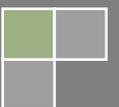


2011

CSA Annual Report

*Fairfax-Falls Church Community Policy
and Management Team*

*Comprehensive Services Act for At-Risk
Youth and Families*



CSA: Purpose and Intent

The Comprehensive Services Act for At-Risk Youth and Families (CSA) is a Virginia law (§2.2-5200) enacted in 1993 to address the rising cost of residential treatment for high-risk youth. It was the stated intention of CSA to create a collaborative system of services and funding that is child-centered, family-focused and community-based when addressing the strengths and needs of troubled and at-risk youths and their families in the Commonwealth. The purpose includes the following key objectives:

- Ensure that services and funding are consistent with the Commonwealth's policies of preserving families and providing the appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public;*
- Identify and intervene early with young children and their families who are at risk of developing emotional or behavioral problems, or both, due to environmental, physical or psychological stress;*
- Design and provide services that are responsive to the unique and diverse strengths and needs of troubled youths and families;*
- Increase interagency collaboration and family involvement in service delivery and management;*
- Encourage a public and private partnership in the delivery of services to troubled and at-risk youths and their families; and*
- Provide communities flexibility in the use of funds and to authorize communities to make decisions and be accountable for providing services in concert with these purposes.*

The Evolution of CSA: Systems of Care Reform

The Comprehensive Services Act for At-risk Youth and Families (CSA) has changed since its early years of implementation. The most recent major developments were prompted by practice issues and fiscal concerns. In November 2008, a Systems of Care (SOC) Reform initiative was undertaken by Fairfax county government, the public schools, and the provider community to address the growth in expenditures for services and supports associated with the Comprehensive Services Act for At-Risk Youth and Families (CSA). CSA expenditures had increased by over 25% between FY 2006 and FY 2008, and were expected to continue to rise. Costs for residential care were 42.4% of all CSA state pool expenditures in FY 07.

In a state-wide analysis conducted at this time of the CSA program, the following concerns were also noted:

- Virginia had too many children in residential care
- Some children were placed in more restrictive, intensive settings than necessary
- Children were staying in residential care too long
- Very few (5%) children in foster care were placed with families and relatives
- Too many children aged out of foster care without achieving permanency

The goals of the SOC reform initiative were:

- Reduce the number of children in residential and group home placements by 33%
- Limit lengths of stay to 6 – 9 months for children with serious emotional/behavioral problems
- Limit FY 09 and 10 expenditures to FY 08 actual expenditures

The work and recommendations developed by the SOC reform initiative can be found in the SOC Services Committee report completed in September 2009, the Developmental Disabilities report completed in June 2010, and the Family & Youth Advocacy/Engagement Committee in July, 2010.

In addition to these local efforts, the state was also engaged in a multi-

year strategy, launched in November, 2007, to establish a Children's Services System Transformation initiative. Thirteen localities, including Fairfax, were invited to serve on the Council on Reform (CORE) to collaboratively plan and implement the following critical reforms targeted at improving outcomes in child welfare at state and local levels:

- To adopt a state-wide philosophy that supports family-focused, child-centered, community-based care with a focus on permanence for all children,
- To establish a state-level practice model reinforced by a uniform training program for resource families as well as local staff in DSS and CSA,
- To create and implement a statewide strategy to increase availability and utilization of relative care and non-relative foster and adoptive placements to ensure that children can be placed in the most family-like setting that meets their needs, and
- To create a robust performance monitoring/quality assurance system to identify and measure outcomes, monitor quality of practice, and improve accountability.

These state and local initiatives have resulted in new services and redesigned processes intended to provide a seamless, improved, cost-effective service approach using the Systems of Care model for all youth by creating and implementing new community-based resources in Fairfax-Falls Church. The reform efforts yielded the following short-term results:

- The goal for reducing CSA expenditures in FY 09 and FY 10 to below FY 08 actual expenditures was met.
- Placements in residential and group home programs were reduced by 21% from 157 youth in January, 2009 to 124 in January, 2010.
- The average length of stay for youth with emotional/behavioral problems in their current placement was within the 6-9 month timeframe; however, cumulative length of stay across placements continues to be a concern.

The Origin of CSA

With the passage of the Comprehensive Services Act, the Virginia General Assembly established one of the nation's first comprehensive systems of care for at-risk youth. This system was put into place to provide treatment services for the growing number of children who exhibit serious emotional and behavioral problems.

The passage of CSA was prompted by numerous problems that plagued the previous system that provided services for at-risk children. Among these problems were a fragmented service delivery system that fostered duplication in the provision of treatment services, and a funding structure that created local incentives to arrange for counseling and related services in the most restrictive and expensive settings.

Through CSA, the General Assembly sought to correct these problems in three ways. First, resources from the multiple funding streams that supported the previous system were combined into one pool of funds. Second, local agencies that are responsible for the provision of services to at-risk children were encouraged to form collaborative arrangements and use the pooled funds to deliver non-duplicative services in the least restrictive settings possible. Finally, to ensure that local CSA programming would not be constrained by State regulations, the General Assembly organized the State structure and leadership for the program with a council of State officials rather than a single agency; gave many of the program oversight responsibilities to local officials; and provided local jurisdictions with the flexibility believed needed to develop and implement service plans for at-risk children. *From Joint Legislative Audit and Review Commission review of the Comprehensive Services Act, 1998*

FY 2011 Outcome Goals

CSA System of Care Outcome Goals for FY 2011 were developed by the SOC Accountability and Stewardship Workgroup consisting of key agency directors and approved by the CPMT. These goals consist of:

- Functional outcomes for youth
- Permanency measures for youth in foster care ¹
- Restrictiveness of living
- Fiscal accountability indices

The CPMT will establish quality and outcome targets for FY 2012 after review of the FY 2011 annual data.

Scope of Annual Report

The efforts at system change have occurred within many agencies and have been at many levels of service delivery within our child-serving county agencies. This report cannot adequately reflect the valuable work of agency staff and the significant progress achieved within individual agencies and at other levels of the system as a whole. This report, therefore, is limited in scope to describing the impact of the system of care initiative on the CSA program and the current status of the SOC initiative as it relates to CSA functions.

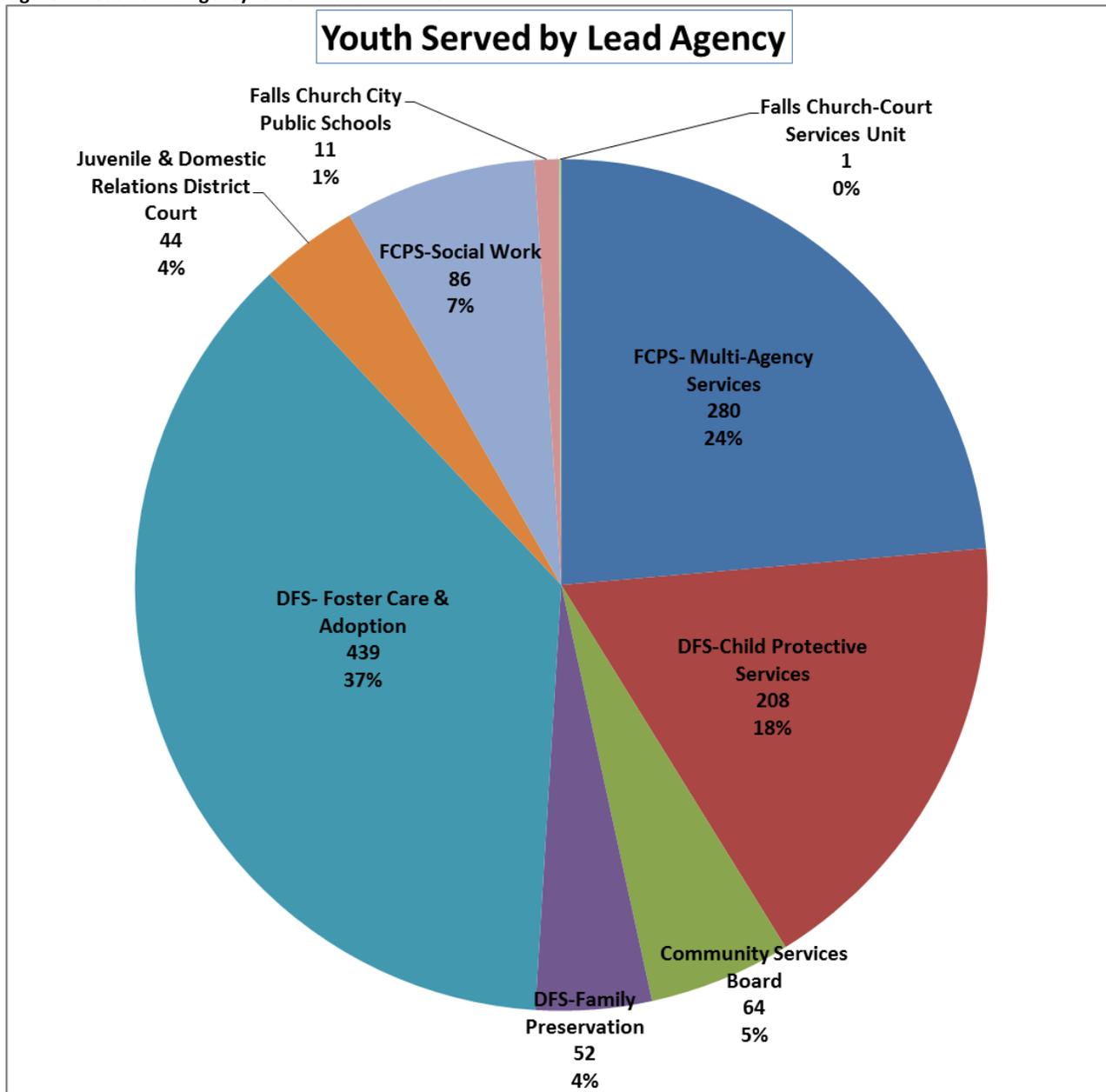


¹ Permanency measures for foster care youth have recently been revised by the state and will not be included in this report.

CSA serves youth from across the schools and public child-serving agencies

Referrals to the CSA program are made by staff from the schools and public child-serving agencies who then function as the lead public agency case manager on behalf of the youth and family. 213 different staff served as lead case manager for CSA-funded youth in FY 2011. The DFS Foster Care & Adoptions program continues to have the greatest share of youth funded by CSA due to the mandates for child welfare services. Youth receiving foster care services account for 37% of the CSA youth; however, lead case management by DFS Child Protective Services (18%) and Family Preservation (4%) result in a total of 59% of youth in CSA involved in our child welfare system. The public schools provide lead agency case management for 24% of youth who receive private special education services through their Individualized Education Program (IEP), 7% by school social workers in FCPS and 1% by Falls Church City school social workers. The Community Services Board (CSB) and juvenile court manage the remaining 5% and 4% of the youth respectively.

Figure 1: Lead Public Agency for CSA Youth in FY 2011



Youth Served in Fairfax-Falls Church CSA

The following table summarizes demographic characteristics for youth served through CSA funding. The majority of youth in CSA are over the age of 12 (62%) and are predominantly male (60%). The most notable change in demographics is the decline in youth served who are identified as Hispanic. The number of youth served varies by approximately 100 youth each year, and on average Fairfax-Falls Church CSA serves 1,100 youth annually. In FY 2011 just over one hundred more youth were served compared to the prior year.

Characteristics of Youth Served in CSA Across Fiscal Years						
		2007	2008	2009	2010	2011
Age						
	0 to 3	10%	10%	9%	10%	9%
	4 to 6	7%	6%	6%	6%	7%
	7 to 12	21%	22%	21%	21%	21.5%
	13 to 17	44%	41%	43%	41%	41%
	18 to 21+	17%	20%	21%	22%	21.5%
Gender						
	Male	58%	60%	58%	59%	59%
	Female	41%	40%	42%	41%	41%
Race						
	White	51%	52%	51%	52%	55%
	Black/African American	33%	32%	31%	28%	26%
	Asian	0%	0%	3%	3%	4%
	Other	14%	17%	14%	16%	15%
	Hispanic	13%	11%	11%	10%	8%
Referral Source						
	Family Services	26%	38%	42%	48%	51%
	Education	8%	12%	20%	23%	26%
	Juvenile Justice	2%	5%	6%	6%	5%
	CSB	1%	3%	4%	6%	6%
	Interagency	60%	39%	26%	17%	12%
	Family	0%	0%	0%	0%	0%
	Other	2%	1%	1%	1%	0%
	Health Department	0%	0%	0%	0	0%
Total Youth Served		1110	1076	1121	1090	1191

Figure 2: Demographic Characteristics of Youth Served in Fairfax-Falls Church CSA

Fewer youth are placed in long-term congregate care

The Systems of Care reform initiative established a goal of increasing the number of youth who reside in family settings. Tracking and reporting about utilization of long-term residential and group home programs is on-going. Point in Time (PIT) counts for residential and group home placements have been reported quarterly since 2008 and these placements have been gradually declining. In the chart below, the PIT count at the end of the last four fiscal years illustrates our system's success in serving more youth in the community.

