Involuntary Outpatient Commitment Program
Care Coordination Teams

Request for Letters of Intent

RLI # 24-001

September 26, 2024

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I. Background

Florida House Bill (HB) 7021, passed in 2024, marks a significant legislative advancement in the state's mental health framework, focusing on enhancing the accessibility and effectiveness of mental health services for individuals with severe mental illness. This bill specifically addresses the need for structured outpatient treatment for individuals who, while not meeting the criteria for involuntary inpatient commitment, require mandatory treatment to prevent deterioration of their mental health condition and potential risk to themselves or others.

The legislation enables courts to order Involuntary Outpatient Commitment (IOC) as part of a broader strategy to provide continuous, community-based care for individuals with severe mental illness. The IOC program is designed to ensure that individuals receive the necessary mental health treatment while remaining in their communities, thereby reducing the need for more restrictive forms of care, such as hospitalization.

BBHC's Role as the Managing Entity: Broward Behavioral Health Coalition (BBHC), as the designated Managing Entity in Broward County, has been tasked with overseeing the implementation of the IOC program countywide. BBHC's responsibilities include coordinating care, ensuring compliance with state regulations, and facilitating the integration of services across various providers. As the Managing Entity, BBHC plays a critical role in ensuring that the objectives of Florida HB 7021 are met effectively and that individuals under IOC orders receive consistent, high-quality care tailored to their specific needs.

Program Objectives: The primary objectives of the IOC program under Florida HB 7021 include:

- **Ensuring Compliance with Treatment:** Establishing a legal mechanism for court-ordered outpatient treatment to ensure that individuals adhere to prescribed treatment plans.
- **Reducing Hospitalizations:** Minimizing the need for involuntary inpatient treatment by providing effective, less restrictive outpatient care options.
- **Improving Individual Outcomes:** Enhancing the quality of life for individuals with severe mental illness by providing continuous, community-based treatment and support.
- **Promoting Public Safety:** Ensuring that individuals who may pose a risk to themselves or others receive the necessary treatment to mitigate potential dangers.

II. Statement of Purpose

The purpose of this Request for Letters of Intent (RLI) is to identify and select highly qualified Care Coordination Teams (CCT) that will be responsible for the oversight and coordination of the Involuntary Outpatient Commitment program in Broward County, as mandated by Florida House Bill 7021. The chosen teams will be essential in executing a structured, legally required approach to outpatient treatment for children and adults with severe mental illness, substance use disorder, and co-occurring conditions who qualify and have been court ordered for involuntary outpatient commitment.

The IOC program is designed to ensure that these individuals receive continuous, community-based care, with the overarching goals of improving their health outcomes, enhancing their quality of life, and reducing the need for more restrictive interventions such as hospitalization. The program also aims to uphold public safety by providing the necessary oversight to prevent potential harm to the individuals themselves and others. The CCTs are a fundamental component in ensuring this process is successfully implemented.

The selected CCTs will be responsible for executing all phases of the IOC program, from initial individual engagement and assessment to ongoing support, monitoring, and final transition to long-term community services. This includes ensuring compliance with court orders, coordinating multidisciplinary services, and maintaining clear and consistent communication with all stakeholders, including the court system, mental health service providers, and an individual's natural support systems.

BBHC, as the Managing Entity, seeks to collaborate with teams that possess the expertise, experience, and capacity to deliver these critical services effectively. The selected teams are expected to demonstrate a deep understanding of the legal and clinical requirements of the IOC program, a commitment to client-centered care, and the ability to navigate the complexities of behavioral health service delivery in a community setting.

This RLI represents an opportunity to make a meaningful impact on the lives of individuals with severe mental illness, substance use disorders, and co-occurring conditions in Broward County. It seeks to establish services that will contribute to the overall improvement of mental health services within our community. Focused on this objective, we invite proposals from qualified Care Coordination Teams who share our vision and commitment to excellence in service delivery.

