

**Office of Comprehensive Services
CSA Service Names and Definitions Workgroup
Report to the State Executive Council
September 19, 2013**

Report Mandate

In March 2013, the SEC approved the charter to create a work group to establish a list of standard service names with brief service descriptions and recommend a reasonable timeline for required reporting utilizing the standard service names.

Background

Beginning in 2013 the Office of Comprehensive Services (OCS) began collecting client-specific service data to enhance analysis and reporting regarding the services provided to children, youth, and families under the Comprehensive Services Act (CSA). Through a proof of concept project in which these data were collected for seven localities, more than 4000 service names were reported. This extreme number was due, in part, to the fact that the data element was collected through an open text field for some localities, but also due 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.

To comply with the Charter, a workgroup was established to develop and review service names and definitions. The workgroup membership is included as Attachment A and the charter for the group is included as Attachment B.

There were four meetings of the Service Definitions Workgroup between June 10 and August 16, 2013. In addition to these four meetings, the Workgroup communicated electronically to review and provide comment on drafted documents.

The product of this workgroup should be considered an initial draft pending review. 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.

The workgroup began the project with naming various services that are being provided across the state. A majority of the work included collecting established definitions from multiple stakeholders in order to not replicate or redefine a service that exists in practice. This draft consolidates those definitions. The names and definitions are included as Attachment C to this report. The service names that have been identified but not yet reviewed for inclusion in the draft document are included as Attachment D.

Discussion

This workgroup acknowledged significant challenges in defining services and reviewing working documents from multiple sources. Such challenges included:

1. The magnitude and complexity of the task will require a continuation of work beyond this reporting to the SEC.
2. There are pending changes to DMAS regulations which will impact relevant service definitions.
3. The collection and analysis of service names and definitions from across multiple entities (DSS, DOE, DMAS, DBHDS, and JLARC) was a significant undertaking.
4. 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, e.g., consolidating and incorporating services identified in Attachment D. 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.

Attachment A

Service Names and Definitions Workgroup Membership

**Service Names and Definitions Workgroup
September 2013**

Ty Parr – Office of Comprehensive Services
Lesley Abashian – Loudoun County CSA
Les Saltzberg – Licensing, Department of Behavioral Health and Developmental Services
Jackie Jury – Frederick CSA
John Dougherty – Virginia Home for Boys and Girls
Kerry Rojas – Phillips Programs
Pam Fisher – Department of Behavior Health and Developmental Services
Stephan Stark – National Counseling Group
Kyle McMahon – Intercept Youth Services
Jamillah Karriem – Hopewell CSA
Martha Carroll – Department of Juvenile Justice
Crystal Bell – Newport News CSA
Sandra Brown – Department of Medical Assistance Services
Jessica Webb – Roanoke County CSA
Margaret Nimmo Crowe - Voices for Virginia's Children
Elizabeth Clark – Hampton CSA
Deborah Evans – For Children's Sake of Virginia
Cathy Pemberton – Powhatan DSS (VLSSE)
Denise Dickerson – Virginia Department of Social Services
Beth Rafferty – Richmond Behavior Health Authority
Janet Areson – VA Municipal League

Attachment B

Service Names and Definitions Workgroup Charter

State Executive Council Workgroup CSA Service Names and Descriptions

Beginning in 2013 the Office of Comprehensive Services (OCS) will collect client-specific service data to enhance analysis and reporting regarding the services provided to children, youth, and families under the Comprehensive Services Act (CSA). Through a proof of concept project in which these data were collected for seven localities, more than 4000 service names were reported. This extreme number was due the fact that the data element was collected through an open text field for the localities participating in this project. While other localities do standardize service names within their locality, there is need to standardize service names across the state to achieve data integrity.

The need for standard service names and descriptions 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 lack of common terminology across systems and agencies to describe particular services. The SLAT identified the need to define services available to children, youth, and families served under the CSA.

