FY 26-27 BBHC Provider Contract Handbook

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I. Introduction

This is the Broward Behavioral Health Coalition, Inc. (BBHC) Provider Contract Handbook referenced in your contract. You will be notified of any changes to this Handbook. This handbook contains programmatic and policy information for services managed by BBHC according to DCF Managing Entity (ME) guidelines. Please refer to your contract with BBHC for specifics, as only those programs and services that pertain to your contract apply to your provider agency.

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II. Service Provision Detail

A. SERVICES TO BE PROVIDED

1. Definition of Terms

The definitions of certain terms used in this Contract can be found in the Broward Behavioral Health Coalition, Inc. ("ME" or "BBHC") Definition of Terms, which is incorporated herein by reference and available on the BBHC website at www.bbhcflorida.org.

2. General Description

a. General Statement

The services provided under this Contract are community-based Substance Abuse and Mental Health ("SAMH") services for a person-centered and family-focused coordinated system of care. The Contract requires the qualified, direct service, community-based Provider to provide services for adults and/or children with behavioral health issues as authorized in §394.9082, Florida Statutes, consistent with Chapters 394, 397, 916, and §985.03, Florida Statutes (as applicable), State Behavioral Health Services Plan dated January 2011, or the latest version thereof, and in the ME contract with the Florida Department of Children & Families ("DCF") ("Prime Contract"), which is incorporated herein by reference and which may be found on BBHC's website. The latest version thereof, and in the ME contract with The School Board of Broward County, which is incorporated herein by reference and which may be found on BBHC's website.

The Provider shall comply with applicable laws, rules, codes, ordinances, certifications, licensing requirements, and the Department's Children and Families Operating Procedures (CFOP).

The Provider shall comply with the requirements of Chapter 65E-14, F.A.C..

The Provider will ensure support for individuals with a disability or with limited English proficiency. The Provider shall comply with CFOP 60-16, located at: https://www.myflfamilies.com/about/additional-services-offices/office-civil-rights/individual-disability, which includes completing the Civil Rights Compliance Checklist, (Form CF 946) within 30 days of the Effective Date and annually by the date specified in CFOP 60-16, thereafter.

For Nutritional Programs and Activities funded through the Department's Office of Economic Self-Sufficiency, the Provider and its subcontractors shall also comply with USDA Food & Nutrition Service Instruction FNS-113-1 to ensure civil rights compliance and prohibit discrimination in nutrition programs and activities.

The Provider's confidentiality procedures shall be at least as protective as the most recent version of the BBHC's and Department's security policies and comply with any applicable professional confidentiality standards.

The Provider shall work in partnership with the ME to meet the needs of individuals, hereinafter referred to as person served, with co-occurring substance abuse and mental health disorders and in need of trauma informed care. The partnership process will be open, transparent, dynamic, fluid, and visible. The process shall also serve as an opportunity for collaboration to continuously improve the quality of services provided to the residents of Broward Country. During the term of the Contract, the ME will require that the Provider participate in the process of improving co-occurring disorder service capability system-wide and in trauma informed care services. The Provider shall participate in the ME's initiatives, as applicable. To which the ME shall advise, notify, or train the Provider, as deemed appropriate and follow all BBHC's Policies and Procedure which are located at www.bbhcflorida.org and is incorporated herein by reference, in the fulfillment of its contractual obligations and to assist the ME in the fulfillment of its contractual obligations as required in the Prime Contract in the following areas:

(1) System of Care Development and Management;
(2) Utilization Management;
(3) Quality Improvement;
(4) Data Collection, Reporting, and Analysis;
(5) Financial Management; and
(6) Disaster Planning and Responsiveness

BBHC shall be the payer of last resort for services provided under this Agreement or Contract. Prior to seeking any BBHC funds for payment, the Provider shall first pursue and exhaust all other applicable sources of funding, reimbursement, or payment for which the services or individual are eligible, including payment from the prior or primary funder, third-party payers, insurance, Medicaid, Medicare, or other available funding sources, as applicable.

BBHC funds shall only be used to pay for eligible services and costs that remain unpaid after all other applicable funding and payment sources have been exhausted or determined to be unavailable. The Provider shall not bill or seek reimbursement from BBHC for any service or cost that is otherwise payable by another funding source.

The Provider shall maintain documentation demonstrating its efforts to obtain payment from the applicable prior or primary funding source and shall provide such documentation to BBHC upon request. If the Provider receives payment from another funding source for a service or cost previously paid by BBHC, the Provider shall promptly notify BBHC and reimburse BBHC to the extent of the duplicate payment.

Nothing in this provision shall be construed to require the Provider to pursue payment from a funding source when doing so is prohibited by applicable law, regulation, payer requirements, or the terms of the applicable funding agreement.

b. Scope of Services

The following scope of service applies to the Contract:

(1) The Provider is responsible for the administration and provision of services to the target person served indicated in exhibit entitled "Person Served" and in accordance with the tasks outlined in this Contract. Services shall be delivered at the locations specified in and in accordance with the Provider's ME-approved Application for Pre-Qualification and Program Description which are incorporated herein by reference.

(2) Services shall be delivered in Broward County, Florida.

c. Major Program Goals

(1) The primary goal is to promote the reduction of substance use, abuse, and dependence and improve the mental health and lives of the people of Broward County by making substance abuse and mental health treatment and support services available through a comprehensive, integrated community-based System of Care, and to engage and encourage persons with, or at-risk of, substance abuse and/or mental illness to live, work, learn, and participate fully in their community.

(2) It is the goal of the ME to improve accountability; ensure quality of care through evidence-based practices ("EBP") and ensure delivery of behavioral health services available through the ME Provider Network and across systems resulting in systematic access to a full continuum of care for all children and adults who enter the publicly-funded behavioral health services systems.

(3) It is the goal to improve co-occurring capability, trauma informed care, and expertise in all programs.

(4) To promote and improve the behavioral health of Broward County by strategically applying substance abuse prevention programs and environmental strategies relevant to community needs through the delivery of substance abuse, mental health and prevention services.

d. Minimum Programmatic Requirements

The Provider shall maintain the following minimum programmatic requirements:

(1) System of Care:
The recovery-oriented system of care must be consumer and family-driven and will:

(a) Be driven by the needs and choices of the person served;
(b) Promote family and personal self-determination and choice;
(c) Be ethically, socially, and culturally/linguistically responsive and responsible; and
(d) Be dedicated to excellence and quality results.

There is a commitment to expand clinical treatment to include the behavioral health EBP and recovery support services in accordance with priorities established by the ME for substance abuse, mental health treatment and/or co-occurring disorders, substance abuse prevention services, substance abuse and mental health treatment capacity, children and families, criminal and juvenile justice, HIV and hepatitis.

(2) Guiding Principles
All services delivered by the Provider shall:

- **(a)** Include the person served and families as full partners in the planning and delivery of services;
- **(b)** Incorporate a broad array of service and support (e.g., physical, emotional, clinical, social, educational, and spiritual);
- **(c)** Meet the person served individualized needs and strengths;
- **(d)** Be provided in the least restrictive clinically appropriate setting;
- **(e)** Be coordinated at the system and service delivery level to ensure multiple services are seamlessly provided;
- **(f)** Be sensitive to cultural and linguistic needs of person served; and
- **(g)** Be gender responsive, e.g., treatment services designed to meet the needs of women.

3. Persons to be Served

Behavioral Health services shall be provided to persons pursuant to §394.674, Florida Statutes, including those individuals who have been identified as requiring priority by state or federal law. These identified priorities include, but are not limited to, the categories in sections (a) through (j), below. Persons in categories (a) and (b) are specifically identified as persons to be given immediate priority over those in any other categories.

a. Pursuant to 45 C.F.R.§96.131, priority admission to pregnant women and women with dependent children by providers receiving Substance Abuse Prevention and Treatment ("SAPT") Block Grant funding;

b. Pursuant to 45 C.F.R. §96.126, compliance with interim services, for injection drug users, by providers receiving SAPT Block Grant funding and treating injection drug users;

c. Priority for services to families with children determined to require substance abuse and mental health services by child protective investigators and also meet the target person served in subsections (a) or (b), above. Such priority shall be limited to individuals not enrolled in managed care or another insurance program, or require services not paid by another payor source, as applicable:

(1) Parents or caregivers in need of adult mental health services pursuant to §394.674(1)(a)2, Florida Statutes, based upon the emotional crisis experienced from the potential removal of children; and

(2) Parents or caregivers in need of adult substance abuse services pursuant to §394.674(1)(c)3, Florida Statutes, based on the risk to the children due to a substance use disorder.

d. Individuals who reside in civil and forensic state Mental Health Treatment Facilities and individuals who are at risk of being admitted into a civil or forensic state Mental Health Treatment Facility pursuant to §394.4573, Florida Statutes, and Rules 65E-15.031 and 65E-15.071, F.A.C.;

e. Individuals who are voluntarily admitted, involuntarily examined, or placed under Part I, Chapter 394, Florida Statutes;

f. Individuals who are involuntarily admitted under Part V, Chapter 397, Florida Statutes;

g. Residents of assisted living facilities as required in §§394.4574 and 429.075, Florida Statutes;

h. Children referred for residential placement in compliance with Rule 65E-9.008(4), F.A.C.;

i. Inmates approaching the End of Sentence pursuant to Children and Families Operating Procedure ("CFOP") 155-47; and

j. In the event of a Presidential Major Disaster Declaration, Crisis Counseling Program ("CCP") services shall be contracted for according to the terms and conditions of any CCP grant award approved by representatives of the Federal Emergency Management Agency ("FEMA") and the Substance Abuse and Mental Health Services Administration ("SAMHSA").

k. Individuals in need of early intervention services for HIV and in compliance with Ch. 65D-30.004(9), F.A.C., and in accordance with **Guidance 33 - HIV Early Intervention Services.**

4. Determination of Individuals Served

BBHC may delegate determinations to the Provider, subject to the provisions of the Paragraph entitled "Contract Document" of the Contract.

a. In no circumstances shall an individual's county of residence be a factor that denies access to service.

b. The Provider shall attest on its monthly invoice submitted to BBHC/Carisk, that at the time of submission, no other funding source was known for the invoiced services.

c. DCF, in accordance with state law, is exclusively responsible for defining Individuals Served for services provided through this Contract. In the event of a dispute, the determination made by the BBHC as directed by DCF is final and binding on all parties.

d. The Department, in accordance with state law, is exclusively responsible for defining "Individuals Served" for behavioral health services provided by network service providers. In the event of a dispute, the determination made by the Department is final and binding on all parties.

B. MANNER OF SERVICE PROVISION

1. **Service Tasks:** The following tasks must be completed during the term of the Contract:

Task List

(1) Based on person served needs, the Provider agrees to provide appropriate services from the list of approved programs/activities described in exhibit, entitled "Service Detail" and the description of such services detailed in the "Application for Pre-Qualification and Program Description". No changes in the array of services shall be made unless prior written approval is furnished by the ME.

(2) The Provider shall serve the number of persons indicated in exhibit, entitled "Person Served" within the activities specified in "Service Detail" exhibit.

(3) The Provider shall ensure EBP are accessible to person served and fidelity maintained by the Provider as described in the Provider's Quality Assurance/Improvement Plan, incorporated herein by reference. The Provider's EBPs, as applicable, will be reviewed by the ME as part of its annual monitoring activities and the Provider agrees to make revisions when the ME determines there is a need.

(4) The Provider shall adhere to treatment group size limitations not to exceed fifteen (15) individuals per group for any clinical therapy service provided. In addition to other programmatic documentation requirements, service documentation to evidence group activities shall include the following:

(a) Data Elements:

- **i.** Service Documentation-Group Sign in Sheet;
- **ii.** Recipient name and identification number;
- **iii.** Staff name and identification number;
- **iv.** Service date;
- **v.** Start time;
- **vi.** Duration;
- **vii.** Covered Service;
- **viii.** Brief description of type of group; and
- **ix.** Program (AMH, ASA, CMH, CSA)

(b) Audit Documentation-Recipient Service/Non-Recipient Chart:

- **i.** Recipient name and identification number or if non-recipient;
- **ii.** Participant's name, address, and relation to recipient;
- **iii.** Staff name and identification number;
- **iv.** Service date;
- **v.** Duration; and
- **vi**. Group progress note

(5) For licensable services, the Provider shall maintain correct and current Florida Agency for Health Care Administration ("AHCA") licenses and only bill for services under those licenses. In the event any of the Provider's licenses are suspended, revoked, expired or terminated, the Provider shall provide immediate written notification to the ME's Contract Manager listed in Number 7 of the Standard Contract. Payment shall be suspended for services delivered by the Provider under such license(s) until said license(s) are reinstated.

(6) If the Provider provides medication management services, it shall ensure person served discharged from state mental health treatment facilities will be maintained on the medication prescribed to the person served by the facility at discharge pursuant to §394.676, Florida Statutes. Maintenance includes performing required lab tests, providing the medication, and providing appropriate physician oversight.

(7) Continuous Quality Improvement Programs: The Provider shall adhere to its Continuous Quality Improvement ("CQI") program included in the Provider's Application for Pre-Qualification and accepted by the ME. The Provider shall ensure the implementation of the Program to monitor and evaluate the appropriateness and quality of care; ensure services are rendered consistently with prevailing professional standards; and to identify and resolve problems objectively and systematically. Additionally, the program must support activities to ensure fraud, waste, and abuse does not occur.

(8) Performance Measures for Continuous Quality Improvement Programs: The Provider shall track by program, as applicable, the performance measures as specified in the **"**Performance Measures for CQI Programs" exhibit.

Performance Measures - The outcome measures established pursuant to Section E.2. The methodology and algorithms to be used in determining performance are outlined in Guidance 24 – Performance Outcomes Measurement Manual.

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Timely Access – BBHC has established specific targets for each subcontract, sufficient to ensure the Network cumulatively reaches the specified network targets.

Table 5 – Network Service Provider Timely Access Measures

Measure Description	Minimum Acceptable ME Network Performance		
	Effective 7/1/2025	Effective 7/1/2027	Effective 7/1/2029
Appointments for urgent services (services needed to preclude a crisis) provided within 48 hours of a request.	70%	80%	90%
Appointments for rapid intervention for children, families, or individuals in distress or at risk for entry into foster care, justice systems or more intensive services within 72 hours from the date of a referral or request for assistance.	70%	80%	90%
Appointments for outpatient follow-up services provided within 7 days after discharge from an inpatient or residential setting.	70%	80%	90%
Appointments for initial assessment are provided within 14 days of a request for treatment.	70%	80%	90%

(9) Trauma Informed Care ("TIC"): The Provider's services shall be delivered in a manner that addresses the impact of trauma on the persons' served development; adjustment; and treatment. This includes comprehensive assessment tools to identify whether the person served is impacted by trauma and appropriate services to successfully treat the persons served.

(10) Recovery Oriented System of Care (ROSC): The Provider shall participate in this initiative through the BBHC Clinical/Quality Improvement Committee which will include the integration of Mental Health and Substance Abuse services. Providers are required to ensure staff are trained and are implementing the ROSC framework.

(11) Cultural and Linguistic Competence: The Provider shall adhere to its Cultural and Linguistic Plan submitted and approved by the ME. The Provider will maintain strategies to increase cultural competence among board members, staff; and family members, when appropriate and ensure person served access that address cultural and linguistic needs and preferences, including but not limited to sign language, Spanish, Creole, translation, and interpretive services.

(12) Medication Assisted Treatment (MAT): It is a requirement that Network Service Providers discuss the option of medication-assisted treatment with individuals with opioid use disorders or alcohol use disorders.

- For individuals with opioid use disorders, the Network Service Provider shall discuss medication-assisted treatment using FDA-approved medications including but not limited to methadone, buprenorphine, and naltrexone.
- For individuals with alcohol use disorders, the Network Service Provider shall discuss medication-assisted treatment using FDA-approved medications including but not limited to Naltrexone (Vivitrol) Injections funded through The Florida Alcohol and Drug Abuse Association (FADAA) as well as disulfiram, and acamprosate products.
- It is a requirement that all Network Service Providers actively link individuals to medication-assisted treatment providers upon request of the individual served;
- It is prohibited to deny an eligible individual's access to the Network Service Provider's program or services based on the individual's current or past use of FDA-approved medications for the treatment of substance use disorders. Specifically, this must include requirements to:
  - Ensure the Network Service Provider's programs and services do not prevent the individual from participating in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program when ordered by a physician who has evaluated the person served and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder;
  - Permit the individual to access medications for FDA-approved medication-assisted treatment by prescription or office-based implantation if the medication is appropriately authorized through prescription by a licensed prescriber or provider.
  - Permit the individuals access to the services allowable based on state and federal regulations.
  - Permit continuation in medication-assisted treatment for as long as the prescriber or medication-assisted treatment provider determines that the medication is clinically beneficial; and
  - Prohibit compelling an individual to no longer use medication-assisted treatment as part of the conditions of any program or services if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.
  - Prohibit caps or limits on the length of medication-assisted treatment, except for limits imposed by a documented lack of eligible public funds.
  - Prohibit mandatory counseling participation requirements and mandatory self-help group participation requirements imposed as a condition of initiating or continuing medications that treat substance use disorders, except those established by methadone providers and applied to individuals on methadone.
  - Prohibit automatic discharges or discontinuation of medications as a consequence of continued substance use or positive drug tests,

unless the combination of substances used is medically contraindicated.

(13) Institutional Review Board ("IRB"): The ME requires the Provider comply with CFOP 215-8, Oversight of Human Subject Research and Institutional Review Board Determination and obtain the prior written approval of the ME for all research conducted by the Provider or any of its employees; contracted organizations; or individuals, or any public or private vendor, even if the aforementioned has their own IRB which has granted approval. CFOP 215-8 is available on the ME website at www.bbhcflorida.org and incorporated herein by reference.

(14) The Provider shall participate in the ME's Peer Review process, when implemented, to assess the quality, appropriateness, and efficacy of services provided to individuals pursuant to 45 CFR §96.136.

(15) The Provider shall maintain a current MOU with the appropriate Federally Qualified Health Center ("FQHC") or hospital district that provides for the integration of primary care services to the medically underserved. The Provider shall submit to the ME's Contract Manager an updated MOU within five (5) calendar days of the effective date of any changes to the MOU on file with the ME.

The Provider shall conduct primary health care screenings, including blood pressure and BMI (waist circumference), as appropriate, unless the type of service prevents it or a waiver is provided by the ME.

(16) Access to Care: The Provider shall ensure individuals needing treatment services will receive services, depending on the severity of individual need, consistent with industry standards for distance and travel time, and as specified in the ME Utilization Management ("UM") protocol, is which is incorporated herein by reference. Non-compliance with timely access to care for services terms will result in a corrective action and may result in a financial penalty as specified in the Paragraph entitled "Financial Penalties for Failure to Take Corrective Action" of the Contract. Further, the Provider shall ensure the needs and preferences of persons served and their families drive treatment planning and service delivery, and persons served and their families (with consent) are involved in all aspects of treatment (pre, during and post); engage persons served , family members, and advocates in the design, development, and evaluation of services; provide persons served with a choice of provider and services, whenever possible; and continuously assess and improve consumer satisfaction.

(17) Clients with special needs: The Provider shall assess the persons served to identify whether specialty services apply including: employability skills training; victimization and trauma; infant mental health; elderly; family; recovery; blind, deaf, or hard of hearing; developmentally disabled; and criminally-involved/forensic. When specialty services are identified as a need and not delivered by the Provider, the Provider shall link the

persons served to an appropriate service agency, engage the service agency in treatment planning and service delivery, as appropriate. As applicable, the Provider shall provide early diagnosis and treatment intervention to enhance recovery and prevent hospitalization and collaborate with the ME and other stakeholders to reduce the admissions and the length of stay for dependent children and adults with mental illness in residential treatment services.

(18) Develop and Disseminate Consumer Manual: The Providers shall make available to all persons served and persons served family members a copy of the BBHC Consumer Manual, which includes information about access procedures; recipient rights and responsibilities; and grievance and appeal procedures. A copy of the BBHC Consumer Manual is available at www.bbhcflorida.org, and is incorporated herein by reference.

(19) Work and Social Opportunities: The Provider will employ Peer Specialist to develop work and social opportunities for persons served and make recommendations to the ME for a consumer-driven system

(20) Assist Stakeholder Involvement in Planning, Evaluation, and Service Delivery:

(a) Provider will assist the ME in engaging local stakeholders, pursuant to §394.9082, Florida Statutes;

(b) Providers shall implement DCF's Recovery Oriented System of Care initiative by affording and ensuring meaningful opportunities for participation of persons served, their families, and peers in governance or advisory bodies of Provider's organization, providing training for their complete participation in such governance activities, and affording meaningful and full participation in the Provider's strategic planning, decision making, governance, implementation, and evaluation of Provider's programs, system of care, and services;

(c) Provider shall work with the ME to provide performance, utilization, and other information as may be required of the ME by DCF.

(21) Client Satisfaction Survey: The Provider shall conduct and submit quarterly Consumer Satisfaction Surveys of persons served. The ME will advise the Provider in writing by July 31st each contract year of the total number of Consumer Satisfaction Surveys that will be required to be submitted quarterly by the Provider for that contract year. Failure to provide the required number of surveys may result in a corrective action and an imposed financial penalty.

(22) Utilization Management: The Provider agrees to participate in all of the requirements of the ME Utilization Management Program as detailed in at www.bbhcflorida.org, and incorporated herein by reference.

(23) Client Trust Funds ("CTF"):

(a) If the Provider is the representative payee for Supplemental Security Income ("SSI"); Social Security Administration ("SSA"); Veterans Administration ("VA"); or other federal benefits on behalf of the persons served, the Provider shall comply with the applicable federal laws including the establishment and management of individual persons served trust accounts (20 CFR §416 and 31 CFR §240). The Provider shall also maintain and submit documentation of all payment/fees received on behalf of ME persons served receiving SSI; SSA; VA; or other federal benefits upon request from the ME.

(b) Any Provider assuming responsibility for administration of the personal property and/or funds of persons served shall follow DCF's Accounting Procedures Manual 7 APM, 6, Volume 7, incorporated herein by reference (available from DCF). The ME; DCF; their designees; or duly authorized individuals may review all records relating to this section. Any shortages of persons served funds attributable to the Provider as determined by the ME shall be repaid by the Provider, plus interest as provided in §55.03, Florida Statutes, within one (1) week of the determination.

(24) Complaints and Grievances: The Provider shall adhere to its ME-approved Complaints and Grievances Policy and Procedures whereby persons served may submit complaints and/or grieve concerns about contracted services delivered by the Provider through a progressive response within the Provider's organization that results in timely resolution and ultimately appeal to the ME for a final determination. The Provider shall ensure all written materials include the telephone number for the ME (954-622-8121) to which consumers, family members, employees, and the public may report grievances, persons served, and staff receive annual training topic evidenced through documentation of successful completion of training in the employee's Personnel File. Persons served and family members shall also be advised of the Provider Policy at intake for services.

(25) The ME and/or DCF have the right to review the Provider's policies, procedures, and plans as they may apply to this Contract. Once reviewed by the ME and/or DCF, the policies and procedures, may be amended provided they conform to state and federal laws, rules and regulations. Substantive amendments to submitted policies, procedures and plans shall be provided to the ME.

(26) The Provider shall provide an annual update to the 2-1-1 Broward Information and Referral Call Center site directly, and within seven (7) business days when program information changes. For instructions to update your agency's information, please contact 2-1-1 Broward or update online at http://www.211-broward.org. Updating provider program information is critical to ensure that a current and centralized information and referral point for services is available to the residents of Broward County. Provider must provide confirmation that 2-1-1

information has been updated annually prior to contract execution.

(27) Integration Task Limits: The Provider shall perform all services under this Contract in accordance with applicable federal, state and local rules, statutes, licensing standards, and policies and procedures. Furthermore, the Provider agrees to abide by the approved documents submitted in its Application for Pre-Qualification and Program Description, and is not authorized by the ME to perform any tasks related to the Contract other than those described therein without the express written consent of the ME.

(28) Suicide Prevention, Treatment and Postvention: BBHC is participating in the Broward County Suicide Prevention Collaborative. Providers will be asked to participate as applicable in the development and implementation of recommendations that result from this effort. BBHC is developing a network wide suicide framework, based on the Zero Suicide Initiative. Providers will be expected to implement the principles that BBHC deems fundamental to ensuring appropriate for the management of suicide prevention, treatment and postvention, within the network.

2. Staffing Requirements

a. Staffing Levels

(1) The Provider shall maintain staffing levels in compliance with applicable professional qualifications, rules, statutes, licensing standards and policies and procedures. See "Minimum Service Requirements" exhibit, which can be located on the BBHC website at www.bbhcflorida.org and is incorporated herein by reference.

(2) The Provider shall engage in recruitment efforts to employ capable and competent staff demonstrated by the persons served. The ME may request documentation evidencing Provider's recruitment efforts in compliance with this requirement.

(3) The Provider shall adhere to applicable BBHC Credentialing Program requirements as detailed in the BBHC Credentialing Policy, which can be located on the BBHC website at www.bbhcflorida.org and is incorporated herein by reference.

b. Professional Qualifications

The Provider shall ensure its staff successfully complete screening for all mental health personnel; substance abuse personnel; chief executive officers; owners; directors; and chief financial officers according to the standards for Level II screening set forth in Chapter 435, and §408.809, Florida Statutes, except as otherwise specified in §394.4572(1)(b)-(c), Florida Statutes; and are of good moral character. For the purposes of this Contract, "mental health personnel" includes all program directors; professional clinicians; staff members; and volunteers working in public or private mental health programs and facilities that have direct contact with individuals held for examination or

admitted for mental health treatment. Screening for substance abuse personnel shall be conducted in accordance with the standards set forth in Chapter 397, Florida Statutes. This requirement shall include all personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services.

c. Staffing Changes

The Provider shall provide written notification to the ME within (10) calendar days of any staffing changes in the positions of Chief Executive Officer; Chief Financial Officer; Medical Director; Clinical Director; IT Director; Dispute Resolution Officer; Data Security Officer; Single Point of Contact in accordance with Section 504 of the Rehabilitation Act of 1973 as required by the Paragraph entitled "Additional Requirements of Law, Regulation, and Funding Source" of the Contract, or any individuals with similar functions.

3. Service Location and Equipment

a. Service Delivery Location and Times

The location, days and times of services will be as specified in the approved documents submitted in the Provider's approved Application for Pre-Qualification and Program Description. The Provider shall submit a written request for approval to the ME prior to making any changes.

b. Equipment

The Provider shall furnish all appropriate equipment necessary for the effective delivery of the services purchased. In the event the Provider is authorized to purchase any non-expendable property with funds under this Contract, the Provider will ensure compliance with BBHC.0038, Property Management, which can be located at www.bbhcflorida.org, and is incorporated herein by reference; DCF Operating procedures as outlined in CFOP 40-5, CFOP 80-2, and Rule 65E-14, F.A.C., as applicable, which are incorporated herein by reference and may be obtained from the ME.

Funds provided under this Contract for the purchase of or improvements to real property are contingent upon the Provider granting the State a security interest in the property at least to the amount of the State funds provided for at least five years from the date of purchase or the completion of the improvements or as further required by law. As a condition of receipt of funds for this purpose, if the Provider disposes of the property before the State's interest is vacated, the Provider shall refund the pro-rata share of the State's initial investment.

4. Deliverables

a. Services

The Provider shall deliver the services specified in and described in the approved documents submitted in the Provider's Application for Pre-Qualification and Program Description submitted by the Provider and as set forth in the Service Detail exhibit.

b. Reports and Data Submission

Where this Contract requires the delivery of reports to the ME, mere receipt by the ME shall not be construed to mean or imply acceptance of those reports. The ME reserves the right to reject reports as incomplete, inadequate, or unacceptable according to the Contract and declare this Contract to be in default.

(1) The Provider shall submit treatment data, as set out in §394.74(3)(e), Florida Statutes and Rule 65E-14.022, F.A.C, and FASAMS DCF Pamphlet 155-2, the most recent version.

(2) In addition to the modifiers to procedure codes currently required to be utilized as per the FASAMS DCF Pamphlet 155-2, the most recent version, the Provider is directed to utilize the modifiers required for services funded as described in the OCA Allocation Instructions handout as revised from time to time, as applicable.

(3) In addition to utilizing, the modifiers to procedure codes for block grant funds identified in Section B. 4. b. (2) above, the Provider shall submit information regarding the amount and number of services paid for by the Community Mental Health Services Block Grant and/or the Substance Abuse Prevention and Treatment Block Grant or other Prevention services utilizing exhibit, entitled "Outreach/Prevention Services Activities Log" and upon request by the ME.

(4) Data shall be submitted electronically to the ME by the 7th of each month following the month of service into the DCF designated prevention database or other data reporting system designated by the ME (the "Portal"). As per the Subcontractor Financial Responsibility Policy #BBHC.0045, Providers are responsible for the quality of their data; therefore, errors in authorizations/certifications and penalties due to exceptions or data errors will result in payment adjustments, regardless if the Provider has banked/excess units. The Provider shall also:

(a) Ensure the data submitted clearly documents all persons served admissions, discharges, and any required clinical form follow-ups which occurred under this Contract and substance abuse prevention services data entered into PBPS (or other data reporting system designated by the ME) and that it clearly documents all program participants, programs and strategies which occurred under this Contract, as applicable;

(b) Ensure all data submitted to Carisk Portal (or other data reporting system designated by the ME) is consistent with the data maintained in the Provider's persons served files and substance abuse prevention services data entered into PBPS (or other data reporting system designated by the ME) is consistent with the data maintained in the Provider files, if applicable;

(c) Acute Care Services: Florida State legislation mandates that Acute Care Providers perform daily submission of Acute Services Census to the Managing Entities. The Managing Entity (ME) and Carisk have designed an acute services data collection and reporting system that makes compliance with the Legislative mandates as easy as possible for those facilities that have been contracted by the ME to provide acute services. This mandate applies to utilization of all acute care licensed beds regardless of funding. The data must be submitted daily; a Provider is required to submit at any time of the day the required data from the previous day. The data from Friday, Saturday, and Sunday can be submitted on Monday.

i. Alternative Method: As per FASAMS DCF Pamphlet 155-2, the most current version, an enrollment record is required for a persons served specific service records be accepted in the system, when funded by DCF. Since this requirement may disrupt the daily submission, the Provider Portal has a funding source code named 'Z-Temp Crisis Svcs'. Using this code, person served-specific service events does not require an enrollment record. However, providers will need to reconcile and update these records with the appropriate funding source code with the monthly submission of data. At this point, the Provider's Portal will enforce the enrollment requirement, if the selected code is a DCF-funded type. As per the title of this section, this is an Alternative Method of data submission, Providers may prefer not to use this option and send enrollments records with the persons served specific services during the daily submission (recommended option).

ii. Non-DCF/ME funded services: Most Providers have been already uploading both DCF/SAMH funded acute services and Non-DCF/Other Funders acute services using Client Specific Services Form/File (recommended). Non-DCF/Other Funders acute services information is used to show aggregated numbers only and will not be shown in the system screen reports nor be sent to DCF. For Non-DCF/ME funded services only, Providers have the option to report the aggregate number of beds utilized on a specific date and funding source using the Non-Client Specific Service Event Form/File. Since these types of services are measured in days, the fields units and participants must match. In the case that these two fields do not match, Carisk will consider that the 'units' field contains the valid number of occupied beds to be reported to DCF and to

be used in the generation of reports. Note that ME has only approved reporting using the Non-Client Specific Form/File when the complete episode of care of the persons served is paid by 3rd party Funders. If a persons served has at least one service in the episode of care funded by the ME/DCF; the complete services dataset must be reported using the Client-Specific Form/File.

(d) In order for DCF to assign a unique identifier according to Florida Statute 394.9082(3)(h) DCF is mandating the DEMO Forms within five business (5) days of initial intake or admission. For simplification, the DEMO Forms must be uploaded on Fridays for all persons served admitted that week.

(e) Review the ME's File Upload History screen in the Carisk Apps Portal to determine the number of records accepted, updated and rejected. Based on this review, the Provider shall download any associated error files to determine which persons served records were rejected and to make sure that the rejected records are corrected and resubmitted in the Carisk Apps Portal on or before the 7th of the month.

(f) Resubmit corrected records no later than the next monthly submission deadline. The failure to submit any data set or the Provider's total monthly submission per data set, which results in a rejection rate of 5% or higher of the number of monthly records submitted may require the Provider to submit a corrective action plan describing how and when the missing data will be submitted or how and when the rejected records will be corrected and resubmitted; and

(g) In accordance with the provisions of §402.73(1), Florida Statutes, and Rule 65-29.001, F.A.C., corrective action plans may be required for non-compliance, nonperformance, or unacceptable performance under this Contract. Penalties may be imposed for failures to implement or to make acceptable progress on such corrective action plans. Failure to implement corrective action plans to the satisfaction of the ME and after receiving due notice, shall be grounds for Contract termination.

(h) The submission of reports or documentation required by this Contract for which the Provider is not able to meet the deadlines due to a BBHC technical issue may be extended upon receipt of a written extension request by the Provider to BBHC. Extensions will be considered on a case-by-case basis and does not absolve the Provider from its responsibilities herein.

(5) A facility designated as a public receiving or treatment facility under this Contract shall report the following Payor Class data to the ME, unless

such data are currently being submitted into the Carisk Apps Portal. Public receiving or treatment facilities that do not submit data into the Carisk Apps Portal, or other data reporting system designated by the ME, shall report these data annually as specified in the Required Reports exhibit, even if such data are currently being submitted to AHCA:

(a) Number of licensed beds available by payor class;
(b) Number of contract days by payor class;
(c) Number of persons served (unduplicated) in program by payor class and diagnoses;
(d) Number of utilized bed days by payor class;
(e) Average length of stay by payor class; and
(f) Total revenues by payor class.

(6) The Provider shall obtain the format and directions for submitting Payor Class data from the ME.

(7) The Provider shall submit Payer Class data to the ME by the date specified in the Required Reports exhibit**.** The final submittal under this Contract shall be submitted to the ME no later than 90 days following the end of the ME's fiscal year (June 30).

(8) The Provider must subtract all units, which are billable to other sources, including Social Security, Medicare payments, managed care, and funds eligible for local matching which include patient fees from first, second, and third-party payers, from each monthly request for payment. Should an overpayment be detected upon reconciliation of payments, the Provider shall immediately refund any overpayment to the ME.

5. Performance Specifications

a. Performance Measures

The Provider shall meet the performance standards and required outcomes as specified in the Substance Abuse & Mental Health Required Performance Outcomes & Outputs exhibit. The Provider agrees the Carisk Apps Portal; PBPS; SAMHIS; and any other data reporting system designated by the ME, will be the sources for all data used to determine compliance with performance standards and outcomes in Output Measures exhibit. Any conflict will be resolved by the ME and the Provider shall adhere to the ME's determination. The Provider shall submit all service-related data for persons served funded in whole or in part by SAMH funds, local match, managed care or other funders. In addition to the performance standards and required outcomes specified in Output Measures exhibit, the Provider shall meet requirements set forth in Section D under Service Provision Detail, of this Handbook, entitled "Special Provisions."

b. Performance Evaluation Methodology

The Provider shall collect information and submit performance data and individual persons served outcomes, to the ME data system in compliance with

FASAMS DCF Pamphlet 155-2, most recent version requirements. The Provider shall maintain the capability to engage in organized performance improvement activities, and to be able to participate in partnership with the ME in performance improvement projects related to system wide transformation and improvement of services for individuals and families. If the Provider fails to meet the Contract standards, the ME, at its exclusive option, may allow a reasonable period for the Provider to correct performance deficiencies. If performance deficiencies are not resolved to the satisfaction of the ME within the prescribed time, the ME will terminate the Contract. Performance data information is posted on DCF's website.

6. Provider Responsibilities

a. Provider Unique Activities

(1) By executing this Contract, the Provider recognizes its responsibility for the tasks, activities, and deliverables described herein, warrants it has fully informed itself of all relevant factors affecting the accomplishment of the tasks, activities and deliverables, and agrees to be fully accountable for the performance thereof whether performed by the Provider or its subcontractors.

(2) The Provider shall ensure invoices submitted to the ME reconcile with the amount of funding and services specified in this Contract, as well as the Provider's agency audit report and persons served information system and reconciled with the Carisk Apps Portal, PBPS, or other data reporting system designated by the ME. If the Provider receives Incidental funding from BBHC, it shall complete the "Incidental Fund Invoice and Expenditure Log for Adult Mental Health Services" exhibit and submit on a monthly basis as supporting documentation for the invoice.

(3) If the Provider receives federal block grant funds from the Substance Abuse Prevention and Treatment or Community Mental Health Block Grants the Provider agrees to comply with Subparts I and II of Part B of Title XIX of the Public Health Service Act, 42 U.S.C. §300x-21, et seq. (as approved September 22, 2000) and the Health and Human Services (HHS) Block Grant regulations (45 CFR Part 96). For Providers who receive Block Grant funds and serve injection drug users they must publicize the following notice: "This program receives federal Substance Abuse Prevention and Treatment Block Grant funds and serves people who inject drugs. This program is therefore federally required to give preference in admitting people into treatment as follows: 1. Pregnant injecting drug users; 2. Pregnant drug users; 3. People who inject drugs; and 4. All others."

(4) If the Provider receives funding from the Substance Abuse Prevention and Treatment Block Grant ("SAPT") it shall maintain compliance with all of the requirements of the Substance Abuse and Mental Health Services Administration ("SAMHSA") Charitable Choice provisions and

the implementing regulations of 42 CFR §54a.

(5) The Provider shall be engaged in performance improvement activities to improve its ability to recognize accurate prevalence of co-occurring disorders in its data system.

(6) The Provider shall provide additional performance information or reports other than those required by this Contract at the request of the ME as may be required by other funding or regulatory agencies.

(7) The Provider shall cooperate with the ME, DCF and other duly authorized representatives of the ME and federal and state representatives when investigations are conducted regarding a regulatory complaint of the Provider as it pertains to the services provided under this Contract.

(8) The Provider shall be responsible for the fiscal integrity of all funds under this Contract, and for demonstrating a comprehensive audit and tracking system exists to account for funding by persons served, and have the ability to provide an audit trail. The Provider's financial management and accounting system must have the capability to generate financial reports on individual service recipient utilization, cost, claims, billing, and collections for the ME. The Provider must maximize all potential sources of revenue to increase services, and institute efficiencies that will consolidate infrastructure and management functions in order to maximize funding.

(9) The Provider shall make available to the ME all evaluations, assessments, surveys, monitoring or other reports and any corrective action plans, related to behavioral health programs, pertaining to outside licensure, accreditation, or other reviews conducted by funding entities or others and received from such other entities within ten (10) business days of receipt by Provider. The Provider shall implement a process for tracking all corrective action plans and submit a copy of the tracking log to the ME upon request.

(10) The Provider shall maintain human resource policies and procedures that provide safeguards to ensure compliance with laws, rules and regulations, and integrate current or new state and federal requirements and policy initiatives into its operations upon provision by the ME of the same.

(11) The Provider shall make available source documentation of units billed by Provider upon request from the ME. The Provider shall track all units billed to the ME by program and by Other Cost Accumulator ("OCA").

(12) The Provider will demonstrate efforts to initiate and support local county implementation of the Medicaid Substance Abuse Local Match Program in order to expand community service capacity through draw down of federal funding.

