Safe and Sound Task Force

Reference Manual

October 2023

Contents

Background, Vision, and Goals 1
Purpose of this Document 2
Task Force Guiding Principles 2
Task Force Organizational Structure, Participants, and Approach 3
Core Team 6
Definitions and Population 7
Problem-Solving Teams 7
Go Teams and Rapid Response 14
Accessing a Go Team/Rapid Response 15
Go Team Participants and Roles 15
How is the Go Team or Rapid Response Team different from FAPT? 17
What Would It Take? 18
System of Care Principles 19
Task Force Trends, Causes, and Projects 20
Four Core Recommendations 22
2023 Task Force Approach and Highlights 25
State Agency Task Force Resources 25
Department of Behavioral Health and Developmental Services 25
Virginia Department of Social Services 28
Department of Medical Assistance Services 29
Office of Children's Services 31
Department of Juvenile Justice 32
Acknowledgements and Conclusion 32

Background, Vision, and Goals

Virginia's child welfare leaders have been making concerted efforts to transform the Commonwealth's system, including focusing on specific challenges around high-acuity youth in foster care. These efforts include strengthening Virginia's focus on kinship and expanding treatment foster care, increasing access to high-quality, evidence-based mental health and other supportive services, fostering a trauma-informed culture throughout child welfare, addressing provider rates, and implementing the Family First Prevention Services Act. This work is consistently challenging and critically important. It also took on new meaning following the pandemic, highlighting gaps in mental health care and elevating the needs of children and families in new ways.

To address long-standing and recent challenges, including placement disruptions and high-acuity youth in foster care sleeping in local offices or other unsuitable locations, Governor Youngkin launched the Safe and Sound Task Force on April 1, 2022. The Task Force's vision is aligned with the Commonwealth's vision for its child welfare system: children should grow up in safe, stable, and secure families that support their long-term well-being. The Task Force was initiated with three phases. The goal of the first phase was to end the phenomenon of youth sleeping in local department of social services offices, hotels, or other unsuitable locations by identifying and securing safe placements for displaced youth. The second phase focused on developing a "reservoir" of safe and appropriate placements for youth who may need them, particularly expanding capacity around kinship and relative placements. The third phase focuses on policy and systems changes in Virginia. These changes will address underlying root causes contributing to the displacement of children in foster care, as well as some of the more foundational elements of foster care, such as mental health and trauma.

Purpose of this Document

This resource serves as a comprehensive reference to the Task Force, offering information about goals, activities, and operations to ensure sustainability. Its primary audience is state agency employees involved in the Core Team responsible for supporting Task Force upkeep and development, as well as administration and state agency leaders who may become involved in supporting or sustaining the Task Force in the future, as well as local agency leadership and staff, statewide and community partners (e.g., associations, advocacy organizations, faith-based partners), providers, and others with an interest in sustaining the goals and objectives of the Task Force.

Task Force Guiding Principles

The Task Force was led by principles found in the Child Welfare and Substance Abuse Mental Health Services Administration (SAMHSA) System of Care:

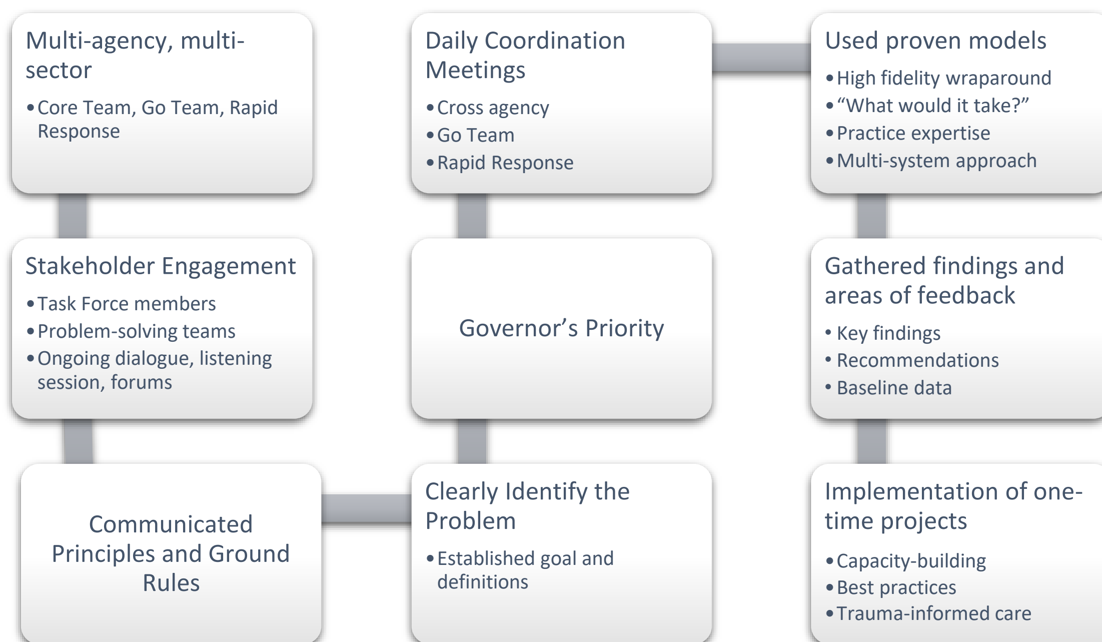
- Youth-centered, family-guided
- Culturally and linguistically competent
- Comprehensive, integrated, and flexible
- Individualized and strength-based
- Collaborative and coordinated
- Research-based, evidence, and practice informed
- Sustained positive outcomes
- Interagency collaboration community-based/least restrictive accountable

Additional guiding questions are provided later in this manual about System of Care principles and questions. Key guiding principles also central to the Task Force included *courage, creativity, coordination, context, commitment, and compassion*. Participants were asked to strive to lead and collaborate with these principles and values in mind.

Task Force Organizational Structure, Participants, and Approach

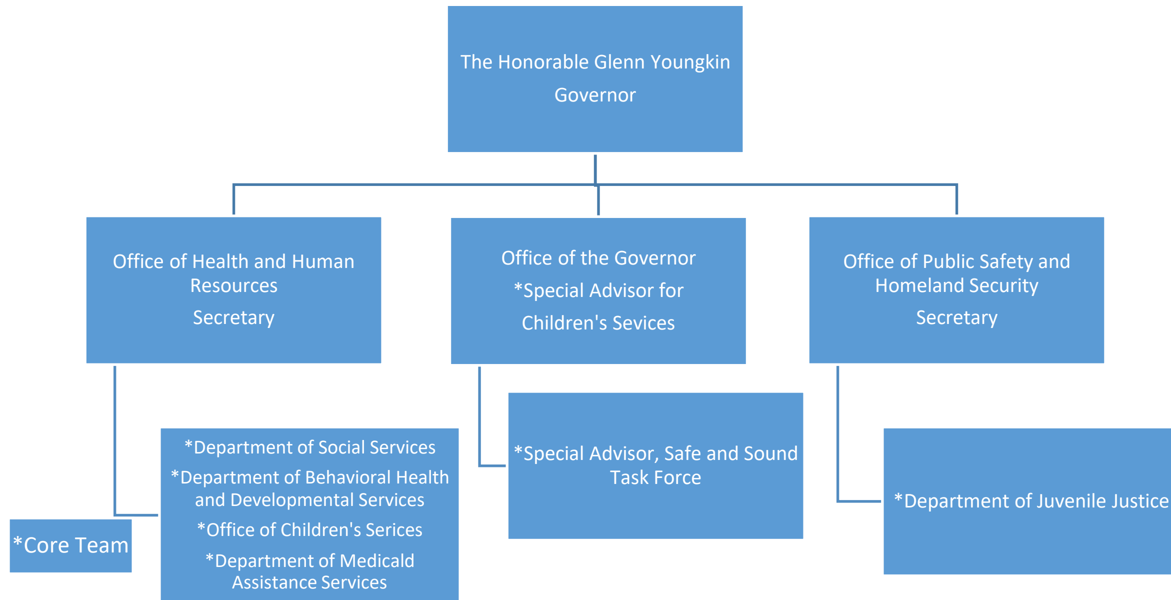
A multi-sector, multi-agency, cross-secretariat model was established to identify and implement the goals of the Task Force. This model recognized the multi-system, complex nature of the problem and that numerous stakeholders have unique and critical roles to play in meeting the Task Force goals. Executive Branch Agencies represented include the Departments of Social Services (VDSS), Medical Assistance Services (DMAS), Behavioral Health and Developmental Services (DBHDS), the Office of Children's Services (OCS), and the Department of Juvenile Justice (DJJ). Each has a crucial role aligned with their authority in the Commonwealth. Private providers, public agencies, non-profit organizations, advocacy organizations, faith-based organizations, and others also comprised Task Force membership. A Special Advisor was assigned to provide dedicated capacity to the Task Force.

