PROCEDURE

Series:	**Operating Procedures**	**COA: NET 4, 5, 6, 7, 8, HR 7** **CFOP: NA**

Procedure Name:	Care Center In Home Support Services
Procedure Number:	OP-1129
Reviewed Date:	10/01/2020
Revision #/Date:	06/22/11, 11/09/15, 01/13/17
Effective Date:	02/20/09
Applicable to:	All Brevard Family Partnership Staff and Contract Providers

SUBJECT: Care Center In-Home /Support Services Authorization Process

PURPOSE: To maximize available resources while supporting families' efforts to build long term sustainability.

PROCEDURE:

References

Florida Statute 39.201
Brevard Family Partnership Policies/Procedures: GOV001, GOV002, AP415, AP432
Brevard Family Partnership Care Plan

Definitions

a. Clinical Services Coordinator (Utilization Review Coordinator) – Employed by Brevard Family Partnership to oversee the authorization and utilization of services and coordinate and facilitate the Standing Team and Family Team Conferences.
b. Dependency Care Manager – Case Management Agency (CMA) staff that provide oversight to child welfare case management activities.
c. Care Plan – Tool utilized by the Care Coordinator to identify family strengths and needs. This plan will be forwarded with the referral request to authorize and guide service provision.
d. Case Plan—Court approved plan for legal cases. This is developed by the CMA Dependency Care Manager.
e. Family Team Conference Process (FTC) – The group of individuals that meet for the primary purpose of coordinating services with the family, discussing care plan progress. The team may include the Care Coordinator, Care Manager, Care Manager Supervisor, parents, substitute care parents, service providers, informal supports, Guardian ad Litem (if assigned), and anyone else the family wished to invite.
f. By-Pass referral—A one-time service referral for a family member who is not engaged in the FTC process.
g. Flex Support Provider – Agency contracted by Brevard Family Partnership to provide flexible services.
h. Utilization Management System – Method to track authorizations, census, and actualizations.

i. Utilization Review/Family Team Conference – Each subsequent review after the initial Family Team Conference of the family's progress, any services to be added or deleted or any additional services required that result in a modification of the care plan and to discuss the effectiveness of the current providers.

Overview

Brevard Family Partnership contracts with Case Management Agencies (CMA) to provide for the day to day oversight of child welfare case management activities for families in the dependency system. Clinical Services Coordinators authorize services and facilitate the Standing Team/Family Team Conference process for the families in the dependency system.

Brevard Family Partnership provides an array of services designed to assist families in regaining optimal functioning and to alleviate family crises that may lead to placement disruption or out of home placement of children. These services are a resource for families that want to prevent the removal of their children, or to support the smooth transition back to their family after reunifications. The services within the system of care are family-focused and responsive to the unique needs of families as well as delivered as close to home and community as possible.

Classification of Services: Florida Safety Decision Making Methodology:

1. **Family Support Services**: Services provided to safe children in high or very high risk households to increase protective factors at a macro level to address barriers to long term safety that includes: Nurturing and Attachment, Social Connections, Social/Emotional Competence of Children, Knowledge of Parenting and of Child and Youth Development, Concrete Support for Parents and Parental Resiliency.
2. **Safety Management Services**: Services provided to unsafe children that immediately and actively protect the child from danger threats when the parent/caregiver cannot as part of a safety plan that includes: Behavioral Management: Supervision, Monitoring, Stress Reduction and Behavior Modification, Crisis Management: Halt Crisis, Mobilize Problem Solving, Reinforce parent/safety provider participation in safety plan, Avoid disruption of in home safety plan, Social Connections; Friendly Visiting, Supervision and Monitoring as a Social Connection, Social Networking and Basic Parenting, Resource Support: Transportation, Housing, Finances, Health Care and Food and Clothing. Separation; One of more family members leaving the home, Babysitting/Daycare and Family Arrangement.
3. **Treatment/Intervention Services**: Services provided to a parent/caregiver that are utilized to achieve fundamental change in functioning and behavior associated with the reason that the child is unsafe, ultimately mitigating the need for a safety plan/safety services that includes: Cognitive: Is aware of self, intellectually able, recognizes threats, recognizes child needs, understands protective role and plans and articulates plan for protection. Behavioral: Controls impulse, takes action, sets aside own needs for a child, demonstrates adequate skills, adaptive as a parent/caregiver and has a history of being protective. Emotional: Meets own emotional needs, is resilient, is tolerate, is stable, expresses love, sensitivity and empathy to the child, is positively attached to the child and is aligned with and supports the child.
4. **Child Well Being Services**: Services utilized to ensure certain desired condition in the life of the child and parent and their needs are met in relation to development that includes: Emotion/Trauma, Behavior, Culture Identity, Development/Learning, Substance Abuse Awareness, Family Relationships, Peer Relationships, Physical Health, Academic Status and Preparation for Independent Living.

