

# CNES Report

CHILDREN NEEDING EXTENSIVE SERVICES (CNES) WORK GROUP  
OF THE CHARLOTTESVILLE/ALBEMARLE COMMISSION ON CHILDREN AND FAMILIES

November 2003



## ACKNOWLEDGMENTS

The Children Needing Extensive Services (CNES) work group, under the direction of the Comprehensive Services Act (CSA) Committee of the Charlottesville/Albemarle Commission on Children and Families (CCF), has compiled this report after four years of intensive work towards completion of its charge as issued in 1998. The expertise and cooperation of professionals from a cross section of the service community have proved to be invaluable. They cannot be thanked enough for their perseverance, insight and commitment to the improvement of the quality of lives for the children in need of extensive services.

Current members of the work group include:

- Kathy Ralston, Chair, Albemarle County Department of Social Services
- Susan Brumfield, Charlottesville Department of Social Services
- Terry Coffey, Albemarle County Department of Social Services
- John Hesperheide, 16th District Juvenile & Domestic Relations Court Service Unit
- Cheryl Lewis, Albemarle County Department of Social Services
- Bill Lieb, Community Attention
- John Pezzoli, Region Ten Community Services Board
- Dasretta Sapp, Charlottesville Public Schools
- Peter Sheras, University of Virginia
- Marti Snell, University of Virginia
- Cindy Stratton, CCF Comprehensive Services Act Coordinator

Many other individuals have participated in the progress and accomplishments of the CNES work group over the last four years and our sincere thanks is extended to each of them for their individual contributions.

- Saphira Baker, Charlottesville/Albemarle Commission on Children and Families
- Julie Benoit, Charlottesville Department of Social Services
- Carl Brown, Court Service Unit
- Rory Carpenter, CCF Juvenile Justice Coordinator
- Lisa Climer, Charlottesville Department of Social Services
- Johnny Ellen, Charlottesville Department of Parks and Leisure Services
- Mike Holmes, Albemarle County Department of Social Services
- Daniel Key, People Places
- Lee Lee Lawless, Juvenile Court Assessment Center
- Cartie Lominack, Shelter for Help In Emergency
- Pat Mullaney, Albemarle County Parks and Recreation Department
- Kris Santa Maria, Charlottesville Department of Social Services
- Jeff Sobel, CCF Private Provider Representative
- Debbie Stone, CCF Comprehensive Services Act Coordinator
- Jennifer Stone, CCF Comprehensive Services Act Coordinator
- Bill Traylor, Charlottesville Department of Social Services



## INTRODUCTION

In 1998, Charlottesville/Albemarle Commission on Children and Families (CCF) members identified Children Needing Extensive Services (CNES) as a priority issue. The original charge to the group was to: Analyze and track the local population needing the most extensive services (primarily funded through CSA) and make recommendations on their current and future service needs. Members defined these children as: *“Children poised to harm themselves or others and likely to require costly out of home placements and innovative treatment programs currently served by one or more agencies on the CSA committee or children currently unknown to these same systems but either they or their families exhibit similar behavior patterns.* The current charge is attached to this report (Appendix A).

To address this priority, the Comprehensive Services Act (CSA) Committee was charged with the development of a CNES work group. Since 1999, the CNES Work Group has conducted research on the characteristics and service histories of children with extensive needs, explored promising practices, convened roundtable discussions with stakeholders, modeled and piloted service enhancements, and assigned pressing issues to other CCF work groups for action, such as those addressing family violence and juvenile justice.

This report summarizes the status of the initiatives undertaken by CNES members, and presents specific recommendations to the Charlottesville/Albemarle Commission on Children and Families (CCF). A table of the full history of the CNES work group’s research and development efforts leading up to these recommendations is attached (Appendix B).

CNES work group members recommend the following four strategies, detailed more fully in the subsequent section. Work group members believe that the all-volunteer committee structure employed to date is insufficient to guide the next phase of implementation for CNES service improvements, and that full development of these recommendations will require additional staff resources.

