Office of Children's Services
Empowering communities to serve youth

CSA Utilization Review: Guidelines for Best Practices

October 2024

What is Utilization Review?

Utilization Review (UR) is the formal assessment of the necessity, efficiency, effectiveness, and appropriateness of services. UR occurs at the child/family service level, and in CSA, it measures the progress of the youth and family toward the goals and objectives in the Individual Family Service Plan (IFSP). UR is the process by which the IFSP and services are reviewed and recommendations provided to the Family Assessment and Planning Team (FAPT), the case manager, and/or the service provider regarding the service plan and funded services. UR is a form of checks and balances; it asks if we are getting what we paid for? Are things getting better? How do we know?

UR is not a pathway to second-guessing the case manager, service provider, or FAPT. UR should be a collaborative component of the service planning process. The goal of UR is not to cut costs or services but rather to evaluate the effectiveness of services and supports. While service reductions may be an outcome of UR, in some instances, UR may lead to a recommendation for an increased level, frequency, or number of services. UR should look at progress objectively to improve the outcomes for youth and families.

Is UR Required?

Yes, UR is required. Section 2.2-5206 of the Code of Virginia requires that the Community Policy and Management Team (CPMT) "establish quality assurance and accountability procedures for program utilization and funds management."

Section 2.2-5208 indicates that FAPT, "in collaboration with the family, shall provide regular monitoring and utilization review of the services and residential placements for the child to determine whether services and placement continue to provide the most appropriate and effective services for the child and family." Additionally, FAPT shall "designate a person who is responsible for monitoring and reporting, as appropriate, on the progress being made in fulfilling the individual family services plan developed for each youth and family, such reports to be made to the team or the responsible local agencies."

All localities must have a UR policy. Your policy should include a plan for how frequently UR is completed, who is responsible for completing UR, and procedures that dictate how UR is completed and recorded. The policy should also indicate who is responsible for overseeing the UR process, how oversight is managed, and how to address circumstances that deviate from the adopted practices, policies, and procedures.

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Utilization Review is part of your community's comprehensive Continuous Quality Improvement (CQI) Plan. CPMT can utilize trends collected at the child and family/service level to guide long-range planning or policy decisions.

Who can do UR?

As noted above, the CPMT designates in its policies and procedures how UR is to be completed. There is great flexibility and many options for how the locality chooses to complete UR, and the community must follow whatever plan they identify in their policies and procedures. The FAPT or the CSA Coordinator can complete UR. Some localities have an Identified UR specialist. UR can be a paper review of progress reports and related documents, a site visit, an interview with the provider, the youth, and the family, or a combination of these. However you choose to execute UR, you must have documentation of its occurrence.

UR can also be purchased as a service using CSA funds. UR can be purchased from the local CSB or a private entity. Remember, all services in CSA are child-specific. As a result, if FAPT recommends, UR can be placed on a youth's IFSP as a service, and CPMT can approve the funding for this service. To assure objectivity and avoid conflict, if purchasing UR from the CSB, the UR specialist should not be providing services to the youth and family. Moreover, if UR is purchased from a private entity, that entity should not be providing services to the youth and family.

Communities can also contract with the Office of Children's Services for State-Sponsored UR (for non-educational residential placements). If your locality uses State-Sponsored UR for non-educational residential placements, you will still need to develop a plan for completing UR for community-based services and other levels of care.

What about IEP Placements?

Due to federal mandates associated with the special education process, the IEP team should complete the Utilization Review for IEP placements based on the goals of the IEP. The CSA UR process for special education services must conform to special education laws. It must not violate the Individuals with Disabilities Education Improvement Act (IDEIA) or state special education regulations. Local CSA programs can expect the school division to share the findings of the IEP review of the student's progress, which meets CSA Utilization Review requirements.

How Frequently Should UR be Completed?

Your local UR plan should specify the frequency with which UR is completed. State Sponsored UR is completed 60 days after the initial placement date and every 90 days thereafter.

