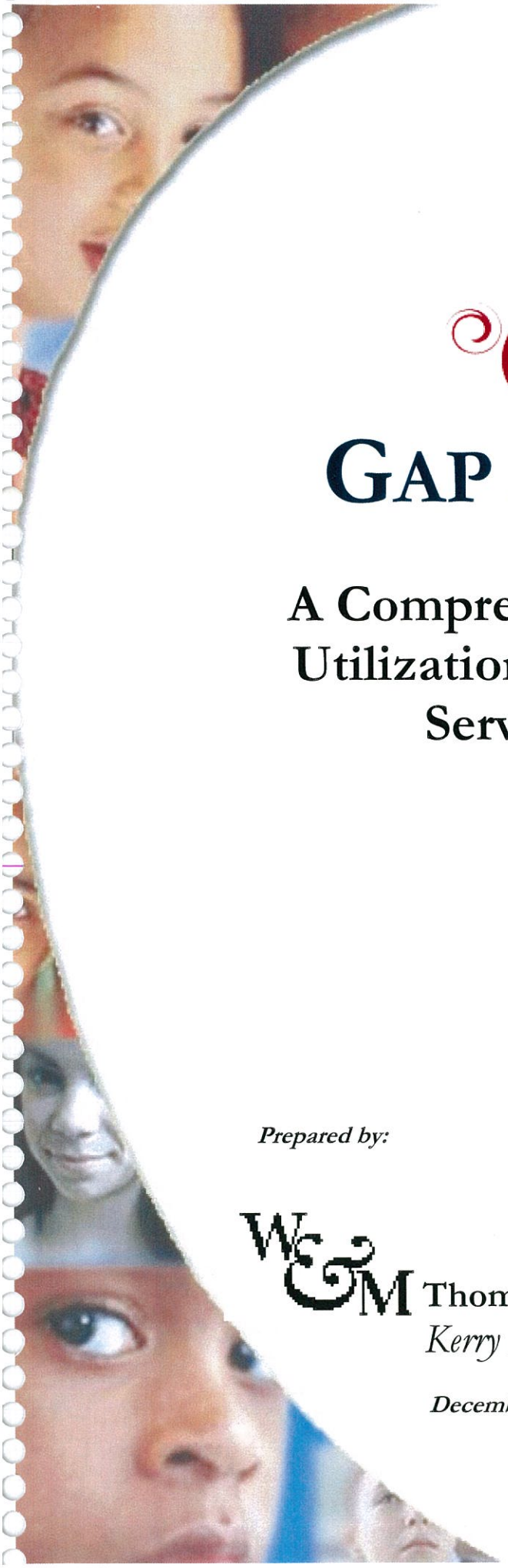

CSA
GAP ANALYSIS

A Comprehensive Analysis of Utilization Management and Service Provision

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December 13, 2003

EXECUTIVE SUMMARY

During the past fifteen months, the state of Virginia's Office of Comprehensive Services (OCS) placed additional emphasis on identifying issues associated with local governments' implementation of CSA. This endeavor is part of OCS' continual responsiveness to the Department of Planning and Budget's (DPB) recommendations in the September 1, 2000 report entitled "A Review of the Budget for the Comprehensive Services Act for At-Risk Youth and Families." The report recommended an "examination of the entire utilization management process for the purpose of incorporating changes to allow for proper follow-up and action."

The William and Mary team was enlisted to assist OCS in compiling and analyzing data to support its goal of examining utilization management (UM). The team employed a three phase approach in assessing gaps in UM in Virginia's 133 localities:

1. Dissemination of Quantitative Survey to all of Virginia's localities
2. Qualitative interviews with five selected localities
3. Formulation of findings and recommendations

Following data collection, the team formulated findings focused on the following policy areas:

- Assessment and Referral
- Collaboration Between the Provider and the Local Government System
- Development and Implementation of the Individual Family Service Plan (IFSP)
- Discharge Planning
- Residential Treatment Issues
- Uniform Data Collection Statewide
- CSA Training

Findings are grouped by quantitative and qualitative data. The majority of the findings were positive and illustrated that CSA coordinators in Virginia are dedicated and hard-working individuals who care deeply about the children they serve.

Based upon the findings the team recommends that OCS consider the following changes and additions to it's UM management plan:

- Consider bringing the utilization review function in-house
- Encourage collective bargaining among adjacent localities
- Provide suggested approaches on developing and implementing IFSPs
- Host Annual CSA Coordination Meetings
- Institutionalize discharge and step-planning at the start of treatment
- Develop programs to address family problems
- Institutionalize basic data collection
- Provide comprehensive training in step-down and discharge
- Establish a mentor program for junior coordinators

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BACKGROUND

The Comprehensive Services Act (CSA) is a 1993 Virginia Law that provides for the pooling of eight specific funding streams used to purchase services for high-risk youth. These funds are returned to Virginia localities with a required state/ local match and are managed by local interagency teams. The purpose of the Act is to provide high quality, child-centered, family-focused, cost-effective, community-based services to high-risk youth and their families.

Over 16,000 children in 2003 have been assisted by the localities of Virginia under the Office of Comprehensive Services (OCS), and over $235 million has been dedicated to this service in 2003. While the total funding for the programs is growing almost every year, the need is growing at an even more rapid pace.

During the past fifteen months, the state of Virginia's OCS placed additional emphasis on identifying issues associated with local governments' implementation of CSA. This endeavor is part of OCS' continual responsiveness to the Department of Planning and Budget's (DPB) recommendations in the September 1, 2000 report entitled "A Review of the Budget for the Comprehensive Services Act for At-Risk Youth and Families." The report recommended an "examination of the entire utilization management process for the purpose of incorporating changes to allow for proper follow-up and action."

The team utilized the findings and recommendations of the DPB report to develop quantitative and qualitative questionnaires to be disseminated to CSA officials and field staff. Based upon this research and the observations and findings of the surveys, the team developed specific policy changes that the State Executive Council might consider for recommendation to the 2004 Virginia General Assembly.

The project tasks consisted of:

1. Identify Areas of Change (Gaps in Service)
2. Examine Best Practices
3. Develop and Administer a Quantitative Survey to Determine Local Attitudes and Opinions Concerning Service Provision
4. Determine Selection Criteria for a Qualitative Survey
5. Develop and Administer a Qualitative Survey to Gain an In-depth Perspective from a Carefully Selected Sample of Counties
6. Synthesize Survey Results, Develop Policy Recommendations

PART I: ASSESSMENT METHODOLOGY

The team used a three phase approach in assessing gaps in utilization management in Virginia's 133 localities:

QUANTITATIVE METHODOLOGY

Under the guidance of Pam Fisher, the team compiled 15 multiple-choice questions focusing on the specific policy issues identified in the DPB report. The survey was pre-tested among three previously identified offices to evaluate the respondent's understanding of the survey, identify potential biases, and investigate difficulty with question order and flow.

On November 5th, the survey began by sending a pre-notice email (See Appendix A). This notification let the locality know that they will need to complete and return the survey, as well as the general purpose of the project. The second mailing was composed of an introductory letter (see Appendix B) and the attached survey (see Appendix C). The survey was disseminated by email and fax to the 130 localities. On November 17th, a reminder email and a thank you email (see Appendix D) were sent. The thank you email was designed to thank those localities that responded to the survey, and the reminder email was a gentle reminder to those that had not yet completed the survey. The final mailing was only sent to those localities that have not yet responded. It is composed of a letter indicating that we have not yet received their completed survey (see Appendix E) and a replacement survey. The techniques used in the design of this survey were created by Don Dillman and have been shown to give the greatest response rate for the effort and monetary expense.[1]

Of the 130 localities surveyed, 77 responded during the time period from November 5th to December 1st.

QUALITATIVE METHODOLOGY

The team conducted qualitative interviews with Portsmouth, Hampton, York, Fairfax and Petersburg. (Please see Appendix F for a list of the qualitative questions.) These five localities were selected based upon the quality of their UM plans, their location in the state, and their size. Questions were developed with the help of the OCS office in Richmond, and the qualitative interview took an average of about one hour to complete.

[1] Dillman, D.A. 1978. *Mail and telephone surveys: The total design method.* Wiley Publishers: New York.

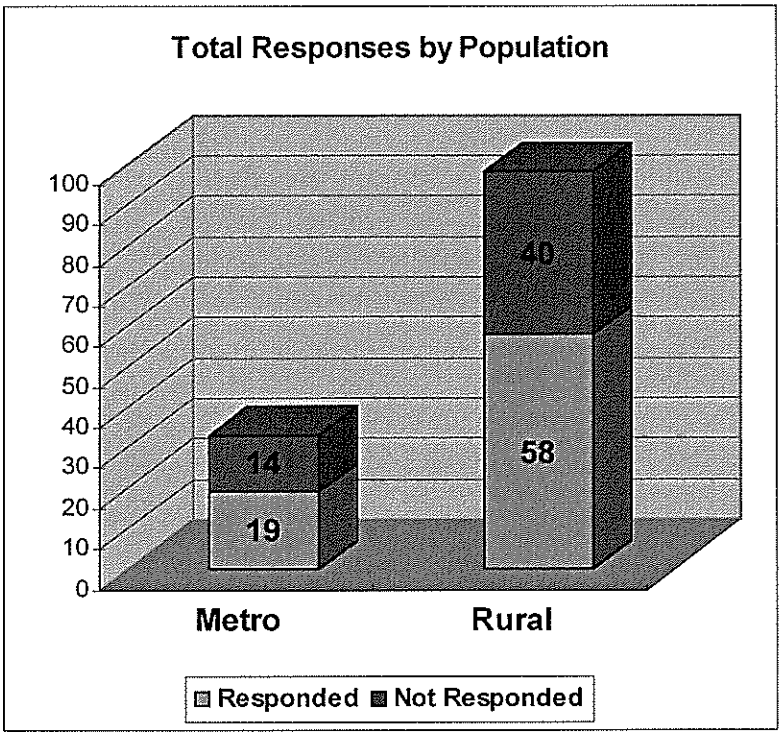
The interviews focused on the following seven policy areas:

- Assessment and Referral
- Collaboration Between the Provider and the Local Government System
- Development and Implementation of the Individual Family Service Plan (IFSP)
- Discharge Planning
- Residential Treatment Issues
- Uniform Data Collection Statewide
- CSA Training

PART II: QUANTITATIVE ANALYSIS

SUMMARY FINDINGS

We received responses from 59 percent (77 out of 131) of the localities to which surveys were sent. The table below illustrates the breakdown of survey participants by "rural" and "metro". "Rural" was defined as a locality with a population of fewer than 50,000, with "metro" being localities with populations greater than 50,000. Using this criteria, the majority of the surveyed localities are considered rural (98 of 133 localities). The response rates of the rural localities paralleled that of the metro localities, at 59 percent for rural and 57.5 percent for metro.



Assessment and Referral

- Although 30 percent of localities do not work with WVMI, the majority of those that do cite clarification of the decision support guidelines and CAFAS scores to be the most important element of WVMI's service.
- Half of the respondents pointed out the importance of assessment.

Collaboration Between the Provider and the Local Government System

- Over the half of the respondents require providers to communicate and report regularly.
- The top three requirements cited refer to communication with providers (83% in total).
- 75 percent of respondents communicate with their providers at least once a month.

Development and Implementation of the Individual Family Service Plan (IFSP)

- Half of the respondents reported that IFSP training would help their locality.

Discharge Planning

- 75 percent of respondents are satisfied with school systems' role.

- Half of the respondents rely primarily on providers for discharge and step-down planning.
- One-fourth of the respondents indicated a lack of step-down planning in their localities.

Residential Treatment Issues

- One-third of respondents indicated that children remain in residential treatment because their conditions require additional treatment.
- Some respondents pointed out that prolonged residential treatment was often a result of a lack of funding and community resources
- Almost 40 percent of respondents feel that psychological evaluations are the greatest determinant in residential treatment referral.
- Almost 50 percent of respondents pointed out that children often remain in residential treatment due to a lack of necessary skills of family and step-down providers.

Uniform Data Collection Statewide

- Over 40 percent of respondents feel that data collection is useful to determine placement types and/or providers.
- Some respondents indicated that they need more data and that they are not satisfied with the current data being provided.
- Six percent of respondents feel that data collection is not helpful.