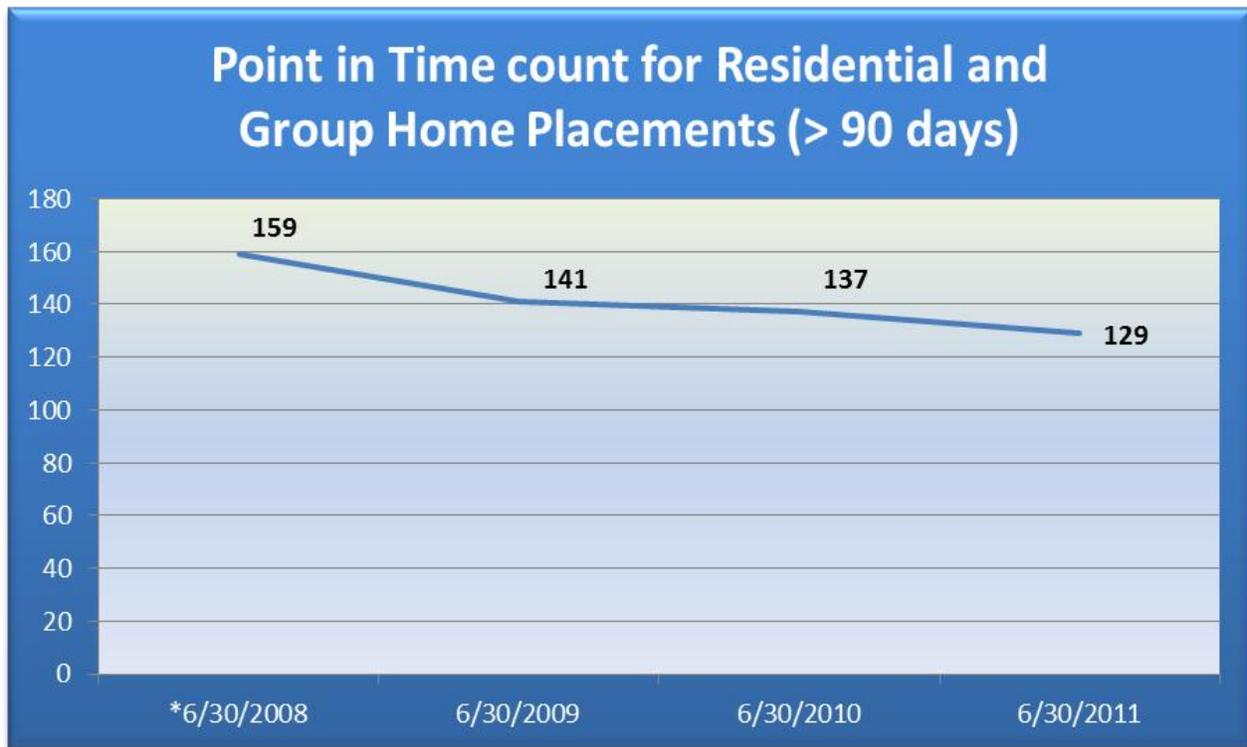


Figure 3: Residential and Group Home Point in Time (PIT) counts for fiscal year end

System of Care goal is for youth in Out-of-home placements to be returned home as quickly as possible. Length of stay remains a system-wide challenge.

Best practice standards indicate that youth with emotional/behavioral challenges receive maximum treatment benefit after residential stays no longer than 6 – 9 months². For youth with emotional/behavioral challenges from our system, the average length of stay (LOS) in their current placement was 276 days as of the end of FY 11. For youth with developmental disabilities, their average LOS in current placement was 1050 days. Youth with developmental disabilities (DD) received an average of 1.62 placements. 22 of the youth with DD have had one placement, 6 youth have had 2 consecutive placements, and 6 youth have had 3 – 4 consecutive placements. 15 of the youth with DD have been in a congregate care setting for four years or longer. Youth whose primary needs are related to emotional/behavioral problems had an average cumulative LOS of 630 days across RTC and GH settings. The average number of placements per youth was 2.39. 35 youth had one placement, 31 youth had two placements, and 32 youth had 3 or more placements.

² Lyons, J.L. and Schneider, A. (2008) An Analysis of the Needs and Strengths of Children and Youth living in Fairfax County, Virginia who were served in residential treatment. Report presented to the Fairfax-Falls Church CPMT in August, 2008.

Services provided to youth and their families have resulted in positive functional outcomes

Youth and family outcomes were measured using the Child and Adolescent Needs and Strengths (CANS) Assessment³ tool that was adopted by Virginia as the mandatory uniform assessment for all CSA-funded youth beginning July, 2009. The analysis of youth and family outcomes was conducted by comparing the initial CANS ratings upon entering the CSA system of care to the youth’s most recent rating in FY 2011. Of the 1,191 youth served in FY 2011, there were 836 youth who had two CANS assessments that would allow for comparison. Only items with ratings of 2 and 3 (moderate and severe) which are considered the “Actionable” level of need were included in the analysis to determine the percentage of youth where the target behavior(s) were rated as improved/better, stayed the same, or were rated as worse. Each chart indicates the prevalence of the need within the youth sampled. Outcomes were calculated at the Domain level which averages the percentages of improvement (better, same, worse) across the items. Outcomes were also calculated at the item level by Domain.

Youth and Family Outcomes across CANS Domains

In Figure 4 below, percentages were aggregated across each CANS domain. After receiving services, 71% of youth and their caregivers received lower ratings on the CANS

CANS Overview

The Child and Adolescent Needs and Strengths (CANS) assessment is a multi-purpose tool developed for children’s services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Case managers, along with youth, families and other stakeholders, complete the CANS as part of the service planning process and CANS ratings are required at defined intervals by service type throughout the duration of service provision.

The CANS contains six domains: Life Domain Functioning, Child Strengths, School, Caregiver Strengths and Needs, Child Behavioral/Emotional Needs, and Child Risk Behaviors. Each of the items within the domains is rated along a continuum: 0 = No evidence; 1 = Watchful waiting/prevention; 2 = Action; 3 = Immediate/Intensive Action. The Child Strengths Domain is rated: 0 = Centerpiece strength; 1 = Strength useful in planning; 2 = Strength identified but must be developed; 3 = No strength identified. – Praed Foundation

domains, Risk Behaviors and Caregiver Strengths and Needs. 61% of youth were as improved on the School domain. The lowest percentage of improvement was noted for Youth Strengths. This finding may indicate that services are not as focused on strengths identification and strengths-building in service delivery as they are in risk-reduction and focus on problem behavior. Case managers’ ratings revealed a small percentage of youth and families were “worse” after receipt of services, ranging from 7% worse in the Life Functioning Domain to 3% worse in the Risk Behavior Domain.

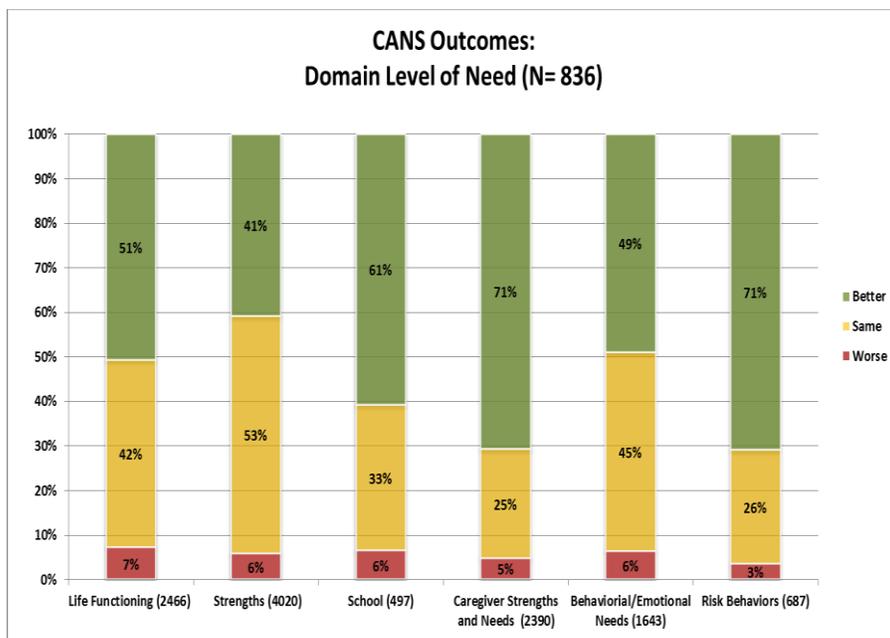


Figure 4: Youth and Family Outcomes across CANS Domains

³ For more information about the CANS see <http://praedfoundation.org/About%20the%20CANS.html>

Youth outcomes within CANS domains

The Life Functioning Domain provides a broad assessment of needs across important aspects of youth daily functioning. Figure 5 displays the results in order of highest percentage of youth rated as “better” after receiving services. Each item also indicates the number of youth with ratings of “2- moderate” and “3- severe.” 73% of the youth who were rated in their initial assessment as having moderate to severe needs related to Sexual Development were rated as better or improved. Youth with moderate to severe needs in the areas of Communication and Developmental showed the smallest percentage of improvement, 32% and 31% respectively, which is consistent

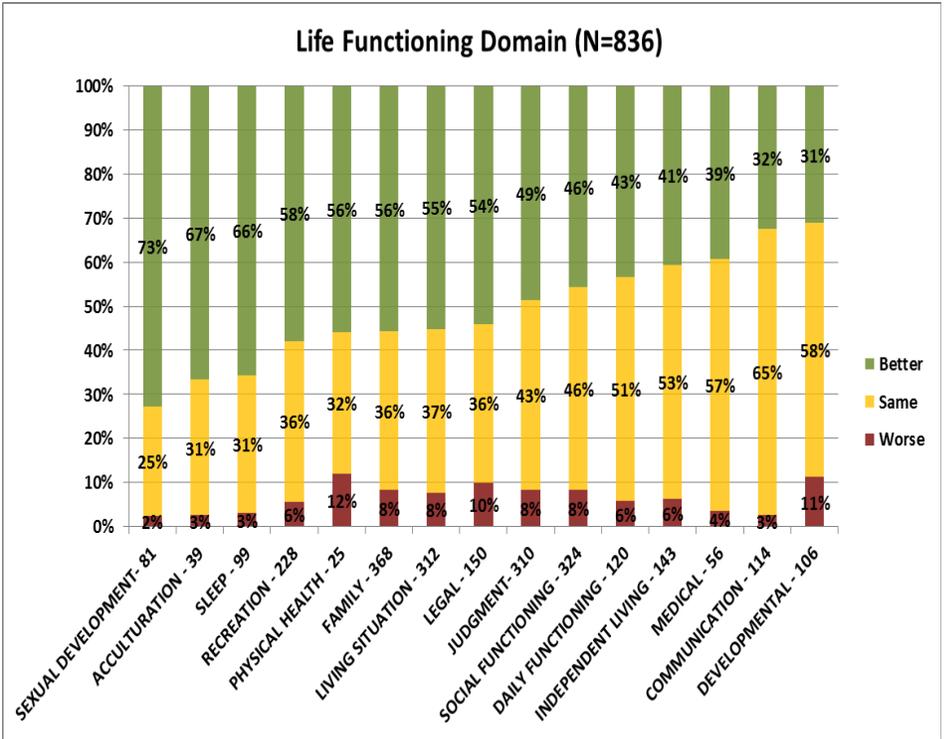


Figure 5: Youth Outcomes on CANS Life Functioning Domain

with these items measuring developmental disabilities. The needs with the highest frequency was Family (n=368), Social Functioning (n=324), and Living Situation (n=312).

