MEMORANDUM

To: Dr. Daniel Carey, Secretary of Health and Human Resources
From: Hannah Adams, Voices for Virginia's Children Intern & UVA Batten School MPP Candidate, on behalf of Advocacy Groups for Children and Families
Advocacy Groups represented include: Voices for Virginia's Children, Families Forward, Early Impact Virginia, Greater Richmond SCAN and Virginia Poverty Law Center.
Date: July 18, 2019
Subject: Meeting the Needs of Children and Adolescents through Behavioral Health Redesign & Family First Prevention Services Act

---

Overview

Over the next few years, Virginia has an unprecedented opportunity to implement two new initiatives that will improve mental health services and family support services. Through the implementation of Family First Prevention Services Act (FFPSA) and Behavioral Health Redesign (Redesign), the Commonwealth can better support families and vulnerable young children by shifting resources towards prevention and evidence-based services. In order to maximize this opportunity our state must have a full understanding of which children and families could be targeted for intervention and the points at which they may access services. The state must also determine where programs currently exist, what programs must be expanded, and how to pay for these initiatives, among other difficult decisions.

This memo is organized to provide some critical questions on different topics in the implementation. Our wish is not only to raise the questions, but also suggest possible next steps. We hope these questions will prompt members of the Three Branch and Redesign Teams to: take a deeper dive into the data and assumptions about implementation; continue to flesh out the implementation timeline and operational plans; and articulate how data collection and measurement systems will be designed.

Critical Questions to Address Before Implementation

What Data is Needed to Better Identify Target Populations?

We believe the most troublesome issue is the lack of data to identify a target population of children, and their caregivers, who would benefit from the mental health and family support services offered through FFPSA and Redesign. For example, the data request to identify the potentially eligible children to be served through FFPSA prevention efforts did not include data on the caregivers and limited information on the services accessed. In the case of Redesign, several of the proposed services do not currently exist and it would be helpful to use population data to obtain a better estimate of who might be eligible for each service. When designing service systems it makes a difference if there are 12,000 or 20,000 potentially eligible children; if those children are school-age or younger; and what is the profile of the caregivers in their family.

Some suggestions to improve access to relevant data include:

- Combine data analysis efforts across VDSS, DMAS and DBHDS to better determine the universe of need for targeted and intensive interventions.
- Gather expertise from existing service providers to analyze which services are currently being provided to potentially eligible children and families and produce a demographic profile of the potentially eligible families.
- Conduct a case review from Prevention Services Units or CSA's in select localities to gather more information to form the profile.
- Prioritize the design of new data collection system to replace OASIS with allows for all the necessary demographics, services, and outcomes for both the children and their families to be tracked.

What is Needed to Better Articulate a Vision for Success?

Family First and Redesign teams have taken extraordinary efforts to engage stakeholders to inform the process. Agency leaders should be proud of the progress being made to date and of being recognized as early adopters and innovators. Designing new services that have not been in place requires this significant effort. However, the path to overall success and impact across agency and programs has not yet been well articulated. More simply, we hope to work towards a clearer picture of which children and families would benefit from these services, how they will be better off, and how this will be measured.

As an example, VDSS has attempted to define primary, secondary and tertiary prevention as it pertains to their current work and apply that to Family First implementation. Their current definition is referring to only preventing a specific outcome -- entry into foster care -- not preventing harm or trauma, as it is used in other settings. This puts the focus on preventing a second episode of child abuse or neglect instead of focusing on preventing conditions that would lead to child abuse/neglect.

It is also needed to better define the continuum of universal to more targeted interventions. This framework is important to look at how children and families are served across systems such as through Virginia Tiered Systems of Supports at VDOE or STEP-VA. Do our definitions of universal to targeted interventions work across systems? Do they accurately reflect increased acuity? Are systems in place to support move families and providers along the continuum to serve families with various needs by age and acuity?

