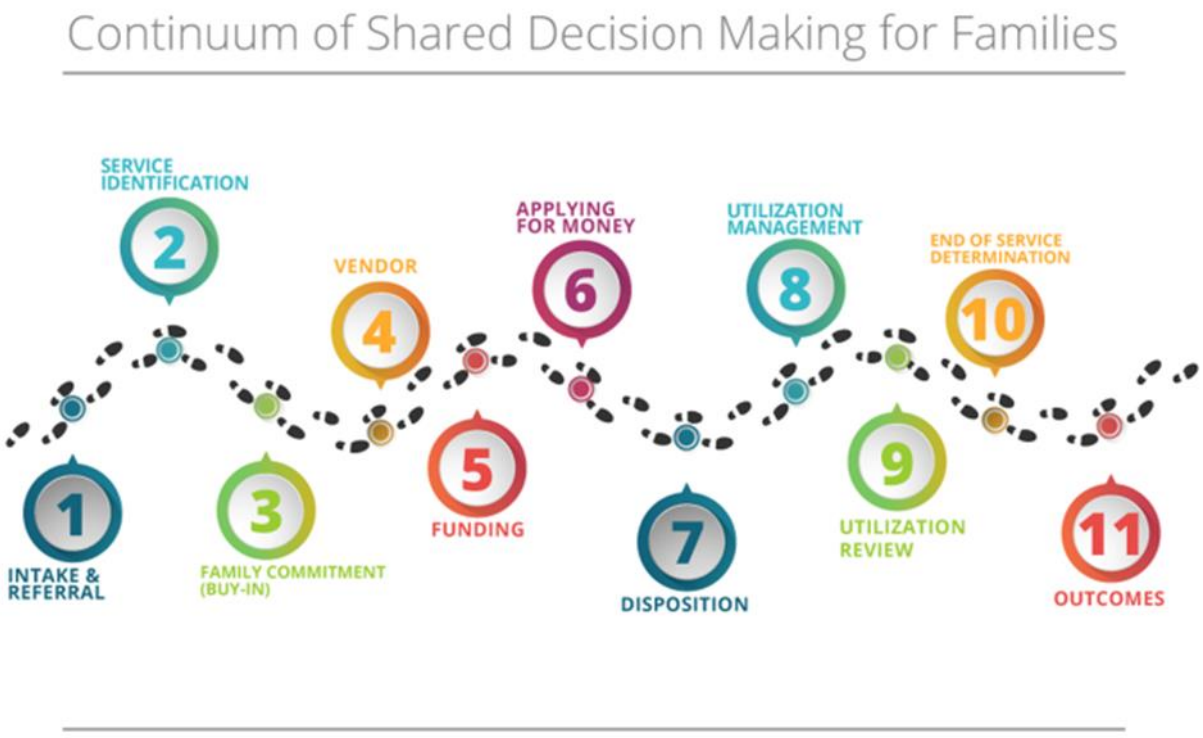
Continuum of Shared Decision Making for Families

The purpose of this document is to offer individuals responsible for responding to the needs of children and families with questions to support identification of the most appropriate services based on the needs of the entire family. While a service may require an identified "client," assessment of the most appropriate service should be inclusive of the current family environment and/or planned permanency. The questions listed for each step are not exhaustive but instead are intended to assist the worker with identification, assessment, and evaluation of the most appropriate service(s) based on the immediate need of the family.



1. INTAKE & REFERRAL: To provide the best services for families by prioritizing their needs and preferences and minimizing duplication of services. The process will ensure the effective use of local resources and collectively track what happens to each family.