- 1) **Continue a Consultant Panel of expert professionals**
- 2) **Establish a Care Coordinator Service**
- 3) **Explore a Secure Communications web site**
- 4) **Create a “Virtual Residential” Program**

**SINCE 1999 THE  
CNES WORK GROUP  
HAS CONDUCTED  
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The report appendices as well as information contained herein represent the careful gathering, analysis, review and synthesizing of case records of children and families.

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These children are often invisible to the community at large, seen only through the lens of budgets, charts and graphs. The “call to arms” for these children is often lacking because there are relatively few CNES children compared to the total population. Since the July 2000 report the CNES caseload has grown from thirty-six to fifty-one currently on CSA caseloads. Issues of safety, costs outpacing the ability of the locality to help these children and the loss of human capital to the community are all compelling reasons to develop alternatives.

These children often become the adults in our communities who end up in our jails, on the street or as members of a second, third and fourth generation of families in the “systems.”

## **RECOMMENDATIONS**

The CNES work group has four final recommendations that require additional staff resources to implement. The work group believes that the recommendations are substantive enough in day-to-day oversight that a work group can not be effective functioning in this role. Furthermore, based on the December 2003 report to the Commission from the CSA Cost Containment Subcommittee, coordination of these recommendations with those already approved by the Commission will be critical.

**A. CONTINUE THE CONSULTANT PANEL(S) FOR ONE YEAR ON A PILOT BASIS WITH UP TO FOUR CNES CASES TO BE IDENTIFIED BY THE CASE AUTHORIZATION AND REVIEW TEAM (CART).**

The work group piloted two multidisciplinary panels comprised of local medical, psychiatric, education, vocational and other professionals who do not normally participate in the Family Assessment Planning Team (FAPT) process yet are highly regarded in the professional community. Panel members were selected not only for their knowledge but also based on



the specific needs of the CNES cases that were selected. Panel members were provided job descriptions for their role and follow up feedback was obtained for fine-tuning the process (Appendices C and D). Upon presentation by the case manager and a review of the case, panel members provided innovative strategies that were implemented by each case manager and, more importantly, had not been thought of at the FAPT/case management level. In evaluating the panel, both case managers believed that the strategies had positive results for their cases and the work group learned that some strategies could be implemented system-wide with positive results. Among the findings that would provide more information to make better decisions are: improved tracking of medication/medical history; better monitoring of children through a care coordinator services; and better documentation of family strengths, educational history and child abuse and neglect. In addition, through the pilot, the work group learned that videotaping the panel would allow for a review of the discussion without extensive note taking and also provide a training opportunity for other case managers.

As a result of the positive feedback from the panel members and case managers involved in the review, the newly identified case-specific and system-wide strategies, the work group believes the panel has promise for future enhancement of how our system deals with CNES children. Every effort will be made to obtain the consultations at a reduced or no cost during the pilot phase (Appendix E). CCF staff availability will depend on whether two new positions – a FAPT Coordinator and Utilization Manager – are funded by the localities in fiscal year 2005, thereby allowing the CSA Coordinator to focus on more innovative prevention and policy issues. The work group envisions the consultant panel potentially blending with recommendation C below through the use of technology that may provide more efficiency for panel members as well as case managers. If CCF staff time allows, evaluation of the effectiveness of the panel would be completed by an appropriate Commission staff member or a re-structured CSA Committee. A table outlining the process for the panel is attached (Appendix F).

***Coordination with the CSA Cost Containment Subcommittee recommendation for establishment of a single Family Assessment and Planning Team*** – Although the CNES Work Group has identified CART as the conduit for cases to the panel, this could change depending on the outcome of the single FAPT concept as well as the strategy identified in the Cost Containment report regarding gaining efficiencies in the CSA Committee/CART structure.