The following is a sample review schedule:

Service Type	Utilization Review Frequency	CANS Administration
Foster care maintenance, including daycare	Based on CPMT policy. Though not required to come to FAPT, best practice encourages a multi-disciplinary review	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Community-based, non-clinical services	Every 6 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Community-based clinical services and/or a combination of two or more services	Every 3 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Intensive in-home services, Therapeutic Foster Care, ICC, or Residential (PRTF or TGH) placement	Every 3 months	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy and/or service/funding requirement
Private day special education services or IEP residential	Completed by the IEP review team	Initial, discharge, and at least annually per SEC policy and as additionally directed by your local CANS reassessment policy
Acute psychiatric (hospital)	Daily monitoring of risk and level of need	

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Quality Utilization Review is Guided by Four Principles:

Below are the four principles of quality UR and questions your local UR *might* ask.

1. Quality UR Begins with Quality, Strengths-Based Service Planning
   - UR is part of the service planning cycle. Developing a solid service plan (IFSP) is the foundation of quality UR. Service plans should incorporate all assessment data, be strengths-driven, include a long-term goal and measurable objectives, include the voice of the youth and family, and convey a complete picture of the youth and family.
   - The long-term goal and objectives in the IFSP should align with the strengths and needs uncovered in the CANS and other assessment information.

2. Quality UR Examines ALL Elements of the Plan of Care
   - A thorough UR should examine the CANS, IFSP, and Provider Treatment Plans. Is there congruence? UR should consider whether the information on these documents is consistent.
   - UR should see if the services match the youth and family's needs.
   - UR should identify if and how youth and family voice is reflected in the service plan.
   - UR should look for evidence of the youth and family's strengths in the IFSP.

3. Quality UR Measures Progress, Provides Recommendations and Monitors the Status of Recommendations
   - UR asks if the youth and family are progressing towards their long-term goals and objectives and looks for evidence of this progress. Are things getting better? How do you know? (e.g., youth and family engagement, changes in treatment goals and objectives, improvement in CANS scores, increase in number of strengths or social connectedness).
   - Are services being implemented as expected?
   - UR considers the barriers to progress; what changes are being made to the service plan to address these needs?
   - UR looks for indicators of discharge planning.
   - UR asks questions and makes recommendations to the FAPT, Case Manager, and/or service provider based upon review. These may focus on services, the IFSP, the involvement of the youth and the family, or other components of the service planning process

4. UR is More Than Quality and Cost of Services
   - UR is a strategy to improve your local System of Care. Themes uncovered during UR are opportunities to improve local service planning. For example, UR might identify a pattern of youth transitioning from residential to the community and then needing to

return to residential; your locality could consider changes to the local service planning process. How will local service planning improve transition planning? What changes are needed with provider relationships or community supports? What is the level of family engagement?

- Findings and trends at the service level can inform the CQI process of the CPMT. In the example above, if UR identifies a pattern of youth transitioning from residential to the community and then needing to return to residential, CPMT might consider long-range planning goals related to congregate care or recidivism. They also might ask if a focus on building community supports and resources is needed? (As this might help with transitioning and maintaining youth at home)
- UR can also identify bright spots of service planning, practices you want to be sure to continue. For example, we always incorporate parent voice in IFSPs as evidenced by one objective in their words.
- UR should capture family and youth satisfaction with services and the CSA process. This information should guide and improve local practices, policies, and procedures.

UR is an Ongoing Cycle

Utilization Review (UR) is an ongoing process. It is not a one-time event but rather a continuous process that repeats itself throughout the youth and family's involvement with CSA. Feedback, recommendations, and questions raised by UR should facilitate dialogue, resulting in improvements in service delivery and outcomes for youth and families.

Tools and Resources for UR:

OCS developed a Model UR Form for local use. This form can be completed at a FAPT meeting or by anyone charged with completing UR. The Model UR Form incorporates best practices of UR identified in these guidelines. It can be found on the CSA website under the Resources Tab under Forms and under Guidance-> Utilization Review. A Sample (completed) UR Form can be found in the resources section of this document.

Your community is encouraged to develop a Family Satisfaction Survey. As noted in these guidelines, feedback from youth and family members regarding services and the local CSA process should be utilized to guide service planning as well as local policies and procedures. A sample survey is in the resources section of this document.

