax High School for the showing of *Angst;* on February 25 at the Athletic Mental Health Conference; and On April 5 at the Fairfax County Public Schools Special Education Conference, attended by over 1,000 family members, youth and FCPS staff.

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 fiscal mapping strategy for children's services, which was presented to SCYPT on April 3.

Service Quality and Access:

A. *Develop/facilitate trainings and outreach materials that increase awareness and knowledge of systems of care values and creates better informed consumers, providers and county and school system staff.* *Develop/facilitate trainings and outreach materials that increase awareness and knowledge of systems of care values and creates better informed consumers, providers and county and school system staff.* A master calendar for children's behavioral health trainings and events and a children's behavioral health resources page were added to the Healthy Minds Fairfax public website in August of 2018. In the third quarter, the calendar received 426 page visits, up from 367 in quarter two and the resources page received 459 page visits, up from 350 in quarter two. A "Guide to Evidence-Based Treatment" workshop was held during the 2019 CSA Symposium - approximately 180 people participated in the training.

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

FY 19	FY18	FY17
194	0	0

B. *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.

C. *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.* HMF funding has expanded the regional mobile stabilization and response service by 20%

GOAL 2: Data Systems
Coordinator: Jim Gillespie

A. *Increase cross-system data sharing.* The HS IT Advisory Committee 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.*

B. *Increase family and youth involvement in system planning and implementation.* In December 2017 CPMT approved revisions to local policies and procedures.
After meeting periodically since 2017, a Northern Virginia Family Network was officially formed in March 2019. An intensive day long planning meeting, facilitated by an expert consultant from FREDLA (facilitation supported by HMF funds), resulted in consensus around formalized procedures and plan of action. A network of more than 10 regional family- and children-focused nonprofit organizations will meet quarterly to collaboratively address its mission of 'elevating the voices of families to improve outcomes for children, youth and young adults across systems of care'.

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 revised CSA provider evaluation/consumer satisfaction surveys, but implementation has been delayed to FY20 due to the transition to a new state data and financial reporting system (LEDRS). A new staff position in the CSA program for FY20 is dedicated to implementation of this goal.

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

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

A. *Implement "gatekeeper trainings" to increase layperson understanding of mental illness, recognition of signs and symptoms of mental illness or emotional crisis, and support of others in accessing help, using a cultural competency lens.* Gatekeeper trainings continue to be provided in a number of ways through Mental Health First Aid, and the Kognito suite of online trainings (including a peer training for teens), and Signs of Suicide. New funding allocated by HMF will expand the implementation of Signs of Suicide to cover all FCPS middle and high schools. The Eric Monday Foundation is developing a web-based training specifically for youth sports coaches; FCPS and multiple youth sports organizations have committed to implementing the training with their coaches.

B. *Promote youth-led initiatives to combat stigma associated with mental illness, treatment, and accessing help.* The CSB awarded seven mini-grants for youth-led projects to address stigma, funded by the regional suicide prevention grant. Eleven high schools are currently implementing Our Minds Matter clubs, developed by the Josh Anderson Foundation.

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
873 (through 3/31/19)	6,597,856	3,298,928

Number of crisis texts and calls:

FY19 YTD	FY18	FY17
1291 text conversations/5941 calls (through 3/31/19)	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. Three-quarters through the fiscal year, 116% more families have been served than in all FY18.

Number of families served by parent support partners:

FY19 year to date	FY18	FY17
119	55	32

B. *Expand evidence-based peer to peer groups, family/community networks.*
On February 7 the CSB launched Heads Up" and "Talk It Out", resource groups for parents and teens (ages 14-17). The groups are available in weekly concurrent sessions. Teens talk about successful, sustainable recovery and resilience through mental health or substance use challenges. Parents acquire resources and discuss ideas on how to help their teen live their healthiest, fullest lives in the aftermath of trauma or through times of emotional distress.

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

FY19 year to date	FY18	FY17
5 parents, 4 youth	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.* A provider directory consisting of those who have been trained in evidenced-based practices is being developed and will be available during the Summer 2019.

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

FY19 (YTD)	FY18	FY17
0 (begins fourth quarter FY19)	0	0

Percentage of users satisfied with on-line navigation tool:

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

B. *Create a clearing house for information on children's behavioral health issues and resources.*

With help from the CSB's web developer, Lara Larson, the Healthy Minds Fairfax website has been redesigned and is currently being tested. The goal is to have a soft launch of the website in the Summer 2019.

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. Beginning in the fall of 2019 psychiatric consultation will be available to Northern Virginia pediatricians, and later in the year they will have the support of a care navigator.

B. *Promote resources to implement tiered levels of integration based on capacity and readiness.*
HMF co-sponsored a REACH behavioral health training for 35 pediatricians in early May. In 2018 an inter-agency workgroup headed by Dr. Gloria Addo-Ayensu developed a community plan to implement integration, including but not limited to consultation, facilitated referral, co-location and full integration, which was endorsed by CPMT in June. The workgroup also developed a project to safely divert youth from hospitalization when appropriate through expansion of CR2 mobile crisis response services, which approved in the county and HMF budgets for FY 2020. CR2 services will be expanded by 20%.

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.*

Healthy Minds Fairfax received an additional $130,00 in the Fairfax County Budget to expand multicultural mental health services to youth. The Underserved Population workgroup is looking at proposals to expand services and will present these proposals for approval in the Summer 2019. area.

