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

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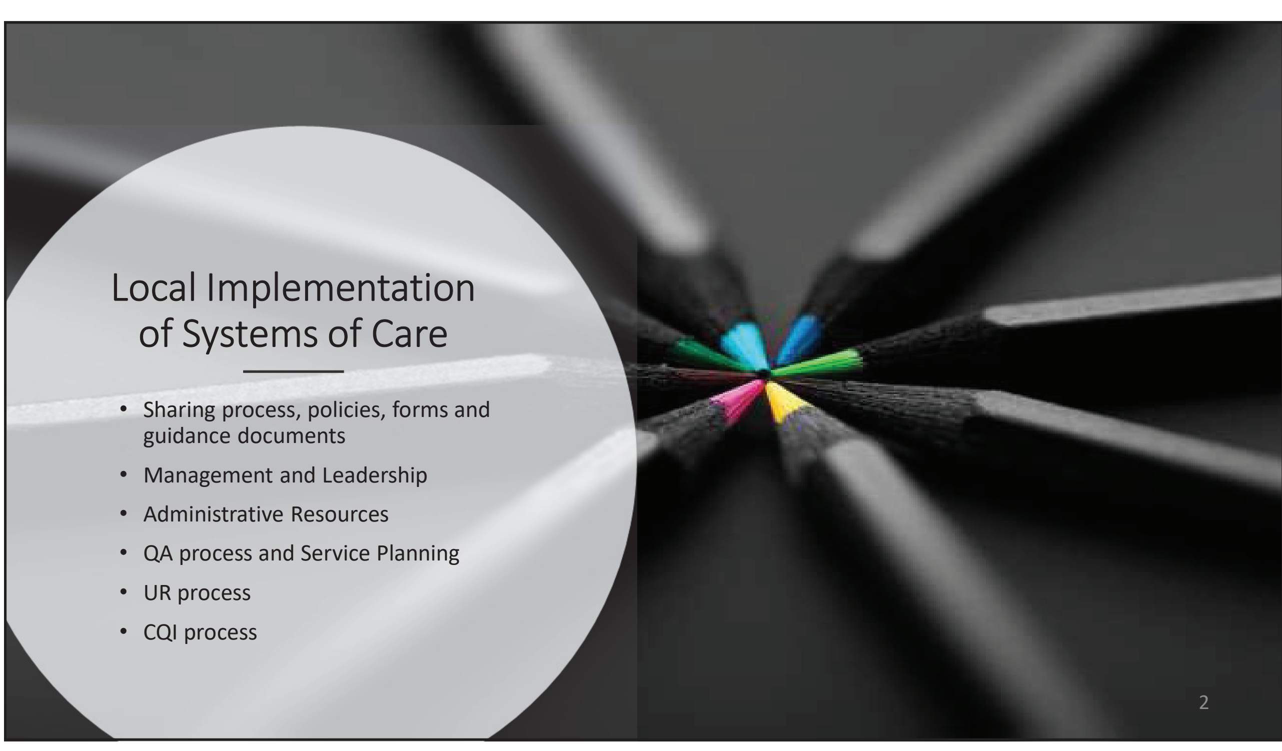

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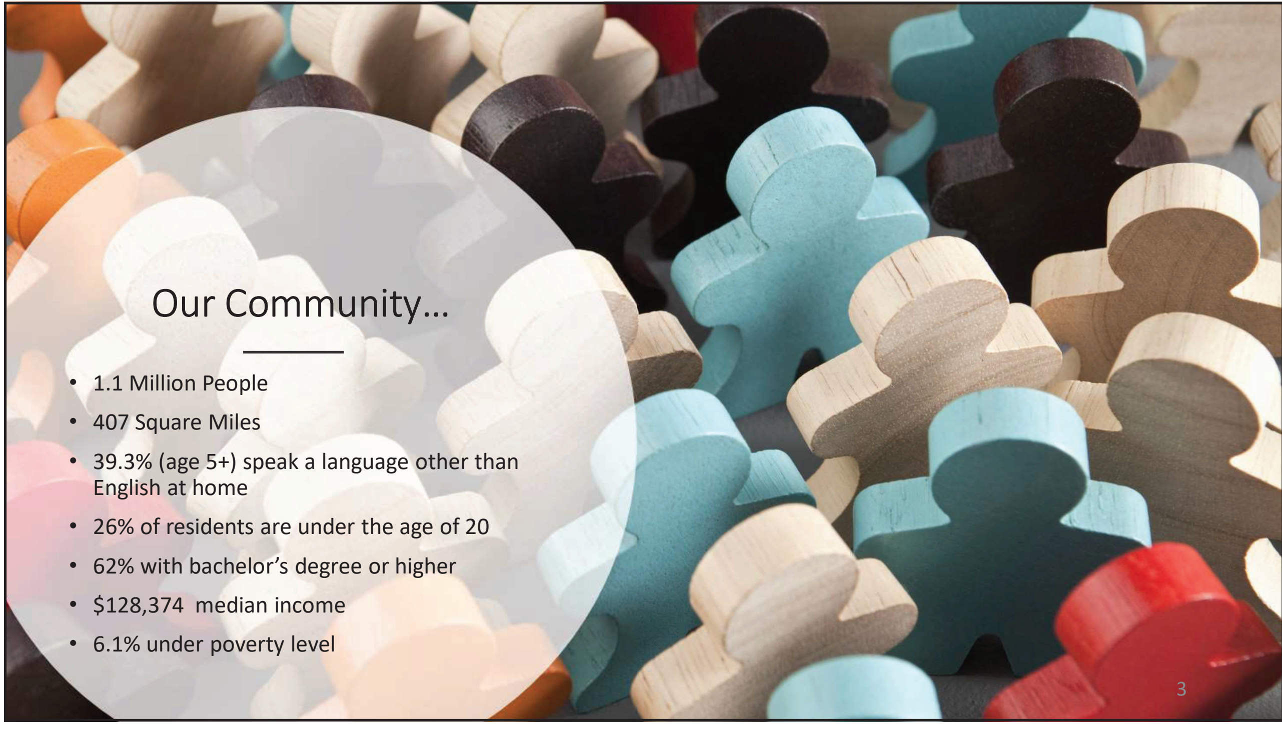

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Our schools serve a diverse student population of more than 178,000 students

- 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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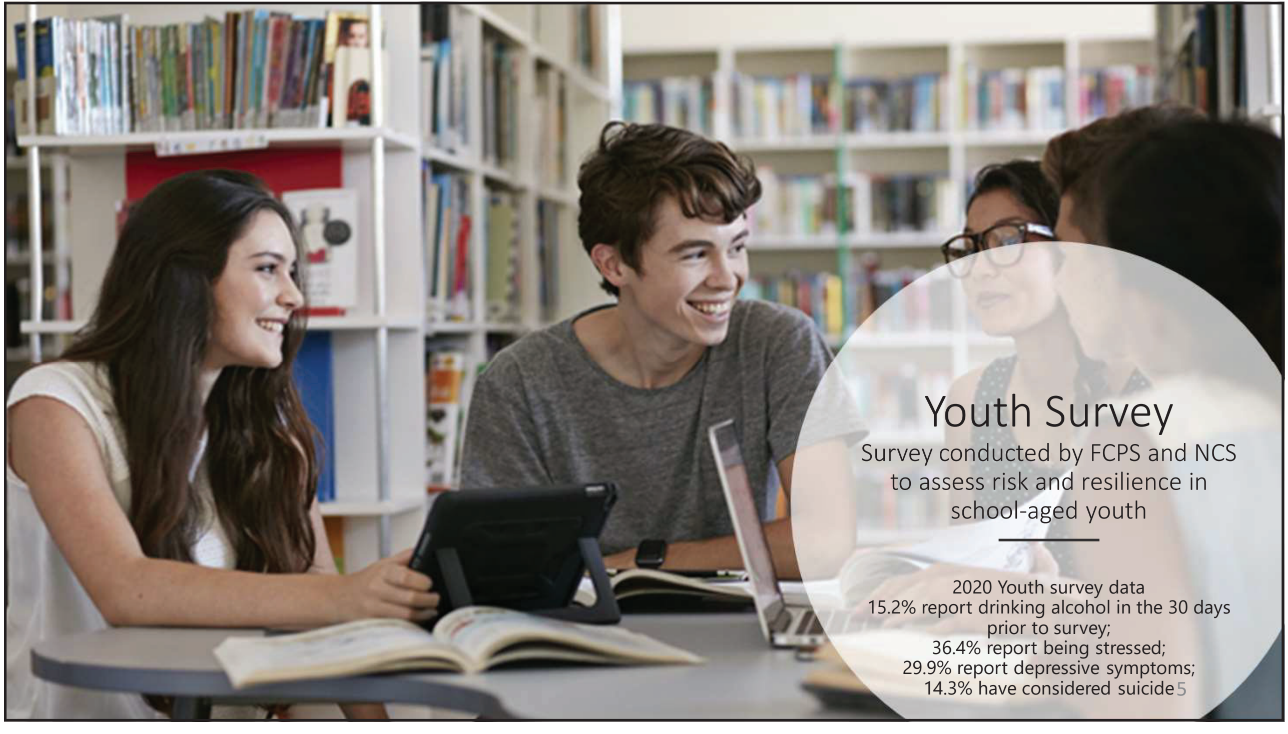

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Fairfax- Falls Church Children's Services Act