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CANVaS 2.0 System Reports

The CANVaS 2.0 system hosts a series of reports that may be useful for carrying out Utilization Review of children and families receiving services through CSA. The Individual Progress Report (IPR) compares a child's ratings on their Initial CANS to the two most recently completed CANS. It may be converted to a graph for a visual comparison. The Permanency Report (available only for the DSS-Enhanced CANS) provides a similar comparison of Initial CANS to the two most recently completed CANS for each Caregiver rated. This report organizes the items by the five Protective Factors in the Strengthening Families model. The Permanency Report also provides a listing of which items have "improved" from a "2" or "3" to a "0" or "1" at the last rating period, so areas of improvement may be quickly noted. These reports are available to case managers who have entered at least one assessment for the child into the system.

The "Longevity Reports" suite available to the CANVaS Local Administrator includes an additional individual child progress report (Individual Collaborative Formulation) with multiple filters to allow more flexibility than the IPR in comparing items across assessments.

A complete descriptions of these reports is found in the CANVaS 2.0 Report Manual, located in the "Documents" folder of CANVaS and on the OCS website at www.csa.virginia.gov/CANS.

Five additional reports can be found in the CSA Data and Outcomes Dashboard (Outcome Measures > CANS > CANVaS Detail Reports), providing aggregate data for localities to assist with community assessment and long-range planning. The Key Intervention Needs by Locality report identifies the items most endorsed in the locality as treatment needs from the Life Functioning, Emotional/Behavioral Needs, and Child Risk domains, allowing for a quick look at what raters have noted as the community's primary needs. The Key Intervention Needs by Domain report identifies the items most endorsed in the locality as treatment needs from the five major CASN domains. The Average Impact by Domain report reflects whether there is an overall improvement in aggregate treatment needs in three major CANS domains (the same domains found in the Key Intervention Needs by Locality report). The Impact by Item report identifies a cohort of children with treatment needs (scores of "2" and "3") by the date of the Initial assessment and compares it to a second assessment, noting what percentage of children show the need is continuing, what percentage show improvement or worsening and what, if any, children show a new treatment need. Finally, the Strengths Development report measures whether or not the aggregate assessments reflect progress in strength-building for the children in the locality.

Resource Materials

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Locality Utilization Review Self-Assessment

1. My locality uses needs and strengths from the CANS (and other assessments) to develop service plans

   Yes No

2. My locality develops service plans that include a long-term goal and measurable objectives

   Yes No

3. The service plans my locality develops include the voice of the youth and family

   Yes No

4. My locality follows a schedule to review the service plan

   Yes No

5. We track progress towards the goal and objectives in the service plan

   Yes No

6. We monitor progress in services

   Yes No

7. The youth and family's perspective on progress (in services and towards the goal and objectives) is collected

   Yes No

8. We provide recommendations for service planning and monitor for implementation of those recommendations

   Yes No

9. We discuss and plan for discharge throughout the service planning process

   Yes No

10. We collect feedback from youth and families about the CSA process and purchased services

    Yes No

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Utilization Review Might Ask….

When Examining the Plan of Care:

- Are the IFSP, provider service plans, and assessment information congruent?
- Does the current CANS match the youth and family's clinical, behavioral, and social presentation?
- Do the recommended/purchased services match the needs identified in the assessment?
- Are the strengths and needs of the youth and family guiding the objectives and goals?
- Is there an IFSP goal and objectives?
- Is the family and youth voice and participation reflected in the IFSP?

When Measuring Progress:

- Are the youth and family progressing towards identified goals in the treatment plan? How do you know? (How is progress measured?)
- If not, what are the barriers/needs towards goal achievement? What steps will be taken to meet these needs?
- Are provider treatment goals updated to reflect progress?
- Is there a clear discharge plan?
- What work is occurring to achieve the discharge plan?
- Is the IFSP updated to reflect needs, strengths, and progress?
- Are there changes in CANS scores?
- Is the overall level of functioning (family and youth) improving? How do you know?
- What changes have occurred in service delivery because of UR recommendations?
- What steps has the FAPT taken to incorporate/consider recommendations from previous reviews?