III. Systemic Program Goals

1. **Ensure Compliance with Court-Mandated Treatment Plans:**
    - **Objective:** Facilitate adherence to court-ordered treatment plans, ensuring that individuals with severe mental illness, substance use disorder, or co-occurring conditions follow through with the prescribed outpatient services.
    - **Approach:** Implement regular monitoring and reporting mechanisms to track compliance and progress, while promptly addressing any deviations from the treatment plan.
2. **Provide Comprehensive, Integrated Care:**
    - **Objective:** Coordinate and ensure the delivery of holistic care that addresses the full spectrum of individuals' needs, including mental health, substance use, and co-occurring conditions.
    - **Approach:** Utilize a multidisciplinary team approach to ensure that all aspects of the individual's health and well-being are addressed, integrating psychiatric care, therapy, substance use treatment, case management, and peer support.
3. **Promote Stabilization and Recovery in the Community:**
    - **Objective:** Support the stabilization and recovery of individuals within their communities, reducing the need for inpatient hospitalization or more restrictive interventions.
    - **Approach:** Engage individuals in intensive, community-based services that promote resilience, self-sufficiency, and long-term recovery, leveraging natural supports and community resources.
4. **Enhance Individual and Family Engagement:**
    - **Objective:** Foster active participation and engagement of individuals and their families in the treatment process, empowering them to take an active role in recovery.
    - **Approach:** Develop individualized care plans in collaboration with individuals and their families, ensuring that their needs, preferences, and strengths are incorporated into the service delivery.
5. **Improve Public Safety and Well-Being:**
    - **Objective:** Reduce potential risks to public safety by ensuring that individuals at risk of harming themselves or others are effectively managed and treated in a less restrictive environment.
    - **Approach:** Implement evidence-based practices and crisis intervention strategies that minimize risk behaviors, while providing appropriate levels of care and supervision.
6. **Facilitate Smooth Transitions Across Levels of Care:**
    - **Objective:** Ensure that individuals transition seamlessly across different levels of care, particularly as they move from intensive services to more routine or maintenance care.
    - **Approach:** Coordinate warm hand-offs and maintain continuity of care as individuals progress through the program phases, eventually transitioning to long-term community-based services.
7. **Meet Legal and Regulatory Requirements:**
    - **Objective:** Adhere to all legal, regulatory, and ethical standards as set forth by Florida HB 7021 and related mental health and substance use disorder regulations.
    - **Approach:** Ensure that all service delivery, documentation, and reporting comply with the court's requirements and state regulations, maintaining transparency and accountability throughout the program.

8. **Support Long-Term Outcomes and Quality of Life:**
    - **Objective:** Enhance long-term outcomes by providing sustained support that helps individuals achieve a higher quality of life, including stable housing, benefit acquisition, employment, and social integration.
    - **Approach:** Implement ongoing support mechanisms, such as supported employment and housing services, which contribute to individuals' overall stability and well-being, even after the IOC order has ended.
9. **Ensure Cultural Competence and Individualized Care:**
    - **Objective:** Provide culturally competent care that is tailored to the unique needs of each individual, recognizing and respecting diversity in all forms.
    - **Approach:** Train staff to be sensitive to cultural, linguistic, and socioeconomic differences, and customize care plans to reflect the individual backgrounds and preferences of individuals and their families.
10. **Monitor and Report Program Effectiveness:**
    - **Objective:** Continuously evaluate the effectiveness of the IOC program, making data-driven adjustments to improve outcomes.
    - **Approach:** Collect and analyze data on an individual's progress, service utilization, and overall program impact, providing regular reports to the court and other stakeholders.

These goals are designed to ensure that the IOC Care Coordination Teams effectively address the complex needs of individuals while fulfilling the legal and therapeutic objectives set forth in Florida HB 7021 and §394.467, Florida Statutes, as amended, and the court system.

IV. Eligibility Criteria

Eligibility Criteria for Children and Transitional Adults:

1. Age Requirement:
    - The child or transitional adult must be under the age of 25 at the time of referral or evaluation. If the individual is between the ages of 18 and 25, they will be placed with the most appropriate team.
2. Mental Health Diagnosis:
    - The child or transitional adult must have a diagnosed severe mental illness, substance use disorder or a co-occurring disorder that significantly impairs their ability to function in daily life and requires integrated treatment and care coordination. This may include, but is not limited to, conditions such as severe depression, bipolar disorder, schizophrenia, or other serious emotional disturbances (SED).
3. Involuntary Outpatient Commitment Order:
    - The child or transitional adult must be under a court order for involuntary outpatient treatment, as per the provisions of Florida HB 7021 and §394.467, Florida Statutes. The order must specify the need for coordinated care to manage their condition in a community setting.
4. Risk of Harm or Deterioration:
    - The child or transitional adult must be at risk of harm to themselves or others including suicidal ideation, aggressive behavior, or other behaviors that pose a significant risk.
5. Inadequate Response to Voluntary Outpatient Treatment:
    - The child or transitional adult must have previously failed to respond adequately to voluntary outpatient treatment or been unable to comply with a voluntary treatment plan, necessitating more structured and mandated intervention.
6. Parental/Guardian Involvement:
    - A parent or legal guardian (when applicable) must be willing to participate in the care coordination process and support the child's treatment plan. This includes providing consent for treatment and participating in meetings and decision-making processes.
7. Geographic and Service Accessibility:
    - The child or transitional adult must reside within Broward County to be served by the IOC care coordination team and be eligible for services provided by the Managing Entity, BBHC.

Eligibility Criteria for Adults:

