



Innovative Strategies for Sustainability and Scalability for Local CSA System of Care

10th Annual Commonwealth of Virginia CSA Conference
October 29, 2021

Fairfax-Falls Church Children's Services Act Program

Janet Bessmer, Director

Sarah Young, FAPT Coordinator

Jeanne Veraska, UR Manager

Patricia E. Arriaza, CSA Operations

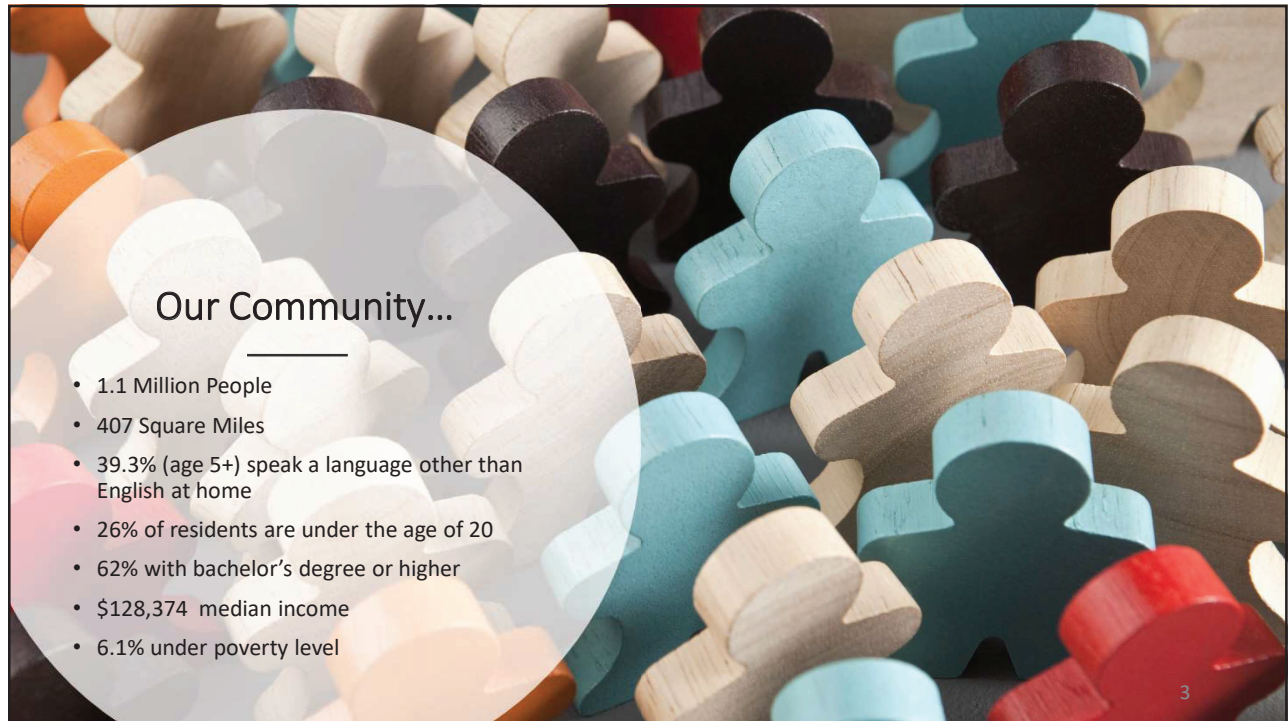
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Local Implementation of Systems of Care

- Sharing process, policies, forms and guidance documents
- Management and Leadership
- Administrative Resources
- QA process and Service Planning
- UR process
- CQI process

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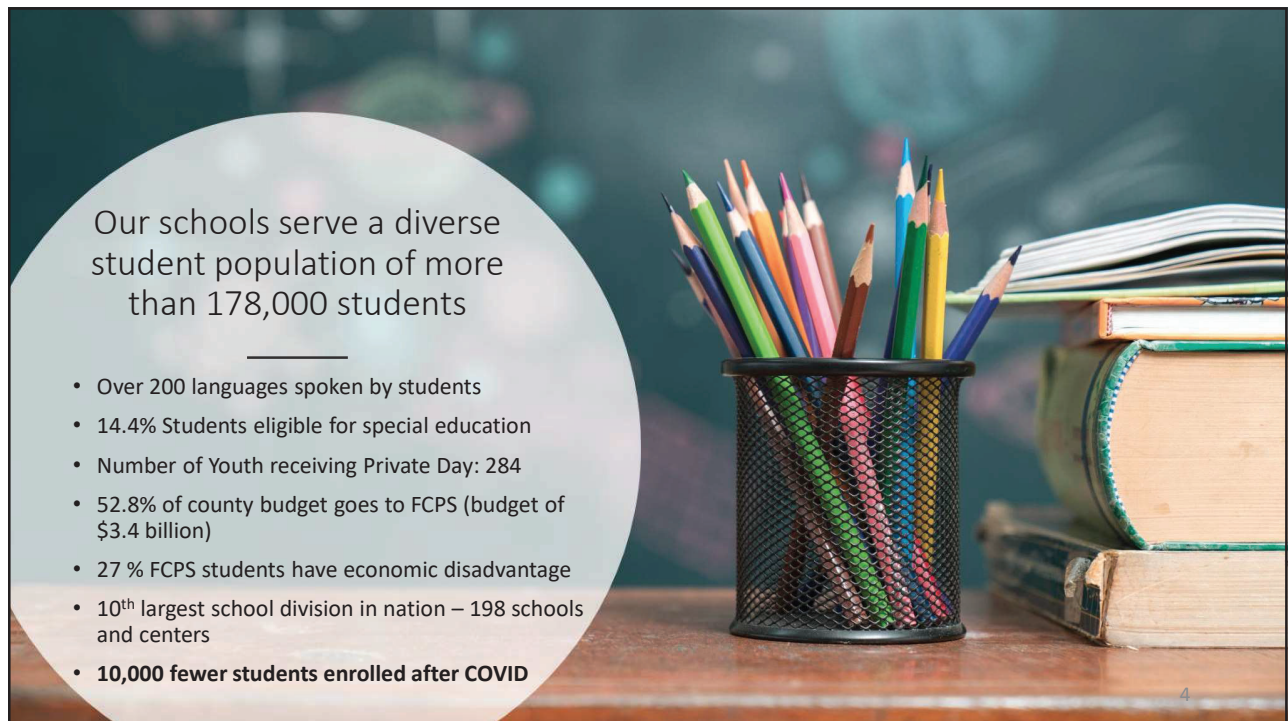
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Our Community...

- 1.1 Million People
- 407 Square Miles
- 39.3% (age 5+) speak a language other than English at home
- 26% of residents are under the age of 20
- 62% with bachelor's degree or higher
- \$128,374 median income
- 6.1% under poverty level

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Our schools serve a diverse student population of more than 178,000 students

- Over 200 languages spoken by students
- 14.4% Students eligible for special education
- Number of Youth receiving Private Day: 284
- 52.8% of county budget goes to FCPS (budget of \$3.4 billion)
- 27 % FCPS students have economic disadvantage
- 10th largest school division in nation – 198 schools and centers
- **10,000 fewer students enrolled after COVID**

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Youth Survey

Survey conducted by FCPS and NCS to assess risk and resilience in school-aged youth

2020 Youth survey data
 15.2% report drinking alcohol in the 30 days prior to survey;
 36.4% report being stressed;
 29.9% report depressive symptoms;
 14.3% have considered suicide⁵

