UTILIZATION MANAGEMENT PLAN 2025-2026

Family Partnerships of Central Florida

Protecting Children, Strengthening Families, Changing Lives.

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***Utilization Management, defined as a** utilization analysis plan to track critical components of service utilization, approve services in a timely manner, and monitor utilization with fiscal oversight.*

Family Partnership of Central Florida's (FPOCF) Approach to Utilization Management

Utilization Management (UM) is the foundation of FPOCF's System of Care (SOC). UM is the process of coordinating, authorizing, and monitoring services and placement for children and families on a continuum of care from entry to exit. The UM process ensures a seamless service delivery system that maximizes resources, mitigates fragmentation and duplication, and builds upon natural supports to support and sustain families' long term.

The utilization review process involves ongoing communication and teamwork between and among Clinical Service and Behavioral Health Coordinators, Behavioral Health Specialists, Case Managers, Multidisciplinary Team (MDT) Coordinators, Family Team Conference members, and attending members, network, and third-party providers. The type of service that is being delivered determines the frequency of internal reviews.

DEFINITIONS

MULTIDISCIPLINARY TEAM (MDT) STAFFINGS

FPOCF implemented MDTs to ensure all voices within the team are heard and input is provided regarding decisions about the children and families served. This process is family focused to help minimize trauma regarding decisions impacting children in care from placement changes, educational needs, separation of siblings, etc., to ensure timely intervention in the least intrusive manner. The MDT process is collaborative and involves shared input from all team members, including but not limited to, the child (as age appropriate), foster parents, caregivers, providers, and others that play significant roles in a child's life. The MDT staffing is facilitated by MDT Coordinators who are trained, strength-based, family-focused facilitators using a proactive approach to ensure the best outcomes for our children.

- MDT staffing's are required for the following:
    - Any change of placement – emergency or planned.
    - Separation of Siblings
    - Human Trafficking
    - Educational Transitions
    - Reunifications
    - Emergency Staffing's
    - Reinstatement of Parental Rights

During the MDT, the team completes a Comprehensive Clinical review to assess the current placement needs for children as identified, to ensure adequate services and support, based on a review of progress notes, provider feedback, and information provided.

FAMILY TEAM CONFERENCING (FTC)

The Family Team Conference is part of the wraparound process that brings people together from different parts of the family's life, holistically. With help from a Care Coordinator, people who serve as resources within the family's life (natural supports), work together, coordinate their activities, and blend their perspectives of the family's situation to create desired change and help strengthen children, families, and communities. This family-centered approach empowers the family to decide how often they would like to schedule their FTC meetings. These can be scheduled as often as weekly or as infrequently as every 90 days. Life circumstances occur outside of the FTC and the family might decide they want to hold an FTC. The family and team

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members can determine at any time that an FTC needs to be convened to discuss new circumstances or information that warrants additional planning.

In addition, and to ensure voice and choice, the family is encouraged to actively participate in making decisions about services and supports based on the family needs including What services have been tried in the past, Expected results of services and supports; How the design of the services and supports utilized meet their needs; How services will be delivered, Expected duration of services and possible alternatives for services; and, How services will be evaluated, along with any other information requested by the family.

The FTC is composed of family members, friends, care managers, and others in the community who may have a relationship with the family (e.g., teachers, clergy, etc.), this team is created to provide the family with the necessary support to ensure the ownership and success of their care plan.

GUIDELINES FOR UTILIZATION MANAGEMENT

The utilization management process links children and families with the appropriate level of service within the following service guidelines. Services are:

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

INTEGRATED UTILIZATION MANAGEMENT

Utilization management, the foundation of the service delivery system at FPOCF, has been integrated into each aspect of the system of care to ensure services are flexible, responsive, and customized to the needs of the children and family. The Out of Home Specialist monitors placement decisions and the use of crisis intervention services daily to ensure that appropriate services are in place. If crisis services are initiated, the Out of Home Care Specialist requests an MDT for follow-up and continuity of service provisions. The Family Team Conference (FTC) or MDT staffing reviews the appropriateness and effectiveness of services being delivered for ongoing authorization, this is also reviewed as part of the Quarterly Case Record Review and other quality assurance reviews. The following questions are addressed during these reviews:

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

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

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Core Components of Family Partnerships of Central Florida Utilization Management System

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

Service Utilization and Authorization

The Clinical Services Coordinators authorize services agreed upon at the Family Team Conference, Standing Team Conference or MDT and advise the providers of the duration, frequency, and specific needs of the consumer. The Clinical Services Coordinators notify providers of the schedule for the upcoming utilization review which should occur minimally prior to the completion of a second twelve-week authorization period for ongoing services. The Family Team or MDT may identify the appropriate provider and the Clinical Services Coordinator and/or assigned member of the Family Team contacts the provider to initiate services. An authorization form is submitted to the provider through the Utilization Management System by the Clinical Services Coordinator.

