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

October 29, 2021
Community Policy and Management Team (CPMT)

Agenda

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

1. **MINUTES:** Approve minutes of September 24, 2021 meeting

2. **ITEMS:**

- **Administrative Items**
  Item A – 1: Revision to CSA Policy Manual: Expedited Service Planning and Emergency Access
  Item A -2: Public Comment to OCS – Policy 3.2 FAPT/MDT and Policy 3.3 Family Engagement

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

- **Information Items**
  Item I – 1: Budget Report
  Item I – 2: Quarterly CPMT Data Report
  Item I – 3: CSB Hospital Diversion Project

- **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

September 24, 2021
Community Policy and Management Team (CPMT)
Virtual Meeting due to COVID-19 Emergency Procedures

Meeting Minutes

Attendees: Lesley Abashian (office), Staci Alexander (home), Michael Becketts (office), Jacqueline Benson (home), Michelle Boyd (home), Deb Evans (home), Annie Henderson (office), Joe Klemmer (home), Richard Leichtweis (home), Chris Leonard (office), Dawn Schaefer (office), Deborah Scott (office), Rebecca Sharp (office), Lloyd Tucker (office), Daryl Washington (home)

Attended but not heard during roll call:

Absent: Gloria Addo-Ayensu, Cristy Gallagher, Robert Bermingham, Nancy Vincent

HMF Attendees: Peter Steinberg, Tracy Davis, Desiree Gordon, Jim Gillespie, John Raekwon (intern)

CSA Management Team Attendees: Kelly Conn-Reda, Xu Han, Barbara Martinez, Terri Byers, Jessica Jackson, Tim Elcesser, Barbara Martinez, Julie Bowman, Jesse Ellis, Matt Thompson, Kamonya Omatete, Cathy Muse

Stakeholders and CSA Program Staff Present: Janet Bessmer, Patricia Arriaza, Sarah Young, Samira Hotochin, Kristina Kallini, Chris Metzbower, Shana Martins, Muhammad "Usman" Saeed, Amee Vyas, Andrew Janos

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 Jackie Benson; 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 Staci Alexander; 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 Annie Henderson; all members agree, motion carries.

Approved:

1. **MINUTES:** Approve minutes of July 30, 2021. *Motion made by Rick Leichtweis; second by Deb Evans; all members agree, motion carries.*

2. **ITEMS:**

- **ADMINISTRATIVE ITEMS:**
  Item A – 1: Approve Reappointment of FAPT Representative. Presented by Sarah Young. Approval of appointment of Nicole O'Connor (Department of Family Services) to serve on the FAPT since the DFS representative that previously served has left the agency. *Motion made by Lesley Abashian; second by Rick Leichtweis; all members agree, motion carries. Michael Becketts abstained*

- **CSA CONTRACT ITEMS:**
  Item C – 1: Monthly Out-of-State Placement Approvals – Presented by Barbara Martinez. Three Child Specific Requests were approved by the CSA Management team since the last CPMT meeting. This makes a total of eight youth placed out of state under a Child Specific Contract. Michael Becketts asked if there is a plan for the student placed in Maplewood School to return to the community as this youth has been in placement since 2015. Barbara Martinez suggested reaching out to Kelly Conn-Reda (MAS) regarding details of plan for return to the community. Michael Becketts requested that someone familiar with the case provide a brief background offline so we can explore other options for this youth if he is not able to return to the community.

- **CSA INFORMATION ITEMS:**
  Item I – 1: Budget Report – Presented by Usman Saeed. Review of budget report.
  Item I – 2: Policy Review of Expedited and Emergency Access to Services. Presented by Janet Bessmer. Members were provided with a summary of the changes/updates to the policy manual that will be proposed at the Oct meeting for approval. Daryl Washington asked if there is an any potential unanticipated risk to family/youth, agency, or any financial risk with these clarifications to the policy manual, specifically with the emergency/expedited services. Janet Bessmer responded that with expediated services there is risk that family or agency will be financially responsible since they are moving forward with a service without official approval from CSA. The current internal procedures to prevent risk of certain emergency placements such as Leland. However, with any new projects we will need to conduct a thorough review to ensure there is no financial risk to youth/families, agencies, etc. Michael Becketts asked who bears the financial risk if the case manager begins services before going through the CSA process first. Janet responded that the agency who initiated the service is financially responsible. Daryl Washington inquired about how this effects the Leland process. Janet stated that there is no intention of changing the current procedures for Leland, just clarification on current process. If anyone sees any language that can affect the current Leland procedures notify Janet before the next CPMT meeting.
  Item I – 3: Annual CSA Policy Manual Updates. Presented by Patricia Arriaza. The changes that were presented were not policy or procedural changes. Edits were made for clarification purposes.
  Item I – 4: Quarterly Serious Incident Report. Presented by Patricia Arriaza. Shared overall volume of SIRs and summarized description of three incidents that were presented to CSA management team.

- **HMF INFORMATION ITEM:**
  Item I – 5: American Rescue Plan Act (ARPA) Funds to Expand Short Term Behavioral Health Services (STBH). Funding was approved for STBH program to expand to 15 elementary schools in were the free and reduced lunch rate is over 70% and in neighborhoods that were disproportionally affected by COVID 19. This funding will also be used to hire another Management Analyst III position for HMF.

- **NOVACO – Private Provider Items –** Deb Evans discussed the intensity of in-home and Evidence Based Treatment (EBT) programs. Providers are finding it difficult to find qualified mental health professionals to fill and/or remain in these positions. It is taking a long time to get workers to

trained/qualified in EBTs. Furthermore, there are not enough referrals coming in to give workers cases. Clinicians are leaving their position due to lack of referrals. Lesley Abashian brought this issue to SLAT. Michael Becketts suggested discussing with agency directors and offered to have NOVCO come to a meeting with surrounding areas DFS directors to raise the issue.

- **CPMT Parent Representative Items –** none

- **Cities of Fairfax and Falls Church Items –** none

- **Public Comment –** Mary Ottinot (parent), who is currently involved in the foster care and mental health systems, had some concerns regarding parent rights and responsibilities and appeals process. Ms. Ottinot also expressed concern regarding oversight, monitoring and accountability of services. She feels that there are deficits in the policy manual and offered to assist with updates to policies. Expressed interest in becoming a parent representative for CPMT.

Next Meeting: October 29, 2021, 1:00 – 3:00pm TBD

Adjourn 2:27 pm – *Motion made by Rick Leichtweis**.** Second by Daryl Washington**.** All members approved.*

Approved:

MEMO TO THE CPMT

October 29, 2021

Administrative Item A- 1: Proposed Revision to Policy on Expedited FAPT Service Planning and Emergency Access to Services

ISSUE: That CPMT approve updates to the section of the local policy manual about Expedited FAPT Service Planning and Emergency Access to Services to reflect current practices and to expand access for youth at-risk of psychiatric hospitalization.

BACKGROUND: The Family Assessment and Planning Teams (FAPTs) meet weekly and review a consent agenda of service requests prior to holding service planning meetings for consideration of residential treatment. For purposes of expediting access to a limited array of services, FAPT serves as a temporary multi-disciplinary team to meet the requirement of "team-based service planning" until a unique multi-disciplinary team for the child can be formed. The services that can be accessed through this process are limited in scope and duration (i.e., not to exceed 60 days) to serve as temporary supports until a full assessment can be completed, a comprehensive service plan developed, and coordination across agencies, providers, and the family can occur. Because the allowable services are specified, time-limited and temporary, utilization review is not conducted.

The consent agenda includes certain types of service requests that either are: 1) for basic supports for team-based planning such as Family Partnership Meeting facilitation, Family Peer Support Partners, and Case Support or 2) are for short-term services that are needed on an emergency basis to include foster homes, Leland House, and interventions requested by DFS child welfare staff to prevent entry into foster care. In addition, this section of the manual describes the process used by direct care staff from the Department of Family Services, Children, Youth & Families Division to obtain approval for a list of supportive services that are consistent with "maintenance" or non-clinical supports for youth using standard language in the IFSP.

The CSA Management Team supports a request by the CSB to add one additional target group to the policy permitting expedited service planning for hospital diversion. The additional section to the policy would permit youth who are at-risk of hospitalization to access short-term, community-based supports until a multi-disciplinary team (MDT) can be convened to develop a comprehensive service plan. Using the FAPT for expedited service planning will offer children and families quicker access to up to 60 days of supports while still permitting CSA staff to review documentation for compliance with funding requirements and provide an authorization prior to the initiation of services.

To implement this expansion of services, the CSA program staff recommend CPMT approval of the following provisions:

- that the initial phase of implementation for hospital diversion offer services to youth who either have been 1) assessed by CSB Emergency Services within the past 14 calendar days, 2) are currently admitted to an acute psychiatric hospital or boarding at a hospital emergency department, or 3) have been discharged from the above mentioned facilities within the past 14 calendar days.

- that CPMT offer a new type of waiver of the parental contribution for up to 60 days for these diversion cases when the youth is a new referral to CSA. Families would complete the parental contribution assessment before authorization of any additional CSA funded services. Active CSA cases may be offered the services, if needed, at the rate within their current Parental Contribution Agreement.

- that the package of services offered for youth needing hospital diversion have an expenditure limit of $5,500 per youth annually. This service limit permits up to 50 hours of home-based intervention, coordination of care and assessment. Providers would be identified who would offer these services which can include case management activities such as referring youth to community resources, assisting them with access to services covered by insurance, convening a Family Resource Meeting and rating the CANS to assist in the development of a longer-term service plan.

Implementation: The plan for implementation should include:

- Development of a referral process and identification of a liaison or point of contact within the county
- Creation of a tracking process of youth outcomes to determine if additional hospitalizations were prevented
- Identification and training of providers to offer these short-term services and provide case management
- Identification of case management resources sufficient to meet the needs of this group
- Establishment of a reasonable implementation date.

FISCAL ANALYSIS:

It is estimated that up to 100 new youth could be linked to needed community-based services for up to 60 days through the proposed Expedited Service Planning process. The County will continue to identify private insurance, Medicaid, or other potential funding services available to a family to fund these needed services for crisis stabilization. However, assuming few resources are identified for this intensive period and a youth qualifies for CSA funding, the per youth cost to CSA pooled funds would be $5,500 for case management, a bio-psychological assessment, and up to 50 hours a week of intensive in-home services. Total costs for the entire population of 100 youth would be $550,000. That amount would be offset with state matching revenue of $76.94%, or $423,170, for a net cost to the County of $126,830. The estimated amount of parental contributions that would not be collected, if the new waiver is approved, is $25,600.

The FY 2022 Adopted Budget Plan for CSA provides sufficient budget at this time to support the estimated $550,000 in costs prior to state reimbursement. The CSA appropriation level will be closely monitored during FY 2022 to assess any additional impacts to the budget resulting from this proposal or from an overall post-pandemic emergency surge in cases, so that the County budget process can be used to request any needed adjustments to the appropriation level. In the longer term, this Expedited Service Planning process is anticipated to result in a positive containment of growth in residential placements, due to a more timely insertion of community base services and case management immediately when a child needs it after referral to the County by a hospital or Crisis Intervention partner.

ATTACHMENT:
Current Policy and Draft Policy Revision

STAFF:
Janet Bessmer, Ph.D., CSA Director
Theresa Byers, DFS Fiscal Manager

Attachment A: Current Policy Manual

8.2 Services Eligible for Expedited FAPT Services Planning

For children in foster care and children at-risk of entering foster care served by DFS Child Protective Services (CPS) and Protection and Preservation Services (PPS) the following services may be requested with standard language incorporated in the IFSP/MAP. The use of standard language incorporated in the IFSP/MAP or IFSP-EZ to request services for children at-risk of entering foster care served by DFS CPS and PPS is limited to six months after the initial CSA service approval.