A Core Team of senior leaders from Task Force state agencies was established, with staffing from the Office of the Governor, Secretary of Health and Human Resources (OSHHR), to coordinate, facilitate, and expedite discussion and decision-making. The broader Task Force members were named and requested to serve in advisory, consultative, and action roles to form, support, advise, and propel the direction of the Task Force. The first two Task Force meetings were held on April 11, 2022 and April 13, 2022. In these meetings Task Force members identified the problem and affirmed guiding principles, values, and broad goals, and discussed and identified challenges and potential solutions. Several other meetings were held during the first year. The chart below shows the strategies used throughout the Task Force. Many strategies are described in this manual.



Around 100 governmental representatives (local, state), providers, statewide and community-based organizations, advocacy and faith-based organizations, concerned citizens and people with lived experience, and others have participated in the Task Force. The Task Force leadership wishes to thank and recognize the expertise, time, and efforts each person has devoted towards the Task Force's current and evolving goals. We express our heartfelt

appreciation to each person for their unwavering commitment and contributions, and willingness to engage in challenging conversations and efforts, to move our collective progress forward. The diagram below depicts the structure of the Task Force and the chart below that describes the role of each participant or organization.



Youth and families with lived experience, citizen advocates
Providers (PRTF, TFC, TGH, CRF, IL, Hospitals)
Office of the Children's Ombudsman
Members of the Virginia General Assembly, Staff, Commission on Youth
Local Departments of Social Services, Community Services Boards, Children's Services Act
Medicaid Managed Care Organizations; Magellan
Juvenile and Domestic Relations Judges; Office of Executive Secretary
Faith-Based Organizations; Advocacy and Community Organizations, Professional & Provider Associations
Office of the Attorney General

Task Force Participants and Roles	
Entity	**Summary of Task Force Role**
Virginia Department of Social Services (VDSS)	Core Team Representation to provide subject matter expertise, technical assistance, and operational process knowledge related to child welfare and VDSS; participate in Task Force Go Team and other Task Force activities as requested
Department of Medical Assistance Services (DMAS)	Core Team Representation to provide subject matter, technical assistance, and operational leadership/expertise related to child welfare and Medicaid-funded behavioral and medical health care services and policy; participate in Task Force Go Team and other Task Force activities as requested.

Department of Behavioral Health and Developmental Services (DBDHS)	Core Team Representation to provide subject matter, technical assistance, and operational leadership/expertise related to MH/SUD/ID and DBHDS; participate in Task Force Go Team and other Task Force activities as requested
Office of Children's Services (OCS)	Core Team Representation to provide subject matter, technical assistance, and operational leadership/expertise related to the children's services system and OCS; participate in Task Force Go Team and other Task Force activities as requested
Department of Juvenile Justice (DJJ)	Core Team Representation to provide subject matter, technical assistance, and operational leadership/expertise related to the juvenile justice system and DJJ; participate in Task Force Go Team and other Task Force activities as requested
Medicaid representative (Service Authorization and Specialty Services Contractor, MCO Foster Care Liaisons, or MCO Behavioral Health Case Manager	Provides subject matter, technical assistance, or operational expertise related to their role in administering foster care coordination, behavioral health, and medical service authorization, non-residential placement options identification, service provider identification, care coordination, and IACCT assistance related to the Medicaid members in their plans or fee-for-service
Local Department of Social Services (LDSS)	Provides subject matter, technical assistance, and operational expertise related to child welfare and LDSS perspective and role; participates in Task Force Go Team and other Task Force activities as requested
Children’s Services Act (CSA)	Provides subject matter, technical assistance, and operational expertise related to children's services (e.g., CSA, FAPT, CPMT); participates in Task Force Go Team and other Task Force activities as requested
Community Services Board (CSB)	Provides subject matter, technical assistance, and operational expertise about community services boards and CSB services and programs; participates in Task Force Go Team and other Task Force activities as requested
Advocacy organizations, associations, non-profits, faith-based organizations, community organizations	Provide subject matter, lived experience, and system experience to shed light on barriers, challenges, and needs to help guide the Task Force efforts
People with lived experience	Provide subject matter, lived experience, and system experience to shed light on barriers, challenges, and needs to help guide the Task Force efforts

Providers (RTC, TGH, LCPA, CRF, IL, sponsored residential)	Provide subject matter, technical assistance, and system experience on Task Force goals and activities; participate in Task Force Go Team and other Task Force activities as requested
Clinicians (i.e., treating therapists) / community-based providers	Provide subject matter, technical assistance, and system experience on Task Force goals and activities; participate in Task Force Go Team and other Task Force activities as requested

Core Team

The Core Team* met approximately weekly throughout the first year of the Task Force to coordinate, identify, plan, and discuss barriers, needs, and challenges across agencies related to high-acuity youth, improve and enhance communication, and build relationships. The dedicated schedule was vital to the Task Force's overarching goal of synergizing efforts, bridging gaps, and creating a more connected, responsive approach. During weekly meetings, the Core Team carried out a range of activities related to the Task Force's goals:

1. Coordination: The Core Team was instrumental in ensuring that the efforts of different agencies were strategically aligned to the greatest extent possible. By bringing together representatives from various agencies, they facilitated the coordination of resources, expertise, and strategies related to challenges facing high-acuity youth and child-serving systems.
2. Identification: Through trend analysis and in-depth discussions, the Core Team identified and cataloged vital issues that continue to challenge high-acuity youth and child-serving systems. This helped shed light on root causes and potential solutions.
3. Planning: The Core Team provided input and feedback on first-year projects, initiatives, and budget and policy development.
4. Discussion: Weekly meetings allowed candid conversations, problem-solving, and sharing of insights and ideas. This helped to foster exchange, build relationships, and contribute to an enriched knowledge base among the team.
5. Communication and relationship building: Recognizing the importance of communication and relationships among the agencies, regular meetings among the Core Team helped to strengthen and enhance professional relationships focused on collaboration, trust, and mutual problem-solving. Building trust and communication on shared goals supports the Task Force's mission.

Core Team Members

Sarah Angel (VDSS), Anna Antell (OCS), Alexis Aplasca (DBHDS, HHR), Angel Clark (formerly DMAS), Nikole Cox (VDSS), Adrienne Fegans (DMAS), Katharine Hunter (DBHDS), Lisa Jobe-Shields (DMAS), Janet Kelly (Office of the Governor/HHR), Nina Marino (DBHDS), Christine Minnick (DMAS), Em Parente (VDSS), Scott Reiner (OCS), Eric Reynolds (Office of Children's Ombudsman), Mira Signer (HHR), Lara Todd (DJJ), Alyssa Ward (formerly DMAS), Shamika Ward (DMAS), Jessica West (formerly HHR), and Kristin Zagar (formerly VDSS).

Definitions and Population

Through the Task Force, definitions and populations of focus were established. Generally, "high-acuity youth" are those youth in the custody of local departments of social services, with multi-system involvement (i.e., child welfare, juvenile justice, mental health), and complex medical and/or behavioral health needs that typically exceed the resources, processes, and expertise of any one provider or system.

Safe and Sound Task Force Priority Populations		
Youth Currently Displaced	**Youth at risk of displacement**	**Youth who are unable to step down from high acuity, congregate settings**
• Youth who are sleeping in a local DSS office or hotel • Youth who are spending >1 night in an emergency department because of a behavioral health or other crisis, discharge or barriers to lesser restrictive settings (e.g., returning to foster or relative home)	• Currently in a foster home but requires a high level of support due to complex behavioral, developmental, and/or medical conditions • Currently in a residential treatment facility and no lesser restrictive environment can be identified pending discharge due to various reasons e.g., No payer, no accepting provider, no family placement available, delayed administrative processes • Youth with escalating behavioral health crisis who may need acute or residential psychiatric care	• Youth who are at CCCA and ready for discharge, but no step-down placement has been identified • Youth who are at private inpatient psychiatric facilities or psychiatric residential facilities who are ready for discharge, but no step-down placement has been identified

"Displaced youth" means a youth in the custody of a local department of social services whose placement is disrupted before its conclusion and for whom an alternative arrangement is not immediately available, or a youth in custody for whom placement is not immediately available when needed. This results in the youth being housed in a setting such as a local department of social services office or a hotel under local department of social services supervision, with an emergent need to identify and secure a safer, more appropriate placement. "Disrupted placement," or disruption or displacement, refers to a licensed, approved foster care placement concluding before the anticipated or planned conclusion.

Problem-Solving Teams

Problem-Solving Teams (PST) were formed three months after the start of the Task Force. The purpose of the Problem-Solving Teams was to bring Task Force participants together in smaller groups to examine specific areas and inform, coordinate, and recommend potential solutions to help shape the Task Force's direction and planning. Six PSTs were formed, each with a specific charge and requested deliverables. After being presented to the entire Task Force in June 2022, the Core Team and staff in the OSHHR further analyzed and prioritized the recommendations. Potential implementation paths were identified: Legislative, Budget, Interagency work, or Agency action. The recommendations were aligned with other state priorities, including the *Right Help, Right Now* Behavioral Health Transformation Plan, and agency initiatives such as Family First Prevention Services. For specific information about the PSTs, reach out to the Task Force.

Below is a summary of the PSTs, charges, recommendations, and possible implementation paths for the recommendations.

1. Transition Protocols PST

Charge: To review and recommend bed-to-bed transfer process, review current QRPT aftercare requirements, review placement process for higher level of care needs, and recommend communication and technical assistance plans.

