

Minutes
Winchester CPMT
10 Baker Street, Conference Room
Tuesday, August 12, 2014
1:30 p.m.

MEMBERS PRESENT

Mary Blowe, City of Winchester
Kelly Bober, Child Advocacy Center
Eden Freeman, City of Winchester
Mark Gleason, Northwestern Community Services Board
Lyda Kiser, Parent Representative
Peter Roussos, Dept. of Juvenile Justice

MEMBERS/OTHERS NOT PRESENT

Dr. Charles Devine, Virginia Dept. of Health
Amber Dopkowski, Winchester Dept. of Social Services
Sarah Kish, Winchester Public Schools
Paul Scardino, National Counseling Group

Others Present:

Karen Farrell, Winchester Comprehensive Services Act
Coordinator
Connie Greer, Winchester Dept. of Social Services
Katherine Hermann, Assistant City Attorney

RECAP OF CPMT VOTES:

Motion:

- Motioned to approve the minutes from June 10, 2014 CPMT Meeting.

- Motion to convene in Executive Session pursuant to 2.2-3711 (A) (4) and (15), and in accordance with the provisions of 2.2 – 5210 of the Code of Virginia for proceedings to consider the appropriate provision of services and funding for a particular child or family or both who have been referred to the family assessment and planning team and whose case is being reviewed by the community policy and management team.

- Motion to come out of Executive Session

- Motion to Certify Compliance by Roll Call Vote Move that the members of the Winchester CPMT certify that to the best of each member’s knowledge, (1) only public business matters lawfully exempted from open meeting requirements, and (2) only such public business matters were identified in the motion by which the closed meeting was convened were heard, discussed, or considered in the closed meeting.

- Motion to Approve All Cases, as presented or amended

- Motion to adjourn CPMT Meeting

Action:

- 1st: Mr. Roussos
- 2nd: Ms. Blowe

- 1st: Ms. Blowe
- 2nd: Ms. Freeman

- 1st: Ms. Kiser
- 2nd: Ms. Bober
- 1st: Ms. Freeman
- 2nd: Mr. Roussos

- 1st: Ms. Freeman
- 2nd: Mr. Roussos
- 1st: Mr. Roussos
- 2nd: Ms. Freeman

Status:

- Approved
- Ms. Bober
abstained
- Approved
unanimously

- Approved
unanimously

Minutes
 Winchester CPMT
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 Tuesday, August 12, 2014
 1:30 p.m.

Item	Discussion	Action
Planning Report-Assignment of Work Committees	1. CPMT Foundation and Structure (Dopkowski, Gleason, Blowe) 2. Common Ground through Education, Training and Shared Expectations (Roussos, Kiser) 3. Data-Driven Accountability and Service Provision (Scardino, Bober) 4. CPMT Services Development (Kish, Devine)	1. No report. 2. Present report in September 3. Reviewing template vendor contracts. Need to schedule next meeting. 4. No report.
b. Intensive Care Coordination Services		ICC explanation and guidance memos were reviewed (attached). Still awaiting a vendor to provide the services for Winchester area.
c. National Center for Missing and Exploited Children	Mr. Gleason explained the collaborative arrangement between NWCSB and the National Center for Missing and Exploited Children (NCMEC). NWCSB is currently the only agency with this relationship.	Mr. Gleason met with National Sherriff's Association to solicit its assistance. Mr. Gleason to report out when model is closer to finalized.
a. New Business OSC Administrative Memo #14-04	July 14, 2014 OCS Administrative Memo #14-04 regarding Standardized Levels of Treatment Foster Care	CPMT reviewed the Memo. CPMT's are charged with ensuring that levels of foster care services are appropriately matched to the individual needs of the foster child. The Family Assessment and Planning Team process currently reviews that, but CPMT will also review.
b. OCS Administrative Memo #14-06	July 30, 2014 OCS Administrative Memo #14-06 regarding Standard Service Names	Effective July 1, 2015, standardized service names will be utilized. Recommendations to establish consistency in reporting will be forthcoming.

