



**CSA Sample Documentation Inventory
and
Suggested Model Utilization Management Plan
(Revised June 2009)**

CSA Sample Documentation Inventory and Suggested Model Utilization Management Plan

Case Name/Number:

Date:

CSA Documentation Inventory

Required Information	Location	N/A - Notes
Case Manager designation		
Parent consent to release information		
Assessment data		
Includes: Completed CANS™		
Parental co-payment assessed		
Service Plan IFSP FC Plan IEP (circle)		
Desired outcomes & timeframes		
Identification of services		
Recommended level of need		
Mitigating circumstances		
FAPT or MDT recommendations		
Parent/Guardian participation & consent to service plan		
CPMT authorization		
Signed vendor contract		
Vendor treatment plan (s)		
Vendor progress report (s)		
Utilization review data		
Updated Service Plan		

MODEL UTILIZATION MANAGEMENT PLAN

Utilization management (UM) is a set of techniques used by or on behalf of purchasers of health and human services to manage the provision of services through systematic data driven processes.

Utilization review (UR) is a major component of the State Executive Council approved utilization management process. Utilization review is a formal assessment of the necessity, efficiency and appropriateness of the services and treatment plan for individual youth served through CSA.

DEFINITIONS:

There are common abbreviations used in the CSA process that can be confusing for people not familiar with the process. The following is a list of some of the most common:

CANS – Child and Adolescent Needs and Strengths assessments. This is the state approved mandatory uniform individual assessment tool for every youth served through CSA.

CPMT – Community Policy and Management Team – the local entity that is responsible for all policies and procedures for the implementation of the CSA structure in the locality.

CSA – Comprehensive Services Act – the legislative authority for providing services across agencies. Commonly used to mean the process through which services are determined and funded.

DSM IV – R – This is the *Diagnostic and Statistical Manual of Mental Disorders*. It is a manual used by clinicians to guide the diagnostic process.

EPSDT – This is the Early Periodic Screening, Diagnosis, and Treatment program of Medicaid. It's required in every state and is designed to improve the health of low-income children, by financing appropriate and necessary pediatric services. [EPSDT Website](#)

FAPT – Family Assessment and Planning Team – the local team that develops and supervises the implementation of services for youth served through CSA.

IEP – Individual Education Plan – This is the plan developed by the local school division for youth with special education needs.

IFSP – Individual and Family Services Plan – This is the plan developed by the FAPT for services for the youth and family. The IFSP is driven by the family and based on the strengths and needs assessed on the CANS.

OSC – Office of Comprehensive Services – This is the state office that oversees and provides technical assistance to the localities for the administration of CSA.

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Localities are in the best position to develop Utilization Management plans that meet their unique needs, however there are some common elements that when incorporated in the plan assist the locality in having a robust and functional plan. To assist localities in assessing their plans, the model UM plan is offered as a way to assure that all aspects of UM and UR are incorporated.

I. ASSESSMENT/REFERRAL

Services for youth and their families should be driven by the needs and preferences of the child and family, and address these needs through a strength-based approach. To facilitate this idea, all referrals to the local government's Family Assessment and Planning Team (FAPT) should include a completed a comprehensive referral packet and/or assessment form. This assessment should cover all aspects of the child's life and assess all 11 life Domain Areas including:

- Income/Economic issues for the family,
- Psychological/Emotional, Spiritual (basic beliefs as well as religious preferences),
- Cultural/Ethnic (the group the family identifies with and the associated positive self-esteem and identity),
- Safety (freedom from illegal behaviors and violent activities),
- Medical concerns or educational needs related to medical concerns,
- Educational/Vocational opportunities or needs,
- Social (friends, social supports who are the people in their lives),
- Family (include people who may not be biologically related, but are considered family),
- Residential (where does the family live?),
- Legal (This includes protection of the family/youths rights as well as any legal involvement).