Service	Foster Care	CPS/PPS/Kinship*
Camp/Socialization/Recreation programs and activities	✓	✓
Summer youth employment programs	✓	✓
Youth & family travel costs for visitation, appointments and training related to the IFSP/MAP or foster care service plan (not for Medicaid or IV-E eligible expenses)	✓	✓
Parenting and anger management classes	✓	✓
Family Partnership Meetings	✓	✓
Translation/Interpretation services to support clinical services only	✓	✓
Court testimony (8 hours per subpoenaed provider per day per hearing; not for expert testimony)	✓	✓
Respite (in-home and out of home)	30 days/year maximum	Maximum of $5,000 and/or 15 calendar days over 6 months and not to exceed 14 consecutive days out of home
Non-Medicaid reimbursable medical expenses excluding behavioral health care services	✓	$1,000 annual maximum
Legal fees	✓	
Driver's education	✓	
School-related fees (excluding private school tuition)	✓	
Out-of-State public school tuition	✓	
Foster/adoptive home studies	✓	
Court-ordered evaluations/assessments from CSA-contracted providers	✓	
Tutoring	$3,000/year max	
***reference UR service authorization note for eligible dates of service**		

Emergency Situations Eligible for Expedited FAPT Service Planning

Emergencies are defined as those crisis situations in which the lead case manager and his/her supervisor, in consultation with the family when possible, agree that the child needs immediate placement or the child and family is in need of immediate services in order to prevent foster care

placement of the child. Per Virginia Code, prior to placing a child outside Fairfax-Falls Church, it is required that all appropriate community services for the child be explored.

When a child has been determined in need of immediate services to prevent foster care placement, documented by a DFS workers' signature on the CSA Eligibility form, community-based services may be approved by FAPT for up to 60 days through an expedited service planning process. Services beyond 60 days require development of an action plan by an FPM or FRM.

When a child in DFS custody must be placed in treatment foster care on an emergency basis, treatment foster care services may be approved by FAPT for up to 60 days through an expedited service planning process. Services beyond 60 days require development of an action plan by an FPM or FRM.

When the residential placement of a youth in foster care is made on an emergency basis a Consent, Case Manager Report to FAPT and CANS must be submitted to the CSA office within two business days and a FAPT review must occur within 14 calendar days after services have commenced. The FAPT review shall be scheduled at least five business days following receipt of a correct Consent, Case Manager Report to FAPT and CANS to provide time for a Utilization Review Report to be completed.

Per Virginia Code, Medicaid providers must be used when available and appropriate. Additionally, providers under contract shall be used when available and appropriate.

Only mandated funds can be used to purchase such services. Funds are not set aside for emergency services for non-mandated youth; therefore, a service authorization must be obtained non-mandated funds must be available prior to commencing services for non-mandated youth. When an emergency as defined above occurs, the lead case manager may proceed to obtain the needed services.
The agency taking the emergency action assumes the role of case manager. If the child/family has a case manager within another agency/department, the agency taking the emergency action will notify that case manager of the emergency authorization as soon as possible.

Procedures for Flexible Response to Emergency Needs

An IFSP-EZ must be submitted to the CSA Office within two business days after community-based services, treatment foster care services, and short-term residential or group home placements (maximum length of stay of 90 days or less) have commenced on an emergency basis. A FAPT review must occur within 14 calendar days following the onset of services in an emergency, or within 14 days of submitting the IFSP/MAP if services have not yet commenced. The CANS must be submitted within 10 calendar days of services commencing.

UR may approve funding for transportation and other short-term/emergency needs that are necessary to support the youth and family in meeting IFSP/MAP goals. Before considering CSA funding the case manager and FAPT shall assess the family's ability to meet their needs without CSA funding, and the availability of other community resources. For families needing support to drive to services or placements, gas cards may be issued, with the amount determined per this scale:

- less than 100 miles/month: $10/month
- 100-150 miles/month: $15/month
- 150-200 miles/month: $20/month

For each additional increment of 50 miles, an additional $5 is provided. Gas cards may be issued prior to the first month of driving, but thereafter actual travel to services placements in the previous month must be verified prior to issuing a card for the next month.

Gift/Gas Card Policy

CSA use of gift/gas cards will be guided by the DFS Gift/Gas Card Policy (effective May 10, 2020).

- Calculation of gift/gas card value shall be based on the lowest value possible to meet the need.
- Gift/gas cards shall:
    - Be maintained in a secure safe;
    - Be tracked using a safe log; and
    - Provided to families via the use of the Gift/Gas Card Request and Client Affidavit. The family will be required to acknowledge review of Terms and Conditions and receipt of card by signing the Client Affidavit.
- The lead case manager shall be responsible for requesting and acquiring the gift/gas card from the designated CSA staff. The lead case manager shall ensure the client signs the Gift/Gas Card Request and Client Affidavit.
- The lead case manager shall be responsible for returning the signed Client Affidavit to designated CSA staff (email is permissible).

Emergency Psychiatric Hospitalizations

In the case of the need for emergency hospitalizations in a private psychiatric facility, all children must be evaluated, and prescreened if appropriate, by CSB Mental Health Services. The purpose of this process is to explore alternatives to hospitalization; determine whether voluntary or involuntary status is appropriate if hospitalization is necessary; assist in securing a bed and to facilitate the hospitalization; and make use of public resources, to include Medicaid. Evaluations and pre-screenings can be arranged through the local CSB Mental Health Resource Team member from the office located in the area where the youth resides. Psychiatric Hospitalizations are typically funded through private insurance or Medicaid and are generally not a CSA-funded service. If you have questions regarding funding, please call the CSA program office at (703) 324-7938.

Attachment B: Proposed Policy Manual

8.2 Services Eligible for Expedited FAPT Service Planning

FAPT reviews requests for services specified on the IFSP-EZ form and can provide expedited team-based service planning on a limited basis. Services are not authorized to begin prior to review of complete documentation by the FAPT.

1. ***Services that support team-based planning (e.g., Case Support, Family Partnership Meetings, and Family Peer Support Partners) may be requested using the IFSP-EZ form.***
2. ***Time-limited services may be requested for youth who are identified for psychiatric hospital diversion. Hospital diversion referrals may be made for children who have been 1) assessed by CSB Emergency Services within the past 14 calendar days, 2) are currently admitted to an acute psychiatric hospital or boarding at a hospital emergency department, or 3) have been discharged from the above mentioned facilities within the past 14 calendar days. Up to 60 days of short-term, community-based services may be approved. Additional services beyond 60 days may be requested using standard procedures with compliance to all CSA requirements.***
3. For children in foster care and children at-risk of entering foster care served by DFS ~~Child Protective Services (CPS) and Protection and Preservation Services (PPS)~~ **Children, Youth and Families Division**, the following services may be requested with standard language incorporated in the IFSP/MAP. The use of standard language incorporated in the IFSP/MAP or IFSP-EZ to request services for children at-risk of entering foster care served by DFS **CYF** ~~CPS and PPS~~ is limited to six months after the initial CSA service approval.

Service	Foster Care	CPS/PPS/Kinship*
Camp/Socialization/Recreation programs and activities	✓	✓
Summer youth employment programs	✓	✓
Youth & family travel costs for visitation, appointments and training related to the IFSP/MAP or foster care service plan (not for Medicaid or IV-E eligible expenses)	✓	✓
Parenting and anger management classes	✓	✓
Family Partnership Meetings	✓	✓
Translation/Interpretation services to support clinical services only	✓	✓
Court testimony (8 hours per subpoenaed provider per day per hearing; not for expert testimony)	✓	✓
Respite (in-home and out of home)	30 days/year maximum	Maximum of $5,000 and/or 15 calendar days over 6 months and not to exceed 14

Service	Foster Care	CPS/PPS/Kinship*
		consecutive days out of home
Non-Medicaid reimbursable medical expenses excluding behavioral health care services	✓	$1,000 annual maximum
Legal fees	✓	
Driver's education	✓	
School-related fees (excluding private school tuition)	✓	
Out-of-State public school tuition	✓	
Foster/adoptive home studies	✓	
Court-ordered evaluations/assessments from CSA-contracted providers	✓	
Tutoring	$3,000/year max	
***reference UR service authorization note for eligible dates of service**		

Emergency Situations Eligible for Expedited FAPT Service Planning

CSA pool funds may not be used to implement service plans developed outside of the FAPT/MDT process. However, CPMT is charged with developing local policy to allow immediate access to pool funds for emergency services. State pool funds may be used for emergency placements/services if the child or youth is assessed by the FAPT/MDT within 14 days of placement/service initiation and the emergency placement/service supported by the FAPT, consistent with the locality's policies. All CSA requirements must be met.

Emergencies are defined as those crisis situations in which the lead case manager and his/her supervisor, in consultation with the family when possible, agree that the child needs immediate placement or the child and family is in need of immediate services in order to prevent foster care placement of the child. **If the child/family has a case manager within another agency/department, the agency taking the emergency action will notify that case manager of the emergency authorization as soon as possible.** Per Virginia Code, prior to placing a child outside Fairfax-Falls Church, it is required that all appropriate community services for the child be explored. **Fairfax-Falls Church CPMT permits initiation of emergency services prior to FAPT review in the following three situations:**

1. **Foster Care Services - When a child in DFS custody must be placed in congregate care on an emergency basis, treatment foster care services may be approved by FAPT for up to 60 days through an expedited service planning process. Services beyond 60 days require development of an action plan by an FPM or FRM.**

   Per Virginia Code, Medicaid providers must be used when available and appropriate. Additionally, providers under contract shall be used when available and appropriate.

2. **Foster Care Prevention Services for Abuse and Neglect - When a child has been determined in need of immediate services to prevent foster care placement, documented by a DFS worker' signature on the CSA Eligibility form, designated community-based services may be supported by FAPT for up to 60 days through an expedited service planning process. Services beyond 60 days require development of an action plan by an FPM or FRM.**

3. **Leland House Services When a youth meets criteria for admission to Leland House based on assessment by CSB Emergency Services or Resource Team staff and has been accepted for admission by the provider, services may commence on an emergency basis. CSA funding is permissible if the service is subsequently reviewed within 14 days and supported by the FAPT AND the FAPT determines that the youth meets CHINS Parental Agreement eligibility criteria. Only mandated funds can be used to purchase such services. Funds are not set aside for emergency services for non-mandated youth; therefore, a service authorization must be obtained, and non-mandated funds must be available**

Procedures for Approval for Emergency Services

A FAPT review must occur within 14 calendar days after services have commenced. Required documentation must be submitted within 2 business days of services commencing to include:

- **IFSP-EZ**
- **Consent**
- **CANS (current <30 days)**
- **Eligibility Determination Form**
- **Parental Contribution Assessment (if applicable)**

CSA funding is not available for any services that have not been reviewed and supported by FAPT within the specified timelines stated above. Additionally, the agency initiating emergency services shall be financially responsible if CSA funding is not available.

~~When a child has been determined in need of immediate services to prevent foster care placement, documented by a DFS workers' signature on the CSA Eligibility form, community-based services may be approved by FAPT for up to 60 days through an expedited service planning process. Services beyond 60 days require development of an action plan by an FPM or FRM.~~

~~When a child in DFS custody must be placed in treatment foster care on an emergency basis, treatment foster care services may be approved by FAPT for up to 60 days through an expedited service planning process. Services beyond 60 days require development of an action plan by an FPM or FRM.~~

~~When the residential placement of a youth in foster care is made on an emergency basis a Consent, Case Manager Report to FAPT and CANS must be submitted to the CSA office within two business days and a FAPT review must occur within 14 calendar days after services have commenced. The FAPT review shall be scheduled at least five business days following receipt of a correct Consent, Case Manager Report to FAPT and CANS to provide time for a Utilization Review Report to be completed.~~

~~Per Virginia Code, Medicaid providers must be used when available and appropriate. Additionally, providers under contract shall be used when available and appropriate.~~

~~Only mandated funds can be used to purchase such services. Funds are not set aside for emergency services for non-mandated youth; therefore, a service authorization must be obtained and non-mandated funds must be available prior to commencing services for non-mandated youth. When an emergency as defined above occurs, the lead case manager may proceed to obtain the needed services.~~

~~The agency taking the emergency action assumes the role of case manager. If the child/family has a case manager within another agency/department, the agency taking the emergency action will notify that case manager of the emergency authorization as soon as possible.~~

~~Procedures for Flexible Response to Emergency Needs~~

~~An IFSP-EZ must be submitted to the CSA Office within two business days after community-based services, treatment foster care services, and short-term residential or group home placements (maximum length of stay of 90 days or less) have commenced on an emergency basis. A FAPT review must occur within 14 calendar days following the onset of services in an emergency, or within 14 days of submitting the IFSP/MAP if services have not yet commenced. The CANS must be submitted within 10 calendar days of services commencing.~~

~~UR may approve funding for transportation and other short-term/emergency needs that are necessary to support the youth and family in meeting IFSP/MAP goals. Before considering CSA funding the case manager and FAPT shall assess the family's ability to meet their needs without CSA funding, and the availability of other community resources. For families needing support to drive to services or placements, gas cards may be issued, with the amount determined per this scale:~~

- ~~less than 100 miles/month: $10/month~~
- ~~100-150 miles/month: $15/month~~
- ~~150-200 miles/month: $20/month~~

~~For each additional increment of 50 miles, an additional $5 is provided.~~

~~Gas cards may be issued prior to the first month of driving, but thereafter actual travel to services placements in the previous month must be verified prior to issuing a card for the next month.~~

Gift/Gas Card Policy (MOVED TO OWN SECTION IN MANUAL (SECTION 25))

CSA use of gift/gas cards will be guided by the DFS Gift/Gas Card Policy (effective May 10, 2020).