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Item	Discussion	Action
c. State Sponsored Utilization Review	June 25, 2014 memo regarding State Sponsored Utilization Review	The State Sponsored Utilization Review Contract signed in 2013 remains in effect until terminated in 5 years (2018) or with 60 days written advance notice.
Motion to Convene in Executive Session	Motion to convene in Executive Session pursuant to 2.2-3711 (A) (4) and (15), and in accordance with the provisions of 2.2 – 5210 of the Code of Virginia for proceedings to consider the appropriate provision of services and funding for a particular child or family or both who have been referred to the family assessment and planning team and whose case is being reviewed by the community policy and management team.	Mr. Gleason asked that the meeting move into Executive Session. On motion by Ms. Blowe, seconded by Ms. Freeman, the meeting moved into Executive Session.
Motion to Come Out of Executive Session & Immediately Reconvene in Open Session		Motion to come out of Executive Session by Ms. Kiser and seconded by Ms. Bober. Approved unanimously.
Motion to Certify Compliance by Roll Call Vote	Move that the members of the Winchester CPMT certify that to the best of each member’s knowledge, (1) only public business matters lawfully exempted from open meeting requirements, and (2) only such public business matters were identified in the motion by which the closed meeting was convened were heard, discussed, or considered in the closed meeting.	Motion to Certify Compliance by Roll Call Vote was made by Ms. Freeman, seconded by Mr. Roussos, and unanimously approved.
Motion to Approve All Cases	Motion to Approve all cases as presented or amended.	All cases were approved unanimously, as noted, on motion by Ms. Freeman, seconded by Mr. Roussos.
Motion to Adjourn/Next Meeting Date	The next CPMT meeting will be held Tuesday August 12, 2014 at 1:30 p.m., Winchester/Frederick County Health Department, 10 Baker Street, Conference Room, Winchester VA	The meeting was adjourned on motion by Mr. Roussos and seconded by Ms. Freeman at 2:45 p.m.

Attachments: July 2014 Financials
 August Agenda Attachments

Transcribed by CPG

July Financials

CSA Pool Reimbursement Request Report Worksheet

Date: August 5, 2014

Period Ending: July, 2014

Chart A

Part 1 - Expenditure Description

	Number of Clients	Gross Total Expenditures	Expenditure Refunds	Net Total Expenditures
I. Congregate Care/Mandated & Non-Mandated Residential Services				
1a. Foster Care - IV-E Child in Licensed Residential Congregate Care				0.00
1b. Foster Care - all other in Licensed Residential Congregate Care			0.31	-0.31
1c. Residential Congregate Care - CSA Parental Agreements; DSS Non-Custodial				0.00
1d. Non-Mandated Services/Residential/Congregate Care				0.00
1e. Educational Services - Congregate Care				0.00

	Number of Clients	Gross Total Expenditures	Expenditure Refunds	Net Total Expenditures
2. Other Mandated Services				
2a. Treatment Foster Care - IV-E				0.00
2a.1 Treatment Foster Care				0.00
2a.2 Treatment Foster Care - CSA Parental Agreements; DSS Non-Custodial				0.00
2b. Specialized Foster Care - IV-E; Community Based Services				0.00
2b.1 Specialized Foster Care			83.94	-83.94
2c. Family Foster Care - IV-E; Community Based Services				0.00
2d. Family Foster Care Maintenance Only	2	1,148.00	966.00	182.00
2e. Family Foster Care - Children Receiving Maintenance/Basic Activities; II	1	541.00	292.00	249.00
2f. Community Based Services			75.00	-75.00
2f.1 Community Transition Services				0.00
2g. Special Education: Private Day Placement				0.00
2h. Wrap-Around Services for Students With Disabilities				0.00
2i. Psychiatric Hospitals/Crisis Stabilization Units				0.00
3. Non-Mandated Services/Community Based				0.00
4. Grand Totals: Sum of categories 1 through 3	3	1,689.00	1,417.25	271.75

Part 2 - Expenditure Refund Description (reported in line 4)

Vendor Refunds and Payment Cancellations	
Parental Co-Payments	
Payments made on behalf of the child (SSA, SSL, VA benefits)	946.00
Child Support Collections through DCSE	471.25
Pool prior-reported expenditures re-claimed under IV-E	
Other	
Total Refunds (must agree with line 4)	1,417.25



Chart B

**CSA Reports
Pool
Reimbursement
Reports
FY15
Transaction
History for
Winchester -
FIPS 840**
Pended Forms are not
on this report

Active Pool Report Preparers
Nancy Valentine (540) 686-4838
Donna Veach (540) 686-4826
Amber Johnson (540) 686-4823
Karen Farrell (540) 686-4832

Transaction History

Match Rate:	Status	Period End	Date Filed	Total Amount	State	Local
0.4587						
Beginning Balance				\$1,195,388.00	\$647,025.72	\$548,362.28
Pool Reimbursement History						
	5	07/31/2014	08/06/2014	\$271.75	\$129.94	\$141.81
Pool Reimbursement Expenditure Totals				\$271.75	\$129.94	\$141.81
Supplement History						
Supplement Totals				\$0.00	\$0.00	\$0.00
CSA System Balance				\$1,195,116.25	\$646,895.78	\$548,220.47