1. Age Requirement:
    - The individual must be 18 years of age or older at the time of referral or evaluation. If the individual is between the ages of 18 and 25, they will be placed with the most appropriate team.
2. Mental Health Diagnosis:
    - The adult must have a diagnosed severe mental illness, substance use disorder or a co-occurring disorder that significantly impairs their ability to function in daily life and requires integrated treatment and care coordination. This may include, but is not limited to, conditions such as severe depression, bipolar disorder, schizophrenia, or other serious emotional disturbances (SED).
3. Involuntary Outpatient Commitment (IOC) Order:
    - The adult must be under a court order for involuntary outpatient treatment in accordance with Florida HB 7021 and §394.467, Florida Statutes. This order must mandate participation in a coordinated care plan to manage their condition within the community.
4. Risk of Harm or Deterioration:
    - The adult must be at significant risk of harming themselves or others due to their mental illness, substance use disorder or a co-occurring disorder. This includes behaviors such as suicidal tendencies, self-neglect, or aggression that necessitates close monitoring and intervention.
5. History of Non-Compliance with Treatment:
    - The adult must have a history of non-compliance with voluntary treatment, leading to repeated hospitalizations, arrests, or other negative outcomes that could be mitigated by a structured, mandatory treatment plan.
6. Functional Impairment:
    - The adult's mental health illness, substance use disorder, or a co-occurring disorder must be causing significant impairment in their ability to manage daily activities, maintain employment, or engage in social relationships, thereby requiring coordinated care to improve their functioning.
7. Geographical and Service Accessibility:
    - The adult must reside within Broward County to be served by the IOC care coordination team and meet the eligibility criteria for services provided by BBHC.

V. Application Process

1. Eligibility for responding to the RLI.

To respond to this RLI, the provider must be a BBHC pre-qualified entity that meets the following criteria:

a. It has a current and valid contract with BBHC and is in compliance with all contractual obligations and performance standards.
b. It has maintained a physical business location in Broward County, where it serves individuals, for at least one (1) year prior to the submission of the proposal.
c. It has a proven track record of providing behavioral health services, (care coordination preferred), for at least three (3) years, and can demonstrate its experience and expertise in serving the target population selected.
d. It has the capacity and readiness to implement the program within 30 days of receiving the notice of award.
e. It has the ability to collect and report data on program outcomes and performance indicators.
f. It agrees to accept any and all referrals from BBHC, which will be court ordered, unless they have no available slots for the program and cannot accommodate the referral within 10 days.

2. Written responses to the RLI

The narrative portion of the application should be no more than ten (10) pages (not including the required budget documents and any supporting attachments) and should cover the following:

a. Abstract: This Request for (RLI) seeks a qualified provider to deliver comprehensive involuntary outpatient care coordination services. Provide a concise overview of your team's qualifications, expertise, and experience relevant to the Involuntary Outpatient Commitment (IOC) program. Highlight your organization's key successes in similar programs.
   - *Agency History and Experience*:
     Please provide a detailed overview of your agency's background in behavioral health care coordination, emphasizing your experience working with court-involved cases. Highlight specific examples of past projects or programs where your agency effectively managed behavioral health services within a legal framework, showcasing your capacity to navigate complex interactions between individuals, healthcare providers, and judicial entities.
   - *Motivations and Objectives:*
     Summarize your team's understanding of the IOC program's goals and how your approach aligns with these objectives. Include a brief statement of your commitment to ensuring the success of the program.
   - *Client Recovery Support:*
     Describe the strategies and methodologies your agency employs to support and enhance client recovery. Provide insights into your approach to case management, individual engagement, and the integration of evidence-based

practices that promote long-term recovery and stability for individuals with behavioral health needs.

b. Capacity Readiness: Detail the preparatory steps your agency has undertaken to establish Care Coordination Teams for the Involuntary Outpatient Care (IOC) program. Highlight your agency's organizational readiness, including relevant infrastructure, existing processes, and any prior experience that demonstrates your capability to manage such a program effectively.

    - Emphasize key strengths such as:
        - Experienced Personnel: Outline the qualifications and expertise of staff members who will be involved in the Care Coordination Team, including their background in behavioral health, legal coordination, and case management.
        - Established Protocols: Describe any existing protocols or frameworks your agency uses for care coordination and how these will be adapted or expanded to meet IOC requirements.
        - Resource Availability: Mention any resources or tools (e.g., electronic health records, client management systems) that will support the implementation and ongoing management of the Care Coordination Team.
    - State Anticipated Implementation Barriers and Solutions: Identify potential challenges you foresee in the implementation process and provide strategies for addressing them. Common barriers might include:
        - Coordination with Court Systems: Discuss any challenges related to aligning with judicial requirements and how you plan to streamline communication and processes with the courts.
        - Staff Training and Adaptation: Address potential issues with training staff to meet the specific needs of IOC individuals and outline your approach to ongoing professional development and support.
        - Resource Allocation: Consider any concerns about resource limitations and detail how you will ensure adequate staffing, funding, and equipment are available for effective implementation.
    - Concerns and Proposed Solutions: Acknowledge any specific concerns you have about the implementation process and propose solutions to mitigate these concerns. For example:
        - Client Engagement Challenges: If there are concerns about engaging individuals who are mandated into care, describe your approach to building rapport and ensuring individual participation.

- System Integration: Discuss any potential difficulties in integrating with existing systems or processes and outline your plan for ensuring seamless integration.
- Compliance and Documentation: Address any concerns related to meeting compliance requirements and maintaining accurate documentation and propose solutions for ensuring adherence to all regulatory and contractual obligations.

c. Proposed Program: Describe your proposed Care Coordination Team(s). See Appendix 1 Program Description to respond to this section.

Be sure to include:

i. *Target Population:* The target population is divided into two key groups: (1) Children and Transitional Adults and (2) Adults. The focus of services for both groups is on the comprehensive care coordination of behavioral health needs, ensuring that individuals receive integrated, age-appropriate support throughout their developmental stages and life transitions.

