FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for AT-RISK CHILDREN, YOUTH & FAMILIES

June 25, 2021
Community Policy and Management Team (CPMT)

Agenda

1:00 p.m. -- Convene meeting ~

1. **MINUTES:** Approve minutes of May 28, 2021 meeting

2. **ITEMS:**

   - **CSA Contract Items**
     Item C – 1: Monthly Out-of-State Placement Approvals – None for May

   - **CSA Information Items**
     Item I – 1: Budget Report
     Item I – 2: Parental Contributions: Billing and Collections Policy
     Item I – 3: CSB Service Update – Daryl Washington, CSB Executive Director
     Item I – 4: Establishment of Multi-Disciplinary Team Process for FFPSA Implementation
     Item I – 5: Review of Human Services Issue Paper for CSA Program

- **NOVACO – Private Provider Items**
- **CPMT Parent Representative Items**
- **Cities of Fairfax and Falls Church Items**
- **Public Comment**

3:00 p.m. – Adjourn

FAIRFAX-FALLS CHURCH CHILDREN'S SERVICES for AT-RISK CHILDREN, YOUTH & FAMILIES

May 28, 2021
Community Policy and Management Team (CPMT)
Virtual Meeting due to COVID-19 Emergency Procedures

Meeting Minutes

Attendees: Lesley Abashian (home), Michael Becketts (home), Jacqueline Benson (home), Robert Bermingham (home), Cristy Gallagher (home), Annie Henderson (office), Joe Klemmer (home), Michael Lane (home), Chris Leonard (office), Deborah Scott (office), Jane Strong (office), Lloyd Tucker (office), Nancy Vincent (home)

Attended but not heard during roll call: Richard Leichtweis (home), Deb Evans,

Absent: Gloria Addo-Ayensu, Michelle Boyd, Rebecca Sharp, Daryl Washington (home), Stacy Alexander (home)

HMF Attendees: Jim Gillespie, Peter Steinberg, Tracy Davis, Desiree Gordon

CSA Management Team Attendees: Adam Cahuantzi, Xu Han, Andrew Janos, Kamonya Omatete, Tim Elcesser, Barbara Martinez, Terri Byers, Jessica Jackson, Kamonya Omatete, Tim Elcesser, Barbara Martinez

Stakeholders and CSA Program Staff Present: Janet Bessmer, Patricia Arriaza, Sarah Young, Samira Hotochin, Lisa Morton, Xu Han, Kristina Kallini, Suzette Reynolds, Chris Metzbower, Shana Martins, Usman Saeed, Jeanne Veraska, Amee Vyas

FOIA Related Motions:

I move that each member's voice may be adequately heard by each other member of this CPMT.
Motion made by Chris Leonard; second by Joe Klemmer; all members agree, motion carries.

Second, having established that each member's voice may be heard by every other member, we must next establish the nature of the emergency that compels these emergency procedures, the fact that we are meeting electronically, what type of electronic communication is being used, and how we have arranged for public access to this meeting.

State of Emergency caused by the COVID-19 pandemic makes it unsafe for this CPMT to physically assemble and unsafe for the public to physically attend any such meeting, and that as such, FOIA's usual procedures, which require the physical assembly of this CPMT and the physical presence of the public, cannot be implemented safely or practically. I further move that this CPMT may conduct this meeting electronically through a dedicated Zoom conferencing line, and that the public may access this meeting by calling Toll Free Call In: 1 888 270 9936 Participant access code: 562732. It is so moved.
Motion made by Chris Leonard; seconded by Michael Lane; all members agree, motion carries.

Finally, it is next required that all the matters addressed on today's are statutorily required or necessary to continue operations and the discharge of the CPMT's lawful purposes, duties, and responsibilities.
Motion made by Chris Leonard; seconded by Jackie Benson; all members agree, motion carries.

Approved:

1. **MINUTES:** Approve minutes of March 26, 2021. *Motion made by Robert Bermingham; second by Michael Becketts; all members agree, motion carries.*

2. **ITEMS:**
   - **CSA Administrative Items**
     Item A – 1: FY22 CPMT Meeting Schedule - Presented by Janet Bessmer. Members were asked to determine if the May 2022 meeting should be scheduled on the third Friday to avoid the Memorial Day weekend. Members agreed that the May meeting should be on May 20, 2022. Chris Leonard asked if we will still be virtual in July? Janet Bessmer responded that we will follow any new guidelines. *Motion made by Jane Strong, seconded by Lesley Abashian; all agree, motion carries.*

   - **CSA Contract Item:** Report on Out of State Provider Approvals – Presented by Barbara Martinez. One of the requests listed in the item withdrew, so there will be three cases presented. Since this is a new report that will be present at each CPMT meeting, members were asked to contact Barbara Martinez if they would like additional information included in this report in the future.

   - **CSA Information Items -**
     Item I – 1: FY 21 Budget Report – Presented by Usman Saeed. Chris Leonard mentioned that the 2020 and 2021 year to date cost comparison does not show much variation for cost per child. This is surprising as the expectation was that there would be more variation due to COVID. Michael Becketts commented that further investigating the types of services that were provided to see if it is comparable to previous years. Michael and Janet will work with finance to provide that information.
     Item I – 2: Proposal for Use of MHI Local Funds in FY 22 – Presented by Jim Gillespie. CSA management team has reviewed and supports the proposal for use of these funds.
     Item I – 3: MHI Local Funding Policy for Coverage of CSA Disallowances – Present by Janet Bessmer. One of the items of proposed for the use of MHI local funds is CSA disallowances. This funding will be used for instances were there has been some sort of administrative or case manager error.
     Item I – 4: Serious Incidents Report 3rd Quarter – Presented by Patricia Arriaza. CSA has started tracking COVID 19 cases as well. Chris Leonard asked what the next steps will be with the school that had 7 restraints. Patricia Arriaza and Adam Cahuantzi responded that in these instances CSA and FCPS-MAS further investigate each incident and discuss any concerns with the school.

   - **NOVACO – Private Provider Items – none**
   - **CPMT Parent Representative Items – none**
   - **Cities of Fairfax and Falls Church Items – none**
   - **Public Comment – none**

Adjourn 1:42 pm – Motion made by Robert Bermingham**.** Second by Michael Becketts**.** *All members approved.*

Next Meeting: June 25, 2021 1:00 – 3:00pm (via Zoom)

Approved:

MEMO TO THE CPMT
June 25, 2021

Information Item I-1: May Budget Report & Status Update, Program Year 2021

ISSUE:
CPMT members monitor CSA expenditures to review trends and provide budget oversight.

BACKGROUND:
The Budget Report to the CPMT has been organized for consistency with LEDRS reporting categories and Service Placement types.

The attached chart details Program Year 2021 cumulative expenditures through May for LEDRS categories, with associated Youth counts. IEP-driven expenditures for Schools are separated out. Further information on the attachment provides additional information on recoveries, unduplicated youth count, and:

-Average cost per child for some Mandated categories
-Average costs for key placement types, such as Residential Treatment Facility, Treatment Foster Home, Education placements.

Total Pooled Expenditures: FY 2021 pooled expenditures through May 2021 equal $27.5M for 962 youth. This amount is a decrease from May last year of approximately $3.5M, or 11.23%. FY 2020 pooled expenditures were $31M for 1,071 youth. DFS will continue to process invoices for service year FY 2021 through August to meet a September 2021 state deadline.