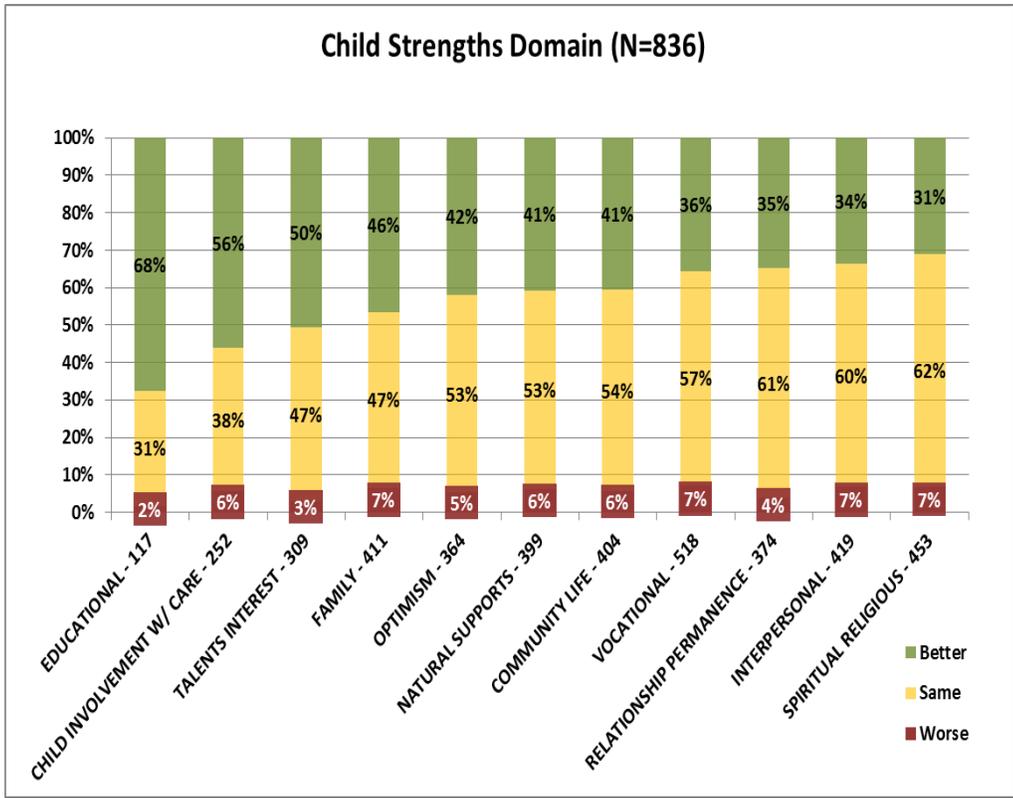
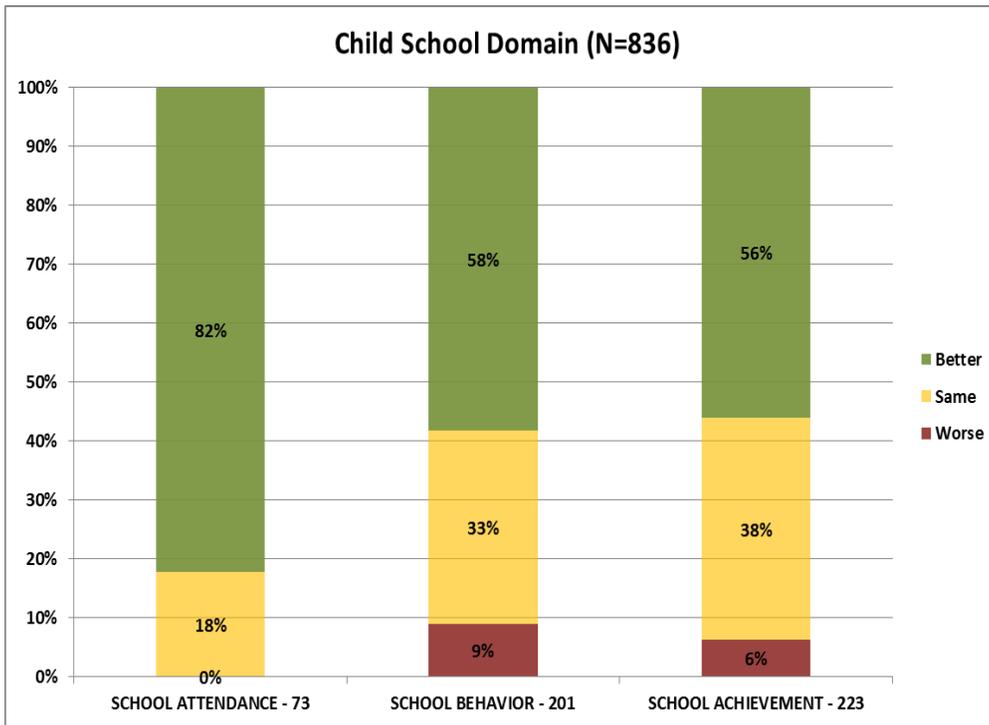


Figure 6: Youth Outcomes on CANS Strengths Domain

for traditional behavioral health care services to focus primarily on needs rather than strengths.

On the Child Strengths Domain, the most frequently identified strength was Vocational (n=518), Spiritual/ Religious (n=453), Interpersonal (n=419) and Family (n=411). 68% of youth were rated as better on Educational strengths after receiving services. For the majority of the items in this domain, youth were rated as remaining the same, ranging from 53% to 62% of youth making no progress towards strengths-building. This pattern has been noted previously in the literature regarding CANS outcomes and likely reflects a tendency



The School domain on the CANS consists of three items – Attendance, Behavior and Achievement. Needs related to Achievement were the most common (n=223) and Attendance was the least commonly identified on this domain (n=73), but was the most responsive to services with 82% of youth rated as better. Behavior and Achievement were rated as improved for 58% and 56% of youth, respectively.

Figure 7: Youth Outcomes on CANS School Domain

The Behavioral/ Emotional Needs domain provides important information about the mental health needs for youth who are referred to CSA for services. The frequency of severe to moderate needs describes the population served. Based on the frequency that items were rated as 2 or 3 which is considered “Actionable,” youth in CSA are presenting with issues related to Impulsivity/ Hyperactivity (N= 297), Oppositional (N= 254), Anger Control (N=244), and Depression (N= 213). Difficulties with Adjustment to Trauma and Anxiety were also regularly endorsed. Substance use was endorsed 51 youth. Psychosis (n=25) and Eating Disturbance (n=19) appear to be less common within the CSA system of care according to these ratings.

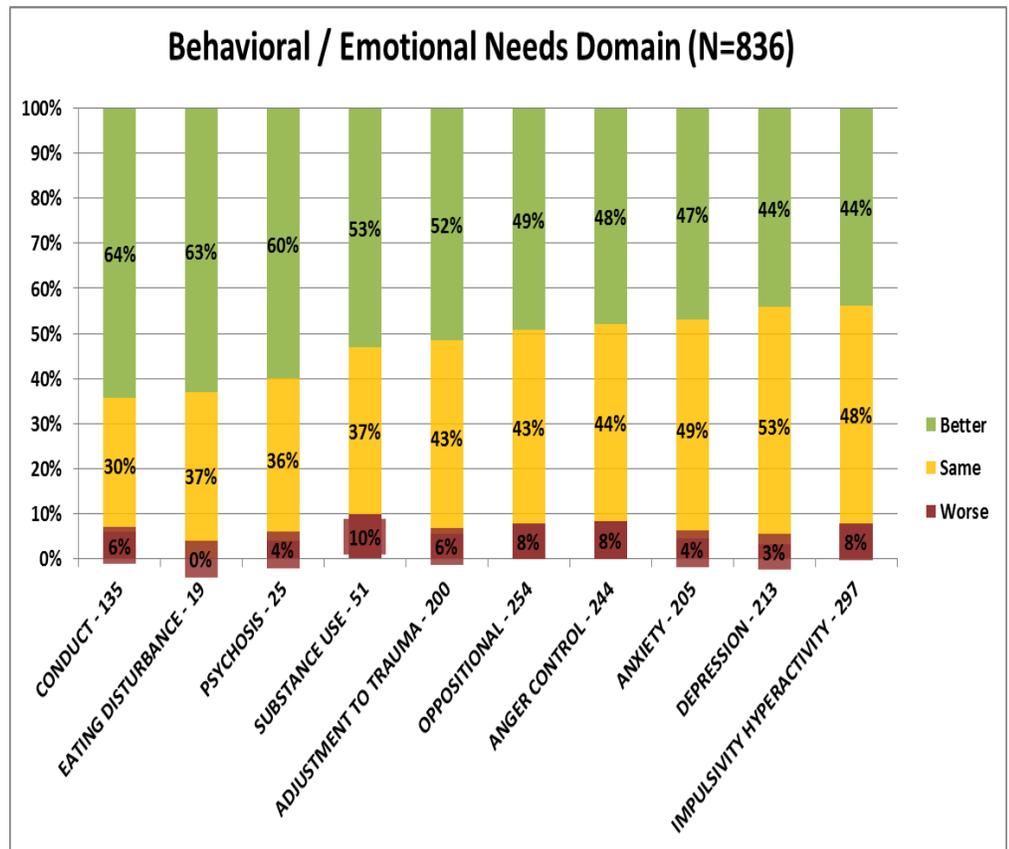


Figure 8: Youth Outcomes for CANS Behavioral/ Emotional Needs Domain

On the Risk Behavior domain, youth outcomes range from 82% improved on ratings of Sexual Aggression to 64% youth improved on Self-Mutilation. Risk behaviors appear to be generally very responsive to services. The percentage of youth who were rated as getting worse ranged from 7% on Runaway, 6% on Delinquent Behavior to 0% on Sexual Aggression and Sexually Reactive Behavior. Prevalence of risk behaviors revealed that 141 youth were rated as having an “Actionable” need on Social Behavior (n=141), Danger to Others (n=81), Suicide Risk (n=72), and Bullying (n=66). Sexual Aggression (n=34) and Fire setting (n=9) were of the lowest frequency in this sample of youth.

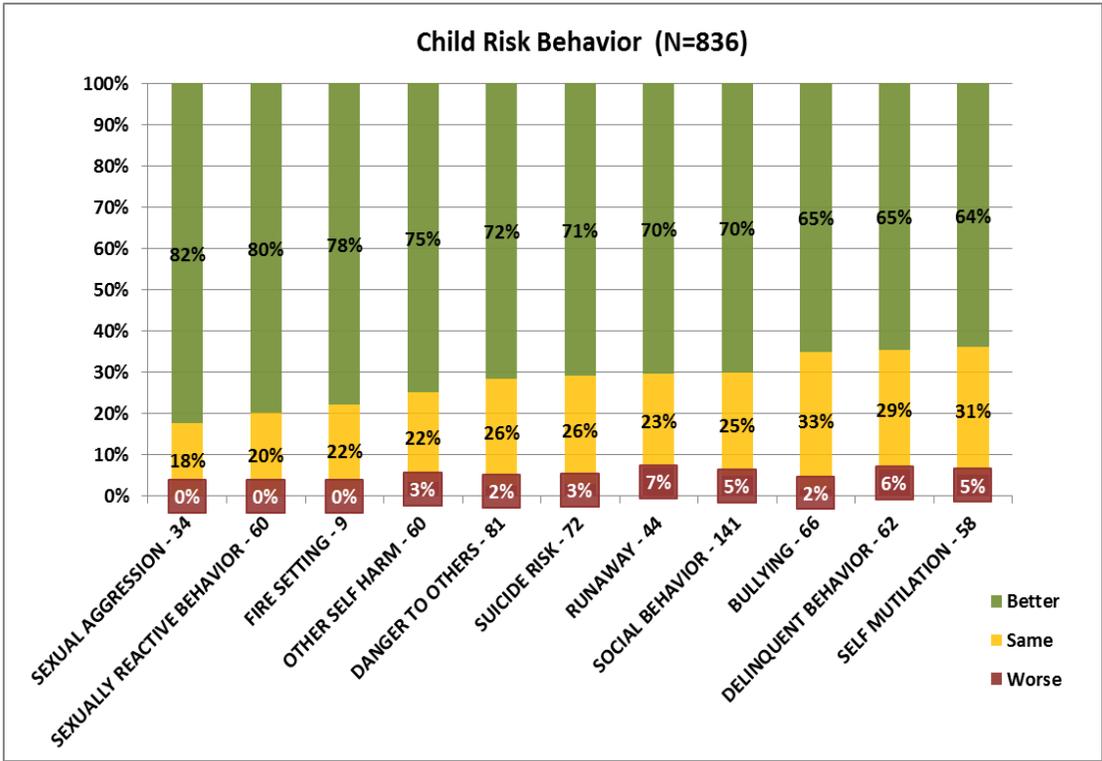


Figure 9: Youth Outcomes for CANS Risk Behavior Domain

Parents are generally “Satisfied” with CSA-funded services

At the end of each fiscal year, parents of youth who have received services under the Foster Care Prevention, Special Education, and Non-mandated funding categories receive a survey asking them to rate their satisfaction with CSA services. Families involved with DFS through Child Protective Services and Foster Care and Adoptions are not included in the survey due to the sometimes involuntary nature of their service plans. The survey solicits family feedback about the perceived helpfulness of services, their participation in the planning process, respect shown to families by staff, and the perceived quality of services provided. The satisfaction ratings are calculated by averaging each person’s response, then the number of Positive Response (3.0 or better) is divided by Total Responses for an Overall Rate of Positive Response. In the past three fiscal years, an average of 500 surveys has been sent out to families, and the average response rate has been 17%.