- Calculation of gift/gas card value shall be based on the lowest value possible to meet the need.
- Gift/gas cards shall:
  - Be maintained in a secure safe;
  - Be tracked using a safe log; and
  - Provided to families via the use of the Gift/Gas Card Request and Client Affidavit. The family will be required to acknowledge review of Terms and Conditions and receipt of card by signing the Client Affidavit.
- The lead case manager shall be responsible for requesting and acquiring the gift/gas card from the designated CSA staff. The lead case manager shall ensure the client signs the Gift/Gas Card Request and Client Affidavit.
- The lead case manager shall be responsible for returning the signed Client Affidavit to designated CSA staff (email is permissible).

Emergency Psychiatric Hospitalizations

In the case of the need for emergency hospitalizations in a private psychiatric facility, all children **must be found eligible for acute care through an emergency services evaluation** ~~be evaluated, and prescreened if appropriate, by~~ **(e.g., CSB Mental Health Services).** The purpose of this process is to

explore alternatives to hospitalization; determine whether voluntary or involuntary status is appropriate if hospitalization is necessary; assist in securing a bed and to facilitate the hospitalization; and make use of public resources, to include Medicaid. Evaluations and pre-screenings can be arranged through the local CSB Mental Health Resource Team member from the office located in the area where the youth resides. Psychiatric hospitalizations are typically funded through private insurance or Medicaid and are generally not a CSA-funded service. **Youth in foster care who require acute psychiatric hospitalizations and have no other funding source may access CSA funding through standard language incorporated in the IFSP/MAP. In situations where extended acute psychiatric hospitalization is needed while waiting for a residential placement to become available, the acute service must be included on the IFSP/MAP and supported by FAPT.** ~~If you have questions regarding funding, please call the CSA program office at (703) 324-7938.~~

8.3 Parental Placements Initiated Prior to CSA Authorization

Parental placements are not eligible for expedited FAPT service planning or emergency access to CSA funding. Families not following the local CSA policies or who place their child in a residential facility prior to participating in a FAPT meeting assume the costs incurred for the placement. All CSA requirements and documentation (such as execution of the CHINS Parental Agreement), including the use of approved providers, shall be met to access CSA pool funds. If, after following the CSA service planning process, the youth is deemed eligible for CSA funds with an approved IFSP, funding is effective no earlier than the date of the FAPT meeting – CSA funds are not retroactive.

MEMO TO THE CPMT

October 29, 2021

Administrative Item A - 2: Public Comment for State Policy Manual Changes - Policy 3.2 FAPT/MDT and Policy 3.3 Family Engagement

ISSUE: That the state Office of Children's Services (OCS) has opened a public comment period for proposed revisions to the state policy manual.

BACKGROUND: In accordance with the State Executive Council for Children's Services (SEC) policy on public participation, the SEC at its meeting on September 9, 2021, approved the following two (2) policies for a 60 day public comment period beginning, Monday, September 13, 2021 and closing on Friday, November 12, 2021 at 5:00 p.m.:

- Proposed SEC Policy 3.3, Family Engagement
- Proposed SEC Policy 3.2, FAPT-MDT

Comments will be accepted through the Policy Public Comments Form on the CSA website: csa.virginia.gov, via e-mail to csa.office@csa.virginia.gov (please use Public Comment in the subject line along with the name of the policy) or via U.S. mail or alternate courier service to: Office of Children's Services, 1604 Santa Rosa Rd., Suite 137, Richmond, VA 23229. ATTN: Public Comment.

RECOMMENDATION: That the CPMT approve submission of public comment:

The Fairfax-Falls Church CPMT supports proposed revisions to Policy 3.2 and Policy 3.3. The role of OCS as defined in these sections is to offer training and technical assistance for localities to achieve the provisions outlined in policy. The approach of continuous quality improvement to support localities where resources may be limited or other barriers exist is recommended.

ATTACHMENT:
Proposed Policy Revisions with Staff Comment

INTERNAL CONTROL IMPACT: None

FISCAL IMPACT: None

STAFF:
Janet Bessmer, Director, CSA
Patricia E. Arriaza, CSA

POLICY 3.2
FAMILY ASSESSMENT AND PLANNING TEAM

3.2.1 Purpose

To define the establishment, appointment, and membership of Family Assessment and Planning Teams (FAPT) and to establish requirements of the policies to be adopted by Community Policy and Management Teams (CPMT) for the designation of Alternative Multidisciplinary Teams (MDT).

Alternative multidisciplinary teams provide a local Children's Services Act program to organize and operate flexibly while maintaining core statutory requirements and adherence to the system of care model.

Commented [AP1]: New section, new language

3.2.2 Authority

A. Section 2.2-2648.D of the *Code of Virginia (COV)* establishes powers and duties of the State Executive Council for Children's Services (SEC). Subsection (14) requires the SEC to "review and approve a request by a CPMT to establish a collaborative, multidisciplinary team process for referral and reviews of children and families according to §2.2-5209."

B. COV Section 2.2-5207 requires that "each community policy and management team shall establish and appoint one or more family assessment and planning teams as the needs of the community require" and lists the required representatives on each FAPT. This section also provides additional information concerning responsibilities of conditions about FAPT membership.

C. COV Section 2.2-5209 states that "the community policy and management team shall establish policies governing the referral of troubled youths and families to the family assessment and planning team or a collaborative, multidisciplinary team process approved by the Council."

Commented [AP2]: New section, new language

3.2.3 Definitions

"Community Policy and Management Teams (CPMT)" is the entity that develops, implements, and monitors the CSA local program through policy development, quality assurance, and oversight functions.

"Family Assessment and Planning Team (FAPT)" is a locality's Multidisciplinary Team (MDT) that implements the CSA by recommending services for children and families. The team considers every child and family's strengths and challenges to address their specific needs as best they *can.* Families are included in all FAPT assessment, service planning, and decision making.

"Multidisciplinary Team (MDT)" is an alternate to a "standard" FAPT that provides an option to local CSA programs to provide review and recommendations for an identified group or type of cases and can complete all of the statutory duties of a standard FAPT, including a recommendation of services for authorization by the CPMT.

"State Executive Council for Children's Services (SEC)" is the supervisory body established in the *Code of Virginia* to oversee the administration of the Children's Services Act (CSA).

"Office of Children's Services (OCS)" serves as the administrative entity of the executive branch of state government and the SEC to ensure that the decisions and policies of the Council are implemented in accordance with the powers and duties granted by statute in the Code of Virginia.

"Parent Representative" is an individual who is a parent and serves in the required role as a member of the FAPT. The parent representative should ideally be a person with "lived experience" and whose child has received services within the purview of, or similar to those provided through, the Children's Services Act.

Commented [AP3]: New section, new language

3.2.4 Establishment, Appointment, and Membership

A. Each CPMT shall establish and appoint one or more family assessment and planning teams ("FAPT") as the needs of the community require to act and perform the powers and duties granted by statute in COV §2.2-5208.

B. Each FAPT shall include the following representatives of the following community agencies who have authority to access services within their respective agencies:

1. Community services board;
2. Juvenile court services unit;
3. Department of social services;
4. School division;
5. If requested by the chair of the CPMT, a representative of the Department of Health;
6. A parent representative; and
7. At the discretion of the CPMT, a representative of a private organization or association of providers for children's or family services and other public agencies.

Commented [AP4]: This section is formatted differently but has essentially the same information as the current policy

C. Parent representatives employed by a public or private program that receives funds through the CSA or agencies represented on a FAPT may serve as a parent representative provided that they do not, as a part of their employment, interact directly on a regular and daily basis with children or supervise employees who interact

Commented [AP5]: "and daily basis" is new language to this provision

directly on a regular basis with children. Notwithstanding this provision, foster parents may serve as parent representatives.

D. Parent representatives serving on the FAPT or members representing private service providers shall abstain from decision-making involving individual cases or agencies in which they have either a personal interest, as defined in §2.2-3101 of the State and Local Government Conflict of Interests Act, or a fiduciary interest.

Commented [AP6]: Slight word tweaks here but the intent hasn't changed

3.2.5 Alternate Multidisciplinary Team

A. As provided for in COV §2.2-2648 (14), the SEC shall review, and may approve, requests from CPMTs to establish a collaborative, multidisciplinary team ("MDT") (see COV §2.2-5209) to meet the requirements of the CSA.

B. Requests for such approval shall be in writing and made available for review by the OCS and the SEC.

C. The CPMT shall develop and approve written policy governing the membership and operation of the MDT. The CPMT shall make these policies available for review to OCS before referral to the SEC for consideration. The policies must specify:

1. The purpose of the MDT, including the types of cases/circumstances that will be considered.
2. How the MDT procedures and practices align and integrate with those of the CPMT's member agencies.
3. 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 foster care prevention.
4. The minimum number of agency representatives to constitute the MDT (from among the FAPT-required agencies). This specification shall identify the agencies that shall be represented on the MDT and processes for soliciting additional input from other agencies, as needed MDTs may include additional members as needed.
5. How the MDT will include family engagement practices and be family-driven (See SEC Policy 3.3).
6. The process through which funding approval requests will be submitted directly from the MDT to the CPMT.

Commented [AP7]: Language in current policy:

b. The policies must specify how the MDT's practices and procedures align and integrate with those of the CPMT's member agencies, and include assurances that the membership of the MDT is family-driven. Documented family team processes adopted by any CPMT member agency (or agencies) can be included by reference in the CPMT's MDT policy to satisfy this requirement.

7. Alternate multidisciplinary teams must meet all relevant statutory and policy requirements of the CSA.

D. Specific requirements for MDT members (i.e., those delineated in Section 3.2.4.C. and 3.2.4.D of this policy) shall apply.

Commented [AP8]: This section requires more specifics in the MDT processes developed by the CPMT than the current policy; however, I'm not seeing significant changes from the intent

They have removed the section that detailed which efforts were to be made to include children receiving services, family members, etc. They also removed the section that detailed the process for CPMTs to request review and approval of the MDT processes – which was redundant since that's include in Policy 3.2.

POLICY 3.3
FAMILY ENGAGEMENT

3.3.1 Purpose

To guide local Community Policy and Management Teams (CPMT) under the Children's Services Act (CSA) concerning effective engagement with children and families seeking and receiving services. Effective family engagement is a core component in the system of care and is essential for achieving positive outcomes for children, families, and communities.

Commented [AP1]: New section, new language

3.3.2 Authority

Commented [AP2]: New section, have added more references from the Code of VA than is in the current policy

A. Section 2.2-5200.A. of the *Code of Virginia (COV)* defines the intention to the CSA "to create a collaborative system of services and funding that is child-centered, family-focused and community-based …" emphasizing the key role of children and families as partners in the CSA process.