The Clinical Services Coordinator reviews all service requests within three business days of receipt from the Care Manager. MDT staffing's are held for youth that display high needs, such as behavioral or emotional, are in high end placements, and for youth that are at risk of disrupting their placements including youth funded through Substance Abuse and Mental Health (SAMH) funds.

The Clinical Services Coordinator maintains the database of all authorizations through Mindshare. This ensures that the team has knowledge of real-time service availability and activity. Each Network Provider submits a monthly invoice to the FPOCF designated staff member through Utilization Review System detailing units actualized for all authorizations. If there is under-utilization for services authorized weekly, authorizations for sessions not utilized

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during that week will no longer be available and will be deleted in Argos and Mindshare to allow for those dollars to be made available for future authorizations. Each FPOCF contracted provider is required to make and report on community linkages secured on behalf of the family. It is critical that providers create community linkages to support and sustain the child and family beyond discharge.

Referrals made to third party reimbursable partner agencies are tracked in Mindshare by the Clinical Services Coordinator and reviewed and reported monthly to monitor partner agencies receiving third-party referrals from FPOCF and to oversee trends associated with service delivery.

Service Authorization Procedure:

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

1. In home support services are offered on a continuum service array to meet the evolving needs of families in complex situations. These support services are designed to assist families in times of stress or acute crisis.
2. Clinical Services Coordinators use a range of supportive and therapeutic services that are customized and individualized to the unique culture and strengths of a child and/or family.
3. Iin-home services are designed to alleviate family stress and address child safety risk factors, to promote parental competence and protective capacities, and to enable families to access resources and natural support networks to achieve long term sustainability.
4. In-home services are family-focused, community, and home-based and are designed to support families to alleviate crises that may lead to out-of-home placement for children.
5. Families receiving in-home support services may be birth families, pre adoptive families relative, non-relative, and fictive kin caregiver families. The goals of these family-focused services are to:
    a. Maintain children safely in their own home.
    b. Support and strengthen the family unit for family preservation.
    c. Assist families in obtaining services and support in a culturally sensitive manner.
    d. Maintain or stabilize placements and.
    e. Create natural supports and linkages that will sustain the family upon discharge.
6. All referrals for In-home support services are made through the Clinical Services Coordinator who prioritizes the referrals based on need, availability of the service and

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funding source. Any service that has been Court ordered is reviewed for clinical necessity and authorized. If the Court ordered service is not clinically indicated, the Clinical Services Coordinator discusses with the Case Manager the next steps to engage all parties and apprise the Court accordingly (in conjunction with Children's Legal Services). The Chief Legal Officer also assists with issues that need to be discussed with the Judiciary in Circuits 9 and 18.

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

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

Continued Review of Criteria:

1. At each Family Team Meeting or MDT, service provision is re assessed and at any critical juncture (defined as a major change in the individual or family status). Since this process is ongoing, it continues throughout the duration of service delivery.
2. In-Home Support Services are authorized in increments not to exceed twelve weeks per authorization. This is intended to ensure the services meet the needs of families and are tailored to meet the changing needs of the family as they arise.
3. Agreement of the FTC or MDT team members may extend the service duration.
4. Reviews are held at a minimum of every twelve weeks to review service delivery prior to the subsequent authorization period.
5. There are measurable goals and outcomes outlined to the provider.
6. On an ongoing basis at a minimum of monthly the Clinical Services Coordinator and Case Manager review and assess service plan implementation, family's progress toward achieving goals, desired outcomes, and the continuing appropriateness of service goals.

Service Criteria:

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

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

1. Clinical Services Coordinator, Case Manager, and providers always treat families with dignity and respect while coordinating visits to the home. Barriers to successful engagement are considered and responded to. The assigned Case Manager and family

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regularly review progress towards family achieving goals and desired outcomes and discuss the continued appropriateness of service goals.

