

AGENDA
State Executive Council
The Comprehensive Services Act for At Risk Youth & Families
December 19, 2013
Dining Hall, UMFS
3900 W. Broad Street
Richmond, VA 23230

- 9:30 a.m. **Welcome & Chair Remarks – Dr. Bill Hazel**
 ➤ **Action Item** – Approval of September Minutes
- 9:40 **SEC Member Comments**
- 9:50 **Executive Director's Report – Susan Clare**
 ➤ SAS Update
 ➤ Budget Items
- 10:10 **Public Comment**
- 10:20 **SLAT Report – Victor Evans**
- Other Business Items**
- 10:30 **Proposed Dispute Resolution Policy (Revised)**
 ➤ **Action Item** – Adoption of Proposed Policy
- 10:45 **Workgroup Report: Standardizing Levels of TFC – Phyllis Savides**
- 11:00 **Proposed Policy: Standardized Levels of Treatment Foster Care – Susan Clare**
 ➤ **Action Item** – Approval to Post for Public Comment
- 11:10 **SEC Outcomes Committee Report**
- 11:20 **Change in DMAS Regulation: Mental Health Support Services – Susan Clare**
- 11:30 **Draft Reports to the General Assembly - Susan Clare**
- Adjourn**

**PROPOSED Schedule for 2014: March 24 (at CSA Conference), June 19,
September 18 and December 18**

3rd Annual CSA Conference
March 24 – 25, 2014

DRAFT

**STATE EXECUTIVE COUNCIL (SEC)
COMPREHENSIVE SERVICES ACT FOR AT RISK YOUTH AND FAMILIES
Dining Hall, UMFS
3900 West Broad Street
Richmond, VA
Thursday, September 19, 2013**

SEC Members Present:

The Honorable William A. (Bill) Hazel, Jr., M.D., Secretary of Health and Human Resources
Karin Addison, Deputy Secretary for Education and Children's Services
The Honorable John Edwards, Member, Virginia Senate (*by conference call in*)
Lelia Hopper for Karl Hade, Executive Secretary of the Supreme Court of Virginia
Jim Stewart, Commissioner, Department of Behavioral Health and Developmental Services
Michael Farley, CEO, Elk Hill, Inc.
Margaret Schultze, Commissioner, Virginia Department of Social Services
Cindi Jones, Director, Department of Medical Assistance Services
Greg Peters, CEO, UMFS
Martin Nohe, Parent Representative
John Eisenberg for Superintendent Patricia Wright, Virginia Department of Education
Robert Hicks for Dr. Cynthia Romero, Commissioner, Virginia Department of Health
The Honorable Patricia O'Bannon, Member, Henrico County Board of Supervisors

SEC Members Absent:

The Honorable Richard "Dickie" Bell, Member, Virginia House of Delegates
Joseph Paxton, Rockingham County Administrator
Mark Gooch, Director, Department of Juvenile Justice
Mary Bunting, Hampton City Manager

Staff Members Present:

Eric Reynolds, Assistant Attorney General, Office of the Attorney General
Susan Cumbia Clare, Executive Director, Office of Comprehensive Services (OCS)
Stacie Fisher, Program Consultant, OCS
Marsha Mucha, Administrative Staff Assistant, OCS

Call to Order and Approval of Minutes

Secretary Hazel called the meeting to order at 9:35 a.m. A quorum was present. Secretary Hazel reported that Senator Edwards had made a request of the SEC that he be allowed to participate in today's meeting via phone call. He is not able to attend in person because of business in Roanoke and, if approved by the Council, will be participating from his office in Roanoke. A motion was made by Michael Farley, seconded by Greg Peters and carried granting Senator Edwards' request to attend today's SEC meeting via phone call.

Secretary Hazel updated members on Virginia's implementation of the Affordable Care Act (ACA) effective October 1, 2013. He asked that the on-line benefit application system (CommonHelp) be avoided if at all possible during the first two weeks of implementation.

DRAFT

October 1, 2013 is also the date Virginians can begin comparing and purchasing insurance through the health insurance marketplace for coverage beginning January 1, 2014.

Secretary Hazel asked Margaret Schultze to provide a brief update on the adoption initiative, Virginia Adopts. Mrs. Schultze reported that since January more than 800 foster care children have been matched with or adopted by families. The goal is to find 1,000 adoptive families to match with 1,000 foster care children during 2013. Karin Addison reported that an adoption event is scheduled to be held on November 16, 2013 at the Science Museum of Virginia.

Secretary Hazel mentioned potential stakeholder interest in reverting CSA match rates back to the 2006 – 2007 level has been brought to his attention. If this were to be done, 89 localities would end up with higher match rates.

The minutes of the July 31, 2013 meeting were approved on a motion by Patricia O'Bannon, seconded by Martin Nohe and carried.

Executive Director's Report

Susan Clare reported on the following items:

- Scott Reiner will join OCS as Assistant Director on September 25, 2013. Mr. Reiner has an extensive background serving at-risk youth primarily within the field of juvenile justice. He has extensive experience with program evaluation, monitoring, and improvement. He has a lengthy history with CSA serving on SLAT, participating in workgroups and major initiatives including development of the Virginia CANS and Children's Services Systems Transformation. Mr. Reiner's focus as Assistant Director will be advancing systems of care statewide.
- SAS recently demonstrated the data integration and analysis system prototype for OCS. Report development is in the final stages and adjustment/improvements have been identified. A demonstration version, with personally identifiable information masked, is in development and will be delivered within the next month. Final delivery of the system to OCS is on target for November 30, 2013. A SAS demonstration will be arranged for state staff before the final product is delivered.

The first submissions of local data files to be submitted on a quarterly basis are due October 15, 2013. The integrity of data analysis will be dependent upon submission of data from 100% of localities in a timely manner. The greatest burden of submission will be for those LDSS offices that have never before entered Title IV-E cases into an on-line system. Martin Nohe suggested that localities probably have some employees that are very good at data entry and perhaps those employees could be reassigned in the short term to meet the initial data entry timeline.

Workgroups will be needed to standardize data elements and to identify functional processes for receipt and use of data.

DRAFT

During discussion, Secretary Hazel noted that as part of the next steps the SEC will need to identify benchmarks that will acknowledge high performers and allow localities room for innovation and improvement. Localities should be encouraged to share best practices.

Public Comment

There was no public comment.

SLAT Report

Victor Evans, SLAT Chair, highlighted the following SLAT activities:

- SLAT has two new primary members representing schools and parents. Also, SLAT will be anticipating a new primary appointment from DJJ, since Scott Reiner is joining OCS.
- SLAT is involved in three major activities:
 - being a resource for and supporting systems of care
 - supporting improvement of OCS training activities by gathering feedback from SLAT members on training needs and assisting OCS with curriculum development
- SLAT continues to address the SEC's Strategic Plan strategies assigned by the SEC. SLAT is focused on policies that govern use of funds and has received detailed presentations from DJJ, OCS, DBHDS and DMAS. At the October SLAT meeting, presentations will be made by DOE and VDSS. Janet Lung and Pam Fisher from DBHDS have coordinated these discussions and are using the information gleaned to coordinate with the SAMHSA grant requirement for development of a fiscal plan for system of care.
- Next SLAT meeting is October 3, 2013.

Report from the CSA Service Names and Definitions Workgroup

Lesley Abashian, the Loudoun County CSA Coordinator and member of the workgroup reported. She also introduced several workgroup members in attendance. Four meetings of the Workgroup were held between June 10 and August 16, 2013.

Beginning in 2013 OCS began collecting client-specific service data to enhance analysis and reporting regarding the services provided to children, youth, and families under CSA. Through a proof of concept project in which these data were collected for seven localities, more than 4,000 service names were reported. The extreme number was due in part to the wide variation in service naming across the localities participating in the project. The project highlighted the need to standardize service names across the state to achieve data integrity. As a result of those findings, the SEC approved the charter to create a workgroup to establish a list of standard service names with brief service descriptions.

The initial draft of "Service Names and Definitions" represents the recommendations of the workgroup approved through consensus. The workgroup remains consistent with its belief that the service names and definitions will not remove or reduce a locality's flexibility to create and provide new services.

DRAFT

This draft consolidates definitions for services that are being provided across the state. Established definitions from multiple stakeholders were collected in order to not replicate or redefine a service that exists in practice. Additional service names have been identified but not yet reviewed for inclusion in the draft document.

The workgroup has acknowledged significant challenges in defining services and reviewing working documents from multiple sources. Such challenges include:

- The magnitude and complexity of the task will require a continuation of work beyond this report to the SEC.
- There are pending changes to DMAS regulations which will impact relevant service definitions.
- The collection and analysis of service names and definitions from across multiple entities was a significant undertaking.
- The need to ensure that each service has a discrete definition so the service names cannot be confused or used interchangeably and to ensure clear distinction between services which require licensure and those which do not.

Recommendations

1. The workgroup should continue its work to ensure a comprehensive listing of service names and definitions. Additional members should be added to the workgroup as needed to ensure representation of all key stakeholders.
2. A timeline for local reporting utilizing standard service names will need to be determined following completion of the final service names document and in consultation with local government reporting entities.

During discussion Secretary Hazel noted that, while it is important to hold localities and providers accountable, there is the concern of over-licensing and being overly restrictive when defining services. Not every service needs to be licensed.

Review of Strategic Plan

Susan Clare asked SEC/SLAT members to divide up into three groups to review the progress on the goals and strategies of the SEC's Strategic Plan. The three goals are:

1. Support implementation of a unified system of care that ensures equal access to services for at risk youth across the Commonwealth.
2. Support informed decision making through utilization of data to improve child and family outcomes and public private performance in the provision of services to children and families.
3. Improving the operational effectiveness of CSA administration.

Goal One Review/Suggestions

Support implementation of a unified system of care that ensures equal access to services for at risk youth across the Commonwealth.

- Add the word "quality" to the goal to read "access to quality services"

- Strategy 1: Include additional strategies to include major initiatives: Magellan/DMAS; foster care children/managed care; systems of care. Include progress, challenges, impact, etc.
- Strategy 1: Provide provision for regular updates on major initiatives (including regular data update) to SEC through agenda item. From time-to-time provide update on service gaps.
- Strategy 3: Rewrite strategy. Identify strengths and how localities can assist/learn from each other.
- Include a strategy on licensing issues and how those issues impact systems of care. Also need to include benchmarks.
- Overall include more progress on implementation of systems of care.

Goal Two Review/Suggestions

Support informed decision making through utilization of data to improve child and family outcomes and public private performance in the provision of services to children and families.

- Strategy 1: Use data to determine the “right” cost of services.
- Strategy 1: Ensure VDSS participation and involvement and examine utilization of CANS for determination of enhanced maintenance, i.e., to use singular assessment tool.
- Strategy 1: Strategies for how to use data to inform service provision.
- Strategy 2: Continue to improve reporting.
- Strategy 3: Create common definitions.

Goal Three Review/Suggestions

Improving the operational effectiveness of CSA administration.

- Strategy 1: Focus audits on high-risk localities. Report the percentage of on-site audits/self-assessments.
- Strategy 1: Publish outcomes of audit. To what degree are the audits reported on the CSA website? Are audit findings being shared or used as learning tools?
- Strategy 2: What is the customer feedback? Are we engaging new audiences? Examine time effectiveness and using meetings that are already scheduled for educational opportunities.
- Strategy 3: Show “hits” on website. Solicit customer satisfaction.
- Strategy 6: Consider more one-on-one meetings between OCS executive director and directors of other child-serving agencies. Meetings would be more detailed and allow for information sharing on initiatives of mutual interest/impact. Meetings should be “old-fashioned” sit down meetings rather than arranged via web-technology.

Other Business

- Secretary Hazel reported that each Health and Human Resources agency has been asked to prepare an agency work plan based on the agency’s statutory requirements, performance management and strategic planning.
- Cindi Jones reported that a smooth transition is anticipated for the December 1, 2013 conversion to Magellan (BHSA). Also the process of transitioning all foster care and

DRAFT

adoptive children to managed care has begun. Tidewater was transitioned on September 1. The rest of the timeline is: Central Virginia, November 1; Northern Virginia, December 1 with the rest of the state following in spring 2014.

- Secretary Hazel reported on the possibility of creating a licensing and accreditation multi-user database to facilitate easier access to licensing information and to decrease duplication of effort.

Adjournment

Lelia Hopper reported that a Best Practices Court would be held December 11 and 12, 2013 in Roanoke. She noted that this would be a great opportunity to report on the data integration project and the Systems of Care grant.

There being no further business the meeting was adjourned at 11:50 a.m.

EXECUTIVE SUMMARY:
SLAT ASSESSMENT
of
SEC's 2011 CSA BIENNIAL PLAN
GOALS and STRATEGIES

for
**Support implementation of a singular, unified system of care that ensures
equal access to services for at-risk youth across the Commonwealth**
December 2013

Enclosed (starting on page 3) is the full report from the State and Local Advisory Team (SLAT) to the State Executive Council (SEC) as requested. The SEC directed the SLAT to complete an analysis of the following goal and strategy in its 2011 CSA Biennial Plan:

- **Goal: Support implementation of a singular, unified system of care that ensures equal access to services for at-risk youth across the Commonwealth.**
- **Strategy: Review and revise the policies of child serving agencies that govern the use of funds (e.g., CSA pool funds, Medicaid, Title IV-E, PSSF, VJCCCA, MH Initiative) to align service criteria, assessment, authorization, and utilization review.**

Presentations and policy reviews began in June 2013 and were completed in December 2013. Each state agency representative on the SLAT used a standardized table to present applicable programs and their characteristics. The ability to complete this task was made possible because of the facilitation conducted by DBHDS members, Janet Lung and Pam Fisher. Complete copies of each agency's table are inserted in the report and followed by a summary of discussion points. The presenting agencies were:

- Department of Juvenile Justice (DJJ) – June 6, 2013
- Office of Comprehensive Services (OCS) – June 6, 2013
- Department of Medical Assistance Services (DMAS) – August 1, 2013
- Department of Behavioral Health and Developmental Services (DBHDS) – August 1, 2013
- Department of Education (DOE) – October 3, 2013
- Department of Social Services (DSS) – October 3, 2013

The SLAT came to the following conclusions as “Overall Findings”:

1. To the extent of the presentations and reviews conducted, the only alignment issue discovered was about “payer of last resort”. For instance, Mental Health Initiative (MHI) guidelines stipulate that MHI funds can't be accessed unless other funding sources are used first. MHI guidelines state, “All available funding sources must be accessed to provide services for these children and adolescents prior to utilizing the MHI funding.” Unless there is a requirement in law that a funding stream must be the “payer of last resort”, the CPMT should decide which funding stream is appropriate to use in each case.
2. Regarding the intent of this project (i.e., to ensure our system of care can be efficiently and effectively administered by localities), the prevalent issue was the lack of familiarity with all possible resources and services.
 - a. To improve awareness at all levels, recommend that charts similar the ones used by SLAT in this report be placed on the OCS web site as a reference for all to use.
 - b. For ease of management to ensure efficiency in use of available funding streams, recommend that OCS create a standardized template for use by CPMTs that lists all funding sources (e.g., VJCCCA, PSSF, etc.) so localities can conduct an annual review of their operations. This would create a more collaborative local planning process with an eye to alignment, braiding and blending.

3. Two relevant issues regarding the quality of our system of care were deemed worthy to present to the SEC for consideration as a goal in a future biennial plan:
 - a. Continuity of care for transitional services when clients are ‘aging out’ of the CSA system.
 - An often repeated dilemma was the realization there is a lack of service support for clients who are no longer eligible for CSA-funded care when continuation of services are needed.
 - Local agency case managers struggle with finding equivalent support for young adults ages 18 thru 24.
 - b. The impact of making the distinction of clients as sum-sufficient (AKA ‘mandated’) and targeted but not sum-sufficient (AKA ‘non mandated’). This eligibility distinction has had the effect of creating a care environment in which children need to get worse before assistance can be provided and of children following through the cracks of our system of care.

This concludes SLAT’s analysis unless further directed by the SEC.

SLAT ASSESSMENT
of
SEC's 2011 CSA BIENNIAL PLAN
GOALS and STRATEGIES
for
Support implementation of a singular, unified system of care that ensures
equal access to services for at-risk youth across the Commonwealth
December 2013

Introduction

The infrastructure for Virginia's system of care is supported through legislation of the Comprehensive Services Act (CSA) in 1993. This landmark legislation gives state and local government agencies the structure to provide a collaborative system of services and funding to address troubled and at-risk youths and their families that is child-centered, family-focused, community-based and cost-effective.

Two teams provide statewide leadership for effective functioning of the CSA. The **State Executive Council (SEC)** is the supervisory council that provides overall leadership for CSA. It oversees the development and implementation of state interagency program and fiscal policies. The SEC is chaired by the Secretary of Health and Human Resources. It is comprised of two General Assembly members, the Office of the Secretary of Health and Human Resource's Special Advisor for Children's Services, the state government agency heads from DOE, DSS, Department of Health (DOH), DBHDS, Department of Medical Assistance Services (DMAS), DJJ, the Office of the Executive Secretary of the Supreme Court, five local government officials (cities and counties), two parents and two private service providers. **The State and Local Advisory Team (SLAT)** is required by statute to advise the SEC by managing cooperative efforts at the state level and to provide support to community efforts. It is comprised of a parent, private provider association representative, representatives from six state agencies, juvenile and domestic relations judge, local CSA Coordinator and representatives from each of five geographic regions of the state who serve on local community and policy management teams.

A primary goal of the SEC strategic plan is to support implementation of a unified system of care, which was a fundamental goal in its 2011 CSA Biennial Plan, as follows: **Support implementation of a singular, unified system of care that ensures equal access to services for at-risk youth across the Commonwealth.** SLAT was tasked to complete the following associated strategy: **Review and revise the policies of child serving agencies that govern the use of funds (e.g., CSA pool funds, Medicaid, Title IV-E, PSSF, VJCCCA, MH Initiative) to align service criteria, assessment, authorization, and utilization review.**

Since the System of Care Expansion Implementation Grant managed by DBHDS requires a strategic financing plan for the same programs being examined by the SLAT, the SEC agreed the work of the its strategic plan and the DBHDS grant financing plan could be accomplished simultaneously.

As a starting point for the work, each state agency representative on the SLAT was asked to present at regularly scheduled SLAT meetings about each of their applicable programs. To standardize agency presentations, a chart was created to list applicable programs and their characteristics and use a discussion guide (see Appendix A for the discussion guide) provided by DBHDS which included questions from "A Self-Assessment Guide: Developing a Comprehensive Financing Plan" (Armstrong et al., 2006). Presentations and policy reviews began in June 2013 and were completed in December 2013. This document is a summary of the presentations. Overall findings are on page 18.

Agency Presentation Dates

Department of Juvenile Justice (DJJ) – June 6, 2013

Office of Comprehensive Services (OCS) – June 6, 2013

Department of Medical Assistance Services (DMAS) – August 1, 2013

Department of Behavioral Health and Developmental Services (DBHDS) – August 1, 2013

Department of Education (DOE) – October 3, 2013

Department of Social Services (DSS) – October 3, 2013

A. Department of Juvenile Justice (DJJ) Presentation

Funding Source	Virginia Juvenile Community Crime Control Act (VJCCCA)	Transitional Services Funds (294)
Service Criteria	Youth must be before the court service unit or juvenile court for a delinquent or status offense. May receive services through age 21. Services can't be provided in a secure detention home setting-must be community based.	Non-residential services only. Must be released from a commitment to DJJ to be eligible. May receive service through age 21 as long as on parole through DJJ.
Assessment for Services	Based on individual program criteria developed in each locality. Certain services require that the youth be eligible to be placed in secure detention per Commonwealth of Virginia. There is no mandated assessment practice.	Parole Officers with input from juvenile correctional center staff. No standard assessment protocol.
Authorization Process	Locality submits a plan for use of allocated VJCCCA funds every two years. Plans are reviewed by DJJ and authorized by the board of Juvenile Justice. Significant changes to plans must go before the Board.	Individual requests for funding are submitted by parole officers for approval at the DJJ Central Office. Approvals are only for child-specific services.
Utilization Review Process	Plans and programs are monitored and audited by DJJ Central Office staff. No specific utilization review of individual cases.	Central Office staff monitor services and expenditures and must approve any extensions beyond the originally authorized amounts.
Services Provided	An array of services (over 20 categories) to include those addressing public safety, competency development and offender accountability. Services may be residential or nonresidential but can't be provided in a secure setting (detention home).	Array of services to assist incarcerated juveniles in successful transitioning to the community. Specific categories of services are designated – not an open menu. Services provided through an array of contracted (mostly private) providers.
Other Notes	Funding includes state allocations and for some localities a required local	

	<p>match (Maintenance of Effort). Appropriations are made by the General Assembly and distributed to localities according to a formula. Services may be provided directly by the locality or through contracts with other public or private providers. Not a child specific funding model. Can fund a program based on projected utilization and need.</p>	
--	--	--

DJJ Discussion Points

1. What disparities in access to services and/or funding exist related to your agency and the at-risk child population served?