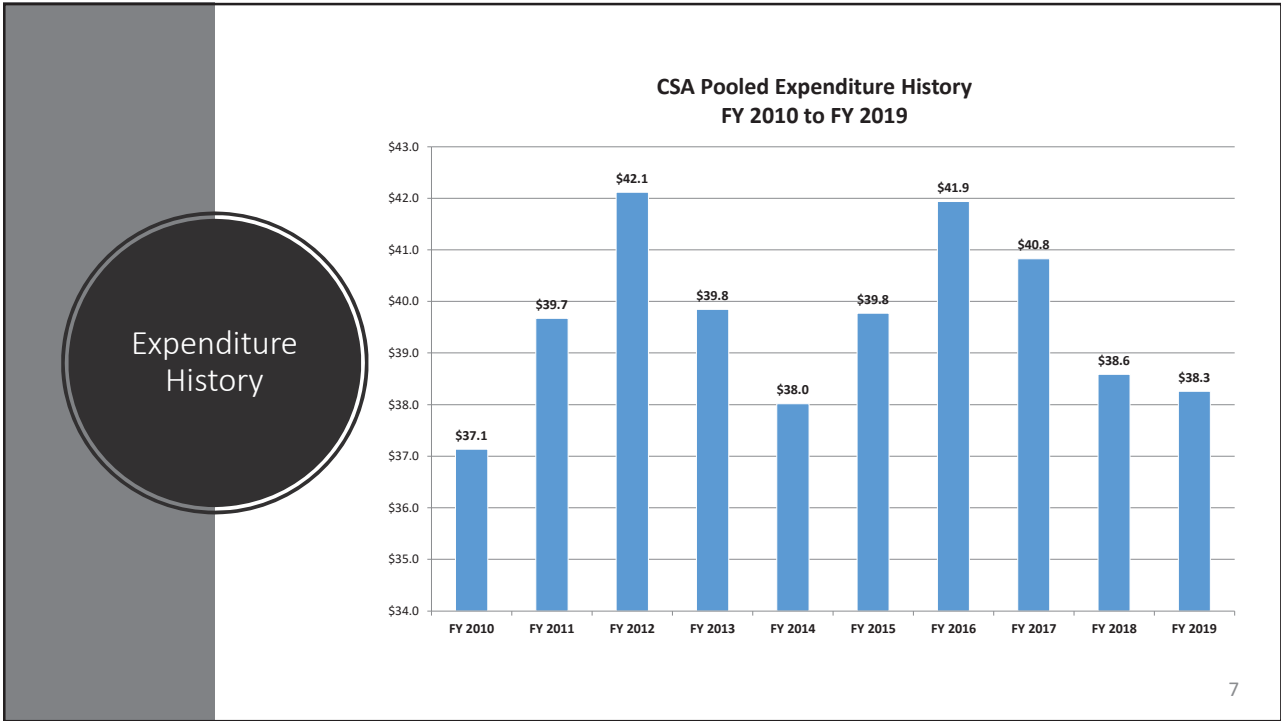
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Fairfax- Falls Church Children's Services Act

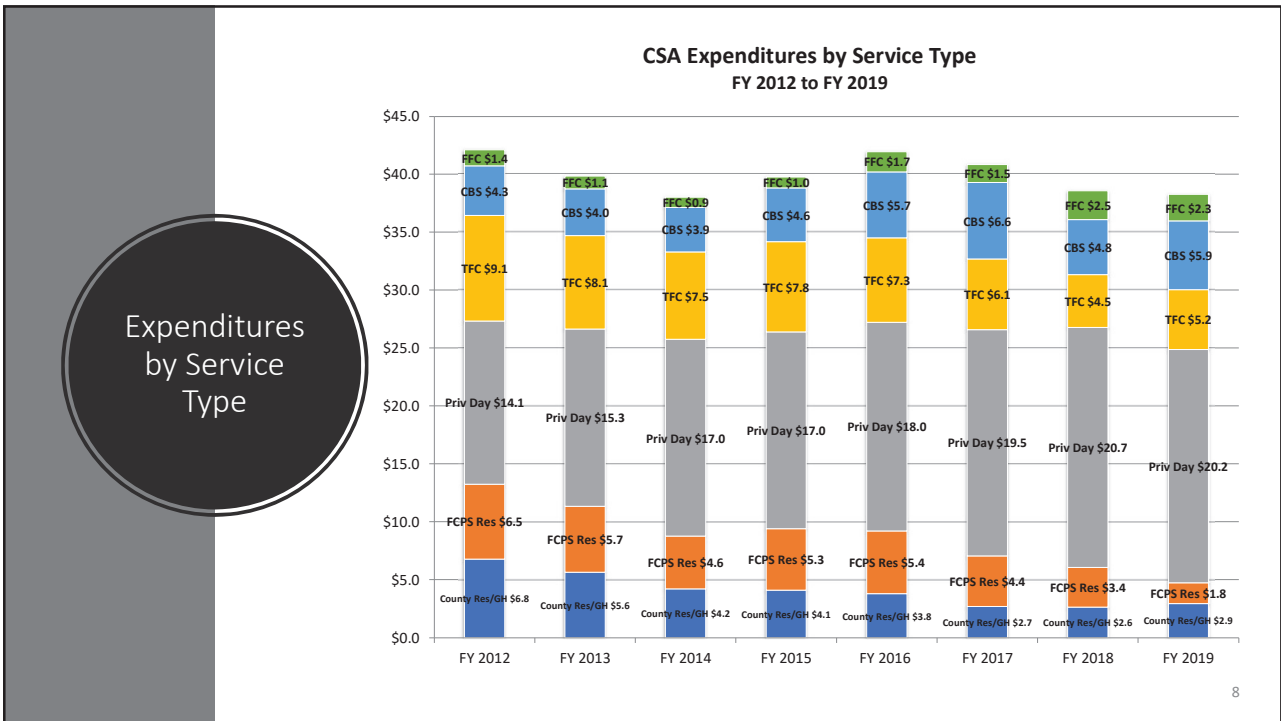
- Fairfax County and Cities of Falls Church and Fairfax
- 1,039 youth served in FY21 (10% fewer)
- \$35.4 million expenditures in FY21 (decrease \$3.0 mil)
- \$1.6 million "protected" funds
- \$1,122,588 for program administration

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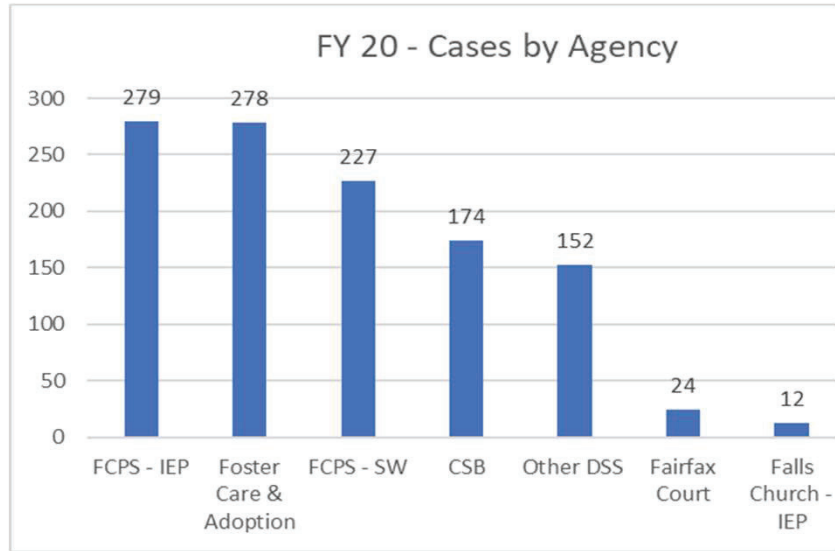


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Cases by Agency



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Our Challenges and Opportunities

- Size of system, number of case managers and staff, volume of service requests
- Diverse community, languages spoken, need for outreach/inclusion/equitable access
- Empowered Community vs. Opportunity Neighborhoods
- Time To Service and Use of Data



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Management and Leadership

- 19 Member CPMT – Five Parent Reps
- CSA Management Team - Roles and Duties
- Administratively housed within DSS
- CPMT Chair – Deputy County Exec for HHS

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CSA Management Team

- Meets twice per month for 2 hours
- Membership reflects CPMT – managers of child-serving programs, budget, finance, contracts and CSA staff
- Review Reports for Oversight – ICC, Case Support
- Develop Proposed Policies and Approve Procedures
- Contracts – rates, child specific contract requests
- CQI – corrective action plans

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Administrative Resources

- CSA program – 11 FTEs
- Contracts – 2.25 FTEs
- Fiscal – 10.5 FTEs
- Budget – 2 FTEs
- VT Contractor – Federal Reimbursement Unit - 2.5 FTEs
- Dept of Tax Administration
- Legal – County Attorneys

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Partnerships

- Providers
 - NOVACO and HB providers
 - Local psychiatric hospitals
 - CSB – Leland House, Case Support, ICC
- Family Advisory Board
- George Mason University – Training Consortium
- Family Support Partners – PRS, UMFS
- Other Agencies –
 - Healthy Minds Fairfax
 - Neighborhood and Community Services - TICN
 - One Fairfax – Equity Initiative in County