2. Service providers exercise vigilance in observing children, ensuring that they are seen as often as indicated on the service referral and that the home appears free of hazards, the children are free of injury, identifying safety risk factors and documenting the outcome of the interaction in the Argos or Mindshare system. Providers are mandatory reporters: required to file a Child Abuse Report when abuse is observed or reported to them in accordance with Florida Statute 39.201 mandatory reporting laws.

Referral for Services:

FPOCF adheres to the principles of wraparound in all aspects of our engagement and interaction with children and families served. Not every child may be actively engaged in the wraparound process, however, through the Clinical Services Coordinators, Case Managers, and the utilization of our referral systems Argos and Mindshare, the team monitors the services the family is engaged in and review notes that have been entered by the provider. The Clinical and/or Utilization Management Team attends Initial Case Transfer staffing to review the child and family strengths, offer insight and recommendations regarding services to ensure strength and needs based planning. Clinical Services Coordinators refer children and their families for appropriate services based on individual needs. Referrals for services are based on professional and ethical determinations of the needs of the family and to every extent possible includes the family's voice and choice.

1. Referrals for services occur as a direct result of recommendations made within an MDT staffing or Family Team Conference.
2. If a child (ren) or family members have Medicaid the Clinical Services Coordinator identifies a provider that bills the insurers directly. The coordinator will ask the identified Case Manager to check whether a child or adult has Medicaid. All referrals for services are checked by the designated staff member to determine whether they have Medicaid coverage. All referrals for Medicaid funded services are tracked. If a child (ren) or family member does not have Medicaid and a referral is made to a provider, the service is provided through purchased services, However, in cases of substance abuse treatment or batterer's intervention programs the client may be responsible for payment (full or partial).
3. The Clinical Services Coordinator monitors all referrals to ensure the family is receiving the service as authorized and maintains regular communication with the provider to assess the family's participation and progress made regarding the service delivered.
4. In cases requiring transition of services every effort will be made to ensure the service being transitioned is linked to a new provider of the same clinical orientation and expertise with cultural competence.
5. As part of the continuous quality improvement process, Clinical Services Coordinators ask families to rate their satisfaction with the service referral process including availability of appropriate services and information regarding how helpful the services were/are to the family as part of the FTC process.
6. If a child enters Licensed Out of Home Care (LOHC) and requires enhanced placement and supports immediately the By-Pass-Referral Process can be utilized: If a child enters LOHC and requires enhancement and supports, bypass referrals to all appropriate and available services must be completed within three business days of placement. This may include but not limited to mentor or behavior buddy support to maintain supervision and safety. The Out of Home Care Specialist coordinates and discusses with the Clinical Services Coordinators

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to ensure appropriate services are identified. Upon determination that a service is warranted, the Case Manager submits the request to the Clinical Services Coordinator to complete the service request in Mindshare.

Flex Support Provider:

Upon receipt of the service request, the provider assigns the appropriate personnel and initiates services. Services authorized are based on the identified needs of the family and focus on the identified tasks within the Care Plan and/or Case Plan goals, the provider must contact the Clinical Services Coordinator to update the Care Plan. This modification will be completed following consultation with the Clinical Services Coordinators, or Behavioral Health Coordinators, at MDT and Care Coordinator at the FTC.

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

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

Informal Supports – During the provision of services, the provider will work with the family to link the family to informal support within the community to continue to support the family following closure. This work should occur each time the provider meets with the family and must be documented in the weekly/monthly note. This is a critical piece in developing long term family sustainability and for families to remain free of formal system involvement.

Utilization Review/ /FTC/ MDT staffing's – During on-going MDT staffing's or FTC the Clinical Services Coordinator, provider, family, and all team members meet to review the progress. At that time, the team determines if services will be re-authorized, terminated, or modified. This step is critical to ensure that services are appropriate and clinically indicated.

Other processes utilized to identify referrals for services:

The Comprehensive Behavioral Health Assessment (CBHA), an in-depth and detailed assessment of children in the child welfare system of care who enter out of home care placement, can be utilized for early engagement in services. The child's social, emotional, behavioral, and developmental functioning is evaluated as well as needs and strengths. A CBHA referral is completed for any child who is a victim of abuse, neglect, and abandonment. Once the assessment is completed, the Behavioral Health Coordinator (BHC) and/or Clinical Services Coordinator provides the completed CBHA recommendations and concerns for the child to the Clinical Services Coordinator, CM, CMS, and the Guardian Ad Litem program. The BHC and/or Clinical Services Coordinator conduct staffing's with the CM and GAL biweekly to ensure all CBHA's are reviewed, and all recommendations are followed. The BHC and/or Clinical Services Coordinator assess services to ensure they are meeting the needs of the child and/or if it needs to be escalated or flagged for a high-end MDT.

