CENTRAL FLORIDA BEHAVIORAL HEALTH NETWORK, INC.

REQUEST FOR PROPOSAL (RFP)

Florida Assertive Community Treatment (FACT) Services in Collier County

RFP #181905FACT
Release Date: March 01, 2019

Contact Person:
Andrea Butler Fernandez, Senior Contract Manager
719 South US Highway 301
Tampa, FL 33619
Procurement@cfbhn.org

Solicitation of Responses

1. Introduction

1.1. Statement of Need

Central Florida Behavioral Health Network, Inc. (CFBHN) is issuing this solicitation for the purpose of obtaining a non-profit vendor in the service areas of **Collier County** to provide Florida Assertive Community Treatment (FACT) services to the identified population. The selected vendor will develop and operationalize services with the collaboration and oversight of CFBHN to ensure continuity and to provide services as determined by CFBHN as well as in **Guidance Document 16 (Appendix IX)** and the **Suncoast Region FACT Regional Operating Procedure (ROP) (Appendix X)**.

1.2. Term of Contract and Renewal

The anticipated initial term of the contract entered into with the successful vendor is thirteen (13) months beginning **June 1, 2019** and ending **June 30, 2020**, with renewal dependent on CFBHN's contract with DCF being renewed. Renewals will be for twelve months in each fiscal year by mutual agreement and shall be contingent on satisfactory performance evaluations and availability of funds. Services included in the RFP may be amended, added to, and/or deleted during the contract negotiations.

1.3. General Information

CFBHN will request, receive and evaluate detailed responses, hereinafter referred to as the "response", from the qualified applicants that have been identified as successfully meeting all eligibility requirements. CFBHN reserves the right to re-bid this RFP if it is determined to be in the best interest of the Suncoast Region. At any time during the RFP process, CFBHN may reject any or all responses, and may modify its statement of services sought, tasks to be performed, or the project description.

Should CFBHN only receive one response, CFBHN may, at our option, exercise the right to terminate the RFP process and move directly into negotiations with said vendor.

1.4. Contract Amount and Funding Source

The amount of the contract resulting from this RFP is $1,220,421 per year as detailed below (subject to the availability of funds). The amounts of the contracts resulting from this RFP will be awarded in the following allocations:

1.4.1. Collier County - $1,220,421

a. **FACT Team Services: $1,010,944**

b. **Incidental Expenses: $209,477**

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The funding for these services comes from the MH073 "other cost accumulator (OCA)". There is no match requirement under this funding. Any renewal of funds shall be in writing and shall be subject to the same terms and conditions as set forth in the initial contract. CFBHN may have some carry forward start up funding available to assist with the transition of the team.

CFBHN calculates the FACT Team Rates based on a census of 98 (as long as the team has 98 persons, the full dollar amount will be earned for the year). With the dollars allocated above, the rate would be calculated as follows:

At least 98 persons on FACT Team * 52 weeks = 5,096 units available for the Fiscal Year

$1,010,944 in Services / 5,096 units available = $198.38

This rate is available to be discussed in negotiations with the vendor who is awarded the funding.

1.5. Posting

All Official Notices, decisions and intended decisions and other matters relating to the procurement will be electronically posted on Central Florida Behavioral Health Network's website at https://www.cfbhn.org/contracting-procurement/.

1.6. Vendor Disqualification

Failure to have performed any contractual obligations with CFBHN or the Department, in a manner satisfactory to CFBHN or the Department, will be sufficient cause for disqualification. To be disqualified as a vendor under this provision, the vendor must have:

- Previously failed to satisfactorily perform in a contract with the Department or CFBHN, been notified by the Department or CFBHN of the unsatisfactory performance, and failed to correct the unsatisfactory performance to the satisfaction of the Department or CFBHN; or
- Had a contract terminated by the Department or CFBHN for cause; or
- Not met all of the mandatory requirements specified in **Section 3.2.**

1.7. Limitations on Contacting CFBHN Personnel

All communications with CFBHN employees as they relate to this RFP are prohibited during the time period in which the RFP is released and throughout the end of the 72-hour period following CFBHN's posting of the notice of intended award. The aforementioned 72-hour period excludes Saturdays, Sundays, and state holidays. Vendors may only communicate via electronic communications to the Procurement Manager or as provided in the solicitation documents. Violation of this provision may result in vendor being disqualified from this procurement.

1.8. Schedule of Events and Deadlines

Any proposal submitted after **April 8, 2019, 12:00 PM** (CFBHN's clock) will not be accepted.

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Activity	Date	Time	Address
Request for Proposal (RFP) Released	03/01/2019	5:00 PM	CFBHN's website: https://www.cfbhn.org/contracting-procurement/
*Vendor Solicitation Conference	03/06/2019	1:00 PM	Conference Call Info: Dial-In: 1-877-273-4202 Conference Room ID: 6511264
Submission of Written Inquiries Due	03/08/2019	5:00 PM	Andrea Butler Fernandez, Senior Contract Manager Procurement@cfbhn.org
Anticipated Date for Posting CFBHN's Response to Inquires	03/12/2019	5:00 PM	CFBHN's website: https://www.cfbhn.org/contracting-procurement/
Mandatory Written Notice of Intent to Participate Due	03/15/2019	5:00 PM	Andrea Butler Fernandez, Senior Contract Manager Procurement@cfbhn.org
Proposals Must be Received by CFBHN	04/08/2019	12:00 PM	Andrea Butler Fernandez, Senior Contract Manager Procurement@cfbhn.org
Opening of RFP(s) and Review of Mandatory Criteria Form	04/08/2019	1:00 PM	CFBHN 719 South US Highway 301 Tampa, FL 33619
Evaluator Team Meeting & Distribution of Proposals	04/09/2019	11:00AM	CFBHN 719 South US Highway 301 Tampa, FL 33619 Conference Call Info: Dial-In: 1-877-273-4202 Conference Room ID: 6511264
Evaluation Period	04/09/2019 to 05/01/2019	N/A	N/A
*Debriefing Meeting of the Evaluators and Ranking of the Responses	05/01/2019	10:00AM	CFBHN 719 South US Highway 301 Tampa, FL 33619 Conference Call Info: Dial-In: 1-877-273-4202 Conference Room ID: 6511264
Invitations to Present Sent	05/02/2019	N/A	Andrea Butler Fernandez, Senior Contract Manager Procurement@cfbhn.org
Presentations	05/08/2019 to 05/10/2019	TBD	CFBHN – Richard Brown Conference Center 8920 Brittany Way Tampa, FL 33619
Posting of Proposal Scores and Notice of Intent to Award the Contract	05/13/2019	4:00 PM	CFBHN's website: https://www.cfbhn.org/contracting-procurement/
72-Hour Protest Period	05/13/2019 to 05/16/2019	4:00 PM	N/A

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Anticipated Negotiation Period	05/20/2019 to 05/24/2019	TBD	CFBHN 719 South US Highway 301 Tampa, FL 33619
Anticipated Effective Date of Contract	05/31/2019	N/A	N/A
Transitioning of Clients	06/01/2019 to 06/30/2019	N/A	N/A
*All vendors are hereby notified that the meetings noted with an asterisk above (*) are public meetings open to the public as provided in Chapter 119, Florida Statutes, and may be electronically recorded by any member of the audience. Although the public is invited, no comments or questions will be taken from vendors or other members of the public (except for the Vendor Solicitation Conference, in which comments and questions will be taken from vendors).			
All times in the Schedule of Activities are local times for the Eastern Time Zone.			

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1.9. Vendor Solicitation Conference

The purpose of the Vendor Solicitation Conference is to review the RFP with interested vendors. CFBHN encourages all vendors to participate in the solicitation conference, during which vendors may pose questions. CFBHN shall be only bound by written information that is contained within the solicitation documents or formally posted as an addendum or a response to questions.

The Vendor Solicitation Conference for this RFP will be held at the time and date specified in **Section 1.8.** Participation in the Vendor Solicitation Conference is not a pre-requisite for acceptance of responses from vendors.

All vendors shall be accorded fair and equal treatment.

1.10. Notice of Intent to Participate

All vendors intending to participate in this RFP must submit a brief written email with a declaration of their intent to participate in this process. The response should also include contact information for a point of contact for the remainder of the RFP. All vendors submitting their responses will receive direct correspondence throughout the procurement. Vendors are still responsible for checking the website for any official updates or modifications to this procurement.

1.11. Written Inquiries

Other than during the Vendor Solicitation Conference, vendor questions will only be accepted if submitted as written inquiries to the Contact Person, specified on the title page of this RFP, via electronic mail, and received on or before the date and time specified in **Section 1.8.**

The emails must have in the subject "**RFP #181905FACT – Inquiries**". Faxes and US Mail inquiries are not acceptable. Copies of responses to all inquiries that require clarifications and/or addenda, to this RFP, will be available by the date and time specified in **Section 1.8.,** through electronic posting at: https://www.cfbhn.org/contracting-procurement/.

1.12. Withdrawal of Response

A written request for withdrawal, signed by the vendor, may be considered if received by CFBHN within 72 hours after the opening time and date indicated in the Schedule of Events and Deadlines (**Section 1.8.**). A request received in accordance with this provision may be granted by CFBHN upon proof of the impossibility to perform, based upon an obvious error on the part of the vendor.

1.13. Receipt and Rejection of Responses or Waiver of Minor Irregularities

1.13.1. Response Deadline

Responses must be received by CFBHN no later than the time, date, and place as indicated in the proceeding deadline schedule. Any response submitted shall remain a valid offer for at least 90 days after the response submission date. No changes, modifications, or additions to the response submitted (after the deadline for response opening has passed) will be accepted by or be binding on CFBHN.

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1.13.2. Receipt Statement

Responses not received at either the specified place, or by the specified date and time, will be rejected, and returned unopened to the vendor by CFBHN. CFBHN will retain one unopened original for use in the event of a dispute.

1.13.3. Right to Waive Minor Irregularities Statement

CFBHN reserves the right to reject any and all responses or to waive minor irregularities when to do so would be in the best interest of the Suncoast Region. Minor irregularity is defined as a variation from the Request for Proposal terms and conditions which do not affect the price of the response, or give the vendor an advantage or benefit not enjoyed by other vendors, or do not adversely impact the interest of CFBHN. At its option, CFBHN may correct minor irregularities but is under no obligation to do so whatsoever.

1.14. Notice of Contract Award

CFBHN intends to award the contract to the responsive vendor that is awarded the highest score, based on the selection criteria set forth in **Section 3.4.3.** and **Section 5.**

CFBHN may consider any information or evidence which comes to its attention and which reflects upon a vendor's capability to fully perform the contract requirements and/or the vendor's demonstration of the level of integrity and reliability which CFBHN determines to be required to assure performance of the contract.

2. Program Expectations

2.1. General Description of Services

FACT teams are bound to comply with DCF's **Guidance Document 16 – Florida Assertive Community Treatment (FACT) Handbook (Appendix IX)** also available at http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities/2018-contract-docs and the **Suncoast Region FACT Regional Operating Procedure (ROP) (Appendix X)**.

FACT teams are required to admit "priority clients" as defined by CFBHN before other referrals can be considered for admission. Referrals that are non-priority clients must be authorized by CFBHN prior to admission.

Priority populations are as follows:

- On wait list for civil state hospital admission;
- In the civil state hospital on the seeking placement list;
- Identified as a High Need/High Utilizer (HNHU) by CFBHN;
- Other referrals made by CFBHN

The vendor will be monitored by CFBHN's Quality Improvement (QI) Team to ensure they are meeting the requirements of the program. FACT-Specific QI Tools currently in use have been included as part of this RFP **(Appendix XI)**.

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2.2. Staffing Standards

Continuity of services is critical to maintaining the stability of the consumers on these teams. All individuals currently working on the FACT teams must be offered an opportunity to interview for a position at the organization who is awarded the contract. Describe what your organization will do to ensure your FACT team(s) are properly staffed at the time of assuming control of the team(s) on July 1st. Please note any exceptions or challenges to meeting the staffing qualification requirements you anticipate (see "Staffing Requirements" on pages 3 to 6 of **Guidance Document 16 (Appendix IX)**.

2.3. Subcontractors

The successful vendor may, only with the prior consent of CFBHN, enter into written subcontract(s) for performance of certain of its functions under the contract. Subcontractors known at the time of proposal submission and the amount of the subcontract shall be identified in the vendor's response to this RFP. The act of subcontracting shall be approved in writing by CFBHN's Contract Manager prior to the effective date of any subcontract. No subcontract which the vendor enters into with respect to performance under the contract resulting from this RFP shall in any way relieve the vendor of any responsibility for performance of its duties. All payments to subcontractors shall be made by the vendor.

2.4. Reports

Please see **Guidance Document 16 (Appendix IX)** for the current DCF reporting requirements. The following reports will be required:

- FACT Weekly Membership Enrollment
- FACT Monthly Census with names, date of admit, and referral source
- FACT Enhancement Reconciliation report
- FACT Monthly Referral Log
- FACT Ad hoc report
- Monthly Vacant Positions report

2.5. Performance Measures

The following are current DCF Performance Measures that will be included in the Subcontract when awarded:

- Percent of adults with severe and persistent mental illnesses who live in a stable housing environment: 90%.
- Average annual days worked for pay for adults with a severe and persistent mental illness: 40.
- Percent of all individuals enrolled will maintain or show improvement in their level of functioning as measured by the Functional Assessment Rating Scale (FARS): 75%.
- Percent of staffing requirements will be maintained monthly: 90%.
- Percent of all individuals enrolled will be admitted to a state mental health treatment facility while receiving FACT services or within thirty (30) days of discharge from the program: 5%.
- Percent of all individuals enrolled shall have a completed psychiatric/social functioning history time line within one hundred twenty (120) days of enrollment with written documentation of the service occurrence in the clinical record: 90%.

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- Percent of all individuals enrolled shall receive work-related services toward a goal of obtaining employment (unless the individual refuses) within one (1) year of enrollment with written documentation of the service occurrence in the clinical record: 50%.
- Percent of all individuals enrolled shall receive housing services toward a goal of obtaining independent, integrated living within one (1) year of enrollment with written documentation of the service occurrence in the clinical record: 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 sixty (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 ninety (90) days of enrollment with written documentation of the service occurrence in the clinical record: 90%.

3. Instructions to Vendors

3.1. General Instructions to Respondents

Vendors shall submit the items identified as mandatory requirements in **Section 3.2.** as well as a response to the following items identified in **Section 3.4.3:**

- Mandatory Requirements (**Section 3.2.**)
- Response (**Section 3.4.3.**)

The Procurement Manager will examine each response to determine whether the vendor meets the Mandatory Requirements specified in **Section 3.2.** A response that fails to meet all of the Mandatory Requirements will be deemed non-responsive and will not be evaluated. An initial determination that a response meets the Mandatory Requirements does not preclude a subsequent determination of non-responsiveness. Responsive submissions will then be scored by an evaluation team, based on the criteria outlined in **Section 3.4.3 and Section 4**.

CFBHN may reject any or all responses, and may modify its' statement of services sought, tasks to be performed, or the project description and re-bid these services or re-negotiate, if it is in the best of interest to CFBHN.

3.2. Response to RFP Mandatory Requirements

The mandatory requirements are described as **MANDATORY CRITERIA** on the RFP Mandatory Criteria Checklist (**APPENDIX I**). Failure to comply with all mandatory requirements will render a proposal non-responsive and ineligible for a qualitative evaluation.

The **MANDATORY CRITERIA** are:

Mandatory Requirements
The proposal is received by the time, date, and at the location specified in **Section 1.8.**

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• The proposal is received by the Procurement Manager by the time, date and at the location specified in the Request for Proposal. (**Section 1.8**)
• CFBHN will validate any applications received to ensure that the Required Documents Checklist (**APPENDIX II**) are complete.
• **Acceptance of Contract Terms and Conditions** form **(APPENDIX III)**
• Signed **Certification of Non-Conviction of Public Entity Crimes** form **(APPENDIX IV)**
• Signed **Statement of Assurances** form **(APPENDIX V)**
• Signed **Statement of No Contract Termination** form **(APPENDIX VI)**
• Signed **Statement of No Involvement** form **(APPENDIX VII)**
• Documentation showing a minimum of 5 years as a non-profit in the behavioral health field
• If the vendor is not a currently contracted provider under CFBHN, submit the following: • Copies of their last two financial and compliance audits conducted through an independent auditing firm. The audit must include financial statements, auditor's report, and management letters. Additionally, the vendor must submit a completed financial risk assessment **(APPENDIX VIII)**. If the vendor is not required to have an audit (as required by OMB Circular A-133), and does not have reports for the two previous years, then corresponding financial statements that include Income Statement, Balance Sheet, and Statement of Cash Flows shall be certified by the agency's Chief Executive Officer, Chief Operating Officer or Chief Financial Officer and shall be submitted, along with the completed financial risk assessment **(APPENDIX VIII)**.

*CFBHN has the right to require any additional information it requires to validate any attestations made in a procurement response or presentation.

For those mandatory criteria that are listed above which require the completion of a form, the forms can be found in **APPENDIX II – APPENDIX VIII** and on CFBHN's website at:

https://www.cfbhn.org/contracting-procurement/

3.3. How to Submit a Proposal

Any response must be received by CFBHN by the deadlines set forth in the Schedule of Events and Deadlines (**Section 1.8.**). Responses not received at either the specified place or by the specified date and time, will be rejected.

3.3.1. Number of Copies Required and Format for Submittal

Vendors shall submit one (1) original and five (5) hard copies of the Response (and attachments). If the original has any color other than black and white, the copies must also contain the same colors. The original responses submitted to CFBHN must contain original signatures of an official who is authorized to bind the vendor to its response. Two (2) electronic copies (on non-rewritable CD-R, DVD-R, or USB storage device) of the response, identical to the hard copies, must also be submitted with the hard copies.

3.3.2. Responses to be in Sealed Envelopes

All original, hard copies, and electronic copies must be submitted in sealed envelopes and must be clearly marked with the title of the response, the RFP number, the vendor's name,

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identification of enclosed documents, and whether it is an original or a copy. Place only one original or one copy of the response in each envelope.

Each envelope must be sealed and addressed as indicated above. The original must be marked as such and the copies identified and numbered (i.e., Original, Copy 1 of 5, etc.).

3.3.3. Hard Copy Response Format

Responses must be typed, double-spaced, on 8½" x 11" paper, and submitted in binders. The required font is Arial, size 12, with a 1 inch margin. Pages must be numbered in a logical, consistent fashion. Figures, charts, and tables should be numbered and referenced by number in the text. No staples, permanent binders, or rubber bands are permitted.

3.3.4. Electronic Copy Response Format

The required electronic format of the responses must be on non-rewritable CD-R, DVD-R, or USB storage device. The software used to produce the electronic files for the Response must be searchable Adobe Portable Document Format ("pdf"), version 6.0 or higher. Responses must be able to be opened and viewed by CFBHN utilizing Adobe Acrobat, version 9.0.

The electronic copies must be identical to the original response submitted, including the format, sequence, and section headings identified in this RFP. The electronic media must be clearly labeled in the same manner as the hard copies and submitted with the corresponding hard copies. The hard copy marked "original" shall take precedence over the electronic version(s) of the response and all non-"original" hard copy versions of the response in the event of any discrepancy. If a discrepancy is found between the hard copy response marked "original" and any of the electronic versions submitted on CD-R, DVD-R, or USB storage device, CFBHN reserves the right, at its sole discretion, to reject the entire response.

3.4. Required Content of the Response

3.4.1. TITLE PAGE

The first page of the response shall be a Title Page that contains the following information:

- RFP Number
- Title of the Response
- Vendor's Legal Name (person, organization, firm)
- Name, Title, Phone Number, Fax Number, Mailing Address and E-Mail Address of the person who can respond to inquiries regarding the response
- Name of the vendor's Project Director (if known)
- Identification of Enclosed Documents

3.4.2. RFP MANDATORY CRITERIA

The vendor shall provide all documents listed as **MANDATORY CRITERIA** as specified in **Section 3.2.**

3.4.3. RESPONSE AND SCORING

The vendor shall respond to the requirements listed throughout this RFP, including the questions detailed below. The maximum points available for each question/response are

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included in parenthesis next to the item.

3.4.3.1. Scope of Work

- Describe the preparations that are necessary to serve individuals returning from the state mental health treatment facility (SMHTF) as well as those who are at a local receiving facility and diverted from going to a SMHTF. (5 points)
- Describe what provisions will be made to ensure prompt response to any "on call" crisis (there is a duty to be available at any time of any day) or crisis calls during normal working hours. Please include time frames for response times, and how staff availability will be ensured (examples may include: housing vendor contacts you and feels the individual is in crisis, the individual contacts you and appears to be in crisis, individual is admitted to a local Baker Act facility or jail, client is at ER and you are notified). (4 points)
- As a result of the comprehensive assessment and planning process, vendors are required to have recovery plans tailored to each individual on the FACT team. Describe how the individuals served on the FACT team will have their needs and desires addressed specifically to them. (3 points)
- Describe the FACT team's role in the system of care and how that role involves participation in community systems meetings/committees. (3 points)
- Describe the approaches your agency offers to address different needs of any potential FACT team member (i.e. mentally or physically challenged, forensic, aging out, substance use disorders, and behavioral issues). (5 points)

3.4.3.2. Discharges

It is required that each FACT team discharge at least 10 individuals each year (and maintain the required census). Please describe the methodology your organization would use to assess which persons should be moved to a less intensive level of treatment. Include in the response:

- What is necessary to prepare an individual to eventually step down from FACT services
- Time frames associated with the discharge planning process
- What measures would be used (frequency of contact, admissions to Baker Act receiving facilities, and a specific measurement tool to evaluate readiness)
- The team's approach/role to this process
- Address the approach to resistance by individual and family and varying stability

3.4.3.3. Transition Plan

Please describe your plan for transitioning the individuals served in the current FACT team into your organization's continuum of care. The vendor selected for this team is

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expected to accept all clients currently receiving FACT services. If the vendor awarded a team is not currently treating the individuals on the FACT team, the following will need to be completed for each individual (detailed on pages 9 to 11 of **Guidance Document 16**):

- "Initial Assessment and Recovery Plan"
- "Comprehensive Assessment"
- "Comprehensive Recovery Plan"

The vendor is also expected to analyze the census to determine which individuals, if any, could be served at a less intensive level of services than FACT.

The successful vendor shall coordinate with Mental Health Resource Center (MHRC) to transition management of the team to their organization. The anticipated transition period will last approximately one month (from June 1st to June 30th)—the awarded team will be in full control of their team as of July 1st. Please include in your response to this section an outline of your organization's resources and structure which will best foster a smooth transition.

3.4.3.4. Vendor Unique Qualifications

Please describe any special capabilities or qualifications your organization believes will enable you to successfully operate a FACT team. Letters of support can be included and scored by evaluators in the response as attachments. Additionally, describe your organization's community relationships/partnerships existing in this community.

Examples of necessary relationships for successful implementation of a FACT team include:

- Linkages with local NAMI chapters and other peer support groups
- Local jail
- Courts
- Emergency rooms and trauma centers
- Local psychiatric inpatient units
- Housing resources
    - Assisted living facilities
    - Adult family care homes
    - Support housing
- Faith-based organizations
- Other behavioral health organizations
- Co-occurring resources (I.e. outpatient/inpatient, support groups, etc.)

Describe the relationships you have within your community that will enable this team to effectively link an individual to the necessary supports the individual needs and/or desires as referenced in their recovery plan. These supports/services would be those that augment the services/supports/treatments that FACT provides (i.e. medical, dental, legal, employment/vocational, day services/activities, substance abuse treatment, and unique psychiatric services not provided by FACT (ECT, behavioral analyst), and leisure interests).

