Brevard Family Partnership

Protecting Children, Strengthening Families, Changing Lives.

Brevard Family Partnership's System of Care Plan

March 2009

(Updated with Name Change – July 2009)

Preface

The legislatively mandated transition to community-based care required lead agencies and community stakeholders to work together in the development of a system of care plan that is responsive to community needs. Ongoing planning begins with: a thorough understanding of the demographics and needs of the children and families; an understanding of the current operations, performance, and plans for improvement; and identification of innovations to remedy or reduce current obstacles to quality care and improved results.

Purpose of the System of Care Plan

This document provides a framework that reflects the ongoing plan of Brevard Family Partnership (BFP) and community stakeholders to, expand, improve, and complement the delivery of child welfare services in Brevard County.. It is not a step-by-step guide to re-engineering but it rather the basis for:, allocating resources within the budget parameters; recruiting, hiring, and training workers; expanding the provider network; working with families—birth, relatives, foster, and adoptive families—and the Brevard community.

Document Development

In developing this system of care document, we have reviewed data that compares performance across Florida's Circuits against national averages. We also examined the findings from the Child & Family Service Review process and the recommendations and action steps the state included in its Program Improvement Plan. We reviewed numerous state and locally sponsored studies that have examined the challenges and opportunities of community-based care and we have relied heavily on the outstanding contribution of Together in Partnership (TIP), further described in the Introduction Section, and the Leadership Roundtable recommendations.

From the initial document in November 2004, this system of care draft has been widely circulated, discussed, and refined as the system has matured over time. The original document was submitted to DCF as a transition contract deliverable and has served as a framework by which the system of care operates since that time.

Document Layout

Section 1 provides an introduction to Brevard Family Partnership (BFP), the Brevard partners and an overview of the philosophical framework of our Brevard system of care.

Section 2 presents an overview of the Brevard child population and the operations of the current Brevard child protection system, depicting case flow from entry to exit from the system.

Section 3 describes the access to services, including easy referral and intake, mobile crisis response, and expedited case transfer.

Section 4 describes BFP's approach to case management and utilization review.

Section 5 describes our approach to engaging families through family conferencing case planning, development of individualized plans that address both strengths and needs of the child and the family, the use of parent mentors/resources, and ongoing monitoring to ensure the system is family-centered.

Section 6 describes the approach to permanency planning and the use of a court liaison to ensure effective working relationships with the court system.

Section 7 describes proposed changes in how assessments are conducted, tracked, and used to develop case plans that are responsive to individual needs.

Section 8 describes out of home capacity, current usage and the steps we will take to ensure stable and appropriate placements.

Section 9 describes the approach to network development and the stimulation of new services and supports that reflect the identified needs of children and families, the approach to home of relative care, and foster care recruitment and retention strategies that ensure that licensed caregivers are partners in case planning.

The **Executive Summary** presents a summary of practice changes and innovations in the BFP System of Care.

The appendices provide details on the BFP organizational structure, the location of service centers and the projected staffing.

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Section 1 Introduction

Brevard Family Partnership (BFP)

Brevard Family Partnership, Inc. (BFP) was formed by the Brevard County Board of County Commissioners, Children's Home Society of Florida and the Devereux Foundation, Inc. specifically for the purpose of developing community-based services and supports for children and families served by the Brevard County child protection and foster care system.

Each of the founding agencies had a shared vision and philosophy of service provision shaped in part by their vast experience in working with vulnerable children and families, by their close collaboration with TIP and the Leadership Roundtable, and by nationally recognized best practices. We have embraced the guiding principles and core values as a model for the system of care that was adopted by the Leadership Roundtable in Brevard.

Our vision for community-based care includes maintaining and strengthening whenever possible the ties between children, families, and communities and causing as little disruption as possible to their lives. In partnership with TIP and the Leadership Roundtable, we have built on strengths of existing services and over time have developed a more effective system of care, responsive to this objective.

This section includes:

- An Overview of BFP Responsibilities
- Our Organizational Structure
- The Administrative Office & Care Centers
- Advisory Boards
- Our Brevard Partners—TIP and the Leadership Roundtable
- Our System of Care Philosophy

Our Guiding Principles

In order to insure the safety, security, and well being of every child in Brevard County, we believe that a seamless continuum of child welfare services must be provided for our children and families to address the prevention, intervention and treatment of child abuse and neglect.

The State of Florida, the courts, law enforcement, the school system, local government, service providers, children and families, foster parents, faith-based organizations and businesses, as well as other community groups and individuals, are critical partners in caring for our community's children.

We believe that securing and mobilizing adequate resources is the responsibility of the entire Brevard community.

We are committed to the development of a child welfare system in which community resources are shared within Brevard County, between counties, and partnerships established to achieve our mission.

Source: TIP and the Leadership Roundtable

1.1 BFP Service & Management Responsibilities

In Florida, lead agencies are charged with the task of identifying, organizing, and coordinating the delivery of services and community resources for children in need of foster care and related services within the parameters of a fixed budget. Some Lead Agencies retain many of the core functions of child welfare including the case management in house. The BFP (BFP) philosophy is to develop new programs within the community, or to pilot the program in house and then contract the function out to the provider community. The structure and business model of BFP is designed to administrate and manage a variety of required services including:

- Child Abuse Prevention
- Family support
- Emergency shelter care
- Protective supervision (voluntary and court ordered)
- Home of relative care
- Foster care
- Therapeutic foster care
- Residential group care
- Pre-and post-adoption
- Case management
- Foster and adoptive home recruitment, licensing/re-licensing, training, and support (DCF retains licensing signature authority)
- Post-placement supervision
- Independent living

BFP is the single point of organizational accountability for developing and managing the system of care to achieve desired outcomes for children. To accomplish this goal, BFP has developed an organizational structure to ensure effective and cost-efficient care. Providers delivering services are directly accountable for quality and documented results. BFP has the management responsibility for:

- Managing intake, referral, assessment and case transfer in collaboration with the department, the courts, and our Case Management Agencies (CMAs);
- Developing a comprehensive array of community-based services and resources through a provider network;
- Facilitating placements that match a child's needs;
- Designing and overseeing an individualized case management system;
- Enhancing the role of licensed and relative caregivers;

- Ensuring consumer involvement and satisfaction at all levels of case management and service delivery
- Managing grievance and appeals by all stakeholders including consumers, members of the community, providers, and any other interested parties;
- Overseeing court-related processes in collaboration with case management agencies and Child Welfare Legal Services;
- Establishing a quality assurance system to ensure continuous improvement in client outcomes and system performance;
- Providing training and professional development services to the provider network and community;
- Reviewing and reconciling provider's claims, ensuring prompt payment;
- Monitoring resource utilization and addressing problems;
- Managing eligibility and Revenue Maximization; and,
- Managing the fixed funds and addressing cost overruns.

1.2 BFP Organizational Structure

The Senior Management Team of BFP consists of the Chief Executive Officer, and four Officers—Chief Operations Officer, Chief Financial Officer, Chief Administrative and Personnel Officer, and Chief Compliance and Utilization Officer, a Director of Operations, Child and Family Services, and two Directors: Utilization Management and Wraparound and Quality Management and Fidelity: (The Appendices contain organizational charts, detailing the staffing).

Care Management services are provided by Children's Home Society (CHS) and Devereux. Throughout this document these agencies are referred to as Care Management Agencies (CMAs). The Appendices contain details on the CMA staffing at each of the Care Centers and the care management model is fully described in Section 4. BFP has outsourced human resources to Administaff.

In all instances, whether provided directly by BFP staff or overseen and managed through contract arrangements, BFP management staff is responsible for the effectiveness and quality of the system of care.

Exhibit 1: Broad Areas of Responsibility for BFP Executive Leadership

Chief Financial Officer	Chief Operations Officer
Financial Contract Compliance	Quality Assurance
IT	Revenue Maximization/Eligibility
Risk Management	Oversight of Care Centers and CMAs
Liaison with Insurance Outsource	Data Entry – FSFN Eligibility Rates
Financial Audits	Court Liaison
Purchasing	Training and Professional Development
Facility Leases & Management	Emergency Response
Budget Management/Fiscal reporting	Intake, & Placement
Claims reconciliation/payment	Magellan funded programs
Accounts receivable/payable	Grant writing
Data Entry – ICWSIS Billing	Permanency Reviews
	Operations Contract Compliance

Chief Compliance & Utilization Officer	Chief Personnel and Administrative Officer
Contract Development and Oversight	Human Resources
Assessment Internal and external monitoring and compliance External Customer Relations	Regulatory Compliance Special Projects and Administrative Contracts Internal Customer Relations Liaison with HR Outsource
Accreditation Support	Maintaining Personnel Records
Grievance, complaints, satisfaction monitoring	Board Liaison Legal Liaison
SAMH funded services	Payroll
Utilization Management	Executive Support
Brevard CARES	Executive Administration

[See Appendices for Organizational Charts]

1.3 BFP Administrative Office & Service Centers

The BFP administrative office is located at 760 North Drive, Melbourne, FL 32934. Administrative and senior management staff are housed at this location.

Care management services (provided by CHS and Devereux) are located in three service centers. In total, the CMAs have 50 care managers. There is one (1) supervisor for every unit of five (5) care managers. Each CMA has a designated CMA Program Director who is responsible for oversight of CMA operations at each Care Center and direct supervision of CMA Supervisors.

All care managers have access to and the support of the Resource Specialists (Court Liaison, Caregiver Liaison, Assessment Specialists, Intake Specialists, Care Coordinators, and Mobile Response Team services). CMA's also have

secondary Adoption Support Coordinators from subcontracted providers responsible for identifying and preparing families for children with adoption as the permanency goal. (The Resource Specialists are more fully described in Section 4). BFP has built capacity through creative, innovative methods to also include Targeted Case Managers on site at each Care Center. Each Care Center has a Care Center Manager (BFP employee) and Care Coordinators (BFP employees) who co-facilitate family team conferencing and coordinate, authorize and monitor utilization and supports. There is one Care Coordinator to every two CMA units.

1.4 BFP Governance & Advisory Boards

The Board of Directors of Brevard Family Partnership, Inc. has up to 11 member seats. There are three members appointed by Brevard County Board of County Commissioners and eight at-large community representatives.

As the Bylaws of BFP set forth, the Board of Directors are responsible for establishing policies, hiring and evaluating the CEO, monitoring overall performance of the system of care, approval of the annual budget,, securing adequate funding and creating a long-range plan for the agency.

The Board of Directors also creates both standing and special committees to ensure programmatic and fiscal success of both the lead agency and the entire system of care. :

Guiding Principle

The development of community services and resources should be accomplished through a multi-disciplinary advisory council that meets regularly to continuously review the service system, recommend policy, evaluate outcomes, and recommend the best use of resources.

Source: TIP & Leadership Roundtable

In addition to the governing body, BFP will use Advisory Boards to review performance and recommend improvements

1.5 Partners in Building the CBC System in Brevard

For five years prior to the organization of Brevard Family Partnership, Inc. (BFP), the community and local service providers worked together to address the issue of child abuse and to improve the service delivery system and design the local system of care. This was accomplished through a group called **Together in Partnership (TIP)** that was authorized and appointed by the Brevard County Board of County Commissioners.

Similarly, the Leadership Roundtable was organized as an executive forum to review, support, fund and advocate for TIP initiatives. These high level Government Officials and CEO's come together to share information and to address Brevard County quality of life and solve community problems. Their individual commitment is evidenced by their self-imposed rule that they will personally participate in the Roundtable meetings and most have appointed a

representative to TIP. Additionally, this group has assumed the duties and responsibilities of Brevard's Community Alliance.

Exhibit 2: TIP Partner Agencies

Brevard County Manager	Department of Juvenile Justice*
211 Brevard	Devereux
Brevard County Sheriff PAL	Early Learning Coalition
B.O.A.T.	Eckerd Youth Alternatives
Brevard Schools Foundation	Family Counseling Center
Brevard Community College Brevard Interfaith Coalition	Healthy Start Coalition
Brevard Workforce Development	Brevard County Parks and Rec
Center for Drug Free Living	Links of Hope
Children's Advocacy Center	Job Link
Child Care Association	Juvenile Justice Council
Children's Home Society	Judicial Circuit 18*
Children's Services Council*	Space Coast Early Steps
Circles of Care, Inc.	South Brevard Women's Center
Citizen volunteers and parents	Public Defender*School Board*
Community Treatment Center	School Readiness Coalition SEDNET (Special Education)
Coalition for Hungry & Homeless	Sheriff*
Connected by 25	State Attorney*
County Commission*	United Way of Brevard*
Crosswinds Youth Services	Wuesthoff Health Systems Inc.
Department of Children & Families*	Yellow Umbrella
Department of Health*	

*Chief executive or administrator sits on Leadership Roundtable

Exhibit 3: Leadership Roundtable Membership

Court Judge, 18th Judicial Circuit	Children's Services Council, Chair
Health Department	DCF Circuit Administrator
Public Defender	Juvenile Justice Circuit Manager
School Superintendent	United Way, President
Sheriff	State Attorney
Brevard County Manager	Brevard Workforce Development Board
Children's Services Council	Legislator

1.6 Overview of the Brevard System of Care Philosophy

The BFP Board of Directors requested the creation of a TIP/CBC Subcommittee to gain broad community input into designing the best system of care for

Brevard's children and families. The subcommittee began meeting in April 2003 and was charged with analyzing the former state run system to identify gaps and needs that would assist in designing a system of care that reflected the unique needs of Brevard County children and families. In May 2004, the BFP Board and the Leadership Roundtable approved the TIP Guiding Principles, which are highlighted in this system of care plan.

BFP has embraced the fundamental philosophy articulated by TIP. The changes proposed in 2004 were designed to replace a traditional child welfare system with a system that is consistent with Wraparound system of care that models CASSP principles. At its heart, Wraparound is a process through which communities—their service systems, health and mental health organizations, schools, courts, faith communities, businesses, families, and more—can come together to "take care of their own." *Wraparound is a definable planning process involving the child and family that is family centered, strength based, and results in a unique plan that is inclusive of community services and natural supports tailored to the unique needs of the child and family to achieve a positive set of outcomes . BFP has been diligent in implementing this philosophical shift from the previous state run model to the model designed by the Brevard community over the past 3 years, and has continually sought out community input as further implementation has progressed.*

Exhibit 4: Traditional Child Welfare and System of Care Models

	Previous Practice	BFP Model
Provider Network	Providers and Case Managers often work in isolation and at times opposition to one another having varied perspectives, approaches and expectations of the family	Service providers are critical partners/members of the team where consensus is established; a coordinated plan developed and adhered to by all parties. No member of the team, outside of legal and court related matters make unilateral decisions. The team is responsible for safety, permanency and well being of the child—including working effectively with the family to achieve those goals.
Consensus/ Coordination/ Collaboration - Across Systems	Coordination, collaboration and consensus building between child welfare, providers, families, mental health, substance abuse, and education system is deficient, duplicative and at times, counterproductive and agencies often operate in silos.	Care Managers and the Care Coordinators coordinate all aspects of care, bringing all parties to the table to devise a flexible, customized, outcome based plan. This prevents duplication, maximizes efficiencies, and addresses every domain with a well coordinated plan of action.

Case Planning	Caseworker often develops the plan with minimal involvement of family or providers and lacking knowledge of availability of services.	Individualized family-team planning process, organized with participation of family members, caregivers and service providers. As an additional tool in case planning, Wraparound Family Team Conferencing is also available when deemed appropriate. .
Intake & Assessment	Emphasis upon placement without front-end evaluation of needs, and access to Diversion and Prevention, I &R, MRT, stabilization services and supports. Deficit-driven, cumbersome, not timely and not integrated in case planning.	Centralized Intake & Assessment explore options and access to diversion services and I & R. CAFAS-administered at front door to drive placement, identification of needs and outcome measurement Identifying strengths and needs are the norm and drive case planning and service
Service Array	Categorical, duplicative, prescribed service delivery system with gaps of essential services.	Flexible support continuum of services purchased on an individualized customized authorization system. Development of MRT, prevention, I & R, respite, a continuum of specialized foster homes that includes medical, progressive levels of therapeutic and enhanced foster care. .
Utilization Management	Plans are devised regardless of availability of services which results in families remaining on wait lists and failing to receive the identified services. No coordination of utilization, prioritization services are secured on a first come first serve basis.	Each service request is customized to the unique needs of the child and family and centrally authorized by Care Coordinators who have “real time” access to services and community resources as alternatives to “paid” services. The frequency and duration of services are authorized by the team and reauthorized as needed at the UR, which is scheduled according to acuity for close monitoring when warranted. This promotes efficient use and maximization of resources that tailors the level, and type of support as progress or need indicates.
Funding	Categorical, restrictions on who gets what, when and for how long.	Restructured payment methodologies and authorizations, centralized flexible fund management to ensure all available alternative funding streams and community resources are accessed.
Outcomes	Lack of cohesion and integration into existing system often resulting in the failure to meet legal mandates.	Emphasis is placed upon a well coordinated, integrated, outcome measurement system beginning with intake; the CAFAS, care plan, authorization and monitoring of services, UR’s, and weekly, monthly and quarterly performance reviews.

Core Components of Our System of Care

A system of care is based upon core values and a principle of practice that is evident from the time the child and family enter the system until the time they exit. The BFP system has been shaped by the work of the community through TIP in the establishment of a Family Centered and Strength Based model of care. As such we adhere to CASSP and wraparound values as central to all of our interactions. This BFP system of care is organized around the flow of cases—from entry to exit from the system—and includes incorporation of best practices related to the following core components and basic beliefs:

Access: Timely interventions and immediate access to appropriate services improve safety, permanency, and well-being results.

Care Management: Effective care management ensures that multiple services are delivered in a coordinated and therapeutic manner resulting in safety, permanency, and well being for the child. The Care Manager is the single and continuous point of accountability for the child and the child’s family.

Family Engagement: The families and surrogate families are full participants in all aspects of the planning and delivery of services. The system of care is culturally competent. Agencies, programs, and services are responsive to the cultural, racial, and ethnic differences of the children and families they serve.

Assessments: Strengths-based formal and informal assessments are routinely conducted throughout the time children and families are in the system. Information obtained from assessments is used to develop case plans and tailor services to identified needs. Assessments are child-centered and family focused, with the strengths and needs of the child and family dictating the types and mix of services provided.

Placements: When placement is needed, children are placed in the least restrictive, most normative environment that is clinically appropriate. Services and placements are individualized services in accordance with the unique needs and potentials of each child.

Services: Children and families have access to a comprehensive array of services that are coordinated across child-serving agencies to address the child and family’s physical, emotional, social, safety, and educational needs. The system of care is community based, with the management and decision-making responsibility resting at the community level.

Section 2: The Child Population, Caseload & Current Performance

Given the reality of limited resources and a goal of transforming the previous system to more closely approximate system of care principles, it is important to begin with an appreciation of case flow and a clear understanding of what is working and not working in the current system.

This section includes:

- An overview of the demographics and characteristics of the children and families in Brevard,
- A detailed description of case flow—from entry to exit from the system
- A profile of the current Brevard caseload and the projections for monthly caseload that were used in planning the system of care.

2.1 Demographics of the Children in Brevard

According to the 2000 census, in the United States there are 72,293,812 children under 18 (an increase of 14% since 1990). In Florida the 2007 population estimate indicates there are 4,179,640 children (or 22.8% of the population), a 9.1% increase in the child population since the 2000 census. [1] In Brevard, there are 111,610 children, representing just over 20% of the general population. [2]

The 2003 Kids Count report by the Annie E. Casey Foundation ranks states on a composite of 10 key indicators of child health, family security, education and youth well being. The latest report is based on data from 1990 through 2000. Florida moved up two notches - from 36th to 34th - in national standings on child well being indicators.

Poverty

While abuse, neglect and other maltreatment occur in every economic strata of society, poverty is one factor that increases the risk of child maltreatment. The Census Bureau uses a set of income thresholds that vary by family size and composition to determine who is poor. For example, in 2009 the poverty threshold for a family of four is $21,204. If a family's total income is less than the family threshold, then that family, and every individual in it, is considered poor. One in 8 children in Florida is poor. [3] The poverty rate in Brevard is significantly higher than the state rate (13.4% of children in Brevard compared to 12.5% statewide). Brevard county has a median income of just over $40,000 which is higher other counties in the district and the state median but slightly lower than the national median of $41,990.

[1] Child population data from the Florida Population Estimates and Projections Ages 0-17, January 1, 2008 (Legislative Economic and Demographic Research office.)
[2] Florida Abuse Hotline Information System, report produced 7/09/03.
[3] KIDS Count Data Book online, 2003.

Racial & Ethnic Composition

The racial and ethnic diversity of America's children continues to increase. In 2000, 65 percent of U.S. children were white, non-Hispanic; 15 percent were black, non-Hispanic; 4 percent were Asian or Pacific Islander; and 1 percent were American Indian or Alaska Native. The number of Hispanic children has increased faster than that of any other racial or ethnic group, growing from 9 percent of the child population in 1980 to 16 percent in 2000. BFP has made adjustments to serve the growing population of Hispanic families by employing bilingual staff and ensuring publications are available in Spanish. .

Nationwide, there is concern that a disproportionate number of minority children end up in the child welfare system. For example, although African Americans constitute 15% of the population, they account for 31% of the founded reports of abuse and neglect and 45% of children placed in out-of-home care. Caucasian children comprise 66% of the population and only 36% of children in out-of-home care.[4]

This disparity is evident in Brevard County where as of January 2009 34% of the children served are African American, while only 9.3% of the general population is African American.

Diversity Matters

All children in the care and custody of the state are entitled to basic protections. Any indication that some children fare better because of their race or ethnic origins is unacceptable.

By understanding the diversity of the population we serve, we continually strive to design culturally competent and diverse systems and monitoring mechanisms to ensure quality care for all children and families.

Age of the Child Welfare Population

The percent of children in the nation's child welfare system under five years of age has grown to 28%. In 1999, 38.8% of Florida children living apart from their families were age 5 or younger, and 9.6% were 16 or older.[5]

In Brevard County, on December 31, 2008, 49.1 percent of the children served are age five and under. At the other end of the age spectrum, 27.6% are over age 11 (with 9.3% between 16-18 years old.)[6] It is particularly important to look at where and how young children are served, with an emphasis on least restrictive setting and the provision of services and supports to meet developmental and attachment needs.

