House Bill 945
Managing Entity (ME) Plan

Region/Circuit(s): SunCoast Region and Circuit 10
Charlotte County

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SECTION 1: EXECUTIVE PLANNING SUMMARY

In July 2020, House Bill (HB) 945 requires Department of Children and Families (DCF) and Agency for Health Care Administration (AHCA) to identify children and adolescents who use crisis stabilization services and to meet behavioral health needs of such children and adolescents; to develop plans promoting coordinated system of care for certain services; require testing of provider network databases maintained by Medicaid managed care plans; require verification of use of certain strategies and outreach before student is removed from school, school transportation, or school-sponsored activity under specified circumstances; provide exception; require DCF and AHCA to assess quality of care provided in crisis stabilization units, (Chapter No. 2020-107).

CFBHN strives to ensure accessibility for any person with a disability, including: physical disabilities; mobility difficulties; visual, hearing and language impairments; developmental and intellectual disabilities; mental illness; and behavioral health conditions. Furthermore, CFBHN commits to providing accessibility without regard to race, color, national origin, disability, age, gender, religious preference, marital status, physical appearance, sex or sexual orientation.

SECTION 2: PLANNING PROCESS FOR A COORDINATED SYSTEM OF CARE

DEFINITIONS

The Managing Entities believe agreed upon definitions of some key terms in House Bill 945 will help ensure consistent planning and implementation across the state. With that in mind, we are using the definitions provided in Appendix 2.1 for this purpose.

Appendix 2.1: **HB 945 Definitions**

Appendix 2.2: **Common Acronyms**

GEOGRAPHICAL CONSIDERATIONS

In an effort to best serve Charlotte County, a plan was established for Charlotte County independent from any additional counties, unless identified services carry over between partnering counties. As such, those communities utilize many of the same resources, including some of the same behavioral health agencies, and often work together to provide services. However, apart from the shared services, it has been determined Charlotte County has services unique to them and thus separate plans are warranted.

PLANNING STRATEGY

In Charlotte County, HB 945 was discussed and reviewed at Charlotte House Bill 945 Meetings or as determined by the Managing Entity until the plan is completed. These meetings include invited key community stakeholders listed on Appendix 2.4 and will be recorded on Appendix 2.3.

This plan was completed in three phases

Phase 1 - CFBHN convened an internal workgroup to establish a framework of the plan and identify key members to be involved in the plan's execution.

Phase 2 – CFBHN participated in planning meetings with fellow Managing Entities (FAME), to develop a uniform and cohesive flow of information and format across each Managing Entity's region and plan. In addition, these meetings allowed for sharing of information, planning ideas, and development of cohesive thought processes across each region.

Phase 3 – CFBHN conducted general community wide meetings with identified community stake holders and state funded agencies. Discussion included the purpose of the plan, roles of those involved, the plan framework, organization and flow. The community worked to develop and analyze identified gaps within each community's system of care, developed graphs and flow charts that provided a visual of how the system of care works. A general information meeting with all counties occurred, followed by bi-monthly county level meetings with identified stakeholders until the plan was completed.

Per statute, CFBHN will reconvene with key community stakeholders every three years to review and amend the plan as necessary. The first review was conducted in the last quarter of 2024.

Appendix 2.3: **HB 945 Meeting Timeline**

Appendix 2.4: **HB 945 Checklist Planning Members**

SECTION 3: INTEGRATION WITH LOCAL PLAN(S)

CFBHN will review existing community-based plans such as the Mental Health plans for Charlotte County Schools the county Transportation Plan relating to transportation of individuals in crisis and the Community Health Improvement Plan.

CFBHN will promote the development and implementation of a coordinated system of care for children, adolescents, and young adults to integrate behavioral health services provided through state funded child serving systems and to facilitate access to mental health and substance use treatment and services.

Appendix 3.1: **Charlotte County Mental Health Assistance Allocation Plan**

Appendix 3.2: **Charlotte County Community Health Improvement Plan (CHIP)**

Appendix 3.3: **Behavioral Health Transportation/Behavioral Health Receiving System (BHRS)**

REVIEW OF BEHAVIORAL HEALTH NEEDS ASSESSMENT

The population of the State of Florida is increasing, and the SunCoast Region and C-10 continue to grow at a faster pace than the state. As the population grows, the need for mental health and substance use disorder treatment also grows. This is shown in the data as the number served over the last several years has increased. To help address the changing population, CFBHN estimates the number needing treatment each year.

RESOURCES AND SERVICES NEEDED TO IMPROVE PATIENT-CENTERED CARE AND PLANNING

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Needed Resources and Services
Shortage of providers and staff
More peer specialists
Aid in transportation
Affordable housing
Bilingual providers
Access to services in a timely manner
Weekend access to behavioral health services
Increased access for uninsured patients
Care coordination

TOP THREE PATIENT-CENTERED RESOURCES

TOP THREE PATIENT-CENTERED RESOURCES
Behavioral Health Service Agencies
Case Management
Access to Services

COMMUNITY HEALTH ASSESSMENTS

The top priorities identified in needs assessments conducted in the SunCoast region included reducing stigma, improving access to behavioral health, and health care services. In Florida, studies have shown that behavioral health disorders are common and begin early in life. Children who have experienced traumatic events in early childhood are at higher risk for negative health, education and social-emotional outcomes. Intervening early by providing access to mental health services when needed has been shown to increase children's resilience to trauma and increase their likelihood of achieving positive health, social-emotional, and educational outcomes. The greatest opportunity for prevention is among young people. There

are multiyear effects of multiple preventive interventions on reducing substance use, conduct disorder, antisocial behavior, aggression, and child maltreatment.

The needs assessment identified these top priorities that impact quality of life for children, adolescents, and young adults:

- Early Diagnosis/Prevention
- Access to Care/Services
- Diet/Nutrition
- Family Support

Appendix 3.4: Community Health Assessment

SECTION 4: COMPREHENSIVE ARRAY OF SERVICES AND SUPPORTS

SERVICE ARRAY

The following chart outlines categories of mental and behavioral health needs and possible corresponding supports and service options. All options may not be available in all counties; however, the County Community Service Array (Appendix 4.2) details the unique service array available in Charlotte County.