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Describe what your agency would do to ensure a broad representation of community stakeholders, individuals, and families are represented on the FACT advisory board.

3.4.3.5. Recovery-Oriented System of Care (ROSC)

Please describe your experience with ROSC and your organization's involvement with the community, stakeholders, and other entities. Include your agency's approach to recovery, the aspects of recovery-oriented system of care, and how these aspects will be reflected in the implementation of your FACT team.

4. Evaluation Methodology

Each item identified in **Section 3.4.3.** above will be scored independently by members of an evaluation team. Scores will then be averaged together for a final score. CFBHN will issue a notice of intent to award this funding and, following a brief protest period, move into negotiations.

Scoring Methodology

Written proposals: Invitations to present will be based on scoring across all categories. The guidance for evaluator scoring can be found in **Appendix XII**. Vendors will have a base score for the general areas of response. The top scorers, as determined by the evaluation team's scores in the Evaluation Tool (see **Appendix XII**) will then be invited to present.

Oral presentations: Presentations will be scored by the evaluators with a base score established for general provisions. The FACT team presentation time is not to last more than 30 minutes. Up to 15 minutes may be reserved for a question period at the end, for a period of 45 minutes total.

Final cumulative scoring (only applicable to vendors who are invited to present): 60% of the final score will be based on the written portion of the RFP response. 40% of the final score will be based on the presentations portion of the procurement process.

5. Supplemental Reference Protocols

The items contained within this document are supplemental requirements related to any procurement posted by Central Florida Behavioral Health Network, Inc. (CFBHN) from September 26, 2018 and forward. It is incorporated by reference, and is posted on on CFBHN's website at:

https://www.cfbhn.org/contracting-procurement/

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APPENDIX I
MANDATORY CRITERIA CHECKLIST

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MANDATORY CRITERIA CHECKLIST			
RFP #:	**181905FACT**		
Print Vendor's Name:			
Print Name of CFBHN **Reviewer**:			
Signature of CFBHN **Reviewer**:		Date:	
Print Name of CFBHN **Witness**:			
Signature of CFBHN **Witness**:		Date:	

1. Was the proposal received by the date and time specified in the RFP and at the specified address?

❑ YES = Pass ❑ NO = Fail

Comments:

2. Did the proposal include the following? (for internal use only)

a. CFBHN Verification that Vendor's **Required Documents Checklist** is complete **(List of documents in APPENDIX II)**	❑ YES = Pass ❑ NO = Fail
b. Vendor's signed **Acceptance of Contract Terms and Conditions** form **(APPENDIX III)**	❑ YES = Pass ❑ NO = Fail
c. Vendor's signed **Certification of Non-Conviction of Public Entity Crimes** form **(APPENDIX IV)**	❑ YES = Pass ❑ NO = Fail
d. Vendor's signed **Statement of Assurances** form **(APPENDIX V)**	❑ YES = Pass ❑ NO = Fail
e. Signed **Statement of No Contract Termination** form **(APPENDIX VI)**	❑ YES = Pass ❑ NO = Fail
f. Signed **Statement of No Involvement** form **(Appendix VII)**	❑ YES = Pass ❑ NO = Fail
g. Documentation showing a minimum of 5 years as a non-profit in the behavioral health field	❑ YES = Pass ❑ NO = Fail
h. If the vendor is not a currently contracted provider under CFBHN, submit the following: Copies of their last two financial and compliance audits conducted through an independent auditing firm. The audit must include financial statements, auditor's report, and management letters. Additionally, the vendor must submit a completed **financial risk assessment (APPENDIX VIII)**. If the vendor is not required to have an audit (as required by OMB Circular A-133), and does not have reports for the two previous years, then corresponding financial statements that include Income Statement, Balance Sheet, and Statement of Cash Flows shall be certified by the agency's Chief Executive Officer, Chief Operating Officer or Chief Financial Officer and	❑ YES = Pass ❑ NO = Fail

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shall be submitted, along with the completed **financial risk assessment (APPENDIX VIII)**.	

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APPENDIX II
REQUIRED DOCUMENTS CHECKLIST

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Required Documents Checklist

Agency Name:_____

Required Document	
1.	Accreditation – this includes the following: *-Accreditation Certificate* *-Accreditation Survey* *-Most recent Accreditation Report* *-Corrective Action or Performance Improvement Plans, and* *-Any Performance Data submitted to your accrediting organizations.*
2.	Attestation Letter for the Deaf and Hard-of-Hearing *-Must be on your agency's letterhead and include *at minimum* Agency's SPOC and Agency's Section 504 Coordinator* *-Applies to employers with 15 or more employees only.* *-Template*
3.	Business Associate Agreement (BAA) *-Template*
4.	Certification of a Drug-Free Workplace Form *-Can be either a written statement or a policy.*
5.	Civil Rights Compliance Checklist *-Applies to employers with 15 or more employees only.* *-Template*
6.	Civil Rights Certificate *-Applies to employers with 15 or more employees only.* *-Template*
7.	Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts – CF 1125 Form -Template
8.	Certification Regarding Lobbying / Certification for Contracts, Grants, Loans, and Cooperative Agreements CF 1123 Form -Template
9.	Cost Allocation Plan *-More Info: 65E-14.017(2)(d)* *-Template*
10.	Current Board Members List, Including Mailing Address, E-Mail Address and Phone Number
11.	Data Universal Numbering System (DUNS) Number
12.	Dispute Resolution – Name **and** Position of Person Assigned *-Note: This is for disputes or issues between the **Subcontractor** and **CFBHN**.*
13.	Federally Approved Indirect Cost Rate Letter *-Please submit the letter showing your agency's federally approved rate.*
14.	Financial Reports - Profit Loss Statement, Balance Sheet, and Statement of Cash Flows
15.	Insurance – Proof of Current General Liability, Automobile Liability, and Professional Liability – Naming the Department of Children and Families **and** Central Florida Behavioral Health Network as additional insureds under the policy(ies) *Optional: We recommend Cyber Insurance Coverage.* *Contract with CFBHN will not be signed if insurance is not in place and meets requirements (A-rating; Names CFBHN/DCF as additional insureds).*
16.	Legal Signing Authority

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Central Florida Behavioral Health Network, Inc. Required Documents Checklist

Agency Name:_____

	-Signed Board Resolution, By-laws, Minutes, Letter, etc. *-Please include ALL persons authorized.*
17.	Licenses – A current copy of all from DCF, AHCA, etc.
18.	Memorandum of Understanding with Federally Qualified Health Centers
19.	NPI – Evidence of a National Provider Identifier
20.	Organization Chart with employee names & positions and date of last revision
21.	Program Description, CF-MH 1045 *-Template*
22.	Provider Fee Policy *-65E-14.014 – SAMH-Funded Entity Responsibilities* *Section (5) (d) – The billing and payment mechanism; third party billings and fee collection procedures which prevent duplicate payments for services provided.* *-Fee policy **OR** signed attestation of the following:* ***All first and third party fees earned are generally retained by the Program/Cost Center in which they are generated. Fees may also be used to support the goals and objectives of provider in accordance with its Strategic Plan, Budget Plan, Staffing Plan and other relevant considerations in order to fulfill its mission statement for the provision of quality services while assuring that it maintains a strong financial position.***
23.	Scrutinized Vendor Certification – CF 1110 Form *-Template*
24.	Sliding Fee Scale Policy **and** Amounts *-Based on the latest poverty guidelines* *http://aspe.hhs.gov/poverty/index.cfm*
25.	Subcontracts for services being subcontracted out by your agency for primary services *-Subcontracting is defined as the following:* *Subcontracting core behavioral health services and health and safety services.* *Examples of subcontracted services are counseling, case management, nursing, medical services, etc.* **Subcontracts must be approved **prior to July 1st**, or provider will be ineligible to bill for services.* *-Note: if your agency has an automatically renewing subcontract, please confirm that it is still valid for the coming fiscal year (19-20).*
List out all subcontracts here: a. b. c. d. e.	
26.	Tax-exempt nonprofit organization *-(501(c)(3)) status (IRS Determination Letter) and Tax Exempt Certificate*

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APPENDIX III
ACCEPTANCE OF CONTRACT TERMS AND CONDITIONS

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Acceptance of Contract Terms and Conditions	
ITN/RFI/RFP #:	**181905FACT**
Print Vendor's Name:	
Print Name of Authorized Representative:	
I, as an authorized representative of the above named vendor, certify that we accept CFBHN's and the Department's requirements, terms and conditions as specified in this Request for Proposal and in CFBHN's Standard Contract.	
Signature of Authorized Representative:	
Title:	
Date:	

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APPENDIX IV
CERTIFICATION OF NON-CONVICTION OF PUBLIC ENTITY CRIMES

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PUBLIC ENTITY CRIME

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to State of Florida Department of Children and Family Services

by _____
[print individual's name and title]
for [print institution's name and business address]

and (if applicable) its Federal Employer Identification Number (FEIN)

(If the entity has no FEIN, include the Social Security Number of the individual signing this sworn statement: _____.)

2. I understand that a "**public entity crime**" as defined in Paragraph 287.133(1)(g), F.S., means a violation of any state or Federal law by a person with respect to and directly related to the transaction of business with any public entity or with an agency or political subdivision of any other state or of the United States, including, but not limited to, any bid or contract for goods or services to be provided to any public entity or an agency or political subdivision of any other state or of the United States and involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentation.

3. I understand that "**convicted**" or "**conviction**" as defined in Paragraph 287.133(1)(b), F.S., means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in any Federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a Jury Verdict, nonjury trial, or entry of a plea of guilty or nolo contendere.

4. I understand that an "**affiliate**" as defined in Paragraph 287.133(1)(a), F.S., means:

a. A predecessor or successor of a person convicted of a public entity crime; or

b. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "**affiliate**" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate.

5. I understand that a "**person**" as defined in Paragraph 287.133{1)(e), F.S., means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which bids or applies to bid on contracts for the provision of goods or services let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term "**person**" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

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PUBLIC ENTITY CRIME

6. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement. [Indicate which statement applies.]

_____ Neither the entity submitting this sworn statement, nor any of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, nor any affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

_____ The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989. However, there has been a subsequent proceeding before a Hearing Officer of the State of Florida, Division of Administrative Hearings and the Final Order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list. [Attach a copy of the final order.]

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH I (ONE) ABOVE IS FOR THAT PUBLIC ENTITY ONLY AND, THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THE PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.017, F.S., FOR CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

_____
[signature]

State of _____
County of _____

Sworn to and subscribed before me this _____ day of _____, 20___.

Personally known _____

OR Produced identification _____ Notary Public - State of _____
_____ My Commission Expires: _____
(type of identification)

_____
(Printed, typed or stamped commissioned name of notary public

APPENDIX V
STATEMENT OF ASSURANCES

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STATEMENT OF ASSURANCES		
RFP #:	**181905FACT**	
Print Vendor's Name:		
Print Name of Authorized Representative:		

Statement	Initials
1. Infrastructure – The vendor shall possess, purchase, or otherwise provide computer and telecommunications equipment and Internet access necessary to participate fully in the initiative.	_____
2. Evaluation – The vendor will cooperate fully with any CFBHN-designated evaluation agency in designing a program evaluation and providing any and all data necessary to conduct process and outcome evaluation.	_____
3. Technical Assistance – The vendor will participate in any CFBHN-conducted, sponsored, or required technical assistance meetings and/or workshops or conferences.	_____
4. Site Visits – The vendor will cooperate fully with the CFBHN and any CFBHN-designated evaluation agency in coordinating site visits.	_____
5. Background Checks – The vendor shall be responsible for providing background checks as a prerequisite of employment in accordance with Chapter 294.4572, Florida Statutes and Chapter 397.451, Florida Statutes.	_____
6. Administrative Requirements – The vendor agrees to comply with the following Office of Management and Budget (OMB) Circulars, as applicable: A-21 Cost Principles for State, Local and Indian Tribal Governments; A-102 Uniform Administrative Requirements for Grants and Agreements with State and Local Governments; A-110 Uniform Administrative Requirements for Grants and Agreements with Institutions; and, A-122 Cost Principles for Non-profit Organizations.	_____
7. Non-discrimination – The vendor agrees that no person will, on the basis of race, color, national origin, creed or religion be excluded from participation in, be refused the benefits of, or be otherwise subjected to discrimination pursuant to the Act governing these funds or any project, program, activity or sub-grant supported by the requirements of, (a) Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended which prohibits discrimination the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended which prohibits discrimination in employment or any program or activity that receives or benefits from federal financial assistance on the basis of handicaps; (d) Age Discrimination Act 1975, as amended which prohibits discrimination on the basis of age, (e) Equal Employment Opportunity Program (EEOP) must meets the requirements of 28 CFR 42.301.	_____

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RFP #:	181905FACT
Print Vendor's Name:	

Statement	Initials
8. Drug-Free Workplace Requirements – The vendor agrees that he/she will provide, or will continue to provide, a drug-free workplace in accordance with 45 CFR Part 82.	_____
9. Confidentiality Requirements – The confidentiality of the recipients of the services provided through this project shall be fully protected in accordance with Federal Confidentiality Regulations pertaining to Alcohol and Drug Abuse Patient Records as outlined in 42 CFR Part 2.	_____
10. Smoke-Free Workplace Requirements – Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.	_____
11. Acceptance of Contract Terms and Conditions – The vendor agrees to the contract Terms and Conditions.	_____
12. No Involvement – The vendor certifies that they, nor any person having an interest in the vendor has been involved in the development of this procurement in any manner.	_____
13. No Contract Termination – The vendor acknowledges that they have never had a contract terminated for not meeting performance measures or for cause.	_____
14. Disqualification for false or misleading information – The vendor acknowledges that any information submitted within this RFP response may lead to the loss of the contract, if awarded.	_____

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APPENDIX VI
STATEMENT OF NO CONTRACT TERMINATION

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Statement of No Contract Termination	
ITN/RFI/RFP #:	**181905FACT**
Print Vendor's Name:	
Print Name of Authorized Representative:	
I, as an authorized representative of the above named vendor, hereby certify that my agency has never had a contract terminated for not meeting performance measures or for cause.	
Signature of Authorized Representative:	
Title:	
Date:	

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APPENDIX VII
STATEMENT OF NO INVOLVEMENT

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Statement of No Involvement	
ITN/RFI/RFP #:	**181905FACT**
Print Vendor's Name:	
Print Name of Authorized Representative:	

I, as an authorized representative of the above named vendor, hereby certify that no member of this firm, nor any person having interest in this firm, has been awarded a contract by the Department of Children and Families or Central Florida Behavioral Health Network, Inc. on a non-competitive basis to:

1. Develop this procurement document
2. Perform a feasibility study concerning the scope of work contained in this procurement document; or
3. Develop a program similar to what is contained in this procurement document.

Signature of Authorized Representative:	
Title:	
Date:	

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APPENDIX VIII
FINANCIAL RISK ASSESSMENT

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Central Florida Behavioral Health Network, Inc.
Collaborating for Excellence

Central Florida Behavioral Health Network
Financial Risk Assessment
Agency Monitoring Tool

AGENCY: _____ **PERIOD:** _____ **DATE:** _____

		Calculated Value				Benchmark	Points Available		Score	Score	Score
		FYE 2016	%	FYE 2017	%				FYE 2016	FYE 2017	TOTAL
1. Unrestricted net assets *This ratio provides an indication of the net resources available to provide services in the future.*	Unrestricted Net Assets / Total Annual Expenses		#VALUE!		#DIV/0!	>.40	2 1 0	Above .40 Between .30 and .39 less than .29	#VALUE!	#DIV/0!	#VALUE!
2. Cash reserves *Cash reserves is a rough measure of the amount of cash on hand to cover future expenses. When calculating total annual expenses, depreciation should not be included for this metric.*	Cash & Securities at end of year / Total Annual Expenses-(less depreciation)		#DIV/0!		#DIV/0!	60 days	3 2 1 0	Above 90 between 65 and 89 between 49 and 64 below 48	#DIV/0!	#DIV/0!	#DIV/0!
3. Receivable days *This number reflects the average length of time required to collect cash from receivable accounts. It is crucial to maintain positive liquidity.*	Total Receivables / Total Unrestricted Revenue		#DIV/0!		#DIV/0!	45 days	2 1 0	Between 0 - 45 days Between 46 - 75 days Above 76 days	#DIV/0!	#DIV/0!	#DIV/0!
4. Payable days *This ratio shows the average number of days that lapse between purchase of material and labor, and payment for them. It is a rough measure of how timely an organization is meeting payment obligations.*	Payables / Total Annual Expenses	0	#DIV/0!	0	#DIV/0!	30 days	2 1 0	Between 0 - 25 days Between 26 - 45 days Above 46 days	#DIV/0!	#DIV/0!	#DIV/0!
5. Working Capital Current ratio *This metric measures the overall liquidity position of an organization. Measures the ability to pay its current obligations using current assets by current liabilities*	Current Assets / Current Liabilities		#DIV/0!		#DIV/0!	2:1	3 2 1 0	Greater than 2 Between 1.50 -1.99 Between 1.00-1.49 Between 0 - .99	#DIV/0!	#DIV/0!	#DIV/0!
6. Audit findings over financial reporting or compliance *Audit findings over internal controls and compliance.*	Review Audit					No Deficiencies	3 0 -1	No deficiencies or material weaknesses Deficiencies identified Material weakness(es) identified	0	0	0

updated 7/5/18

Maximum Points Available Per Year: 15 **Score** #VALUE! #DIV/0!
Maximum Points Available TOTAL 30 **Total Score** #VALUE!

FOR CFBHN USE ONLY

Check all measures against submitted financials _____ CFBHN Staff Initials
Check all formulas _____ CFBHN Staff Initials
Enter CFBHN validated Total Score _____ CFBHN Staff Initials

CFBHN Reviewer Name: _____
Date: _____

APPENDIX IX
DEPARTMENT OF CHILDREN AND FAMILIES
GUIDANCE DOCUMENT 16
FLORIDA ASSERTIVE COMMUNITY TREATMENT (FACT) HANDBOOK

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Guidance 16
Florida Assertive Community Treatment (FACT) Handbook

Contract Reference: *Sections A-1.1 and C-1.3.2*

I OVERVIEW

In an effort to promote independent, integrated living for individuals with serious psychiatric disabilities, Florida Assertive Community Treatment (FACT) teams provide a 24-hour-a-day, seven-days-a week, multidisciplinary approach to deliver comprehensive care to people where they live, work or go to school, and spend their leisure time. The programmatic goals are to prevent recurrent hospitalization and incarceration and improve community involvement and overall quality of life for program participants. This handbook provides guidance to the Managing Entities on the programmatic expectations for a Network Service Provider implementing FACT. It was developed based on the Tool for Measurement of Assertive Community Treatment (TMACT) Protocol.[1]

[1] Monroe-DeVita, M., Moser, L.L. & Teague, G.B. (2011). *The tool for measurement of assertive community treatment (TMACT).* Unpublished measure.

I.A. PROGRAM DESCRIPTION

FACT team core elements include a multi-disciplinary 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. Program characteristics include:

- The provider is the primary provider of services and fixed point of accountability;
- Services are primarily provided out of office;
- Services are flexible and highly individualized;
- There exists an assertive, "can do" approach to service delivery; and
- Services are provided continuously over time.

A typical FACT participant may present with diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorder, major depression, and personality disorders. Challenges associated with these illnesses are often compounded by co-occurring substance use issues, physical health problems, and mild intellectual disabilities. These individuals are at high risk of repeated psychiatric admissions and have typically experienced prolonged inpatient psychiatric hospitalization or repeated admissions to crisis stabilization units. Many are involved in the criminal justice system and face the possibility of incarceration.

The FACT team delivers services on a long-term basis with continuity of caregivers over time. Emphasis is on recovery, choice, outreach, relationship building, and individualization of services. Enhancement funds are available to assist with housing costs, medication costs, and other needs identified in the recovery planning process. The number and frequency of contacts is set through collaboration rather than service limits. The team is available on nights, weekends, and holidays. Service intensity is dependent on need and can vary from minimally once weekly to several contacts per day. On average, participants receive 3 weekly face-to-face contacts. This flexibility allows the team to quickly ramp up service provision when a program participant exhibits signs of decompensation prior to a crisis ensuing. Teams must provide a minimum of 75% of all services and supports in the community. This means providing services in areas that best meet the needs of the individual, such as the home, on the street, or in another location of the participant's choosing.

There are no mandated minimum or maximum lengths of stay in the program. However, it is expected that individuals will be assisted in attaining recovery goals, thereby enabling transition to less intensive community services. The team conducts regular assessment of the need for services and uses explicit criteria for participant transfer to less intensive service options. Transition is gradual, individualized and actively involves the participant and the next provider to ensure effective coordination and engagement.

The team approach to delivering services and lack of service limits make FACT a unique service. There is no Medicaid state plan service equivalent to FACT; therefore, it is not covered by managed medical assistance or specialty plans. The program is funded through a combination of state general revenue and Medicaid administrative matching.

I.B. PROGRAM GOALS

The FACT program goals are to:

- Implement with fidelity to the ACT model;
- Promote and incorporate recovery principles in service delivery;
- Eliminate or lessen the debilitating symptoms of mental illness and co-occurring substance use that the individual may experience;
- Meet basic needs and enhance quality of life;

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- Improve socialization and development of natural supports;
- Support with finding and keeping competitive employment;
- Reduce hospitalization;
- Increase days in the community;
- Collaborate with the criminal justice system to minimize or divert incarcerations; and
- Lessen the role of families and significant others in providing care.

II. PROVIDER RESPONSIBILITIES AND EXPECTATIONS

II.A. STAFFING REQUIREMENTS

- **Minimum Staffing Standards**

FACT staffing configurations combine practitioners with varying backgrounds in education, training, and experience. This diverse range of skills and expertise enhances the team's ability to provide comprehensive care based on individual needs. The ratio of participants to direct service staff members should not exceed 10:1. Hours of operation and staff coverage provide services seven days per week with two overlapping eight hour shifts, operating a minimum of twelve hours per day on weekdays and eight hours each weekend day and holiday. The team operates an after-hours on-call system with a FACT team professional.

Based on the TMACT, the minimum staffing patterns are:

# of Participants	Minimum Direct Service[2] FTE	Minimum Total FTE
105	10.3	12.3
100	10.0	11.8
95	9.7	11.5
90	9.4	11.2
85	9.1	10.9

Within the guidelines of the prescribed staff to participant ratios presented in the previous staffing chart, teams may exercise a degree of flexibility in team composition. However, a FACT team must minimally include:

- One full-time Team Leader;
- One part-time Psychiatrist or Psychiatric Advanced Registered Nurse Practitioner (ARNP);
- One nurse for every 35 participants, one of whom must be a full-time registered nurse required to be on duty Monday through Friday;
- 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 Administrative Assistant.

[2] Direct service staff does not include the psychiatric care provider or administrative staff.

- **Staff Roles and Credentials**

The provider must maintain a current organizational chart indicating required staff and displaying organizational relationships and responsibilities, lines of administrative oversight, and clinical supervision.

- **Team Leader**

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:

- Clinical Social Worker;
- Marriage and Family Therapist;
- Mental Health Counselor;
- Psychiatrist;
- Registered Nurse; or
- Psychologist.