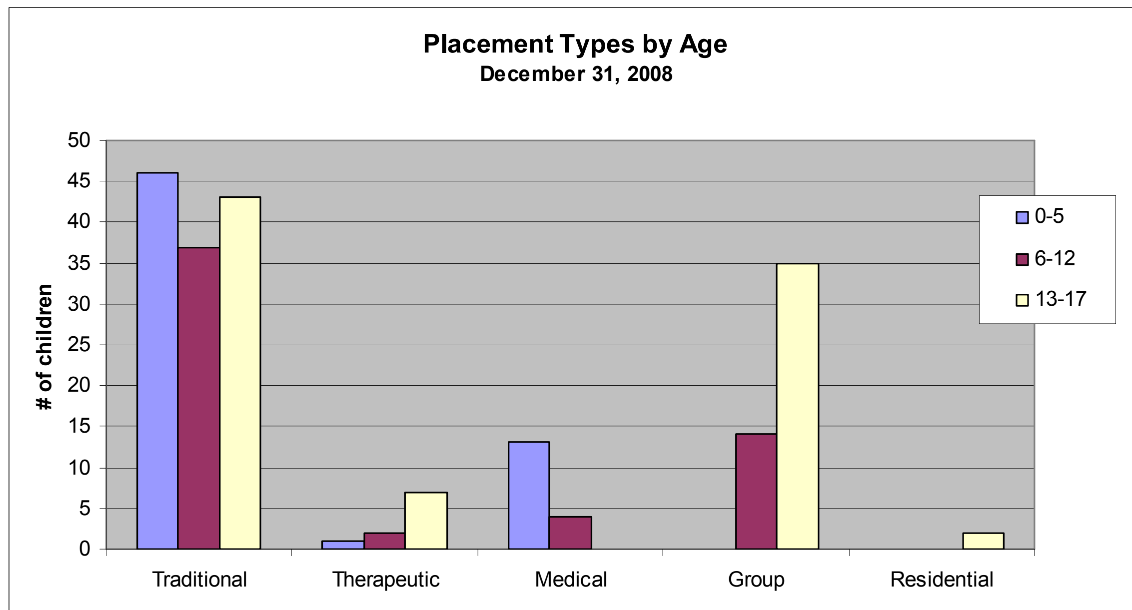
Age Matters

It is important to match services to the individual needs of the child. At a minimum we must know the percent of the child population that is under school age, and the percent that is aging out of the system.

[4] NCANDS and AFCARS, 2001.
[5] DHHS (2002), Child welfare outcomes report.
[6] Children Active Receiving Services FSFN report 12/31/08.

It is easy to see the impact of age on placement trends in Brevard. Just over three-quarters (76.7%) of the children age 0-5 are in traditional foster homes, while only 64.9% of the children aged 6-12 are in that level of care. The age groups most likely to be placed in congregate settings are adolescents—42.5% of all teenagers in licensed out-of-home care are in group homes or residential treatment centers.

Exhibit 5: Licensed Placements by Age



2.2 Case Flow & Current Performance

It is critical to examine how children are currently served in order to identify areas where Brevard is not meeting state or national standards and those where excellence is evident. This baseline information was used to craft the system of care components and it also provides a benchmark with which to measure our success or failure in meeting improvement goals.

<u>To develop a snapshot of current performance, we looked at data specifically related to how children enter the system, where they are served while they are in the system, and how they exit the system to permanency.</u>

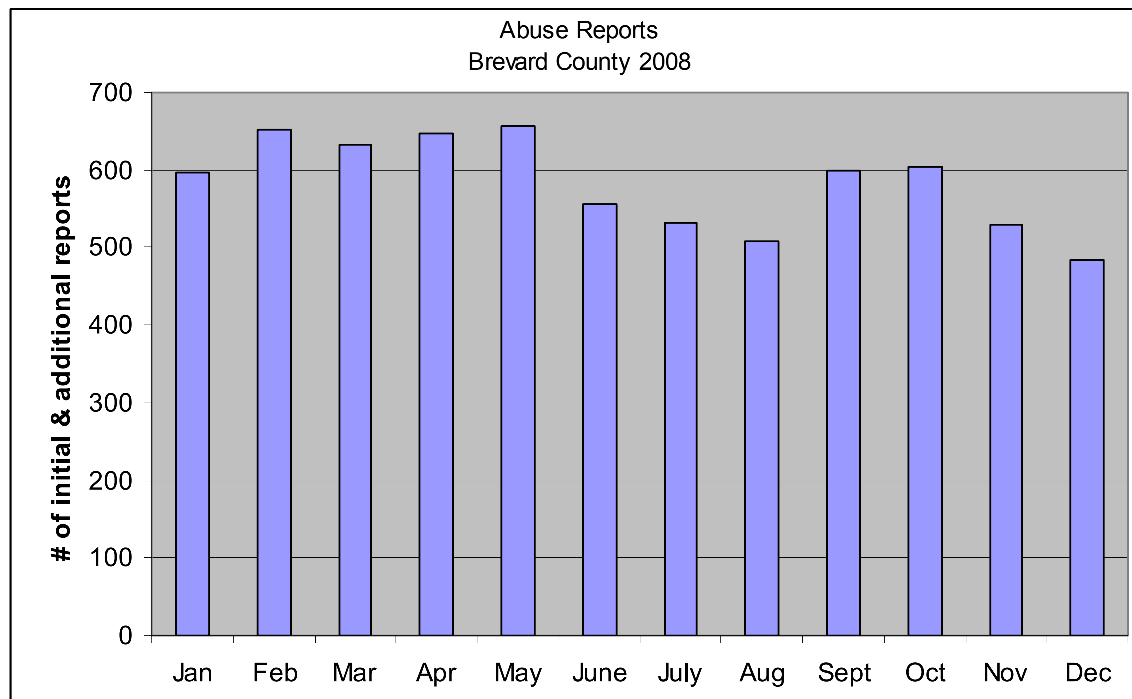
How Children Enter the Child Welfare System

In the vast majority of cases, children enter the child welfare system following a call to the Florida Abuse Hotline and a protective service investigation.

In 2008, the State of Florida received 190,563 initial & additional reports to the Hotline. The monthly reporting rate varies significantly by district and/or by counties within a district. For instance, in December 2008, 13,472 reports were received statewide ranging from an average low of 1.46% reports per 1000 general child population in Taylor County, to a high of 10.83% reports per 1000 child population in Gilchrist County

In December 2008, the average monthly rate of reports to the Hotline per 1000 child population in Brevard was 4.41, which is higher than the statewide rate of 3.33 per 1000 child population and higher than the other three counties in the district. For the 12 months between January 2008 and December 2008, DCF conducted an average of 583 protective investigations per month in Brevard. The number has remained fairly constant ranging from a high of 656 in May 2008 to a low of 484 in December 2008.

Exhibit 6: Monthly Abuse Reports: Brevard County 2008-initial and additional reports requiring an investigation

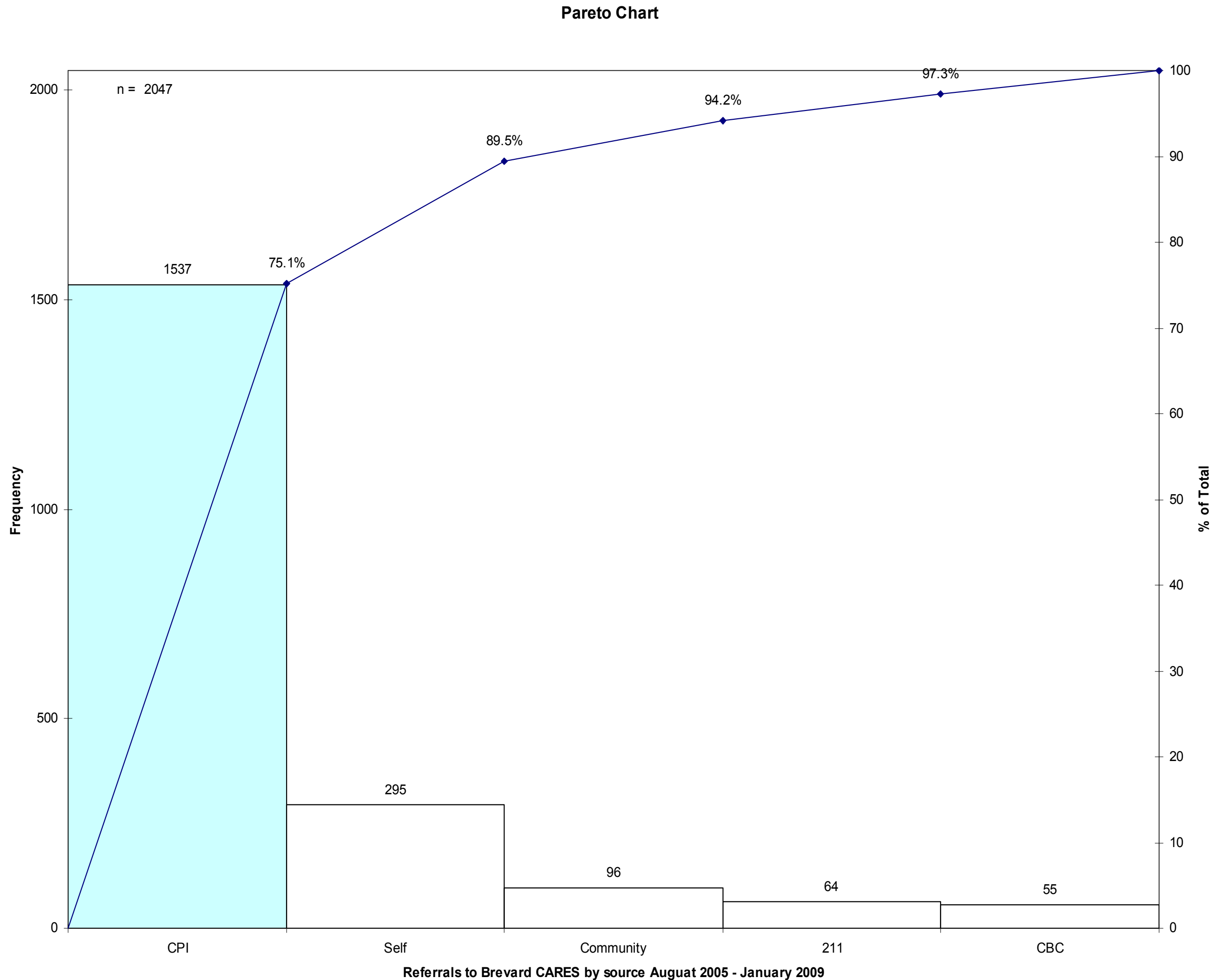


Findings of Abuse and Neglect

Currently the top three maltreatment indicators in Brevard County are substance abuse, family violence threatens child and inadequate supervision. In an attempt to assist dependency care managers in coordinating services for families who have identified substance abuse and family violence issues, BFP has contracted with local domestic violence and substance abuse treatment staff to be collocated in the care centers.

Since the inception of the Brevard CARES program in August 2005 over 4,000 children and 2,050 families have been referred for prevention services and diverted from entering the formal system. 75 % of the referrals to the CARES program come from DCF protective investigators. With the remainder coming from family self referral,, community sources, or a step down from dependency care management.

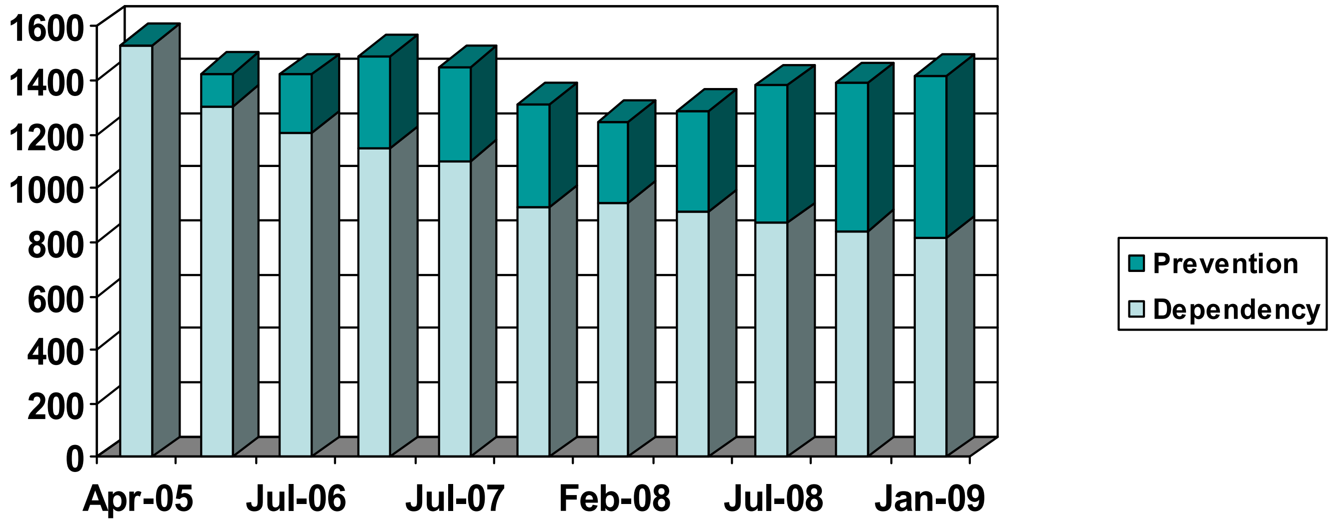
Exhibit 7: 2005-2008 Referrals to CARES by source



Where Children Are Served Within the System

The number of children entering the system as active dependents was approximately 96 per month in the period June 2005 through July 2008. During that time the monthly number of children entering receiving in-home services increased 20% from FY 2004-2005 when DCF managed the child welfare system. Out-of-home care entries have dropped by 30% over that same time. The increased capacity of local service providers and implementation of the Brevard CARES program has been instrumental in reducing the number of children who are removed from their homes.

Since the implementation of the Brevard CARES program, there has been a steady decline in the number of children receiving traditional dependency care management, The chart below indicates that while approximately the same number of children are being served since the transition of services in July 2005, the fully 40% now receive services through Brevard CARES.

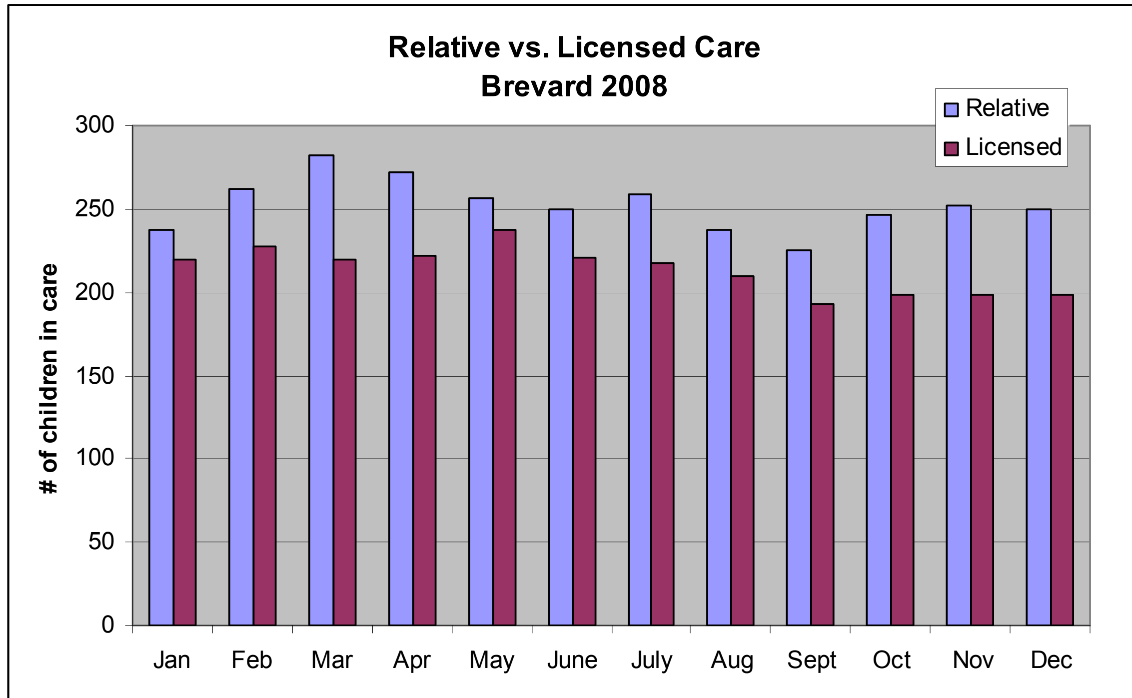


Funding to support the increased need for in home services has been made available by the IV-E waiver that the State of Florida received effective October 2006. The waiver allows BFP to reinvest formerly restricted funding that was only available to support children in out of home placements to now pay for services while children remain with their families and in the local community. BFP also reinvests the savings from the reduction in the number of children in out of home placements, and the reduction in funded dependency care management positions to provide a full array of early intervention and front end prevention services to the families receiving services through our signature prevention program Brevard C.A.R.E.S.

For children in out of home care, the majority are placed with relatives and non relative providers in the community. In January 2009, 52% of the children in out of home care were placed with relatives and non relatives. In an effort to assist these families who provide unlicensed placement for children removed from their parents, BFP partners with The University of South Florida's pilot Kinship Navigator Program.

In 2008, BFP was selected as the pilot for the Kinship Care Navigator program to provide support for relative and non relative caregivers in navigating the child welfare system BFP also added an informational newsletter that is sent to all relative and non relative caregivers upon initial placement. The "Caregiver Corner" is received quarterly by both licensed and non licensed placements. Recently, BFP has launched a support group for relative and adoptive parents.

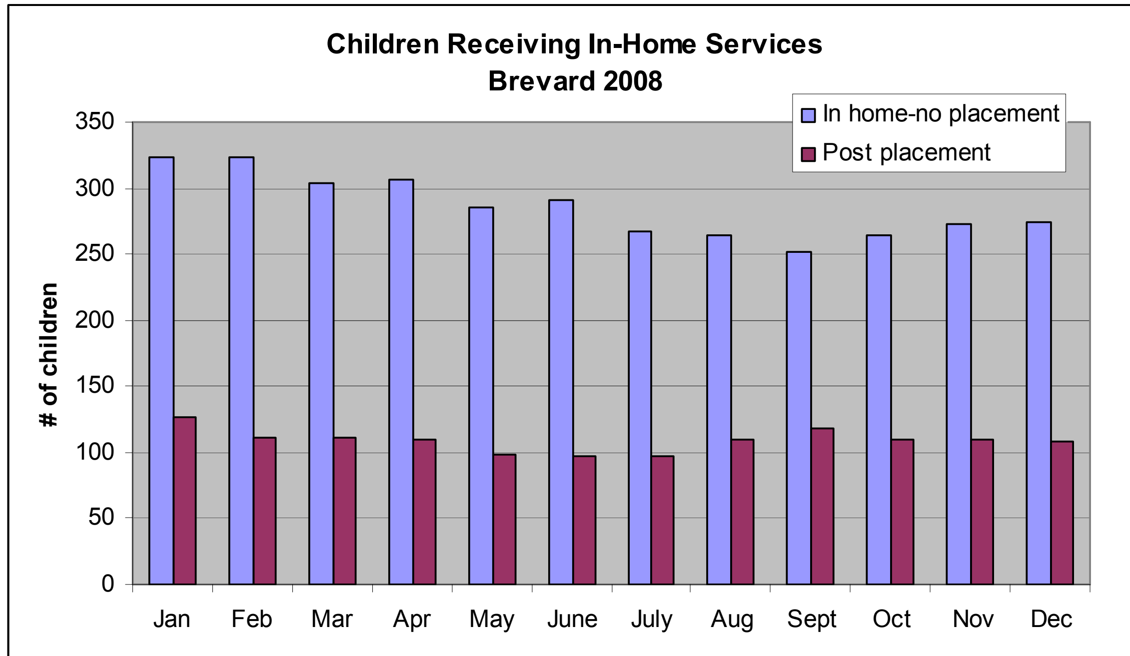
Exhibit 9: Children in Relative Care and Licensed Out of Home Care



A Closer Look at the Current Brevard Caseload

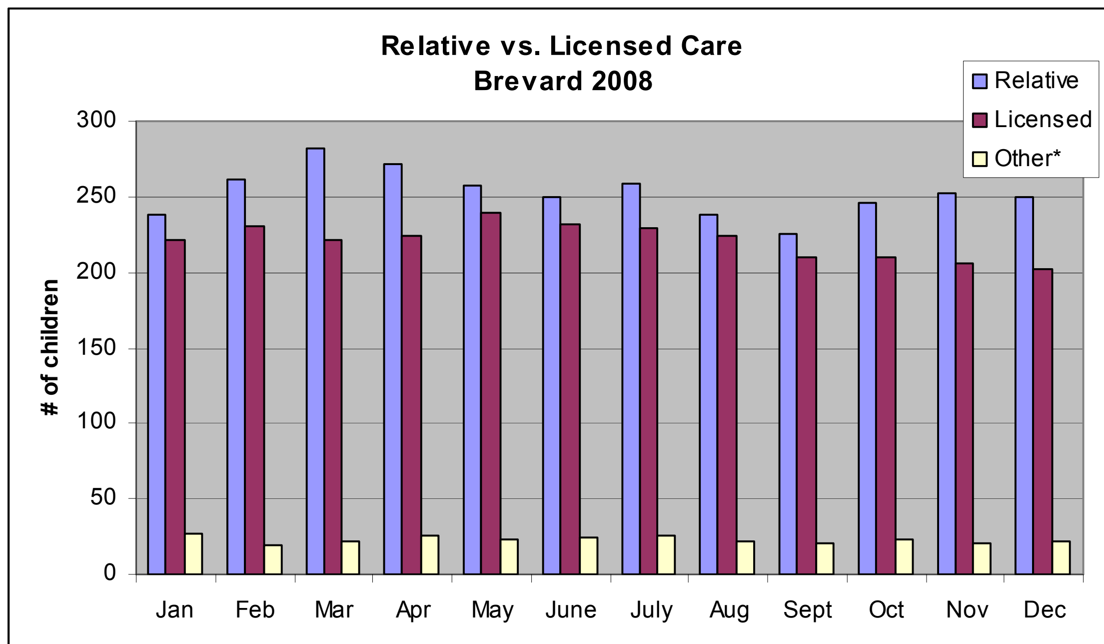
The average number of children active receiving services for 2008 has been 891, with a monthly average of 394 receiving in home services and 496 in out of home care. Of the 394 children typically receiving in home care each month in 2008, about 285 children per month were referred for in home services. An additional 109 children per month were in post placement supervision.

Exhibit 10: Children Receiving In-Home Services



The number of children in out of home care has consistently decreased since 2004 when the average was 761 to a 2008 monthly average of 496. In the first six months of 2008, the average number of children in out of home care averaged 512 while the second half of 2008 decreased to an average of 481 children in out of home care.