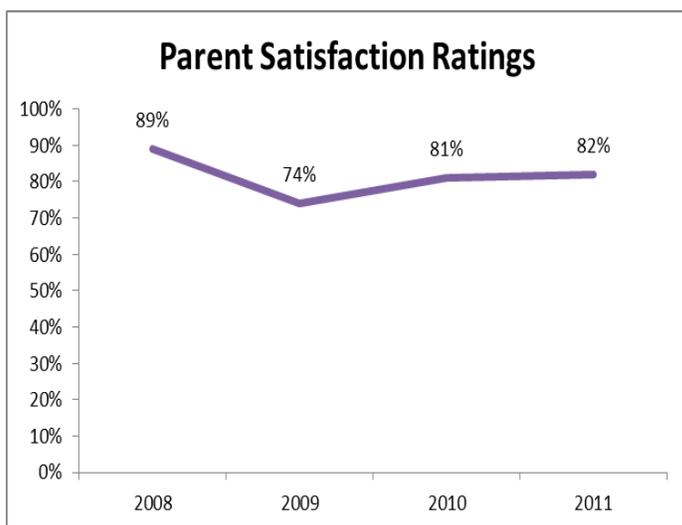


Figure 10: Parent Satisfaction Survey Results

Rising CSA expenditures in previous fiscal years prompted SOC reforms

FY 2011 expenditures were \$39.7 million which is an increase of \$ 2.6 million from the previous fiscal year.

Although expenditures have increased, they did not reach the peak attained in FY 2008. As noted previously, CSA expenditures had increased by over 25% between FY 2006 and FY 2008 which prompted changes in policies and processes to contain costs and reform practice. Overall expenditures for the CSA program remain a concern requiring on-going coordinated action by stakeholder agencies.

The analysis of expenditure trends for this past fiscal year shows increases in the following four areas:

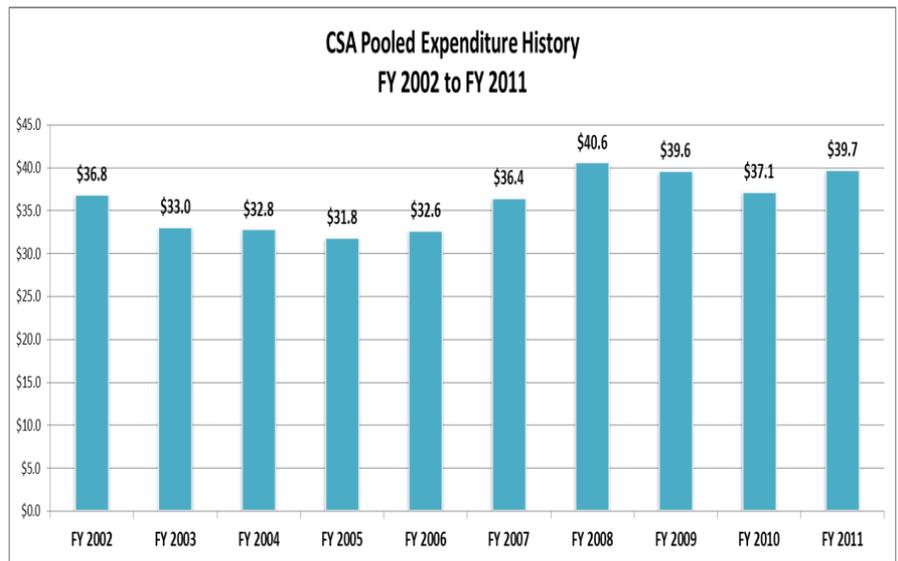


Figure 11: Total CSA Pooled Expenditures across Fiscal Years

1. Private Day IEP services – increased by \$1.3 million, # youth served increased
2. Treatment Foster Care (TFC) Services – increased by \$0.9 million, # youth served decreased
3. Residential IEP services – increased by \$1.2 million, # youth served stable
4. Community-based interventions – increased by \$0.5 million, # youth served increased

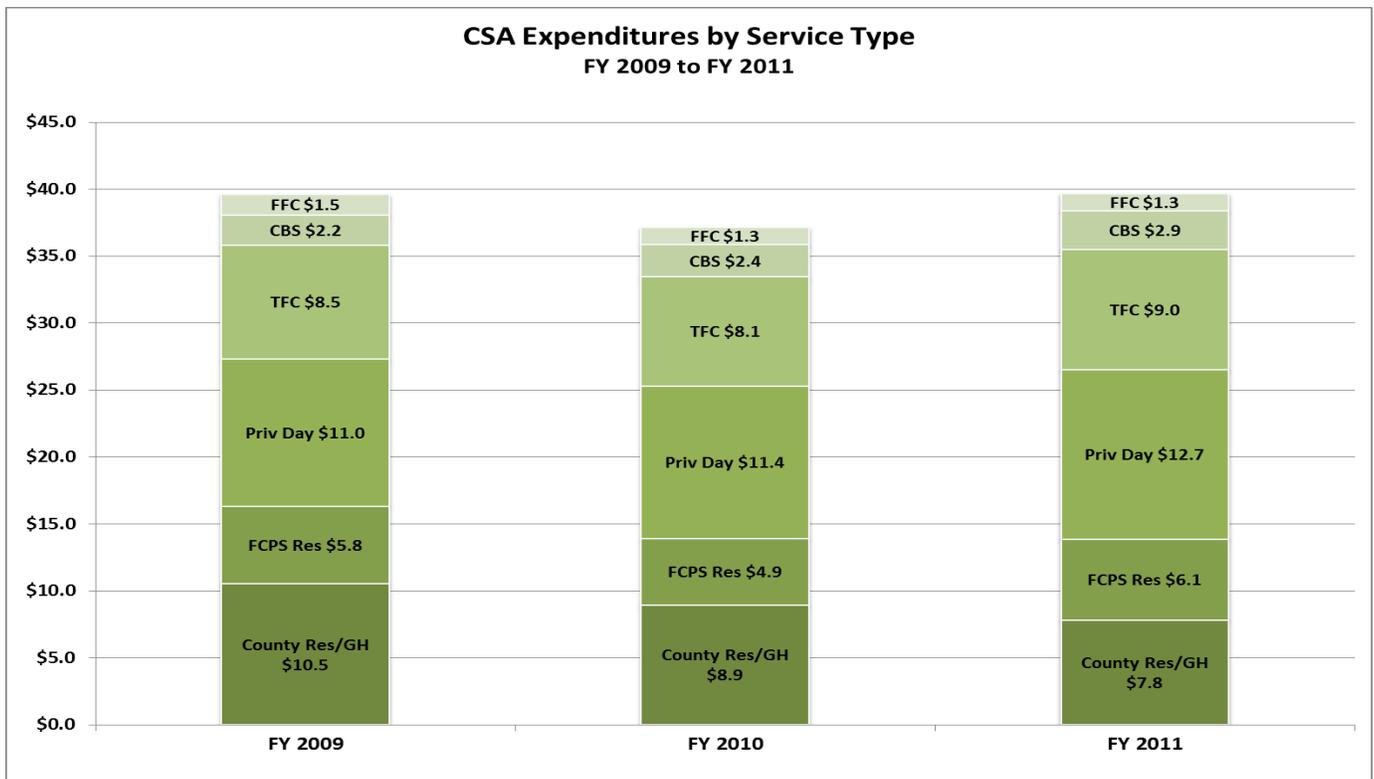


Figure 12: CSA Expenditures by Service types labeled as FFC - Family Foster Care; CBS - Community-based Service; TFC - Treatment Foster Care; Priv Day - Private Day School; FCPS Res - Residential IEP; County Res/GH - Residential treatment or group home placement by county agency

Utilization and Expenditures for Private Day IEP services increased in FY 2011

Expenditures for Private Day school programs have increased over the past three fiscal years. Some Private Day placements are not initiated by the IEP process but are associated with group home placements for youth who are placed by county agencies in other parts of the state. If the school system where the group home is located cannot meet the youths' educational needs, an IEP will be developed for the youths' educational programming. Expenditures associated with this type of Private Day program are noted as "County" in the chart and are also known as "Other Agency Placed" by FCPS MAS staff. Private Day services that are determined by the IEP process solely for educational purposes are noted as "FCPS" in the chart. Please note that the "FCPS" figures also include the private day placements for Falls-Church City Public Schools.

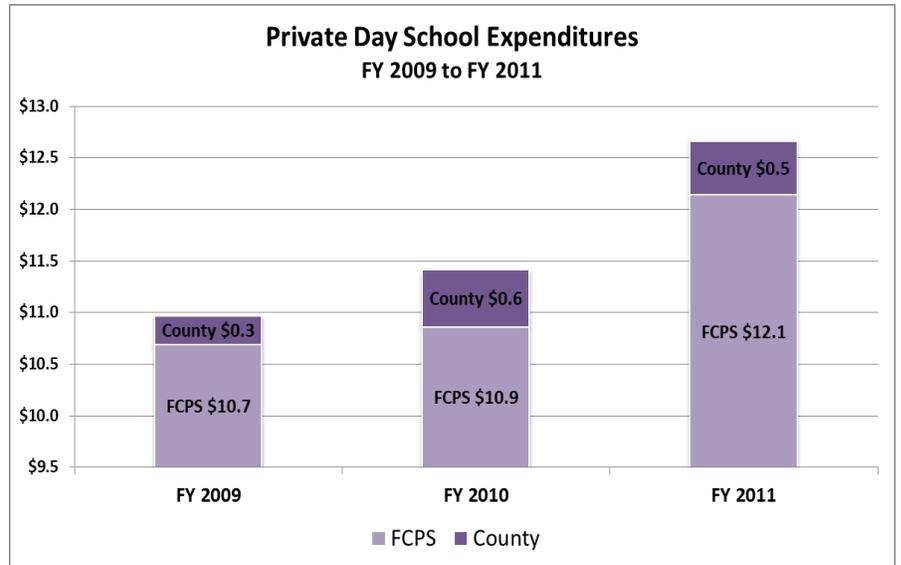


Figure 13: Expenditures for Private Day Schools across Fiscal Years

As shown in the chart, expenditures for the "FCPS" Private Day services have increased by \$1.2 million in the past fiscal year. The number of youth served in Private Day has increased by 21 youth.

One factor related to cost is youth disability and/or type of program. Private Day schools that serve youth with Autism and other developmental disabilities (DD) are typically more intensive and therefore, expensive than schools

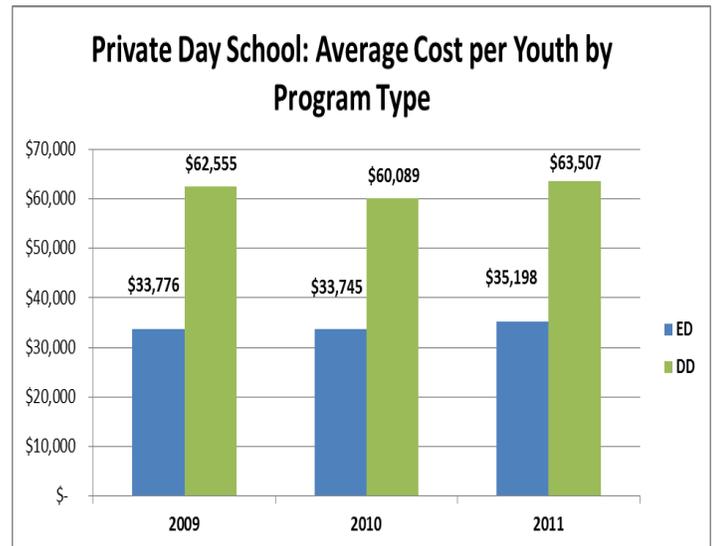


Figure 14: Average Cost of Private Day School by Program Type

designed to serve youth with emotional disabilities (ED). When private day expenditures were divided by program type (DD vs. ED), the cost per student is significantly higher for DD programs.

As the composition of students served in Private Day programs includes more youth with DD, expenditures in this area will likely continue to rise.