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Local CSA Family Satisfaction Survey

At the FAPT meeting, I was treated with dignity and respect:

Yes No

I knew what to expect (who would be there, where they would sit, where I would sit, what would be discussed, and how long it would last) before I attended the FAPT meeting:

Yes No

At the FAPT meeting, I was encouraged to share the strengths and needs of my family:

Yes No

My views about my family's strengths and needs guided decisions made at the FAPT:

Yes No

During the FAPT meeting, they used language I understood, and I understood the decisions made about my family:

Yes No

I knew who to call and (how to reach them) if I had questions or concerns about CSA:

Yes No

The bright spot of CSA is/was:

The greatest challenge of CSA is/was:

What else would you like to share about your experience with CSA?

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Local CSA Family Satisfaction Survey

The services and supports provided were helpful to my family

Yes No

How have the services provided helped your family?

What concerns do you have regarding the services provided?

How is the service provider planning with you for discharge from the service?

How is the service provider connecting you to community resources?

What else would you like to share about the services provided to your family?

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(Sample) Office of Children's Services (Sample)

State-Sponsored Utilization Review
Initial Utilization Review

Client: John Smith

DOB/Age: Age: 16

Social Security #: xxx-xx-xxxx

CSA Contact Person: Robert Anderson

CSA Locality: City of Oz

Service Provider: Residential Facility

Admission Date: 4/23/2015

Reporting Period: Initial

Review Date: 8/2/2015

Date of Most Recent CANS Administration: 4/29/2015

Case History and Reason for Placement:

John Smith is in the custody of the XYZ County DSS. John was ordered into foster care in April 2015 following a probation violation. Before placement in foster care, John resided with his paternal grandmother. This was a short-term placement following the disruption of placement with his maternal grandparents after their home was raided and a "meth lab" was discovered.

Submitted documentation reports that John is on probation following an incident of "rape, sodomy, and kidnapping of a 9-year-old girl." It is also written that John has a substance abuse history and that his paternal grandmother "could not control John and his behaviors."

Residential Facility documentation reports that "John needs the Residential Facility placement to develop a trusting relationship, provide stability, supervision, and structure to assist him with his intensive needs."

Diagnosis (if available):

None provided

Psychological Evaluation Findings (if available):

None Provided

Current Medications:

None Provided

Services Utilized in the Past:

Submitted documentation reports that John previously attended sex offender treatment "but was removed from the treatment due to lack of participation and missing too many sessions." Before placement in the Residential Facility, John was placed in detention twice (January 2015 and April 2015) for probation violations.

Client and Family Strengths:

Per CANS:

Child: Family, Optimism, Educational, Talents/Interest, and Involvement with Care.

Family: Involvement with Care, Residential Stability, Mental Health, Substance Use, Developmental, Accessibility to Child Care Services, Family Stress, Self-Care/Daily-Living, Educational Attainment, Legal, Financial Resources, Transportation, and Safety.

Per IFSP:

John has a desire for a fresh start. He has expressed the need for drug treatment and the willingness to comply with services. John's mother and grandmother support him.

Per Residential Facility Service Plan:

John is very engaging, can articulate his needs, and is currently motivated.

Treatment Concerns/Challenges:

The submitted documentation references a serious sexual offending charge ("rape, sodomy, and kidnapping of a 9-year-old girl) for John.

Submitted documentation identifies significant substance abuse needs for Name and his family.

SERVICE PLAN REVIEW (includes Foster Care Plan, if applicable)

Include description and notes related to progress or lack of progress for each goal:

IFSP Goals/Objectives	Service Provider Goals/Objectives
Goal 1: "Name will return home to his grandmother once his behaviors have stabilized and his services are well established." **Objective**: Name will participate in all recommended services while in foster care, including sex offender treatment. John will also maintain relationships with his grandmother, mother, and brother.	**Goal 1**: "Name will identify reasons that he was placed on probation and reasons for substance use and will discuss and utilize coping strategies to refrain from substance use and follow all probation rules." **Progress** as noted on the Residential Facility May 2015 Progress Report: Name has been very open regarding his history and reasons for substance use. He continues to be open and cooperative with KPACT and the Residential Facility. He has followed the probation rules and is working on completing his community service.
Goal 2: "Name will complete a psychological evaluation to assess further needs." **Objective:** Name will keep any appointments related to his psychological assessment.	**Goal 2**: "Name will follow the rules and regulations of the Residential Facility and will participate in family activities." **Progress,** as noted on the Residential Facility, May 2015 Progress Report: Name had followed all rules and participated in all family activities of the Residential Facility. He has increasingly interacted with the family and appears more comfortable in the home.
Goal 3: "Name will remain substance free." **Objective:** Name will work with his Life Coach to develop healthy ways to cope instead of using drugs.	

Is the local CSA case manager participating in Service Planning/Treatment Team meetings with the service provider?
If so, how?

The submitted documentation does not provide this information.

Is the service provider participating in FAPT Meetings? If so, how?

The submitted documentation does not provide this information.

Discharge Plan:

The Residential Facility Treatment Plan, dated May 2015, states that "the focus of John's placement is to help him stabilize and integrate into the Residential Facility and community while maintaining the goal to return to his mother."

John's IFSP states, "John will return home or step down to a TFC home once his behaviors have stabilized and he has well-established services. The target date for this transition is 12/31/15."

Recommendations:

The submitted documentation states that John's mother will need to complete substance abuse treatment and a parenting class before Name can return to her. It is written that John's mother is "very involved and is also cooperating with DSS"; however, information about her completion/enrollment in required treatment is not mentioned. Is John's mother enrolled in substance abuse treatment? What about John's grandparents? Submitted documentation states that his mother was in the home of his grandparents when it was raided as a "meth lab." This same documentation writes that both John's mother and grandparents tested positive for substances. Did John's mother reside with his grandparents? Is this the home that John will return to? As a result of the above-referenced "meth lab," one wonders about the importance of John's grandparents also completing substance abuse treatment.

It also seems essential to ensure that John and his mother have opportunities to engage in services together before his return home. What opportunities exist or will exist for John and his mother to receive family therapy or other treatment services to address the family system needs (supervision and the creation of a home that is safe, productive, and free of triggering situations and people)? For John to successfully return home (maintain in the community, be free of substances, and not engage in additional criminal behavior), it seems essential to ensure that Name and his mother have opportunities to engage in services together.

It is noted in the Residential Facility Progress Report that "beginning in June, DSS will begin to schedule supervised visitations with mom and grandmother." Have these visitations occurred? What needs/strengths have been uncovered because of these visitations?

What do John, his mother, and his grandmother enjoy doing together? What are their interests? How do they spend time during visitation? John's CANS identifies Talents/Interests as a strength. What are his talents/strengths? What opportunities does he have to participate in these activities? Are these activities that he can do with his mom/grandmother? How can his talent/interest be used to build their relationship? In addition to treatment services, deepening John's relationship with his mom and grandmother and increasing the pro-social activities they engage in seems an essential component of service planning.

The submitted documentation references a serious charge for John related to sexual offending behavior (rape, sodomy, and kidnapping of a 9-year-old girl). The need for John to participate in sex offender treatment is referenced; however, the submitted documentation does not provide information regarding John's level of engagement or progress in his sex offender treatment. Is John compliant with this treatment? What level of progress has occurred? One also wonders about John's risk of re-offending. When planning John's discharge, transition, or future services, it seems essential to understand his level of progress as well as future risks related to sexual offending behavior.

John's IFSP writes that a psychological evaluation will be completed. Has this evaluation occurred? What were the diagnostic impressions and treatment recommendations that resulted from the evaluation?

The May 2015 Residential Facility Progress Report writes that John's discharge/step-down date is December 2015. This discharge/transition is related to the stabilization of John's behaviors and ensuring that "he has well-established services"; however, measurable objectives and treatment needs are not provided. John's most recent Residential Facility Progress Report writes about the ongoing positive engagement in services. This raises the following questions:

- At what point will John be ready to transition to a lower level of care? How will the locality/provider know that John is prepared for this transition? (What treatment/behavioral objectives will indicate that John is ready for this transition?)
- What is needed for John to achieve these treatment objectives?
- What efforts are occurring to plan for his discharge/transition to a lower level of care?
- What will John need to transition to a lower level of care?
- What is John's vision for his transition from his residential placement? Who does he identify as his helpers in achieving this vision? What does he identify as his needs?