	Program Year 2020	Program Year 2021	Change Amt	Change %
Residential Treatment & Education	$4,490,149	$3,485,987	($1,004,162)	-22.36%
Private Day Special Education	$15,814,656	$15,753,874	($60,782)	-0.38%
Non-Residential Foster Home/Other	$6,982,077	$5,335,740	($1,646,337)	-23.58%
Community Services	$3,519,329	$2,982,201	($537,128)	-15.26%
Non-Mandated Services (All)	$939,609	$838,931	($100,678)	-10.71%
Recoveries	($757,847)	($887,292)	($129,445)	17.08%
Total Expenditures	**$30,987,973**	**$27,509,441**	**($3,478,532)**	**-11.23%**
Residential Treatment & Education	133	113	(20)	-15.04%
Private Day Special Education	300	284	(16)	-5.33%
Non-Residential Foster Home/Other	364	324	(40)	-10.99%
Community Services	731	637	(94)	-12.86%
Non-Mandated Services (All)	191	182	(9)	-4.71%
Unique Count All Categories	**1,719**	**1,540**	**(179)**	**-10.41%**
Unduplicated Youth Count	**1,071**	**962**	**(109)**	**-10.18%**

RECOMMENDATION:
For CPMT members to accept the May Program Year 2021 budget report as submitted.

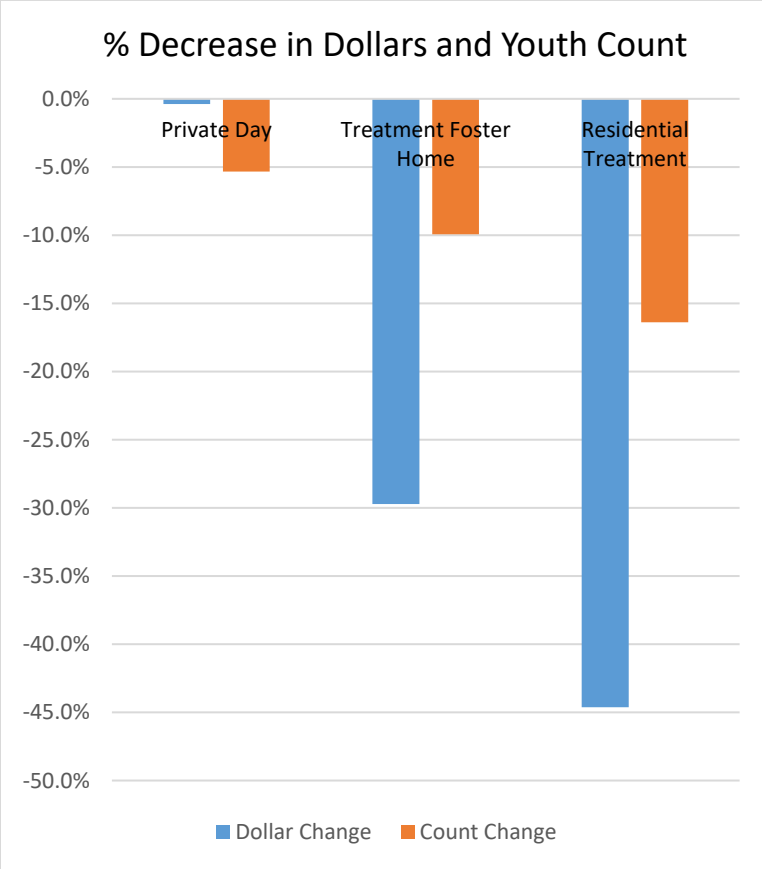
NOTES:

Three areas account for $2.3M of the total $3.5M decrease in pooled expenditures from last May YTD (Please refer to the other detailed CPMT Chart for these distinct categories). These are shown on the bar chart below.

Private Day has a small % decrease in youth count, but expenditures hold relatively even with the prior year, due to a slight increase in average cost per child. Since this area has a high average cost of $55,471 per child and 57% of CSA expenditures in FY 2021 to date, it demands close monitoring.

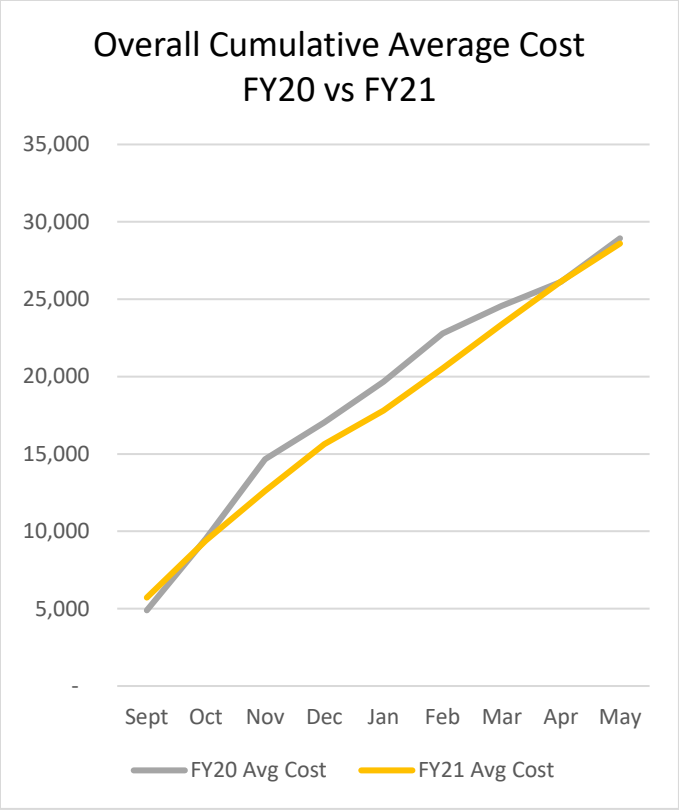
Treatment Foster Home has a moderate % decrease in youth count that is outmatched by a much larger % drop in dollars. Overall, costs are $1.4M lower, some due to the reduction of 13 in youth count, some due to $444k in transportation savings, and some due to expenditure alignment with the supervision and services received by the specific children in care. The absence of transportation to school, while many schools went to virtual format, created the transportation savings.

Residential Treatment Facility has a moderate % decrease in youth count that is outmatched by a significant % drop in dollars. Overall, costs are $0.85M lower, in part due to having 10 fewer youth in residential, but also due to factors such as a positive impact on expenses of the service needs of the specific children in care, and to savings realized by the application of other non-CSA funding sources such as Medicaid to cover expenses.



The overall cumulative average cost per child funded in CSA, $28,596, is charted below at the same level in April and May of FY 2020 and FY 2021.

Prior to the pandemic, the average FY 2020 cumulative cost per child had been trending higher, as seen in the grey FY 2020 line in the chart below. The trajectory of that line changed in the last quarter as the pandemic emerged, and a slightly higher percentage of youth were then served in Non-Residential settings rather than Residential settings.



ATTACHMENT:
Budget Chart

STAFF:
Terri Byers, Timothy Elcesser, Xu Han and Usman Saeed (DFS)

Program Year 2021 Year To Date CSA Expenditures and Youth Served (through May Payment)

Mandated/ Non-Mandat	Residential/ Non-Residential	Serv Type Descrip	Local Match Rate	County & Foster Care	Youth in Category	Schools (IEP Only)	Youth in Category	Total Expenditures
Mandated	**Residential**	Residential Treatment Facility	57.64%	$1,060,001	51			$1,060,001
		Group Home	57.64%	$273,853	9			$273,853
		Education - for Residential Medicaid Placements	46.11%	$59,342	6	$909,858	20	$969,200
		Education for Residential Non-Medicaid Placements	46.11%	$32,635	2	$1,087,875	14	$1,120,510
		Temp Care Facility and Services	57.64%	$62,423	11			$62,423
	Residential Total			$1,488,254	79	$1,997,733	34	$3,485,987
	Non Residential	Special Education Private Day	46.11%	$406,612	7	$15,347,261	277	$15,753,874
		Wrap-Around for Students with Disab	46.11%	$182,399	42			$182,399
		Treatment Foster Home	46.11%	$3,227,647	118			$3,227,647
		Foster Care Mtce	46.11%	$1,330,321	129			$1,330,321
		Independent Living Stipend	46.11%	$146,455	21			$146,455
		Community Based Service	23.06%	$2,343,550	505			$2,343,550
		ICC	23.06%	$638,651	132			$638,651
		Independent Living Arrangement	46.11%	$448,918	14			$448,918
	Non Residential Total			$8,724,554	968	$15,347,261	277	$24,071,815
Mandated Total				**$10,212,807**	**1047**	**$17,344,995**	**311**	**$27,557,802**
Non-Mandated	**Residential**	Residential Treatment Facility	57.64%	$84,212	7			$84,212
	Residential Total			$84,212	7			$84,212
	Non Residential	Community Based Service	23.06%	$672,599	148			$672,599
		ICC	23.06%	$82,120	27			$82,120
	Non Residential Total			$754,719	175		0	$754,719
Non-Mandated Total				**$838,931**	**182**		**0**	**$838,931**
Grand Total (with Duplicated Youth Count)				**$11,051,738**	**1,229**	**$17,344,995**	**311**	**$28,396,733**