B. COV Section 2.2-2506 states that the CPMT "shall manage the cooperative efforts in each community to serve better the needs of troubled and at-risk youth and their families…" This responsibility includes the duty to: "Develop interagency policies and procedures to govern the provision of services to children and families in its community. (§2.2-5206(1))

C. COV Section 2.2-2508 (2) specifies that the Family Assessment and Planning Team (FAPT) shall "Provide for family participation in all aspects of assessment, planning, and implementation of services."

D. COV Section 2.2-2508 (3) specifies that the FAPT shall: "Provide for the participation of foster parents in the assessment, planning, and implementation of services when a child has a program goal of permanent foster care or is in a long-term foster care placement."… "The opinions of the foster parents shall be considered by the family assessment and planning team in its deliberations."

E. COV Section 2.2-2649 (4) requires the Office of Children's Services (OCS) to "provide training and technical assistance to localities in the provision of efficient and effective services that are responsive to the strengths and needs of troubled youth and their families." COV Section 2.2-2649 (10) requires OCS to identify, disseminate, and provide annual training for CSA staff and other interested parties on best practices and evidence-based practices related to the CSA program.

3.3.3 Definitions

Commented [AP3]: New section

"Community Policy and Management Team (CMPT)" is the entity that develops, implements, and monitors the local CSA program through policy development, quality assurance, and oversight functions.

For this policy's purpose, "*Family"* is broadly defined to include the youth and all persons the youth considers/defines as part of their family and who may be involved with or affected by the services provided. The family includes birth parents, relative or fictive kin, adoptive parents, foster parents, grandparents, siblings (including half- and adult siblings), legal custodians, natural supports, and any other primary or secondary caretakers, including prospective caretakers in the case of children in the custody of a child-servicing agency.

"Family engagement" is a relationship-focused approach to establish and maintain full participation of families in the CSA process to make decisions leading to successful long-term outcomes. Families must be included as critical stakeholders to promote the safety, permanency, and well-being of youth and their families. Family engagement acknowledges, respects, and incorporates the family's unique history and experiences, including cultural, linguistic, and other essential aspects of self-identity into all decision-making processes.

"Family Assessment and Planning Team (FAPT)" is a locality's Multidisciplinary Team (MDT) that implements the CSA by recommending services for children and families. When making a decision, the team will take into consideration every child and family's unique strengths and challenges when addressing their specific needs as best they can. Families are included in all FAPT assessment, service planning, and decision making.

"System of Care" is the collaborative framework used in CSA to address youth and families' needs, ideally generating optimal solutions to complex situations. The System of Care places the youth and family in the central role in service planning.

3.3.4 Values Statements

Commented [AP4]: New section/heading, they have streamlined and reformatted the language that is in the current policy.

A. The State Executive Council for Children's Services (SEC) maintains that meeting the legislative intent for family participation in CSA must go beyond simply inviting family members to attend FAPT meetings and informing them about the decisions made in the FAPT process. The decision-making process must be family-driven.

B. The underlying values of CSA and the System of Care include the following beliefs:

   1. All families have strengths;

   2. Families are the experts on themselves;

3. Families deserve to be treated with dignity and respect;
4. When supported, families can make well-informed decisions about themselves and their children;
5. Family voice and choice is a trauma-informed approach to service engagement;
6. Families are shaped by their rich and unique histories and cultural backgrounds. This includes the entirety of those elements that shape individual members' identities and the family as a whole. Such elements include but are not limited to race, ethnicity, culture, religion, language, sexual orientation, gender identity, disability status, and history of personal and collective trauma.
7. Outcomes improve when families are involved in decision-making; and
8. A team that genuinely includes youth and family is often more capable of creative and high-quality decision-making than individuals or groups of professionals alone.

3.3.5 CSA Family Engagement Requirements

A. CPMTs must have written policies for FAPT processes that describe how they ensure family and youth involvement in the assessment, planning, delivery, and review of services.
   1. Policies should make allowances for family members who cannot attend meetings held during regular business hours. Local CSA programs should consider holding FAPT meetings at non-traditional hours, prioritizing maximum family engagement.
   2. Local CSA programs should explore and, where feasible, arrange audio, video, and other Access and Functional Needs component platforms for virtual participation, when appropriate.

B. All communication with youth and family, whether oral or in writing, will be provided, as feasible, in the youth and family's language of choice, and be mindful of various dialects and literacy needs.
   1. CSA programs and participating agencies should identify resources and arrange for translation services where needed.
   2. CSA program policies and practices should incorporate a review process to assure that all communication materials are easily understandable and accessible to families. This should include minimal use of jargon and technical language.

Commented [AP5]: New language

Commented [AP6]: New language

Commented [AP7]: Updated language. Current language in policy: A team is often more capable of creative and high-quality decision-making than an individual.

Commented [AP8]: New section, this section has some of the same elements that are in current policy, but are more specific about actions to be taken. The wording has also been streamlined.

Commented [AP9]: Current language in policy: CPMTs must have written policies for FAPT/MDT agencies that outline the processes that will insure the best chance of family involvement.

3. The Office of Children's Services will provide a list of resources to assist localities with this requirement.

C. The CPMT is responsible for equitable, consistent, efficient, and effective CSA services to children and their families. Redundant or duplicative processes should be streamlined, both within the CSA program and across child-serving agencies, to promote family engagement.

1. For example, processes that require a youth and family to repeatedly "tell their story," which may be a traumatic trigger, should be eliminated to the greatest extent possible.

D. Youth and family shall be given accurate information regarding the CSA process, their role and rights during the process, and how decisions are made regarding service delivery. This information includes an explanation of the affiliations and roles of the various participant in the process.

1. Training, along with general information regarding the eligibility for CSA and the CSA decision-making process, should be available for all interested stakeholders.

E. CPMTs are responsible for implementing procedures to assess and measure the quality of family engagement protocols and processes. These include, but are not limited to, periodic surveys of youth and families to better understand the CSA process from their perspectives. Local CSA programs should strive to stay aware of the success of their family engagement efforts and areas for improvement.

E. CSA program staff and agency participants should hold themselves to the highest standards of respect for and responsiveness to all aspects of diversity, including differences in race, economic status, culture, disability status, gender identity, and other areas when interacting with youth and family.

F. Local CSA programs should engage in outreach regarding the CSA process to marginalized youth and families, including, but not limited to, non-English speakers, those experiencing housing insecurity, and those experiencing poverty. In doing so, the CPMT should form partnerships with diverse and representative families, businesses, and community organizations.

Commented [AP10]: Current language requires CPMT to provide policies to FAPT/MDTs that insure CSA services. This moves the responsibility up to CPMT insuring equitable, consistent, etc. CSA services.

Current language in policy:
The CPMT is responsible for providing policies for FAPTs/MDTs that insure consistent, efficient, and effective CSA services to children and their families. Redundant or duplicative processes must be streamlined across child-serving agencies to promote family engagement but CPMT policy also must describe how they align and integrate with those of the CPMT's member agencies.

Commented [AP11]: Pared down language but the gist is essentially the same – to ensure families are informed on process. The training component seems to be new.

Current policy:
CPMTs are responsible for instituting policies and practices that inform, prepare, and support family members for their participation in CSA, throughout the duration of their CSA services. This should be accomplished through communication and interaction methods that are appropriate to the family's cultural and linguistic needs and preferences, including providing written material to family members. Meaningful family member participation is possible only if family members understand their rights and responsibilities with respect to CSA services; and if they are fully informed about and prepared to participate in the assessment, planning and service delivery process in their locality.

Commented [AP12]: New requirement

Commented [AP13]: New language

Commented [AP14]: New language

3.3.6 Role of the Office of Children's Services (OCS)

Commented [AP15]: New section, new language

A. Following its statutory responsibilities (OCS) will provide training and technical assistance to local CSA programs regarding family engagement. Such training and technical assistance can take place through a variety of formats and delivery mechanisms.

   1. OCS shall review family engagement practices in local CSA programs as a component of its interactions with local CSA programs. OCS will compile periodic state-level reports summarizing family engagement practices, activities, and available resources.
   2. OCS shall provide tools (e.g., a model family survey, program self-assessment frameworks) for use by local CSA programs in evaluating and improving their family engagement policies and practices.

MEMO TO THE CPMT
Oct 29, 2021

Information Item I-1: Sep Budget Report & Status Update, Program Year 2022

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 2022 cumulative expenditures through September 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: Pooled expenditures through Sep 2021 for FY22 equal $2.45M for 523 youths. This amount is a decrease from last year of approximately $607K, or 19.8%. YTD Pooled expenditures for FY21 equaled $3.06M for 536 youths.

	Program Year 2021	Program Year 2022	Change Amt	Change %
Residential Treatment & Education	$483,298	$309,148	($174,150)	-36.03%
Private Day Special Education	$1,462,846	$1,248,681	($214,165)	-14.64%
Non-Residential Foster Home/Other	$794,269	$747,172	($47,097)	-5.93%
Community Services	$454,998	$410,095	($44,903)	-9.87%
Non-Mandated Services (All)	$114,687	$61,865	($52,822)	-46.06%
Recoveries	($246,225)	($320,098)	($73,873)	30.00%
Total Expenditures	**$3,063,874**	**$2,456,863**	**($607,011)**	**-19.81%**
Residential Treatment & Education	34	23	(11)	-32.35%
Private Day Special Education	141	151	10	7.09%
Non-Residential Foster Home/Other	153	170	17	11.11%
Community Services	279	289	10	3.58%
Non-Mandated Services (All)	80	57	(23)	-28.75%
Unique Count All Categories	**687**	**690**	**3**	**0.44%**
Unduplicated Youth Count	**536**	**523**	**(13)**	**-2.43%**

Note: The number of youths served is unduplicated within individual categories, but not across categories.

Expenditure claims are submitted to the State Office of Children's Services (OCS) through September.

RECOMMENDATION:
For CPMT members to accept the September Program Year 2022 budget report as submitted.

ATTACHMENT:
Budget Chart

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

NOTE:

PIT (point in time) counts for 3 areas for by the end of September FY21 vs FY22
Treatment Foster home: 67 – 54
Special Education: 246 – 249
Residential Treatment Facility: 38 – 38

Expenses paid do not sync with PIT count in some areas due to timing of invoices paid, for example, Special education cost PIT shows 3 more enrollment at end of September, but expenses paid are $214k lower this year than last year. We will continue to monitor the expense data.

Program Year 2022 Year To Date CSA Expenditures and Youth Served (through September Payment)

Mandated/ Non-Manda	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%	$120,377	14			$120,377
		Group Home	57.64%	$50,483	3			$50,483
		Education - for Residential Medicaid Placements	46.11%	$10,081	2	$85,403	2	$95,483
		Education for Residential Non-Medicaid Placements	46.11%	$0	0	$34,424	1	$34,424
		Temp Care Facility and Services	57.64%	$8,382	1			$8,382
	Residential Total			$189,322	20	$119,827	3	$309,148
	Non Residential	Special Education Private Day	46.11%	$24,208	4	$1,224,473	147	$1,248,681
		Wrap-Around for Students with Disab	46.11%	$22,220	19			$22,220
		Treatment Foster Home	46.11%	$343,597	49			$343,597
		Foster Care Mtce	46.11%	$247,792	74			$247,792
		Independent Living Stipend	46.11%	$65,099	20			$65,099
		Community Based Service	23.06%	$323,197	213			$323,197
		ICC	23.06%	$86,898	76			$86,898
		Independent Living Arrangement	46.11%	$68,465	8			$68,465
	Non Residential Total			$1,181,475	463	$1,224,473	147	$2,405,947
Mandated Total				**$1,370,796**	**483**	**$1,344,299**	**150**	**$2,715,096**
Non-Mandated	**Residential**	Residential Treatment Facility	57.64%	$15,820	2			$15,820
		Temp Care Facility and Services	57.64%	$724	1			$724
	Residential Total			$16,544	3	$0	0	$16,544
	Non Residential	Community Based Service	23.06%	$39,196	34			$39,196
		ICC	23.06%	$6,126	20			$6,126
	Non Residential Total			$45,322	54	$0	0	$45,322
Non-Mandated Total				**$61,865**	**57**		**0**	**$61,865**
Grand Total (with Duplicated Youth Count)				**$1,432,662**	**540**		**150**	**$2,776,961**

Recoveries	**-$320,098**
Total Net of Recoveries	**$2,456,863**
Unduplicated child count	523

Key Indicators		
Cost Per Child	**Prog Yr 2021 YTD**	**Prog Yr 2022 YTD**
Average Cost Per Child Based on Total Expenditures /All Services (unduplicated)	$5,716	$4,698
Average Cost Per Child Mandated Residential (unduplicated)	$16,110	$14,721
Average Cost Per Child Mandated Non- Residential (unduplicated)	$5,909	$5,076
Average Cost Mandated Community Based Services Per Child (unduplicated)	$1,558	$1,517
Average costs for key placement types		
Average Cost for Residential Treatment Facility (Non-IEP)	$11,485	$8,598
Average Cost for Treatment Foster Home	$6,785	$7,012
Average Education Cost for Residential Medicaid Placement (Residential)	$15,040	$23,871
Average Education Cost for Residential Non-Medicaid Placement (Residential)	$24,514	$34,424
Average Special Education Cost for Private Day (Non-Residential)	$10,375	$8,269
Average Cost for Non-Mandated Placement	$1,434	$1,153

Program Year 2022 Year To Date CSA Expenditures and Youth Served (through September Payment)

Category	Program Year 2022 Allocation	Year to Date Expenditure (Net)	Percent Remaining
SPED Wrap-Around Program Year 2022 Allocation	$694,188	$20,348	97%
Non Mandated Program Year 2022	$1,630,458	$23,874	99%
Program Year 2022 Total Allocation	$42,187,551	$2,456,863	94%

MEMO TO THE CPMT

October 29, 2021

Information Item I- 2: Quarterly CPMT Data Report, FY 22 Quarter 1

ISSUE: That the CPMT receive regular management reports about utilization of services, duration of services, outcomes, and performance measures.