Transaction History without WRAP Dollars

Match Rate:	Status	Period End	Date Filed	Total Amount	State	Local
0.4587						
Beginning Balance				\$1,176,583.00	\$636,846.99	\$539,736.01
Pool Reimbursement History						
	-	07/31/2014	08/06/2014	\$271.75	\$129.94	\$141.81
Pool Reimbursement Expenditure Totals				\$271.75	\$129.94	\$141.81

Supplement History

Supplement			
Totals	\$0.00	\$0.00	\$0.00

CSA System Balance (Non-WRAP):	\$1,176,311.25	\$636,717.05	\$539,594.20
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Transaction History WRAP dollars only

Match Rate:	Status Period End	Date Filed	Total Amount	State	Local
0.4587					

WRAP Allocation Additions History

	08/06/2014	\$18,805.00	\$10,178.00	\$8,626.00
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WRAP Allocation Additions Totals		\$18,805.00	\$10,178.00	\$8,626.00
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Pool Reimbursement History - WRAP only

	07/31/2014	08/06/2014	\$0.00	\$0.00	\$0.00
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Pool Reimbursement Expenditure Totals -WRAP only			\$0.00	\$0.00	\$0.00
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CSA System Balance (WRAP only):	\$0.00	\$0.00	\$0.00
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Wrap-Around Services for Students with Disabilities
2014 - 2015

Chart C

Child	7	2	9	11	13	12	6	TOTAL SPENT
Agency Worker	WPS-NREP Clatter	WPS-NREP Clatter	WPS-NREP Clatter	WPS Kish	WPS Kish	WPS-NREP Clatter	NWCSB Hines	
JUL								0.00
AUG								
SEP								
OCT								
NOV								
DEC								
JAN								
FEB								
MAR								
APR								
MAY								
JUN								
TOTAL/ CHILD								
				Beginning Balance				18,805.00
				Disbursed				0.00
				Encumbered				0.00
				Remaining Funds				18,805.00

August Attachments

State Executive Council for the Comprehensive Services Act

Policy: Intensive Care Coordination Adopted April 30, 2013

Definition of Intensive Care Coordination

Intensive Care Coordination shall include facilitating necessary services provided to a youth and his/her family designed for the specific purpose of maintaining the youth in, or transitioning the youth to, a family-based or community based setting. Intensive Care Coordination Services are characterized by activities that extend beyond regular case management services that are within the normal scope of responsibilities of the public child serving systems and that are beyond the scope of services defined by the Department of Medical Assistance Services as "Mental Health Case Management."

Population to be Served by Intensive Care Coordination

Youth shall be identified for Intensive Care Coordination by the Family Assessment and Planning team (FAPT). Eligible youth shall include:

1. Youth placed in out-of-home care¹
2. Youth at risk of placement in out-of-home care²

¹Out-of-home care is defined as one or more of the following:

- Level A or Level B group home
- Regular foster home, if currently residing with biological family and due to behavioral problems is at risk of placement into DSS custody
- Treatment foster care placement, if currently residing with biological family or a regular foster family and due to behavioral problems is at risk of removal to higher level of care
- Level C residential facility
- Emergency shelter (when placement is due to child's MH/behavioral problems)
- Psychiatric hospitalization
- Juvenile justice/incarceration placement (detention, corrections)

²At-risk of placement in out-of home care is defined as one or more of the following:

- The youth currently has escalating behaviors that have put him or others at immediate risk of physical injury.
- Within the past 2-4 weeks the parent or legal guardian has been unable to manage the mental, behavioral or emotional problems of the youth in the home and is actively seeking out-of-home care.
- One of more of the following services has been provided to the youth within the past 30 days and has not ameliorated the presenting issues:
 - o Crisis Intervention
 - o Crisis Stabilization
 - o Outpatient Psychotherapy
 - o Outpatient Substance Abuse Services
 - o Mental Health Support

NOTE: Intensive Care Coordination cannot be provided to individuals receiving other reimbursed case management including Treatment Foster Care-Case Management, Mental Health Case Management, Substance Abuse Case Management, or case management provided through Medicaid waivers.

Providers of Intensive Care Coordination

Providers of ICC shall meet the following staffing requirements:

- 1) Employ at least one supervisory/management staff who has documentation establishing completion of annual training in the national model of "High Fidelity Wraparound" as required for supervisors and management/administrators (such documentation shall be maintained in the individual's personnel file);
- 2) Employ at least one staff member who has documentation establishing completion of annual training in the national model of "High Fidelity Wraparound" as required for practitioners (i.e., Intensive Care Coordinators). Such documentation shall be maintained in the individual's personnel file.