Exhibit 11: Children in Out-of-Home Care (Jan 2008-December 2008)

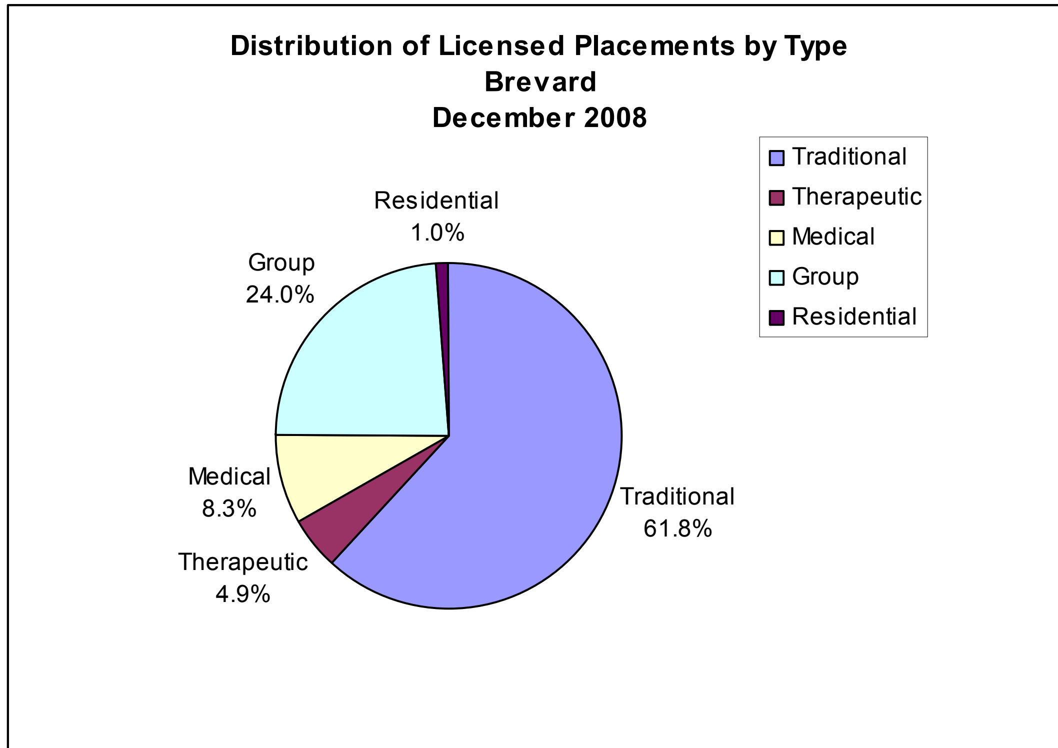


*Other includes such placements as runaway, DS, DJJ, shelters and hospitals

The Distribution of Licensed Out-of-Home Care Placements

In December 2008, there were just over 200 Brevard children in licensed out of home care divided between foster care homes (61.8% reside in traditional homes, 4.9% in therapeutic homes, 8.3% in medical homes, 24% in group homes and 1.0% in residential treatment facilities).

Exhibit 12: Distribution of Licensed Out-of-Home Care Placements December 2008



In addition to the five categories listed above, in December 2008, there were 89 youth aged 18-23 receiving Road To Independence or Transitional Support Services. There were nine youth incarcerated and four youth listed as runaways.

There are 80 children available for adoption with 58 in identified homes. Nineteen children are placed out of county in family foster homes with nine of those being licensed relatives. BFP has surpassed its adoption goals every fiscal year since July of 2005. Seventy-seven adoptions finalized in FY 07-08 which was 124.2% of our goal. As of the end of December 2008, BFP has finalized 37 adoptions, which is 58.7% of our goal for FY 08-09.

Length of Stay

One measure of success in the local child welfare system of care is the number of children whose cases are closed in less than a year. In 2002, according to AFCARS data, the state's median length of stay for children was 16.1 months.[7] According to FSFN data, at the end of December 2008, the state's median LOS for all types of care is now 12 months.

> **Length of Stay Matters**
>
> BFP has to continue to achieve good results for children entering the system while focusing increased attention to those children who have been in out of home care an extended period of

The median length of stay in Brevard for all types of cases is better than statewide performance at 10 months.

Exhibit 13: Brevard Median Length of Stay Compared to District and State[8]

# of Children	Relative/Non-relative			Licensed Homes/Facilities			Total
	<12 months	>12 months	Median LOS	< 12 months	> 12 months	Median LOS	Total Median LOS
Brevard	189	55	7	64	87	17	**10**
District	635	293	8	346	415	14	**11**
State	6,187	3,764	9	3,155	4,339	16	**12**

Research is clear that the longer a child remains in care, the more difficult it becomes to achieve permanency. It is therefore important to know how many children have been in care for prolonged periods of time—for example, over 24 months.

When you look more closely at the data, it is also clear that placement type and legal status are correlated with length of stay. In the following pages, we look at the ages and length of stay data for children served in-home, with relatives and non-relatives and in licensed out-of-home care.

Length of Stay for Children Served In-Home

There was a period of time in 1998-2000 when few children and families were able to receive voluntary services. Today, Florida, like other states, serves many children and families under voluntary service agreements, with no court involvement. It appears that in Brevard (as in most other states) children served voluntarily tend to be involved with the system for a shorter period of time than children under court supervision.

[8] Children in Out-of-Home Care By Time in Care, FSFN, 12/31/08.

At the end of December 2008, there were 353 children living with their parents and being supervised by the state. Over three quarters (273) live with one parent and less than one quarter (80) live with two parents. Over half of these children (56.7%) were in the system voluntarily with no court involvement. Of the 200 children in voluntary services, 19 (9.5%) have been receiving services over 12 months. Of the 153 children with court involvement, 65 (43.3%) have been receiving services over 12 months.

Exhibit 14: Children living at home with parents by age at the end of December 2008 (N=353)

Children living with:	Ages 0-5	6-12	13-17	Total
One parent	139	102	32	273
Two parents	57	22	1	80
Total # of children living at home	196	124	33	353

Length of Stay for Children in Relative & Non-Relative Care

More than one in four of the 205 children living with relatives (28.4%) on December 31, 2008, had been in the system more than 12 months although only 17.2% of the children in relative care had been in their current removal episode over one year.[9] Over half (61.5%) of the children in relative care are under five years old. Nine children live in Florida but outside Brevard County. Four live in District 7, outside the county, in Orlando and Oviedo. One-third of the children in relative care in Florida and outside of the county had been in care more than 12 months. There were 9 children living with relatives outside the state. Of these, five, or 55.6%, had been in care for more than 12 months, 2 were just at 12 months and 3 were less than 12 months..

Under one third (31.1%) of the 45 children living with approved non-relative caregivers had been in care over 12 months. Only 2 of the children placed with non-relatives live outside the county with one in District 7, and one in Brandon, FL.

Looking at the number of children receiving relative and non-relative care by age, it appears that it is much easier to find relatives willing to take on the responsibility of caring for younger children than older children. BFP has continues to seek new evidence based best practice programs including “Father Finders” to place more of a focus on identifying fathers and paternal relatives .

[9] Children Active Receiving Services FSFN report 12/31/08.

Exhibit 15: Children Living with Relative and Non-relative Caregivers by Age (N=250)

Children living with:	Ages 0-5	6-12	13-17	Total
Approved Relatives	**126**	**58**	**21**	**205**
Approved non-relative caregivers	**22**	**15**	**8**	**45**
Total # children with approved relatives/non-relatives	**148**	**73**	**29**	**250**

Length of Stay for All Children in Out of Home Care

Children removed between 10/01/07 and 12/31/07 should reach permanency between 10/01/08 and 12/31/08. According to the Florida Safe families Network (FSFN) report *Children Achieving Permanency within 12 Months*, 50.0% of the Brevard children in care during this time frame have reached permanency on schedule. While this may seem low, statewide only 38.1% of the children in care attained permanency within 12 months. According to HSn 2006 data, children in relative/non-relative care are more likely than children in licensed foster care to attain permanency within 12 months.[10]

Exhibit 16: Percent Of Children Exiting Out of Home Care Within 12 Months

For children removed during the period 01/01/05 through 12/31/05	Brevard County	Florida
Approved Relative/Non Relative Care	68.3%	57.1%
Foster Care	54.3%	50.4%
Group Homes and Residential Treatment Centers	64.9%	44.8%
Total Licensed Substitute Care	57.4%	49.5%

[10] Children Exiting Out-of-Home care Within 12 Months, HSn reports 01/01/06-12/31/06.

How Children Leave the System

Adoption Matters

CBC of Brevard has exceeded its adoption target in each year of operation. The creation of the Heart Gallery has greatly increased the exposure of children available for adoption in Brevard County.

Nationwide in 2006, approximately 53% of children were reunited with parents, 17% were adopted, 11% exited to live with relatives/guardians, 9% were emancipated, 5% entered into a guardianship, 2% transferred to another agency, 2% were on runaway, 0.2% were due to death and 0.8% were listed as "missing data".[11]

Although no national data is available for 2008, the Florida children left licensed care for the following reasons, 40.8% were reunified, 26.3% entered into a guardianship, 22.4% were adopted, 8.6% were emancipated or aged out, 1.7% were released to relatives, 0.1% were on runaway and 0.1% were due to death.

The permanency alternatives allowed under Florida law include reunification, adoption, and permanent guardianship. Children also leave the system to the Independent Living program or age out of the system (emancipation). Reunification and adoption offer children the greatest hope and best legal protections for permanent connections to a caring family.

The following table depicts the primary case plan goals for children in the current caseload (as of 12/31/08).

Exhibit 17: Primary Permanency Goals for Current Caseload (N=856)

Primary Goal	# of children	Percent
Maintain Child in Home	338	39.5%
Reunification	293	34.2%
Adoption	105	12.3%
Another Planned Permanent Living Arrangement/IL	55	6.4%
Permanent Guardianship	32	3.7%
Case Goal Not Established	33	3.9%
Total	**856**	**100.0%**

Brevard has an outstanding success rate in finalizing adoptions within 24 months. Brevard's 2008 performance surpasses the overall state performance. Based on data from the FSFN report titled *Children Adopted Within 24 Months* for the calendar year beginning on 01/01/08, 64 children were adopted in Brevard County through 12/31/08. Of those children, 34 or 53.1% were adopted within two years, with the state statistic at 43.9%. The median length of stay in the

[11] Number of Children Exiting Out-of-Home Care, by reason for Discharge (2006), Child Welfare League of America, National Data Analysis System, http://ndas.cwla.org

system for Brevard children being adopted was 9 months. As a comparison, statewide, the median length of stay before adoption was 16 months.

BFP works collaboratively with its Care Management Agencies to ensure all Care Managers and Supervisors understand that timely and safe achievement of permanency is the primary goal for every child in their caseload.

Rate of Re-Entry

While moving children through the system quickly is important, it is also critical that the child's safety always comes first. Brevard County has historically not done as well in this area. In FY 03-04 58.5% of the children reunified returned to out of home care within 12 months in Brevard County. In FY 06-07 the rate for Brevard was 15.7% which is 0.7% below the national median for this measure. BFP continues to analyze the reasons for reentry and to attempt to address identified gaps in the system. .

2.3 System of Care Monthly Projections*

Using averages and trends from the cases staffed into BFP over the initial 3 years of operation, the following chart outlines the projected number of children that will come into care monthly and the average caseload to be expected each month. These are the numbers that used to project our staffing needs, and plan for implementation.

Exhibit 19: Monthly Projections

PROJECTED MONTHLY INTAKE	
470	Investigations per month
65	Children entering in-home care
190	Children entering Brevard CARES
30	Children entering out-of-home care
285	**Average Number of Children Entering Per Month**
PROJECTED MONTHLY CASELOAD	
220	In-Home (not placed)
120	In-Home (Post placement supervision)
560	Brevard CARES
900	**Average number of children receiving in home services**
250	Relative/nonrelative placements
220	BFP custody (Licensed Care)
470	**Average number of children in out of home care**

**Numbers rounded to tens*

2.4 Summary of Promising Trends and Challenges

There are promising trends in the data. Among them are the following:

- 90% of the children entering the BFP system of care are served in their own homes, with the majority never experiencing a placement.
- 40% of the children served are served through the BFP prevention program.
- Homes of relative and non-relative care are clearly a preferred placement option for children in out of home care.
- The length of stay and achievement of permanency within 12 months in all types of care is better than state or District averages.
- Brevard continuously has exceeded performance targets in the number of adoption finalizations in the last three years of operations.

Based on our analysis, the below was identified:

- An updated Foster Care Recruitment and Retention Plan is developed annually that includes a data analysis of current providers and trends.

- Fewer and fewer children are being placed out of county. Typically, out of county placement only occurs when the appropriate placement is not available within the county. An example might be an Agency for Persons with Disabilities Group Home or a Medicaid funded Residential Treatment Facility.
- One new CPA, Kidspeace, has been added for fiscal year 2008-2009. Kidspeace specializes in therapeutic placements.
- Over half of the children in out of home care are living with relatives or non relatives who need help navigating the child welfare service system and accessing services and supports.
- While the rate of re-entry in Brevard has improved it remains higher than state or national averages.

BFP plans to address the identified challenges in Brevard by:

- Increasing the number and types of foster care beds available,
- Ongoing recruitment of foster families.
- Expanding the capacity of child placing agencies (CPAs),
- Recruitment of both adoptive and foster families.
- Coordinating with the Department of Children and Families Central Region Licensing Office for training on licensing activities,
- Offering both pre- and post- adoption support for families,
- The addition of a comprehensive child abuse prevention program, Brevard Collaboration, Advocacy, Resources, Education and Support or Brevard C.A.R.E.S.
- Partnering with neighboring CBCs to create a regional recruiting campaign, and
- Providing specialized staff support
    - Caregiver Liaison
    - Care Coordinators that specialize in Prevention
    - Family Partners
    - Court Liaison

Section 3: Access to the System of Care

Timely interventions and immediate access to appropriate services improve safety, permanency, and well-being results.

Children and their families need easy access to the services they need without encountering barriers or waiting lists. They need to be able to move seamlessly from one service to another as their changing needs dictate. Services should be geographically and linguistically accessible, as well as culturally and clinically appropriate.

This section includes a description of changes and innovations that reflect system of care values related to access to services, while also addressing issues identified through the CFSR, PIP, and TIP recommendations.

Guiding Principle

A single point of entry into the child welfare system has been implemented to assure children and families access to treatment and consistency of treatment.

This should facilitate a reduction of duplication of services, a match of children and their alternative care provider to allow for a successful placement, and establishment of a plan of service based upon a comprehensive assessment of the child's needs.

Source: TIP and Leadership Roundtable

This section includes:

- An overview of how children and families currently access services
- BFP accountability for access to services
- An easy intake process for all types of referrals
- Seamless transfer of Case Management
- The introduction of crisis response services
- An overview of QA mechanisms related to access to services

3.1 The Current System

The Protective Investigator Responds to a Report of Abuse or Neglect:

As previously described, a child's journey into child welfare system typically begins with a call to the Hotline and an allegation of abuse, neglect, or abandonment. While BFP does not have responsibility for the initial decisions that are made by the PIs and the courts, we are directly impacted by the results of those actions. We have designed a system of care that supports the PIs in their critical work and ensures a smooth transition of case management responsibilities to BFP at the earliest appropriate time.

Challenge

High caseloads, turnover, and other workload issues cause delays in initiating timely investigations, in completing assessments and in closing cases in 60 days.

Source: CFSR

In Florida, the initiation of an investigation—currently defined as "first completed or attempted face-to-face contact with the victim(s) of the report"—is supposed to occur within 24 hours after the Florida Abuse Hotline accepts a report. Prior abuse reports on the child and allegations against the alleged perpetrator are checked at the DCF central office and re-checked in the local district. Cases are coded as either "immediate" response (within 3 hours) or within "24 hour response". The district office assigns the case to a Protective Investigator (PI) who begins the investigation. The State Statutes allow 60 days to complete the investigation. After that time, the case is considered backlogged. Ideally, investigations are initiated and completed by the protective investigator in a timely and appropriate manner—higher risk cases receiving priority attention without causing backlogs in less serious cases.

A Determination is Made About the Need for Services

The PI determines if the child is in immediate danger or whether there is evidence of the allegation and identifies the person(s) responsible for the abuse or neglect. Throughout the investigation, the PI must make decisions about the need for emergency services and the need for court petitions and placement. Depending on the level of risks and supports available (which may change over time), the PI's can:

- Close the case with no service needs being identified and no services provided;
- Identify the need for linkage to community resources and supports including the Brevard C.A.R.E.S program and make a referral at any time during the investigation;
- Leave the child at home and refer for services under a voluntary services agreement;
- Leave the child at home, but seek court ordered protective supervision;
- Place the child with a relative or family friend (non-relative placement); or,
- Place the child in a shelter facility or foster home (shelter status).
- Access Mobile Response Team in an effort to prevent removal whenever possible.

After the transfer to CBC, the PI may make a referral to BFP at any point in the investigation when it is determined that the child and family need information and referral to community agencies, ongoing services, or placement. The following table summarizes the key decisions made by the PI.

The Service Worker Initiates Services

Currently, if the PI determines ongoing services are needed a Team Staffing is scheduled. The staffing is requested within 24-72 hours of the investigation being commenced and the assigned services counselor initiates contact with the family within three workdays of being assigned the service case. The PI may also make a referral for Flexible Supports for families at-risk of placement. Monthly face-to-face contact is required for with all children active to services.

3.2 Overview of BFP Accountability

The BFP Director of Operations, Child and Family Services, who reports to the Chief Operations Officer, is responsible for overseeing the intake, assessment, placement, and BFP centralized point of access.

The BFP Intake Specialists, who report to the Utilization Program Manager, have direct responsibility for day-to-day coordination and tracking of intake, assessment, placement and case transfer information.

Under community-based care, at any point in the investigation when the PI determines that the child and family are in need of services or supports or the child is in need of placement, a referral will be made to BFP.

BFP has implemented a number of improvements to the system that are responsive to identified areas needing improvement including: 1) an easy referral and intake process (BFP centralized point of access) 2) a seamless case transfer process, and 3) the option of having immediate crisis intervention and stabilization services (Mobile Response). Each of these changes is described below.

3.3 Referral & Intake Tailored to Meet Child & Family Needs

BFP believes the PI should not encounter any barriers in referring children and families for services as soon as the need is apparent. We further believe that the sooner the Care Manager can begin to engage and work with the child and the family, the more successful we will be in attaining safety, permanency, and well-being goals.

PI's are able to refer children for placement services 24/7, 365 days a year. An on-call system has been established to facilitate placement of children outside of normal business hours. A streamlined intake process has been created that provides a single point of accountability for the coordination of services and supports for all children and families referred. The centralization ensures that information is gathered, documented in state data systems and communicated to relevant parties to facilitate the initiation of placements and services. The expedited timeframe ensures that children and families do not have to wait for services that could vastly improve their chances for success.

BFP accepts referrals from the PI for all children and families in need of services, supports, or placement, including the following:

Low risk cases (Referred for Information and Referral)—PIs sometimes have cases where there is no evidence of abuse or neglect and no identified need for "formal" services. At the same time, the PI may see a need for linkage to community resources to improve child or family functioning and reduce future risks.

The system of care "model," developed by TIP and approved by the Leadership Roundtable, recommended that the lead agency support information and referral for front-end prevention efforts to ensure at-risk families who may not require

entry into the system will receive adequate support and resources to prevent a future episode. BFP has worked collaboratively with the community and stakeholders to achieve this goal over the first three years of operation. .

We have developed a two-tiered approach:

Families in Need of General Information: If the PI believes that families are in need of general community referrals, the PI can refer the family to "FIRST CALL FOR HELP" (211) for free access to health and human services in their communities. These 211 services provide a critical connection between individuals and families in need and the appropriate community based organizations and government agencies. They provide callers with information about and referrals to services such as:

- Basic human need resources – food banks, clothing closets, shelter, rent assistance, utility assistance.
- Physical and mental health resources – health insurance programs, Medicaid, Medicare, maternal health, Kid Care, crisis intervention services, support groups, drug and alcohol intervention and rehabilitation.
- Work supports – financial assistance, job training, transportation assistance, education programs.
- Supports for elder and persons with disabilities – adult day care, congregate meals, Meals on Wheels, respite care, home health care, transportation, homemaker services.
- Children, youth and family supports – child care, after school programs, Head Start, summer camps, family resource programs, mentoring, tutoring, protective services.
- If the 211 operator believes that the family calling would be best served through BFP Prevention Services, a referral is made to BFP intake to assign to Brevard C.A.R.E.S.

Families Needing More Support: If the PI believes the family needs a more personal approach and face-to-face contact and the case is determined to be of low risk, the PI can also make a referral to the Brevard C.A.R.E.S. prevention program. A Care Coordinator and Family Partner will be assigned to facilitate a wraparound family team and ensure the family has access to community resources. In those cases, the Intake Specialist receives the family information from the PI and provides the information to the C.A.R.E.S. Program Manager for assignment The BFP Intake Specialist ensures that this is an appropriate referral for the prevention program through an established set of criteria. The PI also has the ability to request one time "flex" funds to alleviate a one time issue for a family that is placing the children at risk. BFP intake staff work with the PI to complete all requisite paperwork and BFP then issues payment to a provider on behalf of the family.

For all I & R cases, the Intake Specialist will accept the referral from the PI by phone. At the time of referral, the PI will provide full contact/demographic information, an initial assessment or risk/safety issues, and a description of the

services that the PI believes are desired or needed by the child/family. The PI will provide the Intake Specialist with a signed release of information form within 24 hours of the referral.

The Intake Specialist will refer the case to an appropriate agency, such as 211, or to the BFP Prevention Coordinator to help families identify and access community services. Within 14 days of initial referral, the Intake Specialist will follow up with families to ensure that referrals for services were provided and helpful. The results of this call will be documented in the BFP system. If no other services or referrals are needed, the case will be closed in the BFP system (and the PI notified).

Voluntary Protective Services—The PI will get a voluntary protective service agreement signed by the family when a determination is made that the family can safely remain together with services but without court involvement. If the family is willing to accept services, the PI will secure the agreement and make the referral to BFP. At the time of referral, the Intake Specialist reviews the intake/enrollment checklist with the PI before accepting the referral. At a minimum, <u>for all voluntary service cases</u>, BFP requires the following information:

- Full contact/demographic information.
- Signed Voluntary Protective Service Agreement
- Initial assessment of risk/safety issues and services needed to reduce future risk
- Prior abuse report history
- Initial service plans and case notes. When it is becomes available, the PI will forward additional information, including criminal records check.

The intake specialist will set a team staffing for the next business day at the care center that will be receiving the case, and it is the responsibility of the PI to deliver the completed intake packet to the care center by 3:00 p.m. the day prior to the staffing.

Contact with the family will be initiated by the CM within 72 hours of assignment of the case, or earlier as determined by the PI and Intake Specialist.

The family's participation will be totally voluntary. During the course of interaction with the family if circumstances warrant, the CM will advise the PI of any information that might indicate a higher level of supervision and court-involvement are needed. BFP and its subcontracted Case Management Agencies will work with DCF's Protective Investigation Unit in those cases which are currently open services cases and new abuse reports are called in. The processes for management of those cases are outlined in the BFP and DCF Protective Investigation Memorandum of Understanding.