**PANEL MEMBERS PROVIDED INNOVATIVE STRATEGIES THAT WERE IMPLEMENTED BY EACH CASE MANAGER AND, MORE IMPORTANTLY, HAD NOT BEEN THOUGHT OF AT THE FAPT/CASE MANAGEMENT LEVEL.**



**B. ESTABLISH A CARE COORDINATOR SERVICE AT REGION TEN COMMUNITY SERVICES BOARD AS A PILOT PROGRAM FOR AT LEAST ONE YEAR TO BE USED IN CONJUNCTION WITH THE CONSULTANT PANEL.**

The complexity of service needs and collaboration between multiple service providers for CNES children requires a level of professional case management and treatment knowledge that includes a vast array of clinical, analytical, mediation, organizational and administrative skills and abilities. The idea of the care coordinator is that a highly trained and experienced clinician is assigned a relatively small caseload of children receiving intensive CSA services, including most often, residential services. The care coordinator will augment the services of the case manager and specialize or target these services on clinical efficacy, utilization management (from a

**THE CARE COORDINATOR WILL AUGMENT THE SERVICES OF THE CASE MANAGER AND SPECIALIZE OR TARGET THESE SERVICES ON CLINICAL EFFICACY, UTILIZATION MANAGEMENT...AND QUALITY ASSURANCE.**

clinical perspective), and quality assurance. It is anticipated that Region Ten would use existing staff for this pilot year to provide this service but would access existing CSA pool funds to purchase the

service. If the pilot is successful then a full time position may be warranted (Appendix G).

***Coordination with CSA Cost Containment Subcommittee recommendation for establishment of a Utilization Manager*** – the Utilization Manager job description outlines responsibilities to facilitate fiscal accountability, monitoring and reporting of vendor effectiveness and cost management, negotiation of service rates and levels and other cost containment activities. The Care Coordinator service would complement the Utilization Manager in that it would provide clinical case management services. Both have a focus on efficient and effective service delivery but from different vantage points. Coordination between the two would provide the highest degree of fiscal and clinical accountability.



**C. EXPLORE CRYPTOHEAVEN OR ANOTHER DESIGNATED SERVICE AS A SECURE WEB-BASED COMMUNICATIONS AND STORAGE SPACE PROVIDER FOR ONGOING DISCUSSION/COMMUNICATION OF CNES OR POTENTIAL CNES CHILDREN.**

The process of coordinating a Consultant Panel for case discussion/review and recommendations is lengthy and can prove untimely to meet the needs of the child, family and or case manager’s service planning needs. The development of a secure web-based communication/storage site (consistent with all applicable state and federal regulations concerning confidentiality for access to case specific information) would be a valuable asset in peer consultation and case management/planning for these children and their families. The development of this system would serve to provide a secure and accessible process for timely consultations and case management brainstorming as well as a potential mechanism to maintain community awareness with regard to the needs of CNES children. The work group’s initial assessment of CryptoHeaven’s web-based service was that it had promise and could be a more efficient way to obtain professional consultation on difficult cases. Site maintenance, monthly fees, set-up fees, etc. would have to be researched and an analysis done regarding the feasibility of this kind of technology (Appendix H).

**THE DEVELOPMENT OF A SECURE WEB-BASED COMMUNICATION/STORAGE SITE WOULD BE A VALUABLE ASSET IN PEER CONSULTATION AND CASE MANAGEMENT/PLANNING...**

**Coordination with the Information Sharing Subcommittee** – Link with the proposed development of an electronic information-sharing system spearheaded by the Juvenile Justice Advisory Committee’s “Information-Sharing Subcommittee”. Both groups seek to make time sensitive information available to case managers and other professionals (with required release of information consent from parents) to improve service delivery, responsive intervention and non-duplication of services.



**D. CREATE A “VIRTUAL RESIDENTIAL PROGRAM” THAT IS COMMUNITY-BASED FOR CNES CHILDREN WHO ARE TRANSITIONING BACK TO THE COMMUNITY OR WHO LIVE IN THE COMMUNITY.**

The work group identified twenty-two solutions to the two common barriers (crisis stabilization and transitions) that are faced by local residential, in-home and day treatment providers (Appendix I). Both are flashpoints for the child, family and community. The work group developed a process to prioritize the list of solutions to both barriers and identified the virtual residential program as the top priority.

