Agenda

Coordinating Council on School Mental Health
Monday, April 15th, 2019 10:00 am – 12:00 pm
@ 64 NY Avenue NE
Room 284

I. Welcome & Introductions

Members of the Coordinating Council and the public introduced themselves.

Dr. Scott introduced the new co-chair, Ms. Atiya Frame, who is serving as DBH's Interim Senior Deputy Director in addition to her role as the Director of Accountability Administration. Ms. Frame joined DBH as a team member in St. Elizabeth's Performance Improvement Department in 2007. She has served as the Director of the Accountability Administration since 2012. She has experience in patient advocacy and quality improvement in the community based provider setting, locally and in other states. Throughout the District Ms. Frame was recognized as a conscientious and pragmatic leader with an ability to manage complex projects and Dr. Nesbitt is confident in her abilities in this new role.
Ms. Frame expressed gratitude for the warm welcome and believes that while she does bring the experience noted in Dr. Scott's introduction, the more valuable experience to serving as Co-chair is being the parent of 2 boys, ages 8 and 16. Ms. Frame noted her experience with school and OSSE collaboration as a parent to address her youngest son's variety of behavioral health needs. She is excited to be a part of the Coordinating Council and offer insight from a parent's perspective where it's needed.

Ms. Thompson reviewed the goal of School-Based Behavioral Health and the charge of the Coordinating Council:

1. **School-Based Behavioral Health Goal**- To create a coordinated and responsive behavioral health system for all students in all public and public charter schools.
2. **Coordinating Council Charge-** To hold agencies and participating stakeholders accountable for timely implementation of the expanded school-based behavioral health system.

II. News, Updates, and Public Comment

A. Co-Chair Update

Mr. Musante welcomed Ms. Frame as the new co-chair and thanked Mr. Mark LeVota for providing additional information needed during the Budget Oversight Hearing. Ms. Thompson also thanked Mr. Musante for providing balance to the Coordinating Council and understanding the importance of focusing on the specifics and all the details of the work presented yet also to remember how much is being accomplished in a short period of time and the complexity and number of moving parts.

B. Council Member News

None provided

C. Public Invitation to Share (5-10 mins)

No public comments provided.

III. Coordinating Council Business

A. Timely Implementation- Year 1

- **Providers in schools update**

  Ms. Thompson has provided two bi-weekly reports for how many providers are physically in schools to date. She suggested providing reports bi-weekly compared to weekly due to the amount of information included.

  - 21/52 schools have providers in schools
  - MBI is serving 8/52 schools (7 DCPS, 1 DCPCS). Asterisk next to MBI partners due to the complexity of understanding existing providers who were part-time and now becoming full-time.
  - 2/4 DBH Clinical Specialists are providing support to the schools.
  - 5 schools are deciding their appropriate path of participation.
    Mr. Howard provided an update on the 4 DCPS schools that are unmatched. Some schools began the matching process early but had certain challenges with the matching process. DCPS was able to re-engage with these schools and they will begin the matching process again. Anacostia will not have a Community Based Organization (CBO) due to their low enrollment but Anacostia does still have a DBH Clinician. The DC Public Charter School Board is awaiting a response from National Collegiate HS.

  Ms. Thompson would like the Provider & School update reports to eventually become a dashboard.

- **Provider and School Activities**

  Emails will go out once Clinicians are in place and the School Mental Health Coordinator is identified. For DCPS, it is better for the process to go through their central office. Mr. Howard has provided the point of contacts to the CBOs that have an MOA in place. For DCPCS, Dr. Scott is responsible for sending the initial information regarding the School Strengthening Tool and then Ms. Brumsted follows-up with additional information and creation of accounts. Once the CBO clinician and School Mental Health Coordinator understand how to complete the School-Strengthening Tool, they will then engage the clinicians on the School Mental Health Team and stakeholders to develop the work plan.

  - 5 of the 9 DC Public Charter schools with providers have completed the online School-Strengthening Tool, 1 completed a work plan and 2 are being developed.

  The CBO Clinician and the identified SMH Coordinator are both given access to input the tool. According to the process, both CBO clinician and the School Mental Health Coordinator facilitate the teaming of the completion of the tool. Once Ms. Brumsted is told who the CBO clinician and the SMH Coordinator are, they receive their webinar and log-in information. DCPS will follow a similar process to track information as well. Mr. Howard will provide the information so that Ms. Brumsted is able to establish the accounts.