<u>Based upon statistical data, BFP is likely to get between 40-50 voluntary supervision children each month.</u>

Protective Supervision In-home—When the PI determines that the child can remain at home with court supervision the PI will initiate the non-shelter

dependency petition and make the referral to BFP for further assessment of service needs and ongoing case management. A Team Staffing (formerly ESI) will be scheduled at the Care Center within 48 hours after the non-shelter petition is files. Mandatory participants include designated BFP Care Center Manager, the assigned Care Manager and the PI. After the case is reviewed and the case transfer task list is completed, the Care Manager will assume responsibility for case management and will make contact with the family within 24 hours (The case transfer task list has been developed jointly by BFP and PI's)**.**

If the Care Manager believes that the family would benefit from a Wraparound Family Team Conference, a referral is made to the assigned BFP Care Coordinator who schedules an initial meeting with the family. At the initial meeting with the family, the BFP Care Coordinator will conduct a Strength and Cultural Discovery and identify the natural supports and schedule the Family Team Conference. All required screens and assessments that have not been previously scheduled by the PI will be addressed prior to the Family Team meeting, and appropriate referrals for services for the child/parents will be made.

Based upon statistical data BFP is likely to receive 10-15 children referred each month for in-home protective supervision.

Children Placed in Relative/Non-relative Care—When the PI decides that placement with a relative or non-relative caregiver is the appropriate decision, the PI will photograph and fingerprint the child, screen for bruises or other visible signs of injury that might require immediate attention, and briefly assess the child for health, mental health or behavioral problems that might jeopardize placement or that might require immediate services following placement. When the PI has all the information needed to complete the Intake/enrollment checklist, the PI will call the BFP Intake Specialist, provide enrollment information, and review any information that might require immediate assessment or services following placement with relatives/non-relatives. At a minimum, for all Relative/Non-relative cases, at the time of the initial intake call the PI will provide BFP with:

- An assessment of family strengths and risks identified at that time,
- Complete child and family contact information, school contacts, list of scheduled court dates or other appointments
- Case notes and any initial service plans, and any other written material related to the CSA.
- Information on medical conditions and medications

The Intake Specialist will contact the Care Center Manager to schedule the Team Staffing with the Care Management Agency for assignment. The CMA will assign a Care Manager within 24 hours of referral.

The Care Center Manager will assign the case to the receiving care management unit and the unit supervisor is then required to review all information in the file in advance of the team staffing, following up on missing information, and creating a document trail showing when information was obtained and to whom it was submitted. A contingency plan will be developed collaboratively with all parties for any missing information.

For completion of the case transfer, a Team Staffing will be held (as described below). After the staffing, the Care Manager will accept case transfer and initiate contact with the child and the relative within 2 days of relative/non-relative placement (or sooner if required by court orders) to arrange for any additional screening or assessments not previously arranged by the PI.

<u>There are currently between 10-15 entries into relative care each month. It is likely that these cases will continue to comprise over half of the children in placement at any time.</u>

Shelter and Foster Care Placements—When the PI 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 PI will request placement services and supports from BFP and file a shelter petition.

The PI will photograph and fingerprint the child, screen for bruises or other visible signs of injury that might require immediate attention, and briefly assess the child for health, mental health or behavioral problems that might jeopardize placement or that might require immediate services following placement. When the PI has all the information needed to complete the Intake/enrollment checklist, the PI will call the Intake Specialist and provide enrollment information. At a minimum, at the time of the initial intake call the PI will provide BFP with:

- An assessment of family strengths and risks identified at that time,
- Complete child and family contact information, school contacts, list of scheduled court dates or other appointments
- Case notes and any initial service plans, and any other written material related to the CSA.
- Information on medical conditions and medications
- General information/observations on the child's metal state, behaviors, and immediate needs.

This information is spelled out on the intake request form required to be completed by PI's when requesting placement.

When the child's placement has been made, the Intake Specialist will notify the Care Center Manager for Care Management Agency assignment and relay all of the intake information. The CMA will assign a Care Manager and a case transfer staffing will be held within one business day of the request from the PI. After the staffing, the Care Manager will accept case transfer and initiate contact with the child within 2 days

The child will be evaluated via the Child and Adolescent Functional Assessment Scale (CAFAS) tool. The CAFAS serves to make early identification of need across 8 domains of the child's life in order to secure services early on. It also serves to guide the appropriate level of placement for the child. BFP will use this assessment to identify the appropriate type of placement and match the child to an appropriate placement –when possible in traditional foster care settings, with therapeutic services wrapped around the child if indicated.

If at the time of initial request for placement it is unclear what the child's clinical and safety needs are, BFP will use the information available at the time to match the child to the most appropriate emergency shelter home or facility where the child will remain until the CAFAS can be completed by the BFP Utilization Review Specialist The Intake Specialist will notify the most suitable CPA who will contact the emergency home or facility and the PI will transport the child.

Statistical data indicates BFP receives approximately 10-15 referrals for licensed placement each month.

3.4 A Seamless Case Transfer Process

BFP has created a seamless case transfer process by offering the Team Staffing process daily. BFP Intake Specialist automatically schedules the Team Staffing for the next business day when a child has been placed in licensed care. Invited participants include the assigned Care Manager, PI, CLS, and designated BFP staff. The team staffing ensures consistency in reviews of all decisions that affect the care and custody of the child. It provides the checks and balances needed to ensure that decisions made are in the best interest of the child and consistent with federal and state policies and practices.

At the Team Staffing, the case is reviewed and agreement is reached on court recommendations and remaining tasks/responsibilities. It is at this time that the preliminary findings from the initial investigation are reviewed along with the plans for visitation and for services to the child and family. The checklist will be completed, indicating primary responsibility for completion of required tasks leading up to disposition—including data and records collection and coordination of court-related activities. The checklist will also include a review of vital information or activities to date including but not limited to:

- Documentation of reasonable efforts to prevent placement
- Diligent search for absent parents, relatives
- Any other court orders and legal documents (birth certificate request)
- Prior abuse report history and any other pertinent information from multiple databases such as DOH, Medicaid
- Medical records and consent for routine medical care;
- Documentation of communication with school and request for education records
- Determination of eligibility (IV-E, Medicaid, TANF)

At the Team Staffing, discussion is held regarding the history and current status of the case, services that are in place or are needed, status of the investigation, etc. All parties attending the staffing identify and assign tasks to facilitate service initiation and closure of any outstanding issues identified at the staffing including identifying/ transferring responsibilities for the remaining steps in the initial response/assessment to the assigned Care Manager, including:

- Protection of the child, collateral contacts, fact finding, and notifying the state attorney, law enforcement, and the Human Rights Advocacy Committee;
- Drafting the case plan with the family;
- Assisting the PIs and legal services with court activities that may be needed including arraignment and review hearings, adjudicatory hearing, predisposition hearing, case plan approval/disposition hearing, priority placement home study request and order of compliance as well as documentation of those activities.
- Arranging additional meetings (family members, protection teams, school, and case review committee) that are pertinent in finalizing the disposition, documenting the outcome of those meetings, and implementing the recommendations.
- Stabilizing crisis situations.
- Providing and documenting the services in the case plan.
- Participating in all decisions about the case until disposition.
- Keeping the PI informed of any information which is provided by the child, parents, relatives or others which would be relevant to the court at the time of disposition

At the conclusion of the discussion, BFP Care Center Manager makes a final decision as to the appropriateness of the legal status, initial case plan, date of acceptance of the case, and CMA and Care Manager Assignment. (Note: If the BFP staff person or Care Manager believes the case is not appropriate or the transfer packet is not complete and they believe that the case should be "denied", the Chief Operations Officer will be contacted immediately. If the parties agree that the case transfer should be postponed, the designated staff person for DCF will be contacted.

The BFP representative attending the team staffing will record all decisions on the Team Staffing Log and will ensure that information becomes a part of the child and family case file within 24 hours of the staffing. After the Team Staffing, all case management responsibilities will transfer to the designated care management agency. The investigator will continue to support BFP with shared information and input until disposition and investigation report closure.

3.5 The Introduction of Crisis Intervention Services

Consistent with TIP recommendations, BFP has implemented a mobile crisis intervention team called the "Mobile Response Team" that consists of Masters Level Therapist available at any time during the life of a case. This service can be requested by the PI at the time of the initial investigation to further assess the situation and work with the family to reduce the level of risk to enable the child to stay safely in the home. This service is also available to support children and families enrolled in the BFP system of care during times of stress or crisis that could threaten child safety or a current placement's stability. The Mobile Response Team is accessed by the BFP Intake Specialists or after hours on call respondent.

After the case has been transferred to the CMA, technical assistance to providers and direct caregivers and linkage to community resources is available through the Intake line. If needed, BFP will deploy the Mobile Response Team to stabilize crises that threaten placement stability and to ensure that the family receives appropriate services and supports following the crisis (these will be facilitated by the assigned Care Manager/Care Coordinators)..

BFP has partnered with DCF and other various community stakeholders to determine the best approach, to identify potential resources, and to project the capacity needed to prevent initial placements and stabilize existing placements.

3.6 Monitoring Results of Intake & Case Transfer Process

The Care Center Managers will examine data on a monthly basis and generate management reports to continuously monitor the intake and case management transfer processes. BFP meets on a regular basis with DCF staff to problem-solve areas that may pose difficulties. Among the data that will be tracked and reviewed are the following:

- Number of and types of referrals each month.
- Time between referral and first contact with the child and with the family by the assigned Care Manager.
- Average time elapsed between referral and initial intervention
- Length of time between initial referral and the Team Staffing (formerly ESI)
- The length of time between initiation of the investigation by the PI and referral to BFP for services.

Section 4: Best Practice in Care Management

Effective care management ensures that multiple services are delivered in a coordinated and therapeutic manner resulting in safety, permanency, and well-being for the child. The Care Manager is the single and continuous point of accountability for the child and the child's family.

This section includes:

- An overview of the current approach
- A summary of the BFP approach and staff accountability
- A detailed description of our Care Management model
- The approach to utilization management and integration with care management
- An overview of the QA mechanisms related to care management & UR

Guiding Principle

Children and families should be assigned a primary case manager throughout the life of the case regardless of the service need - voluntary family services, voluntary or court ordered protective supervision, foster care, and adoption and related services.

Though multiple agencies may be involved in providing services, the primary case manager should coordinate and facilitate the provision of services to the child and family to insure continuity of care, treatment, and timely achievement of the permanency goal.

Source: TIP and the Leadership Roundtable

4.1 The Current Approach

In the present system, Dependency Care Managers are assigned to service units in three service centers. The Dependency Care Managers are responsible for completing initial assessments, engaging parents, caregivers, and children when age appropriate, in the development of case plans to address presenting concerns, actively participating in the Wraparound Family Team Conferencing process to identify service needs and referrals, updating case plans as needed, providing reports and testimony to the court when services are court ordered, participating in reunification staffing when cases involve removals, and providing recommendations regarding the termination of services.

High turnover, vacancies, and high caseloads have been cited nationally as barriers to effective case management. BFP currently has the lowest rate of turnover in case management in the state of Florida. In addition, caseloads and levels of support are within the guidelines as set by the Child Welfare League of America, even as the number of care manager positions has been reduced each year of operation. .

4.2 An Overview of the BFP Approach

Accountability for Case Management

As previously noted, BFP subcontracts for case management services with Children's Home Society and Devereux Florida. These agencies, described throughout this document as the Care Management Agencies (CMAs), are responsible for assigning a Care Manager when they receive a referral from the BFP Service Center Manager.

The Care Managers (CMs) are **supervised** by Dependency Care Manager Supervisors, who in turn are supervised by Care Management Program Directors.,.

The BFP Director of Quality Operations is responsible for overseeing the performance of the BFP Care Center Managers. The Care Center Managers oversee day-to-day operations at each Center. The Director of Utilization Management/ wraparound supervises the Care Coordinators who are assigned to assist CMA units, authorize services, provide consultation, and to co-facilitate and track Wraparound Family Team meetings and conduct ongoing utilization review.

While we will rely upon different CMAs for care management, all will share the same vision and operate under the same policies, procedures with the same level of supports and resources at their disposal. There are a number of mechanisms to ensure that the care management services and supports are consistent across Care Centers and CMAs. For example, BFP has:

- Maintained equitable caseloads across CMAs—The BFP goal is to maintain caseloads that do not exceed 1:20 (children) per Care Manager, and a 1:7 supervisor/staff ratio. Current caseloads are at a ratio of 1:16.
- Developed and implemented care management training for all CMA staff that will build common knowledge base and skills, including the provision of Child Welfare Pre Service Training for all care management staff;
- Use the same client management system and decision support tools;
- Provide equal access to supports, regardless of Care Center.

> **Guiding Principles**
>
> Case load size should be set and maintained in compliance with national standards and guidelines set forth by the Council on Accreditation or any other such nationally recognized organization.
>
> **Source**: TIP & Leadership Roundtable

As depicted in the Appendices: Care Center Charts, the two CMAs will be co-located in the current service centers.

The Assignment of Cases to Care Management Agencies

The Intake Specialist will notify the Care Center Manager of a new referral. The BFP Care Center Managers will review background data obtained at the time of referral to determine whether one CMA has had prior contact with a child, a sibling of a child, or the child has special needs where one agency has expertise.

If no other mitigating circumstances exist, cases will be assigned to CMAs on a rotational basis.

The Care Center Manager sends a copy of the intake and referral packet to the receiving CMA's assigned contact. At the time of referral, the Care Center Manager and the CMA staff establish the timeframe for initial contact with the child and family by the assigned Care Manager. The CMA is responsible for entering the CM assigned to the case into the (FSFN) client record within 12 hours of accepting a referral.

The Intake Specialist is responsible for forwarding case information regarding the new referral for subsequent scheduling of the Team Staffing.

Each of the CMAs will have the same number of FTEs (Care Managers, Supervisors, and Family Support Staff). The staffing for each CMA at each service center is depicted in the Care Center charts in the Appendices.

Exhibit 20: Summary of Case Management Agency Staffing

CMA	Supervisors	Care Managers	Family Support	Total
CHS	5	25	5	**35**
Devereux	5	25	5	**35**

Responsibilities of the Care Managers

Regardless of the Care Management Agency, the roles and responsibilities of Care Managers are the same and include the following:

Initial case supervision when a child is placed in shelter status requires the Care Manager to:

- Coordinate identified services and supports in concert with Care Coordinator and intake.
- Conduct diligent search for a missing parent and explore relative placements.
- Notify CLS if an out-of-state placement appears possible so a request for an order of compliance can be made.
- Keep the parent/guardian informed of the case status.
- Arrange for family visitation as determined by the court.
- Visit the child and family once per week (minimum).
- Determine the need for ongoing service intervention and the convening of a Family Care Team.

In the pre-disposition phase, case management duties include:

- Accomplishing remaining steps in the initial assessment of safety/risk, including fact-finding, notification of state attorney, law enforcement, and the Human Rights Advocacy Committee, as indicated.

- Scheduling the Wraparound Family Team meeting with the Care Coordinator and attending the Family Team meeting, if indicated.
- Collecting all assessment information from any records and working to secure assessments, as needed.
- Developing and coordinating a case plan that is based on identified strengths and needs.
- Keeping the PI informed about any information which is provided by the child, parents, relatives who would be relevant to the court, including family cooperation, follow through on service referrals, the conditions of the home and interfamilial relationships.

The ongoing responsibilities of Care Managers throughout the time the case is opened will be the same across CMAs and will include but are not limited to:

- Requesting a Wraparound Family Team meeting when determined necessary
- Facilitating follow-up assessments with BFP assessment unit, as needed.
- Developing and periodically reviewing the Case Plan with the Family Team Request to convene the Family Team when the current plan is insufficient.
- Working with the BFP Care Coordinators to access services from the network and identify community supports.
- Providing coordination with any other public sector caseworkers and with the courts.
- Working with CLS to prepare court-related documents.
- Managing and monitoring progress on safety, permanency, and well-being goals
- Preparing discharge plans and handling case closure
- Coordinating with providers of health and behavioral health care services.
- Participating in BFP Permanency Planning review meetings.
- Having regular contact with the child and family and ensuring visitation as defined in the case plan and consistent with BFP standards.
- Entering and maintaining up to date case activity in FSFN.

Guiding Principles

Case managers should have specific performance standards and their compliance with such should be evaluated annually.

Source: TIP and the Leadership Roundtable

4.3 New Approaches and Added Supports

The BFP approach to care management is designed to achieve: 1) continuity in Care Managers; 2) cohesive teams; 3) enhanced opportunities for supervision; 4) access to resource specialists; 5) basic tools to make the work manageable; 6) and training that builds needed skills and competencies. Each of these areas is briefly described:

1. Continuity in Care Managers

Changes in Care Managers disrupt relationships for children who can ill-afford the time it takes to re-establish trust. Children in child welfare have already experienced the pain of abuse, neglect, and severed relationships; they should not have to face losing a consistent source of support after they enter the system. With every transfer the potential also exists for vital information to be lost along the way, for court deadlines to be missed and for “stories” to have to be re-told by vulnerable children and their families. Progress towards the end goals of safety, permanency, and well-being may be delayed.

BFP is committed to the concept of a single Care Manager who maintains a manageable caseload and is, therefore, able to establish a meaningful relationship with the child and be the single and continuous point of contact for the child and family from entry until exit from services. Statewide surveys indicate that care managers in the BFP system of care are among the highest paid, and have the lowest average caseload size. BFP system Care Manager turnover is also the lowest in the State of Florida.

2. Enhanced supervision

It has been consistently reported that too much of the supervisor’s time is spent reviewing process deadlines and responding to crises, leaving too little time for supervision that can help Care Managers improve practices and become more effective in working with families toward safety, permanency, and well-being goals. Supervisors also lack basic, standardized tools to help them conduct a thorough case review.

While supervision is provided by the CMAs and not BFP, the standards for supervision are incorporated into the CMA contracts to ensure adequate and appropriate supervision occurs. Each child is required to have a supervisory review of their case at a minimum of once every 90 days. BFP has provided supervising for Excellence Training at no cost to staff at our contracted CMA’s.

3. Access to resource specialists

In addition to clerical support and team support, Care Managers also have access to resource specialists. Even with lower caseloads that meet national standards, Care Managers cannot be expected to have all the knowledge and skills needed to identify and respond to all of the complex needs of all children and families. BFP has utilized a number of different types of resource specialists who are able to support Care Managers on a case-by-case basis and attend Wraparound Family Team meetings when requested. The specialists include BFP staff, as well as individuals with special expertise from the community who serve as consultants on special cases. The Care Coordinator and is the gate-

keeper of all requests for access to resource specialists. This will allow prioritization of support, tracking of level of support utilized and requested, and attendance at Wraparound Family Team meetings.

Our goal is to have access to specialists with expertise in a number of critical areas, including:

Certified Behavioral Analyst (CBA)**-** BFP has a CBA located at the BFP Administrative office site. A significant number of children have mental health problems or significant conduct and behavior disorders that can present unique challenges for caregivers. Care Managers sometimes struggle in making determinations about whether these children can be safely maintained in their own homes or in relative or foster care homes while their behavioral health issues are being addressed. The CBA is available to help the Care Managers in reviewing behavioral health screens and assessment information to determine the services and supports that the child needs to safely stay in a home setting. In addition, the CBA serves as coaches for caregivers—helping them to develop and implement behavior management plans to care for children with challenging behaviors, including chronic elopement.

Targeted Case Managers (TCM)**-** Children meeting criteria can be assigned a Targeted Case Manager. The TCMs have been allocated space at each Care Center. When it becomes apparent through the assessment that the child needs TCM and is eligible, the TCM will support the Care Manager and participate in case reviews as a member of the team.

Adoption Support**-** When termination of parental rights has occurred, the Care Managers requests the secondary assignment of an Adoption Support Coordinator though the BFP Adoptions Program Manager. An Adoption Support Coordinator is assigned for completion of adoption specific activities and the Care Manager still retains primary responsibility for case management. Based on our strong belief in the importance of a single care management model, this approach to contracting for adoption support is the most appropriate.

The majority of children available for adoption are actually adopted by their current foster parents. The Adoption Support Coordinator has the responsibility of managing the court-related activities and ensuring the case moves to finalization within the timeframes specified in the contract. This includes the efforts to finalize the permanency goal of adoption through matching events, child specific recruitment, enrollment on the Adoption Exchange System, assisting with the child's Heart Gallery production activities. and preparing an updated Child Study for each available child. Quarterly staffings are conducted to ensure adoption efforts. The assessment of the prospective caregiver through process of completing a home study including any training and family assessment activities are be completed. This also includes home visits and the background screening process.

For some children with TPR as a goal, there may be no readily identifiable resources. In those cases, BFP Adoption Recruiters will be responsible for recruiting prospective parents, MAPP training, and conducting home studies, of families that have completed adopt only MAPP. The Adoption Support

Coordinator will also attend any other related meetings, specific to the child available for adoption, and be a part of the CM team while the primary CM might continue to support the child until movement to the adoptive home or at the time of finalization.

Court Liaison: Given the critical importance of working effectively with the court system (and the recent funding reductions to support the "model" court), BFP employs a full time Court Liaison to work directly with case management agency and other designated court staff on scheduling, tracking of Judicial Reviews and other hearings, problem-solving whenever issues emerge, interfacing with the Dependency and Delinquency Judge and completing on site drug testing with instantaneous results. The Liaison will also be a resource to the PI's and CMAs in helping to prepare or review court documents.

Mobile Response**:** As previously described, BFP has subcontracted with Devereux to provide a team of Masters Level Therapist to provide crisis intervention to prevent an initial removal or to stabilize an existing placement, through purchase of service agreements. For open cases that are at risk, the CM contacts the BFP Intake Specialist to arrange for immediate on-site support from one of the BFP's mobile response subcontractors.

Caregiver Liaison: BFP employs a full time Caregiver Liaison to support out of home caregivers including relatives, non relatives, foster parents and adoptive parents. The Caregiver Liaison leads the Children's Collaboration Committee and works closely with the Foster Parent Association and Child Placing Agencies for support and advocacy.

5. Basic tools to make the work manageable

BFP has ensured that Care Managers and Care Centers are adequately equipped with:

- Voicemail
- Adequate fax machines, printers, and copiers to eliminate "wait time"
- Cell phones
- Computers
- Access to user-friendly client management systems and real-time online provider directories.

Guiding Principles
Recruitment, training, and retention of qualified competent case managers must be a priority for the child welfare system of care.

Source: TIP and the Leadership Roundtable

6. Training to ensure the knowledge, skills, competencies to succeed

Experienced workers often report that current training is repetitious, out-of-date, and/or irrelevant. Inexperienced staff sometimes report that what is taught is not related to or reinforced by actual practice.