Clinical	Family	Payer	Other
Case conceptualization: What are the presenting issues, individual & familial characteristics, prognosis, etc.?	Why is the family here today? What do they want and what do they need?	What insurance does this family have?	What barriers does this family have?
What clinically is needed for this family? (Whole system consideration)	What is the family makeup & history?		
What will discharge/step-down/generalization to family stability plan be?	What is the family's availability for services?		
What is the permanency plan?	Has the family had services in the past? If yes, what was their experience?		
	Is the family open to receiving services?		
	What is the family's commitment level?		
	What family barriers exist? (Home, school, community, work, financial)		
	Who/What are the family's natural supports / connection to the community? (Individual, spiritual, groups, associations)		

2. SERVICE IDENTIFICATION: To determine an evidenced-based treatment, with experience treating presenting issues, that improves the overall functioning of the child and family.

Clinical	Family	Payer	Other
What is the primary presenting issue for treatment?	Which service responds to the family's stated need?	****Thinking ahead**** Will you have a payer for this service?	How long has the service been in existence?
What types of treatment are most appropriate for the presenting issue?	What commitment is required of the family?		How successful is this treatment – short term / long term?
Treatment triage: What is needed now versus later?	What is the family's commitment level?		What is the average length of service?
What are the anticipated treatment barriers? (Matching of staff based on family need)	What family barriers exist? (Home, school, community, work)		Is the service / staff trauma informed?
Does this problem area require an EBP?	Will the identified service create new family barriers? (Home, school, community, work)		Who is the target population for the service?
Is the best service offered in my area? What is the availability?	Will the family incur additional expenses to participate in the service?		Does the service/model pair well with other services?
	How many services does the family already have? We don't want to overservice families.		

3. FAMILY COMMITMENT (BUY-IN): To provide the best services for families by prioritizing their needs and preferences and minimizing duplication of services. The process will ensure the effective use of local resources and collectively track what happens to each family.

Clinical	Family	Payer	Other
What are the family's experiences with treatment?	Explain what the treatment looks like.	****Thinking ahead**** What does this payer require? (family engagement, attendance at meetings)	
What are the clinical recommendations for service/treatment?	Explain why this service will be most helpful to the family.	****Thinking ahead**** You may have a vendor in mind. Before discussing any vendor with the family, get with the funding source to ascertain if they are contracted to offer the service.	
Are there MH, trauma, cultural, developmental, Social Determinants of Health considerations, etc. that would limit the family from clinically engaging?	Ask the family – Does this service sound like it will meet your family's needs based on what was discussed during the intake process?		
	Ask the family - Do you understand the requirements, expectations, and outcomes of this treatment?		
	Ask the family – Do you see any barriers to participating in this service?		
	Ask the family – Do you agree with this service for your family?		

4. VENDOR: To secure a provider with demonstrated success, accreditations, licenses, and skills professionals to treat the presenting issue.

Clinical	Family	Payer	Other
What do I know about this vendor?	Based on what I know about the vendor, is the provider a good fit for my family?	What payer sources is the vendor(s) contracted with?	Is the vendor responsive? And collaborative?
Is this an evidenced-based treatment?	What will this vendor do to help my family?	Does the vendor understand the requirements of the payer selected?	Does the vendor provide timely billing, monthlies, etc.?
What are the training requirements for staff?	How successful is this vendor with treatment for families like mine?	Does the vendor **AND** payer understand expectations of service clinically and based on the payer requirements?	Is the vendor licensed and able to provide the service within scope?
What does supervision look like? Does it follow best practice?	What is the timeframe from initial referral to start of service?		What is the vendor's reputation like?
What is the matching process for the staff to client?			Stability - What does practitioner turnover look like? How could this impact the family/client outcomes?
What does oversight for fidelity look like?			Is the provider accredited?
What are the monthly clinical outcomes to be provided?			