General Description

1. In home and support services are offered on a continuum service array 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. Brevard Family Partnership's 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 and other support services are designed to enhance caregiver protective capacities and address the identified danger threat, to promote parental competence, and to enable families to access resources and natural support networks in order to develop long term sustainability.
4. In-home services and other support services are family-focused, community and home-based and are designed to support families to alleviate crises that may lead or have led to out-of-home placement for children.
5. Families receiving In-home and other support services may be birth families, foster families, 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 families preparing to reunite,
    c. Assist families in obtaining services and supports in a culturally sensitive manner,
    d. Maintain or stabilize placements,
    e. To create natural supports and linkages that will sustain the family upon discharge.
6. The Case Management Agency Dependency Care Manager (DCM) may request a family be provided a variety of specialized services depending on the family need. All referrals for In-home support services and other support services must be made through the Clinical Services Coordinator. The Clinical Services Coordinator prioritizes the referrals based on needs identified, availability of the service, and available funding.

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

1. Families must include one or more children, birth through 17 years.
2. The Dependency Care Manager making the referral 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 what providers they are referred to. All initial services are discussed with the family during the initial standing team/case planning meeting. If the family is in the Family Team Conference (FTC) process this discussion will be held in an FTC.
3. A Standing Team Conference, Family Team Conference, permanency staffing Case Planning staffing, Out of home care review, Conditions for Return staffing, Clinical Review or simply a consultation between a supervisor and Care Manager could recommend a service. By-pass referrals (service referrals made outside of the above staffings or court) are used only in the case of a critical need which cannot wait for a team to be scheduled.

4. 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.
5. Families have the capacity to participate and can be expected to benefit from community or home-based services.
6. Without provision of service, the child(ren) are vulnerable to an identified danger threat and at risk of removal/placement disruption or the service is needed to support reunification.
7. 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.
8. The service is court ordered. For services that are court ordered, the court order must be scanned and sent to the Clinical Services Coordinator. The referral for court ordered services will also be sent through the Utilization Management System as are all referrals for services, including those paid by BFP and third parties.

Continued Review of Criteria

1. In-Home Services or other flexible 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 as they arise.
2. The service duration may be extended by agreement of the STC or FTC Team. If the initial service was authorized without an STC or FTC then a meeting will be required to re-authorize the service (see By-Pass Referral below).
3. There will be measurable goals and outcomes outlined to the provider. Outcome statements should be written in accordance with S.M.A.R.T. criteria. (Specific, Measurable, Attainable, Reasonable, and Timely)
4. Dependency Care Managers are required to inform Clinical Services Coordinator when a family will close out of the dependency system.
5. It is the responsibility of the Clinical Services Coordinator assigned to ensure the case is still open if they are reviewing a Request for Re-authorization of a service. Clinical Services Coordinators discuss a second Request for Re-authorization with the DCM. As part of this discussion, a review of progress notes and utilization will occur. For services that have been in place for 22-24 sessions, a review must occur during a scheduled staffing and will include the provider of this service.

Termination of Service Criteria

1. The children and/or family's documented goals and objectives have been substantially met.
2. The child and/or family are not making progress toward the initially stated goals and there is no reasonable expectation of progress.
3. The child and/or family, guardian, and/or custodian are not vested in achieving the stated goals of the service, despite the provider's attempts to address non-compliance issues.
4. Any time a service is being considered for termination based on the above criteria, discussion with the family or youth as appropriate, should include reasons why they were

not vested in the service or reasons why they did not feel they were making progress. Discussions should also include whether another service would better meet the needs of a particular individual or family.

Dependency Care Manager, Clinical Services Coordinator, In-Home Support Services Provider Roles

1. Dependency Care Managers, Clinical Services Coordinators, and Providers will always treat families with dignity and respect while coordinating visits to the home. Barriers to successful engagement will be considered and responded to.
2. Service Provider will maintain 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 on the weekly progress note form.