The BFP approach to training transmits the values of the system and builds the competencies necessary to engage in family-centered practice that focuses on safety, permanency, and well-being. BFP trains all Child Welfare Pre-Service to Care Managers and Protective Investigators. BFP also completes all certification

oversight for PI's and Care Managers to become certified Child Protection Professionals.

BFP also trains Supervising for Excellence, Motivational Interviewing, and other trainings identified as necessary through Quality Assurance activities.

4.4 Standards for CMAs

BFP ensures that Care Managers respond to children and families in a timely manner and that they maintain frequent and meaningful contact with the child and family throughout the time the case is open. In addition, Care Managers will be required to achieve mandated tasks within established timeframes. The response time for the Care Managers to make contact with the child and family will vary depending on initial assessment of risk and service or placement needs.

Normal response requires contact with the family within twenty-four (24) hours:

If an immediate crisis follow-up or placement is not necessary, the care management agency will assign a Care Manager who will establish an initial contact with the family within 24 hours of assignment at the team staffing.

Ongoing Contact with the Family-

The care management agency will ensure that Care Managers see each child and family as often as necessary to carry out the case plan and at a minimum each child will be seen in their location once every 30 days.. Care Managers are also responsible for visiting with caregivers who have had children removed monthly in an effort to continually engage the families in meeting the goals of the case plan. .

4.5 The BFP Approach to Utilization Management

For each child in out-of-home care placement or receiving protective services, the appropriateness of the placement and services are not only reviewed by the FTC and the Permanency Planning Review teams, they are also reviewed internally through the BFP 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, as described below.

For each child requiring an out-of-home placement in a Specialized Therapeutic level of care, pre-authorization must be obtained by the Substance Abuse and Mental Health Program Office or through the Child Welfare Pre-paid Mental Health Plan (CWPMHP) by the BFP Utilization Management (UM) Program Manager. Medical Necessity Criteria must be established in order to access this level of care. This is completed through review at the Clinical Review Staffing. Once MNC is established a review with a Magellan Care Manager is completed and the Utilization Program Manager enters the information into the BFP Magellan database.

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. The core team members that participate in the Clinical Review Process include the BFP Utilization Program Manager, BFP Intake Specialist, Substance Abuse and Mental Health (SAMH) Representative, Independent Living Specialist, School Board Representative, BFP Consulting Psychologist and corresponding Targeted Case Manager, Therapist and Child Welfare Care Manager. Clinical Reviews are held weekly. Requests for Clinical Review staffings are submitted to the UM Program Manager.

The BFP Care Coordinators will authorize services requested by the Care Managers and as determined by the Wraparound Family Team consistent with the needs of the family and case plan. The BFP Intake Specialists will ensure consistent implementation of placement protocols and service guidelines to ensure that children are placed appropriately and that settings and services match identified needs. The Care Coordinators will input data into the UM system that will support utilization review, including: tracking authorizations, services delivered, and reconciling and paying claims for services delivered by network providers. Network providers will be required to have authorization from BFP in order to receive reimbursement for claims submitted for the delivery of services to children and families.

The utilization review process involves ongoing communication and teamwork between and among the internal UR staff, the care managers, the FTC, and network 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;
- Unavailable through alternative sources;
- Be least restrictive placement possible;
- Must fall within approved protocols and pathways;
- Must be family-focused, if possible, and allow for families to express their voice and choice with providers of services; and,
- Tailored and responsive to the changing needs of children families
- Must be community-based and as close to home as possible.

The Authorization/Payment Process

The authority and responsibility to authorize a service rests with the Care coordinators and ultimately the leadership of BFP. The authorization process varies depending on how the service need is identified.

Resolving Differences

If the Care Manager and the Family Team request services that are not initially authorized by the Care Coordinator, every effort will be made to revise the plans to fall within prescribed guidelines. When agreement cannot be reached with the Care Manager, the BFP Director of Utilization Management/ Wraparound will review the request. If the Director is uncertain, the Chief Compliance and Utilization Officer will have final authority. BFP will track and report on a monthly basis all cases that fell outside UR guidelines and the decisions that were made.

Types of Reviews

Concurrent utilization reviews

In addition to the monitoring that occurs in the Wraparound Family Team and by the Care Manager and supervisor, BFP will use concurrent reviews to monitor the provision of services by the network. The frequency of concurrent reviews will be determined by the placement, the cost of the placement, and the payment rate.

Given the unique pattern of service use in Brevard, UR will serve not as a mechanism to restrict care, but rather as another vehicle for monitoring the appropriateness of care. UR will help to ensure that children get the services they need, when they need them, in the right amount—no more and no less.

Retrospective Utilization Review

An aggregate retrospective UR will occur every six months to look at the effectiveness of services used by different groups of children and families and to recommend changes based on findings. The BFP Director of Quality Management and Care 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 reflect the child's and family's condition at time of discharge.
- Discharge summary reflects adequate aftercare support, as necessary.

The BFP senior management team will be responsible for reviewing utilization review functions at monthly meetings. The team will review utilization data to

identify problems and recommend and implement changes in program policies, professional staff practices and/or staff development programs as indicated by analysis of review findings.

Exhibit 22: Components of the 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 Specialists at time of initial referral and by Care 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 or high utilization patterns	**Re-authorization** – Level of care and step down reviews/staffing with Care 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 and have adequate documentation? **Quality of Care Reviews** –Were services provided appropriate? **Best Practice Reviews** – What were the results of the interventions?

Integrated Utilization Management

Utilization management is the foundation of the service delivery system at BFP. 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 Staff are tracked and monitored by the Director of Operations daily to ensure that appropriate services are in place. At Team Staffings, the Care Center Manager will include the Care Coordinator, if crisis services were initiated. The team will review the services engaged by the CPI for on-going authorization. The Family Team Conference will review the appropriateness and effectiveness of services being delivered during the ongoing Family Team Conferences. The appropriateness and effectiveness of services will also be reviewed as part of the Quarterly Supervisor Case Record Review and CWIQA Peer Reviews. The following questions will be addressee 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?

Every month, the BFP Management will review the operation 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 is a problem with the funding mix available to serve the population. The BFP Management will continuously monitor these processes to ensure that the intended results are achieved.

Utilization Management is the hallmark of the BFP System of Care. It ensures that all services are appropriate and meet the ongoing needs and preference of our families. In addition to a mechanism for authorizing and managing services, it creates a process for continuous review and monitoring of services being provided in order to ensure that families are receiving and continue to receive quality services in a timely fashion.

4.6 QA Related to Case Management and Utilization Review

Case Management Monitoring

BFP is working with DCF and its CMAs to review 100 cases per year using a standardized QA review tool.

Among the data that monitored related to case management are the following:

- Percent of Children receiving Medical and dental services within the time frame specified
- Percent of cases where Care Manager contact with family occurred in required timeframe and frequency
- Percent of cases where child contact occurred as required by standards
- Percent of relevant services identified in the case plan
- Percent of services identified that were implemented;
- Percent of children who have regular visits with their parents when placed in out of home care.
- Percent of children who have regular sibling visits when separated in out of home care.
- Documentation of supervisory review of cases, and that the care manager followed up on the recommendations of the review.

Monitoring the Utilization Review Results

The goals are to reduce inappropriate placements, ensure appropriateness of placements, reduce length of stay, and support permanency, safety, and well-being goal attainment. A number of indicators will be examined on an ongoing basis to determine whether the UR processes are working as intended. Among the data to be reviewed are:

- Number of children in inappropriate placements as identified in the CAFAS
- Overall reduction in length of stay
- Reduction in recidivism/re-entry
- Time and success rate in achieving permanency
- Placement stability of children in out of home care
- Parent/Caregiver involvement in FTC.

Section 5 Family Engagement

In principle and in federal regulation, family-centered practice is the core strategy for building effective and ethical child welfare practice. BFP believes that:

- Families should participate as full partners in all stages of the decision-making and treatment planning processes for their child(ren).
- Family members should be able to access the services they need through family-focused service interventions.
- At the system level, families and their informal and community support network should be included in planning, implementing, and evaluating the system of care.

Guiding Principle

Family relationships should be emphasized, supported and maintained throughout the life of the case. All children should be placed in the least restrictive setting and all siblings should be placed together whenever placement in substitute care is necessary. Family visitations should take place on a frequent and consistent basis.

Source: TIP and Leadership Roundtable

In short, BFP has placed great emphasis upon creating a system of care that is family centered and strength based with much of the focus on engaging, including and supporting families—whether they are birth, relative, foster, or adoptive families. This section describes our approach and includes:

- An overview of features of the system of care that are evidence of a family-centered case practice model
- A description our approach to wraparound family team meetings,
- The Individualized Case Plan
- Monitoring our approach

5.1 Family-Centered Practice

Family-centered practice is more than just engaging the parents in the development of the child's case plan; it also entails focusing on meeting the identified needs of the parents and linking families more effectively with the supports and community resources that will sustain them upon exiting the system. The willingness to reach out and engage families is a fundamental element of BFP system of care.

There are a number of features, some previously described, that characterize our approach to family-centered practice:

Substantial Change

BFP has built a unique Prevention Program, Brevard C.A.R.E.S. that makes every service available to families in dependency available to families receiving Prevention Services.

- A Wraparound approach to care planning, and service delivery- The Wraparound process reflects an unconditional commitment to create services and supports "that are customized, flexible and meet the unique needs of the family" with a focus on achieving positive and effective partnerships that flexibly access resources to wrap services and supports around identified needs.
- Aggressive outreach to engage, include and connect families and keep them connected- BFP has developed strict standards for the case management agencies (exceeding state requirements) to follow in initiating contact with families, in scheduling and attending the initial Wraparound Family Team meeting, in ongoing face-to-face contact throughout the time the case is opened, and in tracking and reporting efforts to re-engage those families who may fail to consistently follow-through with appointments or visitation.
- Frequent and meaningful visitation- BFP continues to ensure that children have frequent opportunities to visit with family members and that visitation is used as a tool to enhance reunification and permanency planning efforts.
- A focus on meeting the identified service needs not only of the child but also of the parents. Care Managers are able to assist parents in accessing an array of services to meet their identified needs—including substance abuse and mental health services. An array of therapeutic and non-therapeutic services and supports will be available through the formal and informal BFP network, including the faith community..
- Engaging fathers in new ways- An overlooked resource for far too many children in care are fathers. Family-centered practice can often look more like “mother involvement.” Addressing father and male involvement is not an easy task. BFP has reached out to national organizations for help in creating innovative approaches to father engagement including the Father Finders program.
- Special attention to family-involvement in working with young children- BFP has provided funding to Healthy Families and Healthy Start to ensure that early childhood development issues are at the forefront of practice when young children enter the system. Beginning in May of 2009 Healthy Start staff will be co located at the Care Centers to assist care managers help to ensure that developmental and attachment needs are met.
- Supports for Relative and Non-relative Caregivers— the BFP Caregiver Liaison reaches out to Relative and non-relative caregivers to ensure that they have the supports they need to care for the children and actively participate in the case planning process. BFP staff also organizes and facilitate peer support groups, and help relative and non-relative caregivers access economic and non-economic supports, and a host of non-traditional community resources.

Family involvement is not limited to the case level. BFP has engaged families throughout the system, including soliciting their input in the Strategic plan, and in the activities completed by the Center for Community Leadership. .

5.2 Wraparound Family Teams

In the BFP system of care children, parents, and other primary caregivers are actively involved in all aspects of case planning and implementation to the degree that they are able and willing and to the extent permitted by the orders of the court and the parent's legal counsel.

BFP has implemented the wraparound family team,[12] shared decision-making process, to assess family strengths and service needs and develop individualized Care Plans. Families, along with their kinship network, are offered full opportunity to be involved as partners in the wraparound family team process so that the resources and strengths of the family and its culture are at the forefront of planning. The family's understanding incorporates a historical perspective of the problems, as well as their efforts to remedy those problems.

This approach helps the family, their relatives, and other kin take ownership of the family's needs, bring their own resources to address those needs, reduce the likelihood of child placement outside the kinship network, and provide a system of oversight to the family's progress in the resolution of their issues.

Guiding Principle

There will be an individualized case and care plan for each child and family receiving services in the BFP System of Care.

In addition some families will also benefit from the development of a customized family team.

A wraparound model is utilized in the development and on-going review of the care planning process to direct and insure the appropriate course of intervention throughout the life of the case.

Parties involved in the family team planning process throughout the case should include but not be limited to: the child, caseworker, family, extended family, friends or neighbors, substitute care takers – foster parents, relatives or non-relatives, service providers, guardian ad litem, and attorneys.

Wraparound Family Team Meetings

BFP has built upon the foundations of Wraparound to create and design its Family Team process. BFP and its CMAs routinely use the Wraparound approach in planning through the use of Wraparound Family Teams. Team meetings are designed to provide assessment of child and family strengths and needs, case planning (including concurrent planning), utilization management, permanency reviews, and the periodic reviews of all sections of the Case Plan. The specific purpose of the family team planning process is to:

1. Help the family identify natural supports and resources and ensure they become part of the team,
2. Clarify with the family the reasons for involvement;

[12] There are dozens of models across the country that use some form of shared decision making and family conferencing in case planning. One task during transition is to evaluate the costs and benefits of varying models and finalize the BFP approach to family conferencing.

3. Focus on the safety and permanency needs of the child;
4. Involve the family in identifying strengths and needs;
5. Authorize and reauthorize services to match the needs of the child and family;
6. Coordinate care and clarify roles;
7. Create on comprehensive integrated plan of care
8. Prevent duplication of services;
9. Clarify expectations for behavioral change with all persons involved; and
10. Acknowledge and build upon the success and commitment to their child; and
11. Transition plan.

The composition of the Family Team ensures that the assessment and Care Plan is individualized to the family's needs. Members of the team may include: family members (including the child, if age appropriate), PI, GALs, Care Manager (and other clinical staff as needed), network provider, caregiver, and any others designated by the family such as teachers, therapists, neighborhood resources. Extended family members, employers, coaches, clergy may also be included at the family's request. Attorney(s) may be present as observers. With coordination provided by the Care Coordinator in concert with the Care Manager, the team will assess strengths, needs, risks, and develop a Care Plan specific to that child's/ family. When parents are unable or unwilling to participate, they are encouraged to share their perspective through alternate means and/or identify relatives, kin or someone of their choosing who can participate in their place.

For children in out-of-home care, foster care agencies are required to support the direct caregivers to enable them to actively participate in the Wraparound Family Team meetings for children in their care to ensure that they are partners in developing and implementing the plan. Caregiver supports may include transportation or help with babysitting/respite for other children in the home. All residential/group care providers are required to attend Wraparound Family Team meetings for the children in their care.

Wraparound Family Team meetings are intended to be scheduled to accommodate the needs of the family ensuring transportation and childcare are available when necessary. Meetings are sensitive to the needs of all participants to ensure the most efficient use of all parties' time. When feasible, Family Team meetings can be integrated into other forums such as School IEP meetings, residential treatment reviews, etc. At a minimum, the Wraparound Family Team meeting will be re-convened every 90 days to evaluate the progress of the child under the Case Plan/Care Plan and to modify, as needed, the services and supports being provided to the child and family.

The Family Team is charged with identifying the families strengths and vision statement, pooling resources including knowledge and expertise, creativity, offering solutions, and proactively seeking services and natural community resources for the child and family that will be included in the care plan to help to resolve problems that resulted in the abuse or neglect complaint. These services

can include: material and financial assistance, mental health, medical assistance, disability assistance, educational advocacy, and substance abuse treatment.

Should the parents or child require services not offered by the BFP network, a referral will be made to the appropriate community service provider or resource. BFP will ensure that the service is provided in a timely manner, even if it means directly providing the service or assisting in funding the service until other resources can be identified and used.

The sharing of information in Family Team meetings is allowable under Florida laws regulating the disclosure of confidential information. However, a confidentiality statement will be signed by all participants in the initial Family Team meeting to ensure that shared confidential information will not be disclosed outside of the meeting.

At each subsequent Family Team (UR) meeting, the progress in reaching the permanency goal and meeting other therapeutic care plan goals will be discussed. In the development of the initial plan and throughout the time the child and family receive services, the Care Manager will be working to set attainable, measurable objectives that are directed towards meeting the safety, permanency, and well-being goals. Discharge planning begins at the first Family Team meeting and aftercare planning is a critical readiness step that precedes discharge.

Whenever a family is reunified by the court after an out of home episode the care manager is required to request a reunification Family Team meeting to address the need for services to maintain the children in the home upon reunification.

Finding Support for Facilitation of the Wraparound Family Team Meeting

Most Care Managers who are trained in Wraparound embrace the concept and recognize the potential benefits. Care Managers will be required to complete phase I of wraparound training as delivered by BFP training staff. Promising results are being achieved with this model and we are committed to finding the resources needed to continue to build on this practice in Brevard.

BFP recognizes that not all Care Managers in Brevard have yet been trained on family team models or fully understand how the Family Teams need to be organized and supported. BFP will utilize the Wraparound Training, trained community and provider representatives, Care Coordinators, Wraparound Consultants and BFP Sr. Staff to ensure that all Care Managers and Supervisors receive training on Wraparound consistent with the BFP system of care.

5.3 Individualized Case Plans

Our case plan will be an individualized, strength-based description of the approach that will be taken to meet all ASFA mandates, addressing the unique needs of children and their families as identified through assessments.

The CFSR and other state reviews have found that parents and children were not consistently involved in developing their case plans and plans were not individualized to child and family needs based on assessment results.

In the BFP system, every child and family has an individualized case plan that accurately describes strengths, needs, and services to be provided to ensure safety, well-being, and permanency for the child within established federal and state mandates. The Case Plan guides all services through case closure and aftercare services.

All case plans describe the family situation, the permanency goal, desired outcomes, tasks and activities, time frames and consequences, and supports and services indicated for the family and for the child to meet all three ASFA mandates. When concurrent planning is indicated, the alternate (concurrent) plan for permanence will be described. Tasks for all parties will be clearly identified with outcomes and time frames. Outcome statements are written in behavioral, measurable language.

All case plans are created and signed by members of the Family, Care Manager, and other members of the Care Team as appropriate. The case plan is formulated and written in the family's primary language. When multiple agencies share responsibility for service provision, the case plan clearly defines responsibility and timelines to insure that service gaps do not occur as a result of shared planning. The Case Plan is implemented for all families (PS) in need of ongoing services whether or not the child is removed from the home.

After the case plans are developed and signed the service authorization will be requested by the Care Manager from the Care Coordinator.

5.4 Monitoring Results

Wraparound Family Team Meetings

- Percent of cases where families are engaged in wraparound.
- Percent of cases where family identified at least one natural support at the conclusion of the family team process.
- Percent of informal supports represented on the family team
- Satisfaction rating of team members regarding the process and outcome

As we build upon fidelity to the wraparound model, the implementation of a wraparound fidelity questionnaire will be used at each family team meeting to ascertain areas of needed improvement. This tool will enable BFP to strengthen and target the aspects of training needed and determine whether case outcomes are tied to lack of fidelity. Research indicates; "where family's have access to service, voice in the planning process and ownership of their plan, outcomes greatly improve."

Section 6 The Courts & Permanency Planning

Child welfare is a system of legal procedures designed to protect the rights of the dependent child as defined by federal and state statutes and regulations. This section includes:

- A description of the legal system in Brevard
- The BFP approach to permanency planning that includes a renewed emphasis on concurrent planning and reviews.
- Monitoring the effectiveness of our permanency efforts

Guiding Principle

The safety, well-being and permanency of the child's living arrangement and the continuity of relationships for the child must be the primary goals of the service delivery system (F.S. Chapter 39).

Source: TIP and Leadership Roundtable

6.1 The "Model" Dependency Court (18th Judicial District)

In 2001, the legislature funded model courts in 7 districts, including Brevard. State funding was lost in 2003 but picked up by the Brevard County Commissioners through October 2009. The Model Court is comprised of a Judge, General Master and two case managers. Together they are responsible for the following:

The Judge manages:

- Shelter hearings,
- Dependency Trials
- TPR hearings
- Judicial Reviews, with a special focus on the most problematic cases, those with sexual abuse or physical abuse of children under 7 years old
- Residential Treatment hearings
- Permanency Hearings

The General Master manages the flow of:

- Arraignments
- Dispositions
- JRs
- Case Plan Acceptance hearings
- Status and Motion Hearings
- CINS/FINS cases

The court case managers are responsible for:

- Explaining the court process to parents at the shelter hearing and providing them dates for arraignment, case plan conference or mediation, Judicial reviews (within 180 days) and Permanency Hearings (within 1 year)

- Prioritizing cases for trial and providing liaison for Court with DCF, providers, GAL, children/families
- Compiling statistical data and daily court information, attending all GM hearings, identifying problems with case plans, monitoring length of stay, especially for children in out of home care for 15 months or longer, and those in residential care.

Courts have a unique perspective in on the system and on child and family problems that threaten child safety and permanency. As a result of the Model Court the average number of months a child's case was open dropped from 28 months to 7 months. The Court also identified keys to reaching permanency within one year that were related to a number of factors, including:

- Close monitoring by the Judge
- Meaningful case plans with clear tasks
- Timely petition filing
- Permanency Hearings
- Dependency/TPR trails held with deliberate speed

A number of conditions have been associated with difficulties reaching or maintaining permanency, including:

- Parental drug addiction
- Physical injuries to a child
- Stakeholders not "knowing" the case
- Lack of housing
- Mental health issues in the parent and/or child
- Domestic violence

BFP strongly supports and will advocate for funding to continue the work of the model court project. However, regardless the court's future funding or staffing it will be the responsibility of BFP to remove barriers and address issues within its control that jeopardize effective court processes. Among other things, we must ensure that:

- Staff turnover is handled in a way that minimizes delays in legal actions;
- Care Managers work effectively with court staff to ensure compliance with statutory timeframes and adherence to court orders;
- Families (including foster families) are kept informed at all stages and engaged in the legal process; and,
- Permanency planning with families results in case plans that are solid legal plans.

The BFP Court Liaison position was specifically created to ensure that BFP and its partners maintain effective working relationships with court staff and meet all

required legal deadlines to ensure safety, permanency and well-being for children.

The remainder of this section related to permanency planning.

6.2 The BFP Approach to Permanency

Staff Accountability

The responsibility for achieving permanency in the timeframes required by law is shared by BFP staff and the CMAs. Direct responsibility for scheduling and convening the Wraparound Family Team meeting is that of the Care Coordinator. The Care Coordinator oversees the team process and the Care Manager oversees the daily needs of the child. It is the responsibility of the Care Manager and his or her supervisor to develop the case plan. In summary the permanency-related responsibilities of the Care Managers are to:

- Participate in the initial preparation and schedule follow-up for family team conferences
- Review shelter orders for assigned cases to ensure follow through on court ordered tasks
- Complete child resource record healthcare information and establish CRR notebook for assigned children in a removal episode.
- Assist with all identified service referrals needed initially and ongoing, e.g., ICCP requests, SIPP referrals, diligent searches, requests for clinical review, etc.
- Document information obtained regarding parents' functioning and participation in services in FSFN.
- Track critical milestones in assigned cases regarding service provision, client participation, judicial reviews and status conferences, and receipt of requested information.