5. FUNDING: To identify cost-effective, sustainable resources in the best interest of all stakeholders.

Clinical	Family	Payer	Other
How do we manage family/client utilization clinically? If families are receiving the right amount of service for the right amount of time, clinical and fiscal outcomes should be in alignment.	Based on the payer, will the family be responsible for any part of the total cost?	What available funding streams are being used: CSA, Medicaid, Commercial, Private Pay, IV-E, PSSF, DJJ via AMI/EBA, VJCCCA, MHI, Adoption Subsidy, Chaffee Funding (IL), EPSDT, CarePortal, ID/DD Waivers?	Is there a more appropriate payer to access?
	What level of participation is required of the family? (Can the family comply)?	Do I need one or more payer sources based on the service(s) requested?	Are you choosing this payer source due to ease of process?
	If the family cannot comply with the service as authorized, will the service cease? Will the family be responsible for full payment?	Will these payers change throughout treatment?	
	If the family cannot comply with the service as authorized, Will the family be responsible for paying more than the agreed upon amount?	Will this service limit utilization of another service and allow for cost control?	
	Does the payer assist with any barrier the family may experience due to requirements of the service and/or payer requirements? (i.e., meeting participation, transportation, missed work)	What will be the cost savings of this service long-term? (Acute, education, reduction in duplicative services)	

	What has been the cost of services historically been for the family?	Does the payer have enough funds to support the service the average length of service?	
	What is the family's responsibility related to the initial request for funding and continuation of funding? (FAPT/Meeting participation)	What happens in the event of a disruption in funding?	
	Will administrative requirements of the funding source create a barrier for the family? (Work, transportation, co-pay)	How long is this service funded?	
		Upon approval, what are the UM/UR requirements for continuation of services (continued funding)?	
		Does the payer require lessor restrictive services to have been attempted based on the needs of the family?	

6. APPLYING FOR MONEY: Effort = Outcomes - To research diverse funding sources and select funding that allows both quality outcomes for the family and demonstrates sound fiscal practices for the payer.

Clinical	Family	Payer	Other
What clinical justification is necessary for the application?	Is the family responsible for completing any part of the application?	Is the service reimbursed by the funding stream?	Is the payer process cumbersome?
		What is the process for applying for the service?	
		Are there deadlines I need to be aware of to access funding?	

7. DISPOSITION: Recommendations for treatment that consider all stakeholders and treatment recommendations/preferences. *****Also, See Appendix A*****

Clinical	Family	Payer	Other
How are clinical services being good stewards of units?	Is the family required to be present?	What services have the family received, and what were the *measurable* outcomes from those services? (Completed, discharged AMA, etc.).	What is the vendor utilization? How much service is the family receiving? Is it too much or too little? What are the challenges or barriers?
How clinically are family/client services managing utilization of authorized services?		What additional services and or supports are needed to maintain placement/stabilize?	
		Can the family meet the requirements of the service based upon other services?	
		Are there Social Determinant of Health barriers limiting the family's ability to engage?	
		What resources does the family need to combat Social Determinant of Health?	
		What will the discharge/step-down/generalization to the family stability plan be?	

8. UTILIZATION MANAGEMENT: A process that evaluates the efficiency, appropriateness, and medical necessity of the treatments, services, procedures, and facilities provided to clients on a case-by-case basis.

Clinical	Family	Payer	Other
What is the provider reporting regarding family engagement?	Is the family participating with the service as indicated?	Based on your locality and payer, certain services have CSA staff to provide additional oversight to comply with UM/UR requirements. How are you partnering with the CSA staff/office to maximize this additional resource/support?	Is this the right service based on family engagement?
Does the initial reason for referral and subsequent goals and objective align with what the service provider is “seeing” and “hearing” from the family?	If no, why?		Are you having effective communication with the service provider? With the family?
Is the provider recommending changes?	Based on the why, what is needed to get the family on track?		
Is the direct service provider a good fit for the family?	Is the direct service provider a good fit for the family?		

9. UTILIZATION REVIEW: A process in which client records are reviewed for accuracy and completion of treatment after the treatment is complete. UR, a separate activity, can be a part of UM (specifically during retrospective review), and can drive changes to the UM process.