Recoveries	**-$887,292**
Total Net of Recoveries	**$27,509,441**
Unduplicated child count	962

Key Indicators

Cost Per Child	**Prog Yr 2020 YTD**	**Prog Yr 2021 YTD**
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$28,934	$28,596
Average Cost Per Child Mandated Residential (unduplicated)	$41,964	$42,000
Average Cost Per Child Mandated Non- Residential (unduplicated)	$27,585	$27,637
Average Cost Mandated Community Based Services Per Child (unduplicated)	$4,351	$4,641
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$31,377	$20,784
Average Cost for Treatment Foster Home	$35,055	$27,353
Average Education Cost for Residential Medicaid Placement (Residential)	$46,391	$37,277
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$63,980	$70,032
Average Special Education Cost for Private Day (Non-Residential)	$52,716	$55,471
Average Cost for Non-Mandated Placement	$4,919	$4,610

Program Year 2021 Year To Date CSA Expenditures and Youth Served (through May Payment)

Category	Program Year 2021 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2021 Allocation	$663,010	$178,684	73%
Non Mandated Program Year 2021	$1,630,458	$781,402	52%
Program Year 2021 Total Allocation	$38,657,566	$27,509,441	29%

Memo to CPMT

June 25, 2021

Information Item I- 2: CSA Parental Contribution: Billing and Collections Policy and Procedure Development

Issue: That the CSA program develop policy for billings and collections of parental contributions in compliance with state policy and local practice.

Background: CSA currently assesses all families for the parental contribution unless prohibited by law such as for special education services and with specific waivers offered for families involved with child welfare specialists to prevent foster care. The parental contribution is based on the family's ability to pay. Low-income families as evidenced by eligibility for programs such as Free/Reduced school meals, TANF, SNAP and income-based Medicaid eligibility receive a 0$ assessed contribution.

As of 03/17/2021, CSA had 134 past due accounts totaling $130,746. Most of the charges are from community-based services not residential care. CSA is prohibited from charging a contribution for Medicaid-funded services even when the locality has a match.

State policy regarding assessing and collecting parental contributions is summarized in the policy below:

4.5.4 Parental Contributions for Services (Adopted February 23, 2000)

Effective February 23, 2000, the CPMT shall consider the following criteria when determining whether parental contributions are appropriate:

1. *Parents of children in out-of-home placements should not be charged a payment for services in addition to the child support order. Instead, for **out-of-home care**, the CPMT shall implement existing state law and policy requiring referral of such cases to the Division of Child Support Enforcement (DCSE). The non-custodial parents of children in out-of-home care are to be referred to the DCSE for the collection of child support. (Statutory authority: COV §63.2-1910)*
2. *Parents of children in **in-home care** should be charged a standard parental co-payment based both on the ability of each parent to pay and the cost of the service. Parents and legal guardians of children receiving in-home care are expected to contribute financially to the cost of services. Each local government shall develop policies to assess this fee. Local governments are encouraged to assess a fee based on a locally developed scale.*

Current local process for collections is to notify parents of delinquency status, place an alert in Harmony, and restrict access to further services until the family has made some effort to make payments in good faith or sought a review of their ability to pay. Our agreement with parents permits referral to the Attorney General's office for collections.

DFS Fiscal staff working with CSA staff have consulted with the Department of Tax Administration (DTA) about their collections process for other human services agencies. DTA performs this function for the SACC, Health Department and CSB where they are also working with vulnerable populations and must follow HIPAA. It is proposed that CSA Parental Contribution accounts are managed using DTA for collections as described below:

Proposed collections process for past delinquent accounts:

The parental contribution agreement signed by families permits the county to collect on debts that are up to 5 years old. DTA will research current addresses and have access to data bases to locate inactive account holders. DFS will follow recommendations by DTA about following up on past overdue accounts.

Proposed collections process for new community-based services/delinquent accounts:

1. Families receive a Welcome Letter explaining the parental contribution process once the assessment is complete. After services are delivered and the county has made a payment to a provider, the family will begin receiving a monthly invoice and will be expected to stay current with their account.
2. Working with the DFS fiscal accounts receivable team, CSA will notify the case manager and DTA when cases are 30 days past due. The case manager will confirm contact with the family to ensure that no financial changes have occurred that might impact ability to pay.
3. Accounts that are more than 60 days past due will be referred to Fairfax County Department of Tax Administration (DTA). Referrals include name of parent, account number from Harmony/SMART, most recent address, phone number, and amount of debt. Notice of the referral will be entered into the CSA information system and notice provided to fiscal/accounts receivable and the case manager.
4. Once referred, DTA will send the family a letter giving them 30 days to respond to DTA. The letter includes information about the fees charged to the family if the debt is referred to a collections agency and encourages them to contact DTA to remedy their delinquent account.
5. For families who respond and have questions about the nature of the debt, DTA will request permission to review the matter with the program to clarify any issues. DTA will also perform a hardship review, considering family income, employment status and other financial factors that impact ability to pay.
6. Based on information in this 30 day review period, DTA working with the CSA program may determine that a reduction in the amount owed is appropriate.

7. If the debt is referred to a collections agency, penalties, interest and fees may be added to the balance. State income tax refunds may be withheld and other actions such as bank liens may be taken to collect the debt.
8. The collections are returned to the agency and will be reconciled with LEDRS as a recovery. Business process needs to be developed for reporting.

Proposed collections process for residential treatment services:

Currently, families complete the copay assessment process and agree to the residential rate. CSA is not permitted to charge a residential copay when a youth is funded by Medicaid. The proposed procedure change would bring the program into compliance with the state policy to refer families seeking residential placements to the Division of Child Support Enforcement. Assessment, billing and collections would be performed by DCSE. Any monies collected would be returned to Fairfax County along with child support payments and reported to OCS in the LEDRS financial report as an expenditure credit.

1. Families would complete a revised Parental Contribution assessment that has a local scale for community-based care and would have a place for families to sign indicating agreement that if residential services are sought, the family will be referred to DCSE.
2. The Federal Reimbursement Unit (FRU) staff who manage our Parental Contribution assessments are also responsible for court proceedings for foster care child support orders. They will assume responsibility for referring families who are approved and the child admitted to residential treatment for an Administrative Support Order (ASO) for child support to cover the start and end dates of services.
3. Parents may provide DCSE with information to request adjustment to child support guidelines during the establishment of an ASO due to family hardship.
4. There is no legal prohibition for child support to be ordered for services that are funded by Medicaid. CSA is also providing a local match to Medicaid funded services and child support would be used to offset the reduction on state reimbursement.
5. FRU would be responsible for DCSE referrals by submitting required documentation and information to DCSE for the establishment and termination of the Administrative Support Order. They currently are informed of residential admissions and discharges for their work on Medicaid documentation submissions.
6. Leland House placements would be exempt from referral to DCSE and a parental contribution would be charged for community-based services provided.