BACKGROUND:

As per § 2.2-5206 the powers and duties of the Community Policy and Management teams, each CPMT "shall manage the cooperative effort in each community to better serve the needs of troubled and at-risk youths and their families and to maximize the use of state and community resources. Every such team shall:

13. Review and analyze data in management reports provided by the Office of Children's Services in accordance with subdivision D 18 of § 2.2-2648 to help evaluate child and family outcomes and public and private provider performance in the provision of services to children and families through the Children's Services Act program. Every team shall also review local and statewide data provided in the management reports on the number of children served, children placed out of state, demographics, types of services provided, duration of services, service expenditures, child and family outcomes, and performance measures. Additionally, teams shall track the utilization and performance of residential placements using data and management reports to develop and implement strategies for returning children placed outside of the Commonwealth, preventing placements, and reducing lengths of stay in residential programs for children who can appropriately and effectively be served in their home, relative's homes, family-like setting, or their community;"

The CSA program provides quarterly data reports to the CPMT to facilitate oversight of key outcomes including the number of youth in long-term residential placements, length of stay and metrics for Intensive Care Coordination.

ATTACHMENT:
Quarterly CPMT Data Report

STAFF:
Patricia E. Arriaza, Management Analyst III, Program Operations
Jeanne E. Veraska, Utilization Review Manager

RBA

Results-Based Accountability
Performance Plan
FY 2022, Quarter 1 Report to CPMT

SUMMARY	
Name of Work	**Children's Services Act (CSA) for At-Risk Youth – Systems of Care**
Agency	Human Services within the Department of Family Services (DFS)
Contact (Name, Phone, Email)	Patricia E. Arriaza, Management Analyst III, 703-324-8241, patricia.arriaza@fairfaxcounty.gov Jeanne E. Veraska, Utilization Review Manager, 703-324-5722, jeanne.veraska@fairfaxcounty.gov
Purpose	The Children's Services Act (CSA) for At-Risk Youth and Families is a law enacted in 1993 that establishes a single state pool of funds to purchase services for at- risk youth and their families. The state funds, combined with local community funds, are managed by local interagency teams who plan and oversee services to youth. The mission of the CSA is 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 youth and their families in the Commonwealth.
Customers	At-risk youth between the ages of 0 to 21 and their families as defined by VA § 2.2-5212
Total Customers	Youth served: FY2021: 1,039 | FY2020: 1,149 | FY2019: 1,252 | FY2018: 1,311 | FY2017: 1,428 |
Total Staff Year Equivalents (SYE)	FY2021: 11 | FY2020: 11 | FY2019: 11 | FY2018: 10 | FY2017: 10 |
Total Budget	FY2021: $35.4 million for CSA pooled funding; $1,140,148 for program administration FY2020: $38.4 million for CSA pooled funding; $1,122,588 for program administration FY2019: $38.3 million for CSA pooled funding; $1,068,171 for program administration FY2018: $38.6 million for CSA pooled funding; $1,053,393 for program administration FY2017: $40.8 million for CSA pooled funding; $1,057,286 for program administration

Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

Summary of Annual and Quarterly[1] Performance Measures	
How Much Was Done?	
1.1	Total Youth Served Annually
1.2.1	Annual CSA Pool-fund Expenditures
1.2.2	Annual CSA Expenditures by Service Type
How Well Was It Done?	
2.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of youth participating in CSA who live in family settings.**
2.1.1	Number of youth in a long-term congregate care setting
2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services
2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**
2.2.1	Average number of days (length of stay) CSA participating children live in congregate care – measured in current setting and at post-discharge
2.2.2	Number of youth entering long-term congregate care settings
2.2.3	Number of youth exiting long-term congregate care settings
2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services
2.3	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment**
2.3.1	JDRDC and DFS data on Relief of Custody Petitions: # ROC petitions filed/# children entering foster care from ROC petitions
2.3.2	Number of children entering foster care from CHINS petitions

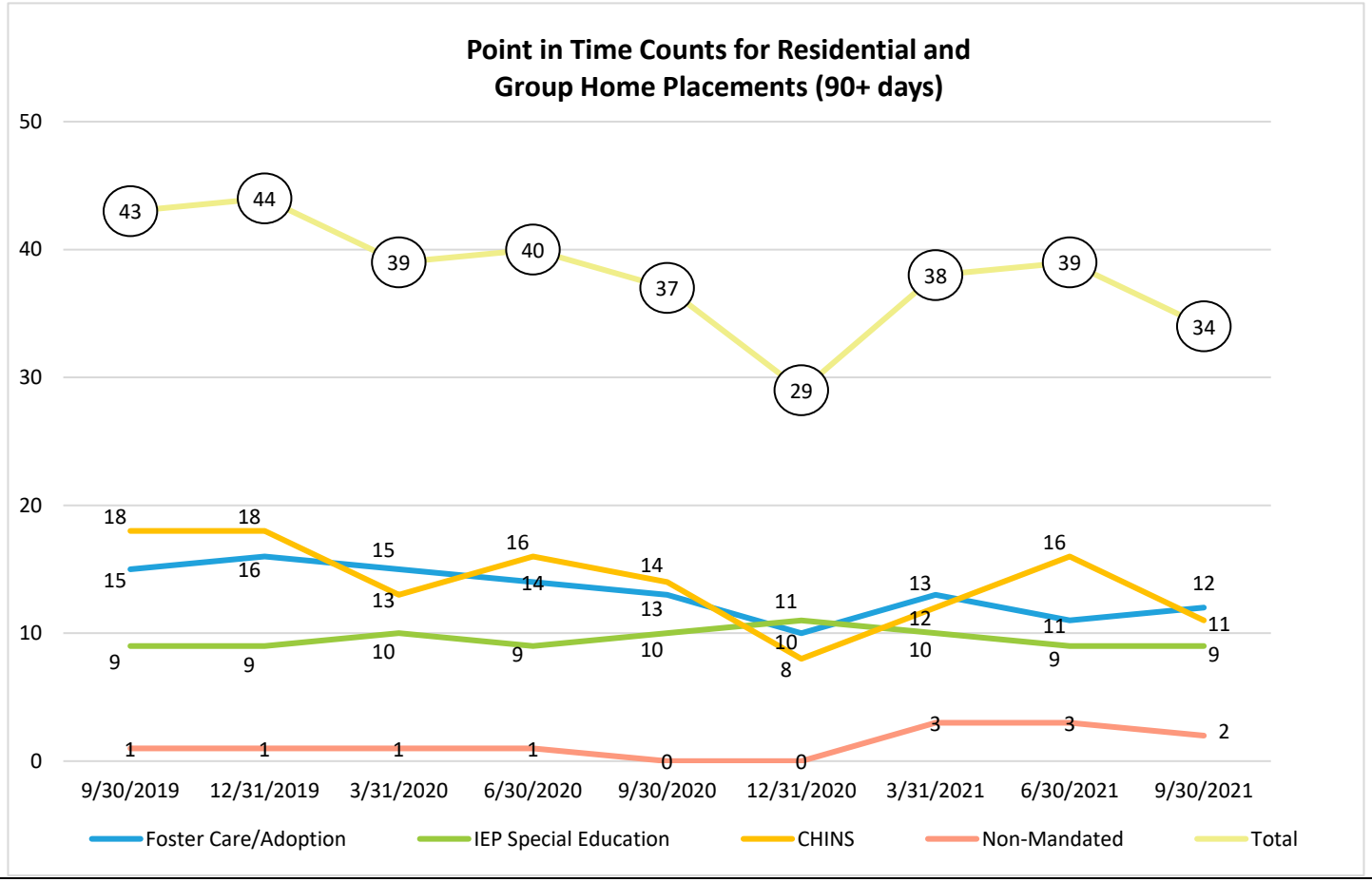
[1] Quarterly performance measures highlighted in blue.

2.3.3	Number of children entering foster care from delinquency petitions	
2.4	**Fiscal Accountability Outcome Goal 1: Fairfax-Falls Church CSA leverages state and local fiscal resources to serve youth and families efficiently**	
2.4.1	Per capita cost per youth receiving CSA services	
2.4.2	Per capita cost per youth receiving residential/ group home services	
2.4.3	Annual per-child unit cost of residential/group home services	
2.5	**Fiscal Accountability Outcome Goal 2: Fairfax-Falls Church is making maximum use of Medicaid as an alternative to CSA or locality funding**	
2.5.1	Percentage of placements in Medicaid-enrolled facilities	
2.5.2	Percentage of Medicaid placements receiving Medicaid reimbursement	
2.6	**Parent Satisfaction Survey**	
2.6.1	Percent of parent survey respondents who are satisfied with CSA services	
	Is Anyone Better Off?	**Headline Measure (HM)**
3.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of children participating in CSA who live in family settings.**	
3.1.1	Percentage of CSA youth who received only community-based services	
3.2	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment.**	
3.2.1	Percentage of children receiving CSA-funded services through the foster care prevention mandate who are successfully prevented from entering foster care	
3.2.2	Percentage of children with families participating in CSA-funded family partnership meetings through the foster care prevention mandate who are successfully prevented from entering foster care after the family partnership meeting	

3.3	**Functional Outcome Goals: Child and Adolescent Needs and Strengths (CANS) outcomes improve for children served by the CSA system of care from initial assessment to second assessment.**	
3.3.1	Percent of positive change in CANS outcomes by domain level of need	
3.4	**Functional Outcome Goal 1: Children participating in CSA-funded services will experience a decline in behaviors that place themselves or others at risk.**	
3.4.1	Percent of positive change in Child Risk Behavior by actionable rating	
3.5	**Functional Outcome Goal 2: Children participating in CSA-funded services will experience a decline in behavioral or emotional symptoms that cause severe/dangerous problems.**	
3.5.1	Percent of positive change in Behavioral/Emotional Needs by actionable rating	
3.6	**Functional Outcome Goal 3: Children participating in CSA-funded services will experience an increase in identified strengths that are useful in addressing their needs and developing resiliency.**	
3.6.1	Percent of positive change in Strength Domain by actionable strength	
3.7	**Functional Outcome Goal 4: Needs and issues of parents/caregivers of children participating in CSA-funded services that negatively impact their care-giving capacity will be reduced.**	
3.7.1	Percent of positive change in Planned Permanency Caregiver functioning by actionable need	