To enhance the value of data analysis, it is necessary that standard service names be utilized statewide to report the services purchased under the CSA. Establishing standardized service names and corresponding descriptions of those services will provide additional benefits including:

- Ensure common language across localities and across agencies,
- Establish delineation between services unique to CSA and those regulated by other state agencies, and
- Facilitate rate negotiation and contracting between localities and private providers, e.g., regional contracting and performance-based contracting.

The purposes of this workgroup will be to:

1. Establish a list of standard service names with brief service descriptions. The descriptions shall be sufficient to distinguish the uniqueness of each service from all others. The development of standard service names is in no way intended to limit the array of services that shall be available to children, youth, and families, i.e., an “other” service name is a reasonable expectation.
2. Recommend a reasonable timeline for required reporting utilizing the standard service names.

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

- CSA coordinators
- VDSS licensing division
- DBHDS licensing division
- DBHDS child services division
- VDSS division of family services
- VLSSE/local social service directors
- VCOPPA/private providers
- Court service units
- Community service boards
- DMAS
- VML and/or VACO
- Office of Comprehensive Services

The workgroup will provide its final recommendations to the SEC no later than September 30, 2013.

Attachment C

Service Names and Definitions Draft

Service Names and Definitions

DRAFT

Acute Psychiatric Hospitalization

Inpatient services that are generally short term and in response to an emergent psychiatric condition. The individual experiences mental health dysfunction requiring immediate clinical attention. The objective is to prevent exacerbation of a condition and to prevent injury to the recipient or others.

Assessment/Evaluation

A tool or series of tools used to report a comprehensive review to make recommendations, provide diagnosis, identify strengths and needs, risk level, and describe the severity of the symptoms.

Community Support Services

Services provided in various community settings to provide individual and family supports necessary to attain and sustain community placement and to preserve the family structure. The services may include individual and family counseling, skill building (coping skills, communication, interpersonal, etc) and behavioral interventions.

Crisis Intervention

Crisis intervention services are mental health care, available 24 hours a day, seven days per week, to provide assistance to individuals experiencing acute mental health dysfunction requiring immediate clinical attention. The objectives are: to prevent exacerbation of a condition; to prevent injury to the member or others; and to provide treatment in the least restrictive setting.

Crisis Stabilization

Crisis Stabilization services are direct mental health care to non-hospitalized individuals (of all ages) experiencing an acute crisis of a psychiatric nature that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization; provide normative environments with a high assurance of safety and security for crisis intervention; stabilize individuals in psychiatric crisis; and mobilize the resources of the community support system, family members, and others for ongoing maintenance, rehabilitation, and recovery.

Day Care Assistance

Child care that provides daily supervision during the foster parents working hours when the child is not in school, facilitates the foster parent's attendance at activities which are beyond the scope of "ordinary parental duties", and is provided in a licensed day care facility or home.

Family Partnership Facilitation

Service is provided by a trained facilitator to conduct a Family Partnership Meeting. The meeting is a relationship focused approach that provides structure for decision making and that

empowers both the family and the community in the decision making process. It extends partnership messages to caregivers, providers and neighborhood stakeholders.

Independent Living Services

Services specifically designed to help adolescents make the transition to living independently as an adult. They provide training in daily living skills as well as vocational and job training.

Intensive Care Coordination

Services conducted by an Intensive Care Coordinator, as defined under the State Executive Council guidelines, for children who are at risk of entering or who are placed in residential care. The purpose of the services are to safely and effectively maintain, transition, or return the child home or to a relative's home, family like setting, or community at the earliest appropriate time that addresses the child's needs. Services must be distinguished as above and beyond the regular case management services provided within the normal scope of responsibilities for the public child serving systems. Services and activities include: Identifying the strengths and needs of the child and his family through conducting or reviewing comprehensive assessments including, but not limited to, information gathered through the mandatory uniform assessment instrument; Identifying specific services and supports necessary to meet the identified needs of the child and his family, building upon the identified strengths; Implementing a plan for returning the youth to his home, relative's home, family-like setting, or community at the earliest appropriate time that addresses his needs, including identification of public or private community-based services to support the youth and his family during transition to community-based care; Implementing a plan for regular monitoring and utilization review of the services and residential placement for the child to determine whether the services and placement continue to provide the most appropriate and effective services for the child and his family.