Attachments:

CSA Parental Contribution Assessment Comparison for Youth Receiving RTC/GH Services with DCSE Child Support VA Guidelines

All scenarios assume:

- Two-parents residing in the home
- Two children, one receiving CSA services, specifically RTC/GH Services
- Standardized CSA Parental Contribution assessment, with no *Other Sources of Income*, both youth under the age of 18 and the Adjusted Household Income of $8,100 allowable for youth in the home under 18 ($4050/child)
- There are other factors individual to family circumstances that can impact the calculations below; described below a very basic scenario

	CSA Parental Contribution Assessment RTC/GH Monthly Parental Contribution Amount	**DCSE Monthly Child Support Guideline Calculation**
$34k gross annual income	**$0**	**$400**
$45k gross annual income	**$0**	**$514**
$50k gross annual income	**$0**	**$574**
$75k gross annual income	**$174**	**$783**
$124,831 (Average Fairfax County) gross annual income [1]	**$491**	**$998**
$250k gross annual income	**$2,015**	**$1,556**
$350k gross annual income	**$4,274**	**$1,868**

[1] U.S. Census Bureau QuickFacts: Fairfax County, Virginia in 2019 dollars

Items to Note: For the DCSE Child Support calculations, there is financial adjustment made for each youth remaining in the home.

	Financial "Credit/Adjustment" Given for Youth Remaining in the Home (thus reducing the Monthly Child Support Amount)
$34k Gross annual income	$664
$45k Gross annual income	$468
$50k Gross annual income	$611
$75k Gross annual income	$835
$124,831 (Average Fairfax County) gross annual income [2]	$1,087
$250k Gross annual income	$1,625
$350k Gross annual income	$1,913

Example: $75K gross annual income / 12 months year=$6,250 gross monthly income

At this monthly gross amount, the VA Child Support Guidelines are reviewed at the $6,250 amount for one child (the one that remains in the home).

$835 is the amount that is subtracted from the gross monthly income amount ($6,250), and with the adjusted gross monthly income, $5,415, the VA Child Support Guidelines are referred to for one child (the one receiving RTC/GH services) the monthly child support amount is $783.

I added this information as it is 'similar' to the CSA assessment process for giving credit of $1,010 for each youth under the age of 18 residing in the home.

[2] U.S. Census Bureau QuickFacts: Fairfax County, Virginia in 2019 dollars

MEMO TO THE CPMT

June 25, 2021

Information Item I - 3: Community Service Board Service Updates

ISSUE: That the CPMT have updated information about current CSB youth crisis and outpatient services as well as services that will be changing over the next 6-24 months.

BACKGROUND: Changes to the following services will be described in a presentation.

- Behavioral Health Crisis Services in Fairfax
    - Local and Regional Crisis Services
    - Regional Call Center
    - Marcus Alert
- Expansion of STEP-VA Services
    - Expansion of Outpatient Services
    - Changes with Peer and Family Support Services
    - Changes with Veteran Services
- Continued Behavioral Healthcare Enhancements with Medicaid.

ATTACHMENT: PowerPoint Presentation

STAFF:
Daryl Washington, Executive Director, Community Services Board

CSB Local and Regional Services Update

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Community Services Board

STEP-VA: System Transformation, Excellence and Performance

FAIRFAX - FALLS CHURCH
Community Services Board

- Regional Crisis Call Center & Platform
- Peer Support Services
- Veterans Services
- Outpatient Services

STEP-VA Service	Fairfax FY 2022	Region 2 FY 2022
Crisis Call Center	*Regional Dollars Only*	*$1,294,600*
Peer Support Services	$221,185	$100,000
Veterans Services	$98,763	$174,600
Outpatient Services	$482,976 ($796,261 Total)	No Regional Funds

Regional Crisis Call Centers and 988

FAIRFAX - FALLS CHURCH
Community Services Board

- Federal legislation passed in 2020 allows the National Suicide Prevention Lifeline (NSPL) to be accessible by dialing 9-8-8 and accessible to localities July 2022
- In the Commonwealth, the Regional Crisis Call Centers will be designation as 9-8-8 Crisis Hotline Centers
- Regional Crisis Call Centers are expected to launch prior to 988, and will eventually be a part of the 988 system
- Goal is to have one number to call for behavioral health crises in our community

Regional Crisis Call Center Scope

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Community Services Board

Centralized number with telephonic, text, and chat options for individuals experiencing a crisis

24/7/365 access

Staffed by clinically trained professional, paraprofessionals, volunteers, and licensed staff, to deliver services through immediate emergency interventions

Capacity to deescalate crises over phone, linkage to regional and local resources, warm handoffs to community-based providers or hospital services, information and referral services and manage dispatch of mobile crisis teams

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Community Services Board

Local Mobile Crisis Response

Mobile Crisis Unit
- 703-573-5679; crisis response to community calls (2 units)

Community Response Team
- Outreach and care coordination for frequent utilizers of public safety services; referred through public safety system

Regional Mobile Crisis Response

REACH (Regional Education and Assessment Crisis Response)
- 855-897-8278); respond when the individual is suspected to have developmental needs

CR2 (Children's Regional Crisis Response)
- 844-627-4747; will respond when a child is suspected to have a behavioral health need.
- This program is expected to expand services to adults in the fall of FY22

What is the Marcus Alert System

The development and implementation of protocols focusing on:

- Full diversion of behavioral health system with specific requirements for mobile crisis and law enforcement
- Protocols to guide any co-responder programs or other community care models; and
- Protocols regarding police presentation, training, and behavior such as use of force in response to behavioral health emergency

Creation of additional mobile crisis or community care teams to respond 24/7.

- A public service campaign
- Launching Dec 2021 – July 2022 to educate the public and promote the Marcus Alert

A voluntary database made available to the 9-1-1 alert system

- Will provide mental health information and emergency contact information for response to an emergency or crisis

Marcus Alert Timeline

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Community Services Board

July 1, 2021

- DBHDS to develop plan, with diverse stakeholder input, for establishment of Marcus Alert and submit to General Assembly.
- Establish a voluntary database (DCJS) available to 911

December 1, 2021

- Establish and fully implement 5 Marcus alert programs and community care or mobile crisis teams. In Northern Virginia, Prince William will establish the 1st Marcus Alert Program.
- Initiate a public campaign to promote the Marcus Alert and create awareness.

July 1, 2022

- Every locality shall have established and implemented local protocols for both the diversion of certain 911 calls to crisis call centers and the participation of law enforcement in the Marcus alert system.
- Establish 5 additional Marcus alert system programs and community care or mobile crisis teams and add additional programs on an annual basis until all localities have Marcus Alert. In Northern Virginia, Fairfax will establish the 2nd Marcus Alert program.

July 1, 2026

- All areas must have Marcus Alert established and fully implemented by this date.

CSB Challenges and Opportunities

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Community Services Board

Medicaid Changes

- Medicaid Expansion
- Behavioral Health Enhancement
- Reimbursement for Substance Use Disorder Services

State Hospital Bed Crisis

- Anticipate Shortage of Available State Hospital Beds Will Continue

Staff Vacancies

- Critical Service Positions (Averaging more than 100)
- Multiple Strategies to Reduce Vacancies
- How to Effectively Align, Diversion First, Marcus Alert and STEP-VA Services and Resources

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Community Services Board

QUESTIONS & DISCUSSION

www.fairfaxcounty.gov/csb

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MEMO TO THE CPMT

June 25, 2021

Information Item I-4: Establishment of a Multi-Disciplinary Team (MDT) Process for FFPSA Implementation

ISSUE: That the Family First Prevention Services Act (FFPSA) will begin implementation effective July 1, 2021. State guidance now requires foster care prevention cases (In-Home Services) to access Title-IVE funded services through a local CSA process with appropriate cross-agency representation.