Recommendations	Possible implementation path(s)
Prioritize the recruitment, retention, and needs of relatives and foster parents to support children and youth's ability to live in a family setting in their community and to meet the needs of “harder to serve” youth.	Legislative action Budget action Interagency work Agency action
Review the Virginia Enhanced Maintenance Assessment Tool (VEMAT) to ensure that the enhanced maintenance rate accurately reflects the support and care that foster parents are required to give children and youth with identified special needs; make recommendations for an updated VEMAT if needed.	Interagency work Agency action
Develop and communicate a training and technical assistance toolkit to help child welfare stakeholders understand the needs of children and youth in foster care.	Interagency work Agency action
Develop a limited number of state-funded or state-managed residential beds	Legislative action Budget action Interagency work Agency action
Explore opportunities to enhance data-sharing across agencies and sectors to improve coordination, enhance efficiencies, identify patterns and trends, and guide decision-making.	Interagency work Agency action Budget action

2. Wrap Around Services PST

Charge: To review existing definitions, models, and services that support wrap-around services in state-level guidance, policy, or practice; review existing funding mechanisms that support access to wrap-around services; recommend and describe the top five priority wrap-around services needed to support a coordinated system of services for children with complex behavioral health and other needs and their families; identify known or perceived gaps in Virginia's systems that prevent access to wrap around models and services for Virginia's youth and families; present recommendations to Safe and Sound Task Force

Recommendations	Possible implementation path(s)
Examine payment structures and service delivery models to enhance rates and services that specifically support youth with higher needs, including youth in foster care.	Legislative action Budget action Interagency work Agency action
Support strategic Medicaid service development to address gaps in ' 'children's community-based continuum (where they are either insufficiently funded or do not currently exist)	Legislative action Budget action Interagency work Agency action
Enhance options and models for professional foster parents	Budget action Interagency work Agency action
Implement a thoughtful, anti-stigma approach to language in seeking placements, support, and addressing unmet needs for youth and families.	Interagency work Agency action
Identify opportunities to support providers in starting sponsored residential services licensed to serve children and adolescents and licensed for mental health and developmental disability.	Interagency work Agency action
Establish a unified trauma-informed care approach in the behavioral health system rooted in training and more clearly and concretely reflected in policy and program requirements to align with the principles of the Family First Prevention Services Act.	Interagency work Agency action
Develop and fund mechanisms for locally-driven cross-system collaboration summits and training to support universal principles, resources, and processes in a locally administered system.	Interagency work Agency action
Direct and hold state-level capacity-building and technical assistance efforts to support efficiency and clarity in local processes and roles/responsibilities across systems	Interagency work Agency action
Foster education and more awareness about how MCOs and LDSS can	Interagency work Agency action

coordinate more effectively to support youth in foster care	
Re-negotiate the relationship between IACCT, FAPT, and CPMT processes to align principles and support greater role clarity and efficiency around placement decisions/processes.	Interagency work Agency action Budget action

3. Capacity and Resources PST

Charge: To review national and state best practices related to accessing community-based services, psychiatric, residential, and other settings for complex/high acuity youth; review funding mechanisms in Virginia to support national and state best practices related to community-based services, psychiatric, residential, and other care settings for complex/high acuity youth; develop recommendations to address perceived and known gaps between best practices, policy, funding, and continuum of care assets; and present recommendations to Safe and Sound Task Force

Recommendations	Possible implementation path(s)
Support rate increases for current providers of children's mental health services.	Interagency work Agency action Budget action Legislative action
Develop a statewide program to increase the capacity of child-serving systems (child welfare, behavioral health, education, etc.) to care for youth with complex needs and multi-system involved youth, including training and access to multi-disciplinary experts.	Interagency work Agency action Budget action
Examine the administrative and regulatory burdens contributing to workforce burnout and creating barriers to innovative solutions for youth with complex needs. This may include the review of DBHDS licensing and human rights regulations and DSS to increase alignment and streamline activities between the systems.	Interagency work Agency action
Prioritize improvements and modernization efforts to state ID/DD, MH, SA provider licensing, LCPA and CRF licensing, and background check systems (VDSS, DBHDS)	Agency action Budget action
Conduct a comprehensive youth and family workforce analysis to understand better the main drivers of retention, recruitment, and career pipeline development and identify the opportunities for further professionalization of direct support professionals.	Interagency work Agency action

Increase licensure and certification reciprocity opportunities within the Department of Health Professions to allow practitioners from other states to enter the Virginia workforce more easily.	Interagency work Agency action Budget action Legislative action
Increase public-private partnerships across the state to meet youth's complex needs, with private partners' greater involvement in developing RFPs to increase engagement and participation in unique funding opportunities.	Budget action Legislative action Agency action
Explore using a standardized level of care tool across all systems of care to increase consistency across the workforce in applying placement principles, improve placement within less restrictive environments, minimize administrative reassessments, and develop a universal application to access behavioral health services.	Interagency work Agency action
Establish a Comprehensive Evaluation and Treatment Center through a public-private partnership or academic setting to improve the overall assessment and treatment for youth in foster care, prevent disrupted placements, and establish a Virginia Center of Excellence for Child Welfare.	Interagency work Agency action Budget action
Establish an urgent outpatient assessment and treatment "bridge to services" clinic model in a high-needs/targeted area.	Interagency work Agency action Budget action
Create awareness of Medicaid Early and Periodic Screening, Diagnostic, and Treatment policies through training and outreach to providers and local agencies.	Interagency work Agency action
Expand training for foster families to understand and meet the broad spectrum of needs of youth with complex system involvement.	Interagency work Agency action Budget action

4. Local Rapid Response

Charge: To recommend a brief local/regional process with a membership concept to prioritize a safe place for youth in foster care to stay when there is not an immediate placement identified; recommend a brief (one-page) communication and technical assistance plan for localities/regions to implement; recommend a transition plan from state-level meetings to regional/local meetings; and, present recommendations to Safe and Sound Task Force.

Recommendations	Possible implementation path(s)
Explore instituting either locally, regionally, or statewide a monthly meeting or forum	Interagency work Agency action

where providers attend, and LDSS has a forum to ask questions, better understand available services and treatments, and potentially "staff" cases.	
Clarify through an interagency agreement which agency oversees what duty or task; if agencies have mutually supportive or overlapping roles, make clear how they should work together.	Interagency work Agency action
Build and enhance sustainable models and processes to support implementing local and/or regional rapid response teams or similar strategies to support high-acuity youth.	Interagency work Agency action Budget action
Determine barriers to implementing a universal referral packet for Psychiatric Residential Treatment Facilities (PRTF) and opportunities to implement a universal referral packet.	Interagency work Agency action Budget action Legislative action
Explore opportunities to implement a statewide referral system or centralized listing to gain efficiencies in seeking admissions to Psychiatric Residential Treatment Facilities (PRTF)	Interagency work Agency action Budget action Legislative action
Explore how to use and leverage the Emergency Department Care Coordination (EDCC) to notify MCOs when a youth in foster care presents in an emergency department.	Interagency work Agency action Budget action
Foster education and awareness about how MCOs and LDSS can coordinate more effectively to support youth in foster care.	Interagency work Agency action

5. Court Community

Charge: To recommend a process for a coordinated response for cross-over youth (shared service need by DJJ and LDSS); recommend a communication plan and/or resource that identifies the services cross-over youth can receive from DJJ, LDSS (Promoting safe and stable families funding, Title IV-E prevention services/Family First), and CSA; present recommendations to Safe and Sound Task Force

Recommendations	Possible implementation path(s)
Encourage or launch the convening of local or regional Safe and Sound Task Forces, or similar groups, to include participation by all relevant public agencies, the legal community, the judiciary, and others to identify unmet needs and gaps related to youth in foster care who are involved in multiple child-serving systems.	Interagency work Agency action

Explore and establish local protocols for earlier youth referral to the local Children's Services Act program before appearances in court, including referrals by the Court Services Unit, schools, LDSS, and community services boards.	Interagency work Agency action
Disseminate national (Robert F. Kennedy Center and Georgetown Center for Juvenile Justice Reform) and state (Commission on Youth) resources on effective models for working with cross-over youth.	Interagency work Agency action
Build cross-system capacity for child welfare principles by training Court Service Unit staff in the DSS Family Partnership Meeting model.	Interagency work Agency action Budget action
Ask the Court Improvement Program to explore model court procedures that might be of value (e.g., the earliest possible notice of a placement issue? the need for an interim hearing to keep a child in the home safely? what time in the day is a petition filed to allow ideal docketing?)	Interagency work Agency action
Develop state-funded and/or state-operated placement options such as using closed (no longer operating) and other available facilities.	Interagency work Agency action Budget action Legislative action

6. Community Engagement

Charge: To review national and state best practice Community Engagement Models; recommend a plan for "wrap around" support for families, relative caregivers, and foster families that supports permanency; recommend a communication and technical assistance plan for localities, funders, and providers to implement; and present recommendations to Safe and Sound Task Force

Recommendations	Possible implementation path(s)
Engage highly effective, low-cost statewide and regional champions to raise awareness about foster care.	Interagency work Agency action
Develop public-private partnerships with existing non-profits experienced in serving vulnerable kids and families.	Interagency work Agency action

Go Teams and Rapid Response

Background

"Go Team" is a term that was developed at the beginning of the Task Force (June 2022) to refer to an interagency process, also developed through the Task Force. Designing a Go Team process and building the capacity to hold Go Teams became a primary activity of the Core Team and some Task Force members at its launch. Go Teams encompass the various state-level and/or local processes needed to meet, discuss, problem-solve, and plan how multiple organizations and the child-serving community can support youth in foster care, particularly high-acuity youth who need an appropriate placement, are currently displaced, or are at risk of displacement. A Go Team is a team of representatives from organizations/agencies with a designated interest or authority, operational responsibility, or specific area of expertise involved in the care of the youth, or an organization/agency that has not been recently involved but is believed to be a gap or need in the youth's care and well-being.