Retrospective Utilization Review

A retrospective Utilization Review (UR) occurs at minimum prior to the completion of a second twelve-week authorization or at minimum every quarter as part of the UR process completed by

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Clinical Services Coordinators to evaluate the effectiveness of services used by diverse groups of children and families and to recommend changes based on findings. The Clinical Services Coordinators share responsibility for conducting the retrospective review. Elements of the discharge and retrospective reviews include:

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

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

Mobile Response Team (MRT) is available 24 hours per day, seven days a week. Access to MRT is available 24 hours per day 7 days per week through FPOCF, Brevard C.A.R.E.S. and Devereux. All Case Management agencies are also on call 24 hours a day, 7 days per week for assistance. In addition, families can contact 211 for additional referrals and service-related issues. All services and program referrals are conducted with the intent of providing the least restrictive and most appropriate service that meets the needs and preferences of the child and family being served. MRT is coordinated through 211 for the tri-counties.

If a Care Manager determines an immediate need for a service authorization and there is no time to schedule a Family Team Conference or MDT staffing, the Care Manager requests the authorization from the Clinical Services Coordinator at the earliest point possible upon identification of need.

Authorization Thresholds
Clinical Services Coordinators cannot authorize any amount that exceeds one twelfth of the total annual budget allocation monthly based on an average of a 60% utilization from the funding sources of Family Support, Family Preservation, Time Limited Reunification, Other Client Services and 100/806 Diagnostic and Evaluation Funds (for non-Medicaid funded children service). It should also be noted that funding through Other Client Services is a funding of last resort. Any request that exceeds this threshold must be approved by the Placement and Behavioral Health Administrator or designee.

Licensed and Non-Licensed Placements
Children entering licensed out of home care must be placed within 4 hours of completion of the Comprehensive Placement Assessment. When the Child Protective Investigator (CPI) has determined that the child must be removed from his/her home and there is no immediate or appropriate relative or non-relative caregiver available for placement, the CPI requests placement services and supports from FPOCF OOHC/Placement Specialists (during both normal business hours and after hours through on call line for placement identification after removal episode).

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The OOHC/Placement Specialists and/or Behavioral Health Coordinators provide authorizations for all licensed placements. These decisions are based on placement protocols and service guidelines to ensure that children are placed appropriately. All enhanced placements requests to included, double bed rates, 1:1 service, etc., must be approved by Senior Director or other designee.

For each child in out-of-home care placement and each child/family receiving services, the appropriateness of the placement and services are not only reviewed at the Family Team Conference (FTC) or the) MDT Staffing's, but they are also reviewed internally through the utilization management process. The objective of utilization review is to ensure optimal quality care in the most effective manner through appropriate allocation of System of Care resources. The necessity of services and overall utilization of all services is reviewed on an ongoing basis through a variety of mechanisms.

High-End Multi-Disciplinary Team Meetings (HLOC MDTs) involve the review of children in licensed out of home care to determine the need for both an increased and decreased (step-down) level of care. Recommendations are based upon medical necessity criteria and are intended to provide guidance for other service options if Specialized Therapeutic Foster Care (STFC), Specialized Therapeutic Group Home (STGH) Care, Qualified Residential Treatment Program (QRTP) and/or Sub-acute Inpatient Psychiatric Program (SIPP) are not recommended. These children must be under the jurisdiction of Brevard, Orange, Seminole, or Osceola County. The core team members that participate in the HLOC MDT include but are not limited to: BHC or designee, Out of Home Care Specialist, Nurse Care Manager, Mental Health Targeted Case Manager if assigned, Therapist if assigned, Dependency Care Manger, and the Sunshine Health Plan representative if applicable. Staffing's are held within 60 days from being placed and every 90 days thereafter for children who are in STFC, QRTP, STGC, or SIPP levels of care. Requests for HLOC MDT's are submitted to the BHC or designee.

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

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

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

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

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

(5) If the motion for placement of the child into residential treatment is approved by the court, the assigned child welfare professional, FPOCF Out of Home Care staff, in accordance with local protocol, will coordinate the placement of the child.