BACKGROUND: The FFPSA is comprehensive federal legislation intended to support evidence-based prevention services to families whose children are otherwise likely to be placed in foster care. By bolstering the provision of community and evidence-based interventions, the expectation is that fewer children enter foster care. The VDSS Prevention Plan includes Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), and Parent-Child Interaction Therapy (PCIT). These are the only prevention services funded by title IV-E when FFPSA is implemented in Virginia on July 1, 2021. For more information on the overall implementation of FFPSA in Virginia, please see https://familyfirstvirginia.com/

These children and families are determined to be eligible for foster care prevention services by DFS staff completing the title IV-E Candidacy Form, which documents the decision that the child is a "Candidate for Foster Care."

> *A "Candidate for Foster Care" is defined as a child identified in a prevention plan as being at imminent risk of entering foster care but who can remain safely in the child's home or in a kinship placement as long as services or programs that are necessary to prevent the entry of the child into foster care are provided. The term includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement."*

Recognizing the inherent value of MDTs, VDSS requires a multi-disciplinary review for all In-Home cases to access title IV-E prevention funds for any of the evidence-based services funded through the FFPSA. As currently required by statute, FAPT review is necessary for In-Home cases that seek CSA funding for foster care prevention services. To meet the MDT requirement for local DSS wishing to access IV-E funded evidence-based prevention services, local governments may choose from the following options:

a. Family Assessment and Planning Team for consultation or comprehensive review
b. Approved Alternate Multi-Disciplinary Team

Fairfax-Falls Church Current Process

Our local CSA program adopted the MDT process for community-based service plan development in FY16. Ratings on the Child and Adolescent Needs Assessment (CANS) tool are used to determine required agency participation in team-based service planning meetings/MDTs. Consistent with our current CSA procedures, if no agency other than LDSS is currently involved

with the family, the LDSS, using the assessment should determine which other agency or agencies should participate. Other parties or providers may participate as deemed necessary to the service planning process. The locality must take the following steps to establish an alternate MDT to implement the FFPSA:

a. The Director, VDSS Division of Family Services, or designee, must approve a request from the CPMT and LDSS Director to establish a collaborative, alternative MDT for accessing title IV-E prevention services funding.
b. Upon approval from VDSS, the CPMT, as provided for in COV §2.2-2648 (14), shall submit the request to the Office of Children's Services (OCS) for presentation to the State Executive Council for Children's Services (SEC), following OCS procedures. The SEC shall review and approve the request, as appropriate. See also: COV §2.2-5209

The CPMT member agencies are being requested to support the establishment of an MDT process that meets VDSS requirements. It is possible that broader agency representation for these MDTs will be needed that meet the needs of this specific target population. For example, some children may not be school-aged and an early childhood or developmental specialist would be more appropriate for service planning. The caregiver may also have unmet behavioral health care needs where representation by adult CSB services would be appropriate.

DFS child welfare staff working with the CSA program and the CSA Management Team will be developing a proposal for the MDT. Agency representation at MDTs and support in the application process is requested of CPMT member agencies.

ATTACHMENT: Guidance for Local Children's Services Act (CSA) Programs on the Virginia Department of Social Services (VDSS) Implementation of In-Home Services and the Family First Prevention Services Act (FFPSA), effective July 1, 2021

STAFF:
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Guidance for Local Children's Services Act (CSA) Programs on the Virginia Department of Social Services (VDSS) Implementation of In-Home Services and the Family First Prevention Services Act (FFPSA)

Effective July 1, 2021

I. Introduction and Purpose

The document guides Community Policy and Management Teams (CPMTs), Family Assessment and Planning Teams (FAPTs), and CSA Coordinators, working with local departments of social services (LDSS), in implementing the new VDSS foster care prevention practice model (referred to as "In-Home Services.")

As a part of In-Home Services, DSS is implementing the federal Family First Prevention Services Act (referred to in this document as FFPSA or "Family First"). FFPSA allows utilization of title IV-E funds to support specific evidence-based services to prevent foster care placement, creating a new funding stream for these services to families through the new In-Home model.

Implementation of the prevention In-Home model and Family First are interrelated. Both focus on the prevention of foster care placement. Consequently, the new In-Home model incorporates Family First requirements for accessing title IV-E funding for prevention services.

This guidance deals specifically with eligibility for title IV-E prevention services, not eligibility for title IV-E foster care. Eligibility for title IV-E prevention services under FFPSA **is not** based on the family's income, deprivation factors, or court documentation as needed for title IV-E foster care eligibility. Neither the implementation of Family First or the In-Home model changes the eligibility requirements for the title IV-E foster care or the process of how that eligibility is determined.

However, Family First does place new requirements on using title IV-E funds for youth in foster care in congregate care placements. Separate guidance for CSA Coordinators and local teams using "Qualified Residential Treatment Programs" (QRTPs) is available.

A. What is the Family First Prevention Services Act (FFPSA)?

The FFPSA is comprehensive federal legislation intended to support evidence-based prevention services to families whose children are otherwise likely to be placed in foster care. By bolstering the provision of community and evidence-based interventions, the expectation is that fewer children enter foster care. Family First allows the use of title IV-E funds, which are 50% federal and 50% state, to achieve this goal.

FFPSA may fund only certain evidence-based practices in mental health, substance use disorders and in-home parenting skills. The federal government has established a

clearinghouse which lists and provides information about evidence-based services that utilize title IV-E funds through the FFPSA. States must also notify the federal government which services they plan to implement through a title IV-E prevention plan. The VDSS Prevention Plan includes Multi-Systemic Therapy (MST), Functional Family Therapy (FFT), and Parent-Child Interaction Therapy (PCIT). These are the only prevention services funded by title IV-E when FFPSA is implemented in Virginia on July 1, 2021.

For more information on the overall implementation of FFPSA in Virginia, please see https://familyfirstvirginia.com/

II. Overview and Components of the VDSS In-Home Model

A. Why is an In-Home Model being Implemented?

The VDSS federal Child and Family Services Review (CFSR) noted areas needing improvement in local DSS practice, particularly the lack of service provision to families who had identified needs. The primary reason identified by a survey of local DSS staff was difficulty in engaging families in the receipt of services.

To address the weaknesses identified in the CFSR, VDSS developed a Program Improvement Plan (PIP) with input from local and state DSS and community partners. As family engagement was determined to be an issue, efforts to develop a more family-focused solution resulted in the reorganization and implementation of the new In-Home model.

B. Eligibility for Foster Care Prevention Services

All (formerly called) LDSS Child Protective Services (CPS) Ongoing and Foster Care Prevention cases are served through the In-Home model. The local DSS opens cases based on a high or very high classification on the Structured Decision Making (SDM) Risk Assessment. The In-Home model also includes "court cases" (e.g., a Child in Need of Services for whom the court has ordered LDSS to provide foster care prevention services).

These children and families are determined to be eligible for foster care prevention services by completing the title IV-E Candidacy Form, which documents the decision that the child is a "Candidate for Foster Care."

> *A "Candidate for Foster Care" is defined as a child identified in a prevention plan as being at imminent risk of entering foster care but who can remain safely in the child's home or in a kinship placement as long as services or programs that are necessary to prevent the entry of the child into foster care are provided. The term includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement."*

"Imminent Risk of Foster Care" is defined in Virginia "as a child and family's circumstances demand that a defined case plan is put into place within 30 days that identifies interventions, services and /or supports and absent these interventions, services and/or supports, foster care placement is the planned arrangement for the child."

Note: These definitions are on the DSS Family First website

The LDSS Family Services Specialist (FSS) completes the "Candidate for Foster Care" Form.