In the BFP system, the Care Coordinators and other Quality and Utilization Management staff also play a role in monitoring and reviewing performance and periodically following up on cases to ensure no barriers have developed that will delay permanency.

An Emphasis on Concurrent Planning

Concurrent planning is a tool that helps meet the requirements of Public Law 96-272 (Adoption Assistance and Child Welfare Act of 1980) and Public Law 105-89 (Adoption and Safe Families Act of 1997). Florida law requires a permanency planning court hearing at least within 12 months of placement to achieve a safe, permanent home for a child in foster care within a reasonable period of time. Through concurrent planning, BFP is prepared to make recommendations about permanency options in a timelier manner. BFP and its care management partners will not wait until the 11th hour when the primary option fails to begin building an alternate plan.

BFP ensures that concurrent planning is practiced by all CMAs. Concurrent planning is a process of working towards a primary permanent plan, such as family reunification, while developing at least one alternative permanency plan at the same time. It is a case management method effective in reducing the length of time a child spends in foster care placement.

The benefits of concurrent permanency planning include the following:

- Reduces length of time children spend in foster care
- Supports developmental needs for continuity and stability in family relationships
- Involves parents and family members early on in case planning and can decrease adversarial relationship between birth families, foster families, and Care Managers
- Can turn a crisis into an opportunity for change and growth
- Can lead to increased safe and early reunification, as well as voluntary relinquishments, rather than adversarial TPR hearings and appeals
- Identifies potential permanency resources from the start of involvement with the family
- Reduces likelihood of adoption disruptions because children are adopted at younger age, often within their own communities or extended family network
- Facilitates recruitment of families interested in the possibility of making a long-term commitment

Criteria for Concurrent Planning

It is appropriate for the Care Manager and the Family Care Team to use concurrent planning when there is not a clear, singular goal in a given case. In best practice, goals should always ensure a child's speedy move to appropriate permanency. Based upon the nature of the child's abuse or neglect and the unlikelihood of reunification, concurrent planning is appropriate. The following child and family factors indicate a low probability of successful reunification and should be indicators that the Care Managers and Family Team consider concurrent planning (these are consistent with current CFOPs):

1) TPR occurred with another child in the family after services were delivered with no change in the family;
2) The parent has killed or seriously harmed another child through abuse or neglect and no significant change has occurred in the interim;
3) The parent has committed felony assault that results in harm to this child or another child;
4) The parent has repeatedly and with premeditation harmed this child;
5) The parent has been diagnosed with severe mental illness and has not responded to previously delivered mental health services and is non-

compliant with medication that could enable the parent to protect and nurture the child.

6) The parent's only support system and means of support is found in illegal drugs, prostitution, or repeated criminal acts.
7) There have been two or more CPS interventions for separate incidents, indicating a pattern of chronic abuse or severe neglect and the lack of responsiveness of parents on each occasion indicates the chronicity of problems;
8) Other children have been placed in foster care or with relatives for periods of time over six months in duration and the original causal factors are unchanged;
9) Parents are addicted to an illegal drug or alcohol, resistant to treatment, and there is a pattern of abuse or neglect associated with that drug usage;
10) The child has been abandoned or once placed, the parents do not visit the child or participate kin case planning;
11) Patterns of domestic violence between the parent and spouse or significant other of one year or longer, resistance of the parent to leave the situation when services and alternatives are offered, with the strong indication that the domestic violence will continue to pose risks to the child;
12) Parents have long-term criminal history and current incarceration and prolonged sentence places the child at risk or long-term or permanent foster care;
13) Child experienced physical or sexual abuse in infancy;
14) Parent is under the age of 16 with no parenting support system and placement of the child with the parent has failed due to parent's behavior;
15) Preventive measures have failed to keep the child with the parent and the child has experienced abuse or neglect during service provision;
16) Parents have asked to relinquish their child following intervention;
17) The child has suffered multiple types of abuse, with a high risk of long-term placement and non-compliance of parents to support permanency planning or reunification.

6.3 Steps in Concurrent Permanency Planning

<u>Thorough Review of New Foster Care Case</u>

When a child enters foster care, concurrent permanency planning begins with a thorough review of the case as part of the Family Team and between the Care Manager and his/her supervisor. The Care Manager must assure that all team members understand the history of the child and family and of DCF/court involvement with the family.

Care Managers must work closely with CWLS and the court system to achieve positive results for children. Critical questions in reviewing cases and beginning the concurrent planning process include:

- What is the central problem that brought this child into care?
- Who are the non-custodial biological parents and have they been contacted?
- Who are the members of this child's kinship support network?
- Is prior and current involvement with this family well documented?
- Is this child Native American or a member of another minority group, thus requiring identification of ethnically similar foster and potential adoptive homes?

Assessment of Family Strengths and Needs / Development of the Case Plan

The assessment of family strengths and needs includes a reasoned assessment of the probability that the child will return home, based on the family's capacity to benefit from services aimed at reunification. The assessment of family strengths and needs will be a ongoing process throughout the time the case is open. The Case Plan: guides services provided; focuses on the central problem or problems that must be corrected before a child is reunified with the family; and identifies short-term objectives and activities that are clear to the parents as well as to Care Managers and other service providers. Completion of activities and progress or lack of progress toward the plan’s objectives is documented.

Most families whose children enter foster care have the potential to make use of services and to improve the conditions in the home that necessitated their child's removal. Many families have appropriate relatives and other kin to take care of their children when the parents cannot. Some families, however, are so troubled and lacking in support systems that continued intervention is not likely to make a meaningful difference in their quality of parenting. Care Managers must identify early those families in which reunification efforts are not likely to be successful.

Search for Relatives and Kin

The Care Manager also continues the work of the PI in conducting a diligent search for relatives or other members of the kinship network immediately upon receiving a new case. Whether or not relatives were identified earlier in DCF’s history with a family, a Care Manager who is receiving new foster care case or who is receiving a open foster care case is responsible for assuring a thorough and documented search for relatives and kin. This process includes:

- Identifying, locating, and contacting non-custodial, alleged and legal fathers (using child support enforcement data bases or other available information systems and placing legal notices in the newspapers, as needed, to find missing parents);
- Conducting a search for responsible relatives by talking with the family and its support network as well as by talking with others who have worked with the family and reviewing agency records;
- Contacting relatives who may be a support and/or placement resource for the child and family;
- Assessing the suitability of relatives who express willingness to be a resource, assisting as needed to meet approval requirements.

Accomplishment of these steps within the first 30-60 days of placement sets the groundwork for a family-centered, culturally competent concurrent planning process.

Develop Alternative Plan (Concurrent)

Care Managers explore options for permanency with relatives or other kin and with foster parents and conduct early assessments of potential permanent resources for the child. Care Managers also begin building the legal case for termination of parental rights and, if adoption is the alternative permanency plan, begin collecting the required information for the adoption process. The development of the alternative permanency plan will be thoroughly documented in the Case Plan.

Full Disclosure

Concurrent permanency planning requires full disclosure of information with parents. Care Managers must be open and honest with parents and must tell them directly:

- Parental rights and responsibilities;
- What is expected of them to achieve reunification;
- The consequences of their actions or inactions
- What alternative permanency plan is under consideration if they do not meet expectations for reunification.

Discussion of voluntary relinquishment of parental rights is an integral part of the Care Manager's work with parents. Parents need to know all of their alternatives from the beginning if they are truly to be empowered to choose the future that is best for themselves and their children.

Guiding Principle

Each child should receive face-to-face contacts based on their status within the child welfare system continuum of care, in compliance with national standards and guidelines set forth by the Council on Accreditation.

We believe it is essential that each child receive face-to-face contacts in order to promote safety, build trust, and facilitate the child achieving permanency.

Focus on Time Limits and Behaviors

When reunification is the goal, the Case Plan, focuses on activities that are behaviorally specific and time limited. The parent's behavior, therefore, determines the outcomes of the case. Parents are expected to complete activities and they must demonstrate progress toward the objectives of the case plan—which they are centrally involved in establishing. Care Managers must be clear with parents that progress depends on what parents actually do, not what they promise to do. By using time limits, the case moves forward more quickly. Parents are expected to meet objectives of the Case Plan within specified time frames and failure to do so will have consequences. Legal requirements for timely court reviews and Permanency Planning review team meetings are also tools for setting clear time limits and moving the case forward.

<u>Effective Use of Parent-Child Visitation</u>

Parents and children who visit regularly are more likely to be reunified. A critical component of the Case Plan is a visitation plan based on the child's age and developmental level that ensures frequent, regular and meaningful contact. Frequent visitation maintains the parents' and child's attachment to each other and keeps the child foremost in the parents' thoughts and concerns. Parents are more likely to work toward reunification when visiting frequently with the child. Visitation also provides opportunities for the Care Manager to observe whether parents are making progress on the objectives of the Case Plan and improving their parenting skills.

<u>A Good Case Plan is a Good Legal Plan</u>

Throughout the life of the case, the Care Manager will document the parent's level of compliance and progress so that if it is necessary to terminate parental rights, the legal case will be well-prepared and ready for filing at that decision point. A good case plan is a good legal plan, but carrying it out requires the Care Manager and CLS to work closely together.

<u>Continually Evaluating Permanency Options</u>

There are only a few viable permanent plan goals: reunification, assignment of legal custody; guardianship with relatives or other kin, and adoption. These options will all be considered and addressed from the beginning of placement and continuously evaluated.

Florida has the option of Another Planned Permanent Living Arrangement. Except in rare instances when it is clearly in the best interest of the child, this will not be considered a viable option by BFP (or by the Children’s Bureau, HHS). It is true that some youth will leave foster care without ever achieving a permanent family—they simply “age out” of the system before finding a permanent home. As the Care Manager and the Family Care Team develop the primary and alternative permanency goals, they will carefully weigh each option and will revisit the progress toward the primary and alternate goal at each Family Team meeting and in BFP permanency reviews.

6.4 Permanency Reviews

BFP Care Center Managers facilitate ongoing Permanency Reviews on all children in out of home care. In addition to monitoring progress towards goals, services and supports; permanency planning will be the primary focus. Care management agency staff will review and report on cases and assess the progress toward permanency..

The Permanency Planning Review Team (PPRT), convened by the Care Center Manager, will meet periodically to review every case where children are in out of home care. The initial review will occur no later than 120 days after custody or placement and at regular intervals following the first review, no longer than 180 days between reviews. These teams are charged with ensuring that every child in foster care placement achieves permanency within one year.

Permanency Planning Review Teams will be open, non-adversarial forums for focusing on casework practice and planning. The Permanency Planning Review process will allow each party involved to have input into service needs of the child and family; to document progress of the parents in improving the conditions that led to foster care placement; to develop the most appropriate permanent plan; and to ensure that permanency is achieved for every child. The review team process also ensures that the plan that is developed will be followed regardless of changes in staff or providers. In addition, parties with disagreements can address them prior to court hearings, helping each to understand the position of the others, and thus providing the opportunity for informed negotiation.

The Permanency Planning review team provides an unbiased, objective, and thorough review of all elements of a child's permanency plan. Participants who will be invited to the PPRT reviews include (but are not limited to) the following:

- Care Managers
- Providers or foster parents of the case under review
- The child's parent(s), unless parental rights have been terminated;
- The child (age 10 years or over, if appropriate);
- CWLS;
- The Parent's attorney; and
- The Guardian ad Litem

Parents will receive adequate notice of the meetings and they will also be informed that they have the right to present information from their perspective. Every effort will be made to meet at a time and location that enables parental participation, including scheduling evening and/or weekend meetings and/or offering remote linkage through teleconferences. Notification to parents and other required participants will be documented in the case record and signatures of all persons attending the PPRT meeting will be recorded on the Case Plan.

The primary purpose of the Permanency Planning Review Team is to ensure that reasonable efforts to achieve a safe, permanent home for a child are being pursued actively. Specifically, the team shall determine:

- The need for continued custody of the child;
- The need for continued placement of the child;
- The appropriateness of the child's current foster care placement;
- If reunification is the plan, the extent of progress made by the parents toward improving the conditions that caused the child to be removed;
- The barriers or safety issues that prevent reunification from being achieved;
- The services that have been provided to help the family achieve the goals identified in the Case Plan;

- The services that are still needed to help the family achieve the goals identified in the Case Plan;
- The extent of compliance with the Case Plan;
- The most appropriate permanent plan for the child and how to achieve the plan;
- The most appropriate alternative permanent plan for the child; and/or
- The expected date by which the permanent plan will be achieved.

6.5 Monitoring Results

Permanency Indicators—broken down by various demographic factors including age, gender, race/ethnicity—that will be tracked by BFP include but are not limited to the following:

- The average length of stay in out-of-home care for children
- The number of children who were adopted within 6, 12, 18 months of TPR
- The number of children in Out of Home Care over 24 months on July 1 that achieve permanency by the following June 30
- The percent of children adopted within 24 months of initial placement.

BFP wants to ensure that older adolescents leaving out-of-home care are prepared for independence and responsible adulthood. A number of indicators related to preparation for adulthood will be tracked, such as:

- Percent of youth receiving formal assessments of self-sufficiency before discharge.
- Percent of youth with completed education plans.
- Percent of youth with completed normalcy plans.
- Number who are complete High School or GED.
- Number who are attending post secondary or vocational education programs.

Section 7: Assessments

In discussions with key stakeholders and review of the federal Child & Family Service Review (CFSR) findings, BFP has identified a number of concerns about how assessments are conducted and how information is currently being used. For example, the CFSR found that assessments are not always done and when they are done they may not be timely and documentation is often lacking. There were particular problems related to physical, dental, and behavioral health assessments. Perhaps, most troubling is the finding that assessments are not always connected to the services that children receive—children and families tend to get the same services regardless of their assessed needs.

System of Care Principle

Assessment occurs throughout the time a child and family receive services.

Screenings and assessments are conducted by qualified professionals and are appropriate to a child's culture, as well as his/her physical, mental/emotional, and developmental condition.

Assessment information is used to guide case planning and the choice of services and supports from the time the child enters the system until the case is closed.

This section includes a description of:

- BFP's accountability & staffing
- A description of the different types of assessments and the proposed changes
- The linkage between assessments and case plans and services provided
- The QA mechanisms to assess our approach to assessments

7.1 Accountability for Assessment

Assessment is a critical component of the intake process that serves to guide service provision, appropriate placement and level of care to adequately meet the needs of clients according to quantitative data. It establishes a baseline and serves as an outcome measurement tool to monitor progress and movement towards goals.

Assessment begins at initial contact and continues throughout the lifetime of the case. In the BFP system, most of the assessment process will involve the Care Manager, the Family Care Team, in an effort to identify strengths, needs, and resources, as well as factors that contribute to child safety risks.

The Director of Operations; Child and Family Services (who reports to the Chief Operations Officer) is responsible for overseeing the Intake-Assessment-and Placement functions.

After the case is transferred to the CMA, the direct responsibility for ensuring that assessments are completed and that the information is used appropriately shifts to the CM team (the Care Manager and the supervisor), and the BFP Care Coordinator.

The BFP Quality & Fidelity staff are responsible for quality assurance related to case management. For example, the QA staff routinely monitor case records

and determine that the assessments were appropriate, have been performed in a timely manner and that follow services identified by the assessment that are requested by the CM reflect assessed needs. It will be the responsibility of the Care Coordinator to work with the CMA to resolve any identified deficits.

The Care Managers are responsible for tracking and monitoring five principal types of assessments:

1. The functional assessments conducted by the BFP Utilization Reviewers shortly after placement of some children in shelter/foster care
2. Physical and dental health screens, assessments and treatment
3. Behavioral health screens and assessments
4. Developmental and educational screens and assessments as needed
5. Referrals for Independent living assessments

7.2 Types of Assessments

BFP intends for the coordinated approach to assessment to result in a comprehensive, consolidated, individualized Case Plan. The types of assessment activities that are tracked by BFP and used by the in developing the case plan are described below:

1. CAFAS as a tool for placement in licensed care

When a child is referred for placement in out of home care, a CAFAS is completed to identify the child's health, mental health, or behavioral problems; evaluate the child's functional status; and assess child and family strengths in order to identify the best placement. The CAFAS is administered every six months for children in traditional foster care and 90 days for children in leveled care

2. Assessing and treating physical and dental needs:

All children placed in shelter status are required to receive the Child Health Check-Up within 72 hours of placement.

Under the BFP system, the Protective Investigator has primary responsible for ensuring that a Child Health Check-Up (formerly known as the EPSDT) is scheduled within 48 hours of intake/enrollment. At the Transfer Staffing, the health information and any recommended services will be reviewed and, if necessary, additional medical care will be sought. Any health concerns identified through the screen will receive medical attention within seven days unless a more prompt response is indicated. Data from the medical screen and services provided will be part of the child's case record and incorporated in the child's case plan.

3. Comprehensive Behavioral Health Assessments

The comprehensive behavioral health assessment is an in-depth and detailed assessment of the child's emotional, social, behavioral and developmental functioning within the family home, school, and community. A comprehensive

behavioral health assessment must include direct observation of the child in the home, school and community, as well as in the clinical setting.

Who May Receive Services

In order to receive a comprehensive behavioral health assessment, a recipient must be 0-20 years of age and meet the following criteria:

- Be experiencing serious emotional disturbance;
- Be a victim of abuse or neglect; and
- Have been determined by the Department of Children and Families district or regional Child Welfare or Community Based Care provider to require out-of-home care.

Or the child must:

- Have committed acts of juvenile delinquency;
- Be suffering from serious emotional disturbance; and
- Have been adjudicated delinquent and committed to the Department of
- Juvenile Justice; and the court must have ordered a low-risk residential community commitment setting for the child.

Or the child must:

- Be a victim of abuse or neglect; and
- Have been determined by the Department of Children and Families district or regional Child Welfare or Community Based Care provider, to require out-of-home care and be placed in shelter status.

Purpose of the CBHA

The goals of a comprehensive behavioral health assessment are to:

- Provide assessment of areas where no other information exists;
- Update pertinent information not considered to be current;
- Integrate and interpret all existing and new assessment information;
- Provide functional information, including strengths and needs, to the referral source, child and family that will aid in the development of long and short-term, culturally sensitive intervention strategies to enable the child to live and receive his or her education in the most inclusive environment;
- Provide specific information and recommendations to accomplish family preservation, re-unification, or re-entry and permanency planning;
- Provide data to promote the most appropriate out-of-home placement, when necessary; and
- Provide information for development of an effective, individualized, strength based, culturally sensitive, comprehensive services plan and a
- Medicaid community behavioral health services individualized treatment plan, when indicated.

4. Educational & Developmental Assessments

BFP Care Managers review the Child Health check ups to identify infants, toddlers, and young children in need of more comprehensive developmental assessments and/or 0-3 or early childhood services.

For school age children, the Care Manager will request and track educational assessment information from the school and ensure that information is included in the child's case file, and submitted to the CM before the first Family Team meeting.

System of Care Principle

The education and developmental needs of children will be identified and met.

Efforts will be made to maintain school stability whenever possible.

Upcoming Change

BFP is planning to co locate an Education Specialist into the care centers to assist CM when children have special educational or developmental needs and help is needed in accessing appropriate services.

The Care Manager will assume responsibility for addressing any school-related difficulties and whenever possible coordinating Case Plans with any existing education plans. The proposed Education Specialist will be sited at the Care Centers to ensure access to the Care Managers. The Education Specialist will serve to support CMA's, parents, caregivers, students and school staff in ensuring that IEPs are completed and that services identified in the IEP are provided.

5. Independent Living Assessment

Nearly 21 percent of the children in licensed out of home care are adolescents age 16 and older who may age out of the system before attaining permanency. It is critically important that these young people are given the skills and supports they need to transition into adulthood. BFP has contracted Independent Living Services who ensure that written, standardized independent living assessments are conducted for youth in foster care. The assessment determines a child's needs for making the transition from foster care to adulthood. A copy of the assessment will be contained in the youth's case record. Areas that must be assessed are:

- Education;
- Financial literacy
- Vocation/job skills;
- Basic living skills; and
- Personal, social and emotional development.

Another agency serving youth in care and young adults who have exited care is the Connected by 25 Brevard program that works at providing enhanced services to ensure that young adults who have exited the system develop permanent connections in the community.

7.3 Assessments that Result in a Consolidated Case Plan

BFP, through the Care Managers, will coordinate/consolidate all assessment information from all assessments into a single Case Plan. The assessment process will ensure that assessments are used to drive a comprehensive, single, individualized case plans. The case plan will be completed within 21 days of initial contact and reviewed at least quarterly thereafter to re-evaluate service needs and safety issues.

The Care Manager's roles in the assessment process:

The assessment process will be individualized based upon each child's needs but it will generally include the following steps for a Care Manager:

1. A review of the documents provided by the protective investigation and other information such as social and family history, school records, previous psychological or psychiatric evaluations, previous safety and treatment reports, and a description of presenting problems.
2. Direct and collateral interviews, direct observations, collateral reports will be completed as part of the Family Care team.
3. Review of the behavioral health screens and any follow-up clinical or substance abuse assessments.
4. When indicated by screens, formal assessment utilizing a battery of psychological tests may be necessary for some children. These formal assessments will be requested by the Care Manager/Family Team and arranged by the BFP Care Coordinator.
5. Problems identified through the screening and assessment process will be treated using appropriate funds, including Medicaid funds for eligible children.
6. The Care Manager is responsible for collecting, reviewing, and sharing all information from assessments with the Family Care team to ensure that services provided under the Case Plan are directly related to identify needs.
7. Safety planning is built into the initial safety assessment done by the investigator but is also a part of ongoing assessment of the Care Managers. Each contact is an opportunity is assess the ongoing safety and well-being of the child in his/her living environment. Certain reports received by DCF will require a child protection team assessment. Team assessments will follow DCF procedures including those required for sexual abuse reports (CFOP 175-20). All findings from the child protection teams will be forwarded to BFP within 24 hours of completion.

   If the child remains in the home, the Care Manager will upon contact with the family (within 24 hours of Team Staffing) develop and/or review the initial safety plan. Safety plan development and reviews will be reflected in all Care Manager chronological notes. The Care Managers will consult with their Supervisor during ongoing supervision to determine the need for adjustments to the safety plan based on changing family circumstances.

Comprehensive review of safety planning will occur at the FTC. The team will ensure the plan is sufficient, and capable of being executed. When applicable, expertise will be sought in the development of plans.