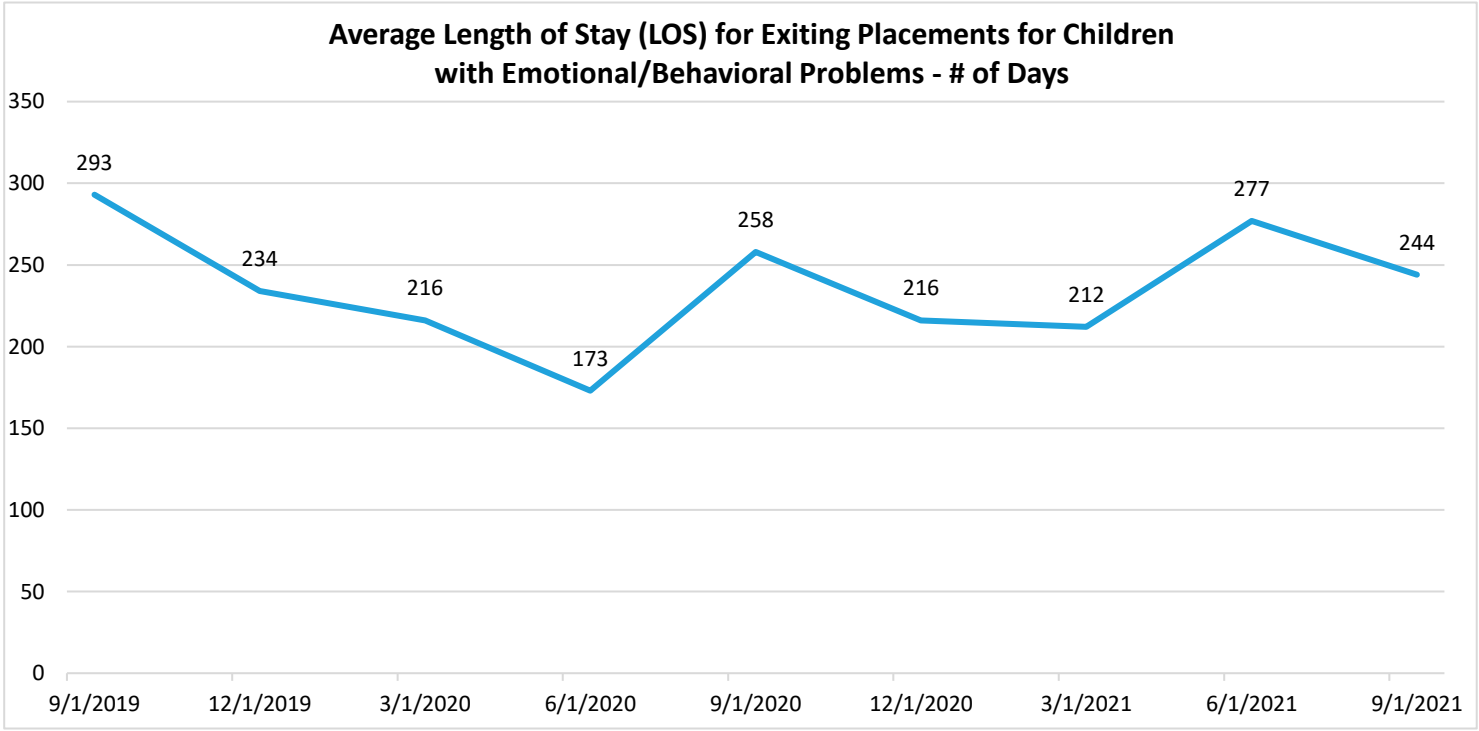
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2022 Q1			
How Well Measure	**Number**	**Title**	**Value**
	2.1	**Restrictiveness of Living Outcome Goal 1: Increase in percentage of children participating in CSA who live in non-residential settings.**	
	2.1.1	Number of youth placed in a long-term congregate care setting	34
Graphs/Charts			
Notes	**Analysis**: Placements by agency: Fairfax County Public Schools: 9; Community Services Board: 13; Foster Care & Adoption: 11; Juvenile & Domestic Court: 1. **Planned Action:** Continue to monitor.		

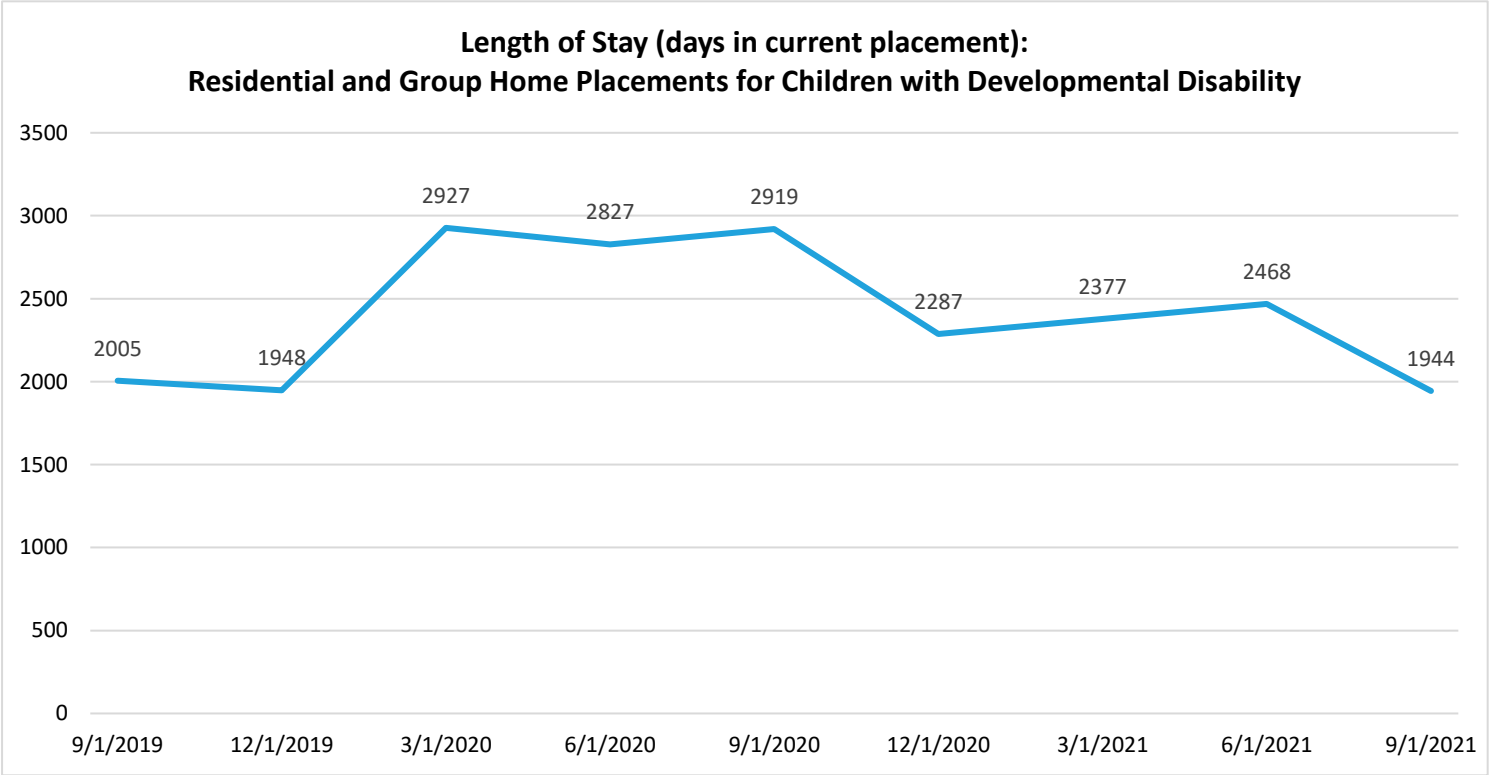
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2022 Q1			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.1	Number of days CSA participating children live in congregate care before being returned to a family setting	244 days for youth with emotional /behavioral disabilities
Graphs/Charts			
Notes	**Analysis:** Best practice indicates that youth with emotional/behavioral problems should be returned to a family setting within 6-9 months [180-270 days]. The length of stay for youth with primarily emotional/behavioral problems exiting placement (n=14) was 244 days at the end of the 1st quarter (LOS ranged from 2 to 1133 days). Ages ranged from 14 to 18, with average age being 17 years. Five (5) of the youth are African American, eight (8) Caucasian, one (1) is Native Hawaiian or Pacific Islander, and one (1) is multi-racial. Of the 14 exits, 6 were from the Community Services Board, 2 from Fairfax County Public Schools, and 6 from Foster Care & Adoption. **Planned Action:** Continue to monitor.		

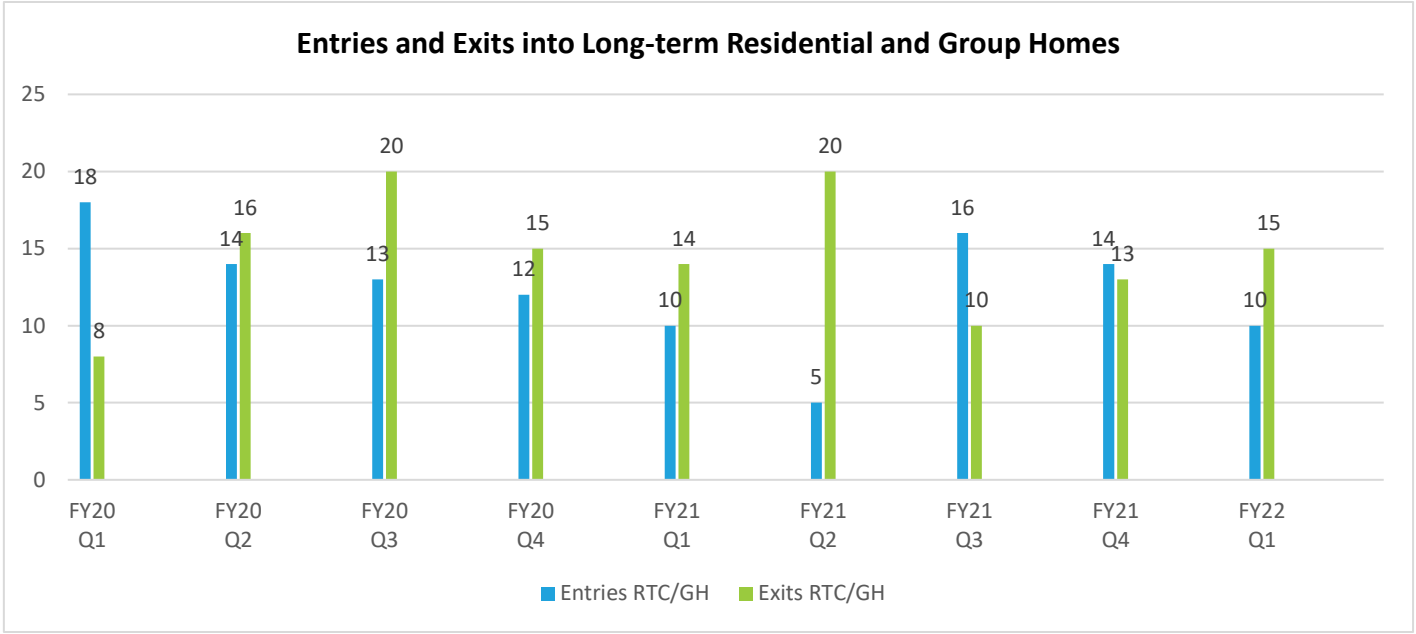
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2022 Q1			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.1	Number of days CSA participating children live in congregate care before being returned to a family setting	1,944 days for youth with developmental disabilities
Graphs/Charts			
Notes	**Analysis:** The length of stay for youth with primary needs from developmental disabilities (n=3) was 1,944 days, range of LOS is 387 to 3,108 days. The three placements are from Fairfax County Public Schools – one youth is in state and two are out-of-state. All youth are male. Two youth are Caucasian and one is African American. The ages range from 17 to 22, with the average age being 20. **Planned Action:** Continue to monitor.		