The Team Leader is responsible for administrative and clinical oversight of the team and functions as a practicing clinician. Preferably, the Team Leader is certified as a clinical supervisor. If the Team Leader is a Registered Nurse, this does not replace the requirement for a registered nurse on duty every weekday. The Team Leader receives clinical supervision from the Psychiatrist or Psychiatric ARNP and administrative supervision from the Chief Executive Officer or designee.

- **Psychiatrist or Psychiatric ARNP**

The Psychiatrist or Psychiatric ARNP provides clinical supervision to the entire team as well as psychopharmacological services for all participants. He or she also monitors non-psychiatric medical conditions and medications, provides brief therapy, and provides diagnostic and medication education to participants, with medication decisions based in a shared decision making paradigm. If participants are hospitalized, he or she communicates directly with the inpatient psychiatric care provider to ensure continuity of care. The Psychiatrist or Psychiatric ARNP also conducts home and community visits with participants as needed. The Psychiatrist must be board certified. If the team employs a Psychiatric ARNP, there must be access to a board-certified Psychiatrist for weekly consultation. A minimum of 32 hours of psychiatric services must be available for participants per week.

- **Nurse**

Preferred staffing for each team includes only Registered Nurses (RNs); however, a team may at minimum include one RN and sufficient additional licensed practical nurses to meet the required ratio. All nurses must have at least one-year experience working with adults with mental illnesses. Nurses perform the following critical roles:

- Manage the medication system;
- Administer and document medication treatment;
- Screen and monitor participants for medical problems/side effects;
- Communicate and coordinate services with other medical providers;
- Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change related to their physical health);

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- Educate other team members on monitoring of psychiatric symptoms and medication side effects; and
- With participant agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).

○ **Peer Specialist**

A Peer Specialist fulfills a unique role in the support and recovery from mental health disorders. A Peer Specialist has lived experience receiving mental health services for severe mental illness. His or her life experience and recovery provides knowledge and insight that professional training cannot replicate. The Peer Specialist is a fully integrated team members who provides individualized support services and promotes self-determination and decision-making. The Peer Specialist provides essential expertise and consultation to the entire team to promote a culture in which each person's point of view and preferences are recognized, understood, respected, and integrated into care. Within one year of employment, the Peer Specialist must meet the professional requirements and standards set forth by the Florida Certification Board and become certified by the state of Florida as a Certified Recovery Peer Specialist for Adults (CRPS-A). His or her mental health professional qualifications are compensated on an equitable basis with other FACT team members.

○ **Substance Abuse Specialist**

There must be at least one Substance Abuse Specialist with 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. Within one year of employment, a bachelor's level Substance Abuse Specialist must meet Florida's standards for certification as an Addiction Professional. The Substance Abuse Specialist provides integrated treatment for co-occurring mental illness and substance use disorders to participants who have a substance use problem. These services include:

- Substance use assessments that consider the relationship between substance use and mental health;
- Assessment and tracking of participants' stages of change readiness and stages of treatment;
- Outreach and motivational interviewing techniques;
- Cognitive behavioral approaches and relapse prevention; and
- Treatment approaches consistent with the participants' stage of change readiness

The Substance Abuse Specialist also provides consultation and training to other team staff on integrated assessment and treatment skills relating to co-occurring disorders.

○ **Vocational Specialist**

There must be at least one Vocational Specialist who has a bachelor's degree and a minimum of one year of experience providing employment services. The Vocational Specialist provides supported employment services as described in the Substance Abuse and Mental Health Services Administration's Supported Employment Evidence-Based Practices (EBP) KIT, which may be downloaded at http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365. Current training and practitioner tools may also be accessed on the Individual Placement and Support (IPS) Employment Center website at http://www.ipsworks.org/.

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The Vocational Specialist also provides consultation and training to other team staff on supported employment approaches.

- **Case Manager**

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. The Case Manager provides the rehabilitation and support functions under clinical supervision and are integral members of individual treatment teams. This includes social and communication skills training and training to enhance participant's independent living. Examples include on-going assessment, problem solving, assistance with activities of daily living, and coaching.

- **Administrative Assistant**

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. Additionally, the Administrative Assistant serves as a liaison between participants and staff, including attending to the needs of office walk-ins and calls from participants and natural supports. The Administrative Assistant actively participates in the daily team meeting.

- **Staff Communication and Planning**

The FACT team conducts daily organizational staff meetings at regularly scheduled times as established by the Team Leader. The team completes the following tasks during the daily meeting:

- Conducts a brief, clinically-relevant review of all participants and contacts (i.e. phone calls, home visits, transporting, etc.) in the past 24 hours and document this information;
- Maintains a weekly schedule for each participant including all treatment and service contacts to be carried out to reach the goals and objectives in the participant's recovery plan;
- Maintains a central file of all weekly schedules;
- Develops a daily staff schedule consisting of a written timetable for all treatment and service contacts to be divided and shared by the staff working that day based on:
  - The weekly schedule for each participant,
  - Emerging needs, and
  - Need for pro-active contacts to prevent future crises; and
  - Revise recovery plans as needed and add service contacts to the daily staff assignment schedule per the revised recovery plans.

II.B. PROGRAM ENROLLMENT

The FACT team should actively and continually recruit new enrollees who could benefit from ACT, including assertive outreach to referral sources outside of usual community mental health settings. Examples include state treatment facilities, community hospitals, crisis stabilization units, emergency rooms, prisons, jails, shelters, and street outreach. The team engages individuals in order to screen them for eligibility and allow them to make an informed decision regarding participation in services. Once threshold and eligibility requirements are met and the individual agrees to participation, the team enrolls applicants. The team should not exceed four admissions per month in order to maintain a stable service environment.

- **Threshold Requirements**

The FACT team must comply with the following parameters when at full capacity or while achieving full

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capacity:

- At least 50 percent of enrolled participants must be directly discharged from a state mental health treatment facility serving the circuit in which the team is located; and
- At least 60 percent of all participants must be eligible for Medicaid.

- **Clinical Eligibility Requirements**

The individual must have a diagnosis within one of the following categories as referenced in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, 5th Edition or the latest edition thereof (see Appendix A for a detailed list of qualifying diagnoses):

- Schizophrenia Spectrum and Other Psychotic Disorders;
- Bipolar and Related Disorders;
- Depressive Disorders;
- Anxiety Disorders;
- Obsessive-Compulsive and Related Disorders;
- Dissociative Disorders;
- Somatic Symptom and Related Disorders; and
- Personality Disorders.

The individual must meet one of the following six criteria:

- High risk for hospital admission or readmission;
- History of prolonged 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 for aftercare services by one (1) of the state's correctional institutions;
- Referred from an inpatient detoxification unit with documented history of co-occurring disorders; or
- Have more than 3 crisis stabilization unit or hospital admissions for mental health crisis stabilization within one year.

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

- 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:
  - Maintaining personal hygiene,
  - Meeting nutritional needs,
  - Caring for personal business affairs,
  - Obtaining medical, legal, and housing services, and
  - Recognizing and avoiding common dangers or hazards to self and possessions;
- 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);

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

As long as the above admission requirements are met, substance use disorders and mild intellectual disabilities, as defined in the DSM-5, cannot be used as a basis to deny FACT services. Individuals will continue membership with their managed medical assistance plan for provision of medical services. FACT will be solely responsible for comprehensive behavioral health services. FACT will coordinate care with an individual's managed medical assistance plan.

II.C. SERVICES AND SUPPORTS

The FACT approach to performing services is based on recovery orientation and promotes empowerment. The guiding principles include participant choice, cultural competence, person-centered planning, rights of persons served, stakeholder inclusion, and voice.

- Using this approach, the FACT team must provide the following services:
  - **Crisis Intervention and 24/7 On-call Coverage**

    The team assists with crisis intervention, referrals, or supportive counseling when needed.
  - **Comprehensive Assessment**

    Within 60 days of admission to FACT, the team completes assessments to guide care.
  - **Natural Support Network Development**

    This develops natural community supports, including extended family and friends, support groups and peer support, and religious and civic organizations.
  - **Case Management**

    The primary case manager, along with the team, coordinates care, advocates on behalf of the participant, and provides access to a variety of services and supports, including but not limited to:
    - Primary health care (medical and dental);
    - Basic needs such as housing and transportation;
    - Educational and employment services; and
    - Legal services.
  - **Enhancement Funds**

    Funding is used to increase or maintain a person's independence and integration into their community. It may be used for costs related to housing, medications, employment, education, and specialized treatment not paid by any other means. Detailed guidelines on the use of enhancement funds may be found in Appendix B, the January 2010 FACT Enhancement Guidelines.

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- **Family Engagement and Education**

With consent of the participant, families are engaged in the treatment process and are educated on topics related to their family member's recovery goals, diagnosis, and illness management.

- **Psychiatric Services**

FACT medical staff provide psychiatric evaluation, medication management, medication education, and medication administration.

- **Rehabilitation Services**

Team members provide skill training in the areas of effective communication, activities of daily living, safety planning, money management, and positive social interactions in order to enhance independent living. This may include modeling behaviors, practicing and role-plays, staff feedback, and ongoing prompting and cuing.

- **Substance Abuse and Co-occurring Services**

Both mental health and substance abuse needs are addressed through integrated screening and assessment, stage of change readiness determination, and therapeutic interventions consistent with the participant's readiness to change behaviors. The treatment approach is based on motivational interviewing and is non-judgmental, stresses engagement, and does not make sobriety a condition of continued treatment.

- **Supported Employment**

This includes vocational assessment, job placement, and ongoing coaching and support (including on-site support) as desired by the participant.

- **Therapy**

Clinicians provide and coordinate individual, group, and family therapy services. The type, frequency and location of therapy provided are based on individual needs and utilize empirically supported techniques for that individual and their symptoms and behaviors.

- **Wellness Management and Recovery Services**

The team assists participants to develop personalized strategies for managing their wellness, set and pursue personal goals, learn information and skills to develop a sense of mastery over their psychiatric illness, and help them put strategies into action in their everyday lives.

- **Transportation**

Staff assists with transportation to medical appointments, court hearings, or other related activities outlined in the care plan.

- **Supported Housing**

The team assists the participant in accessing affordable, safe, permanent housing of their choice through provision of multiple housing options with assured tenancy rights regardless of progress or success in services.

- **Competency Training**

For participants who are adjudicated incompetent to proceed, the team will provide competency restoration training and assist the participant through the legal process.

- **Initial Assessment and Recovery Plan**

The Team Leader in coordination with the Psychiatrist or Psychiatric ARNP performs an initial assessment and develops an initial plan of care on the day of the participant's admission to the program.

The participant and designated team members will be actively involved in the development of the plan. This is intended to ensure that immediate needs for medication, treatment, and basic needs are not delayed. The required components of an initial assessment, at a minimum, include:

- A brief mental status examination;
- Assessment of symptoms;
- An initial psychosocial history;
- An initial health/medical assessment;
- A review of previous clinical information obtained at the time of admission;
- A preliminary identification of the participant's housing, financial and employment status; and
- A preliminary review of the participant's strengths, challenges, and preferences.

- **Comprehensive Assessment**

The Team Leader assigns the individual's treatment team, including the Psychiatrist or Psychiatric ARNP and primary case manager on the day of admission. The team is responsible for preparing a written comprehensive assessment within 60 days of the participant's admission to the program. The comprehensive assessment must meet the following requirements:

- Each assessment area is completed by a team member with skill and knowledge in the area being assessed and is based upon all available information.
- At minimum, the comprehensive assessment includes:
  - Psychiatric history and diagnosis;
  - Mental status;
  - Strengths, abilities, and preferences;
  - Physical health;
  - History and current use of drugs or alcohol;
  - Education and employment history and current status;
  - Social development and functioning;
  - Activities of daily living;
  - Family and social relationships and supports; and
  - Recommendations for care.
- To supplement the comprehensive assessment, the team completes a psychiatric/social functioning history time line no later than 120 days after the first day of admission.
- The team updates assessments at least annually and uses the updated assessments to update the recovery plan. All necessary areas essential for planning must be included in the updated assessment.

- **Comprehensive Recovery Plan**

The team completes a comprehensive recovery plan as an expansion of the initial plan within 90 days of admission, following completion of all assessments. The Comprehensive Recover Plan shall adhere to the following guidelines:

- Planning is person-centered and actively involves the participant, guardian (if any), and family members and significant others the participant wishes to participate.
- The plan is reviewed and updated, at minimum, every six months during planned meetings, unless clinically indicated earlier, by the treatment team and the participant.
- The plan is based on assessment findings and:
  - Identifies the participant's strengths, resources, needs and limitations;
  - Identifies short and long-term goals with timelines;
  - Identifies participant's preferences for services;
  - Outlines measurable treatment objectives and the services and activities necessary to meet the objectives and needs of the participant; and
  - Targets a range of life domains such as symptom management, education, transportation, housing, activities of daily living, employment, daily structure, and family and social relationships, should the assessment identify a need and the individual agrees to identify a goal in that area.

II.D. ADMINISTRATIVE TASKS

The FACT team performs administrative tasks that include the following:

- Establishment and maintenance of written policies and procedures for:
  - Personnel,
  - Program organization,
  - Admission and discharge criteria and procedures,
  - Assessments and recovery planning,
  - Provision of services,
  - Medical records management,
  - Quality assurance/quality improvement,
  - Risk management, and
  - Rights of persons served.
- Accurate record keeping reflecting specific services offered to and provided for each participant, available for review to managing entity and Department staff;
- Coordination of services with other entities to ensure the needs of the participant are addressed at any given time;
- Providing staff training and supervision to ensure staff is aware of their obligations as an employee; and
- A plan for supporting participants in the event of a disaster including contingencies for staff, provision of needed services, medications, and post-disaster related activities.

II.E. FACT TRANSFERS

When a participant plans to move out of the area, the team is responsible for transfers to the FACT team serving the new location. The originating team contacts the receiving team to determine if they have capacity to accept

the transfer and a date of transfer. Once this has been established, the originating team must, with consent, send the receiving team a comprehensive referral packet.

FACT teams are obligated to accept any transfers if the team has capacity. Both the originating and receiving teams will make every effort to ensure the participant has stable housing. Upon arrival, the receiving team shall review the participant's clinical records, conduct an initial assessment and admission process, assess the person's current medication regime, consult with the program Psychiatrist and conduct a new comprehensive assessment or develop a new recovery plan.

When an individual meets criteria and there is capacity, the team must accept and enroll all referrals from the Departments' Substance Abuse and Mental Health regional office or the Managing Entity.

II.F. DISCHARGE PROCESS

During the daily meetings, the team assess participants for the continued need for FACT services. If it is determined that the participant could be successful in a lower level of care, the team starts addressing transition goals with the participant. This process may take time and early engagement with potential new service providers to acclimate the participant.

- Discharges are tracked and fall into these 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 outside of the geographic areas of the FACT team's responsibility;
    - 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;
    - The participant has been admitted to a state mental health treatment facility and has remained in such facility for a period exceeding six months, 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 year;
    - 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, and the participant or legal guardian;
    - Documentation of referral information made to other agencies upon discharge; and
    - Documentation that the participant was advised he or she may return to the FACT team if they desire and space is available.

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II.G. FACT ADVISORY COMMITTEE

Advisory committees are a group of volunteer stakeholders that come together to support and guide a FACT team and ensure the team's work is consistent with those portions of the NAMI-published National Program Standards for ACT Teams, revised June 2003[3], that have been adopted by the Department. The advisory committee's primary functions are to promote quality programs consistent with these standards and assist in the oversight of the program through monitoring, problem solving, and mediating grievances or complaints made by participants or their families. Details regarding implementation and operation of the advisory committee, including a FACT Model Fidelity Review sample, can be found in Appendix C.

II.H. REPORTS

FACT teams are responsible for submitting the following reports to the managing entity in a timely and accurate manner:

- **FACT Enhancement Reconciliation Report**

This quarterly report displays the team's monthly expenditures of enhancement funds.

- **FACT Ad Hoc Quarterly Report**

This report displays the team's monthly census and aggregate client data for types of housing, employment/volunteer status, crisis stabilization admissions, state hospitalizations, educational status, and types of discharges.

- **Incident Reports**

The team must comply with the reporting requirements of the Department's Children and Families Operating Procedure CFOP 215-6 "Incident Reporting and Analysis System – IRAS."

- **Vacant Position(s) Reports**

This monthly report displays positions required by this program and whether the positions were filled or vacant for the reporting month.

3 Allness, Deborah J., and William H. Knoedler. A Manual for ACT Start-up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses. Arlington, VA: NAMI, 2003. Print.

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II.I. OUTCOME MEASURES

- The team is required to meet the following numerical targets for the target population "Adults with Serious and Persistent Mental Illness" as established in the General Appropriations Act:4
    - 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 also incorporate the following performance 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 time line within 120 days of enrollment with written documentation of the service occurrence in the clinical record.
    - 50 percent of all individuals enrolled shall receive work-related services toward a goal of obtaining employment within one year of enrollment with written documentation of the service occurrence in the clinical record.
    - 90 percent of all individuals enrolled shall receive housing services toward a goal of obtaining independent, integrated living within one year of enrollment with written documentation of the service occurrence in the clinical record.
    - 90 percent of staffing requirements will be maintained monthly.
    - Five percent or less of all individuals enrolled will be admitted to a state mental health treatment facility while receiving FACT services or within thirty (30) days of discharge from the program.
    - 75 percent of all individuals enrolled will maintain or show improvement in their level of functioning as measured by the Functional Assessment Rating Scale (FARS).

[4] See ME Contract Exhibit E – Minimum Performance Standards at http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities/2016-contract-docs

III. MANAGING ENTITY RESPONSIBILITIES AND EXPECTATIONS

The Managing Entities are responsible for:

- Oversight of FACT requirements including report and invoice approvals;
- Provision of technical assistance to teams as needed;
- Participation in and oversight of advisory committees;
- Assistance with the timely and efficient transfers from state mental health treatment facilities to teams;
- Identification of need for additional FACT teams; and
- Monitoring of the program including:
    - Medical record reviews,
    - Personnel records review,
    - Policy and procedure reviews,
    - Staff credentials review,
    - Participant interviews, and
    - Follow up with corrective action plans, if indicated.

Managing Entities shall determine the eligibility of Network Service Providers and non-Network Service Providers to provide services funded with FACT Enhancement Funds.

- Such determination will be based on licensure or certification in good standing, history of licensing or certification complaints, appropriateness of services, staff training and qualifications, evidence of staff and organizational competency, interviews with organization staff, and other knowledge of significance unique to the individual provider.
- Treatment providers must be licensed by the Department, Agency for Health Care Administration (AHCA), or a related professional license.
- Recovery support providers not licensed by the Department or AHCA must provide documentation of applicable professional certifications.

IV. DEFINITION OF KEY TERMS

The following definitions facilitate a common understanding of key terms used in this Handbook:

Comprehensive assessment means an organized process of gathering information to evaluate a person's mental and interactional status and his or her treatment, rehabilitation, and support needs that will enhance recovery. The results of the assessment are used to develop an individual recovery plan for the person.

Culturally competent services means acknowledging and incorporating variances in normative acceptable behaviors, beliefs and values in determining an individual's mental wellness/illness and incorporating those variances into assessments and treatment that promotes recovery.

Empowerment means the process where the provider of services encourages the individual to make choices in matters affecting their lives and to accept personal responsibility for those choices. The empowerment process will include, but is not limited to: 1) freedom of choice regarding services; 2) influence over the operation and structure of service provision; 3) participation in system-wide recovery planning; and 4) participation in decision-making at the community level.

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Engage as it relates to new admissions means the process of identifying, recruiting and considering a person for enrollment in FACT. A person being considered for FACT who is in a state mental health treatment facility, local hospital or crisis stabilization unit (CSU) cannot be enrolled until discharge takes place. Team members may begin to visit the person in the hospital and participate in developing the discharge plan, but will not officially assume responsibility to provide treatment services until the person is discharged. A person already enrolled in a FACT program continues to be enrolled even though hospitalization via a CSU, local hospital or state mental health treatment facility occurs. Even though a person going through the engagement process has not formally been enrolled in a team, the team must keep a written record on:

- Activities that took place during the engagement process;
- The person's response to engagement activities; and
- The name of the FACT staff member conducting the engagement activities.

Functional Assessment Rating Scale (FARS) means the rating scale adopted by the Office of Substance Abuse and Mental Health that is to be administered consistent with the most current version of the department's pamphlet 155-2 as it is developed.

Incompetent to proceed means the condition of a defendant being unable to proceed at any material stage of a criminal proceeding due to mental impairment. Those stages shall include a trial of the case and pretrial hearings involving questions of fact on which the defendant might be expected to testify. It shall also include an entry of a plea, proceedings for violations of probation or violations of community control, sentencing, and hearings on issues regarding a defendant's failure to comply with court orders. It also considers conditions or other matters in which the mental competence of the defendant is necessary for a just resolution of the issues being considered.

Initial assessment and recovery plan means the initial evaluation of a person's mental health status and initial practical resource needs (e.g., housing, finances). The initial recovery plan is completed on the day of admission and guides services until the comprehensive assessment and recovery plan are completed.

Mental illness means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with a person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance use.[5]

Not guilty by reason of insanity means a ruling by a court acquitting a defendant of criminal charges because of a mental deficiency or illness sufficient under the law to preclude conviction.

Psychiatric/social functioning history time line means the process that helps to organize, chronicle and evaluate **information** about significant events in a person's life, experience with mental illness, and treatment history.

Psychotropic medication means any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or anti-anxiety agents.

Recovery means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Recovery Plan means the culmination of a continuing process involving the participant, family or other supports upon consent, and the team. The plan reflects individualized service activity and intensity to meet person-specific needs that promote recovery. The plan documents the person's goals and the services necessary to achieve them. The plan must reflect the individual's preferences for services and choices in the selection of living arrangements. The plan delineates the roles and responsibilities of the team members who will carry out the services.

[5] Chapter 394.455(28), F.S.

Recovery Plan Review means a written summary describing the person's progress since the last recovery-planning meeting; it outlines interactional strengths and limitations at the time the recovery plan is rewritten.

Rehabilitation means services and supports that promote recovery, full community integration and improved quality of life for persons diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives. Rehabilitation services are collaborative, person directed and individualized. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning, and social environments of their choice.[6]

[6] Allness, Deborah J., and William H. Knoedler. *A Manual for ACT Start-up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses*. Arlington, VA: NAMI, 2003. Print.