Intensive In-Home Services

IIH services for Children/Adolescents under age 21 are intensive, 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 out-of-home placement due to documented clinical needs 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.

(Level A) Community-Based Residential Services for Children and Adolescents Under 21

Community-Based Residential Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This residential service will provide structure for daily activities, psycho-education, and therapeutic supervision and activities to ensure the attainment of therapeutic mental health goals as identified in the

treatment plan. The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Service authorization is required for Medicaid reimbursement. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or academic-educational needs of the member.

(Level B) Therapeutic Behavioral Services

Therapeutic Behavioral Services for Children and Adolescents under 21 are a combination of therapeutic services rendered in a residential setting. This service will provide structure for daily activities, psycho-education, therapeutic supervision and activities, and mental health care to ensure the attainment of therapeutic mental health goals as identified in the treatment plan. The child/adolescent must also receive psychotherapy services in addition to the therapeutic residential services. Room and board costs are not included in the reimbursement for this service. Only programs/facilities with 16 or fewer beds are eligible to provide this service. This service does not include interventions and activities designed only to meet the supportive non-mental health special needs, including but not limited to personal care, habilitation, or the academic educational needs of the members. Service authorization is required for Medicaid reimbursement. See Appendix C for service authorization information.

(Level C) Residential Treatment Facility

A 24-hour-per-day specialized form of highly organized, intensive, and planned therapeutic interventions, which shall be utilized to treat severe mental, emotional, and behavioral disorders of individuals 21 years old or younger. All services must be provided at the facility as part of the therapeutic milieu.

Maintenance - Basic

Service payments made on behalf of a child in foster care to cover the cost of (and the cost of providing) food, clothing, shelter, daily supervision, school supplies, a child's personal incidentals, liability insurance with respect to a child, and reasonable travel for the child to visit with family or other caretakers and to remain in his or her previous school placement.

Maintenance – Clothing Supplement

Payments, as determined and scheduled by VDSS, for clothing outside of basic maintenance.

Maintenance - Enhanced

The amount paid to a foster or adoptive parent over and above the basic foster care maintenance payment. It is based on the needs of the child for additional supervision and support by the foster or adoptive parent as identified by the VEMAT.

Maintenance – Independent Living

Payments to youth specifically in independent living arrangements.

Maintenance – Transportation

Per title IV-E and Fostering Connections, payments made for the child include visit family including parents, relatives and siblings, costs for the child to be transported to the school in which the child was placed prior to the current foster care placement, costs may include purchase of the child's bus/plane tickets; mileage (at the state rate) for the driver to transport the child.

Mental Health Case Management

Mental health case management is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services. Case management does not include the provision of direct services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, as long as the treatment for the substance abuse condition is intended to positively impact the mental health condition. The impact of the substance abuse condition on the mental health condition must be documented in the service specific provider assessment, the ISP, and the progress notes.

Mental Health Support

Mental health support services (MHSS) are training and support to enable individuals with significant psychiatric functional limitations to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. The recommended age to receive the service will increase from 16 to 18 years of age as this service is focused on assisting clients to live independently. Persons under 18 may still be eligible for Mental Health Support Services if medical necessity criteria are met. This service is not a substitution for mental health counseling or psychotherapy.

Mentoring

Services in which children are appropriately matched with screened and trained adults for one-on-one relationships, involving meetings and activities on a regular basis, intended to meet in part, the child's need for involvement with a caring and supportive adult who provides a positive role model.

(MST) Multi-systemic Therapy

An evidenced based, integrative, family-based treatment with focus on improving psychosocial functioning for youth and families so that the need for out-of-home placements is reduced or eliminated.

