UTILIZATION MANAGEMENT PLAN

FY 2021-2022

Brevard Family Partnership
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Utilization Management Plan

A utilization analysis and plan to track critical components of service utilization, approve services in a timely manner, and monitor utilization with fiscal oversight.

BREVARD FAMILY PARTNERSHIP APPROACH TO UTILIZATION MANAGEMENT

Utilization Management (UM) is the foundation of the Brevard System of Care (SOC). UM is the process of coordinating, authorizing, and monitoring services and 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, Family Team Conference (FTC) and Standing Team Conference (STC) members, network, and third-party providers. The type of service that is being delivered determines the frequency of internal reviews.

GUIDELINES FOR UTILIZATION MANAGEMENT

The utilization management process ensures children and families are linked with the appropriate level of service within the following service guidelines. All services are:

- Customized to meet identified needs.
- Delivered in the least restrictive placement possible.
- Family-centered, youth driven, and consumer focused.
- Community-based and as close to home as possible and
- Culturally sensitive and competent.

INTEGRATED UTILIZATION MANAGEMENT

Utilization management 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 made by the Intake Specialists are tracked, monitored, and reviewed by the Director of Intake, Placement, and Assessment daily. This helps to ensure needs assessment and authorization of services are appropriate to support the placement. If crisis services are needed, the Intake Specialist requests a team staffing (FTC or STC). The Family Team Conference (FTC) or Standing Team Conference (STC) reviews the appropriateness and effectiveness of services being delivered during these multidisciplinary meetings for ongoing authorization for families that meet FTC prioritization criteria. The appropriateness and effectiveness of services is also reviewed as part of the Quarterly Supervisor Case Record

Review and other quality assurance peer reviews. The following questions are 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 treatment goals been met?
- Is the initial permanency plan still appropriate?

BFP conducts a monthly review of the operational and financial performance of purchased services. This review also includes a performance review of the BFP contracted providers as well as eligibility to monitor funds to serve the population. BFP Management and Leadership Team continuously monitors these processes to ensure that the intended results are achieved.

Components of BFP Utilization Management System

Type	Review	Management
Prospective (Prior to interventions/ 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 Specialists at time of initial referral and by Clinical Services Coordinators after development and any revision of case plans.
Concurrent (During interventions/treatment/ service)	**Concurrent Review** Review of progress reports, treatment/service plan reviews Review of high utilization patterns	**Re-authorization** Level of care and step-down reviews/staffing with Clinical Services Coordinators and CMAs **High Intensity Reviews** Multidisciplinary Team (MDT)review of high utilizers and placements with an extended length of stay (exceeding the targets)
Retrospective – (After interventions/ 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 services agreed upon at the Family Team or Standing Team Conference and advise the providers of the duration, frequency, and specific needs of the child and families served. The Family Team or Standing Team identifies the appropriate provider and the Clinical Services Coordinator and/or assigned member of the Family Team contacts the provider to initiate services. An authorization form is submitted to the provider through Mindshare by the Clinical Services Coordinator.

The Clinical Services Coordinator reviews all service requests within two business days of receipt from Care Manager. For families not receiving Family Team Conferencing, Standing Team Conferences are held for youth that display high needs, (behavioral or emotional), are in high end placements, and for youth at risk of placement disruption and youth utilizing SAMH funding.

The Clinical Services Coordinator maintains the database of all authorizations through Mindshare. This ensures that the team has knowledge of real time service availability and activity. The Network Providers submit a monthly invoice to the BFP designated staff member through Mindshare detailing units actualized for all authorizations. If there is under-utilization of services authorized weekly, service units. Each BFP contracted provider is required to make and report on community linkages 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 are tracked in Mindshare by the Clinical Services Coordinator. These referrals are also reviewed and reported monthly to monitor partner agencies receiving third-party referrals from BFP and to oversee trends associated with service delivery.

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 service 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. Services are started no later than one to two days from authorization date. 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 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 use a range of supportive and therapeutic services that are customized and individualized to the unique culture and strengths of a 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 capacities, and to enable families to access resources and natural support networks 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 relative, non-relative, and fictive kin caregiver families. The goals of these family-focused services are to:

   a. Maintain children safely in their own home.
   b. Support and strengthen the 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. Create natural supports and linkages that will sustain the family upon discharge.

6. All referrals for In-home support services are made through the BFP Clinical Services Coordinator. The Clinical Services Coordinator prioritizes the referrals based on need, availability of the service and funding source. Any service that has been Court ordered is reviewed for clinical necessity and authorized. If the Court ordered service is not clinically indicated, the Clinical Services Coordinator discusses with the Case Manager the next steps to engage all parties and apprise the Court accordingly (in conjunction with Children's Legal Services).