Children and their families who meet these foster care prevention criteria established by VDSS are eligible for CSA and sum sufficient services under CSA (COV §§ 63.2-905, 2.2-5211.B3., 2.2-5211.C., and 2.2-5212.4.). It is important to note that these children and families (CPS Ongoing or Foster Care Prevention) are already eligible for CSA services under the eligibility categories in the cited statutes.

The designation as a "Candidate for Foster Care" makes the child and family eligible for foster care prevention, no matter whether any specific funding source, including CSA, is accessed. However, this designation assures a child and family's eligibility for any of the evidence-based services offered in Virginia through FFPSA beginning July 1, 2021. As noted earlier, these three services are Multi-Systemic Therapy (MST), Family Functional Therapy (FFT), and Parent-Child Interaction Therapy (PCIT). Additional services are likely to be added to this list in the coming years.

C. Service Provision

1. What is Multi-Systemic Therapy?

Multi-systemic Therapy (MST) is an intensive treatment delivered in multiple settings. MST aims to promote pro-social behavior and reduce criminal activity, mental health symptomology, out-of-home placements, and illicit substance use in 12 – 17-year-old youth. MST addresses core causes of delinquent and antisocial conduct by identifying key drivers of the behaviors through an ecological assessment of the youth, family, school, peers, and community. Intervention strategies are individualized to address the identified drivers of behavior. More information about MST is found at: https://www.mstservices.com/.

2. What is Functional Family Therapy (FFT)?

Functional Family Therapy (FFT) is a short-term, family-based intervention program for youth and their families. FFT aims to address risk and protective factors that impact the adaptive development of 11 to 18-year-old youth referred for behavioral or emotional problems. Family discord is also a target. More information about FFT is found at: https://www.fftllc.com/.

3. What is Parent-Child Interaction Therapy?

Parent-Child Interaction Therapy (PCIT) provides coaching to parents by a therapist trained in behavior-management and relationship skills. PCIT is a program for two to seven-year-old children and their parents or caregiver to decrease externalizing child behavior problems, increase positive parenting behaviors, and improve the parent-child relationship. During weekly sessions, therapists coach caregivers in child-centered play, communication, increasing child compliance, and problem-solving. More information about PCIT is found at: http://www.pcit.org/.

Additional information on all three evidence-based practices is found at: https://familyfirstvirginia.com/

4. Other Prevention Services

Provision of services to children and families through the "In-Home" model is not limited to identified evidence-based services funded by title IV-E through FFPSA. Families may receive a wide range of prevention services. These include but are not limited to: mental health interventions; substance use disorder treatment; concrete supports (e.g., financial assistance with utilities, housing, transportation); or other community-based services (e.g., mentoring, individual or family support services or interventions). As is current practice, these services are funded from the appropriate source such as Medicaid, CSA, Community Services Board (CSB) Mental Health Initiative, DSS Promoting Safe and Stable Families (PSSF), and other designated DSS funding. FFPSA does not restrict the provision of other foster care prevention services. Instead, it simply adds a new funding source for the evidence-based services.

D. Assessment with the Child and Adolescent Needs and Strengths (CANS)

The implementation of FFPSA requires the use of an evidence-based functional assessment, such as the CANS. The CANS allows LDSS professionals to improve identification of a family's needs and strengths, service planning and provision, and ongoing review of the services' effectiveness in foster care prevention cases.

As the CANS is the mandatory uniform assessment instrument for CSA, a structure exists to support its use with In-Home cases. Currently, the CANS is administered to children and families receiving foster care prevention services reviewed by FAPT for possible CSA funding. The online CANS software system (CANVaS) is utilized for assessments of all foster care prevention cases (i.e., In-Home cases), even if CSA funding is not sought or provided. However, the system needs to have a way to identify which assessments are "CSA" and those done for In-Home cases. The rater identifies In-Home cases at the individual assessment level.

VDSS requires the administration of the CANS every 90 days for children and caregivers served through the In-Home model to assure the ongoing assessment of the family's needs and

strengths and evaluate progress towards meeting the goals on the prevention plan. Efforts should be made to avoid duplication of assessments. For example, a CANS assessment completed in the past 30 days for an In-Home case may be accepted by CSA if the child and family are referred to FAPT.

Local DSS agencies are encouraged to identify additional CANVaS Local Administrators (also known as DSU/RAs) to assist with case manager account creation, monitoring of completed CANS and access to the system reports for DSS, including In-Home cases.

Newly identified LDSS Local Administrators should review the guide describing the primary responsibilities of Local Administrators found on the OCS website in the CANS folder (www.csa.virginia.gov/CANS) or the "Documents" folder in CANVaS. There are no changes to the process for creating Local Administrators. The "Request to Create or Reactivate a Local Administrator Account" form must be completed, signed by the user and the user's supervisor, and sent to the attention of Carol Wilson in the Office of Children's Services (carol.wilson@csa.virginia.gov). A copy of the user's CANS certification must be attached.

The goal of the implementation of CANS is not only to meet a federal requirement for those cases that might require FFPSA funding. The intent is for the local DSS and community to have a commonly used and recognized functional assessment to help local foster care prevention staff carry out their job responsibilities. The use of the CANS acknowledges that the first step in providing human services is an assessment that allows a community, agency, and family members to identify strengths and needs and determine how to move forward in service plan development and implementation. Reassessments evaluate the progress towards those goals and allow the team to assess if other services may be more effective.

III. The Multi-Disciplinary Approach

A. The intent of MDT review

Recognizing that children and families are the community's shared responsibility, not any single agency's, VDSS requires multi-disciplinary teams to support the new In-Home service delivery model. MDTs are frequently used in children's services, particularly since the advent of the System of Care philosophy and principles in the 1980s.

Until this shift in services to children and families, service provision was primarily determined by the family's presenting problem and the agency to which they were referred. This practice resulted in inefficient and ineffective fragmentation and duplication of services provided through what are known as "silos," meaning agencies operated independently of each other.

The System of Care philosophy introduced the idea that families are ideally viewed holistically, not parceled out into separate program areas to address different issues. Families who come to the attention of agencies may have complex needs requiring a multi-disciplinary approach. The

focus on seeing the child and family as part of the community emerged. No one agency is responsible for working with the child and family; instead, the expertise and resources of all of the community's agencies should be brought to bear.

Multi-disciplinary review and coordination of services gather the community's strengths and resources to address the family's needs. The goal is to integrate the family into successful functioning in the community, not resolve an immediate crisis and "close the case." All community partners have the responsibility to provide the support the family needs. Without such a community-wide approach, the families and children in foster care prevention continue to be seen as "DSS cases." They may be likely to cycle back to DSS intervention through generations, or as Court Services Unit (CSU) cases with youth who move from juvenile status offenses, to delinquency and then adult crime.

B. Multi-disciplinary Review Teams and the In-Home Model

Recognizing the inherent value of MDTs, VDSS requires a multi-disciplinary review for all In-Home cases to access title IV-E prevention funds for any of the evidence-based services funded through the FFPSA. As currently required by statute, FAPT review is necessary for In-Home cases that seek CSA funding for foster care prevention services.

To meet the MDT requirement for local DSS wishing to access IV-E funded evidence-based prevention services, local governments may choose from the following options:

A. *Family Assessment and Planning Team (Comprehensive)*

A locality may opt to have In-Home cases reviewed by the regular FAPT, following the current local process for multi-disciplinary review and coordination of funding and services through CSA.

1. Family Assessment and Planning Team (Consultative)

As an alternative, a locality may wish to use the model of a "consultative" FAPT with reduced expectations and requirements. For example, the VDSS prevention plan may serve as the service plan. **The purpose of this team review is not to determine eligibility for CSA or provide funding through CSA but to provide the multi-disciplinary perspective regarding the use of an Evidence Based Practice (EBP).** As this is not a FAPT determining the CSA eligibility of youth or use of CSA funds, reduced documentation is permissible. This documentation may include a referral cover sheet, the VDSS prevention plan, which may substitute for the Individual and Family Services Plan (IFSP), and a current CANS. The FSS verbally provides the consultative FAPT with summary information.