  Discussion Points:

  - **If providers are in schools that are not a part of the top 25% of highest need schools, how are they resourced, communicated with, and what's the sustainability? Are those schools a part of**

another process outside of this expansion process? What are the plans/deliverables to measure success of those providers in schools as a result of other funding streams?
This is a rolling implementation with the intention to have all of the schools included in this expansion and have an overarching framework be in the awareness and the practice of all public and public charter schools, with the initial window being 3-5 years. If the Coordinating Council is aware of providers included in the expansion and working within other schools, there should be coordination for:

1. how or when will they be involved in upcoming cohorts and
2. communicating with schools to help forecast out regarding what is coming; what to expect to help integrate within schools; how the activities and process fit in with what the schools are currently doing; and how they integrate it into what they do.

DCPS has 11 mental health providers that are authorized to be in DC Public Schools and Mr. Howard oversees those partnerships, even if they are not included in the expansion project. Providers submit quarterly reports to principals and monthly reports to Mr. Howard. There is a mechanism to ensure better oversight of the "*what* and *why"* of the provider's services in the schools.

- Ms. Brumsted reviewed the process when a school has an existing tool for assessing need and how to fold that existing work into the Work Plan. An example is St. Colletta, where the entire student population served is students with disabilities, the school has an existing process for assessing need and documenting needs assessment for tiered programming. They were not required to complete the School Strengthening Tool because they were able to discuss with us their high quality implementation plan that was already completed.

- In **Cohort 2,** we are working with schools that are still higher need and may have some structures and processes in place, so it is important to define what the Council considers as a high quality needs assessment to eliminate duplicative processes for schools that already have systems in place.

- Ms. Whalen noted the importance of making sure to provide the description of the students being served in schools (i.e. children with disabilities); who are providing the services in the specific school; and the mechanism used beyond IEP's is to be captured in our reporting. This will help to make sure that we are comparing apples to apples when we conduct the evaluation.
  Ms. Thompson explained it's not the Coordinating Council's job to impose a structure and sweep out an existing structure. The Council's plan is to create an overarching system, framework of thought and to increase the consistency and the standards across systems and schools and recognizing that there is a lot of variation.

- Ms. Parrella stated the importance of allowing a relationship to develop to facilitate more buy-in as schools engage in the work of prioritization of needs and services. There is a need to be intentional, thoughtful, as well as successful in the partnership.

- **Is it buy-in to the School Strengthening Tool or buy-in to the expansion?**

  Ms. Brumsted reiterated that schools are not required to complete the School Strengthening Tool when they have a quality (to be defined) needs assessment tool. The work plan that is completed by all schools will help to identify gaps and areas of growth as it relates to the resources She clarified that her previous description regarding St. Coletta or similar schools was not about buy-in to the school-based behavioral health services. Ms. Barnes added feedback that the gap that St. Coletta identified for services was support for families and that service will be filled by the DBH Clinical Specialist. In other schools where the gap is prevention and early intervention, the DBH Clinical Specialist will provide those services.

- **For children who have non-social emotional IEPs, can they still benefit from the services/be served?**
  Ms. Barnes noted that in cases of students who have an IEP not related to therapy, yet it is needed, those students go through the regular process to get connected with services within the school. Having an IEP should not prevent a student from receiving mental health services. However, Dr. Oruh noted an inconsistency in what Ms. Barnes described and Dr. Oruh's experience. It was acknowledged that it is important to follow-up and facilitate problem-solving when there is a difference between experience and expectation of access to services. Ms. Whalen suggested that the Coordinating Council explore how the schools with self-contained classrooms have incorporated tiered services and pushed into classrooms. It is important to obtain lessons learned and explore the possibility of including presentations within Community of Practice sessions.

➢ **Community of Practice procurement update**
Dr. Scott provided an update regarding the Community of Practice Procurement.
"The Office of Contracting and Procurement has notified the offerors with our intention to make an award. The offeror with the highest evaluated score is anticipated to respond back to OCP's letter of intent by April 16th, 2019. Final OCP pre-paperwork to support an award is being finalized as we simultaneously work with our procurement partners, DBH staff, to generate the funding document (purchase order). OCP will be issuing the final contract document to the successful offeror by COB, April 15h, 2019. OCP does not foresee any compliance delays as several documents have been verified and/or routed to the appropriate agency for review. There has not been any request for vendor corrections or notices of non-compliance which generally indicates we will receive a successful verification process. The award date will be pending the offeror's review submitted back to OCP with their signed award."