(13) The Provider shall maintain in one place for easy accessibility and review by ME all policies, procedures, tools, and plans adopted by the Provider. The Provider's policies, procedures, and plans must conform to state and federal laws, regulations, rules, and minimally meet the expectations and requirements contained in applicable ME and DCF operating procedures as they may pertain to the services provided under this Contract.

(14) The Provider shall maintain a mechanism for monitoring, updating, and disseminating policies and procedures regarding compliance with current government laws, rules, practices, regulations, and the ME's policies and procedures.

b. Coordination with other Providers/Entities

1. In its role as an Adult Mental Health and or Adult Substance Abuse service provider, Provider agrees to cooperate with ME in the development and maintenance of care coordination and integrated care systems that address the provision of appropriate services to persons who have behavioral health problems and leave the criminal justice system. Additionally, Provider shall cooperate with ME in the development and implementation of cooperative agreements with other external stakeholders involved in the care, treatment, and success of adult mental health and adult substance abuse individuals.

2. Plan for Care Coordination

(i) The Provider agrees to coordinate services with other providers and state entities rendering services to children, adults, and families, as applicable, as the need is identified by the ME;

(ii) When indicated by the ME, the Provider will ensure substance abuse and/or mental health services are available to persons served by the Broward Sheriff's Office's ("BSO") Protective Investigators to support the principle of keeping children in the home whenever possible. Priority for behavioral health services shall be given to families with children determined to be "unsafe" by the BSO's child protective investigators. Such priority is limited to individuals who are not eligible for managed care, or who require services not included as reimbursable by managed care, as defined in Person Served exhibit.

The failure of other providers or entities does not relieve the Provider of accountability for tasks or services the Provider is obligated to perform pursuant to this Contract.

b. **Minimum Service Requirements:** See "Minimum Service Requirements" exhibit.

7. Managing Entity Responsibilities

a. Managing Entity Obligations

(1) The ME is solely responsible for the oversight of the Provider and enforcement of all terms and conditions of this contract. Any and all inquiries and issues arising under this Contract are to be brought solely and directly to the ME for consideration and resolution between the Provider and the ME. In any event, the ME's decision is final on all issues and subject to the ME's appeal process and legal rights of the Provider.

(2) The ME is responsible for the administration, management, and oversight of subcontracts and the provision of behavioral health services in Broward County through its subcontracted providers. This also includes statewide beds as specified in the Prime Contract, and in this Contract.

(3) The ME will approve standardized tools and assessments, which must be used to determine placement and level of care for all persons served.

b. Monitoring Requirements

(1) The ME will monitor the Provider in accordance with this Contract and ME's monitoring Policy and related procedures entitled Contract/Program Monitoring policy (BBHC.0081) which can be located at www.bbhcflorida.org and is incorporated herein by reference. The Provider shall comply with any coordination or documentation required by the ME to successfully evaluate the programs, and shall provide complete access to all records, including budget and financial information, related to services provided under this Contract, regardless of the source of funds.

(2) At the sole discretion of the ME, if there is a threat to health, life, safety or well-being of clients, the ME may require immediate corrective action or take such other action, as the ME deems appropriate. Failure to implement corrective action plans to the satisfaction of the ME and after receiving due notice, shall be grounds for Contract termination in whole or in part.

c. Training and Technical Assistance

(1) The ME will provide technical assistance and support to the Provider to ensure the continued integration of services and support for persons served, to include but not limited to quality improvement activities to implement EBP treatment protocols; the application of process improvement methods to improve the coordination of access; and services that are culturally and linguistically appropriate.

(2) The ME will provide technical assistance and support to the Provider for the maintenance and reporting of data on the performance standards that are specified in Output Measures exhibit.

(3) The ME may implement a training program for its staff and the Provider staff. The trainings assure that staff receives externally mandated and internal training. The ME may coordinate training or directly provide training to Provider staff.

d. Review Compliance with Utilization Management Criteria

(1) As part of the quality improvement program, the ME will provide or coordinate reviews of service compliance with criteria and practice guidelines, such as retrospective reviews to ensure the level of placement of clients is appropriate. The ME will take corrective action to resolve situations in which the Provider is not following the guidelines or working to help the system meet its utilization goals. Providers shall comply with the requirements and protocols for "Utilization Management", which is located on the ME website at www.bbhcflorida.org and is incorporated herein by reference.

(2) The ME may request supporting documentation and review source documentation of units billed to the ME.

e. Juvenile Incompetent to Proceed Program:
The ME will manage the Juvenile Incompetent to Proceed ("JITP") Program pursuant to §985.19, Florida Statutes and DCF's operating procedures. In addition, the ME will ensure all youth involved with the JITP program are linked with the appropriate mental health services and reduce the time to access treatment services.

f. Residential Level 1 Services
The ME will ensure Residential Level 1 is available to youth in the community. The ME will establish a comprehensive assessment process to determine when youth are most appropriately served within residential facilities or in their home. The ME will establish a system of intensive in-home services for the most severely disturbed youth and families as an alternative to residential facilities.

C. Compensation:

1. The Provider shall be paid in accordance with the terms contained in the following exhibits as completed by the appropriate party and as more particularly set forth in Section VII "Method of Payment" herein below:

Method of Payment
Invoice, which is located in the Carisk Apps Portal
Service Detail
Funding Detail
Local Match Plan

D. Special Provisions

1. The Provider shall not charge the ME an administrative cost in excess of **9.99%** of the total Contract amount.

2. Incident Reports

a. The Provider shall submit incident reports that meet eligibility criteria to the ME and enter into the Incident Reporting and Analysis System ("IRAS") pursuant to the ME's Incident Reporting Policy and Procedure entitled, "BBHC.0013, Critical Incident Reporting" which is located at www.bbhcflorida.org and is incorporated herein by reference. The Provider and any subcontractor must comply with and inform its employees of the mandatory reporting requirements. The Provider is advised certain incidents may warrant additional follow-up by the ME, which may include on-site investigations or requests for additional information or documentation. When additional information or documentation is requested, the Provider shall submit the information requested by the ME as required above. It is the responsibility of the Provider to maintain an Incident Reporting Logbook listing all incidents reported by the Provider, with the following information: persons' served initials, incident report tracking number from IRAS (if applicable), incident report category, date and time of incident, and follow-up action taken.

b. All Providers (inpatient and outpatient) will report seclusion and restraint events in SAMHIS and in accordance with Rule 65E-5.180(7) (g), F.A.C.

3. Mental Health providers shall participate in DCF's aftercare referral process for formerly incarcerated individuals with severe and persistent mental illness or serious mental illness who are released to the community or who are determined to be in need of long-term hospitalization. Participation shall be as specified in CFOP 155-47, "Processing Referrals from the Department of Corrections" which can be located at www.bbhcflorida.org and is incorporated herein by reference.

4. Involuntary Outpatient Placements: If referred, the Provider shall deliver services to persons who have been court ordered into involuntary outpatient placement in accordance with §394.4655, Florida Statutes

5. Children's Mental Health Services, including services for Severely Emotionally Disturbed Children, Emotionally Disturbed Children and their Families, if services to such consumers are offered: The key strategic objectives and strategies that support DCF's mission and direct the provision of services to Florida's residents are detailed in the Substance Abuse and Mental Health Services Plan 2014-2016, or the latest revision thereof, which is incorporated herein by reference.

Providers shall comply with the DCF Standards regarding "Children's Mental Health Services."

6. Service Provision Requirements for Substance Abuse Prevention and Treatment Block Grants, if applicable.

(a) The Provider agrees to comply with the data submission requirements outlined in FASAMS DCF Pamphlet 155-2, most recent version and with the funding restrictions outlined in "SAMH OCA's and Funding Restrictions" and which are incorporated herein by reference.

(b) The Provider is required to utilize the modifiers to procedure codes required for Block Grant funds as per FASAMS DCF Pamphlet 155-2, most recent version.

(c) The Provider agrees to comply with applicable data submission requirements outlined in Required Reports exhibit.

(d) The Provider shall make available, either directly or by arrangement with others, tuberculosis services to include counseling, testing, and referral for evaluation and treatment.

(e) The Provider shall use SAPT funds provided under this Contract to support both substance abuse treatment services and appropriate co-occurring disorder treatment services for individuals with a co-occurring mental disorder only if the funds allocated are used to support substance abuse prevention and treatment services and are tracked to the specific substance abuse activity as listed in Service Detail exhibit.

7. The Provider agrees to maximize the use of state residents, state products, and other Florida-based businesses in fulfilling its contractual duties under this Contract.

8. Option for Increased Services: The Provider acknowledges and agrees the Contract may be amended to include additional, negotiated services as deemed necessary by the ME. Additional services can only be increased when the Provider demonstrates competence in the provision of contractual services and meets the criteria established by the ME. The ME shall determine in its sole discretion at what time and to which Provider and in what amount is to be given to Providers for additional services.

9. Sliding Fee Scale: The ME requires the Provider to comply with the provisions of Rule 65E-14.018, Florida Administrative Code. The Provider shall adhere to the Sliding Fee Scale submitted in its approved Application for Pre-Qualification and Program Description and submit an annual update to the ME.

10. Transportation Disadvantaged: The Provider agrees to comply with the provisions of chapter 427, Florida Statutes, Part I, Transportation Services, and Chapter 41-2, Florida Administrative Code, Commission for the Transportation Disadvantaged, if public funds provided under this Contract will be used to transport person served. The Provider agrees to comply with the provisions DCF operating procedure CFOP 40-5, Acquisition of Vehicles for Transporting Disadvantaged Person served if public funds provided under this Contract will be used to purchase vehicles, which will be used to transport person served.

11. Medicaid Enrollment

(a) Those providers with a Contract that meet Medicaid MMA provider criteria and with funding in excess of $500,000 annually shall enroll as a Medicaid MMA provider within ninety (90) days of Contract execution. A waiver of the ninety (90) day requirement may be obtained through the ME.

(b) All providers whose contracts are $500,000 or more annually and enrolled as a Medicaid MMA provider shall participate in the Medicaid Administrative Claiming program as required AHCA and DCF.

(c) Participation in the Medicaid Administrative Claiming program is optional for those Substance Abuse and Mental Health providers who are enrolled as Medicaid MMA providers with contract amounts less than $500,000 annually, and who have the technological capability to participate electronically.

(d) As applicable, the Provider shall comply with changes to Medicaid effective July 1, 2014, or as may be further amended thereafter.

(e) Requirements for all Medicaid-enrolled Network Service Providers, prior to invoicing the Managing Entity for any services provided to any Medicaid-enrolled recipients, to document the Network Service Provider has:

- Submitted a prior authorization request for any Medicaid-covered services provided.
- Appealed any denied prior authorizations.
- Provided assistance to appeal a denial of eligibility or coverage.
- Verified the provided service is not a covered service under Florida Medicaid, as defined in Chapter 59G-4, F.A.C., or is not available through the individual's MMA Plan.
- In cases where the individuals Medicaid-covered service limit has been exhausted for mental health services, an appropriately licensed mental health professional has issued a written clinical determination that the individual continues to need the specific mental health treatment service provided.
- In cases where the individual's Medicaid-covered service limit has been exhausted for substance use disorder treatment services a qualified professional as defined in § 397.311(35), F.S., has issued a written clinical determination that the individual continues to need the specific service provided.

12. National Provider Identifier ("NPI"): The Provider shall obtain and use an NPI, a HIPAA standard unique health identifier for health care providers.

13. Ethical Conduct: The Provider hereby acknowledges it understands performance under this Contract involves the expenditure of public funds from both the state and federal governments, and that the acceptance of such funds obligates the Provider to

perform its services in accordance with the very highest standards of ethical conduct. No employee, director, officer, agent of the Provider shall engage in any business, financial or legal relationships that undermine the public trust, whether the conduct is unethical, or lends itself to the appearance of ethical impropriety. Providers' directors, officers or employees shall not participate in any matter that would inure to their special private gain or loss and shall recuse themselves accordingly. Public funds may not be used for purposes of lobbying, or for political contributions, or for any expense related to such activities, pursuant to the Paragraph entitled "Additional Requirements of Law, Regulation, and Funding Source" of the Contract. The Provider understands that the ME is mandated to conduct business in the Sunshine, pursuant to section 286.011, Florida Statutes, and chapter 119, Florida Public Records Law, and that all issues relating to the business of the ME and the Provider are public record and subject to full disclosure, except as may be set forth in an exception to the Public Records Laws. The Provider understands that attempting to exercise undue influence on the ME, DCF, and either of their employees to allow deviation or variance from the terms of this Contract other than a negotiated, publicly disclosed amendment, is prohibited by the State of Florida, pursuant to §286.011, Florida Statutes. The Provider's conduct is subject to all State and federal laws governing the conduct of entities engaged in the business of providing services to government.

14. **Davis-Bacon Act** - Appendix II to Part 75 (D) Davis-Bacon Act, as amended (40 U.S.C. 3141-3148). When required by Federal program legislation, all prime construction contracts in excess of $2,000 awarded by non-Federal entities must include a provision for compliance with the Davis-Bacon Act (40 U.S.C. 3141-3144, and 3146-3148) as supplemented by Department of Labor regulations (29 CFR part 5). In accordance with the statute, contractors must be required to pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor. In addition, contractors must be required to pay wages not less than once a week. The non-Federal entity must place a copy of the current prevailing wage determination issued by the Department of Labor in each solicitation. The decision to award a contract or subcontract must be conditioned upon the acceptance of the wage determination. The non-Federal entity must report all suspected or reported violations to the Federal awarding agency. The contracts must also include a provision for compliance with the Copeland "Anti-Kickback" Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR part 3). The Act provides that each contractor or subrecipient must be prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The non-Federal entity must report all suspected or reported violations to the Federal awarding agency.

15. **Contract Work Hours and Safety Standards Act -** Appendix II to Part 75 (E) Contract Work Hours and Safety Standards Act (40 U.S.C. 3701-3708). Where applicable, all contracts awarded by the non-Federal entity in excess of $100,000 that involve the employment of mechanics or laborers must include a provision for compliance with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR part 5). Under 40 U.S.C. 3702 of the Act, each contractor must be required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40

hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

Rights to Inventions Made Under a Contract or Agreement - Appendix II to Part 75 (F) Rights to Inventions Made Under a Contract or Agreement. If the Federal award meets the definition of "funding agreement" under 37 CFR 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR part 401 and any implementing regulations issued by the awarding agency.

Debarment and Suspension - Appendix II to Part 75 (H) Debarment and Suspension (Executive Orders 12549 and 12689)—A contract award (see 2 CFR 180.220) must not be made to parties listed on the government-wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR part 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549. Note: Contractors not registered with SAM.gov can still be debarred.

Information Technology Resources: If applicable, the Providers must receive written approval from the ME prior to purchasing any Information Technology Resource (ITR) with Contract funds. The Provider will not be reimbursed for any ITR purchases made prior to obtaining the ME's written approval.

15. **Programmatic, Fiscal & Contractual Contract File References:** All of the documentation submitted by the Provider which may include, but not be limited to the Provider's original proposal, Program Description, Projected Covered Service Operating and Capital Budget, Agency Capacity Report and Personnel Detail Record, are herein incorporated by reference for programmatic, contractual and fiscal assurances of service provision as applicable. These referenced contractual documents will be part of the ME's file. The terms and conditions of this Contract shall prevail over those documents incorporated by this reference in the Contract.

16. **Employee Loans:** Funds provided by the ME to the Provider under this Contract shall not be used by the Provider to make loans to their employees, officers, directors and/or subcontractors. Violation of this provision shall be considered a breach of contract and the termination of this Contract shall be in accordance with the Paragraph entitled "The Following Termination Provisions Apply to this Contract" of the Contract. A loan is defined as any advancement of money for which the repayment period extends beyond

the next scheduled pay period.

17. **Travel:** The Provider's internal procedures will assure that: travel voucher Form DFS-AA-15, State of Florida Voucher for Reimbursement of Traveling Expenses, incorporated herein by reference, be utilized completed and maintained on file by the Provider. Original receipts for expenses incurred during officially authorized travel, items such as car rental and air transportation, parking and lodging, tolls and fares, must be maintained on file by the Provider. Section 287.058(1)(b), Florida Statutes, requires bills for any travel expense shall be maintained in accordance with §112.061, Florida Statutes, governing payments for traveling expenses. CFOP 40-1, Official Travel of State Employees and Non-Employees, provides further explanation, clarification, and instruction regarding the reimbursement of traveling expenses necessarily incurred during the performance of business. The Provider must retain on file documentation of all travel expenses to include the following data elements: name of the traveler, dates of travel, travel destination, purpose of travel, hours of departure and return, per diem or meals allowance, map mileage, incidental expenses, signature of payee and payee's supervisor.

18. **Property and Title to Vehicles**

a. Property

(1) Nonexpendable property is defined as tangible personal property of a non-consumable nature that has an acquisition value or cost of $1,000 or more per unit and an expected useful life of at least one year, and hardback covered bound books that are not circulated to students or the general public, the value or cost of which is $250 or more. Hardback books with a value or cost of $100 or more should be classified as nonexpendable property only if they are circulated to students or to the general public. All computers, including all desktop and laptop computers, regardless of the acquisition cost or value are classified as nonexpendable property. Motor vehicles include any automobile, truck, airplane, boat or other mobile equipment used for transporting persons or cargo.

(2) When government-funded property will be assigned to a provider for use in performance of a contract, the title for that property or vehicle shall be immediately transferred to the Provider where it shall remain until this Contract is terminated or until other disposition instructions are furnished by the ME's contract manager. When property is transferred to the Provider, the ME shall pay for the title transfer. The Provider's responsibility starts when the fully accounted for property or vehicle is assigned to and accepted by the Provider. Business arrangements made between the Provider and its subcontractors shall not permit the transfer of title of state property to subcontractors. While such business arrangements may provide for subcontractor participation in the use and maintenance of the property under their control, the ME shall hold the provider solely responsible for the use and condition of said property. Provider inventories shall be conducted in accordance with DCF operating procedure CFOP 80-2.

(3) If any property is purchased by the Provider with funds provided by this Contract, the Provider shall inventory all nonexpendable property including all computers. A copy of which shall be submitted to the ME along with the expenditure report for the period in which it was purchased. At least annually, the Provider shall submit a complete inventory of all such property to the ME whether new purchases have been made or not.

(4) The **Provider Inventory List,** provided by the ME upon request, and incorporated herein by reference, shall include, at a minimum, the identification number; year and/or model, a description of the property, its use and condition, current location, the name of the property custodian, class code (use state standard codes for capital assets), if a group, record the number and description of the components making up the group, name, make, or manufacturer, serial number(s), if any, and if an automobile, the VIN and certificate number; acquisition date, original acquisition cost, funding source, information needed to calculate the federal and/or State share of its cost.

(5) The ME must provide disposition instructions to the Provider prior to the end of the Contract. The Provider cannot dispose of any property that reverts to the ME without the ME's approval. The Provider shall furnish a Closeout Inventory Form no later than 30 days before the completion or termination of this Contract. The Closeout Inventory Form shall include all nonexpendable property including all computers purchased by the Provider. The Closeout Inventory Form shall contain, at a minimum, the same information required by the annual inventory.

(6) The Provider hereby agrees all inventories required by this Contract shall be current and accurate and reflect the date of the inventory. If the original acquisition cost of a property item is not available at the time of inventory, an estimated value shall be agreed upon by both the Provider and the ME and shall be used in place of the original acquisition cost.

(7) Title (ownership) to and possession of all property purchased by the Provider pursuant to this Contract shall be vested in the ME upon completion or termination of this Contract. During the term of this Contract, the Provider is responsible for insuring all property purchased by or transferred to the Provider is in good working order. The Provider hereby agrees to pay the cost of transferring title to and possession of any property for which ownership is evidenced by a certificate of title. The Provider shall be responsible for repaying to the ME the replacement cost of any property inventoried and not transferred to the ME upon completion or termination of this Contract. When property transfers from the Provider to the ME, the Provider shall be responsible for paying for the title transfer.

(8) If the Provider replaces or disposes of property purchased by the Provider pursuant to this Contract, the Provider is required to provide accurate and complete information pertaining to replacement or

disposition of the property as required on the Provider's annual inventory.

(9) To the extent permitted by State law, the Provider hereby agrees to indemnify the ME and DCF against any claim or loss arising out of the operations of any motor vehicle purchased by or transferred to the Provider pursuant to this Contract.

(10) A formal contract amendment is required prior to the purchase of any property item not specifically listed in the approved Contract budget.

(11) All intellectual property requirement of this contract shall ensure to the benefit of both BBHC and DCF.

b. Title to Vehicles

(1) Title (ownership) to, and possession of, all vehicles acquired with funds from this Contract shall be vested in the ME upon completion or termination of the Contract. The Provider will retain custody and control during the Contract period, including extensions and renewals.

(2) During the term of this Contract, title to vehicles furnished by using state or federal funds shall not be vested in the Provider. Subcontractors shall not be assigned or transferred title to these vehicles. To the extent permitted by State law, the Provider hereby agrees to indemnify the ME and DCF against any claim or loss arising out of the operations of any motor vehicle purchased by or transferred to the Provider pursuant to this Contract.

19. **Certificates of Insurance:** Certificates of Insurance must comply with the requirements found in the Prime Contract including but not limited to, JHME2: 4.8. Insurance.

E. List of Exhibits

The Provider agrees to comply, as applicable, with the exhibits listed below. The following Exhibits or the latest revisions thereof, are incorporated herein by reference, and are located on the BBHC website at www.bbhcflorida.org.

Exhibit Title	Applicable Services	Location
Persons to be Served	All	Handbook
Method of Payment	All	Handbook
Required Reports	All	Handbook
Substance Abuse and Mental Health Required Performance Outcomes (Titled; Output Measures)	All	Contract
Request for Reimbursement (Invoice)	All	Carisk Apps
Minimum Service Requirements	All	Handbook

Service Detail Rates	All	Contract Handbook
Purchased Beds	Residential; Room & Board; SRT; CSU; Detox	Contract
Funding Detail	All	Contract
Local Match Plan	All	Contract
Outreach/Prevention Activities Service Log	Outreach and Prevention Services	BBHC Website
National Voter Registration Monthly Report	Direct Service Providers	Carisk Apps
TANF Program Participant Log	TANF-Funded	BBHC Website
Incidental Fund Invoice and Expenditure Log	Providers with Incidental Funding	BBHC Website/ Carisk Apps
Performance Measures - Continuous Quality Improvement Programs		Handbook
Consumer Satisfaction Survey	Direct Service Providers	DCF and BBHC Website

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III. Monitoring and Audits

In addition to reviews of audits conducted in accordance with 2 Code of Federal Regulations (CFR) §§ 200.500- 200.521 and § 215.97, F.S., as revised, the ME will monitor or conduct oversight reviews to evaluate compliance with contract, management and programmatic requirements. Such monitoring or other oversight procedures may include, but not be limited to, on-site visits by the ME, limited scope audits as defined by Uniform Grant Guidance 2 CFR §200, as revised, or other procedures, including desk reviews. By entering into this Contract, the recipient agrees to comply and cooperate with any monitoring procedures deemed appropriate by the ME. In the event the ME determines a limited scope audit of the recipient is appropriate, the recipient agrees to comply with any additional instructions provided by the ME regarding such audit. The recipient further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by DCF's inspector general, the state's Chief Financial Officer or the Auditor General.

A. PART I: FEDERAL REQUIREMENTS

The Network Provider shall comply with the provisions of Federal law and regulations including, but not limited to, 2 CFR, Part 200, and other applicable regulations. This part is applicable if the recipient is a State or local government or a non-profit organization as defined in 2 CFR §§ 200.500-200.521, as revised.

If Provider Contract contains $10,000 or more of Federal Funds, the Network Provider shall comply with Executive Order 11246, Equal Employment Opportunity, as amended by Executive Order 11375 and others, and as supplemented in Department of Labor regulation 41 CFR, Part 60 if applicable.

If Provider Contract contains over $100,000 of Federal Funds, the Network Provider shall comply with all applicable standards, orders, or regulations issued under section 306 of the Clean Air Act, as amended (42 U.S.C. § 7401 et seq.), section 508 of the Federal Water Pollution Control Act, as amended (33 U.S.C. § 1251 et seq.), Executive Order 11738, as amended and where applicable, and Environmental Protection Agency regulations (2 CFR, Part 1500). The Network Provider shall report any violations of the above to the ME and the Department.

If Provider Contract provides services to children up to age 18, the Network Provider shall comply with the Pro-Children Act of 1994 (20 U.S.C. § 6081). Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation or the imposition of an administrative compliance order on the responsible entity, or both.

In the event the recipient expends $500,000 *($750,000 for fiscal years beginning on or after December 26, 2014*) or more in Federal awards during its fiscal year, the recipient must have a single or program-specific audit conducted in accordance with the provisions of 2 CFR §§ 200.500-200.521, as revised. The recipient agrees to provide a copy of the single audit to the ME and its contract manager. In the event the recipient expends less than $500,000 *($750,000 for fiscal years beginning on or after December 26, 2014*) in Federal awards during its fiscal year, the recipient agrees to provide certification to the ME and its contract manager that a single audit was not required. In determining the Federal awards expended during its fiscal year, the recipient shall consider all sources of Federal awards, including Federal resources received from the Department of Children & Families, Federal government (direct), other state agencies, and other non-state entities. The determination of amounts of Federal awards expended should be in accordance with guidelines established by 2 CFR §§

200.500-200.521, as revised. An audit of the recipient conducted by the Auditor General in accordance with the provisions of 2 CFR Part 200 §§ 200.500-200.521 will meet the requirements of this part. In connection with the above audit requirements, the recipient shall fulfill the requirements relative to auditee responsibilities as provided in 2 CFR § 200.508, as revised.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the ME in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the ME shall be fully disclosed in the audit report package with reference to the specific contract number.

Single Audit Information for Recipients of Recovery Act Funds:

(a) To maximize the transparency and accountability of funds authorized under the American Recovery and Reinvestment Act of 2009 (Pub. L. 111–5) (Recovery Act) as required by Congress and in accordance with 2 CFR 215.21 ‘‘Uniform Administrative Requirements for Grants and Agreements’’ and OMB Circular A–102 Common Rules provisions, recipients agree to maintain records that identify adequately the source and application of Recovery Act funds. OMB Circular A–102 is available at http://www.whitehouse.gov/omb/circulars/a102/a102.html.

(b) For recipients covered by the Single Audit Act Amendments of 1996 and OMB Circular A–133, ‘‘Audits of States, Local Governments, and Non-Profit Organizations,’’ recipients agree to separately identify the expenditures for Federal awards under the Recovery Act on the Schedule of Expenditures of Federal Awards (“SEFA”) and the Data Collection Form (SF–SAC) required by OMB Circular A–133. OMB Circular A–133 is available https://www.whitehouse.gov/omb/information-resources/guidance/compliance-supplement/.This shall be accomplished by identifying expenditures for Federal awards made under the Recovery Act separately on the SEFA, and as separate rows under Item 9 of Part III on the SF–SAC by CFDA number, and inclusion of the prefix ‘‘ARRA-’’ in identifying the name of the Federal program on the SEFA and as the first characters in Item 9d of Part III on the SF–SAC.

(c) Recipients agree to separately identify to each sub-recipient, and document at the time of sub-award and at the time of disbursement of funds, the Federal award number, CFDA number, and amount of Recovery Act funds. When a recipient awards Recovery Act funds for an existing program, the information furnished to sub-recipients shall distinguish the sub-awards of incremental Recovery Act funds from regular sub-awards under the existing program.

(d) Recipients agree to require their sub-recipients to include on their SEFA information to specifically identify Recovery Act funding similar to the requirements for the recipient SEFA described above. This information is needed to allow the recipient to properly monitor sub-recipient expenditure of ARRA funds as well as oversight by the Federal awarding agencies, offices of Inspector General and the Government Accountability Office.

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B. PART II: STATE REQUIREMENTS

This part is applicable if the recipient is a non-State entity as defined by §215.97(2), Florida Statutes.

In the event the recipient expends $750,000 or more in state financial assistance during its fiscal year, the recipient must have a State single or project-specific audit conducted in accordance with §215.97, Florida Statutes; applicable rules of the Department of Financial Services; and Chapters 10.550 (local governmental entities) or 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General. The recipient agrees to provide a copy of the single audit to the ME and its contract manager. In the event the recipient expends less than $750,000 in State financial assistance during its fiscal year, the recipient agrees to provide certification to the ME and its contract manager that a single audit was not required. In determining the state financial assistance expended during its fiscal year, the recipient shall consider all sources of state financial assistance, including state financial assistance received from the ME, other state agencies, and other non-state entities. State financial assistance does not include Federal direct or pass-through awards and resources received by a non-state entity for Federal program matching requirements.

In connection with the audit requirements addressed in the preceding paragraph, the recipient shall ensure that the audit complies with the requirements of Section §215.97(8), Florida Statutes. This includes submission of a financial reporting package as defined by §215.97(2), Florida Statutes, and Chapters 10.550 or 10.650, Rules of the Auditor General.

The schedule of expenditures should disclose the expenditures by contract number for each contract with the ME in effect during the audit period. The financial statements should disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due the ME shall be fully disclosed in the audit report package with reference to the specific contract number.

C. PART III: REPORT SUBMISSION

Any reports, management letters, or other information required to be submitted to the ME pursuant to this agreement shall be submitted within **170** days after the end of the Provider's fiscal year or within 30 days of the recipient's receipt of the audit report, whichever occurs first, directly to each of the following unless otherwise required by Florida Statutes:

A. ME for this Contract one (1) electronic copy and management letter, if issued

B. Reporting packages for audits conducted in accordance with Uniform Grant Guidance 2 CFR §200, as revised, and required by Part I of this Contract shall be submitted, when required by § .320(d), Uniform Grant Guidance 2 CFR §200, as revised, by or on behalf of the recipient directly to the Federal Audit Clearinghouse using the Federal Audit Clearinghouse's Internet Data Entry System at:

https://harvester.census.gov/facweb/ and other Federal agencies and pass-through entities in accordance with Uniform Grant Guidance 2 CFR §200, as revised.

D. PART IV: RECORD RETENTION

The recipient shall retain sufficient records demonstrating its compliance with the terms of this Contract for a period of six years from the date the audit report is issued and shall allow the ME or its designee, Chief Financial Officer, or Auditor General access to such records upon request. The recipient shall ensure that audit working papers are made available to the ME or its designee, Chief Financial Officer or Auditor General upon request for a period of three years from the date the audit report is issued, unless extended in writing by the ME.

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IV. HIPAA

This Attachment contains the terms and conditions governing the Provider's access to and use of Protected Health Information ("PHI") and provides the permissible uses and disclosures of protected health information by the Provider, also called the "Business Associate."

A. Section 1. Definitions

1.1 Catch-all definitions:
The following terms used in this Attachment shall have the same meaning as those terms in the Health Insurance Portability and Accountability Act ("HIPAA") Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

1.2 Specific definitions:

1.2.1 "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR §160.103, and for purposes of this Attachment shall specifically refer to the Provider.

1.2.2 "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR §160.103, and for purposes of this Attachment shall refer to the Department.

1.2.3 "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

1.2.4 "Subcontractor" shall generally have the same meaning as the term "subcontractor" at 45 CFR §160.103 and is defined as an individual to whom a business associate delegates a function, activity, service, other than in the capacity of a member of the workforce of such business associate.

B. Section 2. Obligations and Activities of Business Associate

2.1 Business Associate agrees to:

2.1.1 Not use or disclose protected health information other than as permitted or required by this Attachment or as required by law;

2.1.2 Use appropriate administrative safeguards as set forth at 45 CFR §164.308, physical safeguards as set forth at 45 CFR §164.310, and technical safeguards as set forth at 45 CFR §164.312; including, policies and procedures regarding the protection of PHI and/or ePHI set forth at 45 CFR §164.316 and the provisions of training on such policies and procedures to applicable employees, independent contractors, and volunteers, that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI and/or ePHI the Provider creates, receives, maintains or transmits on behalf of the Department/Managing Entity;

2.1.3 Acknowledge that (a) the foregoing safeguards, policies and procedures requirements shall apply to the Business Associate in the same manner that such requirements apply to the Department/Managing Entity and (b) the Business Associate's and their Subcontractors are directly liable under the civil and criminal enforcement provisions set forth at Section 13404 of the HITECH

Act and section 45 CFR §§164.500 and 164.502(E) of the Privacy Rule (42 U.S.C.1320d-5 and 1320d-6), as amended, for failure to comply with the safeguards, policies and procedures requirements and any guidance issued by the Secretary of Health and Human Services with respect to such requirements;

2.1.4 Report to covered entity any use or disclosure of protected health information not provided for by this Attachment of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR §164.410, and any security incident of which it becomes aware;

2.1.5 Notify the Managing Entity's Security Officer, Privacy Officer and the Contract Manager as soon as possible, but no later than 24 hours following the determination of any breach or potential breach of personal and confidential departmental/Managing Entity data;

2.1.6 Notify the Privacy Officer and Contract Manager within 24 hours of notification by the US Department of Health and Human Services of any investigations, compliance reviews or inquiries by the US Department of Health and Human Services concerning violations of HIPAA (Privacy, Security Breach).

2.1.7 Provide any additional information requested by the Department/Managing Entity for purposes of investigating and responding to a breach;

2.1.8 Provide at Business Associate's own cost notice to affected parties no later than 30 days following the determination of any potential breach of personal or confidential departmental/Managing Entity data as provided in §817.5681, Florida Statutes;

2.1.9 Implement at Business Associate's own cost measures deemed appropriate by the Department/Managing Entity to avoid or mitigate potential injury to any person due to a breach or potential breach of personal and confidential departmental/Managing Entity data;

2.1.10 Take immediate steps to limit or avoid the recurrence of any security breach and take any other action pertaining to such unauthorized access or disclosure required by applicable federal and state laws and regulations regardless of any actions taken by the Department/Managing Entity;

2.1.11 The Provider shall notify BBHC and DCF within 24 hours, following the determination of any potential or actual unauthorized disclosure or access to the Department's information systems or to any client or other confidential information.

2.1.12 In accordance with 45 CFR §§164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information. Business Associate's must attain satisfactory assurance in the form of a written contract or other written agreement with their business associate's or subcontractor's that meets the applicable requirements of §164.504(e)(2) that the Business Associate or Subcontractor will appropriately safeguard the information. For prior contracts or other arrangements, the provider shall provide written certification that its implementation complies with the terms of 45 CFR §164.532(d);

2.1.13 Make available protected health information in a designated record set to covered entity as necessary to satisfy covered entity's obligations under 45CFR §164.524;

2.1.14 Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR §164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR §164.526;

2.1.15 Maintain and make available the information required to provide an accounting of disclosures to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR §164.528;

2.1.16 To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

2.1.17 Make its internal practices, books, and records available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance with the HIPAA Rules.

C. Section 3. Permitted Uses and Disclosures by Business Associate

3.1 The Business associate may only use or disclose protected health information covered under this Attachment as listed below:

3.1.1 The Business Associate may use and disclose the Department/Managing Entity's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) in performing its obligations pursuant to this Attachment.

3.1.2 The Business Associate may use the Department/Managing Entity's PHI and/or ePHI received or created by Business Associate (or its agents and subcontractors) for archival purposes.

3.1.3 The Business Associate may use PHI and/or ePHI created or received in its capacity as a Business Associate of the Department/Managing Entity for the proper management and administration of the Business Associate if such use is necessary (a) for the proper management and administration of Business Associate or (b) to carry out the legal responsibilities of Business Associate.

3.1 4 The Business Associate may disclose PHI and/or ePHI created or received in its capacity as a Business Associate of the Department/Managing Entity for the proper management and administration of the Business Associate if (a) the disclosure is required by law or (b) the Business Associate (1) obtains reasonable assurances from the person to whom the PHI and/or ePHI is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person and (2) the person agrees to notify the Business Associate of any instances of which It becomes aware in which the confidentiality and security of the PHI and/or ePHI has been breached.

3.1.5 The Business Associate may aggregate the PHI and/or ePHI created or received pursuant this Attachment with the PHI and/or ePHI of other covered entities that Business Associate has in its possession through its capacity as a Business Associate of such covered entities for the purpose of providing the Department/Managing Entity with data analyses relating to the health care operations of the Department/Managing Entity (as defined in 45 C.F.R.§164.501).

3.1.6 The Business Associate may de identify any and all PHI and/or ePHI received or created pursuant to this Attachment, provided that the de-identification process conforms to the requirements of 45 CFR §164.514(b).

3.1.7 Follow guidance in the HIPAA Rule regarding marketing, fundraising and research located at Sections 45 CFR § 164.501,45 CFR §164.506 and 45 CFR §164.514.

D. Section 4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices & Restrictions

4.1 Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR §164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

4.2 Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

4.3 Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR §164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

E. Section 5. Termination

5.1 Termination for Cause

5.1.1 Upon the Department/Managing Entity's knowledge of a material breach by the Business Associate, the Department/Managing Entity shall either:

5.1.1.1 Provide an opportunity for the Business Associate to cure the breach or end the violation and terminate the Agreement or discontinue access to PHI if the Business Associate does not cure the breach or end the violation within the time specified by the Department/Managing Entity;

5.1.1.2 Immediately terminate this Agreement or discontinue access to PHI if the Business Associate has breached a material term of this Attachment and does not end the violation; or

5.1.1.3 If neither termination nor cure is feasible, the Department/Managing Entity shall report the violation to the Secretary of the Department of Health and Human Services.

5.2 Obligations of Business Associate upon Termination

5.2.1 Upon termination of this Attachment for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

5.2.1.1 Retain only that protected health information which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

5.2.1.2 Return to covered entity, or other entity as specified by the Department/Managing Entity or, if permission is granted by the

Department/Managing Entity, destroy the remaining protected health information that the Business Associate still maintains in any form;

5.2.1.3 Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as Business Associate retains the protected health information;

5.2.1.4 Not use or disclose the protected health information retained by Business Associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out at paragraphs 3.1.3 and 3.1.4 above under "Permitted Uses and Disclosures by Business Associate" which applied prior to termination; and

5.2.1.5 Return to covered entity, or other entity as specified by the Department/Managing Entity or, if permission is granted by the Department/Managing Entity, destroy the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

5.2.1.6 The obligations of business associate under this Section shall survive the termination of this Attachment.

F. Section 6. Miscellaneous

6.1 A regulatory reference in this Attachment to a section in the HIPAA Rules means the section as in effect or as amended.

6.2 The Parties agree to take such action as is necessary to amend this Attachment from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

6.3 Any ambiguity in this Attachment shall be interpreted to permit compliance with the HIPAA Rules.

6.4 42 CFR Part 2 - Confidentiality of Substance Use Disorder Patient Records. The 42 CFR Part 2 regulations protect person served records created by federally assisted programs for the treatment of substance use disorders (SUD). 42 CFR Part 2 has been revised to further facilitate better coordination of care in response to the opioid epidemic while maintaining its confidentiality protections against unauthorized disclosure and use. 42 CFR Part 2 continues to prohibit law enforcement's use of SUD patient records in criminal prosecutions against patients, absent a court order. 42 CFR Part 2 also continues to restrict the disclosure of SUD treatment records without patient consent, other than as statutorily authorized in the context of a bona fide medical emergency; or for the purpose of scientific research, audit, or program evaluation; or based on an appropriate court order.