Clinical	Family	Payer	Other
Was fidelity to the service/model met? If not, why?	How satisfied is the family with services?	Does the number of sessions provided: 1. equal the number of authorized service hours/units allotted? 2. Meet the expectations set for by the model? (fidelity to model)	Is there a reduction in utilization of higher levels of care (ED visits, hospitalizations, acute), improved school functioning?
Does the client feel progress has occurred?	Does the family report improvement in the areas identified under "reason for referral". Do YOU agree with the family?	Based on your locality and payer, certain services have CSA staff to provide additional oversight to comply with UM/UR requirements. How are you partnering with the CSA staff/office to meet the UR process?	Did you review clinical and payer outcomes? (i.e., model fidelity outcomes, utilization of authorization, length of stay)
	What's working? What's not?	**See UR Guidance documents below**	
	Does the family feel progress has occurred?		

Utilization Review Might Ask….

When Examining the Plan of Care:

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

When Measuring Progress:

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

Source: https://www.csa.virginia.gov/content/doc/Utilization_Review_Guidelines.pdf (page 9)

Questions for families

1. What are some of your family strengths? What good things do you want us to know about your family?
2. What are some of your child/children's strengths? What good things do you want us to know about your child (talents, skills, personality traits, etc.)?
3. What difficulties are you or your child currently experiencing (frequency, duration, severity are key)?
4. Tell us about a time when things we are going well.
5. Who do you turn to when you need help (family, friends, neighbors, church, counselors, etc.)?
6. What other things do you think you need to better assist you, your child, and your family as a whole?
7. Is there anything else you would like for the team to know?

Source: City of Roanoke CSA

10. END OF SERVICE DETERMINATION: The process in which the planning team evaluates if the therapeutic value of the service has been maximized by the family. This determination is a component of utilization management and utilization review.

Clinical	Family	Payer	Other
Has the family's primary reason for referral been addressed and met?	Is the family ready to cease services?	What is the maximum duration for authorization of the service by the payer source?	Has the family/provider/ worker established natural resources in the community?
Can the family's progress continue with a lessor intensive service?	If no, what are the reasons cited to continue services? Fear based or continued need?	**Questions asked during UR will apply to End of Service Determination.	
Has the family maximized the therapeutic value of the service?			

11. OUTCOMES: Mental health outcome measures are tools that evaluate changes in mental health by capturing metrics across multiple areas of client functioning, symptoms, and treatment experiences at baseline and after treatment has begun.

Clinical	Family	Payer	Other
1. Is there measurable improvement in the family's quality of life? 2. Is there amelioration or improvement in the presenting issue at referral? 3. Do clinical measures, screenings, and assessments support improved data? 4. Did family complete treatment as defined by model? 5. Are gains maintained 30/60/90-days post-discharge?	Did the primary identified client: 1. Access a similar or higher level of care service within 90 or 180 days of service? 2. Enter into custody? 3. Become involved with the court/new charges? 4. Receive In-school, was suspended, expelled, drop out of school?	Did the service utilization result in lower costs of care?	Were client and family satisfaction surveys completed for vendor, service, and payer?
	Did a family member connected to the primary identified client: 1. Have a mental health crisis? 2. Enter into custody? 3. Become involved with the court/new charges? 4. Receive in-school, was suspended, expelled, drop out of school?	Was treatment successful as defined by the family, clinical, and payer goals? 1. No higher level of care at discharge? 2. No lateral service or placement at discharge?	
		Did the client remain at discharge level of care or placement 30/60/90 days post-discharge?	

NOTES:

Answering Your Way to the Desired Outcome:
Ask the Right Questions. Get the Right Services.