There are disparities in access to services in that local governments in Virginia have significant autonomy in utilizing VJCCCA funding for different services. Other disparities exist for youth that age into adulthood while receiving DJJ services. These youth often have difficulty securing housing and employment as well as mental health services when they reach eighteen. Another issue is the increasing number of youth labeled as sex offenders. Although all of the juvenile facilities have mental health staff and excellent treatment outcomes for this population, relapse prevention resources for the number of youth that need it are lacking in the community.

Another significant disparity exists with CSA funding. Youth in the DJJ population often fall in to the "non-mandated" category. The children who would have been served by the applicable CSA special education or foster care criteria are considered "mandated" for service. This is because there is "sum sufficient" language attached to them in the Federal law and/or the Code of Virginia. These special education and foster care children are the only populations state and local governments are required to appropriate sufficient funds to serve. There is some funding from the CSA pool allocated for the non-mandated populations, but many localities choose to use it for the mandated populations because there is still a huge need for services beyond the mandated funding in the child welfare and special education populations.

Are there any entitlements administered by your agency?

No entitlements.

Identify gaps between needs and current funding.

The most significant gap is the need for services and supports for transition age youth (ages 18-21). As noted previously, many are unable to return home and struggle to find housing, education, employment, supports and services. Most re-entry councils and workgroups in Virginia are focused on improving resources for adult re-entry in to the community. Also, halfway houses are now considered to be extensions of the DJJ facilities making eligibility criteria stringent.

2. Are you able to identify utilization patterns and expenditures associated with high costs and/or poor outcomes within your child serving system? If so, describe.

VJCCCA current spending is at approximately \$11M state funds, with almost equal the amount of local funds and once was as high as \$30M. Some localities have mixed in other funds to support the funding.

B. Office of Comprehensive Services (OCS) Presentation

Funding Source	CSA State Funds Pool
Service Criteria	Youth must be eligible as stated in Virginia Code. Mandated populations include foster care youth, youth at risk for foster care, and youth being served through special education services. COV § 2.2-5212 A. COV § 2.2-5212 B. Service must not be the responsibility of another agency. CSA funds must not be used to supplant other funding sources.
Assessment for Services	The Child and Adolescent Needs and Strengths Assessment (CANS)
Authorization Process	The Family Assessment and Planning Team (FAPT) and/or Multidisciplinary Team develops the service plan. The Community Policy and Management Team (CPMT) authorizes funding.
Utilization Review Process	Each locality must have a utilization management plan.
Services Provided	Services designed to meet the unique needs of eligible youth and families. Foster care services including prevention of foster care. Special education services in private day and private residential settings.

OCS Discussion Points

1. What disparities in access to services and/or funding exist related to your agency and the at-risk child population served? Are there any entitlements administered by your agency?

Foster care and special education youth are mandated to receive funding. There are other youth populations that are at risk that do not receive funding (non-mandated population). These often include children with mental health needs that do not fall in to the foster care and/or special education categories.

Identify gaps between needs and current funding.

There are issues with children who fall in to the non-mandated category for CSA. The allocation for the non-mandated population is much less than that for the mandated category. The pool funding allocation for both the mandated and non-mandated categories is based on a formula for each locality, and they are required to provide a local match for the funding. The CPMT for each locality authorizes the funding and often the non-mandated population does not get served due to lack of resources at the local level to provide the match. Some localities move the non-mandated funds in to the mandated funds because of the overwhelming needs of youth eligible for these funds. In addition, some localities erroneously believe they cannot apply for a supplemental allocation from the OCS if they have used any of their funds for the non-mandated population.

Another issue is the fact that the Individual Education Program (IEP) meetings and plan development are separate from the FAPT process. Many localities have difficulty agreeing on service plans for youth that include both IEP elements as well as other service needs.

2. Are you able to identify utilization patterns and expenditures associated with high costs and/or poor outcomes within your child serving system? If so, describe.

The fact that CSA is locally administered has historically made it difficult to identify utilization patterns and expenditures statewide. However, the Office of Comprehensive Services is currently participating in a data analysis project with Casey Family Programs and the SAS Institute to perform outcome analysis of services provided through CSA (SAS Proof of Concept Project). The SAS project will provide data that matches youth functioning to the services they are receiving including the provider name where they are receiving the services.

C. Department of Medical Assistance Services (DMAS) Presentation

Funding Source/Service Name	Medicaid/Level C Residential Treatment	Medicaid/Intensive In-home Services	Medicaid/Therapeutic Day Treatment
Service Criteria	For individuals under the age of 21 whose treatment needs cannot be met by ambulatory care resources available in the community, for whom proper treatment of their psychiatric condition requires services on an inpatient basis under the direction of a physician.	Intensive in-home services to children and adolescents under age 21 are time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from an out-of-home placement due to a documented medical need of the child. These services provide crisis treatment; individual and family counseling; and communication skills (e.g., counseling to assist the child and his parents to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response.	Therapeutic day treatment shall be provided two or more hours per day in order to provide therapeutic interventions. Day treatment programs provide evaluation; medication education and management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy.

<p>Assessment for Services</p>	<p>The need for services must be certified by an independent team that includes a licensed physician who: has competence in dx and tx of pediatric mental illness, and has knowledge of individual's mental health history and current situation.</p>	<p>Independent Clinical Assessment is required. Service-specific provider assessment is also required. Eligibility criteria: Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis: a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community. b. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary. c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. These services shall be provided when the clinical needs of the child put at risk for out-of-home placement: a. When services that are far more intensive than</p>	<p>Independent Clinical Assessment is required. Service-specific provider assessment is also required. Eligibility criteria: Therapeutic day treatment is appropriate for children and adolescents who meet one of the following: a. Children and adolescents who require year-round treatment in order to sustain behavior or emotional gains. b. Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without: (1) This programming during the school day; or (2) This programming to supplement the school day or school year. c. Children and adolescents who would otherwise be placed on homebound instruction because of severe emotional/behavior problems that interfere with learning. d. Children and adolescents who (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality. e. Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that</p>
---------------------------------------	---	--	--

		<p>outpatient clinic care are required to stabilize the child in the family situation, or</p> <p>b. When the child's residence as the setting for services is more likely to be successful than a clinic.</p>	<p>they cannot function in these programs without additional services.</p> <p>Individuals qualifying for this service shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral or emotional illness which results in significant functional impairments in major life activities. Individuals shall meet at least two of the following criteria on a continuing or intermittent basis:</p> <p>a. Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.</p> <p>b. Exhibit such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.</p> <p>c. Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior</p>
<p>Authorization Process</p>	<p>Services must be authorized by DMAS' service authorization contractor. The information that is required for authorization includes: Completed UAI</p>	<p>Services must be authorized by DMAS' service authorization contractor. The information that is required for authorization includes: 1-Independent clinical assessment (VICAP) 2- identify how individual</p>	<p>Services must be authorized by DMAS' service authorization contractor. The information that is required for authorization includes: 1-Independent clinical assessment (VICAP) 2-Identify how individual</p>

	<ul style="list-style-type: none"> • Certificate of need indicating that ambulatory care resources in the community do not meet the specific treatment needs of the individual; proper treatment of the individual's psychiatric condition requires treatment on an inpatient basis under the direction of a physician; and the services can be reasonably expected to improve the individual's condition or prevent regression • DSM Diagnosis • Description of individual's behavior for 7 days immediately prior to admission • Description of alternative placements that have been tried or explored and the outcome of each • The individual's functional level and clinical stability • The level of family support Available, and • Initial Plan of Care 	<p>meets each eligibility criterion</p> <p>3-A narrative of the behaviors exhibited over the past 30 days that place the child at risk of removal from the home due to a clinical need and warrant the requested level of care. (Explain the frequency, intensity and duration of each behavior, and progress/lack of progress towards treatment goals)</p>	<p>meets each eligibility criterion</p> <p>3-Describe current symptoms and behaviors or other pertinent information. Explain the frequency, intensity and duration of each behavior.</p>
Utilization Review Process	DMAS performs utilization reviews through in-house staff and contractors. A selection of providers are reviewed each year. UR findings will result in retractions.	DMAS performs utilization reviews through in-house staff and contractors. A selection of providers are reviewed each year. UR findings will result in retractions.	DMAS performs utilization reviews through in-house staff and contractors. A selection of providers are reviewed each year. UR findings will result in retractions.
Services Provided	Residential treatment services directed by a physician.	Crisis treatment; individual and family counseling; and communication skills (e.g.,	Day treatment programs provide evaluation; medication education and

		counseling to assist the child and his parents to understand and practice appropriate problem solving, anger management, and interpersonal interaction, etc.); case management activities and coordination with other required services; and 24-hour emergency response.	management; opportunities to learn and use daily living skills and to enhance social and interpersonal skills (e.g., problem solving, anger management, community responsibility, increased impulse control, and appropriate peer relations, etc.); and individual, group and family psychotherapy.
--	--	--	---

DMAS Discussion Points

- 1. What disparities in access to services and/or funding exist related to your agency and the at-risk child population served? Are there any entitlements administered by your agency? Identify gaps between needs and current funding.**

Although the Medicaid income related eligibility requirements are more open for children than adults, requirements are narrow and some of the most stringent in the U.S. The eligibility process is done through local social service offices and is complex. In addition, even though many children may access services through the EPSDT Program, it is a time consuming and lengthy process.

Other limitations to services include Virginia’s focus on the medical aspects of behavioral health care for reimbursement and low reimbursement rates. Low reimbursement makes it difficult to enroll providers in some service modalities. Also, the Medicaid system involves a number of funding pools with requirements for each which leads to service access and availability issues.

There are several waivers for children but all of them are focused on the intellectual or developmental disabilities populations. These waivers will cover behavioral health services for the children that have them however, none of them are solely focused on youth with behavioral health or serious emotional disturbance other than the Psychiatric Residential Treatment Facilities (PRTF) waiver which is ending. Slots for waivers are often full and waiting lists are long. There is also lack of clarity on how to access and use waivers.

SEE APPENDIX FOR LIST OF CURRENT BEHAVIORAL HEALTH AND WAIVER SERVICES AVAILABLE THROUGH DMAS

- 2. Are you able to identify utilization patterns and expenditures associated with high costs and/or poor outcomes within your child serving system? If so, describe.**

DMAS is able to identify utilization patterns and expenditures associate with high costs but not individual child outcomes.

D. Department of Behavioral Health and Developmental Services (DBHDS) Presentation

Funding Source	Community Services Performance Contract	Mental Health Initiative Funds	Commonwealth Center for Children and
-----------------------	--	---------------------------------------	---

Service Criteria	<p>State and federal appropriations and required local matching funds for community services are allocated to the community services boards (CSB) via a funding formula through a performance contract with DBHDS. Each CSB has a Performance Contract which governs their use and reporting on funds. Certain portions of the funding are restricted for children and have special service requirements. These include:</p> <ul style="list-style-type: none"> -Child Set Aside of the Mental Health Block Grant -Funds for CSB services in Juvenile Detention Centers -Mental Health Initiative Funding -New state appropriations for specific services; most recent are the Crisis Response Services allocation beginning September 2012. 	<p>The Mental Health Initiative (MHI) Fund was established by the General Assembly in FY 2000 to create a dedicated source of funding (\$4,125,000) for mental health and substance abuse services for children and adolescents with serious emotional disturbances (SED) who are not mandated for the Comprehensive Services Act (CSA). In FY 2002, the General Assembly added additional funding (\$2,000,000) to the MHI Fund, created in prior years. The increased allocation provides for a total of \$6,125,000 in MHI funding</p>	Adolescents
Assessment for Services	<p>Process decided by CSB; varies by CSB.</p>	<p>Identified and assessed through the local government Family and Assessment Planning Teams and approved by the Community Policy and Management Teams.</p>	<p>A child must be prescreened and determined to be in danger by a pre-screener from the home community service board (CSB).</p>
Authorization Process	<p>Process decided by CSB; varies by CSB.</p>	<p>FAPT, CPMT</p>	<p>See above.</p>
Utilization Review Process	<p>Process decided by CSB; varies by CSB.</p>	<p>Varies depending on locality. Guidelines require that the CPMT have a policy to oversee the utilization of these funds.</p>	<p>CCCA has a nursing utilization review coordinator who provides contact with insurance carriers and Medicaid regarding justifications for continued hospitalization and other coverage issues, attending treatment team meetings to stay informed</p>

			of discharge planning and barriers, and maintaining data regarding continued stays.
Services Provided	Each CSB has a varying service array for children. Every CSB is required in code to provide Emergency Services and Case Management Services.	Community based services only – no inpatient or residential.	Inpatient acute psychiatric services only.
Other Notes	Each CSB has an individual mix of funding sources, depending upon the funding formula, how many Medicaid recipients they serve, and the array of children’s services they provide.		

DBHDS Discussion Points

1. What disparities in access to services and/or funding exist related to your agency and the at-risk child population served?

CSBs are agents of local government and state appropriations are allocated through the DBHDS performance contract once per year. The state appropriation is small and CSBs receive differing amounts based on a formula. The Virginia Association of Community Services Board, a lobbying organization that represents the CSBs in state and federal public policy matters, provides an annual report of funding sources for CSBs. The FY12 report indicates the following funding sources: state 24%, local 25%, federal 5%, Medicaid 45%, and Other 1%. Since allocations are small CSBs are forced to operate as businesses despite the fact that they serve mostly indigent populations. CSBs largely serve the adult population with about 23% of services going towards children.

There are “payor of last resort” issues in Virginia. For example, the Guidelines for Mental Health Initiative (MHI) funding may lead some localities to believe that these funds can’t be accessed unless other funding sources are accessed first. Language from MHI Guidelines states: “All available funding sources must be accessed to provide services for these children and adolescents prior to utilizing the MHI funding. These sources include, but are not limited to, CSA non-mandated funding, Medicaid, Children’s Medical Security Insurance Plan, Family Access to Medical Insurance Security, private insurance, and other federal, state, or local funds. Other federal or state funds include: Promoting Safe & Stable Families funds, mental health federal block grant funds, Virginia Juvenile Community Crime Control Act funds, and other state mental health general funds used by CSBs for child and adolescent services.” This is also an issue with CSA funding and Medicaid, i.e. that some localities struggle in knowing which funding source should be accessed first and whether or not they will be audited with paybacks.

All of the Mental Health Initiative Funding is usually spent each year by CSBs and more is needed for seriously emotionally disturbed youth (non-mandated CSA population).

Are there any entitlements administered by your agency?

No entitlements but CSBs are required by code to provide crisis prescreening for potential hospitalization and if funding is available case management services for children.

Identify gaps between needs and current funding.

Crisis Response Services, Child Psychiatry, Case Management/Intensive Care Coordination and In-home Services were identified as primary service needs in the 2011 304M Report: A Plan for Community Based Children’s Behavioral Health Services in Virginia. Also, there is difficulty finding funding for children with serious emotional disturbance that are not eligible for Medicaid and do not fall in to one of the CSA mandated populations (foster care, at risk for foster care, and special education).

2. Are you able to identify utilization patterns and expenditures associated with high costs and/or poor outcomes within your child serving system? If so, describe.

The DBHDS data system only collects descriptive information on children such as number of children served in broad based service categories.

E. Department of Social Services (DSS) Presentation

Funding Source	Title IV-E Foster Care Funds	Title IV-B, sub-part 2, Promoting Safe and Stable Families Funds	Title IV-E Chafee Independent Living Services Funds and Educational And Training Voucher Funds
Service Criteria	<p>Available only for youth in foster care who meet Title IV-E eligibility criteria.</p> <p>May receive services through age 19 under certain conditions.</p> <p>Services only include room, board, personal incidentals, specific transportation needs and clothing. Counseling, education, medical and other services are not allowed. Youth must reside in certain types of approved placements.</p>	<p>PSSF funds provide services for families in three categories of need: family preservation; family support and time-limited reunification services for families whose children are in foster care (within 15 months of entry into foster care). Family preservation and family support provide services for families where there are children at risk of foster care placement.</p> <p>Services are provided based on criteria provided by VDSS through an annual funding application process. If a locality’s</p>	<p>Service criteria are based on federal Title IV-E criteria as they relate to older youth in foster care and those children adopted from foster care.</p> <p>For IL services, all children in foster care age 14 and older are eligible for specific assessment and service provision designed to enhance their independent living skills (e.g., money management, household maintenance, etc.). Children who have been adopted from the foster care system are eligible for these services</p>

		<p>funding application is approved, each locality determines client-specific approval criteria based on the program of services approved by the state as a result of the application process.</p>	<p>as well.</p> <p>Education and Training Vouchers (ETV) are available for children in foster care who have completed secondary education and wish to/are enrolled in post-secondary educational or vocational training programs. Children adopted from the foster care system at or after age 16 are also eligible for these ETV services.</p>
<p>Assessment for Services</p>	<p>Based on federal Title IV-E eligibility criteria including compliance with AFDC criteria as defined in 1996 and on-going criteria such as timeliness of court hearings, placements in approved placement types, etc.</p>	<p>Services are determined by the local FAPT/CPMT process.</p>	<p>VDSS requires that children in foster care must be assessed for IL skill development needs. VDSS promotes and supports the Casey Life Skills Assessment Tool but accepts the Daniel Memorial or other formalized life skill assessment results as the basis for child-specific IL skill training.</p> <p>ETV funds does not require assessment but is based solely on the youths approval for entrance into a post-secondary educational or vocational program.</p>
<p>Authorization Process</p>	<p>Locality is required to assess IV-E eligibility for every youth within 45 days of entrance into foster care. Child remains eligible for IV-E funding throughout the foster care episode unless placement changes to unallowable placement type or court hearing timeframes or required court order language is not. In compliance with federal</p>	<p>Localities must submit a funding application request to VDSS for each of the funding categories that spell out how the funds will be used. Localities are allocated a specific amount of funds based on a formula developed by the state and community stakeholders.</p>	<p>LDSS are allocated funds based on historic patterns of eligible youth in care.</p> <p>For IL funding, LDSS must submit an annual application for access to allocated funds that specifies what outcomes they will focus on with their youth.</p> <p>For ETV funds, funds are</p>

	requirements.		allocated based on number of youth who are eligible based on secondary school graduation and/or enrollment in post-secondary educational or vocational programs. ETV funds must be authorized only for those areas of service allowed by federal law.
Utilization Review Process	Eligibility reviews of eligible cases statewide are conducted by state Title IV-E staff on an on-going basis.	The local CPMT must ensure submission of quarterly reports to VDSS regarding how funds were used in accordance with the approved annual funding application.	VDSS reviews quarterly reports from LDSS summarizing the use of funds based on their original application package and outcomes identified.
Services Provided	<p>Room, board, clothing, personal incidentals, transportation to see family or attend school of origin are provided.</p> <p>These services are available for children placed in a continuum of services (i.e., foster care home to residential placement) as long as the placement type is consistent with federal Title IV-E criteria.</p>	<p>Services under each category are quite broad but must fit into the following parameters:</p> <ul style="list-style-type: none"> • Family Preservation: Help families alleviate crises that might lead to out-of-home placements of children because of abuse, neglect, or parental inability to care for their children. These services help maintain the safety of children in their own homes, support families preparing to reunify or adopt, and assist families in obtaining other services to meet multiple needs. • Family Support: Voluntary, preventive activities to help families nurture their children. These services are designed to alleviate stress and help parents care for their children's well-being before a 	<p>IL services include a wide range of services that enhance foster care or adopted youth's ability to function as interdependent adults. Service categories are consistent with federally mandated IL skill categories (e.g., money management, etc.).</p> <p>ETV provides up to \$5,000 per year to support tuition, books and other school or vocational program supplies. A percentage of living expenses may also be covered.</p>

		<p>crisis occurs. They connect families with available community resources and supportive networks which assist parents with child rearing. Family support activities include respite care for parents and care givers, early development screening of children to identify their needs, tutoring health education for youth, and a range of center-based activities. Services often are provided at the local level by community-based organizations.</p> <ul style="list-style-type: none"> • Time-limited Family Reunification: Facilitate a reunification of the child safely and appropriately within a timely fashion, but only during the 15-month period that begins on the date that the child is considered to have entered foster care. Services are for the child and the parents or primary care giver. Such services may include individual, group, and family counseling; inpatient, residential, or outpatient substance abuse treatment services; mental health services; assistance to address domestic violence; services designed to provide temporary child care and therapeutic services for families, 	
--	--	--	--

		including crisis nurseries; and transportation to or from any of the services.	
Other Notes	<p>Funding includes a state match of approximately 50%. There is no local match.</p> <p>Appropriations are made by the General Assembly and distributed to localities according to a formula based on IV-E eligible vs. non IV-E eligible children in care.</p> <p>Eligibility for Title IV-E funded services varies throughout the life a foster care episode based on changes in child's living circumstance, court hearing requirements.</p> <p>State and federal funds are sum-sufficient based on eligible children.</p>	<p>Allocations for funding are based on a state-wide methodology that considers and weighs selected variables that impact service needs for families at risk of or involved in the child welfare system (e.g., poverty; CPS referrals; etc.)</p> <p>Approval of each localities application for funding is dependent on a locality specific needs assessment consistent with federal PSSF service provision criteria.</p>	

DSS Discussion Points

- 1. What disparities in access to services and/or funding exist related to your agency and the at-risk child population served? Are there any entitlements administered by your agency?**

Title IV-E funds are drawn down from federal government based on state's previous year's expenditures, number of children in foster care, and penetration rate. They are federally regulated with strict funding criteria based on income, resource limits, removal from legal custodian, deprivation, age, and citizenship. Before accessing funding, courts must find that it is contrary to the welfare of the child for them to remain in the home and reasonable efforts must have been made to prevent the removal.