Utilization Review Consultant: Anna Antell, LCSW

Next Review Date: November 2, 2015

CC: CPMT Chair

(Sample) Office of Children's Services (Sample)

State-Sponsored Utilization Review
Subsequent Utilization Review

Client: Mary Anderson

DOB/Age: Age: 14

Social Security #: zzz-zz-zzzz

CSA Contact Person: Susan Jones

CSA Locality: ABC County

Service Provider: Residential Facility

Admission Date: 6/25/2015

Reporting Period: September 2015-January 2016

Review Date: 1/8/2016

Date of Most Recent CANS Administration: 12/10/2015

Case History and Reason for Placement:

The Case History and Reason for Placement were summarized in the Initial Desk Review completed in September 2015.

Diagnosis (if available):

DSM V Diagnosis:

296.89 Other specified bipolar disorder

309.81 Posttraumatic stress disorder

298.8 Other specified psychosis

Bilateral patellofemoral pain

Severe Stressors (early childhood abuse, neglect, and abandonment), current family conflict

(Per Residential Facility Individual Plan of Care dated 9/24/2015)

Psychological Evaluation Findings (if available):

No report is noted or provided.

Current Medications:

Lamictal - 150mg, twice daily

Seroquel XR- 100 mg every evening

(Per Residential Facility Individual Plan of Care dated 9/24/2015)

Services Utilized in the Past:

The Service Use History was summarized in the Initial Desk Review completed in September 2015.

Client and Family Strengths:

Per CANS:

Child: Educational, Talents/Interest, and Involvement with Care,

Family: Supervision, Involvement with Care, Knowledge, Organization, Social Resources, Residential Stability, Physical Health, Mental Health, Substance Use, Developmental, Accessibility to Child Care Services, Family Stress, Self-Care/Daily Living, Employment/Educational Functioning, Educational Attainment, Legal, Financial Resources, Transportation, and Safety.

Per IFSP:

"Mary is interested in art and writing. Mary is intelligent both academically and cognitively. Mary understands her need for treatment and has begun work towards her treatment goals."

Per Residential Facility Individual Plan of Care:

"Gifted, intelligent, and very supportive adoptive family"

Current Treatment Concerns/Challenges:

The September 2015 Residential Facility Individual Plan of Care states that "during this reporting period, Mary continues to struggle to ask for staff support at times." The document also states that "the staff encourages her to be more assertive and stop apologizing for everything as well as creating crises when affected by negative peers."

The October 2015 IFSP writes that "Mary has not been calling her mother consistently while being placed at the Residential Facility and has been avoiding difficult conversations

surrounding treatment. Ms. Mother has participated in a majority of family therapy via telephone."

The submitted State Sponsored UR Checklist writes that "Mary continues to struggle with mood dysregulation, self-harming behaviors, and suicidal ideations and needs to remain at Residential Facility."

Current Treatment Strengths/Progress:

The September 2015 Residential Facility Individual Plan of Care writes, "During this reporting period, Mary continues to interact appropriately on the unit and is mindful of her boundaries. Also, she continues to be assertive when communicating her wants and needs." This report also writes that "unit staff reports significant progress in Mary's behavior since admission as she interacts well with staff, follows redirection well, interacts well with peers, and shows signs of leadership."

The submitted State Sponsored UR Checklist writes, "Mary has developed a healthy, trusting relationship with her therapist at the facility. Mary is receptive to working toward her goal of expressing her emotions regarding her strained relationship with her mother. She is demonstrating good coping skills during stressful situations regarding disagreements with other residents at the facility."

The October 2015 IFSP states that Mary "has improved in her level of optimism and has been able to identify positives about herself. Mary has also become more involved with her treatment and has identified her challenges. She has decreased her oppositional behaviors and anger." This document also states, "Mary reported that she has been better about being honest with her therapist and teacher and has been honest during treatment."