Appendix

Appendix A

Family Assessment and Planning Team (FAPT) Meeting Stages

1. **Before the Meeting:**
    a. Worker should:
        i. Prepare family members, participants for the meeting, explain the FAPT process, answer any questions.
        ii. If the legal guardian of the identified CSA client is not able to participate, the case is cancelled (only exception is foster care).
        iii. If the identified client is the legal guardian of a foster care child or Fostering Futures youth that is 18, they must be an active participate in the meeting. If they do not attend or join, the case is cancelled (no exceptions).
        iv. All providers need to be prepared to participate in the meeting. This is especially important for our children placed in a Group Home or Residential Facility as this is our most restrictive level of care. Updates are crucial to the decision-making process and absent emergency circumstances the meeting will not proceed without a vendor representative participating.
        v. For new service requests, please do not invite a provider to participate in the meeting. The team is familiar with most of our service options and having a specific provider join the initial meeting is not helpful in the brainstorming process.
    b. FAPT should:
        i. When necessary, hold a brief brainstorming session before the case begins.
        ii. Think of questions to ask case manager and service ideas.
        iii. Wait until all members are ready and conversation has ceased to begin the next case.

2. **Introduction – FAPT Chair**
    a. Introductions of people and agencies, ask participants to introduce themselves.
    b. Review meeting guidelines, this includes guidelines outlined for cases with an interpreter.
    c. Review meeting etiquette, this includes muting your phone when not speaking to reduce the background noise and turning your camera on. FAPT representatives should always be visible!
    d. State that if anyone is recording the meeting that is prohibited, advise them of this and have the recording stopped or stop the meeting.

3. **Identify the Situation**
    a. Case manager summarizes:
        i. Purpose of meeting (specific request, brainstorming)
        ii. Case history (brief historical overview with focus on more recent information)
    b. Discussion of:
        i. Services requested
        ii. Reasoning for requesting specific services

4. **Assess the Situation**
    a. Discuss areas of Concern or Progress
        i. Home
        ii. School
        iii. Community
    b. Progress towards goals, family strengths
    c. Develop Ideas
    d. Plan for discharge or termination/transition of services

5. **Consensus/Decision**
    a. Description of services recommended or approved
    b. Explanation of procedure for final approval and start of service
    c. Team members are expected to outline a plan or ideas that are realistic for the family to pursue, even outside of CSA

6. **Closing/Recap**
    a. Opportunity for all to ask questions or voice concerns
    b. Summarize the plan and ensure that everyone understands, CSA staff documenting all case specifics and audit required elements
    c. Discuss/plan for the next meeting (set date if possible)

FAPT Meeting Guidelines for the FAPT and all Guests

- Meetings will be emotionally and physically safe for all.
- Treat everyone with dignity and respect, avoid profane or threatening language.
- FAPT representatives should always be visible to our case managers, families, and guests.
- All cell phones and electronics must be on vibrate or silent mode, if you use the phone during a case you need to explain you are looking something up relevant to the discussion or that you apologize and have an emergency. Please do not answer the phone during a meeting if the call is not about the meeting.
- **If joining remotely, please ensure you are in a location that is private. FAPT meetings are not open to the public. The information shared is protected in accordance with Section 2.2-5210, Code of Virginia.**
- The team may have beverages and food, but any food should be put away when guests enter the meeting.
- Only one person should speak at a time, no interruptions please. Everyone will have an opportunity to speak. At times we might accidently speak over one another but the facilitator will ensure everyone has the opportunity to contribute discussion during the meeting.
- All conversations should be with the entire group.
- Information will be kept private per statue.
- It is OK to disagree; it is a multi-disciplinary team!
- The facilitator can end the meeting or request a break if necessary.
- If the meeting requires more time than what is allotted on the agenda the facilitator will try to move the meeting to another date within the previously approved funding cycle. When this happens, the FAPT representative attached to the agency that has the next case is responsible for communicating the delay to the worker that has the delayed/next meeting.

- The FAPT does NOT have the authority to recommend plans with the utilization of CSA funds for children that are not CSA eligible. Not every child is CSA eligible or eligible for the service requested.
- The FAPT does NOT have the authority to recommend plans with CSA expenditures that are not in compliance with federal and state laws, state and local policies or the CSA Contract.
- The FAPT must have the appropriate case specific documentation and required documents to review a case and make a recommendation. This includes a clear outline of the case specifics, case history, family unit information, presenting concern (frequency, severity, duration, attached hospital records, etc.), CANS Assessment from the past 30 days, monthly CSA reports, evaluations and the VEMAT. If required documentation is missing or incorrect, the facilitator will cancel the meeting and schedule another.