Occupational therapy

Special Education Service that is identified within an IEP with a designation while in a private day education placement means services provided by a qualified occupational therapist or services provided under the direction or supervision of a qualified occupational therapist and

includes: 1. Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation; 2. Improving ability to perform tasks for independent functioning if functions are impaired or lost; and 3. Preventing, through early intervention, initial or further impairment or loss of function.

Other

Additional services that will ensure the safety and well-being of children at risk of out of home placement or that will enhance reunification efforts.

Parent Support

Community based support services targeted to assist parents in effectively meeting the needs of their children in a safe, positive and healthy manner.

Private Day Education

Special Education service provided in a licensed, privately owned and operated preschool, school, or educational organization to persons determined to have a disability as defined by the Regulations governing Special Education Programs for Children with Disabilities in Virginia.

Residential Education

Education provided in a licensed, privately owned and operated residential facility where the person resides 24 hours a day, including special education services that require placement in a residential program.

Respite

Service that provides short term care, supervision, and support to youth for the purpose of providing relief to the primary care giver while supporting the emotional, physical, and mental well being of the youth and their family/guardian.

Speech-language pathology services

Special Education Service that is identified within an IEP with a designation while in a private day education placement means the following: 1. Identification of children with speech or language impairments; 2. Diagnosis and appraisal of specific speech or language impairments; 3. Referral for medical or other professional attention necessary for the habilitation of speech or language impairments; 4. Provision of speech and language services for the habilitation or prevention of communicative impairments; and 5. Counseling and guidance of parents, children, and teachers regarding speech and language impairments.

Substance Abuse Case Management

Substance Abuse case management assists children, adults, and their families with accessing needed medical, psychiatric, substance abuse, social, educational, vocational services and other supports essential to meeting basic needs. If an individual has co-occurring mental health and substance abuse disorders, the case manager shall include activities to address both the mental

health and substance use disorders. Only one type of case management may be billed at one time.

Therapeutic Day Treatment (TDT) for Children and Adolescents

Covered services are a combination of psychotherapeutic interventions combined with medication education and mental health treatment offered in programs of two or more hours per day with groups of children and adolescents (up to the age of 21 as a EPSDT service).

Therapeutic Mentoring

Services to meet the individual needs of a youth who is experiencing significant social, emotional, behavioral, and/or family impairments that require therapeutic interventions provided by a trained professional to maintain or transition to the least restrictive community placement.

Transportation

This includes assistance that will enable a parent or a child to attend counseling, parenting classes, court, local DSS appointments, visitations with a child, visitations with an parent, medical appointments, or other pre-approved appointments.

(TFC-CM) Treatment Foster Care Case Management

A component of treatment foster care through which a case manager provides treatment planning, monitors the treatment plan, and links the child to other community resources as necessary to address the special identified needs of the child. TFC-CM focuses on a continuity of services that is goal-directed and results-oriented. Services shall not include room and board.

(TFC-SS) Treatment Foster Care Support and Supervision

TFC Support and Supervision services include, but not limited to, recruiting, training, assessing and retaining TFC parents; making placement arrangements; purchasing/ensuring child has adequate clothing; providing transportation; counseling with child to prepare for visits with biological family; providing support and education for TFC parents regarding management of child's behavior; providing ongoing information and counseling to child regarding permanency goals; preparing a child for adoption; 24/7 crisis intervention and support for both child and TFC family; developing and writing reports for FAPT; attending and presenting at FAPT meetings; administering TFC parent payments; identifying adoption placements; assessment of adoption placements; and arranging adoption placements. The provision of services will vary for each child based on that child's specific needs.