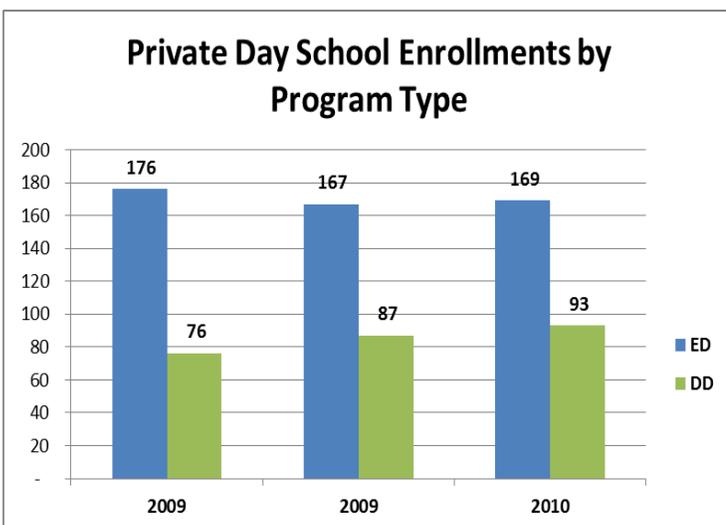


Figure 15: Private Day School Utilization by Program Type

Expenditures for Treatment Foster Care services continue to rise

Expenditures for Treatment/Therapeutic Foster Care (TFC) services increased by \$0.9 million in FY 11. However, the number of youth served decreased by 12% or 33 youth.

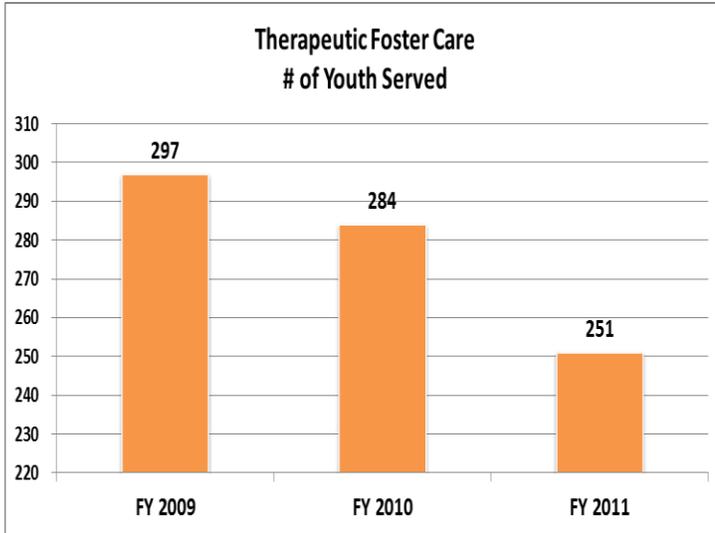


Figure 16: Youth Served in TFC across Fiscal Years

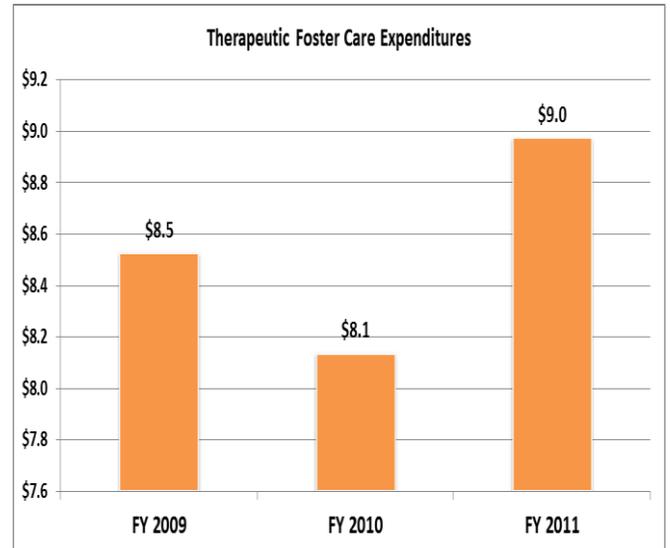


Figure 17: Therapeutic Foster Care Expenditures across Fiscal Years

The average cost per youth served in TFC is over \$35,000 annually. Further review of the services provided to youth in TFC confirms findings from

earlier fiscal analysis of TFC provided to the CPMT. Cost increases are in the following areas:

- Payments to foster parents for “Additional Daily Supervision”
- Teen services or after-school programming
- Transportation
- Home-based services

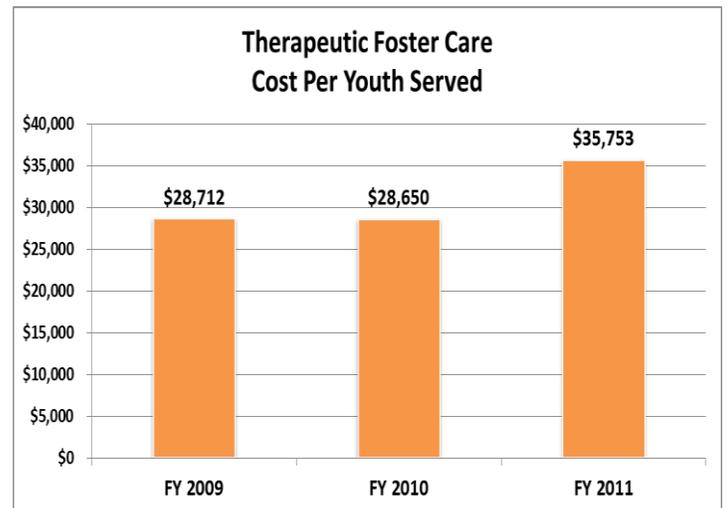


Figure 18: Cost of TFC per Youth Served across Fiscal Years

Costs for Additional Daily Supervision (ADS) have risen by approximately \$250,000 from FY10 to FY11. Federal IV-E funding covers ADS payments for youth who qualify; however, fewer youth in Fairfax meet the criteria and the costs are then covered by CSA. In addition, the implementation of the Virginia Enhanced Maintenance Assessment Tool (VEMAT), an attempt to standardize payments to families for youth with special needs, appears to have resulted in higher payments to foster parents. Services provided to teens in after-school therapeutic programming have also risen by approximately \$250,000 in the past year. Transportation services for youth to attend visitation with their families and other appointments has increased by \$150,000. Finally, expenditures for home-based services that are focused on supervised visitation and reunification efforts have risen by \$100,000 this past fiscal year. The number of youth receiving TFC services has decreased in the past few years, reflecting the reduced number of youth in foster care. It is possible that the youth who remain in TFC require more intensive and thus costly services in order to maintain them in the community and/or achieve their permanency goals.

Costs for Residential IEP services increased

In FY 11, expenditures rose by \$1.2 million for IEP residential services; the number of youth receiving residential programming was relatively stable, increasing only by 2 youth.

The cost per youth served in residential to fulfill their IEP is over \$116,000 per year. This average is much higher than for youth who receive residential programming under other mandate categories. As documented in CPMT quarterly data reports, IEP residential placements are less likely to be supported by Medicaid funding. Therefore, the full cost of services is covered by state and local CSA pooled funds.

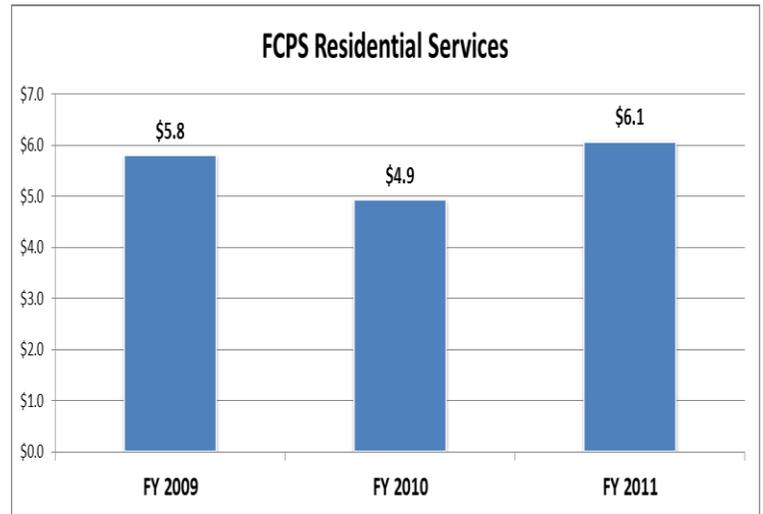


Figure 19: FCPS IEP Residential Services Expenditures

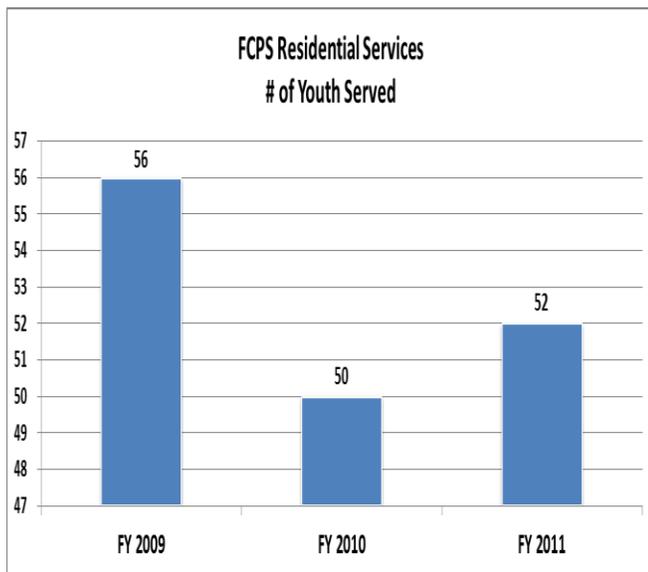


Figure 20: Youth Served by FCPS IEP Residential Services

In addition, youth with developmental disabilities often require programming that is more intensive and therefore costly. The county has been successful in partnering with some private providers to utilize the Early, Periodic, Screening Diagnosis, and Treatment (EPSDT) program within Medicaid to cover costs associated with the care of youth with developmental disabilities. Youth served under the IEP are eligible for this Medicaid program when placed with a Medicaid-enrolled provider and when families are agreeable to applying for Medicaid for those youth who are not already enrolled.

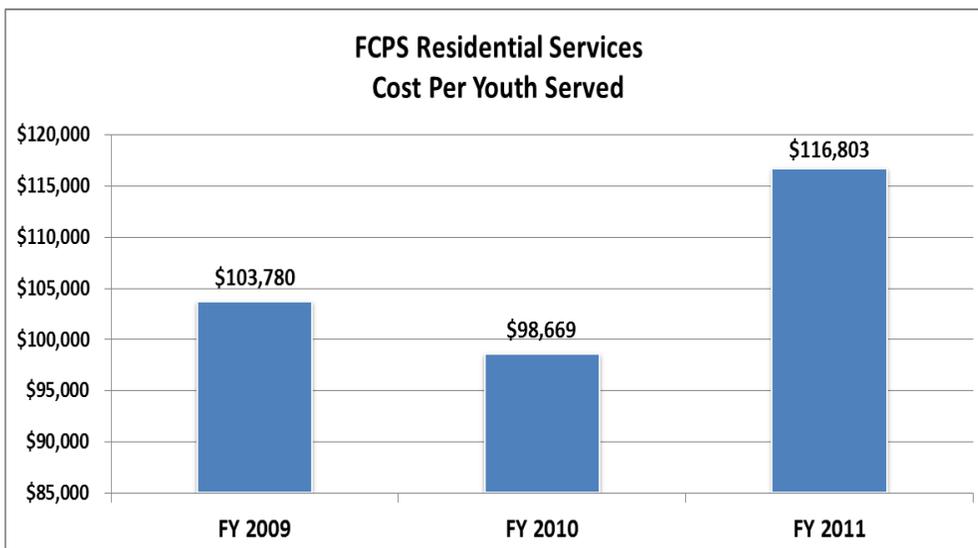


Figure 21: Cost per Youth for FCPS Residential IEP Services

Residential expenditures for other mandate categories have decreased

The expenditures decreased by \$1.1 million in FY 11 for short-term and long-term residential services for youth referred by county agencies. 269 youth were served across the various mandate categories. Placements at Leland

House and other short-term programs likely accounts for the increases noted in the number of youth served and has likely reduced the average cost per youth. It is important to note that although more youth were served, the expenditures decreased for residential services.