FAPT Preparation for Team Members

- Always try to review packets prior to FAPT, this is why they are sent in advance of the meetings.
- If you have any questions about information in a packet, please email the FAPT Facilitator.
- When you make arrangements for someone to cover for you, email the FAPT Facilitator so this can be noted on the agenda for that day.
- If someone is covering for you and the packets have already been emailed, it is your responsibility to email them to the individual covering within your agency.
- Each core agency outlined a plan to ensure FAPT meetings are covered. Please follow the plan your agency has. If you do not know the plan, please email your CPMT representative to request it.

FAPT Meeting Goals for the Facilitator and Team Members

- Be cognizant of the meeting agenda and work very hard to stay on time so that the next case managers and vendors will be available for the meeting. In the rare event the meeting requires more time than allotted, re-schedule it.
- Work to promote a connection with families, cases should typically be brought for planning, not a specific request, but when the team is not able to approve what is requested outline a more appropriate recommendation in accordance with CSA regulations, try to convey an optimistic perspective about how the services can help.
- Families should not leave a FAPT meeting without a recommendation. When consensus is not possible, the team has an obligation to provide an alternative plan.
- Being a FAPT representative is a privilege and great responsibility in serving our community!

FAPT Family Engagement Tool

1. What are some of your family strengths? What good things do you want us to know about your family?
2. What are some of your child/children's strengths? What good things do you want us to know about your child (talents, skills, personality traits, etc.)?
3. What difficulties are you or your child currently experiencing (frequency, duration, severity are key)?
4. Tell us about a time when things are going well.
5. Who do you turn to when you need help (family, friends, neighbors, church, counselors, etc.)?
6. What other things do you think you need to better assist you, your child, and your family as a whole?
7. Is there anything else you would like for the team to know?

Source: City of Roanoke CSA

Appendix B

CSA Utilization Review: Guidelines for Best Practices
(September 2020)

Quality Utilization Review is Guided by Four Principles:

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

1. Quality UR Begins with Quality, Strengths-Based Service Planning

• UR is part of the service planning cycle. Developing a strong service plan (IFSP) is the foundation of quality UR. Service plans should incorporate all assessment data, be strengths driven, include a long-term goal as well as measurable objectives, include the voice of the youth and family and convey a complete picture of the youth and family.

• The long-term goal and objectives in the IFSP should align with the strengths and needs uncovered in the CANS and other assessment information.

2. Quality UR Examines ALL Elements of the Plan of Care

• Thorough UR should examine the CANS, IFSP and Provider Treatment Plans; is there congruence? UR should consider if information on these documents is consistent.

• UR should look to see if the services match the needs of the youth and family.

• UR should identify if and how youth and family voice is reflected in the service plan.

• UR should look for evidence of the strengths of the youth and family in the IFSP.

3. Quality UR Measures Progress, Provides Recommendations, and Monitors the Status of Recommendations

• UR asks if the youth and family are making progress towards their long-term goals and objectives and looks for evidence of this progress. Are things getting better? How do you know? (e.g., youth and family engagement, changes in treatment goals and objectives, improvement in CANS scores, increase in number of strengths or social connectedness).

• Are services being implemented as expected?

• UR considers the barriers to progress; what changes are occurring to the service plan in order to address these needs?

• UR looks for indicators of discharge planning.

• UR asks questions and makes recommendations to the FAPT, Case Manager and/or service provider based upon review. These may focus on services, the IFSP, the

involvement of the youth and the family or other components of the service planning process

4. UR is More Than Quality and Cost of Services

• UR is a strategy to improve your local System of Care. Themes uncovered during UR are opportunities improve local service planning. For example, UR might identify a pattern of youth transitioning from residential to the community and then needing to return to residential; your locality could consider changes to the local service planning process.