The following chart outlines and compares the expectations of a Consultative and Comprehensive FAPT.

Activity	IN-HOME CONSULTATIVE FAPT	COMPREHENSIVE FAPT (likely to, or needing CSA funding)
Eligibility	Children and families being served through "In-Home" practice standards as established by the Virginia Department of Social Services (VDSS) who meet the criteria established for "imminent risk" as defined by VDSS. These children and families are eligible (and sum-sufficient) for CSA as they are receiving foster care prevention services in accordance with COV §63.2-905 (Foster Care Services).	
Referral Process	**Services not funded by CSA may begin before FAPT review.** While only essential referral information is encouraged, localities should decide what information is needed to offer a helpful consultation. The In-Home worker could provide a simplified referral cover sheet, the proposed prevention plan, and an oral description of the case (e.g., why the family came to the attention of DSS, why an in-home case is opened, needs and strengths as identified on the CANS, what services or supports are in place or DSS plans to put in place, etc.) VDSS Prevention plans may substitute for IFSPs.	If a case never requires CSA funds, a Comprehensive FAPT is unnecessary. If at the "In-Home" (Consultative) FAPT it is determined that CSA funds are needed, local practice determines what information from the "In-Home FAPT" may be used for referral to a Comprehensive FAPT to eliminate duplicative information/ paperwork. If known at the outset that CSA funds are needed or likely to be needed, the case should go directly to Comprehensive FAPT using current local CSA processes (no Consultative FAPT held).
CANS Requirements	Every 90 days as determined by VDSS. CANVaS is modified to flag In-Home cases when no CSA funding is accessed.	No changes to State Executive Council (SEC) Policy or current local practice. A new CANS is not needed for a Comprehensive FAPT if a CANS was completed in the previous 30 days.
FAPT Roles/Activities	FAPT's role is one of consultation, coordination, service recommendations, and periodic case reviews.	No changes to current practice.
Time Frames for Action by FAPT	VDSS policy requires a Prevention Plan and a CANS done within the first 30 days. Services funded by FFPSA may begin before FAPT review.	Cases should be reviewed promptly. Local CPMTs are required by Code to have policies allowing immediate access to funds for placement and services. If emergency CSA funding is needed, the case comes to Comprehensive FAPT with the usual 14-day requirement for FAPT review of emergency placements/services.
Service Plan Requirements	In-Home Prevention Plan to include a parental signature.	In-Home Prevention Plan to include a parental signature.
Audit Requirements	Title IV-E funding is reviewed/audited by VDSS.	No change to current practice. CSA funds are subject to OCS audit.

Activity	IN-HOME CONSULTATIVE FAPT	COMPREHENSIVE FAPT (likely to, or needing CSA funding)
CPMT Role/Activities	Current role of policy and practice oversight/coordination. Broad system oversight/CQI at the local level. Encourage review of data in light of new structure and practices (outcomes, increased referrals for/use of CSA funds for FC prevention, implementation of evidence-based practices through FFPSA, etc.). Discuss how to integrate EBPs across all child-serving systems. Develop policy re: the referral and operation of the Consultative FAPT. CPMT authorization of non-CSA expenditures is not required.	Current role of policy and practice oversight/coordination. Broad system oversight/CQI at the local level. Encourage review of data in light of new structure and practices (outcomes, increased referrals for/use of CSA funds for FC prevention, implementation of evidence-based practices through FFPSA, etc.). Discuss how to integrate EBPs across all child-serving systems. Develop policy re: the referral and operation of the Consultative FAPT. CPMT authorization of CSA expenditures.
Data Requirements	CANVaS captures assessment data from In-Home cases. These cases are entered into LEDRS as title IV-E/FFPSA. Required data from EBPs is tracked by FFPSA evaluators and included in the service provider contracts.	No changes to current state practice.
Case Review Requirements (UR)	As determined by VDSS.	No changes to the current state or local practice.
Use of Approved Alternate MDT for In-Home Cases	May be appropriate. MDTs may have specialized focus and slightly different requirements. MDTs require VDSS and SEC approval.	No changes to current local practice. MDTs require SEC approval.
Service Contracting, Invoicing, and Payment	VDSS reimburses the LDSS through a budget line in LASER. VDSS (along with OCS) issued an EBP "model contract template" for either local CSA or LDSS that includes standard service prices. The locality determines how contracting, invoicing, and payment for services occur.	Current contracting, invoicing, and payment practices continue.
Parental Co-Payment	No co-pay required unless the funding source used requires a co-pay.	No changes to current state and local co-payment policies.
Local Policy Development	Localities develop minimal standards for referral to Consultative FAPT and include this in local policy. The policy should describe how FAPT is used as a consultative multi-disciplinary team.	Local CPMTs are required by Code to have policies that allow immediate access to funds for placement and services. If emergency CSA funding is needed, the case comes directly to the Comprehensive FAPT with the usual 14-day requirement for review. The locality develops policy describing how In-Home cases previously

Activity	IN-HOME CONSULTATIVE FAPT	COMPREHENSIVE FAPT (likely to, or needing CSA funding)
		heard by Consultative FAPT are referred to Comprehensive FAPT.

a. Referral from a Consultative FAPT to a Comprehensive CSA FAPT

The consultative FAPT may, during its review, determine that additional services are needed for the child and family. If so, the consultative FAPT "refers" the case to a (Comprehensive) FAPT. Each locality must develop a policy regarding how these referrals are made and the associated expectations. Once the case is referred to the FAPT process for possible CSA funding, it is treated like any other case coming to FAPT. The CPMT must approve CSA funding.

2. Approved Alternate Multi-Disciplinary Team (MDT)

The third option for localities is to request an alternative MDT to review only In-Home cases seeking access to a title IV-E funded EBP. The Code of Virginia provides for such alternate multi-disciplinary teams (MDTs), established per COV §2.2-2648 (14) and State Executive for Children's Services Policy 3.2.2.

Creation and implementation of an approved alternate MDT allows a local government to design a team which best fits local needs. Decisions such as which agencies would serve on the team, if other parties will be represented on the team (e.g., private providers), whether it is a standing or ad hoc group and whether there is a financial limit (e.g., only hearing cases with a potential cost of up to a certain amount) are determined by the CPMT, which then submits the request to VDSS and then OCS to review for SEC approval. If an alternate MDT is established and approved, it may substitute for a Comprehensive FAPT. A request for CSA funding may be submitted directly from an alternate MDT to the CPMT.