MENTAL AND BEHAVIORAL HEALTH CONTINUUM

Overview: Mental & Behavioral Health Services and Supports in the Community			
PREVENTION	**Economic Stability**	**Access to Health Care**	**Social & Community – Protective Factors**
	❖ Homeless Coalitions (Gulf Coast Partnership) ❖ Workforce Board ❖ DCF ESS & Care Coordination ❖ Social Security/ Disability ❖ HOPE Florida Pathway to Prosperity ❖ DCF/BHIS Parent Education Classes ❖ DCF/BHIS Navigation Program ❖ Medicaid Eligibility Enrollment Brokers ❖ Housing Authority	❖ Department of Health ❖ Federally Qualified Health Centers (FQHC) ❖ Health Insurance - Case Manager ❖ AHCA ❖ APD	❖ Children's Alliance/ Councils / Taskforces ❖ Community Council Against Substance Abuse (CCASA) ❖ Healthy Start/ Help Me Grow/ Healthy Families ❖ Parent-Teacher Groups ❖ Social / Community Groups ❖ Boys & Girls Clubs/ YMCAs ❖ CBC Neighborhood Projects ❖ NAMI Lee/Charlotte/Hendry ❖ Faith Based Youth Group ❖ Drop in Center ❖ RCO (Kathy's Place) ❖ Resiliency Education in schools ❖ Prevention services
SCREENING/ DIAGNOSIS	**Medical/ Developmental Assessments**	**Educational Assessments**	**Mental/ Behavioral Health Assessments**
	❖ Health Insurance – Private providers ❖ Department of Health ❖ Federally Qualified Health Centers FQHCs ❖ School System – Students Services ❖ CBHC/CCPS Collaboration ❖ Early Steps/ FDLRS ❖ Healthy Start/ Healthy Families ❖ Early Learning Coalition – Inclusion Specialists	❖ School System – Student Services ❖ Private Providers / Health Insurance– Psycho-Educational Testing ❖ Center for Autism & Related Disabilities ❖ Vocational Rehab	❖ Health Insurance – Private Providers ❖ School System – Student Services ❖ ME – Community Mental Health Centers ❖ DJJ – Comprehensive Evaluations ❖ DCF – Foster Care CBHA ❖ Center for Autism & Related Disabilities ❖ CBHS/CCPS Collaboration ❖ Hospital Systems

Less Intensive/Restrictive | More Intensive/Restrictive

MENTAL AND BEHAVIORAL HEALTH CONTINUUM

	Outpatient Services	Intensive Outpatient Services	Inpatient Treatment/ Residential Programs
TREATMENT	❖ Outpatient Counseling (Individual, Family, Group) ❖ Psychiatric – Medication Management ❖ Medication Assisted Treatment (MAT) ❖ Non-traditional therapy (Equine) ❖ Targeted Case Management ❖ Care Coordination	❖ Increased or Intensive Counseling/ Therapy ❖ Multidisciplinary Teams (CAT Team, FACT Teams, FST, FWTT) ❖ Wraparound Teams ❖ Applied Behavioral Analysis ❖ CBC Diversion Programs ❖ Home Health/Personal Care Assistance ❖ Partial Hospitalization Program (PHP) ❖ CCBHC	❖ Behavioral Health Overlay Services (BHOS) group home ❖ Specialized Therapeutic Group Home (STGH) ❖ Intermediate Care Facility (ICF) ❖ Impatient Competency Restoration (JITP) ❖ State Mental Health Hospital ❖ Statewide Inpatient Psychiatric Placement (SIPP) ❖ Therapeutic Foster Home ❖ Therapeutic Foster Group Home ❖ Assisted Living Facility (ALF) ❖ SRT Residential
	Hotlines/Triage	**Emergency Treatment**	**Emergency Placement**
CRISIS/ ACUTE	❖ Mobile Response Teams ❖ Community Mental Health Centers -Crisis Lines ❖ 211 ❖ ME – Access to Care Line ❖ Law Enforcement Crisis Intervention Teams ❖ 988 Suicide & Crisis Lifeline	❖ Baker Act – Receiving Facility ❖ Marchman Act – ARF ❖ Hospital Emergency Room	❖ Mental Health Respite ❖ Florida Network of Youth Shelters ❖ Domestic Violence Shelter ❖ Homeless Emergency Shelter ❖ Foster Care (Abuse, Neglect, Abandonment) ❖ Better Together
	Education & Training	**Support Groups**	**Peer Support**
RECOVERY/	❖ ME ❖ Community Coalitions/ Alliances ❖ Recovery Community Organization (RCO) ❖ Hospitals ❖ NAMI ❖ Awareness Groups ❖ NAMI Lee/Charlotte/Hendry ❖ BHIS-Parent Education Program	❖ Caregiver & Youth Support Groups ❖ CBC – Kinship Support Groups/ Foster & Adoptive Groups ❖ NAMI Lee/Charlotte/Hendry ❖ Recovery Community Organization (RCO)	❖ Community Clubhouses/Support Programs ❖ NAMI Lee/Charlotte/Hendry ❖ Recovery Community Organization (RCO) ❖ Share Spot Drop In Center ❖ Faith Based Youth Groups

Less Intensive/Restrictive | More Intensive/Restrictive

COUNTY COMMUNITY SERVICE ARRAY

Charlotte County's Service Array		
Community Services	**Age groups served (0-18 years)**	**Age groups Served (18+ years)**
Prevention services	X	X
Home-based services	X	X
School-based services	X	X
Family Therapy	X	X
Family Support	X	X
Case Management	X	X
Outpatient Services	X	X
Day Treatment		X
Respite Services/Personal Supports (18+)	X	X
Therapeutic Foster Care/Therapeutic Family Care (18+)	X	X
Trauma Informed Services	X	X
Services for victims of sex offenses	X	X
Crisis Stabilization	X	X
Residential Treatment		X
Peer Supports	X	X

Appendix 4.1: 65e-14, Service Definitions

Appendix 4.2: Service Array Resources

COMPREHENSIVE COORDINATED CARE

A 'No Wrong Door' approach means that every door in the public support service system should be the right door with a range of services being accessible to everyone from multiple points of entry. This commits all services to respond to the individual's needs through either providing direct services or linkage and case coordination, rather than sending a person from one agency to another. Section 394.4573(1)(d), F.S., defines the No Wrong Door (NWD) model as "a model for the delivery of acute care services to persons who have mental health or substance use disorders, or both, which optimizes access to care regardless of the entry point to the behavioral health care system.

