UTILIZATION MANAGEMENT PLAN

FY 16-17

Brevard Family Partnership
A Community Based Care Agency
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Utilization Management Plan

Complete a utilization analysis and develop a plan to track critical components of service utilization, approve services in a timely manner, and monitor utilization against available funds.

THE BREVARD FAMILY PARTNERSHIP APPROACH TO UTILIZATION MANAGEMENT

Utilization Management (UM) is the foundation of the Brevard system of care. UM is the process of coordinating, authorizing and monitoring services or placement for children and families on a continuum of care from entry to exit. The UM system is designed to ensure a seamless service delivery system that maximizes resources, mitigates fragmentation and duplication and builds upon natural supports within the community to support and sustain families long term.

The **utilization review** process involves ongoing communication and teamwork between and among the internal Clinical Service Coordinators, Case Managers, and the Family Team Conference (FTC) and Standing Team Conference (STC) members, and network and third party providers. The type of service that is being delivered will determine the frequency of internal reviews.

GUIDELINES FOR UTILIZATION MANAGEMENT

The utilization management process will link children and families with the appropriate level of service within the following service guidelines. Services must:

- Be adequate to meet identified needs;
- Be delivered in the least restrictive placement possible;
- Fall within approved protocols and pathways;
- Be family-consumer focused;
- Be community-based and as close to home as possible and
- Be culturally sensitive and competent.

INTEGRATED UTILIZATION MANAGEMENT

Utilization management is the foundation of the service delivery system at Brevard Family Partnership. It has been integrated into each aspect of the system of care to ensure services are flexible, responsive and customized to the needs of the child and family. Placement decisions and use of crisis intervention services made by the Intake Specialists are tracked and monitored by the Director of Intake, Assessment and Placement daily to ensure that appropriate services are in place. If crisis services were initiated, the Intake Specialist will inform the team at time that the team staffing is initiated. The Family Team Conference (FTC) or Standing Team Conference (STC) will review the appropriateness and effectiveness of services being delivered

during the ongoing Family Team Conferences for ongoing authorization for those families that meet FTC prioritization criteria. The appropriateness and effectiveness of services will also be reviewed as part of the Quarterly Supervisor Case Record Review and other quality assurance peer reviews. The following questions will be addressed during these reviews:

- Have the conditions requiring intervention been reduced or eliminated?
- Is the child thriving in the current placement?
- When formal therapy is being provided, have the treatment goals been met?
- Is the initial permanency plan still appropriate?

BFP conducts a monthly review of the operational and financial performance of the system of care. This review will also look at the performance of the BFP contracted providers as well as the eligibility mix of the clients to determine if there are any issues with the funding available to serve the population. BFP Management and Leadership will continuously monitor these processes to ensure that the intended results are achieved.

Components of BFP Utilization Management System

Type	Review	Management
Prospective (Prior to treatment/ Service)	**Prospective Review** Review of assessments and evaluations	**Prior Authorization** Prior authorization of service based on need and appropriateness of care conducted by Intake and/or Child and Family Services Specialists at time of initial referral and by Clinical Services Coordinators after development and any revision of case plans.
Concurrent (During treatment/ service)	**Concurrent Review** Review of progress reports, treatment/service plan reviews Review of high-cost of high utilization patterns	**Re-authorization** Level of care and step down reviews/staffing with Clinical Services Coordinators and CMAs **High Intensity Reviews** Clinical review of clients in high cost placements or in placements for lengths of stay (exceeding the targets)
Retrospective – (After treatment/ service)	**Retrospective Review** Review of sample of case record – entry to discharge	**Program Integrity Reviews** Did services provided have adequate documentation? **Quality of Care Reviews** Were services provided appropriate? **Best Practice Reviews** What were the results of the interventions?

Service Utilization and Authorization

The Clinical Services Coordinators authorize the services that have been agreed upon at the Family Team or Standing Team Conference and advises the providers of the duration, frequency and specific needs of the consumer. They will notify them of the schedule for the upcoming utilization review which should occur at minimum prior to the completion of a second twelve week authorization period for certain ongoing services. The Family Team or Standing Team will identify the appropriate provider and the Clinical Services Coordinator and/or assigned member of the Family Team will contact the provider to initiate services. An authorization form will be submitted to the provider through Mindshare by the Clinical Services Coordinator.