Discussion Points:

- Mr. Howard stated a need for clarification for CBOs and principals regarding the CBO's role in crisis response. It was reiterated that the DBH/School Mental Health Program is responsible for conducting crisis response as needed by LEAs. The CBOs will be trained in understanding the framework that the DBH/School Mental Health Program would use when responding in their schools.

B. Timely Implementation- Year 2

- **Forensic Analysis of year 1/Forecast of year 2**

  Ms. Thompson explained that the Coordinating Council is focused on how to move forward in year 2 in order to have a result that matches with the school year. The focus is on how to get providers into the schools at the beginning of the school year to ensure participation for a full year partnership. Ms. Thompson provided highlights of the handout for the analysis of year 1 (actual) implementation compared to year 2 (forecast). The handout looked at the first year implementation to see how long it took for the different steps and to identify those places where we might have time savings.

  - It took upwards of 6 months to determine what the funding formula would be for the provider partnerships. Started in August to look at different ways to fund the providers. We were trying to measure unmet need and realized it was very complicated to measure a level of resources. Then, recognizing that we are going into high need schools, decided to fund all CBO school placements at the same amount. DBH came through with funding o ensure that every provider in a school would be funded at about 50% of the clinician's cost and the cover of a small amount of the supervisor's time. It was hard to move the other implementation pieces forward while we were having the funding amount discussion. That area of reflecting on a financial viable grant amount is a non-recurring discussion that will not have to happen in year 2 which creates time savings.
  - The MOA and revision of the Agreement to Proceed took approximately from August to December to move through reviews. This process is also a non-recurring activity that will not happen in year 2.
  - The execution of a 5-year data sharing agreement that does not need to renew with option years facilitates the data for the prioritization to be available in August of the previous year so that the school prioritization can be done earlier.
  - The School & Provider Matching process- 6 month (September 2018-February 2019) process with a lot of matches occurring in February. Hoping to cut the time to 3 months, although ambitious, it can be done. The NOFA has been shared with the Provider Network and the RFA will be posted on April 26, 2019. Recognition given to Dr. Nesbitt, Ms. Dunbar, Dr. Scott, and team for completing the work to post the NOFA and RFA.

  Ms. Thompson proposed to start the matching before the providers are selected with the thinking that the majority of providers are existing. Mr. Howard stated that for new providers who did not have a program or were in the process of establishing a program, that was a barrier for DCPS vetting.

  Discussion Points:

  - Ms. Frame posed the question whether there is something that DBH can do on the front end through the DBH certification process to decrease the amount of time for the DCPS vetting.
  - It was noted that not every provider is certified by DBH
  - Mr. Howard stated that timing is essential for DCPS, all mental health program managers will be meeting with principals to discuss the upcoming year during May and June after the impact season.

Dr. Scott will look into identifying which DCPCS MOA's are 3 years, so that the process may be looked into where the duration is less than 3 years. Mr. Howard stated that he will share the template for DCPS 3 year MOA with the charter schools.
The school & provider matching is the heaviest lift. Ms. Thompson, Dr. Scott and Mr. Howard will begin outlining lessons learned; how to streamline; and points of intersection with the schools and providers that facilitate each of them doing the due diligence that they need to do in order to make decisions. Members were reminded that during the March meeting, Ms. Brumsted presented the Readiness timeline from the Provider perspective and the School's perspective.

Ms. Thompson noted the needed balance of the Council not setting ourselves up to not meet our goals yet also being ambitious.