CFBHN acute care providers adopted the NWD philosophy to ensure that a person is assessed utilizing co-occurring capable processes. The goal is to link the person to the appropriate needed services, in the right frequency, and at the appropriate level of care. This includes treatment and social support services. The

NWD philosophy provides easy and convenient access to treatment. The acute care providers and local receiving facilities, transportation companies and law enforcement have agreements in place to ensure the most efficient and least impactful process to the individual.

The commitment to the NWD concept was fully implemented in various counties in the SunCoast Region via Central Receiving Systems (CRS). Although the concept is throughout the region, and ongoing training and contract requirements are in place, these services offered at the current CRS facilities represent a more advanced model that reaches across professions and service providers, including medical services.

CHILDREN'S SYSTEM OF CARE

The Children's System of Care is a partnership between state and community stakeholders from child-serving systems. The intent of the system of care is to provide a framework to guide service systems to improve the lives of children, youth, and their families with mental health challenges.

Core Values of the Children's System of Care include:

- Family-Driven and Youth-Guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
- Community-Based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of processes, and relationships at the community level.
- Culturally and Linguistically Competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports and to eliminate disparities in care.

Guiding Principles of the Children's System of Care include:

1. Ensure availability of and access to a broad, flexible array of effective, community-based services and supports for children, youth, and their families that addresses their emotional, social, educational, and physical needs, including traditional and nontraditional services as well as natural and informal supports.
2. Provide individualized services in accordance with the unique potential and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Ensure that services and supports include evidence-informed and promising practices, as well as interventions supported by practice based evidence, to ensure the effectiveness of services and improve outcomes for children, youth, and their families.
4. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.

5. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their communities, states, territories, tribes, and nation.
6. Ensure that services are integrated at the system level, with linkages between child-serving agencies and programs across administrative and funding boundaries and mechanisms for system-level management, coordination, and integrated care management.
7. Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children, youth, and their families can move through the system of services in accordance with their changing needs.
8. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
9. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult-service system as needed.
10. Incorporate or link with mental health promotion, prevention, and early identification and intervention to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
11. Incorporate continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
12. Protect the rights of children, youth, and families and promote effective advocacy efforts.
13. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; and ensure that services are sensitive and responsive to these differences.

HIGH FIDELITY WRAPAROUND, IF APPLICABLE

High Fidelity Wraparound is an evidence-informed practice used to operationalize System of Care values and principles, typically when providing case management to youth and families. Wraparound provides tools to implement a team-based, highly individualized planning process to assist youth and families in reaching their goals. Wraparound is built on key system of care values**:** family-driven, youth-guided, culturally and linguistically competent, team-based, collaborative, individualized, and outcome-based. The intervention adheres to specified phases of engagement, individualized care planning, identifying strengths, leveraging natural supports, and monitoring progress. Further, Wraparound focuses on building self-efficacy by using a team approach. Preparation for the Wraparound process requires an in-depth assessment of the strengths and needs of the family with a strong emphasis on understanding the family's culture as well as how their values and beliefs will impact services. The team works together to develop an integrated plan across child and young adult serving systems. There is continued attention to adapting the plan to the changing needs of the family as well as a significant amount of time spent on crisis and safety

planning. Wraparound is an intensive process designed to equip the family with the supports they need and decrease their reliance on traditional services. This is accomplished by effective transition planning that begins on the first day of Wraparound enrollment. Implementation of high-fidelity wraparound in a community results in better outcomes for children, adolescents and families and provides a significant cost savings to a community.
*Does not exist currently at this time.

PREVENTION & EARLY INTERVENTION

Prevention refers to the proactive approach to preclude, forestall, or impede the development of substance use or mental health related problems. Strategies focus on increasing public awareness and education, community-based processes, and incorporating evidence-based practices.

CFBHN works collaboratively alongside substance use prevention network service providers and drug free coalitions in each County throughout the SunCoast Region/C10 to deliver quality community-based processes, environmental strategies, and information dissemination regarding maintaining health and wellness.

Substance Use Prevention is a proactive, comprehensive system that is designed to preclude, forestall, or impede the development of substance use problems, primarily for youth. This is best accomplished using ongoing strategies such as increasing public awareness and education, community-based processes and evidence-based practices.

In recent years, prevention efforts have shifted more to the local and county levels, giving individual communities the opportunity to identify their own unique prevention needs and develop action plans in response. Local communities participate in community needs assessments, strategic planning, goal setting, data-driven evaluation, social marketing, mass media, technology, resource sharing, economic impact, community-level education and continuous quality improvement. Having a sharper community focus allows prevention strategies to have a greater impact locally and statewide on behavioral change by shifting social, cultural and community environments.

Substance Use Prevention benefits the health and safety of Florida's citizens by affecting long-lasting, positive change among youth and adults at risk for use, abuse, misuse and addiction. CFBHN has maintained quarterly workgroups to continue promote Substance Use prevention principles in service delivery throughout the SunCoast Region and Circuit 10.

CARE COORDINATION (PER GUIDANCE DOCUMENT 4)

Care Coordination serves to assist individuals who are not connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person's overall well-being, such as primary physical health care,

housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is connected to the care that meets their needs.

Care Coordination is not a service in and of itself, it is a collaborative effort to efficiently target treatment resources to needs, effectively manage and reduce risk, and promote accurate diagnosis and treatment due to consistency of information and shared information. This approach includes coordination at the funder level through data surveillance, information sharing across regional and system partners, partnerships with community stakeholders (i.e., housing providers, judiciary, primary care, etc.), and purchase of needed services and supports.

At the provider level, it includes a thorough assessment of needs inclusive of a level of care determination and active linkage and communication with existing and newly identified services and supports. Care Coordination assesses for and addresses behavioral health issues as well as medical, social, housing, and interpersonal needs that impact the individual's status. It is a mechanism for linking providers of different services to enable shared information, joint planning efforts, and coordinated/collaborative treatment. Engagement of available social supports to address identified basic needs for resources such as applying for insurance/disability benefits, housing, food, and work programs is essential. Care Coordination also facilitates transitions between providers, episodes of care, across lifespan changes, and across trajectory of illness.

At the individual level, it incorporates shared decision making in planning and service determinations and emphasizes self-management. Individuals served and family members should be the drivers of their goals and recognized as the experts on their needs and what works for them.

Care Coordination is not intended to replace case management. Based on the individual's needs and wishes, case management may be a service identified in their care plan that they will be referred to. Once an individual is successfully linked with a case manager, they would assume the responsibilities of coordinating care.