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V. Cost Reimbursement for Participants of Evidence Based Practice Trainings

Evidence Based Practice trainings are essential for quality improvement of service delivery of BBHC's Provider Network. Those staff that provides direct services and who were paid on a direct contact hour for the time they participate in an Evidence Based Practice training or activity will now be paid on a cost reimbursement basis. The selected participants will be prior authorized by Broward Behavioral Health Coalition prior to the actual attendance at the training. Providers must request approval for training reimbursement from the BBHC CQI Coordinator no later seven (7) calendar days prior to date of training; at that time all required documents described in the policy must be submitted or provider will risk training obtaining approval.

The following hourly rates will be paid to the provider for the time their staff spend participating in the BBHC selected Evidence Based Practice training. This rate is based on the average network salary for the position plus fringe benefits and an allowance for the operational expenses to support the position.

The rates are as follows:

Position Title	Rate
Clinician (Master's level individuals that provide individual, group, assessment, evaluations)	$67.96
Case manager (Bachelor's level mental health/substance use service linkage, supportive employment, assessors, supportive housing, transitional youth Coordinators, any case management function type paid through direct service)	$59.32
Employment Specialists (Supported employment, job development, job coaching, any employment related outreach, treatment planning, and support)	$59.32
Housing Specialists (Supportive housing, tenancy supports, landlord relations, move in supports, any housing related outreach, treatment planning, and support)	$59.32
TIP Coaches/Transition Facilitators (Youth-related treatment planning and linkage to services, housing, employment, personal connections, social supports, school system, DJJ, child welfare, or other transition-age youth needs)	$59.32
Peer Specialist (Wellness recovery action planning (WRAP), one on one mentoring, and individuals billed under recovery and support)	$40.11

VI. Person to be Served

A. General Description

The Provider shall furnish services funded by this Contract to the target population(s) as it appears on, Persons Served exhibit.

B. Client/Participant Eligibility

(1) The Provider agrees that all persons meeting the target population descriptions found in Persons Served exhibit are eligible for services based on the availability of resources. A detailed description of each target Service category is contained in §394.674, Florida Statutes, and as described in the FASAMS DCF Pamphlet 155-2, most recent version, based on the availability of resources. FASAMS DCF Pamphlet 155-2, most recent version is incorporated herein by reference.

(2) This Contract precludes the Provider from billing the ME for services provided to Medicaid eligible individuals, which are reimbursable by Medicaid.

(3) This contract requires that all Medicaid-enrolled Network Service Providers, prior to invoicing BBHC for any services provided to any Medicaid-enrolled recipients, to document the Provider has:

- Submitted a prior authorization request for any Medicaid-covered services provided.
- Appealed any denied prior authorizations.
- Provided assistance to appeal a denial of eligibility or coverage.
- Verified the provided service is not a covered service under Florida Medicaid, as defined in Chapter 59G-4, F.A.C., or is not available through the individual's MMA Plan.
- In cases where the individuals Medicaid-covered service limit has been exhausted for mental health services, an appropriately licensed mental health professional has issued a written clinical determination that the individual continues to need the specific mental health treatment service provided.
- In cases where the individual's Medicaid-covered service limit has been exhausted for substance use disorder treatment services a qualified professional as defined in § 397.311(35), F.S., has issued a written clinical determination that the individual continues to need the specific service provided.

(4) Priority for Behavioral Health Services shall be given to families with children determined to be "unsafe" by child protective investigators. Such priority is limited to individuals that are not Medicaid eligible or require services that are not included as reimbursable by Medicaid. Eligibility for services is found, pursuant to:

(a) §394.674(a)(2), Florida Statutes, for adult mental health services for the parents, based upon the emotional crisis experienced from the potential removal of children.

(b) §394.674(c)3., Florida Statutes, Substance abuse eligibility is based on parents who put children at risk due to a substance abuse disorder.

(5) Mental health crisis intervention and crisis stabilization facility services, and substance abuse detoxification and addiction receiving facility services, shall be provided to all persons meeting the criteria for admission, subject to the availability of beds and/or funds.

NOTE: All Designated Receiving Facilities must enter data into the Department's Baker Act data portal.

C. Client/Participant Determination

(1) Determination of persons' served eligibility is the responsibility of the Provider. The Provider shall adhere to the eligibility requirements as specified in the Minimum Service Requirements Document. BBHC reserves the right to review the Provider's determination of client eligibility and override the determination of the Provider. When this occurs, the Provider will immediately provide services to the consumer until such time the consumer completes their treatment, voluntarily leaves the program, or the ME's decision is overturned as a result of the dispute resolution.

(2) In the event of a dispute as to BBHC's determination regarding eligibility, dispute resolution, as described in the entitled Paragraph "Dispute Resolution" of the Contract, shall be entered into. An eligibility dispute shall not preclude the provision of services to Individuals Served, unless the dispute resolution process reverses the ME's determination. The determination made by the ME is final and binding on all parties.

(3) The ME may delegate the Individuals Served eligibility determinations to the Provider, subject to the determination of the ME.

(4) Participant eligibility (Direct Prevention) and target population eligibility (Community Prevention) shall also be based upon the community action plan or on the relevant epidemiology data.

D. Contract Limits

(1) The Provider is not authorized to bill the ME for more units than are specified in Service Detail Document, or for more units than can be purchased with the amount of funds specified in the Service Detail Document, included as an attachment to the Contract, subject to the availability of funds. An exception is granted at the end of the Contract, when the ME, at its sole discretion, may pay, subject to the availability of funds, the Provider for "Uncompensated Units Reimbursement Funds", in whole or in part, or not at all as determined by the delivery of services in excess of those units of service the ME is required to pay. The ME's obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature and the Contract between the ME and DCF.

(2) The Provider agrees that funds provided in this Contract will not be used to serve persons outside the target population(s) specified in Person Served exhibit. NOTE: Prevention funds allocated to underage drinking programs and activities targeting eighteen (18) to twenty (20) year old individuals may be taken from Adult Substance

Abuse Prevention funds.

(3) The provision of services required under this Contract are limited to eligible children, and adults receiving authorized services within the counties outlined in Service Provision Detail, Section A.2.b.(2) and limited by the availability of funds.

(4) The Provider may not authorize or incur indebtedness on behalf of the ME.

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VII. Method of Payment

Invoices shall be submitted in sufficient detail to capture, report, and test the validity of expenditures and service utilization (including minimum data elements) for the completion of a pre-audit and post-audit and to satisfy the Department's application and reporting requirements.

A. Payment Clauses

1. **This is a fixed price (unit cost) contract**. The unit prices are listed under BBHC Rates in this handbook. The ME shall pay for contracted services according to the terms and conditions of this Contract as it appears on the Funding Detail exhibit. When services are paid based on deliverables performance will be determined by the Provider delivering and billing for services in excess of those units of service BBHC will be required to pay. BBHC's obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature and the Contract JHME2 between BBHC and the Florida Department of Children and Families ("DCF"). Any costs or services eligible to be paid for under any other contract or from any other source are not eligible for payment under this Contract.

2. Aftercare, Intervention, Outpatient, and Recovery Support Services (Substance Abuse) are eligible for special group rates. Group services shall be billed on the basis of a contact hour, at 25% of the Contract's established rate for the individual services for the same covered service. Excluding Outpatient, total hourly reimbursement for group services shall not exceed the charges for fifteen (15) individuals per group. Group size limitations outlined in the current Medicaid Handbook apply to Outpatient group services funded under this Contract.

3. Pursuant to §394.76(3), Florida Statutes, the Provider agrees to provide local matching funds in the amount stated in the Funding Detail.

4. The ME shall reduce or withhold funds pursuant to Rule 65-29.001, F.A.C., if the Provider fails to comply with the terms of this Contract and/or fails to submit client reports and/or data as required in FASAMS DCF Pamphlet 155-2, most recent version, Rule 65E-14, F.A.C., and in accordance with Required Reports exhibit.

5. When the ME finds cause to reduce or withhold funds invoiced by the Provider, the ME will provide written explanation of the reason(s) to the Provider.

6. If the Provider closes or suspends the provision of services funded by this Contract, it agrees to provide the ME with no less than ninety (90) calendar days of notification. Failure to provide written notice of close or suspend services may result in termination of this Contract.

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B. BBHC FY 26-27

Covered Services	FY 26-27
Aftercare - Individual	$ 71.08
Aftercare - Group	$ 17.77
Assessment	$ 113.33
BNet	$ 1,258.53
Case Management	$ 85.28
Clubhouse	$ 49.07
Crisis Stabilization	$ 510.64
Crisis Support/Emergency	$ 74.57
Day Care	$ 42.42
Day Treatment	$ 79.27
Drop-In/Self Help Centers	$ 54.04
Information Referral	$ 46.73
Incidental Expenses	$ 1.00
In-Home and On-Site	$ 99.01
Inpatient	$ 510.64
Intervention - Individual	$ 92.38
Intervention - Group	$ 23.10
Medical Services	$ 427.86
Medication Assisted Treatment	$ 24.55
Outpatient - Individual	$ 106.92
Outpatient - Group	$ 26.73
Outreach	$ 74.67
Prevention - Indicated	$ 84.82
Prevention - Selective	$ 84.82
Prevention - Universal Direct	$ 84.82
Prevention - Universal Indirect	$ 84.82
Recovery Support - Individual	$ 72.22
Recovery Support - Group	$ 18.06
Residential Level I	$ 309.02
Residential Level II	$ 285.45
Residential Level III	$ 173.75

Covered Services	FY 26-27
Residential Level IV	$ 80.64
Room & Board with Supervision Level I	$ 171.84
Room & Board with Supervision Level II	$ 158.21
Room & Board with Supervision Level III	$ 116.54
Short Term Residential Treatment (SRT)	$ 510.64
Substance Abuse Inpatient Detox	$ 403.42
Substance Abuse Outpatient Detox	$ 124.72
Supported Employment	$ 82.96
Supportive Housing/Living	$ 80.79

C. Additional Release of Funds

At its sole discretion, the ME may approve the release of more than the monthly pro-rated amount when the Provider submits a written request justifying the release of additional funds.

D. Medicaid Billing

1. The ME and the Provider agree DCF, through its contract with the ME, is not a liable as a third party for Medicaid eligible services provided to individuals that meet the eligibility criteria for Medicaid. Authorized Provider services shall be reimbursed in the following order of precedence:

- **a.** Any liable first, second, and/or third-party payors;
- **b.** Medicaid, pursuant to §409.910, Florida Statutes, if the individual meets the eligibility criteria for Medicaid, and the service is Medicaid eligible; and
- **c.** DCF through the ME (only if none of the above are available or eligible for payment)

NOTE: Providers should be leveraging funding with other funding sources.

2. The Provider shall identify and report Medicaid earnings separate from all other fees. Medicaid earnings cannot be used as local match.

3. The Provider shall ensure Medicaid payments are accounted for using generally accepted accounting practices and in adherence to federal and State laws, rules and regulations.

4. In no event shall both Medicaid and the ME be billed for the same service.

5. Providers operating a residential treatment facility licensed as a crisis stabilization unit ("CSU"); detoxification facility ("Detox"); short-term residential treatment ("SRT") facility; residential treatment facility Levels 1 or 2; or therapeutic group home with greater than sixteen (16) beds are not permitted to bill or knowingly access Medicaid Fee For-Service programs for any services with the exception of case management for individuals eligible for Medicaid while in these facilities.

6. A provider operating a children's residential treatment center of greater than 16 beds is not permitted to bill or knowingly access Medicaid Fee-For Service programs for any services for individuals meeting the eligibility criteria for Medicaid in these facilities except as permitted under the Medicaid State Inpatient Psychiatric Program Waiver.

7. The Provider shall assist eligible persons served in preparing and submitting a Medicaid application, including assistance with medical documentation required in the disability determination process.

8. The Provider agrees to assist Medicaid covered eligible persons served of a Medicaid capitated entity in obtaining covered mental health services it determines medically necessary. This assistance shall include assisting clients in appealing a denial of services.

E. Payments from Medicaid Managed Medical Assistance (MMA) Programs, or Provider Services Networks

Unless waived in this Contract, the Provider agrees payments from a health maintenance organization ("HMO"); or provider services network will be considered third party payer contractual fees as defined in Rule 65E-14.001(2)(z), F.A.C. Services which are covered by the sub-capitated contracts and provided to persons covered by these contracts shall not be billed to the ME.

F. Temporary Assistance to Needy Families ("TANF")

1. The Provider's attention is directed to its obligations under applicable parts of Part A or Title IV of the Social Security Act and the Provider agrees TANF funds shall be expended for TANF participants as outlined in the Temporary Assistance to Needy Families (TANF) Guidelines. TANF Guidelines can be obtained from BBHC or accessed through the Florida Department of Children and Families (DCF) website under the Guidance Documents, where the TANF Funding Guidance is housed.

2. The Contract shall specify the unit cost rate for each covered service contracted for TANF funding, which shall be the same rate as for non-TANF funding, but the Contract shall not specify the number of TANF units or the amount of TANF funding for individual covered services.

3. Provider's that receive TANF funds shall complete the TANF Program Participant Log, and maintain on file, as supporting documentation for the applicable invoice.

G. Invoice Requirements

1. The rates negotiated with the Provider Network will be used to reimburse for services.

2. The Provider is required to comply with Rule 65E-14.021, F.A.C., Schedule of Covered Services, including but not limited to: covered services; unit measurements; descriptions; program areas; data elements; maximum unit cost rates; required fiscal reports; program description; setting unit cost rates; payment for services including allowable and unallowable units; and requests for payments.

3. The Provider shall request monthly reimbursement for services rendered via the completion of the Invoice for Services as required in this Contract and as specified in Required Reports exhibit.

4. If no services are due to be invoiced from the preceding month, the Provider shall submit written document to the ME indicating this information within seven (7) days following the end of the month. If the Provider fails to submit written documentation of no reimbursement due, within thirty (30) calendar days following the end of the month, then ME may reallocate funds. If the Provider fails to submit written documentation of no reimbursement due for two (2) consecutive months within a twelve (12) month period, ME may exercise its termination clause.

5. The Provider's final invoice must reconcile actual service units provided during the Contract with the amount paid by ME. The Provider shall submit its fiscal year final invoice to ME as specified in Required Reports exhibit.

6. Pursuant to Rule 65E-14.021(10)(b)6. b., F.A.C., worksheet shall not exceed the total number of units reported and accepted in the ME data system pursuant to Rule 65E-14.022, F.A.C.

7. Pursuant to Rule 65E-14.021(10)(a)2., F.A.C., any costs or service units paid pursuant to another contract, or another source are not eligible for payment under this Contract. The Provider must subtract all units which are billable to Medicaid, and all units for client services paid from other sources, including Social Security, Medicare payments, and funds eligible for local matching which include patient fees from first, second, and third-party payers, from each monthly invoice.

H. Supporting Documentation

1. The Provider agrees to maintain and submit to the ME, service documentation for each service billed or subtracted to the ME. The Provider shall track all units billed to the ME by program and by Other Cost Accumulator (OCA). Proper service documentation for each covered service is outlined in Rule 65E-14.021, and F.A.C., regarding “Covered Service Description-Substance Abuse Recovery Support Services (Individual and Group)”; “Covered Service Description-Evidence-Based Practices”; and “TANF SAMH Guidelines and TANF SAMH Incidental Expenditures for Housing Assistance”, as applicable.

2. The Provider shall ensure all services provided are entered into the ME identified data system(s) for Prevention Services.

I. Financial Responsibility Policy

BBHC has developed the Subcontractor Financial Responsibility Policy to set up processes that will ensure subcontractor compliance with contractually required data and records submission. The purpose of the Subcontractor Financial Responsibility Policy is to ensure subcontractor compliance with contractual requirements regarding data and records submission.

Providers that do not submit all required records for enrollment service and discharge, for all funding sources may incur a financial penalty that may reduce their monthly invoice cap (prorated share) by funding pool (OCAs) until the items are corrected and/or submitted, as required. Failure to comply with any provisions of this policy will result in subcontractor non-compliance of their contract and could result in termination of subcontractor's contract.

A. Penalties Due to Missing Discharge Records

The percentage of missing admissions, outcome measures and discharges will be calculated for all contracted providers. Exceptions greater than 3% may be considered for financial penalty.

Providers with exception rates, by program, that are greater than 3% may be placed on a 30-day correction action. Failure to comply with the corrective action will result in a reduction to the providers' monthly invoice cap (prorated share) by their exception rate, up to a maximum reduction of 10% of the amount invoiced. Should the provider make corrections to the extent that they fall on or below the 3% threshold, no penalty shall be taken.

B. Penalties Due to Incorrect Data

Providers must upload data to the Provider Portal by the due dates. Once the data is uploaded it will be reviewed by Carisk and if there are any data entry errors in excess of 3%, the providers will be notified.

Providers must correct the errors within 3-4 days, or as requested. If providers are non-responsive and the data is not corrected there will be a financial penalty of 3%, the following month.

If a provider continues to have the same data error for three (3) consecutive months, then there will be a financial penalty of up to 6% and the provider will be placed on corrective action.

C. Maximum Combined Penalty Reduction

The maximum combined penalty reduction in the monthly-prorated share for providers not compliant with the above categories will not exceed 10% of the entire contract prorated share.

Penalties will be recalculated every month; therefore, once items are corrected, corresponding penalties are removed, and the providers will be able to invoice all the unpaid units up to the prorated share in the subsequent monthly invoice.

D. Adjustment Completion Deadline

All adjustments must be completed before the end of the fiscal year. Any fund balance, based on invoice and data, not being corrected will result in the provider lapsing funds for the fiscal year.

J. Funding Sweeps

The Provider agrees a review of the funding utilization rate or pattern of the Provider may be conducted by the ME. Based upon such review, if it is determined the rate of utilization may result in a lapse of funds, the ME may amend the Provider's Contract to prevent the lapse of funds. Furthermore, the Provider's Contract may be amended by the ME in order to meet the changing needs of the system of care. The ME will notify the Provider in writing of the need for an amendment prior to increases or decreases to the Contract amount.

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VIII. Required Reports

Required Reports	Due Date	# of Copies	Send to
PAM155-2 Monthly Service Data	Seventh (7) calendar day of the following month for which services were rendered	NA	Carisk Portal / PBPS
Invoice and Supporting documentation	10th calendar day of the following month for which services were provided	1	BBHC Provider SharePoint - Invoices
Outreach/Prevention/ TANF Services Log	As Requested	1	BBHC Provider SharePoint - Invoices
Incident Reports	As required in QI001BBHC.0013 Incident Reporting Policy	1	IRAS and incidentreporting@bbhcflorida.org
Financial Statements (Balance Sheet and Statement of Activity)	Quarterly on October 7; January 7; April 7; July 7	1	BBHC Provider SharePoint
Voter Registration Report (As applicable)	Seventh (7) calendar day of the following month for which services were rendered	1	Carisk Partners
Consumer Satisfaction Survey (As Applicable)	Quarterly on September 30; December 31; March 31; June 30	1	DCF Website
Transitional Voucher Report (Quarterly)	Quarterly on the 10th of the month following end of each quarter	1	Carisk Required Reports Portal
Family Intensive Treatment (FIT) Team Report	10th calendar day of the following month for which services were provided	1	Carisk Required Reports Portal

Required Reports	Due Date	# of Copies	Send to
Family Support Teams	10th calendar day of the following month for which services were provided	1	Carisk Required Reports Portal
Family Engagement Program	5th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Children Care Coordination	5th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Care Coordination Monthly Report and Care Coordination Monthly Census	10th calendar day of the following month for which services were provided	1	Carisk Required Reports Portal
Clubhouse - Employment Report	10th calendar day of the following month for which services were provided	1	Carisk Required Reports Portal
Short-term Residential Treatment (SRT)	10th calendar day of the following month for which services were provided	1	Carisk Required Reports Portal
Year-End Financial Reports for Providers Not Requiring Audits Per Monitoring and Audits Section			
Schedule of State Earnings	45 calendar days after the end of the Provider's fiscal year.	1	Carisk Required Reports Portal
Schedule of Related Party Transaction Adjustments	45 calendar days after the end of the Provider's fiscal year.	1	Carisk Required Reports Portal
Projected Covered Service Operating and Capital Budget Actual Expenses &Revenues Schedule	45 calendar days after the end of the Provider's fiscal year.	1	Carisk Required Reports Portal
Schedule of Bed-Day Availability Payments	45 calendar days after the end of the Provider's fiscal year.	1	Carisk Required Reports Portal
Agency Prepared Financial Statements (Balance Sheet and Statement of Activity)	45 calendar days after the end of the Provider's fiscal year.	1	Carisk Required Reports Portal

Year-End Financial Reports for Providers Requiring Audits Per Monitoring and Audits Section			
Financial & Compliance Audit to include the necessary schedules per **Monitoring and Audits Section** Including: 1. Schedule of State Earnings 2. Schedule of Related Party Transaction Adjustments 3. Projected Covered Service Operating and Capital Budget (Actual Expenses &Revenues Schedule) 4. Schedule of Bed-Day Availability Payments 5. Agency Prepared Financial Statements (Balance Sheet and Statement of Activity)	170 calendar days after the end of the Provider's fiscal year or 30 calendar days after its completion, whichever comes first. (See **Monitoring and Audits Section)**	1	Carisk Required Reports Portal
Substance Abuse Providers			
Annual Report for HIV Early Intervention Services (SAPT Block Grant Set Aside Funded Services Only)	Upon Request	1	As Requested
Annual Report for Pregnant Women and Women with Dependent Children (SAPT Block Grant Set Aside Funded Services Only)	Upon Request	1	As Requested
Narrative Block Grant Report – as requested – once a year			
Miscellaneous			
Return on Investment Report	Quarterly on the 10th of the month following end of each quarter	1	Carisk Required Reports Portal
Florida Assertive Community Treatment (FACT) Quarterly Report	Quarterly on the 10th of the month following end of each quarter	1	Carisk Required Reports Portal
Florida Assertive Community Treatment (FACT) 1. Census 2. Outcomes Report 3. Vacancies	10th calendar day of the following month for which services were provided	1	Carisk Required Reports Portal

Required Reports	Due Date	# of Copies	Send to
PBPS Data Entry Training Report for Prevention Program Coordinator and any data entry staff, if applicable (Prevention Service Providers)	Upon Request	1	Carisk Apps
Prevention Services Invoices Back-Up Report printed from PBPS (Prevention Services Providers)	7th calendar day of the following month for which services were rendered	1	Carisk Apps
Coalition Activities Report (Prevention Services Providers)	Quarterly on October 7; January 7; April 7; July 7	1	Carisk Apps
CAT Team Monthly Reporting Template and CAT Team Waiting List	10th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Early Treatment Team	5th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Final Invoice	By July 10 of each fiscal year	1	Carisk Apps Portal
Civil Rights Compliance Questionnaire	June 30	1	Carisk Required Reports Portal
Tangible Property Inventory Report (As applicable)	April 15	1	Managing Director of Admin. and Quality Improvement
TANF SAMH Program Logs and Service Data (As applicable)	Upon Request	1	Carisk Apps

ADA Client Communication Assessment Auxiliary Aid Service Record Monthly Summary Report (As applicable)	By the 5th business day following the reporting month	1	Carisk Required Reports Portal
External Quality Assurance Reviews, Monitoring Reports, Surveys & Corrective Action Plans	As specified in the Paragraph entitled “Inspections and Corrective Action” of the Contract	1	BBHC Provider SharePoint
Payer Class Data	7th calendar day for the following month for which services were rendered	1	Carisk Apps
PATH Reports	Quarterly on the 10th of the month following end of each quarter	1	Carisk Required Reports Portal
PATH Annual Reports (As applicable)	Drafts to be submitted to ME for Southern Region’s SAMH Program Office	1	Carisk Required Reports Portal
Mental Health ALF Report (As applicable)	Quarterly on October 15; January 15; April 15; and July 15	1	Carisk Required Reports Portal
Waitlist - Length of Stay by Level of Care	10th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Hospital Bridge Report	10th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Recovery Community Organization (RCO) Report	10th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Mobile Response Team Report	10th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Progress Exchange Reports	5th calendar day for the following month for which services were provided	1	Child Welfare Integration Manager

Forensic Services			
Forensic Reports	5th calendar day for the following month for which services were provided		Carisk Required Reports Portal
Post Arrest Diversion Report	5th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Conditional Release Report (As applicable)	5th calendar day for the following month for which services were provided	1	Carisk Required Reports Portal
Forensic Residential Treatment Facility Census & Waitlist	10th calendar day of the following month for which services were provided	1	Carisk Required Reports Portal

IX. Minimum Service Requirements

For form, refer to BBHC Website: http://www.bbhcflorida.org/

The Provider and its subcontractors shall be knowledgeable of and fully comply with all applicable state and federal laws, rules and regulations, as amended from time to time, that affect the subject areas of the Contract. Authorities include, but are not limited to, the following:

A. PROGRAMMATIC AUTHORITY (FEDERAL)

1. Mental Health

   42 U.S.C. 300x to 300x-9 *(Block Grant for community Mental Health Services)*
   https://www.law.cornell.edu/uscode/text/42/chapter-6A/subchapter-XVII/part-B+

2. Substance Abuse Prevention and Treatment Block Grant (SAPT)

   42 U.S.C. 290kk, et seq.*(Limitation on use of funds for certain purposes)*
   https://www.law.cornell.edu/uscode/text/42/290kk

   42 U.S.C. 300x-21 to 300x-35 and 300x-51 to 300x-66*(SA Treatment & Prevention Block Grants)* https://www.law.cornell.edu/uscode/text/42/chapter-6A/subchapter-XVII/part-B

   42 CFR, Part 54 *(Charitable choice)*
   https://www.ecfr.gov/current/title-42/chapter-I/subchapter-D/part-54

   45 CFR 96.120 – 137 *(SA Treatment & Prevention Block Grants)*
   https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-96/subpart-L/section-96.120

   Restrictions on expenditures of SAPT

   45 CFR 96.135
   https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-A/part-96/subpart-L/section-96.135

3. Substance Abuse-Confidentiality

   42 CFR, Part 2
   https://www.ecfr.gov/current/title-42/chapter-I/subchapter-A/part-2

4. Health Insurance Portability and Accountability Act (HIPAA)

   45 CFR 164
   https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-C/part-164

5. Social Security Income for the Aged, Blind and Disabled

   20 CFR 416
   https://www.ecfr.gov/current/title-20/chapter-III/part-416

6. Endorsement and Payment of Checks Drawn on the United States Treasury
   31 CFR 240 relating to SSA
   https://www.ecfr.gov/current/title-31/subtitle-B/chapter-II/subchapter-A/part-240

7. Temporary Assistance to Needy Families (TANF)

   Part A, Title IV of the Social Security Act

   45 CFR, Part 260
   https://www.ecfr.gov/current/title-45/subtitle-B/chapter-II/part-260
   http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr260_03.html

   Section 414.1585, F.S.
   http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0400-0499/0414/Sections/0414.1585.html

8. Positive Alternatives to Homelessness (PATH)

   Public Health Services Act, Title V, Part C, Section 521, as amended
   42 U.S.C. 290cc-21 et. seq.
   https://www.law.cornell.edu/uscode/text/42/chapter-6A
   Stewart B. McKinney Homeless Assistance Amendments Act of 1990, Public Law 101-645
   https://www.congress.gov/bill/101st-congress/house-bill/3789

   42 CFR, Part 54
   https://www.law.cornell.edu/cfr/text/42/part-54

9. Americans with Disabilities Act of 1990

   42 U.S.C. 12101 et seq.
   https://www.law.cornell.edu/uscode/text/42/12101

B. FLORIDA STATUTES

All State of Florida Statutes can be found at the following website:
http://www.leg.state.fl.us/statutes/index.cfm?Mode=ViewStatutes&Submenu=1

1. Child Welfare and Community Based Care

Chapter 39, F.S.	Proceedings Relating to Children
Chapter 119, F.S.	Public Records
Chapter 402, F.S.	Health and Human Services; Miscellaneous Provisions
Chapter 435, F.S.	Employment Screening
Chapter 490, F.S.	Psychological Services
Chapter 491, F.S.	Clinical, Counseling and Psychotherapy services

Chapter 1002, F.S.	Student and Parental Rights and Educational Choices
Section 402.3057, F.S.	Persons not required to be re-fingerprinted or rescreened
Section 414.295, F.S.	Temporary Cash Assistance; Public Records Exemptions

2. Substance Abuse and Mental Health Services

Chapter 381, F.S.	Public Health General Provisions
Chapter 386, F.S.	Particular Conditions Affecting Public Health
Chapter 395, F.S.	Hospital Licensing and Regulation
Chapter 394, F.S.	Mental Health
Chapter 397, F.S.	Substance Abuse Services
Chapter 400, F.S.	Nursing Home and Related Health Care Facilities
Chapter 435, F.S.	Employment Screening
Chapter 458, F.S.	Medical Practice
Chapter 459, F.S.	Osteopathic Medicine
Chapter 464, F.S.	Nursing
Chapter 465, F.S.	Pharmacy
Chapter 490, F.S.	Psychological Services
Chapter 491, F.S.	Clinical, Counseling and Psychotherapy Services
Chapter 499, F.S.	Drug, Cosmetic and Household Products
Chapter 553, F.S.	Building Construction Standards
Chapter 893, F.S.	Drug Abuse Prevention and Control
Section 409.906(8), F.S.	Optional Medicaid – Community Mental Health Services

3. Developmental Disabilities

Chapter 393, F.S.	Developmental Disabilities

4. Adult Protective Services

Chapter 415, F.S.	Adult Protective Services

5. Forensics

Chapter, F.S.916, F.S.	Mentally Deficient and Mentally Ill Defendants.
Chapter 985, F.S.	Juvenile Justice; Interstate Compact on Juveniles
Section 985.19, F.S.	Incompetency in Juvenile Delinquency Cases
Section 985.24, F.S.	Interstate Compact on Juveniles; Use of detention; Prohibitions

6. Florida Assertive Community Treatment (FACT)

General Appropriations Act
https://www.flsenate.gov/Session/Appropriations/2018

7. State Administrative Procedures and Services

Chapter 120, F.S.	Administrative Procedures Act
Chapter 287, F.S.	Procurement of Personal Property and Services
Chapter 815, F.S.	Computer - Related Crimes

Section 112.061, F.S.	Per diem and Travel Expenses*
Section 112.3185, F.S.	Additional Standards for State Agency Employees
Section 215.422, F.S.	Payments, Warrants & Invoices; Processing Times
Section 216.181(16)(b), F.S.	Advanced funds invested in interest bearing accounts

***Travel Expenses are specified in the DFS Reference Guide for State Expenditures**
https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E/subject-group-ECFRed1f39f9b3d4e72/section-200.475

The Provider is required to comply with Department of Financial Services' (DFS) "Reference Guide for State Expenditures" and active DFS Comptroller or Chief Financial Officer Memoranda. If this Contract is funded by state financial assistance, those funds may only be used for allowable costs between the Effective Date and the End Date. Absent the Department's authorization, unused state financial assistance funds must be returned to the Department.

C. FLORIDA ADMINISTRATIVE CODE (RULES)

1. Child Welfare and Community Based Care

   All references to F.A.C. may be found at the following website:
   https://www.flrules.org/default.asp

Rule 65C-12, F.A.C.	Emergency Shelter Care
Rule 65C-13, F.A.C.	Substitute Care of Children
Rule 65C-14, F.A.C.	Group Care
Rule 65C-15, F.A.C.	Child Placing Agencies

2. Substance Abuse and Mental Health Services

Rule 65C-12, F.A.C.	Emergency Shelter Care
Rule 65D-30, F.A.C.	Substance Abuse Services Office
Rule 65E-4, F.A.C.	Community Mental Health Regulation
Rule 65E-5, F.A.C.	Mental Health Act Regulation
Rule 65E-10, F.A.C.	Psychotic and Emotionally Disturbed Children Purchase of Residential Services Rules
Rule 65E-12, F.A.C.	Public Mental Health, Crisis Stabilization Units, Short Term Residential Treatment Programs
Rule 65E-14, F.A.C.	Community Substance Abuse and Mental Health Services- Financial Rules
Rule 65E-15, F.A.C.	Continuity of Care Case Management
Rule 65E-20, F.A.C.	Forensic Client Services Act Regulation

3. Financial Penalties

Rule 65-29, F.A.C.	Penalties on Service Providers

4. Reduction/ Withholding of Funds

Rule 65-29.001, F.A.C.	Financial Penalties for a Provider's Failure to Comply with a Requirement for Corrective Action

D. MISCELLANEOUS

1. **Written Notice**
   Providers are required to submit written notice to BBHC and the Department prior to awarding Department funds through a non-competitive procurement if said purchase exceeds $65,000.

   Providers are required to submit written notice to BBHC and the Department prior to entering into any agreement with a person or entity that is being contracted with as a single source purchase.

2. **Department of Children and Families Operating Procedures**

   CFOP 155-10, Services for Children with Mental Health & Any Co-occurring Substance Abuse Treatment Needs In Out of Home Care Placements

   CFOP 215-6, Incident Reporting and Client Risk Prevention

3. **Federal Cost Principles**

   Uniform Grant Guidance

   OMB Circular A-21, Cost Principles for Educational Institutions

   OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments

   OMB Circular A102, Grants and Cooperative Agreements with State and Local Governments
   OMB Circular A-122, Cost Principles for Non-profit Organizations

4. **Audits**

   Uniform Grant Guidance

   OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations

   Section 215.97, F.S., Florida Single Audit Act
   Comptrollers Memorandum #03 (1999-2000): Florida Single Audit Act Implementation

5. **Administrative Requirements**

   45 CFR Part 75 - Uniform Administrative Requirements, Cost Principles, And Audit Requirements for HHS Awards

   45 CFR, Part 92 - Uniform Administration Requirements

   OMB Circular A110, Uniform Administrative Requirements for Grants and Other Agreements

6. **Data Collection and Reporting Requirements**

   Rule 65E-14.022, F.A.C.

   Section 397.321(3)(c), F.S., Data collection & dissemination system

   Section 394.74(3)(e), F.S., Data Submission

   Section 394.77, F.S., Uniform management information, accounting, and reporting systems for providers.

   CFP 155-2, Mental Health and Substance Abuse Data Measurement Handbook

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X. PATH Broward

The Projects for Assistance in Transition from Homelessness (PATH) is funded by a formula grant authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. PATH grants are distributed annually by SAMHSA to all 50 states, the District of Columbia, Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, and the U.S. Virgin Islands. PATH, the first major federal legislative response to homelessness, is administered by and funded through the Center for Mental Health Services (CMHS), a division of SAMHSA, within the U.S. Department of Health and Human Services (HHS). BBHC PATH programs will be in alignment with the **DCF Guidance 15 - Projects for Assistance in Transition from Homelessness (PATH)**
.
States and territories are referred to as PATH grantees. The Department of Children and Families SAMH Program Office is the PATH grantee for Florida, who works with the MEs to oversee the programs, Local Intended Use Plans (LIUP) and annual budgets.

The goal of the PATH program is to reduce or eliminate homelessness for individuals with serious mental illnesses or co-occurring serious mental illness and substance use disorders, who are experiencing homelessness or are at imminent risk of becoming homeless. PATH funds are used to provide an array of allowable services, including street outreach, case management, and services that are not supported by mainstream mental health programs.

PATH Providers:
The minimum responsibilities and expectations of PATH providers are listed below.

1. PATH providers are expected to integrate SAMHSA's definition and principles of recovery into their programs to the greatest extent possible.

2. PATH providers are expected to integrate positive programmatic involvement of individuals with mental health issues and their family members when possible, into the program design. This reconnection should be facilitated meaningfully and span all aspects of the organization's activities as described below.

3. It is crucial for PATH providers to establish relationships with the local CoC, Housing Authorities, landlords, faith-based organizations, and other agencies/organizations providing services and supports to individuals who are experiencing homelessness.

4. PATH providers should ensure that individuals enrolled in PATH are transitioned to mainstream services, with the understanding that these services will remain available to the consumer after their transition out of homelessness. The PATH program encourages a focus on sustainable mental health services and housing. Other mainstream services of importance are services that provide health care, employment/vocational training, community connection, support, and resources for daily needs.

5. Establish a service plan for all PATH-enrolled individuals including:
    a. Goals to obtain community mental health services for the individual;
    b. Coordinating and obtaining needed services for the individual, including services relating to shelter, daily living activities, personal and benefits planning, transportation, habilitation and rehabilitation services, prevocational and employment services, and permanent housing;

c. Assistance to obtain income and income support services, including housing assistance, Supplemental Nutrition Assistance Program (SNAP) benefits, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI);
d. Referrals to other appropriate services; and
e. Review of the plan not less than once every three months.

6. Maintain individual client files containing an intake form, a determination of eligibility for PATH-funded services, a service plan, and progress notes for each person served with PATH funds.

7. Maintain individual client files containing an intake form, a determination of eligibility for PATH-funded services, a service plan, and progress notes for each person served with PATH funds.

8. PATH providers are responsible for prioritizing PATH services to veterans and individuals experiencing chronic homelessness who meet PATH eligibility.

9. PATH outreach requires multiple contacts to build a trusting relationship and engage individuals eligible for PATH services. After becoming enrolled in PATH, continued contacts with the individual are needed to assist the individuals in meeting basic needs, medical care, benefits, housing, and mental health treatment and supports. Most of the staff work time is spent working directly with the individual. Work hours should be flexible and not necessarily 8:00 a.m. to 5:00 p.m. Staff should flex work hours to work early mornings, early evenings, and weekends because individuals who are experiencing homelessness may be more visible during these times, especially in camps or street locations.

10. PATH providers should hold team meetings frequently, even as often as weekly, to ensure good communication among team members. It is recommended that the team members work together and share caseloads so more than one staff member is familiar with the consumers and could provide SAMHSA's Homeless and Housing Resource Network PATH services. For example, it is crucial to take action as soon as individuals enrolled in PATH make the commitment to participate in mental health treatment because this opportunity may not last. If the primary staff member is not available, another staff member would need to assist the individual. Team meetings are also important for discussing challenges that staff may have during outreach or while engaging and providing services to individuals experiencing homelessness and serious mental illness.

11. PATH staff members work with the most vulnerable individuals in our communities. These are individuals who have active symptoms of mental illness and with whom it may be difficult to engage. It is crucial for staff to be supported in the work they do, to be offered opportunities for growth, and to feel satisfied with the work they are doing. Staff supervision is important to advancing these goals. Supervisors are responsible for providing the support necessary to identify instances of "burnout," identify the need for additional training to improve skills, and to assist staff with alternative methods for providing service to those individuals that may be a challenge to work with. Supervision should be scheduled as often as the individual staff member deems necessary.