How will local service planning improve transition planning? What changes are needed with provider relationships or community supports? What is the level of family engagement?

• Findings and trends at the service level can inform the CQI process of the CPMT. In the example above, if UR identifies a pattern of youth transitioning from residential to the community and then needing to return to residential, CPMT might consider long-range planning goals related to use of congregate care or recidivism. They also might ask if a focus on building community supports and resources is needed? (As this might help with transitioning and maintaining youth at home)

• UR can also identify bright spots of service planning, practices you want to be sure to continue. For example, we always ensure to incorporate parent voice in IFSP's as evidenced by one objective in their words.

• UR should capture family and youth satisfaction with services and the CSA process. This information should guide and improve local practices, policies, and procedures.

Source: **https://www.csa.virginia.gov/content/doc/Utilization_Review_Guidelines.pdf** (page 4)

Appendix C

CSA Utilization Review: Guidelines for Best Practices (September 2020)

Local CSA Family Satisfaction Survey

Questions	Yes	No
At the FAPT meeting, I was treated with dignity and respect		
I knew what to expect (who would be there, where they would sit, where I would sit, what would be discussed and how long it would last) before I attended the FAPT meeting		
At the FAPT meeting, I was encouraged to share the strengths and needs of my family:		
My views about my family's strengths and needs guided decisions made at the FAPT:		
During the FAPT meeting, they used language I understood, and I understood the decisions made about my family:		
I knew who to call and (how to reach them) if I had questions or concerns about CSA:		
The services and supports provided were helpful to my family?		

The greatest challenge of CSA is/was:

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

How have the services provided helped your family?

What concerns do you have regarding the services provided?

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

How is the service provider connecting you to community resources?

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

Source: **https://www.csa.virginia.gov/content/doc/Utilization_Review_Guidelines.pdf** (page 10)

Appendix D

AT-RISK YOUTH AND FAMILY SERVICES

PARENT QUESTIONNAIRE

Instructions: In order to help us provide better service to youth and families, we would like to know what you think of the Family Assessment and Planning Team (FAPT) meeting you recently attended. Please complete this brief questionnaire then place it at the receptionist's desk or where directed by your FAPT Chair. Do not write your name on the questionnaire. Your answers are confidential and will not affect your case in any way.

THANK YOU!

For the following questions, please use this scale (circle one):
SA = Strongly Agree
A = Agree
U = Uncertain
D = Disagree
SD = Strongly Disagree

1. Your worker gave you adequate information beforehand to understand the purpose of the FAPT meeting.
SA A U D SD

2. Your worker gave you adequate information prior to the FAPT meeting to understand the service options available to your family.
SA A U D SD

3. You were comfortable presenting your concerns to the team.
SA A U D SD

4. Your concerns were heard and considered by the FAPT team.
SA A U D SD

5. The team appeared knowledgeable about your child's problems and needs.
SA A U D SD

6. The team appeared knowledgeable about your family's situation.
SA A U D SD

7. The team appeared interested in the welfare of your child.
SA A U D SD

8. You were treated with courtesy by the FAPT team.
SA A U D SD

9. You participated in the development of the service plan at the FAPT team.
SA A U D SD

10. You fully participated in the entire FAPT team meeting.
SA A U D SD

11. You are satisfied with the service plan developed for your child at the FAPT meeting.
SA A U D SD

12. If you disagreed with the FAPT recommendations you had the opportunity to express your concerns.
SA A U D SD

The following questions provide additional information to aid us in evaluating our services, however, you do not have to respond if you do not want to.