- 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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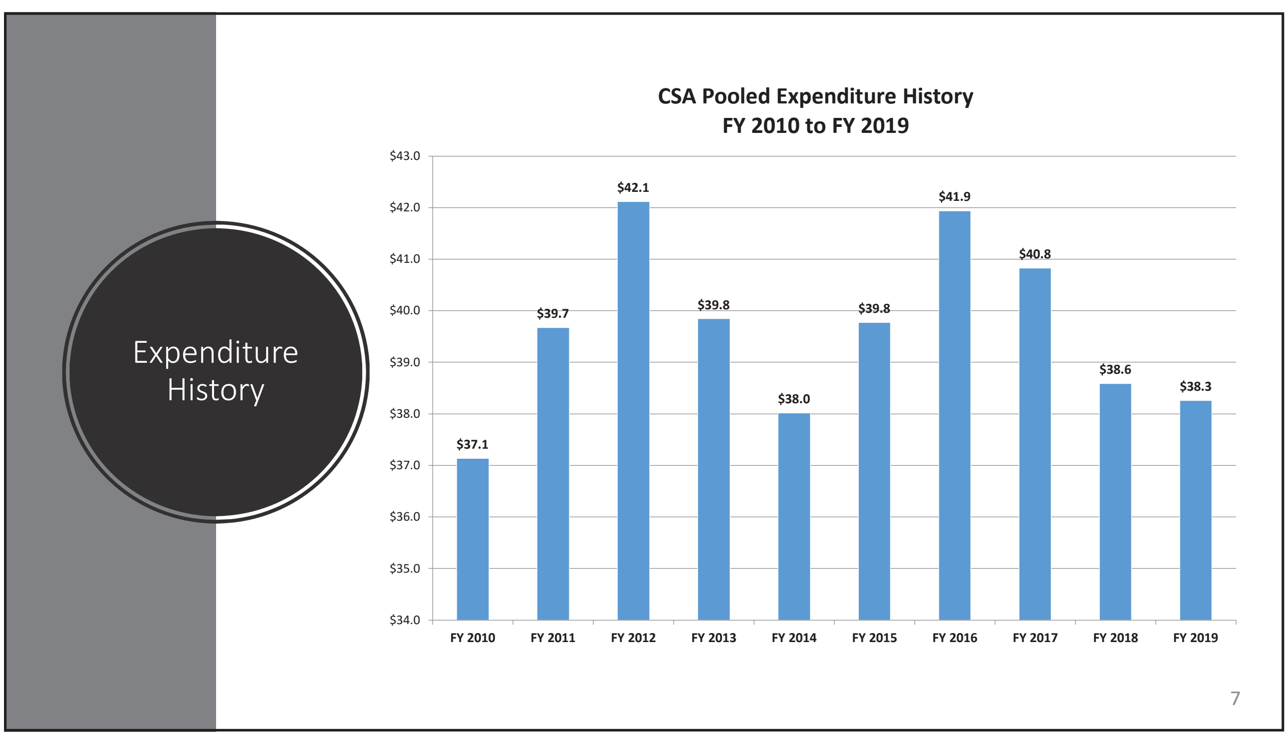

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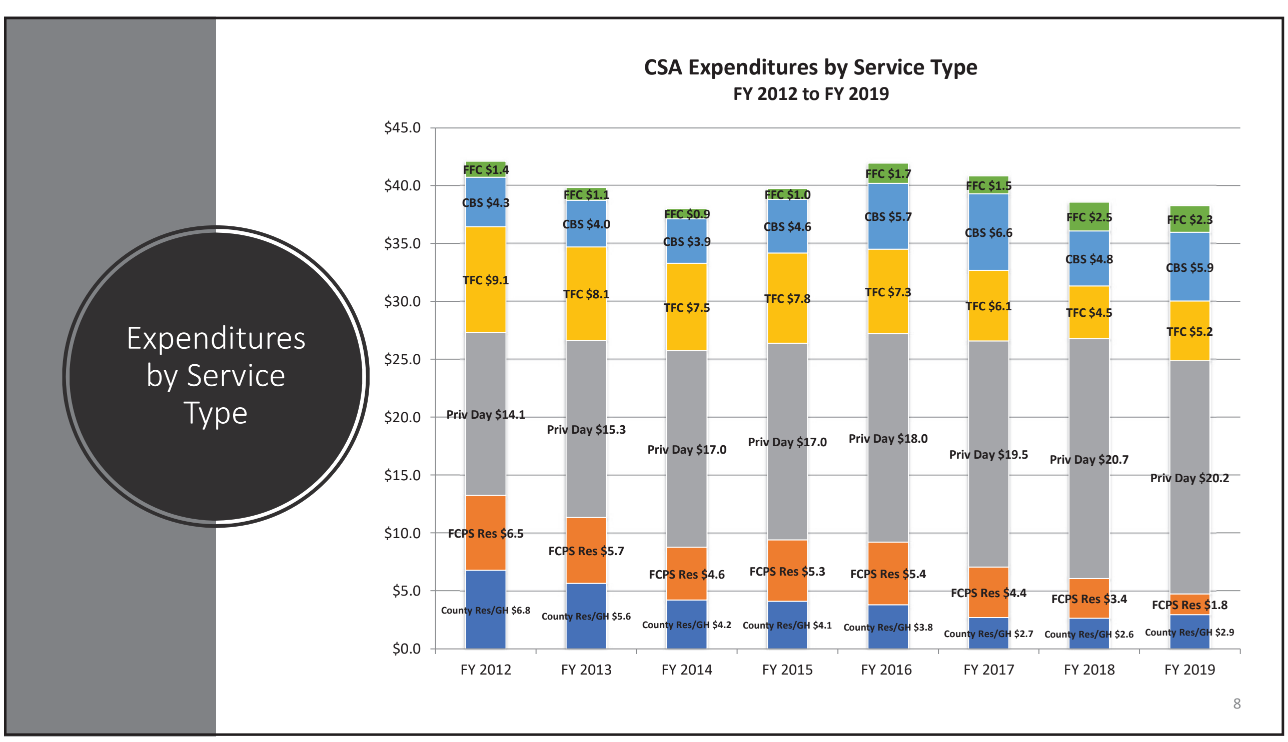

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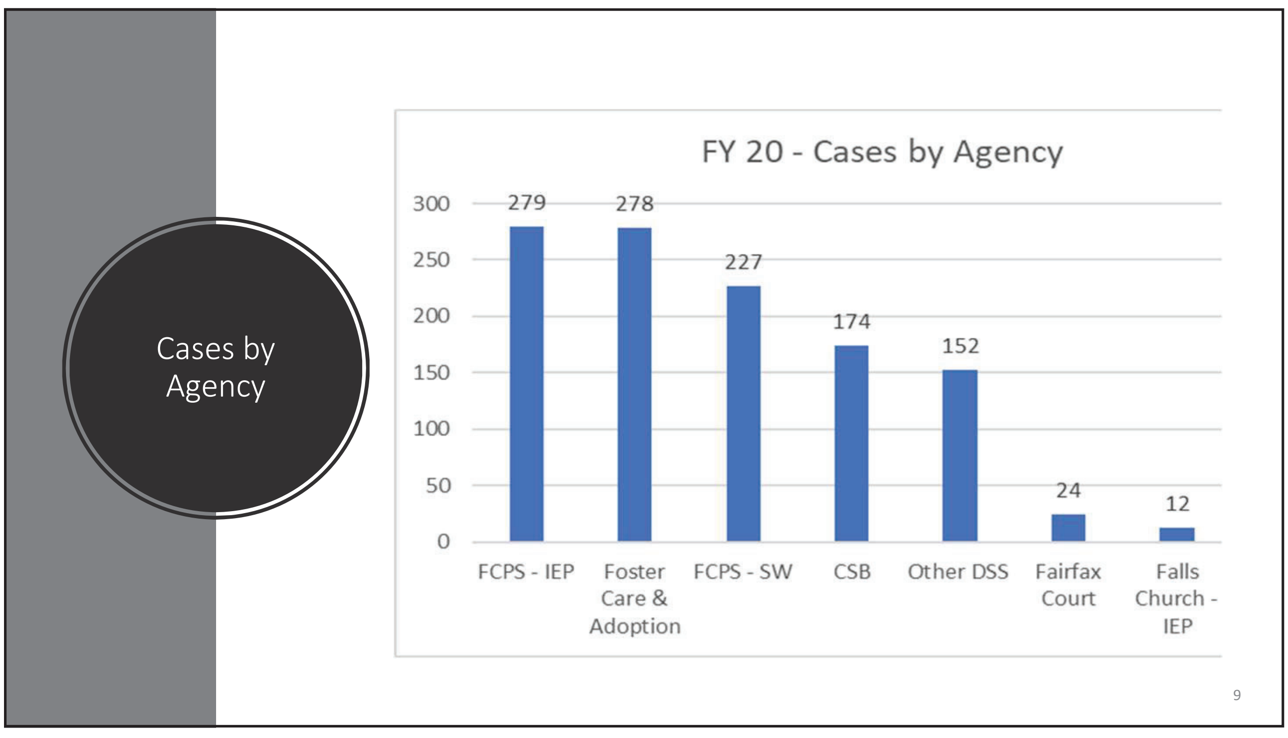

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Our Challenges and Opportunities