12. PATH providers must ensure that PATH staff members receive the training necessary to perform the highest quality of work. It is recommended that all staff receive training in the following areas:

    a. Outreach and engagement
    b. Motivational interviewing
    c. Trauma-informed care (TIC)
    d. Cultural and linguistic competency
    e. Recovery
    f. Person-centered thinking
    g. Crisis response and suicide prevention (e.g., applied suicide intervention skills training)
    h. Housing First
    i. Critical Time Intervention (CTI)

Additionally, PATH providers must maintain program data and complete the annual report. The ME will work with DCF annually to compile and review the Local Intended Use Plan (LIUP) and budget. Providers must:

- Enter quarterly summary information about PATH programs and services into the PATH Data Exchange (PDX) at https://pathpdx.samhsa.gov no later than the 10th of the month following the quarter of services.
- Submit an annual report into PATH Data Exchange no later than November 17th via the PATH Data Exchange (PDX) at https://www.pathpdx.org/.
- Keep track of SSI/SSDI application data on SOAR tracking PDF and submit to ME by the 10th of every month.
- Provide at least one dollar of local matching funds for every three dollars of PATH funds received and expend local matching funds to provide eligible services to PATH eligible persons. Match-funded expenditures must align with the services identified in the Local Intended Use Plan. The formula to be followed is cited in Title V, Part C, Section 524 of the Public Health Services Act (42 U.S.C. 290cc-21 et. seq.).
- Ensure the accuracy of data submitted for the PATH Annual Report.
- Enter data into the PDX portal for final review by the ME.
- Ensure timely submission of the PATH Annual Report to the ME.
- Participate in monitoring at least annually to ensure the minimum program priorities indicated above are provided, PATH funds are expended appropriately, and data is collected and reported for the PATH Annual Report.
- Participate in any local, state or national calls, trainings or learning collaborative.

SOURCE: https://pathpdx.samhsa.gov/users/sign_in

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XI. Statewide Inpatient Psychiatric Programs (SIPP) Services

Statewide Inpatient Psychiatric Program (SIPP) services are to provide extended psychiatric residential treatment with the goal of facilitating successful return to treatment in a community-based setting. SIPP services include:

- Individual plan of care
- Assessment
- Routine medical and dental care
- Certified educational programming
- Recreational, vocational, and behavior analysis service
- Therapeutic home assignment

Services to be Performed. During the term of this Agreement, the Network Provider will maintain licensure as a Residential Treatment Center or Psychiatric Hospital under either Chapters 6 5M-9 or 59A·3 of the Florida Administrative Code and perform SIPP services a s contracted with the Agency for Health Care Administration (AHCA) for non-Medicaid children.

Compensation. For the period of the Agreement, the Network Provider agrees to accept the negotiated daily rate; for the "ME" pre-approved service, based on bed day utilization.

Changes to Level of Service. The Network Provider agrees that any changes to a participant's approved level of service must be authorized by the "ME" before delivery of additional services. Services not previously approved by the "ME" shall not be reimbursable.

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XII. Early Treatment Team Program formerly known as First Episode

See NAVIGATE manuals for more information on program requirements

- The First Episode Psychosis Program follows the NAVIGATE Model.
- The program **teaches young people and their families the skills** and information needed to get back on their feet and work towards a productive, full life.
- The program **involves several different interventions,** including medication management, resiliency training, help getting back to work or school, and a family support/education program to increase the success of recovery.
- These **interventions are effective** in helping people get on with their lives even after they have experienced these kinds of problems.
- Individuals will learn strategies that will help them to **pursue their goals** and get on with their lives.
- Individuals will **learn coping strategies** that will help them better manage their illness and psychotic symptoms.
- Individuals will be **working with a team** to help with their goals. The team includes the following members:
  - Director: Coordinates and leads the team, and provides the Family Education Program
  - Prescriber: Provides individualized medication treatment (e.g., psychiatrist or nurse)
  - Clinicians: Two clinicians who provide Individualized Resiliency Training and case management
  - Supported Employment and Education Specialist: Provides individualized rapid job search and follow-along supports
- Team Meetings: NAVIGATE team meetings occur weekly to develop possible ideas on preliminary treatment plans for new young people, discuss and review progress, and address any issues. The Director leads the team meetings.
- Supervision Meetings: The Director meets with the two clinicians for one hour weekly and meets with the Employment and Education Specialist for one hour a week.
- Collaborative Treatment Planning and Review Meeting: These meetings occur within one month of a young person's enrollment into the NAVIGATE program. A one-hour collaborative meeting occurs with the young person, relatives and significant other (if applicable), the Director, and any other members of the NAVIGATE team who are involved in treatment planning.
  - At least every six months after completing the initial collaborative treatment plan, the team comes together to complete a review.

Collaborative Treatment Planning and Reviews

MEETING	TEAM MEMBERS PRESENT	WHEN
Preparation for Collaborative Treatment Planning Meeting (approx. 20-30 minutes)	All NAVIGATE Team Members	3-4 weeks after a young person begins NAVIGATE, during the weekly team meeting
Collaborative Treatment Planning Meeting (30-60 minutes)	NAVIGATE Director and most relevant team member(s), young person, family members (and other supporters)	One month after a young person begins NAVIGATE
Preparation for Collaborative Review Meeting (20-30 minutes)	All NAVIGATE Team Members	Before Collaborative Review Meeting, during the weekly team meeting
Collaborative Review Meeting (30-60 minutes)	NAVIGATE Director and most relevant team member(s), young person, family members (and other supporters)	Every six months after the development of the initial treatment plan

The NAVIGATE Model

TREATMENT	PROVIDER	AIMS
Medication Management	Psychiatrist, Nurse	• Monitor the use of medication to reduce symptom distress • Prevent relapses to help achieve desired goals
Family Education	Program Director	• Teach families about psychosis • Provide skills to help families move forward in recovery • Reduce family stress through improved communication and problem-solving skills • Educate natural supports on ways to assist young people in illness management and obtaining goals
Individual Resiliency Training	Individual Resiliency Trainer (IRT) Clinician	• Teach about psychosis and processing the experience • Help young people achieve their personal goals by teaching about their disorder and its treatment • Reduce self-stigmatizing beliefs • Help young people learn social and resiliency skills

Supported Employment/Education	Trained Employment/ Education Specialist (SEE)	• Provide individual employment services to young people with a desire to work • Find competitive employment in community settings (not sheltered or transitional work) with a rapid job search (rather than long vocational assessments or prevocational training) • Provide support based on the preferences of young people (e.g., type of job, decision to disclose mental health challenges to an employer) • Follow-along support for those employed or in school

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XIII. Family Engagement Program (FEP)

I) *Philosophy of the Program:*

- The goal of the Family Engagement Program (FEP) is to link caregivers/parents to a SUD evaluation/assessment within 48 business hours of referral when there is an open Child Protection Case, and to share the assessment findings and recommendations with CPI and enter into FSFN promptly. Services are provided by a team of peer advocates (4) all in recovery and who bring experience with the child welfare system and provide outreach and assertive linkage to needed resources in order to lessen the likelihood of child abuse and neglect and reduce the potential for further child dependency actions, by motivating the family to follow the clinically recommended services. The program adheres to system of care values which include but are not limited to: Strength based; Collaborative and Integrated; Persistent Commitment; Community based; Culturally Competent; and Outcome Driven.

II) *Program Description: (program is being updated to align with state requirements.)*

- The FEP team members are an outreach service of the Department of Children and Families (DCF) Child Protection Investigations Section (CPIS). The team is supervised by a licensed behavioral health professional. The FEP serves families with children (ages 0-10) for whom the child abuse investigation by the CPI or Behavioral Health Consultant (BHC) Brief Assessment, revealed suspected or substantiated substance use that require intervention to prevent occurrence of repeated maltreatment.

- The team leader is available as a support to the DCF Child Protective Investigations Section (CPIS) Office and provides oversight and supervision for the team and is available as a support to the DCF/CPIS unit in staffing challenging cases and ensuring integration and collaboration between the team, DCF and community partners.

- FEP is responsible for establishing a protocol for referral process to be shared with CPIS along with any other prospective referral source and posted on the Center for Child Welfare website. To be developed by Provider and Approved by ME. The revised referral protocol is to be included in the FEP Manual.

- FEP is responsible for maintaining a call center based on a provider block scheduling protocol for referral process to be shared with CPIS and posted on the Center for Child Welfare website. To be developed by Provider and Approved by ME. The revised referral protocol is to be included in the FEP Manual. All referrals are to be thought BBHC Cognito Portal link below. All subsequent referral outcomes are to be tracked in FEP SMARTHSEET database.
  https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/FAMILYENGAGEMENTPROGRAMREFERRAL

- The FEP call center is responsible for receiving calls from the caregiver, CPI and/or BHC to provide a scheduled assessment (to include date, time, and provider location) within 48 business hours of the call, M-F 9:00am—5:00pm. If a FEP call is unable to be completed for any reason, FEP is responsible to follow up within 24 business hours of Cognito referral and provide the caregiver with a scheduled assessment (date, time and location of provider). All efforts are to be documented in FSFN and shared directly with referral source.

- During the assessment and resulting recommendation process, the FEP Peer Specialist works to engage and motivate the parent/caregiver in understanding the resulting recommendation, how following the resulting recommendation can create positive family changes, and the benefits of engaging in services. The FEP team will also address with the caregiver/family any barriers the caregiver has experienced or is experiencing, with completing the assessment, entering into recommended service. This is including, but not limited to, lack of appropriate engagement efforts needed to motivate the caregiver through the change process, lack of transportation, lack of childcare, etc.

- The team will ensure a "warm hand off" to the selected provider and provide any needed concrete support to ensure a successful link. The team will close cases once the "warm hand off" is completed and the caregiver/family has successfully completed at least two outpatient appointments or two weeks of group and/or residential services. In cases where providers contact FEP after a "warm hand off" is completed and FEP case closure, reporting client disengagement, FEP will make all reasonable efforts to reengage with the family to determine what barriers are being experienced leading to the disengagement, plan to overcome barriers and document all efforts in FSFN.

- The team will utilize flexible funds for concrete support, pro social activities, and to remove barriers associated with the recovery process.

- The team will collaborate with CPIs to obtain any needed background information on referred families.

- Peer Specialists update CPI's/BHC's on a regular basis via email and/or phone contact with all progress made/not made and document such information in FSFN within 48 business hours of action completion. This includes the outcomes of the substance use assessments, the UA results, and the treatment recommendations.

- Peer Specialists also update caregivers/parents on the outcomes of the substance use assessments, UA results, and treatment recommendations via a phone call and/or in person visit to ensure a mutual understanding of the assessment and resulting recommendations understand the recommendations.

- Upon case closure, Peer Specialists notify the CPIs via email and provide a closing summary. This closing summary, is to uploaded into the file cabinet in FSFN, within 5 business days of closure.

- Provider Management will maintain a data tracking log in SMARTSHEET for all referrals to include the data elements outlined in the SMARTSHEET database.

- FEP will maintain a record of each referral in the BBHC Smartsheet system and the Florida Safe Families Network (FSFN). The record shall contain the referring documents, all drug test results, screenings, signed consents, assessments and any other records that pertain to the family's episode of care with the Family Engagement Program.

- **All documentation shall be entered into FSFN within 48 hours**. Including but not limited to referral, intake, SUD evaluation, drug test results, and treatment information.

- FEP Provider is responsible for conducting weekly random reviews to ensure documentation in FSFN is completed within 48 hours.

- FEP provider will be responsible for remedial action to be taken to ensure documentation is completed.

Caregivers/Parents referred to FEP will receive engagement and outreach services to encourage participation in the most appropriate treatment services to address the recommendations of the assessment**.**

FEP will accommodate any caregiver and family when services are needed, even if those supports/services fall outside of standard business hours.

Admission Criteria:
1. Youth 10 and under
2. Resident of Broward County
3. Referred by DCF/CPIS

Discharge Criteria/Transition
1. Successfully linked to a substance use treatment provider.
2. If a caregiver declines services at any point while the case is open
3. No longer a resident of Broward County
4. If no contact is made

III) ***Measurable Program Outcomes and Objectives:***
1. FEP provides a scheduled SUD assessment (date, time and provider location) within 48 business hours of referral to FEP.
2. 70 percent of the referrals to FEP from CPIS complete an assessment.
   a) Best efforts are to be made to ensure parents/caregivers are successfully engaged in the appropriate services within 7 days of the assessment.

IV) ***Mechanisms to address the Needs of Special Populations:***
All persons served will be assessed for their individual needs to address abuse/neglect and overall family functioning in their household. Ethnic, cultural, linguistic, and spiritual traditions of the person served are respected and incorporated into service delivery whenever appropriate and applicable. All services meet or exceed the required standards of the Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act. Staff is also expected to conduct themselves in a manner agreeable to the diverse population served. Any special needs are to be assessed throughout treatment and referrals are to be made as clinically indicated and desired by the person served.

V) ***Staffing Structure and Resources:***
This Program is staffed by one (1) Master level clinician and five (5) Peer Specialists under the supervision of a licensed coordinator. Staff members are housed at DCF CPIS and have access to their conference and interview rooms that ensures confidentiality, if needed. All staff have access to resource guides including the Connections Book, DCF Directory, and First Call for Help to ensure up to date information on other service providers, advocacy/self-help groups,

financial aid, legal aid, housing, and other needed resources. The program will make every attempt to provide access to staff that is culturally and linguistically diverse to reflect the population served as well as provide cultural training.

VI) ***Procedures to support Interdisciplinary Team Interaction:***

Every family entering the program is discussed with a supervisor after completion of the initial contact and referred to the most appropriate interventions. In addition, the FEP staff work closely with the case managers, DCF/CPIS and/or ChildNet professionals and participate in interdisciplinary meetings to ensure continued collaboration. The team maintains on their staff a Licensed Practitioner of the Healing Arts, mental health technicians, parent advocates, and medical staff that are available to all persons served via the internal referral process. Peer Specialist completing the intake will ascertain through the engagement process what other family members, and/or professional supports are involved with the caregiver. With the caregiver's consent and signed releases, peer specialist will attempt to engage and collaborate with any identified supports.

Training Activities for Staff Competency

All staff members attend a three-day Orientation upon hire regarding agency policies / procedures and agency required trainings. In addition, assessors receive ongoing trainings on principals of abuse/neglect, WRAP training, WRAP facilitator training as available and the entire team will have training in Motivational Interviewing. The team shall also receive training in Trauma Informed Care and Mental Health First Aid training, as available. In addition, therapists receive weekly supervision by their supervisor who has extensive experience with the population served. Staff members are also able to attend internal and external trainings on topics related to their job at the supervisor's discretion.

All Peer Advocates on the team are to have personal lived experience in recovery from substance use. BBHC funds the Peer Certification training through South Florida Wellness Network. Peers who are not certified must obtain the Provisional Peer Certification within nine (9) months from the date of hire. All Peers on the team are to receive the training, work experience hours, and certification (CRPS-A) through the Florida Certification Board within 12 months of hire.

Ongoing CEU's are required on a yearly basis to maintain certification.

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XIV. Family Support Team

PURPOSE AND GOALS

The Family Support Teams (FST) provide family-centered services to children and their caregivers who frequently utilize crisis stabilization units, placing them at increased risk of family disruption and out-of-home placement. FST supports youth and families in stabilizing both the child and the home environment while facilitating timely connections to appropriate services such as State Inpatient Psychiatric Program (SIPP) or community-based supports.

FST services are time-limited and focused on stabilization, education, and empowerment. It serves as a single point of contact, coordinating care and guiding families through complex systems until sustainable supports are in place. The team works collaboratively to ensure access to services that promote overall well-being, including primary health care, behavioral health, housing, and social connectedness, education, vocational resources, peer and natural supports, and when applicable, involvement with the justice system.

Through comprehensive coordination and cross-system collaboration, FST promotes continuity of care and helps families build the foundation needed to maintain long-term stability within the community.

The short-term goals of Family Support Teams are to:

1. Ensure that any youth/support system needing services does not experience gap in services.
2. Stabilizing youth and their home environment until recommended higher level of care is available or until youth and their home environment are stable enough to transition to a lower level of care.
3. Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and

focus on the child and family's wellness and community integration.

The long-term goals of the Family Response Team are to:

1. Shift from an acute care model of care to a recovery model; and
2. Offer an array of services and supports to meet an individual's chosen pathway to recovery.
3. Client and family de-escalation of behaviors.

PRIORITY POPULATIONS

Individuals at a CSU or in the community that require but are not limited to services such as behavioral health, primary care, peer and natural supports, housing, education, and employment.

1. With history or previous CSU/Baker Acts.
2. Who have high utilization of services.
3. With multiple service needs with at least one of the problem areas identified as "severe", pregnant youth, IV drug users, and/or serious mental illness.
4. With a Serious Mental Illness (SMI) awaiting placement in or discharge from a Statewide Inpatient Psychiatric Program (SIPP) back to the community.
5. With a SMI and/or substance use disorder (SUD) who account for a disproportionate amount of behavioral health expenditures.
6. With a SMI and/or SUD who have a history of multiple arrests, involuntary placements, or violations of probation leading to placement in detention or commitment centers.

7. With involvement in the child welfare system or behavioral health system who are suspected to be involved or are involved in human trafficking.
8. Without a strong support system that can support the child with ongoing services in the community.

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NETWORK SERVICE PROVIDER RESPONSIBILITIES

Network Service Provider responsibilities include:

1. Engage the individual and their support system in their current settings, community, CCU and SIPPs.
2. Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.
3. Serve as single point of accountability for the coordination of a child's care with all involved parties (i.e., juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).
4. Develop a plan with the children and family based on shared decision making that emphasizes individual and home environment stabilization, self-management, recovery, and wellness.
5. Provide frequent contact during the time of services.
6. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.
7. For children or support person who require medications, ensure linkage to psychiatric services.
8. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.
9. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.
10. Attend community staffing's regarding youth enrolled in FST.
11. Ensure linkage with Managed Care case manager when applicable.
12. Enroll 45 unduplicated youth per fiscal year and maintain a monthly caseload of 15 youth.
13. Submit monthly DCF Reports (Appendix 1 & Appendix 2) to BBHC by the 5th of each month.
14. Attend a monthly FST Update meeting with BBHC.
15. Attend a joint FST Update meeting with BBHC every other month.
16. Referrals are submitted via Cognito
17. Submit FST Admission Notice within 72 hours of admission.
18. Submit FST Discharge Notice within 72 hours of discharge.

OUTCOMES

- Number of children linked to community programs
- Number of clients enrolled in Medicaid Managed Plans
- Number of children involved with Child Welfare
- Number of children involved with DJJ

Performance Measures

- School, Preschool and Daycare Attendance
- Improved Level of Functioning, based upon CFAR, FARS, or CANS
- Living in a community Setting
- Improved Family Functioning based upon NCFAS – G+R, or CANS

CARE COORDINATION ALLOWABLE COVERED SERVICES

The following is a list of allowable covered services as defined in Ch. 65E-14.021, F.A.C.

1. Intervention

Refer to Guidance 40 For additional details

XV. Family Intensive Treatment Team (FITT)

I) ***Philosophy of the Program:***

Family Intensive Treatment (FIT) Teams are a service delivery model that provides community-based behavioral health treatment and support to families with child welfare involvement and parental substance misuse. FIT Teams are a multidisciplinary approach to behavioral health intervention in the overall system of care that provides early identification and coordination, as well as support to families through navigation of the child welfare and treatment processes. The BBHC FITT Teams will abide by the
Guidance 18 - Family Intensive Treatment (FIT) Model Guidelines and Requirements.

II) ***Program Description:***

The Family Intensive Treatment Team(s) delivers intensive treatment interventions targeted to families with high-risk child abuse cases, (as defined by the Motivational Support Program Protocols, "*Unsafe*", "*Conditionally Safe*", "*Risk*" or as otherwise defined by the Department of Children and Families), due to parental substance use and/or mental health issues. This program has been designed to demonstrate that rapid identification of parental behavioral health disorders, immediate access to evidence-based practices and multi-disciplinary teaming will result in better outcomes for children and their families. The project provides family-based integrated services. It documents the qualitative and quantitative system components necessary to be responsive to the needs of caregivers/parents with behavioral health disorders and their young children. Services are provided in the home for an average of 6 months and include assessment, multi system care coordination, individual/family therapy, parenting interventions, psychiatric evaluation, medication management, and access to residential and primary health.

III) ***Admission Criteria:***

1. Have a substance use disorder;
2. A child in the family has been determined to be "unsafe," with a priority given to families with
3. children 0 – 10 years old have been referred by a child protective investigator (CPI), dependency case manager, or community-based care (CBC) lead agency;
4. Are either under judicial supervision in dependency court (both in-home and out-of-*home). For out-of-home cases, only those caregivers/parents with goal of reunification, or have been assessed as unsafe; and
5. The eligible parent/guardian is willing to participate in treatment or is court-ordered to participate in services. In either case, enhanced efforts to engage and retain the parent/guardian in treatment is expected as a crucial element of FIT treatment services.

IV) ***Program Goals:***

- Increase immediate access to substance use and co-occurring mental health services for caregivers/parents in the child welfare system;
- Increase children's safety and reduce risks;
- Increase parental protective capacity; and
- Reduce rates of re-abuse and neglect of children with caregivers/parents with a substance use disorder.
- Reduce the number of out of home placements and the time the children remain in the child welfare system.

- Help substance using caregivers/parents overcome addictions and improve involvement in recovery services.

V) ***Measurable Program Objectives:***

1. Accept families referred by the child protective investigator, child welfare case manager, community-based care lead agency and/or the Motivational Support Program (formerly known as Family Intervention Specialists).

2. Initiate contact with the family within 2 business days of the referral. The FIT team Provider shall ensure that initial and reoccurring efforts to contact and engage the referred families are documented.

3. Document the date of enrollment as the date the caregivers/parents signed consent for services.

4. Complete the initial assessments to determine the level of care and severity within 15 business days of enrollment and include the following assessments, at a minimum:
   a. American Society of Addiction Medicine (ASAM) to assess level of care; and
   b. Biopsychosocial Assessment to assess the severity of substance use disorders and other behavioral health needs.

5. Provide treatment services by the clinician within 2 business days of completing the initial assessments (ASAM & Biopsychosocial). The completion of the treatment plan with the family may be the first service.

6. Complete additional assessments within 30 calendar days of enrollment.

7. Each family shall have a comprehensive treatment plan, which is completed no more than 30 days after intake to guide the provision of FIT services. At a minimum, the treatment plan shall:
   a. Be developed with the participation of the family receiving services;
   b. Specify the specific services and supports to be provided;
   c. Specify measurable treatment objectives, goals and target dates for services and supports; and
   d. Be reviewed, revised or updated every three months, or more frequently as needed to address changes in circumstances impacting treatment, with the participation of the parent(s) receiving services.

8. Provide immediate access to substance use disorder treatment within 48 hours of the assessment being completed, if necessary. Telehealth/telemedicine can be used to facilitate service provision.

9. No later than seven 7 business days prior to a family's discharge from services:
   a. Review the family's treatment during a multidisciplinary team meeting to ensure that the family is receiving adequate behavioral health services that addresses the behavioral health condition and promote relapse prevention and recovery;
   b. Complete a Discharge Summary containing:
      1) The reason for the discharge;
      2) A summary of FIT services and supports provided to the family;
      3) A summary of resource linkages or referrals made to other services or supports on behalf of the family; and

4) A summary of each family member's progress toward each treatment goal in the treatment plan.

10. On a monthly basis, submit the Template 17-FIT Reporting template by the 12th of the month to the Managing Entity.

11. **On a monthly basis, submit a comprehensive update as to the family's progress directly into the Florida Safe Families Network database.**

VI) ***Discharge Criteria:***

Persons may be discharged after they complete treatment goals or are provided with a "warm hand off" to an appropriate service provider. It is anticipated that at discharge 90% of caregivers/parents served will be living in a stable housing environment and that 80% of caregivers/parents served will have improved their level of functioning as measured by the DLA-20. 80% of caregivers/parents that complete the pre and post AAPI-2 shall improve their parenting score from admission to discharge. The FIT team provider will complete 85% of discharge summaries within 7 business days prior to discharge. The FIT team will have 85% of the initial care assessments (ASAM and Biopsychosocial) completed within 15 business days of enrollment.

FIT team providers shall engage all families, who have successfully completed their treatment goals, in aftercare services in an effort to foster continued positive outcomes and protective factors. Aftercare services may consist of, but are not limited to support groups, peer support services, home visits, telephone calls, and case management services. Incidental funds may also be used to assist families with aftercare expenses. Aftercare services may be provided for up to 6 months.

VII) ***Mechanisms to address the Needs of Special Populations:***

All persons served will be assessed for their individual needs to address abuse/neglect and overall family functioning in their household. Ethnic, cultural, linguistic, and spiritual traditions of the person served are respected and incorporated into service delivery whenever appropriate and applicable. All services meet or exceed the required standards of the Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act. Staff is also expected to conduct themselves in a manner agreeable to the diverse population served. Any special needs are to be assessed throughout treatment and referrals are to be made as clinically indicated and desired by the person served.

VIII) ***Staffing Structure and Resources:***

a. **One (1)** Program Manager
b. **Three (3)** Behavioral Health Clinicians
c. **Three (3)** Specialized Care Coordinators
d. **Three (3)** Family Support/Peer Mentors

The Program Manager shall, at a minimum, posses: A master's degree in a behavioral health field, such as psychology, mental health counseling, social work, or marriage and family therapy; and a minimum of three years of experience working with families with behavioral health needs. Education may be substituted for experience.

The Behavioral Health Clinician shall, at a minimum, posses: A master's degree in a behavioral health field, such as psychology, mental health counseling, social work, or marriage and family therapy; and a minimum of two years of experience working with individuals with behavioral health needs.

The Specialized Care Coordinator shall, at a minimum, posses: A bachelor's degree in a social services discipline. Which includes the study of human behavior and development; and a minimum of one year of experience working with individuals with behavioral health needs; or a bachelor's degree with a major in another field and a minimum of three year of experience working with individuals with behavioral health needs.

The Family/Peer Mentors shall, at a minimum, possess at least three years of sustained recovery from addiction, and have had prior involvement with child welfare; or Certification as a Certified Peer Recovery Specialist by the Florida Certification Board.
The program will make every attempt to provide access to staff that is culturally and linguistically diverse to reflect the population served as well as provide cultural training.

IX) *Procedures to support Interdisciplinary Team Interaction:*

One Child, One Family, One Team, One Plan
The Child and Family Team, on a practice level, is where the rubber meets the road and system of care is actively implemented to promote positive outcomes for youth and families. A Child and Family Team is built around the family to make sure that each family's strengths are promoted and their needs are met. Team members including the Peer Mentor, Clinician and Dependency Case Manager work together with the family to write an individualize plan based on what the parent/child/youth wants and needs and will include action steps to meet the dependency case plan goals.

The FITT TEAM utilizes the Wraparound process to provide specialized care coordination which uses a multi-disciplinary team to promote access to a variety of services and supports, including but not limited to: Domestic violence services; Medical and dental health care; Basic needs such as housing, food, and transportation; Educational and training services; Employment and vocational services; Legal services; and other therapeutic components of the family's treatment, services, or supports as needed.

X) *Training Activities for Staff Competency:*

The Specialized Care Coordinator and Peer Mentor will receive two (2) days of classroom training that lays the groundwork for "what is Wraparound." They will then spend an average of twenty (20) hours shadowing seasoned certified staff and two (2) hours of coaching per week until competency is demonstrated, typically within six (6) months of hire. Coaching is scheduled with staff to take place in the office to review work documents and in the field for live observation. Field observations occur at the family's home (or at a location chosen by the family) and are conducted at times that are convenient for youth and families served, including days, evenings and weekends. Peer supervision consists of monthly case presentations where new and seasoned staff have the opportunity to present to one another and receive feedback from their peers regarding their own Wraparound practice skills.

The Behavioral Health Clinicians will utilize and draw upon several different evidenced based practices such as Positive Parenting Program (Triple P), Cognitive Behavioral Therapy (CBT), Solution-Focused therapy, Trauma-Informed Care, Motivational Interviewing and Child Parent Psychotherapy (CPP) based upon the individualized needs of families served.

All the staff involved in the project will receive training regarding how trauma affects the lives of individuals seeking services. Upon three months of hire they will receive training in Trauma Informed Care and Motivational interviewing.

XI) ***Peer Support Services:***

Peer support for crisis intervention, referrals, and therapeutic mentoring; is available 24 hours per day, seven days per week.

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XVI. Florida Assertive Community Treatment (FACT) Program

The Florida Assertive Community Treatment team is a transdisciplinary clinical team approach with a fixed point of responsibility for directly providing the majority of treatment, rehabilitation and support services to identified individuals with mental health and co-occurring disorders.

The FACT Program must be in compliance with AHCA guidelines and **DCF's Guidance 16**, as applicable.

Program Description:

The FACT team is recovery-oriented, strengths-based, and person-centered. The FACT team provides a comprehensive array of services for program participants, such as: helping find and maintain safe and stable housing; furthering education or gaining employment; education about mental health challenges and treatment options; assisting with overall health care needs; assisting with co-occurring substance abuse recovery; developing practical life skills; providing medication oversight and support; and working closely with individuals' families and other natural supports. The FACT team primarily provides services to participants where they live, work, or other preferred settings, and are available 24 hours a day, 7 days a week. The programmatic goals are to prevent recurrent hospitalization and incarceration, as well as improve community involvement and overall quality of life for program participants.

Program Goals:

1. Implement with fidelity to the Assertive Community Treatment (ACT) model,
2. Promote and incorporate recovery principles in service delivery,
3. Eliminate or lessen the debilitating symptoms of serious mental illness and co-occurring substance use that the individual may experience,
4. Meet basic needs and enhance quality of life,
5. Improve socialization and development of natural supports,
6. Support with finding and keeping competitive employment,
7. Reduce hospitalization.

Staffing Requirements:

- One full-time Team Leader,
- One part-time 1 Psychiatrist or Psychiatric Advanced Practice Registered Nurse (APRN),
- One nurse for every 35 participants
- One full-time Peer Specialist,
- One full-time Substance Abuse Specialist,
- One full-time Vocational Specialist,
- One full-time Case Manager, and
- One full-time 1 Administrative Assistant.

The Team Leader must be a full-time employee with full clinical, administrative, and supervisory responsibility to the team with no responsibility to any other programs during the 40-hour workweek and possess a Florida license in one of the following professions: Licensed Clinical Social Worker, Marriage and Family Therapist, or Mental Health Counselor licensed, Psychiatrist licensed, Psychologist licensed.

The Psychiatrist or Psychiatric APRN provides clinical consultation to the entire team and also monitor non-psychiatric medical conditions and medications, provides brief therapy, and provides diagnostic and medication education to participants. The Psychiatrist or Psychiatric APRN also conduct home and community visits with participants as needed. The nurse must be a full-time Registered Nurse (RN) required to be on duty Monday through Friday.

Peer Specialists must provide individualized support services and promote self-determination and decision-making. Substance Abuse Specialist must obtain a bachelor's or master's degree in psychology, social work, counseling, or other behavioral science; and two years of experience working with individuals with co-occurring disorders. Bachelor's level substance abuse specialists must be certified as a Certified Addiction Professional. Vocational Specialist must obtain a bachelor's degree and a minimum of one year of experience providing employment services.

The Case Manager provides the rehabilitation and support functions under clinical supervision and are integral members of individual treatment teams. This position requires a minimum of a bachelor's degree in a behavioral science and a minimum of one year of work experience with adults with psychiatric disabilities.

An Administrative Assistant is responsible for organizing, coordinating, and monitoring the non-clinical operations of FACT. Functions include direct support to staff, including monitoring and coordinating daily team schedules and supporting staff in both the office and field.

The FACT team conducts daily organizational staff meetings at regularly scheduled times as established by the Team Leader. The FACT team conducts treatment planning meetings under the supervision of the Team Leader.

Program Criteria:

The individual must meet one of the following seven (7) criteria:

- More than three crisis stabilization unit or psychiatric inpatient admissions within one year,
- History of psychiatric inpatient stays of more than 90 days within one year,
- History of more than three (3) episodes of criminal justice involvement within one year,
- Referred by one of the state's correctional institutions for services upon release,
- Referred from an inpatient detoxification unit with documented history of co-occurring disorders,
- Referred for services by one of Florida's state hospitals, or
- High risk for hospital admission or readmission.

The individual must meet at least three of the following six characteristics:

1. Inability to consistently perform the range of practical daily living tasks required for basic adult interactional roles in the community without significant assistance from others. Examples of these tasks include:
2. Maintaining personal hygiene,
3. Meeting nutritional needs,
4. Caring for personal business affairs,
5. Obtaining medical, legal, and housing services, and
6. Recognizing and avoiding common dangers or hazards to self and possessions.
7. Inability to maintain employment at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting or child-care tasks and responsibilities),

8. Inability to maintain a stable living situation (repeated evictions, loss of housing, or no housing),
9. Co-occurring substance use disorder of significant duration (greater than six months) or co-occurring mild intellectual disability,
10. Destructive behavior to self or others, or
11. High-risk of or recent history of criminal justice involvement (arrest and incarceration).

The FACT team engages recipients, providing them with information about the FACT program, screen them for eligibility, allow them to make an informed decision regarding participation in FACT services. Once a recipient expresses interest in, and desire for, participation in FACT services and meets eligibility requirements, the FACT team enrolls them in the program.

The maximum number of participants (including Florida Medicaid recipients and individuals who are not Medicaid recipients) served by a FACT team is 120, unless approved by the Department of Children and Families (DCF). the FACT team must prioritize enrolling participants directly discharged from a state mental health treatment facility.

Services & Support:

The FACT team must provide the following services to the participants:

1. Crisis Intervention
2. Comprehensive Assessment
3. Natural Support Network Development
4. Case Management
5. Enhancement Funds
6. Family Engagement and Education
7. Psychiatric Services
8. Rehabilitation Services
9. Substance Use and Co-occurring Services
10. Supported Employment
11. Therapy
12. Wellness Management and Recovery Services
13. Transportation
14. Supported Housing
15. Competency Training

Discharge Criteria:

Discharges and fall into the following categories:

- The participant demonstrates an ability to perform successfully in major role areas (i.e., work, social, and self-care) over time without requiring assistance from the program and no longer requires this level of care (i.e., successful completion).
- The participant moves out of the FACT team's service area.
- The participant requests discharge or chooses not to participate in services, despite the team's repeated efforts to develop a recovery plan acceptable to the participant.
- Following a six (6) month period in which the participant has been admitted to a state mental health treatment facility and there is no anticipated date of discharge.
- The participant has been adjudicated guilty of a felony crime and subsequently sent to a state or federal prison for a sentence that exceeds one (1) year. Otherwise, the participant remains enrolled with the FACT Team.
- The participant was admitted to a nursing facility for long-term care due to a medical condition, and there is no anticipated date of discharge.

- The participant dies.

The team must document the discharge process in the participant's medical record, including:

- The reason(s) for discharge.
- The participant's status and condition at discharge.
- A final evaluation summary of the participant's progress toward the outcomes and goals set forth in the recovery plan.
- A plan developed in conjunction with the participant for treatment upon discharge and for follow-up that includes the signature of the primary case manager, Team Leader, Psychiatrist/Psychiatric APRN, and participant/legal guardian. If the FACT participant or guardian is not available to sign the discharge plan, the reason will be documented in the plan.
- Documentation of referral information made to other agencies upon discharge.
- Documentation that the participant was advised he or she may return to the FACT team if they desire and space is available.

Required FACT Reports

- FACT Enhancement Reconciliation Report
  - This quarterly report displays the team's monthly expenditures of enhancement funds.
- Template 29 – FACT Report
  - This is a quarterly report to display the team's monthly census and aggregate client data
- FACT Census and Vacant Position(s) Reports due monthly

Outcome Measures:

- Percent of adults with severe and persistent mental illnesses who live in stable housing environment that is equal to or greater than 90 percent or the most current General Appropriations Act working papers transmitted to the Department of Children and Families; and,
- Average annual days worked for pay for adults with a severe and persistent mental illness that is equal to or greater than 40 days worked for pay or the most current General Appropriations Act working papers transmitted to the Department of Children and Families.
- FACT teams must incorporate the following performance measures:
- Fewer than 10 percent of all individuals enrolled will be admitted to a state mental health treatment facility while receiving FACT services.
- Within thirty (30) days of discharge from the program, fewer than 10 percent of all individuals will be readmitted to a state mental health treatment facility.
- 75 percent of all individuals enrolled will either maintain or show improvement in their level of functioning, as measured by the Functional Assessment Rating Scale (FARS).
- FACT teams must also incorporate the following process measures:
- 90 percent of all initial assessments shall be completed on the day of the person's enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of all comprehensive assessments shall be completed within 60 days of the person's enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of all individuals enrolled shall have an individualized, comprehensive recovery plan within 90 days of enrollment with written documentation of the service occurrence in the clinical record.

- 90 percent of all individuals enrolled shall have a completed psychiatric/social functioning history timeline within 120 days of enrollment

Refer to DCF Guidance 16

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XVII. Florida FACT Tier 4 High Acuity Treatment Team (HATT)

FACT Tier 4 (High Acuity Treatment Team, herein referred to as "HATT team"), is a team that will provide a level of care between Florida Assertive Community Team and Care Coordination team.

PROGRAM DESCRIPTION

The HATT team will deliver comprehensive care and promote independent, integrated living for individuals with serious mental illness, while facilitating the effective delivery of health care services. The HATT team will offer the participants to move through their episodes of care with the most guidance available.

The goals of HATT are:

- Serve a total of 50-60 participants, over a period of 9-12 months
- Prioritize an individual's wellness and community integration.
- Facilitate transitions from higher levels of care to the community
- Facilitate transitions from lower intensity to a higher level of care with intensity, as needed
- Decrease hospitalizations, inpatient care, incarcerations, and homelessness.
- Implement with support to the Assertive Community Treatment (ACT) model
- Promote and incorporate recovery principles in service delivery
- Eliminate or lessen the debilitating symptoms of serious mental illness and co-occurring substance use that the individual may experience
- Meet basic needs and enhance quality of life
- Improve socialization and development of natural supports
- Support with finding and keeping competitive employment

PRIORITY POPULATIONS

1. Adults who are eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S.; including persons meeting all other eligibility criteria who are under insured;
2. Adults with a primary serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services
3. Adults with a SMI awaiting discharge from a state mental health treatment facility (SMHTF) back to the community.
4. Adults who do not meet criteria for FACT services may require a higher level of care than Care Coordination services.
5. Individuals with primary mental health diagnosis who are charged with a felony offense and, prior to adjudication, are referred to the HATT by duly authorized representatives of local law enforcement, local courts, the State Attorney, the Public Defender, and the Managing Entity.

HATT OVERVIEW

The above agency will provide transition services through their HATT team. The HATT team will consist of 50-60 participants that will receive services over a period of 9-12 months. The HATT team will provide an effective transition between higher levels of care and lower levels of care. The HATT team in conjunction with BBHC will focus on the individuals' needs, determine level of care, link with existing and newly identified services and supports. The HATT team will consist of a psychiatrist, therapist, care coordinator, and peer specialist. The HATT team will conduct biweekly treatment team meetings and will provide assessment/clinical services, intervention/crisis support, case management, and peer support. The HATT team will be available 24/7 for crisis issues.

The HATT team will conduct assessments, LOCUS, and develop treatment plans. Each participants' treatment plan should address all team members through one goal stated. Each goal of the treatment plan should be acknowledged by all team members and should work together simultaneously to achieve goals. All treatment plans should address discharge planning.

HATT REFERRAL PROCESS

If the criteria for the HATT team eligibility is met, follow the process below to have individuals placed on a HATT team.
Referral Process:

1. The HATT team Application Request Form link is submitted via Cognito secure link to BBHC with attachments:
   - Supporting Clinical Documentation
   - LOCUS (Level of Care Utilization System)
   - Request for Data Sharing Form
   - Release of Information for Protected Health Information
2. BBHC Adult Care Coordination Team Manager reviews Cognito application for appropriateness, for the referred level of care, pre-authorizes for screening and sends to the network Provider and referral source.
3. The provider logs referrals on Screening List, coordinates screening with referral source and provides Cognito Screening Disposition to BBHC and referral source.
4. If approved and enrolled, the provider will submit a Cognito Admission Form via link to BBHC. BBHC will provide an authorization number including start and ending date of authorization, for 6 months.
5. If approved and waitlisted, the individual will be logged on BBHC Provider waitlist until enrollment date is identified among both parties. Screening disposition will be uploaded via Cognito link. Interim Services will be identified.
6. If declined, the BBHC Provider will provide a reasoning for the decline via Cognito disposition and provide a recommendation for other services to BBHC and the referral source.