The alternate MDT may not be the DSS Family Partnership Meeting, held at specific and critical decision points. The alternative MDT may be a "Child and Family Team," with the inclusion of the requirements outlined in this document. To become an approved MDT, the Child and Family Team must meet the approval process for an alternate MDT. The partner agency representatives are determined based on the specific needs of the child and family as determined by the CANS and the LDSS. For example, the child's CSB therapist may serve as the CSB representative. If no agency other than LDSS is currently involved with the family, the LDSS, using the assessment should determine which other agency or agencies should participate. Other parties or providers may participate as deemed necessary to the service planning process. The locality must take the following steps to establish an alternate MDT to implement the FFPSA:

a. The Director, VDSS Division of Family Services, or designee, must approve a request from the CPMT and LDSS Director to establish a collaborative, alternative MDT for

accessing title IV-E prevention services funding. Upon approval from VDSS, the CPMT, as provided for in COV §2.2-2648 (14), shall submit the request to the Office of Children's Services (OCS) for presentation to the State Executive Council for Children's Services (SEC), following OCS procedures. The SEC shall review and approve the request, as appropriate. See also: COV §2.2-5209.

b. Requests for such approval shall be in writing and made available for review by the VDSS, OCS, and the SEC.
c. The CPMT and LDSS shall develop and approve written policies governing the membership and operation of the MDT. The CPMT and LDSS shall make these policies available for review to VDSS and OCS before referral to the SEC for consideration. The policies must specify:
    i. The purpose of the MDT, including the types of cases/circumstances that will be considered.
    ii. How the MDT procedures and practices align and integrate with those of the CPMT's member agencies.
    iii. Whether the MDT shall be a standing team that meets regularly or if it will operate on an ad hoc basis. If on an ad hoc basis, under what circumstances will the MDT be convened and through what procedure. Examples of regular, standing MDTs include teams for children in residential care, truancy cases, or In-Home Services/foster care prevention.
    iv. The minimum number of agency representatives constituting the MDT (from among the FAPT-required member agencies). This specification shall identify the agencies represented on the MDT and processes for soliciting additional input from other agencies, as needed.
    v. How the MDT includes family engagement practices and be family-driven.
    vi. The process through which funding approval requests will be submitted directly from the MDT to the CPMT for any CSA-funded expenditures and from the MDT to the LDSS for Family First title IV-E prevention expenditures.
    vii. The process through which title IV-E prevention expenditures will be submitted through the Local Expenditure, Data and Reimbursement System (LEDRS) T4E (Title IV-E) file.
    viii. How the MDT will utilize: interagency collaboration and family involvement to assess the family's strengths and needs; assessment tools to identify appropriate services; monitor service delivery and progress towards treatment goals; and establish ongoing community support for the family for when the child welfare case is closed.
    ix. How the MDT process and outcomes are regularly documented and reviewed.

If the option of an approved alternate MDT is chosen, the locality needs to establish this process and include it in its written policy.

C. Local Procedures Regarding the Multidisciplinary Review

Each local DSS, CSA, including FAPT and CPMT, and agency partners must work collaboratively to decide how to incorporate the requirement for multi-disciplinary review of In-Home cases seeking FFPSA funding. One of the three described above options must be chosen. Local policy will reflect the expected flow of In-Home cases seeking title IV-E funding for EBP services from LDSS to either the comprehensive FAPT, the consultative FAPT, or an approved MDT.

IV. Role of the CPMT

Consistent with the statutory expectations of the CSA, the CPMT provides oversight and leadership in coordinating the community's response to all identified children and families, including those receiving title IV-E funded foster care prevention services. With the introduction of the FFPSA, this role includes maintaining awareness of the utilization and impact of the new In-Home prevention practices (e.g., increased/decreased referrals for the use of CSA funds for foster care prevention, outcomes, and the integration of evidence-based practices across all child-serving agencies)

There are no changes regarding statutory expectations and the roles of FAPT and CPMT in the implementation of CSA, including eligibility and funding. FAPT may provide a multi-disciplinary review for any referred child and family in the community, even if CSA funds are not needed.

V. Contracts

Each locality determines how contracting, invoicing, and payment for the title IV-E funded evidence-based services are managed. Localities may use existing CSA contracting, purchasing, and invoice processing systems or develop FFPSA-specific processes. As Family First funding is directed from VDSS to the local DSS, LDSS agencies use current financial processes to obtain reimbursement through the VDSS LASER system. However, Family First requires specific client-specific data not captured in LASER. Following VDSS guidance, this information is to be submitted through the title IV-E capabilities of the CSA LEDRS system.

OCS Administrative Memo #21-08 provides a model contract template for the evidence-based services which may be purchased either through title IV-E or CSA.

VI. Use of the Local Expenditure, Data, and Reimbursement System (LEDRS)

Effective July 1, 2021, the LDSS shall submit all expenditures of title IV-E payments for Foster Care and In-Home Prevention Services through the Local Expenditure, Data, and Reimbursement System (LEDRS) T4E (title IV-E) file. The VDSS Division of Family Services and the Office of Children's Services (OCS) worked collaboratively to update the current LEDRS

system to accommodate the additional required federal reporting for the Family First Prevention Service Act (Family First).

The LEDRS T4E file submission with the appropriate filename must be submitted quarterly based on the schedule below.

Date Range	Expenditure File Report Due	Filename
July 1 - Sept 30	31-Oct	T4E_*FIPS*_Q_*YYYY*_1_1.txt
Oct 1 - Dec 31	31-Jan	T4E_*FIPS*_Q_*YYYY*_2_1.txt
Jan 1 - Mar 31	30-Apr	T4E_*FIPS*_Q_*YYYY*_3_1.txt
Apr 1 - Jun 30	31-Jul	T4E_*FIPS*_Q_*YYYY*_4_1.txt

FIPS = County FIPS Code (no padding of zeros)
YYYY = 4 digit calendar year of the file submission

The submission through LEDRS of expenditures of title IV-E funds for both Foster Care and In-Home Prevention Services allows VDSS to enhance their quality assurance and accountability reviews of title IV-E.

VII. DSS State and Federal Reporting

LDSS shall submit all required state and federal reporting for all title IV-E prevention services funding. The following information shall be submitted through a combination of methods, including LEDRS, LASER, and the Child Welfare Information System:

A. Client-Level Information and Spending

	Child Welfare Information System (OASIS/Compass Mobile)	LEDRS
Client's Full Name	X	X
Date of Birth	X	X
Client ID	X	X
Child's Case ID	X	
Identified Referral Reason	X	
Service Name	X	X
Service Start Date	X	X

Service End Date (projected end date if service is still ongoing)	X	X
Total Estimated Cost of Services		X
Total Amount Billed For Service		X

B. Budget Line 835 IV-E Prevention Services Information (LASER)

1. Total amount allocated
2. Actual use of funds
3. Projected use of funds

MEMO TO THE CPMT
June 25, 2021

Information Item I- 5: Review of Human Services Issue Paper for CSA Program

ISSUE:
Board input is being solicited in the development of the Human Services Issue paper for program areas. That the CPMT members would review the CSA program section and offer guidance to be considered by the Board of Supervisors.

BACKGROUND:
In preparation for upcoming legislative sessions, the County annually develops a summary of human services issues and positions for review by the Board of Supervisors. The County Executive has asked for agency review by **July 8, 2021,** and input from Boards, Authorities, and Commissions by **August 3, 2021.** Revisions to existing items in the Issue Paper will be presented to the Board in a draft of the Issue Paper (not re-vetted by the Board as a new item).

The following section represents the position for CSA with a revision proposed by CSA staff:

Children's Services Act (CSA)

Support continued state responsibility for funding mandated CSA services on a sum sufficient basis. Oppose changes to CSA that shift costs to local governments, or disrupt the responsibilities and authorities assigned to the County by CSA. Also support the current structure, which requires that service decisions are made at the local level and are provided based on the needs of each child, ensuring that service expenditures are approved through local processes.

CSA provides funding to plan and provide services to children who: have serious emotional or behavioral problems; need residential care services; need special education through a private school program; or receive foster care services. It is a state-local partnership requiring an aggregate match of approximately 46 percent in Fairfax County. Children receiving certain special education and foster care services are the only groups considered mandated for service, and sum sufficient language ensures state and local governments provide funding necessary for such youth. As a redesign for the provision of behavioral health care services occurs at the state level to include changes to the state's Medicaid plan, the County should support policy alignment with CSA and continued local decision-making. ~~*State rate-setting, and a study of rate-setting for public day special education services, needs to be closely monitored for any potential local impact.*~~. *Planning in FY 22 to re-organize funding for private special education services from CSA to VDOE will require local participation and monitoring to assess budgetary and service integration impact*. *(Updates and reaffirms previous position.)*

ATTACHMENT:
None

STAFF:
Janet Bessmer, Program Manager,
Children's Services Act