Effective Care Coordination must be flexible and respond to the needs of the communities and individuals served incorporating new clinical research and meeting evolving federal and state requirements. Changes to the Care Coordination processes are driven through the collection and analysis of data. The data used to monitor and inform the Care Coordination processes come from a variety of sources and include treatment outcomes, cost of care, QA/QI monitoring reviews, satisfaction survey information, risk management/incident reporting, and information from individuals served, and other stakeholders, including funders. Using data as the catalyst for change transforms the system from reactive to proactive by analyzing data trends, identifying opportunities for improvement, and initiating quality improvement activities.

The short-term goals of implementing Care Coordination are to:

- Improve transitions from acute and restrictive to less restrictive community-based levels of care,
- Increase diversions from state mental health treatment facility admissions,

- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness,
- Focus on an individual's wellness, physical health, and community integration,
- Reduce entry into the child welfare system, and
- Increase knowledge of, and access to, community-based services and supports.

The long-term goals of implementing Care Coordination are to:

- Shift from an acute care model of care to a recovery model; and
- Offer an array of services and supports to meet an individual's chosen pathway to recovery.

Appendix 4.3: Guidance Document 4, Care Coordination

Appendix 4.4: Florida Service Navigation Worksheet

COMMUNICATION, COLLABORATION, AND COMMUNITY EDUCATION

It is important for providers to address the provision of services and supports from a comprehensive recovery-oriented approach, which includes coordination with other key system of care entities providing services and supports individuals in need of behavioral health services. In collaboration with and based on the preferences of the individual receiving services and their parent/legal guardian (if applicable). Providers should identify and coordinate efforts with other key community stakeholders.

MOBILE RESPONSE TEAMS (MRT) – CRISIS SUPPORT

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around them. It can be caused by a variety of factors at any hour of the day.
Family members and caregivers of an individual experiencing a mental health crisis are often ill-equipped to handle these situations and need the advice and support of professionals. All too frequently, law enforcement or EMTs are called to respond to mental health crises, and they often lack the training and experience to effectively handle the situation. Mobile response teams can be beneficial in such instances.

The goal of the MRT is to reduce trauma whenever possible by safely diverting an individual from unnecessary admission to emergency departments, psychiatric hospitals, or juvenile or adult criminal justice settings. Services provided by the MRT include evaluation and assessment, development of safety or crisis plans, providing or facilitating stabilization services, supportive crisis counseling, education, development of coping skills, and linkage to appropriate resources.

MRTs are intended to provide on-demand crisis intervention services in any setting in which a behavioral health crisis occurs including but not limited to homes, schools, the community, and emergency departments. Mobile response services must be available 24 hours a day, 7 days a week. Services are provided by a team of licensed professionals, master's level professionals, and paraprofessionals trained in crisis intervention skills. In addition to helping resolve the crisis, MRTs work with individuals and families to

identify resources, provide linkages, and develop strategies for effectively dealing with potential future crises.

Intervention is warranted when a crisis interferes with the ability to function and places the individual at risk of self-harm, harm to others, or disruption of services or living environment. The individual may present with an overt change in functioning or have difficulty coping with traumatic life events. Mobile Response Teams may coordinate in-person services with law enforcement to provide additional safety when appropriate and necessary.

Supporting the 'No Wrong Door' model, MRTs provide warm hand-offs and referrals to other services in the community to meet the ongoing needs of the individual and will follow up to determine that the appropriate linkage is made. When the situation warrants, MRTs will assist the individual being received by a designated receiving facility or a licensed substance use provider for further evaluation. Peer support services can be an effective way to connect individuals and families experiencing behavioral health crises with resources, support them in engaging in services, and assist them with navigating the system. It is not required that the MRT have an individual team member who is either credentialed as a Certified Recovery Peer Specialist or working toward credentialing; however, it is encouraged.

Guiding Principles of Mobile Response Teams:

The following System of Care values and principles are the foundation of MRTs and are the driving force behind systemic change.

- **Strength-based** – move the focus from the deficits of the individual and family to focusing on their strengths and resources related to the goal of recovery. This includes viewing the individual and family as resourceful and resilient.
- **Family-driven and youth-guided** – recognize that families have the primary decision-making role in the care of their children. The individual's and family's preferences should guide care.
- **Community based** with an optimal service array – provide services in the least restrictive setting possible, ideally in the community. Individuals should be able to obtain any behavioral health service they need in their home community. Peer support is an important component of services.
- **Trauma sensitive** – respond to the impact of trauma, emphasizing physical, psychological, and emotional safety for both service providers and individuals; and create opportunities for individuals to rebuild a sense of control and empowerment.
- **Culturally and linguistically competent** – be respectful of, and responsive to, the health, beliefs, practices, and cultural and linguistic needs of diverse individuals. "Culture" is a term that goes beyond race and ethnicity to include characteristics such as age, gender, sexual orientation, disability, religion, income level, education, geographical location. Cultural competence applies to organizations as well as individuals. Cultural Competence is a set of behaviors, attitudes, and policies that come together in a system to work effectively in multicultural situations. Linguistic competence is the ability to communicate effectively in a way that can be easily understood by diverse audiences.

- **Coordinated** – provide care coordination for individuals with serious behavioral health conditions with an emphasis on individualized services across providers and systems. At the system level, leverage resources by analyzing funding gaps, assessing the use of existing resources from all funding streams, and identifying strategies to close the funding gaps, including the options of blending and braiding of funding sources.
- **Outcome-focused** – ensure that programmatic outcome data is accessible to mangers, stakeholders, and decision makers, and that the data is meaningful and useful to those individuals. Collect feedback from each individual and family regarding the service delivery to improve outcomes of care that inform, individualize, and improve provider service delivery.

Appendix 4.5: **List of Mobile Response Team by location and contact info**

Appendix 4.6: **Guidance Document 34, Mobile Response Teams (MRTs)**

COMMUNITY ACTION TREATMENT (CAT) TEAMS

CAT teams provide community-based services to children ages 11 to 21 with a mental health or co-occurring substance use diagnosis with any accompanying characteristics such as being at-risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care; having two or more hospitalizations or repeated failures; involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or poor academic performance or suspensions. Children younger than 11 may be candidates if they display two or more of the aforementioned characteristics.

Program Goals

CAT is intended to be a safe and effective alternative to out-of-home placement for children with serious behavioral health conditions. Upon successful completion, the family should have the skills and natural support system needed to maintain improvements made during services.