REPORTING AND PERFORMANCE MEASURES

The Department shall provide the Managing Entities with Access databases for each HATT team provider. Managing Entity subcontracts shall require the HATT team provider to enter all client data into the Access database and export the data on a monthly basis. The Managing Entity shall submit HATT team data to the Department no later than the 18th day of each month following service delivery.

Monthly and yearly service targets should be determined by the Managing Entity, taking into account capacity of the HATT Team provider, needs of families served, as well as geographical considerations. The targets should assume that families will remain in treatment and after care for several months. For additional performance outcomes, not rolled into data, the provider will submit this information in the discharge summary to the ME.

In the event the HATT Team Provider fails to achieve the minimum performance measures, the Managing Entity may apply appropriate financial consequences.

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XVIII. Community Action Treatment (CAT) Team Program

The Community Action Treatment (CAT) team provides intensive, integrated, individually tailored community-based behavioral health treatment and family-focused support services. The CAT team serves young people ages 11 through 21 who struggle with severe mental health and co-occurring substance misuse. The multidimensional Team of professionals will support clients and their families to improve the psychosocial functioning of young people across settings, to increase the ability of the family to manage and help their child with challenges related to severe emotional disturbance, and to strengthen family functioning. These improvements will reduce the occurrences of mental health crisis necessitating hospitalization, out of home placement or other highly restrictive interventions and increase health and wellness.

The CAT Team must consist of a full-time Clinical Team Leader, a psychiatrist or Advanced Registered Nurse Practitioner (ARNP), a Registered or Licensed Practical Nurse, Therapists, a Case Manager, Therapeutic Mentors, and Support Specialists such as a Young Adult or Family Peer Specialist. The CAT Team will work collaboratively to provide comprehensive behavioral health services to address the needs of the young person and their family. It will coordinate with other service providers and assist the family in developing or strengthening their natural support system. The CAT Team is available 24/7. If interventions outside the scope of the Team's expertise or qualifications are required (i.e., eating disorder treatment, behavior analysis, psychological testing, etc.), referrals will be made to specialists, with follow-up from the Team. The CAT Team's service delivery is flexible, using a "whatever it takes" approach to assist the young person and their family in achieving their goals.

Financial Consequences:
Financial consequences for not maintaining the minimum service target will be levied as **DCF Guidance 32**.

Services Include:

- Individual and family psychotherapy
- Individual and family skills training
- Crisis assistance
- Medication management
- Medication education
- Peer and family support services
- Case management and care coordination
- Psychoeducation, consultation, and coordination with the client's support system
- Clinical consultation to the client's school or employer
- Coordination with, or performance of, crisis intervention and stabilization services
- Transition services
- Housing access support
- Legal system coordination

Admission Criteria:

- The young person must be aged 11 to 21
- The young person must have a mental health diagnosis or co-occurring substance misuse diagnosis with at least one accompanying characteristic such as: being at risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care; having two or more hospitalizations or repeated failures; involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or poor academic performance or suspensions.

- Children younger than age 11 may be candidates if they meet two or more of the characteristics mentioned above.

Screening, Assessment, and Procedure Requirements:

- Referrals to the CAT Team will be submitted electronically using BBHC Online Portal. Documentation substantiating mental health history such as biopsychosocial, mental health records, psychological or psychiatric evaluations, etc. should be uploaded to submitted referrals.
- Within 45 days of admission to the Team, the CAT provider will complete the North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R).
- CAT will utilize a variety of reliable and valid screening and assessment tools such as the Ca-LOCUS or LOCUS, as part of the assessment process, with a focus on screening for co-occurring mental health and substance use disorders. The screening and assessment process will identify competencies and resources as well as needs across multiple life domains, such as education, vocation, mental health, substance use, primary health, and social connections.
- Within 30 days of admission to the CAT Team, the provider will complete an Initial Plan of Care.
- Within 60 days of admission to the CAT Team, the provider will review the Initial Plan of Care and update as needed.
- After review, the Initial Plan of Care becomes the Master Plan of Care.
- The Master Plan of Care will be reviewed and revised every three months after the date of creation until discharge or as needed to address changes that impact treatment and discharge planning.
- The provider will conduct weekly CAT Team Staffing's with the entire Team in attendance to thoroughly review the young person's progress.
- The provider will participate in monthly Case Reviews with the Managing Entity and Clinicians will present a case on a rotating basis.
- The provider will submit the Screening Dispositions in the BBHC Portal within 7 days of screening.
- The provider will submit the Enrollment/Admission Notice in the BBHC Portal within 72 hours of enrolling.

Models and Approaches to be utilized include but are not limited to:

- Transition to Independence Process (TIP)
- The Research and Training Center for Pathways to Positive Futures (Pathways)
- National Wraparound Initiative
- Positive Youth Development (PYD)
- Youth M.O.V.E.

Required Weekly & Monthly Reporting

- CAT providers must submit the CAT Monthly Data Reporting Template on the date specified by the ME (Managing Entity) and should include the following:
- School Attendance – Individuals receiving services shall attend an average of 80% of school days.
- CFARS (Children's Functional Assessment Rating Scales) will be used for individuals under 18 years of age and FARS (Functional Assessment Rating Scale) for individuals 18 years of age or older.
- 80% of individuals receiving services shall improve their level of functioning from admission to discharge.

- Living in a Community Setting – Individuals receiving services will spend a minimum of 90% of their days living in a community setting.
- North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R) - 65% of individuals and families receiving services shall demonstrate improved family functioning as demonstrated improvement in the Child Well-Being domain between admission and discharge.
- The NCFAS-G+R is not required for individuals 18 years of age and older.
- CAT providers are required to submit a Monthly Census on the 4th day of each month to the ME (Managing Entity) which includes the following:
    - Name, DOB, Peer Specialist, Therapist, Case Manager/TIP Coach, Eligibility Criteria, Medicaid/Insurance, Authorization #, Admission Date, etc. and includes names of clients admitted to Inpatient Psychiatric Units or Hospitals.
- CAT providers are required to submit the current CAT Waiting List and Screening List to the Managing Entity on the 4th day of each month to the ME (Managing Entity) which includes the following:
    - Waiting List: Name, DOB, Gender, Date Referred, Screening Date, Projected Admission Date, Interim Services, Agency Providing Interim Services, Discharge Date.
    - Pending Screening List: Name, SS#, DOB, Gender, Referral Date, Referral Source and Screening Date.

Serving Young Adults

The CAT program serves young adults up to the age of twenty-one (21), which includes young adults ages eighteen (18) up to twenty (20) who are legally considered adults. Network Service Providers serving these young adults must consider their legal rights to make decisions about their treatment, who will be involved, and with whom information will be shared. In keeping with the focus of the CAT model, Network Service Providers should support the young person to enhance and develop relationships and supports within their family and community, guided by their preferences.

Discharge

As part of the discharge planning process, CAT teams assist in the identification of additional resources that help individuals and families maintain progress made in treatment. As the individual moves into the discharge phase of treatment, the CAT Team may determine the need to modify the service array or frequency of services to ease the transition to less intensive services and supports. Throughout treatment, the Network Service Provider should focus on the successful transition from services.

The Treatment Discharge Notice in the BBHC Portal must be completed within 7 days of discharge from the CAT Team and the Discharge Summary is required to be uploaded.

The Discharge Summary should include containing the following:

1. The reason for the discharge.
2. A summary of CAT services and supports provided to the individual.
3. A summary of the individual's progress towards each treatment goal in the Master Plan of Care.
4. A summary of resource linkages or referrals made to other services or supports on behalf of the individual.; and
5. Information documenting the warm handoff between the CAT Team and provider individual has been linked for continuing services.

Refer to Guidance 32 for additional details

XIX. Forensic Multidisciplinary Team (FMT)

The Forensic Multidisciplinary Team (FMT) is a service-delivery model for providing comprehensive community-based treatment to persons with severe and persistent mental illnesses and legal issues, considered to be in Chapter 916 known as ITP (Incompetent to Proceed) or NGI (Not Guilty for Insanity). The FMT team is the central point for delivering services required by each client to live successfully in the community by optimizing their independence. Delivering the needed level of support in an assertive manner, appropriate service planning and coordination, advocacy, flexibility, attention to medications and response during times of crisis are the hallmarks of this approach.

The FMT program is adapted from the ACT (Assertive Community Treatment) model. Like ACT, FMT is an intensive team comprised of multidisciplinary staff that predominantly provides all services to the individuals served. The BBHC FMT program will abide by the DCF **Guidance 28 - Forensic Multidisciplinary Team**

The team is comprised of a team leader, psychiatrist, nurse, peer specialist, therapist, 2 case managers and an administrative assistant. The number of staff members is directly related to the number of clients on the team. The FMT team has a maximum caseload of 45 clients at any given time. This case size assists with the provision of intensive programming with client contact of 3 times per week. Contacts could be made through various means such as face to face visits, tele-health, telephone calls and include psychiatric and medication visits. Psychiatric visits can range from 1 time a month or more often, based on client needs. 75% of services are provided in the community and non-traditional settings. These settings include client's home, parks, work areas, or other settings feasible for community integration. The team provides the majority of treatment, support and rehabilitation services and assists with the brokerage of a few specialized services as necessary. Due to the forensic and legal involvement of all individuals served, participation in the courts and other judiciary processes are amongst the many responsibilities of the team.

The program goals include:

1. Diverting individuals who do not require the intensity of a forensic secure placement from the criminal justice system to community-based care;
2. Eliminating or lessening the debilitating symptoms of mental illness that the individual experiences;
3. Addressing and treating co-occurring mental health and substance abuse disorders;
4. Reducing hospitalization;
5. Increasing days in the community by facilitating and encouraging stable living environments; and
6. Collaborating with the criminal justice system to minimize or divert incarcerations.

Admission criteria include:

- Clients must be at least 18 years of age
- Resident of Broward County for 30 days or more
- History of Psychiatric hospitalizations or demonstrates high risk for admission or re-admission or repeated crisis stabilization contacts in the past 6 months
- Determined by a court to be ITP, or NGI pursuant to Chapter, 916, F.S. or
- Person with a serious and persistent mental illness who are arrested and, prior to adjudication are referred to FMT

Staffing Standards

The FMT staffing configuration is comprised of practitioners with a diverse range of skills and expertise. This enhances the team's ability to provide comprehensive care based on the individual's needs. The FMT shall maintain a Case Manager-to-Individual ratio of no more than 1:15.

The FMT shall employ a minimum of:

- 1 Full-Time Equivalent (FTE) Licensed Team Leader;
- 3 FTE Case Managers;
- 0.5 FTE Psychiatric Advanced Registered Nurse Practitioner (ARNP) or Psychiatrist;
- 1 FTE Therapist; and
- 0.5 FTE Administrative Assistant.

Services

This service shall be available 24 hours a day, seven days per week. The team must operate an after hour on-call system at all times, staffed with a mental health professional. The frequency of service is determined by the ME, as 3 face-to-face contacts a week for each client. Telemedicine/telehealth shall be introduced within the provision of services. For example, one of the face-to-face contacts can be delivered via telehealth/telemedicine.

The FMT shall offer the following services.

a. Crisis Intervention and On-Call Coverage
b. Comprehensive Assessments
c. Case Management and Intensive Case Management
d. Medical Services
e. Substance Abuse and Co-Occurring Services
f. In-Home and On-Site Services
g. Incidental Expenses

Services can be provided via telehealth/telemedicine

The FMT Team Leader is required to provide a Monthly Census by the 5th of each month; and a Weekly Waiting list to the BBHC Forensic Coordinator, by Friday at Noon. In addition, by the 15th of each month, they shall submit the data elements required by Template 25 - Forensic Multidisciplinary Team Report. All these reports will be sent to the BBHC Forensic Coordinator.

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XVIII. Central Receiving System (CRS)

BBHC has created a Central Receiving System in accordance of **Guidance 27 - Central Receiving Systems**, which is the overarching rule.

PROGRAM DESCRIPTION: The Centralized Receiving System is designed to provide adults experiencing a crisis a convenient point of entry into the mental health and substance use systems for immediate assessment as well as subsequent referral and linkage to appropriate and available providers and services. Individuals will be assessed for care based on a triage model of urgency, in which concerns for safety to self and to others based on Baker Act criteria and Marchman Act criteria are addressed first.

The goals of the CRS are to:

- Provide initial assessments, triage, case management and related services;
- Provide opportunities for jail diversion, offering a more suitable and less costly alternative to incarceration;
- Reduce the inappropriate utilization of emergency rooms;
- Increase the quality and quantity of services through coordination of care and recovery support services;
- Implement standardized assessment tools and procedures for services; and
- Improve access and reduce processing time for law enforcement officials transporting individuals needing behavioral health services.

The LOCUS (Level of Care Utilization System) and SPDAT (Service Prioritization Decision Assistance Tool), standardized assessment tools, will be utilized for further determination of needs. Individuals will be offered referral and/or linkage to appropriate providers and services based on their desired need(s) as well as the professional determination of evaluating staff.

The CRS provides opportunities for jail diversion, offering a more suitable and less costly alternative to incarceration; reduce the inappropriate utilization of emergency rooms; increase the quality and quantity of services through coordination of care and recovery support services; demonstrate improved coordination of care and improvements in client outcomes; and improve access and reduce processing time for persons served and law enforcement officials transporting the target population. Henderson Behavioral Health's CRS is aligned with The Triple Aim of improving population health and the patient experience of care, while reducing per capita cost.

Location

The Centralized Receiving Center (CRC) will be located at Henderson Behavioral Health, Headway Office Park Location, 4720 North State Road 7, Building B, Lauderdale Lakes, Florida 33319. The Center will be open 24/7/365 days of the year to provide immediate access to emergency services and Coordination of Care for the targeted population for Law Enforcement and Hospital Emergency Departments.

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The CRC will be one of four multi-entry drop-off sites currently identified for Law Enforcement to bring individuals, and is designed for those not meeting the criteria for involuntary hospitalization under the Baker Act or Marchman Act;

- Memorial Regional Emergency Room in Hollywood,
- Broward Addiction Recovery Center (BARC) and
- Henderson's Crisis Stabilization Unit are also identified "drop-off" sites.

Targeted Population

Adults male and female, over 18 years of age, with behavioral health and/or substance use issues who are in need of an involuntary evaluation or stabilization under a Baker Act or Marchman Act as well as Crisis Support services as defined in subsections 394.67 (170-(18), F.S. "Crisis services" means short-term evaluation, stabilization, and brief intervention services provided to a person who is experiencing an acute mental or emotional crisis to prevent further deterioration of the person's mental health and whom may give informed consent for voluntary treatment.

Other characteristics that are typical of the targeted population may include:

- High risk of over-reliance on utilizing the most costly and restrictive levels of care, including emergency rooms, crisis stabilization units, repeated &/or prolonged psychiatric hospitalizations, and intermediate or long-term institutionalization;
- Involvement in the judiciary system due to various misdemeanor and felony charges, often leading to incarceration;
- Episodic or chronic homelessness, often precipitated by lack of access to affordable, safe and decent housing of their choice.

Eligibility/ Entry Criteria:

1. Age 18 and older
2. Residents of Broward County
3. Those who are experiencing a substance abuse or a severe psychiatric or emotional episode of crisis or have a severe and persistent major mental illness, (i.e., schizophrenia, schizoaffective disorder, bipolar disorder, or major depression), that had been identified by Law Enforcement and/or Hospital Emergency Departments and do not meet criteria to be admitted for inpatient care.

Services Provided:

1. Psychiatric/diagnostic evaluations
2. Crisis counseling and intervention
3. Outpatient Therapy
4. Assessment of co-occurring disorders
5. Case Management and/or Care Coordination
6. Recovery Support
7. Linkage and referral
8. Evaluation and arrangement for inpatient hospitalization, as necessary

Transition and Discharge:

A Transition/Action Plan shall be completed by the practitioner/treatment team, with the person served, and when applicable, a family/significant other, when the person may benefit from a different level of care and/or additional services within Henderson Behavioral Health (HBH) or is being discharged from the program/organization.

Performance Measures

Subcontracts must adopt, at a minimum, performance measures to evaluate the impact of the CRS project within the community. Per Section 2.4 of the RFA, and as detailed in Tab 4 of the grantee's application, performance measures and methodologies must be related to the grantee's specific CRS project and must include, at a minimum, measures to address the following outcomes:

- Reduce drop-off processing time by law enforcement officers for admission to crisis services;
- Increase participant access to community-based behavioral health services after referral;
- Reduce the number of individuals admitted to a state mental health treatment facility
- Two additional output, process, or outcome measures tailored to the specific CRS project.

Reports:

3. Detailed Quarterly Report compiling the monthly data.

l) Project Status Report: Monthly report due by the 5th of the month consisting of the following subsections:

A. Data/Outcome measures reported for each month and since inception:

b) Number of individuals served at each CRS location, including Memorial ER, BARC, Henderson CSU and the Henderson CRC facility;
c) Number of individuals seen at Community Court
d) Number of individuals diverted from Hospitalization
e) Number of individuals assisted with SOAR applications
f) Percent of individuals linked with Community Resources
g) Number of MOU's
h) Number of SPDATs
i) Number of HOH Opioid Referrals
j) Estimated savings to the Legal system
k) Estimated Savings to the Behavioral Health System

B. Community Education/Outreach:

- Number of Community Presentations/Collaborative
- Meetings/Attempted
- Contacts/Law Enforcement Education/Roll Call

C. Referral Sources: Breakdown including subsections:

- Hospitals
- Law Enforcement Municipalities
- Broward Sheriff's Office by City

Monthly Client Volume including number individuals served in Graph format

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XX. Mobile Response Team (MRT)

The Mobile Response Team (MRT) provides on-site behavioral health crisis intervention services to individuals in any setting in which a behavioral health crisis is occurring, including homes, schools and emergency departments. Mobile response services are available 24/7 by a team of professionals and paraprofessionals, who are trained in crisis intervention skills to ensure timely access to supports and services. In addition to helping resolve the crisis, teams work with the individual and their families to identify and develop strategies for effectively dealing with potential future crises. MRT providers are responsible for working with stakeholders to develop a community plan for immediate response and de-escalation, but also crisis and safety planning. Stakeholder collaboration must include law enforcement and school superintendents, but may also include other areas within education, emergency responders, businesses, other health and human service-related providers, family advocacy groups, peer organizations, and emergency dispatchers (i.e., 211 and 911 lines). Telehealth/telemedicine shall be utilized to facilitate and expedite this emergency response.

I) The MRT provides behavioral health crisis intervention services to young people who meet at least one of the following criteria:
II) Have an emotional disturbance;
III) Are experiencing a mental or emotional crisis;
IV) Are experiencing escalating emotional or behavioral health reactions and symptoms that impact their ability to function normally within their environment; or
V) Are served by the child welfare system and are experiencing or are at high risk of placement instability.

The MRT must complete the following activities:

- Display the number to their MRT on the start page of their public-facing website.
- Ensure their local 2-1-1 and 988 Florida Lifeline center provider(s) have information on the MRT and how to refer individuals in need.
- Triage new requests to determine the level of severity and prioritize new requests that meet the clinical threshold for an in-person response.
- Conduct screening and assessment of individuals that may be a danger to themselves, or others as established by s. 394.463, F.S.
- Provide in-person response to calls meeting the clinical threshold within 60 minutes after prioritization. While in-person responses may be provided via telehealth, teams are expected to respond to the location where the crisis is occurring when determined safe.
- Provide behavioral health crisis-oriented services that are responsive to the needs of the individuals and their family or other natural support system.
- Utilize evidence-based practices to deescalate and respond to behavioral health challenges and to reduce the potential for future crises. When evidence-based practices are not available, the MRT shall use approaches based on clinical judgement and within the scope of their practice.
- Provide a warm handoff to referred services and brief care coordination by facilitating the transition to ongoing services for at least 72 hours. Warm handoff means that the MRT provider actively connects the individual to another service provider.
- Coordinate with the CBCs to provide information about the MRT services to foster parents.
- Report to the Managing Entities on the performance outputs in Section G and the number of individuals who did not require an involuntary examination that were actively linked to the appropriate level of care with a community provider for ongoing behavioral health services.

- Use the same suicide risk assessment instrument adopted by the district school board pursuant to s. 1006.07(11), F.S., and approved by the Department of Education pursuant to s. 1012.583, F.S. The MRT provider will accept suicide risk assessments completed by qualified school staff pursuant to s. 394.495 (3), F.S., on the same day of the response to avoid duplication of assessment on the youth. Approved instruments are available at: https://www.fldoe.org/schools/k-12-public-schools/sss/suicide-prevent.stml.
- Obtain an average response time within 60 minutes.
- Complete a minimum of seven (7) formal outreach activities conducted annually. This may include activities such as presenting at School Board meetings, community health fairs, and community partner meetings. Targets for outreach activities may include detoxification programs, emergency departments, schools and colleges, community behavioral health providers, law enforcement and other first responders, child protective investigators, dependency case managers, parents, family and youth run organizations, Agency for Persons with Disabilities, Department of Juvenile Justice, group homes, foster care organizations, 2-1-1 and other social service type call centers, as well as community leaders such as county commissions and city government. Providers may also utilize local media outlets, including television and radio, to advertise for and inform the general public about MRT services available.

All BBHC Contracted Providers must provide contact information for MRTs to parents and caregivers of children and to adults who receive safety-net behavioral health services. This initiative is guided by the DCF **MRT Guidance 34**.

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XXI. Mothers In Recovery (MIR)

The MIR treatment and prevention program is designed to reduce the number of babies born with Neonatal Abstinence Syndrome due to opioid exposure in utero. This aim will be achieved through targeting prevention and treatment strategies for pregnant women, women with dependent children and women of childbearing age through a three-pronged process:

a. Community outreach and education regarding substance use disorders, comorbid mental health disorders, the dangers of drug and alcohol use during pregnancy, and providing referral information.
b. Universal screening during medical encounters—emergency department visits, primary care visits and OB/GYN visits in order to provide brief intervention and linking with treatment.
c. Outpatient substance abuse treatment provided through collaborative/integrated services including motivational enhancement therapy, cognitive skills therapy and relapse prevention, and trauma informed care.

Deliverables

a. Staffing
b. Equipment
c. Program Implementation
d. Outpatient Treatment Services
e. Outreach and Education Services
f. Program Outcome Reports

Program Outcomes

Method	Outcome	Measurement
Provide substance abuse prevention education & outreach	100 women will be provided with substance abuse prevention education and referral information.	Electronic Health Record (EHR) documentation of patient outreach encounters, sign in sheets for group education and outreach events
Provide universal screening for substance use disorders	100 women will be screened for substance use disorders using evidence-based screening tools	Electronic Health Record (EHR) documentation of completed screening
Provide evidence-based outpatient substance abuse treatment	50 women will receive integrated substance abuse treatment focused on motivational enhancement, skill building and relapse prevention	Electronic Health Record (HER) documentation, urine toxicology results, group sign in sheets
Reduce the incidence of Neonatal Abstinence Syndrome	75% of women who receive MIR services will give birth to neonates born drug free.	EHR documentation

XXII. Medication Assisted Treatment (MAT) Program

The BBHC Medication Assisted Treatment (MAT) Program includes person centered, recovery-oriented, and comprehensive care model to treat persons with opioid use disorders that features a phased treatment approach. The phase model assumes that although some clients need long-term MAT, the types and intensity of services they need vary throughout treatment and should be determined by the individual needs of the client. The four general phases of MAT are induction, stabilization, maintenance, and discontinuation/sustained recovery. The services provided in each phase of treatment are defined by clinical needs and programmatic considerations.

The goals for each phase are as follows:

1) Induction phase—medically monitored startup of buprenorphine, long-acting naltrexone, and/or other MAT medications;
2) Stabilization phase—address cravings and triggers, develop a long-term recovery plan. The stabilization phase should include integrated primary care services;
3) Maintenance phase-- with ongoing peer support, medication management and a compendium of supportive services;
4) Discontinuation/Sustained Recovery Phase—this the final phase where the client is given the choice/opportunity to discontinue medication while still receiving supportive services.

Peer support services are utilized throughout all phases of the program.

BBHC MAT programs will prioritize the high-risk populations: pregnant women, intravenous drug users, women with dependent children aged 0-5, caregivers/parents involved in the child welfare system, minorities, persons with HIV/AIDS, and consumers with criminal justice involvement. A Recovery-Oriented Systems of Care model is utilized to provide comprehensive, continuous care to treat the consumer during all phases of MAT treatment.

BBHC MAT programs may utilize the following evidence-based models, not limited to: 1) Emergency Initiation of MAT; 2) Medicaid Health Home Model for the Treatment of Opioid Use Disorders; and 3) Detoxification – Office-Based Opioid Treatment.

BBHC MAT Programs will include both medication maintenance with Subutex (Buprenorphine), Suboxone (Buprenorphine/Naloxone) or Vivitrol (Naltrexone) and medication-assisted detoxification/taper with Subutex or Suboxone. Additional services should include a harm reduction program for caregivers and consumers who are trained on the proper use of the Narcan Kits. Consumers will receive treatment that is integrated and coordinated within all primary, acute, and behavioral health settings.

Following is a brief overview of the BBHC MAT Services and Phases of Treatment:

MAT services include:

- Aftercare
- Case Management
- Crisis Support/Emergency
- Day Treatment
- Incidental Expenses (excluding housing/rental assistance and direct payments to participants)
- In-Home and On-Site

- Medical Services
- Medication-Assisted Treatment (methadone maintenance, buprenorphine maintenance or oral naltrexone)
- Outpatient
- Outpatient Detoxification
- Outreach (to identify and link individuals with opioid use disorders to medication-assisted treatment providers)
- Recovery Support
- Supported Employment
- Supportive Housing/Living
- Substance Use Detoxification
- Residential Treatment

I. Coordination of Care and Integrated Treatment

BBHC MAT services will prioritize care coordination through all levels of care, health promotion through integrated primary/behavioral health clinic, transitional care/follow up services, peer recovery support services, consumer and family support, access to consumer-run Drop-In Centers and comprehensive substance abuse and mental health treatment. The MAT teams will ensure that consumers with opioid use disorders who are seeking treatment will have access to evidence-based, medication assisted treatment services.

II. Focus on Engagement and Access to Treatment

In order for MAT to be effective, it must be readily accessible. The first goal of MAT is to engage individuals diagnosed with opioid use and/or stimulant use disorder in treatment. All MAT programs should have a targeted approach to outreach and providing recovery support to persons in need of services. Peer specialists are key staff who can provide initial care coordination, identify and begin to address immediate needs and help increase motivation for treatment.
In addition, BBHC has focused on improving access to MAT services for these by improving infrastructure and collaboration among treatment providers at all levels of care. MAT programs should design programs that focus on effective and expedited access to medication to optimize engagement in treatment and promote retention.

III. Phased Treatment Approach

Best practice for MAT recommends that medication-assisted treatment is conceptualized in terms of phases of treatment so that interventions are matched to levels of client progress and intended outcomes. A phased treatment approach is outcome-oriented and engages clients, program staff and community resources through a series of successive, integrated interventions, with each phase built on another and directly related to client progress. Such a model helps staff understand the complex dynamics of MAT, helps better address the potential challenges that may arise, and helps organize interventions based on client needs.

The phases of treatment are as follows:

1. **Induction Phase (2-4 weeks induction period, includes Assessment and Medical Services).**
   The induction phase is the initial period—treatment is focused on starting buprenorphine or other MAT medications and eliminating use of illicit opioids and abuse of other psychoactive

substances while lessening the intensity of the co-occurring disorders and addressing the medical, social, legal, family, and other problems associated with addiction. It is recommended that more intensive services are provided during the induction phase, especially for clients with serious co-occurring disorders or social or medical problems. Services may include:

- Psychiatric evaluation
- Physical examination
- Biopsychosocial/ Initial treatment plan
- Labs
- Medication Reconciliation
- Daily Clinic Visit
  - Medication Administration/Observation
  - Medication Management
  - Medication Education
  - Evidence Based Assessment
- Individual Recovery Support

2. Stabilization Phase (4-6 weeks)

The stabilization phase is focused on stabilizing the dosage of MAT medication. During this phase, co-occurring psychiatric disorders and medical conditions should also be addressed. The goal of this phase is to control cravings, address triggers and begin to develop a long-term recovery plan. Services may include

- Group Therapy
- Psychiatric evaluation
- Psychiatric follow up/medication management
- Medication Assisted Treatment
- Medications
- Individual therapy
- Labs (urine toxicology)
- Recovery support (group and individual)
- Primary Care Services

3. Maintenance Phase (2 - 4 months)

The primary goal of the maintenance phase of treatment is to empower clients to cope with their major life stressors—drug or alcohol abuse, medical concerns, co-occurring disorders, vocational and educational needs, family dynamics, and legal issues—so they can pursue longer term goals such as education, employment, and family reconciliation. Targeted trauma services should be provided during this phase. Quality of life issues such as stable, recovery-oriented housing, establishing recovery supports in the community, vocational rehabilitation and developing values-based life goals should be addressed in the maintenance phase. Services may include:

- Medication Assisted Treatment
- Intervention Services (individual therapy)
- Aftercare groups & Individual Recovery Support
- Labs (urine toxicology)
- Medications
- Primary and specialty medical services

4. Discontinuation/Sustained Recovery Phase (30-90 Days):

It is important that any decision to taper from opioid treatment medication be made without coercion and include careful consideration of a client's wishes and preferences, level of motivation, length of addiction, results of previous attempts at tapering, family involvement and stability, and disengagement from activities with others who use substances. A client considering dose tapering should understand that the chance of relapse to drug use remains and some level of discomfort exists even if the dose is reduced slowly over months.

BBHC MAT program services must be more responsive and increased in frequency and/or intensity during the discontinuation phase to address the psychological components of addiction, and to ensure support for long-term recovery. Peer services are particularly well-suited during this phase. As medication is being tapered, intensified services should include counseling, peer recovery support and monitoring of client's behavioral and emotional conditions. Clients considered for medication tapering should demonstrate sufficient motivation to undertake this process, including acceptance of the need for increased behavioral interventions. Tapering from medication can be difficult, and clients should understand the advantages and disadvantages of both tapering from and continuing on medication maintenance as they decide which path is best for them. Individuals who are determined to need ongoing MAT maintenance will be referred to an appropriate provider in the community that can best meet their needs. BBHC MAT providers will ensure the provision of supportive services throughout the transition.

Long-acting Naltrexone treatment for 6-9 months may be a viable option at the end of the discontinuation phase for those individuals who meet the criteria.

Aftercare services should be initiated during the tapering phase and include a focus on linking with community supports, reinforcing the need for ongoing preventive medical care, and an emphasis on establishing participation in fellowship meetings and the development of long-term plans for continued progress in recovery.

5. Government Performance and Results Modernization Act of 2010 (GPRA)

Providers of treatment and recovery support services are required to collect data at five data collection points:

1. Baseline:
    - Residential Facilities - must be completed within 3 days after the individual enters the program.
    - Non-Residential - must be completed within 4 days after the individual enters the program.
2. 6 months post intake follow-up:
    - The window period allowed for GPRA follow-up interviews is one month before the (3 or 6 month) anniversary date and up to two months after the (3 or 6 months) anniversary date.
3. Discharge:
    - Discharge interviews must be completed on the day of discharge, regardless of length of stay in the program (i.e., 1 day length of treatment still needs a discharge GPRA completed).

- If an individual has not finished treatment, drops out, or is not present the day of discharge, the project will have 14 days after discharge to find the individual and conduct the in-person discharge interview. If the interview has not been conducted by day 15, conduct an administrative discharge. For an administrative discharge when the interview is not conducted, interviewers must complete the first four items in Section A (Client ID, Client Type, Contract/ Grant ID, Interview Type), Section J (Discharge), and Section K (Services Received) and mark that the interview was not completed.

MAT Programs and EMS Collaboration: Consumers that have overdosed and presented in the emergency department will be offered MAT and will be visited daily for up to seven days by local EMS staff and a MAT Program Recovery Support Specialist. These staff will provide a daily dose of medication and link the consumer to ongoing recovery treatment services and the MAT Program.

Hospital Bridge programs, which initiate medication assisted treatment (MAT) services in the Emergency Department and link individuals to longer-term care through a community-based network MAT service provider,

DCF Guidance and Overview can be found on the DCF website in the Florida State Opioid Response Project Overview.

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XXIII. Competency Restoration Program (CRT)

Competency Restoration Training (CRT), utilizing the United States Supreme Court "Dusky" standards for determining a defendant's competence to proceed to trial. The training uses experiential techniques appropriate for the developmental capacity of participating clients to provide education on the legal system to include consideration of charges, penalties, court personnel, verdicts, possible pleas, relevant testifying, assisting legal counsel and appropriate courtroom behavior.

CRT accepts referrals from the Court for clients who have been adjudicated Incompetent to Proceed (ITP) and therefore ordered to complete CRT. Classes may be conducted with no more than 15 participants. During the first session, participants complete opening paperwork and are advised of participation requirements; applicable policies and procedures, class schedule; and complete a pre-Test. Classes are conducted in community sites that are reasonably accessible via public transportation, the office location, and other locations as determined appropriate by BBHC or utilizing online communication platforms. When ordered by the court, the Provider will provide CRT to individuals in the jail. The Provider must make every attempt to assign clients enrolled in CRT to a location closest to his/her home or service provider.

Clinical staff shall conduct ongoing testing and assessment of clients' progress toward restoration and shall provide reports advising all parties if an individual has achieved maximum benefits from the training. Progress reports detailing client's attendance and participation in training will be submitted to the Court, during scheduled hearings.

CRT cycles will be 12 weeks long, and clients will be assessed after completion of the first cycle. If it is determined that the individual requires additional training, they will be ordered to complete a second cycle of CRT.

Once the Provider has determined that a client has been restored to competency or remains incompetent after a second cycle (non-restorable), they will submit copies of their assessment to the court, SAO & defense counsel with the recommendation to vacate the order for CRT. The Provider will continue to provide CRT until otherwise ordered by the Court, or unless advised by BBHC.

The Provider shall submit the CRT Tracking Log and the CRT Placements Log to BBHC by the 5th of every month.

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XXIV. Adult Post-Arrest Diversion Program

This program is designed to divert individuals charged with 3rd degree or 2nd degree non-violent felonies who experience serious mental illnesses (SMI, e.g., schizophrenia, schizo-affective disorder, bipolar disorder, major depression, or post-traumatic stress disorder) or co-occurring serious mental illnesses and substance use disorders, from the Criminal Justice System into comprehensive community- based treatment and support services. All participants must meet the clinical criteria as well as the legal criteria, and The Public Defender (Defense Attorney) and the State Attorney must provide approval for program participation.

1. APPLICATION

Applicants for entry into the Felony Mental Health Post-Arrest Diversion Program must be referred to the State Attorney's Office by the public defender, defense council, and BBHC via Cognito Forms. Applicants must be diagnosed with a Severe Mental Illness and meet all other requirements listed below. Once the case is approved by State Attorney's Office, case will be sent to the Provider for processing.

2. PAST ADULT OFFENSE HISTORY

The State Attorney's Office will review, on a case-by-case basis, applicants with up to five prior misdemeanors and up to one prior felony (arrest or disposition) where the applicant's mental health was a factor in the commission of those crime(s). The SAO will ultimately decide on client's eligibility to participate in the program.

3. PAST JUVENILE OFFENSE HISTORY

Applicants who are twenty-five (25) years of age or younger who have extensive prior criminal juvenile record (up to five prior misdemeanors and up to one prior felony arrest or disposition), will be reviewed for entry into the program on a case-by-case basis.

4. OFFENSE

The criminal offense for which the applicant has been arrested or charged must be a nonviolent third-degree felony. Any charge involving a firearm is excluded. However, other criminal offenses will be evaluated on a case-by-case basis at the discretion of the State Attorney's Office.

5. CONSENT OF VICTIM(S) REQUIRED

The victim(s) of the offense for which the applicant was arrested must consent to the applicant participating in the program.

6. RESTITUTION REQUIRED

If a person or an insurance carrier, suffered monetary loss that can be determined without controversy as a direct result of the commission of the offense for which the applicant was arrested, the applicant must be ready, willing and able to make full restitution.

7. WAIVER OF RIGHTS REQUIRED

If an individual desires to be considered for entry into the program, upon applying for entry into the program and prior to any further processing of such application, the applicant must voluntarily, knowingly and intelligently execute a document to be provided that they he/she has been fully advised of his/her right to a Speedy Trial and has agreed to waive the right to a Speedy Trial on the said offense. The applicant shall waive his/her right to a Speedy Trial until the applicant successfully completes the program or is terminated from the program. At the time of

application for entry into the program the applicant's attorney shall confirm in writing that they have advised the applicant of these same rights.

The applicant voluntarily, knowingly, and intelligently waives the filing of formal charges and/or information related to their arrest and all-time requirements or limitation under the law for filing same.

The applicant waives any and all laboratory testing of the evidence related to their arrest including but not limited to testing of controlled or chemical substances, DNA, fingerprint comparison, and or trace evidence, unless this agreement is terminated, and criminal charges are filed.

8. SPECIAL CONDITIONS

a. The applicant must agree to participate in any counseling programs or group counseling sessions required by their case manager for satisfactory completion of the diversion program.
b. The applicant will sign medical and mental health release forms for medical and mental health records to allow the program case manager, the State Attorney's Office, the Court, and their attorney access to review the medical and mental health records, and reports as they relate to qualification and participation in this program.
c. The participant agrees to appear for all required appearances as required by the Felony Mental Health Post-Arrest Diversion Program, the State Attorney's Office, or the Court.

9. FAILURE TO COMPLY

The failure to comply with any of the requirements of the program or any conditions of release will result in termination and removal from the program at the discretion of the State Attorney's Office and is not reviewable by the court. The case will then be reviewed and considered for filing of the criminal charges. Post Arrest Diversion Program

The Post Arrest Diversion team is responsible for submitting a monthly report including: census, number of graduations/terminations, number of assessments completed, and a total of clients who completed orientation for each month. The report is due to BBHC by the 5th of every month.

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XXV. Crisis Intervention Team (CIT) Program

Crisis Intervention Team (CIT) began in Memphis in the late 1980s and has been widely adopted around the country. CIT is an effective law enforcement response program designed for first responders who handle crisis calls involving people with mental illness including those with co-occurring substance use disorders. CIT emphasizes a partnership between law enforcement, the behavioral healthcare and treatment systems, mental health advocacy groups, and consumers of mental health services and their families.

CIT, "The Memphis Model", was developed around a set of core elements which have led to the success of this program. Absent these core elements, we believe a law enforcement response to those in crisis with a mental illness will be less effective.

Background:
In an effort to be pro-active, the Department of Children and Families/Substance Abuse and Mental Health Program Office in partnership with BBHC contracted community Providers of Broward County brought in Major Sam Cochran and Dr. Randy Dupont from Memphis to conduct a two-day presentation on their model. Local mental health and substance abuse providers were invited along with every law enforcement agency in the county, consumers, and family members, state and county personnel, and other advocates. A series of meetings were held to determine how to move forward with this project.