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Technology

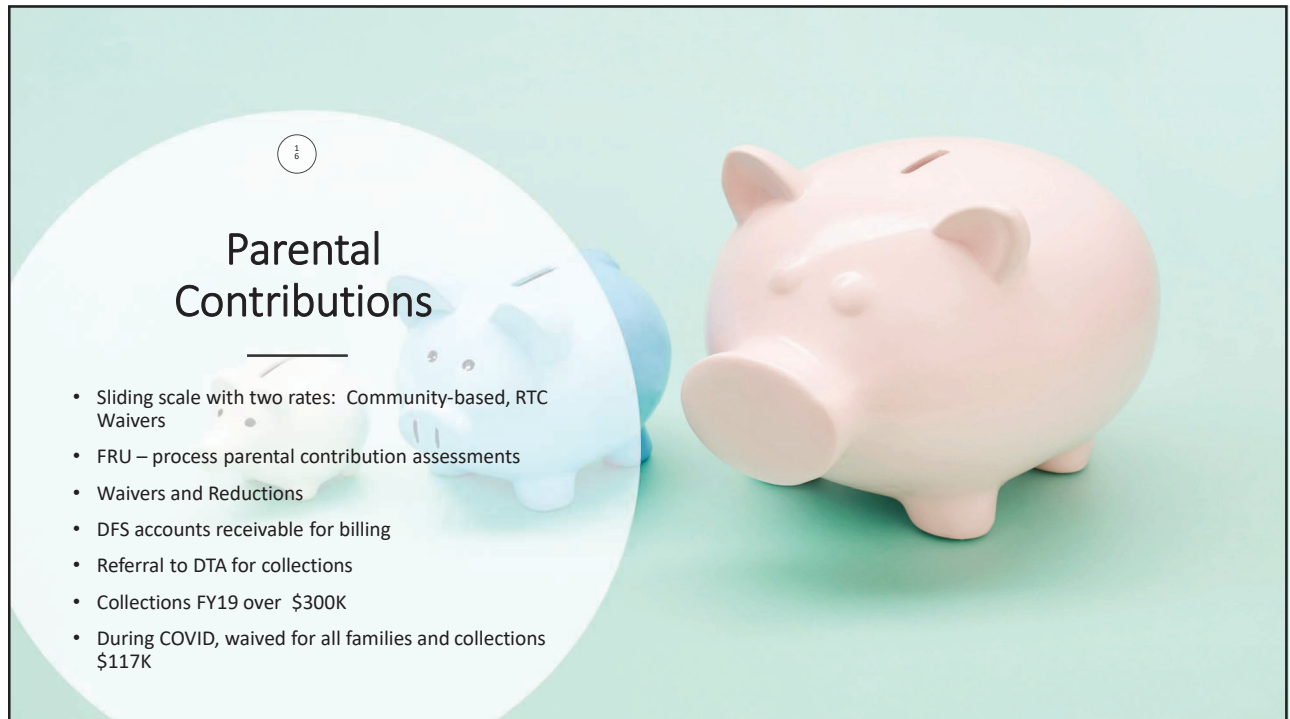
- Central Information System with multiple Fund Codes
- One set of contracts, one system, one set of fiscal staff
- DocuSign, Zoom/Teams for virtual meetings
- Electronic Document Management System
- Scalability for FFPSA
- Designing new IT system that will have provider portal, worker automation, validation checks



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Parental Contributions

- Sliding scale with two rates: Community-based, RTC Waivers
- FRU – process parental contribution assessments
- Waivers and Reductions
- DFS accounts receivable for billing
- Referral to DTA for collections
- Collections FY19 over \$300K
- During COVID, waived for all families and collections \$117K



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Scale and Waivers



PLEASE CHECK ALL THAT APPLY

1. Child/Youth has been found eligible for free or reduced school meals*
 _____ Signature _____ Date

FCPS or FCCPS Social Worker Name _____ Signature _____ Date _____

2. Child/Youth receives income-based Medicaid, TANF, SNAP benefits* CSA Verification: _____

3. Community Based Services Request for Kin Caregiver* _____

4. PPS/CPS Waiver (waiver is valid for 6 months) – *If this box is checked/sign your parental contribution assessment is complete. Please submit page one to the CSA office.*
 _____ Signature _____ Date _____

PPS/CPS Worker Name _____ Signature _____ Date _____

FINANCIAL INFORMATION	
Parent/Guardian #1 Annual Gross Income (Please submit copies of 2 most recent paystubs)	\$
Parent/Guardian #2 Annual Gross Income (Please submit copies of 2 most recent paystubs)	\$
Other Sources of Income (Ex: child support, alimony, Social Security, unemployment) (Please submit supporting documents)	\$
Total Annual Household Income	\$ 0
CALCULATE ADJUSTED HOUSEHOLD INCOME (AHI)	
Number of dependent children under the age of 18	0
Deduction (# of children x \$4,050)	\$ 0
Subtract Deduction from Total Annual Household Income to get Adjusted Household Income	\$ 0

Use this chart to calculate your Parental Contributions Assessment:			
Tier	Adjusted Household Income (AHI)	Community-Based Services	Residential Group Home
1	\$48,599 - And Below	\$0	\$0
2	\$48,600 - \$55,599	\$67	\$135
3	\$55,600 - \$62,599	\$77	\$154
4	\$62,600 - \$69,599	\$86	\$174
5	\$69,600 - \$76,599	\$96	\$193
6	\$76,600 - \$83,599	\$106	\$213
7	\$83,600 - \$93,599	\$203	\$361
8	\$93,600 - \$103,599	\$228	\$405
9	\$103,600 - \$113,599	\$252	\$448
10	\$113,600 - \$123,599	\$276	\$491
11	\$123,600 - \$133,599	\$301	\$534
12	\$133,600 - \$143,599	\$325	\$578
13	\$143,600 - \$158,599	\$454	\$799
14	\$158,600 - \$173,599	\$501	\$882
15	\$173,600 - \$188,599	\$548	\$966
16	\$188,600 - \$203,599	\$596	\$1,049
17	\$203,600 - \$218,599	\$643	\$1,133
18	\$218,600 - \$233,599	\$691	\$1,216
19	\$233,600 - \$324,999	5% of AHI - 12	10% of AHI - 12
20	\$325,000 - \$374,999	8% of AHI - 12	15% of AHI - 12
21	\$375,000 - and Above	10% of AHI - 12	20% of AHI - 12

Determine the parental contribution by using the Parental Contribution Scale.
 * Monthly parental contribution amounts are provided for Tiers 1 - 18.
 * Tiers 19-21, parental contribution amounts are calculated based on the percentages and formula provided in the scale.

Example #1:
 Annual Household Income = \$67,500
 3 children under age 18 x \$4,050 = \$12,150
 Adjusted Household Income = \$55,350
 Tier 2, CBS = \$67, RS/GH = \$135

Example #2:
 Annual Household Income = \$240,000
 4 children under age 18 x \$4,050 = \$16,200
 Adjusted Household Income = \$223,800
 Tier 18, CBS = \$691, RS/GH = \$1,216

Example #3:
 Annual Household Income = \$324,500
 1 child under age 18 x \$4,050 = \$4,050
 Adjusted Household Income = \$320,450
 Tier 19, CBS = 5% of AHI 12
 RS/GH = 10% of AHI 12
 CBS = \$1,335.21, RS/GH = \$2,670.42

PARENTAL CONTRIBUTION ASSESSMENT	
Parental Contribution for Community-Based Services Monthly \$	Parental Contribution for Residential Group Home Services Monthly \$
I would like to set up a payment plan <input type="checkbox"/> yes <input type="checkbox"/> no	
I would like to request a reduction or waiver <input type="checkbox"/> yes (please complete the next sections) <input type="checkbox"/> no (review & sign page 4)	

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System Sustainability

- Pre- 2015 Reached a "Tipping Point" with Five FAPTs plus Committee for Non-mandated Funding Prioritization
- Amount of paper documents
- Delays to get to standing FAPTs
- Insufficient attention to each cases, volume not quality
- Parents not in attendance at FAPT, Child Specific Team pre-meetings
- Significant Redesign starting FY16
- Graduated Review – most attention to RTC requests
- MDT and UR for service authorization