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Any child requiring placement in a Specialized Therapeutic Foster Home Level I or Level II is reviewed and approved by the HLOC MDT for determination of Medical Necessity Criteria including admission criteria. Children in a STFC Level I or Level II are reviewed at a minimum every 30 days to determine ongoing Medical Necessity Criteria (continuing stay criteria). The HLOC MDT assesses whether the child requires STFC services or with less intensive services. Once approved the Behavioral Health Coordinator collaborates with the identified provider to obtain authorization for funding.

FPOCF's Utilization Management Activities and Purpose

Utilization Management Activity	Purpose
Quarterly Quality Service Review	Review the appropriateness and effectiveness of services delivered
Monthly Review of Purchased Services	Review operational and financial/fiscal performance of purchased services
High Utilization Services Reviews	Review families with multiple services, services provided for extended period and costly service delivery
Submit Service Requests from CMA within 3 days of receipt	Ensure clinically appropriate and prioritize service referrals based on need, availability of service and funding source, if Court ordered authorize immediately
Prospective Utilization Review	Prior to authorization of service based on need and appropriateness at time of initial referral and after development and any revision of case plans.
Concurrent Utilization Review	Prior to reauthorization of service to review progress reports, treatment plans and high utilization patterns
Retrospective Utilization Review	After interventions/treatment and services- Ensures clinical integrity to evaluate quality of service and best practice reviews entailing: Did services provided have adequate documentation? Were services provided appropriate? What were the results of the interventions? Occurs minimally prior to second 12-week authorization
Track Medicaid Funded Referrals	Referrals made to third party reimbursable partner agencies are tracked in Mindshare, reviewed, and reported monthly to monitor partner agencies receiving third-party referrals from FPOCF and to oversee trends associated with service delivery.
Collaborative Review of Service Delivery	On an ongoing basis at a minimum of monthly the Clinical Services Coordinator and Behavioral Health Specialist review and assess service plan implementation, family's progress toward achieving goals, desired outcomes, and the continuing appropriateness of service goals.

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Distributes the CBHA, recommendations and concerns for the child to the Clinical Care Coordinator, CM, CMS, and the Guardian Ad Litem program	The BHC conducts staffing with the CM and GAL biweekly to ensure all CBHA's are reviewed and to ensure all recommendations are being followed. The BHC consults with the Clinical Services Coordinators to assess services to ensure they are meeting the needs of the child and/or if it needs to be escalated or flagged for a high-end MDT
Distribute Satisfaction Survey to Families	As part of the continuous quality improvement process, families rate their satisfaction with the service referral process including availability of appropriate services and information regarding how helpful the services were/are to the family
High Utilization Placement Review	Any child with a double rate or daily rate standard rate exceeding the high utilization threshold is reviewed every 30 days, to evaluate is level of care still required, are appropriate services in place to help support and stabilize child and when is step down to least restrictive level indicated based on treatment plan?
Enhanced service provision for children entering Licensed Out Of Home Care (OOHC) that requires enhancement and supports for stabilization.	Coordinate service provision, discuss with Clinical Services Coordinator to ensure appropriate services are identified and authorized, and engage licensed placement.
Trauma screening after a child's removal from his or her home within 21 days of removal	FPOCF and DCF CPI's complete trauma screening using the Pediatric ACES and Related Life Screener (PEARLS) and as indicated appropriate and necessary by the screening, refer the child to services and interventions
Daily OOHC Meeting	Daily huddle of the OOHC team to assess needs, discuss upcoming placement moves, assign tasks, and evaluate any on call placements including disruptions and unplanned moves that occurred the day prior. In addition, the OOHC Manager reviews ongoing tasks, assigns a champion for children as needed, and ensures communication occurs with the Behavioral Health team as needed for service implementation.
Monthly Licensing Meeting	The Senior Director of Licensing Levels 2 to 5 facilitates a meeting, which includes all licensing staff, Out of Home Care and Behavioral Health team members. This forum provides the opportunity to discuss any needs in the home, review homes that may need some additional support due to the behaviors being displayed in the home, discussion of overcapacity waivers, and homes on hold.

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Weekly Behavioral Health Meeting	Team meeting that includes the Behavioral Health Coordinators, MDT Coordinators, and Clinical Services Specialists, to review all youth, in all levels of care that have escalated and/or flagged due to increased needs for services, supports, Baker Acts, high end placements, etc. This forum allows for a comprehensive review of to support the youth and families to remain in the current level of care and/or review those youth deemed ready to step down to ensure all services/supports are in place for a successful transition.
Monthly OOHC Reviews	The team completes a Comprehensive Clinical review to assess the current placement needs for youth as they are identified, to ensure adequate services and supports are in place, based on a review of progress notes, provider feedback, and information provided from the OOHC team.