Intensive Care Coordination shall be provided by Intensive Care Coordinators who possess a Bachelor's degree with at least two years of direct, clinical experience providing children's mental health services to children with a mental health diagnosis. Intensive Care Coordinators shall complete training in the national model of "High Fidelity Wraparound" as required for practitioners. Intensive Care Coordinators shall participate in ongoing coaching activities.

Providers of Intensive Care Coordination shall ensure supervision of all Intensive Care Coordinators to include clinical supervision at least once per week. All supervision must be documented, to include the date, begin time, end time, topics discussed, and signature and credentials of the supervisor. **Supervisors of Intensive Care Coordination shall possess a Master's degree in social work, counseling, psychology, sociology, special education, human, child, or family development, cognitive or behavioral sciences, marriage and family therapy, or art or music therapy with at least four years of direct, clinical experience in providing children's mental health services to children with a mental health diagnosis. Supervisors shall either be licensed mental health professionals (as that term is defined in 12 VAC35-105-20) or a documented Resident or Supervisee of the Virginia Board of Counseling, Psychology, or Social Work with specific clinical duties at a specific location pre-approved in writing by the applicable Board.** Supervisors of Intensive Care Coordination shall complete training in the national model of "High Fidelity Wraparound" as required for supervisors and management/administrators

Training for Intensive Care Coordination

Training in the national model of "High Fidelity Wraparound" shall be required for all Intensive Care Coordinators and Supervisors including participation in annual refresher training. Training and ongoing coaching shall be coordinated by the Office of Comprehensive Services with consultation and support from the Department of Behavioral Health and Developmental Services.



COMMONWEALTH of VIRGINIA

Susan Cumbia Clare, M.Ed
Executive Director

OFFICE OF COMPREHENSIVE SERVICES
Administering the Comprehensive Services Act for At-Risk Youth and Families

ADMINISTRATIVE MEMO #14-04

TO: CPMT CHAIRS
CSA COORDINATORS

FROM: SUSAN CUMBIA CLARE

DATE: JULY 14, 2014

SUBJECT: STANDARDIZED LEVELS OF TREATMENT FOSTER CARE

On June 20, 2014, the State Executive Council (SEC) adopted policy supporting the implementation of standardized levels of care for services purchased from private licensed child placing agencies and approved related guidelines. The July 1, 2015 effective date of this policy will enable private providers to make necessary adjustments to services and localities to transition services outlined in the individual family service plans of children.

The policy reflects the culmination of work by the "Standardizing Levels of Care in Treatment Foster Care" workgroup which was established in response to language first included in the 2011 Appropriation Act, Item 274 M, requiring the SEC to authorize guidelines for treatment foster care. The workgroup was comprised of representatives of various stakeholder groups including private providers; local departments of social services; the Virginia Municipal League; local CSA coordinators; the Virginia Department of Social Services, licensing division and family services division; the Virginia Department of Medical Assistance Services; and the Office of Comprehensive Services. The SEC commended the workgroup members for exemplary collaboration in the development of recommendations and guidelines.

In addition to recommending the policy, the workgroup developed guidelines for implementing standardized levels of care. These guidelines, entitled "Guidelines for Determining Levels of Care for Foster Care Services with Licensed Child Placing Agencies," are attached.

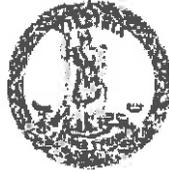
The adopted policy is as follows:

Effective July 1, 2015, when purchasing foster care services through a licensed child placing agency, Community Policy and Management Teams shall ensure that levels of foster care services are appropriately matched to the individual needs of a child or youth in accordance with the SEC approved "Guidelines for Determining Levels of Care for Foster Care Services with Licensed Child Placing Agencies."

The Office of Comprehensive Services will provide information and training on the policy and guidelines in the coming months. Questions regarding the policy or guidelines may be directed to Carol Wilson, 804-662-9817, or to the Office of Comprehensive Services at the following e-mail address: csa.office@csa.virginia.gov.

Attachment

**Cc: Margaret Schultze, Commissioner, Virginia Department of Social Services
Charlie Laslie, President, Virginia Coalition of Private Provider Associations**



COMMONWEALTH of VIRGINIA

Susan Cumbia Clare, M.Ed
Executive Director

OFFICE OF COMPREHENSIVE SERVICES
Administering the Comprehensive Services Act for At-Risk Youth and Families

ADMINISTRATIVE MEMO #14-06

TO: CPMT CHAIRS
CSA COORDINATORS

FROM: SUSAN CUMBIA CLARE

DATE: July 30, 2014

SUBJECT: STANDARD SERVICE NAMES

In March 2013 the State Executive Council established a workgroup to identify standard service names and descriptions to be utilized statewide to report services purchased under the Comprehensive Services Act. The workgroup completed its task and reported to the SEC in March 2014. The SEC expressed its support for implementation of standard service names.