The following sources may contain information related to the above life domains and could be useful in addition to a face-to-face family assessment:

- Recent social history,
- Recent psychological evaluation,
- Recent psychiatric evaluation (including all five DSM-IV axes),
- Recent CANS summary page,
- Latest physical exam (including any documentation of any medical issues/problems and current medications),

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- Summary of past placement and treatment history (including what the family and youth perceived as useful and what was not useful),
- Current IEP,
- Recent educational testing,
- Record of court involvement,
- Foster care service plan.

If these items are used, confer with the family as to the correctness of the content as they perceive it. Often the family will have different views of events and circumstances described in the formal documents that are helpful in assisting the family with telling their story. Other items needed during the assessment process include parental/guardian signatures and/or the youth's signature as developmentally appropriate, on a Release of Information form, and a document describing parental rights. In addition, the child and family should be assessed for eligibility or access to alternate payment sources (i.e. Medicaid, IV-E funding, and for non-mandated children parental co-pay ability or insurance).

The Case Manager, Service Coordinator, or other designated person from the referring agency collects the assessment and referral information including gathering the family history and strengths. Prior to scheduling the FAPT meeting, a review of the case referral and assessment information should be completed by the designee of the FAPT to ensure that the child is eligible and appropriate for CSA funding. Any mitigating circumstances that would support the level of care being considered would be appropriate to include in the documentation.

If the child is found eligible and appropriate for services by the FAPT designee, then the referral information should be sent to the person responsible for scheduling the initial FAPT meeting. The CSA coordinator or a designated FAPT member should also review the information to ensure an appropriate referral. Distributing copies of the referral packet to all members of the team helps assure that everyone has some familiarity with the youth and family being presented.

It is strongly recommended that all interested parties, including legal guardians, foster parents, extended and adoptive families and anyone the family sees as a support in their community participate in all FAPT meetings, especially the initial FAPT meeting. The child and family are involved in all aspects of the development and implementation of the Individual Family Service Plan (IFSP).

LINKS/ATTACHMENTS: Tools for Gathering of Assessment/Referral Information:

- Comprehensive Family Assessment Guidelines for Child Welfare

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- http://www.acf.hhs.gov/programs/cb/pubs/family_assessment/index.htm
- Key Elements of Team Decision Making
 - <http://www.aecf.org/upload/pdf/files/familytofamily/keyelements.pdf>

II. IDENTIFICATION OF OUTCOMES/GOALS FOR TREATMENT

After review of assessment information at the initial FAPT meeting, with the full participation of the youth and family, outcomes and goals should be developed based on the strengths of the youth and family and encompassing the needs that are to be addressed. It is important to remember that this is the youth and family's plan, which the professionals have helped them to define. It is not the professional's plan that the family has been allowed to review.

The CANS is a tool that has been adopted to assist localities in assessing a youth and family's strengths and needs. Any item in the CANS that reaches the level of a 2 or 3 is considered an actionable need and should be addressed in the plan of care developed by the family and team.

Long-term goals are broader than objectives, and should describe the desired behavior changes that are being addressed in the IFSP over the next 12 months. The goals should be directly related to the CANS assessment dimensions and address all actionable needs.

Example of a long-term goal for a youth in a residential facility: Youth will learn replacement behaviors for aggression to the extent that he can safely return to a community setting.

Objectives should describe the desired behavior changes that are being addressed in the IFSP or provider plan that will be the focus of treatment over the next few weeks or months. They should be related to the broader long-term goals, but more specific, measurable, and observable. Terms such as uncooperative, aggressive, disrespectful are not measurable. Instead, look at the actual behaviors or verbalizations that lead to that conclusion. Writing goals in terms of increasing the desired behaviors helps focus on the family and youth's strengths and emphasizes the idea that people believe the youth can behave differently. There is a basic and underlying reason for the behavior the youth or family is exhibiting that can be fulfilled through another behavior. If the reason can be discerned, then an alternative can be planned. Time frames for completion and the persons/agency responsible for coordination of each short-term goal should be identified on the IFSP.

Example of an objective that correlates to the above long-term goal: Youth will identify and practice 3 behaviors to be used in place of hitting peers prior to the next review period. Target Date: April 15, 2010. (FAPT may defer objective to the service provider treatment plan and

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concentrate on the long - term goals while others may take a more active role in the treatment planning process depending on the individual needs of the family and youth.)