Discussion Points:

- **RFA for new providers, does it include asking whether they are certified with DBH as a core services agency? If they are, could it quicken the process of receiving an MOA?**
  It requires being paneled with each of the managed care plans and an FQHC may not be certified through DBH and wouldn't need to be to participate in the expansion.
- Make sure on the front end that the expansion language is matching. If a provider doesn't have any school mental health experience and you are coming to DCPS to provide those services, the vetting process asks questions about the capacity to provide those services.
- In the RFA, there is the ability for the evaluators to look at experience with providing child services. The belief that we operate from is that the CBO can be supported to help translate that experience into school-based work and the certification with DBH is not required under the current grant.
- **Why can't the MOA process match with the selection of the provider? The providers are being vetted through DBH and again by DCPS, it is very time consuming.**
  Mr. Howard explained that it is complicated because there is mental health in central office and then also in schools. There have been 2 to 3 CBO that started within the DCPS system and ended with no transition. This created concern from the Deputy Chancellor level on down about their accountability and sustainability to the DCPS system. The vetting process is a mandate directly from the Deputy Chancellor and the Instructional Superintendents. There are requests, outside of the expansion, from mental health agencies who attempt to get into the school system through the principals. This is the best process at the moment to ensure the best quality of services.
- There should be a way to consolidate the processes so it does not affect the services provided to the students.
- **As a provider, how is the majority of the MOA process done while determining the match?**
  For DCPS, the 2 partners that are not a part of the expansion project are already being engaged now to begin the MOA process that is aligned with the expansion project. Mr. LeVota offered the following to operationalize the movement of the MOA process:

    - If any new provider submits an application, perhaps it might be helpful at the submission point that the CBO is sent a template of the MOA and instructed to contact Mr. Howard to get started with the DCPS MOA process.

Dr. Acosta Price also stated the importance of encouraging new providers to apply to join the work.

- **School prioritization recommendation**

  Dr. Schumacher provided an overview of the handouts for the School Prioritization.
  A review was provided regarding the determination of the Top 52 schools in Cohort 1. Administrative data was used from SY 2016-2017 including 4 criteria: OSSE at-risk score, out of school suspension, attendance and IEP. The OSSE at-risk score was purposely triple weighted because it is a combination factor, and we wanted to marry both internal and external factors. Adult schools, online schools and early childhood campuses were removed.
  For determining Cohort 2- we replicated a similar process except that we used SY 2017-2018 data, included Pre-K campuses, removed schools from cohort 1 and ranked the remaining schools. For the packet of handouts, there was one set of rankings with same weighting criteria using 17-18 data and the second rankings with the same weighting of last year but with the addition of English Language Learner status. The concern being that the at-risk score may disproportionately leave out the newly arrived and immigrant families, which have high-risk for mental health disorders. The idea was to layer on English language learners status to acknowledge that gap. It is also acknowledged that we are working with proxy measures. Not all English Language Learners have mental health disorders and not every child who is absent from school has a mental health disorder.

  - The Data and Evaluation committee is recommending using the second ranking that includes ELL status. Eight schools are impacted by the addition of ELL status and minimal change to the ranking as a whole. After consultations with Ms. Parrella and others, the Data and Evaluation committee believes that the schools being elevated with the asterisk for the ELL status are likely to show mental health need.

  Corrections were noted regarding two schools included in error in the ranking – a school that is closing and an adult only school.

  Discussion Points:

  - **What tools or data were used to support the mental health pieces with English Language Learners?**
    No data specific to DC regarding English Language Learners status specifically. We have data through the Youth Risk Behavior survey and other national data sets that show kids who are newly arrived immigrants, before, during and after their immigration or just being part of an immigrant family, are much more likely to have mental health disorders.
  - Immigration can put children at greater risk for stress which can put kids at greater risk for certain mental health problems.
  - There is a study that looked at parent stress within undocumented families and the impact on the child's mental health
  - Immigration status can be related to the access to health care

- Not sure that immigrant status connects to greater mental health disorders; it may moderate stress
- **What's the cut off number for schools this year for Cohort 2?** 67 schools
- In the future, it is important to explore access to health care and the connection to triggering a mental health crisis.
- **When using the calculation for out of school suspension, how would we adjust with that because we should be seeing a significant lowering of out of school suspensions?**
  Next year, as schools are re-ranked, we should anticipate that there will be similar impact across all schools, if schools included in cohort 1 and 2 are removed.
- **If Hispanic or non-Hispanic status is the measure and not immigrant status, how are English speaking immigrant populations or non-Latino speaking immigrant populations that are going through similar documentation issues, similar stress factors, lack of access to health care, captured? If they are not ELL yet are immigrants or are ELL and non-Latino?**
  ELL captures all non-English languages not just Spanish. In terms of the Youth Risk Behavior Survey results, there were staggering correlations for Latinas. It's not that it's not capturing it in totality but when looking at rate of suicidality they were extremely high for middle school girls who identified as Latina. This is DC data captured from last year.