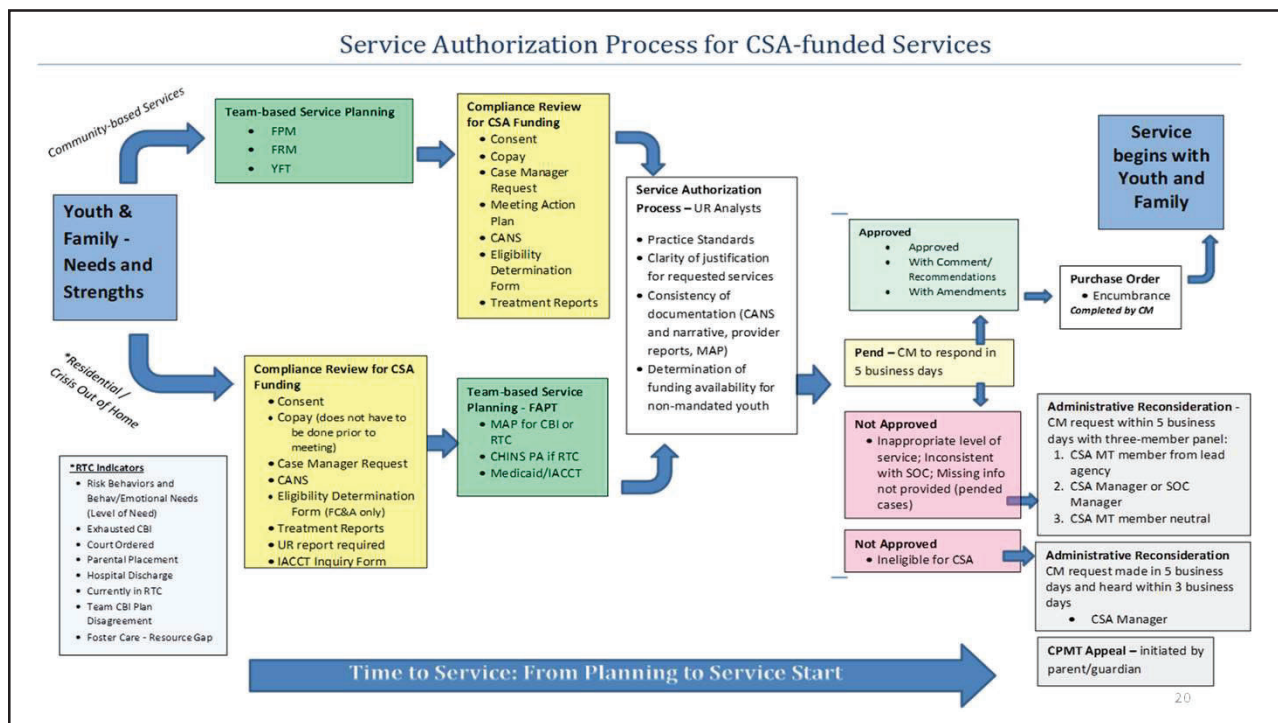


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CSA Requirements for All Services

- Parental contribution assessment
- Contracted provider
- Time-limited, self-sustaining, natural supports
- Use of Medicaid, private insurance, other resource first
- CANS
- Fiscally accountable, efficient
- Least restrictive



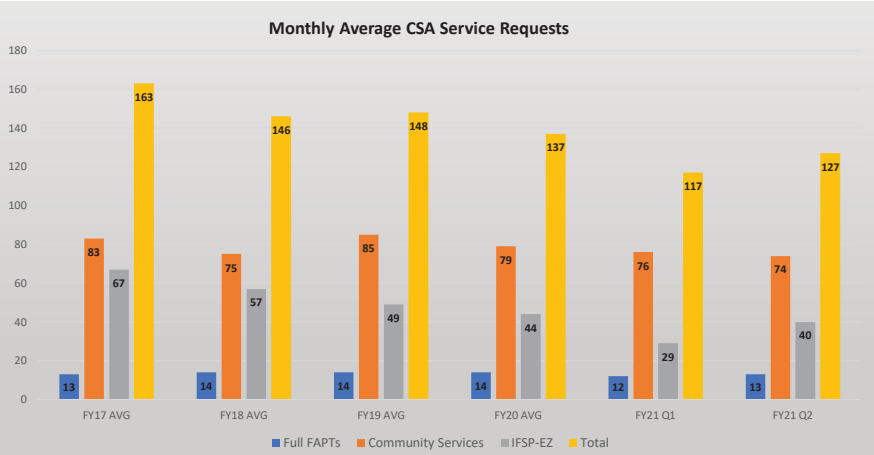
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From October-December (FY21 Q2) there were a total of **380** service requests processed by CSA:

- **40** requests for FAPT meetings
- **221** requests for Community Based services (handled by UR analysts)
- **120** requests for services via the IFSP-EZ (consent agenda items for FAPT review)