GOALS/OBJECTIVES REVIEW (includes Foster Care Plan if applicable)

Include description and notes related to progress or lack of progress for each goal:

ISFP Goals/Objectives	Provider Goals/Objectives
Long Term Goals: 1. Mary and her family will communicate by expressing their feelings to each other healthily and appropriately. 2. Mary will develop appropriate coping strategies to express her emotions and feelings and use them daily. 3. Mary will eliminate self-harm behaviors and suicidal ideations	**Goal 1**: Mary will be able to cope effectively without engaging in suicidal or self-injurious thoughts/behaviors (including withholding, bingeing, and purging food) within 90 days of discharge. **Objectives:** Use effective communication by consistently verbalizing her needs and complete Chapter 3 in the DBT skills workbook. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Mary has identified a desire to increase her ability to ask for what she needs instead of shutting down or becoming overwhelmed with emotion. Continue work on DBT skills. Interpersonal effectiveness regarding mindfulness in conversation will be a focal point.
	Goal 2: Mary will externalize thoughts and feelings related to trauma/stress to not engage in any verbal/physical aggression or property destruction within 90 days of discharge. **Objectives:** Ability to follow first prompt 75% of the time. Identify and practice verbalizing three positive affirmations. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Mary has earned and maintained level 5 of 5. Mary has expressed anxiety about being able to follow staff's directions and would like to be encouraged to do so over the next review period. Mary has processed challenges and reports a readiness and willingness to develop positive affirmations to support positive self-esteem.

	Goal 3: Mary will appropriately express her thoughts and feelings and implement assertiveness skills with her family instead of holding her feelings inside until she reacts aggressively or with deception 90 days before discharge. **Objectives:** Mary and her mother will process Mary's emotional block to treatment progress. Mary will practice externalizing thoughts and feelings using "I" statements and appropriate eye contact. During weekly family therapy sessions, Mary will initiate discussion of at least one treatment goal-related topic. **Progress** as noted on the Residential Facility Individual Plan of Care dated 9/24/2015: Mary and her mother have begun identifying emotional blocks. Mary acknowledges that she often tries to find the "right" answer rather than speaking authentically.

Is the local CSA case manager participating in Service Planning/Treatment Team meetings with the service provider? If so, how?

Submitted documentation indicates that the CSA Case Manager participates in Treatment Meetings by phone.

Is the service provider participating in FAPT Meetings? If so, how?

The submitted documentation indicates that the provider participated in FAPT by phone.

Discharge Plan:

Mary's IFSP writes that "Mary indicated to the team that she will be ready to return home when she is able, to be honest with herself and others, has more confidence in herself and her ability, does not allow her past to define her, and continues to apply what she has learned."

The Residential Facility Individual Plan of Care, dated 9/24/2015, states that discharge criteria are the following: "Mary will be free from all self-harm (including binging/purging/ restricting) for 60 days before discharge. Mary will be free from all aggression for 60 days before discharge. Mary will be able to use honest, effective communication with her mother instead of lying or withholding her thoughts and emotions 30 days before discharge. Mary will participate in

several successful TLOA, gradually leading up to overnight, to determine readiness for discharge."

Recommendations:

The submitted documentation provides evidence of Mary's strong progress in her treatment at the Residential Facility. While it is understood that Mary has additional treatment needs that require ongoing residential placement, the locality is still encouraged to begin thinking about Mary's discharge from residential treatment. Given the intensity of Mary's pre-placement behaviors, successful discharge planning will require collaborative, deliberate, and individualized planning. Such planning will be most effective if it begins as part of Mary's treatment at the Residential Facility.

Mary's ability to return and maintain at home will require that she internalizes her treatment gains and can apply the skills learned at the Residential Facility in varied settings. Allowing Mary to be with her family in their home and in the community provides opportunities to utilize these skills. Submitted documentation writes of one off-campus pass for Mary and her mother; has Mary had additional opportunities to be outside the residential facility with her mother?