**A POTENTIAL STRESS POINT FOR THE CHILD, THE FAMILY AND THE COMMUNITY IS THE TRANSITION FROM THE RESIDENTIAL SETTING TO THE HOME COMMUNITY.**

“Virtual Residential” is defined here as a coordinated, child specific set of services which “wrap-around” a child in such an intensive, comprehensive fashion as to emulate a residential setting in the home community, changing over time as the child’s needs change.

Each report that the CNES work group has generated from community roundtables or internal analysis has had one common theme. CNES children are our most expensive children to care for and changing from a residential approach to a community-based approach will not necessarily result in dollar savings. Their needs are great, and providing care, whether it is in a “secure building” or in a “secure virtual building” will be costly. Most CNES children will continue to need residential care due to their presenting behaviors and problems. Residential care is a positive and needed structure but often results in a loss to the child of community and family ties that provides a link to their past and their future that is unsettling if it goes on too long. This happens regardless of the best efforts of case managers to maintain those ties.

A potential stress point for the child, the family and the community is the transition from the residential setting to the home community. Transition, if managed with the right kind of support can re-link the child and family or community in a positive way creating more opportunity for a positive outcome. But, if the right supports are not in place, it often results in poor outcomes



and continued costly residential placement. A particular challenge is having a place for the child to live such as a group home, therapeutic foster home, kinship foster home or similar living situation during the transition. A virtual residential program would provide a step down to a team of service providers where the residential structure would continue for a specified period of time depending on the child's needs, providing a smoother transition for everyone

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involved. It would likely involve intensive in-home and school services with twenty-four/seven accountability. Each child would have a personally designed virtual residential program based on their needs and the needs of the family/placement provider and the community prior to the child's re-entry to the community. Services would be customized by the FAPT/case manager with the goal of maintaining a structured set of services that emulate a residential structure within the child's home community. Some services may not be readily available and would have to be created by local providers. Others may be readily available but may need to be enhanced to accommodate the extensive support that would be needed. The team of service providers would have clear expectations for outcomes and meet regularly to discuss the case. One of

the most positive outcomes would be the child's continued link to their home community and the family's investment in their child's success.

Many local providers, through the roundtable discussion, identified this as a need. Yet, there is no clear leader to galvanize these providers into action. To that end, CCF should provide a process and an expectation for providers to meet, create and put into action memorandums of agreement to ensure that a collaborative approach is in place with all of our local providers to provide the services identified.

**Coordination with CSA Cost Containment Subcommittee** – the Utilization Manager could include this collaboration and resulting action as part of reporting on vendor effectiveness. Additionally, the virtual residential programming is seen as part of a continuum with the crisis/stabilization services outlined in the Cost Containment subcommittee report.



## **BACKGROUND**

The CNES Work Group has developed the above recommendations as a result of three phases of operation. While a full status report follows, the work group produced two earlier reports, implemented recommended strategies, held several roundtables, and piloted innovative initiatives beginning in 1999.

### **1999-2000**

In 1999, the CNES Work Group was charged by CCF to focus on four milestones:

- Contact vendors currently in use and ask them to propose service alternatives to our higher cost placements;
- Determine whether the current programming offered through our schools, recreation programs, libraries, etc., is sufficient for the community to care for these children;
- Contact local hospitals (University of Virginia Hospital, Martha Jefferson Hospital and Charter Behavioral Health System of Charlottesville) to determine use of bed space at reduced rates with privileges from local providers to provide services, and;
- Finalize the Request for Proposals (RFP) developed by the Community Policy Management Team (CPMT) in 1998 and obtain bids.

The Commission was hopeful that the implementation of these milestones could help achieve success by having the ability to make ongoing cost comparisons, by the development of programs structured for this population, by lowering costs and by achieving the same or greater success with the children and families.