There is also some confusion among providers as to what types of services IV-E funding pays for. The SLAT parent representative, reports that respite care providers in Northern Virginia feel they need to follow Title IV-E federal laws when providing respite care to families. For example, the respite care application process is quite tedious and lengthy and it requires the legality of parents turning over their

children to the respite care providers for the weekend that they are providing care - as if they are their foster care parents. This is an issue that could deter many families from going through the process.

In addition, there is national debate as to whether the IV-E policies are outdated. Current funding is based on 1996 AFDC rules. The federal government is looking at the following creative strategies to increase access: waivers of poverty criteria, waivers for states to draw down a lump sum rather than a per child basis, and waivers to allow states to use the funding for child welfare where they see it is appropriate.

Title IV-B funds (Promoting Safe and Stable Families) are spent in disparate ways because local CPMTs are the entities that decide how to spend the funding, and the local DSS serves as the fiscal agent. However, funds allow for the following coordinated community programs: 1) family support services, 2) family preservation services, 3) time-limited family reunification services, and 4) adoption promotion and support services. A minimum of 20% must be spent on each of the service categories unless the state receives a waiver of this percentage. Prevention of foster care is a major focus for this funding stream.

Chafee Independent Living Funds provide services to eligible youth 14 years and older. They include specific assessment and service provision designed to enhance independent living skills and transition to adulthood. Youth are able to receive services until age 21. Educational training vouchers pay for state universities in Virginia, but must be approved by the state DSS office (current spending approximately \$500,000).

Identify gaps between needs and current funding.

DSS-IVE Funds

- Unallowable costs include any type of service payments including medical, dental, mental health treatment, academic services, travel for family to visit child, counseling, DSS staff time associated with travel

DSS-PSSF (Promoting Safe and Stable Families) Funds-Title IV-B

- Burdensome in that every 5 years the CPMT must come up with a plan on how to spend the money including annual updates.

2. Are you able to identify utilization patterns and expenditures associated with high costs and/or poor outcomes within your child serving system? If so, describe.

DSS is only capable of identifying trends such as amount spent and number of youth served by various funding streams, i.e. IV-E, IV-B

F. Department of Education (DOE) Discussion Points (The standardized chart was not applicable for DOE presentation.)

1. **What disparities in access to services and/or funding exist related to your agency and the at-risk child population served?** The Department of Education is only focused on troubled or at risk youth as it pertains to their education. All funding is viewed through an educational lens. Schools are not necessarily looking through a social or emotional lens.

Are there any entitlements administered by your agency?

Title I funding serves impoverished students. It provides financial assistance to local educational agencies (LEAs) and schools with high numbers or high percentages of children from low-income families to help ensure that all children meet challenging state academic standards.

The Federal Perkins Loan Program provides low interest loans to help needy students finance the costs of postsecondary education.

Federal Funds

Federal funds are available both for preschool and school-age special education programs. The amounts received by each school division are determined by a formula that considers historical federal funding, total school enrollment, and poverty level.

Also, in years when the increase in the federal IDEA appropriation to the state exceeds the rate of inflation, the state must award a “sliver” of the overall grant to localities for capacity building. The Virginia Department of Education may award these sliver grants on a targeted basis, competitively, or by formula.

In any given year the Department of Education, as its discretion, may also offer other federal grant opportunities designed for statewide program improvement.

School divisions must apply annually for any federal funds, and cannot commingle federal special education funds with other funds. Upon approval from the State, the school division spends the money and then is reimbursed for approved expenditures.

School divisions may also seek federal Medicaid reimbursement for certain students and services by applying to the Department of Medical Assistance Services to be an approved provider.

For **special education** students 14 years and older schools are required to provide **transitional services**.

Identify gaps between needs and current funding.

Funding and education for homeless students is an issue that comes up frequently. Currently there is a Governor’s homelessness workgroup that SLAT could partner with to explore options to serve this population.

- 2. Are you able to identify utilization patterns and expenditures associated with high costs and/or poor outcomes within your child serving system? If so, describe.**

Only for academic data.

OVERALL FINDINGS:

4. To the extent of the presentations and reviews conducted, the only alignment issue discovered was about “payer of last resort”. For instance, Mental Health Initiative (MHI) guidelines stipulate that MHI funds can’t be accessed unless other funding sources are used first. MHI guidelines state, “All available funding sources must be accessed to provide services for these children and adolescents prior to utilizing the MHI funding.” Unless there is a requirement in law that a funding stream must be the “payer of last resort”, the CPMT should decide which funding stream is appropriate to use in each case.

5. Regarding the intent of this project (i.e., to ensure our system of care can be efficiently and effectively administered by localities), the prevalent issue was the lack of familiarity with all possible resources and services.
 - a. To improve awareness at all levels, recommend that charts similar the ones used by SLAT in this report be placed on the OCS web site as a reference for all to use.
 - b. For ease of management to ensure efficiency in use of available funding streams, recommend that OCS create a standardized template for use by CPMTs that lists all funding sources (e.g., VJCCCA, PSSF, etc.) so localities can conduct an annual review of their operations. This would create a more collaborative local planning process with an eye to alignment, braiding and blending.
6. Two relevant issues regarding the quality of our system of care were deemed worthy to present to the SEC for consideration as a goal in a future biennial plan:
 - a. Continuity of care for transitional services when clients are ‘aging out’ of the CSA system.
 - An often repeated dilemma was the realization there is a lack of service support for clients who are no longer eligible for CSA-funded care when continuation of services are needed.
 - Local agency case managers struggle with finding equivalent support for young adults ages 18 thru 24.
 - b. The impact of making the distinction of clients as sum-sufficient (AKA ‘mandated’) and targeted but not sum-sufficient (AKA ‘non mandated’). This eligibility distinction has had the effect of creating a care environment in which children need to get worse before assistance can be provided and of children following through the cracks of our system of care.

References

Armstrong, M.I., Pires, S.A., McCarthy, J., Stroul, B.A., Wood, G.M., & Pizzigati, K., (2006). A self-assessment and planning guide: Developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-01). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children’s Mental Health.

Appendix A

Presentation Discussion Format

1. What disparities in access to services and/or funding exist related to your agency and the at-risk child population served? Are there any entitlements administered by your agency? Identify gaps between needs and current funding.
2. Are you able to identify utilization patterns and expenditures associated with high costs and/or poor outcomes within your child serving system? If so, describe.
3. Do you have a data system for ongoing tracking of utilization and expenditures for these services and supports?
4. Which financing strategies and structures to support effective systems of care are in place now in your system? Which ones need to be developed? Consider the following:
 - How your system could financially link with other child serving systems
 - Potential uses of Medicaid dollars, IV-E dollars, CSA dollars, third party payers
 - How your system could be connected or integrated with block grants
 - How your system could be included and integrated in the implementation of the Affordable Care Act

5. Which financing strategies and/or structures may be difficult to accomplish but could have a major impact, i.e., which ones would need to be accomplished with a long-range strategy?
6. What strategies may be relatively easy to achieve and viewed as short-term wins, i.e., which ones could be accomplished through immediate action?
7. What agency policies may need revision to support a unified system of care that ensures equal access to services?

Appendix B

DMAS Behavioral Health and Waiver Services

1. Psychiatric Hospitalization
 - a. Freestanding psychiatric hospitals-under age 21
 - b. Psychiatric units in general, acute care hospitals
2. Residential Placement-under age 21 only
 - a. Level C-Medicaid pays for treatment only, not room and board
 - b. Level B group homes-Medicaid pays for treatment only, not room and board
 - c. Level A group homes-Medicaid pays for treatment only, not room and board
3. Outpatient Psychiatric and Substance Abuse Services
4. Community Mental Health Rehab Services
 - a. Intensive In-home (under age 21 only)
 - b. Therapeutic Day Treatment (under age 21 only)
 - c. Treatment Foster Care-Case Management
 - d. Mental Health Case Management
 - i. At risk of Serious Emotional Disturbance (SED) through age 7
 - ii. Children with SED under age 18
 - iii. Adults with Serious Mental Illness (SMI) age 18 and above
 - e. Mental Health Support (recommended for age 18 and above)
 - f. Crisis Intervention
 - g. Crisis Stabilization
 - h. Intensive Community Treatment
 - i. Psychosocial Rehabilitation
 - j. Day Treatment/ Partial Hospitalization
5. Community-based Substance Abuse (SA) Treatment
 - a. SA Crisis Intervention
 - b. SA Intensive Outpatient
 - c. SA Day Treatment
 - d. Opioid Treatment
 - e. SA Case Management
 - f. SA Residential Treatment for Pregnant Women

g. SA Residential Day Treatment for Pregnant Women

6. Waiver Services

- a. Elderly or Disabled Consumer Direction (EDCD) Waiver-for those who are disabled/elderly or who meet Nursing Facility level of care
- b. Intellectual Disabilities (ID) Waiver-for those who meet the level of care for an Intermediate Care Facility for the Intellectually Disabled (ICF/ID)
- c. ID case Management-for those who meet the ID definition
- d. Day Support Waiver-to provide support in the community for individuals who are on the ID Waiver waiting list
- e. Developmental Disability (DD) Waiver-for those who meet level of care for ICF/DD age 6 and over
- f. DD case management-for those on DD Waiver or DD waiver waiting list
- g. Technology Assisted Waiver

7. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services; child specific services including:

- a. Nursing
- b. Personal Care
- c. Hearing and audiology
- d. Inpatient
- e. Applied Behavior Analysis Therapy

State & Local Advisory Team
Review of
Proposed Policy Amendment: Dispute Resolution Process

To: State Executive Council for the Comprehensive Services Act

As directed, the SLAT completed a review of the July 2013 proposed policy for presentation to the SEC on December 19, 2013. (The revised policy proposal of November 22, 2013, was used to finalize this report.) The basis of the proposed policy was to address the following statement of need, "The current dispute resolution process lacks detail regarding how informal and formal proceedings shall be conducted, representation by counsel, and timelines for decisions."

Overall, the SLAT supports the objectives and the need for the proposed policy. Our review was a collaborative approach of various perspectives by local and state agencies and by public and private providers. We offer the following findings as suggested improvements to the "Proposed Policy" section:

- A. The need for clarity regarding measuring days as 'business' versus 'calendar' days..
 1. Sometimes "days" were specifically stated as 'business' days.
 2. Sometimes "days" were simply stated as days without any qualification.
 3. **RECOMMENDATIONS:**
 - i. Each mention of "days" needs to specify business or calendar days.
 - ii. Change "30 days" to "60 calendar days" in §B.2. "Within **30 days** of issuance of the formal written notice from the Executive Director, a CPMT appealing such finding and action ~~may~~ shall file a written Request for Reconsideration ...".
 - a. CPMTs throughout the commonwealth typically meet only once a month. Also, there are a good number of CPMTs that represent multiple localities. Therefore, additional time is needed to properly complete staffing and a legal review before submitting a written request.
 - b. The revised proposal does include a reference to APA standards, as follows: "The APA also sets 30 days as the time for response at different stages, however, the SEC may consider extending this to 45 days in light of some of the public comments made regarding how often some CPMTs meet.". However, since no formal obligation was created for CSA and the SEC to comply with APA standards, the SLAT feels there is sufficient justification to allow up to 60 calendar days for a CPMT to prepare and submit a written Request for Reconsideration.
- B. Matters of concern to make the new process as efficient and as fair as possible.
 1. Efficiency issue: Create opportunities to use teleconferences when possible and agreeable to both parties. In §A.3., it states, "All hearings and meetings related to appeals shall be held in the ~~city of~~ Richmond, Virginia area. Informal hearings may be held at an alternate location as agreed to by all parties."
 - i. Create the flexibility of a case-by-case decision making process that allows for appeal hearings and meetings to be conducted in the most efficient manner. It is possible that the best place to hold such meetings may be at the locality or via a teleconference or a mixture of local and state sites when there are multiple meetings. Precedence exists to convene such meetings at a locality.
 - ii. **RECOMMENDATION:** Change the statement from, "All hearings and meetings related to appeals shall be held in the ~~city of~~ Richmond, Virginia area. Informal hearings may be held at an alternate location as agreed to by all parties." to "All hearings and meetings related to appeals shall

be held in a manner that both parties agree regarding location or the use of teleconferencing. If such an agreement is not reached at least two weeks prior to the scheduled event, the default is to convene in the Richmond, Virginia area.”

2. Fairness issue to have a “level playing field”: Establish the formal hearing as an unbiased venue to determine if an allegation of noncompliance is to be founded or dismissed. In §B.4.b., fourth line, it states, “The burden of proof shall be upon the CPMT.”
 - i. Specifying that the burden of proof rests with only one party (the local CPMT) during a formal hearing to resolve allegation(s) of noncompliance relieves the other party (the Commonwealth agency) of responsibilities to fully justify the allegation(s).
 - ii. The basis of CSA as a system of care is to have a strong partnership of state and local agencies. The revised proposal does include a reference to APA standards, as follows: “The APA also places the burden of proof on the appellant to show how the agency’s final decision was in error.”. However, since no formal obligation was created for CSA and the SEC to comply with APA standards, the SLAT feels there is sufficient justification to create an appeal hearing whereby both parties share the responsibility to justify their position before the SEC in order for the SEC to make an informed decision.
 - iii. **RECOMMENDATION:** Delete the statement.
3. §B.4.i.1) now §B.4.f.1), “Timetable for decision”. The consensus was it is not timely enough.
 - i. The revised proposal states, “The decision of the State Executive Council shall be rendered within 30 days of the formal hearing. If the State Executive Council fails to render a decision within 30 days, the CPMT may provide written notice to the Office of Comprehensive Services that a decision is due. If the State Executive Council does not render a decision with 30 days from its receipt of such notice, the decision is deemed to be in favor of the CPMT.”
 - ii. The basic requirement for rendering a decision within 30 days (that should be specified as ‘calendar’ days) rests with the SEC. Making CPMTs responsible to enforce SEC responsibilities was seen as too unique.
 - iii. **RECOMMENDATION:** If there is a need to allow for circumstances to complete a finding, recommend the following change: “The decision of the State Executive Council shall be rendered within 30 calendar days of the formal hearing. If the State Executive Council is not able ~~fails~~ to render a decision within 30 calendar days, the State Executive Council shall provide the CPMT ~~may provide~~ written notice of the need for additional time not to exceed another 30 calendar days of when the ~~to the Office of Comprehensive Services that~~ a decision is due. If the State Executive Council does not render a decision within the established time (i.e., within the 30 calendar days of the formal hearing or the additional days not to exceed 30 more calendar days) ~~30 days from its receipt of such notice~~, the decision is deemed to be in favor of the CPMT.”.

Proposed Policy Amendment: Dispute Resolution Process

*Proposed Amendments Based on Public Comments
November 22, 2013*

Proposed Policy

A. APPEALABLE ACTIONS; PARTIES; VENUE; WRITTEN DECISIONS

1. Administrative actions that may be appealed through the dispute resolution process are:
 - a. Denial, in whole or in part, by the Office of Comprehensive Services of financial reimbursement for expenditures incurred by a community policy and management team pursuant to Va. Code § 2.2-2648(D)(20); and
 - b. Request by the Office of Comprehensive Services for the recoupment of prior reimbursement provided to a CPMT, pursuant to Va. Code § 2.2-2648(D)(20).
2. Only a CPMT can file an appeal. Appeals are not available to clients of CSA services or to any subgroup of the CPMT, including any member agency or individual member.
3. All hearings and meetings related to appeals shall be held in the ~~city of~~ Richmond, Virginia area. Informal hearings may be held at an alternate location as agreed to by all parties.
4. The terms of any final case decision by the Office of Comprehensive Services or State Executive Council, as signed by it, rendered at the informal or formal stages of the Appeal Process shall be served upon the CPMT by mail unless service otherwise made is duly acknowledged by them in writing. The signed originals shall remain in the custody of the Office of Comprehensive Services as public records; and they, or facsimiles thereof, together with the full record or file in every case shall be made available for public inspection or copying except (i) so far as the Office of Comprehensive Services may withhold the same in whole or part for the purpose of protecting individuals mentioned from personal embarrassment, obloquy, or disclosures of a private nature including statements respecting the physical, mental, moral, or financial condition of such individuals or (ii) for trade secrets or, so far as protected by other laws, other commercial or industrial information imparted in confidence.
- 4.5. The CPMT shall be entitled to be represented by counsel at all hearings and meetings related to appeals.

B. APPEAL PROCESS

1. Written finding. Upon receipt by the CPMT of a formal written notice from the Executive Director of OCS which communicates a finding by the Executive Director requiring action pursuant to subsection A(1), and the basis for such finding. a local CPMT shall have the right to appeal such finding and action.
2. Request for Reconsideration. Within 30 days of issuance of the formal written notice from the Executive Director, a CPMT appealing such finding and action ~~may shall~~ file a written Request for Reconsideration with the Executive Director stating its intention to appeal the

finding and action and the reasons why the CPMT claims the finding and action are not appropriate. If the formal written notice from the Executive Director is delivered to the CPMT by regular mail, 3 days shall be added to the time in which the CPMT must respond. The Request for Reconsideration shall also include a request for the informal conference pursuant to subsection B(3). The CPMT may waive its right to the informal conference and submit a Notice of Appeal requesting a formal hearing before the Council pursuant to subsection B(4). The Notice of Appeal shall include a statement of the finding and/or action by the Executive Director being appealed and a brief statement of the reasons why the CPMT claims the finding and/or action are not appropriate.

3. Informal conference.

- a. The informal conference shall be held within 15 business days of the Executive Director's receipt of the Request for Reconsideration unless both parties agree in writing to hold the informal conference at a later date.
- b. The purpose of the informal conference is to allow the CPMT to present, and the Executive Director to consider, any additional facts and reasons providing the basis for the CPMT's appeal of the written findings and action by the Executive Director.
- c. The CPMT shall have the right to (i) receive reasonable notice thereof, (ii) appear in person and to be represented by counsel, (iii) have other witnesses appear for the informal presentation of factual data, argument, or proof related to the matter, (iv) have notice of any contrary fact basis of information in the possession of the OCS that can be relied upon in making an adverse decision, and (v) be informed, briefly and generally in writing, of the factual or procedural basis for a decision in any case prior to the commencement of the informal conference.
- d. The Office of Comprehensive Services may, in its decision, rely upon public data, documents or information only when OCS has provided all parties with advance notice of its intent to consider such public data, documents or information. This requirement shall not apply to OCS's reliance on administrative precedent.
- e. The Executive Director shall have the right to have counsel for the informal conference.
- f. The CPMT shall have the right and option to submit any documentation to support its case prior to, during, and/or at any time subsequent to the informal conference and prior to the rendering of the Executive Director's written determination.
- g. Within 30 business days following the conclusion of the informal conference, or the receipt by the Executive Director of all relevant documents or exhibits, whichever is later, the Executive Director shall render a final decision. The parties may agree in writing to extend this period of time.
- h. In the event the Executive Director who issued the written notice of finding and action is unable to conduct the informal conference or issue a written determination following the informal conference due to sickness, disability, or termination of their official capacity with the Office of Comprehensive Services, the timeframe provisions herein shall commence from the date that either alternate Office of Comprehensive Services personnel are assigned to the matter or a new proceeding is conducted, if necessary,

whichever is later. The Office of Comprehensive Services shall provide notice within five days to the CPMT of any such inability or incapacity of the Executive Director that necessitates a replacement or a new proceeding.