The goals of the CAT program are to:

1. Strengthen the family and support systems for youth and young adults to assist them to live successfully in the community;
2. Improve school related outcomes such as attendance, grades, and graduation rates;
3. Decrease out-of-home placements;
4. Improve family and youth functioning;
5. Decrease substance use and abuse;
6. Decrease psychiatric hospitalizations;
7. Transition into age-appropriate services; and
8. Increase health and wellness.

Eligibility

The following participation criteria are established in proviso, and have been included in the CAT contract:

1. Individuals aged 11 to 21 with a mental health diagnosis or co-occurring substance use diagnosis with one or more of the following accompanying characteristics:
    a. The individual is at-risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care;
    b. The individual has had two or more periods of hospitalization or repeated failures;
    c. The individual has had involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or
    d. The individual has poor academic performance or suspensions.
2. Children younger than 11 with a mental health diagnosis or co-occurring substance use diagnosis may be candidates if they meet two or more of the above characteristics.

CAT Model

The CAT model is an integrated service delivery approach that utilizes a team of individuals to comprehensively address the needs of the young person, and their family, to include the following staff:

- A full-time Team Leader,
- Mental Health Clinicians,
- A Psychiatrist or Advanced Registered Nurse Practitioner (part-time),
- A Registered or Licensed Nurse (part-time),
- A Case Manager,
- Therapeutic Mentors, and
- Support Staff.

The Provider must have these staff as part of the team; however, the number of staff and the functions they perform may vary by team in response to local needs and as approved by the contract manager. CAT members work collaboratively to deliver the majority of behavioral health services, coordinate with other service providers when necessary, and assist the family in developing or strengthening their natural support system.

CAT funds are used to address the therapeutic needs of the eligible youth or young adult receiving services. However, the CAT model is based on a family-centered approach in which the CAT team assists parents/caregivers to obtain services and supports, which may include the provision of information and education about how to obtain services and supports and assistance with referrals. The number of sessions and the frequency with which they are provided is set through collaboration rather than service limits. The team is available on nights, weekends, and holidays. In the event that interventions out of the scope of the team's expertise or qualifications (i.e., eating disorder treatment, behavior analysis, psychological testing, substance use treatment, etc.) are required, referrals are made to specialists, with follow-up from the team. This flexibility in service delivery is intended to promote a "whatever it takes" approach to assisting young people and their families to achieve their goals.

Appendix 4.7: List of CAT teams by location and contact info

Appendix 4.8: Guidance Document 32, Community Action Treatment (CAT) Teams

CRISIS STABILIZATION UNITS (CSU) – CHILDREN AND ADULTS

Crisis stabilization services provide short-term psychiatric stabilization and detoxification services for individuals who are experiencing a behavioral health crisis. CSUs are not medical hospitals and follow their own medical exclusionary criteria to determine admission. (Additional information regarding medical exclusionary criteria can be found in the Behavioral Health Transportation Plan, Appendix 3.3) Individuals referred to a CSU receive diagnostic evaluation by a treatment team composed of a physician, registered nurse, and professional counselor. If it is determined treatment is needed, an individual can be admitted to the CSU, either voluntary or involuntary. If it is determined admission to the CSU is not appropriate, an individual is referred to the appropriate level of care (for example, to an acute care facility for medical intervention, a regional state hospital, private provider or to an outpatient program).

For a list of CSU providers, refer to the County Community Service Array, Appendix 4.2.

TELEHEALTH

Telehealth services can be provided via a multitude of platforms, allowing for diversity in meeting the needs of both the provider and individuals and is utilized whenever possible to better meet the needs of our families.
Telehealth has allowed organizations to provide individual, group, and family therapy, as well as crisis services to individuals when barriers such as transportation, childcare, social distancing, medical concerns, etc. exist. It also allows providers to serve clients from surrounding areas, as well as individuals in remote locations. Some providers provide individuals with equipment, such as tablets and internet hot spots, to ensure their ability to participate in telehealth services. Telehealth allows for faster service delivery, as it eliminates the time commitment of travel for either party allowing for easier scheduling and increased availability on the part of the provider.

The use of telehealth can allow the providers some insight into the home setting. Therapists may utilize therapeutic interactive games for individual or groups sessions during telehealth sessions, allowing for assessment of parental understanding and participation in treatment.

For a list of telehealth providers, refer to the County Community Service Array, Appendix 4.2.

SECTION 5: INTEGRATED SERVICE DELIVERY APPROACHES

CHILD WELFARE INTEGRATION

Family Centered Services

Families involved in the child welfare system of care are a priority population and Network Service Providers and Child Welfare professionals collaborate for families with behavioral health concerns. Providers have dedicated referral processes, highly trained staff, specialized treatment programs, and other targeted efforts to serve this population. Communication between providers and child welfare professionals is key.; Parties communicate through multi-disciplinary staffings, Florida Safe Families Network (FSFN) notes, phone and email correspondence, joint visits, etc. Some providers have staff co-located with case

management, investigations, or the court system. Parties work together to identify systematic barriers and improve service delivery.

Individuals involved with child welfare with behavioral health concerns will have access to programs such as Family Intensive Treatment (FIT) teams and Family Intervention Specialists (FIS). FIT provides intensive in-home substance use and mental health treatment, parenting, counseling, case management and other services as needed. FIS links parents with available services and providers in the community. Both programs are designed to strengthen the family with the intention of reunification and/or stabilization within the home. These programs are constantly evolving to ensure that the needs of the child welfare population are being met as effectively as possible.

Behavioral Health Consultants (BHC) are masters level licensed clinicians supporting Child Protective Investigators (CPI). BHCs act as behavioral health subject matter experts and provide assistance to the CPIs for investigations. They are available for joint visits to the home with the CPI, record reviews, and general case consultations.

Appendix 5.1: FIT/FIS/BHC Team providers and locations

Appendix 5.2: Guidance Document 18, Family Intensive Services (FIT) Teams

Appendix 5.3: Guidance Document 19, Child Welfare

SCHOOLS AND EARLY LEARNING COALITION INTEGRATION

Marjory Stoneman Douglas School Public Safety Act

Following the tragedy at Marjory Stoneman Douglas High School in February 2018, Governor Scott issued Executive Order 18-81. The order directed the local Behavioral Health Managing Entity to meet with local authorities, including the school districts, with the goals of improving communication, collaboration and coordination of services. In addition to the Executive Order, the Florida State Legislature passed the Marjory Stoneman Douglas School Public Safety Act that provided funding for the recommendations in the Governor's Major Action Plan.