Attachment D

Additional Service Names

Additional Service Names for Consideration

1:1 Support Service
Behavior Specialist
Counseling
Family Care Coordination
Head Injury Rehabilitation
Home Based Services
ID Program
Indirect Costs
Intensive Behavioral Support
KPACT
Legal Services
Life and Social Skills
Medical Services
Medication Management
Peer Parent Support
Placement Services
Reunification Service
School Based Aide
Step Down Services
Stipend
Summer School
Supervised Visitation
Supervision and Counseling
TFC Administrative Fee
Therapeutic Recreation
Trauma Based Services
Tutoring

**Office of Comprehensive Services
Biennial Report to the General Assembly and
Community Policy and Management Teams**

Progress Report on Comprehensive Services to Children, Youth and Families

December 2013

Report Mandate

Virginia Code, §2.2-2648.21, requires that the State Executive Council for Comprehensive Services for At-Risk Youth and Families shall:

Biennially publish and disseminate to members of the General Assembly and community policy and management teams a state progress report on comprehensive services to children, youth and families and a plan for such services for the next succeeding biennium. The state plan shall:

- a. Provide a fiscal profile of current and previous years' federal and state expenditures for a comprehensive service system for children, youth and families;*
- b. Incorporate information and recommendations from local comprehensive service systems with responsibility for planning and delivering services to children, youth and families;*
- c. Identify and establish goals for comprehensive services and the estimated costs of implementing these goals, report progress toward previously identified goals and establish priorities for the coming biennium;*
- d. Report and analyze expenditures associated with children who do not receive pool funding and have emotional and behavioral problems;*
- e. Identify funding streams used to purchase services in addition to pooled, Medicaid, and Title IV-E funding; and*
- f. Include such other information or recommendations as may be necessary and appropriate for the improvement and coordinated development of the state's comprehensive services system;*

Background

The statutory purpose of the Comprehensive Services Act (CSA) is to create a system of services and funding for troubled youth and their families that is child centered, family focused, and community based. The statutory purposes of the CSA are 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.

The State Executive Council (SEC) serves as the supervisory council that provides leadership for the CSA (§2.2-2648). 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 or a designated deputy. The council is comprised of the following members:

- two General Assembly members,
- the Governor's Special Advisor on Children's Services (ex-officio member),
- agency heads from the departments of:
 - Education
 - Social Services
 - Health
 - Behavioral Health and Developmental Services
 - Medical Assistance Services
 - Juvenile Justice, and
 - Office of the Executive Secretary of the Supreme Court
- five local government officials,
- two parents, and
- two private providers.

The State and Local Advisory Team (SLAT) advises the SEC on state interagency program 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, and the effects of proposed policies, regulations and guidelines (§2.2-5202). The SLAT is comprised of the following members: representatives of Community and Policy Management Teams from the five different geographical areas of the Commonwealth; a parent; a private provider; a local Comprehensive Services Act coordinator or program manager; and a juvenile and domestic relations district court judge; and one representative from each of the following state agencies:

- Health,
- Juvenile Justice,
- Social Services,
- Behavioral Health and Developmental Services,
- Medical Assistance Services, and
- Education.

The Office of Comprehensive Services (OCS) serves as the administrative entity of the SEC and ensures that its decisions are implemented (§2.2-2649).

The CSA is administered at the local level by Community Policy and Management Teams (CPMTs) which have statutory responsibility for managing funds and developing interagency policies to govern implementation of CSA within communities (§2.2-5206). Family Assessment and Planning Teams (FAPTs) provide for family participation, assess the strengths and needs of children and their families, develop individual family services plans, and make recommendations for funding to the CPMT (§2.2-5208).

Funding for services under the CSA is shared by the state and local governments. The local base match rate is defined in Item 274 C.2 of the Appropriations Act as follows:

"Local Match. All localities are required to appropriate a local match for the base year

funding consisting of the actual aggregate local match rate based on actual total 1997 program expenditures for the Comprehensive Services Act for At-Risk Youth and Families”.