- i. The CPMT may contest the final decision of the Executive Director by submitting to the OCS a written Notice of Appeal requesting a formal hearing before the State Executive Council within 30 days of the issuance of the Executive Director's final decision. If the Executive Director's final decision is delivered to the CPMT by regular mail, 3 days shall be added to time in which the CPMT must respond. If the OCS does not receive such a Notice of Appeal within this time period, the CPMT shall be deemed to accept the final decision of the Executive Director and shall immediately comply therewith. The Notice of Appeal shall include a statement of the finding and/or action by the Executive Director being appealed and a brief statement of the reasons why the CPMT claims the finding and/or action are not appropriate.

4. Formal hearing.

- a. Within 5 business days of receipt by the Executive Director of the Notice of Appeal submitted by a CPMT, the Executive Director shall contact the CPMT chair to schedule a mutually agreeable date for the formal hearing and to establish guidelines for the receipt of documentation supporting the Notice of Appeal.
- b. In all such formal proceedings all parties shall be entitled to be accompanied by and represented by counsel, to submit oral and documentary evidence and rebuttal proofs, to conduct such cross-examination as may elicit a full and fair disclosure of the facts, and to have the proceedings completed and a decision made. The burden of proof shall be upon the CPMT. The presiding officer at the proceedings may (i) administer oaths and affirmations, (ii) receive probative evidence, exclude irrelevant, immaterial, insubstantial, privileged, or repetitive proofs, rebuttal, or cross-examination, rule upon offers of proof, and oversee a verbatim recording of the evidence, (iii) hold conferences for the settlement or simplification of issues by consent, (iv) dispose of procedural requests, and (v) regulate and expedite the course of the hearing.
- c. ~~The Chair of the State Executive Council shall designate a three member panel from the membership of the Council to conduct the formal hearings and shall designate one of the panel members to the Chair of the Council shall serve as presiding officer. The panel shall consist of one state government representative, one local government representative, and a parent or private provider representative. The panel shall prepare a written recommendation of disposition to include:~~ The decision of the State Executive Council shall be final and shall be made in writing in the form of a Final Order of Disposition. The Final Order of Disposition shall include:
 - 1) written findings of fact,
 - 2) conclusions of law or policy,
 - 3) rationale for its ~~recommendation conclusion~~, including the identification of any documents or policies upon which the ~~recommendation conclusion~~ was made, and
 - 4) the ~~recommendation of disposition including any recommended corrective action plan and/or any repayment plan.~~

~~If the panel recommendation is not unanimous, there shall be a written dissent.~~

~~e. Prior to the issuance of the written recommendation of disposition by the panel, both parties shall be given the opportunity, upon request, to submit in writing for the record (i) proposed findings and conclusions and (ii) statements of reasons therefor.~~

~~f. The recommendation of disposition shall be mailed to the parties.~~

~~g. The recommendation of disposition and documentation relied upon shall be available for review at the Office of Comprehensive Services at least 14 business days prior to the next meeting of the State Executive Council or by appointment.~~

~~h.d. The State Executive Council shall address the panel's recommendation of disposition at its next meeting. Panel members shall be excluded from the discussion and vote of the State Executive Council. The State Executive Council shall give deference to findings by the panel explicitly based on the demeanor of witnesses.~~

~~i.e. The decision of the State Executive Council shall be final and shall be made in writing in the form of a Final Order of Disposition.~~

~~j.f. Timetable for decision~~

~~1) The recommendation of disposition by the hearing panel shall be provided within 90 days from the date of the formal hearing, or such time as mutually agreed upon by the CPMT and the presiding officer of the formal hearing.~~

~~2)1) The decision of the State Executive Council shall be rendered within 390 days of receipt of the Notice of Appeal submitted by a CPMT of the formal hearing, from the date the Council receives the hearing panel's recommendation of disposition. If the State Executive Council fails to render a decision within 390 days, the CPMT may provide written notice to the Office of Comprehensive Services that a decision is due. If the State Executive Council does not render a decision with 30 days from its receipt of such notice, the decision is deemed to be in favor of the CPMT.~~

~~3)2) The provisions of subsection 11 and 2 notwithstanding, if a quorum of the Council is unable to be met at the time the Council makes its decision due to a member's sickness, disability, or termination of their official capacity with the State Executive Council in the event any member of the State Executive Council who participated in the formal proceedings is unable to attend to official duties due to sickness, disability, or termination of their official capacity with State Executive Council, then the timeframe provisions of subsection 11 and 2 shall be reset and commence from the date that either new board members are assigned to the matter or a new proceeding is conducted if needed, whichever is later. The Office of Comprehensive Services shall provide notice within five business days to the CPMT of any incapacity of the State Executive Council members that necessitates a replacement or a new proceeding.~~

Comments: The Administrative Process Act was used as a model to develop this process. Modifications were made to apply to the CSA program, but certain procedural presumptions and terms are adapted directly from the APA. For example, some public comments addressed the timing of the receipt and issuance of certain notices. The APA states that the date a final agency decision is issued is the date that it is sent by the agency to the appellant. The days in which the appellant responds is dependent upon that date of issuance, not the date that the appellant receives the final decision. The APA adds 3 days to the time period in which the appellant responds if the final decision is delivered to the appellant by regular mail in order to account for potential delays in delivery by the postal service. The APA also defines the date of receipt of any notices sent by an appellant to an agency as the date the notice was actually received and date-stamped by the agency. The APA also sets 30 days as the time for response at different stages, however, the SEC may consider extending this to 45 days in light of some of the public comments made regarding how often some CPMTs meet. The APA also places the burden of proof on the appellant to show how the agency's final decision was in error. Some comments requested that the Executive Director have the burden of proof to show that the CPMT was in error.

Office of Comprehensive Services
Standardizing Levels of Care in Treatment Foster Care Workgroup
Report to the State Executive Council
December 19, 2013

Report Mandate

The “Standardizing Levels of Care in Treatment Foster Care” workgroup was established to address recommendations made in April 2012 by the “Treatment Foster Care Workgroup” charged with developing *Guidelines for the Use of Treatment Foster Care under the Comprehensive Services Act*.

The initial workgroup had made recommendations for further review of several issues including the following:

- 1) There is a need for private child placing agencies to offer basic level, i.e., non-treatment foster care services.
- 2) There is a need for greater uniformity across private child placing agencies in the offered levels of treatment foster care.

In March 2013, the State Executive Council authorized the Office of Comprehensive Services to solicit the participation of representatives of a number of stakeholder groups and establish a workgroup to address these two issues. One purpose of the workgroup was to clarify if there were any barriers which would prevent Licensed Child-Placing Agencies (LCPA) from providing “non-treatment” foster care, and also to develop uniformity across levels of treatment foster care offered by LCPA to simplify the current system and enhance communication and understanding between local government and private providers.

The workgroup was asked to review for consistency the Department of Social Services (DSS) LCPA regulations and standards as well as the Treatment Foster Care-Case Management (TFC-CM) regulations of the Department of Medical Assistance Services (DMAS). A chart comparing the VDSS and DMAS regulations was reviewed at the first workgroup meeting. As VDSS Licensing has made a concerted effort in recent revisions to create consistency with DMAS regulations for TFC-CM, the workgroup did not further explore this request.

Background

Participation of representatives of the stakeholder groups outlined in the charge dated March 14, 2013 was solicited by the Office of Comprehensive Services. The workgroup membership is included as Attachment A to this report and the charge to the workgroup is included as Attachment B.

The workgroup first met on June 14, 2013 and met a total of four times, with numerous electronic communications throughout the time period of June through December 2013.

The proposed “Guidelines for Determining Levels of Care for Foster Care Services with Licensed Child Placement Agencies” (Attachment C) represents the discussions and collaborative work of the workgroup members.

Discussion

Each topic below was discussed in-depth by the workgroup members.

Standardization of Levels:

Each Licensed Child Placing Agency that provides treatment foster care establishes its own level system, so the number of levels, the meaning of each level, as well as the costs and the associated expectations, vary across the state. When dealing with individual LCPAs, local government staff must know how a particular provider defines each level. A provider may define levels by age groupings, VEMAT scores, severity of need and/or behavior, sibling groups, stability in placement, specialized populations or any combination of these (or other) variables. A significant expected advantage of the workgroup's product is standardization of the number of levels as well as the meaning associated with each level of treatment foster care offered by LCPAs. As one workgroup member succinctly stated "at least, now at FAPT everyone will be speaking the same language."

Currently, some LCPAs offer a "basic" level of care in an effort to meet the needs identified by localities for non-treatment foster care. However, as with the TFC levels, each provider defines what this level of care encompasses. The workgroup's effort will assist in standardizing these expectations.

Possible Barriers:

Some providers in the past expressed concern that VDSS Licensing standards would not permit them to offer "non-treatment" foster care; that a Licensed Child Placing Agency authorized to provide treatment foster care was obligated to provide this more intensive level of care to any child the agency served. The Division of VDSS Licensing Programs (DOLP) has clarified that Licensed Child Placing Agencies (LCPAs) may provide non-treatment foster care. As the standards are higher for treatment foster care, an agency may be authorized to provide "traditional" foster care if authorized to provide treatment foster care. LCPAs are not obligated to provide a treatment level of care if the child does not need treatment. The same is true for those agencies with Council on Accreditation (COA) credentials. The child's needs drive the type of foster care to be provided. The agency is accountable for meeting the needs of each child at the appropriate level.

Other Considerations:

The Levels of Care TFC workgroup was instructed to not consider cost in the development of the model, rather the system should be designed considering the needs and best interests of the children and families served. There are no set or suggested cost rates or ranges for any level. The workgroup was not directed to develop financial criteria associated with each level and providers and FAPT/CPMTs would continue to negotiate the rates as is currently done.

Initially, the workgroup considered listing potential services for each level; however, it was decided this would lead to prescriptiveness. Flexibility in service provision is a critical tenet of CSA and services should always be individualized for that child and family.

Recommendations of the Workgroup

The workgroup respectfully recommends that the State Executive Council:

1. Request feedback from TFC workgroup members regarding any potential revisions to the proposed guidelines that may result from public comments received.
2. Approve the proposed "Guidelines for Determining of Levels Care for Foster Care Services with Licensed Child Placing Agencies" after receiving public comment.
3. Adopt a policy statement requiring implementation of the "Guidelines for Determining of Levels Care for Foster Care Services with Licensed Child Placing Agencies" after receiving public comment.

ATTACHMENT A

Standardizing Levels of Treatment Foster Care

Workgroup Membership

**State Executive Council
Comprehensive Services Act (CSA)
Treatment Foster Care Workgroup
Member Contact List**

Name and Contact Information	Representing:
<p>Janet Areson Director, Policy Development Virginia Municipal League 13 East Franklin Street Richmond, VA 23219 804) 523-8522 jareson@vml.org</p>	<p>Virginia Municipal League (local government)</p>
<p>Penny Combs People Places, Inc. 1215 N. Augusta St. Staunton, VA 24401 540.885.8841 penny.combs@peopleplaces.org</p>	<p>Private Provider</p>
<p>Sheila Crossen-Powell Director, Hanover Department of Social Services 12304 Washington Highway Ashland, Virginia 23005 804-365-4122 sheila.crossen-powell@dss.virginia.gov</p>	<p>Local Department of Social Services</p>
<p>Andrew Crawford Director, Bedford County Social Services 119 Main Street Post Office Box 1187 Bedford, VA 24523 Phone 540-586-7750 x 2226 andrew.crawford@dss.virginia.gov</p>	<p>Local Department of Social Services</p>
<p>Robin Ely Licensing Administrator Virginia Department of Social Services 1604 Santa Rosa Road, Suite 130 Richmond, VA 23229 (804) 662-7367 robin.ely@dss.virginia.gov</p>	<p>VDSS Division of Licensing Programs-Child Welfare</p>
<p>Kellie Evans VP of Residential Services The Up Center 6350 Center Dr. Bldg. 5 Ste. 215 Norfolk, VA 23502 Phone: (757) 965-8667 Kellie.evans@theupcenter.org</p>	<p>Private Provider</p>

<p>Michael Gasper Executive Director Extra Special Parents Office: (804) 714-1776 Cell: (804) 814-7324 mgasper@espva.org</p>	Private Provider
<p>Tom Hall DePaul Community Resources thall@depaulcr.org</p>	Private Provider
<p>Krystal Hulette CSA Coordinator/ Youth & Family Services Manager 122 E. Main Street Suite G-01 Bedford, VA 24523 Telephone: 540-586-7652 ext. 1376 khulette@co.bedford.va.us</p>	CSA Coordinator
<p>Jermaine Johnson Executive Director Adolescent and Family Growth Center, Inc. 8000 Forbes Place Springfield, VA 22151 703.425.9200 Ext. 228 jhjohnson@afgcinc.com</p>	Private Provider
<p>Marcy Johnson Vice President, Programs UMFS 3900 West Broad Street Richmond, VA 23230 (804) 353-4461, ext. 1105 mjohnson@umfs.org</p>	Private Provider
<p>Mills Jones Director, Office on Youth/ CSA Goochland County 1800 Sandy Hook Road, P.O. Box 910 Goochland, VA 23063 Phone: (804) 556-5875 mjones@co.goochland.va.us</p>	CSA Coordinator
<p>Charles Laslie State Director of Foster Care Braley and Thompson, Inc. 13625 Office Place, Suite 101 Woodbridge, Virginia 22192 Phone: 703-878-8216 claslie@rescare.com</p>	Private Provider

<p>Emily McClellan Behavioral Health Policy Analyst Dept. of Medical Assistance Services 600 W. Broad Street Richmond, VA 23219 804-225-4272 emily.mcclellan@dmas.virginia.gov</p>	<p>Virginia Department of Medical Assistance Services</p>
<p>Em Parente Program Manager Virginia Department of Social Services 801 East Main Street Richmond, VA 23219 em.parente@dss.virginia.gov</p>	<p>VDSS-Family Services</p>
<p>Riva O'Sullivan Henrico County DSS 8600 Dixon Powers Drive Henrico, Virginia 23273 osu@henrico.co.va.us</p>	<p>Local Department of Social Services</p>
<p>Phyllis Savides Assistant Director Albemarle County Department of Social Services 1600 Fifth Street Charlottesville, Virginia 22902 (434) 972-4011 x3177 psavides@albemarle.org</p>	<p>Local Department of Social Services</p>
<p>Shannon Updike Foster Care Supervisor HopeTree Family Services 3309 West Hundred Road / PO Box 3779 Chester, Virginia 23831 Phone (804) 201-9006 Shannon@hopetreefs.org</p>	<p>Private Provider</p>
<p>Carol Wilson Program Consultant Office of Comprehensive Services 1604 Santa Rosa Road, Suite 137 Richmond, VA 23229 (804) 662-9817 carol.wilson@csa.virginia.gov</p>	<p>Office of Comprehensive Services (facilitator)</p>

ATTACHMENT B

Standardizing Levels of Treatment Foster Care

Workgroup Charter

State Executive Council Workgroup

Standardizing Levels of Care in Treatment Foster Care

The 2011 Appropriation Act required that the State Executive Council authorize guidelines for access to and the provision of treatment foster care (TFC). A workgroup was appointed and recommended guidelines to the SEC. The SEC adopted the Treatment Foster Care Guidelines in April 2012. In addition to the TFC guidelines, the workgroup recommended that the SEC consider several issues to support appropriate utilization of TFC in the Commonwealth.

The need for examination of TFC levels of care was also identified through the public comment process on a proposed SEC policy. These comments, as well as review of the proposed policy statement by the State and Local Advisory Team (SLAT), highlighted the need for further examination of the levels of care as well as the purpose and utilization of TFC-Case Management.

The purpose of this workgroup will be to address two of the issues identified by the original TFC Workgroup. These are:

1. There is a need for private child placing agencies to offer basic level, i.e., non-treatment, foster care services.
2. There is a need for greater uniformity across private child placing agencies in the offered levels of treatment foster care.

In addition, the workgroup will examine Department of Medical Assistance Services (DMAS) regulations and provider requirements for TFC-CM and licensing requirements of the Virginia Department of Social Services (VDSS) for Licensed Child Placing Agencies and provide recommendations to ensure clarity and consistency across agency requirements.

The SEC directs the Office of Comprehensive Services to solicit the participation of representatives of the following stakeholder groups and to establish this workgroup:

- Licensed child placing agencies (at least one provider from each of the five regions of the state)
- VDSS licensing unit
- VDSS division of family services
- VLSSE/local social services directors
- CSA coordinators
- DMAS
- VML and/or VACO

By June 1, 2013 the workgroup will provide the SEC a statement of work to include the group's goals, a project timeline, and the date for providing final recommendations to the SEC.

ATTACHMENT C

Guidelines for Determining Levels of Care for Foster Care Services with Licensed Child Placing Agencies

**Guidelines for Determining Levels of Care for Foster Care Services
with Licensed Child Placing Agencies
December 2013**

Procedures for Determining Level of Care

- I. The determination of the appropriate service level is always based on the individual child's specific needs and strengths.
- II. The Family Assessment and Planning Team (FAPT), or approved Multi Disciplinary Team (MDT), and the licensed child placing agency shall work collaboratively in the assessment, decision-making and service delivery process to determine the appropriate level of care for the child.
- III. Children shall be placed at the Assessment Treatment Level upon initial placement with a LCPA and when a child is moved from to a new LCPA.
- IV. The maximum stay at the Assessment Treatment Level shall not exceed sixty days to complete a needs assessment and service plan, per requirements of the Virginia Department of Social Services, Division of Licensing Programs. An accurate and thorough assessment of the child's strengths and needs shall be made.
- V. Following the assessment, the assessment shall be provided by the LCPA to the FAPT/MDT with recommendation of level of care.
- VI. The determination of level of care shall be made collaboratively based on all available information and documentation of the child's needs by FAPT/MDT and the LCPA.
- VII. Determination of the initial level of care and a child's movement between levels of care will be based on a combination of factors, including but not limited to: child's current and past behavior, needs and strengths, number of placements the child has experienced, ratings on the CANS, VEMAT, and any other available assessments, anticipated level of support needed for the foster home, and available documentation such as psychological evaluations and foster parent, school , case manager and provider reports, etc.

Levels of Care Criteria:

Basic Foster Care: Children served at the non-treatment level of foster care may be developmentally on target, demonstrate age appropriate behaviors, be able to participate in community activities without restriction, or be the sibling of a child who meets the criteria for ongoing TFC placement. Children shall be served at the Basic Foster Care level (non-treatment level) if the assessment indicates treatment foster care services are not needed.

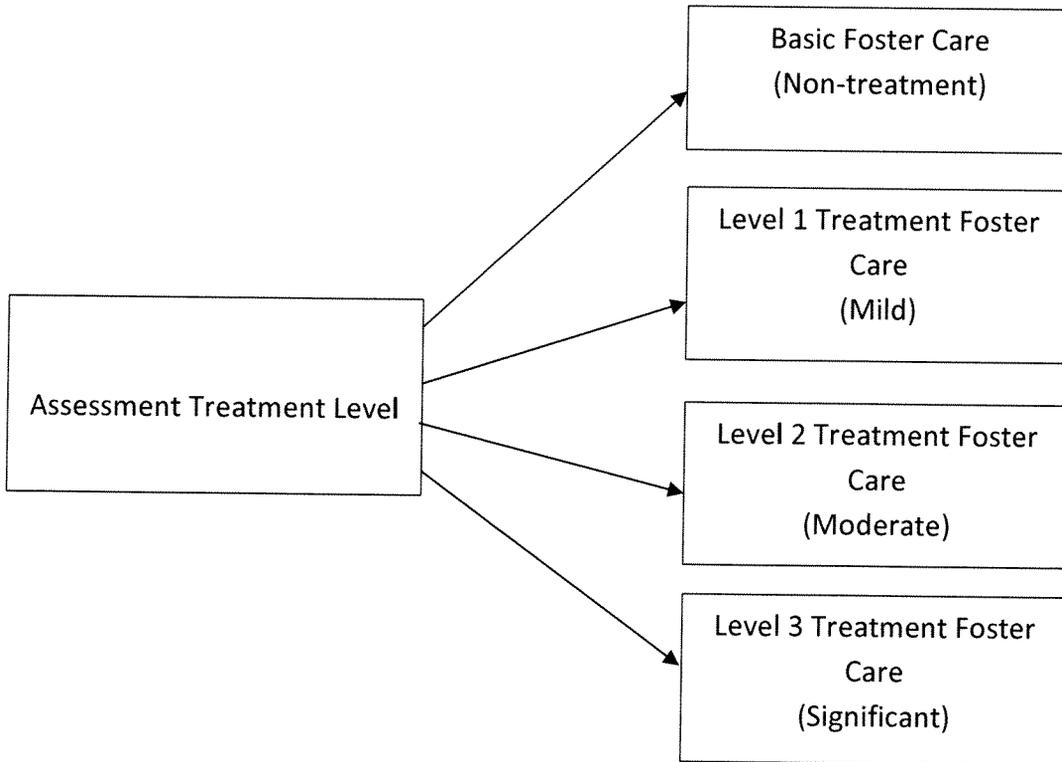
Treatment Foster Care Levels 1, 2 and 3 represent ongoing treatment placement levels, with Level 1 representing mild treatment needs, Level 2 moderate treatment needs and Level 3 significant treatment needs.