CFBHN works with each county school district in the SunCoast Region and Circuit 10 on contracted funding through the managing entity for utilization of telehealth in the school system as it is provided by the Department of Children and Families. In addition, CFBHN provides technical assistance and support to the school districts in the SunCoast Region and Circuit 10 regarding expansion of telehealth services for mental health within the school system through the Cares Funding provided by the state to each school district.

Early Learning Coalition

The Early Learning Coalition of Florida's Heartland (ELCFH), serving Highlands, Hardee, Desoto and Charlotte Counties, exists to provide financial aid for childcare services for economically disadvantaged and at-risk children ages birth to 13 years old. Families qualify for services based

on assessed gross annual income and family size with a verified purpose for service, referral by an approved referring agency, or a documented parental disability. Childcare services are provided through local, contracted childcare providers with emphasis on quality. Children ages 6 weeks to 60 months also have access to developmental screening to help identify needs affecting growth and learning prior to school entry. The ELCFH also administers the Voluntary Prekindergarten Program for the afore listed four county service area.

Appendix 5.4: School District Mental Health Plan

JUVENILE JUSTICE INTEGRATION

CFBHN will collaborate with juvenile justice on identification of high-risk youth identified as "crossover" youth during multidisciplinary team staffings lock-out staffings, children to assist with the provision of community resources to divert high-risk youth from deeper end systems. CFBHN I collaborates with juvenile justice system of care contacts within the SunCoast Region and Circuit 10 on improved efficiencies to identify high- risk youth earlier and linkage of appropriate community resources.

AGENCY FOR PERSONS WITH DISABILITIES (APD)

CFBHN collaborates with APD on any high risk youth identified during the youth at risk staffings, children specific staffing team staffings, and other interagency staffings involving the managing entity that would require the assistance of possible APD services to discuss possible community resources and continuation of collaborative communication strategies.

MEDICAID MANAGED CARE PLANS

CFBHN will coordinate with Medicaid Managed Care Plans during the CFBHN Children Specific Staffing Team Process for the continued referral process for non-child welfare youth to the statewide inpatient psychiatric programs and therapeutic group homes. CFBHN adheres to this coordination through weekly Children Specific Staffing Team (CSST) Staffings with the Medicaid Managed Care Plans and continued notification of interagency staffings to the Medicaid Managed Care Plans involving high risk youth when applicable. CFBHN will coordinate with the Medicaid Managed Care Plans on community opportunities to be trained on wraparound and utilization of Medicaid reimbursable covered and in lieu of codes and provide technical assistance and support of the wraparound certification of community providers within the SunCoast Region and Circuit 10 to be able to utilize these billable codes.

Medicaid Managed Care Plans available in Charlotte County

CMS

Children's Medical Services (CMS) Health Plan provides all traditional Medicaid covered medical services, which include behavioral health, pharmacy, and transportation to Florida's most vulnerable population. In addition to the traditional Medicaid services, CMS Health Plan also provides expanded benefits, which

includes services such as tutoring, grocery allowance, housing allowance, swimming lessons, home meal delivery post facility discharge and nutritional counseling. CMS members also have access to our Community Help Line – where they can be connected to a variety of community resources. We understand that having these supports in place allow families to focus on their healthcare. The CMS Plan also received approval to provide In Lieu of Services (ILOS) which are non-traditional Medicaid services. These include community based wraparound services, partial hospitalization, intensive outpatient program, mobile crisis, peer support, multi-systemic therapy, infant mental health pre and post testing, family training for child development, crisis stabilization unit, specialty psychiatric hospitals, ambulatory detox, detox at addiction receiving facility, Short Term Residential (SRT) and nursing homes. CMS children also fall under the scope of Early and Periodic Screening, Diagnostic and Treatment (EPSDT), and often access Pet, Equine, Art and Music Therapy when determined to be medically necessary. In order to help children/families navigate the complex system of care, CMS Health Plan assigns each member a designated Care Manager that helps the family coordinate services, and collaborates with the community stakeholders. This includes the Managing Entity on any complex cases that require MDT/Special staffing to leverage all services/benefits to ensure the child gets the right services in the least restrictive level of care.

Humana

Your Humana Healthy Horizons™ in Florida Medical Plan includes medical, pharmacy, vision, and hearing coverage, as well as coverage related to COVID-19 and telehealth services. Please see link for additional information. www.humana.com/HealthyFlorida

Simply

Simply Healthcare has partnered with the Florida Chapter of the American Academy of Pediatrics to provide a variety of resources to support mental health in children, including:

- Important Resources
  - National Suicide Prevention Lifeline
  - Community Assistance Programs
  - Florida Chapter of the American Academy of Pediatrics – Parent Resources
  - Hope for Healing – access to mental health and substance abuse resources
  - Partner Toolkit
    - Provider Resources
    - Educator Resources
    - Community Resources

Please go to www.SimplyHealthyMinds.com for more information!

Sunshine Health

In Florida, most Medicaid recipients are enrolled in the Statewide Medicaid Managed Care program (SMMC). The program includes multiple Managed Medical Assistance (MMA) Managed Care Health Plans in the AHCA regions throughout the state. These SMMC Health Plans provide Medicaid covered services, which include behavioral health, pharmacy, and transportation services. Sunshine Health operates a statewide MMA Plan and Long-Term Care services, as well as the Serious Mental Illness (SMI) Specialty Plan, the Child Welfare (CW) Specialty Plan, and the Children's Medical Services (CMS) Plan that serve unique populations. In addition to covering basic Medicaid state plan services, the SMMC Health Plans and Specialty Plans also offer alternative In Lieu of Services (ILOS) that allow

for a behavioral health continuum of care services, and all Sunshine Health Plans cover an array of Expanded Benefits. Furthermore, the Specialty Plans offer specialized programs, supports, Case Management, and Care Coordination services.

CFBHN coordinates with local Medicaid Managed Care Health Plans for children enrolled in Medicaid, including the Specialty Plans. Health Plan Case Managers/Care Coordinators participate in the CFBHN/System of Care staffing process for high-risk children and those in residential care. CFBHN adheres to this coordination through local child-specific staffings with the Medicaid Managed Care Plans and continued notification of interagency staffings to the Medicaid Managed Care Plans involving high-risk youth, when applicable. Sunshine Health Case Managers/Care Coordinators can be contacted through a single point of access at sunshine_child_welfare@centene.com. Case Managers/Care Coordinators also routinely collaborate on members receiving services funded by CFBHN, such as the Community Action Team (CAT) to ensure continuity of care. Sunshine Health is engaged with statewide efforts to review the services of youth with acute behavioral health needs, such as the Department of Children and Families' SIPP Workgroup. Behavioral Health ILOS, such as Partial Hospitalization and Intensive Outpatient Services, are available through Sunshine Health to prevent admission or readmission to inpatient psychiatric services.