Parents, foster parents, guardians and other interested parties should be included in the identification of goals. The youth should also be included in goal setting as age and appropriateness of inclusion permits. Parents/Guardians and the youth should sign the initial IFSP and any updates, to indicate their consent and agreeability to the plan.

Other plans of care such as the foster care service plan or Individual Education Plan (IEP) should be referenced in the overall service plan and the goals and objectives should be complementary in each plan.

III. DEVELOPMENT OF THE SERVICE PLAN

The IFSP is developed by the youth, family, case manager, and the FAPT. Developing an individualized plan of care for the youth and family includes using the strengths of the family unit and the natural community supports as well as the professional services available that meet the family's needs. Every effort should be made to keep the family together and safe. Priority should be given to keeping the child in the community if he/she must be removed from the home to facilitate family therapy and visitation. Settings that are more restrictive should be considered only if they are necessary for the youth, family or community safety or are essential for adequate treatment of the youth's condition.

Efforts should be made to utilize Medicaid, including EPSDT, and/or IV-E funds, whenever possible. Consider the use of Medicaid and/or IV-E facilities if the child is eligible for these funding sources.

While each locality should make appropriate decisions for the locality, the guidelines for the Frequency of Administration of the CANS may provide a rule of thumb for the frequency of UR.

If the youth is receiving solely non-clinical community based services such as mentoring, job coaching in their home, relative home, regular foster home or independent living arrangement, a UR may only be needed every 6 months, or more frequently based on the needs of the youth and family

If the youth and family are receiving or may need clinical services such as substance abuse treatment, sexual offender treatment, anger management or a combination of two or more

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services such as a parent aide, respite care, or after school program, then it may be appropriate to do a UR every 3 months.

If the youth is receiving or may need intensive in-home services, therapeutic foster care or residential care, UR would be appropriate at least every 3 months. If the child is in a psychiatric hospital, or a psychiatric residential treatment facility, more frequent reviews would be appropriate. In the case of psychiatric hospitalization, it may be appropriate to contact the hospital on a weekly or even daily basis depending on the severity of the youth's symptoms.

Determine any mitigating circumstances (unique and challenging situations) that need to be considered in determining the level of need and choice of service provider. Mitigating circumstances may provide a rationale for selecting certain services and/or placements over others. Mitigating circumstances may warrant consideration of more restrictive placements than those identified after initial assessment. If mitigating circumstances are a factor in placement decisions or in an adjustment of the level of need, they should be documented clearly in the case file.

Examples of Common Mitigating Circumstances

System Factors	Individual Factors
Placement safety	Ineffectiveness of current treatment
Community safety	Child's unwillingness to cooperate with treatment
Community attitude towards children with serious emotional disturbance	Family preferences for or against particular treatment modalities
Community resources	Resources of the caregiver, family, and/or extended family
Legal constraints	

The IFSP should clearly indicate the youth and family's strengths, the youth's level of need, most recent DSM-IV diagnoses, service history, medications and medical problems (if any), education placement, legal history (if any), current needs, goals and objectives to be addressed (Remember SMART: Specific, Measurable, Achievable, Realistic and Time-based), specific

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time frames to meet these objectives, person(s) and/or agency responsible for implementing each objective, services that were approved, appropriate funding source, potential service providers/vendors and the next utilization review date.

For children receiving special education services, a copy of the most current IEP should be included in the CSA file along with the IFSP.

LINKS/ATTACHMENTS: Tools for writing behavioral Plans:

- Writing Measurable Behavioral Objectives
http://www.collaboration.me.uk/BEHAVIOR_MODIFICATION.php
- #### IV. CONTRACT NEGOTIATION

The FAPT, with the assistance of the family and case manager, is responsible for identifying the vendors to provide services. The service fee directory on the CSA web site can be used to identify potential providers. In addition, the provider must be properly licensed to provide the services offered, must have current insurance that meets the local governments (county/city) insurance requirements, and must provide acceptable documentation of both.