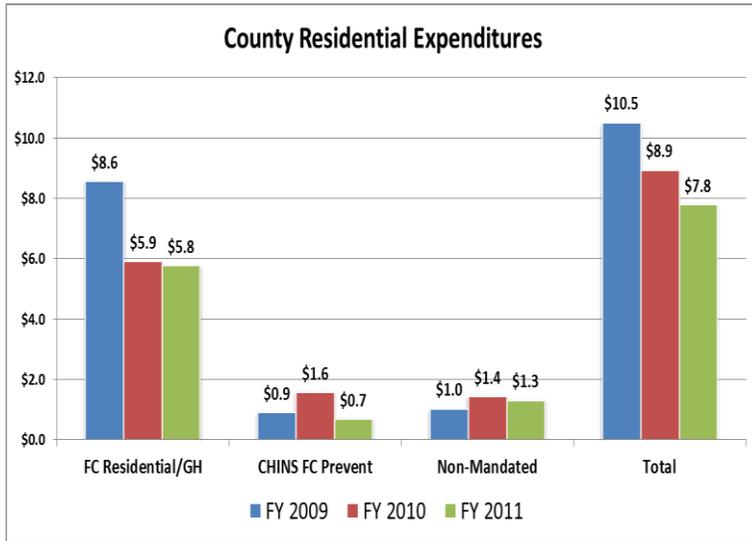


Figure 22: Expenditures for County Agency Residential and Group Home Placements

Overall, the average cost per youth is fairly low, compared to the cost for TFC and for Residential IEP services. This analysis does include the costs for “short-term” out-of-home programs such as Leland House for crisis stabilization services. Inclusion of short-term programs accounts for some of the reduced per child cost. In addition, the VA code requires staff to utilize medicaid-enrolled programs and medicaid funding for services whenever available and appropriate. These cost figures

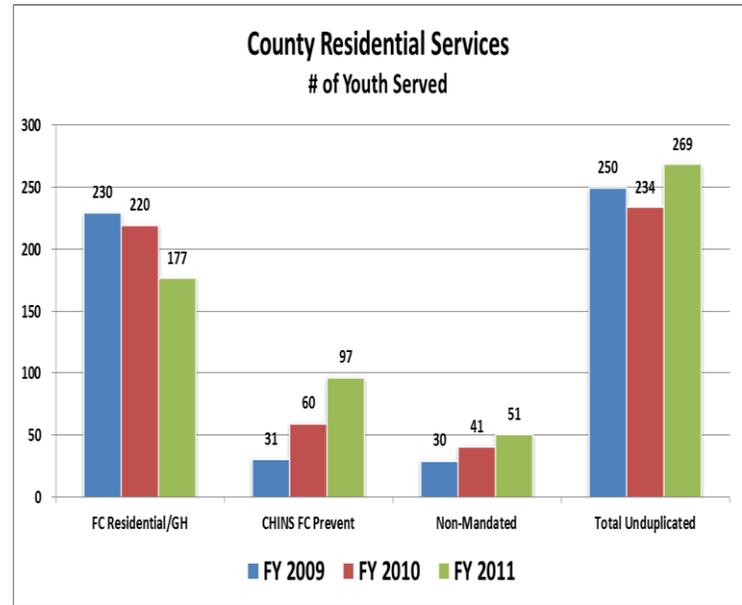


Figure 23: Youth Served by County Agency Residential and Group Home Placements

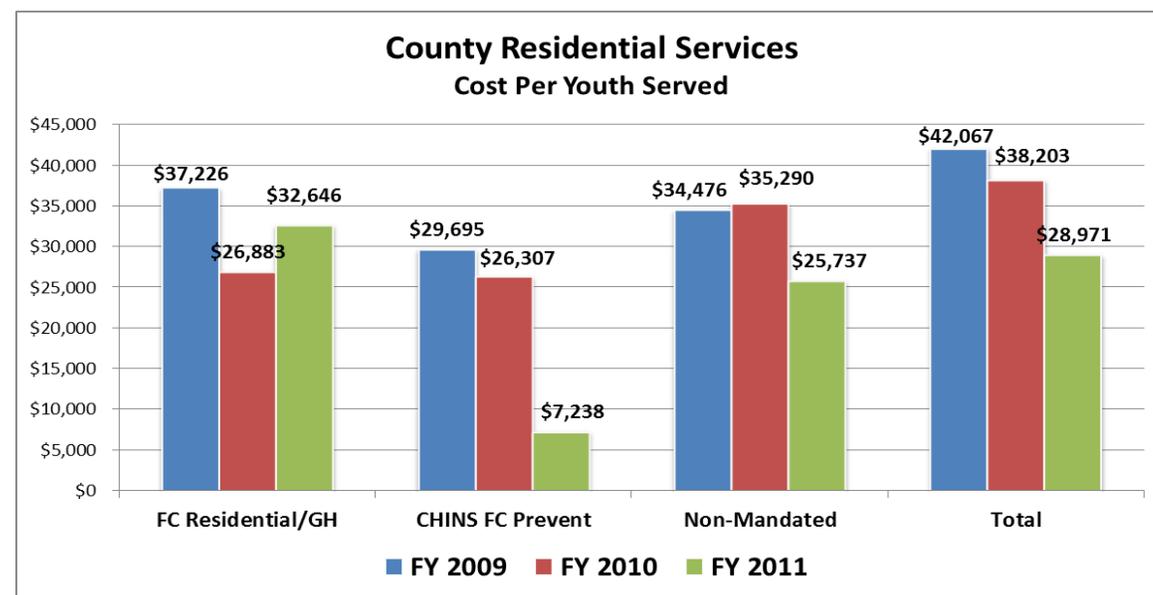
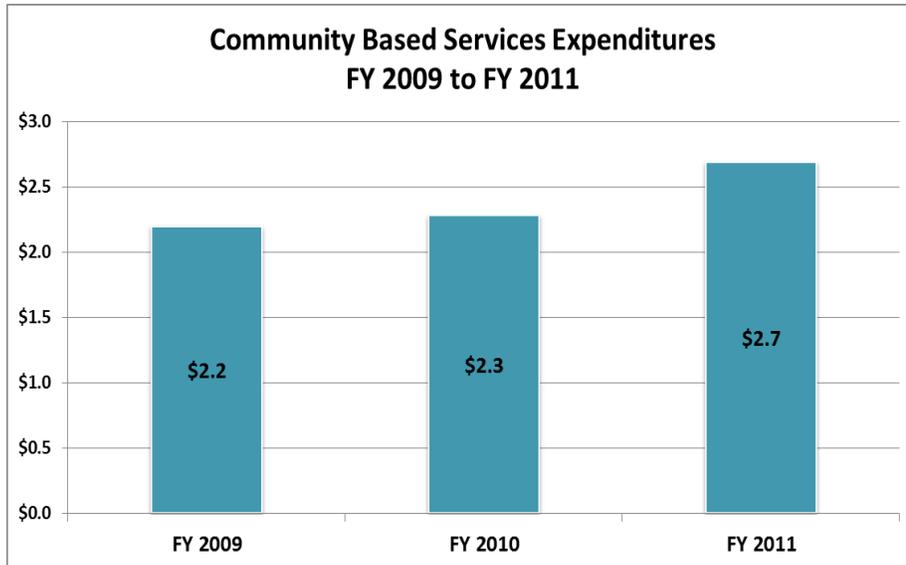


Figure 24: Cost per Youth Served by Mandate Type for County Agency Residential and Group Home Placements

suggest that services are being provided in an efficient and cost-effective manner.

CSA supports strategic investment in community-based interventions



In FY 11, expenditures for community-based services increased by \$0.4 million.

Figure 25: Expenditures for Community-based Services across Fiscal Years

Over 100 additional youth received community-based services than in previous years which likely reflects the use of the Family Partnership Program in Department of Family Services (DFS) and the Community Services Board (CSB) Intensive Care Coordination (ICC) program. Both of these initiatives are described in more detail later in the report as part of on-going system reform efforts.

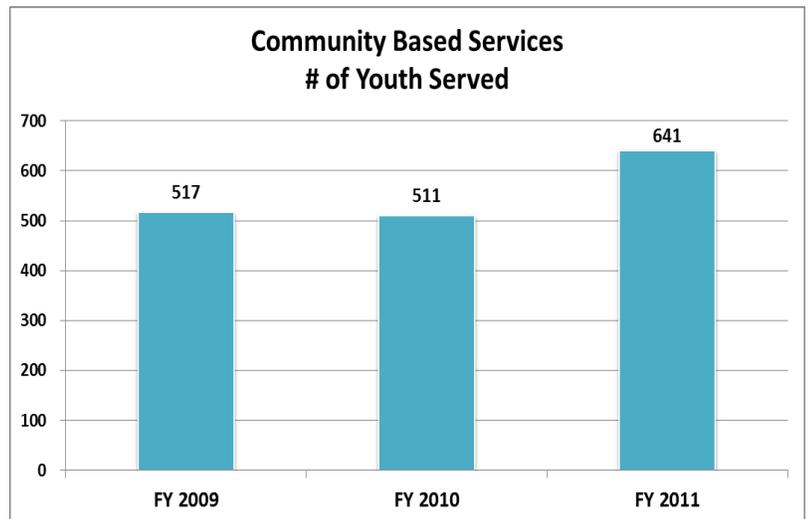
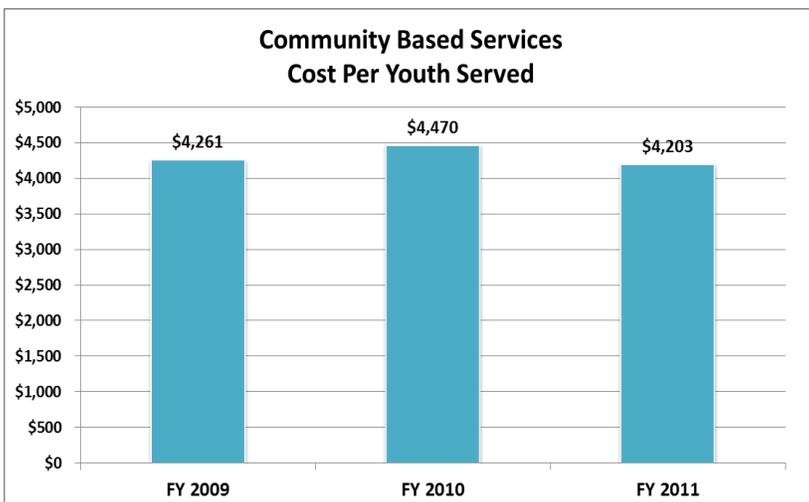


Figure 26: Youth Served by Community-based Services



The average cost of community-based interventions per youth was less than \$4,500 annually. In addition to Family Partnership Services and ICC, community-based interventions include home-based services, mental health assessments and evaluations, outpatient therapy, and transportation.

Figure 27: Cost per Youth Served with Community-based Services

Fiscal accountability is an important system goal

One measure of fiscal accountability is the cost of service per child served compared to the population of the jurisdiction which is the “per capita unit cost.” With a population of 1,116,623 in our locality, the CSA expenditures per capita were lower than the state-wide average and lower than several of our neighboring jurisdictions in the Northern region for FY 2011.

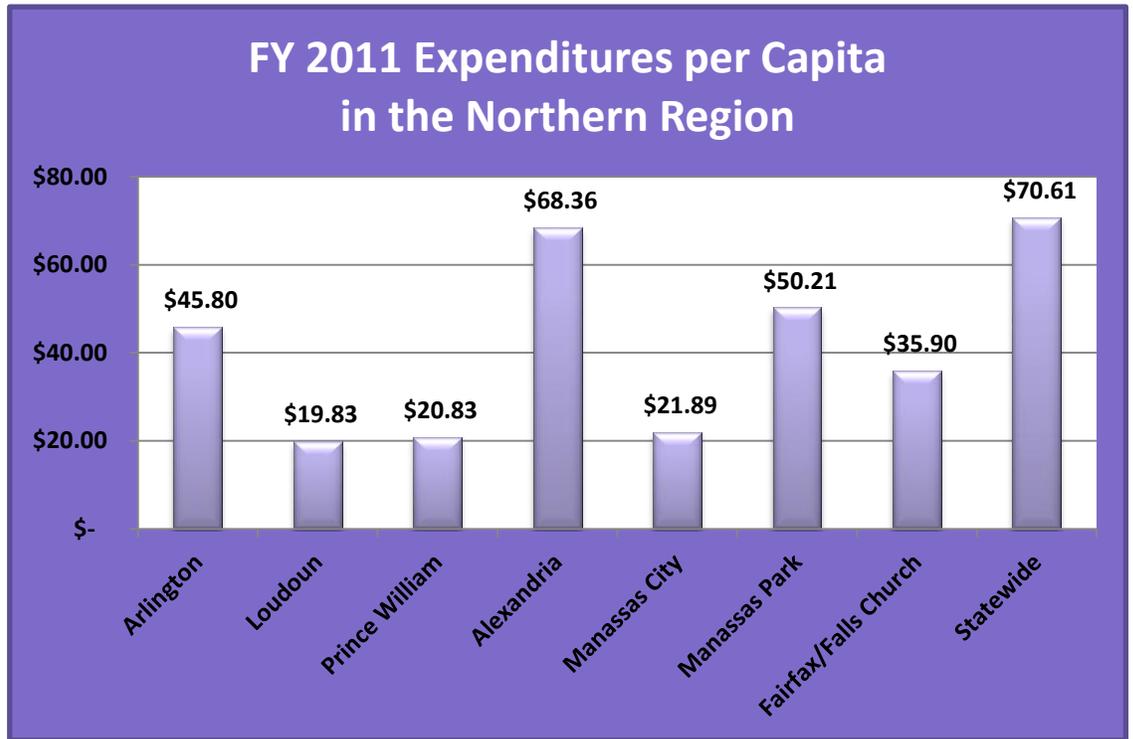


Figure 28: Expenditures per Capita for CSA Youth in Northern Virginia Region

The per capita expenditures for congregate care for Fairfax-Falls Church are much lower than the state-wide average; however, our costs are greater than surrounding jurisdictions.