The Fort Lauderdale Police Department enthusiastically stepped forward to serve as the pilot project for CIT in Broward County. Because of their unique homeless outreach activities and concerns for how people are treated, they embraced the program.

A team of dedicated individuals formed the CIT Development Workgroup comprised of, Fort Lauderdale Police Department, BBHC contracted community Providers, Department of Children and Enforcement, the Florida Council for Community Mental Health and the Florida Alcohol and Drug Abuse Association.

About three years ago, CIT of Broward expanded the training to detention deputies. Every year, two cohort groups participate in CIT program specifically designed to meet their unique needs and their role in our current system of care.

Goals for Florida CIT Programs:
CIT is a community partnership between law enforcement agencies, the local mental health and substance use treatment systems, mental health advocacy groups, and consumers of behavioral health care services and their families. CIT is more than just a training. It establishes teams of trained officers within each law enforcement agency to respond effectively to people with mental illnesses, including those with co-occurring substance use disorders that are in crisis.

Communities which establish CIT programs do so with the following goals in mind

- Better prepare police officers to handle crises involving people with mental illnesses, including those with co-occurring substance use disorders.
- Increase law enforcement officer safety, consumer safety and overall community safety.
- Collaboratively, make the mental health system more understandable, responsive, and accessible to law enforcement officers to the greatest extent possible with community resources.

1. Supply law enforcement officers with the resources to appropriately refer people in the need of care to the mental health/substance use treatment system.
2. Improve access to mental health/substance use treatment in general and crisis care in specific for people who are encountered by law enforcement.

The **monthly** training coordinated by United Way of Broward County emphasizes the understanding of mental illnesses, including substance use disorders and how it affects a person's life, the development of communication skills, practical experience and scenario-based training. Officers are able to learn from and engage with mental health professionals, consumers and family members both in the classroom and in the field during site visits.
This intensive training attempts to provide a common base of knowledge about mental illness and give the officers a basic foundation from which to build. The course is intended to provide officers with skills to:

- Recognize signs and symptoms of mental illness and co-occurring disorders.
- Recognize whether those signs and symptoms represent a crisis situation De-escalate mental illness crisis.
- Know where to take consumers in crisis.
- Know appropriate steps to follow up, such as contacting case managers, providing families with community resources, etc.
- Learn how to problem-solve with the treatment system.
- Recognize the needs of special populations (LGBTQ and Veterans) and how to successfully intervene in a way that is culturally responsive.
- Understand what autism is and how people are affected by it, various challenges when interacting with someone on the autism spectrum, and strategies to help reduce stress and or anxiety in people with autism.

CIT Broward Curriculum:

1. Introduction
2. Clinical Issues Related to Adult Mental Health
3. Legal Issues and Processes – Baker Act & Marchman Act
4. Clinical Issues Related to Elderly Care
5. Youth Mental Health
6. Development Disabilities
7. Autism
8. LBGTQ related issues
9. Personality Disorders
10. Post-Traumatic Stress Disorders
11. Suicide Prevention and Intervention
12. Crisis Intervention
13. Crisis Communication & De-escalation
14. Scenario Based Training
15. Self-Care
16. Resource Panel
17. Consumer & Family Panel

Monthly trainings could not take place without the full engagement of community partners, who provide experts to present on various topics, role players for scenario-based training segment, consumers and family members for panels, and facilities to tour during the site visit segment of the week. CIT Broward thrives because it engages our entire system of care. Refresher trainings are also provided periodically.

XXVI. SOAR Requirements

SOAR is a national project funded by the Substance Abuse and Mental Health Service Administration (SAMHSA) that is designed to increase access to SSI/SSDI for eligible adults with mental illnesses who are homeless or at-risk of homelessness. BBHC, as part of a DCF Statewide Initiative, is responsible to assure that the SOAR process is implemented within our region in collaboration with key stakeholders. BBHC SOAR programs are in alignment **Guidance 9 - Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach Access, and Recovery (SOAR)**

Access to SSI/SSDI is a major tool in recovery from mental illness and homelessness. Without these benefits, it is extraordinarily difficult for individuals we serve to engage in treatment, to keep appointments, to maintain housing, enter the workforce, and to meet other basic needs. The goal of the SOAR process is to reduce or eliminate homelessness by reducing financial barriers that impede recovery. The SOAR process assists a defined target population: adults with mental illnesses or co-occurring disorders who are homeless or at risk of homelessness. The process assists these individuals by increasing access to SSI/SSDI benefits.

The SOAR *Stepping Stones to Recovery* training provides all staff a good introduction to the SOAR processes. Trainings focus on the initial application and thorough documentation of the disability using a Medical Summary Report to avoid appeals, reduce the need for consultative exams, increase approval rates, and reduce times to decisions. The SOAR raining options is currently under review by the Department of Children and Families.

To this end, BBHC has employed a SOAR Local Lead who has completed the SOAR online training and Leadership Academy and is available to provide technical assistance, in collaboration with DCF and the SAMHSA funded SOAR Technical Assistance Center. The ME's SOAR Local Lead also identifies other local team leads and trainers available in the area to assist as needed.

Requirements:

1) BBHC network service providers that offer adult case management and outreach services to persons with mental health and/or co-occurring disorders must designate one (1) primary SOAR representative who is responsible for the provider-level SOAR implementation initiative and who is responsible for solely processing SOAR applications, reporting to, and coordinating with the ME for SOAR contract compliance.
   - SOAR initiative targets mental health primary individuals where substance use is not material to diagnosis.
2) SOAR caseworker supervisors must complete the SOAR training for an introduction to SOAR and to aid in supervision.
3) Documentation of the SOAR training Certificate of Completion will be maintained in the personnel file and submitted to BBHC.
4) Providers must report data and outcomes to the BBHC SOAR Lead via SOAR Tracking PDF by the 10th of every month.
   - Number of SOAR-assisted SSI/SSDI applications;
   - Decisions on applications, including appeals; and
   - Numbers of days until applications are approved from date of application submission to date of decision.
5) SOAR trained staff must complete the online training or a qualified refresher training every three (3) years.

6) Complete and submit SOAR quarterly reports to BBHC SOAR Local Lead in alignment with the BBHC Fiscal Year, gathered from SOAR PDF Tracking submissions..
7) SOAR trained staff must attend the regularly convened local SOAR Managers and Processors meetings.

Outcomes:

1) Each dedicated SOAR caseworker is required to assist with at least 30 SSI/SSDI applications per fiscal year.
   a. Assign a Network Service Provider staff member responsible for data submission quality control;
   b. Track 100% of SOAR applications via SOAR PDF Tracking submissions.

2) BBHC-contracted agencies that provide services to CoC-funded Permanent Supportive Housing participants must use the SOAR screening tool, *Identifying SOAR Applicants*, to evaluate at least 90% of BBHC-funded PSH participants if the persons served meets any of the following criteria:
   a. Reporting zero income
   b. Working but earn less than the substantial gainful activity level
   c. Using BBHC Incidental Funds to pay for housing-related expenses (rent, utilities)

3) BBHC-contracted agencies that provide services to CoC-funded Permanent Supportive Housing participants must assist 90% of PSH participants who are determined SOAR eligible based on the screening tool to apply for SSI/SSDI.

4) Require all Providers which serve the target population to:
   a. Complete all SSI/SSDI applications within 60 days of the protective filing date, defined as the time when an applicant first contacts the Social Security Administration indicating an intent to file for SSI/SSDI;
   b. If applicable, complete the appeal process for those applications which may be denied upon initial review;
   c. Maintain a minimum completion rate of 75% of applications are completed and submitted within 60 days of the Protective Filing Date;
   d. Maintain a minimum rate of 65% of submitted applications are approved on the initial submission; and
   e. Achieve a negotiated minimum quarterly target for completed SSI/SSDI applications that is determined and agreed on by both parties.

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XXVII. School Behavioral Health Services Program (SBHSP)

The School Behavioral Health Services Program (SBHSP) is a collaboration between the Broward Behavioral Health Coalition, Inc. (BBHC) and the School Board of Broward County (SBBC). This program aims to improve behavioral health outcomes for Broward County's students and their families by strengthening connections within the community through the use of developmentally appropriate and individualized behavioral health services. BBHC strives to foster an innovative, person-specific approach and collaborative model of care to meet the needs of the students and their families. The criteria to receive services through the SBHSP is that a student must reside in Broward County, attend a district public school in Broward County, and be diagnosed with or suspected of meeting a behavioral health disorder criterion.

This initiative ensures that students who experience difficulties due to behavioral health issues receive effective and developmentally appropriate services to meet their needs. This initiative also increases the collaboration and communication between the behavioral health and school systems for enhanced coordination of services and support for students and their families.

Referral & Enrollment Process

In order to meet the behavioral health needs of the diverse district student population within Broward County, district students requiring behavioral health services will be identified and referred by school level or district level personnel to BBHC's Intake Coordinator, via the BBHC Online Portal.

Referral and Care Coordination Services

Upon referral from SBBC, BBHC's designated Intake Coordinator will review the referral. The Intake Coordinator will determine the necessary services required by the student, identify the best available service provider within the provider network capable of addressing the needs identified for the student and any parental preferences. The student will be assigned to the appropriate network provider via the BBHC Online Portal. The Intake Coordinator will facilitate the introduction of the student and their family to their assigned provider, who will conduct the Biopsychosocial Assessment and Evaluation Services, if needed.

Biopsychosocial Assessment and Evaluation Services

BBHC will provide all biopsychosocial assessment and evaluation services through the selected network service provider, based on the specific needs identified for the student. Assessments must be conducted by a licensed clinician or by a clinician under the supervision of a licensed clinician, based on BBHC's policy. Assessments and evaluations must be completed within fifteen (15) calendar days of receipt of the referral from the SBBC. Assessment reports must include the provider's recommendation of services required, which will be shared with the student, their family, and the student's school/referral source.

Continued Care Coordination and Continued Behavioral Health Services

BBHC's Care Coordinators will manage all referrals following completion of the assessment, coordinate any continued care needs, and continue to work with the student and family to facilitate access to the services recommended. Enrollment for these services must occur within thirty (30) calendar days from completing the assessment or evaluation. Behavioral health services rendered must be billed based on BBHC's rates when the student or their family does not have insurance

coverage through Medicaid or private insurance. Network providers must complete quarterly reports on the progress of students being served and participate in staffings for students, as necessary.

Covered Services and Rates Per Hour
See below the covered services allowed through this program. The rates will be aligned with BBHC's rates. The rates will be an attachment to each year's contract/agreement. Each rate will have its specific time allowed, for example, with assessments the rate is per hour.

1. Assessment
2. Case Management
3. In-Home and On-Site
4. Medical Services
5. Outpatient Group
6. Outpatient Individual
7. Supported Employment/Education
8. Supportive Housing/Living

BBHC or its network providers may recommend additional behavioral health services such as family counseling, multidisciplinary team treatment, and treatment planning. Providers will participate in BBHC meetings regarding the SBHSP, as necessary.

Provider will only invoice BBHC for services when the student does not have Medicaid or private insurance, and in the case where Medicaid or their insurance does not cover the specific service provided. BBHC will also allow invoicing for service denied by Medicaid or other insurance as long as it is supported by clinical documentation justifying a continued need for service. Furthermore, BBHC will allow invoicing when Medicaid or other insurance coverage has been exhausted. All the supporting documentation for these cases must be maintained in the students' files for potential audit.

Programmatic Forms
All forms will be found on the BBHC Online Portal.

1. Referral Form
2. Screening & Assessment Form
3. 4 Week Enrollment Update
4. Enrollment Admission Notice
5. Quarterly Progress Report
6. Discharge Form

Service Provider(s) Safeguarding the Confidentiality of Education Records

a. Privacy. Notwithstanding any provision to the contrary within this Agreement, a Ser- vice Provider shall:

   1. Fully comply with the requirements of Sections 1002.22, 1002.221, and 1002.222, Florida Statutes; the Family Educational Rights and Privacy Act, 20 U.S.C § 1232g (FERPA) and its implementing regulations (34 C.F.R. Part 99), and any other state or federal law or regulation regarding the confidentiality of district school student information and records; and

2. Hold any education records in strict confidence and not use or re-disclose same except as required by this Agreement or as required or permitted by law unless the parent of each district school student or a district school student aged 18 or older whose education records are to be shared provides prior written consent for their release; and

3. Utilize the education records solely for the purposes of providing products and services as contemplated under this Agreement; and shall not share, publish, sell, dis- tribute, target advertise, or display education records to any third party, and any such use shall be in full compliance with Section 1006.1494, Florida Statutes; and shall otherwise be in full compliance with Section 1006.1494, Florida Statutes; and

4. Notify SBBC's Privacy Officer immediately by telephone at 754-321-1900, and email at privacy@browardschools.com upon discovery of a hard copy breach of confidentiality of education records; and take all necessary notification steps as may be re- quired by federal and Florida law.

b. IT Security. Notwithstanding any provision to the contrary within this Agreement, a Service Provider shall:

1. Ensure that, at all times, all of Service Provider's employees who have access to any education records during the term of their employment shall abide strictly by Service Provider's obligations under this Agreement, and that access to education records is limited only to Service Provider's employees that require the information to carry out the responsibilities under this Agreement and shall provide said list of employees to SBBC upon request; and

2. Safeguard each education record through appropriate administrative, physical and technological standards to ensure that adequate controls are in place to protect the education records and information in accordance with FERPA's privacy requirements; and

3. Notify SBBC's IT Security Assistant Director by telephone at 754-321- 0300, and email at privacy@browardschools.com immediately upon discovery of an electronic breach of confidentiality of education records and take all necessary notification steps as may be required by federal and Florida law, including, but not limited to, those required by Section 501.171, Florida Statutes; and

4. Fully cooperate with appropriate SBBC employees, including SBBC's Privacy Officer and/or Information Technology employees, to resolve any privacy investigations and concerns in a timely manner; and

5. Prepare and distribute, at Service Provider's own and sole cost, any and all information breach notifications required under federal and Florida Law, or reimburse SBBC for any direct costs incurred by SBBC for doing so, including, but not limited to, those required by Section 501.171, Florida Statutes; and

6. Be responsible for any fines or penalties for failure to meet information breach notice requirements under federal and/or Florida law; and

7. Provide SBBC with the name and contact information of Service Provider's employee who shall serve as SBBC's primary security contact and who shall be available to assist SBBC in resolving obligations associated with a security breach of confidentiality of education records; and

8. Purge education records from any media once the media is no longer in use by Service Provider or is to be disposed by Service Provider; and

9. Return, at SBBC's request, all education records to SBBC (at no additional cost and in a format that is compatible with SBBC's information technology systems) upon termination of this Agreement or purge the education records in compliance with the applicable Florida Retention Schedules and provide SBBC with a written acknowledgment of said disposition. All education records remain the property of SBBC, and any party contracting with SBBC or Service Provider serves solely and only as custodian of such information pursuant to this Agreement and claims no ownership or property rights thereto.

c. Liability. Service Provider shall, for itself, its officers, employees, agents, representatives, contractors, or subcontractors, fully indemnify and hold harmless SBBC and its officers and employees for any violation of this section, including, without limitation, defending SBBC and its officers and employees against any complaint, administrative or judicial proceeding, payment of any penalty imposed upon SBBC, or payment of any and all costs, damages, judgments, or losses incurred by or imposed upon SBBC arising out of a breach of this covenant by the Service Provider, or an officer, employee, agent, representative, contractor, or sub-contractor of the Ser- vice Provider to the extent that the Service Provider or an officer, employee, agent, representative, contractor, or sub-contractor of the Service Provider shall either intentionally or negligently violate the provisions of this section or of Sections 1002.22 and/or 1002.221, Florida Statutes.

d. The obligations under this section shall survive the termination of all performance required of the Service Provider or the conclusion of all obligations existing under this Agreement, whichever is later.

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XXVIII. Family Connections Through Peer Recovery (Family-CPR) Project

The original Family-CPR project was implemented as a five-year Federal research grant awarded to BBHC in full partnership with ChildNet and the Broward County Recovery Community Organization, South Florida Wellness Network (SFWN). Due to the success of the project, BBHC and partners have sustained the project since the closing of the grant. The program uses specifically developed interventions including peer support, Motivational Interviewing, and a closely coordinated team approach to increase family based protective factors.

Identification of Families:

I. Families will be identified for referral to Family-Connections through Peer Recovery (Family-CPR) by ChildNet DCMs, Supervisors and Directors, when children have been deemed "unsafe" by Child Protection, due in part to parental SUD and/or mental health disorder.

II. Once identified the DCM, DCM supervisor, or DCM Director will determine if the family would benefit from the Family CPR peer support and family centered services, through contact with the parent. The DCM, DCM supervisor or DCM Director, contact the identified parent(s) via phone and provide a brief overview of peer support services and inquire if the identified parent(s) is/are motivated to engage in Family CPR Services.

Referral Process:

I. Once affirmative parental engagement to participate in Family-CPR is identified, ChildNet is to complete the Family CPR referral form in Cognito using the link below, and upload the Case Opening Document as well as the Dependency Case Manger Assignment Form, and email Scleek@BBHCflorida.org to report a referral has been made.

https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/FamilyCPRRequestForPeerServices

II. Within 48 business hours of email and referral receival, BBHC Family CPR team will review documents.

III. If referral meets Family CPR criteria, BBHC will email the Family CPR referral form and supporting documentation to:
   a. The Provider—
      1. The Provider then processes the referral.
      2. The Provider is then responsible for contacting DCM and/or DCM supervisor to facilitate the completion of the referral.
      3. Upon Peer initial contact with referred parent, peer with notify BBHC Family CPR team and DCM team, via email, to provide date of successfully completed contact.

BBHC Clinical & Operational Oversight Meetings:
Regularly scheduled meetings where all families are discussed in a structured way. For any families requiring more than 15 minutes to review, a separate meeting will be scheduled.
Family CPR Peer(s) role;

a. The assigned peer will attend Family-CPR clinical oversight meetings with all DCM teams when assigned to work with families on the DCM caseload. If a Family-CPR peer is unable to attend a clinical meeting or staffing, they will email: DCM, DCM supervisor and BBHC.
b. To be reviewed by team during meetings:
    1. MI Fidelity Check- Family CPR Project Director, will assist with assessment of current participant Stage of Change utilizing behaviorally specific information provided by Family CPR Peer. PD will review MI techniques, skills, and mindset for the current SOC, with Family CPR Peer.
    2. BARC-10 Fidelity Check—PD and Peer will review BARC-10 for the purposes of ensuring an ongoing assessment of strengths and gaps in each dimension is occurring, between Family CPR Peer and participant, to promote participant insight as to the external and internal resources available to help in recovery thereby increasing participant access to valuable opportunities.
    3. Recovery Capital Fidelity Check—PD and Peer will review monthly Wellness Plans developed by participant and Family CPR Peer for the purposes of monitoring for SMART goal development, and alignment with corresponding BARC-10, as recommended by the Recovery Capital Model. Rationale: Building up recovery capital is an essential goal of peer recovery support services as they partner with individuals toward a healthier future. Individual success depends, in part, on the quality of the recovery plans they develop through that collaboration.

Dependency Case Manager Role;

a. The Dependency Case Manager (DCM) will attend monthly staffing with BBHC and Family-CPR peers. If the DCM is unable to attend said staffing, they will email: Family CPR Peer, Family CPR Peer supervisor and BBHC.
b. DCM will provide active input into the Family CPR meeting form and surrounding discussion as appropriate. Operational oversight will be provided, addressing barriers to accessing provider treatment services, and information sharing.
c. Clinical Oversight will be provided, as related to the Family CPR clinical Approach, and facilitate the completion of the Family CPR meeting form.
d. BBHC will monitor for fidelity to MI by assisting with identifying participant Stage of Change and the MI techniques, skills, and mindset for the current SOC.

Staffing Cases, Team Meetings with Providers and Family Team Meetings:
A meeting specifically scheduled to address emergent issues related to a case.

a. These meetings can be requested to BBHC by any party, DCM, Peer, Family, or treatment provider.
b. They will be scheduled based on the urgency and availability of the required participants.
c. BBHC will oversee the scheduling of these meetings. The goal will be to get as many participants as possible.

Court Hearings:

a. DCM will oversee the formal court reports.
b. Family Peers will NOT testify, as this is a real potential challenge to the inherent nature of their work with families. The only exception will be a subpoena Ducos Tecum.
c. Family Peers will attend only for emotional support for the family that requires it.

Trainings:

a. Motivational Interviewing Training
b. Substance Use Awareness within a Recovery Oriented System of Care Framework
c. Family CPR Approach Presentation

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XXIX. Power of Peers (POP)

The original POP Pilot Project was implemented based on the fact that individuals being discharged from South Florida State Hospital face many challenges. It was acknowledged that the first thirty (30) days from discharge are critical in terms of the person's successful transition to the community.

In an effort to assist with this transition, a pool of certified Peer Specialists was identified to best match the person being discharged in terms of age, sex, culture, and other factors. They began to visit the hospital resident within 30 days of discharge and develop a relationship with them. On the day of discharge, the peer meets them at their new "home" wherever that is (ALF, residential program, family home, SRO, etc.) and helps them acclimate to their new surroundings. They continue to assist the individual with whatever they need, link them to a drop-in center as appropriate or other support services, work with them to develop a WRAP Plan, and other activities of the person's choosing. Together the peer and the person served would decide how often and how long the connection would remain. This Peer Specialist becomes a "natural support" and can make a difference in how well the person succeeds in the community.

It is important that the Peer Specialists work under a licensed clinician to insure if there are any serious issues that arise, they can be addressed professionally and swiftly, particularly if clinical intervention is indicated. Regular supervision meetings are required so case issues are addressed and also to make sure that the peers are receiving clinical oversight for their own well-being.

Based on the success of this pilot program, it has been expanded to include those Baker Act receiving facilities and detoxification units funded by Broward Behavioral Health Coalition. It is anticipated that inclusion of these facilities and linkage to peers in recovery, will result in a reduction of readmissions for Baker Acts and/or detoxification.
During the course of their contacts, the Peer Specialists would also have contact with the facility staff and the case manager, if applicable to ensure communication is maintained.

Requirements of the Peer Specialists providing services:

1. Complete WRAP (Wellness Recovery Action Plan) Training within 6- months of hire.
2. Complete Peer Specialist Training to obtain certification through the Florida Certification Board within eighteen (18) months year of hire.

Following are some of the activities to be tracked:

1. Number of contacts on a weekly basis
2. Identify linkage to services/activities
3. Requests of the person discharged
4. Clinical intervention referrals
5. Supervision activities with the licensed clinician
6. Others to be determined
7. All peers funded for the Power of Peers Program are required to attend 90% of all scheduled Power of Peers Meetings set by BBHC Transition to Independence (TIP)

Guidance: Florida Department of Children and Families Substance Abuse and Mental Health Program (DCF-SAMH): Florida Peer Services Guidance Handbook
https://www.myflfamilies.com/service-programs/samh/publications/docs/peer-services/DCF-Peer-Guidance.pdf

XXX. Transitional to Independence Process (TIP) Broward TIP Collaborative

THE BROWARD TIP COLLABORATIVE was developed in 2016 as a result of the expansion of TIP services across funders in Broward County (County, BBHC, CSC). This Collaborative provides a venue for peer-to-peer learning, ongoing coaching, and implementation guidance for professionals who are committed to implement the TIP Model for transition-aged youth experiencing mental health and co-occurring issues. Participating providers will learn to do the TIP Model with a high degree of skill and fidelity. Transition Facilitators (i.e., Wellness Coaches or other similar job title) will improve their ability to engage youth and emerging adults through relationship development and TIP core practices. The Collaborative will meet quarterly to provide support for agencies.

TIP Quality Assessment Reviews

TIP providers must participate in the TIP Model Quality Assessment Reviews when notified by BBHC. Providers who perform well on these quality assessment reviews will not need another review until 3 years later. Those providers who do not perform well on these reviews will need a follow-up review within 9-12 months to ensure continued improvement.

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XXXI. One Community Partnership 4 (OCP4)

One Community Partnership 4 (OCP4) System of Care grant focuses on children ages 4-11 years old who are at risk of or have been diagnosed with a serious emotional disturbance (SED) along with their families/caregivers. OCP4 aims to expand mental health screenings for these children for early identification of behavioral health needs. Children who are identified as having a behavioral health need and their families are referred to developmentally appropriate supports based on their individual needs. OCP4 will train VPK and School Mental Health staff on the Pediatric ACEs and Related Life Events Screener (PEARLS) and the Strengths and Difficulties Questionnaire (SDQ) so that screening can take place sustainably after OCP4 sunsets.

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XXXII. Supported Employment/ Individual Placement and (IPS)

Individual Placement and Support (IPS) is a model of supported employment/education designed for people with serious mental illness. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment. IPS includes mainstream education and technical training as ways to advance career paths. IPS relies on the following principles:

- Zero exclusion
- Competitive employment
- Rapid job search
- Systematic job development
- Integrated Services
- Benefits Planning
- Time unlimited supports
- Worker preferences

Providers must provide services to transition-age youth from TIP providers as part of the OCP3 initiative if applicable. Organizations providing IPS services must meet fidelity by adhering to the Supported Employment Fidelity Scale found on the https://ipsworks.org website. Providers agree to attend relevant OCP3 committees, participate in monthly consultation sessions with
BBHC staff and participate in training as scheduled. Providers must enter all services into the portal using the Supported Employment code.
IPS Team:
Providers will develop a supported employment team comprised of:

1 IPS Supervisor per 10 employment specialists:

- Provides oversight to the IPS supported employment program. Ensures good program outcomes through training, supervision, and field mentoring. Attempts to meet most people who receive IPS services. Monitors outcomes and implements quality improvement plans.
- Acts as a liaison to other departments and agencies. The supervisor provides supervision to no more than ten employment specialists. Provides IPS supported employment services for a caseload of no more than eight people (only if there are no supervisory duties outside of IPS).

2 Employment Specialists:

- Provides all phases of employment services to a caseload of no more than 20 individuals, including intake, engagement, assessment, job placement, job coaching, and follow-along support to assist clients in obtaining and maintaining employment that is consistent with their vocational goals.
- Vocational Peer (optional): assist persons served in developing coping and problem-solving strategies for illness self-management before and doing employment; draw on lived experiences and empathy to promote hope, insights, and skills; help engage in treatment and employment/educational plans, and access community supports.

Referral Process for Providers Providing IPS Services Externally:

Providers that are serving individuals externally within BBHC's provider network ensure that the referral source completes the following forms in Cognito: referral forms, the extension for service request forms for the continuation of services, and discharge forms.

IPS Data Reporting:
IPS rosters must be submitted monthly to BBHC by the 5th of every month. IPS providers registered with the National IPS Center's web portal must enter IPS data by the 10th day after each quarterly.

IPS Training and Technical Assistance:
Providers are required to attend all training and meetings and ensure that any new staff take the IPS supervisor or practitioner skills online course on the www.IPSWorks.org website, and submit monthly rosters, monthly caseload report, and any annual reports as requested from BBHC.
Providers will develop their own internal IPS Steering Committee, which consists of the IPS team, leadership staff, and community stakeholders (e.g., other community providers and community employers) to help plan and monitor IPS Supported Employment implementation and sustainment. BBHC will participate in each organization's steering committee as per toolkit implementation recommendations to ensure collaboration and sustainability. IPS Supervisors and a representative from IPS provider agencies are required to attend BBHC's quarterly IPS Learning Community meetings.

Visit the IPS Center's website www.IPSworks.org for more information about the steering committee.

Vocational Rehabilitation Contract:
All IPS Providers must submit an application to the Vocational Rehabilitation for a supported employment contract within the first six months of implementing the IPS model to maximize funding for necessary employment services (e.g., school tuition payment, dental services, books).

IPS Fidelity Reviews:
Providers are to coordinate a fidelity visit with BBHC's IPS designated fidelity reviewers for their baseline review after six-months of implementation. The fidelity reviewers will utilize the IPS 25-item quality improvement tool (refer to the IPS Center's fidelity scale) to assess the IPS program's performance. Providers need to achieve a Fair Fidelity score after six-months of implementation. The fidelity reviewers will provide a finalized report with the results 60-days after the initial fidelity visit. Providers who achieve Fair Fidelity will continue to be annually assessed (as applicable) by BBHC's fidelity reviewers and must maintain a Good Fidelity score after the first annual fidelity review. Providers who fail to score Fair Fidelity on their baseline review will undergo another six-month fidelity assessment to measure the quality of improvement. Providers are required to adhere to the IPS program's fidelity via the fidelity scale found at www.IPSWorks.org, adhere to the Continuous Quality Improvement and Program Evaluation Process.

IPS Outcomes/Indicators:
BBHC's clients will receive individualized IPS services (job coaching, interview skills, and resume preparation). IPS providers must meet the following outcomes:

- 75% of people served for a minimum of 30 days will receive an individual career profile
- 65% of people served will have secure employment at the time of discharge from the IPS program

- 75% of program graduates will remain gainfully employed for at least one month after discharge from services
- Providers delivering IPS services will maintain a minimum annual competitive employment rate of 55 % -75%.

Other Supported Employment

Providers receiving funding for supported employment services must submit all reports requested by DCF to BBHC on the 10th of the month following the reporting period unless otherwise specified. BBHC may ask for revisions to reports, and providers are responsible for resubmitting all reports after correction.

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XXXIII. Supportive Housing (PSH)

The BBHC-funded Supported Housing (SH) program was created in 2016 to expand independent living opportunities in the community for persons served within the Substance Abuse and Mental Health (SAMH) System of Care in Broward, who otherwise may be limited to housing placement in a congregate living arrangement, discharging to homelessness, or dependent living without the option to reintegrate into the community. Offering the resources and supports to obtain and retain participant-chosen independent living opportunities with full tenancy rights, paired with community-based services determined by the participant are supported by the service providers across multiple systems of care.

Adults, ages 18 years old and above, who have a mental health and/or co-occurring diagnosis can and meet the target population's admission criteria may be referred to both Archways and Henderson Behavioral Health for placement in a BBHC-funded SH program. Currently, BBHC provides funding to support 10 participants in Archways' SH program and 83 participants in Henderson Behavioral Health's SH program. The Henderson SH program includes funding to support 33 One Community Partnership-enrolled young adults, in their SH program. Henderson Behavioral Health maintains the role of the housing provider and the TIP providers maintain the responsibility of providing participant-driven supportive services to assist with housing retention and the participant's wellness and recovery for those that are enrolled in the young adult program. There is also funding for 50 adult participants within the 83 total available spots.

Referrals for both Archways and Henderson Behavioral Health can be submitted by both inter-agency service providers and outside-agency service providers within the community.

Organizations providing SH services must meet fidelity by adhering to the Permanent Supportive Housing Evidence-Based Practices (EBP) KIT fidelity scale on SAMHSA website.

Providers agree to attend relevant OCP committees, participate in monthly consultation session with BBHC staff, provide rosters on clients served as requested, and participate in TIP Solutions Review calls as scheduled. All services must be entered into the Carisk Partners portal using the Supportive Housing Code.

TARGETED POPULATION(S):

- Individuals who do not meet the Federal HUD Definition of Homeless, Category 1 (Literally homeless) or Category 4 (Currently fleeing domestic violence); and are therefore not eligible for Homeless Continuum of Care assistance.
- Individuals who are exiting a Residential Treatment Facility and who lack the resources and supports necessary to obtain housing in the community.
- Individuals who are currently residing in a Recovery Residence.
- Individuals who are housing insecure or have not maintained a lease in their own name within the last 60 days and lack the resources and supports to secure a lease in their own name.
- Individuals who are at-risk of homelessness.

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XXXIV. BBHC Housing Initiative

BBHC began implementing its Housing Initiative as part of a state requirement from DCF for all Managing Entities, hence all BBHC housing program will abide by **Guidance 21 - Housing Coordination**.

Mission: to address accessibility, sustainability, and wrap-around supports for persons with mental illness and substance use issues who are homeless, at-risk of homelessness or are exiting institutional care and need on-going supports to live independently.

Purpose:

- Increase and improve collaboration and coordination with COC, Florida Housing Finance Corporation (FHFC), and other key state and local agencies as they relate to housing-related services;
- Find safe, affordable, stable housing for individuals with mental health and/or co-occurring diagnoses;
- Ensure that these individuals receive the necessary support services to be successful in the community; and
- Increase the number of discharges from state mental health treatment facilities to stable community housing in lieu of discharges to community crisis stabilization units, to addiction receiving facilities, or to placements increasing the risk of subsequent homelessness.

PROVIDER REQUIREMENTS:

- Only Hospitals, CSUs, CRSs and Detox Providers are currently required to submit referrals per initiative requirements; training is being provided to eligible RTFs for further expansion.
- Providers must ensure that all eligible clients are screened upon intake and the policies below are followed.
- Referrals are only accepted from BBHC-trained staff who maintain familiarity with the Behavioral Healthcare & CoC Homeless Housing Systems Integration process, HUD Homeless Definitions, and utilization of the VI-SPDAT ("Vulnerability Index- Service Prioritization Decision Assistance Tool") Training - Single Adult, Youth, and Family.

Referral Process

1. Referrals must be sent to BBHC within 24 hours of completing the housing referral packet:
    a. Faxed to BBHC at 954-332-1476
    b. Encrypted e-mail to: housing@bbhcflorida.org
    c. Via Cognito Forms Link: https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/HousingReferralEligibilityChecklist2
2. The Director of Housing and SOAR Entitlements or BBHC Housing Specialist will enter the data into HMIS within 48 hours of receiving the referral.
3. The Director of Housing and SOAR Entitlements or BBHC Housing Specialist will provide the referring agency with a confirmation e-mail detailing that the applicant is entered into HMIS.
4. Individuals that do not meet **both** the HUD definition of homeless *and* behavioral health criteria are not to be referred.
5. Only individuals who meet the criteria for Categories 1 or 4 of HUD's definition of homeless will be entered into the CoC's HMIS system.
6. Incomplete referral packets will not be accepted.

BBHC's ROLE: Through this initiative, BBHC has hired a Director of Housing and SOAR Entitlements to support implementation and technical assistance for the network. The Director of Housing and SOAR Entitlements or BBHC Housing Specialist will:

1. Evaluate applications, confirming eligibility according to HUD's definition of homeless categories.
2. Refer to SOAR Coordinator if individual meets criteria for further SOAR screening.
3. Search for referred applicant in HMIS prior to entering data, ensuring no duplication.
4. Verify documentation of homeless history in HMIS.
5. Enter applicant data into HMIS, initiating referral to the CoC for individuals who meet Category 1 or Category 4 of HUD homeless definition.
6. Track applicants who meet Category 2 or Category 3 of HUD homeless definitions in an internal BBHC database.
7. Refer Category 2 and 3 individuals to agencies that provide homeless prevention funding and services.
8. Track applicant through treatment, advising discharge planner or social worker of 80, 60 and 30-day time limitations prior to discharge from institutional care facility
    - Ensure length of stay does not exceed 89 days, unless medically necessary.
9. Link applicant to primary behavioral health case manager during stay at institutional care facility.
10. Communicate status of applicant to CoC's Chronic Workgroup, providing updates throughout duration of care
11. Comply with HUD's recordkeeping requirements by utilizing BBHC's data management system to document admission to and discharge from care facility in HMIS
12. Investigate homeless episode prior to facility entry (i.e.: police records, outreach, etc.)
13. Provide follow-up six months and one-year after exiting facility

Please refer to the Housing Manual on the BBHC website for full details. https://bbhcflorida.org/housing-initiative/

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XXXV. Short- Term Respite Program (Substance Use or Co-Occurring)

Purpose: Short- Term Respite Program is designated for Substance Use or Co-Occurring individuals:

1) who have relapsed on substances and need a safe place to stay for a short time;
2) those who require a short gap for transitional or residential treatment facility (RTF/ALF) placement;
3) are in transit to court ordered program **and** the designated aftercare location is already identified.

Capacity: Minimum 20 beds

Duration: 0-14 days. Anticipated length of stay is 72 hours per individual. Extended stay may be approved on an individual basis.

Exclusions: No one in a medical crisis, all individuals must be able to manage their ADLs independently.

Procedure:

1. The referring BBHC Network Provider must submit the Short-Term Respite form using the Cognito link below:

Fellowship:
https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/bbhcrespitebedrequestapprovalform

- Call phone number 754-757-9147
- 24 hours a day to complete required phone assessment.

Note: The aftercare location verification must be uploaded to the request form.

Verification of the Aftercare Plan Include:

- **Residential Treatment Facility (RTF)-** authorization uploaded with admission date.
- **FARR Recovery Residence-** email verifying eligibility to Return or Admission date.
- **Assisted Living Facility-** email verifying eligibility to Return or Admission date.
- **Family/Friend-** email verification with date to return to family/friend and contact information.

2. BBHC will provide disposition to request and send back to the referring BBHC Network Provider within 48 business hours or less. If the request is approved, The Provider will be copied on the email. The referring BBHC Network Provider is responsible for bringing the BBHC Approval Authorization with the individual upon admission.

Program Expectations:

Individuals who are accepted into the Respite are given the opportunity to stay in a safe and sober housing environment; to continue working on their recovery program, they will be provided with Peer Recovery Support Services (PRSS). The peers provide emotional, informational, instrumental support, to include but not limited to: peer mentoring and peer-led support groups. Job information sharing, connecting clients with social health services and other resources, recovery navigational support, life skills workshops and much more. Individuals are expected to be engaged in the daily activities at the respite, which will continue to evolve as the population grows.

- Once at the respite, belongings will be safe-guarded and only necessities will be permitted, to include extra clothing, recovery literature, etc.
- Individuals should only leave the property with a verified scheduled appointment and with accompaniment, unless coordinated with notice.
- Cellphones will not be permitted. Individuals will be able to make a short phone call at scheduled times.
- If the person has prescribed medication, Respite staff will store the medication in the designated secured/locked location and provide medication oversight with documentation.
- Urinalysis and Breathalyzer will be performed upon intake and documented.
- Respite Staff member will complete the basic intake packet with the individual.
- Provider staff must accompany individual to any appointments outside of the Respite Program while residing on the premises.
- Breakfast, sandwich lunch, and dinner is provided.

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XXXVI. MH Respite Services Program Summary

Mental Health Respite Housing is designated for individuals living with a Mental Health/or Substance Use diagnosis and:

- Who are being discharged from an Acute Care Unit, CSU or Residential Program that need a safe place to stay for a short period of time. Have relapsed on substances and need a safe place to stay for a short time.
- Require a short gap for transitional or residential treatment facility (RTF/ALF) placement and/or;
- Are in transit to a court ordered program **and** the designated aftercare location is already identified.

Exclusions: No one in a medical crisis. All individuals must be able to manage their ADLs independently.

SCOPE OF SERVICES

- The Respite Housing can provide short-term respite services for up to 30 days, contingent on BBHC authorization. The anticipated length of stay is 30 days, per individual. Extended stay may be approved on a case-by-case basis. Individuals will be provided with three meals per day, linens (bedding and towels), laundry facilities, and hygiene products.
- The Respite Housing providers will participate in BBHC trainings to best serve participants in the BBHC network.
- The Respite Housing providers will submit daily census to BBHC's Housing Coordinator or designated BBHC staff.
- The Respite Housing Providers will provide oversight and support for community services. There will be access to Peer Recovery Support Services (PRSS). The peers provide emotional, informational, instrumental support, to include but not limited to the following: peer mentoring, peer-led support groups, job information sharing, connecting clients with social health services and other resources, recovery navigational support, life skills and much more.