Placement agreements or contracts should be signed with all vendors that provide services. The locality is buying a service and can discuss and negotiate with the vendor for the services needed for the youth and family. The locality does not have to accept the package of services that the vendor provides to all children. It is important to remember that in order for a plan to be individualized, the vendor also has to provide individualized service planning. Terms should be negotiated that hold the provider accountable for all aspects of service delivery. The following is a list of items to consider in negotiations with providers:

- Whether or not the provider is enrolled to provide services for Medicaid reimbursement
- Reference checks on the provider, to include previous employers, colleagues/associates, and other jurisdictions
- Verify current licensure/certification with the appropriate organizations
- Criminal background checks on employers of the provider and if applicable, the results of any Child Protective Services investigations on employees
- Ability, capacity, and skill of the provider to provide the services required, including verifiable competencies and accreditation

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- The quality of the provider's performance and compliance with parameters on previous contracts or services, where applicable
- Whether the provider is in arrears to the city/county on a debt or contract, or is in default on a surety to the city/county, or whether the provider's taxes or assessments are delinquent
- Rates for services to be delivered

Direct treatment issues to consider when contracting include:

- Requiring the provider to be present at FAPT meetings
- Requiring the development of a written treatment plan that correlates with the IFSP
- Requiring monthly utilization review and/or progress reports
- Allowing chart and on-site reviews by local government staff
- Requiring the provider to collect and report fiscal and service data for the purpose of utilization review

It is recommended that local governments track their experiences with providers so that informed decisions can be made when selecting and contracting with providers in the future. One way to track the data is through an assessment or survey of the provider upon termination of services. Items to consider assessing in a survey include the following:

- Did the vendor follow expectations specified in the contract?
- Was the vendor billing timely and appropriate according to the contract parameters?
- Was the billing clear regarding charges for services delivered?
- Was progress made for the child? If so, what type?
- Was the proposed discharge date met? If no, why not?
- What obstacles or barriers, if any, were encountered with the provider?
- What were the successful events?
- Will you recommend the vendor for future use? If not, why?

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If case managers are expected to negotiate contracts, they should be provided training, guidelines, and support by management staff in achieving this task.

LINKS/ATTACHMENTS: Sample of Comprehensive Vendor Contracts, Sample of a Vendor Evaluation Survey

- [Charles City/New Kent](#) 
- [Fairfax/Falls Church](#)
- [Richmond City](#) 
- [Arlington](#)  (Vendor evaluation survey)

V. IMPLEMENTATION OF THE SERVICE PLAN

Case progress should be assessed and discussed at scheduled FAPT meetings. It is strongly recommended that the service provider attend FAPT meetings with the youth and family and submit written progress reports for each meeting. In addition, the provider treatment plan should correlate with the IFSP. The FAPT meeting should be used to process all gathered information available since the last meeting, and to make decisions regarding components of the service plan. Progress or lack of progress should be assessed for each goal of the IFSP. FAPT members, the case manager, and the family should work collaboratively to ensure that the goals and services are still appropriate to meet the needs of the child. If goals are no longer appropriate, the goals, as well as the corresponding services and interventions should be updated. If however, there is little or no progress towards the goals in the IFSP, and the goals are still appropriate, it is necessary to reassess the interventions being provided by the service provider. All Service Providers should include next steps planning in their service plans.

Between scheduled FAPT meetings, the case manager is responsible for initiating all approved services, monitoring the effectiveness and delivery of these services, and ensuring that the family is in agreement with, understands and participates in the services.

Transition/step-down planning should begin at the start of service planning, preferably at the initial FAPT meeting or shortly thereafter. The IFSP should indicate the identified step-down plan and issues that must be resolved to assist in transitioning to least restrictive services. It is recommended that goals for step-down be developed and included in the IFSP.