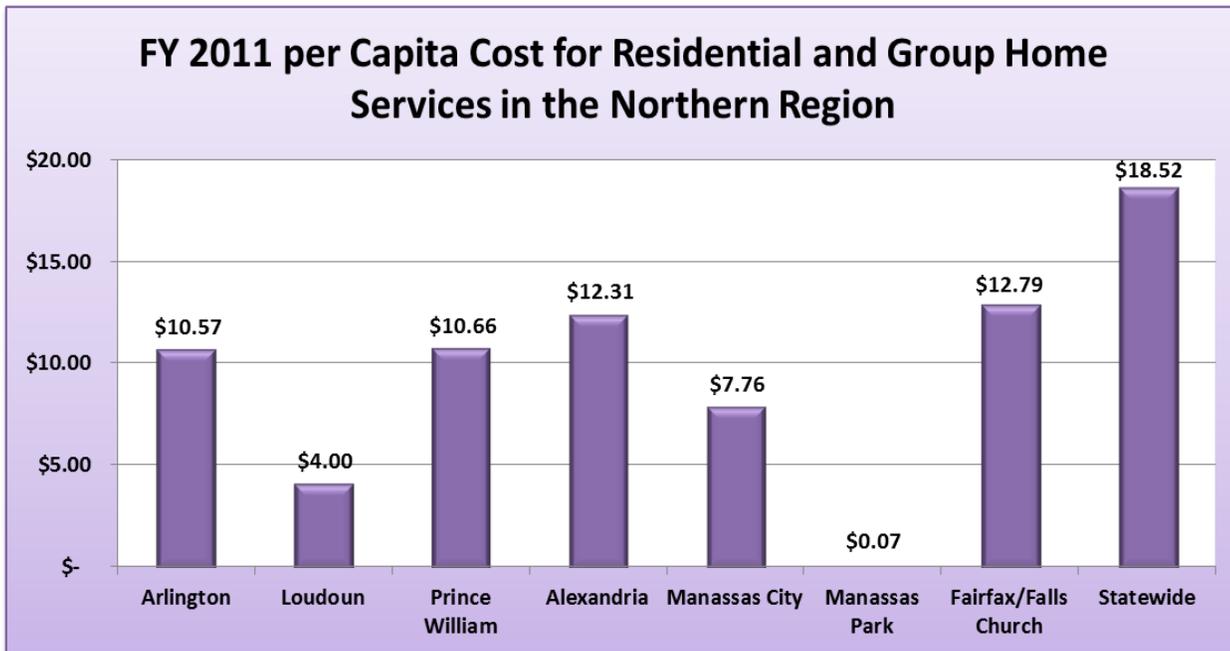


Figure 29: Per Capita Cost for Congregate Care in Northern Virginia Region

Another measure of fiscal accountability is the average annual cost per youth served with CSA funding. The annual per-child cost for congregate care (residential and group home placements) in Fairfax-Falls Church CSA exceeds the state-wide average and our surrounding jurisdictions in the Northern region.

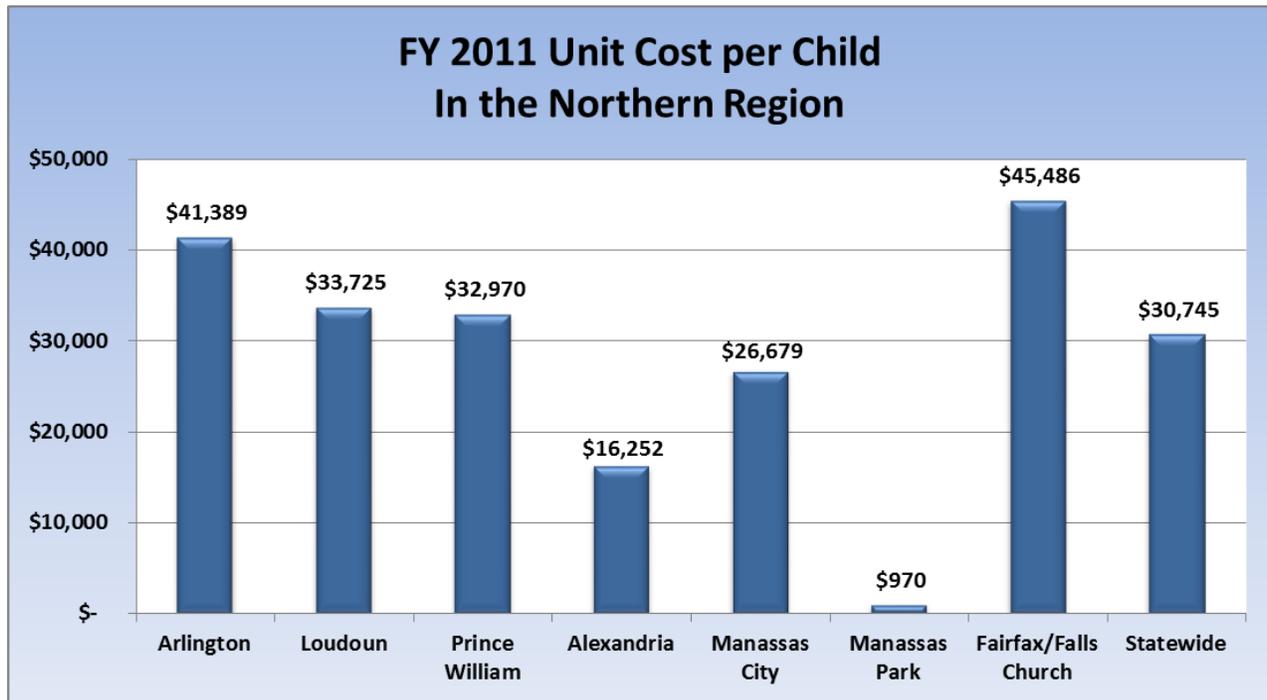


Figure 30: Per child unit cost for Congregate Care Placements

Alternative funding sources are used efficiently for services to youth and families

Medicaid Reimbursement

The Department of Medical Assistance (DMAS) reimburses Psychiatric Residential Treatment Facilities (PRTFs) directly for Medicaid-approved expenses. Local CSA programs pay a local match for the state’s portion of the Medicaid reimbursement for services to youth from each jurisdiction which is then deducted from the state allocation. In the table below, total DMAS payments have exceeded \$5 million annually for FY 2010 to FY 2011, indicating that our system is utilizing alternative funding sources effectively. The methodology used to estimate local savings uses the residential/group home local match rate (57.64%) which represents the vast majority of expenditures paid by DMAS for CSA youth. These figures do not include other Medicaid programs, such as waivers or EPSDT, or any Medicaid services accessed prior to a child accessing CSA services.

	FY 2009	FY 2010	% Change FY 2009 to FY 2010	FY 2011	% Change FY 2010 to FY 2011
DMAS Payments	\$4,845,476	\$5,247,279	8.29%	\$5,248,325	0.02%
Estimated Local Savings	\$1,396,466	\$1,512,266	8.29%	\$1,512,567	0.02%

Figure 31: Medicaid Payments for Psychiatric Residential Treatment Facilities

Use of Medicaid funding from the Early Periodic Screening Diagnosis and Treatment (EPSDT) program results in local savings

Unlike the reimbursement for psychiatric residential programs, EPSDT funding does not require a local match. Youth with developmental disabilities who are served in residential programs such as Grafton may qualify for Medicaid reimbursement for services under the criteria for EPSDT. Payments are made directly to the provider and therefore, our jurisdiction does not have this data. Grafton reported that EPSDT funded \$2,597,911 for services to youth from our locality from January, 2008 through October, 2009. Grafton provided an updated report that they have billed EPSDT for \$2.4 million in FY 10 and \$2.1 million for services on behalf of youth from Fairfax-Falls Church CSA in FY 11.

Proposed Quality and Outcome Targets for FY 2012

The Systems of Care Accountability and Stewardship workgroup comprised of three department directors proposed Quality and Outcome Targets for FY 12. The workgroup proposes that our measures remain largely the same as FY 11 and are within the following general categories:

- Restrictiveness of Living outcome goals – length of stay for youth discharged from RTC/GH (new)
- Functional outcomes – CANS, Parent Satisfaction
- Fiscal Accountability
- Foster Care Prevention – effectiveness of interventions in reducing foster care entry

Partners and strategies for ongoing system change

Intensive Care Coordination: Outcomes from first year implementation

Intensive Care Coordination (ICC) is a family-driven, youth-guided, team-based approach to help youths and their families who are at-risk of out-of-home placement. ICC follows guiding principles from the wraparound approach:

- All children need and deserve loving, permanent homes and family connections.
- Safety comes first.
- Parents and families have the right and responsibility to raise their own children.
- Services should be planned in a way that honors and reflects the family's values and preferences.
- Whenever possible, children and youth need to be served in their community.
- If a placement outside the community is necessary, it needs to be as brief as possible. The ICC team will help the family find and develop the supports needed to make sure that the child's return home is safe and successful.

The Intensive Care Coordination program, developed by the Community Service Board, began accepting youth in November, 2010 and has the capacity to serve 60 – 65 youth at any given time. The following data describes their initial outcomes for November, 2010 through September, 2011.

ICC Utilization:

- 85 children were served by ICC
 - 28 children received less than 3 months of ICC services
 - 40 children received ICC services for 3-6 months
 - 17 children received ICC services for 6 or more months
- 54 of the 85 children were referred to prevent residential placement
 - 33 out of 54 children received at least 3 months of ICC and were included in further analysis
- 31 of the 85 children were referred to assist in discharge from residential to the community
 - 24 of the 31 children received at least 3 months of ICC and were included in further analysis

Restrictiveness of Living Outcomes:

- Of the 33 children referred to prevent residential placements who met the criteria for analysis, 32 youth were still in the community at 3 months, achieving the goal of 97% remaining in the community.
- Of the 33 children referred to prevent residential placements, 6 months have elapsed between ICC initiation and analysis for 26 youth. 24 of those 26 youth reside in the community, achieving the goal of 92% remaining in the community.
- Of the 24 children referred for discharge from residential, 13 children or 54% returned from residential within 3 months.
- Of those 13 children who stepped down from residential placements, 11 children met the criteria of having 6 months elapse since discharge. 10 of the 11 children, or 92% of the children remained out of residential placements.

Functional Outcomes:

22 youth had CANS assessments completed 6 months after ICC initiation which was compared to their CANS at the initiation of ICC services. Ratings on the domain for Child Behavioral and Emotional Needs indicate improvements for youth as shown in the figure below. The percentage of youth showing improvements on their ratings was highest for Psychosis (n =1), Conduct (n= 9), and Anger Control (n=13).

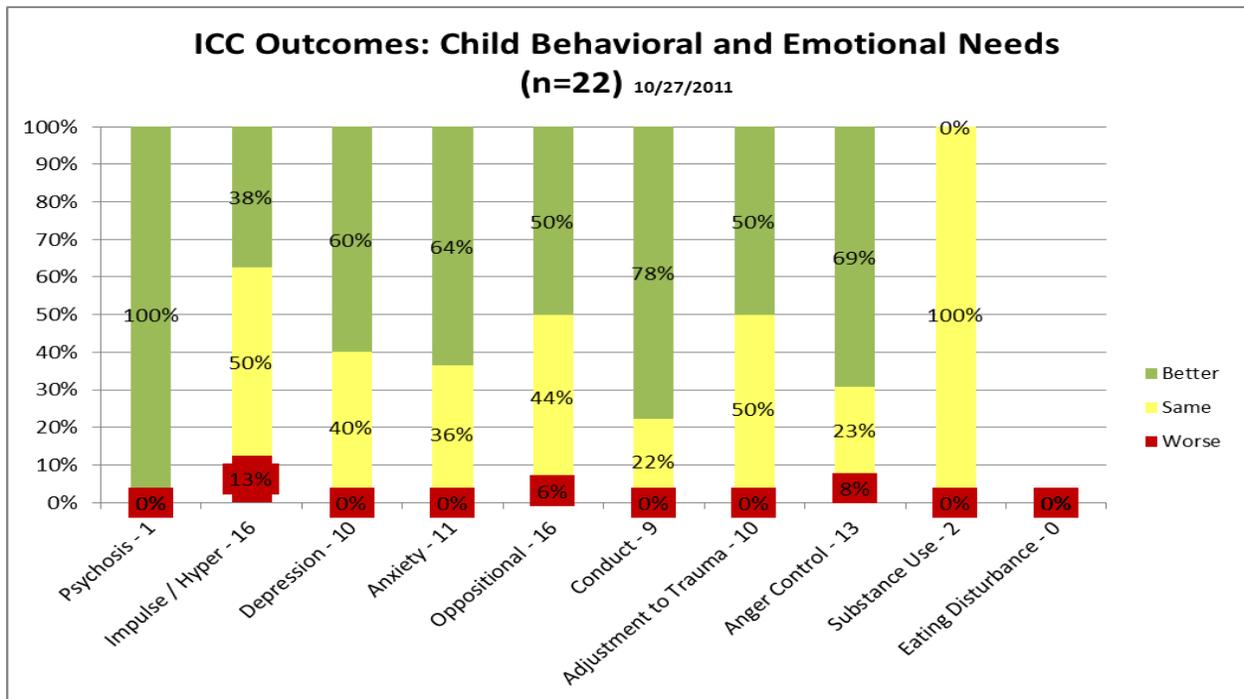


Figure 32: Youth Outcomes on CANS Behavioral/Emotional Needs Domain for ICC Youth

On the Risk Behavior domain, Social Behavior (n = 9) and Delinquent Behavior (n =8) were the most prevalent and 78% and 75% of youth, respectively, were rated as having a lower level of need. Danger to Others (n=5) and Bullying (n=4) also showed improvement with ICC services.