Performance and Expenditures

Increasing utilization of community based services to decrease reliance on restrictive, residential services is a key CSA performance measure. In a 2007 report on residential services and the CSA, the Joint Legislative Audit and Review Committee (JLARC) identified that community based service gaps are the primary obstacle to serving children in the most appropriate, least restrictive setting. Following that report, the Casey Strategic Consulting Group provided policy advice to assist Virginia in achieving goals to reduce utilization of residential care, to increase services to youth in their homes, and to enable investment of funds for the development of community based services. The policy advice recommended a system of financial incentives to encourage local practices in support of these objectives.

Since 2008, several significant strategies have been implemented to decrease reliance on residential care as a service to youth. These strategies have included:

- 1) In July 2008 the State Executive Council approved a hierarchy of service categories with an accompanying incentive match rate system for implementation in FY2009. At present, the local government match rate is 25% above the base match for residential services and 50% below the base match for community-based services.
- 2) The *Children's Services Systems Transformation* initiative was implemented statewide beginning in 2008. This initiative was designed to change local practice to increase use of community-based services.

These two initiatives have, in fact, had significant impact on the overall service expenditures under the Comprehensive Services Act. Expenditures are illustrated in the graph below:

Insert table

In addition to decreasing overall service expenditures for the past three years, these initiatives have successfully changed local practice with the following measurable results:

reduction to the number of residential placements,
increased family-based placements, and
fewer youth in foster care.

These initiatives have contributed positively to the CSA goal of increasing the percentage that

community based services represent of total CSA services. To date, however, the state has not yet achieved its target of 50% of all services funded under the CSA being community-based services. The increase in the percent of community-based services is illustrated in the chart below:

WORKING DOCUMENT

Insert table

While the *Children's Services Systems Transformation* initiative can be considered complete, focused discipline on aligning practice and policies must be maintained. The role that the match rate system has played in supporting change to local practice should not be underestimated.

The following table summarizes state pool fund expenditures by specific service categories:

Insert table

As discussed in the 2007 JLARC report on residential services provided through the CSA, a true picture of the total expenditures for services to at-risk youth and families cannot be seen by looking at CSA expenditures alone given that other funding streams support these same services.

Federal funding sources, i.e., Medicaid and Title IV-E, provide support to some CSA placements and services. Residential treatment programs and treatment foster care services to a single youth may be funded by a combination of Medicaid, Title IV-E, and CSA dollars depending upon youth and provider eligibility. For Medicaid-eligible youth utilizing Medicaid-eligible services, Medicaid funds treatment components of CSA residential placements and treatment foster care services when youth meet criteria of medical necessity. There is a state and local match to these Medicaid funded services. For eligible youth, Title IV-E funds are used to pay certain costs, e.g., the maintenance costs, associated with residential placements and treatment foster care services.

The chart below illustrates expenditures for CSA funded youth combining these multiple funding sources:

Insert chart

Funding For Youth Outside of the Comprehensive Services Act

Additional fund sources are available within communities for services to at-risk youth outside of the Comprehensive Services Act. These funding streams are described below.

Children's Mental Health Initiative (Administered by DBHDS)

The Mental Health Initiative (MHI) Fund was established by the General Assembly in FY 2000 to create a dedicated source of funding 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).

The MHI fund was designed to address some of the gaps in funding for services for non-CSA mandated children and adolescents. In addition to using these funds, a collaborative, interagency approach with creative and innovative treatment strategies is encouraged to serve this challenging population of children and families in need. Principles to facilitate the consistent use and management of these funds across Virginia include:

MHI funds must be used exclusively to serve new, currently un-served children and adolescents or provide additional services to underserved children and adolescents with serious emotional disturbances and related disorders that are not mandated to receive services under the CSA. Children and adolescents must be under 18 years of age at the time services are initiated.

Services must be based on the individual needs of the child or adolescent and must be included in an individualized services plan. Services must be child-centered, family focused, and community-based. The participation of families is integral in the planning of these services.

CSBs must develop referral and access protocols that assure effective linkages with key stakeholder agencies and entities in the community (e.g., CSA, social services, schools, and juvenile justice services, detention centers).