Ms. Brumsted noted that the Council needs to remember, although it is easy to focus on tier 3 services, the goal is to build a multi-tiered system of support and to keep in mind what the students within the District have need. It is important to strengthen the school climate and how this program can be used to drive school climate change. Switching to the lens of prevention can ultimately decrease the number of students in tier 3.

Mr. Weeden asked if we are going to take on 100+ schools in the last year of the expansion. Ms. Thompson responded that it remains to be decided regarding the remainder of schools to be added to the expansion in the third year. She believes that DBH is looking to potentially add a 4th year roll-out. It also involves looking at what is needed to manage as well as the capacity to bring on additional schools and partnerships in 1 year. The Coordinating Council should begin to look at the model for schools that are less high need and the supporting of all tiers in schools. The Task Force deliberations noted 3-5 years.

The analysis was done to remain with at-risk as 50% of the weight. The analysis without ELL status, it is 3 times weighted as was done last year and in the analysis with EL status, it is weighted 4 times but in the end either way remains 50% of the overall weight.

Ms. Raiford posed questions to the Council regarding what are the goals and expectations at the Coordinating Council level, school level, and CBO level. Ms. Raiford's questions were noted by Ms. Thompson as being at the core of the broader evaluation framework. We have not dug into that as a body to the degree to know that we have started to answer those questions. We will pick up the questions posed by Ms. Raiford.

Discussion Points:

- **For schools that drop out of the top 67 for cohort 2 due to adding ELL status, is there wiggle room to ensure they can still be added to Cohort 2?**
  Whatever criteria used to define need, is the criteria that will need to be used. It is not intended to essentially do a hybrid of both lists at the same time. This process will happen again next year and will roll out to additional schools at that phase as well. Mr. Weeden stated that it is important to give schools clarity regarding the number of years for the roll-out (i.e., 3-5 years) so that schools may plan.

How do we as a Coordinating Council also layer on whether or not the school in the top 67 has a DBH Clinician currently? Do they have a school mental health team and/or school-based providers? In the interest of keeping things consistent from year to year and knowing in the coming years all schools will have access to these services, the Data and Evaluation committee's recommendation is that a school having a DBH Clinician was not to be a consideration as part of the identification process. Schools have various resources. We are not in a place of weighting one resource over another resource. We remain committed to looking at that question over time, tracking resources, and using the various assessment tools on the front end and throughout.

- Dr. Acosta Price emphasized that having a high need and having an unmet high need are two different things. We don't have an answer yet for unmet need. Being a high need school does not mean they do not have a host of providers and resources and we should distinguish the differences. Every school should have the opportunity to be able to decide collaboratively and identify available resources.
- Mr. Howard stated that as we plan for next year, DCPS has 2 schools that are not accounted for because they are new schools and there is no data yet. One could be a potential challenge depending on how the enrollment rolls out.
- There was an idea stated to ensure that the weighted formula includes community trauma.
- Dr. Schumacher invited input for next year regarding Administrative data that we are systematically collecting that may be considered as a proxy measure.

The Coordinating Council voted on the recommendation approach to determine the next cohort of schools. The recommendation is to use the school data set as described except that the pre-k only is included. The data set is all of the schools, excluding the first year cohort, adult only schools, online schools and secure facilities. The data elements are the OSSE at-risk formula, the IEP, absenteeism and out of school suspension, and English Language Learners. Methodology is using an average z score where the OSSE at-risk formula is weighted equal to the sum of the other individual indicators.

- Mr. Musante, Co-chair entertained a motion. Dr. Price offered a motion to accept the recommendation of the Data and Evaluation committee. The motion received a second. Mr. Musante conducted a vote on the motion and following the nature of the vote -- instructed to let the record show that it was a unanimous vote. School List is approved.

If there are any schools that are closing, the member is to email Ms. Thompson, Dr. Scott, Dr. Schumacher and the co-chairs.

- **Provider Grant RFA update**

The NOFA will be published on April 26th, 2019. The NOFA was uploaded by General Counsel then it was provided to provider network to be uploaded on the DBH website this week.