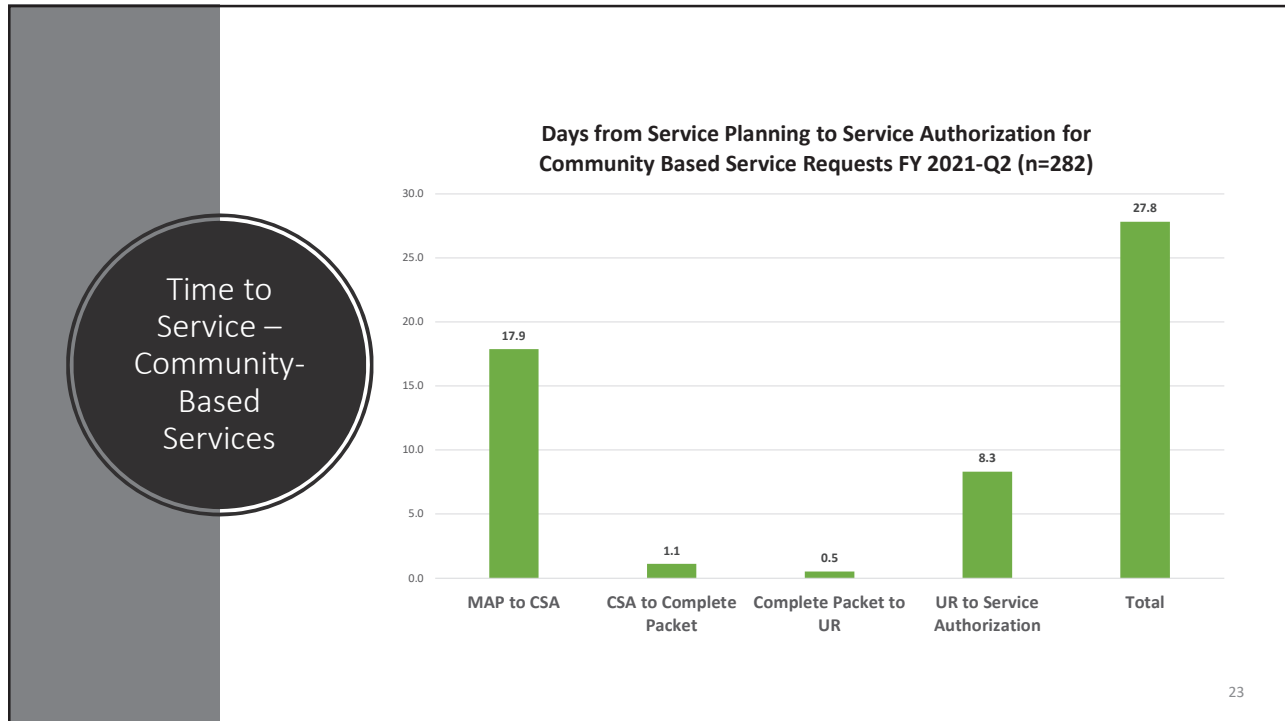
CSA Service Request Volume



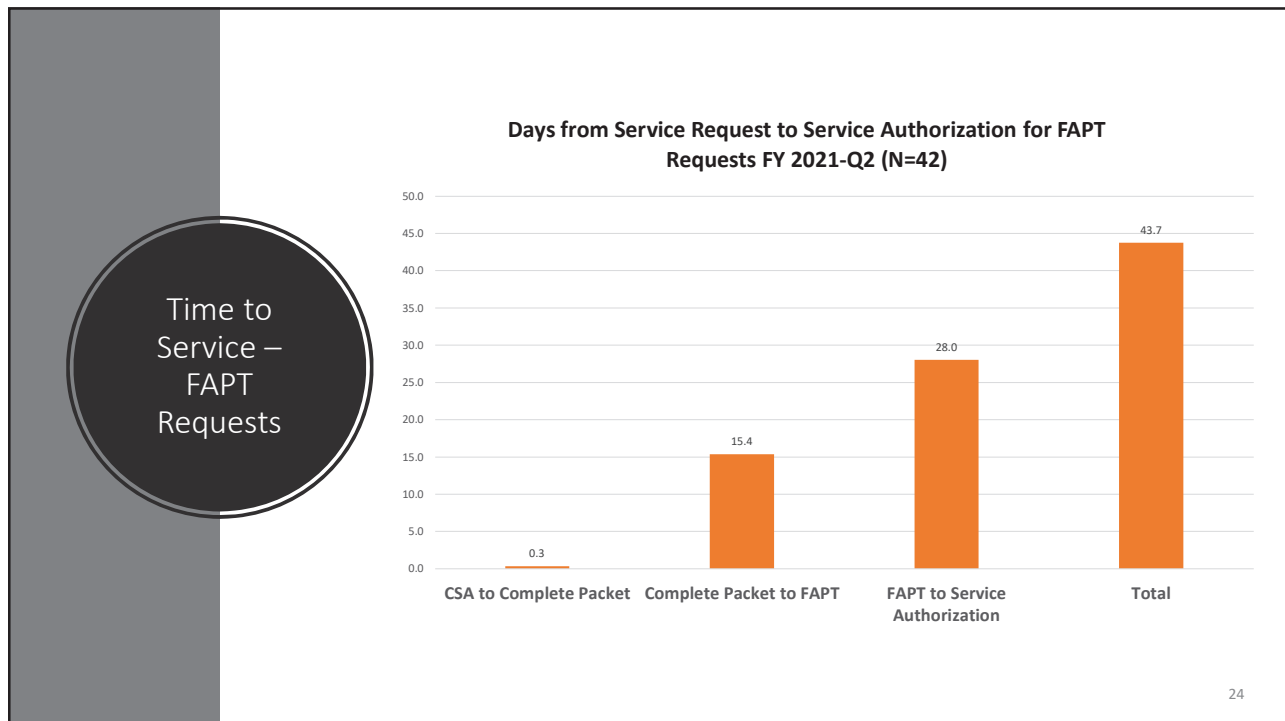
Period	Full FAPTs	Community Services	IFSP-EZ	Total
FY17 AVG	13	83	67	163
FY18 AVG	14	75	57	146
FY19 AVG	14	85	49	148
FY20 AVG	14	79	44	137
FY21 Q1	12	76	29	117
FY21 Q2	13	74	40	127

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Utilization Review



Team



Reports and
Recommendations



Consultations



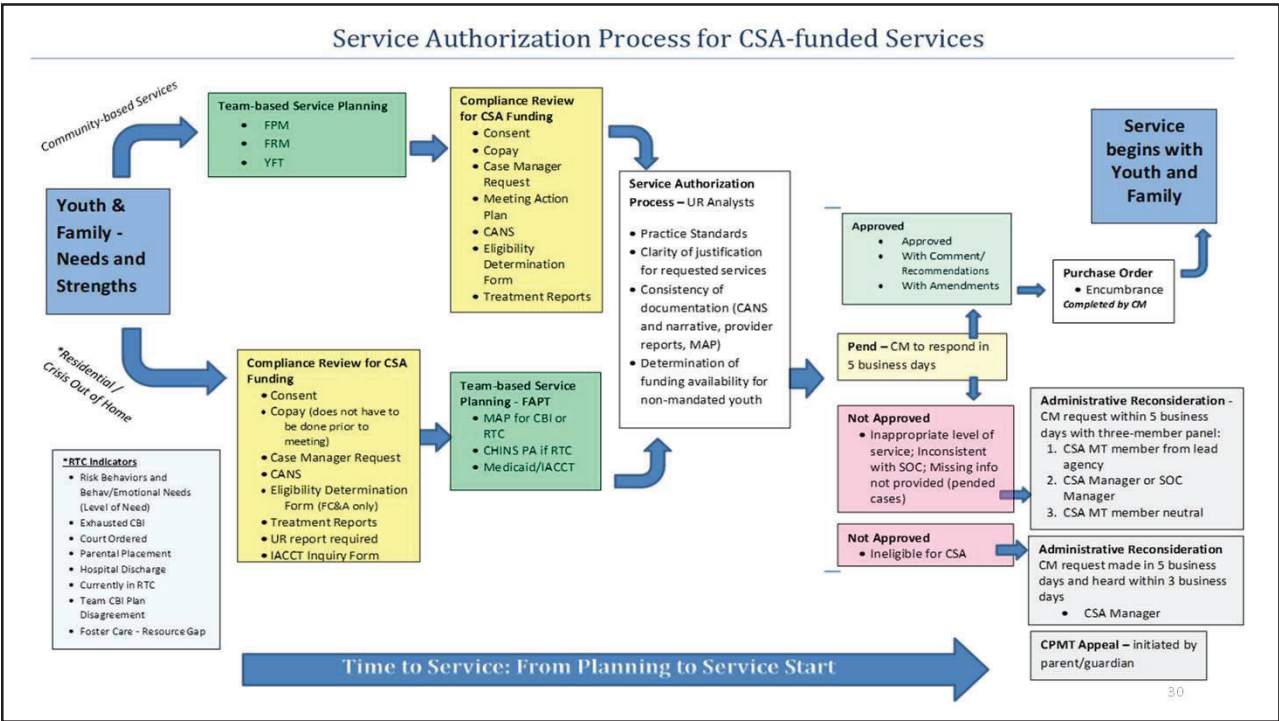
Documentation

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Service Authorizations

- Delegated authority by CPMT
- IT system used to document authorization
- Case manager selects provider and requests Purchase Order

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Utilization
Review for
Case
Managers

CASE MANAGEMENT JOB AIDE

What is UR and why are they calling me?

Utilization review (UR) is a formal assessment of the necessity, efficiency, and appropriateness of the services and treatment plan for an individual. UR asks, "Is it the right service, at the right time, with the right provider?" UR also provides a method for assessing the quality of services, performance improvement, and tracking of provider treatment outcomes across the CSA system. When determining your plan of care, consider the following:

1. Collaboration

Is there evidence of **effective collaboration** among key members, including the youth and family? Is the youth and family in agreement with the plan? Is there any disagreement among team members? Do you have the right people on the team?

2. Progress and Barriers

If request is for an extension, identify **progress towards goals and barriers to progress**. Are the services in place effective? Why or why not? If there is no progress or worsening symptoms and behaviors, what will be different this time? What changes have been made to the treatment interventions? Consider changes in CANS scores.

3. Supports

For RTC placements, what **supports and preparations** are needed in the home and community in order for the youth to return home in a timely manner? Consider how often is the family visiting and participating in family therapy. Have there been any home passes?

4. Best Match

Is the provider the **best match** for the youth, family, and situation? If not, have you considered a different provider? Sometimes the service is right, but there is a mismatch in provider. If what you're doing isn't working, you need to try something new. More of the same is unlikely to produce a different result.

5. Strengths and Needs

What are the **strengths and needs** of the youth and family? What are the actionable CANS scores that need to be considered in the service plan? Identify strengths and natural/community supports that may be accessed to address the needs. Consider level of risk when determining level of care. What is the least restrictive setting that will keep the youth, family, and community safe?

6. Least Restrictive

Have **least restrictive options** been tried? Have private insurance options been exhausted? For RTC consideration, has an intensive community based plan been attempted? Intensive community based services include ICC, home-based services, intensive out-patient, day treatment, and partial hospitalization programs with adjunct interventions such as mentoring, recreational activities, and other natural supports.

7. Transition Plan

Is there a **transition plan**? Discharge planning and termination begins at the start of services. What is the estimated length of service, and what preparations are being made to prepare the youth and family to step-down to less restrictive services? Be sure to include community programs such as school-based programs, prevention programs, recreational programs, and volunteering/employment opportunities. Also include linkage to the families' natural supports such as extended family and faith based communities.

8. Evidence and Trauma

Use of **evidence and trauma informed practices**. Case conceptualization is key to identifying appropriate, effective interventions. What is the theoretical rationale for the interventions chosen on the care plan? If there is a history of trauma, are all providers and team members trauma informed? If not, who could provide this education to the team?