APPENDIX A - DSM-5 DIAGNOSES AND ICD-10 CODES

Schizophrenia Spectrum and Other Psychotic Disorders
F20.81 Schizophreniform disorder
F25.0 Schizoaffective disorder, Bipolar type F25.1 Schizoaffective disorder, Depressive type)
F20.9 Schizophrenia
F22 Delusional disorder
F28 Other specified schizophrenia spectrum and other psychotic disorder
F29 Unspecified schizophrenia spectrum and other psychotic disorder
Bipolar and Related Disorders
F31.10 Bipolar I disorder, Current or most recent episode manic, without psychotic features, unspecified) F31.0 Bipolar I disorder, Current or most recent episode hypomanic
F31.11 Bipolar I disorder, Current or most recent episode manic, mild
F31.12 Bipolar I disorder, Current or most recent episode manic, moderate
F31.13 Bipolar I disorder, Current or most recent episode manic, severe
F31.2 Bipolar I disorder, Current or most recent episode manic, with psychotic features
F31.73 Bipolar I disorder, Current or most recent episode manic, in partial remission F31.71 Bipolar I disorder, Current or most recent episode hypomanic, in partial remission
F31.74 Bipolar I disorder, Current or most recent episode manic, in full remission F31.72 Bipolar I disorder, Current or most recent episode hypomanic, in full remission
F31.30 Bipolar I disorder, Current or most recent episode depressed, mild or moderate severity, unspecified
F31.31 Bipolar I disorder, Current or most recent episode depressed, mild
F31.32 Bipolar I disorder, Current or most recent episode depressed, moderate
F31.4 Bipolar I disorder, Current or most recent episode depressed, severe
F31.5 Bipolar I disorder, Current or most recent episode depressed, with psychotic features
F31.75 Bipolar I disorder, Current or most recent episode depressed, in partial remission
F31.76 Bipolar I disorder, Current or most recent episode depressed, in full remission
F31.70 Bipolar I disorder, Currently in remission, most recent episode unspecified
F31.9 Unspecified bipolar and related disorder
F31.81 Bipolar II disorder F31.89 Other specified bipolar and related disorder
F34.89 Other specified persistent mood disorders
Depressive Disorders
F32.9 Unspecified depressive disorder
F32.0 Major depressive disorder, Single episode, mild
F32.1 Major depressive disorder, Single episode, moderate
F32.2 Major depressive disorder, Single episode, severe
F32.3 Major depressive disorder, Single episode, with psychotic features
F32.4 Major depressive disorder, Single episode, in partial remission
F32.5 Major depressive disorder, Single episode, in full remission
F32.89 Other specified depressive episodes
F33.9 Major depressive disorder, Recurrent episode, unspecified
F33.0 Major depressive disorder, Recurrent episode, mild
F33.1 Major depressive disorder, Recurrent episode, moderate
F33.2 Major depressive disorder, Recurrent episode, severe
F33.3 Major depressive disorder, Recurrent episode, with psychotic features
F33.41 Major depressive disorder, Recurrent episode, in partial remission

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F33.42 Major depressive disorder, Recurrent episode, in full remission
Anxiety Disorders
F41.9 Unspecified anxiety disorder
F41.0 Panic disorder
F41.1 Generalized anxiety disorder
F41.8 Other specified anxiety disorder
F40.00 Agoraphobia
F40.01 Agoraphobia with panic disorder
F40.02 Agoraphobia without panic disorder
F40.10 Social anxiety disorder (social phobia)
Specific Phobia ICD-10 code is based on the phobic stimulus: F40.218 Animal F40.228 Natural environment F40.230 Fear of blood F40.231 Fear of injections and transfusions F40.232 Fear of other medical care F40.233 Fear of injury F40.248 Situational (e.g., airplanes, elevators, enclosed places) F40.298 Specific phobia, Other
Obsessive-Compulsive and Related Disorders
F42.2 Mixed obsessional thoughts and acts F42.3 Hoarding disorder F42.4 Excoriation (skin-picking) disorder F42.8 Other obsessive-compulsive disorder F42.9 Obsessive-compulsive disorder unspecified F60.5 Obsessive-compulsive personality disorder
F45.22 Body dysmorphic disorder
Dissociative Disorders
F44.0 Dissociative amnesia
F44.1 Dissociative amnesia, with dissociative fugue
F44.81 Dissociative identity disorder
F44.89 Other specified dissociative disorder F44.9 Unspecified dissociative disorder
F48.1 Depersonalization/derealization disorder
Somatic Symptom and Related Disorders
Conversion disorder (functional neurological symptom disorder) - ICD-10 code is based on the symptom type: F44.4 With abnormal movement F44.5 With attacks or seizures F44.6 With anesthesia or sensory loss F44.7 With mixed symptoms
F68.10 Factitious disorder
F45.21 Illness anxiety disorder
F45.1 Somatic symptom disorder) F45.9 Unspecified somatic symptom and related disorder
F45.8 Other specified somatic symptom and related disorder

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Personality Disorders
F60.0 Paranoid personality disorder
F60.1 Schizoid personality disorder
F21 Schizotypal personality disorder
F60.5 Obsessive-compulsive personality disorder
F60.4 Histrionic personality disorder
F60.7 Dependent personality disorder)
F60.2 Antisocial personality disorder
F60.81 Narcissistic personality disorder
F60.6 Avoidant personality disorder
F60.3 Borderline personality disorder
F60.89 Other specified personality disorder
F60.9 Unspecified personality disorder

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APPENDIX B – FACT ENHANCEMENT GUIDELINES

Introduction

One of the goals of FACT is to promote and respect self-determination, recovery, and full community inclusion. Participation provides the individual with the opportunity to select the services and commodities that they deem necessary for recovery for the purpose of consumption, housing needs, employment, volunteering, or training/education, and facilitates achievement of the individual's recovery plan.

An integral part of participation is accepting responsibility for choosing, spending, recording, and learning how best to use limited funds to achieve a desired state of mental wellness and productivity. The program believes that individuals are capable of purchasing needed services and commodities that will help them on their road to recovery. Individual choice drives this system of purchasing.

The program provides access to public funds to purchase adjunct services or commodities not directly provided by the FACT team. Funding is used to increase or maintain a person's independence and integration into their community. Funding may be used for costs related to housing, pharmaceuticals, tangible items needed for employment/education or other meaningful activity, and specialized treatment (not paid by any other means).

Definitions

1. "Assistive Care Services" or "ACS" means a state payment for services provided by qualified residential care facilities. Funds transferred from the Department of Children and Families to Medicaid draw down federal Title XIX matching funds. This Medicaid optional state plan service is for low-income people who live in qualified assisted living facilities (ALFs), adult family-care homes (AFCHs) and residential treatment facilities (RTFs).
2. "Commodities" means supplies, materials, goods, merchandise, equipment, information technology, and other personal property. The definition does not include pharmaceuticals, medical treatment, glasses, hearing aids, or lab work.
3. "Indigent Drug Program" or "IDP" means the provision of psychotropic medications for individuals served by the Department who have a mental illness, reside in the community and who do not have other means of purchasing prescribed psychotropic medications.
4. "OSS" means Optional State Supplementation, a state program to supplement payments to eligible individuals residing in Assisted Living Facilities, Adult Family-Care Homes, family placement, or any other specialized living arrangement.
5. "Payer of Last Resort" means using FACT enhancement funds after exhausting all other potential sources of funds.
6. "Recovery Plan" means an individual's service/treatment plan
7. "Services" means pharmaceuticals, lab work, treatment, housing assistance, or other assistance given to benefit a person.
8. "SSDI" means Social Security Disability Income that is paid to a person and certain members of the person's family if the person is "insured", meaning the person has worked the required number of quarters and paid social security taxes.
9. "SSI" means Supplemental Security Income, a federal income supplement program funded by general tax revenue designed to provide cash to help aged, blind and disabled people who have little or no income to meet basic needs for food, clothing and shelter.

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Guidelines on the Use of Funds

1. **Ensuring FACT team enhancement funds is the payer of last resort**

Participants must take responsibility in locating other sources of funding for services or commodities prior to requesting FACT enhancement funds for the purchase. FACT staff, in collaboration with the participant, must determine if there is another payer source, such as Medicaid, Medicare, OSS, SSI, SSDI, IDP, or ACS. The primary case manager must submit a certification form with the monthly invoice. The certification states that due diligence was exercised in searching for alternative funding to pay for the commodity or service prior to the use of enhancement funds. If the commodity or service is ongoing, certification is only required for the original purchase. Examples of ongoing purchases include utility and phone bills, refills of existing prescriptions, or any other like commodity or service.

2. **Price Quotes**

Participants are required to provide three price quotes from different vendors for any single commodity costing in excess of $300. These price quotes may be in the form of vendor circulars or advertisements, vendor website item and price descriptions, in-store price comparisons, and telephone price quotes. Telephone should only be considered if other means of securing a price quote are not possible. Quotes received over the phone and in-store must be verified/witnessed by staff and documented (includes date and time). Documentation of the price quotes must be filed (may be separate file from clinical record) and available for audit when requested.

3. **Emergency purchase**

An emergency is considered an unexpected event that causes immediate danger to the health, safety, or welfare of the individual. In such cases, there might not be time to secure three price quotes (e.g., towing vehicle from roadway). An emergency purchase without three quotes must be justified and documented to be considered for payment or reimbursement. Emergency purchases must be documented in the clinical record, and if deemed an ongoing need, must be added to the recovery plan.

4. **Recovery plan**

The member's recovery plan must incorporate the purchase of any commodity or service. The member's recovery plan must explain how the purchase will promote one or more of the member's recovery goals.

5. **Dental services, hearing aids, and eyeglass purchases**

Medically necessary (recommended by medical practitioner) professional hearing, dental, and vision services will be paid by the program after all other resources have been exhausted. Decorative or cosmetic purchases, such as color contacts, may not be paid for with FACT enhancement funds.

6. **Payment / Reimbursement rate**

Commodities and services purchased are paid or reimbursed at a negotiated rate between the participant and FACT case manager and are dependent on the participant's ability to pay.

7. **Making the purchase**

The accepted purchase price (quotes and receipt) must be dated subsequent to the incorporation of the purchase into the recovery plan. For approved purchases, the participant can either:

a) Make the purchase using his or her own funds and later, be reimbursed, or

b) Provide an original, itemized estimate of the needed purchase that shows the name of the vendor, the anticipated purchase date, the item, and the amount of the purchase (along with documentation of price quotes).

The amount paid or reimbursed will include the actual price of the item and may include tax, if applicable. Tips are not reimbursed. It is the participant's responsibility for ensuring the quality of the item purchased. If a purchased item is defective, inoperable, or unusable, it is the participant's responsibility to resolve the matter with the vendor.

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Criteria for purchase approval (Must be able to answer "yes" to all questions)

1. Does the purchase directly relate to identified needs outlined in the participant's recovery plan?
2. Does the purchase promote independence?
3. Will the purchase enhance employability or recovery for the individual?
4. Have all other options been explored and exhausted prior to requesting the purchase with FACT enhancement funds?
5. Is the amount of the proposed expenditure reasonable?
6. Is the budget to fulfill the request available?
7. Is the date on the receipt for the purchase subsequent to the effective date of the current recovery plan?
8. Is the receipt original?
9. Does the receipt contain vendor information printed on the receipt (name of vendor, address, phone number, etc.)?

Examples of purchases that may be authorized if all criteria above are met

1. Co-pays for adjunct services purchased with Medicaid or Medicare funds.
2. Housing subsidy. Enhancement funds may be used for payments to Assisted Living Facilities (above OSS rate), but all available options that could best meet the individual's needs should be considered (such as Therapeutic Family Care homes, permanent supportive housing, rental subsidies for current lease).
3. Medication.
4. Transportation or mileage reimbursement.
5. Services related to developing employability.
6. Smoking cessation activities under the supervision of a medical doctor.
7. Non-cosmetic dental work.
8. Hearing aids.
9. Non-cosmetic eye glasses and non-disposable contacts once per year, unless otherwise noted by a licensed eye care professional.
10. Haircuts from a professional at a current reasonable rate.
11. Facial cosmetic and make-up products for the purposes of camouflaging medical conditions, such as facial scars, burns, etc., and for the purposes of seeking or participating in employment.
12. Tutoring.
13. Face-to-face and distance learning educational classes.
14. Time-limited assistance to secure or maintain a more independent living arrangement.
15. Time-limited assistance with vehicle repair for purposes of employment, education and/or transportation or other recovery goal with the intent to increase independence for the person served. Alternative transportation (bus, bike, cab use) should be considered in lieu of vehicle repair if the cost to repair in in excess of $1,000.00 or the budget does not permit the expenditures.
16. Specialized treatment not provided by FACT team and not paid for by any other means (e.g. eating disorders,

behavioral analyst, health club/gym). Approval must be obtained from Managing Entity for expenditures exceeding $1,500.00.

17. Purchase of lawn maintenance service, when explicitly justified by the individual's recovery plan.
18. Socialization activities aimed at improving social or behavioral skills (i.e., activities for depressed or agoraphobic individuals). Such activities should provide a means for improving communication skills, interpersonal skills, reducing public anxiety, and/or practicing adaptive behaviors in a public setting. Any social events, services, or activities paid for by enhancement funds should be based on the individuals' assessed needs and reflected in their recovery plan.
19. Support tools promoting the safety and security of the individual, including fire alarms, disability aids such as char, shower or stair rails when explicitly justified by the individual's recovery plan and no other resource is available.

Examples of disallowed purchases:

1. Rent reimbursement for an expired rental lease.
2. Payments to facilities or recovery residences that are not licensed or certified in good standing according to state law.
3. Motel room(s) beyond 21 days. (Motel rooms for more than 21 days may be authorized if the team makes an ongoing and consistent effort to find more permanent housing, and this is fully documented in the recovery plan).
4. Purchase of automobiles, sport utility vehicles (SUVs), minivans, motorcycles, recreational scooters or recreational vehicles.
5. Long distance telephone service.
6. Major repairs or renovations of rental property.
7. Pay-per-View or enhanced programming cable or satellite service.
8. Television larger than 21-inch screen, Video Cassette Recorders (VCRs), Digital Video Disc (DVD) or Blue Ray players, video game consoles, stereos, MP3 Players, IPods, IPads or other types of entertainment appliances.
9. Designer sunglasses.
10. Beauty aids such as spa services, including but not limited to, facials, makeup applications, aromatherapy massage, body waxing, manicure, pedicure, therapeutic body wraps, micro dermabrasion, tanning booth sessions, wigs and hair pieces, or cosmetics (aside from the purposes described above).
11. Ongoing or continuous purchase of over-the-counter medications in excess of 7 days per episode for allergies and flu-like symptoms.
12. Acupuncture without a prescription/order/referral from the program Psychiatrist.
13. Petty cash for general use.
14. Purchase or rental of firearms.
15. Purchase of alcoholic beverages.
16. Purchase of contraband or illegal products or services.
17. Purchase of tobacco products.
18. Purchase of pets.
19. Purchase or rental of boats.

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20. Purchase or lease of burglar alarms.
21. Purchase or lease of cell phones.
22. Purchase or lease of diving equipment.
23. Internet service.
24. Purchase for 3rd parties.
25. Purchase of pornographic books, magazines, or videos.
26. Payment of credit card balances.
27. Payment of court-ordered costs, fines, restitution, or other similar debts.

Participant Certification and Assurances

FACT team participants are not guaranteed access to enhancement funds. Purchase approval is dependent on the following guidelines:

- All other options have been explored and exhausted prior to requesting the purchase with FACT enhancement funds.
- The purchase directly relates to identified needs outlined in the participant's recovery plan.
- The purchase promotes independence.
- The purchase enhances employability or recovery for the individual.
- The amount of the proposed expenditure is reasonable.
- The budget to fulfill the request is available
- The date on the receipt for the purchase must be after the effective date of the current recovery plan.
- Individual must provide an original receipt.
- The receipt must contain vendor information printed on the receipt (name of vendor, address, phone number, etc.).

1. By signing below, I agree to adhere to these guidelines and understand that I am responsible for the outcome of all purchases that I make under this program.
2. I agree not to hold the FACT program responsible if I make purchases that are beyond the scope of purchases incorporated into my recovery plan amount, and understand that the program is not responsible for the choices I make regarding my personal finances.

The FACT participant receives a signed copy of these guidelines. The original signed document remains part of the participant's clinical record.

I, _____, have received, reviewed, and agree to the Florida FACT Enhancement Funds guidelines.

Certification Statement as Payer of Last Resort

(Required only on initial purchases of commodities and services)

Name of FACT Participant: _____

Date of Purchase: _____

Name of Vendor: _____

Cost of Item/Service: _____

Item(s)/Services Purchased: _____

_____

_____

Relationship to Recovery Plan (Complete the following table):

Recovery Plan Goal	Relationship to Purchase
What goal on the recovery plan does this purchase relate?	
How will this purchase assist in meeting the goal?	
How many more times is this service estimated to be needed?	

I, _____ primary case manager and/or member of the above-named individual's Treatment Team, certify that this purchase is made to support the person's recovery plan. I further certify that all other resources have been explored and exhausted prior to purchasing this service/commodity with payer of last resort enhancement funds.

_____

Signature Date

APPENDIX C – FACT ADVISORY COMMITTEES

A FACT Advisory Committee (Committee) is a group of volunteer stakeholders that come together to ensure the FACT team's work is consistent with the portions of the NAMI-published National Program Standards for ACT Teams[7] that have been adopted by the Department. The Committee's primary functions are to promote quality FACT programs and assist in the oversight of the program through monitoring, problem solving, and mediating grievances. Committees are independent of the provider operating the team and therefore have no role in the governance of the team. Committees may, at their discretion, develop additional procedures beyond those identified below.

Purpose:

The purpose of the Advisory Committee is to guide and support local team activities by monitoring on-going operations; promoting the team's work in the community; and ensuring the team provides each participant quality and recovery- oriented services.

Membership:

The contracting managing entity (ME) approves individual membership to the Committee. Committees have a minimum of 10 members that consist of at least 26 percent people with psychiatric disabilities and 25 percent family members. Other members may represent stakeholders such as local homeless coalitions, local law enforcement agencies, jail personnel, county commissioners, other providers, hospital representatives, Medicaid, faith-based entities and advocacy groups. Membership that is representative of the local cultural and linguistic populations is strongly encouraged. The Committee must be committed to promoting recovery and empowerment.

The provider operating the FACT team is responsible for recruiting Committee members. Names of nominated individuals are submitted to the contracting ME for approval of membership. Membership may be rescinded if, in the view of the contracting ME an adversarial relationship has developed between the provider, Committee and the contracting managing and a good faith effort on the part of the ME to resolve the adversarial environment has failed.

Membership Qualifications:

Committee members should be knowledgeable about psychiatric disabilities and the challenges that people with these disabilities face living in the community. Members should be good problem solvers with a positive attitude and be objective and seek to understand the views of all stakeholders. People in recovery and their families are strong candidates for membership.

Membership Requirements:

Committee members become familiar with the Program Standards for ACT Teams and the FACT Handbook. Committees meet quarterly or more frequently if desired and members agree to serve at least a 2-year term, staggering termination to maintain a core of experienced members on the Committee. Although Committee Bylaws are not required, it is suggested the Committee elect a Chairperson. If a Chairperson is elected, the Committee must establish a protocol for such election including term of office, method of election, including use of proxy votes and specific duties of the Chairperson. Minutes of Committee meetings are recorded and submitted to the provider's Chief Executive Officer, the FACT Team Leader, and Managing Entity staff.

Approving and Rescinding Membership:

The contracting ME may use the following criteria in approving and rescinding membership on Committees. These guidelines are subject to change based upon the accumulation of practices, data and issues that may evolve over the course of time and experience.

Approving Membership

- Expressed willingness to volunteer time;

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[7] The National Program Standards for Act Teams may be accessed at: http://www.nami.org/Template.cfm?Section=ACT-TA_Center&template=/ContentManagement/ContentDisplay.cfm&ContentID=50248

- Expressed interest in Florida's adult community mental health service delivery system;
- Expressed willingness to learn the ACT model of service intervention;
- Expressed willingness to participate in public forums;
- Meets at least one of the membership groups identified as representative of community stakeholders; and
- Has been approved by the contracting ME.

Rescinding Membership

- Repeated unexcused absence from Committee meetings (as determined by the Chair); or
- Creating an adversarial environment that is prolonged for three months or more and such environment diminishes the supportive, collaborative relationship that must exist between the contracting ME, the provider and the Committee.

FACT Advisory Committee Member Roles:

1. Advocating on behalf of individuals with psychiatric disabilities.
2. Becoming knowledgeable of the ACT model and the NAMI Manual for ACT Start-Up[8];.
3. Identifying community resources for the team such as affordable housing, employment opportunities, and social outlets/supports.
4. Promoting awareness of the team in the community through community dialogues when requested.
5. Providing support, guidance and assistance to the team.
6. Monitoring ACT fidelity by administering the "FACT Model Fidelity Review" on an annual basis.[9]
7. Participating in planned technical assistance site visits conducted by the Managing Entity to teams.
8. Mediating complaints or grievances between meetings. It is the responsibility of the Chair to convene a mediating panel made up of three Committee members.
9. Spending at least one day observing a daily organizational meeting, recovery planning meeting or accompanying a team member on a field visit (with consent).[10]
10. Reviewing and commenting on the team's enhancement expenditures and quarterly ad hoc data reports.
11. Developing a schedule of activities for the year.
12. Serving as a resource to the team to problem-solve local issues that may be barriers to successful outcomes.
13. Participating in the development of a protocol for communications between the team, its administration and the ME to be approved by the ME prior to implementation.[11]

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[8] Allness, Deborah J., and William H. Knoedler. *A Manual for ACT Start-up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses*. Arlington, VA: NAMI, 2003. Print.

[9] The FACT Model Fidelity Review is a modified form of the PACT Model Fidelity Review published by the National PACT Center and contains recommended standards. The protocol is attached to this Appendix C, revised May 2014.

[10] Due to the size of Advisory Committees, no more than 2 members should schedule attendance at any one meeting at any given time and with prior agreement by the Team Leader.

[11] A suggested format is attached but may be modified at the discretion of the entities developing the protocol.

Providers' Role Relating to FACT Advisory Committees:

1. Attending Committee meetings by the Team Leaders and the provider's Chief Executive Office/Executive Director or designee.
2. Providing enhancement expenditures and quarterly ad hoc data reports.
3. Presenting any grievances/complaints and their outcome.
4. Forwarding of grievances/complaints not resolved at the team level within two weeks from date of filing to the team's Committee Chair who will convene a grievance mediating panel.
5. Participating in the development of a communication protocol between the team, its administration, the Committee and the ME for approval from the ME prior to implementation.
6. Providing the Committee with the necessary administrative support to ensure that documents are provided and minutes of meetings are distributed.

Managing Entity's Role Relating to FACT Advisory Committees:

1. Inviting the Chair of the Committee to participate in on-site technical assistance and programmatic monitoring completed by the ME.
2. Attending Committee meetings.
3. Participating in the development of a communication protocol between the team, its administration, the Committee and the ME. Upon completion, prepare an approval memo to the team, its administration and the Committee that the protocol is approved for implementation.
4. Serving as a liaison and resource person to the Committee for system issues that impact the team's successful outcomes.

Confidentiality

By law, Committee members do not have access to the medical record of participants without the specific, written agreement of the individual. Committee members who may also serve on other councils or entities that, in the course of their duties, have statutory authority to access and review medical records are prohibited from sharing the findings of such reviews with other Committee members without the specific, written agreement of the individual. The specific agreement must be time-limited and can be changed by the individual at any time.

FACT Advisory Committee Agenda Template

Committee meetings address the following items:

- Call to Order and roll call;
- Report of Committee Activities;
- Report on Enhancement Expenditures;
- Report on the FACT Quarterly Data; and
- Report on Grievances Mediated and Outcomes.

Other Business

Next Meeting Date

Adjournment

Suggested Format for Communications Protocol

I. Purpose

The purpose of this protocol is to ensure that a mechanism of communication is in place that enables the Committee, the provider, the contracting ME and the team to conduct its business while promoting the goals of the FACT initiative. This protocol is not intended to restrict any form of communication between individuals or entities but is intended to establish an agreement between the entities referenced above as to a preferred schedule of time for such communications.

II. Hours of Communication

It is agreed by all parties that business relating to the mission and intent of the Committee can best be served by calling between the hours of _____and _____Monday through Friday. Weekends and holidays will not be used for conducting routine business.

III. Communication Contacts

It is agreed by all parties that the following persons and phone numbers will be designated the primary and secondary contacts:

Primary Contacts:

For the Committee _____ Phone _____

For the FACT Team _____ Phone _____

For the Managing Entity _____ Phone _____

Secondary Contacts:

For the Committee _____ Phone _____

For the FACT Team _____ Phone _____

For the Managing Entity _____ Phone _____

IV. Mitigating Factors

It is agreed by all parties that certain situations may arise that require the parties to prepare, locate, copy and fax or e-mail information. When a request is made for written information, it is agreed that an appropriate response time to complete the request is _____days from the date of the request.