The Clinical Services Coordinator will review all service requests within 48 hours of receipt from Care Manager. For those families that are not receiving Family Team Conferencing, the initial Standing Team will be held ideally within the first 30 days of service delivery start date but no later than 8 weeks from the service delivery start date.

The Clinical Services Coordinator will maintain the database of all authorizations through Mindshare. This will ensure that the team will have knowledge of real time service availability and activity. The Network Providers will submit to the BFP designated staff a monthly invoice through Mindshare detailing all units actualized for all authorizations. If there is under-utilization for services authorized weekly, sessions not be utilized during that week and will no longer be available within the authorization and will be deleted in Mindshare to allow for those dollars to be made available for future authorizations. Each BFP contracted provider is required to make and report on community linkages they have secured on behalf of the family. It is critical that providers create community linkages to support and sustain the child and family beyond discharge.

Referrals made to third party reimbursable partner agencies will be tracked in Mindshare by the Clinical Services Coordinator and reported on monthly to monitor partner agencies receiving a large number of third-party referrals from BFP and oversee the trends associated with the delivery of service.

Service Authorization Procedure:

The initial service authorization and reauthorization occurs through a web based interactive database (Mindshare) in which the Clinical Services Coordinator authorizes a service with duration and frequency of service dictated by unit of services delivery. The service authorization is electronically submitted to the provider through the web based automated system which provides a confirmation that the provider has received the service authorization and services are started no later than one to two days of authorization. After initial contact is made by the provider, progress notes are entered into Mindshare and monitoring takes place through the receipt of provider progress reports, provider contacts and service provider's participation in the Family Team or Standing Team Conferencing process. The service provider verifies within the first two weeks of service delivery that the service is appropriate. If there are any complaints or problems that develop in the delivery of services or with the person that is receiving services, every effort is made for expeditious resolution at the lowest level possible. BFP Clinical Services Coordinators tailor the type and frequency of services according to the family's need, level of acuity, risk and intensity of service provision required. Flexible supports and the use of in home supports are inclusive of the following:

1. In home support services are offered on a continuum service array in order to meet the evolving needs of families in complex situations. These support services are designed

to assist families in times of stress or acute crisis.

2. BFP Clinical Services Coordinators goal is to use a range of supportive and therapeutic services that are customized and individualized to the unique culture and strengths of a particular child and/or family.
3. In general, In-home services are designed to alleviate family stress and child safety risk factors, to promote parental competence and protective capacity, and to enable families to access resources and natural support networks in order to develop long term sustainability.
4. In-home services are family-focused, community and home-based and are designed to support families to alleviate crises that may lead to out-of-home placement for children.
5. Families receiving In-home support services may be birth families, pre adoptive families or relative/non-relative caregiver families. The goals of these family-focused services are to:
   a. Maintain children safely in their own home;
   b. Support and strengthen family unit for Family Preservation;
   c. Assist families in obtaining services and supports in a culturally sensitive manner;
   d. Maintain or stabilize placements and;
   e. To create natural supports and linkages that will sustain the family upon discharge.
6. All referrals for In-home support services must be made through the BFP Clinical Services Coordinator. The Clinical Services Coordinator prioritizes the referrals based on need and availability of the service and available funding. Any service that has been Court ordered will be reviewed for clinical necessity and authorized. If the Court ordered service is not clinically indicated, the Clinical Services Coordinator will discuss with the Case Manager the next steps to engage all parties on the case and apprise the Court accordingly (in conjunction with CLS).

Eligibility for In-Home Support Services *(All criteria must be met)*

1. The Case Manager making the referral to the Clinical Services Coordinator must have discussed the support services with the family, and at least one parent or other primary care giver indicates that he/she is willing and able to participate. Families are provided the opportunity to have voice and choice over which providers they are referred to.
2. When a service is requested there should be a reasonable likelihood that the service will result in the expected outcome so the family will benefit from the service.
3. Families have the capacity to participate and can be expected to benefit from community or home-based services.
4. Without provision of service the child (ren) are at risk of removal/placement disruption.
5. Alternate, less intensive intervention strategies have been tried, without success or were considered but determined not to be in the best interest of the family or child/adolescent.