- *Children and Transitional Adults*: This group includes children, through adolescence, and transitional adults, up to age 25, who are in the process of moving from adolescence to full independence. The services for this population are centered on the care coordination of behavioral health, addressing their mental, emotional, and social well-being. Key areas of focus include early intervention, behavioral health assessments, counseling, family support, and life skills training. For transitional adults, services also extend to address the unique challenges of young adulthood, such as managing mental health during the transition to independent living, education, employment, and housing. The goal is to ensure a seamless transition from childhood through adolescence and into early adulthood, with coordinated care that supports overall well-being.

- *Adults*: The adult population includes individuals beyond the transitional phase. Although these individuals are typically aged 26 and older, they may be 18 and older, and may require continued support for behavioral health needs. Services for adults focus on the care coordination of mental health services, substance use treatment, and other behavioral health interventions necessary to maintain their independence and quality of life. Programs should be responsive to the evolving needs of adults, offering tailored support that includes workforce development, housing stability, and other critical areas that contribute to sustained mental health and well-being.

ii. *Description of the team composition:* Provide an organizational chart or similar representation of your care coordination team. Clearly identify each team member's role within the project. Include Key Personnel detailing the qualifications, certifications, and relevant experience of each team member. Highlight specific expertise in areas such as psychiatric care, case management, therapy, and peer support. Make sure the Roles and Responsibilities of each team member are clearly outlined, emphasizing how their expertise will contribute to the successful implementation of the IOC program. Include any subcontractors or partner organizations and specify their roles.

iii. Provide the physical location of your program: Describe the challenges that you foresee in serving individuals throughout the county and what you intend to do to address those challenges.

iv. Describe the implementation start-up process in terms of:
   - Staffing, experience required for staff by position, caseload sizes, referrals, and outreach.
   - Number to be served in the program in the first year; and
   - Staff to be hired/already hired.

v. Identify the salary payment system that will address challenges with recruitment and retention of professional staff. Please include salary scales.

vi. Staff members for these teams will be required to be full time and excusably dedicated to the program. Explain how your agency will ensure this requirement will be implemented to the program.

d. Community Relations and Partnerships: Strong community relationships and partnerships are essential for any program, and they are particularly crucial for the success of Involuntary Outpatient Care (IOC) Care Coordination Teams. These teams will need to effectively navigate and integrate a diverse range of services provided by various agencies to ensure comprehensive and coordinated care for individuals.

i. Importance of Community and Provider Partnerships: For IOC Care Coordination Teams, the ability to work collaboratively with multiple service providers is paramount. Individuals will require access to a wide array of services, from mental health and substance abuse treatment to housing and vocational support. Teams must maintain a clear oversight of the comprehensive treatment process, ensuring that each individual receives appropriate care tailored to their needs, regardless of the service provider.

ii. Examples of Successful Inter-Provider Collaborations: Demonstrating past success in inter-provider collaborations ***will be critical***. Please provide specific examples of previous collaborations where your agency effectively

coordinated with other providers to deliver integrated services. Highlight instances where these partnerships led to improved individual outcomes and efficient service delivery.

For example:

- Case Study of Integrated Care: Describe a project where your agency worked with mental health services, substance abuse treatment providers, and housing agencies to support an individual with complex needs, illustrating how seamless coordination led to successful individual recovery.
- Collaborative Service Delivery: Provide an example of a time when your agency coordinated with multiple providers to successfully transition individuals to a new program or service, showcasing how the collaboration improved service access and individual satisfaction.

iii. Documentation and Support Letters: To validate your agency's capacity for effective inter-agency coordination, include support letters from community partners or other relevant documents. These should attest to your agency's collaborative efforts and successful outcomes in previous partnerships, **with specific emphasis on receiving and making referrals for treatment to and from your agency and successfully collaborating in cases**.

iv. Medicaid: Describe whether you currently have contracts with the Medical Management Agencies (MMAs), and if so, with whom. If you have no such agreements, describe your current plans or efforts to attain.

VI. Other Selection Criteria

a. Agency CEO/Executive Director's commitment to participate in an organizational change process to implement an IOC Care Coordination Team, including participation in fidelity evaluation processes.
b. Strength of the agency demonstrated by its commitment to incorporate individuals with lived experience in their workforce.
c. You must include an acknowledgment statement that any monthly and quarterly outcome data report(s) will be reported to BBHC and that the agency shall cooperate with BBHC's periodic site visits for technical assistance.

VII. Line-Item Budget: Provide a detailed line-item budget for the first year of the program, assuming full capacity. The budget should include all projected costs that will be associated with the IOC Care Coordination Team, including flex/incidental funds. Demonstrate how your budget is both cost-effective and sufficient to cover all aspects of the program, ensuring quality service delivery without unnecessary expenditure.