The need to standardize service names across localities was highlighted in part by a proof-of-concept project in which data on CSA purchased services were collected from seven localities. Analysis of that small subset of data revealed in excess of 4,000 service names. This extreme number was attributed not only to the common practice of using an open text field in the data system used to track purchased services, but also to the wide variance in service names used across the local CSA programs. Additionally, the use of a single, generic name to describe widely dissimilar services was identified as a common issue across the state.

As the Office of Comprehensive Services has initiated the routine collection, integration, and analysis of data regarding client-specific services, the need to standardize service names and ensure common definitions is essential to ensure meaningful analysis and reporting. The comprehensive list of service names and definitions, created by the workgroup and refined through consultation with partner state agencies and local stakeholders, is attached. It is important that localities understand the following regarding use of these service names:

1. The description of each service is designed to distinguish the uniqueness of the service from all other services, while at the same time be broad enough to allow flexibility to match the

service to a particular child's strengths and needs. For example, an outpatient therapy using a particular modality, such as "art therapy," would be reported under the service name "Outpatient Services."

2. Where particular limiting requirements are applicable to a service, e.g., licensing or eligibility requirements, those requirements are reflected either in the definition or through a footnote referencing the regulatory authority.
3. There exists an "Other" service name to enable reporting of a service that is of such a unique nature that it does not fit an identified service name and definition. Reporting of a service as "Other" is expected to be infrequent and will be monitored on a regular basis. OCS will, on an annual basis, add a service name to the list if there is sufficient evidence to suggest it is a commonly used service that cannot be appropriately reported under an existing service name. Adequate notice will be provided to enable updating of local data reporting systems prior to implementation of any new service name.
4. Local governments will be required to begin reporting using only the standard service names effective July 1, 2015. This implementation date provides time for localities to adjust local practices and update data reporting systems to implement use of the standard names. It is anticipated that local data systems will include the service names in a "drop down" list to ensure the integrity of data submission. OCS will implement data quality standards to reject service names that do not conform to the standard service names.

A review of all data elements reported to OCS is currently underway and recommendations to establish consistency in reporting across localities will be forthcoming. The standardization of data, including the use of standard service names, will enhance the integrity of data analysis and reporting. Resulting data analyses will increase state and local capacity to make data-informed decisions to improve program performance.

Questions about the standard service names may be directed by e-mail to csa.office@csa.virginia.gov or by phone to one of the program consultants listed below:

Anna Antell, 804-662-9136
Brady Nemeyer, 804-662-9819
Carol Wilson, 804-662-9817



COMMONWEALTH of VIRGINIA

OFFICE OF COMPREHENSIVE SERVICES
Administering the Comprehensive Services Act for At-Risk Youth and Families

Susan Cumbia Clark, M.Ed.
Executive Director

MEMORANDUM

TO: CSA Coordinators
CPMT Chairs

FROM: Scott Reiner, Assistant Director 

RE: State Sponsored Utilization Review

DATE: June 25, 2014

In accordance with elements of the Comprehensive Services Act (i.e., §2.2-2648 (15) and §2.2-5206(6)), the Office of Comprehensive Services (OCS) makes available utilization review services ("State Sponsored Utilization Review") for localities that lack the capacity for internal utilization review and/or who document that state-sponsored utilization review is their plan for meeting these requirements for children placed in residential facilities. Utilization review of non-residential cases and cases placed in residential care for educational reasons (IEP) remain the sole responsibility of the locality.

OCS has reviewed and revised the agreement for State Sponsored Utilization Review (UR). The agreement sets the parameters under which utilization review for children in residential placements through the CSA is provided, and is a voluntary agreement between the locality and OCS. Localities opting to utilize State Sponsored Utilization Review through OCS will be required to sign this new agreement. A copy of that Agreement is attached to this memo.

The primary change to prior practice is that with the exception of cases that are in residential placement for educational reasons only (IEP), all CSA cases placed in a residential program will now be submitted for Utilization Review (this includes cases in which Medicaid is funding the Room/Board and/or specific treatment services). This change is being made with recognition that the funding source does not drive how youth are treated, such that all CSA youth should receive the same level of review and attention. Other changes to the existing agreement are technical in nature for the purpose of clarity.

If your locality wishes to receive State Sponsored Utilization Review, please properly execute the agreement and return two signed original copies to OCS by September 1, 2014. OCS will then endorse the agreements and return an original copy.