Some suggestions to better articulate the vision include:

- Ask stakeholders across child welfare, mental health, family support, and education to define primary, secondary, and tertiary interventions, to better reflect how children are potentially

served across systems. The example provided of the chart outlining interventions by the"age and acuity" of children and their caregivers seeks to do that.
- Categorize the services funded through FFPSA and Redesign to determine the best fit for the needs of Virginia's children. Examine the potential funding sources based on clearinghouse guidance and what other "promising practices" could be identified to fill gaps.
- Fully articulate how primary prevention activities can and should fulfill a vision of nurturing and supported families for all children. Seek the perspectives of families and children/youth impacted by these changes to better understand the best fit for program implementation. Use this information to consider if prevention should be defined in code.

What Supports are Needed for Professionals in Order to Implement Interventions?
Professionals working with children and families face challenges to scale up and serve families at capacity. These obstacles include: low reimbursement rates, long wait periods to access training necessary to obtain the appropriate credentials, costly processes to maintain program fidelity and issues with data and evidence management. Despite these challenges, scaling up services through the public and private sectors allows for greater flexibility in implementation and a greater reach of services. As advocates, we championed a request to scale up evidence based programs, but the implementation plans have shifted as leaders attempt to get a better picture of the families and children impacted and the available services. Service providers must have the latest information to consider how they should shift business models to best meet the changing needs.

Some suggestions to better support behavioral health professionals include:
- Creating a state-supported technical assistance center for this array of evidence-based mental health services. This technical assistance center could be analogous to the role of Early Impact Virginia to support home visiting programs and professionals.
- Creating a "Center of Excellence," perhaps in conjunction with a state university that would allow for the study and evaluation of evidence-based practices and cultural adaptations that would meet the needs of all populations.
- Fully maximizing Medicaid reimbursement for existing behavioral health services, such as promoting billing for parent-child outpatient therapy or home visiting and increasing reimbursement rates.

What is Needed to Retain Employees Involved with Case Management and Care Coordination?
One of the major issues plaguing the systems is the lack of available, seasoned workers who are providing and facilitating these services in the field. Vicarious trauma, high caseloads and low salaries contribute to burnout among DSS workers and behavioral health professionals in the field. For example, child welfare workers are paid an average rate of $29,930. In addition, for Family First to be successfully implemented, significant buy-in is needed from local agency directors and their staff, to transform from a system accustomed to investigations and removals to one that is strengths-focused --

preventing entry into foster care. In addition, local and state agencies we need to work collaboratively and across programs in new ways to serve families better.

Some suggestions to better recruit and retain the public sector include:

- Increasing standards of work and increasing pay to reflect those standards.
- Creating a policy that would allow state DSS and localities to split retirement participation.
- Implementing trauma-informed practices within organizations that reduce secondary trauma burden and prevent burnout.
- Support current staff transitioning into positions that are prevention focused and provide training to all agency staff on implementation plans.

What are the Most Appropriate Venues for Families to Access Programs and Services?
As advocates we believe the ideal implementation would be when prevention and supportive services could be provided to as many families as possible, in the most encouraging and culturally competent methods possible. Our current systems can provide roadblocks for many families-- the stigma/perception of child protective services or behavioral health services, the timeliness of FAPT meetings, or the cultural adaptability of evidence-based practices, among others are challenges to face. We should explore eliminating these barriers where we can.

In particular, we must consider the potential role of CSA in helping to provide services to families. There are pros and cons of relying on CSA to help implement and scale-up more evidence programs that are being discussed and should continue to be fully understood or explored before making implementation decisions.

Some suggestions to determine the appropriate venues for program access include:

- Engaging primary care providers to help screen and identify potential families that could benefit from either mental health services or family support programs.
- Consider multiple access points for families to receive referrals.
- Examine how home visiting programs can align with local social service departments to ensure potential utilization of FFPSA for home visiting if appropriate.
- Consider the pros and cons of using CSA offices as system managers or gatekeepers. What is working well in CSA offices, what is not working well, and what can be expanded.
- Make significant efforts to improve case management services across systems.

Conclusion
We believe that including even a few of these steps could allow for a smoother and more successful implementation of these ambitious initiatives. For example, the data alignment and program mapping in the attached chart are starting points to further explore the questions presented in this memo. Taking additional steps for a well-thought out, interagency implementation and investing upfront to

ensure long-term sustainability of these new efforts will ensure these initiatives improve outcomes for all children and families in the Commonwealth.