Month and year of FAPT meeting _____

Your child's race: White _____ Black _____ Asian _____ Other _____

Is your child of Hispanic origin? _____

Your child's age _____

Is your child: (check all that apply)

In DSS custody ☐	Involved in juvenile court ☐	In a psychiatric facility ☐
On probation ☐	In a learning center ☐	In a residential center ☐
In a foster home ☐	In your home ☐	In an emergency shelter ☐
In respite care ☐	In a detention center ☐	

Your child's education status (check one):

Regular classroom ☐	Special education ☐	Gifted program ☐
Residential school ☐	Special day school ☐	Homebound ☐
Home schooling ☐	Not currently enrolled ☐	Dropped out ☐
Expelled-alternative education ☐	Vocational/technical School ☐	Graduated ☐

Please list your child's three biggest problems: _____

_____

_____

Source: Prince William CSA

Appendix E

Office of Children's Services

State Sponsored Utilization Review
Review Checklist

Submission Date:
Locality/FIPS:
Contact Name: **Title:**
Mailing Address:
Telephone:
Fax:

Please Check One:

☐ **60 Day Initial Review**.
☐ **90 Day Re-Review**

Please provide all required information in the designated space.

Child's Last Name: First MI
Male ☐ Female ☐ Date of Birth SSN - -
Medicaid Eligible ☐ yes ☐ no Medicaid Number:
Grade in School
Special Education ☐ yes ☐ no If yes, specify type
Local Custody ☐ yes ☐ no
Juvenile Court Involvement ☐ yes ☐ no If yes, specify
Court-Ordered Placement? ☐ yes ☐ no Provide details, or attach court order.

Parent/Legal Guardian
Relationship to Child Phone
Last Name First Name MI
Address

Parent/Legal Guardian
Relationship to Child Phone
Last Name First Name MI
Address

Facility Name
Address
Contact Name Title
Telephone FAX

Admission Date Anticipated Length of Stay
Current Admission Reason -*state briefly*
Date Next FAPT review:
Provider at FAPT meeting? ☐ yes ☐ no
Caseworker at Provider Treatment Team meeting? ☐ yes ☐ no

Documents Attached

Information for Initial Reviews should include the following:

CSA Review Checklist as Coversheet ☐
FAPT documentation that addresses the placement (FAPT minutes, case documentation submitted to CPMT, FAPT Referral Form) ☐
Most recent CANS assessment ☐
Most recent IFSP ☐
Most recent Foster Care Plan (if applicable) ☐
Information about prior placements (if applicable) ☐
Psychotropic Medication information ☐
Most recent Magellan (Medicaid) authorization/UM form (if applicable) ☐
Service Plan/Treatment Plan and progress reports from placement ☐
Psychological (if available) ☐
Discharge Plan ☐

Information for Subsequent Reviews should include the following:

CSA Review Checklist as Coversheet ☐
FAPT documentation that addresses the placement (FAPT minutes, case documentation submitted to CPMT, FAPT Referral Form) ☐
Most recent CANS assessment ☐
Most recent IFSP ☐
Most recent Foster Care Plan (if applicable) ☐
Psychotropic Medication information ☐
Most recent Magellan (Medicaid) authorization/UM form (if applicable) ☐
Service Plan/Treatment Plan and progress reports from placement ☐
Discharge Plan ☐
Changes and/or actions in the Service Plan/IFSP in response to most recent UR ☐

Comments

Source: CSA_Checklist_For_UR_Submissions.docx (live.com) or go to

https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.csa.virginia.gov%2Fcontent%2Fpdf%2FCSA_Checklist_For_UR_Submissions.docx&wdOrigin=BROWSELINK

Appendix F

Social Determinants of Health

The social determinants of health (SDoH) are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.

The SDH have an important influence on health inequities - the unfair and avoidable differences in health status seen within and between countries. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

The following list provides examples of the social determinants of health, which can influence health equity in positive and negative ways:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.

Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health. For example, numerous studies suggest that SDoH account for between 30-55% of health outcomes. In addition, estimates show that the contribution of sectors outside health to population health outcomes exceeds the contribution from the health sector.

This graphic shows the six pillars of CDC's work to address SDOH, which is depicted as the interplay of social and structural conditions, and that SDOH is one factor that contributes to overall equity.

Source: https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

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