Through efforts to leverage Medicaid, CFBHN works with Sunshine Health on opportunities to utilize other Behavioral Health ILOS, Expanded Benefits, and case management programs offered when beneficial for mutually-served children. Sunshine Health works with providers for technical assistance on network credentialing, contracting, eligibility, and claims submissions for ILOS to offer a wider selection of treatment options in the community. Sunshine Health works in partnership with CFBHN/ County Crisis System of Care (mobile response team), hospitals, schools, justice system and other entities participating in this plan to advance the efforts to direct member care to the right level service, for the right amount of time and duration. Through this collaboration, the intent is to reduce unnecessary and potentially preventable Baker Act admissions for children. Sunshine Health also promotes the use of efficacious services, such as peer support and the expansion of evidence-based programs. Sunshine Health offers technical assistance to providers on utilizing our various ILOS, including Multi-Systemic Therapy (MST). Expanded Benefits, such as Equine, Art, and Music Therapy, offer additional therapeutic options for members. Sunshine Health has established agreements with each of the Behavioral Health Hubs to support their efforts in improving access to child/youth behavioral health services through training and consultation to pediatricians throughout the state. CFBHN partners with Sunshine Health for community and provider training opportunities on topics, such as Trauma Informed Care and High-Fidelity Wraparound.

Sunshine Health continues to fully support, and participate in, the establishment of the ongoing activities and goals created in the HB 945 Managing Entity Plan.

Vivida

Vivida Health delegates all contractually required behavioral health services to Beacon Health Options. Through its integrated care model, Beacon supports care coordination with community resources, providers, NGOs and NFPs in delivering care and wrap around services to Vivida members needing behavioral health care. Beacon has an extensive network of behavioral health providers that supports its efforts to get Vivida members the behavioral health care they need in the most appropriate and expeditious manner possible.

United Healthcare

As a part of our mission to help people live healthier lives and make the health system work better for everyone, United Healthcare is focused on ensuring that our high-risk youth have access to high quality mental health services and supporting coordination with supportive entities such as the Department of Children and Families and the regional managing entities. United Healthcare looks to support our youth and families through a number of care engagement and peer support services to help our members function and live independently in the community. Community outreach and education helps promote positive mental healthcare resources within the community.

United Healthcare also offer great benefits, inclusive of expanded benefits and in lieu of services. United Healthcare provides all services covered under traditional Medicaid; medical, behavioral health, pharmacy, and transportation benefits. United Healthcare also offers expanded benefits such has home delivered meals after hospitalization, over the counter monthly stipend, swimming lessons, transition age youth flex fund, peer supportive texting, and sensory toys for ADHD. In lieu of services include Intensive Outpatient Treatment and Partial Hospitalization Programs, Mobile Crisis, Peer Support, Community Based Wrap Around Services, Multisystemic Therapy, and Functional Family Therapy. New evidence-based practices are also included in the benefits such as, Homebuilders, Parent Child Interactive Therapy, Brief Strategic Family Therapy, and Nurse Family Partnership. By ensuring that members managing serious mental health or substance use disorder issues receive access to the right care at the right time, United Healthcare can support and promote the best outcomes.

Medicaid (AHCA) Eligible Services (Hyperlinks listed below)	
Family Planning Waiver Services	*Home Health Services*
Behavioral Analysis	*Hospital - Inpatient*
Behavioral Health Overlay Services	*Hospital - Outpatient*
Assistive Care Services	*Hospital - State Mental Health*
Certified Substance Abuse County Match	*Medical Foster Care (MFC) Services*
Community Behavioral Health Services	*Specialized Therapeutic Foster Care*
County Health Department (CHD)Services	*Statewide Inpatient Psychiatric Program Services*
Early Intervention Services	*Targeted Case Management -Child Health*
Targeted Case Management - Children at Risk of Abuse and Neglect	*Prescribed Drug Services*
Transportation - Non-Emergency	*Targeted Case Management - Mental Health*
In Lieu Of Services	

Appendix 5.5 Statewide Medicaid Managed Care Contact Info

YOUTH SERVED BY MULTIPLE SYSTEMS

CFBHN collaborates with community partners in the SunCoast Region and Circuit 10 through local review team conferences, crossover staffings, youth at risk staffings and interagency staffings to identify high risk youth and provide technical assistance on available community resources to divert the high risk youth served by multiple systems in deeper end systems of care. CFBHN provides technical assistance and support in cross over staffings and youth multiple system work groups when possible to identify system improvement processes.

CFBHN promotes the use of High Fidelity Wraparound to providers of services to assist children, youth, and their families to meet their needs and achieve their unique recovery pathway. CFBHN will continue to collaborate with SunCoast and Circuit 10 regional Wraparound certified trainers and coaches to build capacity for funding sustainability.

CFBHN participates in the Children Specific Staffing Team (CSST) staffings with the Managed Medicare Care Plans and other community stakeholders. The purpose of these staffings is to review information for high risk, non-child welfare youth who have been referred to Statewide Inpatient Psychiatric Program (SIPP) or Therapeutic Group Homes. Parties discuss the needs of the youth to ensure the appropriate treatment is sought and necessary referrals are made.

CFBHN participates in local review team staffings in the SunCoast Region and Circuit 10 when possible to provide technical assistance and support to community stakeholders in efforts to divert children and youth from higher levels of care. CFBHN also provides technical assistance and support to child welfare community based care organization (CBC) organizations on earlier identification of high risk youth.

Appendix 5.6: Medicaid's Role in Children's Staffings

Appendix 5.7: Child Staffing Process Framework

Appendix 5.8: Medicaid Child Staffing Process

Appendix 5.9: Medicaid Notification of Staffing Form

Appendix 5.10: DCF/AHCA Report and Flowchart

FAMILY FIRST PREVENTION SERVICES ACT (FFPSA)

The Family First Prevention Services Act was passed into law on February 9, 2018, and aims to prevent unnecessary removal of children and youth from their families by allowing federal funding for mental health services, substance use treatment, and in-home parenting skill training. Additional emphasis is placed on reducing placement in group homes by encouraging placement within family foster homes. FFPSA includes significant amendments to Title IV-E (foster care, adoption assistance, and Chafee independent living services) and Title IV-B (child welfare services).