### **1999-2000**

In July 2000, the CNES work group issued a report of their findings (Appendix J), with the following recommendations:

- CCF should host a local roundtable discussion with vendors and service providers (inclusive of area hospitals, public recreation, police, juvenile justice, schools) to brainstorm about, or design, services in the community



to meet the needs of these children and families;

- CCF should initiate a “wake-up” call to area leaders and the community at large in the form of presentations, roundtable discussions, etc. CCF should take the lead on initiating a public dialogue about the problem;
- CCF should develop a guide for recommended funding priorities for the two local governments as well as a guide for private funding sources, and
- Social workers, counselors, teachers, and others who work with children and youth should receive training in early screening and identification of drug and alcohol use or dependence, depression, and hyperactivity and attention deficit disorders. Routine early screening programs should be instituted.

### **2000-2001**

CCF asked the work group to pursue these recommendations and report back upon completion. In October 2000, the work group held a community roundtable discussion among sixty-five professionals including CCF members, practitioners from the fields of education, social services, mental health and juvenile justice, the State Office of Comprehensive Services and private service providers. A third report of findings to the CCF was completed in December 2000 (Appendix K), with the following recommendations:

- Continue and expand upon the “team approach” of collaboration among agencies to plan services and provide case management for the children with the greatest needs;
- Bring services into the communities where and when they are needed most to strengthen early intervention and prevention efforts;
- Improve the system of services for transitioning children back to the community from residential placements;
- Tackle domestic violence in cooperative efforts throughout the community, to lessen negative effects on children’s intellectual, emotional and behavioral development;
- Fill the gaps in local services, including an assessment/diagnostic center and a secure facility to provide a continuum of emergency, short-term and long-term crisis services.



## 2003 REPORT ON STATUS OF ALL RECOMMENDATIONS TO DATE

1. To contact vendors currently in use and ask them to propose service alternatives to our higher cost placements.

***Accomplished:** Held two Roundtables with in-home providers, therapeutic foster care and residential providers to discuss service alternatives, barriers and solutions to community-based services. Identified common solutions.*

2. Determine whether the current programming offered through our schools, recreation programs, libraries, etc., is sufficient for the community to care for these children.

***Partially Accomplished:** A discussion was held with area professionals including local government and Parks and Recreation officials to conduct an informal inventory of these services, but the work group did not formally assess whether they were sufficient.*

3. Contact local hospitals (UVAH, MJH and Charter Behavioral Health) to determine use of bed space at reduced rates with privileges from local providers to provide services.

***Not completed:** During the time period of the CNES work group, the two sole providers of adolescent psychiatric beds (Charter and UVA Hospital) in the community closed. None of the local hospitals responded to the RFI issued by the work group.*

4. Finalize the Request for Proposals (RFP) developed by the CPMT in 1998 and obtain bids.

***Modified:** Determined that RFP was too outdated, had too many legal obstacles and was broader than CNES focus. Instead, issued a Request for Information (RFI) with CNES focus to determine vendor interest in locating the service in this community. Determined that no vendors were willing to develop a program locally that would meet our needs due to scope, number of children eligible and cost.*

5. CCF should host a local roundtable discussion of vendors and service providers (inclusive of area hospitals, public recreation, police, juvenile justice, schools) to brainstorm about, or design, services in the community to meet the needs of these families.



**Accomplished:** Roundtable hosted in October 2000. Report issued December 2000 with five recommendations for improved services.

**6. CCF should initiate a “wake-up” call to area leaders and the community at large in the form of presentations, roundtable discussions, etc. CCF should take the lead on initiating a public dialogue about the problem.**

**Underway:** CCF Legislative Forums, annual reports and research briefs have included data on CNES to raise awareness on the needs of these children, yet there has been no public dialogue to date. Not a recommendation for CNES Work Group.

**7. CCF should develop a guide for recommended funding priorities for the two local governments as well as a guide for private funding sources.**

**Not completed:** CCF has insufficient staff resources to complete.

**8. Social workers, counselors, teachers, and others who work with children and youth should receive training in early screening and identification of drug and alcohol use of dependence, depression, and hyperactivity and attention deficit disorders. Routine early screening programs should be instituted.**

**Delegated:** Current screening tools were identified, however the work group, in collaboration with Juvenile Justice Advisory Committee, recommended a new work group on interagency risk and need screening process. That group is currently drafting a tool.