- 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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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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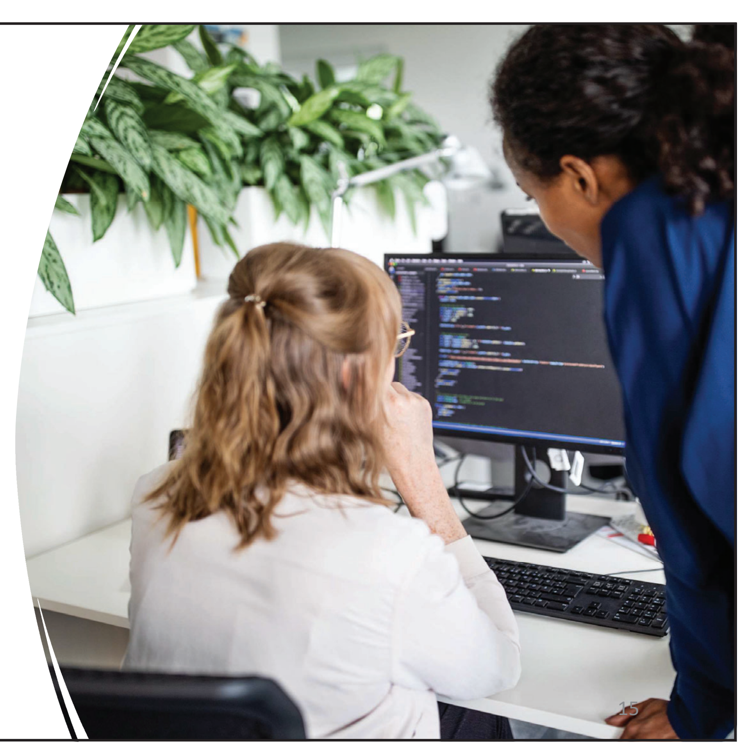
Technology

- 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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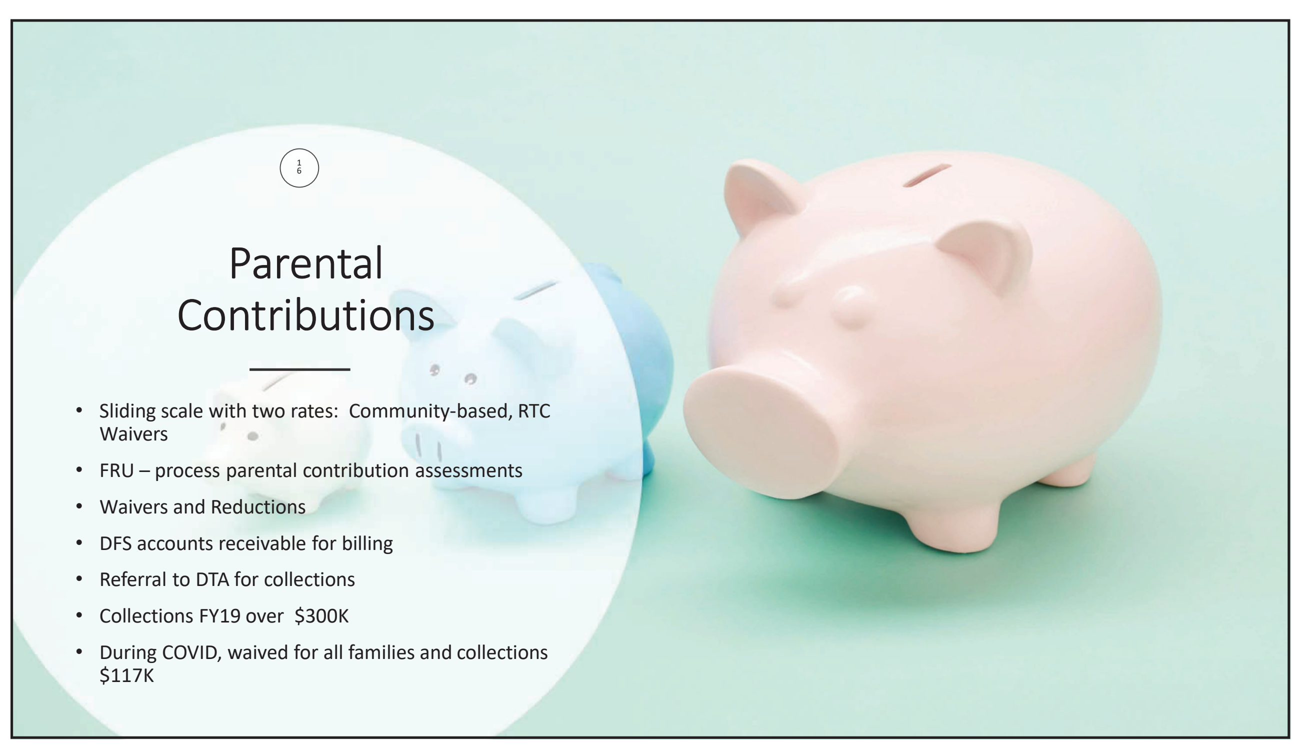

Parental Contributions

- 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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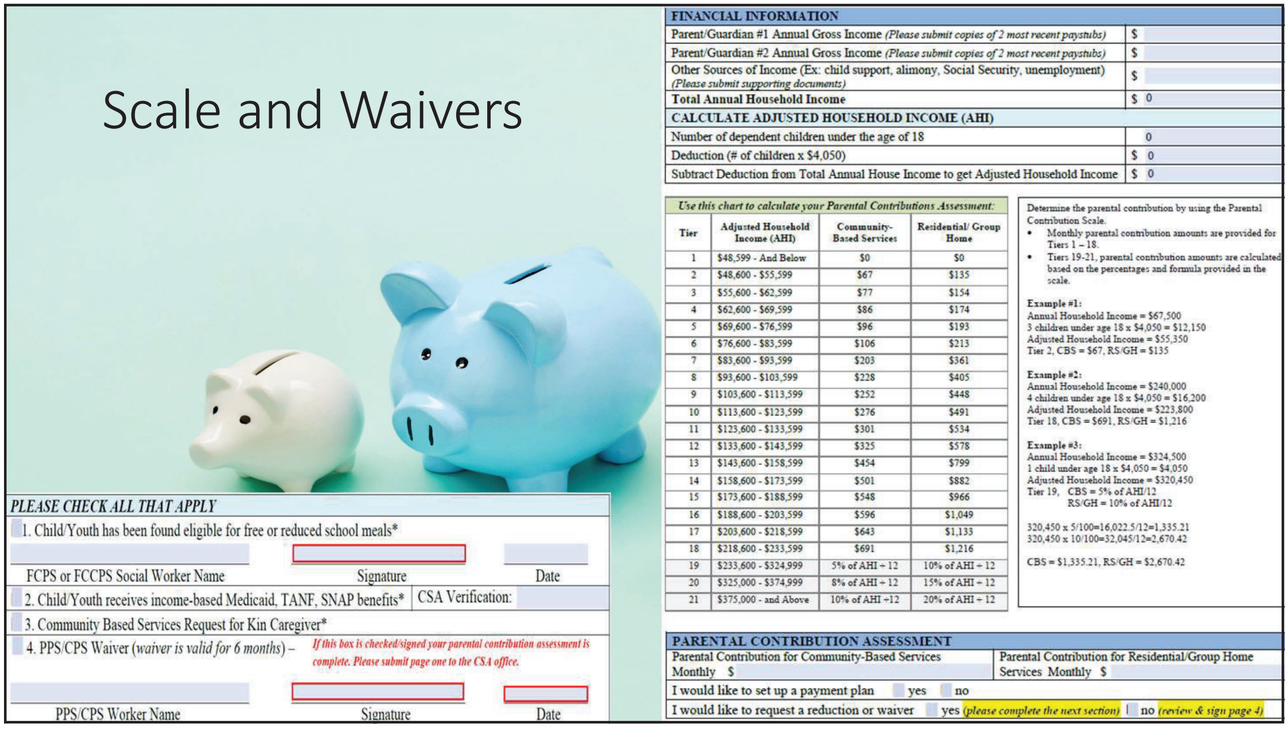

FINANCIAL INFORMATION	
Parent/Guardian #1 Annual Gross Income *(Please submit copies of 2 most recent paystubs)*	$
Parent/Guardian #2 Annual Gross Income *(Please submit copies of 2 most recent paystubs)*	$
Other Sources of Income (Ex: child support, alimony, Social Security, unemployment) *(Please submit 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 House 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

320,450 x 5/100=16,022.5/12=1,335.21
320,450 x 10/100=32,045/12=2,670.42

CBS = $1,335.21, RS/GH = $2,670.42

PLEASE CHECK ALL THAT APPLY

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

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/signed your parental contribution assessment is complete. Please submit page one to the CSA office.*

PPS/CPS Worker Name | Signature | Date

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 ☐ yes ☐ no

I would like to request a reduction or waiver ☐ yes *(please complete the next section)* ☐ no *(review & sign page 4)*