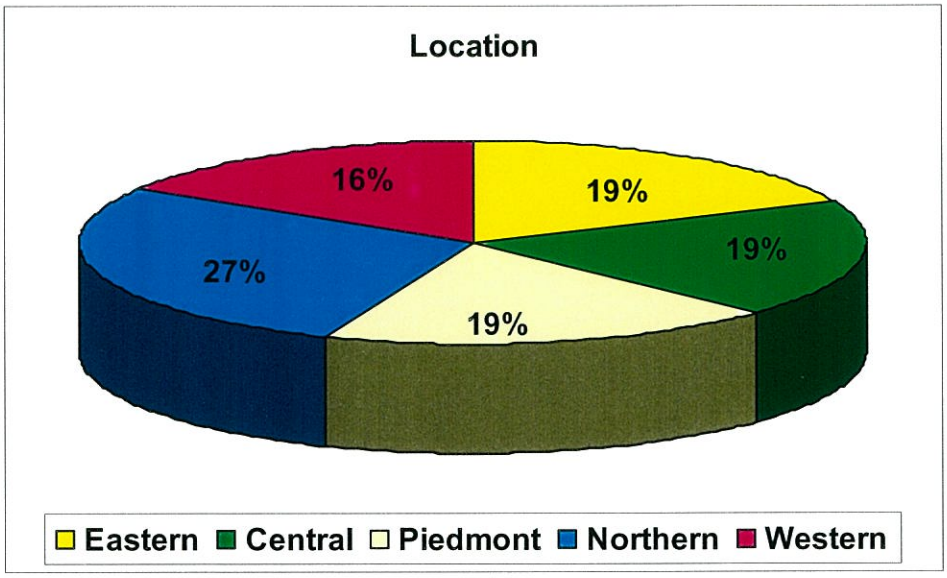
CSA Training

- While in question one, half of the respondents cited a need for increased IFSP training, in question four, 31 percent cited step-down planning as being most beneficial in terms of training needs.
- Over one-third of respondents learned from other coordinators.
- Only about 10 percent of respondents used the web site, while materials and support from CSA/OCS were utilized by almost 40 percent.
- One-third of respondents have backgrounds of social work and mental health at the college level

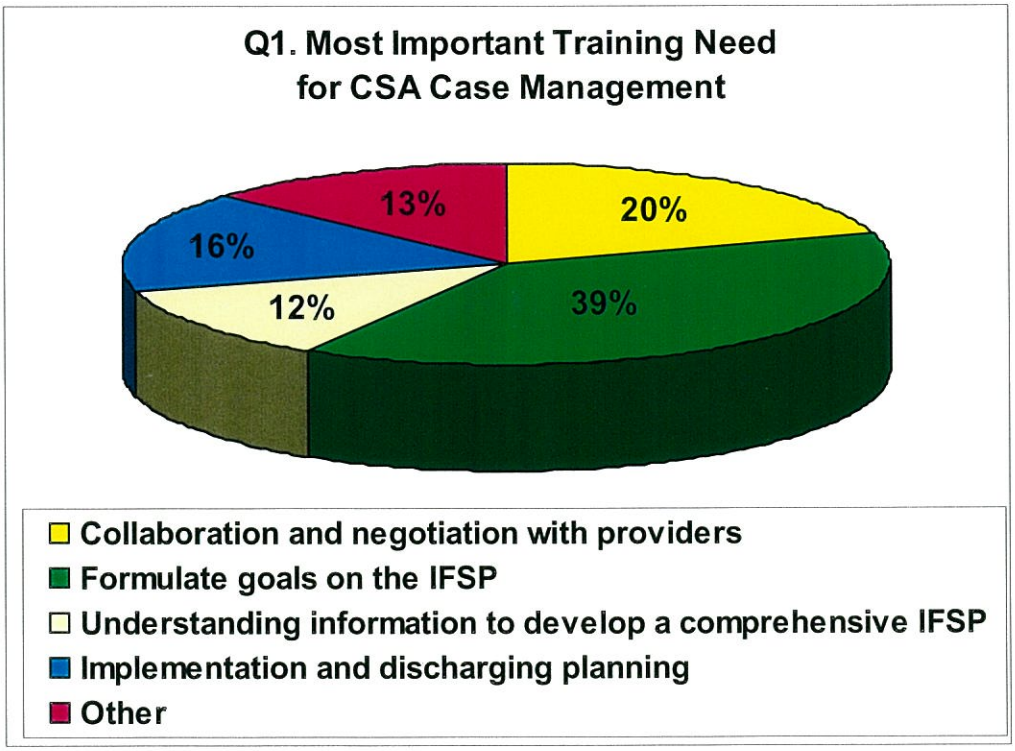
DETAILED FINDINGS

Please note that responses listed in the category "Other" are listed for each question in Appendix G

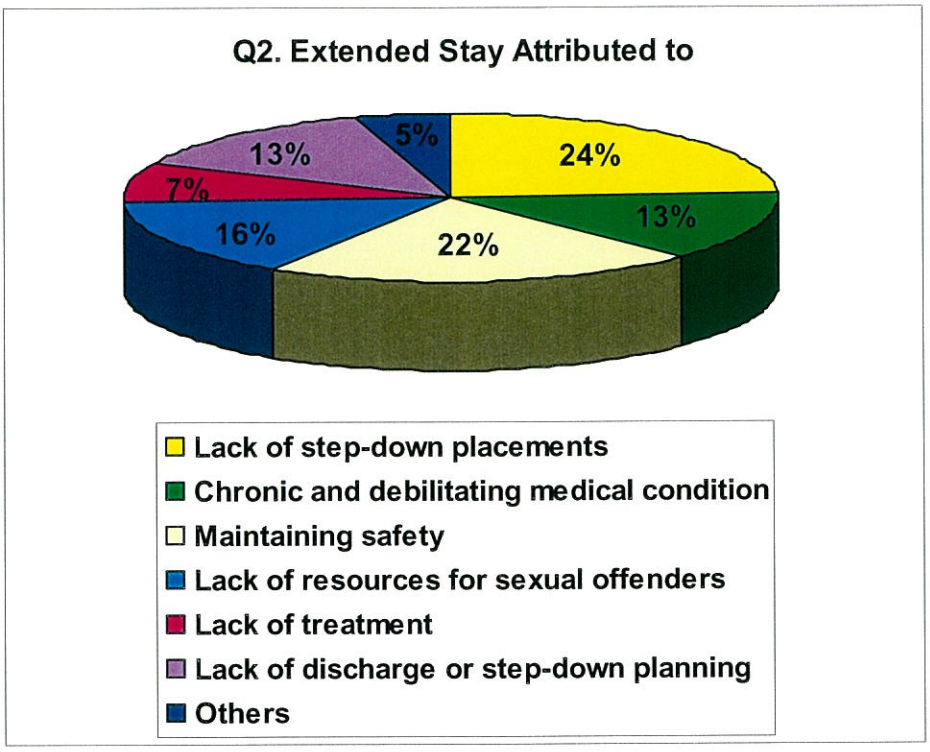
Location of survey respondents:



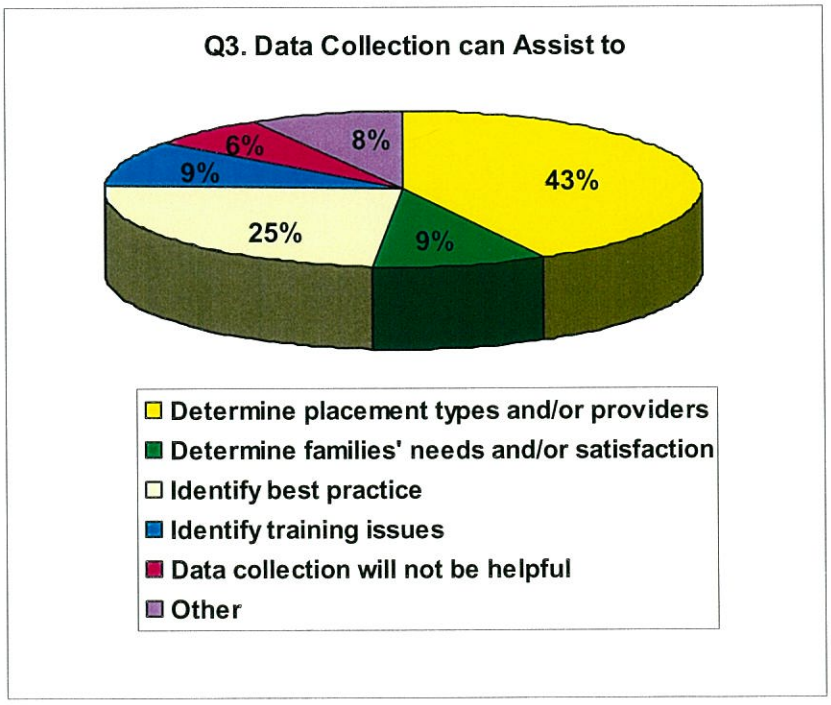
1) In my opinion the most important training need for CSA case managers is



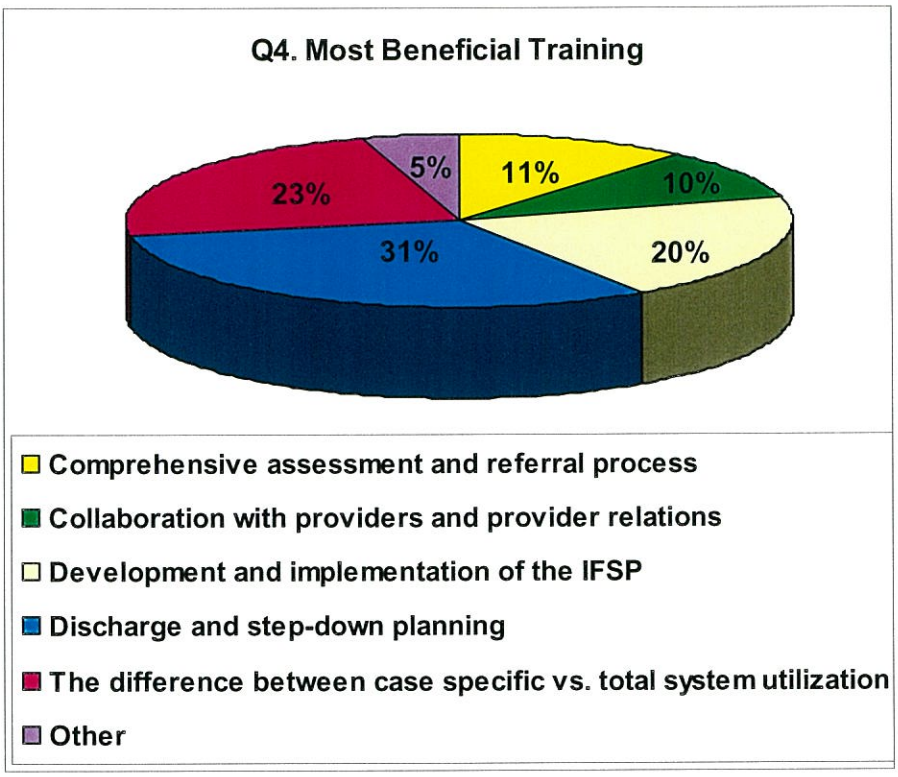
2) Extended lengths of stay in residential treatment facilities can be attributed to (indicate all that apply):



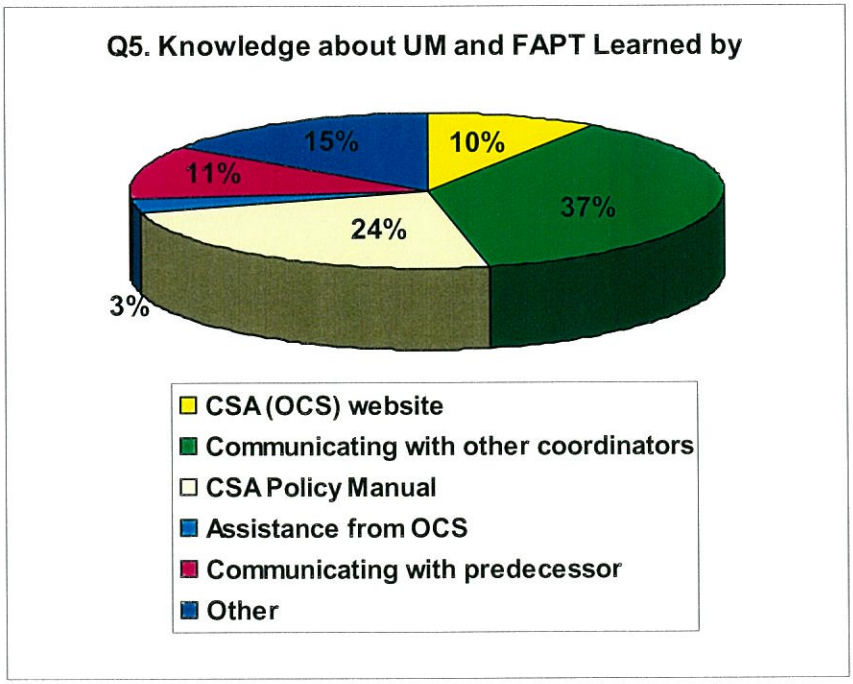
3) The primary way data collection can assist my local government is:



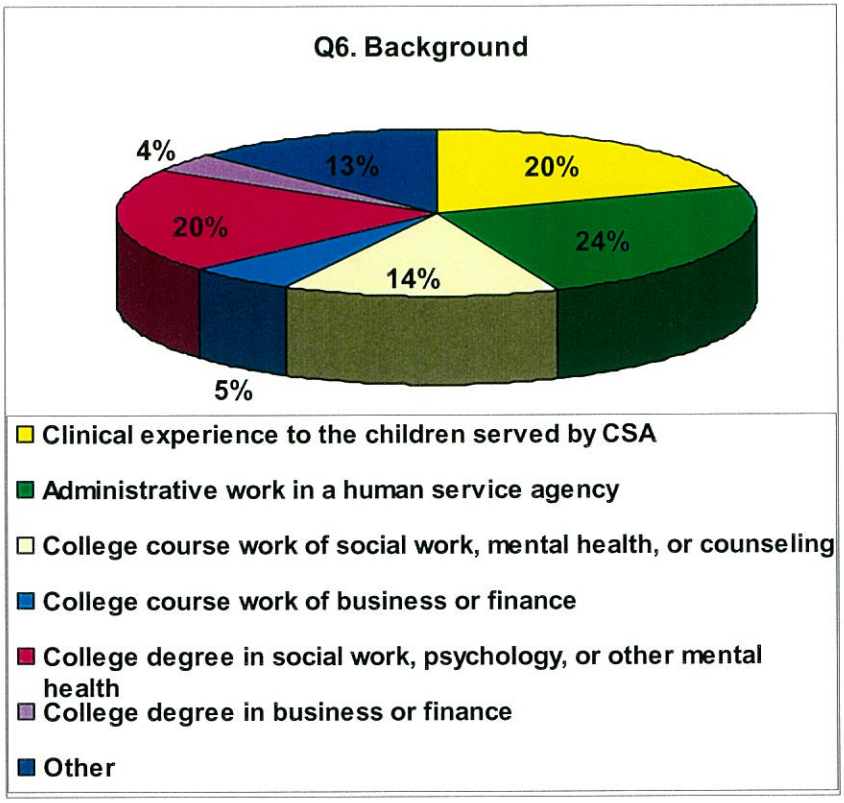
4) With regard to utilization management and the FAPT process, as CSA coordinator, I feel that I could most benefit from training on:



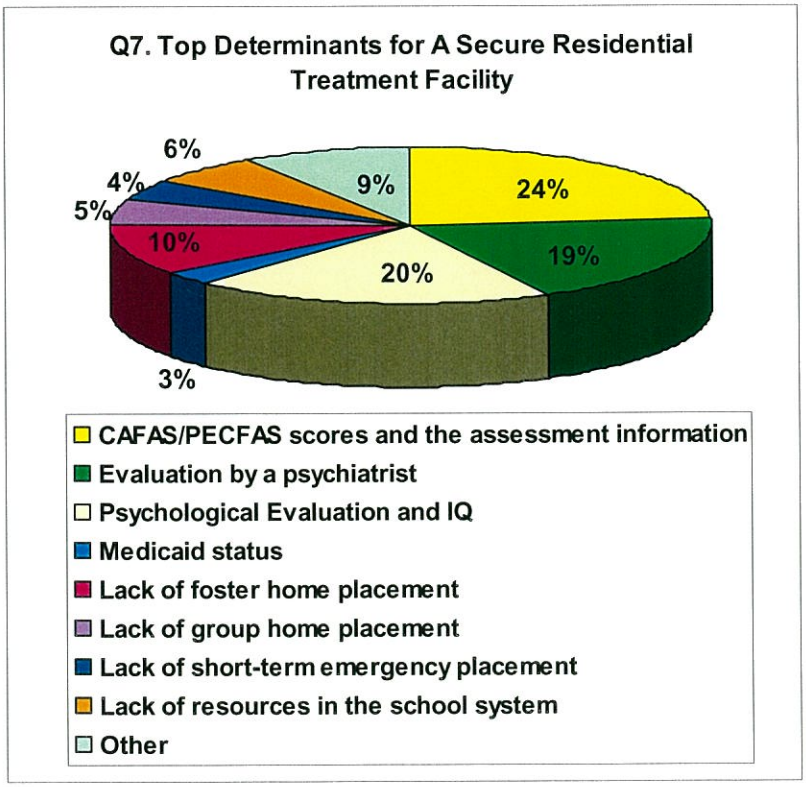
5) When I first entered my job as CSA coordinator, I mostly gained knowledge about utilization management and the FAPT process by:



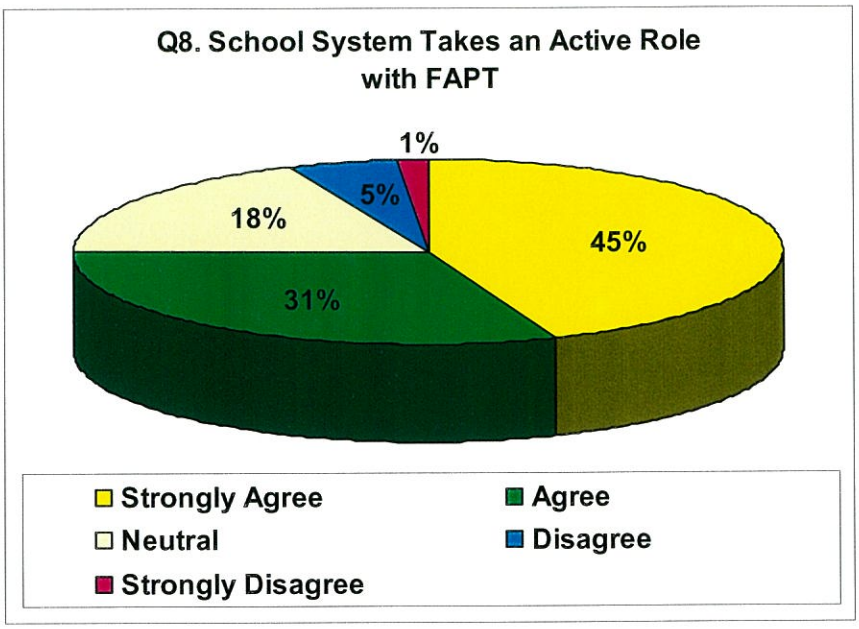
6) Describe your background prior to becoming a CSA Coordinator (indicate all that apply):



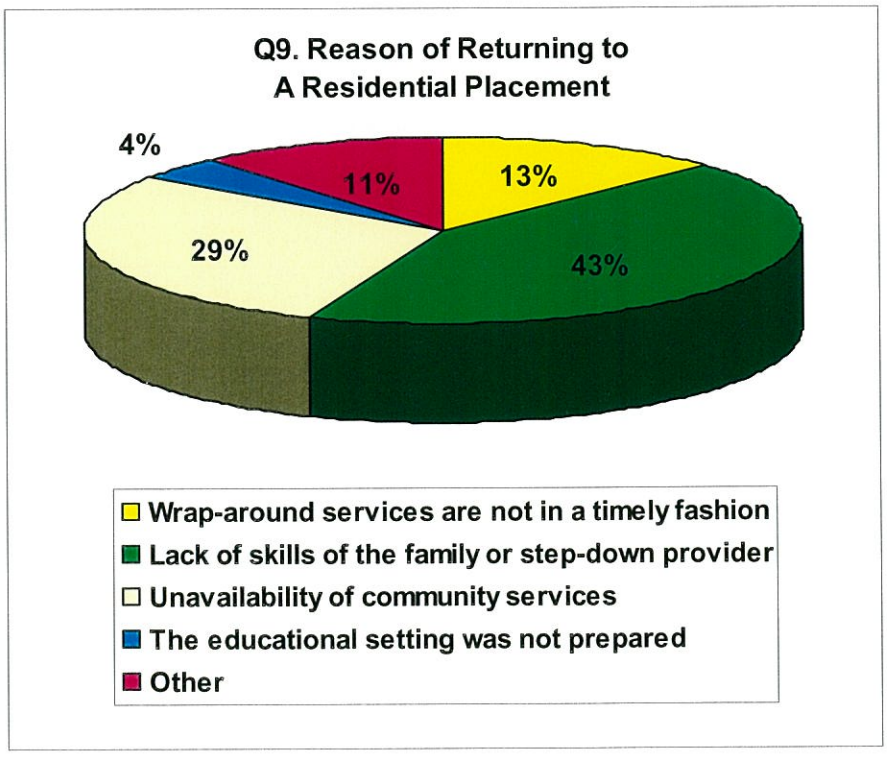
7) In my locality, the three top determinants for a child being referred to a secure residential treatment facility are (please indicate the three from the choices listed)



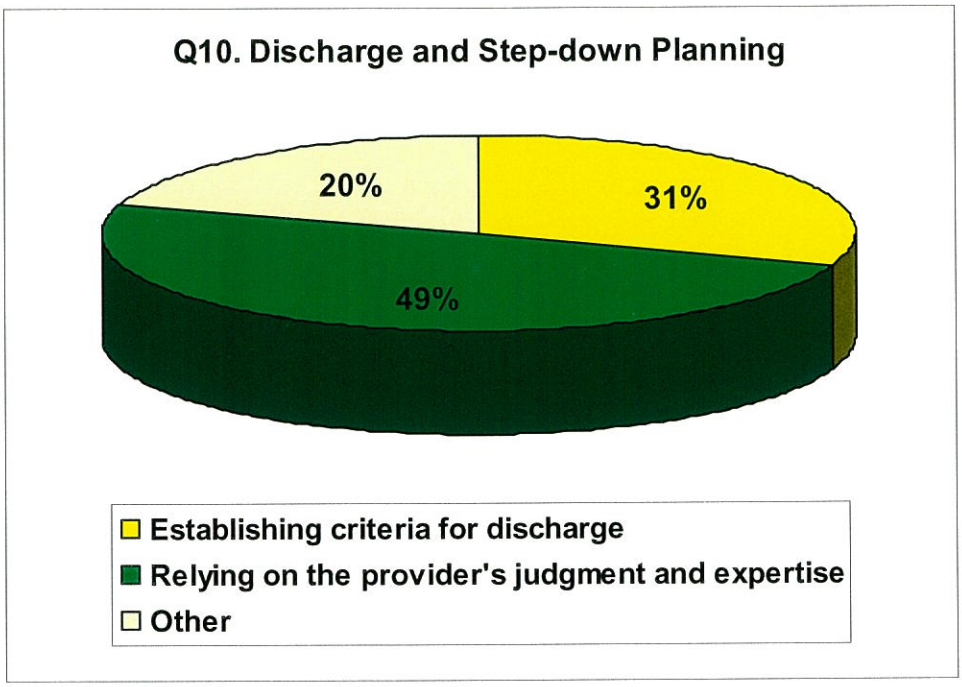
8) My school system takes an active role in working with FAPT to keep children in the community:



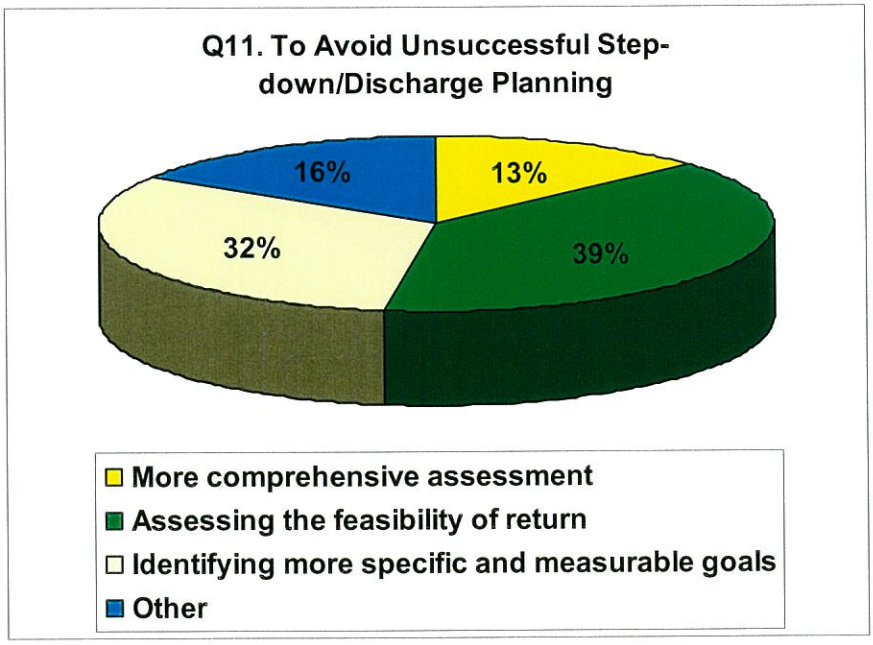
9) Which of the following do you believe contributes most in a child returning to a residential placement?



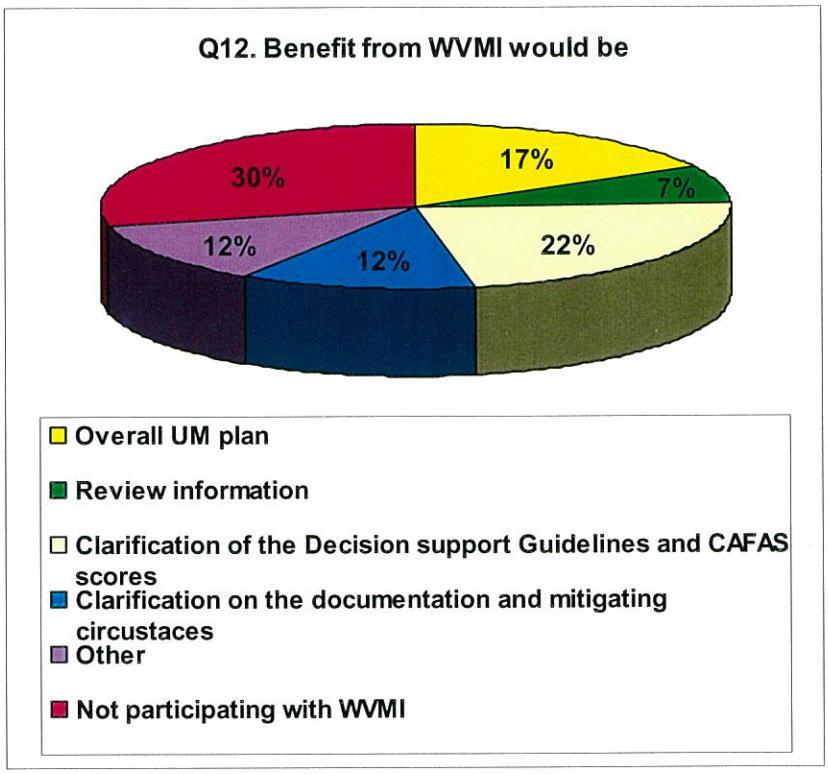
10) Regarding discharge planning/step-down planning my locality:



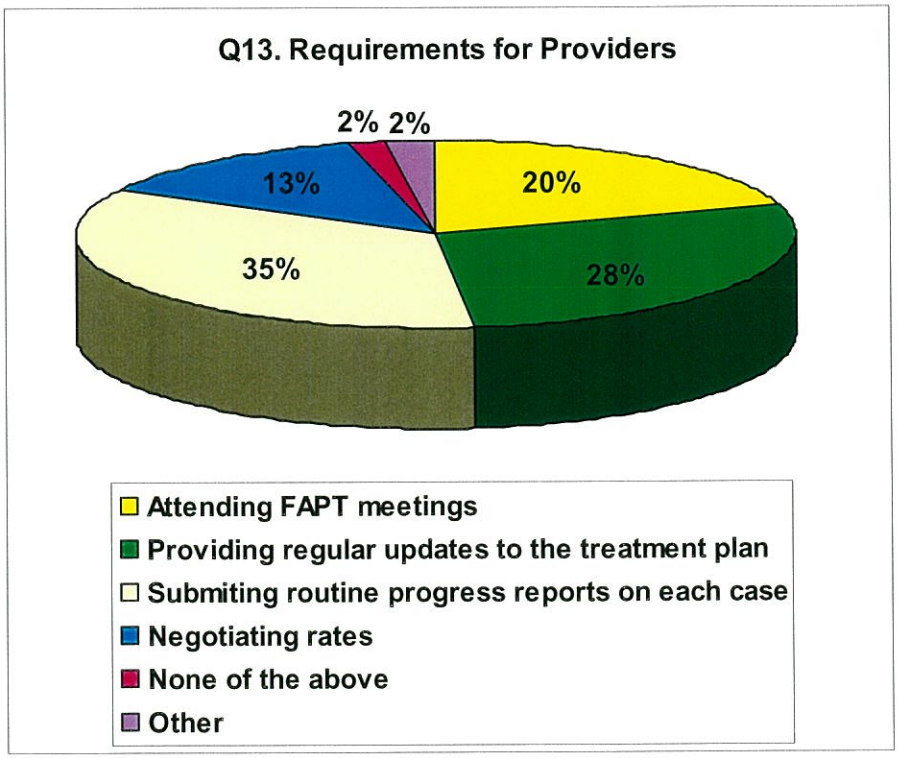
11) To avoid unsuccessful step-down/discharge planning, which of these would be most helpful to your locality?