Level 1 Treatment Foster Care (Mild): A child served at Level 1 ongoing treatment foster care will demonstrate a mild level of social/emotional/behavioral/medical/personal care needs or impairment for normal range of age and development; *such as but not limited to, depression, anxiety, impulsivity, hyperactivity, anger control, adjustment to trauma, oppositional, substance use, eating disorder, physical health condition, developmental delay, or intellectual.* The child's needs require monitoring or agency may need to provide services to lessen likelihood needs will return.

Level 2 Treatment Foster Care (Moderate): A child served at Level 2 ongoing treatment foster care will demonstrate a moderate level of social/emotional/behavioral/medical/personal care needs or impairment for normal range of age and development; *such as but not limited to, depression, anxiety, impulsivity, hyperactivity, anger control, adjustment to trauma, oppositional, substance use, eating disorder, physical health condition, developmental delay, or intellectual.* The child's needs require that action (interventions, services, supports, etc.) be taken to address, remedy or ameliorate the needs.

Level 3 Treatment Foster Care (Significant): A child served at Level 3 ongoing treatment foster care will demonstrate a significant level of social/emotional/behavioral/medical/personal care needs or impairment for normal range of age and development; *such as but not limited to, depression, anxiety, impulsivity, hyperactivity, anger control, adjustment to trauma, oppositional, substance use, eating disorder, physical health condition, developmental delay, or intellectual.* The child's needs are of such acuity or severity that they require intensive action (interventions, services, supports, etc.) be taken to address, remedy or ameliorate the needs. A child served at this level may be at risk of residential placement.

Flow Chart



Proposed Policy:
Purchase of Foster Care Services from Licensed Child Placing Agencies
Recommendation to the State Executive Council
from the Executive Director of the Office of Comprehensive Services
December 2013

Authority

Code of Virginia, §2.2-2649. Office of Comprehensive Services for At-Risk Youth and Families established; powers and duties.

B. The director of the Office of Comprehensive Services for At-Risk Youth and Families shall:

- 1. Develop and recommend to the state executive council programs and fiscal policies that promote and support cooperation and collaboration in the provision of services to troubled and at-risk youths and their families at the state and local levels;*
- 2. Develop and recommend to the Council state interagency policies governing the use, distribution and monitoring of moneys in the state pool of funds and the state trust fund;*

Code of Virginia, § 2.2-2648. State Executive Council for Comprehensive Services for At-Risk Youth and Families; membership; meetings; powers and duties.

D. The Council shall have the following powers and duties:

- 3. Provide for the establishment of interagency programmatic and fiscal policies developed by the Office of Comprehensive Services for At-Risk Youth and Families, which support the purposes of the Comprehensive Services Act (§ 2.2-5200 et seq.), through the promulgation of regulations by the participating state boards or by administrative action, as appropriate;*

Statement of Need

The 2011 Appropriation Act, Item 274 M, required the following:

“The State Executive Council (SEC) shall authorize guidelines for therapeutic foster care (TFC) services, including a standardized definition of therapeutic foster care services, uniform service needs criteria required for the utilization of therapeutic foster care services, uniform placement outcome goals to include length of stay targets when the service is indicated and uniform contracting requirements when purchasing therapeutic foster care services. The SEC shall authorize the use of regional contracts for the provision of TFC services. The SEC shall direct the Office of Comprehensive Services to (i) work with stakeholders to develop these guidelines for the provision of TFC and (ii) develop regional contracts for the provision of TFC, with the goal of decreasing the unit cost of social services and maintaining or increasing the quality and effectiveness of the services. The SEC shall focus its attention on rural areas and areas with few service providers. Training will be provided for all local departments of social services, family assessment and planning teams, community policy and management teams and therapeutic foster care services providers on these guidelines. The Director of the Office of Comprehensive Services shall report the progress of these efforts to the SEC at its regularly scheduled meetings.”

In April 2012, the SEC adopted “Guidelines for the Use of Treatment Foster Care Under the Comprehensive Services Act” per recommendations of a workgroup convened to address the Appropriation Act requirements. In addition to the guidelines developed, the workgroup recommended further review of identified issues regarding the provision of foster care services including the need for private agencies to offer basic (i.e., non-treatment) level homes and the need for greater uniformity across private agencies in the offered levels of treatment foster care. OCS was authorized by the SEC in March 2013 to establish a workgroup to address these recommendations.

Proposed Policy

Effective July 1, 2014, when purchasing foster care services through a licensed child placing agency, Community Policy and Management Teams shall ensure that levels of foster care service are appropriately matched to the individual needs of a child or youth in accordance with the SEC approved "Guidelines for Determining Levels of Care for Foster Care Services with Licensed Child Placing Agencies."

OCS Recommendations

1. Post the proposed policy, "Purchase of Foster Care Services from Licensed Child Placing Agencies," and the proposed "Guidelines for Determining Levels of Care for Foster Care Services with Licensed Child Placing Agencies" for a 60 day public comment period.
2. Consider policy revisions per public comment (March 2014).
3. Approve guidelines (March 2014).
4. Adopt policy (March 2014).



Department of Medical Assistance Services
 800 East Broad Street, Suite 1300
 Richmond, Virginia 23219
<http://dmasva.dmas.virginia.gov>

Mental Health Skill Building Services

FACT SHEET

<p>What is this service?</p>	<p>Mental Health Skill-Building Services (MHSS) is the new name for Mental Health Support Services (MHSS). The name change reflects that MHSS is a training service -- not a mental health clinical service, a preventative service, social welfare, nor a crisis service. MHSS is a training service for individuals with significant mental illness. The service is designed to train individuals in functional skills and appropriate behavior related to the individual's health and safety, activities of daily living, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition. MHSS is intended to enable individuals with significant mental illness to achieve and maintain community stability and independence in the most appropriate, least restrictive environment.</p>														
<p>What were the costs of MHSS?</p>	<div style="display: flex; align-items: center;"> <div style="flex: 1;"> <table border="1"> <caption>MHSS Expenditures (Estimated)</caption> <thead> <tr> <th>Year</th> <th>Expenditure (\$)</th> </tr> </thead> <tbody> <tr> <td>2008</td> <td>40,000,000</td> </tr> <tr> <td>2009</td> <td>60,000,000</td> </tr> <tr> <td>2010</td> <td>80,000,000</td> </tr> <tr> <td>2011</td> <td>130,000,000</td> </tr> <tr> <td>2012</td> <td>170,000,000</td> </tr> <tr> <td>2013</td> <td>210,000,000</td> </tr> </tbody> </table> </div> <div style="flex: 1; padding-left: 20px;"> <p>Since fiscal year 2008, there has been a \$178 million increase in the cost of this service. The expenditures have risen 384% in five (5) years.</p> </div> </div>	Year	Expenditure (\$)	2008	40,000,000	2009	60,000,000	2010	80,000,000	2011	130,000,000	2012	170,000,000	2013	210,000,000
Year	Expenditure (\$)														
2008	40,000,000														
2009	60,000,000														
2010	80,000,000														
2011	130,000,000														
2012	170,000,000														
2013	210,000,000														
<p>Why were changes needed?</p>	<p>Vague eligibility criteria allowed individuals who do not have significant mental illness to receive MHSS. Often MHSS was being utilized as companion care, rather than skill building/training for individuals with significant mental illness.</p>														
<p>What are the units and rate?</p>	<p>One unit = 1 to 2.99 hours per day Two units = 3 to 4.99 hours per day Three units = 5 to 6.99 hours per day Four units = 7 or more hours per day</p> <p>DMAS anticipates a rate structure change will occur in 2014. Once the modified rate structure is finalized, DMAS will notify providers.</p>														
<p>Limits</p>	<ul style="list-style-type: none"> • A maximum of 372 units of Mental Health Skill Building may be prior authorized annually. • A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. • Each July 1st all service limits will be set to zero. 														

<p>What are the new service eligibility requirements for MHSS services?</p>	<p>An individual must meet all of the following:</p> <ul style="list-style-type: none"> • Have a need for individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management; • Have a qualifying mental health diagnosis (psychotic disorder, major depressive disorder – recurrent, or bipolar disorder I or II). If an individual has another disorder (such as, but not limited to PTSD and anxiety disorders) they may meet eligibility requirements if a physician determines it is a significant mental illness that results in severe and recurrent disability that produces functional limitations in major life activities, and the individual requires individualized training in order to achieve or maintain independent living in the community (this must be documented by the physician); • Have a prior history of qualifying mental health treatment (psychiatric hospitalization, residential treatment, residential crisis stabilization, PACT or ICT services, RTC-Level C placement, or TDO evaluation by a CSB/BHA due to mental health decompensation). This bullet must be met in order to be initially admitted to services, however not for subsequent authorizations; • Have had a prescription for an anti-psychotic, mood stabilizing, or anti-depressant medication within the twelve months prior to the assessment date unless a physician documents that such medication is medically contraindicated. This bullet must be met in order to be initially admitted to services, however not for subsequent authorizations; and • If an individual is under the age of 21, they must be in an independent living situation or transferring into one within six months.
<p>Service Authorizations</p>	<p>The new service eligibility criteria, service definition, requirements for service provision, and limits and exclusions will be applied to all new service authorization requests and to re-authorization requests as they occur on or after December 1, 2013.</p> <p>All requests submitted to Magellan for service authorization will require the new eligibility requirements to be met.</p>
<p>How do the changes relate to overlaps with other services?</p>	<p>The changes will prohibit duplication of services by prohibiting overlaps of MHSS with:</p> <ul style="list-style-type: none"> • ID or DD Waiver- in-home residential services or congregate residential services through the waivers; • DSS or CSA- independent living skills services; • Treatment foster care; and • Inpatient services: hospitals and intermediate care facilities for the intellectually disabled. <p>The changes will limit the amount of MHSS that may be provided in assisted living facilities, group homes, nursing homes, and psychiatric residential treatment centers (Level C).</p>
<p>Staff Qualifications</p>	<ul style="list-style-type: none"> • MHSS may be provided by mental health paraprofessionals. An individual may qualify as a paraprofessional through several avenues, including 90 hours of classroom experience and 12 weeks of experience under the supervision of qualified staff. • The assessment shall be performed by an LMHP, LMHP Resident, or LMHP Supervisee. • The ISP shall be written by a QMHP-A, QMHP-C, LMHP, LMHP Resident, or LMHP Supervisee within 30 days of admission.
<p>Effective date</p>	<p>The service eligibility changes for new authorizations will go into effect December 1, 2013. All reauthorizations must meet the eligibility criteria at the time of reauthorization.</p>
<p>Who to contact?</p>	<p>Please contact the DMAS Office of Behavioral Health at: CMHRS@dmas.virginia.gov</p>

OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES



The Comprehensive Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Comprehensive Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

- Child and family directed care,
- Equitable access to quality services,
- Responsible and effective use of public funds,
- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.



IMPACT OF THE INCENTIVE MATCH RATE SYSTEM

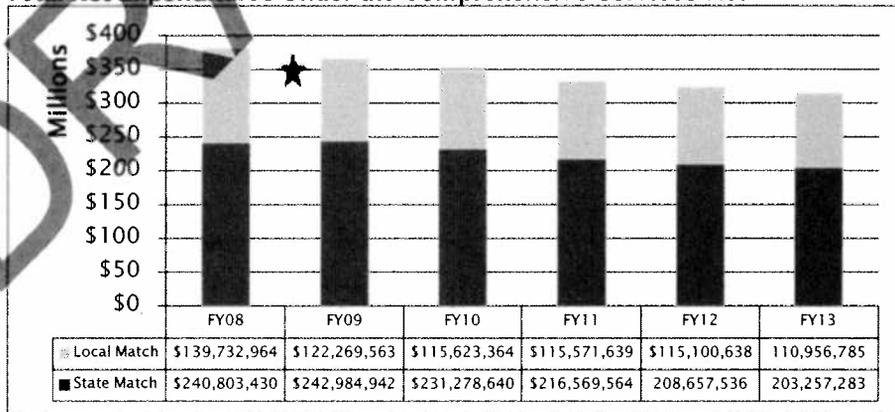
Annual Report to the Governor and General Assembly, December 2013
In accordance with the 2013 Appropriation Act, Chapter 806, Item 283 (C)(3)(c)

Funding for services to children and families under the Comprehensive Services Act (CSA) is a shared responsibility of state and local governments. The incentive-based match rate system was designed to change practices so as to reduce reliance on residential care, serve children in their homes, and invest funds for the development of community based services. The incentive match rate system encourages the delivery of services consistent with the statutory purposes of the CSA, i.e., to:

- preserve and strengthen families;
- design and provide services that are responsive to the unique and diverse strengths and needs of troubled youth and families and;
- provide appropriate services in the least restrictive environment, while protecting the welfare of children and maintaining the safety of the public.

Under the incentive match rate system, a locality's share of residential services is 25% above its base match rate; the locality's share of community-based services is 50% below its base match rate.

Total Net Expenditures Under the Comprehensive Services Act



★ Implementation of the incentive match rate system

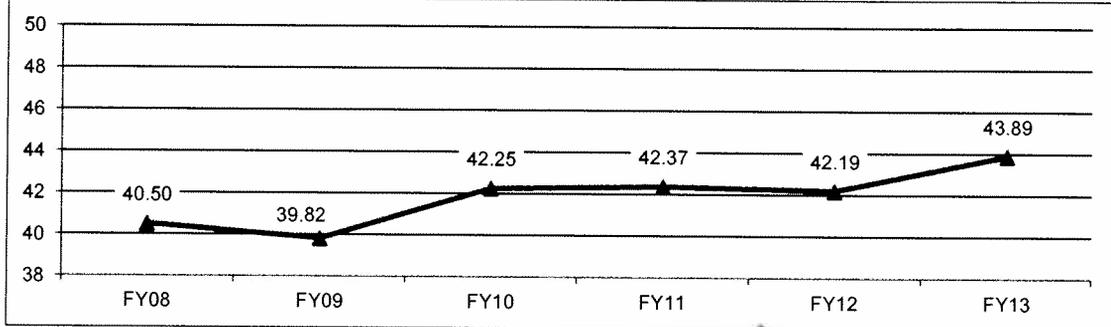
Effective Match Rate

	FY08	FY09	FY10	FY11	FY12	FY13
Effective Local Match Rate	35.80%	33.48%	33.33%	34.79%	35.55%	35.31%
Effective State Match Rate	64.20%	66.52%	66.67%	65.21%	64.45%	64.69%

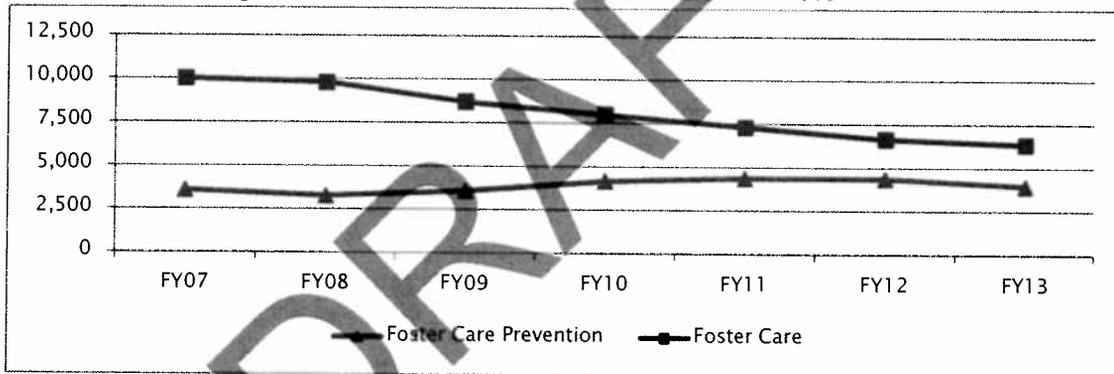
The "effective match rate" reflects the impact of the mix of services at various match rates

IMPACT OF THE INCENTIVE MATCH RATE SYSTEM ON THE CARE AND TREATMENT OF YOUTH

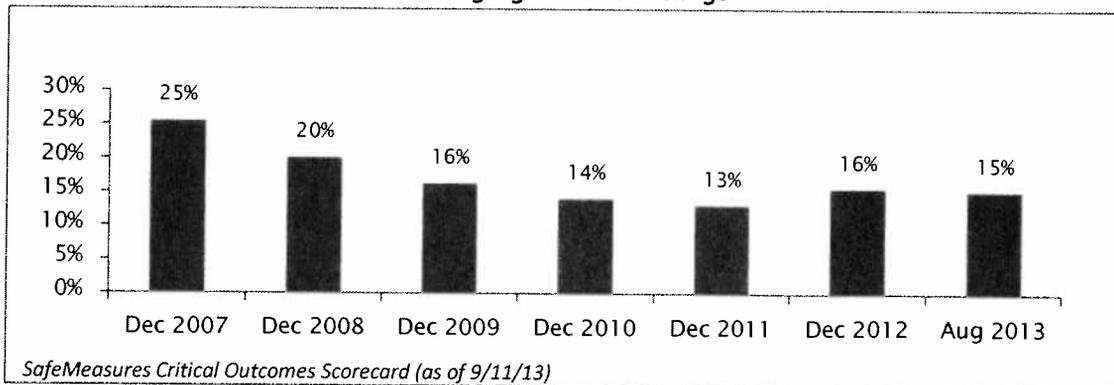
Percent of Youth Served in Community-Based Settings (Target = 50%)



Number of Youth Receiving Foster Care and Foster Care Prevention Services



Percent of Youth in Foster Care Placed in Congregate Care Settings



OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES



The Comprehensive Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Comprehensive Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

- Child and family directed care,
- Equitable access to quality services,
- Responsible and effective use of public funds,
- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.

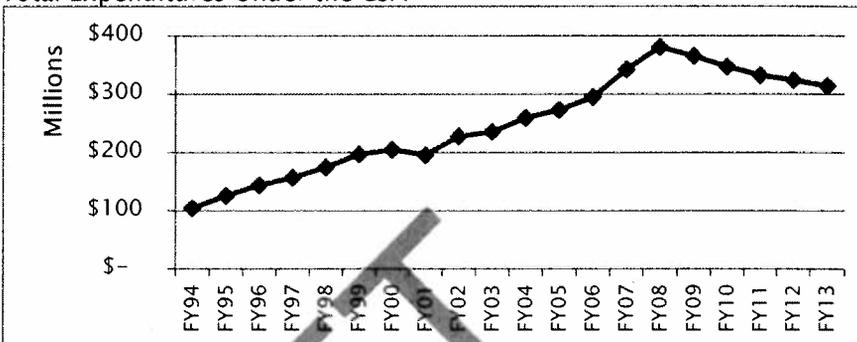


PROGRESS REPORT ON COMPREHENSIVE SERVICES TO AT-RISK YOUTH AND FAMILIES

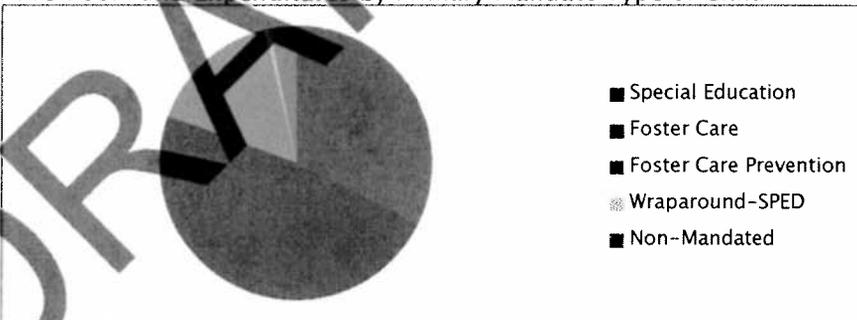
Biennial Report to the General Assembly, December 2013

In accordance with 2013 Appropriation Act, Chapter 806, Item 283 (5)(H)

Total Expenditures Under the CSA



FY13 Pool Fund Expenditures by Primary Mandate Type of Child



Additional Contributions to CSA Funded Services

	FY12	FY13
Medicaid (Treatment Foster Care, Residential Care)	\$ 67,290,950	\$ 74,185,835
Title IV-E (Foster Care Maintenance)	\$ 49,689,712	\$ 43,318,409

Alternate funding is utilized for eligible youth and eligible services when available.