VIII. Other Applications Requirements

a. Agencies may only submit one (1) Response to this RLI.
b. Applicants can be awarded one (1) or more than one team.
c. Agencies responding must submit their proposal electronically. The maximum award per team will be $200,000
d. Include a breakdown of your proposed units of service including.
e. Number of individuals to be served

XIII. Audit Requirements and Fiscal Soundness

Applicants must submit one (1) electronic or digital copy of their most recent annual financial statements (within 180 days after the close of the applicant's most recent fiscal year-end) that have been audited by a Certified Public Accounting (CPA) firm licensed to do business in the State of Florida and prepared in accordance with Generally Accepted Accounting Principles (GAAP) and standards contained in Government Auditing Standards and OMB 1-133. Applicant agencies with total annual revenues of less than $750,000 may submit their most recent annual financial statements that have been reviewed or compiled by a CPA firm licensed to do business in the State of Florida and prepared in accordance with GAAP. The Independent Auditor's Report must contain an unqualified audit opinion without expressing "going concern" disclosures, and the Statement of Financial Position must show positive Net Assets.

IX. Due Date – Fatal Flaw

All responses to this RLI are due and must be received at the email address referenced below by Friday, October 25, 2024, on or before Noon. Failure to timely deliver submissions is a fatal flaw rendering the submittal non-responsive and illegible for consideration.

X. Pre-Bid Conference

Participation in the Pre-Bid Conference on Tuesday, October 1, 2024, time to be announced, virtually through Microsoft Teams is recommended but not required. However, it will be the only opportunity for verbal discussion of questions and answers about this RLI solicitation.

After the close of the Pre-Bid Conference, there will be an opportunity for submission of additional written questions by email on or before Wednesday, October 2, 2024, 12:00 P.M.

The email to be utilized is*: providers.bbhc@cariskpartners.com*. To ensure that your question is readily identifiable, the subject line of the email must include the RLI number.

A summary of all written questions and answers will be posted on the BBHC website at www.bbhcflorida.org on Friday, October 2, 2024, 4:00 PM. It will be your responsibility to check for and obtain such information.

XI. Performance Measures and Outcomes

All program performance outcomes and reports must be submitted in accordance with the specified deadlines and requirements. Timely and accurate reporting is mandatory and must be entered into the Carisk Portal located at apps.CariskPartners.com as required. Compliance with these reporting protocols is essential to ensure the effective monitoring and evaluation of program performance, and any delays or discrepancies in submission will be addressed in accordance with the terms of the contract.

XII. Selections Process

All RLI responses will be evaluated by a Rating Committee comprised of community subject matter experts. A numerical scoring evaluation as identified in Appendix II will be used to identify the most persuasive proposals. Once a proposal is selected, the Rating Committee will make a funding recommendation.

BBHC retains the right to accept, modify, negotiate, or reject terms of any responses to this RLI.

At any time during the selection process, BBHC reserves the right, in its sole and complete discretion, to:

- conduct face-to-face or virtual interviews with any, all, or selected applicants.
- require submission of additional or revised responses.
- terminate negotiations or re-open negotiations with any applicant; or
- take other administrative actions deemed necessary by BBHC in its sole discretion to finalize funding awards.

BBHC shall further have the right in its sole discretion and in the best interest of BBHC to reject any responses or waive any minor irregularity or technicality in the responses received. BBHC further reserves the right without prejudice to reject any or all proposals.

XIII. Timetable:

ACTIVITY	TIMEFRAME
Dates Available:	9/26/24 - 10/25/24
Solicitation Conference (Pre-Bid Conference)	10/1/24
Submission of Written Questions	10/2/24
Posting of Responses to Written Questions	10/4/24
Reviewers Meeting (for raters only)	10/11/27
Deadline for Receipt of RLI Responses	**10/25/24**
Opening of RLIs Interviews/Reviewer's Meeting (Public Meeting)	11/5/24
Contract Negotiations	11/7/24 -11/8/24
Contract Execution	12/1/24

See Appendix 3 for more details

XIX. Terms of Agreement

The initial term of service for contracts awarded under this procurement is December 1, 2024, through June 30, 2025 (7 months). At the sole discretion of BBHC, two (2) optional renewals for the period of July 1, 2025, through June 30, 2026, and July 1, 2026, through June 30, 2027, may be authorized, but are contingent upon availability of funding, agency viability, positive performance, and successful re-negotiation of all terms. BBHC reserves the option of having further contract renewals.

XX. Background Screenings

All staff who work in direct contact with children and adults, including employees and volunteers, must comply with Level 2 background screening and fingerprinting requirements in accordance with Chapters 402, 435, and §§39.001, 943.0542, 984.01, and 1012.465, Florida Statutes, and Broward County background screening requirements, as applicable. The program must maintain staff personnel files, which reflect that a screening result was received and reviewed to determine employment eligibility prior to employment and throughout participation in this program.

XXI. Cone of Silence

Interested applicants responding to this solicitation, or persons acting on their behalf, may not contact any employee, agent, or board member of BBHC, Carisk Partners or the Florida Department of Children and Families (DCF) concerning any aspect of this RLI, except through submission of questions into the Carisk Portal located at apps.CariskPartners.com . This Cone of Silence begins upon the RLI release on September 26, 2024, until the posting of award notice on November 21, 2024. Violation of this provision may be grounds for disqualification from the selection process for this RLI.