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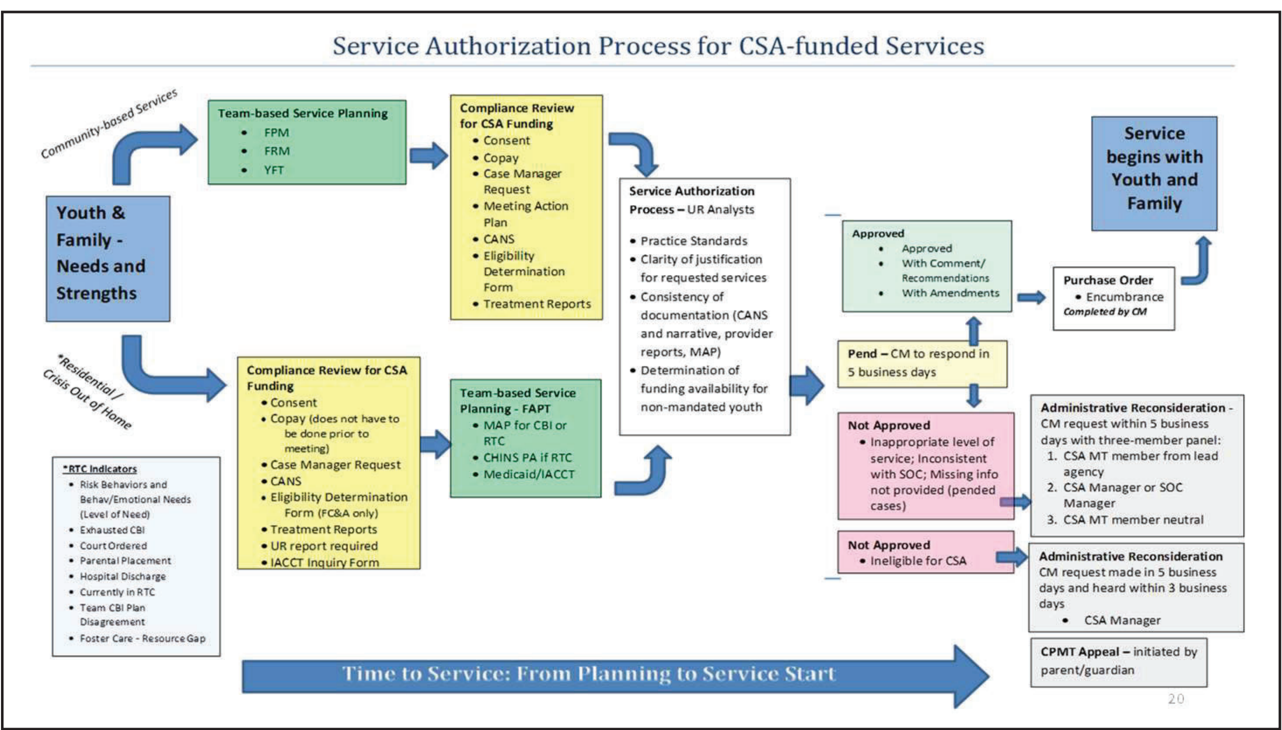

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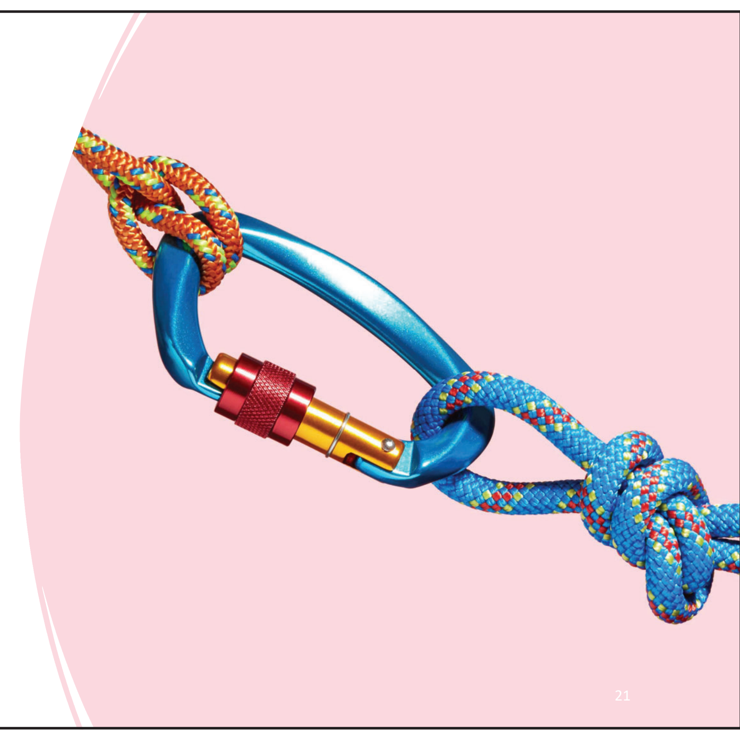
CSA Requirements for All Services

- 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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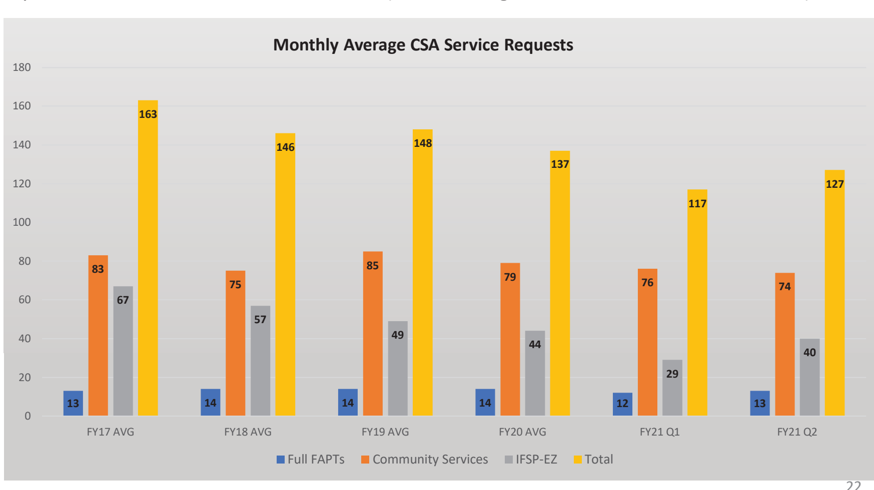
CSA Service Request Volume

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)



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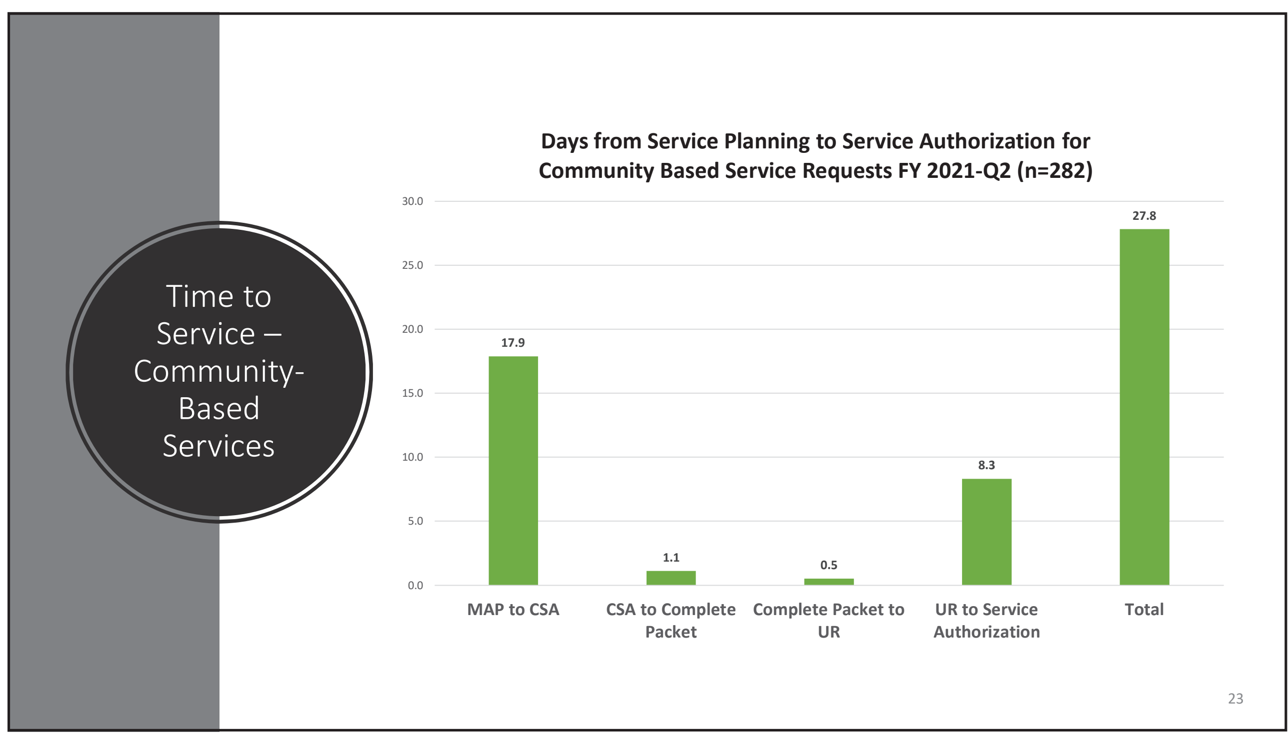