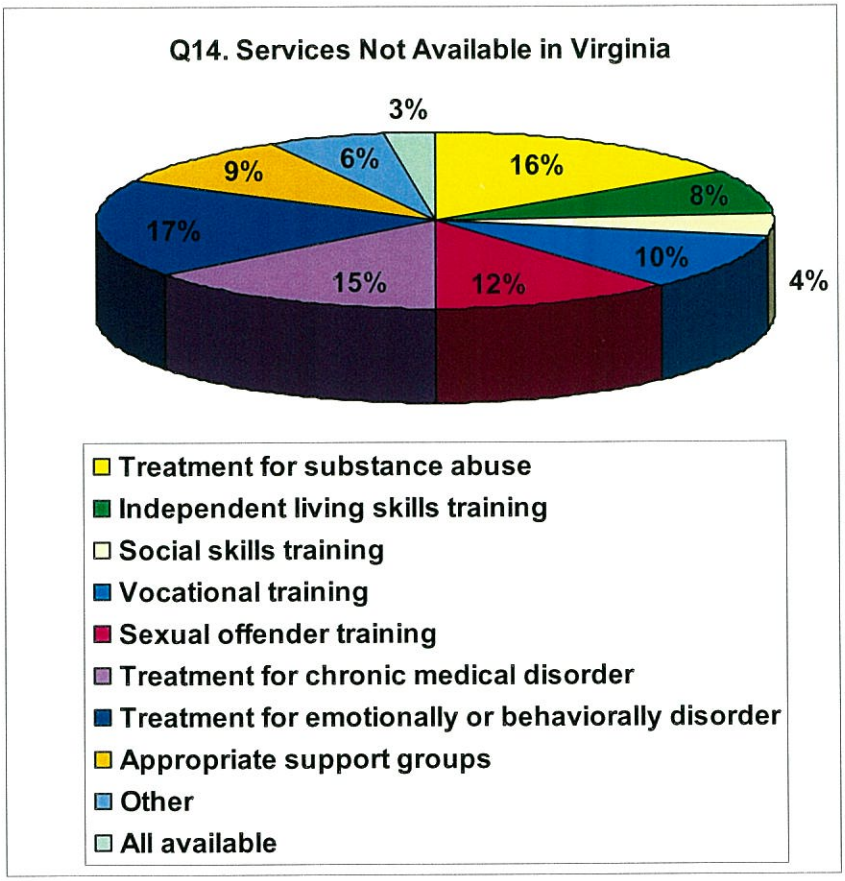
12) I believe my locality would benefit most from WVMI participation if:



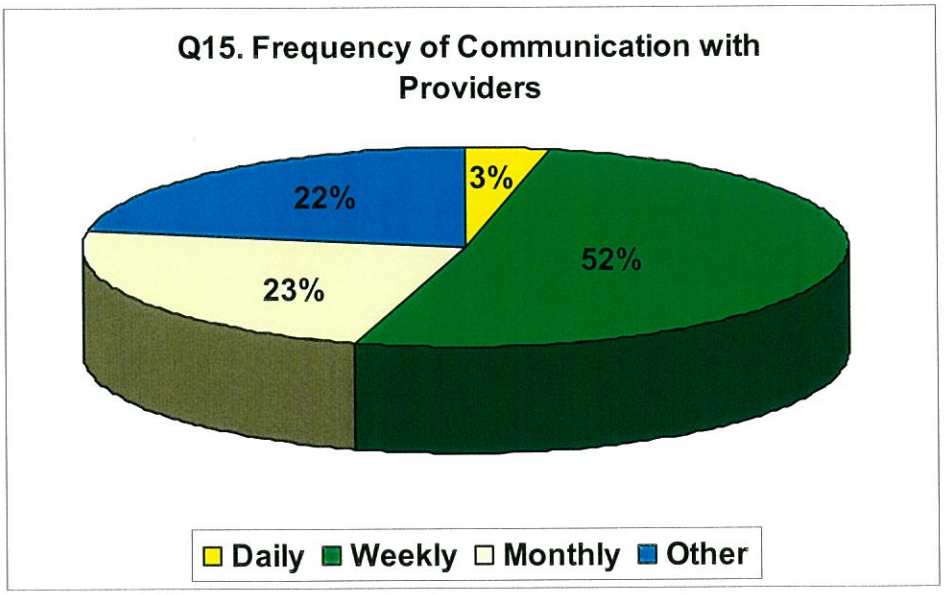
13) My locality requires that its providers (indicate all that apply):



14) The following services are not readily available in residential treatment



15) For each case placed in a secure residential treatment facility, my locality communicates with its providers:



SUMMARY FINDINGS

Assessment and Referral

Each locality interviewed stressed that assessment and referral were child specific and not program specific. Therefore, treatment decisions are based on the needs of the child and not necessarily on the structure of available programs and services. For this reason, localities view assessment and referral as a comprehensive review based upon CAFAS scores, behavior, professional evaluation and the family dynamic.

All of the localities indicated that they require provider attendance at FAPT meetings. In some instances, this is stipulated in the provider's contract, whereas in other cases, it is proscribed but not mandated. The localities use the FAPT process to assess the IFSP and track progress. In smaller localities, the FAPT is the primary method by which assessment and referral take place. Larger localities use provider treatment plans in parallel with the IFSP. This allows the larger localities to modify treatment in the interim between FAPT meetings, which typically take place only every three months.

There was a great deal of dissatisfaction articulated by the localities with WVMI. Comments in this area ranged from moderately dissatisfied to highly critical of the evaluation methods employed by WVMI. Some localities do not see WVMI as useful. They feel that they do not need an individual, despite his/her level of education, who is removed from the day-to-day processes of CSA, to review their work. For many, WVMI was referred to as a bureaucratic impediment with no value added. For them, it makes little sense to send written documents to an office to let that office determine a child's needs, when localities feel they can assess need just as adequately if not more effectively.

The methods by which WVMI could assess a child's needs were also suspect among the localities. Because WVMI is off-site, they could not amply weigh the child's treatment needs vis a vis his/her potential impact on the community. Many also believe that WVMI utilized only the CAFAS score in assessing a child, and felt that if this was the only criterion by which a child was measured, that they could perform this duty in-house. In addition, many localities resent the massive amounts of paper work that they are required to fax to WVMI.

One locality suggested that WVMI should assist in placement, as well as evaluation. This would ease the burden of limited staff in a number of localities.

Collaboration between the Provider and the Local Government System

The localities interviewed stated that they collaborate and negotiate with providers regarding service agreement/contract issues. Larger localities are in a better position to negotiate with providers due to the extensive number of children under their care. For example, while Fairfax employs a team manager designated to negotiate with providers, smaller localities must be price-takers due to the limited availability of providers. In addition, smaller localities have little or no bargaining position with their providers because they cannot take advantage of the economies of scale afforded to localities that serve larger populations.

Responses concerning the area of rate negotiations varied. Larger localities like Fairfax employ comprehensive contracts that encompass rates, treatment planning, and performance assessment. Fairfax is particularly unique in its contract language; utilizing a clause that

ensures that the provider is not allowed to charge any other public governmental buyer less than it charges Fairfax. Smaller localities like Petersburg use Purchase Orders to contract with providers. All of the smaller localities indicated that there was little room for negotiating rates with providers, however York-Poquoson indicated efforts to negotiate the services received for the established rate. In this way, smaller localities can have some hand in negotiation of services for the child without requiring the provider to lower rates.

York-Poquoson described efforts in the Hampton Roads area to combine influence of several localities in order to conduct more efficient negotiations with providers. They were unsuccessful for reasons such as difference of locality size, motivation, and enthusiasm.

Development and Implementation of the Individual Family Service Plan (IFSP)
The localities interviewed require their providers to submit progress reports on a regular basis. The IFSPs are used as a tool to assess the child's progress, given a baseline assessment at the initiation of treatment. In smaller localities, this assessment is done informally through FAPT meetings and discussions with providers. Medium sized and larger localities employ specific and measurable goals that track progress as it relates to changes in the CAFAS score, behavior and provider feedback. As stated earlier, the IFSPs are uniformly child specific, and there is no broad-based evaluation method routinely employed in developing IFSPs.

In larger localities like Fairfax, IFSP implementation includes collaboration between the locality and the provider utilizing both boiler-plate contract language; as well as planning on an individual child basis. Smaller localities rely on monthly vendor reports, FAPT meetings and home visits to address the goals set forth in the IFSPs. Some localities stated that IFSP development and implementation were weak areas for them because of time and resource constraints in their respective localities. For this reason, these localities are forced to rely more heavily on provider input and recommendations, than larger localities with greater resources.

Discharge Planning
All of the localities stated that discharge planning begins very early in CSA's involvement with a child. For example, Petersburg indicated that discharge planning was a collaborative effort between the placement agency and the provider. They refrain from relying wholly on a provider's recommendation and rather, examine the child's needs holistically through progress reports, FAPT, and treatment team meetings.

In Portsmouth, the approach is similar. They employ one position that manages all of the child's Medicaid and WVMI paper work. They meet with the FAPT team and DSS staff to develop sound step-down planning that addresses the child's current and future needs. They begin thinking about the step-down process the moment they open and begin to staff the case. By using this method, they begin with the end goal in mind and the process is very directed toward the goal.

Hampton and York-Poquoson also employ a team approach to discharge planning. They continuously examine a child's long and short-term goals and objectives to ensure effective step-down planning.

Like Petersburg, Fairfax also refrains from relying only on the judgment of its providers when formulating discharge plans. At the onset of a child's treatment, Fairfax reviews the available step-down resources and designs its treatment plans cognizant of the child's eventual discharge. They utilize FAPT to determine if a child's treatment has been maximized. Given other duties associated with case management (particularly those staff in foster care and

special education), monitoring a child's treatment in residential facilities is unfortunately often limited. For this reason, the Fairfax CSA office will be adding three Utilization Review specialists to its staff. Please see Exhibit I for Fairfax County's proposed revision to utilization management.

Residential Treatment Issues

The localities indicated that in very few instances is a child referred to residential treatment for lack of other resources. Residential referrals are based largely upon the child's CAFAS score and more importantly, his or her exhibited behavior. In smaller localities, the cost of residential treatment is prohibitive so these localities reserve residential referrals for only the most urgent cases. Larger localities like Fairfax have access to other treatment options. For them, the child's Medicaid status is not a determinant. Other localities indicated that residential referrals are determined through a team approach involving the child's FAPT and caseworker. Communication between the CSA coordinator and foster care were cited as key elements in ensuring a smooth transition into residential treatment.

Uniform Data Collection

Most of the localities interviewed do not have any formal processes for collecting and analyzing data. They rely on anecdotal evidence collected through their experiences with various providers. Data collection is an informal process and the effectiveness and efficiency of providers is assessed on an ad hoc, case-by-case basis.

Larger localities like Fairfax employ a number of methods to assess their providers. Inherent in their provider contracts (see Exhibit II) is a great deal of due diligence collected prior to any provider being added to their provider directory. Case managers are prohibited from using providers not listed in the local directory and if they seek to do so, must gain approval from the CPMT, where the provider must undergo an extensive background and reference check. In addition, the case manager must show that the provider offers some skill or service not available through those providers currently listed in the directory. This includes a language or cultural specialization.

In addition to collecting extensive data on its providers through its contracting process, Fairfax also employs a vendor evaluation form (see Exhibit IV) that is completed by the case manager. This form seeks to assess the vendors' performance as it relates to the particular child being treated. In this manner, Fairfax can collect quantitative data on its vendors relative to specific cases. This helps them to determine not only which vendors provide excellent service, but in which treatment areas certain vendors excel.

Fairfax and Portsmouth employ Parent Satisfaction Surveys (see Exhibit III) to assess a family's satisfaction with the quality of care provided by a vendor. Hampton has also indicated that it is considering a similar survey that would be brought before the FAPT in routine meetings. In Petersburg, CSA uses the FAPT meetings, in which the families are routinely involved, to field any complaints by the parents with regard to vendors.

In smaller localities, the CSA coordinator relies on the data collected by the vendors but there is no formal process for utilizing or evaluating this data.

CSA Training

The level of training provided varied significantly among the localities interviewed. In Petersburg, for example, employs no formal mechanism by which to identify training needs among its case managers and providers. Training is delivered on an ad hoc basis as identified

by staff. Fairfax, however, provides routine training opportunities in a variety of areas. They maintain a CSA training calendar and have a staff member that oversees this area (see Exhibit V).

The localities identified a number of areas in which specific training would be helpful. Undoubtedly because of its size, Petersburg believes that training should start at the basic levels of treatment planning. It should focus not only on CSA issues, but should be broad based and cover things like specific conditions (i.e. "what is autism?"). Other localities indicated a need for training in negotiating with providers, and setting measurable goals in the IFSPs. Because of its extensive involvement and experience in training, Fairfax feels quite comfortable in its ability to continue administering training to its staff. They did note, however, that training in Medicaid for the RTCs and TFCs would be beneficial because Medicaid is so complex and difficult to understand.

The localities interviewed also indicated that they collaborate and share best practices, wherever possible, with CSA coordinators in other localities. They mentioned using discussion groups in yahoo, as well as the CSA website to communicate. In Portsmouth and Hampton, staff meets every other month with coordinators across the state and, every other month for regional Hampton Roads coordinators.

Some localities indicated that they rarely receive guidance from central OCS staff, and when they do, that guidance could be more collaborative in nature. In addition, most of the localities stated that the CSA Policy Manual provided by OCS is not helpful because it fails to address important elements of the position, and it is quite large and difficult to navigate.

Overall, the majority of the localities did not feel that training was as important as increasing resources in terms of staff. These localities believe that a lack of staff inhibits their progress more than a lack of training.

Assessment and Referral

- **Consider bringing the utilization review function in-house**
  A majority of the localities surveyed, as well as those interviewed indicated a great deal of dissatisfaction with WVMI's assessment methods. While the majority of localities do not have the resources to hire permanent UR staff, evidence suggests that moving the UR function from WVMI to OCS makes sense. OCS could recruit UR specialists regionally, or according to functional area, that could provide assessment services for CSA children. Unlike WVMI, these specialists could work more closely with the cases due to proximity. In addition, OCS could mandate assessment procedures, but also feel comfortable in allowing a degree of subjectivity as they will have selected and trained the UR staff personally. The major flaw in WVMI assessment appears to stem from the fact that while CSA treatment is child-specific, WVMI assessment is largely case-specific and dependent upon quantifiable criteria such as CAFAS. In many instances, subjective factors (such as behavior) are not quantifiable. For these children, WVMI assessment fails to adequately address their problems.