XXII. Appeal Process

Protests, appeals, and disputes are limited to procedural grounds.

An applicant that is aggrieved by a procedural determination in the competitive process may file a written claim to appeal, protest, or dispute the decision within seventy-two (72) hours following the receipt of written notification from BBHC of the applicant's failure to advance to the next step of review due to a critical flaw, or within seventy-two (72) hours following BBHC's notice of the solicitation decision or funding award on the BBHC website. A formal written protest shall be filed within ten (10) days after the notice of protest is filed and shall state with particularity the facts and law upon which the protest is based.

Calculation of the 72-hour deadline for filing of the notice of protest shall not include weekends or BBHC holidays in the calculation of such a deadline.

Protests, appeals, or disputes may only challenge a procedural matter related to the solicitation. They may not challenge discretionary issues, such as the relative weight of the evaluation criteria or the formula specified for assigning points contained in the solicitation. A protest, appeal, or dispute is limited to challenging errors in procedural due process, errors in mathematical calculations, or omissions to score sections by the review team.

Protests, appeals, or disputes must comply with BBHC Procurement Policy and Procedures, posted on the BBHC website, www.bbhcflorida.org.

Failure to submit a notice, written protest, or bond within the required time frame shall constitute a waiver of such party's right to protest.

When protesting, appealing, or disputing a decision, the protestor must post a bond equal to one percent (1%) of BBHC's estimated contract amount. The bond is not to be filed with the notice of appeal, protest, or dispute but must be presented with the formal written protest, appeal, or dispute within the ten (10) day period for filing the same. The estimated contract amount shall be based upon the contract price submitted by the protestor. If no contract price was submitted, BBHC shall provide the estimated contract amount to the protestor within 72 hours after the notice of protest, appeal, or dispute has been filed. The estimated contract amount is not subject to protest. The bond shall be conditioned on the payment of all costs and charges adjudicated against the protestor in the administrative hearing in which the action is brought, and in any subsequent appellate court proceeding. Failure to file the proper bond at the time of filing the formal protest, appeal, or dispute will result in a rejection of the protest. In lieu of a bond, BBHC may accept a cashier's check, official bank check, or money order in the amount of the bond.

XXIII. Resources

Involuntary Outpatient Commitment, also known as Assisted Outpatient Treatment (AOT) in Florida, is a legal process where individuals with severe mental illness can be court-ordered to follow a treatment plan while living in the community. This process is outlined by Florida's Baker Act and Marchman Act laws.

Here are some key resources for practices, guidelines, and legal information regarding Involuntary Outpatient Commitment for both adults and children in Florida:

Florida Department of Children and Families (DCF)

- DCF provides guidelines and information on mental health services, including involuntary outpatient treatment under the Baker Act.
- Baker Act Information
- Marchman Act Information

The Florida Mental Health Act (Baker Act) Handbook

- This comprehensive guide covers the procedures, criteria, and rights related to involuntary commitment, including outpatient treatment.
- Baker Act Handbook PDF

Florida Courts Website

- Offers information about the legal process, court forms, and procedures for initiating involuntary outpatient treatment.
- Florida Courts - Mental Health

Broward County Clerk of Courts

These resources provide detailed information on procedures, legal guidelines, and support systems available for implementing and understanding Involuntary Outpatient Commitment in Florida.

https://samhweb.myflfamilies.com/FARS/fars/FARS%20User%20manual.pdf

Appendix 1

Program Description

This program is designed to deliver structured, mandatory outpatient treatment to individuals who meet the criteria for involuntary outpatient commitment under Florida law. It is divided into three (3) critical phases, each with specific goals and activities aimed at ensuring comprehensive care and successful outcomes for participants.

The immediate care coordination objectives prioritize the wellness of families by enhancing their natural support systems within the community. They aim to improve transitions from acute and restrictive services mandated by child welfare to community-based services, family supports, and the maintenance of long-term family and individual recovery tailored to meet the diverse needs of each family and its members.

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The Care Coordination Team will consist of two (2) key positions, each contributing to the delivery of comprehensive and effective services to individuals. Both positions will operate under the direct supervision of a licensed clinician, ensuring that all clinical activities are conducted with the highest standards of care.

1. **Clinical Case Manager:**
   The Clinical Case Manager, a master's level clinician, will be responsible for conducting comprehensive assessments, evaluating the appropriate level of care, and developing high-level service plans tailored to each individual's needs. This role requires advanced clinical expertise to ensure that all assessments and plans are aligned with best practices and meet the individual's requirements, while abiding by the court requirements. The Clinical Case Manager will oversee the coordination of services, ensuring that the care provided is both effective and appropriate for the individual's situation.
2. **Peer Specialist:**
   The Peer Specialist will provide direct support to individuals, utilizing their lived experience to offer guidance, encouragement, and practical assistance. This position is essential for fostering a supportive and empathetic environment, helping individuals navigate their treatment plans, and encouraging adherence to the care strategies developed by the Clinical Case Manager. The Peer Specialist will work closely with the Clinical Case Manager to ensure a cohesive and integrated approach to individual care.