PROCEDURE

- The Network Provider submits the Respite Request using the Cognito link and it will electronically be sent to the designated BBHC Housing Coordinator for review.
  Cognito Link- Homes United:
  https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/bbhchomesunitedmentalhealthrespiteform

The aftercare location verification must be identified in the request.

Verification of the Aftercare Plan include:

- **Residential Treatment Facility (RTF)**: Anticipated date of admission
- **FARR Recovery Residence**: E-mail verifying eligibility to Return or Admission date
- **Assisted Living Facility**: E-mail verifying eligibility to Return or Admission date
- **Family/Friend**: Email verification with date of return to family/friend and contact information for the individual.

BBHC will provide disposition to request and send back to the referring BBHC Network Provider within 48 business hours or less. If the request is approved, the Respite Provider will be copied on the e-mail. The referring BBHC Network Provider is responsible for bringing the BBHC Approval Authorization with the individual upon admission.

The Respite Provider will submit a daily census to support the admission disposition process to: wking@bbhcflorida.org or designated BBHC staff.

The Respite Provider will submit the monthly invoice to wking@bbhcflorida.org or designated BBHC staff by the 5th of the following month for processing. BBHC will manage the census for the Respite Housing Program.

EXPECTATIONS

- Clients are expected to be engaged in the daily activities at the respite, which will continue to evolve as the population grows.
- Once at the respite, clients' belongings will be searched and only necessities will be permitted (include extra clothing, recovery literature, etc.)
- Respite Staff members will complete the basic intake packet with client.
- Breakfast, sandwich lunch, and dinner will be provided.
- Clients will not be permitted to leave the property.
- Cellphones will not be permitted without authorization from the Respite housing providers.
- Clients will be able to make a short phone call at scheduled times.
- If client has prescribed medication, Respite staff will provide locked storage and store the medication in the designated secured/locked location and provide medication oversight with tracking documentation.
- While clients are residing in the respite housing program, BBHC Network Providers must accompany and/or assist in coordination for individuals to any appointments outside of the Respite Program.

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XXXVII. Transitional Housing Program Summary

The Mental Health Bridge/Transitional Housing Program is designated for housing homeless individuals who:

- Are living with Mental Health Diagnosis and/or a co-occurring diagnosis.
- May need a safe place to stay while transitioning to community living.
- Require a short gap of housing funding to continue the pathway to Treatment allowing the individual to become independently financially self-sufficient.

Exclusions: No one in a medical crisis. All individuals must be able to manage their ADL's **independently.**

Scope of Services:

Bridge/Transitional housing may assist individuals for 1 to 6 months or longer based on a case-by-case basis and is contingent upon BBHC authorization. The anticipated length of funding is 1 to 6 months, per individual. Extended stay may be approved on a case-by-case basis.

1. Individuals will be provided with technology, if needed, to participate in substance use/ or Mental Health Treatment per their community treatment provider and aftercare plan. Assistance may include: an office or designated area with a computer to participate in therapeutic groups, individual therapy or other appointments.
2. A Food pantry, and assistance with linens (bedding and towels), laundry facilities, and hygiene products, if needed.
3. The Bridge/Transitional Housing Providers will participate in BBHC trainings to best serve participants in Bridge/Transitional Housing Program.
4. The Bridge/Transitional Housing providers will provide a monthly census to BBHC's Housing Coordinator or designated BBHC staff.
5. The Transitional Housing providers will provide access to Peer Recovery Support Services (PRSS). The peers provide emotional, informational, instrumental support, to include but not limited to the following: peer mentoring, peer-led support groups, job information sharing, connecting clients with social health services and other resources, recovery navigational support, life skills workshops and much more.

PROCEDURE

The Network Provider will submit the Bridge/Transitional Housing Request using the Cognito link below and it will electronically be sent to the designated BBHC Housing Coordinator or designated staff for review.

Cognito Links:

Homes United:
https://www.cognitoforms.com/BrowardBehavioralHealthCoalition/BBHCHomesUnitedTransitionalHousingOrBridgeTransitionalForm

1. The aftercare location verification must be identified in the request. Verification of the Aftercare Plan include:

The treatment provider and services for the individual to continue Substance Use/Mental Health Treatment.

- **Residential Treatment Facility (RTF)**: Anticipated date of admission
- **FARR Recovery Residence**: E-mail verifying eligibility to Return or Admission date
- **Assisted Living Facility**: E-mail verifying eligibility to Return or Admission date
- **Family/Friend**: Email verification with date of return to family/friend and contact information for the individual.

2. BBHC will provide disposition to request and send back to the referring BBHC Network Provider within 48 business hours or less. If the request is approved, The Transitional Housing Providers will be copied on the e-mail. The referring BBHC Network Provider is responsible for bringing the BBHC Approval Authorization with the individual upon admission.

The Bridge/Transitional Housing Provider will submit a daily census to support the admission disposition process to: wking@bbhcflorida.org or designated BBHC staff.

3. The Bridge/Transitional Housing Provider will submit the monthly invoice to wking@bbhcflorida.org or designated BBHC staff by the 5th of the following month for processing or provide a copy of the invoice to the appropriate network provider for processing depending on agreements. BBHC will manage the census for the Bridge/Transitional Housing Program.

EXPECTATIONS

A. Clients are expected to be engaged in the daily activities while residing in Transitional Housing.
B. The Bridge/Transitional Housing clients' belongings maybe searched and only necessities will be permitted (include extra clothing, recovery literature, etc.)
C. The Bridge/Transitional Housing Staff members will complete the basic intake packet with client.
D. Food and other necessities are the responsibility of the individual. However, needs may be assessed and coordinated by the Bridge/Transitional Housing providers and network providers on a case-by-case basis.
E. Clients will be able to participate in their treatment, including access to a computer to participate in the virtual groups, individual therapy, or other appointments, if needed.
F. While clients are residing in the Bridge/Transitional Housing program, BBHC Network Providers must identify the treatment appointments designated for the individual.

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XXXVIII. BBHC Care Coordination

BBHC began implementing the Care Coordination Program as part of a state requirement from DCF for all Managing Entities and will abide by **Guidance 4 - Care Coordination**.

PURPOSE AND GOALS

Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person's overall well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is adequately connected to the care that meets their needs.

The short-term goals of implementing Care Coordination are to:

- Improve transitions from acute and restrictive to less restrictive community-based levels of care;
- Increase diversions from state mental health treatment facility admissions;
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and
- Focus on an individual's wellness and community integration.

The long-term goals of implementing Care Coordination are to:

- Shift from an acute care model of care to a recovery model; and
- Offer an array of services and supports to meet an individual's chosen pathway to recovery.

PRIORITY POPULATIONS

Pursuant to s. 394.9082(3)(c), F.S., the Department has defined several priority populations to potentially benefit from Care Coordination. Managing Entities and provider agencies are expected to utilize at least 50% of allocated funds in OCAs MH0CN and MS0CN to serve the following populations.

1. Adults with a serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. For the purposes of this document, high utilization is defined as:

    a. Adults with three (3) or more acute care admissions within 180 days, or
    b. Adults with acute care admissions that last 16 days or longer, or
    c. Adults with three (3) or more evaluations at an acute care facility within 180 days, regardless of admission.
    d. Has a SMI or SUD Diagnosis and a history of multiple arrests, involuntary placements or violations of parole that led to institutionalizations or incarceration.

2. Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.

The Department has defined additional populations to benefit from Care Coordination using funds in OCAs MHCAS and MSCAS.

Under OCA MHCAS:

1. Children and parents or caretakers in the child welfare system with behavioral health needs, including adolescents, as defined in s. 394.492, who require assistance in transitioning to services provided in 4 the adult system of care.
2. Children and adolescents with a mental health diagnosis, SUD, or co-occurring disorders who demonstrate high utilization. For the purposes of this document, high utilization is defined as: children and adolescents under 18 years of age with three (3) or more admissions into a crisis stabilization unit or an inpatient psychiatric hospital within 180 days, including:
    a. Children being discharged from Baker Act Receiving Facilities, Emergency Rooms, jails, or juvenile justice facilities at least one time, who are at risk of re-entry into these institutions or of high utilization for crisis stabilization.
    b. Children and adolescents who have recently resided in, or are currently awaiting admission to or discharge from, a treatment facility for children and adolescents as defined in s. 394.455, which includes facilities (hospital, community facility, public or private facility, or receiving or treatment facility) and residential facilities for mental health, or co-occurring disorders.
3. Children not currently receiving services by a CAT Team.

Under OCA MSCAS:

1. Families with infants experiencing or at risk for Neonatal Abstinence Syndrome or Substance Exposed Newborn.

The following populations may receive Care Coordination from the remaining balance of OCAs MS0CN and MH0CN allocated funds with Department Regional Office approval.

1. Persons with a SED, SMI, SUD, or co-occurring disorders who are involved with the criminal justice system, including: a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.
2. Caretakers and parents with an SMI, SUD, or co-occurring disorders considered at risk for involvement with child welfare.
3. Individuals identified by the Department, Managing Entities, or Network Service Providers as potentially high risk due to concerns that warrant Care Coordination.

Care Coordination under these OCAs cannot be provided to individuals enrolled in the following team-based services FACT, Coordinated Specialty Care for Early Mental Illness, CAT, FIT, Comprehensive Community Service Teams, Forensic Multidisciplinary Teams, and any other local multidisciplinary treatment teams that include case management.

If necessary, Managing Entities and Network Service Providers may implement a time-limited transition plan for individuals in the process of connecting to a case manager or team-based services that includes case managers (excluding Dependency Case Management and medical case management). The transition must ensure Care Coordination may not exceed 90 days during which time both a case manager and a care coordinator may provide services to the same individual unless a longer duration is specifically approved by the Department. The transition plan shall be designed to ensure a warm hand-off and successful case management engagement.

NETWORK SERVICE PROVIDER RESPONSIBILITIES

1. Assess organizational culture and develop mechanisms to incorporate the core values and competencies of Care Coordination into daily practice.

2. Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.

3. Serve as single point of accountability for the coordination of an individual's care with all involved parties (i.e., criminal or juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).

4. Engage the individual in their current setting, such as the crisis stabilization unit (CSU), SMHTF, homeless shelter, detoxification unit, etc. Individuals served should not be expected to come to the care coordinator.

5. Develop a care plan with the individual based on shared decision-making that emphasizes self-management, recovery and wellness. This must include transition to community-based services and/or supports.

6. Provide frequent contact within the first 30 days of services, which could consist of visits daily to three times per week. This includes telephone contact or face-to-face contact (which may be conducted electronically). Leaving a voicemail is not considered contact. If the individual served is not responding to attempted contacts, the provider must document this in the clinical record and make active attempts to locate and engage the individual.

7. Provide 24/7 on-call availability.

8. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.

9. Assess the individual for eligibility of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Veteran's Administration benefits, housing benefits, and public benefits, and assist them in obtaining eligible benefits. When applying for SSI or SSDI benefits, providers must use the SSI/SSDI Outreach, Access, and Recovery (SOAR) application process. Free training is available at: https://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training.

10. For individuals who require medications, ensure linkage to psychiatric services within 7 days of discharge from higher levels of care. If no appointments are available, document this in the medical record and notify the managing entity.

11. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.

12. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.

13. Notify the Managing Entity of individuals identified for Care Coordination from the priority population specified in section II.1.c

CARE COORDINATION ALLOWABLE COVERED SERVICES

Care Coordination is a bundled service approach that is reported through an expenditure Other Cost Accumulator in accordance with Pamphlet 155-2. Pursuant to Ch. 65E-14.014, F.A.C., providers may not bill for services for individuals who have third party insurance coverage when the services provided are paid under the insurance plan or recipients of Medicaid, or another publicly funded health benefits assistance program, when the services provided are paid by said program. The following is a list of allowable covered services as defined in Ch. 65E-14.021, F.A.C.

a. Outreach
b. Assessment
c. Crisis Support/Emergency
d. Recovery Support
e. Supportive Housing
f. Intervention

For additional information, please refer to DCF **Guidance 4, Care Coordination.**

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Care Coordination Teams

The provider agencies will provide transition services through their Care Coordination Teams. Critical Time Intervention (CTI) will be one of the evidenced-based practices utilized to effectively transition individuals from higher levels of care. Care Coordination Teams will provide an Intensive Case Management Team approach in conjunction with the BBHC Care Coordinator, which will focus on the individuals' needs, determine level of care, link with existing and newly identified services and supports. The Care Coordination Team will consist of a licensed clinician, an intensive case manager, and a peer specialist. The caseload of each team will range between 15-20 clients. The teams will conduct weekly treatment team meetings and will provide assessment/clinical services, intervention/crisis support, case management, and peer support. The services provided by the Care Coordination Teams are time-limited, with a heavy concentration on educating and empowering the person/family served, engaging and getting to know the person's needs and natural supports, and providing a single point of contact until a person is adequately connected to the ongoing care that meets their needs. The Care Coordination Teams will be available 24/7 for crisis issues.

The Critical Time Intervention Model (CTI) is the evidenced based practice used for the Care Coordination program. The characteristics of this model include:

Principles of CTI:

1. Focuses on a critical transition period and is time-limited.
2. Enhances continuity of care, aims to prevent recurrent homelessness, incarcerations and placement in higher levels of care such as hospitals, receiving facilities, crisis stabilization, inpatient facilities, detox, etc.
3. Identifies and strengthens formal and natural community supports.
4. Complements rather than duplicates existing services.

Phases of CTI and Treatment Planning:

- Pre-CTI: Services begin before an individual is discharged from their placement and to establish an initial relationship before the transition begins.

- Phase 1: Transition to the Community – Frequent contact with the individual in the community, focus on engaging individual with services, identifying and addressing housing-related issues in order to prevent homelessness or housing instability. A transition plan is implemented while providing emotional support.
    - Complete CTI Phase Plan & Treatment Plan Form – At the beginning of phase 1. Treatment plans should be completed within two weeks of authorization.
    - Specify goals, reason and strategies for goals for the corresponding CTI phase.
    - Complete ongoing progress notes documenting interactions with client. Discharge planning discussion should occur throughout the phases.
    - Complete the Summary of Goals form within two weeks prior to the second phase indicating status of goals for Phase 1.
    - Complete LOCUS
    - Participate in Utilization Review

- Phase 2: Tryout – The team encourages individuals to manage problems independently after connecting them to supportive services.
    - Complete CTI Phase Plan & Treatment for Phase 2
    - Specify goals, reason and strategies for goals for the corresponding CTI phase

- Complete ongoing progress notes documenting interactions with client. Discharge planning discussion should occur throughout the phases.
- Complete the Summary of Goals form within two weeks prior to the third phase indicating status of goals for Phase 2.
- Complete LOCUS
- Participate in Utilization Review

- Phase 3: Transfer of Care - Promotes transfer from CTI to other formal and informal community supports and termination of CTI services occurs once a support network is safely in place.
  - Complete CTI Phase Plan & Treatment for Phase 3
  - Specify goals, reason and strategies for goals for the corresponding CTI phase
  - Complete ongoing progress notes documenting interactions with client.
  - Complete the Summary of Goals form within two weeks prior to the end of the third phase indicating status of goals for phase 3 and while enrolled in the Care Coordination program.
  - Complete LOCUS
  - Document client outcome and transition from the team including documentation of a warm hand-off meeting at the next level of care.
  - Discharge

Services Provided per Treatment Phase

Phase 1/Months 1-3:

Using CTI, The Care Coordination Team provides assessments of individual needs, develops and implements an individualized treatment plan of service to meet those needs. During this period, the Care Coordination Team frequently engages with the individual making home visits, providing services such as introducing the individual to providers, meeting with caregivers, and helping the individual access and connect with service providers that can potentially be a part of their support system. Focus is on meeting the individuals' immediate needs such as housing, food, medical care, medication management as well as therapeutic services. Individual is accompanied when connecting to with community providers and receives assistance accessing benefits (Medicaid, Disability, etc.).

Phase 2/Months 4-6:

Using CTI, The Care Coordination Team will again assess the individual and continue to support the individuals' engagement and participation in services. The individuals' ability to use problem-solving skills to navigate independently is assessed. As needed, case management, community-based visits and services is provided along with psychoeducation about becoming independent and being able to self-manage and navigate community services. The Care Coordination Team begins to decrease the intense level of services provided during months 1-3. There are less frequent meetings, problem solving, and troubleshooting is provided along with crisis interventions as needed.

Phase 3/Months 7-9:

Using CTI, The Care Coordination Teams assess the individual's level of functioning and readiness for discharge from the Care Coordination Team. The Care Coordination Team continues to remain available to help the individual problem solve and utilize providers and natural support systems. During this period, the individual along with their providers and natural supports will agree on a long-term support system and plan in order to help the individual remain stable in the community. Prior to discharge a final meeting is held to recognize the individual achievements and the ongoing plan that has been agreed upon.

Reports:

A. Care Coordination monthly census is due to the BBHC Care Coordinator by the 5th of the month.

B. The Care Coordination provider waitlist and screening list is due to the BBHC Care Coordination Manager weekly on Fridays by 12 PM.

For additional information, please refer to **DCF Guidance 4, Care Coordination**

For additional information, please refer to the **BBHC Care Coordination Manual**.

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XXXIX. Peer Navigation Program

Purpose and Goals:
The Peer Navigation Program was implemented in response to the statewide initiative, called 4DX, which includes a goal to reduce recidivism for individuals, admitted to an acute care, crisis stabilization, or detoxification unit by. This program includes embedding a Care Coordination Team (CCT) Peer Navigator daily into each high level of care unit funded by BBHC. The CCT Peer Navigator will be introduced as a part of the treatment team and provide recovery-oriented education and support of peer services available in the community.

Eligibility Criteria:
The CCT Peer Navigator, unit treatment team, and BBHC will work closely as a team with a focus to provide support to individuals who are experiencing their first or second admission to each unit, along with those who are considered high utilizers of care to engage and provide short term support and to bridge the connection to after care upon discharge. The CCT Peer Navigator will be a support to the existing Power of Peers (POP) initiative, which has been providing community-based peer support with a longer duration of services, which began with the high utilizers.

The CCT Peer Navigator will work in collaboration with the inpatient units using a care coordination approach in assessing and assisting individuals to:

Identify their needs and to obtain and maintain self-sufficiency
Complete and maintain the recovery capital scale assessment to engage and collaborate with individuals.
Assist to establish goals that facilitate self-empowerment.
Work in partnership with other programs to meet the needs of the individuals.

Program Process:
The CCT Peer Navigator will be introduced to the individual in person or via video conferencing or telephonically, based on BBHC data and in collaboration with unit staff.

While the person served is being stabilized, the peer navigator may begin engagement daily to introduce navigation services with the consideration of what the individual may identify as their needs and preferences.

Upon engagement/assessment and relationship building, the peer navigator may assist with referrals to a community provider and linkages to programs and/or local resources. Peer navigator engagement would exist during the acute care stay but would not exceed 4 weeks post-discharge from the unit, unless request to extend services have been approved.

If the individual needs longer term support, they can be referred and transferred through a warm handoff to a Power of Peers provider for longer-term peer support.

While on the unit, the CCT Peer Navigator may:
- Meet individually or in small groups to discuss an introduction to wellness plans.
- Assist participants in determining a plan of action to overcome existing barriers and work with participants in their attainment of self-sufficiency and wellness.
- Begin to develop individualized goals.
- Introduce wellness plans with the individual and in collaboration with the unit treatment team to

prepare for their discharge and plan for aftercare in collaboration with a final discharge.

- Telehealth: The use of technology presents another promising practice in coordinating care, specifically as it related to access. Please note that telehealth/telephonic connections have been used during the COVID-19 health crisis and have shown thus far to be helpful in continuing to serve individuals in Care Coordination programs. Please see **Guidance 4**, which references a Department of Veterans Affairs (VA) initiative, which piloted a care coordination telehealth project and appeared promising. Telehealth might be useful for continued use during times of crisis and as needed if the client and or provider are impaired in meeting face to face.

It is important for the CCT Peer Navigator to effectively communicate, listen, and understand the problems, concerns, and barriers faced by individuals and/or families. The CCT Peer Navigator can introduce the program and services through various formats including but not limited to workshops, trainings, events and support groups. Creating a "natural support" can make a difference in how well the person succeeds in the community.

Program supervision and oversight:

CCT Peer Navigators will be required to attend supervision and regular meetings/calls as needed by the Provider and the Unit to which they are assigned. In addition, there will be a licensed clinician providing oversight for the CCT Peer Navigators via a weekly conference call to ensure any issues can be addressed professionally and swiftly, especially if clinical intervention is needed.

Program time allocation:

- CCT Peer Navigators will spend 75 percent of their work week on the acute care unit. Communication may be accomplished via telephonic/telehealth.
- The remaining 25 percent of the worktime is utilized by the CCT Peer Navigator with the follow up necessary for recently discharged individuals.

The time spent off the unit by the CCT Peer Navigator with the individual allows for short-term support in the community and then if needed, connection to a Peer Specialist if needed.

Based on the success of this program, it is anticipated that inclusion of these facilities and linkage to peers in recovery, this will result in a reduction of readmissions for Baker Acts and/or detoxification.

BBHC Requirements and Training:

The CCT Peer Navigators will participate in the designated trainings specific to the unit they are assigned, which may vary. Training may include local, state, and federal standards and regulations pertaining to the provision of services.

1. Complete WRAP (Wellness Recovery Action Plan) Training within six (6) months of employment.
2. Complete CCT Peer Specialist Training to obtain certification through the Florida Certification Board within eighteen months (18 months) of hire.

Reports and Outcomes:

The Peer Navigator will submit a Monthly Census Report due by the 5th of the month.

XL. Care Coordination Team – Child Welfare (CW)

1. Definition of the Program:

Section 394.4573(1)(a), F.S., defines Care Coordination-CW as "the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individual who are not yet effectively connected with services to ensure service linkage."

Care Coordination-CW is the organization of care activities between two or more participants including the family served (with consent), involved in the family's care to facilitate the effective delivery of behavioral health, primary health care, developmental, and mental health services. The population to be served through Care Coordination-CW will be child welfare families that have experienced a judicial removal episode due to caregiver Substance Use Disorder (SUD). With priority given to caregivers with Opiate Use Disorder (OUD). It offers the opportunity to share information in a timely manner and ensures the families being served are followed and supported as they progress through their recovery process. In child welfare, the standard practice has been that once the case is closed, the family may no longer receive the services and support needed to maintain the gains achieved during the life of the case. Due to a lack of support, many of these families cycle through the child welfare system experiencing multiple episodes of removal. In turn, the caregiver's cycle through the mental health/substance abuse system, and the children experience the repeated trauma of removal and the negative impact of their caregivers(s) SUD. This leads to the de-compensation of the family unit and creates immense costs for multiple publicly funded systems.

2. Purpose of the Program:

Care Coordination Teams (CCT)-CW will provide supportive services to families in the child welfare system, or who are at risk entry into the child welfare system, due to caregiver SUD (Substance Use Disorder), with priority given to OUD (Opiate Use Disorder). Care Coordination Teams provide an Intensive Case Management Team approach, in conjunction with the support of a BBHC Care Coordination Manager, the Dependency Case Manager (DCM) (CA) assigned to the case, ChildNet Care Coordination Manager, the family and all providers serving the family. The CCT-CW will assist the CA and the family by staging referrals, ensuring families are linked in a timely manner to the appropriate services, and monitoring the families progress in services. CCT-CW will also facilitate families in building an informal Recovery Support network.

Critical Time Intervention (CTI) will be one of the evidenced-based practices utilized to effectively transition families from the child welfare system. which will focus on the family's strengths and needs to determine the appropriate level of support needed, and link with existing and newly identified services and supports. Each Care Coordination-CW Team will consist of an intensive case manager, and a peer specialist, supervised by a licensed clinician. The caseload of each team will range between 10-15 families. The teams will conduct weekly treatment team meetings and will coordinate for assessment/clinical services, and will directly provide intervention/crisis support, case management, and peer support. The services provided by the Care Coordination-CW Teams are time-limited, with a heavy concentration on educating and empowering the family served, engaging and getting to know the family's strengths, needs and natural supports, and providing a single point of contact until a family is adequately connected to the ongoing support needed to maintain long-term recovery. The Care Coordination-CW Teams will be available 24/7 for crisis support.

3. Goals of the Program:

Care Coordination-CW Short-Term Goals:

- Prioritize the family's wellness and enhance their natural recovery supports within the community.
- Assist the family with meeting case plan goals by staging appropriate referrals.
- Communicate with the Dependency Case Manager (DCM) and support the family with communicating on progress.
- Increase overall family stability and wellbeing, thereby decreasing the risk factors associated with another removal episode.
- 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.

Care Coordination-CW Long-Term Goals:

- Help service providers shift from an acute care model to a Recovery-Oriented System of Care (ROSC) Model.

Help communities provide a wide array of services and supports tailored to meet the diverse needs specific to each family and each member within the family unit.

4. Admission Criteria for the Program:

- Families must have experienced a judicial intervention due to caregiver SUD, with priority given to caregivers with OUD.
- Child Welfare families who are not effectively connected with services and supports.
- Child Welfare families who are transitioning successfully from mandated child welfare services to effective community-based care.
- Child Welfare families who are high utilizers of services in behavioral health, primary care, peer, natural supports, housing, education, and vocational.
- Child Welfare family's needs can include at-risk to manageable substance abuse problems with a high recidivism rate into SUD treatment and further episodes of removal due to caregiver SUD/OUD.
- Non-Child Welfare families that have been identified as high risk of entering into the Child Welfare System due to parental/caregiver substance use disorder.

5. Treatment Model for the Program:

The primary Treatment Model utilized by the Care Coordination-CW Teams is the evidence-based practice (EBP), Critical Time Intervention (CTI). Critical Time Intervention is used to provide recovery-oriented services to individuals and families receiving Care Coordination-CW. This model is on the SAMHSA National Registry of Evidence-Based Programs and Practices (NREPP) and was "designed as a short-term intervention for people adjusting to a "critical time" of transition in their lives". Within the CTI model, Motivational Interviewing, Wellness Recovery Action Planning (WRAP) and Family Wellness Recovery Action Planning (F-WRAP) are also utilized to ensure that families receive treatment/ancillary services to meet their needs. The Teams receive training and coaching to ensure program fidelity. More information about CTI can be found on www.criticaltime.org.

VI). Covered Services for the Program:

1. Outreach
2. Assessment
3. Crisis Support/Emergency
4. Recovery Support
5. Supportive Housing
6. Intervention

VII) Phases of the Program:

- Pre-CTI: Services begin before Termination of Child Welfare Supervision (TOS) to establish an initial relationship before the transition begins.

- Phase 1: Transition to the Community – Frequent contact with the family in the community, focus on engaging the family with services, identifying and addressing housing-related issues in order to prevent homelessness or housing instability, and identifying and addressing what is needed to support long-term family recovery. A transition plan is implemented while providing emotional support.
    - Complete CTI Phase Plan & Treatment Plan Form – At the beginning of phase 1. Treatment plans should be completed within two weeks of authorization
    - Completion of the Recovery Capital Scale Inventory (RCSI). This inventory is to be reviewed with the caregivers at the commencement of each ongoing phase.
    - Specify goals, reason and strategies for goals for the corresponding CTI phase
    - Complete ongoing progress notes documenting interactions with the family. Discharge planning discussion should occur throughout the phases.
    - Complete the Summary of Goals form within two weeks prior to the second phase indicating status of goals for Phase 1
    - Participate in Utilization Review led by BBHC Care Coordination Manager and CCT-CW Care Coordinator
    - If the team is unable to complete the WRAP in Phase I due to family crisis, this is to be documented throughout the client record and is to be completed when appropriate as determined by the provider, family and funding source.

- Phase 2: Tryout – The team encourages families to manage problems independently, with the assistance of natural supports, after connecting them to supportive services.
    - Complete CTI Phase Plan & Treatment for Phase 2
    - Specify goals, reason and strategies for goals for the corresponding CTI phase
    - Complete ongoing progress notes documenting interactions with the family. Discharge planning discussion should occur throughout the phases.
    - Complete the Summary of Goals form within two weeks prior to the third phase indicating status of goals for Phase 2

- Phase 3: Transfer of Care - Promotes transfer from CTI to other formal and informal community supports and termination of CTI services occurs once a family support network is safely in place.
    - Complete CTI Phase Plan & Treatment for Phase 3
    - Specify goals, reason and strategies for goals for the corresponding CTI phase
    - Complete ongoing progress notes documenting interactions with the family

- Complete the Summary of Family Centered Goals form within two weeks prior to the end of the third phase indicating status of goals for phase 3 and while enrolled in the Care Coordination-CW program
- Document caregiver and family outcomes and transition from the team including documentation of a warm hand-off meeting at the next level of care
- Discharge

Monthly Progress Reports shall be completed by the 10th of each month and uploaded to the FSFN file cabinet. Monthly Progress Reports format is provided through the BBHC Cognito link. This form is to be used and not to be substituted.

It is to be noted that a Wellness Recovery Action Plan cannot be completed when a family is in crisis.

VIII) Staffing Requirements of the Program:

CCT-CW Supervisor (1.0 FTE)

Must be a full-time employee and possess a Florida license in one of the following professions:

(a) Mental Health Counselor;
(b) Clinical Social Worker;
(c) Marriage & Family Therapist;

The Supervisor is responsible for administrative and clinical supervision of the CCT-CW and functions as a practicing clinician. The CCT- CW Supervisor must have at least five (5) years of full-time work experience with children and families in the child welfare system, as well as prior supervisory experience. This position will ensure that the program complies with Chapter 394, F.S. and Chapters 65E-5, 65E-12, and 65E-14, F.A.C.

Case Manager (1.0 FTE)

The Case Manager must have a minimum of a bachelor's degree in a behavioral science. Case Managers must have a minimum of one (1) year of work experience with children and families within the child welfare system. Case Managers are to be supervised by the CCT-CW Supervisor. Case Managers are primarily responsible for providing or coordinating the required services on behalf of the families as more fully set forth below.

Certified Peer Specialists (1.0 FTEs)

This individual will use their own unique, life altering personal recovery experience to guide and support others who are in recovery or are in the process of beginning their recovery journey. This individual must personally be in recovery from substance use disorder (SUD). Additionally, they must be trained in, and use the Family Wellness Recovery Action Planning (F-WRAP) recovery model as part of their treatment protocol, as well as individual WRAP for the caregiver(s). The Peer Specialist must obtain a Certified Recovery Peer Specialist (CRPS-A) certification with the Florida Certification Board.

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XLI. Care Coordination Team – Children

PURPOSE AND GOALS

Care Coordination serves to assist children and their families in the process of transitioning from Children Crisis Stabilization Units (CCSU), Statewide Inpatient Psychiatric Program (SIPP) and after an episode of Mobile Response Team (MRT) intervention until they are effectively connected with services and supports needed to transition to appropriate level of care. The Children Care Coordination Team (CCCT) will ensure that the children are effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. It will also assist the families of these children to support and guide them through the process. This includes services and supports that affect both the children and families' well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation, and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is adequately connected to the care that meets their needs.

The short-term goals of implementing Care Coordination are to:

- Improve transitions from acute and restrictive to less restrictive community-based levels of care.
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and
- Focus on the child and family's wellness and community integration.

The long-term goals of implementing Care Coordination are to:

- Shift from an acute care model of care to a recovery model; and
- Offer an array of services and supports to meet an individual's chosen pathway to recovery.

PRIORITY POPULATIONS

Individuals at a CSU and SIPPs that require but are not limited to services such as behavioral health, primary care, peer and natural supports, housing, education, and employment.

- With history or previous CSU/Baker Acts.
- Who have high utilization of services.
- With multiple service needs with at least one of the problem areas identified as "severe", pregnant youth, IV drug users, and/or serious mental illness.
- With a Serious Mental Illness (SMI) awaiting placement in a civil state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.
- With a SMI and/or substance use disorder (SUD) who account for a disproportionate amount of behavioral health expenditures.
- With a SMI and/or SUD who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.
- With involvement in the child welfare system or behavioral health system who are suspected to be involved or are involved in human trafficking.
- Without a strong support system that can support the child with ongoing services in the community.

NETWORK SERVICE PROVIDER RESPONSIBILITIES

Network Service Provider responsibilities include:

1. Engage the individual in their current settings, CCU and SIPPs.
2. Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.
3. Serve as single point of accountability for the coordination of a child's care with all involved parties (i.e., juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).
4. Develop a plan with the children and family based on shared decision making that emphasizes self-management, recovery, and wellness. This must include transition to community-based services and/or supports.
5. Provide frequent contact during the time of services,
6. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.
7. For children who require medications, ensure linkage to psychiatric services
8. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.
9. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community-based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.
10. Ensure linkage with Managed Care case manager when applicable

CARE COORDINATION ALLOWABLE COVERED SERVICES

The following is a list of allowable covered services as defined in Ch. 65E-14.021, F.A.C.

- Outreach
- Crisis Support/Emergency

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XLII. Transitional Voucher Procedure

Purpose:

This project provides care coordination and vouchers to purchase treatment and support services for adults transitioning from Florida Assertive Community Treatment (FACT) teams, acute crisis services, and institutional settings to independent community living; and individuals experiencing homelessness, at risk for homelessness, or receiving care coordination services. Vouchers may also be utilized to assist eligible individuals maintain their current level of care by achieving residential stability. The Transitional Voucher project is a flexible, consumer-directed voucher system designed to bridge the gap for persons with behavioral health disorders as they transition from acute or more restrictive levels of care to lower levels of care. The intent of this project is to enable individuals to live independently in the community with treatment and support services based on need and choice and build a support system to sustain their independence, recovery, and overall well-being.

The project aims to:

- Prevent recurrent hospitalization and incarceration;
- Provide safe, affordable, and stable housing opportunities;
- Maximize use of FACT resources and community supports;
- Increase participant choice and self-determination in their treatment and support service selection; and
- Improve community involvement and overall quality of life for program participants

The service is time limited financial assistance based on the individuals' needs and care plan objectives. Individuals have limited resources available or they have exhausted other financial resources including insurance; and have complex needs, which may require multi-agency involvement.

Eligibility (All funds are time-limited):

Persons eligible for services under this component must be currently receiving Department-funded SAMH services pursuant to Chapters 394 and 397, F.S., and must meet one the following alternative characteristics:

A. Experiencing homelessness; meaning an individual who lacks housing, including:

1. An individual whose primary overnight residence is a temporary accommodation provided by a supervised public or private facility, or

2. An individual who resides in transitional housing, or

3. An individual at risk for homelessness

Or

B. Receiving Care Coordination services pursuant to **Guidance 4.**

Or

C. Participating in FACT teams not listed in Table 1 and ready to transition to a lower level of care.

Individuals must be receiving substance use and/or mental health services and be served by a Care Coordination Team funded by BBHC.

Allowable Expenses

1. Transitional Voucher services may be authorized only to the extent that they are reasonable, allowable and necessary as determined through the assessment process; are clearly identified in the care plan; and only when no other funds are available to meet the expense.

2. The person served is the primary decision maker as to the services and supports to be purchased and from what vendor those services are procured.

3. Allowable expenses include the following Covered Services as defined by Rule 65E-14.021, F.A.C.:

a. Aftercare;
b. Assessment;
c. Case Management;
d. Day Care;
e. Day Treatment;
f. Incidental Expenses;
g. In-Home and On-Site;
i. Intervention;
j. Medical Services;
k. Medication-Assisted Treatment;
l. Outpatient;
m. Recovery Support;
n. Respite Services;
o. Substance Abuse Outpatient Detoxification;
p. Supported Employment; and
q. Supportive Housing/Living.

4. Allowable Incidental Expenses include time limited transportation, childcare, housing assistance, clothing, educational services, vocational services, medical care, housing subsidies, pharmaceuticals and other incidentals as approved by the Managing Entity in compliance with Rule 65E-14.021, F.A.C.

5. Network Service Providers and non-Network Service Providers must adhere to:

a. State purchasing guidelines for allowable expenses as promulgated by the Department and the Department of Financial Services
b. The requirements of Rule 65E-14, F.A.C., and
c. Managing Entity protocols regarding allowable purchases.

6. Managing Entities must request prior approval by the Department for the use of Transitional Voucher funds to purchase services from a licensed Assisted Living Facility (ALF). When utilizing an ALF, the request must include documentation showing due diligence was exercised in searching for less restrictive housing in these cases.

Restrictions and Limitations:

- Voucher funds are the payer of last resort
- Directly support documented treatment/service goals of the client
- Receipts must be maintained by the agency
- Invoice and treatment plan for requested service must be uploaded to the Transitional Voucher request form in the Cognito link.
- Individuals should increasingly demonstrate the ability to self-manage and/or transition to other fund sources based on access to disability benefits, insurance, employment, and/or housing vouchers
- Requests for Assisted Living Facilities (ALFs) rental assistance require DCF for approval.

Housing funds must be for allowable placements such as licensed facilities or certified recovery homes or provide a current lease agreement. Eligible Housing Subsidy requests will include those allowable under the DCF guidelines such as licensed facilities, FARR certified homes, and/or a current lease agreement.

Provider Responsibilities:

Providers shall:

1. Provide Care Coordination services to coordinate services with other providers and organizations to ensure the needs of the participant are addressed at any given time;

2. Utilize the SSI/SSDI Outreach, Access, and Recovery (SOAR) model to assist project participants in applying for SSI/SSDI benefits;

3. Monitor each participant's progress and work with providers to adjust services or providers as needed;

4. Ensure Transitional Voucher funds are used only for services and supports that cannot be paid for by another funding source; specifically:

a. Network Service Providers and participants are responsible for locating other non-SAMH payor sources for services or supports prior to using Transitional Voucher funds.

b. In collaboration with the participant, Network Service Providers must certify no other payer source is available and due diligence was exercised in searching for alternative funding prior to the use of Transitional Voucher funds. Network Service Providers must submit a signed certification for each use of Transitional Voucher funds with the monthly invoice.

5. Establish accurate record keeping that reflects specific services offered to and provided for each participant; and

Agency Responsibilities:

It is the responsibility of the agency to develop an agency-specific policy and procedure to ensure accuracy, accountability, and responsibility for the funds requested and approved.

- The information will include initials or record identifier of individuals served
- Amount expended, service/item purchased, date of purchase, case manager involved

Procedure for Accessing Transitional Voucher Funds when authorization is required:

- Case Manager/Agency Designee will complete a BBHC Transitional Voucher Request/Application via the secure Carisk portal on behalf of the individual being served with the necessary supporting documents.
- Supporting Documents include: BBHC Transitional Voucher Request/Application
- Copy of the current Phase plan justifying the need for the requested service
- Transitional Voucher Program (TVP) Assessment Scale for ALF fund requests (due at phase change)
- Copy of Invoice for requested service or applicable lease agreement.
- BBHC Care Coordination Manager will review and authorize the request within 72 hours.
- Case Manager/Agency Designee is responsible for following their agency's internal policy to obtain and disburse the requested funds.
- The Agency Designee is responsible for documenting and maintaining records of the Transitional Voucher funds provided on behalf of their clients.
- BBHC Care Coordination Managers will also maintain a monthly tracking log of Transitional Voucher funds that have been approved.
- BBHC Care Coordination Manager will submit all ALF rent subsidy requests to DCF for approval to reflect: 1) the provider looked for alternative funding source.
- 2) services clearly identified in the care plan; 3) due diligence was exercised in searching for less restrictive housing. This process may add 48 hours to the voucher disposition.
- Transitional Voucher Request Process:
- Referral → Carisk App→ Authorization # → Reimbursement
- Provider Flow:
- Transitional Voucher requests will go to the link below which is the Carisk Partners App (apps.cariskpartners.com).
- Once submitted, BBHC will review for either approval or denial and the Provider will be notified through email by the Carisk App. within 48 hours. If approved, an authorization number will also be provided in the email.
- At the end of each month, the Provider's uploaded data must include:
- Voucher information with the appropriate OCA's (modifier 4) and
- Voucher Tracking # entered in the Provider Information field in the portal.
- The fact that a voucher has been approved does not guarantee payment unless the corresponding data and required support are accurately uploaded.
- The provider will only be paid for vouchers that are authorized by BBHC contract manager through the Carisk portal.
- After second billing cycle reconciliation of an authorized voucher not ever invoiced or paid, with no response to justify the delay, the Authorization # for payment will expire and be voided.
- A new request will have to be submitted if the item is still needed.
- This list of voided approvals will be sent to the provider as it generates in the usual monthly report.