Continued Review of Criteria:

1. At each Family Team or Standing Team Conference, service provision is re assessed and at any critical juncture which is defined as a major change in the individual or family status. Since this process is ongoing, it continues throughout the duration of service delivery,

2. In-Home Support Services are authorized in increments not to exceed twelve weeks per authorization. This is intended to ensure the services meet the needs of families and are tailored to meet the changing needs of the family as they arise.
3. The service duration may be extended by agreement of the FTC or Standing Team members.
4. Standing Teams are held at a minimum of every twelve weeks to review service delivery prior to subsequent authorization period.
5. There are measurable goals and outcomes outlined to the provider.
6. On an ongoing basis at a minimum of monthly the Clinical Services Coordinator and Case Manager review and assess service plan implementation, family's progress toward achieving goals, desired outcomes and the continuing appropriateness of agreed upon service goals.

Termination of Service Criteria:

1. The children and/or family's documented goals and objectives have been substantially met.
2. The child's and/or family are not making progress toward the initially stated goals and there is no reasonable expectation of progress.
3. The child's and/or family, guardian, and/or custodian are not vested in achieving the stated goals, despite the provider's attempts to address non-compliance issues.
4. The provider is not successfully engaged with the family in the process.

Clinical Services Coordinators, Case Managers and In-Home Support Services Provider Roles:

1. Clinical Services Coordinator, Case Manager and providers always treat families with dignity and respect while coordinating visits to the home. Barriers to successful engagement will be considered and responded to. The assigned Case Manager and family regularly review progress towards family achieving goals and desired outcomes and discuss the continued appropriateness of agreed upon service goals.
2. Service providers exercise vigilance in observing children, ensuring that they are seen as often as indicated on the service referral and that the home appears free of hazards, the children appear free of injury, identifying safety risk factors and document the outcome of the interaction in the Mindshare system. Providers are required to file a Child Abuse Report when abuse is observed or reported to them by a family member in accordance with Florida Statute 39.201 mandatory reporting laws.

Referral for Services:

Clinical Services Coordinators refer children and their families for appropriate services as a result of care plan development and individual need. Referral for services are solely based on professional and ethical determinations of the needs of the family and to every extent possible, family choice.

1. Referrals for services will occur as a direct result of care plan development within the Family Team or Standing Team Conference.

2. Whenever possible, families will be given options for providers and allowed to exercise voice, choice, and ownership.
3. Referrals for services will be made on the family's behalf by the Clinical Services Coordinator.
4. If child (ren) or family members have Medicaid the Clinical Services Coordinator will identify to find a provider that can invoice these insurers directly. The Coordinator will ask the identified Case Manager to check whether a child or adult has Medicaid. All referrals for services will be checked by the designated staff member to determine whether they have Medicaid coverage. All referrals for Medicaid funded services will be tracked. If a child (ren) or family member does not have Medicaid and a referral is made to a provider then BFP will fund the service. However, in cases of substance abuse treatment or batterer's intervention programs the client may be directly responsible for payment.
5. The Clinical Services Coordinator will monitor all referrals to ensure the family is receiving the service as authorized, and will maintain regular communication with the provider to assess the family's participation and progress made regarding the service delivered.
6. In cases requiring transition of services every effort will be made to ensure the service being transitioned is linked to a new provider of the same clinical orientation and expertise.
7. As part of the continuous quality improvement process, Clinical Services Coordinators ask families to rate their satisfaction with the service referral process including availability of appropriate services and information regarding how helpful the services were/are to the family as part of the STC or FTC process.

If a family is not engaged in the STC or FTC process the following outlines steps to take:

1. By-Pass-Referral Process: If a family has not been engaged through the STC or FTC process, the Clinical Services Coordinator can request In-Home Support Services through a by-pass referral. Upon determination that a service is warranted, the Clinical Services Coordinator will complete the following steps to request flex support services:

    a. Complete Service Request Form in Mindshare;
    b. The Case Manager will submit the request to the Clinical Services Coordinator for approval.

Flex Support Provider:
Upon receipt of the Service Request, the provider will assign the appropriate personnel and initiate services. These supports will be provided based on the identified needs of the family and focus on the identified tasks within the Care Plan. To modify the Care Plan goals, the provider must contact the Clinical Services Coordinator to update the Care Plan. This modification will be completed following consultation with the Care Coordinator and when possible at the STC or FTC.

a. Weekly/Monthly Reports - The provider completes a weekly progress report in the Mindshare system for the identified family ongoing, unless the provider's contract calls for monthly submission of reports.

b. Over-Utilization – If the provider encounters a crisis situation that warrants immediate over-utilization above the current authorized amount of units, the provider will address the crisis. Immediately following the crisis (within 24 hours), the provider will provide a written Request for Additional Units request to the Clinical Services Coordinator including a summary of the crisis for review of this request.

c. Informal Supports – During the provision of services, the Provider will work with the family to link the family to informal supports within the community to continue to support the family following closure. This work should be occurring each time the provider meets with the family and must be documented on the weekly/monthly note. This is a critical piece in developing long term family sustainability.