Funding Outside of the CSA for At-Risk Youth and Families

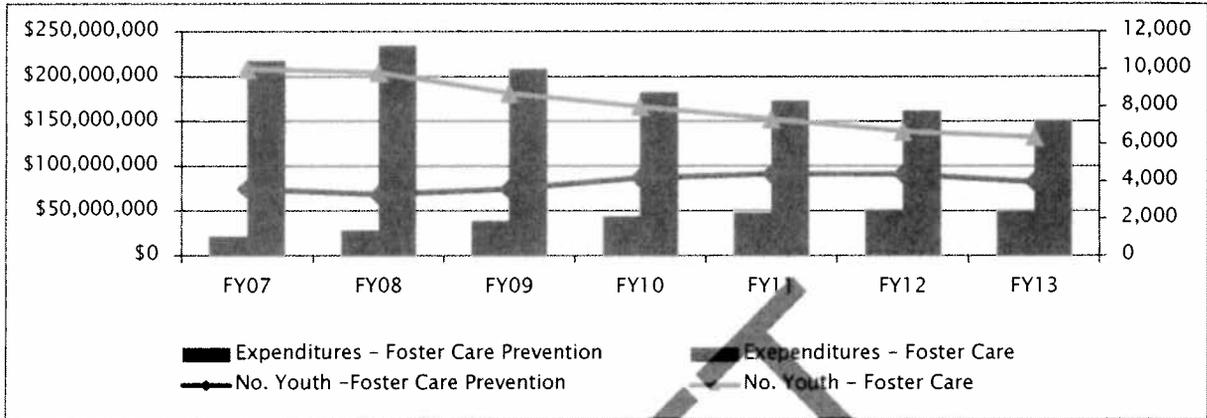
	FY12	FY13
Children's Mental Health Initiative Funds	\$ 5,648,128	\$ 5,648,128
Promoting Safe & Stable Families Funds*	\$ 8,228,931	\$ 6,426,061
Virginia Juvenile Community Crime Control Act Funds	\$ 10,034,252	\$ 9,946,039
TOTAL	\$ 23,911,311	\$ 22,020,228

*approximately 75% Federal Funds

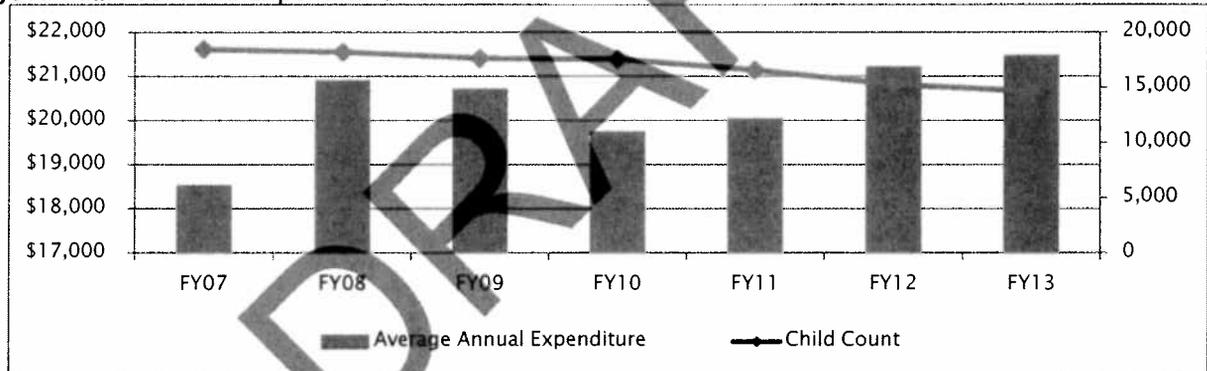
KEY DATA

Reinvestment of Dollars Saved Through Change in Service Delivery

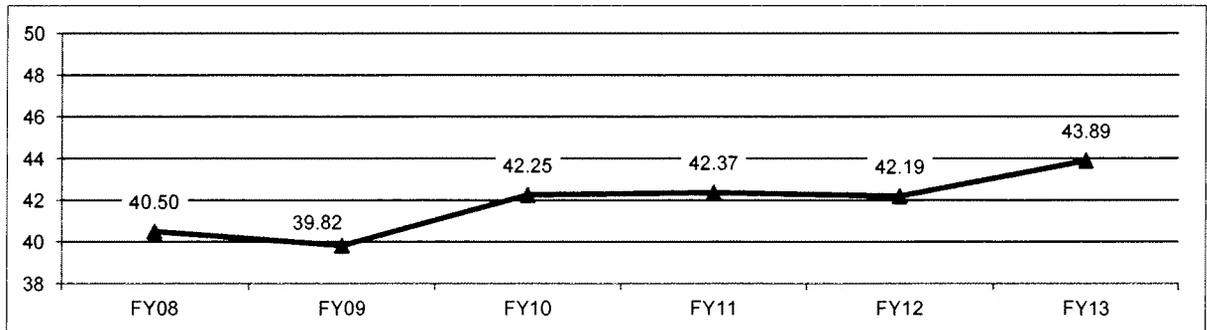
As the number of youth in foster care and expenditures for foster care services have declined, there have been corresponding increases in the number of youth provided foster care prevention services and the expenditures for those prevention services as illustrated in the graph below:



Average Annual Pool Fund Expenditure Per Youth



Percentage of Youth Served in Community-Based Settings (Target = 50%)



PROGRESS ON GOALS AND STRATEGIES OF THE FY12–FY14 BIENNIUM

GOAL 1: Support implementation of a unified system of care that ensures equal access to services for at risk youth across the Commonwealth.

Strategy	Progress
<p>1. Review and revise the policies of child serving agencies that govern the use of funds (e.g., CSA pool funds, Medicaid, Title IV-E, PSSF, VJCCCA, MH Initiative) to align:</p> <ul style="list-style-type: none"> • service criteria • assessment • authorization • utilization review 	<p>The SLAT is actively addressing this goal through examination of the requirements of fund streams available through state agencies. The SLAT is working collaboratively with the Department of Behavioral Health Services to inform its development of a “Strategic Financing Plan” as per requirements of an existing grant through SAMHSA to expand systems of care across the Commonwealth.</p>
<p>2. Ensure protected, i.e., “non-mandated,” allocations are utilized for youth who are included in the target population but who are not otherwise eligible for mandated services.</p>	<p>The SEC adopted a policy on July 30, 2013 which requires consistent use of definitions, eligibility criteria, and service requirements across DMAS and CSA for community-based behavioral health services of Intensive In-Home, Mental Health Support Services, and Therapeutic Day Treatment.</p>
<p>3. Support local development of services through state facilitated collaborative meetings between regional representatives and private providers.</p>	<p>Strategy requires allocation of additional General Funds. Budget proposal was submitted Fall 2013.</p>
<p>4. Review, revise, and recommend policy and/or statute to enable development of new services which will address identified service gaps.</p>	<p>The SEC Finance Committee and the Office of Comprehensive Services sponsored a meeting in southwest Virginia between private providers and local government representatives on February 5, 2013. Additional meetings will be scheduled.</p>
<p>5. Examine and address inadvertent fiscal incentives for residential placement, parental placement, avoidance of FAPT/MDT process, e.g.,</p> <ul style="list-style-type: none"> • Medicaid match • Family-of-one eligibility • Education costs 	<p>The SEC adopted revision to its “Carve Out Policy” which permits localities to allocate a portion Pool Funds for service development. Implementation of the policy requires allocation of additional General Funds. Budget proposal submitted, Fall 2013.</p>
<p>6. Support cross-secretariat leadership (i.e., HHR, Education, and Public Safety) on practice issues for the delivery and assessment of children’s services at the state level.</p>	<p>The SLAT has plans to address this goal during FY2014.</p> <p>Coordination across Secretariats has been evidenced by:</p> <ul style="list-style-type: none"> • Cross-Secretariat discussion regarding issues of homelessness and youth exiting DJJ system including representatives of HHR and Public Safety Secretariats. • Position of Deputy Secretary of Education and Children’s Services was established.

GOAL 2: Support informed decision making through utilization of data to improve child and family outcomes and public and private performance in the provision of services to children and families.

Strategy	Progress
1. Enhance collection, analysis, and utilization of appropriate client level data to enable comprehensive analysis of needs, services, providers, and outcomes.	As of July 15, 2013, client level data for period 7/1/2010 – 6/30/2013 was collected as follows: <ul style="list-style-type: none"> • CSA expenditure data (105 out of 131 local communities), • Title IV-E expenditure data (111 out of 131 localities), • Medicaid expenditure data for community-based behavioral health services, Data analytics system will be delivered to OCS from private contractor (SAS) on 11/30/2013. As of August 19, 2013, a web-based client data reporting system (CBDRS) was made available to localities to enable reporting of client level data for communities without electronic data systems.
2. Improve availability of meaningful data via CSA statistics web page.	Revised statistical reports are under development by OCS Information Technology team.
3. Develop and implement training for users to sustain data systems.	Training on use of the CBDRS was provided in August 2013 via three Webinar sessions. Workgroups of local users will be assembled in FY2014 to advise and assist in training.

GOAL 3: Improve the operational effectiveness of CSA administration.

Strategy	Progress
1. Support a comprehensive internal audit program designed to evaluate financial and programmatic processes and provide consultation and recommendations for improvement.	The OCS Audit Plan for Fiscal Years 2013–2015 was published in June 2012 and updated in July 2012. As of June 30, 2013, the status of local audits was as follows: <ul style="list-style-type: none"> • On-site audits: 6 complete; 2 in progress • Self-assessments: 3 complete, 5 in progress • Special projects: 1 complete Audit findings are published to the Web to serve as a tool to keep local governments informed. Local government feedback regarding the audit process is collected following each audit to enable continuous review and improvement of the process.
2. Enhance the engagement of CPMT representatives (including parents and private providers), juvenile judges, school superintendents, government administrators, and elected leaders in local administration of the CSA through increased opportunities for education regarding the CSA.	Two statewide conferences were conducted with more than 450 local CSA team participants represented. Participants by locality and stakeholder group are summarized in the <i>FY2012</i> and <i>FY2013 Annual Report to the General Assembly Regarding Training Under the CSA</i> . Additional trainings have been held for individual stakeholder groups. Training activities and participants are summarized in the <i>FY 2012</i> and <i>FY2013 Annual Report to the General Assembly Regarding Training Under the CSA</i> .
3. Update CSA Manual for increased usability.	Updates to the CSA Manual have been made as new policies and guidelines were adopted. The Executive Director’s Focus Group of CSA coordinators has been tasked with advising on format improvements.
4. Enhance fiscal and data reporting requirements to reduce local administrative burden and improve utilization of data for program evaluation and improvement.	Conversion of existing data reporting applications is under development by the OCS Information Technology Team.

- | | |
|---|---|
| 5. Implement robust training plan. | The SEC has approved a comprehensive training plan submitted by the OCS for each fiscal year. Training activities and participants are summarized in the <i>FY 2012 Annual Report to the General Assembly Regarding Training Under the CSA</i> and the <i>FY2013 Annual Report to the General Assembly Regarding Training Under the CSA</i> . |
| 6. Build/enhance a systemic culture of collaboration across state and local CSA stakeholders through technical assistance in team building, communication, consensus building, etc. | OCS provided technical assistance to communities in response to requests for assistance with team building, communication, and program improvement. Training activities and participants are summarized in the <i>FY 2012 Annual Report to the General Assembly Regarding Training Under the CSA</i> and the <i>FY2013 Annual Report to the General Assembly Regarding Training Under the CSA</i> . |
| 7. Enhance collaboration between SLAT and SEC through annual joint meeting for review of strategic planning initiatives. | Joint meetings of the SLAT and SEC for strategic planning were held in September 2012 and September 2013. |

FY13–FY15 BIENNIAL PLAN

GOAL 1: Support implementation of a singular, unified system of care that ensures equitable access to quality services for at risk youth across the Commonwealth.

Strategy	Responsible Body	Target Completion Date
1. Review and revise the policies of child serving agencies that govern the use of funds (e.g., CSA pool funds, Medicaid, Title IV-E, PSSF, VJCCCA, MH Initiative) to align: <ul style="list-style-type: none"> • service criteria • assessment • authorization • utilization review 	SEC (via SLAT)	7/31/2014
2. Ensure protected, i.e., “non-mandated,” allocations are utilized for youth who are included in the target population but who are not otherwise eligible for mandated services.	SEC	7/31/2014
3. Assist local governments to address service gaps through state facilitated meetings between regional CPMT representatives and private providers.	SEC Finance Committee	06/30/2016
4. Examine and address inadvertent fiscal incentives for residential placement, parental placement, avoidance of FAPT/MDT process.	SEC (via SLAT)	7/31/2014
5. Support cross-secretariat leadership (i.e., HHR, Education, and Public Safety) on practice issues for the delivery and assessment of children’s services at the state level.	SEC	6/30/2016

GOAL 2: Support informed decision making through utilization of data to improve child and family outcomes and public and private performance in the provision of services to children and families.

Strategy	Responsible Body	Target Completion Date
1. Enhance collection, analysis, and utilization of appropriate client level data to enable comprehensive analysis of needs, services, providers, and outcomes.	OCS	6/30/2016
2. Improve availability of meaningful data via CSA statistics web page.	OCS	6/30/2016
3. Develop and implement training for users to sustain data systems.	OCS	6/30/2016
4. Enhance utilization of the Child and Adolescent Needs and Strengths Assessment (CANS) for service planning and identification of needs; explore utilization of CANS to establish need and amount of enhanced maintenance (additional daily supervision) for youth in foster care.	OCS and VDSS	6/30/2015

GOAL 3: Improve the operational effectiveness of CSA administration.

Strategy	Responsible Body	Target Completion Date
1. Enhance the engagement of CPMT representatives (including parents and private providers), juvenile judges, school superintendents, government administrators, and elected leaders in local administration of the CSA through increased opportunities for education regarding the CSA.	SEC	6/30/2016
2. Update CSA Manual for increased usability.	OCS	12/31/2014
3. Enhance fiscal and data reporting requirements to reduce local administrative burden and improve utilization of data for program evaluation and improvement.	OCS	6/30/2016
4. Enhance collaboration between SLAT and SEC through annual joint meeting for review of strategic planning initiatives.	SEC	6/30/2016
5. Enhance communication across SEC members through reporting at SEC meetings regarding policy and program initiatives impacting upon children's services, e.g., Three Branch Institute, Magellan contract, SAMHSA grant.	SEC	6/30/2016
6. Develop and implement a system for program evaluation designed to assess state and local achievement of performance outcomes, implementation of best practices, and needs for technical assistance and training.	OCS	6/30/2016

OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES



The Comprehensive Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Comprehensive Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

- Child and family directed care,
- Equitable access to quality services,
- Responsible and effective use of public funds,
- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.



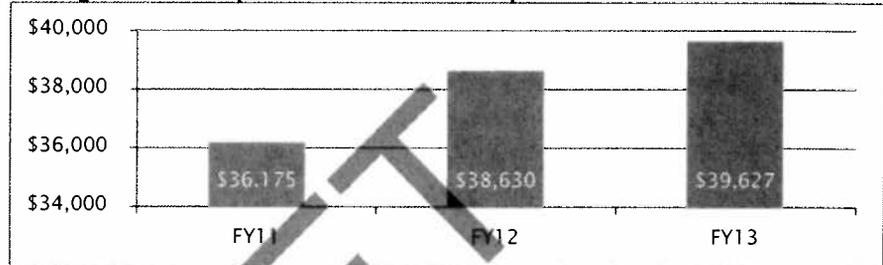
SPECIAL EDUCATION SERVICES UNDER THE CSA

Annual Report to the General Assembly, December 2013

In accordance with 2013 Appropriation Act, Chapter 806, Item 283 (N)(2), (N)(3)

Children and youth with disabilities placed for purposes of special education in approved private school educational programs are included in the CSA target population and are eligible for funding (Code of Virginia §2.2-5211).

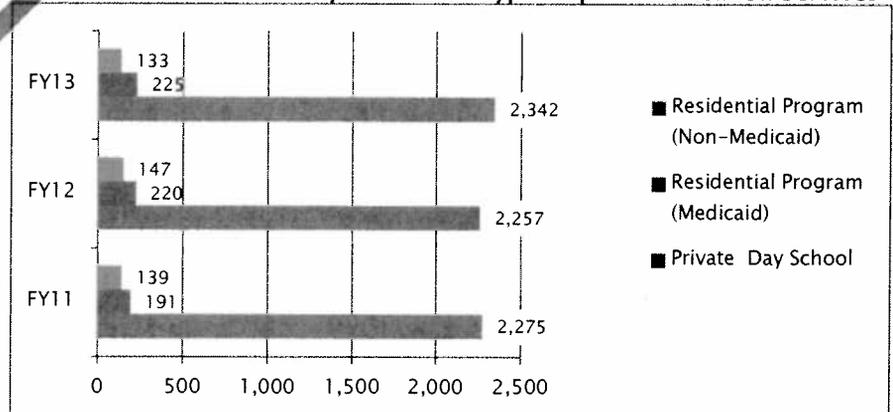
Average Annual Expenditure Per Child - Special Education Services



Net Expenditures by Placement Type - Special Education Services

	FY11	FY12	FY13
Private Day School	\$72,919,258	\$78,724,431	\$85,521,889
Residential Program (Medicaid)	\$5,238,511	\$5,783,148	\$6,439,138
Residential Program (Non-Medicaid)	\$9,266,474	\$9,746,140	\$9,263,610
Total	\$87,424,243	\$94,253,719	\$101,224,637

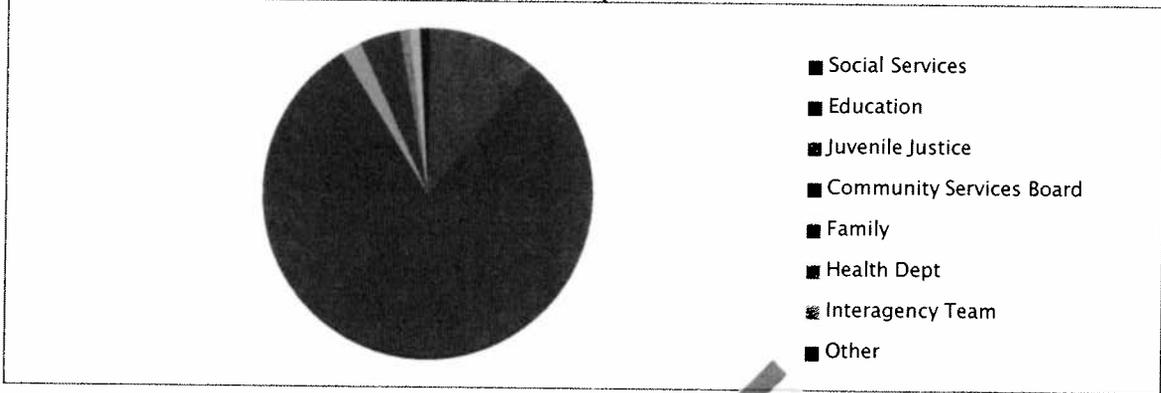
Number of Youth Served by Placement Type - Special Education Services



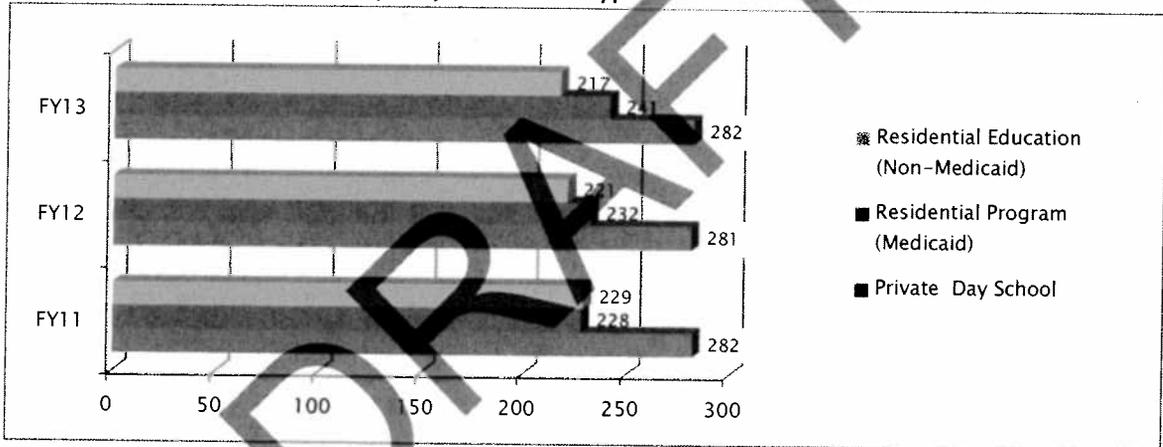
FY13 total unduplicated count of youth who received services in accordance with an Individualized Education Program (IEP) requiring private school placement = 2709.