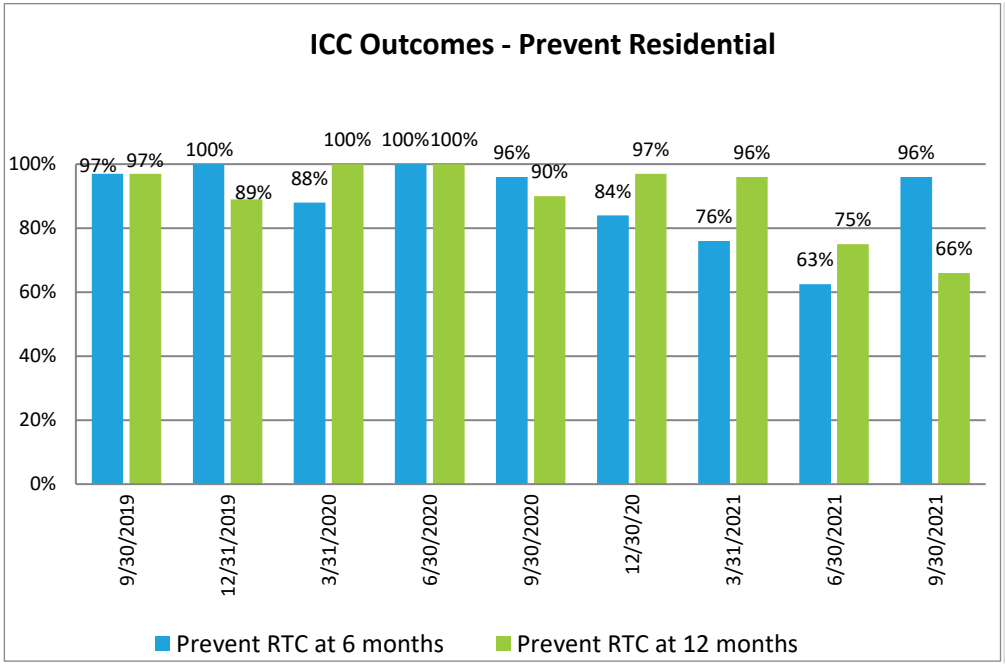
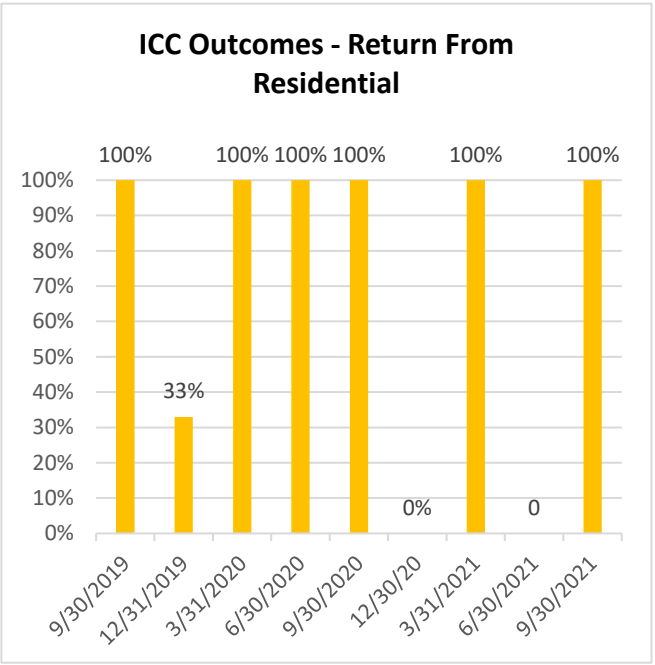
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2022 Q1			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.2.2	Number of youth entering long-term congregate care settings	10
	2.2.3	Number of youth exiting long-term congregate care settings	15
Graphs/Charts			
Notes	**Analysis:** There were 10 entries and 15 exits this quarter. **Planned Action:** Inform families about evidence-based treatments available in the community, e.g. Multysistemic Therapy, Functional Family Therapy, etc. Utilize EBTs to support successful return to a community/family-based setting. Utilize Leland House and crisis stabilization services to meet youth with intensive needs in the community, even during a crisis.		

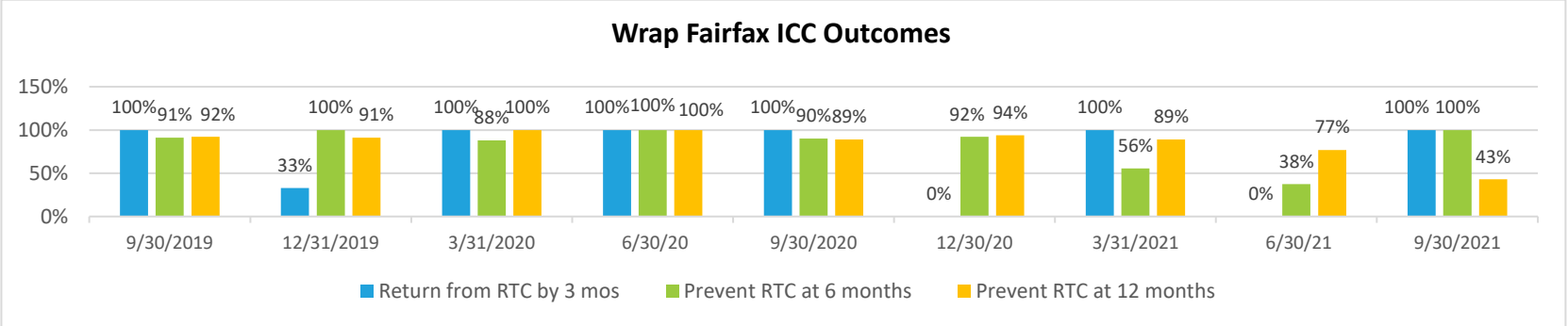
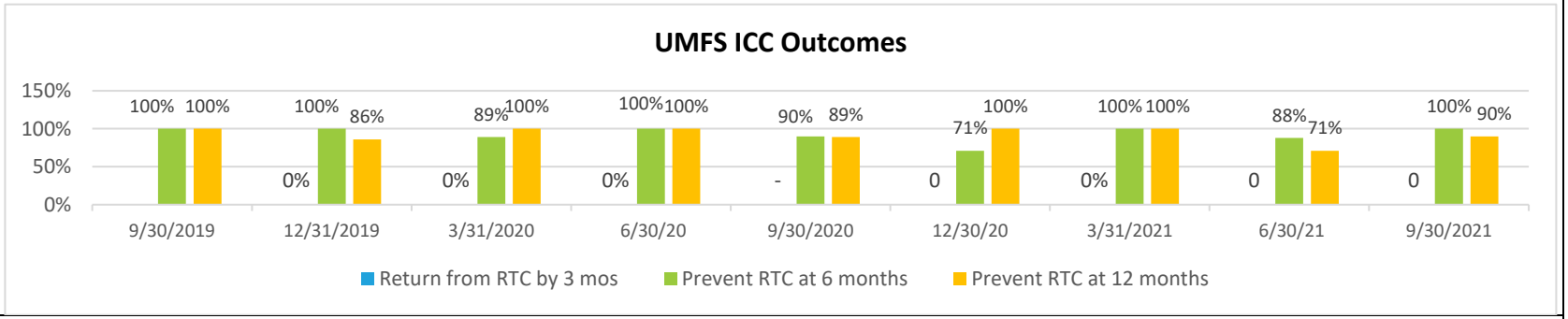
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2022 Q1			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services	96%/66%
	2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services	100%
Graphs/ Charts			
			
Notes	**Analysis:** 96% (22 of 23) of youth were maintained in the community 6 months after initiation of ICC services. 66% (10 of 15) of youth remained in the community 12 months after the initiation of ICC services. The one (1) ICC youth who participated in ICC successfully returned from residential or group home placement within three months of initiation of services. **Planned Action:** Use fidelity monitoring tools developed by the Wraparound Evaluation & Research Team (WERT) to monitor the providers' fidelity to the Wraparound model. The ICC Stakeholder group continues to meet quarterly to address system implementation issues as needed.		

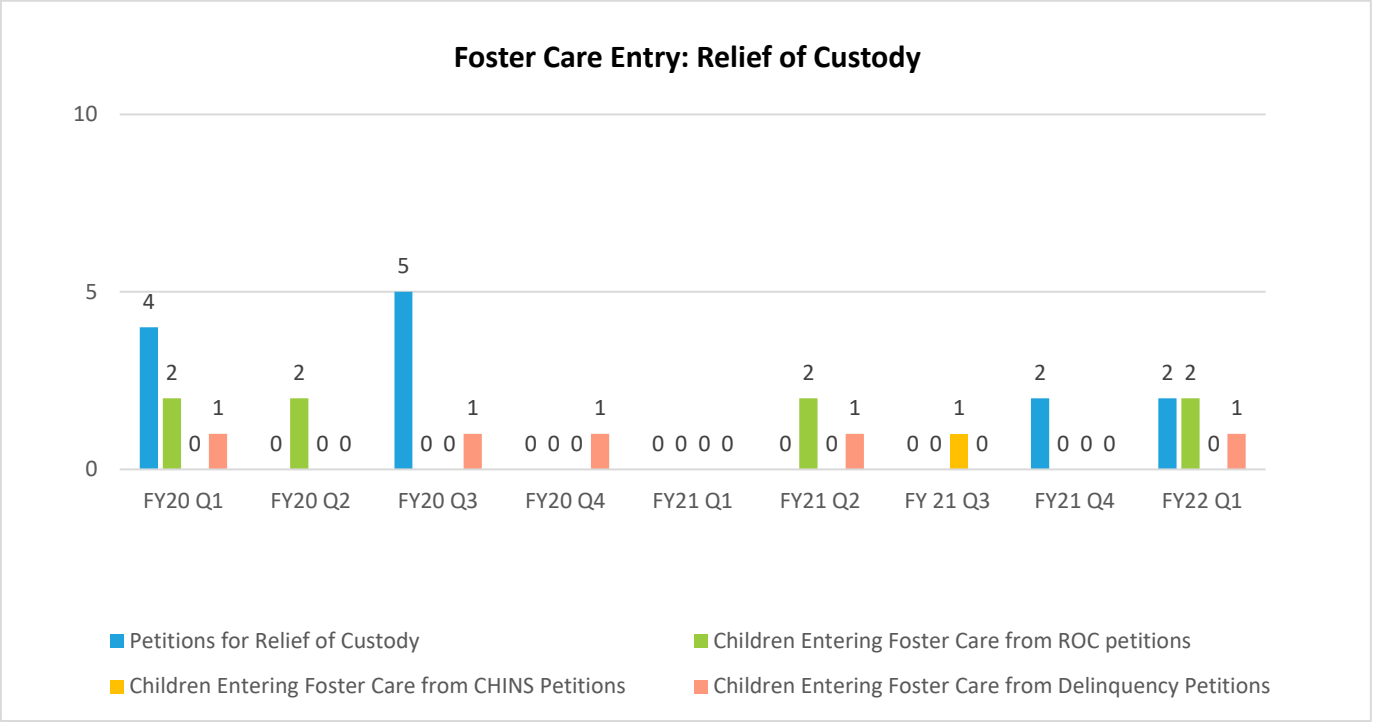
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2022 Q1			
How Well Measure	**Number**	**Title**	**Value**
	2.2	**Restrictiveness of Living Outcome Goal 2: Children participating in CSA living in congregate care are returned as quickly as possible to a family setting.**	
	2.1.2	Percentage of youth participating in Intensive Care Coordination who are successfully prevented from entering residential or group home placement six months and twelve months after initiation of services	**Wrap Fairfax:** 100%/43% **UMFS:** 100%/90%
	2.2.4	Percentage of youth participating in Intensive Care Coordination who are successfully returned from residential or group home placement within three months of initiation of services	**Wrap Fairfax:** 100% **UMFS:** --
Graphs/ Charts			
			
Notes	**Analysis: Wraparound Fairfax:** 100% (n=11) of youth were maintained in the community 6 months after initiation of ICC services. 43% (3 of 7) of youth remained in the community 12 months after the initiation of ICC services. The one (1) ICC youth who participated in ICC returned from residential or group home placement within three months of initiation of services. **UMFS:** 100% (n=10) of youth were maintained in the community 6 months after initiation of ICC services. 90% (7 of 8) of youth remained in the community 12 months after the initiation of ICC services.		