Utilization Review/STC/FTC – During on-going STC or FTC's the Clinical Services Coordinator, provider, family, and anyone the family invites to the STC/FTC will meet to review the progress. At that time, the team will determine if services will be re-authorized, terminated or modified. This step is critical to ensure the family continues

Retrospective Utilization Review

A retrospective Utilization Review will occur at minimum prior to the completion of a second 12 week authorization or at minimum every quarter as part of the UR process completed by Clinical Services Coordinators to look at the effectiveness of services used by different groups of children and families and to recommend changes based on findings. The Clinical Services Coordinators will share responsibility for conducting the retrospective review. Elements of the discharge and retrospective reviews include:

- Evidence that services delivered were indicated.
- Evidence that clients benefited as expected from services.
- Evidence that discharge and aftercare planning was initiated early in the case.
- Progress toward discharge is regularly documented.
- Discharge summary reflects the child's and family's condition at time of discharge.
- Discharge summary reflects adequate aftercare support as necessary.

In addition to the Utilization Review Process, a review of cases which required multiple services and/or services that were provided over an extended period of time should also occur at minimum this type of review should include the Clinical Services Coordinator, Case Manager and provider of the services. This team will be responsible for reviewing cases of high service utilization. The team will review utilization data, progress notes, Comprehensive Behavioral Health Assessments, and any psychological or psychiatric reports, etc. to identify problems, and recommend and implement changes in services, as needed.

Immediate Access to Services

All services and programs within BFP are accessible through contact with the Intake Specialists of Brevard Family Partnership. Intake Specialists are the BFP "**Centralized Point of Access**" for the child protection investigators, case management agencies, community and other providers. The BFP Intake Specialists will authorize access to immediate response services through the two tracks, Information and Referral and Mobile Response Team. Mobile Response Team (MRT) is available 24 hours per day, seven days a week. Access to MRT and placement is available 24 hours per day 7 days per week. Case Management agencies are also on call 24

hours a day 7 days per week to provide assistance. In addition, families can contact 211 Brevard Information System for additional referrals and service related issues. All services and program referrals are conducted with the intent for providing the least restrictive and most appropriate service that meets the needs and preferences of the child and family being served.

If a Care Manager determines an immediate need for a service authorization and there is no time to convene a Family Team Conference or Standing Team Conference, the Care Manager will request the authorization for through the Clinical Services Coordinator.

Authorization Thresholds

Clinical Services Coordinators cannot authorize any amount that exceeds one twelfth of the total annual budget allocation for the year on a monthly basis based on an average of a 60% utilization from the funding sources of Family Support, Family Preservation, Time Limited Reunification, Other Client Services and 100/800 Diagnostic and Evaluation Funds (for services for children only that are non-Medicaid funded). It should also be noted that funding through Other Client Services is a funding of last resort. Any request that exceeds this threshold must be approved by Senior Director of Programs.

Licensed and Non-Licensed Placements

Children entering licensed out of home care must be placed within 4 hours of receipt of the Pre-Placement Tool. When the Child Protective Investigator (CPI) has determined that the child must be taken out of his/her home and there is no immediate or appropriate relative available for placement, the CPI will request placement services and supports from BFP Intake Specialists during both normal business hours and after hours through on call line for placement identification and file a shelter petition.

The BFP Intake Specialists will make authorization decision for all licensed placements. These decisions will be based on placement protocols and service guidelines to ensure that children are placed appropriately. The CAFAS will be administered within 14 business days by the Assessment Specialist and this will be used to guide placement and service need decisions.

For each child in out-of-home care placement and each child/family receiving services, the appropriateness of the placement and services are not only reviewed at the Family Team Conference (FTC) or the Standing Team Conference (STC), they are also reviewed internally through the utilization management process which includes the assessment of children in Care, using the C.A.F.A.S., as well as a review of medical necessity criteria. The objective of utilization review is to assure optimal quality care in the most effective manner through appropriate allocation of the system of care resources. The necessity of services and overall utilization of all services will be reviewed on an ongoing basis through a variety of mechanisms.