Continuous Quality Improvement

- Quality Assurance & Monitoring
- Training
- Communication



QA & Monitoring Structure

- Oversight and guidance
 - CPMT
 - CSA Management Team
- Operational
 - CSA staff – 1 staff fully dedicated to CQI work, percentage of 1 other position
 - Contracts staff – assist with developing contracts and communication with providers
 - Case Managers

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Quality Assurance and Monitoring Plan



Developed and implemented in 2020, built on existing work



Includes work of case managers and system partners



Moves work from being primarily reactive to being more proactive

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Quality Assurance and Monitoring Plan Tasks

- Parent satisfaction surveys – done by 3rd party company – has increased response rate, continuous rather than annually, able to pinpoint individual provider responses
- Review and tracking of Serious Incident Reports
- Review, assessment, and monitoring of provider Corrective Action Plans
- High Fidelity Wraparound monitoring – WFI, DART, technical assistance by VWIC
- Monitoring of Medicaid eligibility documentation requirements
- Service summaries – done every 2 month, allow case managers to report concerns about hours, services, contract non-compliance
- Monitoring of monthly/quarterly progress reports – timely submission and meet all contract reporting requirements
- Site visits – contract monitoring and quality assurance
- FRM/FAPT survey of family satisfaction with process
- Case Support monitoring
- Follow up on parental contribution concerns from parents
- Ad hoc follow up on issues not covered above



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Corrective Action Plan Process

- ❖ Corrective Action Plan Process (CAP) is initiated when CSA Management Team (MT) determines CAP is required by provider based on information presented to MT through Serious Incident Reports (SIRs) or agency/CSA staff report.
- ❖ Department of Procurement and Materials Management (DPMM) contracts staff notifies Provider that a CAP is being requested and is provided the CAP template.
- ❖ CSA Continuous Quality Improvement (CQI) staff will do an initial review of CAP to determine all findings have been addressed and if needed, backup documentation has been provided.
- ❖ CSA CQI staff have 3 business days from receipt of CAP to review for appropriateness of response. This will initiate one of two possible actions, listed below:
 - ❖ CAP is accepted by CSA CQI staff
 - ❖ CSA CQI staff will develop a monitoring plan
 - OR**
 - ❖ CAP is not accepted by CSA CQI staff
- ❖ DPMM contracts staff will notify provider of any insufficiencies in CAP response.
- ❖ Final CAP and monitoring plan is presented to CSA MT for acceptance and approval.
- ❖ Within 5 business days of CSA MT decision, DPMM will notify provider that CSA MT has accepted the provider's CAP and will include the monitoring plan approved by the CSA Management Team.
- ❖ CSA CQI staff will implement the monitoring plan.
- ❖ CAP monitoring results are reported to CSA MT by CSA CQI staff.
- ❖ CSA MT determines if CAP actions have been adequately completed. If yes, CAP is "closed".
 - ❖ If CAP monitoring identifies continuing issues, CSA MT will discuss subsequent action.
- ❖ DPMM notifies provider of any ongoing concerns or that CAP is closed.

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Corrective
Action Plan
Template

Fairfax-Falls Church Children's Services Act
Corrective Action Plan

Provider Name	
Provider Contact Name	Contact Title
Contact Phone	Contact Email

Finding: Finding number 1			
1	2	3	4
CORRECTIVE ACTION Corrective action must include: • Steps to correct the specific concerns identified by CSA Management Team/reviewers. • Steps to identify and correct similar issues which may be present within the agency but not specifically identified by CSA Management Team/reviewers. • If corrective action includes staff meetings and trainings, backup documentation must be submitted (date/time of meeting/training, attendance/sign in sheet. Additionally, for trainings, name and credentials of trainer, name of training.)	QUALITY ASSURANCE AND MONITORING • Include steps to monitor status and prevent recurrence of similar problems in the future. • Each corrective action step in column 1 must have corresponding quality assurance/monitoring activity listed in this column.	NAME & TITLE OF RESPONSIBLE PERSON • Ensure each corrective action step in column 2 has the name and title of the person responsible for coordinating corrective action and monitoring for quality assurance.	TARGET DATE FOR COMPLETION • If multiple actions are associated with a finding, list target date for each action. All corrective actions must be completed within 45 days of submission of CAP to CSA Management Team unless an extension is granted.
1			
2			

Finding: Finding number 2			
1	2	3	4
CORRECTIVE ACTION Corrective action must include: • Steps to correct the specific concerns identified by CSA Management Team/reviewers. • Steps to identify and correct similar issues which may be present within the agency but not specifically identified by CSA Management Team/reviewers. • If corrective action includes staff meetings and trainings, backup documentation must be submitted (date/time of meeting/training, attendance/sign in sheet. Additionally, for trainings, name and credentials of trainer, name of training.)	QUALITY ASSURANCE AND MONITORING • Include steps to monitor status and prevent recurrence of similar problems in the future. • Each corrective action step in column 1 must have corresponding quality assurance/monitoring activity listed in this column.	NAME & TITLE OF RESPONSIBLE PERSON • Ensure each corrective action step in column 2 has the name and title of the person responsible for coordinating corrective action and monitoring for quality assurance.	TARGET DATE FOR COMPLETION • If multiple actions are associated with a finding, list target date for each action. All corrective actions must be completed within 45 days of submission of CAP to CSA Management Team unless an extension is granted.
1			
2			

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Wraparound
Fidelity
Monitoring

- Use of established monitoring tools (WFI, DART) from the Wraparound Evaluation & Research Team (WERT) based in the University of Seattle
- Done locally by CSA staff from FY2018 to FY2020; moved to Virginia Wraparound Implementation Center (VWIC) for FY21
- ICC Stakeholders Workgroup is used to develop monitoring structure and troubleshoot challenges
- WFI low results lead to an inability to make generalizations about the efficacy of the program; however, the results can still be used in continuous quality improvement plans

Year/Cycle	Families Surveyed	Responses
FY18*	16	4 (25%)
FY19-Cycle 1	19	11 (58%)
FY19-Cycle 2	15	8 (53%)
FY20-Cycle 1	35	15 (43%)
Total	85	38 (45%)

*Survey activities began in the Spring of 2018 therefore only one survey cycle was completed in FY2018.

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Using the Data

- Data reports to CPMT – SIRs, FAPT & UR Residential Entry, Quarterly Reports
- Negative trends are addressed directly with the provider
- Plans to share family satisfaction survey results with providers
- Fidelity monitoring data is shared with wraparound providers to improve service delivery
- Plans to roll up data collected into a “provider profile” that will be shared with case managers to help in provider selection
- Provider profile will be shared with providers

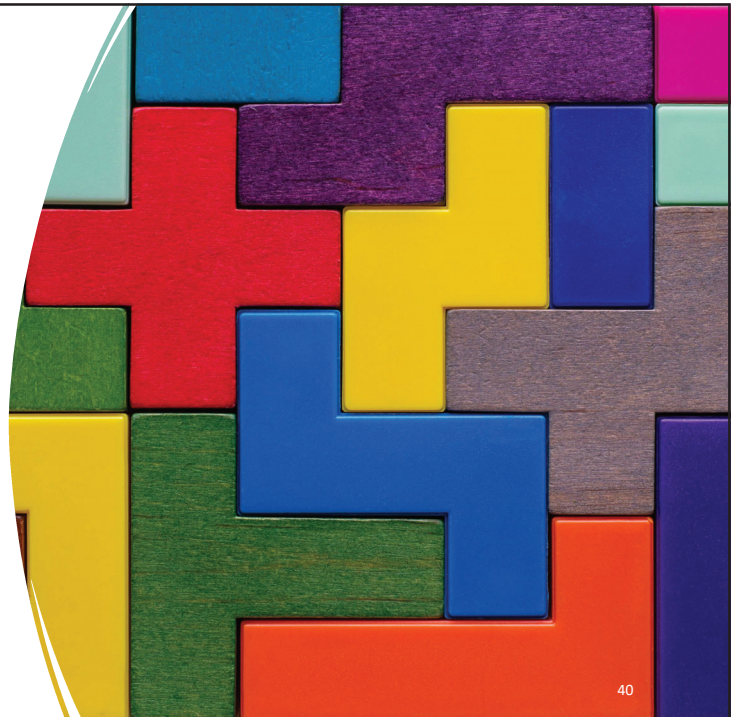


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Training Goals

- Ensure system partners are familiar with CSA system of care philosophy, processes and policy
- Build on skills and knowledge of case managers so they can best serve youth and families
- Ensure families understand CSA processes



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Training

Mandatory Training:

- Part 1: System of Care Principles & Standards
- Part 2: Facilitating Family Resource Meetings
- Part 3: Accessing CSA Services
- CANS certification (online at Praed website)

Additional Trainings

- Parental Contribution 101
- Evidence-based Treatments (for case managers and parents)
- CANS Boosters, Use of CANS in Treatment Planning
- Equity and Implicit Bias
- Generational Trauma in African Americans