**9. Continue and expand upon the “team approach” of collaboration among agencies to plan services and provide case management for the children with the greatest needs.**

**Accomplished:** Work group designed and piloted a Consultant Panel concept. Recommends continued piloting of the concept for one year to determine if initial positive results continue.



**THE WORK GROUP  
RECOMMENDATIONS  
ARE NECESSARY  
FOR ADDRESSING  
THE CHALLENGES  
FACED BY THE  
LOCALITIES IN  
SERVING CHILDREN  
NEEDING EXTENSIVE  
SERVICES.**

- 10. Bring services into the communities where and when they are needed most to strengthen early intervention and prevention efforts.**

***Delegated:** Work group determined that existing early intervention programs through the Partnership For Children (PFC) were effectively working on this recommendation and further efforts would be duplicative. Commission staff and members on the PFC help maintain the thread with early intervention and impact on CNES later.*

- 11. Improve the system of services for transitioning children back to the community from residential placements.**

***Partially Accomplished:** A common system of services has been identified using two Roundtable discussions. Work group recommendations for enhanced services for children in transition are in this report.*

- 12. Tackle domestic violence in cooperative efforts throughout the community, to lessen negative effects on children’s intellectual, emotional and behavioral development.**

***Delegated:** In collaboration with the Juvenile Justice Advisory Committee and the Charlottesville/Albemarle Council on Sexual & Domestic Violence, the CNES Work Group recommended a new Domestic Violence work group of the Commission. The new work group was established in 2002.*

- 13. Fill the gaps in local services, including an assessment/diagnostic center and a secure facility to provide a continuum of emergency, short-term and long-term crisis services.**

***Partially Accomplished:** A Request for Information (RFI) was issued but no vendors were found to provide specific service as outlined. New recommendations for a “virtual residential” placement program in the community among other services to fill the gaps are in this report. CSA Cost Containment Subcommittee issues same recommendation, November 2003.*



## CONCLUSION AND NEXT STEPS

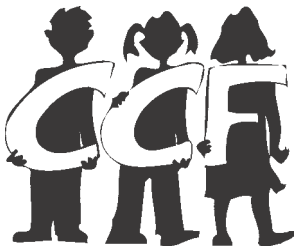
The CNES work group has finished their work and requests that the Commission accept this final report as a closeout report. Although the implementation of the work group's recommendations may not guarantee lower cost of services, we anticipate the following outcomes:

- An effective approach is in place for CNES to assure that all efforts have been made to assist a child within reasonable cost considerations;
- A vehicle is in place where professionals can bring innovative strategies regarding untried interventions that may help the child more in the long term than conventional strategies;
- The best available local expertise is leveraged to work with CNES families, and community resources are effectively utilized;
- CART, FAPTS and CSA committee members are provided with up to date research and best practices on creative and effective interventions.

The work group recommendations are necessary for addressing the challenges faced by the localities in serving children needing extensive services. The increase in the number of CNES children since the establishment of the work group in 1999, the identification of gaps to the provision of effective and efficient services, and the anticipated outcomes noted above point to the importance of implementing the recommendations contained in this report.

### APPENDICES:

- A. CNES Charter
- B. Chronological View of CNES Work Group Process
- C. Consultant Panel Job Description
- D. Feedback Form/Pilot Results
- E. Consultant Panel Anticipated Costs
- F. Consultant Panel Process
- G. Care Coordinator Job Description
- H. Crypto Heaven Web Sheet
- I. Common Barriers & Solutions to Community Based Services
- J. Executive Summary – CNES Report July 2000
- K. Executive Summary – CNES Report December 2000



**Charlottesville/Albemarle Commission on Children and Families**

**P.O. Box 911, Charlottesville, Virginia 22902**

**Phone: 434-970-3550**

**Fax: 434-970-3653**

**E-mail: [feedback/ccf@charlottesville.org](mailto:feedback/ccf@charlottesville.org)**

**Web: [www.ccfinfo.org](http://www.ccfinfo.org)**