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 as to 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 are expected to benefit from community or home-based services.

4. Without provision of service the child (ren) is 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.

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 STC 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 service goals.

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, despite the provider's attempts to engage in service provision.
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 are 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 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 documenting the outcome of the interaction in the Mindshare system. Providers are mandatory reporters: required to file a Child Abuse Report to the Florida abuse hotline when abuse is observed or reported to them in accordance with Florida Statute 39.201 mandatory reporting laws.

Referral for Services:

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

1. Referrals for services occur as a direct result of care plan development within the Family Team or Standing Team Conference.
2. Whenever possible, families are given options for providers and allowed to exercise voice, choice, and ownership.
3. Referrals for services are 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 a provider that bill the 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 are tracked. If a child (ren) or family member does not have Medicaid and a referral is made to a provider, the service will be provided through purchased services, However, in cases of substance abuse treatment or batterer's intervention programs the client may be directly responsible for payment (full or partial that may be based on a sliding fee scale).
5. The Clinical Services Coordinator monitors all referrals to ensure the family is receiving the service as authorized and maintains 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 with cultural competence.
7. As part of the continuous quality improvement process, provider and case management surveys are distributed for feedback 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. After analysis and data aggregation of the responses, results and recommendations are shared. Modifications to the process are made as appropriate.

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 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.

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.

Over-Utilization – If the provider encounters a crisis that warrants immediate over-utilization above the current authorized number 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.

Informal and Natural Supports – During the provision of services, the provider will work with the family to link the family to informal and natural 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 all team members meet to review the progress. At that time, the team determines if services will be re-authorized, terminated, or modified. This step is critical to ensure that services are appropriate and clinically indicated.

Retrospective Utilization Review

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

- Evidence that services delivered were clinically indicated.
- Evidence that clients benefited as expected from services.
- Evidence that discharges 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 with transition planning and linkages to community resources as necessary and appropriate.

In addition to the Utilization Reviews, a review of cases which required multiple services and/or services that were provided over an extended time should also occur at minimum of every 90 days. This type of review includes the Clinical Services Coordinator, Case Manager, and provider of the services. This team is also responsible for reviewing cases of high service utilization. The team reviews utilization data, progress notes, Comprehensive Behavioral Health Assessments, and psychological or psychiatric reports, etc. to recommend and implement changes in services, as needed.

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 through Brevard C.A.R.E.S. Family Allies Case Management agencies are also on call 24 hours a day 7 days per week for assistance. In addition, families can contact 211 Brevard for additional referrals and service-related issues. All services and program referrals are conducted with the intent of 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 requests the authorization from the Clinical Services Coordinator.

Authorization Thresholds

Clinical Services Coordinators cannot authorize any amount that exceeds one twelfth of the total annual budget allocation monthly based on an average of a 60% utilization from the funding sources of Family Support, Family Preservation, Time Limited Reunification, Other Client Services and 100/806 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 Executive of Programs.

Licensed and Non-Licensed Placements

Children entering licensed out of home care must be placed within 4 hours of receipt of the Comprehensive Placement Assessment. When the Child Protective Investigator (CPI) has determined that the child must be removed from 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 provide authorizations for all licensed placements. These decisions are based on placement protocols and service guidelines to ensure that children are placed appropriately.

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), but they are also reviewed internally through the utilization management process. The objective of utilization review is to ensure optimal quality care in the most effective manner through appropriate allocation of SOC resources. The necessity of services and overall utilization of all services is reviewed on an ongoing basis through a variety of mechanisms.

1. **Multi-Disciplinary Team Meetings (MDT's)** involve the review of children in licensed out of home care to determine the need for both an increased and decreased (step-down) level of care. Recommendations are based upon medical necessity criteria and are intended to provide guidance for other service options if Specialized Therapeutic Foster Care (STFC) and Specialized Therapeutic Group Home (STGH) Care or a Qualified Residential Treatment Program (QRTP) are not recommended. These children must be under the jurisdiction of Brevard County. The core team members that participate in the MDT include but are not limited to: BFP Behavioral Health (BHC) Coordinator or designee, BFP Intake Specialist, BFP Nurse Care Manager, Mental Health Targeted Case Manager if assigned, Therapist if assigned, Dependency Care Manger, and the Sunshine Health Plan representative if applicable. Staffing's are held within 60 days from being placed and every 90 days thereafter for children who are in STFC, QRTP, STGC, or SIPP levels of care. Requests for MDT's are submitted to the BFP BHC or designee. Effective October 1, 2021, MDTs are also held for all initial placements, changes in physical custody, changes in educational placement, placement decisions involving siblings, and other complex important decisions related to the child. In cases where there is not a unanimous consensus the Department will make a best interest determination and report to the court within established time

frames.