Both the Clinical Case Manager and the Peer Specialist will be under the direct supervision of a licensed clinician, ensuring that all actions and decisions are clinically sound and in the best interest of the individuals.

Caseload Size and Expectations:

The caseload of each team will range between 20-25 individuals, with the distribution varying based on the phase each individual is in. Teams will manage fewer individuals in Phase One, where intensive support is required, and more individuals in Phase Three, as they progress towards greater independence.

The services provided by the Involuntary Outpatient Commitment Care Coordination Teams are time-limited, field based, with heavy concentration treatment coordination. The Care Coordination teams will focus on empowering the individual, linking with treatment while building upon the strengths, needs and natural supports. The team will provide a single point of contact for the courts until the individual is adequately connected to the ongoing support needed to maintain long term recovery and the court order is vacated.

Program Phases and Flow:

Phase 1: Intensive Engagement and Assessment

Objective: Establish a foundation for treatment through discharge planning with the referring treatment provider, assessments and immediate service coordination.

- **Initiation:** *(first contact with treatment provider being made within **one (1)** business day of receipt of referral)* Engage individuals through the intake process, securing consent, and completing necessary legal and clinical documentation.
- **Assessments:** Work with the referring treatment provider to ensure there is a current (within six (6) months) comprehensive Bio-Psycho-Social Assessment to understand the individual's holistic needs and two (2) current (within six (6) months) Level of Care assessments using LOCUS or CaLOCUS to determine the appropriate intensity of services. If these assessments are not part of the clinical documentation, then the team will complete them.
- **Service Coordination:** Initiate immediate referrals to essential services to develop a services plan, including but not limited to:
    - Psychiatric care
    - Case Management
    - Therapeutic interventions
    - Peer support services
    - Benefits assistance (SOAR)
    - Supported Employment (IPS)
    - Housing or Supported Housing services.
    - Residential services
    - Multidisciplinary team support
- Assist referring treatment provider in the completion of the Involuntary Outpatient Commitment petition.

At the beginning of the phase the individual is still at the referring treatment provider, and the CCT will support and actively participate in the discharge planning to be submitted to the court.

During this phase, contact frequency is expected to be intensive, with an average of at least three (3) face-to-face meetings per week. Telehealth services may be utilized where suitable so long as there is at least one (1) face-to-face meeting in person each week.

The conclusion of this phase will depend on when individuals are deemed engaged in the various services identified as necessary in the treatment plan as approved by the court.

Phase 2: Structured Support and Monitoring

Objective: Ensure stability and continuous progress through regular monitoring and support, while preparing for eventual transition.

- **Ongoing Engagement:** Maintain consistent face-to-face contact with individuals, with a minimum of one (1) session per week.
- **Actively Monitoring** service delivery and individual progress, adjusting care plans as needed.
- **Reporting and Support Development:** Prepare and submit reports to the court, and BBHC, as required by the program.
- **Facilitate the Development of Natural Support Systems** (family, community resources, etc.) to enhance individual stability. Activate natural supports to prepare for the upcoming phase.
- **Benefits and Employment Support:** Follow-up on benefits acquisition to ensure individuals receive all entitled support. Provide ongoing assistance with employment support, focusing on readiness and sustained engagement.
- **Readiness for Transition:** Continuously evaluate the individual's readiness for transition to less intensive services.

The frequency of face-to-face interactions may decrease but shall not fall below one (1) contact per week. Telehealth can be utilized where suitable, but there should be at least one (1) in person contact per month. All these interactions are based on individual needs, with the team increasing contact frequency in times of crisis.

This phase is the longest in duration and is designed to continue until expiration of the court's order or when the court determines that the individual no longer meets the criteria for involuntary services and discharges the individual from involuntary services. . During this extended period, it is expected that the majority of the treatment plan goals will be accomplished. The duration of this phase allows for comprehensive progress and ensures that the individual is fully prepared for the transition to a less restrictive status, which may include the individual's transfer to voluntary status.

Phase 3: Transition and Continuity of Care

Objective: Successfully transition individuals to ongoing community-based services with a focus on continuity of care.

- **Discharge Planning** begins at the initiation of the Involuntary Outpatient Commitment Care Coordination process and will be discussed with the individual, provider Care Coordination Team, the judiciary personnel, and the BBHC Care Coordination Manager.
- **Care Transition:** Facilitate the seamless transition of care from the IOC program to long-term, community-based services.
- **Warm Hand-Offs:** Ensure all necessary warm hand-offs are completed, connecting individuals directly with new service providers.
  A warm handoff is defined as face-to-face transition meeting should be held with the aftercare provider and the person served, and their preferred supports, such as a family member or peer specialist within two weeks of the termination of the IOC Care

Coordination team. (This transition meeting should occur regardless of if the court order was resolved at a prior time)

- **Final Reporting:** Prepare and submit a comprehensive final report to the court, detailing the individual's progress and transition plan.