V. Agreements

The parties, by their signature, will make a good faith effort to communicate with each other within the agreed upon parameters established above.

_____ _____

For the Committee Date

_____ _____

For the Team Date

_____ _____

For the Provider Date

_____ _____

For the Managing Entity Date

Instructions for Completing the FACT Model Fidelity Review

This is a quality improvement exercise and not intended to serve as a contractual compliance activity. Committee members conducting this survey are prohibited from reviewing individual clinical records. Feedback to the Team Leader at the end of the review will be helpful for continuous quality improvement. This activity will require 7 exercises:

1. Reviewing the staffing chart;
2. Reviewing position descriptions;
3. Reviewing policies and procedures;
4. Touring the entire team office space;
5. Interviewing the Team Leader;
6. Observing a daily organizational meeting; and
7. Reviewing the posted 2-month schedule of treatment team meetings.

Using the attached FACT Model Fidelity Review instrument, please complete the following:

1. Check either "Y" for yes or "N" for no at the time of the review;
2. Please note any discrepancies from the standards on a separate page; and
3. Using the results of the survey, prepare a summary of findings to share with the Team Leader.

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FACT MODEL FIDELITY REVIEW

Standard	Element	Y	N
A. Staff Composition	Look at staffing chart for documentation		
	The ratio of participants to direct service staff members should not exceed 10:1		
	Psychiatrist or Psychiatric ARNP @ a minimum of .32 hours of services for each 100 participants per week		
	1 Administrative Assistant		
	1 FTE Team Leader (licensed professional)		
	1 Nurse for every 35 participants – at least one must be a FTE RN		
	1 FTE Case Manager		
	1 FTE Substance Abuse Specialist		
	1 FTE Peer Specialist		
	1 FTE Vocational Specialist		
B. Key Staff Roles	Look at position descriptions for documentation		
1. Team Leader	Leads daily organizational team meeting		
	Available to team for clinical supervision		
	Provides 1:1 supervision to staff		
	Functions as a practicing clinician		
	Assigns team members including a primary case manager to each new participant		
2. Psychiatrist or ARNP	Conducts psychiatric & health assessments		
	Supervises psychiatric/psychopharmacological treatment of all enrolled participants		
	Monitors non-psychiatric medical conditions & medications		
	Supervises medication management system with nurses		
	Provides brief therapy and diagnostic/medication education to enrolled participants		
	Provides crisis intervention on-site		
	Provides family interventions and psycho-education		
	Attends daily organizational & recovery planning meetings		
	Provides clinical supervision to staff including RN and LPNs		
	If participant is hospitalized, actively collaborates with inpatient care providers to ensure continuity of care		
	If ARNP, must have continual access to and weekly consultation with a board-certified Psychiatrist		
3. Nurses	RN, LPN and MD manage medication system		
	Administer and document medication treatment		
	Screen and monitor for medical problems and side effects		
	Coordinate services with other health providers		
	Provide education on health promotion & prevention, education side effects, and strategies for medication compliance		
4. Vocational Specialist Specialist	Serves as mentor to staff for employment assessment and planning		
	Maintains liaison with DVR and training agencies		
	Provides full range of work services (job development, assessment, job support, career counseling)		
5. Peer Specialist	Position is integrated within the team		

Standard	Element	Y	N
	Shares roles with other team members		
	Provides individual and group support services		
6. Substance Abuse Specialist	Serves as mentor to staff for assessing, planning and treating substance use		
	Provides supportive treatment individually & in groups (i.e., CBT, motivational interviewing, relapse prevention)		
	Completes substance use assessments that consider the relationship between substance use and mental health		
C. Program Size & Intensity	Look at policies for documentation		
	Participants are contacted face-to-face an average of 3 times per week, based on the participant's individual needs		
	Clinically compromised participants are contacted multiple times daily		
D. Admission & Discharge Criteria	Look at policies for documentation		
	Admission criteria specify target population		
	Discharge criteria include demonstrated ability to perform successfully in major role areas over time		
	Discharges mutually determined by participant and team		
	Team assumes long-term treatment orientation		
E. Office Space	Tour office space for documentation		
	Easily accessible to participants and families		
	Common workspace, layout promotes communication		
	In office medication storage area		
F. Inter-Agency Relationships	Interview Team Leader and ask for evidence of collaboration for documentation		
	Active collaboration with other human services providers		
	Active participant-specific liaison with SSA, health care providers, other agency assigned workers		

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Standard	Element	Y	N
G. Hours of Operation	Look at policies for documentation		
	Staff on duty 7 days per week		
	Program operates 12 hours on weekdays		
	Program operates at least 8 hours on weekend days and holidays		
	Team members are on-call all other hours for 24 hour coverage		
	Team members available by phone and face-to-face with back-up by Team Leader and Psychiatrist or ARNP		
H. Team Communication & Planning	Look at policies, observe daily organizational meeting and ask to see 2-month posting of treatment team meetings for documentation		
	Organizational team meeting held daily M-F		
	Meeting completed within 45-6O minutes		
	Member status reviewed via daily log and staff report		
	Team leader facilitates discussion & recovery planning		
	Services & contacts scheduled per recovery plans and triage		
	Staff assignments determined		
	Daily staff assignments prepared schedule		
	Service provision monitored and coordinated		
	All staff contacts with participants are logged		
	Recovery planning meetings held weekly		
	Recovery planning meetings held by senior staff		
	Recovery planning meetings schedule posted 2 months ahead		

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I. Policy and Procedure Manual	Look at policies for documentation		
	Admission and discharge criteria and procedures		
	Job descriptions, performance appraisals, training plan		
	Program organization & operation (program hours, on-call, service intensity, staff communication, team approach & staff supervision)		
	Assessment and recovery planning		
	Medical records management		
	Service Scope		
	a. Case management		
	b. Crisis assessment & intervention		
	c. Symptom assessment, management & supportive therapy		
	d. Medication prescription, administration, monitoring & documentation		
	e. Substance abuse services		
	f. Work related services		
	g. Activities of daily living		
	h. Social, interpersonal relationships & leisure time		
	i. Support services		
	j. Education & support to families & other supports		
	Enrolled participant rights		
	Program performance improvement and evaluation		
	80% of participants live in independent community living		
	Legal advocacy provided as needed		

NOTES:

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APPENDIX X
SUNCOAST REGION FACT
REGIONAL OPERATING PROCEDURE (ROP)

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Update Effective Date- 7/1/2018
CENTRAL FLORIDA BEHAVIORAL HEALTH NETWORK
SCR/C10 FACT OPERATION PROCEDURES
CIRCUITS 6, 10, 12, 13, 20

ROP-1. Purpose

The services provided under this ROP are community-based mental health services provided to adults as authorized in section 394.74, F.S. and DCF GD #16-FACT. Florida Assertive Community Treatment (FACT) teams provide intensives, assertive community-based treatment that includes rehabilitation and support services for persons with psychiatric disabilities. These disabilities are typically schizophrenia, other psychotic disorders (e.g. schizoaffective disorder), mood disorders such as bipolar disorders and major depression, and personality disorders such as obsessive-compulsive disorders, posttraumatic stress disorders, anorexia nervosa, borderline personality disorders, and dissociative identity disorders. These individuals must first meet the definition of mental illness according to Chapter 394, Florida Statutes (F.S.), and be in one of the target groups that fall under the auspices of the departmental performance measures as required by the Government Performance and Accountability Act of 1994.

FACT services are provided under the following authority:

Chapter 39
FS 393
FS 394
FS 394.67(15)
FS415
FS 916
FACT Incorporated Document #16 (2017)

CFBHN SCR/C10 FACT ROP should be viewed in conjunction with the most current DCF FACT Incorporated Document #16. CFBHN specific requirements in addition to the GD #16 are outlined below.

ROP-2. Scope

FACT services under CFBHN are in the Suncoast Region and Circuit 10. Counties included are:

Circuit 6 (Pinellas and Pasco)
Circuit 10 (Polk, Highlands and Hardee)
Circuit 12 (Sarasota, Manatee and DeSoto)
Circuit 13 (Hillsborough)
Circuit 20 (Charlotte, Lee, Collier, Hendry and Glades)

ROP-3. Major Program Goals

The major FACT program goals are to:

A. Implement the FACT programs as described in this ROP, and
B. Achieve measures of successful outcomes including the following:
    1. Lessening or eliminating the debilitating symptoms of mental illness that the individual experiences, and minimize or prevent recurrent acute episodes of the illness, and promote recovery;
    2. Meeting basic needs and enhance quality of life;
    3. Improving interactions in adult social and employment roles and responsibilities;
    4. Reducing hospitalizations;
    5. Increasing days in the community;
    6. Collaborating with the criminal justice system to minimize or divert incarcerations; and
    7. Lessening the families and significant others' role of providing care.

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ROP-4. Individuals to Be Served

A. Persons who receive FACT services have severe mental illness symptoms and impairments that are not adequately served in the traditional service delivery system. They are at high risk of repeated psychiatric hospital admissions, prolonged inpatient psychiatric hospitalization, or repeated crisis stabilization unit use because of their severe psychiatric symptoms and significant interactional impairments and lack of available community-based services. Many may have co-occurring substance abuse disorders and some may have co-occurring mild intellectual disabilities. Many may be homeless and/or involved with the local judiciary due to various misdemeanor violations.

B. The provider shall provide supports and services in ways that recognize the cultural differences in persons who have long lasting psychiatric disabilities. The provider shall also provide services and supports that meet the needs of persons with severe and persistent mental illness. These same persons may be physically disabled, HIV positive or have AIDS and/or who may have co-occurring substance abuse disorders or co-occurring mild intellectual disabilities.

ROP-5. Service Recipient Determination

A. CFBHN must review and provide approval or disapproval of all **admissions** to the FACT teams within five working days upon notification by the FACT team. CFBHN shall also approve/disapprove **discharges** from the FACT team within the same time frame. Each FACT provider must accept for enrollment all referrals made by the Regional DCF SAMH office or CFBHN.

B. **PRIORITY POPULATIONS considered for admission to the CFBHN Fact Teams are referrals in the following categories from one of CFBHN 14 counties:**

1. Diversions from State Hospital Admissions, referred by CFBHN (Under an Involuntary Inpatient Order (BA8) or a Voluntary pending State Hospital admission).
    a. Referrals received from CFBHN in this category must be screened and findings reported to CFBHN within 10 business days from the date CFBHN makes the referral.
2. Discharges from Civil State Treatment Facilities in Florida
3. High Utilizers of PUBLIC CSU'S beds
4. Aging out Children with history of psychiatric treatment and diagnosis' served by the FACT team

C. Admission criteria to the FACT program contain three major areas:

1. **Threshold Requirements:**
   FACT teams must comply with the following parameters when at full capacity or while achieving full capacity:
    a. At least 50 percent (50%) of FACT members enrolled must be directly discharged from the state hospital (SMHTF) serving the circuit where the FACT team exists.
    b. At least 60 % of all participants must be eligible for Medicaid. The team approach to delivering services and lack of service limits make FACT a unique service. There is no Medicaid state plan service equivalent to FACT; therefore, it is not covered by managed medical assistance or specialty plans. The program is funded through a combination of state general revenue and Medicaid administrative matching.
    c. The FACT team capacity is 100 persons. CFBHN FACT teams will work to coordinate admissions and discharges so that their census is minimally 98 so they may draw down there funding however the expectation is that the team will strive to remain at a census of 100.
    d. CFBHN reserves the right to alter or adjust the number of persons enrolled by any amount.
    e. The provider shall submit a weekly census report to their SharePoint agency site. If the provider fails to meet the required enrollment levels as stated in Substance Abuse and Mental Health Required Outcomes and Outputs, for thirty (30) calendar days, CFBHN may require the provider to develop a corrective action plan stating how the provider plans

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to comply with the enrollment requirement. Then, if the provider fails to remedy the situation within sixty (60) calendar days, CFBHN may apply a financial penalty as stated in the department's Standard Contract, Section III, B., Section 402.73(1) F.S., and 6-29.001 F.A.C.

2. **Clinical Requirements**

The individual must have a diagnosis within one of the following categories as referenced in the American Psychiatric Association's Diagnostic and Statistical Manual 5th Edition or the latest revised edition thereof, see Appendix A of the DCF GD #16 (2017) for a detailed list of qualifying diagnosis:

- Schizophrenia Spectrum and Other Psychotic Disorders;
- Bipolar and Related Disorders;
- Depressive Disorders;
- Anxiety Disorders;
- Obsessive-Compulsive and Related Disorders;
- Dissociative Disorders;
- Somatic Symptom and Related Disorders; and
- Personality Disorders.

a. Additionally, the individual must meet one of the following six criteria:
   - Demonstrate a high risk for hospital admission or readmission;
   - Have prolonged inpatient days (more than 90 days within one calendar year);
   - Have repeated (more than three (3) episodes per calendar year) local criminal justice involvement;
   - Have been referred for aftercare services by one (1) of the state's correctional institutions;
   - Referred from an inpatient detoxification unit and documented history of co-occurring disorders; or
   - Have more than 3 admissions to an inpatient Baker Act facility within one calendar year crisis stabilization contacts; and

b. Meet at least three (3) of the following six (6) characteristics:
   - Inability to consistently perform the range of practical daily living tasks required for basic adult interactional roles in the community. These tasks include maintaining personal hygiene, meeting nutritional needs, or caring for personal business affairs. The tasks may also include obtaining medical, legal, and housing services, recognizing and avoiding common dangers or hazards to self and possessions;
   - 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);
   - Inability to maintain a safe living situation (repeated evictions, loss of housing, or no housing);
   - Coexisting substance use disorder of significant duration (greater than six months) or coexisting mild intellectual disability;
   - Destructive behavior to self or others; or
   - High-risk or recent history of criminal justice involvement (arrest and incarceration).

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ROP-6. Forensic Requirements (Please see current CFBHN SCR Forensic ROP)

ROP-7. Manner of Service Provision

A. The FACT approach to performing services is based on recovery orientation and promotes empowerment. The guiding principles include participant choice, cultural competence, person-centered planning, rights of persons served, stakeholder inclusion, and voice.

B. The FACT team will assist in the design and implementation of an individualized recovery plan for each individual. Services will include the provision of the specified mental health treatment, rehabilitation and support services listed below, as well as competency training for individuals adjudicated incompetent to proceed, and such other medical, vocational, social, educational and rehabilitative services the person's condition requires to assist in successful community living. The following are services that FACT teams must provide:

1. Crisis assessment and intervention;
2. Comprehensive assessment;
3. Natural Support Network Development
4. Case Management

The primary case manager, along with the team, coordinates care, advocates on behalf of the participant, and provides access to a variety of services and supports, including but not limited to: primary health care (medical and dental); basic needs such as housing and transportation; educational and employment services; and legal services.

ROP-8. Service Areas

The provider agrees to provide the following Treatment, Rehabilitation, and Support Services to all FACT individuals.

A. Treatment Services:

1. The provider shall provide an initial assessment and recovery plan. The team leader with the active participation of the person served and the Psychiatrist or Psychiatric ARNP, shall do an Initial assessment and recovery plan on the day of the person's admission to the FACT program. The required components of an initial assessment, at a minimum, include:
    a. A mental status examination;
    b. Assessment of symptoms;
    c. An initial psychosocial history;
    d. An initial health/medical assessment;
    e. A review of previous clinical information obtained at the time of admission;
    f. A preliminary identification of the person's housing, financial and employment status, and
    g. A preliminary review of their strengths, challenges and preferences.
2. The provider shall develop a Comprehensive assessment. The comprehensive assessment shall be initiated and completed within sixty (60) days of the person's admission to the FACT program following these requirements:
    a. Each assessment area shall be completed by the FACT team member with skill and knowledge in the area being assessed and shall be based upon all available information, including self-reports, reports of family members, upon consent, and other significant parties, and written summaries from other agencies, including police, courts, and outpatient and inpatient facilities where applicable.
    b. The comprehensive assessment shall include an evaluation of the following areas:
        - Psychiatric history, mental status and a DSM-IV diagnosis;
        - Strengths, abilities, and preferences;

- Physical health assessment;
- History and current use of drugs or alcohol;
- Education and employment history/current status;
- Social development and functioning;
- Assessment of activities of daily living;
- Assessment of family relationships;
- Recommendations for care.

c. The enrolled person's individual treatment team (ITT) will assume responsibility for preparing the written assessment.
d. The person's psychiatrist/Psychiatric ARNP, primary case manager, and individual treatment team members shall be assigned by the team leader on the day of admission.
e. To supplement the comprehensive assessment, a psychiatric/social functioning history time line no later than 120 days after the first day of admission.
f. Assessments shall be updated annually and utilized in the updating of the recovery plan. All necessary areas essential for planning should be included in the updated assessment.

3. The provider shall develop a Comprehensive Recovery Plan no later than 90 days from date of enrollment, following the completion of the assessments. The recovery plan is a reflection of the person's needs, strengths, resources, needs, limitations and preferences. It identifies specific measurable long and short-term goals along with the specific services and activities necessary for the person to meet those goals and improve his or her capacity to interact in the community and achieve recovery.
    a. The recovery plan shall be developed in collaboration with the person, guardian, if any, and when feasible and upon consent, the person's family. The person's active participation in the development of the recovery plan shall be documented in the progress notes.
    b. FACT team members and the person served shall meet at regularly scheduled times for recovery planning meetings to review and update the plan or at other significant points in the person's life that would warrant a recovery plan update. Reviewing/Updating the plan should not exceed six (6) months.
    c. The person shall have the option of asking others to attend the meeting.
    d. Each recovery plan shall be based on current assessment findings and/or annual updated assessments shall be used in the updating of the recovery plan. The recovery plan shall consider needs in the following areas:
        - symptom stability and management, education, transportation, housing, activities of daily living, employment, daily structure, and family and social relationships
        - The provider shall provide crisis assessment and intervention. Crisis assessment and intervention shall be provided on a twenty-four (24) hours per day, seven (7) days per week basis. These services will include telephone and face-to-face contact. This service requires the establishment of an on-call schedule to implement a crisis contingency plan.
        - The provider shall provide symptom assessment, management and individual supportive therapy.
        - The provider shall provide medication prescription, administration, monitoring and documentation.
        - The provider hereby agrees to provide substance abuse services to persons with co-occurring mental health and substance use disorders.

B. Rehabilitation Services

1. The provider hereby agrees to provide work-related services. Such services shall help persons find and maintain employment in community-based job sites and include:
    a. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs;
    b. Assessment of the effect on the person's symptoms of mental illness on employment, with identification of specific behaviors that interfere with the person's work performance and development of interventions to reduce or eliminate those behaviors;
    c. Development of an ongoing employment rehabilitation plan to help each person establish the skills necessary to find and maintain a job;
    d. Individual supportive therapy to assist persons served to identify and cope with the symptoms of mental illness that may interfere with their work performance;
    e. On-the-job or work-related crisis intervention;
    f. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of clothing, wake-up calls, and transportation; and
    g. Educating the person enrolled as to work incentives such as the Social Security Administration's Ticket to Work and P.A.S.S. (Plans for Achieving Self Support). Work-related activities are a critical element toward recovery and achieving successful community tenure.
2. The provider hereby agrees to provide support in activities of daily living. Such services shall support activities of daily living in community-based settings, typically in the person's home, and will include:
    a. Individualized assessment;
    b. Problem solving;
    c. Side-by-side assistance and support;
    d. Skill training;
    e. Ongoing supervision such as prompting, assignments, monitoring, encouragement; and
    f. Environmental adaptations to assist persons to gain or use the skills required to:
        - Carry out personal hygiene and grooming tasks;
        - Perform household activities including house cleaning, cooking, grocery shopping, and laundry;
        - Find and maintain or retain housing that is safe and affordable;
        - Develop or improve money-management skills;
        - Use available transportation; and
        - Have and effectively use a personal physician and dentist.
3. The provider hereby agrees to provide social, interpersonal relationship and leisure time training and support. Such services shall include:
    a. Supportive individual therapy such as problem solving, role-playing, modeling, and support;
    b. Social-skill teaching, and assertiveness training;
    c. Planning;
    d. Structuring and prompting of social and leisure-time activities;
    e. Side-by-side support and coaching; and
    f. Organizing individual and group social and recreational activities to structure the persons' time, increase their social experience, and provide them with opportunities to practice social skills and receive feedback and support required to:

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- Improve communication skills, develop assertiveness, and increase self-esteem as necessary;
- Develop social skills, increase social experiences, and where appropriate, develop meaningful personal relationships
- Plan use of leisure time;
- Relate to landlords, neighbors, and others effectively; and
- Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities.

C. **Support Services**

1. The provider shall provide FACT case management services. The primary case manager shall coordinate and monitor the activities of the individual treatment team. The primary case manager has primary responsibility to coordinate the development of the recovery plan, to provide individual supportive therapy, to ensure immediate changes are made in recovery plans as the persons' needs change, and to advocate for the person' rights and preferences. Additionally,
    a. The primary case manager is the first staff person called on when the person is in crisis and, upon consent, is the primary support person and educator to the individual persons' family.
    b. All staff on the FACT team has the responsibility to provide case management services.
    c. Members of the persons' individual treatment team share these tasks with the case manager and are responsible to perform the tasks when the primary case manager is not working or not available.
2. The provider hereby agrees to provide supportive services. These services or direct assistance shall ensure that persons obtain the basic necessities of daily life and include, but are not necessarily limited to:
    a. Medical, dental and vision services;
    b. Financial support;
    c. Social services;
    d. Transportation; and
    e. Advocacy.
3. The provider hereby agrees to provide and/or arrange for safe, decent, affordable living arrangements. This service shall ensure that a person is given the opportunity to obtain the type of living arrangement of his or her choice. This service requires that a FACT team member have knowledge about the housing resources within the community where the FACT program is located. The FACT Team member should also have knowledge and skills in accessing Section 8 rental vouchers from local housing authorities, have an awareness of Housing and Urban Development (HUD) housing availability and working with landlords in the community to secure a lease that specifies the terms and conditions of the rental and be aware of the program's housing subsidy.
4. The provider hereby agrees to provide education, support and consultation services to the person's family and significant others. Such services shall be provided to family members and significant others, with the person's agreement or consent, and shall include:
    a. Education about the person's illness and the role of the family in the recovery process;
    b. Intervention to resolve conflict; and
    c. Ongoing communication and collaboration, face-to-face and by telephone, between team members and the family.
    d. The provider hereby agrees to provide other unique, person-specific services as necessary to implement a person's recovery plan. These unique, person-specific services

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are services that may be required to ensure a person's treatment and service needs are fully addressed.

When using this service category, the specific service or services to be rendered must be identified with an estimation of the time frame the service or services will be provided.