Court-Ordered Supervision

1. If at any time the Service Provider is denied entry into a home under court-ordered supervision, the provider must immediately notify the Dependency Care Manager who will:
    a. Clearly advise the family that when appointments are not kept or providers are not allowed in the home, such action generates concern about the safety and well-being of the child.
    b. Assess the concern for the child, in discussion with the CMA supervisor, service provider and/or supervisor, and Care Coordinator.
    c. The DCM will document these concerns in FSFN.
    d. An STC or FTC should occur immediately to address concerns.
2. If at any time the DCM or the service provider becomes concerned about the immediate safety and well-being of any child in the home, that person will contact the Florida Abuse Hotline in accordance with Florida Statute 39.201.

Non-Judicial In-Home Services

1. If at any time the In-Home service provider is denied access to the home of a child under Non Judicial In Home Services, the provider will assess the potential risk and safety of the child acknowledging the family is under no court order to oblige with services.
2. If access is denied and the provider has concerns for the safety of the child, the service provider will report the event to the DCM who will:
    a. Clearly advise the family that when appointments are not kept or providers are not allowed in the home, such action generates concern about the safety and well-being of the child.
    b. Assess the concern for the child, through discussion with the CMA supervisor, provider and/or supervisor, and Care Coordinator.
    c. The DCM will document the concerns in the child's FSFN case record and will staff the case with Child Welfare Legal regarding possible dependency.

d. An STC or FTC should occur immediately to address concerns.

3. Providers are mandated reporters and will be required to file a Child Abuse Report when abuse is observed or reported to them by a family member. If at any time Brevard Family Partnership or the service provider becomes concerned about the immediate safety and well-being of any child in the home, the person will contact the Florida Abuse Hotline in accordance with Florida Statute 39.201 or the Department of Children and Families Investigations if the concern is the same as the reason for agency involvement.

Referral for Services

Brevard Family Partnership will refer children and their families for appropriate services identified in the Family Functioning Assessment – On going, case plan development and individual need. Referral for service shall be solely based on professional and ethical determinations of the needs of the family and to every extent possible, family choice. See Brevard Family Partnership GOV Ethics 001 and Conflict of Interest 002.

1. Referrals for services will occur as a direct result of the Family Functioning Assessment – Ongoing, case plan development, and/or care plan development within the STC or FTC.
2. Whenever possible, families will be given options for providers and allowed to exercise voice, choice, and ownership.
3. If a service requested is court ordered, the DCM will notify the Clinical Services Coordinator of the Court ordered service within 2-3 business days of the Court executing the order. This said notification will occur through the Service referral. The Care Manager will also scan the Court's order to the Clinical Services Coordinator.
4. Referrals for services will be made on the family's behalf by the DCM through the Clinical Services Coordinator.
5. If child (ren) or family members have Medicaid then the Clinical Services Coordinator will work to find a provider that can invoice these insurers directly. The Clinical Services Coordinator will verify whether a child or adult has Medicaid. All referrals for services will be checked by the designated Clinical Services Coordinator to determine whether they Medicaid coverage. If a child(ren) or family member is not Medicaid eligible and a referral is made to a provider, then Brevard Family Partnership will fund the service. However, in cases of substance abuse treatment or batterer's intervention programs the client may be directly responsible to fund the service. Other third-party funders will also be reviewed prior to utilizing funds provided through Brevard Family Partnership in order to maximize funds available to children and families served.
6. The Clinical Services Coordinator, in conjunction with the DCM 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.
7. 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.
8. As part of the continuous quality improvement process, the Wraparound Fidelity Liaison and Clinical Services Coordinator/Care Coordinators will ask families to rate their satisfaction with the Family Team Conference process and service referral process

including availability of appropriate services and information regarding how helpful the services were/are to the family as part of the FTC process.

There are three primary types of funding sources available to support families in meeting their needs. Contract Flex funds, Flex funds for tangible goods, and 100/800 funds. The Clinical Services Coordinator/Care Coordinator are responsible for ensuring that funds are appropriately used for eligible services and eligible clients and will determine which funds to access to provide services for clients and will be responsible for the approval and submission of appropriate referrals directly to providers of services. All questions from providers regarding authorizations should be directed to the Clinical Services Coordinator/Care Coordinator directly.