SPECIAL EDUCATION SERVICES FUNDED UNDER THE COMPREHENSIVE SERVICES ACT

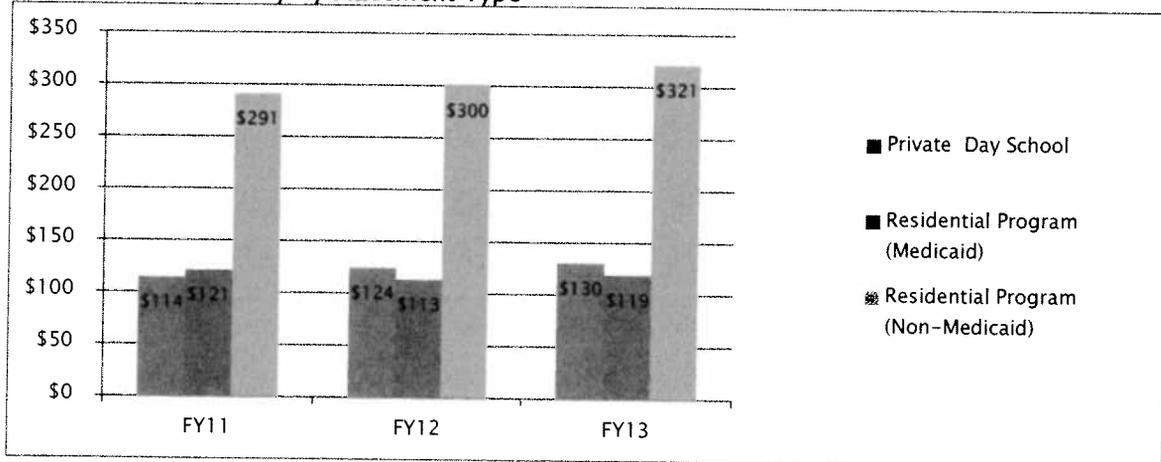
Sources of Initial Referral for Youth Receiving Private Day School Services



Average Length of Stay (Number of Days) by Placement Type



Average Cost Per Child Per Day by Placement Type



OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES



The Comprehensive Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Comprehensive Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

- Child and family directed care,
- Equitable access to quality services,
- Responsible and effective use of public funds,
- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.



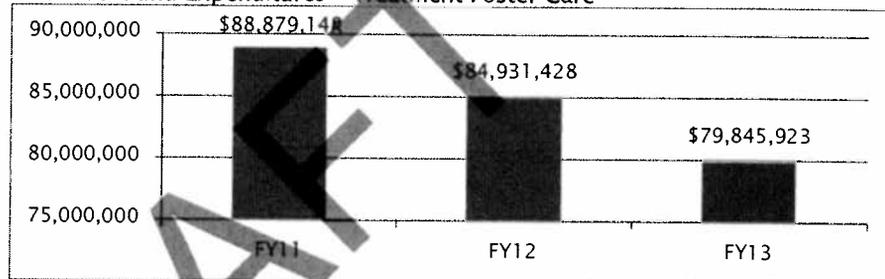
TREATMENT FOSTER CARE SERVICES UNDER THE CSA

Annual Report to the General Assembly, December 2013

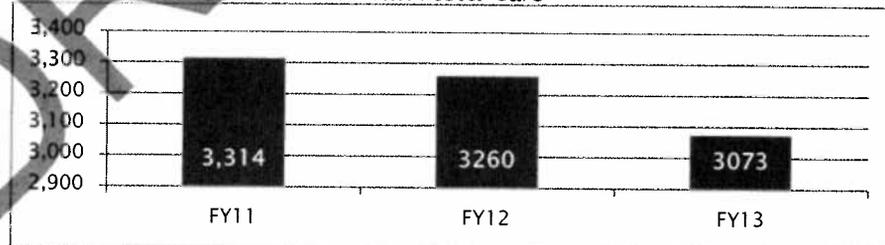
In accordance with 2013 Appropriation Act, Chapter 806, Item 283 (N)(3)

Treatment foster care (TFC) is a community-based program where services are designed to address the special needs of children. Services to the children are delivered primarily by treatment foster parents who are trained, supervised, and supported by agency staff. Treatment is primarily foster family based and is planned and delivered by a treatment team. Treatment foster care focuses on a continuity of services, is goal-directed and results oriented, and emphasizes permanency planning for the child in care.

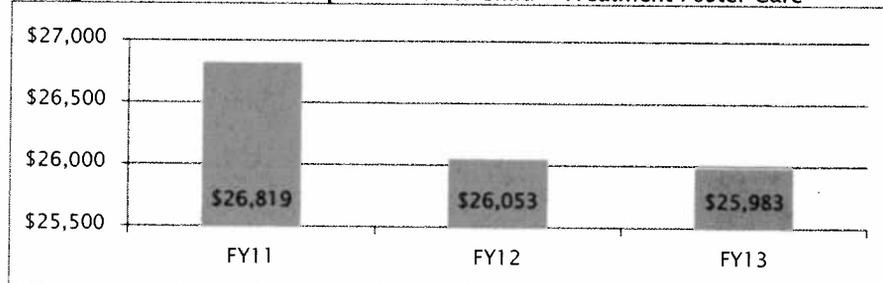
Total Pool Fund Expenditures - Treatment Foster Care



Number of Youth Served - Treatment Foster Care

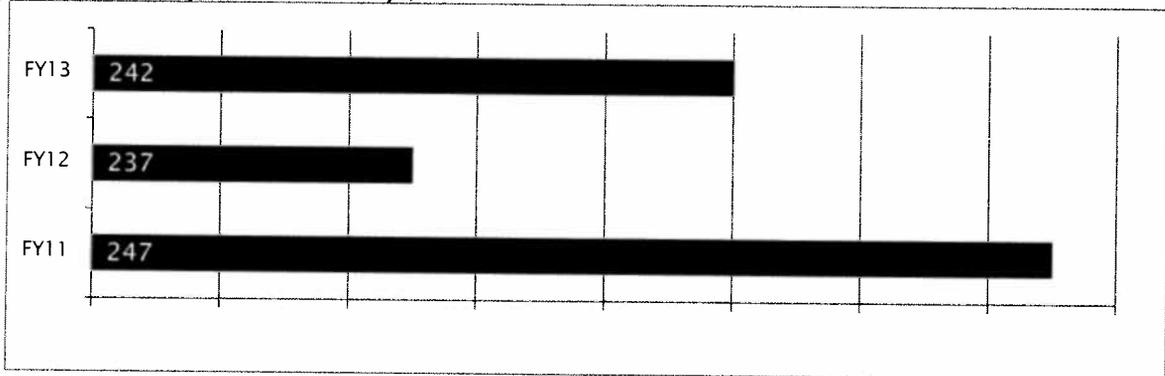


Average Annual Pool Fund Expenditure Per Child - Treatment Foster Care

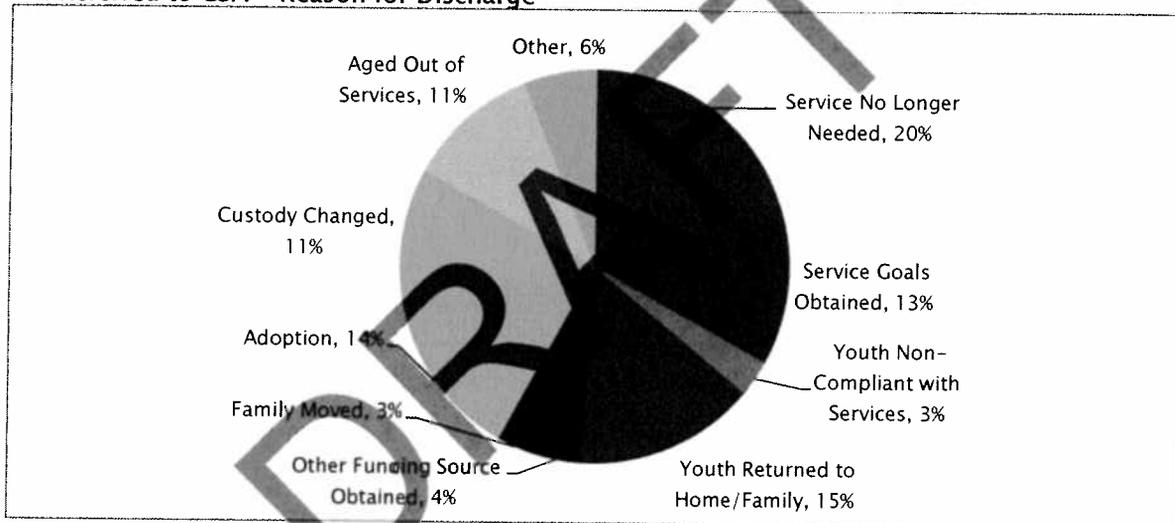


TREATMENT FOSTER CARE SERVICES

Average Length of Stay (Number of Days) Per Child



DSS Youth Referred to CSA – Reason for Discharge



OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES



The Comprehensive Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Comprehensive Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

- Child and family directed care,
- Equitable access to quality services,
- Responsible and effective use of public funds,
- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.



Office of
Comprehensive
Services

Empowering communities to serve youth

REGIONAL AND STATEWIDE TRAINING REGARDING CSA

Annual Report to the General Assembly, December 2013

In accordance with 2013 Appropriation Act, Chapter 806, Item 283 (B)(6)

The mission of the Office of Comprehensive Services (OCS) is to facilitate 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 of Virginia. To support this mission, OCS develops and implements annually a robust training plan. In accordance with the 2013 training plan, the following activities were implemented:

- The 2nd Annual Commonwealth of Virginia CSA Conference, "20/20: Celebrating 20 Years with Focus for Success," was provided for an audience of 477 participants. Individual training sessions are summarized on pages 4 and 5 of this report.

Participant Summary:

120 out of 131 localities were represented

State agency participants	37
Local CSA Staff (Coordinator/UR Specialist/Other)	125
Family Assessment and Planning Team Members	107
Community Policy and Management Team Members	98
Local agency case managers/supervisors	35
Private Providers (registrants & sponsors)	51
Other: Advocate, Parent, Child Organization	24

- Twenty-two regional and stakeholder trainings were provided to 925 participants. Training topics, dates, and participant numbers are summarized on pages 2 and 3 of this report.
- Online training materials were made available through the Commonwealth of Virginia's Knowledge Center.
- Site-based technical assistance was provided per requests of local and regional CSA stakeholders.
- Online "Ask OCS Help Desk" was maintained.

FUNDS EXPENDED FOR REGIONAL AND STATEWIDE TRAINING

2 nd Annual CSA Conference	\$ 35,000
On-line Training/Certification: Uniform Assessment Instrument	\$ 22,000
TOTAL*	\$ 57,000

**Total does not include costs for mileage, lodging, and training materials for regional training sessions conducted by the Office of Comprehensive Services.*

**OUTREACH TRAINING FOR REGIONAL AND STAKEHOLDER CONSTITUENTS
FISCAL YEAR 2013**

Participant evaluations of training sessions are available for review at the Office of Comprehensive Services

TOPIC (Trainer, Agency/Organization)	PARTICIPANT GROUP	DATE	NUMBER PARTICIPANTS
CSA and Social Services (Clare, OCS)	VDSS Regional Office – Central Office Staff	8/9/2012	26
Detangling CSA (Parr, OCS)	Southwest CSA Vendor Fair and Training Day	9/7/2012	14
Using CANS in Service Planning (Wilson, OCS)	Southwest Vendor Fair/CSA Coordinators/Providers	9/7/2012	22
CSA and DJJ (Clare, OCS)	Statewide DJJ Annual Leadership Conference	9/18/2012	75
Rating CANS or "Why Can't I Pass the Test?" (Wilson, OCS)	Richmond City DSS CIS and Foster Care staff	9/21/2012	30
CANS/Service Planning–Coordinating w/Providers (Wilson, OCS)	Richmond City FAPT/Private Providers/RBHA	9/21/2012	18
Detangling CSA (Nemeyer, OCS)	Eastern Region Community Day	9/21/2012	30
Update on Activities of the CSA State Executive Council (Clare, OCS)	Virginia Coalition of Private Provider Associations	10/11/2012	70
Detangling CSA (Clare, OCS)	Local DSS Director's Learning Experience	10/19/2012	22
Denial of Funds, Audits, Title IV–E (Clare, OCS)	NOVA DSS Directors	10/26/2012	28
CSA: A Shared State–Local Responsibility (Clare, OCS)	Virginia Association of Counties Annual Conference	11/12/2012	29
Intensive Care Coordination for Providers (Pegram, OCS; Kim Coviello, U of MD)	Providers of ICC – Cohort I	3/11/2013	43
Intensive Care Coordination for FAPT and CPMT Members (Fisher, OCS)	Northern Virginia Region	3/11/2013	72
Intensive Care Coordination for FAPT and CPMT Members (Fisher, OCS)	Central Virginia Region	3/12/2013	88
Intensive Care Coordination for FAPT and CPMT Members (Fisher, OCS)	Tidewater Region	3/13/2013	64
LDSS Director role in CSA (Clare, OCS)	Local Directors of Social Services Learning Experience	3/30/2013	21

Leadership in Navigating CSA for New Sped Directors (Clare, OCS)	New Sped Directors Academy	4/9/2013	26
Intensive Care Coordination for FAPT and CPMT Members (Fisher, OCS)	Western Virginia Region – Bristol	4/18/2013	56
Intensive Care Coordination for FAPT and CPMT Members (Fisher, OCS)	Western Virginia Region – Salem	4/19/2013	68
Funding Children's Mental Health Services (Clare, OCS; Lung, DBHDS)	Juvenile Judges Annual Conference	4/23/2013	30
Intensive Care Coordination for Providers (Pegram, OCS; Kim Coviello, U of MD)	Providers of ICC –Cohort II	5/1/2013	43
Intensive Care Coordination for FAPT and CPMT Members (Fisher, OCS)	Western Virginia Region – Roanoke	5/1/2013	50
Total Number of Participants Trained – Regional Training Sessions			925

DRAFT

**2nd ANNUAL CSA CONFERENCE
BREAKOUT TRAINING SESSIONS
APRIL 29–MAY 1, 2013**

Participant evaluations for training sessions are available for review at the Office of Comprehensive Services

TOPIC	TRAINER	NUMBER PARTICIPANTS
Pre-conference Workshop: Seminar for CSA Coordinators	Mike Terkeltaub, Executive Director Triad Training & Consulting Center	85
Applying Multicultural Sensitivity when Collaborating with Families	Alli Ventura, PhD, LCP Virginia Treatment Center for Children	45
Blending and Braiding Funds to Support a System of Care	Susan Cumbia Clare Executive Director, OCS	102
Can CSA Pay?	Stacie Fisher, Program Consultant Office of Comprehensive Services	103
Intensive Care Coordination, Wrap Around and Systems of Care	Kim Coviello, Training Specialist Institute for Innovation & Implementation, University of Md.	31
Child Serving Agency Missions, Outcomes, and Requirements	Pat Haymes, Director Division of Special Edu., DOE	94
	Alex Kamberis, Asst. Director Child & Family Services, VDSS	
	Janet Lung, DBHDS, Director Children's Services, DBHDS	
	Scott Reiner, Regional Program Mgr. Department of Juvenile Justice	
CSA Contracting: Best Practices Through Partnership and Shared Vision	Vanessa Lane Grafton Integrated Health Network	66
	Karen Reilly-Jones, CSA Coordinator Chesterfield-Colonial Heights	
CSA Parental Agreements and DSS Non-Custodial Agreements	Carol Wilson, Program Consultant Office of Comprehensive Services	89
	Lisa Tulley, Permanency Manager Virginia Dept. of Social Services	

Developing Stakeholders: Building and Navigating Community Partnerships	Tonya L. Pulliam, MSW Pulliam Innovative Consulting Firm	64
Families in the Driver's Seat – Strategies for Partnering with and Engaging Families	Stephany Melton National Alliance on Mental Illness VA	80
From Assessment to Results: Utilizing the CANS in Developing and Assessing the IFSP	Carol Wilson, Program Consultant Office of Comprehensive Services	73
Keynote Session Follow-Up: Using Your Magic to Serve Youth	Rich Ferguson – Magic Maker™	82
OCS Program Audits	Stephanie Bacote, Program Auditor Annette Larkin, Program Auditor Office of Comprehensive Services	127
Prevalence, Identification and Entry into Domestic Minor Sex Trafficking: Part I	Elizabeth Schaife, Dir. of Training Dr. Courtney Gaskins, Program Svs. Youth for Tomorrow	61
Prevalence, Identification and Entry into Domestic Minor Sex Trafficking: Part II	Elizabeth Schaife, Dir. of Training Dr. Courtney Gaskins, Program Svs. Youth for Tomorrow	49
State Share Revenue Reconciliation and Medicaid Local Match Calculations	Chuck Savage, Business Manager Office of Comprehensive Services	37
Successes and Reforms in Children's Services	Karin Addison, Deputy Secretary Health & Human Services and Education	66
Understanding Medicaid Services	Emily McClellan & Brian Campbell VA Dept. of Medical Assistance Svs.	106
Using the CANS for Local Program Outcomes Evaluation	Christopher Metzbower Janet Bessmer Fairfax County	77
What Does "Trauma Informed Care" Really Mean?	J. Kellie Evans, Vice President UP Center	104
Where Do "U" Fit Into the UM Process: Achieving the Goals with UM/UR	Mills Jones, CSA Director Goochland County	73
	Sherri McFaden, Utilization Mgr. Prince William County	

Total Cumulative Count of Individuals Trained in Breakout Sessions: 1,614

NOTE: conference participants had the opportunity to participate in up to six breakout sessions

OFFICE OF COMPREHENSIVE SERVICES

ADMINISTERING THE COMPREHENSIVE SERVICES ACT FOR AT-RISK YOUTH AND FAMILIES



The Comprehensive Services Act (CSA, §2.2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

The CSA establishes local multidisciplinary teams responsible to work with families to plan services according to each child's unique strengths and needs and to administer the community's CSA activities.

The Office of Comprehensive Services (OCS) is the administrative entity responsible for ensuring effective and efficient implementation of the CSA across the Commonwealth.

Guiding principles for OCS include:

- Child and family directed care,
- Equitable access to quality services,
- Responsible and effective use of public funds,
- Support for effective, evidence-based practices, and
- Collaborative partnerships across state, local, public, and private stakeholders.



UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA

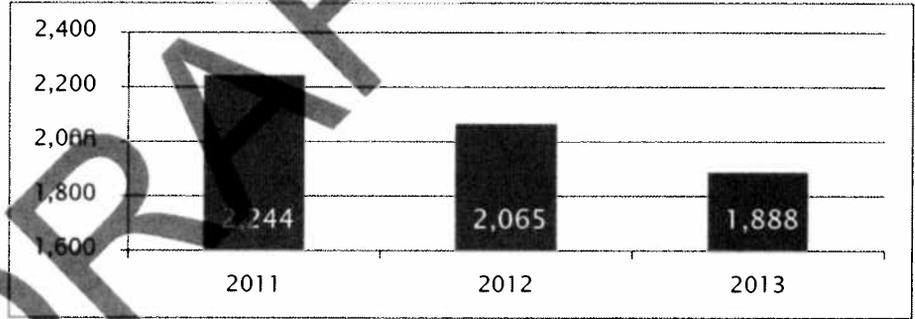
Annual Report to the Governor and General Assembly, December 2013
In accordance with 2013 Appropriation Act, Chapter 806, Item 283 (B)(2)(d)

Since 2008 several significant strategies have been successful in decreasing the placement of children and youth into residential care. Strategies included implementation of the *Children's Services System Transformation* initiative and implementation of an incentive match rate system designed to encourage serving children and youth in community-based settings.