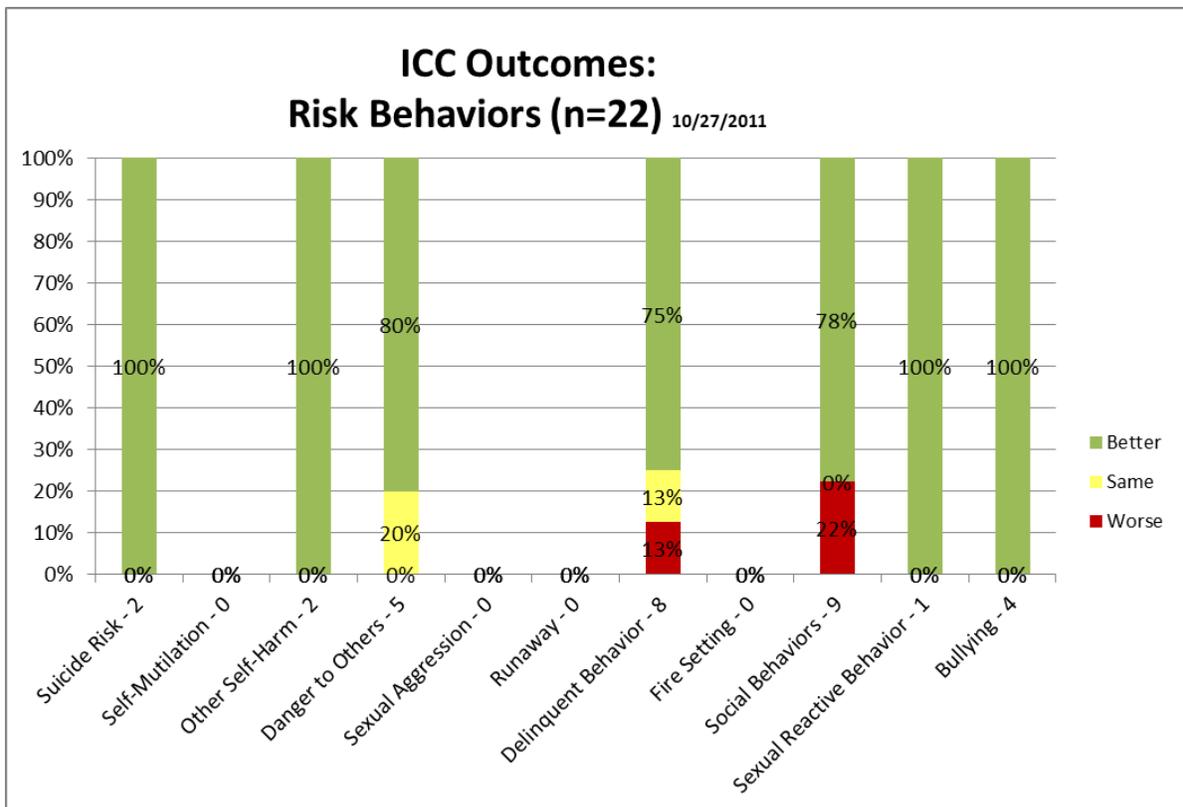


Figure 33: Youth Outcomes for CANS Risk Behavior Domain for ICC Youth

Family Partnership Program

The Department of Family Services Children, Youth and Families (CYF) Division officially launched a new program --- the Family Partnership Program on July 1, 2010. This program reflects the extensive work by state and local child welfare representatives for over two years to modify current practice to more effectively support and strengthen permanent family connections for children and families. The decision to launch this new program significantly increases the capacity of DFS to partner and support families in their efforts to care for their children, thus reducing out-of-home placements and increasing relative and community placement.

Family partnership meetings are required to occur at five critical decision points for youth involved in the child welfare system:

- Emergency Removal or At Risk of Out of Home Placement
- Very High or High Risk Child Assessment
- Prior to Placement Change/Disruption
- Prior to Change of Goal
- Requested Meeting by birth, foster and adoptive parent, legal guardian and the social worker

The program offers different types of services: Family Partnership Meeting, Family Group Conferences and Follow-Up Meetings. The purpose of the Family Partnership Meetings/Family Group Conference is to provide support to families with at-risk children in a strength-based, family driven team setting. This method of practice is a focused approach that provides structure for decision making and that empowers both the family and the community in the decision making process.

The approach to partnering with families reflects the belief in the following key elements:

- All Families have strengths
- Families are the experts on themselves
- Families deserve to be treated with dignity and respect
- Families can make well-informed decisions about keeping their children safe when supported
- Outcomes improve when families are involved in decision-making
- A team is often more capable of creative and high-quality decision-making than an individual

The Children, Youth and Families Division set several programmatic goals:

- 75% of children prevented from entering foster care
- 50% of children returned home/permanency within 6 months post FPM's
- Reduce multiple moves, leading to a permanent home for children

Our data informs us that we have exceeded our goals:

- 92% of children were prevented from entering foster care after FPM
- 63% of children in foster care returned home/permanency within 6 months post FPM/FGC
- Not currently available - unable to capture data due to earlier data system change

Throughout the country and in Virginia, there is evidence that a deliberate, structured approach to working with families, professionals and community partners can make a significant difference in the lives of children and families. DFS has begun the work to expand the model of Family Partnership/Family Group Conference to other agencies including the Juvenile and Domestic Relations District Court, Community Service Board, Fairfax County Public Schools and Falls Church City Public School. These partners, along with the community, are integral to supporting children and families across our system of care.

CSA System of Care Initiative: Action Plan for FY 2012

The following table describes ongoing efforts by the CPMT to proceed with system changes and improvements to enhance service delivery to youth and families while striving for system efficiencies and fiscal accountability. Completed tasks are noted below.

FY 2012 CPMT/CSA Action Plan: Proposed Revision October 28, 2011	CPMT Review Scheduled
Propose practice standards	July 22 
Review other local audit findings and local compliance	September 23 
Nominate CPMT parent representatives	October 28 
Provide Falls Church PS MIS access and solve CANS data entry issues	October 28
Approve practice standards	Oct 28 & Nov 18 
Enhance CSA fiscal report format	November 18 
Approve FY 12 CSA inter-agency training plan	November 18 
Approve compliance plan	November 18 
Approve CST re-design	January 13
Approve quality and outcome targets and present FY 11 annual report	January 13 
Service gap analysis and out-of-state placement study	January 13
Approve provider evaluation and FY 13 contracting processes	January 27
Approve ongoing quality assurance plan	February 24
Enhance utilization and FAPT review processes	March 23
Update CSA Management Team charter and composition	April 27
Approve plan to implement new evidence-based practices	April 27
Study "optional" special education mandate and its potential to support services for youth with autism	April 27

Fairfax-Falls Church CPMT Mission and Principles

Mission: To provide leadership in the development of new concepts and approaches in the provision of services to children, youth and families of Fairfax County and the Cities of Fairfax and Falls Church. The primary focus of the CPMT is to lead the way to effective and efficient services for the children already or at risk of experiencing emotional/behavioral problems, especially those at risk of or in need of out of home placements, and their families.

Philosophy: *The most important community responsibility is the well-being of children.* Children belong with families who nurture and protect them, children deserve healthy relationships, and families deserve to live in safe environments.

CPMT Principles	Systems of Care Principles
<i>Services are supportive to children and their families, providing them with the opportunity to succeed in the community to the fullest extent possible;</i>	<i>Our system will support families to fulfill their primary responsibility for the safety, the physical and emotional health, the financial and educational wellbeing of their children.</i>
<i>Needs of children and families will be met in the least restrictive way, with families fully participating in the decision making process;</i> <i>The family unit will remain intact whenever possible, and issues are to be addressed in the context of the family unit;</i> <i>Services will be community-based whenever possible, and children will be placed outside of the community only when absolutely necessary.</i>	<i>Children are best served with their own families.</i> <i>Keeping children and families together and preventing entry into any type of out of home placement is the best possible use of resources.</i>
<i>All agencies providing services will work together, cooperatively, with each other and with the family, to gain maximum benefit from the available resources.</i>	<i>Our system embraces the concepts of shared resources, decision making and responsibility for outcomes. All stakeholders will work together collaboratively with each other and the family to gain maximum benefits from available resources.</i>
<i>Services are flexible and comprehensive to meet the individual needs of children and families;</i>	<i>Children and families will receive individualized services in accordance with expressed needs.</i>
<i>Services are easily accessible to residents of the community, regardless of where they live, their native language or culture, their level of income, or their level of functioning;</i>	<i>Our families will receive culturally and linguistically responsive services.</i>
<i>Services are integrated into the community, in the neighborhoods where the people who need them live;</i>	<i>Children with emotional, intellectual or behavioral challenges will receive integrated services and care coordination in a seamless manner.</i>
<i>Services are family focused to promote the well-being of the child and community;</i>	<i>Our system will be youth guided and family driven with the family identifying their own strengths and needs and determining the types and mix of services and desired outcomes within the resources available.</i>
<i>Services are responsive to people and adaptable to their changing needs;</i>	<i>County, community and private agencies will embrace, value, and celebrate the diverse cultures of their children, youth and families and will work to eliminate disparities in outcomes.</i>
<i>Services are provided through collaborative and cooperative partnerships between people living in their community and public and private organizations.</i>	<i>We will be accountable at the individual child and family, system, and community levels for desired outcomes, safety and cost effectiveness.</i>

Fairfax-Falls Church Community Policy and Management Team

Patricia Harrison (Chair)

Deputy County Executive

Gloria Addo-Ayensu, M.D.
Director, Health Department

Louise H. Armitage
Human Services Coordinator
City of Fairfax

Robert A. Bermingham, Jr.
Director of Court Services, Juvenile
and Domestic Relations District Court

Nannette M. Bowler,
Director,
Department of Family Services

George Braunstein,
Executive Director
Fairfax-Falls Church Community
Services Board

Earl Conklin
Director, Falls Church City Court
Services, Department of Community
Services

Kim Dockery,
Asst. Superintendent
Department of Special Services
Fairfax County Public Schools

Kristen J. Eisenhart, Ph.D.
Parent Representative

Elizabeth Germer,
Director, Special Education & Student
Services, Falls Church City Schools

M. Gail Ledford, Ph.D.
Director,
Department of Administration for
Human Services

Rick Leichtweis, Ph.D.
Senior Director, Inova Kellar Center
Private Provider/NOVACO
Representative

Christopher A. Leonard,
Director,
Department of Neighborhood and
Community Services

Susan E. Lydick
Parent Representative

Hallie Marcotte,
Director, Office of Special Education
Procedural Support,
Fairfax County Public Schools

Irene M. Moore
Parent Representative

Carmen Patricia Ojeda
Parent Representative

Mary Ann Panarelli,
Director, Office of Intervention &
Prevention Services, Fairfax County
Public Schools

Sandy Porteous,
Phillips Family Partners
Private Provider/NOVACO
Representative

COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES

Fairfax- Falls Church Human Services
12011 Government Center Parkway, Suite 500
Fairfax, VA 22035-1102
Phone: (703) 324-7938
Fax: (703) 324-7929
TTY: 222-9452

James Gillespie, LCSW, MPA
CSA Program Manager