Services should be provided in the least restrictive and most appropriate settings, including homes, schools, pre-schools, community centers, group homes, and juvenile detention centers.

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.

Services that are most appropriate for use of MHI funds include: emergency, local inpatient, outpatient, intensive in-home, therapeutic day treatment, alternative day support (including specialized after school and summer camp, behavior aide, or other wrap-around services), and highly intensive, intensive, supervised family support services (including therapeutic foster care or

residential respite care). In general, services should have the purpose of keeping children in their homes and communities and preserving families whenever possible.

Promoting Safe and Stable Families Funds (Administered by VDSS)

The Promoting Safe and Stable Families Program (PSSF) is designed to assist children and families resolve crises, connect with necessary and appropriate services, and remain safely together in their own homes whenever possible. This program helps more than 15,000 children and families each year. Localities develop a plan for its use based on a Community Needs Assessment. Funds may be managed locally by the CSA Community Policy and Management Team (CPMT) or the local department of social services.

Services are provided to meet the following objectives:

- Prevent or eliminate the need for out-of-home placements of children
- Promote family strength and stability
- Enhance parental functioning
- Protect children
- Assess and make changes in state and local service delivery systems

Promoting Safe and Stable Families funds may be provided through local public or private agencies, or individuals, or any combination of resources. Funds may be used for services that support the following:

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 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.

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.

Adoption Promotion and Support: Encourage adoption from the foster care system, when adoptions promote the best interests of children, including such activities as pre and post

adoptive services and activities designed to expedite the adoption process and support adoptive families.

Virginia Juvenile Community Crime Control Act Funds (Administered by DJJ)

Funding is allocated to each local governing body through a formula based on a variety of factors including the number and types of arrests in a locality and the average daily cost for serving a child. To ensure that localities do not renege on their prior commitment to youth, they must maintain the same level of contributions to these programs as they made in FY1995 in order to receive state funding.

Participation in Virginia Juvenile Community Crime Control Act Funds (VJCCCA) is voluntary. In order to receive funding, the locality must have a plan for how they will use the funding approved by the Board of Juvenile Justice. All 134 cities and counties in Virginia participate in VJCCCA. Some localities have combined programs and funding across jurisdictions. Development of the plan requires consultation with judges, court service unit directors and CSA Community Policy and Management Teams (CPMTs). The local governing body designates who will be responsible for developing and managing the plan. In over half the localities, this responsibility has been delegated to the court service unit.

All VJCCCA funding must be used to serve “juveniles before intake on complaints or the court on petitions alleging that the juvenile is a child in need of services, child in need of supervision or delinquent” (§16.1-309.2). Local governing bodies may provide services directly or purchase them from other public or private agencies. There are no specific types of programs or services required. The intent is for programs and services to be developed to fit the needs of each particular locality.

Positive aspects and benefits of VJCCCA include the following:

- Judges have additional alternative sentencing options,
- Communities have received additional funding to create or enhance programs,
- Localities have greater flexibility to design programs to meet the needs of their communities,
- The number and variety of programs and services available for youth has increased in most communities, and
- Programs and services appear to be serving more youth in their own community.

Expenditures for at-risk youth and families who may be served outside of the CSA are shown in the table below:

Insert table

Summary

APPENDIX A

Progress on Goals and Strategies

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>The SEC adopted a policy on July 30, 2013 which requires consistent use of definitions, eligibility criteria, and service requirements between DMAS and CSA for community-based behavioral health services of Intensive In-Home, Mental Health Support Services, and Therapeutic Day Treatment.</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>Strategy requires allocation of additional General Funds.</p>
<p>3. Support local development of services through state facilitated collaborative meetings between regional representatives and private providers.</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 XX, XXX.</p>
<p>4. Review, revise, recommend policy and/or statute to enable development of new services which will address identified service gaps.</p>	<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.</p>
<p>5. Examine and address inadvertent fiscal incentives for residential placement, parental placement, avoidance of FAPT/MDT process, e.g.,</p>	<p>The SLAT has plans to address this goal during FY2014.</p>

- Medicaid match
- Family-of-one eligibility
- Education costs

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.