Go Teams provide a setting to facilitate critical discussions and help determine what each agency or organization may need to do to facilitate and/or accept placement, what each organization's role is to identify and support placement needs, and how each can support the placement needs. The Go Team process is centered on the value of shared responsibility towards supporting youth and their needs yet firmly recognizes that each organization has specific duties and authorities assigned to it to support the youth. These responsibilities often work best when conducted in a planned, coordinated, and prioritized manner. Teams and participants must be able to quickly gather with the identified team roster and have appropriate decision-makers involved. Go Teams help to ensure maximum coordination and cooperation among all involved entities. The flow chart shows a visual.

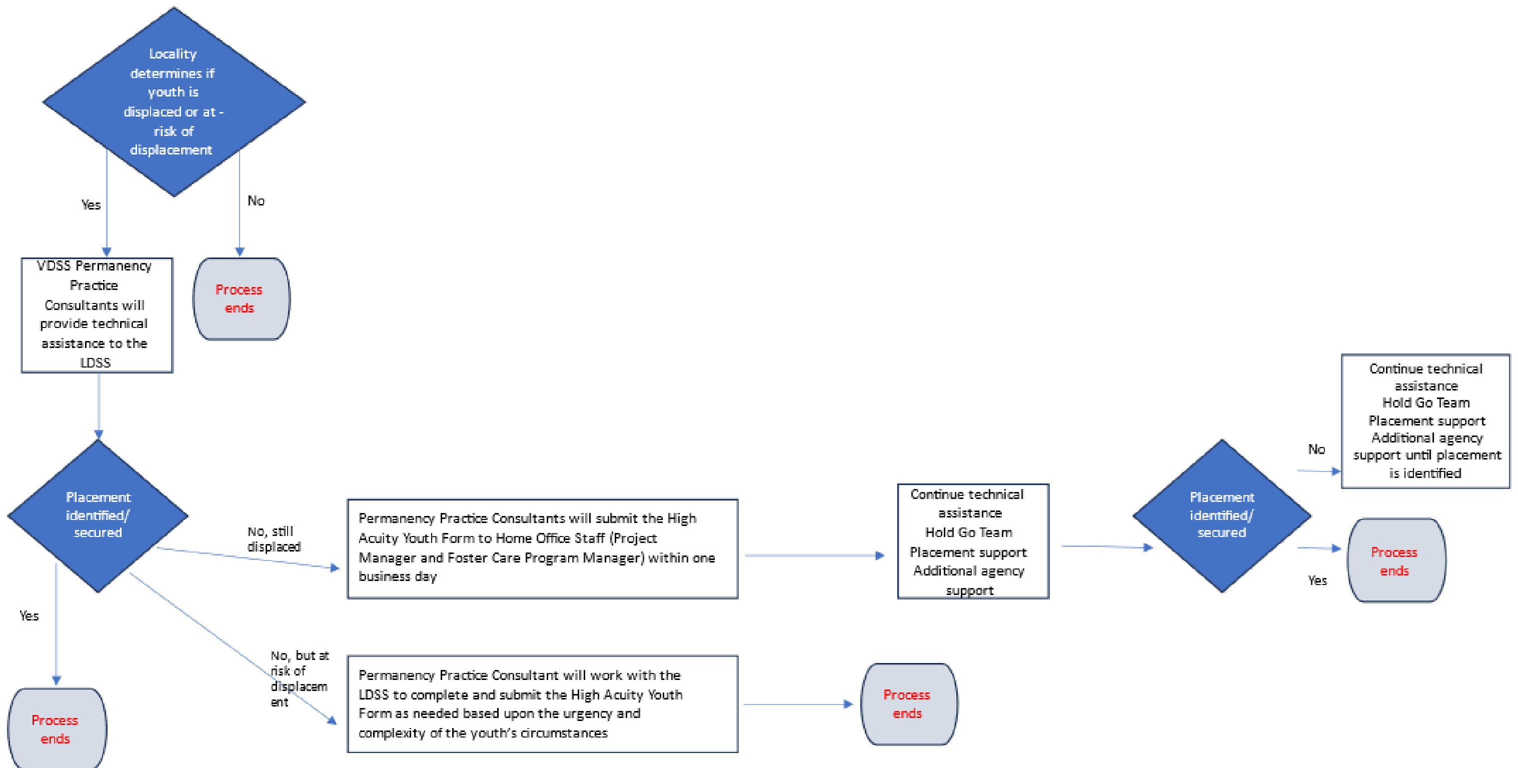
"Rapid response" is similar to a Go Team and intentionally includes potential placement providers that have worked with the youth in the past (such as an immediate past provider) or may be able to serve the youth (foster care, independent living, residential, etc.) based on their current level of care needs.

Core elements

- ✓ They are centered on best practices and subject matter expertise to support the youth's needs
- ✓ They provide and expedite operational requirements to move through "system" requirements (e.g., funding, licensing)
- ✓ They are held with urgency and prioritization (of time, resources, planning)
- ✓ Being able to convene quickly at a pre-set time
- ✓ Having designated members of a team who are responsible for participating (or designating others in their absence) in Go Teams/Rapid Response to provide operational or subject matter expertise
- ✓ There is a pre-determined agency and person with the responsibility and authority to convene the necessary representatives
- ✓ A shared understanding that the interagency process is centered on the value of shared responsibility that leverages individual agencies/authorities
- ✓ The participants involved know their roles and responsibilities
- ✓ Information is shared ahead of time (background, history at minimum)
- ✓ There is a predictable format for the meeting

- ✓ A designated person facilitates the meeting and does follow-up based on actions determined in the meeting.

Accessing a Go Team/Rapid Response



Go Team Participants and Roles

Go Team Participants and Roles	
Entity	**Summary of Role**
VDSS	Provide practice and technical assistance related to kinship/relative care, foster care and foster care system, and child welfare practices.
DMAS	Provide technical assistance related to child welfare, behavioral health, children's services, and Medicaid policy and programs, including managed care and fee for service. Serves as liaison between the Go Team organizer and the youth's assigned MCO or the BHSA.
DBHDS	Provide technical assistance and subject matter expertise around DD/BH provider licensing, waiver services, policy and programs that serve children and adolescents, subject matter expertise on behavioral

	health and developmental services and systems, and the community services board system.
OCS	Provide technical assistance, policy and practice guidance related to CSA policies, and liaisons with local CSA/FAPTs.
DJJ	Provide technical assistance/liaison around dually-involved youth (i.e., child welfare and juvenile justice), subject matter expertise about DJJ responsibilities and resources, liaisons with detention centers, and similar activities.
LDSS	Provide information about the youth's long-term goals and recommendations about immediate placement needs, strengths, service needs, health history, and referral history.
Medicaid representative (Service Authorization and Specialty Services Contractor, MCO Foster Care Liaisons, or MCO Behavioral Health Case Manager	Provide technical assistance, foster care coordination, behavioral health, and medical service authorization, non-residential placement options identification, service provider identification, care coordination, and IACCT assistance related to the Medicaid members in their plans.
CSA	Provide information and technical assistance related to child-serving agencies in the community and information about local community resources and services.
CSB	Provide information about developmental services waivers and procedures for youth with waivers; provides information related to CSB services the youth receives or could be eligible for.
CCCA	Provide a level of care recommendation, treatment plan updates, discharge barrier context, and knowledge of youth in the CCCA setting.
Providers (RTC, TGH, LCPA, CRF, IL, sponsored residential)	Provide insight into admission or waitlist acceptability; coordinate with relevant offices/agencies on specific needs to support placement (e.g., DBHDS on licensing variance requests, Medicaid to authorize services, etc.); identify whether/how they may be able to support step-down or placement needs of youth.
Clinicians (i.e., treating therapists) / community-based providers	Provide current clinical knowledge of youth in support of goals; provides insight to providers considering placement.
Court Services Unit	Provide knowledge of the youth and services that they may receive/have been receiving, system expertise, and technical assistance to support appropriate placement.
Juvenile Detention Centers	Provide knowledge of the youth and services that they may receive/have been receiving, system expertise, and technical assistance to support appropriate placement.

How is the Go Team or Rapid Response Team different from FAPT?