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VI. CASE SPECIFIC UTILIZATION REVIEW

Utilization review for youth served through the FAPT process includes but is not limited to:

1. Verification of date services initiated.
2. Verification of delivery of service(s).
3. Verification of quality of service(s).
4. Progress in meeting identified, specific short-term outcomes and goals in Individual Family Services Plan (IFSP) or the IEP as appropriate. (The Utilization Review of the IEP is done by the local school division. Any services in the IFSP that provide support to the family around the IEP are reviewed through the local CSA UM process.)
5. Youth and family's progress in working toward identified, specific long-range outcomes.
6. Current medication status, as applicable including medication changes and corresponding symptoms change.
7. Educational progress.
8. Verification of school attendance.
9. Written materials outlining all modifications vendor has made to IFSP.
10. Current CANS summary sheet if applicable.
11. Participation of family/legal guardian in client interventions and in other services included in the IFSP or the IEP, as appropriate.
12. Strategies being implemented to engage families if they are not currently participating.
13. Changes in plan being made if progress toward meeting goals is not being made. (May include changing services and/or vendors or reconsidering outcomes).
14. Documentation of successful interventions if goals are being met and plan for transition to less restrictive level of care.
15. Date for next utilization review.

Using the data gathered from the utilization review, the person or person's responsible for UR report to the FAPT (if the FAPT is not the entity responsible for UR) and the FAPT takes any necessary actions related to the service plan. Possible actions may include:

- Change length of time for current services
- Change outcomes/goals
- Change placement or provider
- Change treatment modality at same level of need
- Change level of need

VII. UTILIZATION REVIEW OF THE SYSTEM

In order to assess whether or not children served by CSA are receiving the most effective treatment and quality care, local governments should collect and analyze not only case specific information, but also aggregate information specific to their own local government's system of care. By evaluating these types of data, local governments can assess how well services are being delivered by providers, as well as the impact they are having on the children served. Data analysis can assist local governments in determining the appropriateness of treatment for a particular type of child disorder, need, whether or not vendors are providing the most beneficial treatment, and ultimately whether or not program changes and policy development are needed for their respective local CSA systems.

Examples of data that can be collected for the purpose of utilization management:

- a. Recidivism rates by problem type and/or provider/level of service (This can be found by looking at the number and dates of services in the CSA Data Set)
- b. Child's level of functioning as measured by the CANS on admission to service as compared to discharge from service (This will be available through the online CANS system in your locality)
- c. Family satisfaction (based on a survey tool)
- d. Number of cases, emotional/behavioral needs and risk behaviors, requiring secure residential facility treatment (The number of residential services is available on the Data Set, The provider report would be an excellent place to find those secure placements)
- e. Percent of total requests for services based on the age of child, needs/risks, and/or reason for admission to services
- f. Average length of stay by diagnosis type and type of placement (i.e. secure residential placement, group home, treatment foster care home) (This can be calculated using the CSA Data Set in an Excel Spreadsheet)
- g. Annual number of cases in relation to type of discharge/step down placement (This will be partially available by looking at the reason for service termination data element in the CSA Data Set.)
- h. Number and needs/risks of cases requiring residential facility placements for more than 12 months. (The number of youth placed in residential are found in CSA Data Set management reports)
- i. For State Sponsored Utilization Management Program participants, number and type of issues represented in monthly feedback letters on cases sent for review.
- j. The number of children readmitted to residential facilities within six months of being discharged from the residential facilities. (This will be available by looking at the individual services for a youth on the child data card or in the Data Set as a whole)
- k. The number of times a parent/guardian/foster parent attends a FAPT meeting over a designated time period (This would need to be collected locally)
- l. Average cost per unit of service for a given time frame (This will be available through the CSA Data Set)
- m. Comparison of lengths of stay to total cost for different residential treatment facilities

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ACKNOWLEDGEMENTS

Arlington County Comprehensive Services Act Office - Vendor Evaluation Form

Alexandria Community Policy and Management Team

Charles City/New Kent Community Policy and Management Team
Vendor Contract Sample

City of Richmond Comprehensive Services Act
Vendor Contract Sample

Consortium of Williamsburg, James City, York and Poquoson
Tool for gathering of assessment and referral information

Fairfax County Comprehensive Services Act Office
Fairfax County Department of Administration for Human Services, Contracts Division

1. Vendor Contract Sample
2. Portions of the narrative from the Contract Negotiation section were taken from the Fairfax-Falls Church CSA. Policies and Procedures Manual