Thank you for your cooperation. If you have any questions, please contact Anna Antell, the Program Consultant responsible for the utilization review process at OCS. Anna can be reached at anna.antell@csa.virginia.gov or 804-662-9136.

**MEMORANDUM OF AGREEMENT BETWEEN
THE VIRGINIA OFFICE OF COMPREHENSIVE SERVICES AND
LOCALITIES PARTICIPATING IN STATE SPONSORED
UTILIZATION REVIEW UNDER THE
COMPREHENSIVE SERVICES ACT**

This Agreement is made and entered into this ___ day of _____, 2014 between the Office of Comprehensive Services (“OCS”) and the Community Policy and Management Team of _____ (name of locality) (“participating CPMTs”).

I. Purpose

This Agreement provides the framework for provision of state sponsored utilization review for selected cases for purposes of partial compliance with § 2.2-2648(15) and § 2.2-5206(6) of the Virginia Comprehensive Services Act (hereinafter referred to as CSA). This Agreement specifically delineates the duties and responsibilities of the “Community Planning and Management Team (hereinafter referred to as the CPMT) of localities electing to obtain such state sponsored utilization review and the Office of Comprehensive Services (hereinafter referred to as the OCS) as well as a mutually agreed upon review process. This Agreement will serve as the locality’s official Utilization Review plan for residential cases.

II. The Review Process

A. General:

1. OCS will provide utilization review services for the cases of children in non-educational residential/congregate care placements under the CSA to participating CPMTs voluntarily choosing to receive state sponsored utilization review. These placements are defined in the CSA Service Categories & Data Set Definitions approved by the State Executive Council and found at:
<http://www.csa.virginia.gov/html/CSA%20service%20categories%20and%20definitions%20-%20December%202011.pdf>.
2. The purpose of utilization review is to provide participating CPMTs information, technical assistance and/or consultation to assist in:
 - Making sound planning decisions to provide appropriate and effective services in the least restrictive environment for individual children that:
 - Tailor services and supports to the unique strengths and needs of children and their families;
 - Build upon natural family and community supports whenever possible;
 - Use public funds appropriately; and
 - Respect that CPMTs make the ultimate decisions on services and funding for a particular child.

- Improving outcomes and services for individual children and their families.
 - Building capacity to implement the utilization review function locally for those communities that wish to do so.
3. In performing utilization review, OCS will consider the placement of and services provided to children whose placements receive any funding through the CSA. With the exception of cases that are in a residential placement for educational reasons only (IEP), all cases placed in a residential program through the FAPT/CPMT will be submitted for review to OCS.
 4. When providing utilization review under this Agreement, OCS will provide qualified personnel to conduct the reviews and may consult with licensed professionals recommended by the Department of Behavioral Health and Developmental Services, if needed, on clinically complex cases.
 5. OCS will develop necessary forms and guidelines for the use of the CPMT in submitting cases for utilization review.
 6. OCS and the CPMT agree to comply with all applicable State and Federal confidentiality requirements and will not re-disclose any confidential information without the authorization of the individual, their parent or legally authorized representative unless otherwise permitted by law.
 7. All communications that include personal identifying information and/or protected health information shall be transmitted in a method that protects the security and confidentiality of such information. Typically this means using only encrypted e-mail communications, hard copy via U.S. Mail or other courier service, and fax transmission only when the recipient is alerted to an impending transmission so that they may be present as that transmission is received.

B. Scope of Review

1. OCS will periodically review all cases submitted under the terms of the Agreement. These reviews will examine all required documentation submitted to OCS by the CPMT relating to individual CSA placements.
2. Upon request of either party, the locality and the OCS will negotiate an on-site CSA review. On-site reviews will be limited to in-state placements.
3. The OCS review will include, but will not be limited to, the following:
 - An initial review, and periodic re-reviews of:
 - the appropriateness of the placement based on the individual and unique needs and strengths of the child and family;

- the appropriateness of the placement facility's treatment plan and the Individual and Family Service Plan (IFSP) developed by the Family Assessment and Planning Team (FAPT), to include the level of family and youth involvement in these plans, as well as the utilization of the information from the Child and Adolescent Needs and Strengths (CANS) assessment in the development of these plans;
- written progress reports and updates including progress or lack of progress on the IFSP goals, to include the appropriateness of goals and objectives, as well as identified strategies to achieve these goals; and
- recommendations for length of stay and discharge planning.

C. Utilization Review Schedule

Children whose stay in the residential placement is less than 60 calendar days are exempt from review.