Additional Duties:

- *Financial:* The Care Coordination Team will be responsible for requesting authorizations from the Broward Behavioral Health Coalition (BBHC) for any treatment services required by individuals. This includes initiating and managing the authorization process to ensure all necessary approvals are obtained promptly. The team must ensure that all requests are accurately completed, submitted in accordance with BBHC guidelines, and documented appropriately. This responsibility is crucial for facilitating access to necessary services and ensuring that individuals receive the appropriate care as per their treatment plans.
- *Clinical Staffing's*: The Care Coordination Team will be responsible for requesting clinical staffing from the Broward Behavioral Health Coalition (BBHC) for cases where an individual is non-compliant and at risk of failing their treatment plan. This includes promptly identifying cases that require additional clinical oversight and submitting requests for specialized staffing as needed. The team will also assist in identifying and including all relevant parties in these cases, ensuring that appropriate stakeholders are engaged and coordinated efforts are made to address the individual's needs effectively. This proactive approach is essential for managing high-risk situations and supporting an individual's adherence to their treatment goals.
- *Incidental requests*: The Care Coordination Team will be responsible for requesting authorizations in advance for eligible incidental payments related to housing or expenses exceeding $500. This includes preparing and submitting detailed requests that include a comprehensive sustainability plan and proper justification for the expenditure. The team must ensure that all requests are thoroughly documented, demonstrating the necessity and appropriateness of the requested funds. Effective management and transparent reporting of these incidental requests are essential for maintaining accountability and ensuring that all financial resources are utilized in accordance with established guidelines and BBHC's requirements**. Families should increasingly demonstrate the ability to self-manage and transition to other fund sources based on access to disability benefits, insurance, employment, and/or housing incidentals.**

  <u>Examples for Eligible Incidental Funds (*if other resources are not available*)</u>:
  - Employment related expenses
  - Housing assistance/subsidies (licensed, FARR Certified, Oxford, current lease)
  - Educational/Vocational services
  - Transportation
  - Day Treatment/Recovery Support
  - Medical Care/Services/Pharmaceuticals
  - Clothing
  - Childcare
  - Respite Services
  - Other incidentals as approved by BBHC in compliance with Rule 65E-14.021, F.A.C.

- *Legal and court duties:* The Care Coordination Team will be responsible for managing all legal and court-related duties as part of the individual's care. This includes attending court proceedings as needed, either in person or by ensuring appropriate representation. The team must also complete or ensure the completion of all required court reports in a timely and accurate manner, in compliance with legal and regulatory standards. Additionally, the

team will be responsible for ensuring that individuals attend all mandated court dates, providing support and reminders as necessary to facilitate their compliance with court orders. These duties are critical to maintaining the legal and procedural integrity of the individual's treatment plan.

- *Transportation Ability*: The team will be responsible for ensuring the safe and efficient transport of individuals to necessary services and support. The proposal should include a comprehensive plan that demonstrates the provider's capability to execute this task effectively, outlining specific strategies, resources, and protocols that will be utilized to ensure safety and reliability in transportation.
- *Crisis Management Capabilities:* The proposal should clearly detail a comprehensive strategy for managing crises and de-escalation, ensuring effective response both during and after regular business hours.

Appendix 2

Score Card

	BBHC BROWARD BEHAVIORAL HEALTH COALITION	RLI #: 24-001
	Rating Factors/Criteria	**Maximum Score**
1	The proposal demonstrate the overall readiness and ability to implement an Involuntary Outpatient Commitment Program Care Coordination Team .	10
2	The proposal demonstrates the ability to work effectively work with the target age group specified in the proposal.	10
3	The proposal ensures that the teams are equipped to serve individuals with mental health, substance abuse, and co-occurring disorders.	15
4	The proposal demonstrates the ability to engage with high-intensity individuals who have a history of non-compliance with treatment.	10
5	The proposal provides detailed description and evidence of their level of partnership with other community service agencies and systems.	10
6	The proposal provides a detailed description and evidence of their ability to follow up with community service agencies providing treatment after the proponent has made the referrals.	15
7	The proposal provides a detailed description and evidence of proponent's experience in working with the court system.	15
8	The proposal provides specific details about experience working across various systems of care.	15
9	The proposal provides specific details about how they will recruit and maintain the staff for an Involuntary Outpatient Commitment Program Care Coordination Team, including their history of staff development and retention.	10
10	The proposal describes clearly the qualifications, experience, and expertise of the proposed staff, that will work with the Involuntary Outpatient Commitment Program Care Coordination Team.	10
11	The proposal outlines a protocol for handling emergencies and crises for individuals enrolled in the Involuntary Outpatient Commitment Program Care Coordination Team.	10
12	The proposal outlines a protocols for handling emergencies that occur after hours and on weekends.	10
13	The proposal demonstrates the ability to effectively engage individuals in care in utilizing and integrating natural supports.	10
14	The proposal provides a detailed description and evidence of the proponent's capacity to adapt flexibly in response to evolving system's requirement	15
15	The proposal demonstrates experience in using evidence-based practices and outlines how these practices will be applied in this program.	10
16	The proposal demonstrates the ability to effectively engage individuals in care in utilizing and integrating peer supports.	10
17	The proposed budget reflects a reasonable and cost effective approach to service delivery	15
	SCORE	200

Appendix 3

Timeline