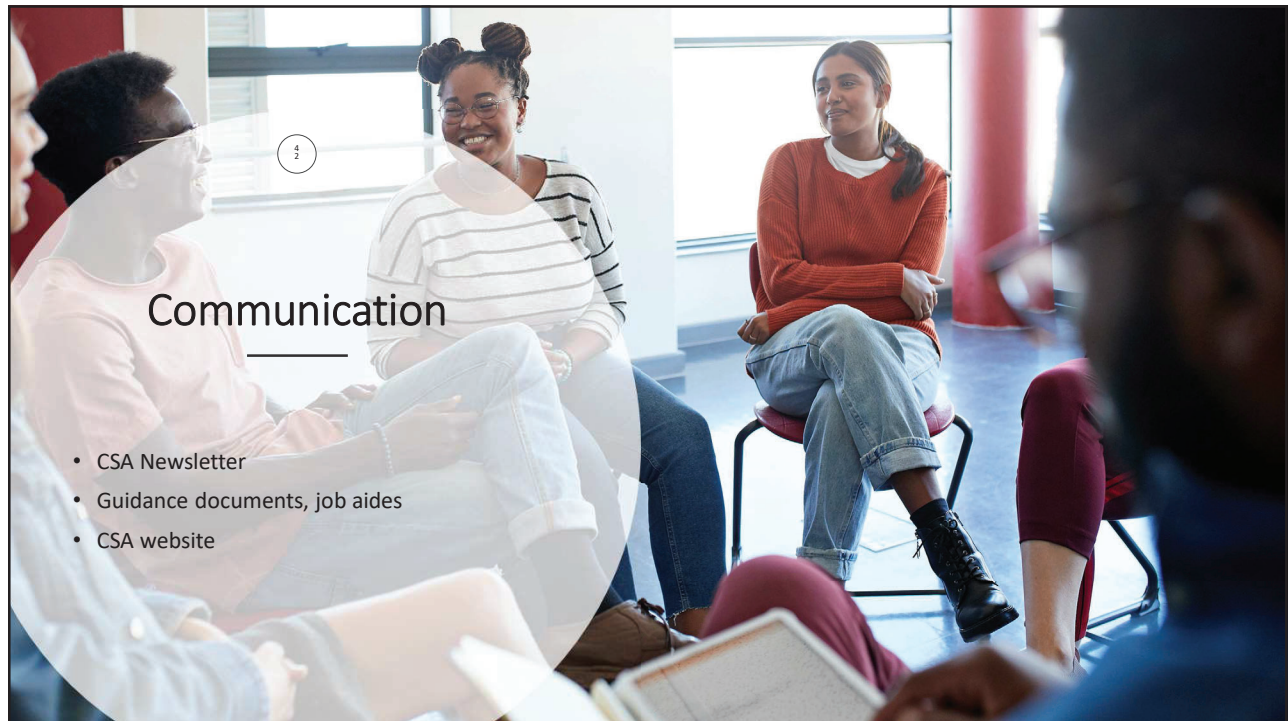


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Communication

- CSA Newsletter
- Guidance documents, job aides
- CSA website



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CSA Newsletter

Newsletter

Children's Services Act Program

UPDATED CONSENT TO EXCHANGE INFORMATION FORM

If you hear CSA Consent Form and shudder a bit, we hear you. Form requirements can sometimes seem unwieldy and frustrating. Which is why we're happy to share that the CSA Consent Form has been updated to be a better, less confusing form for families to complete and you, as case managers, to explain.

Keeping families informed on how their information is being used is important to all of us, so the updated form clearly lays out which organizations will be exchanging client information. The list of records that may be shared has also been streamlined from 16 options to 8. This is hopefully less confusing for everyone.

And the best thing of all, the CSA Consent can now be in effect from the date of signature until the child reaches the age of 18 or until the end of the child and family's participation in CSA services. Case managers will no longer have to worry about keeping up with expired consent!

The updated Consent Form is available on the CSA public and Sharepoint sites in seven languages—Arabic, Chinese, English, Farsi, Korean, Spanish and Vietnamese. To watch a brief video that walks you through the updates to the form, please visit www.csa.com

NOVEMBER 2021

IN THIS ISSUE

- Updated Consent to Exchange Information
- Meet Our New UR Analyst
- Recruiting for the Fairfax County Youth Advisory Council
- Healthy Minds Fairfax's New Program for Transition Age Youth

ENTERING CANS RATINGS IN CANVAS

Case managers are expected to enter CANS (Child and Adolescents Needs and Strengths) ratings into the state information system—CANVAS. Visit the Office for Children's Services website for CANVAS training videos and user manual — <https://www.csa.virginia.gov/Cans/index>.

Creating a CANVAS account is easy — just complete the [CANVAS New Case Manager Account form](#) and return it to CSA along with your CANS Training Certificate.

UPDATE: CANS "BUBBLE" FORMS TO BE REMOVED FROM CSA WEBSITES ON SEPTEMBER 1, 2021

As you know, the use of the state CANVAS system is required for all CANS assessments. Therefore, the CANS "bubble sheet" forms on the CSA website(s) will be taken down on September 1, 2021. If you have



Questions/Concerns About Possible Fraud?

If you have concerns about service delivery, the Service Summaries distributed by CSA are a good mechanism for reporting those concerns. CSA program staff are also always available to discuss any questions or concerns you may have.

Additionally, a more formal process can be followed by contacting the Fairfax County Fraud Hotline at 703.787.3243 to report an allegation. The calls are reviewed and followed up on by the Internal Audit Office.


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Case Manager Job Aide on Evidence Based Treatments

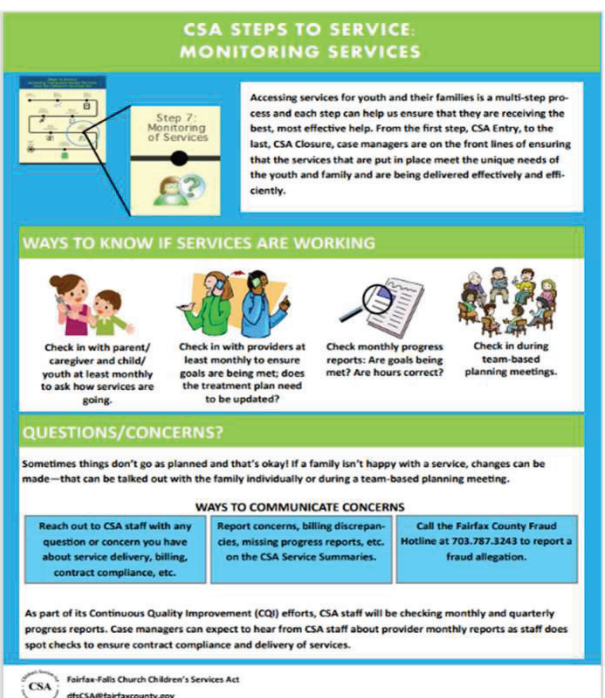
Parent-Child Interaction Therapy (PCIT)	MATCH-ADTC	Dialectical Behavioral Therapy (DBT-A)	Core Competencies in Cognitive Behavioral Therapy (CBT)	Cognitive Behavioral Therapy (TF-CBT)	Functional Family Therapy (FFT)	Multisystemic Therapy (MST)
Parent training/coaching in a clinic setting for young children with behavioral problems	A Modular Approach to Therapy using CBT for Children with Anxiety, Depression, Trauma, and Conduct Problems	For youth with emotion regulation and high risk behavioral struggles	For adolescents with anxiety, depression, trauma, substance use and conduct problems	Treatment for youth who are impacted by trauma and their families offered in a variety of settings	Intensive in-home family therapy for youth with behavioral or emotional problems including substance use	Intensive community-based treatment for youth with disruptive behavior, mood, and/or substance use that may result in community sanctions
REFERRAL CRITERIA	REFERRAL CRITERIA	REFERRAL CRITERIA	REFERRAL CRITERIA	REFERRAL CRITERIA	REFERRAL CRITERIA	REFERRAL CRITERIA
<ul style="list-style-type: none"> Ages 2-7 Children experiencing relational problems with caregivers Refusal/Defiance of adult requests Difficulty in childcare/school settings Easy loss of temper F D Q B 	<ul style="list-style-type: none"> Ages 6-13 Mood/Depressive Disorders Anxiety Disorders Post-Traumatic Stress Disorder (PTSD) Disruptive/Externalizing Behavioral Struggles 	<ul style="list-style-type: none"> Ages 7 and above Mood lability or frequent shifts in mood Struggle managing anger Unstable relationships Efforts to avoid actual or perceived loss 	<ul style="list-style-type: none"> Ages 13-18 Mood/Depressive Disorders Anxiety Disorders Post-Traumatic Stress Disorder (PTSD) Disruptive/Externalizing Behavioral Struggles, high risk behaviors 	<ul style="list-style-type: none"> Ages 3-21 Youth who have experienced trauma such as: <ul style="list-style-type: none"> Sexual Abuse Domestic Violence Traumatic Grief Disasters 	<ul style="list-style-type: none"> Ages 11-18 Caregiver must agree to attend all sessions Externalizing Adolescent Behavior <ul style="list-style-type: none"> Conduct Disorder Oppositional Defiant Disorder 	<ul style="list-style-type: none"> Ages 11-17 At risk of being removed from home due to disruptive, delinquent, substance-using, and antisocial behavior Youth who have significant emotional and behavioral problems and may cement
<ul style="list-style-type: none"> Resistant or unresponsive treatment preferences At least one caregiver willing to attend weekly sessions regularly and with ability to practice at least 3 times weekly with the child 	<ul style="list-style-type: none"> Spectrum Disorder (ASD), or eating disorder Sexually harmful behaviors Acute suicidality 	<ul style="list-style-type: none"> Feelings of emptiness Dissociation 	<ul style="list-style-type: none"> School Refusal/Truancy 	<ul style="list-style-type: none"> Anxiety Externalizing Behavior Problems Relationship and Attachment Sexually Reactive Behavior School Problems Cognitive Problems 	<ul style="list-style-type: none"> Youth have to be in the community or ready to return to the community Youth have to have a family and the family has to be willing to participate 	<ul style="list-style-type: none"> Youth living independently or youth for whom a primary caregiver committed to longer-term care of the youth cannot be identified Youth whose psychiatric needs are the primary reason leading to referral, or who have severe and serious psychiatric issues Actively suicidal and/or homicidal Treatment for sexually offending behavior is primary Youth with moderate to severe difficulties with social communication, social interaction, and repetitive behaviors, which may be captured by a diagnosis on the autism spectrum Youth for whom an intellectual disability is the only influence on
EXCLUSIONARY CRITERIA		EXCLUSIONARY CRITERIA	EXCLUSIONARY CRITERIA	EXCLUSIONARY CRITERIA	EXCLUSIONARY CRITERIA	
<ul style="list-style-type: none"> Caregiver IQ <75 		<ul style="list-style-type: none"> Age 6 and younger Primary diagnosis of psychosis, intellectual disability, Autism Spectrum Disorder (ASD) Active psychosis IQ less than 70, severe learning disabilities and/or cognitive impairment Caregiver inability to participate in family skills based interventions Unwillingness or disinterest in reducing suicidal thoughts, self-harm or other risky behaviors 	<ul style="list-style-type: none"> Age 12 and younger Primary diagnosis of psychosis, intellectual disability, Autism Spectrum Disorder (ASD), or eating disorder Sexually harmful behaviors Acute suicidality 	<ul style="list-style-type: none"> Youth who are acutely suicidal or homicidal 	<ul style="list-style-type: none"> Youth 10 years or below as primary referral Youth has identified family with a shared history, sense of future, and some level of cohabitation Youth is scheduled to be placed outside of the home (RTC, DJJ foster care, etc.) Treatment for sexually offending behavior is primary Youth who have severe psychiatric illness Youth who are currently experiencing 	