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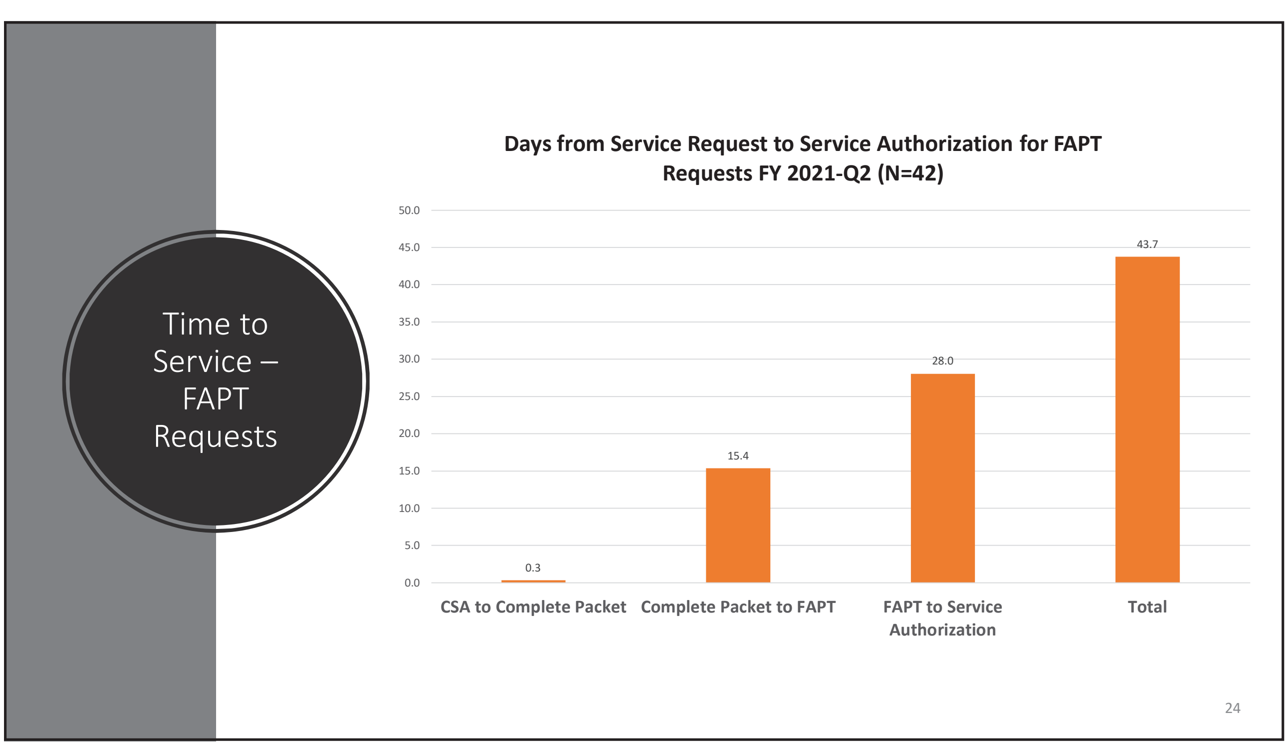

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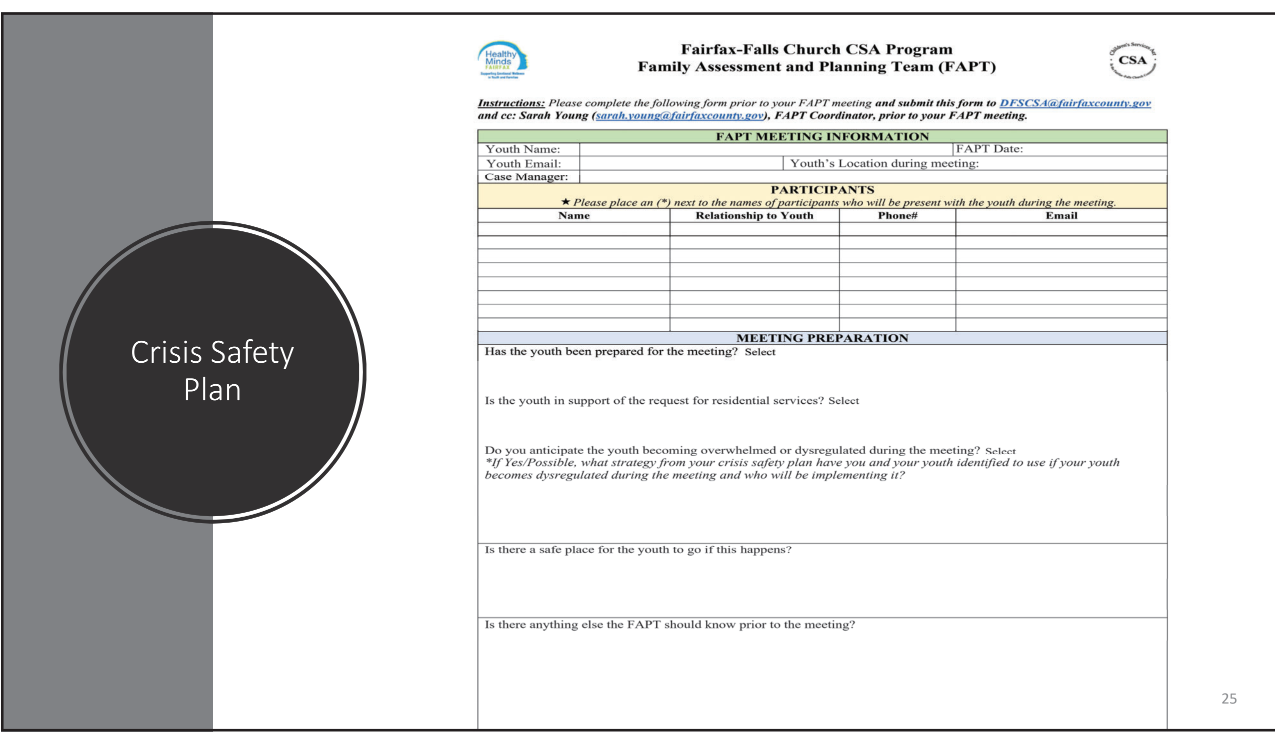

Fairfax-Falls Church CSA Program
Family Assessment and Planning Team (FAPT)

Instructions: *Please complete the following form prior to your FAPT meeting* ***and submit this form to DFSCSA@fairfaxcounty.gov and cc: Sarah Young (sarah.young@fairfaxcounty.gov), FAPT Coordinator, prior to your FAPT meeting.***

FAPT MEETING INFORMATION		
Youth Name:		FAPT Date:
Youth Email:		Youth's Location during meeting:
Case Manager:		

PARTICIPANTS
★ *Please place an (*) next to the names of participants who will be present with the youth during the meeting.*

Name	Relationship to Youth	Phone#	Email

MEETING PREPARATION

Has the youth been prepared for the meeting? Select

Is the youth in support of the request for residential services? Select

Do you anticipate the youth becoming overwhelmed or dysregulated during the meeting? Select
**If Yes/Possible, what strategy from your crisis safety plan have you and your youth identified to use if your youth becomes dysregulated during the meeting and who will be implementing it?*

Is there a safe place for the youth to go if this happens?

Is there anything else the FAPT should know prior to the meeting?

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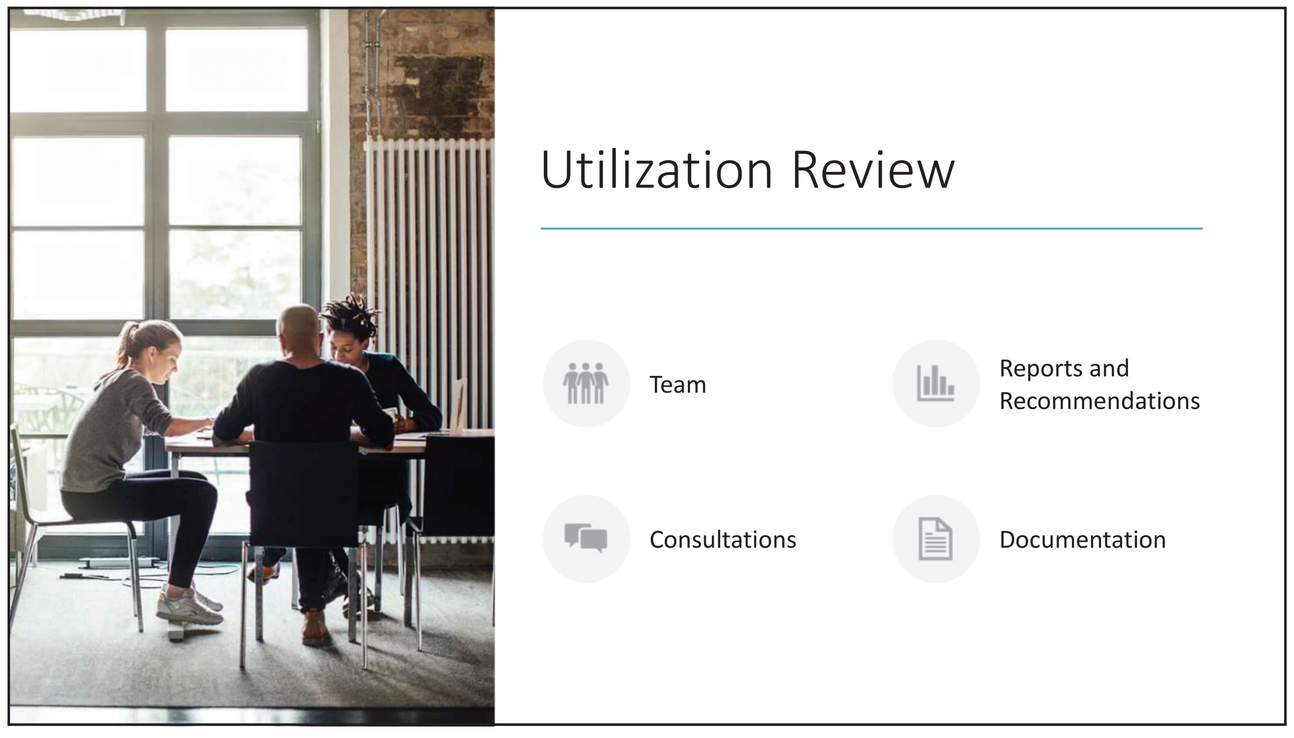