D. OTHER RESPONSIBILITIES

1. The FACT team shall be available to provide treatment, rehabilitation, and support activities seven (7) days per week, with two (2) overlapping shifts and operate a minimum of twelve (12) hours per day on weekdays; and eight (8) hours each weekend day and every holiday. .
2. The FACT team agrees to operate an after-hours on-call system staffed by staff experienced and skilled in crisis-intervention procedures. Staff shall be on-call and available to respond to persons' needs by telephone or in person.
3. Psychiatric backup shall also be available during all off-hours periods. If availability of the FACT team's psychiatrist/Psychiatric ARNP during all hours is not feasible, alternative psychiatric backup should be arranged.
4. The FACT team shall have the capacity to provide multiple contacts per week to persons experiencing severe symptoms or significant problems in daily living. These multiple contacts may be as frequent as two (2) to three (3) times per day, seven (7) days per week, depending on need. Many if not all staff shall share responsibility for addressing the needs of all persons requiring frequent contacts.
5. The FACT team shall have the capacity to rapidly increase service intensity to a person when his or her status requires it.
6. The FACT team shall have contact with each person once per week with a mean (i.e., average) of three contacts per week for all persons. For individuals currently in local psychiatric inpatient hospitals, visits will occur minimally one time per week. For individuals currently in a Civil Treatment Facility contact with state treatment facility staff is to occur monthly and conference calls may be used to participate in recovery planning. Individuals in a Forensic State Treatment Facility, quarterly visits will occur unless otherwise waived by CFBHN. As part of recovery plan development, in preparation of graduation goals, frequency of contact with the individual served will be based on the individual's needs and the level and intensity agreed upon in the current recovery plan.
7. The FACT team shall provide 75 percent (75%) of its service contacts in the community, from non-office or non-facility-based settings. The FACT team will maintain data to verify this requirement is being met.
8. The FACT team shall conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader.
9. The FACT team will maintain an electronic or manual record.
10. The daily organizational staff meeting will commence with a review of the daily log, to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all persons served.
11. The FACT team, under the direction of the team leader, shall maintain a weekly schedule for each person served. The weekly schedule is a written schedule of all treatment and service contacts, which staff must carry out to fulfill the goals and objectives in the person's recovery plan. The team will maintain a central file of all weekly schedules.
12. The FACT team, under the direction of the team leader, shall develop a daily staff assignment schedule from the central file of all weekly schedules. The daily staff assignment schedule is a written timetable for all treatment and service contacts, to be divided and shared by the staff working on that day.
13. The daily organizational staff meeting will include a review by the shift manager of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the shift

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manager will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day and the shift manager will be responsible for assuring that all tasks are completed.

14. At the daily organizational meeting, the FACT team shall also revise recovery plans as needed, plan for emergency crisis situations, and add service contacts to the daily staff assignment schedule per the revised recovery plans.
15. If the provider is the represented payee for supplemental security income, social security benefits, VA Benefits, or other federal benefits on behalf of the individual, the provider agrees to comply with the applicable federal laws including the establishment and management of the individual's trust accounts (20CFR416 and 31CFR240 and DCF Accounting Procedures Manual 7APM6).
16. **All teams will develop a policy and procedure that addresses the practice of disposing of clients belongings. The Policy must include clients signed and dated consent, listing of type of belongings disposed and the reason for the disposal of the belongings. Additionally, this action shall be documented in the progress notes. If the action is in accordance with a Recovery Plan goal, it must be referenced in the progress notes and included in the signed consent/listing of belongings. Pictures of the belongings may also be used if it is felt to be necessary.**

ROP-9. Administrative Tasks

The provider shall be responsible for performing the following administrative tasks:

A. Supervision shall include regular meetings with individual staff to review cases, assess performance, and give feedback.
B. The provider shall establish and maintain written program organization policies and procedures including required hours of operation and coverage, service intensity, staff communication and planning, emphasis on teamwork approach, staff supervision, and place of treatment that includes a minimum of 75 percent (75%) of service delivery takes place out of the office.
C. The provider shall establish and maintain written policies and procedures that include the following:
    1. Initial assessment and initial recovery plans;
    2. Comprehensive assessments and annual assessment updates;
    3. Recovery planning and updates;
    4. Case management;
    5. Crisis assessment and intervention
    6. Symptom assessment, management, and individual supportive therapy;
    7. Medication prescription, administration, monitoring, and documentation;
    8. Substance use services for persons with co-occurring substance use disorders;
    9. Work-related services;
    10. Activities of daily living;
    11. Social, interpersonal relationship and leisure-time skill training;
    12. Support services;
    13. Provisions or arrangements for safe, decent, affordable living arrangements; an
    14. Education, support and consultation to the person's family and significant others.
    15. Other unique, person-specific services that may be necessary.
D. The provider shall develop policy and procedure for the admissions and discharge process.
E. The provider shall establish and maintain written medical records and records management policies and procedures.
F. The provider shall establish and maintain a written Quality Assurance/Quality Improvement performance policy and procedure.
G. The provider shall establish and maintain a written risk management policy and procedure.

H. The provider shall establish and maintain written policies and procedures on the rights of persons served by the FACT team.
I. The provider shall keep accurate records reflecting the specific services offered to each person. All records of care, treatment, supervision and support shall become part of the treatment records and made available to CFBHN upon request. Each person's record shall be available for review at all times to CFBHN staff.
J. The provider shall coordinate services with other entities to ensure the needs of the person served are addressed at any given time.
K. The provider shall develop a summary plan for providing FACT services in case of disaster. The following elements shall be included in the plan:
    1. The plan shall describe how the provider would work with CFBHN to assure the safety of the individual and to provide continuity of needed services and supports;
    2. The plan shall provide back-up contingencies for staff, medications, and other supports required; and
    3. The plan shall demonstrate how the provider will work with the local disaster response system to promote the best interest of the individuals being served.
    4. A description of how the provision of FACT services would not be downgraded in the event of a disaster and what corrective remedies would be used to ensure continued operations.
    5. A description of the provider's approach for addressing post-traumatic stress disorders and other post-disaster recovery-related activities.
    6. A copy of the detailed plan shall be provided to the CFBHN at the beginning of each new service Fiscal Year. The provider agrees to review and, if necessary, update annually.

ROP-10. Inter CFBHN Network Referrals

A. When an individual plans to move out of the county/circuit served by the team, the team shall contact CFBHN and request their assistance in arranging for the referral of services from the Suncoast Region/C10 to different Fact team. The originating SCR/C10 FACT team shall contact the receiving circuit to determine:
B. SCR/C10 FACT teams will prioritize acceptance of any FACT team members referred from within the SCR/C10 as well as from other Fact teams within the state of Florida, if the team has capacity. Upon arrival, the receiving team shall review the clinical record and use this information in the development of the initial assessment/initial recovery plan and admission process, assess the person's current medication regime, consult with the program psychiatrist and follow the enrollment process identified for all new enrollees.
C. The provider must enroll all referrals from the Department of Children and Families' Substance Abuse and Mental Health Circuit Program Office and CFBHN.

ROP-11. Criteria for discharge from FACT

Discharges from the FACT team may occur when persons served by the FACT team meet <u>one</u> of the criteria from the following category:

A. Reason for discharge:
    1. The person moves **outside of the geographic areas** of the FACT team's responsibility. In such cases, the FACT team shall notify CFBHN of the pending relocation. The FACT team, in consultation with CFBHN, if necessary, arranges for referral to mental health services to a provider with a FACT team where the person is moving or link with mental health services (CM, ICM, OP) <u>appropriate to the level of need of the individual being transferred</u>;
    2. The person moves **outside of the State of Florida**. In such cases, the FACT team <u>will not</u> administratively discharge the person until a period of sixty (60) days has passed. Efforts to link to mental health services should be documented in the record;

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3. 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);
4. The **person requests** discharge, despite the team's repeated efforts to develop a recovery plan acceptable to the person served by the team or the person served abandons all treatment/services offered or provided by FACT. When this criterion is used, documentation of the efforts to continue FACT services without success must be clearly described in the clinical record. Discharge may occur after 45 days from the date of the person's signed/documented verbal request. If the person served rescinds the discharge request FACT services will resume to their previous level for the person served;
5. The person has been admitted to a civil state mental health treatment facility and has remained in such facility for a period exceeding one year and after direct consultation with the individual's treatment team at the facility, it has been determined that there is no immediate, anticipated date of discharge; or the person has been adjudicated guilty of a felony crime and subsequently sent to state or federal prison for a sentence that exceeds one year or is in a skilled nursing facility and it is determined that return to the community is not possible due to the clinical needs of the individual served.

B. Documentation of discharge process:
There must be documentation in the medical record of the following discharge tasks:
1. The reason(s) for discharge;
2. The person's status and condition at discharge and a signed approval for request of discharge by CFBHN designee
3. A written final evaluation summary of the person's progress toward the desired outcomes and goals set forth in the person's recovery plan;
4. A plan developed in conjunction with the person served by the FACT team for treatment upon discharge and for follow-up that includes the signature of the primary case manager, team leader and psychiatrist, the signature of the person or legal guardian, if appointed; and discharge planning activities including linkages and transitional plans to other providers;
5. There must be documentation in the clinical record that the person discharged was advised he or she may return to the FACT Team if they desire and if space is available.

ROP-12. Staffing Requirements

Minimum Staffing Standards

FACT staffing configurations are comprised of practitioners with varying backgrounds in education, training, and experience. This diverse range of skills and expertise enhances the team's ability to provide comprehensive care based on individual needs. **The ratio of FACT participants to direct service staff members should not exceed 10:1. Hours of operation** and staff coverage is available to provide services **seven days per week with two overlapping eight hour shifts, operating a minimum of twelve hours per day on weekdays and eight hours each weekend day and holiday.** The FACT team operates an after-hours on-call system with a mental health professional on-call at all times.

Based on the TMACT, below are the **minimum staffing** patterns for FACT:

# of Participants	Minimum Direct Service[1] FTE	Minimum Total FTE
105	10.3	12.3
100	10.0	11.8
95	9.7	11.5
90	9.4	11.2
85	9.1	10.9

There is some flexibility in the composition of FACT team professionals, within the guidelines of the prescribed staff to participant ratio. However, a FACT team must **minimally include**:

1. One team leader;
2. One part-time psychiatrist or psychiatric advanced registered nurse practitioner (ARNP);
3. One nurse for every 35 participants, one of whom must be a full-time registered nurse (RN) who is required to be on duty each workweek day defined as Monday through Friday;
4. One full-time peer specialist;
5. One full-time substance abuse specialist;
6. One full-time vocational specialist;
7. One full-time case manager; and
8. One administrative assistant.

Staff Roles and Credentials

The provider must maintain a current **organizational chart** indicating required staff and displaying organizational relationships and responsibility, lines of administrative oversight, and clinical supervision.

Team Leader

The team leader must be a full-time employee and possess a Florida license in one of the following professions:

- Clinical Social Worker;
- Marriage & Family Therapist;
- Mental Health Counselor;
- Psychiatrist;
- Registered Nurse; or
- Psychologist.

He/she is responsible for administrative and clinical oversight of the team and functions as a practicing clinician. If the team leader is a registered nurse, this will not replace the requirement for a registered nurse on duty every weekday. The team leader receives clinical supervision from the psychiatrist or psychiatric ARNP and administrative supervision from the Chief Executive Officer or designee.

Psychiatrist or Psychiatric ARNP

The psychiatrist or psychiatric ARNP provides clinical supervision to the entire team as well as psychopharmacological services for all FACT participants. He/she also monitors non-psychiatric medical conditions and medications, provides brief therapy, and provides diagnostic and medication education to participants, with medication decisions based in a shared decision making paradigm. If consumers are hospitalized, he/she communicates directly with the inpatient

[1]Direct service staff does not include the psychiatric care provider or administrative staff.

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psychiatric care provider to ensure continuity of care and conducts home and community visits as needed. The program psychiatrist must be board certified. If the FACT team employs a psychiatric ARNP, there must be access to a board certified psychiatrist for weekly consultation. A minimum of .32 hours of psychiatric services must be available for every FACT participant per week. (e.g., 32 hours for 100 FACT members).

Nurse

Preferred staffing for each FACT team includes only RN's; however, one (1) RN and licensed practical nurses (s) (LPN) are deemed an acceptable minimum. The RN must have at least one year experience working with adults with mental illnesses. Nurses perform the following critical roles:

- Manage the medication system;
- Administer and document medication treatment;
- Screen and monitor participants for medical problems/side effects;
- Communicate and coordinate services with other medical providers;
- Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change);
- Educate other team members on monitoring of psychiatric symptoms and medication side effects; and
- With participant agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).

Peer Specialist

A Peer Specialist fulfills a unique role in the support and recovery from mental health disorders. A Peer Specialist has lived experience receiving mental health services for severe mental illness. His or her life experience and recovery provides knowledge and insight that professional training cannot replicate. The Peer Specialist is a fully integrated team members who provides individualized support services and promotes self-determination and decision-making. The Peer Specialist provides essential expertise and consultation to the entire team to promote a culture in which each person's point of view and preferences are recognized, understood, respected, and integrated into care. Within one year of employment, the Peer Specialist must meet the professional requirements and standards set forth by the Florida Certification Board and become certified by the state of Florida as a Certified Recovery Peer Specialist for Adults (CRPS-A). His or her mental health professional qualifications are compensated on an equitable basis with other FACT team members.

Substance Abuse Specialist

There must be at least one Substance Abuse Specialist with 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. Within one year of employment, a bachelor's level Substance Abuse Specialist must meet Florida's standards for certification as an Addiction Professional. The Substance Abuse Specialist provides integrated treatment for co-occurring mental illness and substance use disorders to participants who have a substance use problem. These services include:

- Substance use assessments that consider the relationship between substance use and mental health;

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- Assessment and tracking of participants' stages of change readiness and stages of treatment;
- Outreach and motivational interviewing techniques;
- Cognitive behavioral approaches and relapse prevention; and
- Treatment approaches consistent with the participants' stage of change readiness

The Substance Abuse Specialist also provides consultation and training to other team staff on integrated assessment and treatment skills relating to co-occurring disorders.

Vocational Specialist
There must be at least one vocational specialist who has a bachelor's degree and a minimum of one year of experience providing employment services. The vocational specialist provides supported employment services as described in the Substance Abuse and Mental Health Services Administration's Supported Employment Evidence-Based Practices (EBP) KIT, which may be downloaded at http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365.

The vocational specialist also provides consultation and training to other FACT team staff on supported employment approaches.

Case Manager
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. The Case Manager provides the rehabilitation and support functions under clinical supervision and are integral members of individual treatment teams. This includes social and communication skills training and training to enhance participant's independent living. Examples include on-going assessment, problem solving, assistance with activities of daily living, and coaching.

Administrative Assistant
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 both in the office and field. Additionally, the assistant serves as a liaison between FACT participants and staff, including attending to the needs of office walk-ins and calls from participants and natural supports. The assistant actively participates in the daily team meeting.

A position shall be deemed not vacant when an employee is temporarily absent due to paid vacation, paid sick leave, management and professional conferences, in-service training, or other temporary leave condition. A position shall be deemed not vacant if filled through the use of overtime, contract services, or temporary employees.

In any event, the provider must perform all functions and services specified in this agreement, regardless of whether these functions are performed by in-house employees, contracted professionals, or other similar contractual arrangements.

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The FACT team, with the exception of the program psychiatrist/Psychiatric ARNP who may be employed or contracted by the team on a part-time basis, shall employ no clinical staff part-time without the written permission of CFBHN staff.

Subcontractors

No subcontracts with organizations to provide FACT services are permitted. However, professional service contracts with individual professionals are permitted.

ROP-13. Service Delivery Location

A. The provider shall establish a central office site and may establish a satellite office site if deemed appropriate. The central office and satellite offices shall include an accessible and comfortable reception area for persons served and their families. It shall also include a team work/meeting room, a shared private room for conducting interviews as needed, a secure medication room and a safe or other locked means of securing an individual's funds and personal items.

B. Each medication room shall have:
   1. Locked areas (e.g. cabinets) where medication stocks, individual-specific medications and medication supplies (e.g., syringes and needles) are kept;
   2. Other storage areas for medication supplies and medical examination equipment;
   3. Work areas where nurses can chart and perform other essential tasks; and
   4. A faucet, sink and medication-dedicated refrigerator within close proximity to the medication room.

C. The sites shall be accessible to public transportation and be safe, clean and well maintained. The offices shall conform to all applicable building codes and possess a current occupancy permit, a current Florida Fire Marshall Inspection and an evacuation plan. All offices offered for providing services under this contract shall be accessible to persons with mobility limitations consistent with the Rehabilitation of the Handicapped Act, P. L. 95-602, and section 504 of the Rehabilitation Act of 1973 as amended, 29 U.S.C. 794.

D. The provider shall notify CFBHN in writing, of changes to service delivery location within seven (7) calendar days

ROP-14. Deliverables

A. Reports
   1. Submit to CFBHN SharePoint the FACT Enhancement Reconciliation Report by the 15th of each month. This report displays the provider's expenditures of enhancement funds for each. The report is segregated into three categories:
      a. Housing expenses;
      b. Medication expenses; and
      c. Flexible funding expenses.
   2. Submit to CFBHN and DCF HQ the FACT Ad Hoc Report by the 15th of each quarter. This report displays the provider's census, types of housing, employment, volunteering or educational pursuits. It also shows the number of local hospitalizations, number of state hospitalizations, and the types of discharges, and FACT team staffing levels.
   3. Submit to CFBHN Vacant Position(s) Report by the 15th of each month. The provider shall report monthly the positions required by this program and whether the positions were filled or vacant for the reporting month.
   4. Submit to CFBHN FACT Referral Log monthly by the 15th of each month.

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5. Submit a Monthly Census by the 5th of each **month**. This census will include client names, date of admission and referral source.

B. Performance Measures
   1. Chapter 394, F. S., requires all providers contracting with CFBHN to comply with its uniform data specifications. Providers shall submit Client specific data: demographic, admission, discharge, enrollment, placement, service, and performance outcome data electronically as specified in CFP 155-2.
   2. Data should be submitted by the 10th of each month.

   The provider shall meet the performance standards and required outcomes specified in **Substance Abuse and Mental Health Required Outcomes and Outputs**. The provider shall upload their **monthly and quarterly** performance outcomes on SharePoint.

C. Performance Measurement Terms
   CFP 155-2 provides the definitions of the data elements used for various performance measures and contains policies and procedures for submitting the required data into the department data system

D. Method of Payment
   1. The provider will utilize its allocation of enhancement funds in accordance with the current DCF Enhancement Guidelines as part of the current DCF Guidance Document 16.
   2. Service delivery costs are based on weekly census. Teams will report weekly census on SharePoint. For each member on the team FACT will be paid a calculated rate in accordance with their contract. Though 100 is the capacity for each team, the teams will be reimbursed at 100% when they reach 98 or more census
   3. The amount of $212.00 per month per person is for enhancement funding budgeting purposes only and is not intended to prohibit the use of less or more funds for specific individuals.
   4. The provider shall not bill Medicaid for FACT services for persons who are enrolled in the FACT program.
   5. Administrative Costs, including any indirect costs that are administrative in nature, must not exceed 10% of the total operating costs of the proposed program budget including the enhancement funds.

ROP-15. Collaboration Activities

The provider recognizes that the team may be subject to re-procurement. As a requirement of providing FACT services the provider agrees to conduct the following activities in the event of a change in providers as a result of the re-procurement process or due to the termination of an existing FACT contract:

A. Collaborating with the new FACT provider to assist in the transition of services including a census of all enrolled individuals that includes the name, any identification number, social security number, address, phone number and the primary case manager and phone number;
B. Assisting in the obtaining of signatures for the release of medical records pertaining to each enrolled individual;
C. Meeting with the new FACT provider to discuss individual case situations to identify treatment, rehabilitation and support needs requiring immediate attention;
D. Providing a complete inventory of medications purchased with FACT funds including the name, address and phone number of the pharmacy serving the existing FACT team;
E. Providing a complete inventory of FACT purchased equipment and supplies for transfer to a new provider;

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F. Providing a complete directory of the FACT Advisory Committee membership including name, address and phone number; and
G. Collaborating with CFBHN to ensure a smooth transition of services and continuity of care.

ROP-16. Definition of Terms

1. Case management means, for FACT purposes only, an organized process of coordination among the interdisciplinary FACT team providing a full range of treatment, rehabilitation and support services in a planned manner that promotes recovery.
2. CFBHN- Central Florida Behavioral Health Network, the managing entity for the Suncoast Region Substance Abuse and Mental Health funding.
3. Circuit means a service area identified by the Department of Children and Families which may include one or more Florida counties. (e.g., Circuit 6 includes Pinellas and Pasco, Circuit 10 includes Hardee/Highlands/Polk counties, Circuit 12 includes Manatee, Sarasota and Desoto, Circuit 13 includes Hillsborough, and Circuit 20 comprised of Charlotte, Lee, Hendry, Glades and Collier).
4. Clinical supervision means regular, face-to-face contact between the designated clinical supervisor and a team member reviewing a person's clinical status and ensuring treatment, rehabilitation and support services are provided within a framework of recovery to that person by the team member consistent with the recovery plan. Clinical supervision occurs during daily organizational staff meetings and recovery planning meetings, or individual one-to-one supervisory sessions and includes review of written documentation such as assessments, treatments, recovery plans, progress notes, and correspondence.
5. Community-based services means mental health and substance abuse services provided outside a state mental health facility.
6. Comprehensive assessment means an organized process of gathering information to evaluate a person's mental and interactional status and his or her treatment, rehabilitation, and support needs that will enhance recovery. The results of the assessment are used to develop an individual recovery plan for the person. Assessments will be updated annually.
7. Commodities means supplies, materials, goods, merchandise, equipment, information technology, and other personal property. The definition does not include pharmaceuticals, medical treatment or procedure, glasses, hearing aids, or lab work.
8. Conditional release means a court ordered plan for providing appropriate outpatient care and treatment for a person found to be incompetent to proceed and for a person found to be not guilty by reason of insanity. The committing court may order a conditional release of any defendant in lieu of an involuntary commitment to a state mental health treatment facility, or upon a recommendation that outpatient treatment of the defendant is appropriate. A written plan for outpatient treatment, including recommendations from qualified professionals, must be filed with the court with copies to all parties. Such a plan may also be submitted by the defendant and filed with the court with copies to all parties.
9. Corrective action plan means a method of redress in the event a provider fails to meet or provide service at the level outlined in the SCR/C10 FACT ROP.
10. Culturally competent services means acknowledging and incorporating variances in normative acceptable behaviors, beliefs and values in determining an individual's mental wellness/illness and incorporating those variances into assessments and treatment that promotes recovery.
11. Daily log means an electronic or manual record to be maintained by the FACT team on a daily basis that provides:
    a. A roster of persons served in the program; and
    b. For each person, a brief documentation of any treatment service contracts that have occurred during the day and a concise behavioral description of the person's clinical status.