Collaboration Between the Provider and the Local Government System

- **Encourage collective negotiating among adjacent localities**
  Fairfax provides a model for best practices in negotiating with providers. Unfortunately, smaller localities cannot adopt these practices because their caseloads are too small to warrant special pricing. Providers in these smaller localities also have no leverage with which to negotiate rates or services. For these reasons, we recommend working with localities that are close enough in proximity to utilize the same providers, to develop a collective negotiating strategy. By collectively negotiating with providers, these smaller localities can take advantage of the economies of scale afforded to larger localities, and obtain services at reduced rates.

Development and Implementation of the Individual Family Service Plan (IFSP)

- **Provide suggested approaches on developing and implementing IFSPs**
  All of the localities surveyed indicated that IFSPs are an important tool in tracking a child's progress. However, the IFSPs are child specific, and there is no broad-based evaluation method routinely employed in developing them. While it is not feasible to develop uniform IFSP guidelines across localities, it is possible to provide suggested approaches tailored for different sized offices. These approaches would be a proactive way to guide localities toward crafting their own best practices in IFSP development and implementation that are specific to their offices.

- **Host Annual CSA Coordination Meetings**
  Survey results illustrated that 37 percent of CSA coordinators communicate with one another to gain insight and information on CSA. At the same time, only 10 percent utilize the CSA website to gain this type of information. For this reason, we recommend that OCS encourage additional collaboration between CSA coordinators across localities by hosting an annual or bi-annual conference, in addition to the bi-monthly meetings of CSA coordinators across the state. The conference would provide an opportunity for CSA coordinators to share experiences and best practices about IFSP development and implementation.

Discharge Planning

- **Institutionalize discharge and step-planning at the start of treatment**
  While some localities indicated that they begin discharge planning early in treatment, others do not. In fact, in half of the localities that returned the survey, discharge planning was done entirely by the providers. For this reason, we recommend institutionalizing discharge and step-down planning at the start of treatment. In much the same way that CAFAS and other assessment criteria are collected when a child enters CSA, coordinators could also begin discharge planning. OCS could institutionalize this process by articulating uniform discharge procedures to which CSA coordinators could adhere. These procedures might include standardized forms that OCS could distribute to the localities detailing suggested approaches to discharge planning. OCS could further institutionalize the process by providing discharge training to various localities, thus underscoring its importance and creating a sense of urgency among coordinators to begin thinking about discharge during the in-take process.

Residential Treatment Issues

- **Develop programs to address family problems**
  For many of the children in residential treatment, there is simply nowhere else for them to go. While certain problems cannot be addressed through any other channel, many localities indicated that some children remain in residential treatment because their family situations are ill-prepared to deal with their specific problems. We recommend that OCS work with providers in various localities to develop family assistance programs. Many localities already work with families through FAPT. These additional programs could be supplemental meetings that provide information and advice on handling child-specific problems in a non-confrontational and educational setting.

Uniform Data Collection Statewide

- **Institutionalize basic data collection**
  Data collection varies considerably across localities. While Fairfax gathers and analyzes a great deal of data, smaller localities do not have the time or resources to perform broad-based data collection. OCS could assist localities in gathering data by providing templates that they can distribute to parents, providers and case-workers. These templates could be tailored to address various issues, such as parent satisfaction and provider feedback. In addition, they could focus on gathering quantitative data, leaving CSA coordinators to continue providing qualitative feedback without having to spend value time gathering statistics. If the templates are standardized across localities, analysis could further be simplified through the utilization of basic analytical tools that are uniform and expeditious.

CSA Training

- **Provide comprehensive training in step-down and discharge**
  The need for additional training was articulated by all of the localities. The types of training requested, however, differed substantially. One area in which all of the localities felt that training would beneficial was step-down and discharge. For this reason, we recommend that OCS make step-down a discharge a training priority.

- **Establish a Mentor Program for Junior Coordinators**
  Although the majority of CSA coordinators have some background in human services, all of the localities interviewed articulated that working as a CSA coordinator could often be difficult and frustrating. In order to alleviate some of the uncertainty and confusion faced by newly hired coordinators, we recommend that OCS establish a mentor network of experienced coordinators to whom junior coordinators can contact for guidance early in their careers. We believe that by providing such a network, OCS can lower the turnover rate of CSA coordinators because new coordinators will not only adopt the best practices of their more senior colleagues, they will also feel more confident and assured in their positions, thus easing the level of frustration often faced by new coordinators.

APPENDIX A: PRENOTICE LETTER

Date: November 5, 2003

To: CSA Coordinators

From: Pam Fisher, Assistance and Compliance Consultant

Subject: William and Mary CSA Gap Analysis Project
Thomas Jefferson Program in Public Policy

To better understand gaps in the Utilization Management framework, graduate students in the College of William and Mary's public policy program have expressed an interest in conducting a systems analysis. Using both quantitative and qualitative surveys to solicit the opinions of local government CSA staff, the graduate students hope to provide information on how localities use the CSA Utilization Management framework, examining the utilization management process and collecting best practices, barriers to the provision of service, assessment and referral issues, as well as collaboration among local agencies.

The students intend to collect their information in two ways through a quantitative survey, which will be distributed to all local government CSA Coordinators, as well as a qualitative survey. The quantitative survey is a short multiple-choice survey. In the next few days, all CSA coordinators and other designated contact persons for those localities that do not have CSA coordinators will be receiving e-mail correspondence from the students with instructions for completing the quantitative survey. As for the qualitative survey, the students will ask five local governments to participate through face-to-face interviews. For the localities chosen for the qualitative survey, the students will be calling to schedule an interview. At the completion of the project, William and Mary will provide the Office of Comprehensive Services and its local government CSA constituents with their findings.

All information collected through the survey is to be confidential. Completed surveys are to be sent to the student project leaders at William & Mary for analysis. In an effort to collect information that can best evaluate the UM framework, the Office of Comprehensive Services will not know which respondent submitted which response. Surveys are due to the William and Mary students by **December 1, 2003.**

If you have any questions about the survey, please contact one of the project leaders at William and Mary.

Kerry Burke	kaburk@wm.edu
Lindy Dingerson	lmding@wm.edu
Akira Hirata	axhira@wm.edu

Thanks in advance for your thoughtful consideration of the topics to be addressed during the survey and for your timely completion of the survey.

APPENDIX B: INTRODUCTORY LETTER

Dear Mr./Ms. CSA Coordinator or CPMT Chair:

In order to better understand gaps in the Utilization Management framework, the Office of Comprehensive Services has teamed up with the College of William and Mary's Graduate Policy Program to conduct a survey of CSA officials. As a part of this effort, we request that you complete the attached survey.

The purpose of the survey is to better understand how localities are using the Utilization Management framework, understand what resources localities currently use, and collect suggestions on how localities can better use the resources available to them. Specifically we are looking to address best management practices, barriers to provision of service, assessment and referral issues, collaboration with local government, development of a service plan, and collection of data.

All information collected through the survey will be kept confidential. The responses will be quantified by William and Mary students and the original survey questionnaires will not be seen by OCS staff. By this method, we can keep track of who has completed the survey, but not the content of the survey responses.

If you have any questions about the survey, please contact one of my associates at William & Mary.

Kerry Burke	kaburk@wm.edu (703) 598-1940
Lindy Dingerson	lmding@wm.edu
Akira Hirata	axhira@wm.edu

Thanks in advance for your thoughtful consideration of the topics to be addressed during the survey and for your timely completion of the survey.

Sincerely,

Pam Fisher
Assistance and Compliance Consultant
Office of Comprehensive Services
1604 Santa Rosa Road
Wythe Building, Suite 137
Richmond, Virginia 23229

APPENDIX C: THE QUANTITATIVE SURVEY

1) The main purpose of Utilization Management (UM) is to:
    a. Assess a child's needs
    b. Define the role of CSA staff
    c. Improve the process of delivering services
    d. Identify services required by children in the community

2) The CAFAS and PECFAS are appropriate tools for assessing the children covered by my office.
    a. Strongly agree
    b. Agree
    c. Neutral
    d. Disagree
    e. Strongly Disagree

3) My office communicates with WVMI by telephone or in person:
    a. Daily
    b. Weekly
    c. Monthly
    d. Only as needed

4) The most important determinant in a child's being referred for residential treatment is:
    a. The child's CAFAS or PECFAS score
    b. The child's DSM IV diagnosis
    c. The child's Medicaid status
    d. The urgency of the child's case

5) For each case, my office communicates with the associated provider:
    a. Daily
    b. Weekly
    c. Monthly
    d. Only as needed

6) Psychiatric and psychological evaluations for children with intensive treatment needs are administered:

   a. Monthly
   b. Quarterly
   c. Annually
   d. Only when recommended by the provider

7) My office requires its providers to (circle all that apply):

   a. Attend Family Assessment and Planning Team (FAPT) meetings
   b. Provide regular updates to the treatment plan based on the Individual Family Service Plan (IFSP)
   c. Submit routine progress reports on each case
   d. None of the above
   e. Other _____

8) The Individual Family Service Plan (IFSP) is based upon:

   a. CAFAS scores
   b. Assessment information collected by the case manager
   c. Both a and b
   d. Other _____

9) Elements of an appropriate discharge plan should include (circle all that apply):

   a. A step-down placement and discharge date
   b. Objective criteria to assess and determine the community's ability to provide for the child's needs after discharge
   c. Risk factors in the community
   d. Other _____

10) Planning for a child's discharge from a medical facility begins:

   a. As soon as the provider recommends discharge
   b. When the child enters the facility
   c. When my staff and the provider collectively determine it is prudent to do so

11) The following services are readily available in my community (check all that apply):

   a. Treatment for substance abuse
   b. Independent living skills training

c. Vocational training

d. Appropriate support groups such as AA or NA

e. Other _____

12) My CSA office routinely employs a mechanism to identify families needs and/or satisfaction with the treatment received

a. Yes

b. No

c. If yes, describe _____

13) There are sufficient providers available in my community to treat the most common and/or difficult disorders:

a. Yes

b. No

c. If no, list deficiencies _____

14) My office would benefit from a uniform means to identify what types of diagnoses or issues are among the most difficult to treat

a. Strongly agree

b. Agree

c. Neutral

d. Disagree

e. Strongly disagree

15) My office would benefit from being exposed to the best practices of other offices:

a. Strongly agree

b. Agree

c. Neutral

d. Disagree

e. Strongly disagree

APPENDIX D: REMINDER NOTICE AND THANK YOU NOTICE

Dear CSA Coordinator:

It has come to our attention that you have not completed the Utilization Management Survey which was sent to you by email on November 7, 2003. This survey is an effort to enhance the effectiveness of the UM process, and you response is very valuable. Please take a moment to fill out the survey and send it to axhira@wm.edu. Thanks in advance for completing and returning this survey.

Sincerely,
W&M Project Team

Dear CSA Coordinator:

Thanks so much for taking the time to fill out the UM survey. Your response is very valuable to us, and we thank you for your timely response.

Sincerely,
W&M Project Team

APPENDIX E: FINAL REMINDER

Dear CSA Coordinator:
We are very excited to have received over 60 responses to our survey thus far. Unfortunately, we are still waiting for your response. We would be very grateful if you could complete the attached survey and return it to me (kaburk@wm.edu), or Akira Hirata at axhira@wm.edu at your earliest convenience. It is our goal that our objective assessment of CSA and Utilization Management will benefit your locality -- but we really need your response in order to achieve this!

Please don't hesitate to contact me by email or telephone (703-598-1940) if you have any questions or concerns about the survey.

Many thanks in advance for your response!

Best regards,
Kerry Burke
Lindy Dingerson
Akira Hirata

APPENDIX F: THE QUALITATIVE SURVEY

Working Document for Qualitative Questions

Name:

Position:

Region:

Date:

How do you and/or what is the best way to collaborate and negotiate with providers regarding service agreement/contract issues (areas to cover)

a. rate setting
b. attendance at FAPT meetings
c. submission of regular progress reports
d. treatment planning.

How do you detect progress in your clients currently (hidden question: do you formulate specific, measurable, and time specific goals on the Individual Family Service Plan (IFSP) so that progress or lack of progress can be detected)

Do you currently collect the following data? What is/would be the value of this type of data? (areas to cover)

a. to determine placement types and/or providers that have the greatest success in achieving desired outcomes,
b. to determine families' needs and/or satisfaction with the treatment received, to identify best practice methodologies with regard to utilization management and provision of services,
c. to identify training issues for case managers and/or providers

How big is the need for training and what areas should be targeted? (areas to cover)

a. How to achieve a comprehensive assessment and referral process.
b. Collaboration with providers and provider relations.
c. Development and implementation of the IFSP.
d. Discharge and step-down planning.

How do new hires gain information about UM and FAPT process? (areas to cover)

a. Reading the state CSA (OCS) website.
b. Communicating with other CSA coordinators.
c. Reading the CSA Policy Manual provided by OCS.
d. Technical assistance from the OCS staff (state office).
e. Communicating with my predecessor in the CSA Coordinator position.

What are your localities determinants for a child being referred to a secure residential treatment facility, and why? (areas to cover)

a. CAFAS/PECFAS scores and the assessment information provided by the case manager or referral agency at intake.
b. Evaluation by a psychiatrist, including DSM IV diagnosis.

c. Psychological Evaluation and IQ determination.
d. Child's Medicaid status.
e. Lack of foster home placement.
f. Lack of group home placement.
g. Lack of short-term emergency placement.
h. Lack of resources in the school system.

What method does your locality use regarding discharge planning/step-down planning? (areas to cover)

a. Establishes criteria for discharge at the onset of the current treatment episode.
b. Relies on the provider's judgment and expertise as to what and when discharge criteria are established.

How does your locality use the WVMI process? What changes would make the process more valuable?