Total Net Expenditures for Residential Care

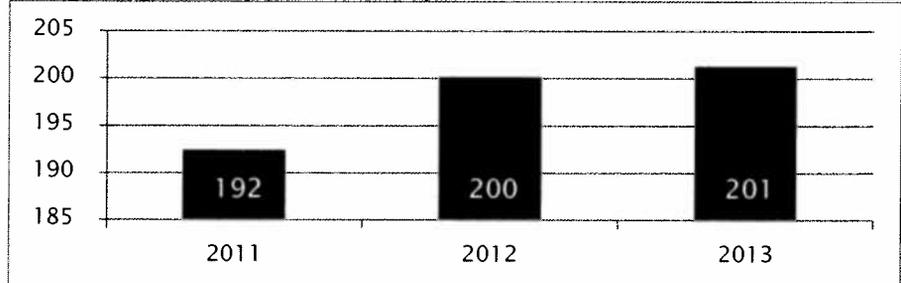
	FY11	FY12	FY13
Temporary Care Facility	\$ 1,285,219	\$ 1,596,438	\$ 1,077,147
Group Home	\$ 25,499,277	\$ 21,292,433	\$ 19,026,708
Residential Treatment Facility	\$ 26,871,773	\$ 27,342,541	\$ 23,153,524
TOTAL	\$ 53,656,269	\$ 50,231,412	\$ 43,257,378

Number of Youth Served in Residential Care



Number reflects the unduplicated count of youth across all residential settings.

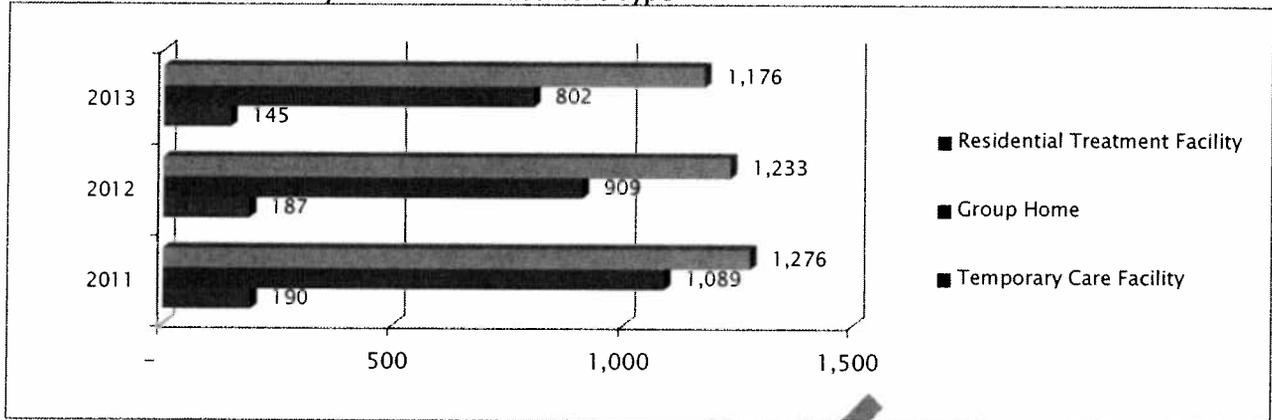
Average Length of Stay (Number of Days) Per Youth in Residential Care



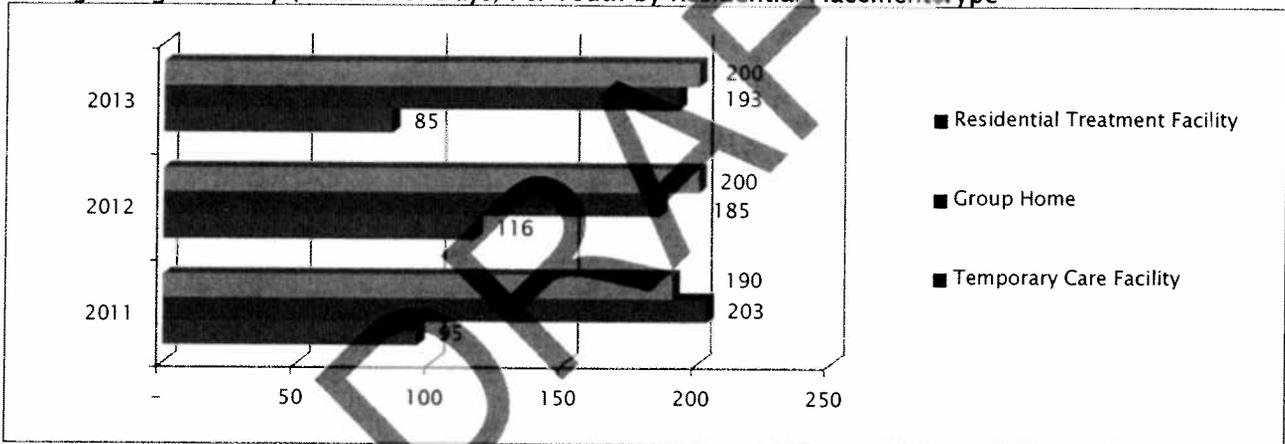
Number reflects the average number of days per youth within the fiscal year (July 1 - June 30) across all residential settings.

UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA

Number of Youth Served by Residential Placement Type



Average Length of Stay (Number of Days) Per Youth by Residential Placement Type



Number reflects the average number of days per youth within the fiscal year (July 1 - June 30) across all residential settings.

Utilization of Residential Care by Locality

See following pages

UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA

Locality	UNDUPLICATED YOUTH COUNT/CUMULATIVE DAYS-ACROSS ALL RESIDENTIAL PLACEMENTS											
	FY11				FY12				FY13			
	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure
Accomack	4	927	232	\$82,633	3	467	156	\$110,955	9	1,426	158	\$153,145
Albemarle	48	9,012	188	\$1,495,702	48	9,477	197	\$1,519,082	56	10,351	185	\$1,355,600
Alleghany	5	1,734	347	\$130,074	9	1,778	198	\$138,467	8	1,750	219	\$138,358
Amelia	2	730	365	\$49,420	3	917	306	\$73,464	6	2,196	366	\$56,592
Amherst	14	4,057	290	\$421,675	12	2,816	235	\$261,497	5	1,022	204	\$143,976
Appomattox	7	971	139	\$113,734	7	1,291	184	\$163,330	9	1,815	202	\$160,914
Arlington	50	12,031	241	\$2,123,282	46	12,411	270	\$1,655,244	46	10,771	234	\$1,081,469
Augusta	18	1,738	97	\$185,018	17	3,457	203	\$214,390	13	2,556	197	\$139,959
Bath	0	0	0	\$0	0	0	0	\$0	0	0	0	\$0
Bedford County	10	1,913	191	\$216,006	10	1,260	126	\$124,144	7	1,610	230	\$194,119
Bland	5	795	159	\$41,057	3	931	310	\$34,928	4	1,102	276	\$36,013
Botetourt	8	1,470	184	\$220,201	5	1,342	268	\$185,771	8	1,088	136	\$136,591
Brunswick	3	548	183	\$73,816	1	365	365	\$29,703	0	0	0	\$0
Buchanan	25	5,138	206	\$632,144	22	6,429	292	\$567,574	17	4,174	246	\$416,285
Buckingham	4	1,318	330	\$102,766	5	1,646	329	\$128,624	3	653	218	\$116,813
Campbell	13	2,757	212	\$207,662	13	2,089	161	\$227,356	18	4,564	254	\$583,913
Caroline	17	3,913	230	\$396,475	12	3,228	269	\$215,355	10	2,410	241	\$336,778
Carroll	25	4,650	186	\$384,485	12	2,669	222	\$233,870	3	625	208	\$98,248
Charles City	2	372	186	\$71,962	0	0	0	\$0	0	0	0	\$0
Charlotte	7	1,142	163	\$71,411	6	970	162	\$84,940	2	428	214	\$34,189
Chesterfield	20	2,288	114	\$422,991	21	2,366	112	\$469,121	21	1,855	88	\$306,242
Clarke	1	365	365	\$106,076	3	659	220	\$152,018	0	0	0	\$0
Craig	7	2,271	324	\$455,860	4	1,100	275	\$41,018	1	366	366	\$1,071
Culpeper	21	6,079	289	\$528,644	15	4,572	305	\$782,367	22	6,060	275	\$839,310
Cumberland	5	1,042	208	\$72,562	5	716	143	\$88,209	2	106	53	\$9,743
Dickenson	18	1,806	100	\$183,966	14	2,244	165	\$212,289	19	3,194	168	\$394,558
Dinwiddie	3	576	192	\$92,250	10	2,070	107	\$146,428	9	1,097	122	\$167,203
Essex	5	940	188	\$57,233	3	168	56	\$6,998	6	1,132	189	\$86,348
Fauquier	14	2,861	204	\$316,649	6	2,999	278	\$348,795	11	2,803	255	\$305,135
Floyd	2	730	365	\$8,195	3	394	131	\$33,678	4	910	228	\$69,955
Fluvanna	14	3,297	236	\$489,165	25	5,594	224	\$740,410	19	4,192	221	\$720,041
Franklin County	27	7,170	266	\$439,904	23	4,898	213	\$276,824	24	6,314	263	\$308,054
Frederick	16	3,268	204	\$584,079	12	2,971	248	\$193,475	9	1,998	222	\$206,290
Giles	2	627	314	\$46,177	8	1,584	198	\$80,582	5	1,066	213	\$252,887
Gloucester	2	357	179	\$73,415	2	406	203	\$48,819	4	1,037	259	\$127,409
Goochland	2	67	34	\$14,811	3	824	275	\$81,371	2	660	330	\$49,814
Grayson	4	643	161	\$76,275	10	1,975	198	\$157,903	7	1,725	246	\$132,702
Greene	3	685	228	\$30,331	1	279	279	\$35,230	2	574	287	\$22,867
Halifax	27	7,870	291	\$1,209,638	24	6,762	282	\$833,975	21	5,577	266	\$669,486
Hanover	21	3,703	176	\$916,749	23	4,724	205	\$989,884	22	4,857	221	\$844,437
Henrico	16	2,513	157	\$257,489	13	2,451	189	\$222,829	17	3,298	194	\$338,131
Henry	7	1,258	180	\$155,950	7	1,488	213	\$149,892	10	2,487	249	\$285,499
Highland	0	0	0	\$0	0	0	0	\$0	0	0	0	\$0
Isle of Wight	1	361	361	\$83,782	1	190	190	\$45,640	1	65	65	\$3,213
James City	5	729	146	\$29,395	2	730	365	\$61,823	1	366	366	\$58,277
King & Queen	0	0	0	\$0	0	0	0	\$0	0	0	0	\$0
King George	30	7,641	255	\$384,968	23	7,141	310	\$520,320	20	5,607	280	\$266,657
King William	0	0	0	\$0	1	99	99	\$18,857	2	77	39	\$14,856
Lancaster	9	1,610	179	\$295,183	10	2,447	245	\$284,364	10	2,597	260	\$483,811
Lee	4	1,400	350	\$23,211	4	188	47	\$30,390	6	1,481	247	\$41,762
Loudoun	29	4,445	153	\$885,398	26	4,048	156	\$695,226	16	1,622	101	\$310,088
Louisa	13	2,780	214	\$336,477	17	5,461	321	\$381,446	9	1,397	155	\$231,848
Lunenburg	10	2,610	261	\$240,948	5	1,491	298	\$39,447	7	2,453	350	\$209,929
Madison	9	1,803	200	\$182,832	14	3,080	220	\$389,128	18	4,888	272	\$678,029
Mathews	2	546	273	\$6,953	1	361	361	\$16,080	0	0	0	\$0

UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA

Locality	UNDUPLICATED YOUTH COUNT/CUMULATIVE DAYS-ACROSS ALL RESIDENTIAL PLACEMENTS											
	FY11				FY12				FY13			
	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure
Mecklenburg	12	3,239	270	\$295,998	5	1,006	201	\$77,544	8	1,597	200	\$192,496
Middlesex	1	62	62	\$5,190	0	0	0	\$0	0	0	0	\$0
Montgomery	11	1,860	169	\$303,435	7	1,829	261	\$284,960	6	1,104	184	\$133,394
Nelson	1	365	365	\$38,926	5	948	190	\$65,352	3	525	175	\$3,032
New Kent	2	562	281	\$99,781	4	626	157	\$90,598	6	551	92	\$89,181
Northampton	5	1,164	233	\$59,876	5	550	110	\$74,899	7	1,946	278	\$134,342
Northumberland	2	334	167	\$2,080	1	1	1	\$22,908	0	0	0	\$0
Nottoway	14	4,085	292	\$519,473	16	4,284	268	\$431,717	17	4,309	253	\$587,099
Orange	8	1,568	196	\$368,583	12	2,438	203	\$489,984	12	2,243	187	\$445,575
Page	10	2,712	271	\$490,590	7	1,302	186	\$391,495	7	1,888	270	\$218,494
Patrick	0	0	0	\$0	0	0	0	\$0	0	0	0	\$0
Pittsylvania	6	1,851	309	\$173,013	8	1,656	207	\$292,600	13	2,537	195	\$263,381
Powhatan	5	846	169	\$93,176	5	1,280	256	\$85,324	5	898	180	\$80,330
Prince Edward	1	202	202	\$5,843	0	0	0	\$0	2	437	219	\$33,797
Prince George	3	913	304	\$46,979	4	759	190	\$80,528	0	0	0	\$0
Prince William	130	25,390	195	\$4,286,044	131	25,948	198	\$4,786,870	102	22,205	218	\$3,967,545
Pulaski	36	5,604	156	\$732,971	37	6,728	182	\$746,303	48	8,601	179	\$1,326,564
Rappahannock	12	2,913	243	\$62,623	15	4,441	293	\$59,556	17	4,233	249	\$298,758
Richmond County	3	903	301	\$112,039	2	396	298	\$9,142	1	194	194	\$28,424
Roanoke County	12	2,425	202	\$220,780	8	2,340	293	\$256,387	9	2,196	244	\$157,849
Rockbridge	20	2,632	132	\$357,834	12	2,942	246	\$251,883	9	2,692	299	\$191,156
Rockingham	31	8,263	267	\$874,972	26	6,677	257	\$991,197	33	7,839	238	\$817,955
Russell	20	3,365	168	\$452,404	21	2,738	130	\$382,550	16	3,836	240	\$299,247
Scott	7	1,225	175	\$195,383	3	793	267	\$159,607	3	373	124	\$10,903
Shenandoah	14	3,501	250	\$290,003	14	2,959	211	\$184,793	15	3,402	227	\$229,079
Smyth	3	97	32	\$39,486	2	78	113	\$29,122	4	368	92	\$41,541
Southampton	2	324	162	\$21,390	5	694	139	\$90,034	3	488	163	\$63,058
Spotsylvania	63	10,882	173	\$1,565,207	46	7,549	166	\$1,211,145	45	6,989	155	\$512,821
Stafford	30	6,325	211	\$708,886	22	7,767	243	\$703,414	25	3,981	159	\$349,145
Surry	0	0	0	\$0	1	150	150	\$60,726	1	366	366	\$142,828
Sussex	6	878	146	\$85,078	1	365	365	\$321	5	1,177	235	\$84,980
Tazewell	5	1,454	291	\$63,612	3	944	315	\$122,709	4	1,098	275	\$115,050
Warren	14	3,026	216	\$331,568	8	1,361	170	\$170,049	5	287	57	\$47,485
Washington	7	1,611	230	\$70,415	24	4,361	182	\$238,873	19	4,090	215	\$177,943
Westmoreland	2	730	365	\$47,673	6	956	159	\$184,334	9	2,077	231	\$307,477
Wise	5	987	197	\$63,633	9	2,525	281	\$214,162	12	2,814	235	\$192,479
Wythe	17	4,972	292	\$402,226	18	4,874	271	\$422,386	16	3,808	238	\$299,225
York	4	950	238	\$104,560	3	633	211	\$60,972	3	420	140	\$97,125
Alexandria	69	9,377	136	\$916,308	58	8,389	145	\$1,004,320	12	1,161	97	\$370,928
Bedford City	3	536	179	\$46,262	3	975	325	\$42,033	1	149	149	\$21,899
Bristol	13	2,671	205	\$186,779	29	6,596	227	\$347,692	32	8,951	280	\$317,480
Buena Vista	6	1,688	281	\$60,273	5	567	113	\$41,714	4	737	184	\$50,867
Charlottesville	58	11,844	204	\$1,777,203	58	10,900	188	\$1,429,979	51	10,854	213	\$1,372,473
Chesapeake	11	1,638	149	\$223,629	7	749	107	\$95,648	15	1,594	106	\$193,833
Colonial Heights	0	0	0	\$0	2	116	58	\$23,434	0	0	0	\$0
Covington	6	1,306	218	\$90,736	12	3,265	272	\$212,187	5	1,329	266	\$77,333
Danville	28	6,006	215	\$673,615	22	4,659	212	\$598,963	16	3,059	191	\$503,034
Franklin City	4	867	217	\$86,074	2	69	35	\$10,240	4	658	165	\$60,745
Fredericksburg	12	1,667	139	\$174,555	8	1,393	174	\$203,304	7	1,134	162	\$113,398
Galax	0	0	0	\$0	4	532	133	\$86,712	4	1,356	339	\$90,310
Hampton	0	0	0	\$0	0	0	0	\$0	0	0	0	\$0
Harrisonburg	31	7,966	257	\$1,212,761	30	8,330	278	\$748,343	22	6,263	285	\$584,015
Hopewell	9	2,492	277	\$242,226	10	1,789	179	\$247,726	7	2,214	316	\$281,426
Lexington	2	277	139	\$12,327	2	177	89	\$566	2	225	113	\$30,760
Lynchburg	59	9,343	158	\$856,662	63	7,777	123	\$621,631	54	7,994	148	\$650,352

UTILIZATION OF RESIDENTIAL CARE UNDER THE CSA

Locality	UNDUPLICATED YOUTH COUNT/CUMULATIVE DAYS-ACROSS ALL RESIDENTIAL PLACEMENTS											
	FY11				FY12				FY13			
	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure	Youth	Days	Avg LOS	Expenditure
Manassas City	8	1,513	189	\$222,248	9	1,736	193	\$124,080	4	501	125	\$24,628
Manassas Park	0	0	0	\$0	0	0	0	\$0	1	15	15	\$400
Martinsville	0	0	0	\$0	0	0	0	\$0	1	366	366	\$50,660
Newport News	4	531	133	\$110,480	5	736	147	\$164,057	4	741	185	\$142,912
Norfolk	120	13,392	112	\$1,481,786	72	9,879	137	\$1,250,618	60	7,054	118	\$899,563
Norton	3	410	137	\$25,430	0	0	0	\$0	4	230	58	\$44,185
Petersburg	35	6,935	198	\$1,011,516	28	4,510	161	\$682,894	21	4,007	191	\$666,865
Poquoson	1	365	365	\$49,114	1	365	365	\$57,088	1	366	366	\$56,505
Portsmouth	8	1,959	245	\$325,474	4	1,213	303	\$103,905	4	1,092	273	\$107,535
Radford	5	971	194	\$78,149	5	1,119	224	\$133,166	8	1,404	176	\$207,734
Richmond City	128	31,920	249	\$2,705,041	93	20,049	216	\$2,208,009	81	15,638	193	\$1,234,387
Roanoke City	52	12,474	240	\$744,261	63	14,573	231	\$1,259,642	61	16,384	269	\$1,501,897
Salem	8	1,388	174	\$216,092	4	832	208	\$59,989	7	1,108	158	\$60,933
Staunton	10	1,149	115	\$167,839	10	1,653	165	\$90,952	8	1,263	158	\$104,177
Suffolk	10	1,566	157	\$146,233	7	874	125	\$117,134	9	1,164	129	\$93,548
Virginia Beach	134	24,796	185	\$3,501,269	125	28,968	232	\$2,854,973	114	23,438	206	\$2,796,167
Waynesboro	3	588	196	\$36,846	3	232	77	\$25,666	8	1,108	139	\$141,669
Williamsburg	3	336	112	\$13,869	3	345	115	\$38,875	3	514	171	\$38,469
Winchester	7	1,534	219	\$192,348	10	1,235	124	\$213,352	4	1,127	282	\$173,959
Greensville/Emporia	3	812	271	\$57,881	2	527	264	\$26,881	4	753	188	\$80,051
Fairfax/Falls Church	251	33,687	134	\$6,391,675	220	33,430	192	\$5,320,762	204	32,189	158	\$4,553,910
Totals	2,244	431,781	192	\$53,656,269	2,065	413,317	200	\$50,231,412	1,888	380,111	201	\$43,257,378

DRAFT