- **Year 1, it was posted in July.**

C. Guide implementation of all elements of the expansion

- **Provider Training & Support**

  Dr. Scott has a meeting on the 2nd and 4th Monday of every month with the CBOs. The 2nd Monday is in person and a conference call for the 4th Monday. In the meetings, it is sharing of the expertise within the group. So far, we have had presenters from the DBH/SMHP supervisory team who talked about supervision. It is a way to support the providers through our available resources pending the ability of getting the Community of Practice up and running. Also, as DBH/SMHP has trainings for their new clinicians, slots are offered to the CBOs. The next trainings in May and June will be the ***Cognitive Behavioral Intervention for Trauma in Schools*** and ***Bounce Back***.

  Aaron from One Common Unity created a shared folder for the CBOs to place resources to help with presentations. DBH Clinical Specialists are also uploading resources and will be providing trainings to CBOs on multi-tiers of services to provide more awareness for what activities support each tiered system.

  We continue to provide our CBOs with support and technical assistance. On our conference call this month, DC Health Care Finance will talk with us about billing. We want to help providers to have the most sustainable programs.

- **Evaluation**

  The Data and Evaluation Committee and Implementation Committee have also provided support regarding the assessment. We have landed on the fact that what we are conducting with the support from the DC Health Team and DBH team is going to be an assessment in a survey format. Additionally, the Implementation Committee is meeting on 4/19th and will take up the topic of the assessment. We will get the survey up and running and determine what audience and what number to target in each school for the assessment.

- **Family & Youth Committee- Family Partnership Event**

  The Family and Youth committee is holding an event next week. The event will be held on April 23rd at Judiciary Square and LEAs will bring their family team, at least 1 parent and 1 student. The meeting is more of an information exchange than a directive to the schools and to ensure better understanding of what is happening on the ground with student and family partnerships. Dr. Scott will send out the letter to the Coordinating Council.

Budget info

This investment builds on Mayor Browser's FY19 $3 million investment which will remain in the DBH budget. The proposed FY20 budget enhancement has funding to expand to an additional 67 public and public charter schools. During the deliberation as the Coordinating Council, as well as the Task Force on School Mental Health, there was a recognition of the need to invest in a pipeline of clinicians. In the enhancement, there is funding support to create a new school mental health graduate internship program and also funding to expand personnel within DBH.

- There is a total of $9 million because the initial $3 million remains in the DBH budget and $6 million is the proposed FY20 enhancement.
- Mr. Musante stated that we do not want to fall in the trap of building bureaucracy by just adding on more people. He has received questions about the budget and has responded that it is impossible to

have the same amount of people and to do the expansion successfully. It is critical to have staff to grow to support success.

Mr. LeVota flagged that it could still be valuable for the Coordinating Council and the broader community if there was a documented spending plan for the $9 million because there has been a lot of confusion. Given that Dr. Scott is not able to provide details for the procurement bullet, Mr. Musante requested that Mr. LeVota's request be taken up in the first 4 bullets. The following provides the requested information:

- **$3,000,000 remains in DBH budget from the FY19**
- **$4,400,694** to cover an additional 67 schools to be served by Community-Based Organizations (CBOs) at a rate of $53,667 per school totaling $3,595,689 plus $805,005 to fund 15 schools added in FY19. Four schools will be covered by DBH hired Clinical Specialists.
- $**250,000** for a graduate internship program to provide a pipeline for licensed mental health professionals for hire by schools and CBOs to provide school-based behavioral health services.
- **$790,000** for 2 DBH Clinical Specialists; 1 DBH Clinical Specialist Supervisor; 1 Project Manager to focus on the Community Based Organizations; and 2 Grant Monitors.

D. Comprehensive inventory

- **School level information**
- **Share for feedback**

E. Cross-system linkages and coordination- request

F. Workforce Development

Workforce development focus group- looking for volunteers to participate

IV. Next Steps- Strategic Planning Process

Upcoming Committee Meetings:

- Implementation meeting: 4/19 10-1130
- Family and Youth Committee: 4/19
- Data and Evaluation Committee: meeting was last week
- School and Provider readiness: A meeting will be scheduled once the Clinical Specialists develop a document to share with principals about teaming, tiered systems and School Mental Health coordinators. Once the document is complete, the committee will review the document. There will be more tasks of the school and provider readiness committee based on feedback from CBOs to Dr. Nesbitt. There is a need to create a guidance document to assist schools in knowing what questions to ask CBOs as they explore their school's needs and the match of services provided by the CBO. And, there is a need to create a guidance document to assist the CBOs in knowing what questions to ask schools as they seek to learn how the school's needs match their experience and services.