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12. Daily organizational staff meeting means a daily staff meeting held at regularly scheduled times under the direction of the team leader (or designee) to:
    a. Briefly review the service contracts that occurred the previous day and their status;
    b. Review the service contracts that are scheduled to be completed during the current day and revise as needed;
    c. Assign staff to carry out the day's service activities;
    d. Revise recovery plans for emergency and crisis situations as needed; and
    e. Use of the daily log and the daily staff assignment schedule to facilitate completion of these tasks.
13. Daily staff assignment schedule means a written daily timetable summarizing all treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly schedules of persons served.
14. Department of Children & Families, Pamphlet 155-2, Mental Health and Substance Abuse Measurement and Data, latest revised edition thereof, means a document promulgated by the department and incorporated by reference in Rule 65E-14, F.A.C. that contains required data reporting elements for substance abuse and mental health services, hereafter referred to as "CFP 155-2", and which can be found at: http://www.myflfamilies.com/service-programs/substance-abuse/pamphlet-155-2 and is incorporated herein by reference.
15. Empowerment means the process where the provider of services encourages the individual to make choices in matters affecting their lives and to accept personal responsibility for those choices. Within the mental health community, empowerment of individuals diagnosed with a mental illness is accomplished through the provision of high service quality and an individual service orientation. These services shall be provided in a professional manner and will be based on equality and respect. The empowerment process will include, but is not limited to, each of four levels:
    a. freedom of choice regarding services;
    b. influence over the operation and structure of service provision;
    c. participation in system-wide human recovery planning; and
    d. participation in decision-making at the community level. This fourth level addresses the role of individuals with disabilities as community citizens in general, not merely as service individuals.
16. Engagement means the process of identifying, recruiting and considering a person for enrollment in FACT. If the person being considered for FACT is in the state hospital, local hospital or CSU, team members will begin to visit the person in the hospital and participate in developing the discharge plan, but will not officially assume responsibility to provide treatment services until the person is discharged. **A person currently in a state hospital, local hospital or Crisis Stabilization Unit (CSU) cannot be "enrolled" in a FACT program until discharge takes place.** A person already "enrolled" in a FACT program continues to be "enrolled" even though hospitalization via a CSU, local hospital or state hospital occurs. Even though a person going through the engagement process has not formally been enrolled in a FACT team, the FACT team must keep a written record on:
    a. What activities took place during the engagement process and the person's response to those activities; and
    b. The name of the FACT staff member conducting the engagement activities.
17. Enhancement funds mean those funds appropriated by the Florida Legislature to purchase adjunct services or commodities not directly provided by the FACT team. Funding is used to increase or maintain a person's independence and integration into their community. Funding may be used for costs related to housing, pharmaceuticals, tangible items needed for employment/education or other meaningful activity, and specialized treatment consistent with a person's recovery plan. FACT team enhancement funds is the payer of last resort, and the primary case manager must certify that due diligence was exercised in searching for alternative funding to pay for the commodity or service prior to the use of enhancement funds. Guidelines

for use of enhancement funds can be found in the "Florida Assertive Community Treatment (FACT) Enhancement Guidelines, **contained in the Guidance Document 16**, most current edition.

18. Enrollment means the act of admitting a person formally into the FACT program. The person agrees to accept services by the FACT team. The most significant distinction between engagement and enrollment is the associated requirements. Enrollment begins when the person being considered agrees to be accepted into the FACT program and the FACT team begins the admission process. The admission process consists of the initial assessment, the initial recovery plan and the identification by the team leader of the person's primary case manager and individualized treatment team. At this time, the sixty (60) day requirement for completing the comprehensive assessment is started. Engagement, on the other hand, are those activities that informally permit the FACT team to learn more about a person being considered for FACT enrollment. FACT team staff shall notify state or local hospitals within five (5) days of making a decision about enrollment of an individual to a FACT team upon their discharge from the hospital or CSU. CSU notification should be sent as soon as a decision is made.
19. From the first day of enrollment, the FACT team is the primary provider of services and has total responsibility to help individuals to meet their needs in all aspects of living in the community
20. Family member means a relative or guardian, (under FS 744); of an individual served with a psychiatric disability that is receiving or has received psychiatric services either through public or private entities.
21. Florida Assertive Community Treatment (FACT) means a self-contained clinical team. It is based on the unique characteristics of the Program of Assertive Community Treatment (PACT) model, an empirically established, evidenced-based model of community-based service intervention. These unique characteristics include:
    a. the provider is the primary provider of services and fixed point of accountability;
    b. services are provided out of office;
    c. services are highly individualized;
    d. there exists an assertive, "can do" approach to service delivery; and
    e. services are provided continuously over time.
22. The FACT team:
    a. Assumes responsibility for directly providing the majority of needed treatment, rehabilitation and support services to identify individuals with psychiatric disabilities in order to achieve recovery.
    b. Minimally refers person served by the FACT team to outside service providers;
    c. Provides services on a long-term care basis with continuity of caregivers over time;
    d. Delivers the majority of the services outside program offices; and
    e. Emphasizes individual preferences, choice, outreach, relationship building, and individualization of services. Persons to be served are individuals who have not been served adequately through traditional service delivery systems. The team leader, program psychiatrist, program assistant and multidisciplinary staff are to ensure service excellence to people served by the team.
23. Forensically involved means any criminal defendant who is mentally ill under court jurisdiction pursuant to Chapter 916, Florida Statutes and who:
    a. Has been determined to need treatment for mental illness;
    b. Has been found incompetent to proceed on a felony offense or has been acquitted of a felony offense by reason of insanity;
    c. Has been determined to not meet criteria for involuntary hospitalization; and
    d. is an adult or a juvenile prosecuted as an adult.
24. Functional Assessment Rating Scale (FARS) means the rating scale adopted by the Mental Health Program Office that is to be administered consistent with the most current version of the department's pamphlet 155-2 as it is developed. **FARS are not completed for FACT clients while they are in a Civil State MH Treatment Facility, the SMHTF completes them.**

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25. Health Insurance Portability and Accountability Act (HIPAA) means the federal law that protects the privacy of individuals' qualifying medical records from disclosure except under specified conditions.
26. Incompetent to proceed means the condition of a defendant being unable to proceed at any material stage of a criminal proceeding due to mental impairment. Those stages shall include a trial of the case and pretrial hearings involving questions of fact on which the defendant might be expected to testify. It shall also include an entry of a plea, proceedings for violations of probation or violation of community control, sentencing, and hearings on issues regarding a defendant's failure to comply with court orders. It also considers conditions or other matters in which the mental competence of the defendant is necessary for a just resolution of the issues being considered.
27. Individual treatment team (ITT) means a group of three to five staff members with a range of clinical and rehabilitation skills who are assigned to the team by the team leader on the day of the person's admission.
28. Individual supportive therapy means verbal therapy, in the form of face-to-face and one-to-one conversations with the person and focuses on helping the person understand and identify symptoms, lessens distress and symptomatology, enhance opportunities for recovery, improves role interactions, and increase participation in and satisfaction with treatment and rehabilitative services.
29. Initial assessment and recovery plan means the initial evaluation of a person's mental health status and his or her recovery and practical resource needs (e.g., housing, finances). The initial recovery plan is completed on the day of admission.
30. Intentional care standards means standards that guide staff in working in ways that is empowering and that support individuals in their recovery process.
31. Medication administration means the physical act of giving medication to a person consistent with the prescription.
32. Medication error means any error in prescribing or administering a specific medication, including errors in writing or transcribing the prescription, or in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.
33. Medication monitoring means a person is observed to determine and identify both beneficial effects and inadvertent or undesirable effects secondary to psychotropic medications.
34. Mental health professional means a person with a master's degree or above in one of the health or social science fields or a Florida Licensed Registered Nurse.
35. Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse.
36. MyFloridaMarketPlace means the system described in Rule 60A-1.030, Florida Administrative Code (F.A.C.) that requires, with few exceptions, vendor registration and payment of fees in order to do business in the state.
37. Not guilty by reason of insanity means a ruling by a court acquitting a defendant of criminal charges because of a mental defect sufficient under the law to preclude conviction.
38. Observation of self-administration means, for FACT purposes only, the act of physically observing an enrolled FACT person taking his or her own medication.
39. PACT Manual means a manual published by NAMI for operating a model of community-based treatment for persons with severe and persistent mental illnesses, cited as Deborah J. Allness, M.S.S.W., William H. Knoedler, M.D., the PACT Manual for PACT Start-up, June 2003 Edition, NAMI Campaign to End Discrimination, NAMI, Anti-Stigma Foundation, Arlington, Virginia.

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40. People First language means written narrative and written communication that eliminates such terms as "client", "patient", or "consumer" and reflects a philosophy and value system that promotes person-centered services, recovery, empowerment, cultural competency and reduces stigma and discrimination.
41. Performance measures means quantitative indicators, outcomes and outputs that can be used by CFBHN to objectively measure a provider's performance.
42. Person with psychiatric disability means individuals with a diagnosis of a psychiatric disability who are receiving services through Florida's adult mental health system of care.
43. Primary staff means, for FACT purposes only, the team member that coordinates and monitors the activities of the individuals' treatment team. .
44. Professional services contract means a contract with a licensed mental health professional to perform the duties that fall within the scope of the person's license on behalf of the FACT team.
45. Psychiatric/social functioning history time line means the process that helps to organize, chronicle and evaluate information about significant events in a person's life, experience with mental illness, and treatment history.
46. Psychotropic medication means any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or anti-anxiety agents.
47. Recovery means a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence. The recovery process describes the manner in which hope, vision, meaning and purpose are restored, and connection to one's community is established or reinstated in spite of the effects of the illness.
48. Recovery Plan means the culmination of a continuing process involving the person served, his or her family or other supports upon consent, and the FACT team. The plan reflects individualized service activity and intensity to meet person-specific treatment, rehabilitation, and support needs that promote recovery. The written recovery plan documents the person's goals and the services necessary to achieve them. The recovery plan must reflect and be consistent with the individual's preferences for services and choices in the selection of living arrangements. The plan also delineates the roles and responsibilities of the Individual Treatment Team members who will carry out the services.
49. Recovery planning meeting means a meeting that must include the person served.
50. Recovery Plan Review means a written summary describing the person's progress since the last recovery-planning meeting; it outlines interactional strengths and limitations at the time the recovery plan is rewritten.
51. Rehabilitation means, for FACT purposes only, the process of helping individuals minimize the effects of the symptoms and impairments of mental illness on major role skills and develop greater competencies in employment, activities of daily living and social performance and promoting recovery.
52. Representative payee means an entity that is legally authorized and appointed by the SS Administration to receive Supplemental Security Income, Social Security benefit, Veterans Administration benefits, or other federal benefits on behalf of individual receiving benefits.
53. SAMH means Substance Abuse and Mental Health in the Department of Children and Families.
54. SAMHIS means the Substance Abuse and Mental Health Data Information System.
55. Self-administration means, for FACT only, the physical act of taking one's own medication.
56. Shift manager means the individual assigned by the team leader and is in charge of developing and implementing the daily staff assignment schedule.
57. Stakeholders mean individuals or organizations that share a mutual interest in improving quality behavioral health care in Florida.
58. Support means providing practical, hands-on assistance to help persons meet the necessities of daily living that will assist a person in their recovery process.

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59. Team leader means the individual who is the licensed clinical and administrative supervisor of the team and also functions as a practicing clinician.
60. Treatment means a systematic approach to relieving the primary manifestations of mental illness. Relieving the symptoms and minimizing the time individuals spend in psychiatric hospitals sets the stage for successful rehabilitation and recovery. Treatment is intended to lessen and remove the symptoms of mental illness, prevent later reoccurrence or worsening of symptoms and helping individuals cope with symptoms when medications and other treatments are only partially successful.
61. Verifiable service means documentation of service provision in compliance with the requirements contained in Rule 65E-14.021, F.A.C.
62. Virtual private network (VPN) means a network that is constructed by using public wires to connect nodes. There are a number of systems that enable the creation of networks using the Internet as the medium for transporting data. These systems use encryption and other security mechanisms to ensure that only authorized users can access the network and that the data cannot be intercepted.
63. Weekly schedule means a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) that fulfills the goals and objectives in a given person's recovery plan. This schedule shall be developed and maintained for each person enrolled in FACT.

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APPENDIX XI
FACT-SPECIFIC QUALITY IMPROVEMENT (QI) MONITORING TOOLS

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Administrative Compliance Tool FY 18-19

Provider:
Date:
Reviewer:

Central Florida Behavioral Health Network, Inc.

*Tool DCF approved: 8/8/2018

#		Applies To	Evidenced by		Yes/No
Access to Services					
1	Policies specifically address access to services, including management of waiting lists and priority populations.	Applies to treatment services only	Policies address each of these elements	FS 394.674	
2	There is a policy or procedure in place to ensure 95% of individuals needing treatment services will receive services, depending on the severity of individual need, within the following time frames: Emergent need: within 6 hours of first contact; Urgent need: within 48 hours of first contact; Routine need: within 10 business days of first contact.		Policy/procedure is in place. Data is collected to ensure compliance.	Contract	
3	There is a policy or procedure in place to show that a single phone number is staffed 24/7 through which individuals may secure information and referral for initial intake with an appropriate provider.	Crisis Support and Detox Funding	Policy/procedure in place	Contract	
Human Resources					
4	A policy is in place that requires, upon hire, an employee to sign the DCF Affidavit of Good Moral Character.	All	Policy/procedure in place	See DCF background screening site: http://www.dcf.state.fl.us/programs/backgroundscreening/matrices.shtml	
5	A policy is in place that requires staff to complete a Level II background screening prior to hire and at 5-year intervals, thereafter. This applies to staff referenced at the link referenced 'Authority.'	All	Policy/procedure in place		
6	A policy is in place that requires employees to report an arrest for a potentially disqualifying offense to the employer, and that requires the employer to remove the employee from client contact until the case is resolved in a manner that qualifies the employee for work.	All	Policy/procedure in place	Contract	
7	A policy is in place that requires staff training on HIPAA regulations and the management of protected health information.	All	Policy/procedure in place	Contract; 45 CFR 164.530(b)	
Consumer Grievances					
8	"Your Rights While Receiving Mental Health Services" is posted in plain view in common areas, and next to telephones, utilized by individuals receiving services. Posting must include phone numbers for CFBHN, the FL Abuse Registry, Disabilities Rights Florida.	CSU	Poster or sign is in view	65E-5.180 (6)(a)	
9	Information on the CFBHN complaint/grievance process is posted in plain view in common areas utilized by individuals receiving services.	All	Poster or sign is in view	Contract	
10	The organization has an established grievance procedure that allows applicants for services or recipients of services to present grievances to its governing authority.	All	Policy/procedure in place	Contract	
Protected Health Information					
11	There are policies or procedures in place in compliance with applicable regulations regarding protected health information (PHI), including: Permitted uses of PHI; Authorized disclosures of consumer PHI; Safeguarding PHI ; and breach notification procedures.	All	Policy/procedure in place	Contract, Attachment V; 45 CFR Parts 160 & 164.530(i); CFOP 50-2;	
12	The organization has designated a Privacy Officer responsible for the development and implementation of policies with respect to protected health information.	All	Privacy Officer is named	45 CFR 164.530 (a)	
13	The organization has identified a Security Officer responsible for the development and implementation of policies and procedures related to electronic security of protected health information.	All	Data Security Officer is named	45 CFR 164.308(a)(2)	
Risk Management					
14	There is a documented procedure in place for reporting managing, following up and preventing significant incidents as required in SunCoast ROP 215-4 and CFOP 215-6. The policy should state that critical incidents must be reported to CFBHN within 3 hours by phone; the electronic report on the incident reporting form is submitted within 24 hours. If the incident is discovered after 3pm it can be called in to the CFBHN 24 hour line or called in by 8:15 am the following morning.	All	Policy/procedure in place	SunCoast ROP 215-4 CFOP 215-6	
15	There is a policy or procedure in place requiring the reporting of missing children that will be made to the appropriate authorities immediately in exigent situations or within four hours in other circumstances.	Programs that serve children	Policy/procedure in place	65C-30.019 CFOP 175-85	
16	There is a policy or procedure in place that outlines the organization's emergency preparedness plan.	All	Policy/procedure in place	Contract	
Financial					
17	There is a policy or procedure in place that specifically states that individuals are not denied care solely due to an inability to pay.	All	Policy/procedure in place	65E-14(f)	
18	For providers that utilize public funds provided in the contract to transport clients: There is a policy or procedure in place to comply with requirements to maintain vehicle trip log with date, name. Procedures include maintaining vehicle trip logs with date, name of individual receiving services transported, destination, odometer readings at pickup and drop-off.	Providers that utilize public funds provided in the contract to transport clients	Policy/procedure in place	CFOP 40-5	

#		Applies To	Evidenced by		Yes/No
19	For provider that utilized public funds provided in this contract to PURCHASE vehicles used to transport clients: There is a policy or procedure in place to comply with cited rules.	Providers that utilized contract funding to PURCHASE vehicles used for client transport	Policy/procedure conforms to cited authority	CFOP 40-5	
Quality and Reporting					
20	There is a policy or procedure in place for facilities (defined in Section 394.455(10) F.S.) who use sedusion and restraint to report SANDR data as required by 65E-5.180(7), F.A.C.	Providers that utilize sedusion and restraint	Policy/procedure in place	394.455(28)F.S.; 394.455(29) F.S.; 65E-5.180(7), F.A.C; DCF Pamphlet 155-2	
21	There are policies specifying that client records are retained for at least seven years after the date of the last entry.	All	Policy/procedure in place	65E-4.014	
Process Review (SAMH and Block Grant)					
22	Shall make available, either directly or by arrangement with others, tuberculosis services to include counseling, testing, and referral for evaluation and treatment. There is a process to secure a timely referral to appropriate services for someone who cannot be served by the agency or the program screening the client.	HIV	Identified process is in place	Contract	
23	There is a policy or procedure in place to describe the infection control program that includes addressing communicable diseases such as HIV and TB.	HIV/Substance Abuse treatment providers	Policy/procedure in place	45 CFR 96.127(a)(3) 45 CFR 96.128(a)(5) Contract	
				Total Yes Responses	0
				Total No Responses	0
				Total Questions Applicable	0
				Percent of Items in Compliance	#DIV/0!

Backup Summary (make detailed notes for any "no" answers)
Question Number:
Question Number:
Question Number:

Employee Verification FY 18-19

Provider:
Date:
Reviewer:

Staff Initials:
Staff ID:
Hire Date:
Status:
Program:

*Tool DCF approved: 8/8/2018

#	Item	1	2	3	4	5	6	7	8	9	10	Results Yes	No	Total	Percentage
1	**Standard:** I-9 and Employment Eligibility System (E-Verify) must be used to verify employment status. **Authority:** CFBHN Contract **Applies to:** All **Note:** Current form is: I-9 Form 7/17/17 N (Dated in bottom left corner) and with expiration date of 8/31/2019. Form I-9 11/14/16 was appropriate for use thru 9/17/17. However, hires made after 9/18/17 should use the form dated 7/17/17 N.														
1(a)	EMPLOYEE portion of I-9 form was completed on, or prior to, hire date.											0	0	0	#DIV/0!
1(b)	EMPLOYER portion of I-9 was completed within 3 days of hire date.											0	0	0	#DIV/0!
1(c)	E-verify process was completed by the employer for the employee.											0	0	0	#DIV/0!
1(d)	E-verify results were obtained and documented within 3 days of hire. Documentation may include the case verification number recorded on the I-9 OR a print out of the case details to be filed with the I-9.											0	0	0	#DIV/0!
2	**Standard:** Staff must undergo Level II security background screening prior to hire and every five years. **Authority:** Contract and DCF Requirements, http://www.dcf.state.fl.us/programs/backgroundscreening/index.shtml **Applies to:** Employees hired after 8/1/10. MH: CEO, CFO, COO, Program Directors, and clinicians. SA: Owners, directors, chief financial officers, and employees who have direct contact with children receiving services or developmentally disabled adults.														
2(a)	Staff files contain DCF, AHCA, or DJJ Level II clearance documentation demonstrating that Level II was conducted **prior to hire**.											0	0	0	#DIV/0!
2(b)	For staff working for the organization for 5 or more years: Staff files contain DCF, AHCA, or DJJ Level II clearance documentation demonstrating that Level II was conducted 5 years from the last screening.											0	0	0	#DIV/0!
3	**Standard:** Agency requires staff to complete Affidavit of Good Character and to report arrests. **Authority:** DCF Screening requirements. **Applies to:** See '2' above. DCF - designated offenses disqualify potential employment; employee arrests for those offenses must be reported, and agency removes individual from client contact during investigation.														
3(a)	DCF Affidavit of Good Moral Character dated, signed and notarized prior to or upon hire date. *** Must use DCF version dated 1/2015.**											0	0	0	#DIV/0!
4	**Standard:** Agency performs local law enforcement record checks **prior to hire.**														
4(a)	An original local law enforcement check was conducted prior to hire date.											0	0	0	#DIV/0!

*Tool DCF approved: 9/8/2018

												Results			
4(b)	Local law enforcement check was completed in the employee's county of residence.											0	0	0	#DIV/0!
5	Standard: Agency complies with training requirements related to serving the deaf and hard of hearing. Authority: Rehabilitation Act of 1973 (Section 504), the ADA and CFOP 60-10 (Chapter 4). Applies to: Agencies that have 15 or more employees only. This number applies to entire company regardless of CFBHN-funded services.														
5(a)	The personnel record includes the 3 printed certificates that demonstrate that the employee completed DCF Deaf and Hard of training: (1) within 60 days of commencing employment; or (2) annually, by formal deadline dated 4/13/18, as required by CFBHN.											0	0	0	#DIV/0!
5(b)	The personnel record has a signed attestation form that indicates that they have taken the Deaf and Hard of Hearing training annually.											0	0	0	#DIV/0!
6	Standard: The organization provides staff training on policies and procedures related to protected health information. Authority: 45 CFR 164.530(b)(2)(A-C) Applies to: All														
6(a)	Personnel record contains documentation of training on this topic at orientation. The law states that the training must be provided "within a reasonable period of time" after the individual joins the covered entity's workforce.											0	0	0	#DIV/0!
6(b)	Documentation of training on this topic at intervals established by the agency. The law requires that the covered entity provide training to any member of its workforce whose functions are affected by a material change in the policies/procedures.											0	0	0	#DIV/0!
Percent of Items in Compliance												0	0	0	#DIV/0!

Backup Summary (make detailed notes for any "no" answers)

Record Number/Question Number:
Record Number/Question Number:
Record Number/Question Number:
Record Number/Question Number:

FACT Administrative FY 18-19

Provider:
Date:
Reviewer:

Central Florida Behavioral Health Network, Inc.

Tool DCF approved: 8/8/2018

		Authority	Evidence	Yes/No
Policy and Procedure Review - Organization has established written policies and procedures in each of the following areas:				
1	Program organization	Guidance Document 16, II.D.	Presence of formal policy and procedure	
2	Admission and discharge criteria and procedures			
3	Assessments and recovery planning			
4	Provision of services			
5	Medical records management			
6	Personnel, to include staffing standards and an organizational chart indicating required staff, lines of administrative oversight, clinical supervision, and organizational relationships			
7	Quality assurance/quality improvement			
8	Risk Management			
9	Rights of persons served			
10	Emergency preparedness - A plan for supporting participants in the event of a disaster including contingencies for staff, provision of needed services, medications, and post-disaster related activities.			
Communications				
11	The FACT team conducts daily organizational staff meetings at regularly scheduled times as established by the Team Leader	Guidance Document 16 II.A.	Meeting schedule and notes	
12	If ARNP is hired, there is evidence of access to a Board Certified psychiatrist for weekly consultation		Notes or other evidence of consultation	
Program Operations / Hours				
13	Staffing patterns indicate that the program is operational 7 days per week, a minimum of 12 hours per weekday and 8 hours per day on weekends. (For reviewers, document time frame in the comment field below)	Guidance Document 16 II.A.	Staff schedule for time period	
14	RN is on duty Monday-Friday (For reviewers, document time frame in the comment field below)		Staff schedule for time period, documentation of work during that time	
15	Program operates an after-hours on-call system with a FACT professional on call at all times		On-call number is operational; staff schedule demonstrates that a professional is on call	
16	Minimum of 32 hours of psychiatric services must be available for every FACT participant per week. (16 hours per 50 clients, 32 hours per 100 clients)		Staff schedule for time period, documentation of work during that time	
17	Agency maintains current credentials for staff.		See FACT Worksheet to transfer score.	
18	Staffing positions are filled with individuals with the required credentials.		See FACT Worksheet to transfer score.	
19	Clinical supervision is documented.		See FACT Worksheet to transfer score.	
	Total Yes Responses			0
	Total No Responses			0
	Total Questions Applicable			0
	Percent of Items in Compliance			#DIV/0!