Guidance Documents – EBT Resources

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Guidance Document –
Monitoring Services



CSA STEPS TO SERVICE: MONITORING SERVICES

Accessing services for youth and their families is a multi-step process and each step can help us ensure that they are receiving the best, most effective help. From the first step, CSA Entry, to the last, CSA Closure, case managers are on the front lines of ensuring that the services that are put in place meet the unique needs of the youth and family and are being delivered effectively and efficiently.

WAYS TO KNOW IF SERVICES ARE WORKING

- Check in with parent/caregiver and child/youth at least monthly to ask how services are going.
- Check in with providers at least monthly to ensure goals are being met; does the treatment plan need to be updated?
- Check monthly progress reports: Are goals being met? Are hours correct?
- Check in during team-based planning meetings.

QUESTIONS/CONCERNS?

Sometimes things don't go as planned and that's okay! If a family isn't happy with a service, changes can be made—that can be talked out with the family individually or during a team-based planning meeting.

WAYS TO COMMUNICATE CONCERNS

- Reach out to CSA staff with any question or concern you have about service delivery, billing, contract compliance, etc.
- Report concerns, billing discrepancies, missing progress reports, etc. on the CSA Service Summaries.
- Call the Fairfax County Fraud Hotline at 703.787.3243 to report a fraud allegation.

As part of its Continuous Quality Improvement (CQI) efforts, CSA staff will be checking monthly and quarterly progress reports. Case managers can expect to hear from CSA staff about provider monthly reports as staff does spot checks to ensure contract compliance and delivery of services.

Fairfax Falls Church Children's Services Act
dfsCSA@fairfaxcounty.gov

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CSA Website



EBT Job Aides for Case Managers

How do I know which treatment to select for my client? A Case Manager Training on EBTs

Multisystemic Therapy

Functional Family Therapy

Dialectical Behavior Therapy for Adolescents (DBT-A)

Parent Child Interaction Therapy

EBT Job Aides for Case Managers

These Job Aides may be helpful when determining which evidence-based treatment is right for the child/youth and family with whom you are working.

- Evidence-based Treatments funded through the Family First Prevention Services Act and CSA
- Evidence-based Treatments: Core Competencies, MATCH-ADTC, and Dialectical Behavioral Therapy
- Evidence-based Treatments: Combined (includes information from the two documents above)

The below presentation was recorded on Friday, August 14th. While the audience that day was social workers from Fairfax County Public Schools, it provides a general overview of the evidence-based treatments available in the county that are referenced on this page.

Slide deck for August 14, 2020 "New Evidence-based Treatments for a Case Manager's Toolkit" presentation

"New" Evidence-based Treatments for a Case Manager's Toolkit
CHILDREN'S SERVICES ACT PROGRAM
AUGUST 2020

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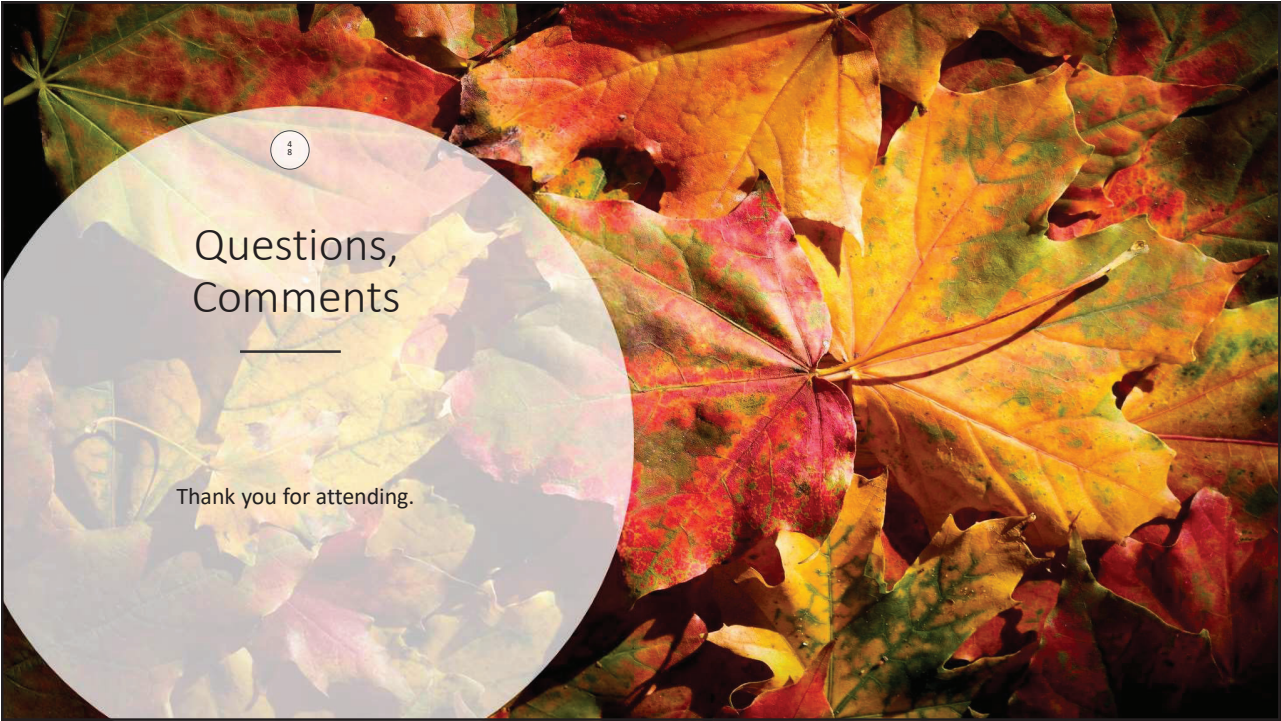
Programmatic Goals

- Reduce Time to Service
 - Use of Technology
- Improve Quality and Effectiveness of Services
 - Promote EBTs
- Promote Equitable Access to Services - Outreach
- Improve Data Analytics and Uses of Data-driven Decisions
- New Behavioral Health Blueprint for County



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Questions,
Comments

Thank you for attending.

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