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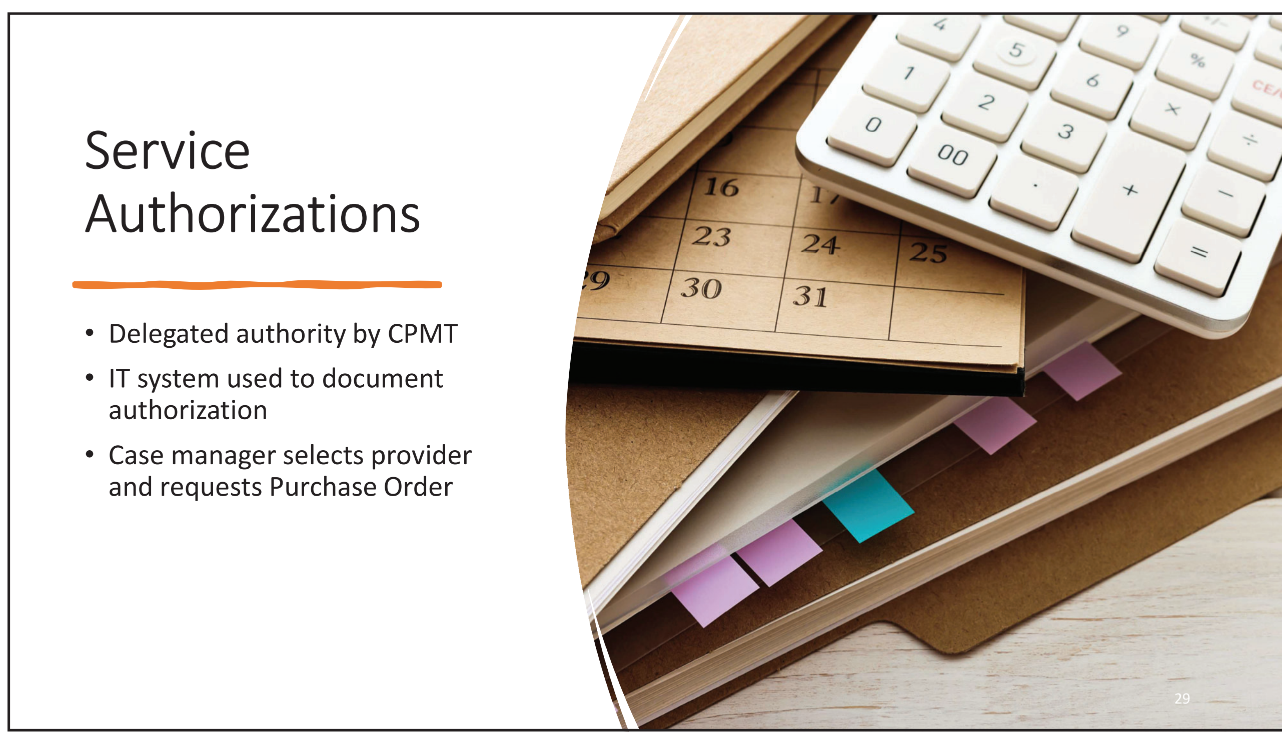

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Service Authorization Process for CSA-funded Services

Youth & Family - Needs and Strengths

Community-based Services

Team-based Service Planning
- FPM
- FRM
- YFT

Compliance Review for CSA Funding
- Consent
- Copay
- Case Manager Request
- Meeting Action Plan
- CANS
- Eligibility Determination Form
- Treatment Reports

**Residential / Crisis Out of Home*

Compliance Review for CSA Funding
- Consent
- Copay (does not have to be done prior to meeting)
- Case Manager Request
- CANS
- Eligibility Determination Form (FC&A only)
- Treatment Reports
- UR report required
- IACCT Inquiry Form

Team-based Service Planning - FAPT
- MAP for CBI or RTC
- CHINS PA if RTC
- Medicaid/IACCT

***RTC Indicators**
- Risk Behaviors and Behav/Emotional Needs (Level of Need)
- Exhausted CBI
- Court Ordered
- Parental Placement
- Hospital Discharge
- Currently in RTC
- Team CBI Plan Disagreement
- Foster Care - Resource Gap

Service Authorization Process – UR Analysts
- Practice Standards
- Clarity of justification for requested services
- Consistency of documentation (CANS and narrative, provider reports, MAP)
- Determination of funding availability for non-mandated youth

Approved
- Approved
- With Comment/ Recommendations
- With Amendments

Purchase Order
- Encumbrance

Completed by CM

Service begins with Youth and Family

Pend – CM to respond in 5 business days

Not Approved
- Inappropriate level of service; Inconsistent with SOC; Missing info not provided (pended cases)

Administrative Reconsideration - CM request within 5 business days with three-member panel:
1. CSA MT member from lead agency
2. CSA Manager or SOC Manager
3. CSA MT member neutral

Not Approved
- Ineligible for CSA

Administrative Reconsideration
CM request made in 5 business days and heard within 3 business days
- CSA Manager

CPMT Appeal – initiated by parent/guardian

Time to Service: From Planning to Service Start

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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?

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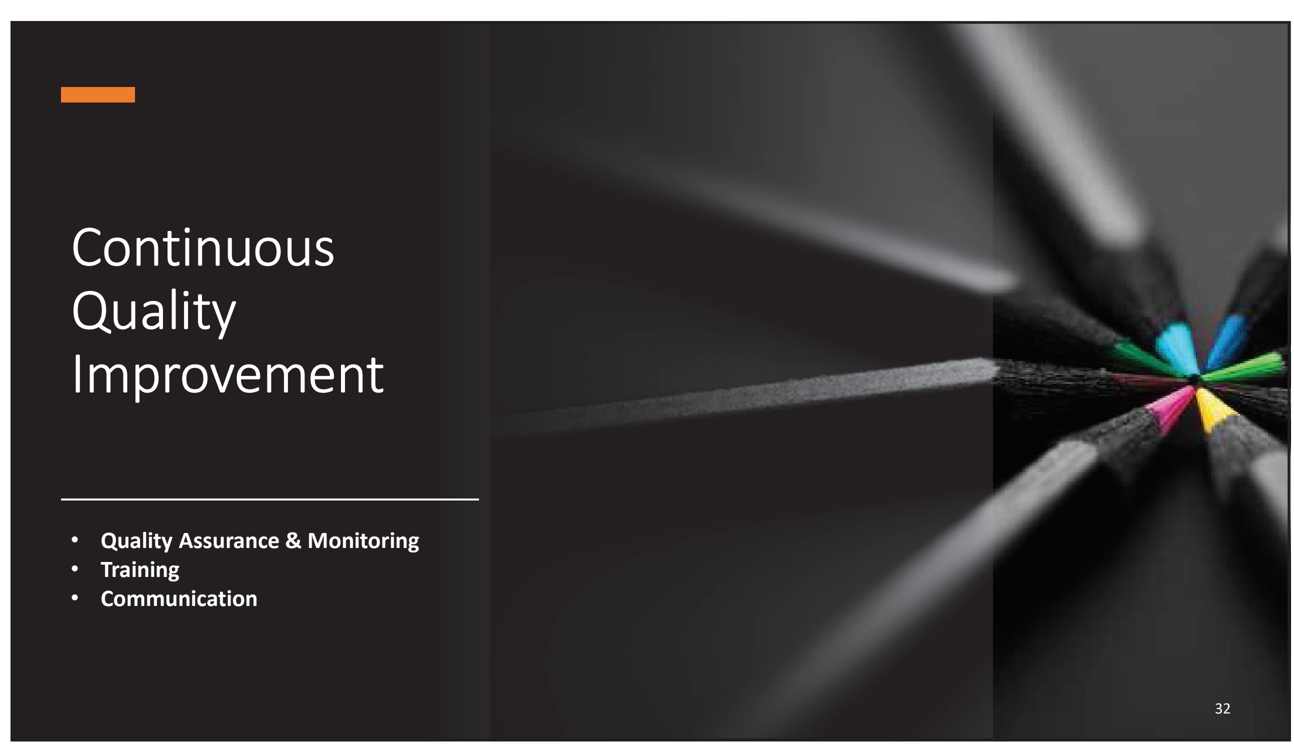

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Quality Assurance and Monitoring Plan Tasks

- 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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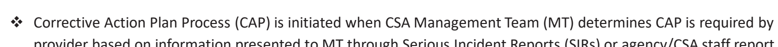
Corrective Action Plan Process