1. Initial Review: Each CPMT will provide the following information to OCS for each CSA placement covered under this agreement within 60 calendar days of the placement. Information for Initial Reviews should include the following:

- CSA Review Checklist (found on the CSA website)
- Documentation from the FAPT addressing the placement (e.g., FAPT minutes, case documentation submitted to the CPMT, etc.)
- Most recent CANS assessment
- Most recent IFSP
- Most recent Foster Care plan (if applicable)
- Information about prior placements (if applicable)
- Psychotropic medication information
- Most recent Magellan (Medicaid) Authorization/UM Form (if applicable)
- Service/treatment plan and progress reports from the placement
- Psychological evaluation, if available
- Discharge plan

2. Subsequent Reviews: After the initial 60-day review, each CPMT will submit information for review every 90 days for the duration of the placement. All subsequent 90-day reviews shall include:

- CSA Review Checklist (found on the CSA website)
- Documentation from the FAPT addressing the placement (e.g., FAPT minutes, case documentation submitted to the CPMT, etc.)
- Most recent CANS assessment (if updated since prior submission)
- Most recent IFSP
- Most recent Foster Care plan (if applicable)
- Psychotropic medication information (if updated since prior submission)
- Most recent Magellan (Medicaid) Authorization/UM Form (if applicable)

- Service/treatment plan reviews and progress reports from the placement
 - Actions/changes in the service plan and/or IFSP taken in response to most recent utilization review
 - Discharge plan
3. Discharge Notification: CPMT will send to OCS the Discharge Notification form (found on the CSA website) within 14 calendar days after child's discharge from the residential placement.
 4. OCS Review Schedule: Within 30 calendar days of receipt from the CPMT of all necessary documentation, OCS will complete the review for each child. If an on-site review is determined to be appropriate, this can be extended an additional 30 calendar days. OCS utilization reviews will be submitted to the CPMT chairperson and the locality's CSA Coordinator.

III. Additional Responsibilities

A. OCS will:

1. Provide, upon request by the CPMT, training and consultation to assist with the effective implementation of this agreement.
2. Perform utilization review pursuant to this agreement at no cost to the locality.

B. The CPMT will:

1. Designate an individual to be responsible for serving as the liaison with OCS and for meeting the obligations identified in this agreement.
2. Document the use of and/or response of the FAPT to the UR recommendations.

IV. PERIOD OF PERFORMANCE

Services under this Agreement will begin July 1, 2014 or the date of signing, whichever is later. This Agreement will automatically renew each year for a period of five years unless either party gives the other party advance written notice of termination 60 days prior to June 30th of each year.

V. TERMINATION

This Agreement may be terminated by the parties by either party giving the other party 60 days written notice of termination.

VI. AMENDMENT

This Agreement may be amended upon the written Agreement of both parties when signed by the parties and attached hereto.

VII. APPROPRIATIONS

Services under this Agreement shall be contingent upon sufficient appropriations for this purpose by the General Assembly.

Commonwealth of Virginia
Office of Comprehensive Services

Community Planning and
Management Team of

(Locality Name)

By: _____
Susan Cumbia Clare
Executive Director

By: _____

Print Name & Title

Date: _____

Date: _____

OFFICE OF COMPREHENSIVE SERVICES

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



What is Intensive Care Coordination in a High Fidelity Wraparound Model?

Why Should ICC in a High Fidelity Wraparound Model be an Important Component of a System of Care Service Continuum? (August 2014)

The Comprehensive Services Act (CSA, §2 2-2648 et seq) was enacted in 1993 to create a collaborative system of services and funding for at-risk youth and families.

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

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

Guiding principles for OCS include:

- Child and family directed care.
- Equitable access to quality services
- Responsible and effective use of public funds.
- Support for effective, evidence-based practices, and
- Collaborative partnerships in implementation of the Comprehensive Services Act.



Office of
Comprehensive
Services

Empowering communities to serve youth

Intensive Care Coordination (ICC) in the High Fidelity Wraparound (HFW) Model provides a structured approach to care coordination that is designed for youth and families where the youth is in, or at risk of, an out-of-home placement. These are youth with complex, challenging behavioral health issues who typically represent the upper 10 – 20% of a “severity pyramid”.

HFW is an evidence-informed practice that is firmly grounded in system of care values including:

- Individualized and family and youth driven services
- Strengths-based practice
- Reliance on natural supports and building self-efficacy
- Team-based practice
- Outcomes-based service planning
- Cultural and linguistic competence

Emerging evidence indicates superior outcomes for youth receiving HFW as compared to those who receive traditional services. Examples include a comparison study completed on youth in child welfare (comparing youth receiving HFW with those receiving “mental health services as usual”) finding that after 18 months, 82% of youth who received wraparound moved to less restrictive, less costly environments, compared with 38% of the comparison group (*Return on Investment in Systems of Care, National Technical Assistance Center for Children's Mental Health, April 2014*).