Strategic Planning: Ms. Thompson will determine what tasks are under specific rubrics and reach out. There will be brainstorming possibly in a google doc and the development of a work plan for the Coordinating Council. We will explore the inter-related school initiatives that exist in the District. We will identify the top 10 initiatives and use the Coordinating Council meetings to educate ourselves on those initiatives,

V. Adjourn

Name	Affiliation/Designation	Attendance	Designee	Attendance
Ms. Maureen Akunwafor	DC Public School Teacher	Not Present		
Ms. Erica Barnes	Department of Behavioral Health	Present		
Dr. Lee Beers	Children's National Health System	Present		
Dr. Deitra Bryant-Mallory	District of Columbia Public Schools	Present	Mr. Orin Howard	Present
Ms. Alyssa Conti	District of Columbia Public Charter School Teacher	Not Present		
Ms. Sharon Dietsche	Department of Behavioral Health	Present		
Dr. Kafui Doe	Department of Health	Present		
Ms. Denise Dunbar	Department of Behavioral Health	Present		
Ms. Atiya Frame (Co-Chair)	Department of Behavioral Health	Present		
Councilmember Vincent Gray	DC Council-Committee on Health	Not Present		
Ms. Sharra Greer	Children's Law Center	Not Present		
Councilmember David Grosso	DC Council-Committee on Education	Not Present	Ms. Katrina Forrest	Present
Mr. Orin Howard	District of Columbia Public Schools	Present		
Ms. Sarah Koreishi	Child and Family Services Administration	Not Present		
Mr. Michael Lamb	Non-Core Services Agency Provider	Not Present		
Mr. Mark LeVota	DC Behavioral Health Association	Present		
Dr. Taiwan Lovelace	Department of Behavioral Health	(On Phone-Present)		
Mr. Nathan Luecking	Department of Behavioral Health	(On Phone-Present)		
Mr. Michael Musante (Co-Chair)	Friends of Choice in Urban Schools (FOCUS)	Present		
Mr. Javon Oliver	Department of Health Care Finance	(On Phone-Present)		
Dr. Chioma Oruh	DC Public School Parent	Present		
Ms. Michelle Palmer	Non-Core Services Agency	Not Present	Rebecca Roesch	Present
Ms. Marisa Parrella	Core Services Agency	Present		
Mr. Scott Pearson	DC Public Charter School Board	Not Present	Ms. Audrey Williams	Not Present

Ms. Juanita Price	Core Services Agency	Not Present	Ms. Natasha St.Amand	Present
Dr. Olga Acosta Price	Milken Institute School of Public Health, GWU	Present		
Ms. Shanica Raiford	Youth Representative	Present		
Mr. Justin Ralston	DC Public School Principal	Not Present		
Dr. Heidi Schumacher	Office of the State Superintendent of Education	Present	Ms. Tia Marie Brumsted	Present
Dr. Charneta Scott	Department of Behavioral Health	Present		
Ms. Colleen Sonosky	Department of Health Care Finance	(On Phone-Present)		
Ms. Aurora Steinle	Office of the Deputy Mayor of Education	(On Phone-Present)		
Ms. Sakina Thompson	Office of the Deputy Mayor for Health and Human Services	Present		
Mr. Raymond Weeden	DC Public Charter School Principal Representative	(On Phone-Present)		
Ms. Molly Whalen	DC Public Charter School Parent	Present		

Name	Agency/Position	Phone	E-Mail
Ms. Veronica Watkins	Catholic Charities		
Mrs. Jennifer Allen	DBH		
Mrs. Marie Morilus-Black	MBI		
Ms. Corinne Meijer	MBI		
Ms. Moriam Animashaun	DC Health		
Dr. Crystal Williams	DBH		
Ms. Lovannia Dofat	Catholic Charities		
Mr. David Esquith	OSSE		
Mr. Andre Edwards	DBH		
Mr. C.Kohlritser	DBH		
Mr. Andre Edwards	DBH		
Ms. Tiffany Wise	DC Health		