- 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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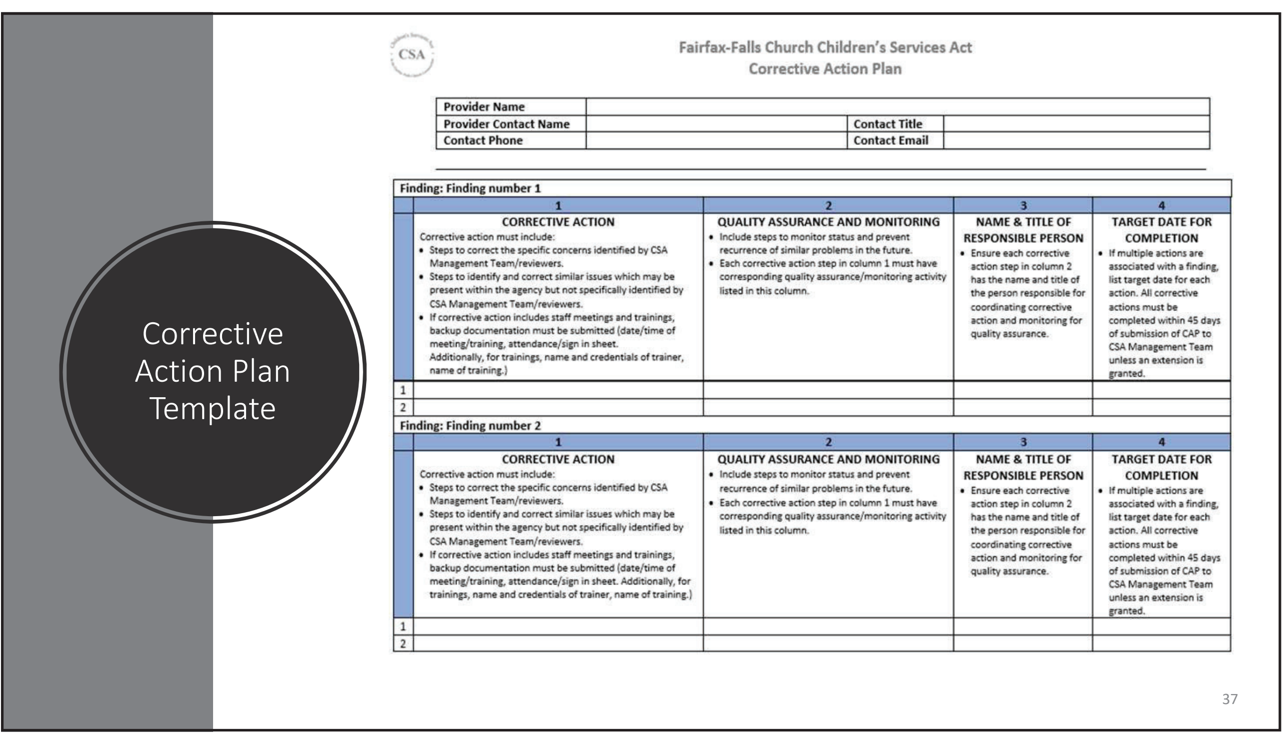

Fairfax-Falls Church Children's Services Act
Corrective Action Plan

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.
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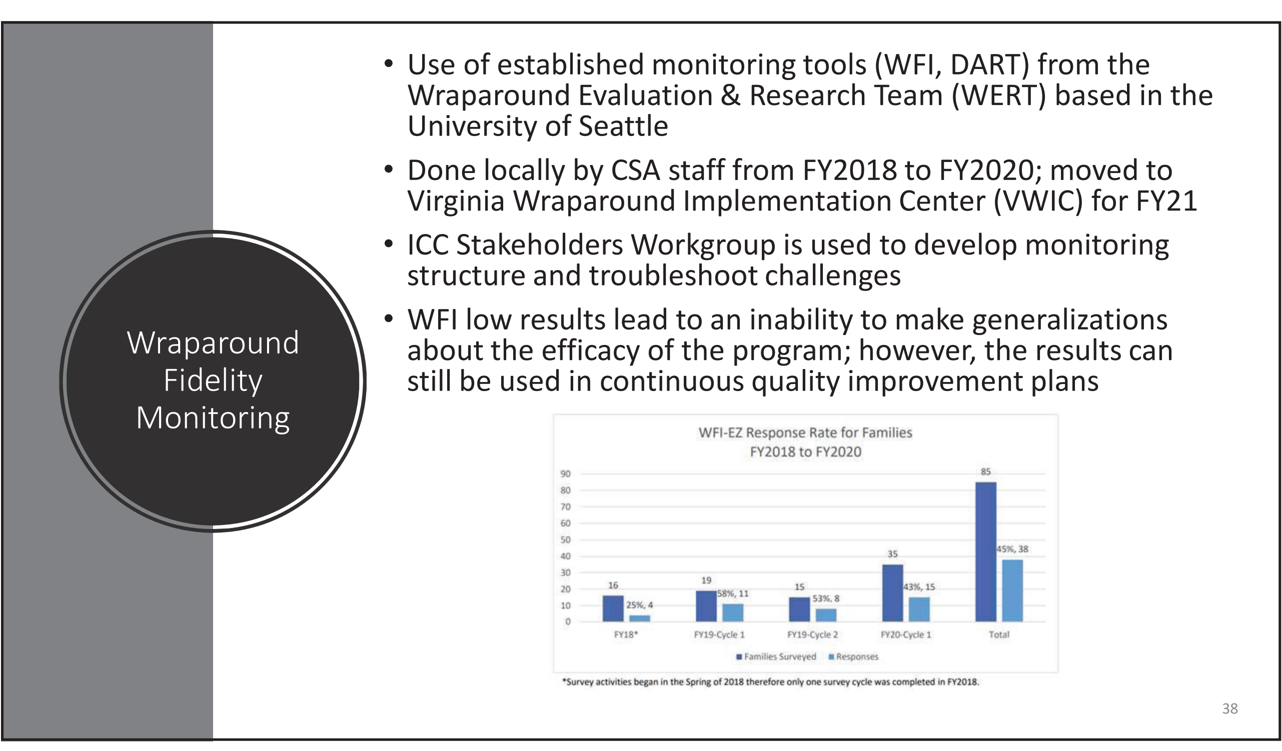

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Using the Data

- 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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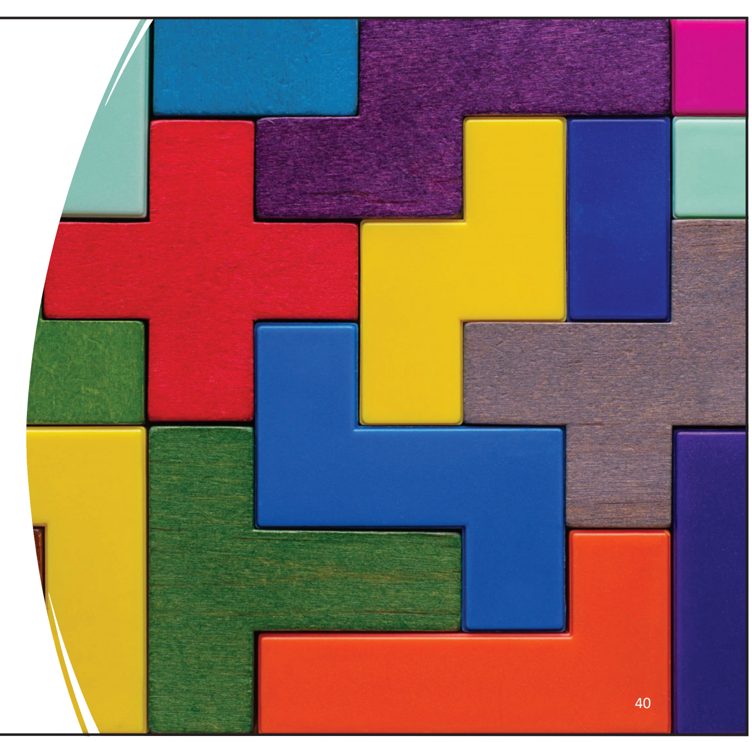
Training Goals

- 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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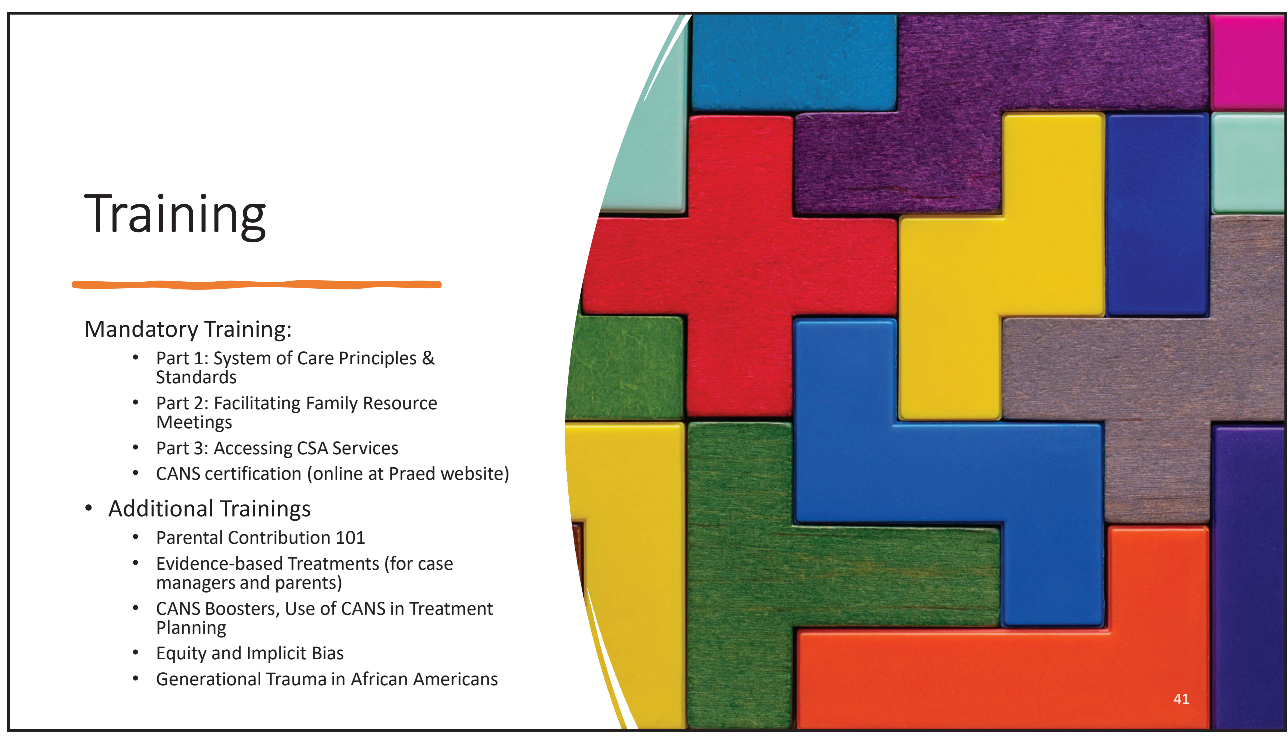