Go Team and Rapid Response have similar characteristics to FAPT but are not intended to replace or duplicate FAPT. Go Team/Rapid Response is a state-level multi-system process to collaborate to address the urgent needs of youth in foster care, and determine what each participant (within the scope of their role and authority) can do in a critical timeframe to facilitate immediate placement of the youth in an approved appropriate setting. A Go Team/Rapid Response must be able to gather with the identified team roster quickly. The representatives should have easy access to the key decision maker they represent, be the decision maker, or be authorized to act on behalf of the decision maker.

The FAPT is the multi-disciplinary process responsible for determining eligibility for CSA, exploring the strengths and needs of individual children and families, and recommending services. The FAPT prepares an individual family service plan (IFSP) with the child and family. FAPT members include representatives from DSS, schools, CSU, CSB, and a parent representative. FAPT may include other members, such as the health department or a service provider. The FAPT process includes completing a standardized assessment called the CANS or the Child and Adolescent Needs and Strengths. The power and duties of FAPT are outlined in the Code of Virginia (§ 2.2-5200). FAPTs generally convene on a scheduled basis, which may vary from locality to locality, with some meeting as often as weekly and others monthly. Although they are not prohibited from doing so, the membership of FAPT does not typically include a representative from the youth's Medicaid (Managed Care) plan, the VDSS Regional Permanency Consultant, or specific private providers who might consider accepting the youth for placement.

What is needed for an effective Go Team Meeting or Rapid Response

- ✓ Dedicated meeting time
- ✓ Necessary participants from involved systems
- ✓ Convener and facilitator (can be the same or different people)
- ✓ Note-taker
- ✓ Access to best practices, technical assistance
- ✓ Agenda/format for the meeting
- ✓ Background and history, health records, clinical justification, level of care(s) recommended
- ✓ OASIS number
- ✓ Medicaid ID and assigned health plan, if applicable
- ✓ Providers, services
- ✓ Encrypted email tool to protect PHI
- ✓ Virtual platform if meeting virtually

Meeting Format

- ✓ 30-40 minutes in length
- ✓ Welcome, introductions
- ✓ The facilitator shares the purpose and goals of the meeting
- ✓ An appropriate person with knowledge of youth/their needs summarizes the youth's recent history and placement needs, youth's long-term goals, desires for placement, strengths, current or needed service needs, and recent referral history
- ✓ Go Team participants seek clarity as needed

- ✓ Group participants brainstorm placement solutions, identify barriers, and who has the authority to help remove/expedite barriers or help troubleshoot
- ✓ A designated person takes notes and disseminates notes to all in attendance for follow-up
- ✓ A designated person follows up as needed with each follow-up item and reports back to the larger group to close the loop when placement is identified or if identified actions are needed.

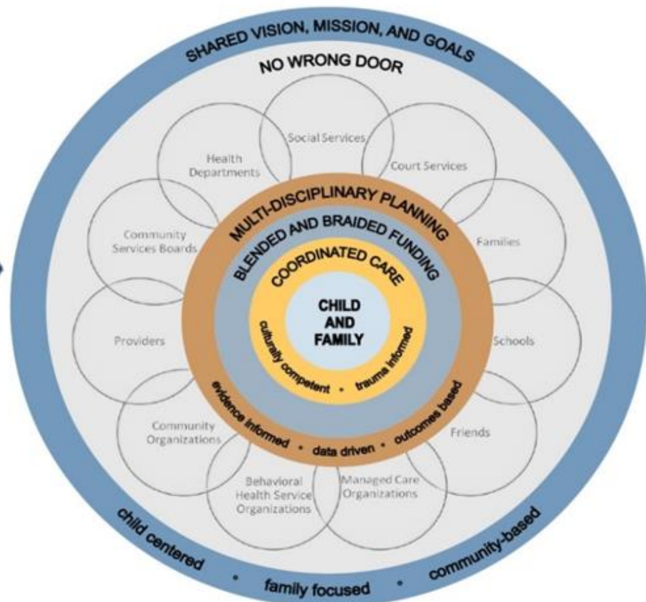
What Would It Take?

"What would it take?" is a philosophy and framework for conversation employed by the Task Force primarily through Go Team and Rapid Response meetings but also more generally in thinking about how best to serve and support high acuity youth, localities, and partners. The approach is based on system of care principles and acknowledges that within a system of care, addressing the unique needs of individuals requires flexibility, coordination, and accountability. By asking "*What Would It Take"* organizations, providers, and others within the system of care utilize a solution-focused perspective to consider how they might be able to support a youth, particularly in emergent or urgent situations. What Would It Take builds off what has worked and remains anchored to where are we going when considering needs. A *What Would It Take* framework leverages all available resources, reaches across systems, and encourages a holistic and creative mindset to address barriers and challenges.

It is a framework for conversation that promotes collaboration and investment in System of Care principles.

It is a holistic, solution-focused approach to planning that builds on creativity, leveraging resources, best practices, and coordinated care.

It is a strengths-based approach. When thinking about needs at the micro and system level, it at asks "what has worked" and "what can we do"?



Virginia's Comprehensive System of Care
Source: Office of Children's Services

System of Care Principles

The following questions are intended as a guide for localities and system partners to consider questions when evaluating their work and for planning as they look to improve their local System of Care. *Source: Office of Children's Services*

System of Care Principles and Questions
Shared Vision • Do we all know what the vision is? (community or individual/child/family level) • How are shared values infused/present in all meetings and interactions? (micro and macro level) • What is working? What has worked in the past? • "What would it take?"
No Wrong Door • Do we have in place a structure to operate in line with this principle? • Does our operating structure align with our community values and goals? • Are services accessible to families? • Do we collect feedback from families regarding access? Which structure/s creates frustration for families? Why? How do we utilize such feedback to increase access?
Multidisciplinary Planning • Is responsibility and ownership shared across all levels of the child serving system? • Does one agency exert excessive influence? • How do we maximize the strengths and knowledge of team members? • What can I/our agency do? • Who are we missing?
Blended and Braided Funding • Are community members/child serving agencies knowledgeable about funds? • Do agency representatives/partners bring knowledge of resources to the table? • Are funds used effectively and efficiently?
Coordinated Care • Do we have a continuum of care of to include prevention, early intervention, treatment and aftercare? • Do we prioritize community-based care? How do we invest in this priority? • How do we engage community support? • What is the role of discharge planning? (especially for high needs youth)
Child Centered and Family Focused • Are services put in place for the youth AND family? • What structures exist for partnering with families and involving youth at the policy, management, and service delivery levels? • How do we provide families with necessary resources to partner effectively? • How do our structures promote or limit participation of diverse families?

Task Force Year Trends, Causes, and Projects

Trends

Three indicators that help shed light on the Task Force's progress, ongoing challenges, and the barriers that must be addressed through sustained policy and other actions were identified for tracking and trending at the beginning of the Task Force. VDSS has the lead role in documenting the indicators each month and monthly and quarterly data is reported to Task Force leadership, as well as with the Core Team.

The indicators include:

- Total referrals (and “new referrals who experienced a displacement”, a subset of “total referrals”);
- Displacements; and
- Days displaced

“Total referrals” is the number of all youth (e.g., youth displaced, youth at risk of displacement) who were referred to the Task Force Go Team or Rapid Response for assistance through the state-level process established for supporting localities needing assistance for high acuity youth (refer to High Acuity Diagram in this manual). “New referrals who experienced a displacement”, a subset of Total Referrals, means youth who have been displaced and were sleeping in an office, hotel, or other similar setting for at least one night.

In 2022, there were variations from quarter to quarter in Total Referrals: there was an increase from Quarter 1 (39 total referrals) to Quarter 2 (57 total referrals) and then a decrease from Quarter 2 (57 total referrals) to Quarter 3 (33 total referrals), and a slight increase from Quarter 3 (33 total referrals) to Quarter 4 (36 total referrals). 2023 similarly experienced variability (Q1 55 total referrals; Q2 59 total referrals; Q3 55 total referrals; Q4 not yet available). Total referrals increased from 129 in the first three quarters of 2022 to 169 in the first three quarters of 2023, a 31% increase. The rise in Total Referrals can be attributed in part to localities’ and other stakeholders’ proactive communication of challenges in securing appropriate placements and active utilization of the state-level support system which was a planned strategy of the Task Force.

Despite a steady influx of new referrals, concerted efforts have led to a 20% reduction in the total days of displacement, demonstrating the Task Force’s commitment and effectiveness in improving outcomes for high acuity children.

“New referrals who experienced a displacement” declined generally quarter over quarter in both 2022 and 2023 (4th Quarter, 2023 is pending). Cumulatively, when comparing the first three quarters of 2022 to the same period in 2023, the number of “new referrals who experienced a displacement” increased by one (1), from 55 in 2022 to 56 in 2023, representing a 1.8% change.

"Displacements" refers to the overall count of displacements where youth were without stable housing/placements, including situations where they had to stay in offices, hotels, or similar places. In 2022, this number fluctuated from one quarter to the next. Initially, it remained relatively stable or decreased (Quarter 1: 26 total displacements; Quarter 2: 26 total displacements) but increased during the last two quarters of 2022 (Quarter 3: 18; Quarter 4: 32). 2023 saw an increase in number of displacements: Quarter 1: 34, Quarter 2:

38, Quarter 3: 39 (Quarter 4, not yet available). When comparing the first three quarters of 2022 to the same period in 2023, there was an overall increase in the number of Displacements from 70 to 111, or a 58% increase. Possible reasons include repeated or multiple displacements within the same time frame.