Mary's successful return home will also depend heavily on her mother's ability to provide permanence. The submitted documentation describes a significant level of at-risk and self-harming behaviors by Mary before placement at the Residential Facility. Family therapy seems crucial to prevent Mary and her family from returning to previous maladaptive patterns upon Mary's return home (thus jeopardizing Mary's permanence within the family). The submitted documentation writes that "it is recommended that Mother follow therapist's recommendations for participating in person versus via phone for family therapy sessions." Has Mary's mother been able to follow through with this recommendation? If not, what are the barriers to accomplishing this task? What does Mary's mom and/or Mary feel is needed for face-to-face family therapy to occur?

Mary has many strengths and documentation notes several interests for Mary. When considering Mary's discharge from the Residential Facility, the locality is encouraged to ensure that Mary's strengths and interests are incorporated into the discharge planning process. By nurturing Mary's strengths and interests (in addition to planning for her treatment needs), the treatment team will promote Mary's resiliency and help Mary to develop natural supports. Resiliency and support will enhance Mary's wellness and self-care. This writer wonders what opportunities exist or can be created for Mary to participate in activities or groups related to writing, art, and poetry. Connecting Mary with such activities or groups might provide opportunities for Mary to develop positive social support. It also seems important to ask Mary about her vision for these interests and talents; how would she like to use them? What about

Tae Kwon Do and basketball? It is important to inquire about Mary's interest in continuing these activities and find opportunities to incorporate them into transition planning.

Mary appears vocal and insightful about her treatment needs and progress. As a result, it seems essential that a discharge plan incorporate Mary's voice. This writer wonders what Mary would say discharge should look like. What is her vision for discharge? Who are her supporters? What/who helps her when things are going well? Mary's IFSP includes Mary's perspective on when she will be ready to return home (honesty with self and others, confidence in herself and her ability, not allowing her past to define her, and continuing to apply what she has learned); this writer wonders what Mary feels she needs to accomplish these tasks? Who does she think can help her achieve these things? What will it look like/how will she (and the team) know that she is ready to return home (meaning, how can her "vision" for returning home be measured)?

Noted actions/changes taken in response to the most recent UR:

The submitted State Sponsored UR Checklist responds to the questions posed in the Initial UR completed in September 2015.

Utilization Review Consultant: Anna Antell, LCSW

Next Review Date: April 8, 2016

CC: CPMT Chair

CSA Utilization Review

Child's Name: **Elizabeth Jones** **Case Number:** Click or tap here to enter text.

Date of Review: Select a date.

1. What services are in place?

Current Services	
Service	**Provider**
Residential Treatment	Click or tap here to enter text.
Parent Coaching	Click or tap here to enter text.
ICC	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.

2. Are services accomplishing the intended goals? ☒ YES ☐ NO

How do you know?

Elizabeth continues to explore her trauma history in treatment at the residential facilility. She is identifying triggers to trauma behaviors and practicing self-soothing strategies. Elizabeth's caregiver participates in weekly family therapy at the residential facility. Parent Coaching is working with Elizabeth's caregiver to develop a household routine and expectations for Elizabeth upon return home. ICC (HFW) is in the Engagement Phase.

3. Does the family (including the youth) believe the services are addressing the needs that brought them to CSA? ☒ YES ☐ NO

How do you know?

Elizabeth's caregiver notes Elizabeth has a brighter affect and during family sessions can communicate her needs more clearly. Elizabether says she feels "better".

4. Discharge Planning: Is there a clear discharge plan? ☒ YES ☐ NO What is the evidence for work toward discharge? What would it take for the youth/family to be discharged from services?

ICC is working with the family to vision what Elizabeth's return home will look like. They are getting to know Elizabeth, her caregiver and all the team members. Elizabeth's caregiver says she will need to know how to manage Elizabeth's trauma in order ofr her to return home.

5. What are the next steps? How will the IFSP goal and objectives be updated to reflect progress or to address barriers? Are changes to services provision warranted? If so, what changes?

Family therapy at the Residential and Parent Coaching should provide education to Elizabeth's caregiver regarding trauma. The ICC team should ensure that HFW planning addresses Elizabeth caregiver's concerns about managing Elizabeth's trauma. Elizabeth should continue work in treatment to understand her trauma triggers and integrate soothing strategies.