8. Minimally, the Care Manager will be responsible for the periodic re-assessment of safety/risks, strengths, and needs especially at critical times in the life of the case, including but not limited to
   a) Receipt of the case from the PI
   b) When a visitation plan is being developed;
   c) When requested by CWLS;
   d) When reunification or unsupervised visitation is under consideration;
   e) Prior to case closure (if TPR has not occurred).

7.4 Quality Assurance & Improvement Related to Assessments

There are multiple checks and balances to ensure that assessments are conducted and that the information is used to develop the case plan and access the services required to meet identified needs. On an ongoing basis the CM Supervisors check records as part of the supervision process to ensure that assessments are included and that there is a connection between what is in the assessment and what is in the case plan. Accurate and timely assessments contribute to future improved results. Among the data to be reviewed by CM supervisors:

- The percent of follow-up mental health or substance abuse assessments that were completed within 14 days of the initial request (based upon the screen)
- Percent of cases with medical/dental check up in timeframes required
- Number/Percent of cases with completed educational assessment.
- Number/Percent of children over 16 with independent living assessment.

Section 8: Placement Capacity & New Supports

BFP works closely with the PIs to ensure that reasonable efforts are made to prevent the removal of a child from his/her home. If the child is removed, BFP ensures that the child is placed in the least restrictive, most family like setting available to meet the child's needs. Once placed, BFP and its care management partners ensure that every effort is made to achieve quick reunification and/or permanent placement with minimum disruption to the child's life. As discussed in the previous section, all steps in the placement decision-making process depend on a thorough and ongoing assessment of safety risks and clinical needs of the child.

This section includes a description of:

- The current approach to placements
- BFP accountability for placements
- Assessment of current out-of-home care capacity
- New practices
- Our QA efforts to evaluate the effectiveness of our placement procedures.

8.1 The Current Approach to Placement

The BFP system of care does a good job in keeping the vast majority of children in their own homes or with relatives. There is an ongoing effort to seek relatives, non-relatives, and absent parents as a first placement resource.

8.2 BFP Accountability for Placements

The Director of Operations; Child and Family Services is responsible for overseeing the Intake-and Placement functions. The BFP Intake Specialists, who report to the Utilization Program Manager, have direct responsibility for day-to-day coordination and tracking of all licensed placements.

8.3 Current Placement Capacity

Foster Care

There were just over 200 Brevard County children living in foster care homes on December 31, 2008. 9 children were living in family foster homes outside Brevard County, 14 in group or residential outside of Brevard and 9 children living out of state with licensed relatives.

Eight Brevard children reside in therapeutic foster home, 49 reside in group homes including specialized therapeutic group homes, 2 children reside in a Residential Treatment facility and 1 in an APD home.

There were 17 children in medical foster care, with only one outside of Brevard County. There are a total of 115 children in traditional foster homes.

Group Homes

There are 50 Brevard children in 20 different group homes in Florida in Brevard, Orange, Osceola, Duval and St. John's Counties. Two-thirds (8) of the 12 children in group homes out of county have been in care longer than 12 months.

It is important to note that some of the out of county group homes offer services for targeted populations like developmental issues or substance abuse. These types of services cost more than a regular group home. These services are also not available in Brevard County.

Exhibit 23: Brevard Group Home Capacity/Children

Brevard Group Homes	Capacity	Brevard Children	Location	> 12 Mos.
COUNTRY ACRES	24	13	TITUSVILLE	7
CROSSWINDS	28	0	COCOA	1
HACIENDA GIRLS RANCH	12	5	MELBOURNE	0
THE HAVEN	22	6	SATELLITE BEACH	13
MY REFUGE	24	6	MELBOURNE	2
NEW LIFE GENERATIONS	6	6	PALM BAY	0
ROYAL PRIESTHOOD	6	3	PALM BAY	13
ALTERNATE FAMILY CARE	6	0	MELBOURNE	2

Exhibit 24: Out Of County Group Homes With Brevard Children

GROUP HOMES WITH BREVARD RESIDENTS	Brevard Children	Location	> 12 MOS
COVENANT KID'S MANOR,. INC.	2	ORLANDO	0
ECKERD WILDERNESS	1	FLORAL CITY	2
GIRLS & BOYS TOWN OF CENTRAL FLA, INC	1	OVIEDO	2
THE GROVE COUNSELING CENTER	1	WINTER SPRINGS	0
ST. AUGUSTINE YOUTH SERVICES	1	SAINT AUGUSTINE	0

Residential Treatment Centers

There are two (2) children residing in residential treatment centers (RTC). Both children are funded through Sub acute Inpatient Partial Hospitalization Program (SIPP).

Out of County/State Children in Brevard Placements

There are approximately 97 children residing in Brevard county in which jurisdiction is outside of Brevard County.

Brevard County currently provides open ongoing services for other states to 16 children from 10 families. Three of the children, from 2 families, were living with one parent, 2 children from one family are placed in an adoptive home, 8 children from 5 families are placed with relatives and 3 children from 2 families are placed in Florida w/ licensed relatives.

Summary Assessment of Licensed Placement Capacity

The length of stay data indicates that children placed away from their home community remain in care for longer periods of time than children placed in Brevard. With that in mind, it was important to analyze the licensed capacity of

each type of out of home care to determine whether there is adequate capacity to allow Brevard children to remain in Brevard.

There are currently 137 active licensed foster homes in Brevard County as of January 2009.

Exhibit 26: DCF Licensed Foster Home Capacity/Beds in Use

DCF LICENSED CAPACITY	HOMES	BEDS IN USE
At capacity	55	219
Vacant	82	74
Over capacity	10	20
Homes specially trained to receive medical children	12	24
TOTAL	**137**	

There are now six child placing agencies (CPAs) operating in Brevard County. With their assistance, the number of licensed homes has grown by 59% over the last five years.

Exhibit 27: Brevard Child Placing Agencies/Homes/DCF Contract

Child Placing Agency (Cpa)	Number Of Beds	Current DCF Brevard Contractor
Devereux Foundation	87	Yes
Alternate Family Care	10	Yes
Children's Home Society	67	Yes
Intervention Services	53	Yes
Florida Mentor	72	Yes
Kidspeace	4	Yes
Sub Total CPA Beds	**293**	
TOTAL BREVARD LICENSED HOMES	**137**	

Licensed Group Homes Capacity

There are eight group homes physically located in Brevard County with a total of 128 beds.

8.4 Next Steps: Increasing the Number and Types of Foster Care Beds

One of the cornerstones of the community's plan for privatization of child welfare services is the belief that **Brevard's children should remain at home in Brevard County**. It is vital that children remain in their communities whenever possible. BFP and it's CPA partners must continue to recruit foster homes in communities in North and Central Brevard to accommodate children removed from those areas to remain tied to their community while in licensed out of home care.

At the present time, there is a sufficient capacity of group home settings in Brevard offering diversity in age, sex and geography. Country Acres houses school age boys and girls in Titusville. Crosswinds support children ages 12 and up in Cocoa. Hacienda Girls Ranch provides homes for school age girls in Melbourne. My Refuge is also in Melbourne and serves both boys and girls in school. The Haven, in Satellite Beach, takes care of younger children ranging in age from 0 to 9.

Devereux Florida is the only residential treatment facility in Brevard. There are some children who need additional services, such as substance abuse treatment, that are not available in Brevard. There are adequate short term, high level services in surrounding counties to meet Brevard's needs and probably not a sufficient demand to develop these types of facilities locally.

8.5 Introducing New Practices and Supports

As described in previous sections, BFP is an immediate resource (24 hours a day/7 days a week) to PIs to assist them in making placement decisions and in facilitating placements when children are separated from their families.

Together, BFP staff and the PIs use protocols and technology to help staff make appropriate placement decisions.

In the following pages we describe: pre-placement protocols and the real-time capacity to access available placement resources.

Intake Protocols for Children in Need of Placement

At the time of referral, the Intake Specialist reviews the steps the PI has taken to ensure that "reasonable efforts" that have been made to:

- Prevent removal of a child from the home
- Consider relative and appropriate non-relative homes as alternative caregivers.
- Determine that crisis stabilization and/or in-home wrap around family supports and safety planning could not ensure the safety of the child in the home or the home of an alternative caregiver.
- Ensure that the safety and best interest of the child are the primary decision factors guiding removal and placement.

The Intake staff also use the information provided by the PI to complete a pre-placement checklist to ensure that consideration is given to:

- Placing all siblings together, when possible and appropriate. The client record will reflect the reason for placing siblings separately, when necessary, and include a sibling visitation plan.
- Placing a child in close proximity to the parent home to facilitate maintaining the parent/child bond through planned visitation.
- Placing the child in the same school catchment area to minimize disruption to the child's education and special education needs. If a child changes schools the client record should reflect that the child is receiving the same educational services in the new school as the child was receiving in the previous school setting.
- Placing the child in the least restrictive, family like setting that will meet the child's behavioral needs (as observed by the PI).

The Intake Specialist will take the information from the PI and finds an appropriate placement. For an initial short-term placement, BFP will make every effort to ensure that children under 12 years of age are placed in a family foster home rather than a facility unless it is necessary for the child's individual clinical or other safety needs. At no time will children aged 5 and under be placed in group care facilities.

Each placement shall consider needs of the child and the strengths and needs of the prospective foster family or the capacities of the residential or group care provider. In all instances:

- Paid placements are made into licensed homes within authorized capacity.
- Children are placed with other children only as appropriate and based upon careful consideration of the mix of children present.
- Children in need of therapeutic service receive it regardless of in-home or out-of-home placement setting.

In addition to reviewing information related to the child's behavioral or clinical needs, consideration will be given to:

- Where the child's friends and relatives live
- Whether the child needs a bedroom of their own or can be with other children
- Any sexual issues
- Medical concerns/medications

BFP utilizes an Initial Pre Placement Tool as a guide. Any other assessments or tests that are available are also utilized.

Real time capacity to weigh different foster care placement options

The Intake Specialist will contact BFP Child Placing Agencies and Provider and Service Directory to identify agencies or individual caregivers that match the child's services and/or placement needs.

As part of their contract requirements, each network provider submit current census data and capacity information on a weekly basis, allowing the BFP staff to see at-a-glance what service and placement options are available. This census log is available to all staff on the BFP Share Drive to further enable the Intake Specialist to plan for placement and non-placement services and to match services and placements to identified child needs.

Once a determination has been made about the level of care needed and any services that should be wrapped around the child or needed supports for the caregiver, the Care Coordinator will subsequently schedule the initial Family Team Conference. With the initial placement, the Intake Specialist will complete the funding letter transmitting notification to the provider the level of care and authorization date.

Data (included in the authorization form) is entered on the BFP Daily Placement Log located on the share drive for subsequent entry into the FSFN system by the BFP ICWSIS Analyst. Any other relevant information is flagged for the BFP eligibility/rev max unit.

BFP will track all instances where children were placed or served outside of appropriate criteria and situations where children are placed in other regions of the district or state while waiting for appropriate placements. The Intake Specialists will monitor placements to ensure that they are appropriate to identified needs.

Efforts to ensure stable placements

In order to care properly for a child being placed in their home, foster parents, relatives or other providers need as much information as possible regarding the reason for the child's placement and the needs of the child.

- Medical information about the child will be shared at the time of placement and updated as new information is learned.
- Specific information about the child's behavior will be relayed at the time of placement with further information after the functional assessment.
- The caregiver/provider will be informed and encouraged to attend the Family Care team.

BFP has many mechanisms to prevent and manage potential placement disruption. One of the best tools to manage placement disruption is to plan for placement supports such as regular and consistent respite care and regular contact and problem-solving meetings between the caregiver/provider and the Care Manager. When a child is in a licensed or unlicensed home, the Care Manager and will have sufficient contact with the caregiver to know when conditions exist that could lead to disruptions. The Care Manager can also request (and BFP Care Coordinator can authorize) a range of family stabilization or supportive services to caregivers as a resource for preventing placement disruptions. BFP maintains a 24-hour, 7-day a week emergency line available to offer telephonic technical assistance or provide on-site emergency response/crisis stabilization services to prevent placement disruption. If a move to respite care or a higher placement level is required, the Care Manager works to ensure that the child/adolescent can return to the previous placement, if appropriate, following stabilization.

8.6 Quality Assurance & Improvement Related to Placements

There are multiple checks and balances to ensure that the BFP approach to placements is working. On an ongoing basis we monitor data (described below) and participate in any quality improvement processes.

Monitoring of Placement Results

- Number and type of placements each month
- Time from removal to placement
- Percent of placements that do not match CAFAS scores
- Percent of placements within county
- Percent of placements where siblings placed together
- Percent of placements where children remain in their own schools
- Number 30 day notices given and reasons for moves.

Obviously it is critical to monitor the safety of children after placement has occurred. BFP will monitor among other things:

- Number of maltreatment reports occurring in out-of-home care settings,
- Number of critical incidents in OHC,
- Number and frequency of runaways.
- Number of homes beyond licensed capacity

Section 9: The BFP Service Array & Provider Network

> **Guiding Principle**
>
> In order to insure the safety, security, and well being of every child in Brevard County, we believe that a seamless continuum of child welfare services must be provided for our children and families to address the prevention, intervention and treatment of child abuse and neglect.
>
> **Source**: TIP and Leadership Roundtable

- This section describes BFP's approach to network development and the creation of expanded service capacity.
- The ideal service array—includes a description of the services that will be provided by BFP contracted or Magellan/Medicaid funded providers and an overview of services accessed or purchased through the network and the process that will be used to prioritize development.
- The approach to network development—includes a description of BFP's provider-related staffing, the types of providers that comprise the network, the application and contracting arrangements, and an overview of the process that will be used to continue develop of the network.
- The approach to network monitoring.

9.1 Assessing Behavioral Health Capacity

BFP has worked collaboratively with the SAMH Program office to plan, problem-solve, train, and refine the CBC system of care, ensuring appropriate linkages and coordination with SAMH providers. BFP and SAMH have entered into an MOU—describing how they will fully integrate services for children in the custody of BFP. Discussions have found common ground in identifying joint issues, system goals, outcomes and recommendations integral to improving services to children and families involved with the child welfare system.

Both SAMH and BFP agree and support the following goals:

a. Children placed in the care and custody of BFP will receive a Comprehensive Behavioral Health Assessment.

b. Children placed in the care and custody of BFP will receive a Child and Adolescent Functional Assessment Scale (CAFAS) assessment by BFP Utilization Review Specialist within ten days of referral. The CAFAS will be updated every 90 days for children in leveled care and will be used as the primary tool in determining the appropriate level of care for the child.

c. If the preliminary screening indicates a potential need for services, a referral for further assessment may be made.

d. The assessment must be conducted or reviewed and approved by a licensed mental health professional and must include a comprehensive review of behavior, education, health and home environment.

e. All children in BFP's care who have mental health services will have an individualized treatment plan.

f. Mental health needs identified through a comprehensive behavioral health assessment will be included in the child's case plan.

g. The case plan will include a description of the mental health needs being addressed and a description of the services to be provided, including type, frequency and durations.

h. For all children who are also served by the Department of Juvenile Justice, planning and service delivery will be coordinated.

i. Brevard Family Partnership will facilitate the planning of the child's mental health issues through the Clinical Review process to include a multidisciplinary team comprised of the group of people brought together to plan and coordinate the needed mental health and related services and to work with the child, BFP and its subcontracted case management agencies as well as the child's natural support system to develop and implement the plan.

j. The above referenced Clinical Review team shall serve as a resource to Family Safety in the development and revision of the child's case plan in support of the child's permanency goals

9.2 Overview of Services Provided Through the BFP Network

The Brevard service array includes services and supports that are funded by traditional child welfare funds including those funded by SAMH (100/800 funds) Medicaid funds, and those funded by other federal, foundation, or local community grant programs. There are some services for which multiple funding sources may be used.

BFP continues to identify and prioritize the services or supports that can be flexibly mixed and matched to meet the specific needs of Brevard's children and their families. The service array CBC has built takes into account the following needs:

- All families need services and supports at some time or another. Families at-risk of abuse or neglect or having their children placed in out-of-home are particularly in need of prevention, early intervention, supportive services, and intensive interventions to help them address the problems that are placing them at risk.
- Children under five years of age are particularly vulnerable to developmental and other problems associated with the trauma of abuse and neglect and the subsequent separation and loss of attachment to parents. To reduce the lasting effects, there must be developmental, age appropriate services to identify and meet their needs.

- At the other end of the age spectrum are older adolescents with limited options for permanency and significant needs for services and supports to help them make the transition to adulthood.
- The reliance on home of relative care as the first placement option means BFP needs to find and access resources that can support these caregivers—from financial assistance to other non-financial supports.
- Children in the foster care system and their parents are at increased risk of having mental health and substance abuse needs. Nationwide it is estimated that between 50-60% of the children in the child welfare system have mental health and emotional needs that require treatment. The state's goal to continue to expand adoption as a permanency option means that resources and supports must be available to children and their adoptive parents to ensure long-term stability of these relationships intended to last a lifetime.

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1. Individualized, flexible services to meet family needs

In the BFP system of care model, families receiving support or therapeutic services may be birth families, relative caregivers, foster families, or adoptive families at risk of disruption. The goals of these services are to:

- Maintain children safely in their own home,
- Support families preparing to reunite or adopt, and
- Assist families in obtaining non-traditional services and supports in the community.

BFP believes that flexibility can be achieved with a broader interpretation, focusing on the intent. We have demonstrated that by using the funds to reduce caseload size and add resource specialist positions we have been able to provide direct or access services that meet the established goals of the program and also allow for the provision of truly individualized services to assist more families. .

2. A full array of placement options

If a child cannot be maintained (with supports and services) without significant risk in his or her own home and relative care is not an option, he or she will be placed in a foster home, residential or group care, or treatment setting most appropriate to clinical, developmental, and safety needs. BFP has developed an array of various placement settings including the following:

- Family foster care
- Enhanced and Therapeutic foster care
- Medical foster homes
- Group homes
- Residential treatment

- Independent living semi-supported group home or apartment arrangements
- Respite care

Within these settings, children and their families are able to obtain an appropriate mix of family-focused services and supports, including mental health and substance abuse assessment and treatment, counseling, education supports, health care and nutrition support, daily living skill-building experiences, reunification and visitation services, and aftercare planning and follow-up services.

The goal of an out-of-home care placement is not just to help children adjust to their temporary placement, but rather to prepare them and their families for permanency through reunification, adoption, or another planned permanent living arrangement.

All out-of-home care placements are subcontracted to BFP licensed network providers. BFP, reviews and approves all placement decisions, make the referral to the appropriate placement agency; and conducting regular reviews of all placements, and through various quality review mechanisms monitor the quality of all out-of-home care services provided.

Guiding Principle

Recruitment, training, and retention of qualified foster and adoptive parents must be a priority for the community. Foster parents should have specific performance standards and their compliance with such should be evaluated annually.

Source: Tip & Leadership Roundtable

3. A Coordinated and Expanded Approach to Foster Care Recruitment, Retention & Support

Most children who are not in home of relative/non-relative care are placed in traditional foster care homes. BFP is working with the community and current foster care providers to continually reduce the number of out-of-county placements. This will allow children to remain in close proximity to home and to maintain school and community connections.

BFP in partnership with each subcontracted Child Placing Agency is responsible for the recruitment of new foster homes. Each Child Placing Agency is also responsible for retention, training, and licensing/re-licensing and ongoing support of foster homes. At the time a new family is recruited in addition to the standard documentation required for licensed foster families, information on each family's location, racial and cultural background, language proficiency, experiences and preferences in serving children from the child welfare system, limitations and strengths, any special areas of expertise, and any desire to become an adoptive parent (if adoption becomes the permanency goal) is considered. Each Child Placing Agency will be required in their contract with BFP to update their census at a minimum of weekly—giving the BFP Intake unit and Care Managers access to up-to-the-minute information on available placements.

Over time, BFP will use contracts for all community providers who wish to provide foster care services. In all of the dialogue with community stakeholders, BFP has consistently heard that foster parents want a meaningful role in decision making for the children in their care, a seat at the table when case plans are

being made and hearings are being held, and ongoing formal and informal opportunities to support and connect to one another..

Recruitment Efforts

BFP has implemented a Recruitment and Retention plan that is updated annually

There are two separate Foster Parent Associations (FPA) who each work in partnership with BFP. Each association provides information about the recruiting program in their monthly newsletter. .

Expanding the Capacity of Child Placing Agencies (CPAs)

Currently, DCF has contracts with six CPAs in Brevard County including Children's Home Society, Crosswinds, Devereux Florida, Intervention Services. Alternate Family Care and Kidspeace. Alternate Family Care, Mentor, Devereux and Kidspeace specialize in therapeutic foster homes while Children's Home Society and Intervention Services focus on .traditional placements

4. Pre-and Post Adoption Services

BFP has exceeded performance targets in each year of operation in the area of Adoption finalizations. Over two thirds of local adoptions are foster parents. Relative caregivers can also adopt when the goal for the child is long term care. New adoptive families must be found for the children that do not have an identified placement, including large sibling groups, special needs children, and teenagers, in order for children to have a lifelong family. All adoptive families need support as their children grow and change.

BFP employs two Adoption Recruiters who participate in adoptive home recruiting, licensing, home study, and pre- and post-adoption support. They also participate in the CPA Partnership to provide a link for families transitioning from licensed caregivers to adoptive homes. These positions are responsible for maintaining contact with adoptive families, establishing Neighborhood Networks for adoption support and mentoring, and coordinating support groups.

When adoption becomes the permanency goal for a child with no apparent adoption resource, the BFP Adoption Support Coordinators will assume responsibility for recruitment, assessment, licensing, training, handling all court-related petitions and hearings following TPR through finalization, pre-adoption placement, managing the post-adoption subsidies, and providing post-adoption supervision and supports to ensure that placements intended to last a lifetime remain stable The Adoption Support Coordinator will work closely with the Care management team and the Care Manager would remain the primary worker throughout the process until finalization with the adoption worker listed as secondary worker in FSFN.

5. Independent Living Services for Youth

There are 100 youth in licensed out of home care age 13 and over. There are also 87 young adults who exited foster care at age 18 who are receiving ongoing services through BFP

While it is important for each of these youth to have a Care Manager working on their permanency plan, it is also essential that they are prepared for independent

living. The Independent Living Contracted Provider and the Connected by 25 Brevard program will link teens to natural supports within the community and assist them with creating a personal support system that will sustain them when they exit the system of care. Brevard is rich with resources and youth and young adults are best served by creating community connections that meet the needs outlined in their individual plan.

The IL program works with the Care Managers to develop the child's independent living plan beginning at age 13 as required by law. They serve as the single point of contact for teens within the system, coordinate social activities, assessments, staffings, and life skill training, as needed. The Il program also supports CM units in putting together and implementing solid plans for particularly young adults..

BFP has worked collaboratively with setting up the Connected by 25 Brevard program to provide enhanced programming to youth in care and young adults who have exited care at age 18. This program identifies opportunities for enhancing current community services, including strategies for maximizing federal independent living dollars and seeking federal and foundation grants.