“Days displaced” refers the cumulative days when youth lacked stable housing, including instances in offices, hotels, or similar locations. In 2022 and 2023, the "total days displaced" decreased in most quarters, with one exception (note: Q4, 2023 data is pending). When comparing the first three quarters of 2022 and 2023, there is a notable 19% reduction in "total days displaced," representing an overall improvement.

Causes

The Problem-Solving Teams and Core Team identified six underlying causes that the Task Force aims to address.

1. Despite an incredibly dedicated workforce and recent system-wide innovations and initiatives, there are capacity limitations and **service gaps across the continuum of care, and lack of comprehensive, system-wide support and infrastructure for relatives and fictive kin**. Service gaps range from adequate mental health and crisis intervention to a lack of sufficient support for relatives willing to provide a home for children, thus keeping them out of the formal foster care system in some instances.

2. There are chronic staffing shortages and related **workforce challenges** in the public and private sectors across child welfare and mental health at all levels of care. Local governments, private service providers, and non-profits that all play a crucial role in child welfare, mental health, and other sectors report difficulty with staff recruitment and retention, among other challenges. Requirements such as mandatory worker background checks also contribute to perceived or actual workforce challenges.

3. **Process and organizational complexity** can cause confusion and operational challenges across agencies and systems. State laws and policies govern specific universal responsibilities, but agencies also have internal policies and procedures relative to meeting agency-specific Code mandates and other requirements (e.g., licensing of providers, human rights protections, federal funding). The web of local, state, and federal laws and regulations is not always consistently clear or easy to navigate despite best efforts around transparency or training and, at times, can even seem to work at cross-purposes or have the perception of doing so (e.g., priorities in one area unintentionally conflict with priorities in another area). The people who work in their organizations/agencies know their processes well but don't always know the procedures and rules of other agencies. Additionally, there is a need to identify and leverage shared priorities and strengthen data-sharing to improve coordination, enhance efficiencies, identify system-wide patterns and trends, and guide decision-making.

4. Often, despite best efforts, there are **"no quick fixes"** and at times, simply "dead ends when trying to find immediate answers. For instance, young individuals or entire communities may have specific and specialized treatment needs, but there might not be enough available resources or knowledge to meet these needs. Addressing complex treatment requirements often involves collaboration among various parties, which can be a slow process to ensure it is done correctly. While solutions are possible, they usually

take time from the idea stage to gaining authorization and finally implementing them, such as state licensing systems and payment procedures. Additionally, it is crucial not to ignore the lack of awareness about the issues affecting local communities, children with high needs, and government agencies. Addressing this problem requires a multifaceted approach to engage the public in helping to find solutions.

5. **Multiple accountable entities** that characterize Virginia's child-serving systems and general decentralization of many authorities (e.g., care coordination, program administration, service delivery, payment, and financing) can result in a lack of clarity around roles and responsibilities, or an overemphasis on independent actions and process instead of coordination of care, quality, and outcomes. A diagram is provided in Appendix B to help visualize this. Like others, Virginia's social services system is supervised by the state but administered locally, which requires careful collaboration, a clear understanding of shared duties, and defining how state and local roles are put into action. Furthermore, various systems and organizations, such as private providers, managed care organizations, community services boards, and local social services, often have professionals with similar titles and job functions, like case managers. It is crucial to comprehend how these roles work together in delivering services and coordinating care, because there aren't always clear lines of authority between them, resulting in fragmented responsibilities and uncoordinated care.

6. The **lack of integrated financing, coordination, and service delivery** for similar priority populations (like youth in foster care) has led to slow progress and incentives that don't always promote quality care among some providers. While various payors like Title IV-E (Family First Prevention Services Act), Virginia Medicaid, and the Children's Services Act (CSA) fund different aspects of medical and behavioral health services for children in foster care, the current setup has its risks. These risks include focusing too much on processes rather than quality, facing challenges in maintaining consistent care, and needing better coordination and accountability. In the case of Psychiatric Residential Treatment Facilities (PRTF), the current setup sometimes allows out-of-state, out-of-network PRTF providers to receive higher payment rates than in-state providers. This can encourage placing youth out of state when such care is required, which affects the continuity of care and best practices in child welfare. These issues also create challenges for the workforce in both public and private sectors, including administrative hurdles, employee burnout, and confusion due to perceived inefficiencies.

Four Core Recommendations

Following one year of work, the Task Force has developed the following four core recommendations to strengthen and improve child-serving systems and policies affecting high-acuity youth in Virginia:

1. **Prioritize the recruitment, retention, and needs of relatives, kin, and foster parents.** Relatives, kinship, and foster families often provide long-term stability and a sense of belonging that can significantly benefit the emotional well-being of youth in foster care and avoid repeated or extended stays in congregate care settings. By focusing on the needs of relatives, kinship, and foster parents at the individual level (e.g., case management, training, resources, wrap around services) as well as through infrastructure and capacity as the state

and local levels), we can create a more supportive environment, reduce disruptions, improve outcomes for youth, and enhance the overall quality of care.

2. **Address gaps in children's community-based continuum and increase access to evidence-based services.**
   Nationally, approximately 55% of youth and young adults do not receive mental health services when they need them. This is particularly concerning for youth in foster care due to the traumatic nature of foster care (grief, loss, and separation) and mental health needs that often confront youth in the child welfare system. Additionally, 1 in 5 Virginia families live in a behavioral health provider shortage where access to critical mental health services is elusive. Enhancing the continuum of services, treatment, and placements for children in foster care at all levels, ranging from early intervention to prevention through residential treatment, is critical.

3. **Improve residential treatment services.**
   Residential treatment represents a specialized and intensive level of care for youth with acute needs. It is important to have thoughtful allocation of this service, and not over-rely on it, awhile ensuring its availability for children who genuinely require it. When this intervention is necessary, it should meet a high standard of quality and effectiveness. It was recognized throughout the Task Force that an improved model of care for residential treatment is needed. This model should enhance access to high-quality, evidence-based care, focusing on trauma-informed practices that align with system of care values. Additionally, systems, processes, and financing should be examined to support high standards of quality and to address gaps in the continuum of care.

4. **Improve integration and collaboration across child-serving systems, including the workforce.**
   Enhancing integration and collaboration across child-serving systems, particularly related to those that serve children and youth in foster care, is crucial for ensuring the well-being of children and families. By simplifying and lowering barriers to families and also workforce, we can minimize bureaucratic hurdles and sometimes even allocate resources more efficiently. A collaborative effort enables a more comprehensive response to the complex needs some youth face and can often prevent gaps in care or avoid systems working at cross-purposes.

Projects

In addition to creating new contract positions (High Acuity Youth Placement Coordinators) providing additional capacity to support the new processes that were launched through the Task Force (e.g., Go Teams, Rapid Response, increased technical assistance for localities), several new projects and pilots occurred in the first year of the Task Force due to one-time funds appropriated as part of the 2022 Special Session to support the goals of the Safe and Sound Task Force (*Item 340 M*). A summary is below.

Exceptional Circumstances Pilot

This pilot program allows for payments of $3000 per month (pro-rated) to be made per household to foster homes with exceptional circumstances. This program is an initiative to address the needs of children in foster care with high-level behavioral concerns who are waiting for a placement or at risk of displacement. The pilot program was initially funded through the Safe and Sound Task Force until May 31, 2023. Foster parents may use the payment for any items or services that enable them to provide near-constant supervision of the child, such as

taking a period of leave from employment during an exceptional circumstance. Through this pilot, VDSS intends to prevent displacement or allow for a placement to occur, which will address the exceptional circumstances. This is designed to serve as a time-limited funding arrangement.

Kinship capacity-building

The Commonwealth of Virginia, in concert with the Safe and Sound Task Force and the Virginia Department of Social Services, remains focused on improving the experiences of families through the development of a Kin First culture. A Kin First culture drives child welfare work by recognizing families as the architects of plans that ensure safety and well-being of children. The development of the Family Seeing™ practice framework, led by Kevin Campbell, centered around the engagement of networks of family members and other significant adults to promote the safety, healthy development, and healing of children and youth involved with government systems, was kicked off in March 2023. The theory of change in Family Seeing™ is that parents, relatives, and other caring adults, within the context of culture, are the agents of change in children's lives (not case managers, models, and services). Through this approach, agencies and staff will support families as they create solutions to challenges and increase daily opportunities to build health, resilience, and well-being.

Child Abuse and Neglect Project ECHO

Implementation of cohort-based training for non-clinical professionals in behavioral health, schools/daycares, juvenile justice, and child welfare, focusing on pediatric mental health, trauma-informed care, human trafficking, and child development, provided through the Children's Hospital of Richmond at Virginia Commonwealth University.