If the Qualified Evaluator (QE) determines the child does need treatment in a residential treatment center and the decision to place is made in accordance with this recommendation, the assigned child welfare professional will immediately notify Children's Legal Services (CLS).

(1) Upon notification, the CLS attorney will file a motion for placement of the child with the court and notify the child's GAL, attorney for the child, and all other parties.

(2) This motion shall include a statement as to why the child is suitable for this placement, why less restrictive alternatives are not appropriate, the goals of treatment, and the written findings of the Qualified Evaluator. This motion shall also state whether all parties, including the child, agree with the decision.

(3) CLS shall ensure the court sets the matter for a status hearing within 48 hours, excluding weekends and holidays, and shall provide timely notice of the date, time, and place of the hearing to all parties and participants, except that the child's attorney or GAL shall notify the child of the date, time, and place of the hearing.

(4) If, at the status hearing, any party disagrees with the recommended placement, then the matter shall be heard by the court within 10 business days.

b. If the motion for placement of the child into residential treatment is approved by the court, the assigned child welfare professional, BFP Intake and Placement staff, in accordance with local protocol, will coordinate the placement of the child.

Any child requiring placement in a Specialized Therapeutic Foster Home Level I or Level II is reviewed and approved by the MDT for determination of Medical Necessity Criteria including admission criteria. Children in a STFC Level I or Level II are reviewed at a minimum every six months to determine ongoing Medical Necessity Criteria (continuing stay criteria). The MDT assesses whether the child requires STFC services or with less intensive services. Once approved the BFP Behavioral Health Coordinator works with the identified provider to obtain authorization for funding.

Denial of Service (Sunshine Funded Levels of Care)

The team members that may participate in the MDS process include the BFP Behavioral Health Coordinator, BFP Intake Specialist, Substance Abuse and Mental Health (SAMH) Representative, Independent Living Specialist, Targeted Case Manager, Therapist and Child Welfare Care Manager. All decisions made through the MDT process are by a majority consensus vote. If a team member disagrees, a follow up MDS\T 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 disagree with the decision made by the Sunshine Health Plan or assigned MMA Plan they are advised to follow the Appeal Process for that plan.

Appeal of Sunshine/ Decisions Process: Final approval for placement and funding is from the Sunshine Clinical Care Manager.

Operational Issue or Concern—An issue or concern of an operational nature that Sunshine Health and its sub-contractors or vendors (including CBCIH and the Community Based Care Lead Agencies) share with Sunshine Health's Child Welfare Program leadership to seek resolution. These issues can be member-specific or general in nature, but they are not considered to be complaints. While they may identify concerns about processes or operations, they are not reported due to member dissatisfaction.

Complaint—Any oral or written expression of dissatisfaction by an enrollee submitted to the Child Welfare Specialty Plan or to a state agency and resolved by close of business the following business day. A complaint is a subcomponent of the grievance system. Complaints that are not resolved within 24 hours become grievances (unless the complaint is from a network provider).

Grievance—An expression of dissatisfaction by or on behalf of an enrollee or a provider to the Sunshine Health Child Welfare Specialty Plan or the Agency for Health Care Administration. This expression of dissatisfaction may be filed either verbally or in writing and may be made directly to Sunshine Health or BFP and/or BFP Client Relations Specialist. Complaints that are not resolved within twenty-four (24) hours become grievances (unless the complaint is from a network provider).

Grievance Procedure and Grievance System—An organized process for addressing enrollees' grievances, including the system for reviewing and resolving enrollee grievances or appeals. Components must include a grievance process, an appeal process, and access to the Medicaid fair hearing.

Complaints and grievances shall be reported to Sunshine Health within twenty-four (24) hours of CBCIH learning of the complaint or grievance.