Additional evidence is found in state-wide initiatives such as Wraparound Maine which found a 28% reduction in total net Medicaid spending for youth served through HFW, even as home and community based services increased. These cost reductions occurred as a result of a 43% drop in the use of psychiatric inpatient treatment, and a 29% decrease in the use of residential treatment (*ICC using High Quality Wraparound: State and Community Profiles, Center for Health Strategies, July 2014*).

Evidence in support of HFW also lies in follow-up outcomes noted in Los Angeles County that over a 12 month follow-up period, 77% of HFW graduates were in less restrictive placements, while 70% of the comparison group (non-HFW recipients) were in more restrictive placements. Additionally at follow up, the mean service costs for youth following completion of HFW were 60% lower than the costs of the comparison group (*Return on Investment in Systems of Care, National Technical Assistance Center for Children's Mental Health, April 2014*).

ICC using the HFW approach is a process of care management that holistically addresses the behavioral and social needs of a youth and family in order to develop self-efficacy. The youth and family are integral to the HFW process which provides them with voice and choice in the selection of their “team”, development of the plan and delivery of services. The youth and family are supported in this team process by the ICC (team facilitator), trained youth and family support partners, the professional system partners and those natural supports identified as important by the family. This team works together to identify the family’s vision, goals and needs and then develops specific measurable plans to accomplish those outcomes making certain to honor the family culture. The HFW model follows a “structured” series of four phases (Engagement and Team Preparation, Planning, Implementation, Transition) with associated activities and hallmarks. These include:

- Specific youth/family orientation and engagement practices
- Development of a short-term Crisis Stabilization Plan which targets pressing needs identified by the family. The development of this plan is done by collaborating with system partners (who may already have a crisis plan in place) and utilizing family and youth voice.
- Completion of a unique form of assessment called a Strengths, Needs and Culture Discovery (SNCD) which is distinct from traditional clinical assessments as its purpose is to tell the family story, does not emphasize diagnosis and avoids a problem-oriented focus. In the Discovery, the youth and family tell their story, share their unique strengths and family culture, define their needs and goals, and come up with a family vision. The Discovery process is informed by system-requirements and mandates if they exist, and the facilitator is responsible for communicating with system partners to understand these mandates.
- The formation of a youth and family team to identify and carry out action plans that are different from traditional service plans by being frequently revised, driven by youth and family preference, with a focus on needs as opposed to services, and the significant reliance on natural supports to accomplish desired outcomes.
- Completion of a Functional Assessment on the team-defined potential crisis behaviors in order to better understand the function/purpose of the behaviors as well as what is reinforcing the behaviors.
- Development of a Crisis Prevention Plan incorporating the Functional Assessment, as well as youth and family voice regarding what the results of the Crisis Prevention Plan should be, and use of a measurement strategy that will determine if the Crisis Prevention Plan is accomplishing what the team wants it to achieve.
- Development of a purposeful transition plan that incorporates formal and natural supports in the community.

The HFW model embraces a specific Theory of Change which centers on increasing youth and family self-efficacy by prioritizing youth and family needs, developing natural supports, and integrating planning. As a result of the Theory of Change, and the structured phases and activities, ICC in a HFW Model is distinct from other clinical and case management approaches.

While ICC in a HFW Model is *not a traditional clinical service*, skilled ICC workers will require and utilize many clinical skills including relationship building/engagement, soliciting and empowering client voice, conflict management, facilitating group process, understanding and management of group dynamics, assessing group themes and needs, knowledge of various clinical and related community services, development of case plans, crisis intervention planning and skills, and monitoring progress. While ICC in a HFW Model is *not traditional case management*, many traditional case management activities (e.g., assessment, case planning, service linkages, advocating for the family and youth, and monitoring progress) are accomplished through the guidance and activities of the team (while reducing the prominence of the case manager as the central figure). Specific case management activities assigned to the ICC Facilitator **by the team** are appropriate (e.g., maintaining communications between team members, assisting the youth/family with referrals and service linkages, advocating for youth/family when needed and desired) and as a result the ICC Facilitator does more than “simply facilitate the team”. It is through an understanding of the family culture that the team is able to successfully develop plans and complete case management activities. Ownership and voice is given back to families who know best what works for them. Emphasis on the HFW Theory of Change which develops youth and family self-efficacy, and following the specific phases and activities of the evidence-informed HFW model also sets ICC in a HFW model apart from traditional case management.