Access to Contract Flexible Fund Services

If a family need a service referral and they are engaged in the Family Team Conferencing process the following outlines steps to take:

1. During the FTC, the family along with the identified Family Team will work to build upon the family strengths to address the identified needs of the family. If the team determines flexible supports are needed to support the family in meeting their goals, the Clinical Services Coordinator will authorize the Flexible Support services.

    a. The team will identify the frequency and duration of the supports needed.
    b. The team will determine the level and type of flexible support needed to meet the needs of the family.
    c. The Care Plan will be the method to document and develop the individualized intervention for the family.
    d. The DCM will complete the Service Request Form and submit any needed accompanying documents.
    e. The DCM will forward the Service referral to the Care Coordinator for all FTC requested services within three business days of the FTC. For those services identified during the initial Standing Team/Case Planning staffing or subsequent Standing Team Conferences, the DCM will forward the Service referral to the Clinical Services Coordinator.
    f. If an evaluation/assessment or any other type of comprehensive report is required on a child or parent, the Clinical Services Coordinator/Care Coordinator must be consulted prior to the submission of the referral for such evaluation in order to ensure the evaluation requested is the most appropriate service to meet the identified goal and outcome.
    g. All criteria listed in above sections will be followed.

2. <u>By-Pass-Referral Process</u>: For cases that are new and/or where there is an emergency or crisis that cannot wait for a staffing to be scheduled, the Care Manager can request In-Home Services or other Support Services through a by-pass referral. Upon determination that a service is warranted, the Care Manager will complete the following steps to request flex support services:

    a. Complete Service Referral and provide accompanying documents.

b. The DCM will forward the referral to Clinical Services Coordinator.
c. The DCM will remain available to the Clinical Services Coordinator to discuss family's strengths and needs so the best possible match of service providers can be made for the family.
d. If the child is out of county or the parents are out of county, the Clinical Services Coordinators will work with Brevard Family Partnership to identify providers to assist the family in meeting their case plan tasks or provide for the needs of children.

3. Limits of the By-Pass Referral: If the family, provider, or care manager wish to re-authorize the initial By-Pass Referral, or authorize a second service, then the family must engage in the STC or FTC process. The By-Pass Referral Process can only be accessed one time per FSFN case name. If additional services need to be added or a re-authorization of the original By-Pass Referral then an STC or FTC must be scheduled. If the child or family is out of county then the By-Pass Referral Process will be accessed for all their service needs.

Access to 100/800 Funds

In addition to all criteria listed above, 100/800 funds are utilized to meet the mental health needs of children in the dependency system. These funds can only be accessed once it is determined the service requested provides for the mental health needs of the child and the child is determined to not have Medicaid or Sunshine Health or that Medicaid or Sunshine Health would not fund the service or if they deny or have lengthy delays in authorizing the funding of the service. The Clinical Services Coordinator/Care Coordinator will exhaust all alternative funding prior to requesting the use of 100/800 funds such as: Private Pay, Private Insurance, and any other in kind or community funding. Documentation required for the use of these funds are: a diagnosis within a year of utilizing these funds, a Case Plan or Care Plan which clearly identifies the treatment goals for the non Medicaid service, and/or the actual treatment plan developed by the provider for the service being funded under 100/800 funds. Examples of services that may be utilized under this funding stream is mentoring or tutoring.

If the DCM is requesting some type of evaluation or assessment they will:

a. Provide clear and meaningful questions that need to be answered by the evaluator or assessor and review this with their supervisor.
b. A CMA supervisor approves the request.
c. The Clinical Services Coordinator will review the referral form for completeness.
d. The Clinical Services Coordinator will verify whether the client has Medicaid.
e. If the client has Medicaid but the service requested is not a service they reimburse, then the Clinical Services Coordinator can approve the referral for use of 100/800 funds but include appropriate documentation required and send these to the Director of Utilization Management at Brevard Family Partnership prior to the approval and submission of these referrals to the provider.
f. If the service requested is billable to Medicaid or Sunshine Health then a third-party referral/authorization will be created in the Automated Utilization Management System and submitted to the respective provider.
g. If the Clinical Services Coordinator or Brevard Family Partnership staff apply for Medicaid funding, and Medicaid does not fund the service within a reasonable time

frame, then this will need to be included in the documentation of the authorization/referral prior to approval for BFP funding.

If the DCM is requesting a service other than an evaluation or assessment, the DCM will complete the Service Referral and submit to the Clinical Services Coordinator as outlined above.