A. CBCIH may receive information related to a potential Complaint, Grievance or Quality of Care Issue from an enrollee, a treatment provider or BFP on behalf of an enrollee.
B. CBCIH Regional Coordinators will immediately notify the Vice President of Operations for CBCIH (or designee) of a complaint or grievance that is reported by:
    1. An enrollee.
    2. BFP on behalf of an enrollee.
    3. A parent, guardian, or caregiver on behalf of an enrollee; or
    4. A provider, either on behalf of an enrollee or due to a specific provider dispute.
C. Within twenty-four (24) hours of receipt of a complaint, grievance, or quality of care issue from BFP, the CBCIH Regional Coordinator enters the information related to the complaint into the Integrate® Notify Application, along with any documentation provided by BFP. The Notify application immediately submits the report and attached documentation directly to / Sunshine Health via email, as indicated below:
   Email: Complaints, grievances and quality of care issues may be submitted via Sunshine Health's secure and monitored notification mailbox, as well as to Sunshine Health's Leadership:
    - SUN_PQI@centene.com; (Complaint)
    - cwsp_notifications@centene.com (Complaint and Grievance)

D. The Integrate® Notify application also provides notification, along with the report and attachments, to the Compliance Committee Members for review.
E. Upon BFP learning of a potential issue, CBCIH staff will be available for consultation, review and/or participation in the MDT process, as well as other case staffing's for enrollees who may be impacted or involved.
F. Per the Vendor Services Agreement, Covered Person complaints, grievances and appeals are not delegated to CBCIH. Nevertheless, CBCIH may be called upon to provide information. A request for information on a standard appeal shall be responded to within 2 business days. An expedited appeal shall be responded to within the same business day.
G. Complaints will be reported to Sunshine Health both as described above and, in a format, frequency and process established by Sunshine Health.
H. Sunshine Health's Quality improvement department is responsible to investigate the potential quality of care issue, complaint, or grievance and to take appropriate action.
I. Sunshine Health must clearly communicate whether the appeal is standard or expedited and give the appropriate deadline at the time of the request.
J. The Regional Coordinator is responsible for monitoring compliance with procedures related to the reporting requirements as part of the quarterly CBC Lead Agency monitoring process.

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

All children residing in QRTP and STGC levels of care must be reviewed through an MDT a minimum of every three months in coordination with the Suitability Assessment requirements. All children residing in STFC must be reviewed at the MDT a minimum of every six months. All Clinical Review Staffing dates, purpose, and outcomes are maintained in a centralized tracking system (Integrate).

Youth Referred to the Brevard Behavioral Health Expansion (BBHE) Team

The BBHE Team:

1) provides direct services to children/youth ages 5-21 with severe emotional disturbance (SED)/severe mental illness (SMI) as well as provide support to their families.
2) expands the use of Evidence Based/Promising Practices (i.e., C.A.R.E.S. Model, Wraparound, etc.).
3) expands Youth Thrive to support and engage children and youth on their path to becoming healthy adults.

Youth served in the Brevard System of Care may be referred to the BBHE Team to receive services. Priority populations include those individuals recognized by child welfare with behavioral health challenges and who identify as:

1) LGBTQ+
2) homeless
3) having a history of suicide ideation
4) having been a patient under a Baker Act (involuntary institutionalization)

The goals of the BBHE Team are to:
Goal 1: Increase availability of Evidence-Based and Promising Practices providing access to quality treatment and recovery services for children/youth with SED/SMI; including related services for their caregivers to reduce risk of Baker Act and suicide.

Goal 2: Demonstrate the improvement of child/youth and family outcomes across multiple life domains (family relationship, living environment, social functioning, recreational, job functioning, developmental, legal, medical, physical health, and education).

Goal 3: Increase collaboration among child welfare, judicial, educational, health, behavioral health, and substance abuse systems, as well as community providers and partners to enhance the System of Care and build a sustainable infrastructure.

Goal 4: To expand the collection and use of data for continuous system improvement, and to implement knowledge-based evaluation to monitor progress and promote replication of proven and promising practices.

Prioritization for Family Team Conferencing (FTC) Referrals

The following criteria has been established for the prioritization of families served in the dependency system. The Wraparound Team Care Coordinators, and Family Partners manage an active caseload of up to 25 families for a duration that does not exceed six months.

Priority 1. a: Families with child (ren) 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 at least one primary maltreatment indicator of substance abuse, mental health, or domestic violence.
2) Family has experienced prior removal episode or prior services (FSS, NJIHS, Dependency)
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 have experienced a removal episode and are receiving intensive substance abuse treatment.

Desired Outcomes:

- Reduction in substance abuse recidivism and parents are safely maintained within the community and engaged in treatment.
- 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 large sibling groups (at least 4 or more) 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, multiple elopements, a mental health diagnosis, substance misuse or co- occurring disorder, and/or DJJ involvement.

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.

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 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 frequency and duration.

Reviewed by:

PHILIP J. SCARPELLI
Chief Executive Officer

Review Date: 8/30/21