6. Health and behavioral health services for parents and children

BFP is working with the Department of Health, Substance Abuse and Mental Health (SAMH) and DCF to review options for expanding capacity.

BFP has executed a MOU with SAMH, that outlines the process when needs are identified by the Care Managers. Families are referred to network providers of treatment or residential placement services. If parents are referred for substance abuse or mental health services, the CM works closely with the behavioral health providers to ensure that case plans are coordinated with the parent's behavioral health treatment plans.
In addition to accessing behavioral health services for BFP children, BFP is committed to continuously building a strong base of internal expertise to assist Care Managers in identifying and responding to behavioral health problems in families. (Our approach to building resource specialist capacity was described in the previous care management section.)

System of Care Principle

In order to succeed with children and their families in meeting ASFA goals, we need effective approaches to engaging other systems—including the schools, the courts, child mental health, and adult behavioral health systems.

Source: Georgetown University National Center, Guidelines for ASFA.

The following mental health services will be sought in varying degrees for children in BFP custody, based on level of care criteria placement**.**

a. Behavioral Health Overlay Services (BHOS) placement: This is a Medicaid program component that enables eligible children placed in designated BFP contracted residential group care programs to receive medically necessary behavioral health services. A provider who is eligible meets the following criteria:

1. Is an enrolled Medicaid Community Mental Health Services provider;
2. Is under contract with BFP and SAMH as a residential group care provider;
3. Has the primary mission to provide an alternative living situation for children who have been adjudicated dependent;
4. Is designated by SAMH as an essential behavioral health care provider and
5. Is certified as eligible by the district SAMH program office and the Agency for Health Care Administration (AHCA) regional office and is under contract with SAMH program office as a provider.

b. Targeted Case Management (TCM) services can be provided for any child under BFP custody with complex clinical mental health needs only when this service is not considered duplicative or fragmented. If it is determined that a Targeted Case Manager is needed, a joint plan will be developed that delineates each of their responsibilities. The addition of a TCM should promote continuity and stability of case management services for the child and the family.

c. Crisis Stabilization Units (CSU): These are designed to provide short term residential evaluation and crisis stabilization for persons experiencing an acute mental or emotional crisis. Children admitted to these facilities are those believed to meet criteria for a Baker Act and ultimately require inpatient psychiatric care during a period of crisis.

d. Day Treatment; This is an integrated program of academic, therapeutic and family services that can be school based or provided at other community sites. Day treatment may be necessary for children who are not able to attend school in a public forum.

e. Family Wraparound Plan: This plan is developed at the initial Wraparound Family Team Meeting and primarily is designed to enable the child to remain in their home (whenever possible) foster home or other community setting. Services include both traditional and non traditional supports as well as highly individualized community support services, including the purchase of needed goods and services identified in the service plan.

f. Outpatient Treatment: Provision of individual group or family treatment including the use of mental health therapists, psychologists and psychiatrists.

g. Respite Care: Planned period of relief for child's caregiver assuming the duties of care-giving for several hours, overnight or for several days.

h. Magellan Behavioral Health and the Child Welfare Pre Paid Mental Health Plan: In February of 2007, a partnership was created with Magellan Behavioral Health Services and the Community Based Care Organization across the state of Florida. Magellan provides services to children in the child welfare system through a pre paid mental health plan. An array of services

are available and require authorization through the BFP Utilization Program Manager. .

The MOU also defines the collaborative process that will be used to access therapeutic placements (including specialized therapeutic foster care, residential mental health treatment, and statewide inpatient psychiatric services).

7. Infancy, Early Childhood & Education Supports

As previously noted, BFP wants to ensure access to appropriate services to meet the needs of very young children who enter the child welfare system. BFP has executed an agreement with Children's Medical Services, the agency charged with the Early Intervention Program for Part C (infants and toddlers), to identify available resources and develop appropriate referral mechanisms.

Every school-age child going into foster care should have continuity of education, assurance that any IEPs continue and remedial education support and specialized assessments are provided as indicated. An educational passport should be used to document their progress and key events. The passport can follow the child through any placement moves until attainment of permanency. BFP is in the process of negotiating an MOU with the Brevard County School Board.

8. Non-traditional, community resources that can be "wrapped" around children and families—before, during, and after their contact with the child welfare system

In addition to the provision of traditional child welfare services, BFP works with the community to identify informal supports that can be used in a wraparound approach to care. Regardless of the placement or legal status of the case, we know that children and families need have access to an enriched menu of community resources tailored to their individual needs. For example, we may have a formalized respite program but a non-formal approach may be developed to utilize a next-door neighbor to allow a parent the opportunity to go grocery shopping. Only through the development of these alternatives, rooted in the neighborhoods, can we expect families served in this system to experience meaningful, sustainable change.

Discharge planning is central to the process from case opening to closure. A central goal is to ensure that when children achieve whatever their permanency plan goal is, that the plan is in fact "permanent." In working with its case management agencies, BFP ensures that an aftercare plan is developed prior to the time the child and family are discharged from the system of care. It specifies variable levels of services and supports to be provided for up to 6 months post case closure, based on child and family needs. The purpose of the aftercare plan is to assure stability of progress and sustainability of the permanency outcome.

Care Managers work with families throughout the time they are involved with BFP to identify and build upon their natural support system and help them identify new community resources. These connections have the potential to provide continuous support to families and contribute to lowering the re-abuse rate for children and families served.

BFP values the resources accessible within Brevard County and has placed emphasis upon utilizing the array of non-traditional services and supports that BFP has established and utilized, and the time it takes to engage the community in support of the system of care through the contribution of time and in-kind services and supports..

9. Effective use of flex funds

BFP Care Managers will have access to flex funds to use to meet child and family needs. Flex funds will be managed centrally by BFP. Requests will be made as part of Family Team and approved by the Care Coordinator (CC), or made directly to CC The request can be as diverse as therapeutic accessing any available funding prior to using flex. Flex will be used for any non-recreation, or paying a bill.

10. The Brevard C.A.R.E.S. Program

The Brevard C.A.R.E.S. (Coordination, Advocacy, Resources, Education, Support) Program provides support to families to help divert them from entering the child welfare system. Brevard C.A.R.E.S. is a process driven program that provides services to families who are experiencing stress, and are in need of support and resources.

The program provides families with the creation of a Wraparound Family Team, which includes creating linkages to natural community supports. The focus of the program is to respond to families who are experiencing the stressors that often result in child abuse by building a network around them that will support and sustain them long term. If they are new in town, have little local support from families and friends, or just don't know how to get help, the Brevard C.A.R.E.S. program will link families with the rich resources that Brevard County has to offer.

Families can be referred to this program by calling the BFP intake line at (321) 752-3226, toll free at 1-888-CARES-09, or by calling 211. Referrals can be made by anyone in the community who knows of a family that could benefit from extra support and assistance; families may self refer to the program.

Once the referral is received by the C.A.R.E.S. program the family is contacted for a strengths/cultural discovery to determine the level of support the family will need. Depending on the needs of the family they may be referred directly for support and assistance or scheduled for a Wraparound Family Team meeting (. During the Family Team a Care Plan will be developed with the family as integral part of the planning process. The Family Team will determine the frequency of follow up FT meetings. The C.A.R.E.S. program is designed to support families intensely upon referral so they may graduate the program within 90-120 days and be able to maintain long term sustainability.

The Brevard C.A.R.E.S. Program adheres to the same Principles and Values supported in the BFP System of Care.

9.3 BFP Network Development

BFP has developed a provider network that is capable of delivering the full array of home, community, and out-of-home care options to meet the individual needs of children and families.

Network Providers have designated a BFP liaison who will serve as the network agency's point of contact and attendee at monthly provider and contract meetings. The network liaison receives and returns the weekly census, ensures BFP polices and procedures are adhered to, assign referrals to the appropriate staff person, ensures attendance at FTC's and UR's, submit monthly and quarterly reports, and participates in the ongoing development of the provider network.

BFP Staff Accountability for Network Support

The Director of Wraparound/Clinical Care, who reports to the Chief Compliance and Utilization Management Officer, is responsible for provider relations. The Contract Manager, who reports to the Chief Compliance and Utilization Management Officer, is responsible for oversight of provider contracts. Our Chief Financial Officer, will have responsibilities for payment functions. The annual onsite provider review and compilation of the satisfaction survey data collection and reports is a shared responsibility of the Compliance and Utilization Division staff.

The first goal of network development is to ensure the stability of current services as we begin to get a better sense of the new services that will be added and those that will need to be expanded. The "ideal network" is not achieved overnight but is built gradually from the current services and seeds of innovative ideas not yet tried.

The make-up of the provider network will change over time—it will be a dynamic group, with opportunities for agencies to build upon strengths and meet the individualized needs of the children and families served. The terms of contracts will also change over time as BFP works with providers to introduce greater accountability –evidenced by the willingness to accept financial risks and rewards based on specified performance indicators and outcomes

Types of Network Providers

There are three types of providers recognized by BFP in the Provider Network:

- Category A providers: Providers who perform a core system of care service, usually governed by local, state, or federal regulatory requirements and normally funded by BFP directly. These providers will have a contract with BFP.
- Category B providers: Providers who may receive referrals from BFP or its subcontractors who perform a vital or mainstream system of care service, normally reimbursed outside of BFP (such as Medicaid/Magellan Reimbursement). These providers may have a Consultant Rate Agreement or a Memorandum of Understanding with BFP.

- Category C Providers: Providers who perform an important, necessary service which supports the system of care, usually considered informal or a natural extension of a service or agency (food pantries, homeless shelters, etc.). These providers may or may not have a Memorandum of Understanding with BFP.

The Application Process for Becoming a Provider

All service providers that wish to join the BFP Provider Network and pursue a contractual relationship for child and family services with BFP will be asked to complete a Request for Qualifications (RFQ). The RFQ is intended to identify and pre-qualify providers that can offer a continuum of services for children and families in Brevard County. The RFQ can be found on the BFP website – www.BFPrevard.org under the "Procurements" section or can be requested from the BFP Contract Manager. The RFQ includes narrative about the responding agency and includes applicable certifications, licensing, insurance, and financial information.

The Contract & Interagency Approval Process

The term "contract" means a formal written agreement executed between BFP and an individual or organization for the procurement of contractual services. The contract will include all terms and conditions governing the nature and delivery of services, provider performance specifications and performance evaluation methodology, record keeping and reporting requirements, payment methodology, penalties for provider's failure to comply, etc. All terms necessary to govern the relationship between BFP and the provider will be set forth in the contract document. The contract will ensure that the provider is held to the highest standards possible for service quality, accountability, economic efficiency, and service effectiveness.

BFP has a procurement and contracting process, which is detailed in BFP OP PR-901 for the Procurement of Commodities or Services and OP CG-302 for Contracting Procedures.

9.4 Ongoing Network Management & Monitoring

Provider Training and Supports

BFP is committed to ensuring that all providers in the network are given a basic orientation on the system of care, policies and procedures related to day-to day operations including but not limited to: the service philosophy, referrals, documentation and reporting requirements, invoicing and payment procedures, and contract monitoring and quality expectations. The orientation is a first step in the development of lasting relationships that will be characterized by mutual respect and trust.

Few agencies in Brevard are accredited by a national accrediting body. In order to ensure that all providers are familiar with standards of best practice, BFP has

held regular best-practice training sessions, targeting different levels of staff in providers and CMAs. Participation is voluntary but BFP tracks attendance and agencies are encouraged to participate.

Monitoring

All BFP subcontracted providers (Category A Providers) receive an on-site annual monitoring. Regular reports from service providers that are contractually required, contract file reviews, informal visits, and on-site monitoring will determine the provider's compliance with the contract terms and conditions, licensing requirements, performance standards, applicable State and Federal statutes and administrative codes, and BFP policies

BFP Website

BFP's Internet website will serve many useful functions. Among them will be the ability to communicate with existing and potential providers, and the ability for providers to communicate with BFP. Examples of web site features include:

- Online provider application process,
- Online provider handbook,
- Posting of upcoming events,
- Posting of Procurements ,
- Links to sites that detail model programs, research, and best-practice approaches, and
- Provider "suggestion pages" where provider agencies can make recommendations to BFP Network Management staff.
- The Heart Gallery

The IT Data Management staff will be responsible for maintaining the BFP website.

Provider Handbook

BFP has developed an online Provider Handbook that incorporates all policies and procedures for a provider. The Provider Handbook describes in detail key policies and procedures including but not limited to: QA/QI activities, clinical best practice guidelines, response to critical incidents, complaint and appeals procedures, the payment and invoicing procedures, confidentiality requirements, service authorization and the concurrent review procedures, medication management, discipline policies, provider rights and responsibilities will be clearly articulated.

Bi-Monthly Provider Meetings

BFP hosts regularly scheduled provider meetings to provide a venue for announcements, updates, and discussion of provider successes and concerns. The Director of Wraparound/Clinical Care will structure the agenda to explore

issues related to network performance and to identify and problem-solve any barriers to quality care. The ongoing opportunity to share strategies and address challenges will build a more cohesive provider network and lead to innovative new practices.

Provider Network Innovations

In addition we will have opportunities throughout the year for providers to come together to discuss network issues, service innovations, and various capacity building opportunities.

Monthly Contract Meetings

BFP conducts monthly contract meetings with Category A Providers to facilitate a time for open communication to discuss key issues and resolve any potential issues.

Newsletters

BFP creates, circulates, and posts various quarterly newsletters including but not limited to: 1) A newsletter highlighting accomplishments, upcoming events, feature stories related to child welfare, and other related items; 2) A second newsletter is developed specifically for the foster and relative caregivers.

Using Technology to Support Communications

The information system will play a vital role in the communication and information sharing process with providers. The process is briefly outlined below:

1. Care Managers will have the ability to be provided a list of services provided to a client, admission and discharge dates, and discharge reasons, in order to effectively communicate case progress to the court in judicial reviews. Services authorized information can be obtained from the Care Coordinator, intake, or the Magellan program manager depending on the service information requested.
2. Providers will also be able to manage capacity at their agency by entering daily census showing available beds to assist BFP with referrals for placement.

Access to Help 24 Hours/day

BFP maintains a 24-hour capacity (through on-call procedure) to respond to provider problems, especially those in which a placement is jeopardized, a child is missing, or other critical incident. The BFP staff person provides technical assistance by phone and, as indicated, on-site support provided by the most appropriate resource person (CMA, Crisis response staff etc.)

9.5 Quality Assurance—Monitoring Performance

The QA/QI and Network Management Plans include a full discussion of the various activities and mechanisms BFP employs to ensure that children and their families are getting the services they need and are benefiting as expected from the services they receive. As part of the QA/QI plan, BFP continually assess the data, identify potential problems and proposed and test solutions.

Executive Summary

The BFP Mission and Values

Brevard Family Partnership, Inc. (BFP) was formed by the Brevard County Board of County Commissioners, Children's Home Society of Florida and The Devereux Foundation, Inc. specifically for the purpose of developing community-based services and supports for children and families served by the Brevard County child protection and foster care system. BFP's mission is *to develop and manage a comprehensive, community-based, coordinated system of care for abused, neglected, and abandoned children and their families.* This mission is driven by one of our core values which is the belief that all children have the inalienable right to grow up safe, healthy and fulfilled in families that love and nurture them.

BFP and all the stakeholders in Brevard County share a vision of how the child welfare system of care should operate to best serve the unique needs of Brevard County children and families. BFP is committed to the following vision:

- The safety of children at all times will be the foremost concern;
- Permanency issues will be resolved in accordance with a child's sense of time;
- Services will be provided by comprehensive, community-based networks of providers who are equipped to manage and deliver all needed services and supports to meet the needs of child abuse and neglect victims and at-risk children and their families;
- Resources will be efficiently and effectively managed to achieve better outcomes for children with the ultimate goal being child safety and permanency within a twelve-month timeframe;
- Financial support will be available from diverse federal, state and local sources and flexibly managed at the local level to meet child and family needs in a timely and appropriate manner; and
- The system will be able to collect and use data to accurately forecast what services and supports are needed, at what level of intensity and duration, and at what cost to achieve desired outcomes for each child and family in need.

The BFP Organizational Structure

The Senior Management Team of BFP consists of the Chief Executive Officer, and four Officers—Chief Operations Officer, Chief Financial Officer, Chief Administrative and Personnel Officer, and Chief Compliance and Utilization Officer, a Director of Operations, Child and Family Services, and two Directors: Utilization Management and Wraparound and Quality Management and Fidelity

BFP subcontracts for case management services from CHS and Devereux.

BFP has implemented a full array of services that are available in the BFP signature prevention/diversion program Brevard C.A.R.E.S.

BFP has outsourced human resources to Administaff. BFP provides in house and subcontracted training/professional development services.

The BFP administrative office is located at 760 North Drive Melbourne, FL 32934. Administrative and senior management staff are housed at this location. Case management services are located in the three current service centers. In total, the CMAs have 10 case management units

Care managers have access to and the support of the Resource Specialists (Caregiver, and Court Liaisons, Contracted Independent Living Services and when needed Mobile Response services) and adoption support from the subcontractor responsible for finding and preparing families for children with adoption as the permanency goal. BFP has built capacity through creative, innovative methods to also include Domestic Violence and Substance Abuse professionals on site at each Care Center as well as Targeted Case Managers..

The Care Centers (North, Central, and South) each have a Care Center Manager (BFP employee). and Care Coordinators (a BFP employee) who co-facilitate family team conferencing and coordinates, authorizes and monitors utilization and supports. Clerical support and records clerks are on site.

The Current Brevard Caseload and Projections

On average, Brevard has 820 children active as case dependents at any given time. Using the averages and trends from the BFP intake data for the period from 7/1/2005 to 6/30/2008 the following chart outlines the projected average intakes and case load for both dependency and Brevard C.A.R.E.S. to be expected each month.

PROJECTED MONTHLY INTAKE	
470	Investigations per month
65	Children entering in-home care
190	Children entering Brevard CARES
30	Children entering out-of-home care
285	**Average Number of Children Entering Per Month**
PROJECTED MONTHLY CASELOAD	
220	In-Home (not placed)
120	In-Home (Post placement supervision)
560	**Brevard CARES**
900	**Average number of children receiving in home services**
250	Relative/nonrelative placements
220	BFP custody (Licensed Care)
470	**Average number of children in out of home care**

Analysis of Current System Strengths and Weaknesses

There are promising trends in the data. Among them are the following:

- 90% of the children entering the BFP system of care are served in their own homes, with the majority never experiencing a placement.
- 40% of the children served are served through the BFP prevention program.
- Homes of relative and non-relative care are clearly a preferred placement option for children in out of home care.
- The length of stay and achievement of permanency within 12 months in all types of care is better than state or District averages.

Brevard continuously has exceeded performance targets in the number of adoption finalizations in the last three years of operations

Based on our analysis, the below was identified:

- An updated Foster Care Recruitment and Retention Plan is developed annually that includes a data analysis of current providers and trends.
- Fewer and fewer children are being placed out of county. Typically, out of county placement only occurs when the appropriate placement is not available within the county. An example might be an Agency for Persons with Disabilities Group Home or a Medicaid funded Residential Treatment Facility.
- One new CPA, Kidspeace, has been added for fiscal year 2008-2009. Kidspeace specializes in therapeutic placements.
- Over half of the children in out of home care are living with relatives or non relatives who need help navigating the child welfare service system and accessing services and supports.
- While the rate of re-entry in Brevard has improved it remains higher than state or national averages.

BFP continues to address the identified challenges in Brevard by:

- Ongoing recruitment of foster families.
- Expanding the capacity of child placing agencies (CPAs),
- Recruitment of both adoptive and foster families.
- Coordinating with the Department of Children and Families Central Region Licensing Office for training on licensing activities,
- Offering both pre- and post- adoption support for families,
- The addition of a comprehensive child abuse prevention program, Brevard Collaboration, Advocacy, Resources, Education and Support or Brevard C.A.R.E.S.
- Providing specialized staff support
    - Caregiver Liaison

- Care Coordinators that specialize in Prevention.
- Family Partners
- Court Liaison

Summary of System of Care Changes & Innovations

The System of Care plan details the ways in which practices have changed since the transition of child welfare services. The following are among the more significant changes:

- Implementation of the Brevard C.A.R.E.S. program; The prevention/diversion program that provides a full array of services to families at risk of abuse or neglect.
- Mobile Response Team: A mobile crisis capacity will enable BFP to work with PIs to reduce initial placements and stabilize placements at risk of disruption.
- 24-hour on call service line available for access to placement and emergency response.
- A streamlined intake and case transfer process that has enabled Protective Investigators to hand off cases within days creating the potential for more timely initiation of services.
- A coordinated approach to assessments that ensures that children and families get the assessments they need and that services are initiated to address needs.
- Child functional assessments (CAFAS) that are administered when a child comes into licensed care, and then every 90 days after for children in leveled care to ensure that children are placed in the appropriate level of care.
- Ongoing utilization review to identify and remedy problems, ensure better management of resources, and higher quality of care.
- Continuity in care management has been provided through the implementation of Brevard C.A.R.E.S. that has led to manageable caseloads, enhanced supervision, and new tools, training, and supports for Care Managers.
- Family-centered practice by way of utilizing wraparound family teams has ensured that all services are “family-friendly.” Families are actively engaged from start to finish in finding solutions to problems that threaten child safety, permanency, and well-being.
- A new approach to contracting for, foster care and adoption services to increase capacity and ensure consistent quality.
- A multi-faceted and targeted network development plan to ensure a broader array of services, including linkage with prevention and early intervention and non-traditional resources.

- BFP, and network providers are held accountable for results. Results-based contracts, improved monitoring, and a data-driven, efficient approach to QA/QI will ensure quality care and improved child and family outcomes.

After implementing the system design based on the guiding principles of the community, BFP has been able to demonstrate improved results, including the following:

- Children live in safe and stable family environments and be protected from abuse and neglect;
- All children will have expedited permanency and stability in their lives;
- Families have enhanced capacity to provide for their children's needs;
- Children are placed in the least restrictive, most home-like setting;
- Children receive appropriate and timely physical and mental health services based on individualized assessments;
- The educational needs of children are incorporated into the service plan to maintain school stability, prevent multiple school changes and address the individual needs of the child;
- Families are offered the necessary substance abuse treatment services to prevent further issues of abuse and neglect;
- Children in care maintain their cultural heritage and family relationships;
- Older foster youth receive independent living skills training to help prepare them for transitioning to adulthood;
- Adopted children and adoptive families have access to post-adoptive services to ensure family stability; and
- Aftercare planning and access to community resources to reduce re-abuse and re-entry into the foster care system.

Brevard Family Partnership prides itself in the use of innovations and best and evidence based practice approaches that continue to strengthen the system of care and improve the quality of life for the children and families we serve.