Internal Carisk-BBHC Flow

- Carisk will pay providers and generate their DVI as usual.
- The fact that a voucher has been approved does not guarantee payment unless the corresponding data and required support are accurately uploaded.
- Carisk will generate and provide a report for BBHC with all the vouchers processed classified, Paid vs Not Paid, and if not paid the reason (No OCA or Mod 4, no data, no supports or not in the BBHC report) by the 15th of the month.
- BBHC will reconcile data. Any items not paid for the first time/cycle will be sent back to the provider for follow up. The provider will be asked to provide a status response with a five-day window.
- For vouchers Not Paid after two billing cycles of reconciliation, the Authorization # for payment will expire and approval will be voided.

References:

LOCUS
Phase Plan
Assessment Tool
Guidance 29 Transitional Voucher Program
Transitional Voucher Program Assessment Scale

Attachment(s):

Transitional Voucher Request/ Approval Form
Treatment Plan
Assessment Tool
Transitional Voucher Program Assessment Scale

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XLIII. Recovery Community Organization (RCO)

Purpose and Goals:
Recovery Community Organizations (RCOs) provide support to the recovery community and their loved ones. RCO's provide a place for members to engage in activities such as advocacy, support groups, wellness, and also provide recovery-focused community education, outreach programs, and peer recovery support services.

Eligibility Criteria:
Individuals and family members of those living with Substance Use and/or Co-Occurring Mental illness seeking supports in recovery.

Covered Services:
1. Outreach
2. Recovery Support (Individual)
3. Recovery Support (Group)
4. Incidentals

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XLIV. Residential Support Coordination

Program Summary

Residential Support Coordination is a service provided through the Taskforce Fore Ending Homelessness for individuals that are at risk of homelessness or are unstably housed or for those that are transitioning out of Residential Treatment Facilities, transitional or respite housing placements, jail release and diversions, acute care facilities, as well as those filtering through the Centralized Receiving Center (CRC) that are not homeless and are within the Broward Behavioral Health Coalition's Provider Network. Broward Behavioral Health Coalition, Inc. (BBHC) will fund 2 Residential Support Coordination positions designated to assist individuals and/or families who have Mental Health or Substance Use disorders with obtaining and maintaining stable and secure housing.

Residential Support Coordinators (RSC) assist individuals with disabilities and their families to develop plans to find the most appropriate services and assistance based on the individual and/or families housing needs. The (RSC) will work closely with Case Managers, Housing Navigators and Peer Support Specialists within BBHC's Provider Network to lend support for linking with long-term housing stability solutions.

- The Residential Support Coordinator (RSC) is the first and best option to help a family determine what services are available to best suit an individual's or family's needs.
- BBHC works closely with Residential Support Coordinators (RSC) in providing referrals for individuals and/or families in need of housing stability assistance.

Scope of Services

Taskforce Force Ending Homelessness, Inc's (RSC) will provide short-term linkage and supports to individuals and/or families that are unstably housed, those that have received eviction notices, those that are set for discharge from Residential Treatment Facilities, Transitional Housing, Respite placements, jail release and diversions, as well as those being discharge from acute care facilities or filtering through the Centralized Receiving Center that are not homeless.

- Individuals and/or families will receive assistance in linkages to community resources that are available to both prevent homelessness and link them with supports to prevent future housing needs by providing information and referrals for diversion and prevention.
- Taskforce Fore Ending Homelessness' (RSC) will participate in BBHC and Community trainings that will enhance their ability to identify and provide appropriate referral linkages for individuals and/or families.

Procedure

- The program can receive referrals from BBHC's Housing and SOAR Entitlements Coordinator, Acute Care Facilities within the BBHC Provider Network, Residential Treatment Facilities, Transitional/Respite Housing Placement providers within the BBHC Provider Network, County Jail Releases, and diversions and through the Centralized Receiving Center that are not homeless.

- RSC will begin engagement daily to introduce RSC services with consideration of what the individual and/or family may identify as their needs. Upon engagement and assessment, the (RSC) may assist with referrals to community providers and linkages to programs and/or local resources. RSC engagement would exist for the first 4 weeks of engagement and is able to be extended if necessary. Longer-term support can be coordinated by the RSC with Network Providers.

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XLV. Coordinated Opioid Recovery (CORE) Network of Addiction Care

The CORE Network establishes a recovery-oriented continuum of care and support for those seeking treatment and recovery support services for substance use disorder. This comprehensive approach expands every aspect of overdose response and treats all primary and secondary impacts of substance use disorder. The CORE Network disrupts the revolving door of substance use disorder, including opioid use disorder, and overdose by providing an evidence based coordinated network of care linking patients to community partners in a continuum from a crisis all the way to lifelong care in an accessible, sustainable way. It incorporates quality improvement through measure outcomes that help sustain the network locally. Department approval is required before implementing any variation of the CORE Network.

Eligibility

The CORE Network prioritizes adults aged 18 or older who experience any of the following:

1. A confirmed or suspected opioid overdose requiring naloxone administration.
2. Signs and symptoms of severe substance use withdrawal.
3. Acute substance use withdrawal as a chief complaint.
4. Individuals seeking support for substance use disorder within a CORE Network.

The CORE Network includes the following tiered approach with a warm handoff provided at each level:

1. Law Enforcement.
2. Rescue response.
3. 24-7 access point for stabilization/assessment.
4. Receiving clinics for long-term treatment.

Law Enforcement

a. Law enforcement is often the first on scene during emergencies, where fire rescue might not typically respond, enabling them to identify individuals in crisis and connect them with appropriate support services.

b. Their early involvement highlights their critical role within the CORE Network, fostering collaboration and timely interventions.

c. Integrating law enforcement into the CORE Network allows them to engage in community activities that inform residents about CORE Networks, how to access services and available support systems. Integrating law enforcement encourages and connects individuals to treatment and recovery support services through CORE Networks.

d. These activities focus on building trust, fostering relationships, and bridging the gap between individuals in crisis and essential treatment services.

Rescue Response

a. Individual in need of services is treated by first responders (fire rescue/ emergency medical services personnel).
b. Treatment includes use of specialized emergency medical services protocols for overdose, acute withdrawal, and can include induction to buprenorphine.
c. Emergency medical services provides a warm handoff to the emergency department or receiving clinic/long-term medication assisted treatment provider.

d. Emergency medical services may provide buprenorphine for patients while waiting for warm handoff to receiving clinic after induction performed by emergency medical services or emergency department.
e. CORE emergency medical service partners will coordinate with other emergency medical service agencies within in their county to follow up with patients who overdosed and received care from a non-CORE Network emergency medical services provider.

Stabilization/Assessment

a. Individual receives treatment at a 24-7 access point.
b. Treatment options include medication-assisted treatment, which entails, at a minimum, the ability to induct individuals on buprenorphine, and issue a prescription for buprenorphine that lasts until their initial appointment with a community-based provider prior to being released from the emergency department.
c. Specialty-trained medical staff recommend the care best suited for the individual and a peer navigator facilitates a warm handoff to the receiving clinic for long-term treatment.

Receiving Clinics/Long-term treatment provider

a. Individual receives long-term-care and wrap around support.
b. Individual is treated by a team of licensed and certified professionals that specialize in treating addiction.
c. Services may include long-term management of medication assisted treatment, therapy, psychiatric services, individualized care coordination, and links to other health services.
d. Individuals shall receive services to address any identified social service needs.
e. Ensure implementation of the Brief Addiction Monitor tool along with other data requirements.
    • The Brief Addiction Monitoring Tool (BAM) is a 17-item, multidimensional, progress-monitoring instrument for patients in treatment for a substance use disorder (SUD). The BAM includes items that assess risk factors for substance use, protective factors that support sobriety, and drug and alcohol use. The BAM assessment tool measures patient outcomes and success of the overall project. Receiving clinics must provide the QR Code and encourage completion of the BAM on all individuals with a substance use disorder, every 30 days. The Department created an application for individuals to complete the BAM via a QR code. In addition to the 17 questions from the BAM, the Department has included several questions related to social determinants of health. It is important to note that these supplementary questions, while valuable and providing deeper insights into patient circumstances, are distinct from the brief addiction monitoring assessment itself, and do not influence the brief addiction monitoring score.

Warm Handoff and Recovery Supports

a. Certified Recovery Peer Specialists utilize direct experience with substance use disorder and recovery to reduce stigma and increase engagement into services.
b. Certified Recovery Peer Specialists facilitate warm handoffs to treatment and recovery community organizations.

XLVI. Case Management Navigation Program

Program Overview

The Case Management Navigation Program shall provide short-term behavioral health navigation to children without formal diagnoses and their families until more permanent connection to mental health support is determined and ensures continuity of care. BBHC's Care Coordination Navigator will assist in facilitating referrals through 2-1-1 or the Provider network and ensuring that funding is solidified for the youth to maintain this service through funded Providers. If children have a need for case management after 60 days, Providers will need to submit a reauthorization request to BBHC.

Clients served through the case management navigation services must:

- Not have a formal behavioral health diagnosis,
- Be under the age of 18 years old, and
- Be at risk or show signs of a behavioral health condition.

Referral Process

A. BBHC will receive navigation referrals from 2-1-1 and send them to Providers through the Carisk portal. Providers must give BBHC a list of staff responsible for receiving referrals. Those staff must complete the required Carisk data system access forms to ensure they have an account to access referrals in the Carisk portal. After Providers reach out to the family and are ready to begin services, Providers must generate a 2-month (60 day) authorization request. Providers will not be able to bill for services rendered before the authorization approval date.

B. When Providers identify children in need of navigation services, they must complete the Navigation Program Referral form link through Cognito. The BBHC Navigation Care Coordinator will review referrals, input them into the Carisk portal, and assign them to the referring Provider unless that Provider is outside of the approved Navigation Providers. Once the Provider reaches out to the family and is ready to begin services, the Provider must generate a 2-month (60 day) authorization request. The Provider will not be able to bill for services rendered before the authorization approval date. Below is the link to the Navigation Referral Form for Providers.

https://www.cognitoforms.com/browardbehavioralhealthcoalition/navigationprogramreferral

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XLVII. Family Well-being Treatment Team Model (FIT LITE)

Philosophy of the Program:
Family Well-being Treatment Teams are a service delivery model that provides community-based behavioral health treatment and support to families with child welfare involvement and concerns of parental mental health, substance use, or co-occurring disorders that are unmanaged or undiagnosed. Family Well-being Treatment Teams are a multidisciplinary approach to behavioral health intervention in the overall system of care that provides early identification, and coordination of timely access to services and enhances support coordination to families through navigation of the child welfare and treatment processes.

The BBHC FITT Teams will abide by the **Guidance 39 - Family Well-being Treatment Model (FIT Lite) Model Guidelines and Requirements.**

Program Description:
Family Well-being Treatment Teams are an adaptation of Florida's Family Intensive Treatment (FIT) model; however, unlike the FIT model, Family Well-being Treatment Teams allow for flexibility with eligibility and approach.

Admission Criteria:
Family Well-being Treatment Teams serve families that meet the following criteria:

1. Eligible for publicly funded substance abuse and mental health services pursuant to section 394.674, Florida Statutes; including persons meeting all other eligibility criteria who are underinsured.
2. Concerns of parental mental health, substance use, or co-occurring disorder that is unmanaged or undiagnosed at the time of referral.
3. Active child welfare involvement at the time of referral.

Program Goals:
- Provide early identification of unmanaged or undiagnosed mental health, substance use, or co-occurring disorders of parent(s)/guardian(s).
- Provide timely access to intensive behavioral health services to address concerns related to the well-being of families, as well as address food insecurity and housing instability.
- Establish a multidisciplinary approach to community behavioral health treatment services and safety planning.
- Coordinate safety planning, service delivery, and engagement strategies with Child Protective Investigators (or other Department representatives), Behavioral Health Consultants, Lead Agencies, Child Welfare Case Management Organizations, Managing Entities, and other providers of services.
- Identify family-driven pathways to recovery and promote sustained recovery through cultural and gender-sensitive treatment and involvement in recovery-oriented services and supports.
- Prevent the need for entry into the child welfare system, thus reducing the number of out-of-home placements when safe to do so.
- Promote increased engagement and retention in treatment services.

Measurable Program Objectives:

The Managing Entity must include the following performance measures in each subcontract:

- Successful completion of treatment or satisfactory progress in recovery.
- Improvement in caregiver protective capacities.
- Stable housing environment.
- School attendance, gainful employment, or other significant indicators of successful community involvement.

1. 50 percent successful completion of treatment or satisfactory progress in recovery of all individuals served.
2. On an annual basis, 75 percent of all individuals served will either maintain or show improvement in their level of functioning, as measured by a valid assessment tool or rating scale.
3. On an annual basis, 75 percent of all individuals served will either maintain or show improvement in their parenting capacity, as measured by a valid assessment tool or rating scale.
4. Upon successful completion, 95 percent of parent(s)/guardian(s) will live in a stable housing environment:
    - Stable housing environment is defined as: Independent Living (Alone, with Relatives, with Non-Relatives), Dependent Living (with Relatives, with Non-Relatives), Foster Care/Home (including Extended Foster Care for ages 18-21), or Supported Housing.
5. Upon successful completion, 95 percent of parent(s)/guardian(s) will have stable employment.
    - Stable employment is defined as: Active military, overseas; Active military, USA; Full-time; Unpaid Family Worker (A family member who works at least 15 hours or more a week without pay in a family-operated enterprise); Part-time; Retired; Homemaker (Manages household for family members); Student; or disabled. Note: If an individual refuses to work because they are making money through illegal activities, they must be coded as Unemployed.
6. Regardless of the discharge reason, all individuals served shall have an average length of stay of 120 days or more.

Mechanisms to address the Needs of Special Populations*:*

All persons served will be assessed for their individual needs to address abuse/neglect and overall family functioning in their household. Ethnic, cultural, linguistic, and spiritual traditions of the person served are respected and incorporated into service delivery whenever appropriate and applicable. All services meet or exceed the required standards of the Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act. Staff is also expected to conduct themselves in a manner agreeable to the diverse population served. Any special needs are to be assessed throughout treatment and referrals are to be made as clinically indicated and desired by the person served.

Staffing Structure and Resources:

a. **One (1)** Program Manager
b. **Three (3)** Behavioral Health Clinicians
c. **Three (3)** Specialized Care Coordinators
d. **Three (3)** Family Support/Peer Mentors

The Program Manager shall, at a minimum, posses: A master's degree in a behavioral health field, such as psychology, mental health counseling, social work, or marriage and family therapy; and a minimum of three years of experience working with families with behavioral health needs. Education may be substituted for experience.

The Behavioral Health Clinician shall, at a minimum, posses: A master's degree in a behavioral health field, such as psychology, mental health counseling, social work, or marriage and family therapy; and a minimum of two years of experience working with individuals with behavioral health needs.

The Specialized Care Coordinator shall, at a minimum, posses: A bachelor's degree in a social services discipline. Which includes the study of human behavior and development; and a minimum of one year of experience working with individuals with behavioral health needs; or a bachelor's degree with a major in another field and a minimum of three year of experience working with individuals with behavioral health needs.

The Family/Peer Mentors shall, at a minimum, possess at least three years of sustained recovery from addiction, and have had prior involvement with child welfare; or Certification as a Certified Peer Recovery Specialist by the Florida Certification Board.

The program will make every attempt to provide access to staff that is culturally and linguistically diverse to reflect the population served as well as provide training.

Procedures to support Interdisciplinary Team Interaction:
One Child, One Family, One Team, One Plan

The Child and Family Team, on a practice level, is where the rubber meets the road and system of care is actively implemented to promote positive outcomes for youth and families. A Child and Family Team is built around the family to make sure that each family's strengths are promoted and their needs are met. Team members including the Peer Mentor, Clinician and Dependency Case Manager work together with the family to write an individualize plan based on what the parent/child/youth wants and needs and will include action steps to meet the dependency case plan goals.

The FITT LITE TEAM utilizes the Wraparound process to provide specialized care coordination which uses a multi-disciplinary team to promote access to a variety of services and supports, including but not limited to: Domestic violence services; Medical and dental health care; Basic needs such as housing, food, and transportation; Educational and training services; Employment and vocational services; Legal services; and other therapeutic components of the family's treatment, services, or supports as needed.

Training Activities for Staff Competency:
The Specialized Care Coordinator and Peer Mentor will receive two (2) days of classroom training that lays the groundwork for "what is Wraparound." They will then spend an average of twenty (20) hours shadowing seasoned certified staff and two (2) hours of coaching per week until competency is demonstrated, typically within six (6) months of hire. Coaching is scheduled with staff to take place in the office to review work documents and in the field for live observation. Field observations occur at the family's home (or at a location chosen by the family) and are conducted at times that are convenient for youth and families served, including days, evenings and weekends. Peer supervision consists of monthly case presentations where

new and seasoned staff have the opportunity to present to one another and receive feedback from their peers regarding their own Wraparound practice skills.

The Behavioral Health Clinicians will utilize and draw upon several different evidenced based practices such as Positive Parenting Program (Triple P), Cognitive Behavioral Therapy (CBT), Solution-Focused therapy, Trauma-Informed Care, Motivational Interviewing and Child Parent Psychotherapy (CPP) based upon the individualized needs of families served.

All the staff involved in the project will receive training regarding how trauma affects the lives of individuals seeking services. Upon three months of hire they will receive training in Trauma Informed Care and Motivational interviewing.

Peer Support Services:
Peer support for crisis intervention, referrals, and therapeutic mentoring; is available 24 hours per day, seven days per week.

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XLVIII. Involuntary Outpatient Placement Treatment (IOPT)

Background
Florida House Bill (HB) 7021, passed in 2024, which specifically addressed 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 Placement Treatment (IOPT) as part of a broader strategy to provide continuous, community-based care for individuals with severe mental illness. The IOPT 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.

Broward Behavioral Health Coalition, Inc. (BBHC) implemented Involuntary Outpatient Placement Treatment (IOPT) Program with high intensity provider IOPT Care Coordination Teams (CCT). The IOPT teams are designed to support a structured, court-ordered framework for outpatient mental health treatment, ensuring that individuals who are at significant risk of harm to themselves or others receive the critical care they need while remaining integrated within their community. The individuals living with severe and persistent mental illness who, without structured treatment, are at risk of repeated hospitalization, legal involvement, or deterioration in functioning. Teams may serve Children, transitional adults and adults, who could be experiencing severe mental Health and/or substance co-occurring illness.

The IOPT CCT teams work collaboratively with treatment providers, courts, and other stakeholders to ensure individuals receive consistent, person-centered services in the least restrictive setting possible. This program supports court-ordered outpatient services within a recovery-oriented and trauma-informed framework, emphasizing continuity of care, client dignity, and reintegration into the community.

Scope of Services:
The IOPT Care Coordination Teams offer coordination for a wide range of clinical and support services, including psychiatric assessment and medication management, intensive case management, individual and group therapy, peer support, relapse prevention planning, and legal coordination. These services are tailored to meet the unique needs of each client and are designed to enhance functioning, promote autonomy, and ensure compliance with court-mandated treatment.

Major Program Goals:
The primary goals of the IOPT Program include:

- Reducing inpatient psychiatric admissions and re-admissions
- Supporting stable community living for individuals with mental illness
- Increasing treatment adherence through supportive legal oversight
- Enhancing life skills, coping strategies, and insight into mental illness
- Ensuring legal compliance and safety for the individual and the public

System of Care:

The IOPT Program functions within a comprehensive system of care, involving collaboration among residential providers, outpatient clinics, hospitals, courts, payee programs, peer specialists, and social services. This network ensures clients receive holistic and coordinated support to address mental health, housing, vocational, and social needs.

III. Persons to Be Served

Target Population:

The program serves adults and children diagnosed with a severe and persistent mental illness who meet legal criteria for involuntary outpatient services. These individuals may have a history of non-compliance with treatment, frequent hospitalizations, or high-risk behaviors that threaten their ability to remain safely in the community without structured support.

Determination of Individuals Served:

Referrals typically originate from psychiatric hospitals, the court system, or community providers. Eligibility is determined based on legal standards and clinical assessments. The individual must meet statutory criteria for IOPT, demonstrate a need for structured outpatient treatment, and be deemed capable of benefiting from services in the community with appropriate oversight.

IV. Manner of Service Provision

Team composition:

The IOPT Care Coordination Team will consist of two key positions, each contributing to the delivery of comprehensive and effective services to clients. 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 client's needs. This role requires advanced clinical expertise to ensure that all assessments and plans are aligned with best practices and meet the client’s individual 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 client’s situation.

2. **Peer Specialist:**

   The Peer Specialist will provide direct support to clients, utilizing their lived experience to offer guidance, encouragement, and practical assistance. This position is essential for fostering a supportive and empathetic environment, helping

clients 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 client 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 clients.

Caseload Size and Expectations:

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

The services provided by the Involuntary Outpatient Placement Treatment 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.

Service Tasks:
The IOPT team carries out several essential functions including:

- Conducting comprehensive intake assessments
- Developing individualized treatment plans with measurable goals
- Monitoring progress and court compliance
- Coordinating with treatment providers and court personnel
- Advocating for housing, benefits, and employment support
- Providing crisis intervention when needed
  Each task is designed to ensure service continuity and reduce the risk of hospitalization or legal regression.

Task List:
A detailed task list is maintained outlining responsibilities such as:

- Initiating contact with referred individuals
- Submitting court documentation
- Facilitating interdisciplinary team meetings
- Tracking medication compliance and therapeutic participation
- Coordinating step-down plans and discharge summaries

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Program Phases and Flow:

Phase 1: Intensive Engagement and Assessment

Objective: Establish a foundation for treatment through thorough assessments and immediate service coordination.

- **Initiation:** *(first contact being made within 1 business day of receipts of referral)* Engage clients through the intake process, securing consent, and completing necessary legal and clinical documentation.
- **Assessment:** *(within 2 business days of first contact)* Conduct a comprehensive Bio-Psycho-Social Assessment to understand the client's holistic needs and perform Level of Care assessments using LOCUS or CALOCUS to determine the appropriate intensity of services.
- **Service Coordination:** Initiate immediate referrals to essential services, including:
  - 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

During this phase, contact frequency is expected to be intensive, with an average of at least three face-to-face meetings per week.

The conclusion of this phase will depend on when individuals are deemed engaged in the various services identified as necessary in the assessments. However, it is expected that this should not require more than 30 to 45 days.

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 clients, with a minimum of one session per week.
- **Actively Monitoring** service delivery and client 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 client stability. Activate natural supports to prepare for the upcoming phase
  - **Benefits and Employment Support:** Follow-up on benefits acquisition to ensure clients receive all entitled support. Provide ongoing assistance with employment support, focusing on readiness and sustained engagement.
- **Readiness for Transition:** Continuously evaluate the client's readiness for transition to less intensive services.

The frequency of face-to-face interactions may decrease but shall not fall below one contact per week. Telehealth can be utilized where suitable, but there should be at least one face-to-face 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 terms of duration and is designed to continue until the client demonstrates sufficient progress to warrant the lifting of the court order. 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 client is fully prepared for the transition to a less restrictive status.

Phase 3: Transition and Continuity of Care

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

- **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 clients directly with new service providers.

A warm handoff is defined as a face-to-face transition meeting should be held with the aftercare provider and the person served, and their preferred support, 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 client'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 clients. 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 clients 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 a client 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 client's needs effectively. This proactive approach is essential for managing high-risk situations and supporting client adherence to their treatment goals.

- Incidental requests: The Care Coordination Team will be responsible for requesting authorization for eligible incidental payments related to housing or expenses exceeding $250. This includes preparing and submitting detailed requests that include a comprehensive sustainability plan and proper justification

for the expenditures. 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 program requirements. Families should increasingly demonstrate the ability to self-manage and/or transition to other fund sources based on access to disability benefits, insurance, employment, and/or housing incidentals.

Examples for Eligible Incidental Funds (If other resources are not available):

- 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 client'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 clients 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 client's treatment plan.

- **Transition and Discharge planning:** Transition begins at the initiation of the Involuntary Outpatient Placement Treatment Care Coordination process and will be discussed with the consumer, provider Care Coordination Team, the judiciary personnel, and the BBHC Care Coordination Manager. To ensure coordination and continuity of care based on the needs and desires of the person served.

a. To identify additional levels of care required/requested by the person served.
b. To ensure follow-up post-discharge services identified by the person served or by the Care Coordination team.
c. To provide adequate care through the coordination of services based upon the individualized needs and desires of the person served
d. To address unanticipated service modification, reduction, or transition/discharge precipitated by funding or other resource issues.
e. To maintain an accurate record of the service history provided for each person served as they progress between services disciplines and when discharged

Access to Care:

Clients may access IOPT services via referral from an inpatient setting, a provider, or a judicial order. Services are available regardless of financial status, and accommodations are made for transportation, telehealth options, and flexible scheduling to improve engagement. The program emphasizes timely intake and transition planning to avoid service gaps.

Clients with Special Needs:

The IOPT Program is committed to inclusivity and accessibility. Services are adapted for clients with physical disabilities, intellectual and developmental differences, co-occurring substance use disorders, and those requiring language interpretation or culturally responsive care. Trauma-informed approaches are embedded throughout all levels of service to ensure safety, empowerment, and healing.

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XLIX. Cultural and Linguistic Competency Plans

Broward Behavioral Health Coalition, as part of its system of care initiative, requires all its network providers to comply with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). The CLAS Standards are a set of recommendations, guidelines and mandates established by the U.S. Department of Health and Human Services (HHS) to advance healthcare, improve quality and help eliminate health care disparities.

A Cultural Linguistic Competence (CLC) Plan assessment tool below was created with the SAMHSA TA Network using the CLAS Standards as benchmarks. This tool is designed for the use to assess the cultural and linguistic competence of service providers. Furthermore, it is a tool for quality assurance and to measure operationalization and implementation.

The tool includes the 4 themes that the CLAS Standards focus on: 1) Introduction: Principal Standard; 2) Governance, Leadership, and Workforce; 3) Communication and Language Assistance; and 4) Engagement, Continuous Improvement, and Accountability. The CLC Assessment Tool also evaluates an organization's progress in two additional domains that are important to cultural and linguistic competence: Family Acknowledgment and Spiritual Cultural Beliefs in Treatment and Discharge.

The CLC Plan is designed to ensure that all of the services and strategies for Broward's System of Care and OCP4 are designed and implemented within the cultural and linguistic context of the children, youth, emerging adults, and families to be served. The overarching goal of the CLCP is to ensure that the system of care adopts a systemic, systematic and strategic approach to increasing the cultural responsiveness of services and supports delivered to children, youth and families. In addition, the CLCP aims to establish a sensitivity for and appreciation of issues throughout the system of care.

BBHC requires all network providers to maintain a CLC Action Plan based on the Assessment tool. Updates to CLC plans must be submitted annually when requested by CQI Department.

CLAS STANDARDS SOURCE: https://www.thinkculturalhealth.hhs.gov/

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L. Minimum Accreditation Standards

As part of a statewide initiative to promote the highest standards of quality, ethics, effectiveness, and accountability in nonprofit mental health and substance use services, BBHC is requiring that all its network providers obtain and maintain national accreditation through any of the associations below:

- Council on Accreditation (COA)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Joint Commission (JAHCO)
- Council on Accreditation of Peer Recovery Support Services (CAPRSS)

Annually or as appropriate:

- All currently accredited agencies must submit evidence of accreditation with expiration dates.
- Agencies not currently accredited must submit a plan to obtain accreditation with timelines, associated fees, and any concerns/barriers. These agencies must start the accreditation process, as appropriate.
- All Agencies must comply, at a minimum, with accreditation standards of a designated accreditation body, if not accredited.

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LI. Performance Measures - CQI Programs

The Provider shall track by Program, as applicable, the following performance measures and report as part of its Quality Assurance ("QA")/Quality Improvement ("QI"). This information shall be made available to BBHC upon request.

Behavioral Mental Health Services (Admission type):

Covered Services

01-Assessment	19- Residential Level 2
03- Crisis Stabilization Unit	20- Residential Level 3
06 Day/Night	21 Residential Level 4
08- In Home/ On-Site	34- FACT
09-Inpatient	35- Outpatient Group
12-Medical Services (psychiatric)	39-Short-term Residential Treatment
14-Outpatient Individual	Miscellaneous - Peer Support Services
18- Residential Level 1	

A. Average number of calendar days between a request for service and the date of the initially scheduled face-to-face appointment, tracked by intake, assessment, counseling/psychotherapy and psychiatric appointments.

B. Percent of clients who do not appear for their initial appointment tracked by intake, assessments, counseling/psychotherapy and psychiatric appointments.

C. Percent of appointments cancelled by the client tracked for all initial appointments by intake, assessments, counseling/psychotherapy and psychiatric services.

D. Percent of appointments cancelled by the staff for all initial appointments for intake, assessment, counseling/psychotherapy and psychiatric services.

E. When funded for Medical Services - Medication error percentage, as documented during the reporting period including: wrong medication, wrong dose or wrong time of administration as reported in inpatient/CSU and residential settings.

LII. Forms (For form refer to BBHC Website: http://www.bbhcflorida.org/)

- Outreach / Prevention Activities Service Log
- National Voter Registration Monthly Report
- TANF Program Participant Log
- TANF Incidental Request Form
- TANF Monthly Income Verification
- Incidental Fund Invoice and Expenditure Log (Exhibit O)

NOTE: The DCF Guidance Documents are incorporated herein by reference and may be found on DCF's website

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LIII. CSC Trauma Services Scope of Work

Trauma Services

The Community Trauma Responsive Counseling Program shall provide trauma therapy to clients (children and adults) who reside in Broward County impacted by significant traumatic events by trained clinicians using: Trauma Focused Cognitive Behavioral Therapy (TF-CBT), Trauma Incident Reduction (TIR), Emotional Freedom Technique (EFT), Brainspotting, EMDR, or another Evidence-Based trauma specific therapeutic model. The purpose of trauma therapy is to offer skills and strategies to better cope with and process emotions and memories tied to the traumatic experience with the goal of creating a healthier and more adaptive response to the traumatic experience. Trauma therapy addresses the symptoms of trauma, such as substance abuse, depression, and anxiety, and prevents or reduces post-traumatic stress, further emotional disturbance, and acting out behaviors.

Desired Population/Types of Referrals

The PROVIDER shall offer services to clients (children and adults) who reside in Broward County impacted by significant traumatic events.

Clients served must meet **one** of the following **Risk Factor(s):**

1. Exhibit signs or symptoms of trauma, be between the ages of 0-17 years old, or have a child in the family between those ages and reside in Broward County.
2. Be a family member of a MSD victim
3. Be a family member of an MSD injured survivor
4. Be an MSD and/or Westglades staff member or their family member
5. Be an MSD and/or Westglades student or their family member
6. Be a first responder to MSD on February 14, 2018 or their family member
7. Exhibit signs or symptoms of trauma as a result of the COVID-19 pandemic

Covered Services

Assessment shall include the systematic collection and integrated review of individual-specific data, such as examinations and evaluations. This data is gathered, analyzed, monitored, and documented to develop the person's individualized plan of treatment and to monitor recovery. Assessment specifically includes efforts to identify the person's key medical and psychological needs, competency to consent to treatment, history of mental illness or substance use and indicators of co-occurring conditions, as well as clinically significant neurological deficits, traumatic brain injury, organicity, physical disability, developmental disability, need for assistive devices, and physical or sexual abuse or trauma.

Outpatient Individual/Family Counseling Outpatient-Individual (Individual/Family Counseling) are services provided in a therapeutic environment which are designed to offer skills and strategies to better cope with and process emotions and memories tied to traumatic experiences with the goal of creating a healthier and more adaptive response to the traumatic experience. Sessions should be provided one time per week. Evidence based trauma focused practices such as Trauma Incident Reduction (TIR), Emotional Freedom Technique (EFT), Trauma Focused – Cognitive Behavioral Therapy (TF-CBT), Brain spotting, Eye Movement Desensitization and Reprocessing (EMDR) shall be used to address the traumatic events that the individuals experienced. The average length of treatment for TF- CBT and TIF ranges from 20-26 sessions.

Outpatient Group Therapy shall be provided in a therapeutic environment designed to offer skills and strategies to better cope with and process emotions and memories tied to traumatic experiences with the goal of creating a healthier and more adaptive response to the traumatic experience. The maximum for each group is 15 individuals.

Drop-In/Self Help Centers shall provide a range of opportunities for persons with emotional disorders to independently develop, operate, and participate in social, recreational, and networking activities. Includes alternative trauma services through the arts for those interested in nontraditional therapy.

Outreach services shall be provided to both individuals and in community groups with the focus on providing education about the potential long term impact of unresolved trauma, signs and symptoms related to trauma, and linkage / warm hand off to services. Outreach services for individuals are designed to: encourage, educate, and engage prospective clients to aid in their recovery from trauma process.

Psychiatric Evaluations (Medical Services) shall be provided to children and/or adults with mental illness, on a regular schedule, with arrangements for non-scheduled visits during times of increased stress or crisis. These services provide primary psychiatric care, therapy, and medication administration provided by an individual licensed under the state of Florida to provide the specific service rendered. These services are designed to improve the functioning or prevent further deterioration of persons with mental health or substance abuse problems, including psychiatric mental status assessment.

Case Management shall consist of activities that identify the recipient's needs, plan services, link the service system with the person, coordinate the various system components, monitor service delivery, and evaluate the effect of the services received. This covered service includes clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.

Recovery Support – **Individual and group** services are designed to support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. Services include substance abuse or mental health education, assistance with coordination of services as needed, skills training, and coaching. This Covered Service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service. For Adult Mental Health and Children's Mental Health Programs, these services are provided by a Certified Family, Veteran, or Recovery Peer Specialist.

****Rates are based on BBHC's established rates.****

LIV. Trauma-Informed Transformation Initiative

Goal: To assist the agency members of the Broward County Behavioral Health Coalition in creating a trauma- informed and trauma-responsive system of care.

Rationale: With the increased awareness of the impact of stress, adversity, and trauma on people's lives, professionals are considering what this means in their specific settings. There is a growing evidence-base documenting the impact of child neglect and abuse (as well as other forms of traumatic stress) on the health, mental health, and behavior of men and women. While research and clinical experience indicate a high incidence of trauma and co-occurring problems, professionals often struggle with the realities of providing effective management and services.

This is particularly challenging when many agencies have staff impacted by trauma in their personal and work lives. In addition, many settings struggle with organizational stress and trauma, which creates additional challenges in the environment and culture of the workplace.

Today the language "trauma informed" is common in many settings. The process of moving from trauma informed to trauma responsive in order to implement trauma-informed care (TIC) is often challenging to administrators and staff.

Strategy: Creating organizational change in a large, complex, and multi-tiered system requires a structured multi- layered process. Historically, large scale organizational change is estimated to be a three-year to five- year process. Success is heavily influenced by the support of visionary leadership.

Work Plan: With 74 programs/agencies (staff total is 3073, ranging from 1 staff member to 695), we recommend working in cohort groups with our Certified Trainer/Consultant, Eileen Russo. Cohorts of 10 programs/agencies would be launched at staggered times with some cohorts with more than 10 (smaller programs). The plan would be to have 6-7 cohorts with one started every 3 months.

The purpose of the kick-off is to begin to acclimate each cohort to the process of becoming trauma-informed/responsive. The topics will include:

- Definitions of trauma-informed, trauma-responsive, and trauma-specific
- Brief overview of trauma
- Brief overview of vicarious trauma and compassion fatigue
- Overview of 5 core values
- Overview of Guide Team (GT) development
- Next steps

Who should attend?

- Those attending should represent various roles across the agency, but not all of those attending should be management/supervisors

Creating a Guide Team

The purpose of a guide team is to guide (rather than steer) the process of becoming trauma-informed/responsive. The composition of the guide team is:

- A chair or co-chairs. It is best to not have this be upper management, but the chair (s) should have or be given some authority to make decisions and help implement recommendations.
- Depending on the size of the agency, a guide team is 5-8 people (no more than 10), that represents various roles throughout the agency, but not all management.
- 2 members of the guide should be current or former recipients of services.

Conclusion

When a Cohort has completed the initiative, it is expected that the Trauma Transformation Implementation Plans that were created during the initiative are reviewed during internal CQI meetings and updated as needed. BBHC reserves the right to review the Implementation Plan during CAR monitoring to ensure that Providers are maintaining a trauma responsive approach for persons served and staff.

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Provider Contract Handbook Updates:

Version	Version Release Date	Sections Updated
4.02	12.22.2020	• Family Engagement Program (FEP) • Family Intensive Treatment Team (FITT) • Care Coordination Team –Child Welfare (CW) • Community Action Team (CAT) • One Community Partnership 3 (OCP3) • SOAR • PATH • Housing Initiative • Mental Health Respite • Transitional Housing Program
5.01	9.9.2021	• Released FY 21-22
5.02	3.31.2022	• Updated Rates • Added Care Coordination Team –Children •
6.01	8.25.2022	• Released FY 22-23 • Update BNet Rate • FACT • School Behavioral Health Services Program (SBHSP) • Family Connections Through Peer Recovery (Family-CPR) Project
6.02	12.30.2022	• Updated Required Reports Table • Added List of Exhibits • Updated Children Care Coordination Team • Added Family Response Teams
7.01	9.28.2023	• Released FY 23-24 • Add Residential Support Coordination • Updated BNet Rate
7.02	1.29.2024	• Update FEP Section • Add Daycare Rate • Add Trauma-Informed Transformation Initiative
8.01	10.24.24	• Released FY 24-25 • Update BNet Rate • Revised Rates for SIPP and SRTs • Removed OCP3 and added OCP4 Descriptions • Removed CCT Transitional Voucher
9.01	7.18.25	• Released FY 25-26 • Update Rates • Added: Case Management Navigation Program Family Well-being Treatment Team Model (FIT LITE) Involuntary Outpatient Placement Treatment (IOPT) Coordinated Opioid Recovery (CORE) Network of Addiction Care

		Involuntary Outpatient Placement Treatment (IOPT) • Updated Sections: Care Coordination Care Coordination (CW) CAT FACT Family Engagement Program FEP FIT MAT MRT OCP4 Transitional Voucher PATH
9.02	9.30.25	• Service Provision Detail- General Description update. • Update BNet Rate
9.03	1.13.26	• Language Update
10.01	9.3.2026	• Release for FY 26-27 • Language Updates