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 2019 CSA Symposium, approximately 200 participants attended a workshop titled, "Respectful Curiosity: The Art of Engagement" which covered topics related to cultural competence, exploring one's own biases and how to meet the client where they're at. Participants reported that the presentation was helpful and content clear. With the completion of the Partnership for a Healthier Fairfax's training on cultural competence completed, the SOC Training Committee will be working with PFHF staff to determine the feasibility of using this training with contracted behavioral health providers and the process and logistics of such a roll-out.

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.

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 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. Year-to-date data indicate even higher call volume in FY19. The PRS CrisisText Connect program engaged in 1815 text conversations with 1582 unique individuals in FY18, a 41% increase over the prior 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 trained 50 providers on Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC) in February. To date this year, they also 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.* Sixty-eight therapists from Health and Human Services and private providers have been trained in the core competencies which include risk assessment and safety planning, Cognitive Behavioral Therapy, Dialectical Behavior Therapy, working with families and providing treatment to those who have experienced a trauma event.

C. *Train County, school staff and providers on EBPs, including how and when to use them. Include a review of practices that are harmful.* Part of the training in the core competencies includes how to provide them to their clients. 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.

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 small workgroup is working on developing a provider directory with the aim of launching it in the Summer 2019.

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

FY19 year to date	FY18	FY17
113	0	0

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

FY19	FY18	FY17
70	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 50 clinicians working with children ages 7-12 were trained in MATCH-ADTC- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems.

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 (The Cost of Caring) that is now available regularly. Trainings and resources on developing trauma-informed spaces are also currently available.

The TICN continues to offer screenings and discussions on the documentary *Resilience*; over 6,000 people have seen it to date. In May and June, the TICN will host screenings of *Broken Places*, which addresses community trauma.

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 TICN continues to host and sponsor screenings of the documentary *Resilience,* and will begin screening *Broken Places* in May. 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 and at the Virginia statewide PTA conference last winter.

In April, the TICN and CSB facilitated a training of trainers in ACE Interface; 30 county, school, and partner staff participated. They are currently developing a broad implementation plan for the initiative.

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. The Health Department and the Department of Housing and Community Development are among agencies whose staff are all being provided the TICN's Trauma 101 training. HCD recently shared an update on their work on the RHA's public website.

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. The CBHC management team has asked HMF staff to continue to review screening tools and develop a protocol for when to use screening tools.

Number of BH screenings (semi-annual measure):

FY19 (YTD)	FY18	FY17
89	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. In November 2018, 45 therapists from Health and Human Services and private providers received training in TF-CBT. They are all, working towards their

national certification in TF-CBT. In February 2019, 50 therapists received Match-ADTC training. MATCH-ADTC is a treatment model that focuses the most common behavioral conditions in children under 12. This treatment model focuses on treatment for depression, anxiety, post-traumatic stress, and conduct issues. 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. 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.

E. *Expand access to timely and available behavioral health services for school age children and youth with emerging behavioral health issues who have not been able to access such services.*
Healthy Minds Fairfax received financial assistance from the Community Services Board to expand STBH services. The service has been expanded to 15 additional schools plus we will accept referrals from the CSB to help prevent families from waiting for services. As a reminder, this service continues to link income eligible youth and families from select school communities to timely and available short-term mental health counseling (up to 8 sessions), funded by Healthy Minds Fairfax.

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

FY19 year to date	FY18	FY17
156	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 focus of this initiative is on building up the pool of provider to help meet the needs of those being referred to the program.

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

FY19 year to date	FY18	FY17
9	0	0

F. *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.

G. *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 was launched and is serving 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.* 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. A subgroup of the CSA Management Team is developing a proposal.

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 Wraparound Fairfax 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 filled 7 positions and their new staff have accepted new cases. There is no longer a waiting list for CSB case management.

E. *Improve the utilization of the annual gaps survey of youth and parents in CSA-SOC to identify needed interventions.* The results of the annual state OCS survey were provided to the CPMT in April, 2019. The qualitative responses were considered very informative.

F. *Develop communication plan to share information about the services and care coordination offered through the SOC process with the broader provider community.* CSA produces a monthly newsletter that contains training announcements and other information pertinent for system partners. See social marketing goals for more information about outreach efforts.

G. *Build system capacity to monitor fidelity to EBT models and conduct outcome evaluation for purchased services.* The WFI-EZ is used to determine fidelity to the High Fidelity Wraparound model by capturing the family and facilitator satisfaction with the wraparound process. The next round of WFI-EZ surveys will be completed in FY19's fourth quarter. Fifty-five families meet the survey criteria, 30% (19) of which will be randomly selected to receive the WFI-EZ. The annual file review, which uses the DART (Document Review Assessment Tool), will begin in May 2019. Additionally, in order to help agency case managers fully understand the role of the ICC facilitator, an ICC/Wraparound training will be held in June 2019. It is hoped that clarification of roles will improve the collaboration between all involved.

H. *Provide IT infrastructure to support data collection for fidelity monitoring and outcome evaluation along with electronic records management.* CSA is working with DFS IT staff to discuss efficiency and streamlining through existing technology for incoming documentation and file maintenance. CSA is part of a pilot using NINTEX forms to replace the current encumbrance form and begin using an electronic workflow. Additional 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.* FAPT parent representative positions have been filled. Recruitment is underway for filling vacant CPMT positions.

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.

A. The Transitional Age Youth Workgroup is working on adding a SOC Principle stating that transitional age youth face unique needs and that our Systems of Care will work to ensure that the transitional age youth successfully transitions to adulthood. This workgroup continues to plan to develop resources and programs for transitional age youth to include a drop-in center. Sample transition assessment and service plan will be made available on the Healthy Minds Fairfax website.