Coordination across Secretariats has been evidenced by:

- 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.

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

1. Enhance collection, analysis, and utilization of appropriate client level data to enable comprehensive analysis of needs, services, providers, and outcomes.

Progress

As of July 15, 2013, client level data for period 7/1/2010 – 6/30/2013 was collected as follows:

- 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 was delivered to OCS from private contractor (SAS) on XX.

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.

Workgroups of local users will be assembled in FY2014 to advise and assist in training.

3. Improve the operational effectiveness of CSA administration.

Strategy

1. Support a comprehensive internal audit program designed to evaluate financial and programmatic processes and provide consultation and recommendations for improvement.
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.
3. Update CSA Manual for increased usability.

Progress

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:

- 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.

Two statewide conferences were conducted with more than 450 local CSA team participants represented. Attendance by stakeholder groups is summarized in the following report: XXX

Additional trainings have been held for individual stakeholder groups. Training activities and participants are summarized in the following report: XXXX

Updates to the CSA Manual have been made as new policies and guidelines were adopted.

The CSA Coordinators Advisory Council 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 following report: XXX |
| 6. Build/enhance a systemic culture of collaboration across state and local CSA stakeholders through technical assistance in team building, communication, consensus building, etc. | As of XX, the OCS provided technical assistance to XX communities in response to requests for assistance with team building, communication, and program improvement. |
| 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 September 2012 XX. |

APPENDIX B

Biennial Plan: Goals and Strategies

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

Strategy	Responsible Body	Dates
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)	1/1/2013- 6/30/2014
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	7/01/2013- 6/30/2014
3. Support local development of services through state facilitated collaborative meetings between regional representatives and private providers.	SEC Finance Committee	10/1/2012- 6/30/2014
4. Review, revise, recommend policy and/or statute to enable development of new services which will address identified service gaps.	SEC Finance Committee	
5. Examine and address inadvertent fiscal incentives for residential placement, parental placement, avoidance of FAPT/MDT process, e.g., <ul style="list-style-type: none"> • Medicaid match • Family-of-one eligibility • Education costs 	SEC (via SLAT)	1/1/2013- 6/30/2014
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.	SEC	1/1/2013- 6/30/2014

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	Dates
1. Enhance collection, analysis, and utilization of appropriate client level data to enable comprehensive analysis of needs, services, providers, and outcomes.	OCS	11/1/2012-6/30/2014
2. Improve availability of meaningful data via CSA statistics web page.	OCS	1/1/2013-6/30/2014
3. Develop and implement training for users to sustain data systems.	OCS	1/1/2013-6/30/2014

3. Improve the operational effectiveness of CSA administration.

Strategy	Responsible Body	Dates
8. Support a comprehensive internal audit program designed to evaluate financial and programmatic processes and provide consultation and recommendations for improvement.	OCS	7/1/2012-6/30/2014
9. 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	10/1/2012-6/30/2014
10. Update CSA Manual for increased usability.	OCS	7/1/2012-4/30/2013
11. Enhance fiscal and data reporting requirements to reduce local administrative burden and improve utilization of data for program evaluation and improvement.	OCS	1/1/2013-6/30/2014
12. Implement robust training plan	OCS	7/1/2012-6/30/2014
13. Build/enhance a systemic culture of collaboration across state and local CSA stakeholders through technical assistance in team building, communication, consensus building, etc.	OCS	7/1/2012-6/30/2014
14. Enhance collaboration between SLAT and SEC through annual joint meeting for review of strategic planning initiatives.	SEC	9/20/2012-6/30/2014

Estimated Costs

The goals and related strategies identified in this plan will be implemented through the budget of the Office of Comprehensive Services. The Office will utilize approximately \$400,000 in general fund for data integration, analysis, and reporting activities in FY2013.