Psychiatric Residential Treatment Facilities Learning Collaborative

A cohort-based collaborative for clinical and executive leaders of four Psychiatric Residential Treatment Facilities (PRTF) delivered by the Center for Evidence-based Partnerships (VCU CEP-Va), Virginia Commonwealth University. Through an evidence-based curriculum, the Learning Collaborative focused on two related but distinct areas of competency: (a) trauma-informed assessment tools helpful in child welfare contexts for treatment progress and gauging readiness for a less intensive form of treatment, and appropriate to the PRTF setting and (b) training and consultation in the use of evidence-based treatment techniques for trauma (e.g., psychoeducation, cognitive restructuring, relaxation) appropriate for the PRTF setting.

Targeted resources to localities

Application-based mini-grants to support local one-time needs aligned with the goals of Safe and Sound, including enhancing access to clinical consultation to support prompt, trauma-informed treatment/assessment/intervention; developing community-based interventions in partnership with providers to expand local capacity; creating or strengthening trauma-informed approaches to support workforce needs; providing training to foster parents, staff, and community partners to enhance trauma-informed or Kin First care, and other gaps and needs as appropriate and approved.

2023 Task Force Approach and Highlights

1. Continuing the collaboration with a Core Team of senior leaders from five state agencies (VDSS, DBHDS, DMAS, OCS, and DJJ) to coordinate, facilitate, and expedite planning and decision-making.

2. Continuing state-level process for responding to youth in foster care in or at risk of sleeping in offices.

3. Providing additional capacity at the state level through Placement Support Specialists and High Acuity Youth Placement Coordinators to support to localities to get involved earlier to support needs of high acuity youth.

4. Recruiting sponsored residential providers to build networks for youth in foster care without ID/DD waivers.

5. Held multiple forums with a range of providers to better understand and address their needs and barriers in serving high acuity youth.

6. Implemented Exceptional Circumstances pilot for youth with high needs and their foster care families

7. Launched enhanced treatment foster care pilot through contracts with 3 organizations

8. Engaged in provider development through new Project ECHO model with VCU CHoR and PRTF Learning Collaborative with VCU Center for Evidence Based Partnerships

9. Developed and launched universal referral pilot to support localities seeking admission to residential treatment for youth in foster care.

10. Developed tools to further strengthen the "What would it take?" system of care approach to build capacity and shift perspectives on supporting and serving high acuity youth in foster care with placement challenges.

11. Advised the Administration with recommendations and strategies for systemic reforms to address underlying elements the Task Force seeks to address.

State Agency Task Force Resources

Department of Behavioral Health and Developmental Services

Licensing

The DBHDS Office of Licensing serves as the regulatory agency for providers of mental health, substance use, and developmental services providers.

Licensed Provider Search

Use the DBHDS Provider Search System to locate licensed providers by a variety of criteria
https://dbhds.virginia.gov/quality-management/office-of-licensing/

Provider Variances

Variance protocol for providers in accordance with 12VAC35-105-120.
https://dbhds.virginia.gov/assets/doc/QMD/OL/variance-protocol-for-providers.pdf

State Operated Facilities

Commonwealth Center for Children and Adolescents (CCCA)

Description: CCCA is the only state-operated Virginia hospital for youth ages 17 and younger. CCCA serves youth under an involuntary commitment order (TDO) to fulfill the Bed of Last Resort statute.
Level of Care: Acute inpatient psychiatric treatment
Average Length of Stay: 5-7 days
Current Bed Capacity: approximately 20
Admission Criteria: Youth must be under a Temporary Detention Order
CCCA Wait List: CCCA serves as the Bed of Last Resort for youth under a temporary detention order when no alternative appropriate acute inpatient psychiatric placement has been identified. The CCCA Admissions office manages the waitlist and closely coordinates with the CSB serving the youth.

CCCA and Safe and Sound Collaborative Discharge Protocol

In August 2023, special protocols were established for Safe and Sound youth at CCCA.
Description: To clarify the process related to coordination and discharge for certain youth at CCCA. The target population of these processes is youth in the custody of local DSS agencies at CCCA who are experiencing discharge barriers affecting their ability to be placed in less restrictive settings, including but not limited to treatment foster care, foster care, congregate care settings, relative or kin placements, or other appropriate settings.

Community Behavioral Health

Are you seeking substance use or mental health services for your child or adolescent?
In Virginia, child and adolescent behavioral health services are provided locally. Community Services Boards (CSBs) are the public community mental health services providers. Many services are also offered by private non- and for-profit providers who are licensed by DBHDS.

Community Services Boards

CSBs provide an array of child and adolescent behavioral health services in most Virginia Communities. Services may include:

- **Outpatient Therapy**: generally provided to individuals on an hourly schedule, on an individual, group, or family basis, and usually occurs in the clinic setting.
- **Case Management**: assist individuals and their family members to access needed services responsive to the individual's needs.
- **Crisis Services**: delivered in the community, home, school, or desired secured environment for individuals in crisis. Services may be mobile or center-based.
- **Emergency Services**: emergency evaluations for psychiatric hospitalization 24 hours per day, seven days a week.
- **Same Day Access**: access a mental health evaluation without an appointment at a CSB throughout Virginia during walk-in hours. Walk-in hours vary by CSB.
- **Substance Use Services:** treatment may include counseling, rehabilitation, or medical or psychiatric care. Services vary by CSB.

Private Providers

Use the DBHDS Provider Search System to locate licensed providers by a variety of criteria: https://dbhds.virginia.gov/quality-management/office-of-licensing/

Comprehensive Crisis Services

The National Suicide Prevention Lifeline is now the 988 Suicide and Crisis Lifeline.

Community Stabilization: the goal of Community Stabilization services is to stabilize the individual within their community and support the individual and/or their support system during the periods

- between an initial Mobile Crisis Response and entry into an established follow-up service at the appropriate level of care
- as a transitional step-down from a higher level of care if the next level of care service is identified but not immediately available for access
- as a diversion to a higher level of care

Call the youth's Medicaid Managed Care Organization (health plan) to inquire about community stabilization providers and start the authorization process

Crisis Stabilization Units: As of July 2023, the following regions have child crisis stabilization units (behavioral health):

- Region 1 (Western): Does not currently have a child crisis stabilization unit
- Region 2 (Northern): Does not currently have a child crisis stabilization unit
- Region 3 (Southwest) 12 beds. PATH CSU serves youth who live in the service area of any Region 3 Community Services Board. https://www.mountrogers.org/wp-content/uploads/PATH-CSU-Brochure-1.pdf . To access or inquire about admission, call your local CSB, call (276) 227-0489, or call 1-800-273-8255
- Region 4 (Richmond Metro/Central Virginia). St. Joseph's Villa (Richmond). 8 beds. Crisis Stabilization Services to children ages 5 to 17 residing in Region IV of Virginia https://www.neverstopbelieving.org/ To access or inquire about admission, call your local CSB, go to the St. Joseph's Villa website, or call 1-800-273-8255
- Region 5 (Eastern). BRIDGES (Windsor; near Suffolk). 6 beds. Short-term residential crisis stabilization services for male and female adolescents up to age 17. Serving Region 5 https://www.wtcsb.org/services/crisis/#crisisservice2 To access or inquire about admission, call your local CSB, go to the WTCSB website, or call 1-800-273-8255

Office of Child and Family Services

https://dbhds.virginia.gov/behavioral-health/office-of-child-and-family-services/

- Improve access to a coordinated, consistent array of behavioral health services across the Commonwealth.
- Promote best practices in children's community-based behavioral health services.
- Seek funding initiatives that support a comprehensive service array.
- Support integration of behavioral health services in primary care and schools
- Promote the system of care philosophy by modeling the principles, collaborating at an interagency level, and involving families and youth.
- Promote opportunities for behavioral health equity across the state in under-served and with groups that have historically experienced racism or oppression in treatment access.
- Promote the development of family support and education.

Developmental Services

Community Services Boards

Community Services Boards provide ID/DD case management for youth receiving waiver services, plus other waiver-related services. https://dbhds.virginia.gov/developmental-services/waiver-services/

Waiver eligibility for youth

https://dbhds.virginia.gov/developmental-services/waiver-services/

How to apply for an emergency waiver slot

DBHDS maintains a pool of Community Living waiver slots that may be assigned to individuals deemed in an emergency status according to certain criteria. Review the criteria here or contact your CSB or DBHDS at emergency_underscore_slotrequest@dbhds.virginia.gov to inquire. https://dbhds.virginia.gov/developmental-services/waiver-services/

REACH

The REACH program is the statewide crisis system of care designed to meet the crisis support needs of individuals who have a developmental disability and are experiencing crisis events that put them at risk for homelessness, incarceration, hospitalization, and/or danger to themselves or others. REACH services are available statewide, with one regional program in each of the Commonwealth's five DD regions (Southwestern, Western, Northern, Central, and Eastern). https://dbhds.virginia.gov/developmental-services/crisis-services/

DD Services for Youth

My Life, My Community is an online tool that helps people with developmental disabilities (DD) and their families answer basic questions about services, supports, and where to find help because sometimes knowing where to start can be challenging. You can also call toll-free at (844) 603-9248.