Access to Funds for Material Goods

Funds for material goods are funds that may be accessed when a family needs assistance in paying for a utility, rent, or other goods. Brevard Family Partnership recognizes there are times when a family is experiencing economic hardship and need a one time or partial payment for a material good. Brevard Family Partnership also values and encourages the long-term sustainability of families and as such limits access to funds for tangible goods so that families can remain independent and not dependent on outside funding.

In addition to the above eligibility criteria the following is also required:

a. To access funds the family may be required to participate in the FTC/STC process to ensure long term sustainability for the family and avoid financial dependency on outside funding.
b. The rationale for access to funds must be tied to a clinical outcome.
c. Prior to applying for funds, the family will have contacted a minimum of two community agencies for assistance in meeting their financial needs.
d. The DCM will provide possible agencies to the family so they may seek financial assistance.
e. The DCM may ask the Clinical Services Coordinator/Care Coordinator for the names of agencies for the family to contact.
f. The family will provide agency name, who they spoke to, and the contact information of the outside agency.
g. The DCM will verify the family contacted outside agencies.
h. The family must complete the Household Budget Worksheet in its entirety.
i. The family must list all incoming funds and outgoing expenditures.
j. The family must show verification or back-up of incoming funds and outgoing expenditures.
k. The DCM is responsible for assisting the family in completing this worksheet in its entirety and then submitting this worksheet to the Clinical Services Coordinator/Care Coordinator.
l. The DCM will complete the Flex Fund Request Form which identifies how the funds prevent removal or support reunification. The form also lists the costs saved by avoiding placement costs.
m. The DCM and their supervisor must sign the form.
n. The DCM will submit to the Clinical Services Coordinator the Household Budget Worksheet; back-up documentation to the Household Budget Worksheet, list of agencies contacted and verification the family contacted the agency, and Flex Fund Request Form.
o. The DCM will obtain from the family the original invoice, bill, or copy of lease. To the extent possible original documents must be obtained.
p. The Clinical Services Coordinator will ensure the Brevard Family Partnership Check Request form is completed.

q. The Clinical Services Coordinator will review the forms and all accompanying documentation for completeness and appropriateness and either return to the DCM for additional information or send to the Brevard Family Partnership Director of Utilization Management or designee.
r. If all paperwork in complete, the Brevard Family Partnership staff will forward to the BFP finance department.

Flexible Support Provider: Upon receipt of the Service Referral, the provider will assign the appropriate personnel and initiate services and services should begin within 7-10 days. These supports will be provided based on the identified needs of the family and focus on the identified tasks within the Case Plan or Care Plan. To modify the Care Plan goals, the Provider must contact the Clinical Services Coordinator/Care Coordinator to update the Care Plan. This modification will be completed as part of an STC/FTC. When a referral is received by a provider the provider will call the DCM to learn more about the family/client and to inform the DCM of the assignment of the case. When a service is ending the provider will contact the DCM approximately one week before closure to inform the DCM the service is ending. This notification will also be documented regularly on the weekly/monthly progress notes which must be included in the Automated UM system. Upon closure the provider will submit a case closure summary through Mindshare as well as provide notification to the DCM so there is appropriate documentation for the case file.

a. Weekly Progress Reports - The provider will complete a weekly progress report through the UM system. For weekly services, the progress notes for the week must be in Mindshare no later than Tuesday 12pm for the preceding week, 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 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/Care Coordinator including a summary of the crisis. The Clinical Services Coordinator/Care Coordinator will consult with their supervisor as part of a review of this request and before authorizing additional units. Following this consultation and approval of this request with their supervisor, the Clinical Services Coordinator will enter the authorization in the Utilization Management system.
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.
d. Utilization Review/FTC – During on-going STC's or FTC's the Clinical Services Coordinator, provider, referring DCM, and family 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 to drive the process in meeting their needs and ensuring family voice and choice.

Process Review: For ongoing review, the DCM, DCM supervisor, Clinical Services Coordinator/Care Coordinator, the Flex Support Providers and Brevard Family Partnership may identify a gap in services or potential improvement that can enhance the process; this must be communicated to the Senior Executive of Programs for review and potential process modification.

BY DIRECTION OF THE CHIEF EXECUTIVE OFFICER:

PHILIP J. SCARPELLI
Chief Executive Officer
Brevard Family Partnership Family of Agencies

APPROVAL DATE: 10/16/2020