Backup Summary (make detailed notes for any "no" answers)
Question Number:
Question Number:
Question Number:

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FACT Tool FY 18-19

Provider:
Date:
Reviewer:

*Tool DCF approved: 8/8/2018

													Results			
#	Item	Authority	1	2	3	4	5	6	7	8	9	10	Yes	No	Total	Percentage
	Client Initials:															
	Client ID:															
	Admit Date:															
	Discharge Date:															
1	Psychiatrist or psychiatric ARNP, primary case manager and treatment team members are assigned by the leader on the day of FACT admission	Guidance Document 16 II.C.(2)											0	0	0	#DIV/0!
	Assessment															
2	Initial Assessment and Initial Plan of Care were completed on the day of FACT admission.	Guidance Document 16 II.C.(1)											0	0	0	#DIV/0!
3	The initial assessment, at a minimum, includes: (1) a brief mental health status examination, (2) Assessment of Symptoms, (3) An initial psychosocial history, (4) and initial health/medical assessment, (5) review of previous clinical information, (6) information on housing, financial and employment status, & (7) information on the individual's strengths, challenges, and preferences.	Guidance Document 16 II.C.(1)											0	0	0	#DIV/0!
4	Comprehensive Assessment was completed within 60 days of admission.	Guidance Document 16 II.C.(2)											0	0	0	#DIV/0!
5	Comprehensive assessment, at a minimum, includes: (1) psychiatric hx and diagnosis, (2) Mental Status, (3) Strengths, abilities and preferences, (4) Physical health, (5) Hx and current use of drugs or alcohol, (6) Education and employment hx with current status, (7) Social development and functioning, (8) Activities of daily living, (9)Family and social relationships (10) Recommendations for care.	Guidance Document 16 II.C.(2)											0	0	0	#DIV/0!
6	Each area of the comprehensive assessment is completed by the FACT team member with skill and knowledge in the area being assessed and is based upon all available information.	Guidance Document 16 II.C.(2)											0	0	0	#DIV/0!
7	The comprehensive assessment shall include a psychiatric/social functioning history time line that is developed within 120 days of admission.	Guidance Document 16 II.C.(2)											0	0	0	#DIV/0!
8	The Comprehensive Assessment has been updated at least annually, and utilized to update the Recovery Plan.	Guidance Document 16 II.C.(2)											0	0	0	#DIV/0!
	Recovery Plan															
9	A Comprehensive Recovery Plan was completed within 90 days of admission.	Guidance Document 16 II.C.(3)											0	0	0	#DIV/0!

#	Item	Authority	1	2	3	4	5	6	7	8	9	10	Yes	No	Total	Percentage
10	The Recovery Plan is person-centered and involves the client, guardian (if any), and family members and significant others the client wishes to participate.	Guidance Document 16 II.C.(3)											0	0	0	#DIV/0!
11	The Recovery Plan: - Identifies the participant's strengths, resources, needs and limitations; - Identifies short and long-term goals with timelines; - Identifies participant's preferences for services; - Outlines measurable treatment objectives and the services and activities necessary to meet the objectives and needs of the participant; and - Targets a range of life domains such as symptom management, education, transportation, housing, activities of daily living, employment, daily structure, and family and social relationships, should the assessment identify a need and the individual agrees to identify a goal in that area.	Guidance Document 16 II.C.(3)											0	0	0	#DIV/0!
12	The Recovery Plan is reviewed and updated minimally every six months during planned meetings, unless clinically indicated earlier, by the treatment team and the FACT participant.	Guidance Document 16 II.C.(3)											0	0	0	#DIV/0!
	Program Service Review: Based on client needs and preferences, the FACT team must provide and document services as follows:															
13	Face to Face Contact: Frequency determined by client choice and treatment plan but face to face contact no less than 1 per week and average of 3 per week.	Guidance Document 16 I.A.											0	0	0	#DIV/0!
14	Community -based services: 75% of the services received by the member have been provided in the community (home, school, work, or other setting outside of provider's office where client spends leisure time.)	Guidance Document 16 I.A.											0	0	0	#DIV/0!
15	Case Management: The team coordinates participant's care, advocates on behalf of the participant, and provides access to a variety of services and supports, including but not limited to medical health care, dental healthcare, housing, transportation, educational services and legal services.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
16	Family Engagement: With the consent of the FACT participant, family is engaged in the in the treatment process and educated on topics related to their family member's recovery goals, diagnosis and illness management.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
17	Psychiatric Services: FACT medical staff provide participant with psychiatric evaluation, medication management, medication education, and medication administration.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
18	Rehabilitation Services: Team provides participant with skill training in the areas of effective communication, activities of daily living, safety planning, money management, and positive social interactions in order to enhance independent living.	Guidance Document 16 II.C.											0	0	0	#DIV/0!

#	Item	Authority	1	2	3	4	5	6	7	8	9	10	Yes	No	Total	Percentage
19	Substance Abuse and Co-Occurring Services: Both mental health and substance abuse needs are addressed through integrated screening and assessment, stage of change readiness determination, and therapeutic interventions consistent with the participant's readiness to change behaviors.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
20	Supported Employment: Participant receives vocational assessment, job placement, and ongoing coaching and support (including on-site support) as desired by the FACT participant.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
21	Therapy: FACT team provides and coordinate individual, group, and family therapy services for the participant.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
22	Wellness Management & Recovery Services: The team assists participant to develop and put into action in daily life personalized strategies for managing wellness, pursuing personal goals, & learning information and skills to develop a sense of mastery over their psychiatric illness.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
23	Staff assists with transportation to medical appointments, court hearings, and related activities outlined in the care plan.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
24	The team assists the participant in accessing affordable, safe, permanent housing of their choice.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
25	If participant is adjudicated incompetent to proceed, the FACT team provides competency restoration training and assists the participant through the legal process.	Guidance Document 16 II.C.											0	0	0	#DIV/0!
												Total	0	0	0	#DIV/0!

Backup Summary (make detailed notes for any "no" answers)
Record Number/Question Number:
Record Number/Question Number:
Record Number/Question Number:

APPENDIX XII
RFP #181905FACT EVALUATION GUIDE

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Evaluator Information

CFBHN RFP #181905FACT
Florida Assertive Community Treatment Team in Collier County

EVALUATION TEAM GROUND RULES

Evaluators are chosen to participate because of their knowledge and skills and because of CFBHN's confidence in their ability to score both independently and fairly. The same scoring principles must be applied to every response received, independent of other evaluators.

1. **ALL** questions related to the solicitation document and the evaluations of the responses must be directed to the procurement manager:

   Andrea Butler Fernandez, Senior Contract Manager
   Central Florida Behavioral Health Network, Inc.
   719 South US Highway 301 Tampa, FL 33619
   (813) 740-4811 Extension 237
   ABFernandez@cfbhn.org

2. Conflict of Interest Questionnaires must to be completed, signed, and dated by all Evaluation Team members. Any identified conflicts of interest will be referred to Legal immediately.

3. Each evaluator will be provided a copy of the solicitation document, all attachments, amendments, and (if applicable) all vendors' inquiries, together with the written answers provided by CFBHN. Each evaluator will also be provided with a copy of each vendor's response, which should be evaluated and scored according to the instructions provided in the solicitation document and the Scoring Sheets.

4. Each member of the Evaluation Team shall independently score each response. No collaboration will be permitted during the scoring process. Do not ask other evaluators questions or share solicitation related information with anyone.

5. Evaluators must not solicit information or submissions from potential or interested offerors.

6. The written proposal is the basis upon which responses are evaluated and scored.

7. Only the Scoring Sheets provided with the solicitation document will be used to record your scores and comments. No additional notes or marks should appear elsewhere in the evaluation materials.

8. All raw scores must be assigned utilizing the scoring system provided in the evaluation manual.

9. Each evaluator should record the page or section number from the response being scored where the primary response was found relating to the criterion. If the response does not

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address an evaluation criterion, evaluators should indicate on the score sheet “not addressed”.

10. Each evaluation criterion must be scored. Evaluators may request assistance in understanding evaluation criteria and responses only from the Procurement Manager, who alone is authorized to seek additional technical help if needed. Technical assistance, if needed, will be provided by non-voting technical advisors and will be uniformly disseminated to all evaluators simultaneously. This may also be accomplished by the Procurement Manager.

11. No attempt by CFBHN personnel or others to influence an evaluator's scoring will be tolerated. If any attempt is made to do so, the evaluator must immediately report the incident to the Procurement Manager. If the Procurement Manager makes such an attempt, the evaluator must immediately report the incident to the Inspector General.

12. To avoid the possibility of protest, all appearances of impropriety must be avoided.

13. Following completion of the independent evaluations of the proposals, the Procurement Manager will hold a Debriefing Meeting for the exclusive purpose of assuring that information has not been overlooked in the scoring of responses. Evaluators should work carefully to be as thorough as possible in order to help the department secure a fair and open competitive procurement. Evaluators may adjust their score at the Debriefing Meeting based on information discussed during the meeting that may have been overlooked/misunderstood which would have otherwise caused the score to increase or decrease.

14. The Debriefing Meeting of the Evaluation Team will be held at the place and time listed in **Section 1.8.**

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Debriefing Meeting of Evaluators

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Florida Assertive Community Treatment Team in Collier County

The main purpose of the Debriefing Meeting of the evaluators is to receive and record all evaluation scores. It is not essential that uniformity in scoring be achieved. It is at this meeting that the procurement manager logs in and records all scores on a spreadsheet and calculates those scores according to the evaluation methodology outlined in the solicitation document.

The following activities should occur prior to the conclusion of the meeting:

1. The procurement manager will confirm that no one has tried to influence any of the evaluators and that they have exercised their own independent judgment in scoring each response independently of any other.

2. The procurement manager will fill out a spreadsheet with the names of the evaluators across the top and the number of the evaluation criterion down the left side. Each evaluator will be asked in turn for the score given to each criterion.

3. Once the spreadsheet is filled out and a score recorded for each criterion for each evaluator, the individual score sheets are collected and placed into the procurement file.

4. The scores are to be calculated in the presence of at least one witness. The final score for each provider will be listed in rank order.

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EVALUATOR'S CONFLICT OF INTEREST
AND
CONFIDENTIALITY OF INFORMATION STATEMENT

Your willingness to participate as an evaluator is an integral part of the procurement process. Central Florida Behavioral Health Network, Inc. (CFBHN) appreciates your assistance and expertise. Your designation as an evaluator for CFBHN requires that you fully understand the policies regarding potential conflicts of interest and the confidential nature of the responses and all that is contained therein.

Confidentiality. The competitive procurement process and the obligations imposed by the laws of the State of Florida require CFBHN to ensure that the competitive process operates in a fair and equitable manner. As an evaluator, you have access to information not generally available to the public and are charged with special professional and ethical responsibilities. You may have access to information about bidders that is to be used only during the evaluation process, and for discussion only with appropriate CFBHN personnel. You shall not discuss the evaluation, scoring, or status of any response or any action affecting any response with any person, firm, corporation, or other outside business entity at any time prior to, during, or after the procurement process. You shall not use such information obtained as an evaluator for any personal benefit, pecuniary or otherwise, nor copy and/or disseminate any portion of any response at any time prior to, during, or after the procurement process.

Conflict of Interest and Ethical Considerations. A conflict of interest or the appearance of a conflict of interest may occur if you or an immediate family member are directly or indirectly involved with an organization that has submitted a response for evaluation. Prior to reviewing any responses, you must inform CFBHN of any potential conflicts of interest or the appearance thereof. If you become aware of any potential conflict of interest as you review a response, you must immediately notify the point of contact for this procurement: *Andrea Butler Fernandez (813) 740-4811*. You may be disqualified as an evaluator if you conduct yourself in a way that could create the appearance of bias or unfair advantage with or on behalf of any competitive bidder, potential bidder, agent, subcontractor, or other business entity, whether through direct association with contractor representatives, indirect associations, through recreational activities or otherwise.

Examples of potentially biasing affiliations or relationships are listed below:

1. Your solicitation, acceptance, or agreement to accept from anyone any benefit, pecuniary or otherwise, as consideration for your decision or recommendation as it pertains to your evaluation of any response.

2. Your affiliation with a bidding company or institution. For example, a conflict may exist when you:

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a. Are employed by or are being considered for employment with the company or institution submitting any bid or hold a consulting, advisory, or other similar position with said company or institution;

b. Hold any current membership on a committee, board, or similar position with the company or institution;

c. Hold ownership of the company or institution, securities, or other evidences of debt;

d. Are currently a student or employee in the department or school submitting a response.

3. Your relationship with someone who has a personal interest in the response. This includes any affiliation or relationship by marriage or through family membership, any business or professional partnership, close personal friendship, or any other relationship that you think might tend to affect your objectivity or judgment or may give an appearance of impropriety to someone viewing it from the outside the relationship.

I have read this document and understand my obligations as explained herein. I further understand that I must advise CFBHN if a conflict currently exists or arises during my term of service as an evaluator. I further understand that I must sign and deliver this statement to CFBHN prior to participating in the evaluation process.

Evaluator Signature: _____

Evaluator Name (Printed): _____

Date: _____ RFP: 181905FACT

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Evaluation Questions

CFBHN RFP #181905FACT
Florida Assertive Community Treatment Team in Collier County

At a minimum, the below items from this RFP should be addressed in your agency's response. Please be as descriptive as possible as to how your agency plans to meet the requirements and goals of each item. Responses exhibiting innovation and creativity will be scored higher than those lacking ingenuity.

- Scope of Work
- Discharges
- Transition Plan
- Staffing
- Vendor Unique Qualifications
- Recovery-Oriented System of Care (ROSC)
- Financial Risk Assessment

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Evaluation Tools

CFBHN RFP #181905FACT
Florida Assertive Community Treatment Team in Collier County

Instructions:

Each of the criterion for this RFP has a score value from 0-10, with 0 being no value and 10 being excellent. A score can be issued in tenths (i.e. 7.3).

Description of Points:

Point Value	Category	Description
10 Points	Excellent	Presentation is **very clear and comprehensive**; Demonstrates **superior** organizational and programmatic capacity; Presentation demonstrates **innovation**; Level of detail leaves the rater with **no** unanswered questions.
8 Points	Good	Presentation is **clear and comprehensive**; Demonstrates **good** organizational and programmatic capacity; Presentation demonstrates **some innovation**; Level of detail leaves the rater with **no** unanswered questions.
5 Points	Fair	Presentation is **somewhat clear but may not be comprehensive**; Demonstrates **fair** organizational and programmatic capacity; Level of detail may leave the rater with **several** unanswered questions.
2 Points	Poor	Presentation is **not clearly presented or comprehensive**; Demonstrates **poor** organizational and programmatic capacity; Level of detail may leave the rater with **many** unanswered questions.
0 Points	Omitted	**Not addressed** in the presentation.

How to Compute Final Written Scores:

1. The scores for each criterion are added together to generate the Total Score for that particular topic.
2. A Weighted Value is assigned to each topic.
3. The Maximum Points given to each topic will be based on the following formula:

   Total Score x Weighted Value = Maximum Points

4. All of the Maximum Points will be added together to derive the Total Response Score.
5. The Total Response Score for all evaluators will be averaged to generate the Average Score for each vendor. Vendors will be ranked based on the Average Scores.

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Point Value for Criteria

#	Criteria	Possible Score	Weighted Value	Maximum Points
1	Scope of Work	20	9	180
2	Discharges	10	8	80
3	Transition Plan	10	8	80
4	Staffing	10	8	80
5	Vendor Unique Qualifications	10	7	70
6	Recovery-Oriented System of Care (ROSC)	10	6	60
7	Financial Risk Assessment	10	3	30
Maximum Possible Score Per Team				**580**

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Vendor Name:	
Description:	**Scope of Work (3.4.3.1)**

FACT team core elements include a multi-disciplinary 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 or co-occurring disorders. Points should be awarded for answering questions thoroughly in a manner which protects the best interests of the individuals as well as the system of care as a whole.

- Describe the preparations that are necessary to serve individuals returning from the state mental health treatment facility (SMHTF) as well as those who are at a local receiving facility and diverted from going to a SMHTF. **(5 points)**
- Describe what provisions will be made to ensure prompt response to any "on call" crisis (there is a duty to be available at any time of any day) or crisis calls during normal working hours. Please include time frames for response times, and how staff availability will be ensured (examples may include: housing vendor contacts you and feels the individual is in crisis, the individual contacts you and appears to be in crisis, individual is admitted to a local Baker Act facility or jail, client is at ER and you are notified). **(4 points)**
- As a result of the comprehensive assessment and planning process, vendors are required to have recovery plans tailored to each individual on the FACT team. Describe how the individuals served on the FACT team will have their needs and desires addressed specifically to them. **(3 points)**
- Describe the FACT team's role in the system of care and how that role involves participation in community systems meetings/committees. **(3 points)**
- Describe the approaches your agency offers to address different needs of any potential FACT team member (i.e. mentally or physically challenged, forensic, aging out, substance use disorders, and behavioral issues). **(5 points)**

Notes:

Evaluator's Score:		**Evaluator's Initials:**	

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Vendor Name:	
Description:	**Discharges (3.4.3.2.)**
Points should be awarded in this section for demonstrating a clinincally sound methodology of discharging those who are most fit to be stepped down to a less intensive level of services.	
Notes:	

Evaluator's Score:		**Evaluator's Initials:**	

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Vendor Name:	
Description:	**Transition Plan (3.4.3.3.)**

Smoothly transitioning these individuals into an organization's continuum of care is critical to the long-term wellbeing of the clients. Points should be awarded for a sound process which maximizes the fluidity of the transition and the required information below:

- "Initial Assessment and Recovery Plan"
- "Comprehensive Assessment"
- "Comprehensive Recovery Plan"

Notes:

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Vendor Name:	
Description:	**Staffing (2.2.)**
Points should be awarded based on the provider's demonstration of their ability to properly staff their team in compliance with **Guidance Document 16**.	
Notes:	

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Vendor Name:	
Description:	**Vendor Unique Qualifications (3.4.3.4.)**
Evaluators may use their discretion in awarding points based on any factors within this section which support an inference that they will be successful with the team.	
Notes:	

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Vendor Name:	
Description:	**Recovery-Oriented System of Care (ROSC) (3.4.3.5.)**
Points should be awarded for responses that demonstrate a comprehensive understanding of ROSC and how those principles translate into running a FACT team.	
Notes:	

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Evaluation of Financial Information

CFBHN RFP #181905FACT
Florida Assertive Community Treatment Team in Collier County

The Financial Stability shall be evaluated by staff in the Finance Department at Central Florida Behavioral Health Network utilizing the scoring sheet and Financial Risk Assessment on the following pages.

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Vendor Name:	
Description:	**Financial Risk Assessment**
Copies of their last two financial and compliance audits conducted through an independent auditing firm. The audit must include financial statements, auditor's report, and management letters. Additionally, the vendor must submit a completed financial risk assessment. If the vendor is not required to have an audit (as required by OMB Circular A-133), and does not have reports for the two previous years, then corresponding financial statements that include Income Statement, Balance Sheet, and Statement of Cash Flows shall be certified by the agency's Chief Executive Officer, Chief Operating Officer or Chief Financial Officer and shall be submitted, along with the completed financial risk assessment.	
Notes:	

Evaluator's Score:		**Evaluator's Initials:**	

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Central Florida Behavioral Health Network
Financial Risk Assessment
Agency Monitoring Tool

AGENCY: _____ **PERIOD:** _____ **DATE:** _____

		Calculated Value				Benchmark	Points Available		Score	Score	Score
		FYE 2016	%	FYE 2017	%				FYE 2016	FYE 2017	TOTAL
1. Unrestricted net assets *This ratio provides an indication of the net resources available to provide services in the future.*	Unrestricted Net Assets / Total Annual Expenses		#VALUE!		#DIV/0!	>.40	2 1 0	Above .40 Between .30 and .39 less than .29	#VALUE!	#DIV/0!	#VALUE!
2. Cash reserves *Cash reserves is a rough measure of the amount of cash on hand to cover future expenses. When calculating total annual expenses, depreciation should not be included for this metric.*	Cash & Securities at end of year / Total Annual Expenses-(less depreciation)		#DIV/0!		#DIV/0!	60 days	3 2 1 0	Above 90 between 65 and 89 between 49 and 64 below 48	#DIV/0!	#DIV/0!	#DIV/0!
3. Receivable days *This number reflects the average length of time required to collect cash from receivable accounts. It is crucial to maintain positive liquidity.*	Total Receivables / Total Unrestricted Revenue		#DIV/0!		#DIV/0!	45 days	2 1 0	Between 0 - 45 days Between 46 - 75 days Above 76 days	#DIV/0!	#DIV/0!	#DIV/0!
4. Payable days *This ratio shows the average number of days that lapse between purchase of material and labor, and payment for them. It is a rough measure of how timely on organization is meeting payment obligations.*	Payables / Total Annual Expenses	0	#DIV/0!	0	#DIV/0!	30 days	2 1 0	Between 0 - 25 days Between 26 - 45 days Above 46 days	#DIV/0!	#DIV/0!	#DIV/0!
5. Working Capital Current ratio *This metric measures the overall liquidity position of an organization. Measures the ability to pay its current obligations using current assets by current liabilities*	Current Assets / Current Liabilities		#DIV/0!		#DIV/0!	2:1	3 2 1 0	Greater than 2 Between 1.50 -1.99 Between 1.00-1.49 Between 0 - .99	#DIV/0!	#DIV/0!	#DIV/0!
6. Audit findings over financial reporting or compliance *Audit findings over internal controls and compliance.*	Review Audit					No Deficiencies	3 0 -1	No deficiencies or material weaknesses Deficiencies identified Material weakness(es) identified	0	0	0

updated 7/5/18

Maximum Points Available Per Year: 15 **Score** #VALUE! #DIV/0!
Maximum Points Available TOTAL 30 **Total Score** #VALUE!

FOR CFBHN USE ONLY

Check all measures against submitted financials _____ CFBHN Staff Initials
Check all formulas _____ CFBHN Staff Initials
Enter CFBHN validated Total Score _____ CFBHN Staff Initials

CFBHN Reviewer Name: _____
Date: _____

Presentation Assessments

Instructions:

Evaluators should assess a score value from 0-10 for each applicable point (with 0 being no value and 10 being excellent). A score can be issued in tenths (i.e. 7.3). The scores will later be weighted to establish the final score.

Vendor Name:	
Description:	**FACT Presentation**
Points should be awarded in this section based on the overall presentation of the provider's ability to succeed in operating a FACT team.	

Point Value	Category	Description
10 Points	Excellent	Presentation is **very clear and comprehensive**; Demonstrates **superior** organizational and programmatic capacity; Presentation demonstrates **innovation**; Level of detail leaves the rater with **no** unanswered questions.
8 Points	Good	Presentation is **clear and comprehensive**; Demonstrates **good** organizational and programmatic capacity; Presentation demonstrates **some innovation**; Level of detail leaves the rater with **no** unanswered questions.
5 Points	Fair	Presentation is **somewhat clear but may not be comprehensive**; Demonstrates **fair** organizational and programmatic capacity; Level of detail may leave the rater with **several** unanswered questions.
2 Points	Poor	Presentation is **not clearly presented or comprehensive**; Demonstrates **poor** organizational and programmatic capacity; Level of detail may leave the rater with **many** unanswered questions.
0 Points	Omitted	**Not addressed** in the presentation.

Notes:

Evaluator's Score:		**Evaluator's Initials:**	

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