Clinical Reviews involve the review of children in licensed out of home care to determine the need for both an increased or decreased level of care. Recommendations are based upon medical necessity criteria and are intended to provide guidance for other service options in the event that Specialized Therapeutic Foster Care (STFC) and Specialized Therapeutic Group Home (STGH) Care are not recommended. These children must be under the jurisdiction of Brevard County and be a part of the District 7B child welfare system in the Central Region. The core team members that participate in the Clinical Review Process include the BFP Director of Intake, Placement and Assessment, BFP Intake Specialist, Substance Abuse and Mental Health (SAMH) Representative, Independent Living Specialist, School Board Representative, ,

Targeted Case Manager, Therapist and Child Welfare Care Manager. Clinical Reviews are held weekly. Requests for Clinical Review staffings are submitted to the Director of Intake, Placement and Assessment.

Any child requiring placement in a Specialized Therapeutic Foster Home Level I or Level II will be reviewed by the Clinical Review/MDT for determination of Medical Necessity Criteria including admission criteria. Children in a STFC Level I or Level II will be reviewed at minimum every six months to determine ongoing Medical Necessity Criteria (continuing stay criteria). The Clinical Review/MDT will assess whether or not the child requires STFC services or may be adequately served with less intensive services. Once approved the Brevard Family Partnership (BFP) Senior Director of Programs will obtain authorization from the Substance Abuse Mental Health Program Office (SAMH) or through the Child Welfare Pre-Paid Mental Health Plan (CWPMHP)..

Children with a CAFAS score that indicates a need for placement in a higher or lesser level of care will be staffed at Clinical Review within 30 days of completion of the assessment. Specialized Therapeutic Group Care (STGC) and Residential Treatment can only be accessed through the Suitability Assessment evaluation. A Suitability Assessment is an independent evaluation completed by a Qualified Evaluator in order to determine the suitability for residential treatment and appropriateness of treatment in a Specialized Therapeutic Group Care setting or Statewide Inpatient Psychiatric Placement (SIPP). In order for a child/adolescent to be admitted, a Qualified Evaluator must conduct an examination and assessment of the child/adolescent and make written findings. Requests for Suitability Assessments are submitted to the BFP Director of Child and Family Services. If a child receives a recommendation for a SIPP or STGC level of care approval must be provided by the Clinical Review Team prior to admission.

Denial of Service (Sunshine/Centpatico Funded Levels of Care)

Clinical Reviews involve the review of children in licensed out of home care to determine the need for both an increased or decreased level of care. Recommendations are based upon medical necessity criteria and are intended to provide guidance for other services options in the event that Specialized Therapeutic Foster Care (STFC) and Specialized Therapeutic Group Home (STGH) Care are not recommended. These children must be under the jurisdiction of Brevard County and be a part of the District 7B child welfare system.

The team members that participate in the Clinical Review Process include the BFP Senior Director of Programs, BFP Intake Specialist, Substance Abuse and Mental Health (SAMH) Representative, Independent Living Specialist, School Board Representative, and corresponding Targeted Case Manager, Therapist and Child Welfare Care Manager. All decisions made by the Clinical Review Team are made by a majority consensus vote. All persons in attendance to the staffing are required to provide written signature of their attendance as well as acknowledgement of the decision made by the team.. If a team member is in disagreement, a follow up with Clinical Review will be scheduled within 30 days to re-review the case and attempt to come to resolution. All decisions made by the BFP Clinical Review Team are recommendations only. Final approval for placement and funding are made by the Clinical Care Manager. Should a member of the child's treatment team be in disagreement with the decision made by the Sunshine Health Plan they would be advise to follow the Sunshine Right To Appeal Process outlined in the Behavioral Health of Florida

Provider Handbook (Section 3: Clinical Operations Standards Right To Appeal and Appeal Process Pages 25-29).

Appeal of Sunshine/Centpatico Decisions Process: Final approval for placement and funding are made by the Sunshine/Centpatico Clinical Care Manager. Should a member of the child's treatment team be in disagreement with the decision made by the Magellan Clinical Care Manager they would be advised to follow the Magellan Right To Appeal Process outlined in the Magellan Behavioral Health of Florida Provider Handbook (Section 3: Clinical Operations Standards Right To Appeal and Appeal Process Pages 25-29).