Virginia Department of Social Services

High Acuity Youth without Placements

The Virginia Department of Social Services (VDSS) is committed to supporting local agencies with high-acuity youth without placement. VDSS has identified ways to support the local departments of social services (LDSS) when they cannot secure placement and the child will or might have to sleep in the office. VDSS FUSION contains Broadcasts that outline various processes and resources available. Please note that FUSION is an internal site only and cannot be accessed by non-VDSS or non-LDSS employees. Broadcast (virginia.gov)

Resources for Foster Care

https://www.dss.virginia.gov/family/fc/index.cgi

Exceptional Circumstances Payments

This program was initially piloted through the Safe and Sound Task Force. The Exceptional Circumstances Payment Pilot Program provides time-limited exceptional payments ($3,000 per month pro-rated for a maximum of 3 months) which are above and beyond the maintenance rate and VEMAT to identified foster parent(s) who are or will provide care and supervision to children in foster care who have behaviors that require an exceptional level of supervision for the child to be successful in a family setting. These funds can be used for an LDSS- or LCPA-approved foster parent, including kinship. The purpose of the payment is to facilitate support activities that would allow the foster parent to provide near constant supervision, such as taking a period of leave from employment. For more information, refer to the most recent VDSS Broadcast or contact your Regional Permanency Consultant.

Department of Medical Assistance Services

The Department of Medical Assistance Services (DMAS) is the single state agency that administers Virginia's Medicaid and CHIP programs and provides oversight of Medicaid policy and benefits. Local Departments of Social Services determine Medicaid eligibility based on DMAS policy. Youth in foster care in the custody of DSS in Virginia are eligible for and enrolled in Medicaid in the foster care aid category (076.) Exceptions include non-Virginia residents and those with financial resources or income that make them ineligible.

Two divisions within DMAS are directly involved in the Safe & Sound Task Force:

- The Health Care Services Division is responsible for the Department's Foster Care Program, including oversight of services and Managed Care Organization (MCO) Care Coordination for foster care members.
- The Behavioral Health Division is responsible for Medicaid-funded behavioral health services and policies, and oversight of the contract with the Behavioral Health Service Administrator (BHSA). The BHSA manages Medicaid-covered Mental Health and Addiction and Recovery Treatment Services (ARTS) for Fee-For-Service enrolled members.

The Child Welfare Program Specialist (fostercare@dmas.virginia.gov) is the point of contact within DMAS for foster care members. It serves as the liaison between partner agencies, contracted MCOs, or the Behavioral Health Service Administrator.

Eligibility and Enrollment

Most (96%) of youth in foster care are enrolled in a contracted Managed Care Organization (MCO) to coordinate and administer Medicaid benefits. However, some exceptions to managed care enrollment are essential to know for youth in foster care. Populations excluded from managed care enrollment and receiving coverage through the Fee-For-Service delivery model include those placed in Psychiatric Residential Treatment (Level C) facilities. For youth in foster care placed in Psychiatric Residential Treatment Facilities, the Behavioral Health Services Administrator (BHSA) manages the placement and treatment services.

Managed Care Organizations

DMAS currently (as of 2023) contracts with five (5) MCOs, which are health plans that coordinate care and provide insurance benefits to Medicaid members, including those in foster care and adoption assistance. Youth in foster care are assigned an MCO case manager who collaborates with youth, foster family (or other placement providers), local DSS worker, and other providers to ensure appropriate, quality, and timely health care services.

How Can an MCO Case Manager Help?

A case manager is a health plan employee who is a health professional with expertise in behavioral health concerns, child welfare, and pediatric specialties. Case managers can assist youth, DSS workers, and foster families in identifying providers (such as primary care physicians, dentists, therapists, or other specialists). Additionally, case managers can connect you to individualized behavioral health services. They can *resolve barriers to treatment,* such as billing and pharmacy issues, and other community resources like food, education, and housing. MCO Case managers can also *provide information* about health benefits and other community resources. Finally, all MCOs have 24-hour nurse advice lines, -toll-free member helplines, disease management programs, and enhanced benefits, especially for youth in foster care.

DSS Workers and Foster Families are encouraged to utilize the assigned MCO Case Manager as necessary to ensure all supportive and wrap-around services can be set up to support each youth before a placement disruption occurs.

Residential Placements & Services (as of September 2023)

Psychiatric Residential Treatment Facilities (PRTF) and Therapeutic Group Homes (TGH) are residential services for children under age 21. These placements must meet medical necessity criteria, and preauthorization is required through the Independent Assessment, Certification, and Coordination Team (IACCT) process. The medical necessity determination for all levels of residential care is made by the BHSA (Magellan of Virginia through October 2023, then Kepro/Acentra Health beginning November 2023).

Please note: these are not intended to be specific instructions but rather a summary of the process. Please contact the Behavioral Health Service Administrator or DMAS with any specific questions about the process.

Independent Assessment, Certification, and Coordination Team (IACCT)

To begin the IACCT process, the DSS worker submits a Residential Inquiry form to Magellan of Virginia. A Residential Care Manager (RCM) then contacts an LDSS worker to discuss the process and complete a Residential Referral form for IACCT Licensed Mental Health Professional (LMHP) review. The LMHP then conducts an independent assessment, reviews for medical necessity, obtains a Certificate of Need (CON) and schedules a Recommendation Meeting (if needed). The treatment team reviews viable options to meet the youth's needs during the Recommendation Meeting if required. Once the IACCT process is complete, the BHSA (Magellan of Virginia) can explain if the service will be authorized.

Emergency Placements: All children placed in a residential treatment facility or therapeutic group home under the LDSS/CSA emergency placement authority shall immediately be referred by the LDSS family service worker to the Family Assessment and Planning Team (FAPT) for consideration through established local practices. The inquiry should be submitted within five

days of the member's placement or when the member becomes eligible for Medicaid. Anyone can submit the inquiry. In this situation, the treatment team completes the CON at the residential placement. The residential facility will provide a copy of the CON to the RCM, and the RCM will provide a copy of the CON to the IACCT LMHP. Other aspects of the IACCT process remain the same.

Services Carved Out of Managed Care Coverage

While youth placed in PRTF are *excluded* from Managed Care Coverage and enrolled in Fee-For-Service during their residential placement, some specific services are carved out of managed care. At the same time, the member continues to be enrolled in an MCO. Benefits for members enrolled in managed care **not covered by the MCOs** are classified as “carved out.” The member remains in the MCO, but services are paid directly by DMAS through fee-for-service. Note: The MCO is responsible for transportation related to carved out services.

Carved out services include:

- Therapeutic Group Home placement management
- Therapeutic Foster Care Case Management (TFC-CM)
- Dental services
- School health services
- DD Waiver services

Dental Services are provided through the Smiles for Children Virginia dental program administered by DentaQuest. There is no separate card for dental coverage. For assistance with locating a provider and scheduling an appointment, call 1-888-912-3456. Additional information can be found at www.dentaquest.com.

To be connected with a child’s MCO care coordinator, BHSA Residential Care Manager, or DentaQuest Outreach Coordinator, email fostercare@dmas.virginia.gov.

Office of Children’s Services

The Children’s Services Act (CSA) is a law enacted in 1993 that establishes a single state pool of funds to support services for eligible youth and their families. State funds, combined with local community funds, are managed by local interagency teams who plan and oversee services to youth. If no other funding source is available, many behavioral health services can be paid for through CSA funds. Information is presented below to help families understand the process of accessing services.

Who is eligible for services through the CSA?

Services through the CSA may be available to a child who meets at least one of the following descriptions as noted in the Code of Virginia §2.2-5212. The Code of Virginia determines eligibility for CSA, and local CSA teams have policies for determining eligibility.

Why would I need CSA?

CSA provides an opportunity to interact with child-serving agencies in your community. Meeting with your local CSA can provide information about community resources and services. For eligible youth and families, CSA can fund certain services and supports.

A Guide to the Children's Services Act for Children and Families

https://www.csa.virginia.gov/content/doc/CSA_Family_Guide_2022.pdf

Where can I go for help with CSA?

Your local CSA Office is the best place to request assistance with the CSA process. You can find their contact information by searching for the CSA Coordinator Role https://www.csa.virginia.gov/UserManagement/Home/LocalGovernmentContacts/0

CSA Contacts

https://www.csa.virginia.gov/Contact/Index/0

Department of Juvenile Justice

The Virginia Department of Juvenile Justice (DJJ) enhances public safety by providing effective accountability measures and interventions that improve the lives of court-involved and committed youth.

Court Service Units (CSU)

The best resources for information on DJJ's programs and services in each city and county are the court service units (CSU) https://djj.virginia.gov/pages/community/court-service-units.htm

For general information on DJJ, please visit the agency's website https://djj.virginia.gov/

Acknowledgements and Conclusion

This Task Force Reference Manual serves as a guide to support the current and evolving work of the Task Force and its partners. We sincerely thank all Task Force participants and contributors who helped shape the contents and efforts behind this resource and who continue to strive towards better outcomes for Virginia's youth and families and the system as a whole.

Please consider this manual as a living document as efforts evolve and grow. If you have feedback, please reach out to the Special Advisor to the Task Force, Mira Signer, at mira.signer@governor.virginia.gov or Janet Kelly, Special Advisor to the Governor for Children, at janet.kelly@governor.virginia.gov.