Denial of Service (Sunshine Funded Levels of Care)
The team members that may participate in the High Level of Care (HLOC) MDT process include the Behavioral Health Coordinator, Out of Home Care Specialist, Substance Abuse and Mental Health (SAMH) Representative, Independent Living Specialist, Targeted Case Manager, Therapist and Child Welfare Care Manager. All decisions made by the multidisciplinary team are made by a majority consensus vote. If a team member disagrees, a follow up HLOC MDT will be scheduled within 30 days to re-review the case and attempt to come to resolution. All decisions made by FPOCF's Clinical Team are recommendations only. The Clinical Services Coordinator and Utilization Management Program Manager make final approval for placement and funding. Should a member of the child's treatment team disagree with the decision made by the Sunshine Health Plan they are advised to follow the Sunshine Right to Appeal Process.

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

Operational Issue or Concern—An issue or concern of an operational nature from Sunshine Health sub-contractors or vendors are shared with Sunshine Health's Child Welfare Program leadership to seek resolution. These issues can be member-specific or general in nature, but they are not considered to be complaints. While they may identify concerns about processes or operations, they are not reported due to member dissatisfaction.

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

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

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

Member Complaints, Grievances and Appeals
• Sunshine Health does not delegate member complaints, grievances, or appeals
• A complaint is any oral or written expression of dissatisfaction by a member submitted to the Health Plan or to a state agency (e.g., AHCA). And it must be resolved within one business day following receipt or it must be managed as a grievance.
• A grievance is an expression of dissatisfaction about any matter other than an adverse decision to a prior authorization request
• An appeal is a request to review an adverse decision as a result of a prior authorization request. Members can request an appeal by phone, in person or in writing. If a member is not happy with Sunshine Health's appeal decision, they can request a Medicaid Fair Hearing.
Confidential and Proprietary Information.

Additional information is already available on the Complaints, Grievances and Appeals webpage on SunshineHealth.com.

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

A. Sunshine may receive information related to a potential Complaint, Grievance or Quality of Care Issue from an enrollee, a treatment provider or FPOCF on behalf of an enrollee.
B. FPOCF will immediately notify the Sunshine Health Child Welfare Director of a complaint or grievance that is reported by:
    1. An enrollee.
    2. FPOCF on behalf of an enrollee.
    3. A parent, guardian, or caregiver on behalf of an enrollee; or
    4. A provider, either on behalf of an enrollee or due to a specific provider dispute.
C. Within twenty-four (24) hours of receipt of a complaint, grievance, or quality of care issue FPOCF designee immediately submits the report and attached documentation directly to / Sunshine Health via email, as indicated below:
    Email: Complaints, grievances, and quality of care issues may be submitted via Sunshine Health's secure and monitored notification mailbox, as well as to Sunshine Health's Leadership:
        - SUN_PQI@centene.com; (Complaint)
        - cwsp_notifications@centene.com (Complaint and Grievance)
D. Complaints will be reported to Sunshine Health both as described above and, in a format, frequency and process established by Sunshine Health.
E. Sunshine Health's Quality improvement department is responsible to investigate the potential quality of care issue, complaint, or grievance and to take appropriate action.
F. Sunshine Health must clearly communicate whether the appeal is standard or expedited and give the appropriate deadline at the time of the request.
G. The Regional Coordinator is responsible for monitoring compliance with procedures related to the reporting requirements as part of the quarterly CBC Lead Agency monitoring process.

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Concurrent Utilization Reviews of Children in Qualified Residential Treatment Program (QRTP), Specialized Therapeutic Group Care (STGH), or Specialized Therapeutic Foster Care (STFC) Levels of Care

All children residing in QRTP, STGC, and SIPP levels of care are reviewed through a HLOC MDT a minimum of every three months in coordination with the Suitability Assessment requirements. All children residing in STFC are reviewed at the HLOC MDT a minimum of every 30 days, unless agreed upon at the previous staffing. All Clinical Review Staffing dates, purpose, and outcomes are maintained in FSFN.

Reviewed by:

PHILIP J. SCARPELLI
Chief Executive Officer

Review Date: August 20, 2025