What are the requirements of your provider? How could the relationship be improved? Do you... (areas to cover)

a. Attend Family Assessment and Planning Team (FAPT) meetings
b. Provide regular updates to the treatment plan based on the Individual Family Service Plan (IFSP)
c. Submit routine progress reports on each case
d. Negotiate rates

APPENDIX G: ADDITIONAL COMMENTS FROM THE QUANTITATIVE SURVEY

2) In my opinion the most important training need for CSA case managers is:

- All of the Above
- Foster care and IV-E Policy training
- All of the above + laws + regulations
- The importance of completing a new CAFAS every three months.
- I do think all of the above are important.
- To promote interagency collaboration at a local level in order to better serve children's needs.
- Understanding the purpose and process of utilization management and review.
- Locating providers who offer superior services and networking case managers with those providers.
- CSA Policies and Procedures – some Still do not understand the difference between mandated and non-mandated. CSA is extra paperwork – case managers know what needs to be done but do not take the time to do it.
- CSA case managers (not CSA coordinators) need to learn about family systems and the importance of engaging the family of CSA clients in treatment. Too many children are taught how to function in relation ship to other adults (therapists, residential, home-based providers, foster parents), but not in relationship to their own families. The families frequently do not make the changes necessary to be effective at parenting the at-risk youth. Secondly, I would want case managers to learn how to develop objectives on the IFSP which target the barriers to a less restrictive treatment setting and how to hold providers accountable to focusing on those barriers.
- b, c, and d are equally important.

3) Extended lengths of stay in residential treatment facilities can be attributed to (indicate all that apply):

- Lack of financial resources and access to community based services
- Treating 11-15 years of dysfunction takes longer than 3 to 6 months.
- Lack of adequate & appropriate community resources for wrap-around services for families & children
- Lack of community resources for step down treatment period- not just sex offender
- Insufficient progress made in reducing the problematic behaviors that led to the placement in the first place.
- Lack of aggressive review, participation in treatment planning, and setting/monitoring progress of appropriate and reachable treatment goals on behalf of the locality.
- ALL OF THE ABOVE. This question is too ambiguous. There could be hundreds of reasons for extended placements. Refer to Mitigating Circumstances for CSA

services.

- Pervasive and multi-generational dysfunction in families, resistance to treatment, mentality in families that child needs to be fixed but they are not in need of treatment, extensive substance abuse in this country.
- Tremendous lack of resources given to workers by the State. Too few workers, too many complex cases with the resulting demands of the court system, Oasis documentation, UM reviews and justifications. Often it's the result of lack of community resources in general.
- Lack of community resources as a whole, especially in rural localities. Many localities lost Offices on Youth (which provided free/low cost prevention and early intervention services) due to the funding loss from DJJ.
- a. Especially group homes
- a. Primarily due to insufficient finding for group homes and foster care rates too low to provide for the children, much less attract foster parents.
- b. For a small segment of the CSA population which is developmentally disabled in addition to having behavioral or emotional problems.
- c. Safety issues account for many, if not most, residential placements. However, the "extended" stays need only occur with a small group that have emotional/behavioral problems as the primary issues. In particular, sexual offenders generally require very long stays due to the safety of the community.
- d. Even regional resources would be helpful
- d. Minimal impact on extended residential. It does not appear that community resources would make a substantial difference for sexual offenders. There are a small proportion who are either young enough of "mild" enough to be treated safely in the community. Increased numbers of TFC homes or group homes which specialize in sexual offenders would certainly assist in reducing residential stays, but the period required for residential treatment is fairly long in any case.
- e. Minimal impact on extended residential. Although there is clearly an insufficient number of programs addressing S.A. issues, the limitation is more related to funding of these programs (insurance, Medicaid do not cove S.A. treatment). Most of the residential programs which focus on S.A. treatment are very time-limited already.
- f. To some extent, the limitations imposed by lack of funding for community-based (non-Medicaid clients) services and the lack of emphasis on family treatment (and the difficulty holding families accountable for making changes) increase the stays of some children in residential settings.

4) The primary way data collection can assist my local government is:

- Use it to justify the distribution of additional funds to serve our families.
- To identify trends in services utilized and costs.
- Current data collection will not adequately meet this need.
- To details the issues involved in the case management of CSA cases and show places that can be improved.
- Describing the Population served by C.S.A. and developing community bases

services to serve them. + The information will eventually lead to C.S.A. policy changes

- Gives exact data for tracking and informational purposes to present to agencies, boards, etc... Helps maintain proper documentation of services, categories, money spent.
- We have a small case load ratio – We know our $$ is spent on Foster Care kids and IEP out of county placement kids. Both are beyond our control – as to kids coming into foster care or moving into the county requiring special education services. WE NEED MORE PREVENTION MONEY AND THE SCHOOL TO COOPERATE IN IDENTIFYING AT RISK KIDS.
- To demonstrate to the State that it should establish more long-term placements for MR/DD/Autistic clients so that localities can devote those resources to prevention efforts. I spend approximately 25% of my funds on about 5% of my kids (those that would have been in State hospitals)
- a. This cannot be done with the new state data collection – it doesn't identify providers. The localities tracking vendor outcomes can certainly benefit from identifying proven services.
- b. In general, the new data collection will be able to provided better information as to the problems/needs, which lead to CSA involvement. The state's CSA data set will not address family satisfaction that is beneficial to those localities assessing it.
- c. If applicable to a very rural area with limited resources.
- c. No, the data set is not large enough, and the treatment protocols not controlled enough, to identify best practices.

5) With regard to utilization management and the FAPT process, as CSA coordinator, I feel that I could most benefit from training on:

- Not sure
- On less paper work.
- Honestly none of these topics interests me since I've been doing it for so long, but more training on IV-E, Medicaid, State funding, REV-Max, how to develop an ICF-MR, etc.
- How to train case managers in items a. through d. personally, I feel quite capable of providing all of the above myself, but the case managers and FAPTs are the ones responsible for items a. through d. in the larger jurisdictions.
- b. In terms of continued statewide support in developing the expectation that this is a part of doing business. When services providers are in limited supply for a specialized type of service, negotiations are tricky.

5) When I first entered my job as CSA coordinator, I mostly gained knowledge about utilization management and the FAPT process by:

- Trial and error
- Prior job experiences
- Going to training and trial & error.
- Training offered at the state level

- My service on the Powhatan and Amelia FAPT Teams.
- I was on the original team charged with developing UM.
- This issue needs more training available to new CSA folks.
- I am the Principal Social Worker and only serve as the CSA coordinator as one of my duties.
- Tracking the CSA legislation through the General Assembly as a Grad student.
- I do a., c., communication with State CSA, state auditing, communication with FAPT, CPMT chairs and case managers.
- Not officially CSA coordinator. I am CSA Clerk and have gained knowledge through various means.
- My position began during the demo project in 1991. I gained my knowledge from the Implementation Manual and support from the OCS staff. I later served on UM/UR committees and workgroups.
- My experience was that a, c, d were usually not helpful to me since the answers I received changed, or what was stated to me verbally was later contradicted in writing, or I was simply referred back to the policy (even though I had called for policy clarification), etc...
- I have been here since the beginning. OCS was a highly disorganized new office trying desperately to implement state codes. I learned by reading the information sent out and by talking with those on various state committees and CPMT chairs who were getting the information.

6) Describe your background prior to becoming a CSA Coordinator (indicate all that apply):

- Foster Care Social worker
- Foster care worker
- MPA (Public Administration)
- Degree in Family and Child Development
- Degree in education and social sciences
- College degree in Criminology/Criminal Justice.
- Private provider marketing and community program development
- Participation on local FAPT teams as a team member
- I am also currently the VJCCCA Coordinator for the City.
- Information Systems Management
- I have an MSW
- College degree in communications and political science.
- Office on youth director
- College degree in Philosophy.
- BA Degree in Political Econ.; 1992 MBA
- Director of non-profit organization
- Worked as a FC social worker at local DSS.
- Graduate degree in human services field
- Psychiatric Nurse Case Manager
- Masters Degree in counseling & coursework in non profit management.

- I'm not a CSA coordinator, but I have e.
- Undergraduate in Sociology ongoing education for MBA... a bit of each above prior work with program development

7) In my locality, the three top determinants for a child being referred to a secure residential treatment facility are (please indicate the three from the choices listed):

- Safety issues
- Court system cases (CHINS)
- It is the most appropriate placement
- If a full assessment says the child needs it
- Professional assessments by qualified staff.
- Risk factors and the child's needs are the primary reason
- Unsuccessful placements in less restrictive environments.
- Every less restrictive treatment model has been unsuccessful
- Severity of child's mental diagnosis and safety of youth and community
- Local resources are inadequate to serve the treatment needs of the child.
- Foster parents not equipped to handle Severely emotionally disturbed youth
- No alternative method for treatment, child's problems exceed all other alternative placements.
- Child's behaviors, safety for self and others and reasons for failed community interventions.
- Most important- the behaviors of the child which make a less restrictive placement impossible.
- Lack of or failure in lower level of care capable of meeting child's mental health, emotional, or safety needs.
- Lack of success with least restrictive community interventions; safety of client due to behaviors or not cooperating with treatment.
- The need for residential placement is assessed based on child's need for the service. This would include almost all of the above determinates.
- I am concerned that there is not option: the child's behavior demands RTC for their/other's safety. Of all the choices, e and f are encountered occasionally.
- Need for services provided by facility (i.e. Secure Facility, On-Site Counseling, On-Site Educational Facilities, Staff Trained to Work with Children with Difficult Behaviors, etc).
- #1 reason for placement in secure residential is the risk of harm to child or others. This is often independent of CAFAS scores and/or psychiatric/psychological evaluations. #2 reason for placement in secure residential is court ordered placement.
- a. CAFAS and assessment information that is provided at the time of the FAPT staffing – most recent assessment, not the intake one

8) My school system takes an active role in working with FAPT to keep children in the community:

- Agree: But needs improvement

9) Which of the following do you believe contributes most in a child returning to a residential placement?

- CHILD'S BEHAVIOR
- The child is extremely damaged
- Failure of parents to follow through with necessary treatment.
- Lack of participation in community based services after Step down
- I feel our community does a great job in trying to prevent a child from returning to the residential setting.
- The child/family does not cooperate with services being provided on the local level, thus resulting in the child's behavioral/emotion regression.
- Primary difficulty is providing a gradual enough transition with sufficient time to identify problems and adjust the services accordingly. Secondary problem is the failure of families to make the changes necessary to be able to adequately take care of their child.
- The list of options seemed to entirely ignore the reality that sometimes seriously emotionally disturbed children don't go to hospitals and get 'fixed', and sometimes need to reenter residential centers to be stabilized. That is not a failure of the discharge planning, but a basic feature of disorders such as Bipolar, Schizotypal, etc.

10) Regarding discharge planning/step-down planning my locality:

- Both A & B
- A mixture of both of the above
- Combination of both A & B
- Realistically, it is a combination of both of these.
- UR Specialist coordinates with the provider.
- Works w/all involved parties to best plan for discharge.
- Establishes criteria for discharge in collaboration with the provider.
- A joint effort by case managers and providers after 30 days of treatment.
- Relies on the case manager to coordinate discharge planning with the provider.
- Relies on case manager agency_ judgment and expertise as to what and when discharge criteria are established.
- Requires a comprehensive collaborative effort between the FAPT, case manager and service provider, which begins at placement.
- Provider judgment + ongoing UM to assess goals established at onset of services.
- The locality relies on input from the provider as to when the treatment objectives

have been accomplished.

- Establishes criteria at the onset that is too broad. We also collaborate with providers on discharge, it is not a unilateral decision.
- Utilizes the services of a clinical case manager who is not related to the facility to provide recommendations and assistance in coordinating discharge.
- It really depends on the child-specific issues, what services are in place, etc, but usually it is both a and b together. We never just blindly accept the provider's word for a child's discharge planning, since that is done before placement and through the child's stay with the provider.
- b. in collaboration with the Case Manager

11) To avoid unsuccessful step-down/discharge planning, which of these would be most helpful to your locality?

- We've had tremendous success in this area.
- Better communication and collaboration with providers.
- Services to the family to assist with the transition home.
- An understanding of the options for discharge at the beginning of the case.
- Greater community based resources (foster homes) to place children in; more UR staff locally to help drive a step down plan
- 'Locality specific' training for case managers so that they can determine what level of behavior is manageable given the locality's resources.
- Making sure the family is prepared for the child to return to the home. (i.e. Counseling, In-home services)
- More time to assess progress vs. Medicaid pressure. Vender attendance at FAPTs for concrete planning.
- Most of our cases in residential do not have a family to return to -- that's the problem not a lack of assessment or goal -setting.
- Funding for overlapping services for longer period to provide more gradual transition. For example, to adequately step children down from residential to TFC (or TFC to family home) it would be helpful to provide home-based services to facilitate the transition over a 2-3 month period while the child is making visits to a TFC home. Currently, Medicaid won't allow home-based services concurrently with residential or TFC case management.
- a. If staff time and funding was available
- b. In relationship with community resources that are available.
- b. In terms of identifying earlier that due to the severity and longevity of pervasive problems, that even with intensive and specialized home-based treatment services, that the family may not achieve a functioning level adequate for the child's success upon returning home.
- Question #11 is particularly concerning and borders on insulting, it sounds as if the three choices are all the localities "fault". We can do all the best assessments available, set specific and measurable goals, and the child could still not make a successful transition due to their own unique set of issues. I question the underlying assumption that if a child needs to return to a more secure facility that

there is a failure anywhere'. No offense to anyone, but some of the questions seem to have been written by someone without adequate knowledge of childhood psychiatric disorders/progression or with experience in residential treatment/group homes/foster homes and what they're able to accomplish.

12)I believe my locality would benefit most from WVMI participation if:

- All of the above
- If WVMI used different review models.
- We had the same checklist as WVMI when doing reviews.
- Not sure is anything else is needed from WVMI that my localities cannot do.
- WVMI would adapt their system to include review of cases that are not receiving services based on medical need.
- My locality does not participate with WVMI. And we never will as long as it's optional.
- WVMI was more knowledgeable of the various facets with which localities deal in serving our children.
- If WVMI provided helpful, meaningful feedback about clinical needs of the case rather than commented on lack of documentation
- Venders & case managers providing the C.S.A. office with the appropriate documentation. Service plans / Progress report & Psychological info to properly conduct the WVMI reviews
- As a locality I feel we understand all the above. Feedback could be presented in a more organized and specific manner. An updated manual explaining specific requirements would be helpful.
- While we don't use WVMI for UM, we would greatly benefit from c., d. We were initially assured that WVMI would never use the CAFAS for determining a child's eligibility for coverage, it is clearly the primary measure for determination. Coordinators/localities would be well served to understand why the criterion seems to be changing, new interpretations made re: coverage, etc.
- f. Because it was more work for no benefit to us as a locality.
- f. But we do for the Medicare cases. WVMI needs to ensure consistency among their reviewers and hire clinically trained staff.