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Guidance Documents – EBT Resources

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 • Ages 2.5-7 • Children experiencing relational problems with caregivers • Refusal/Defiance of adult requests • Difficulty in childcare/school settings • Easy loss of temper … concerns • At least one caregiver willing to attend weekly sessions regularly and with ability to practice at least 3 times weekly with the child	**REFERRAL CRITERIA** • Ages 6-13 • Mood/Depressive Disorders • Anxiety Disorders • Post-Traumatic Stress Disorder (PTSD) • Disruptive/Externalizing Behavioral Struggles … Spectrum Disorder (ASD), or eating disorder • Sexually harmful behaviors • Acute suicidality	**REFERRAL CRITERIA** • Ages 7 and above • Mood lability or frequent shifts in mood • Struggle managing anger • Unstable relationships • Efforts to avoid actual or perceived loss … • Dissociation	**REFERRAL CRITERIA** • Ages 13-18 • Mood/Depressive Disorders • Anxiety Disorders • Post-Traumatic Stress Disorder (PTSD) • Disruptive/Externalizing Behavioral Struggles, high risk behaviors … • School Refusal/Truancy	**REFERRAL CRITERIA** • Ages 3-21 • Youth who have experienced trauma such as: • Sexual Abuse • Domestic Violence • Traumatic Grief • Disasters … • Anxiety • Externalizing Behavior Problems • Relationship and Attachment • Sexually Reactive Behavior • School Problems • Cognitive Problems • Participation of a non-offending parent or caregiver	**REFERRAL CRITERIA** • Ages 11-18 • Caregiver must agree to attend all sessions • Externalizing Adolescent Behavior • Conduct Disorder • Oppositional Defiant Disorder … • 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	**REFERRAL CRITERIA** • Ages 11-17 • At risk of being removed from home due to disruptive, delinquent, substance-using, and antisocial behavior • Youth who have significant emotional or behavioral problems and may …
EXCLUSIONARY CRITERIA • Caregiver IQ <75		**EXCLUSIONARY CRITERIA** • 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	**EXCLUSIONARY CRITERIA** • Age 12 and younger • Primary diagnosis of psychosis, intellectual disability, Autism Spectrum Disorder (ASD), or eating disorder • Sexually harmful behaviors • Acute suicidality	**EXCLUSIONARY CRITERIA** • Youth who are acutely suicidal or homicidal	**EXCLUSIONARY CRITERIA** • 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	• 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

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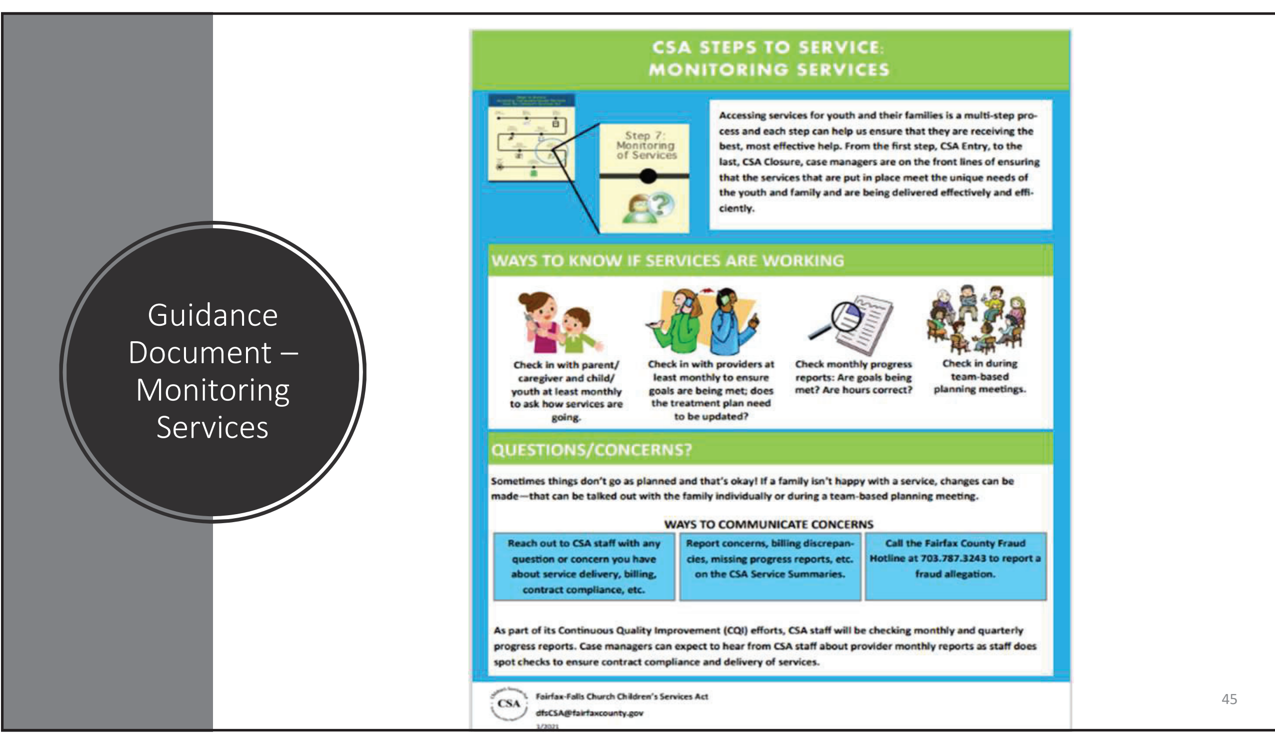

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Programmatic Goals

- 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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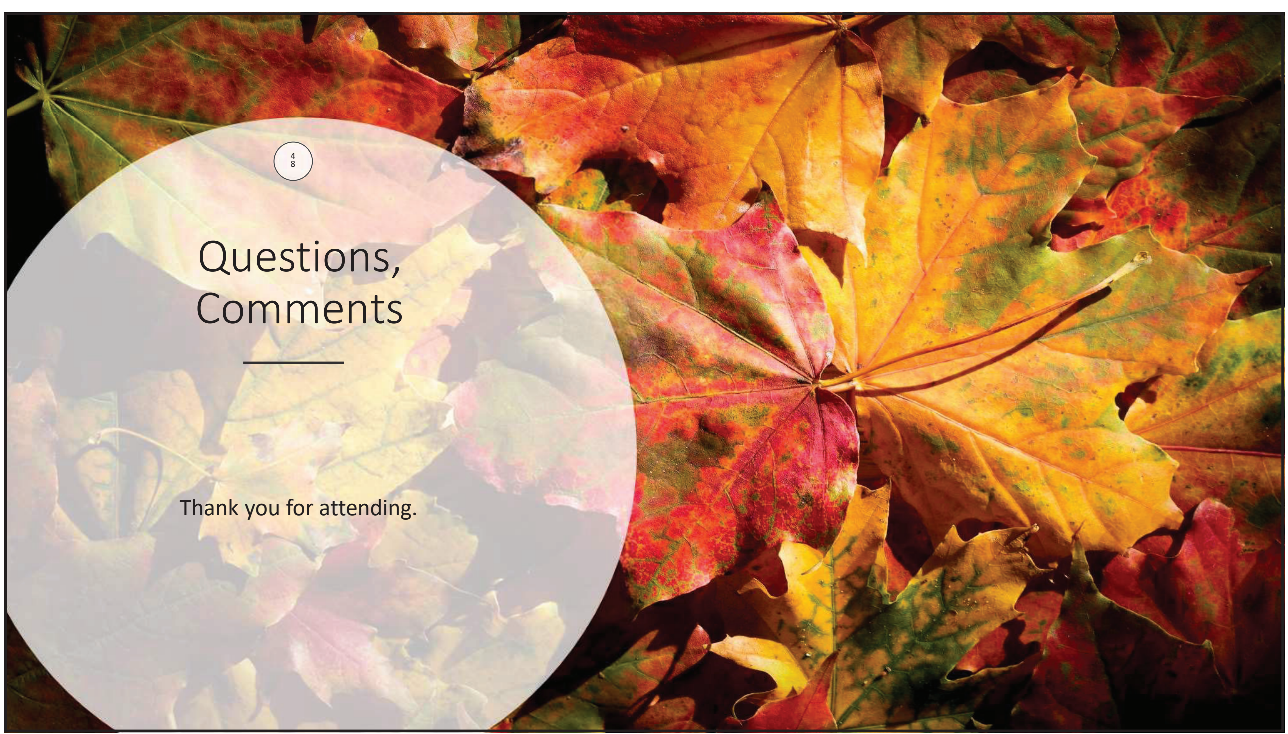

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