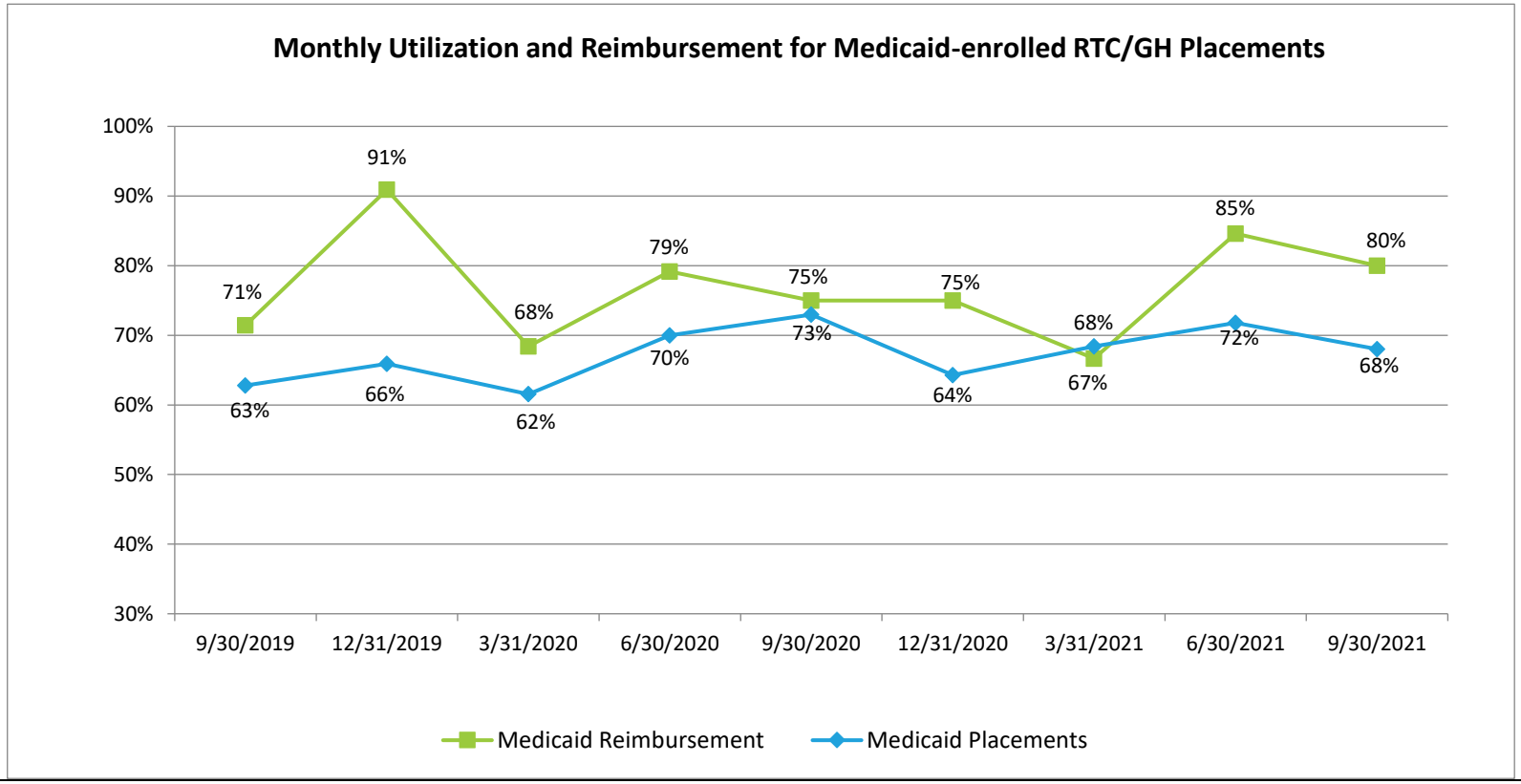
Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2022 Q1			
How Well Measure	**Number**	**Title**	**Value**
	2.3	**Permanency Outcome Goal: Prevent entry into foster care for reasons other than maltreatment**	
	2.3.1	JDRDC and DFS data on Relief of Custody Petitions: # ROC petitions filed/# children entering foster care from ROC petitions	1 filed / 2 entries
	2.3.2	Number of children entering foster care from CHINS petitions	0
	2.3.3	Number of children entering foster care from delinquency petitions	1
Graphs/ Charts			
Notes	**Analysis**: 2 ROCs were received, 1 was filed, 1 is pending. No youth entered foster care from a CHINS; one youth entered foster care rom a delinquency petition. **Planned Action**: Continue to monitor.		

Results-Based Accountability Performance Plan

Children's Services Act (CSA) System of Care

FY 2022 Q1			
How Well Measure	**Number**	**Title**	**Value**
	2.5	**Fiscal Accountability Outcome Goal: Fairfax-Falls Church CSA leverages state and local fiscal resources to serve youth and families efficiently**	
	2.5.1	Percentage of placements in Medicaid-enrolled facilities	68%
	2.5.2	Percentage of Medicaid placements receiving Medicaid reimbursement	80%
Graphs/Charts			
Notes	**Analysis**: There are 23 (68%) Medicaid placements and 11 (32%) non-Medicaid placements. Of those 23 placements, 20 (87%) are eligible for Medicaid with 16 (80%) approved; 2 (10%) denied; and 2 (10%) pending. The two denials were approved at the beginning of placement but were later denied for continued stay due to no longer meeting Magellan medical necessity criteria.		

MEMO TO THE CPMT

October 29, 2021

Information Item I – 3:

ISSUE:
CSB Hospital Diversion Project

BACKGROUND:
In the summer of 2021 the CSB convened a series of meetings with local hospitals, the CR2 and REACH regional crisis stabilization programs and CSA to address the pressing issue of youth being boarded at local emergency departments awaiting psychiatric hospital beds. The problem has been building for years but hospital bed restrictions due to COVID has turned it into a crisis. The mental health workforce shortage has continued to restrict hospital bed capacity as COVID has eased. And a surge of youth coming to emergency departments for behavioral health issues has greatly increased pressure on the system. Local hospital emergency departments are experiencing long delays in placing youth in hospitals, often resulting in stays in the emergency department of several days. Once hospitalized many youth are unable to discharge on a timely basis due to delays in accessing necessary services.

The data on increasing youth behavioral health needs is compelling. Nationally, since the pandemic:

- The proportion of mental health-related ED visits for children ages 5-11 increased 24% and for youth 12-17, 31% (CDC).
- ED visits for suspected suicide attempts by teenage girls increased 50% (Dartmouth study).
- Rates of anxiety and depression among college students have increased.
- One in four young adults has struggled with suicidal thoughts (CDC).

Local trends mirror those of the nation:

- In CY 2020 the rate of Emergency Department visits for suicide attempts and ideation rose quickly for 10 -17 and 18 - 24-year-olds.*
- 2021 Inova ED visits for youth with behavioral health issues increasing by 28%.
- Dominion Hospital and Inova child and adolescent inpatient programs are at capacity and running wait lists, as are partial hospitalization and eating disorder programs.*
- The long-standing shortage of pediatric psychiatric hospital beds became a crisis in the summer of 2021 as CCCA decreased its capacity by 63%.
- By June, 65 youth had waited at least 48 hours in Inova EDs in Calendar Year 2021, an increase of 40 (160%) over all of 2020.

*Children's Mental Health Report to the Board of Supervisors (April 2021)

In response, on July 30 the CPMT approved a proposal to increase CSB-provided CSA case support services by adding three Behavioral Health Specialist II positions. It is estimated that the additional capacity will be apportioned to carry 15 Leland House cases currently carried by FCPS, to take on 10 other high-risk cases currently carried by FCPS and to serve 20 youth at risk of hospitalization and needing expedited CSA or MHI funded services.

With the additional capacity it is anticipated that CSB will case manage all youth during their stay in Leland House and for at least 4.5 months afterward, assume case management from FCPS of some youth with complex needs and risk behaviors, and develop an expedited process for accessing CSA and MHI services for youth at risk of hospitalization.

As part of the July 30 CPMT item expanding case support services CSB committed to expediting access to CSA services for approximately 20 youth at risk of hospitalization. With some turnover of youth served over time that could grow to 40 youth served annually. Currently, accessing CSA services typically takes several weeks and requires several steps, including assigning a public agency case manager, convening a team-based planning meeting, completing a fee assessment, obtaining funding authorization, securing a provider and generating a purchase order. The exception is access to Leland House (a 45-day local residential service) for CHINS-mandated youth at risk of hospitalization, for whom the process has been condensed to a few days.

Current Status:

In October the CSB finalized a plan for expediting access to CSB case management for youth at high risk of hospitalization. CSB will accept referrals of up to twenty youth at high risk for hospitalization. Families may also access public agency services through CSB Entry for CSB services, or the CSA Office. Expedited Referrals will be accepted from CR2 and REACH for youth at the emergency department or CSB Emergency Services or having been served by them within the past 60 days, and youth in the hospital or having been hospitalized within the past 60 days.

The CSB will offer case management services, to include connecting families to CSB services and/or intensive services provided privately, as necessary. The family is also expected to access services through their commercial insurance or Medicaid as appropriate. Case management services will be provided at no cost to the family, although there may be fees for other services provided by the CSB or accessed privately. See the attached Hospital Diversion Pilot Project: October – December 2021 for additional information.

ATTACHMENT:
Hospital Diversion Pilot Project: October – December 2021

STAFF:
Jim Gillespie, LCSW, MPA
CSB Youth and Family Service Director

FAIRFAX · FALLS CHURCH
Community Services Board

Hospital Diversion Pilot Project: October-December 2021

Project Summary

- CSB will accept referrals of up to twenty youth at risk for hospitalization during a nine-week period, between October 11 and December 12. Families may also access public agency services through contact CSB Entry for CSB services, or the CSA Office for assignment of a CSA case manager.
- Referrals will be accepted from CR2 and REACH for youth at the emergency department or CSB Emergency Services or having been served by them within the past 60 days, and youth in the hospital or having been hospitalized within the past 60 days.
- The process of referring youth currently hospitalized for CSB and/or CSA case management will be reviewed and expedited if possible.
- The CSB, CR2 and REACH will jointly develop criteria for considering youth for referral.
- The CSB will offer case management services, to include connecting families to CSB services and/or intensive services provided privately, as necessary. The family is expected to access services through their commercial insurance or Medicaid as appropriate.
- Case management services will be provided at no cost to the family, although there may be fees for other services provided by the CSB or accessed privately.

How to make a referral

- Referrals from to CSB can only be made with the consent of the youth's parent or legal guardian, or the youth if age 14 or over.
- The CR2 or REACH mental health professional should complete the CSB Youth and Family Direct Referral Form along with a signed consent to release information.
- The CR2 or REACH mental health professional should review CSB Direct Referral Information for Parents with the parents.
- The referral form and consent are to be sent by secure email to the CSB Youth and Family Intensive Manager.
    - Jessica Jackson, Jessica.jackson@fairfaxcounty.gov

Youth who are most appropriate for CSB services

- Children and adolescents with behavioral health problems that significantly impact their mood, thinking, and/or behavior. The problems are often significantly disabling as compared to the functioning of most youth their age. The problems may be of recent onset or they have been going on for some time. OR
- Children and adolescents who have serious needs that cannot be met elsewhere or who do not have alternative resources such as commercial insurance to meet their needs. AND
- Youth at high risk for hospitalization due to behavioral health issues that place themselves or others at risk, and existing services and supports available to the family are unable to mitigate the risk.

What should the referring mental health professional expect?

- CSB will send a secure mail confirming receipt to the referring mental health professional within **one business day of** receiving the referral.
- A CSB case manager will make a contact call to the youth and family within **two business days** of receiving the referral.
- The CSB case manager will make at least two attempts to contact the youth and family via the telephone number(s) provided. If an appointment has not been made in **one week** the referral will be closed and family may directly contact CSB Entry for CSB services, or the CSA Office for assignment of a CSA case manager.
- The CSB case manager will contact the referring mental health professional within **five business days** of receiving the referral with a report on the status of engaging the youth and family in services.