13)My locality requires its providers to (indicate all that apply):

- Attend court hearings, etc.
- Case workers assigned by providers encouraged to attend.
- It would be nice if providers did all the things listed above.
- By speaker phone or/and in person when new IFSP is written or if disagreement with provider.
- None of the above – We are working on this currently to improve and meet requirements.
- Yes to a, b, c, d, but with d sometimes the rates are acceptable and no formal negotiation is required.

- We have quite a few requirements in our written agreement for the purchase of services, such as, requirements regarding court attendance and notification of Medicaid status changes. Remarkably, providers have attempted to charge us thousands for Medicaid denials solely due to the providers' failure to provide Medicaid information – we refuse to pay per our written agreement.
- a. Occasionally
- a. When asked.
- b. + foster care plan.
- c. Monthly
- c. Submit routine progress reports on most case, especially residential
- d. Attempted but not a requirement.
- d. For the most part, this is a joke when you have as few cases as we do.

14) The following services are not readily available in residential treatment settings in Virginia (indicate all that apply):

- UNK
- Treatment for traumatic brain injury
- Sex offender and other safety type issues for MR children
- Services for mentally retarded teens with behavioral problems.
- TREATMENT FOR ACTIVELY AGGRESSIVE YOUTH
- What constitutes "readily"?
- Group Homes with therapeutic components
- Not in Southwestern Virginia where we want to place our children.
- Many of these services are listed as available by providers, but the quality/availability of the service is questionable.
- Although these services are available within residential settings, they are not available in this community as a single service.
- Sufficient home-based services to families to assist with transitions. Grafton does not provide this as part of its service delivery system, for example, whereby the staff most familiar with the child can physically go to the home and assist directly with transition services.
- We have found that there are VA programs for most problem types. We seek an out of state placement for a variety of reasons including: 1) our children have not succeeded in a VA program, 2) VA programs will not accept our youth due to severity of problem, 3) the quality of the program due to staff turnover, inexperienced young therapists, etc. is not adequate to meet the needs of our youth.
- a. Only 2 in VA
- a. inadequate
- a. Not available in many regions, not with adequate funding.
- b. exists only minimally
- b. Not available in many regions, no funding for non-mandated.
- d. Not included in most residential- most are too medically-model oriented
- e. Very expensive

- e. Most prevalent
- e. Not available in many regions.
- f. very expensive
- f. not available for teens
- f: VERY FEW - State hospital used to provide
- f. Not only not readily available. But frequently requires out-of-state placement
- g. Not available in all regions.
- g. VERY FEW – State hospital used to provide
- h. for children.
- h. AA or NA in most communities
- h. Very few residential providers have AA or NA groups within the residential setting.
- h. We would likely find this in the community, residential SA placement would be for detox, etc
- j. varies form provider to provider.
- a-d. not specialized or in depth

14) For each case placed in a secure residential treatment facility, my locality communicates with the associated provider:

- Weekly- minimally
- Weekly (depends upon severity)
- Weekly or more often as needed
- Monthly or as needed
- More than monthly, less than weekly.
- Quarterly
- Depends on the case and the situation
- Depending on the needs of the child.
- Varies from case to case- individualized.
- It varies from one to three times a month
- As needed, usually weekly to monthly.
- On an as need basis not to be longer than weekly.
- I don't know-this is the case worker's responsibility.
- Varies case to case bases no less than monthly.
- Weekly- case manager, monthly- FAPT
- At least, could be daily and /or weekly depending on case situation.
- The case manager communicates with the facility. I do not know how often.
- Only when needing info for review- which we are currently working on as well to meet requirements and better serve the children.
- At least monthly, but often weekly or daily, depending on the timing of discharge, recurrent "critical incidents", etc.
- Monthly documentation of progress, telephone communication occurs as needed.

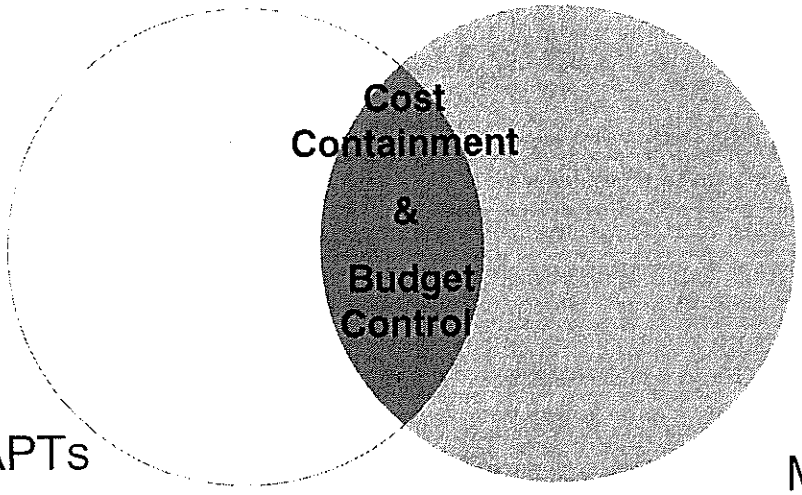
- More than weekly but less than daily; contacts completed by clinical case manager, social worker/service coordinator and/or CSA representatives.
- We have very few children in secure residential treatment facilities. In fact, at this time we have only 1.
- I have no way to know this information and I am sure that it varies with each situation and case manager.

EXHIBIT I: FAIRFAX COUNTY'S PROPOSED REVISION TO UTILIZATION MANAGEMENT

Proposed Revision to Utilization Management

UR

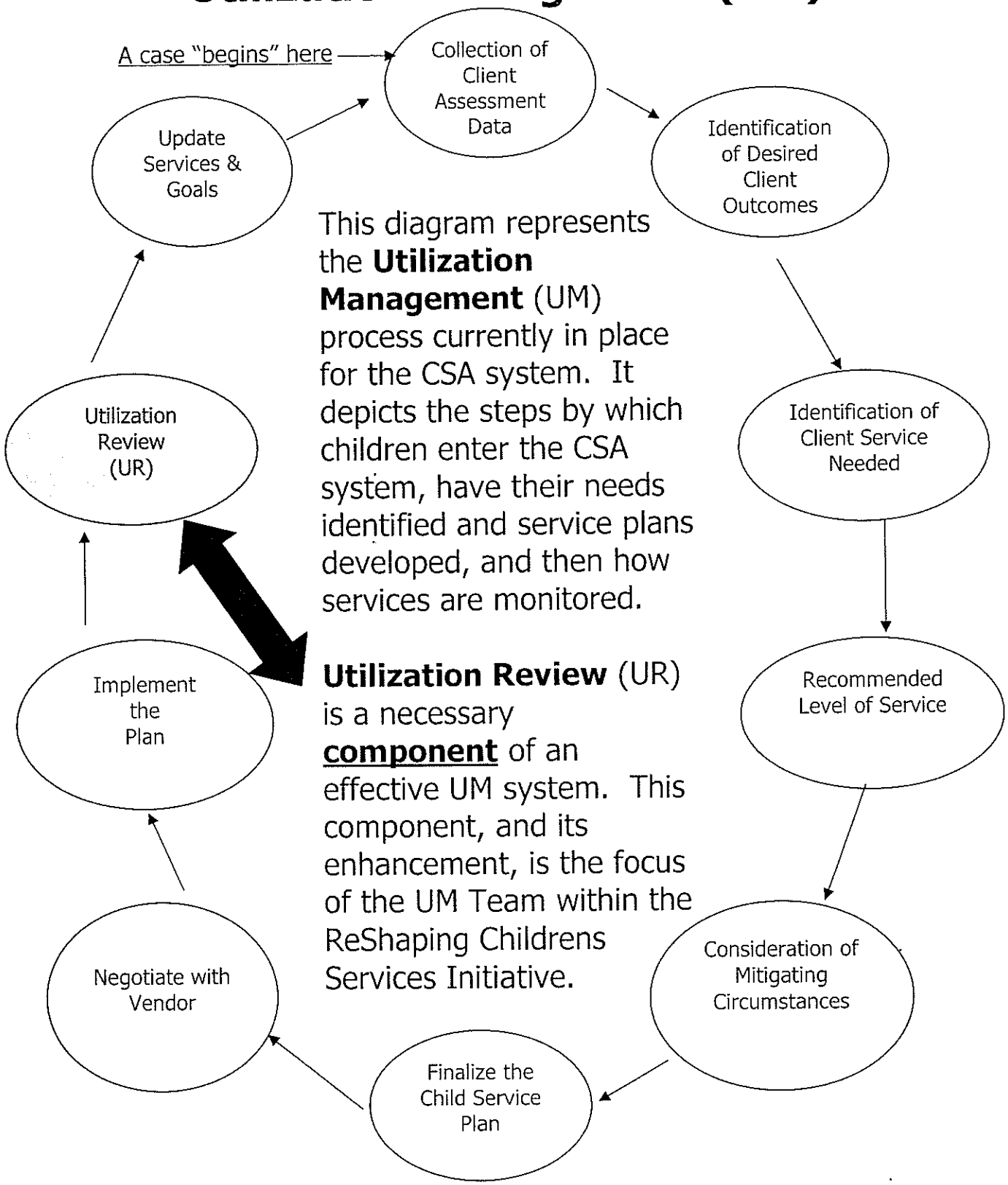
New function



CSTs & FAPTs

Case Manager

Utilization Management (UM)



This diagram represents the **Utilization Management** (UM) process currently in place for the CSA system. It depicts the steps by which children enter the CSA system, have their needs identified and service plans developed, and then how services are monitored.

Utilization Review (UR) is a necessary **component** of an effective UM system. This component, and its enhancement, is the focus of the UM Team within the ReShaping Childrens Services Initiative.

Utilization Management and Clinical Utilization Review ~

Background:

- Utilization Management (UM) can be broadly **defined** as "deliberate action to induce a more economical mix of treatment [options] without sacrificing . . . outcomes".

- The essence of the **definition** of Utilization Review (UR) is "the use of independent professionals to scrutinize and curb unnecessary services". UR, as proposed for select CSA residential cases, is a collaborative professional clinical review to ensure that clinical treatment services are "no more, no less" than is necessary. UR ensures that sound business, clinical and case management practices are integrated.

- UR staff does not have the legal authority to determine IEP placements, nor the legal custodial authority to determine foster care placements. Rather, UR staff has responsibility to provide expert recommendations regarding placement, treatment and length of stay in facilities.

- Standards for utilization management and review are currently inconsistent across our system of care. Today's clinical UR practices vary at all levels of our system: case manager, CST, FAPT, Contract Team and other agency teams. This inconsistency permeates the following areas: appropriateness of clinical care and length of stay, as well as attention to the cost of service. The details of this recommendation will address the following issues and concerns:
  a) Inefficient and inconsistent utilization review activities among the entities noted above due to varying levels of expertise, focus, workload, and time constraints
  b) Inconsistent management of length of stays. UR will ensure that service interventions are not longer than are clinically necessary, and that step-down opportunities are utilized as soon as they are clinically indicated
  c) Meeting the state requirements for Utilization Management so to obtain the state for CSA funding
  d) Significant increases in treatment costs that cause budget overruns
  e) Inconsistent monitoring of clinical treatment progress

Recommendations:

- Implement an integrated internal (rather than externally purchased) UR function for select residential cases.
- Create standardized, streamlined, and integrated approach to UM to assist with providing appropriate level of service for youth utilizing the expertise of case managers, FAPTs, the contract workgroups, MH and ADS Resource Teams, Court Placement Team, and the providers.
- UR staff will function under CSA. To ensure that effective clinical expertise is maintained in the UR process, the three disability areas within the CSB will be utilized for regular, clinical case staffings.
- Hire three staff SYEs as UR Specialists for Phase I - one will serve as supervisor.

Utilization Management and Clinical Utilization Review ~

Rationale for Internal UR:

- Ability to set the cost for UR function
- Public staff oversight of (primarily) privately purchased services
- Approach can be tailored to the needs of our local system
- Knowledge and close linkages with our local CSA contracting processes
- Investment in the community's system of care and its outcomes for our youth and families, both clinically and financially, because the UR function is a *part* of the system
- Ability to more fully integrate the UR function throughout the various components of the local human services system, i.e. CSTs, FAPTs, Contracts Workgroups, Management Team, CPMT

Implementation: (While it is recognized that UR runs the gamut of involvement from initial service selection to service closure, the intensity of the involvement of the UR Specialist will vary depending upon the particular circumstances of the case.)

Phase I ~

- Develop the UR criteria and protocols
- Analyze CSA caseload data and identify number of residential treatment cases
- Hire and train UR staff
- Select specific cases for UR
- Train Case Managers and FAPTs
- Design and conduct preliminary evaluation
- Assess the need for additional UR staff

Phase II ~

- Refine the evaluation process
- Begin UR for:
- IEP residential placements
- Other youth with chronic needs requiring long-term residential care

The UR Specialists coordinate with CSA Case Managers, FAPTs and Residential Providers on the following activities:

- Provides on-going information to CSTs, IEPs, IDTs, and FAPTs regarding the child's clinical treatment progress and future service needs
- Participates in CST and FAPT processes on select residential cases to ensure appropriate client/clinical treatment match
- Determining when step-down is clinically indicated
- Monitors clinical treatment plan and progress of clinical treatment goals
- Assists in the negotiation with the provider regarding acceptance of youth who are difficult to place
- Reviewing provider clinical treatment progress reports which may include periodic record review as needed
- Ensuring youth is benefiting in a timely way from the treatment
- Facilitating the timely revision of provider's clinical treatment plan (non-IEP and non-Foster Care Service Plan) as needed

Utilization Management and Clinical Utilization Review ~

The UR Specialists support placement and treatment decisions by:

- Providing information on evidence-based practice
- Providing information to CSTs, IEPs, IDTs, and FAPTs regarding provides' abilities to meet clinical treatment needs of youth
- Possessing knowledge about funding sources therefore ensuring that revenues are maximized (e.g. private insurance, Medicaid, community resources)
- Informing Case Managers regarding availability of placement resources
- Assisting in monitoring provider performance in coordination with the Contracts Team
- Assisting in identifying provider strengths and opportunities for improvement
- Helps to quantify service gaps

What Actions are Needed from the Leadership Group?