Concurrent Utilization Reviews of Children in STGC or STFC Levels of Care

All children residing in STGC levels of care must be reviewed at the Clinical Review staffing a minimum of every 3 months in coordination with the Suitability Assessment requirements. All children residing in STFC must be reviewed at the Clinical Review staffing a minimum of every 6 months. All Clinical Review Staffing dates, purpose and outcomes are maintained in a centralized tracking system (BFP Magellan Database). In addition, copies of all Clinical Review Agendas are maintained by the BFP Senior Director of Programs.

Prioritization for Family Team Conferencing (FTC) Referrals: The following criteria has been established for the prioritization of families that will receive Family Team Conferencing. The Wraparound Fidelity Liaison and Family Partner will manage an active caseload of up to 25 families for a duration that does not exceed six months.

Priority 1. a: Families with child or children aged 0-3 (or at least one child if sibling group) residing in Licensed Out of Home Care with a goal of reunification and has met at least two of the following conditions:

1) Family has primary maltreatment indicator of substance abuse, mental health or domestic violence;

2) Family has experienced prior removal episode and

3) Family has history of five or more priors with DCF.

Desired Outcomes:

- Reduction in average length of stay in out of home care placement;
- Reduction in total number of placements;
- Increased visitation resulting in expedited reunification;
- Improved Family Functioning;
- Permanency goal of reunification achieved;
- Increased natural and community supports and
- Reduced recidivism.

Priority 1.b: Families who are participating in Family Drug Court, have experienced a removal episode and are receiving intensive substance abuse treatment.

Desired Outcomes:

- Reduction in substance abuse recidivism;
  Parents are safely maintained within the community and engaged in treatment;
- Successful completion of Family Drug Court;
- Improved Family Functioning;
- Increased natural and community supports and
- Expedited reunification.

Priority 1.c: Any family that is Court ordered to receive a Family Team Conference.

Priority 2: Families with children aged 3-5 (or at least one child if sibling group) residing in Licensed Out of Home Care with a goal of reunification and has met at least two of the following conditions:

1) Family has primary maltreatment indicator of substance abuse, domestic violence or mental health;

2) Family has experienced prior removal episode and

3) Family has history of five or more priors with DCF.

Desired Outcomes:

- Reduction in average length of stay in out of home care placement;
- Reduction in total number of placements;
- Increased visitation resulting in expedited reunification;
- Increased natural and community supports;
- Improved Family Functioning and
- Permanency goal of reunification achieved.

Priority 3: Families with children residing in Licensed Out of Home Care with a goal of reunification in which children have experienced multiple placement disruptions due to the presence of Human Trafficking involvement. a mental health diagnosis, substance misuse or co-occurring disorder.

Desired Outcomes:

- Reduction in number of crisis and restrictive psychiatric placements;
- Engagement in treatment;
- Increased natural and community supports;
- Step down to less restrictive level of care and
- Permanency goal of reunification achieved.

Service Authorization

PI FLEX FUNDS

PI Flex Funds are dollars that can be used for the alternate care of children as a means of preventing the family from entering the child welfare system and/or child abuse prevention program. Brevard CARES will authorize the use of PI flex funds by Child Protective Investigators based on need and appropriateness of request.

Resolving Differences

All disputes related to CPI Flex Funds are to be resolved the same day they arise or as soon as possible. If agreement cannot be reached between the assigned PI, PI Supervisor, Brevard CARES Program Manager or designee and then the disagreement will be referred to the Brevard C.A.R.E.S. Executive Director and DCF Operations Manager. A joint consultation shall be held if necessary. If there is still supervisor disagreement, then the issue will be referred to the BFP Chief Executive Officer or appointed designee and the DCF Regional Managing Director or appointed designee. The persons designated to resolve these disputes shall meet and/or initiate discussion as soon as necessary practicable to resolve the dispute within three business days.

Case Plan Services

The Case Plan is developed based on the decisions made by the Family Team or the initial Standing Team/Case Plan Conference held by the Clinical Services Coordinator which includes the Care Manager, family, and other members of the family's team. The parties work together to assure that planned services are (1) necessary, (2) linked to the case plan that was developed at the FTC, (3) appropriate based on the child/family need, and (4) delivered in the correct setting, for the necessary length of time.

Reviewed by:

Dr. Patricia Nellius
Chief Executive Officer

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