- Approve the recommendation to move forward with an internal UR component
- Charter a team (members of the current UM subgroup) to "flesh out" a detailed implementation plan to include, but not be limited to:
  - Job descriptions of UR Specialists
  - Specific identification of types of cases
  - Design evaluation component

EXHIBIT II: FAIRFAX COUNTY'S PROVIDER CONTRACT TEMPLATE

1. GRANTS AND CONTRACTUAL AGREEMENTS FOR SERVICE DELIVERY

The CPMT in seeking grants or resources for services shall obtain the approval of the governing body of each jurisdiction. It is Fairfax County policy that agencies obtain authorization from the Board of Supervisors to submit grant applications. When submitting a proposal for Trust Fund or other grant money, the CPMT and staff from the participating jurisdictions will be actively involved in conducting a needs assessment, identifying priority goals in conjunction with long-term strategic planning and planning for evaluation.

When required under the Virginia Public Procurement Act process, the CPMT, through the Fairfax County Purchasing and Supply Management Agency, will announce a request for proposals to solicit contracts to provide grant-funded services. Proposals will be evaluated by a selection panel in accordance with a standardized set of criteria.

2. BIDS FOR NEW SERVICES

2.1. Single Umbrella Agreement

All Fairfax County agencies purchasing services from private providers serving at-risk youth and families under the CSA will utilize standard umbrella agreements for services. These agreements contain general terms and conditions including indemnification language of the County, insurance requirements, process for resolution of disputes and reporting requirements. Providers are required to sign an Agreement for Purchase of Services to do business with the CPMT. The CSA Program Manager has signature authority for agreements entered into by the CPMT.

There are two Agreements for Purchase of Services, one issued to outpatient therapists and the second to all other providers. These Agreements serve as the basic agreement between the CPMT and the provider and must be signed by both parties before actual services can be rendered. Such agreements do not represent any specific request for service. Rather, as each child specific requirement for service arises, an individual purchase of service order is issued pursuant to the Agreement for Purchase of Services specifying the service(s) required, the rate(s) of the services and the unit number of services being contracted. The purchase of service order must be signed by both the provider and the CPMT designee. The CPMT signature authority on the purchase order is delegated to the CSA Fiscal Administrator or designee.

19.2 Protocols for Fairfax-Falls Church CSA Contracts Pursuing New Provider Contracts and Adding New Services

Before entering into any agreements with a service provider, the CSA Management Team has been tasked with screening potential providers and making a recommendation to the CPMT. New Providers, or new services with existing Providers, will be considered when it is determined that the current service delivery system capacity:

a. Poses a waiting time for service for children identified to be in need of service

b. Can not meet the "special" needs of a specific child or group of children, i.e. language, disability, location, etc., and

c. Can not address the service gaps identified by Case Managers or FAPTs.

19.3Items CSA Management Team May Consider in Deciding to Contract or Not with a Potential Provider:

- Licensing/certification status of the provider (if applicable)
- Medicaid enrollment/application status of the provider (if applicable)
- Reference checks, to include previous employers, colleagues/associates, other jurisdictions, and licensing/certification bodies
- The ability, capacity and skill of the provider to provide the services required
- Ability of the provider to provide services promptly, or within the time specified, without delay or interference
- The character, integrity, reliability, reputation, judgment, experience and efficiency of the provider
- The quality of performance on previous contracts or services (where applicable)
- The previous and existing compliance by the provider with laws and ordinances relating to the contract or service
- Sufficiency of the financial resources of the provider to provide the service
- The quality, availability and adaptability of the services to the particular use required
- The ability of the provider to provide future services for the use of the subject of the contract
- The number and scope of the conditions attached to the agreement
- Whether the provider is in arrears to the County on a debt or contract or is in default on a surety to the County or whether the provider's County taxes or assessments are delinquent, and
- Such other information as may be secured by the CPMT or its agent having a bearing on the decision to award a contract.

19.4Provider Requirements that <u>must</u> be met to Proceed with Contracting:

- Provider must be in the Virginia State Service Fee Directory (SFD) or willing to enter their organization, services, and current rates. Provider must be entered in the SFD prior to actually providing CSA funded services
- The Provider must be properly licensed to provide the service(s) offered (if required), must have current insurance that meets the County's insurance requirements, and must provide acceptable documentation of both

19.5Certifying Provider Qualifications

Licensed/ Certified Providers: Those providers requiring state licensing need to adhere to established state licensing procedures and have a current state license. Providers need to maintain state established operating standards. For example, the Core Standards for Interdepartmental Licensure and Certification of Residential facilities for Children (CORE) continue to apply to Virginia providers and are enforced by the child serving agencies of Virginia including the Departments of

Youth and Family, Education, Mental Health, and Mental Retardation, and Social Services. For those Virginia facilities subject to CORE, a state interdepartmental licensure/certification team continues to conduct a review at the time of initial licensure application and upon its subsequent renewal. The providers must provide the following information in order for the CSA Management Team to consider recommending approval to the CPMT:

- Each potential provider will complete and sign the Agreement for Purchase of Services, pertinent Addenda indicating the specific services provided, and Rate Sheets indicating the breakdown of service costs
- Each potential provider, where appropriate, will complete and sign information sheets requesting a listing of all degrees, accreditation(s), three references, and insurance coverage.
- Each licensed/ certified provider will provide a current license/certification.

19.6Providers With No Licensing/ Certification Requirements

There are providers for which there are no licensing requirements. These providers must provide the following information in order for the CSA Management Team to consider recommending approval to the CPMT:

- Each potential provider will complete and sign the Agreement for Purchase of Services, pertinent Addenda indicating the specific services provided, and Rate Sheets indicating the breakdown of service costs
- Each provider, where appropriate, will complete and sign an information sheet requesting a listing of all degrees, accreditation, three references, and insurance coverage.
- References

19.7 Routine Procurement Procedures

Agency Case Managers will follow the procurement process under the CSA. Such procedures will include the purchase of goods and non-specialized service

19.8Identifying Providers for Child Specific Needs

Prior to each fiscal year, on or around July 1, the CSA Contracts Management Unit will circulate the CSA Provider Directory to all CSA user agencies. The Provider Directory identifies all providers with whom the CPMT has contracted to provide client services. Updates will be distributed to Case Managers when new providers or services with existing providers are added

19.9 Initiating Services from a Provider

Authorized case management staff will complete a CSA financial Authorization to Encumber form to initiate a purchase order for services by selecting the provider from the Provider Directory. The financial authorization form will be routed to the CSA Financial Management Unit to verify that a valid agreement exists; that when required, FAPT approval has been obtained; and to issue a

child specific purchase of service order, complete with purchase of service invoices.

Routine services or purchases will not be initiated until an agreement has been signed and a purchase of service order issued.

19.10Emergency Placements/Services

- There may be circumstances when the emergency placement of a child or purchase of clothing will occur after hours or on weekends. Case Managers are authorized to secure emergency services for up to 14 days without prior FAPT approval. These cases will then be reviewed according to FAPT procedures.

- There are other emergencies when the Case Manager requests the services of a provider with whom the CPMT does not have an agreement. In those instances the Case Manager submits a Provider Information Sheet to the CSA Contracts Management staff. The Provider Information Sheet must be signed by the requesting Case Manager's agency director or, as designated by the requesting agency director, the CSA Management Team agency representative, prior to the CSA Contracts Management staff initiating procedures to pursue an agreement with the proposed provider.

The Provider Information Sheet must be completed, signed and submitted to CSA Contracts Management staff requesting approval of a Child Specific Contract.

The agency director or a designated agency management representative must sign the Provider Information Sheet to indicate that:

- all local resources and existing approved providers were explored and are unable to meet the youth's current needs. (The Interstate Compact Approval of an out-of-state placement indicates that such efforts have been made);

- the requesting agency will accept responsibility for payment of the cost of the placement if the child is placed without an existing agreement, should the CPMT not approve the proposed Agreement.

Case Managers should consult with the agency director or CSA Management Team agency representative to determine the procedures to follow to obtain written approvals regarding any services which are requested on a child specific basis from a provider with whom the CPMT does not have an existing agreement.

19.11 Selection of Providers

- CSA Provider Directory as a resource reference – All providers of services who have signed an Agreement for Purchase of Services with the Fairfax-Falls Church CPMT are listed in the local CSA Provider Directory. This Directory is distributed by the CSA Contracts Management Staff at the beginning of each fiscal year, and updated

periodically throughout the year. Case Managers are instructed to reference this Directory first and use those providers listed.

- Service Fee Directory as a resource reference – All organizations providing services under CSA, including organizations providing outpatient therapy, must be listed in the State Service Fee Directory. This is not required of individual Outpatient Therapists in private practice who are not part of a larger organization. Should none of the CPMT contracted providers be available, the Case Manager may consider other providers not currently under agreement with the CPMT if the provider is listed in the State Service Fee Directory. These providers are to be given second priority, and must be willing to enter into an Agreement for Purchase of Services with the CPMT, prior to commencing services. Providers who are not in the State Service Fee Directory and/or who do not sign an Agreement for Purchase of Services with the CPMT will not be reimbursed for services using CSA pool funds.

EXHIBIT III: FAIRFAX COUNTY'S PARENT SATISFACTION SURVEY

FAIRFAX-FALLS CHURCH COMPREHENSIVE SERVICE ACT
PARENT SATISFACTION SURVEY FORM

Thank you for completing this survey. Your responses will help us to evaluate and improve our services. Please return this survey in the self- addressed, stamped envelope provided. If you have any questions, please contact Chris Metzbower at (703)324-7890.

PLEASE CIRCLE ONLY ONE ANSWER PER QUESTION

In general, how satisfied are/were you with....

1. ...helpfulness of the services you/your child received?

Very Dissatisfied **Dissatisfied** **Satisfied** **Very Satisfied** **Not Sure**

2. ...the opportunity to participate in treatment/educational planning for your child?

Very Dissatisfied **Dissatisfied** **Satisfied** **Very Satisfied** **Not Sure**

3. ...the respect shown to you and your child, including respect for your social/cultural background?

Very Dissatisfied **Dissatisfied** **Satisfied** **Very Satisfied** **Not Sure**

4. ...the quality of the service(s) provided during the last 3 - 6 months?

Very Dissatisfied **Dissatisfied** **Satisfied** **Very Satisfied** **Not Sure**

5. ...your child's current behavior?

Very Dissatisfied **Dissatisfied** **Satisfied** **Very Satisfied** **Not Sure**

6. ...your child's educational progress?

Very Dissatisfied **Dissatisfied** **Satisfied** **Very Satisfied** **Not Sure**

7. ...the progress your child made in achieving the goals listed on the Individual Family Service plan (IFSP) or on the Individualized Education Program (IEP)?

Very Dissatisfied **Dissatisfied** **Satisfied** **Very Satisfied** **Not Sure**

Please use the back of this from, if additional space is needed.

8. What did you like best about the program or services you received? _____

_____

_____

9. What could we do to make our services better? _____

_____

_____

Thank you again for your help in completing this survey!

Form Number _____ **Date Sent** ____/____/____ **Date Entered** ____/____/____ **Revised 8/03**

EXHIBIT IV: FAIRFAX COUNTY'S CMPT VENDOR EVALUATION FORM

FAIRFAX -FALLS CHURCH CPMT VENDOR EVALUATION FORM

Provider:_____ Case Manager/ Agency:_____/_____

Case: _____ Male / Female _ DOB: ___/___/_____

Start Date: _____ End Date: _____

Type of service: ☐ Day School ☐ Home Based ☐ Residential ☐ TFC
☐ Therapist ☐ Independent Living ☐ Specialized Services

1. What type of difficulties did the client experience that were the focus of this treatment? (check all that apply)

Affective / Behavioral		Aggression	Substance Abuse	Cognitive D/O	Physical
☐ Depression	☐ Truancy	☐ To peers	☐ Alcohol	☐ Bizarre Behav.	☐ Blind
☐ Bipolar D/O	☐ Oppositional	☐ To parents	☐ Marijuana	☐ Delusion/Hallucin	☐ Deaf
☐ Suicidal	☐ Conduct D/O	☐ To siblings	☐ Polysubstance	☐ Learning D/O	☐ Gen. Medical
☐ ADHD	☐ Sexual Promisc.	☐ To authority	☐ Dependence	☐ Develop. D/O	☐ Head Injury
☐ Sex Abused	☐ Pregnant/Maternal			☐ Autism	☐ Obesity
☐ Run away	☐ Court Involved			☐ MR	☐ Other
☐ React. Attach.	☐ Fire Starting				
	☐ Sex Offender				

Other:_____

2. What type of difficulties did the family demonstrate? (check all that apply, explain other)

☐ Mental Illness	☐ Abuse/Neglect	☐ Violent to partner	Other
☐ Substance Abuse	☐ Sexually Abusive	☐ Abandoned/rejected	

3. How was the provider during the process?	Poor		Fair		Excellent	
Admission / referral process?	1	2	3	4	5	_
Case treatment / service planning process?	1	2	3	4	5	_
Timeliness of written reports?	1	2	3	4	5	_
Completeness of written reports?	1	2	3	4	5	_
Regularity / value of verbal communications?	1	2	3	4	5	_
How appropriate were services to treatment objectives?	1	2	3	4	5	_
Physical environment?	1	2	3	4	5	_
Continuity of case workers (i.e. no turnover)?	1	2	3	4	5	_
How successful at engaging parents/family in process?	1	2	3	4	5	_

4. How successful was the outcome?

☐ a) No change or worsening
☐ b) Minimal change if any
☐ c) Progress made, not complete
☐ d) Some improvements
☐ e) Desired outcome obtained

Describe what you think helped or inhibited the change: _____

5. Would you use/recommend this vendor again?	No		Maybe		Definitely	
	1	2	3	4	5	_

6. Following these services did the child require:

☐ More restrictive services ☐ Less restrictive services ☐ Same level of services

Please add any additional comments on the back.

Please Return this form to:
Chris Metzbower, CSA Analyst
The Department of Family Services
B-3, 5th Floor

EXHIBIT V: FAIRFAX COUNTY'S 2003 TRAINING AGENDA TEMPLATE

Fairfax-Falls Church CSA Training Calendar
For
Fiscal Year 2004

Date	Topic	Trainer(s)	Number Attending
July			
August 12, 2003	CAFAS & Medicaid	Sharon Justinian, Chris Metzbower	
September 17, 2003	CST Facilitation Skills	Sharon Justinian	