The FFPSA implementation provided an opportunity for Florida to enhance its community-based model by deepening its commitment to prevention and enhancing partnerships with stakeholders to ensure that evidence-based services are readily available within local communities to improve long-term safety, permanency, and well-being outcomes for children and families. The Department is enhancing and expanding Florida's child welfare approach by integrating services to holistically address the needs of children and their families and prevent further crisis. The Department will operationalize and hardwire prevention into the culture and practice of the Department, modernize and create efficiencies in our systems to improve workforce stability and capacity, improve accountability and quality across all systems, and improve financial health by leveraging all revenue sources to improve the service array in Florida's communities under the IV-E waiver, by helping communities build an array of evidence-based programs and a network of providers to provide coordinated, wrap-around care to meet the holistic needs of children and families. Florida families will have 'No Wrong Door' to access community-based, coordinated, quality, and evidence-based services at the right time to meet their unique and specific needs and to support long term well-being.

Florida's Family First Prevention Plan (FFPP) provides a framework for how Florida intends to use FFPSA to implement and provide family-centered, trauma-informed, evidence-based services to families with the goal of preventing children and families from entering crisis services like foster care, strengthening families, and improving safety, permanency, and well-being outcomes.

Key FFPSA Provisions

- Prevention services under Title IV-E of the Social Security Act - Allows the option to use Title IV-E funds to provide evidence-based mental health programs, substance abuse prevention and treatment, in-home parent skill-based programs and kinship navigator programs for up to 12 months for children and youth at imminent risk of entering foster care.

- Enhanced support under Title IV-B – Eliminates the current 15-month time limit on the family reunification services for children and youth in foster care and clarifies that a child returning home will now have access to 15-months of family reunification services beginning on the date the child returns home.

- Ensuring the necessity of a placement that is not a foster family home - Places a limit of two weeks on federal payments for placements that are not foster homes or specified residential group care. To claim federal funding for a child placed in a residential group home after 14 days, the residential group home must be a specified setting required to meet the needs of the child.

Multidisciplinary (MDT) and Evidence-Based Practice (EBP) Teams

The first key FFPSA provision listed above guides the development and implementation of family-centered teams to support families with children who are at risk of removal. Families served will include either a parent or caregiver with unmet needs related to a behavioral health condition and/or a child with emotional

or behavioral concerns that place them at risk of entering out-of-home placement such as foster care, inpatient psychiatric, or juvenile justice commitment programs.

Centerstone Contracts with CFBHN to implement the Family Wellbeing Treatment Team - known as FLITE - in Lee, Collier, Charlotte, Hendry, and Glades Counties. The team provides intensive services to families involved in the child welfare system with concerns of *unmanaged or undiagnosed* mental health, substance use, *or* co-occurring disorders of the parent(s) / guardian(s). This teaming approach in the system of care allows for the early identification of at-risk families, coordination of timely linkage to services, and supports families with navigating the dependency system and SU/MH treatment services.

Title IV-E Prevention Services Clearinghouse (provided by the Department of Health and Human Services)

Appendix 5.10: FFPSA Information and Florida FFPP Information

Appendix 5.12: Guidance Document 39

TRAINING NEEDS

CFBHN collaborates with community stakeholders to identify emerging trends and assist providers in implementing and evaluating appropriate Evidence Based Programs and training needs. CFBHN provides or subcontracts children's system of care trainings including, Wraparound 101 Training, Wellness Recovery Action Plan (WRAP), Development of Youth At Risk Staffing Models working with DCF and other trainings focused on this population. CFBHN contracts also require NSPs to ensure that the following trainings are provided to appropriate staff:

- Recovery Capital Training- Recovery Peer Specialists (RPS)
- Peer Supervision Training- RPS Supervisors
- DCF's Recovery Management Curriculum- New hires all seven modules and all staff complete one module at annual training

The Substance Abuse and Mental Health Services Administration (SAMHSA) encourages promising practices such as Mental Health First Aid, Youth Mental Health First Aid, Motivational Interviewing, Stages of Change, Recovery Oriented System of Care (ROSC), Wellness Recovery Action Plan (WRAP), High-Fidelity Wraparound, and Human Trafficking. Training in Trauma Informed Care and Trust Based Relational Interventions (TBRI) would also be beneficial.

SECTION 6: REGIONAL, EVIDENCE-INFORMED, INNOVATIONS FOR YOUTH AND ADULTS

RECOVERY ORIENTED SYSTEM OF CARE (ROSC)

CFBHN promotes the development and implementation of a coordinated recovery-oriented system of care (ROSC). A coordinated recovery-oriented system of care offers a full array of behavioral and related services in a region or community by all service providers, participating either under contract with a managing entity or through community partnerships or mutual agreements. A recovery-oriented system of care is provided through a no-wrong-door model, to the extent allowed by available resources.

Recovery- oriented care is based on the premise that persons served under the framework of recovery management are empowered to direct their recovery. Under a recovery management framework, recovery is person driven, strengths based and built on the foundation of self-determination and self-direction. Individuals are empowered and provided the resources necessary to make informed decisions in regard to the services and supports they choose for their individualized recovery.

CFBHN in collaboration with DCF has implemented ROSC throughout the SunCoast Region and continues to provide monitoring and technical assistance for NSPs using Recovery Oriented Monitoring (ROM), the Self-Assessment Planning Tool (SAPT) and Recovery Self-Assessment surveys (RSA), SunCoast Peer Learning Community and the SunCoast Region ROSC Learning Community.

Appendix 6.1: Guidance Document 35, Recovery Management Practices

VOICE, CHOICE, AND INDIVIDUALIZATION OF SERVICES

Wellness Recovery Action Plan (WRAP), certified by SAMHSA as an evidence-based intervention, is a personalized wellness plan which allows an individual to develop a plan that assists them in dealing with uncomfortable and distressing behaviors and feelings by developing responses that assist the individual in handling those responses.

WELCOMING, ENGAGING, AND CULTURALLY AND LINGUISTICALLY APPROPRIATE CARE

CFBHN strives to ensure accessibility for any person with a disability, including physical disabilities; mobility difficulties; visual, hearing and language impairments; developmental and intellectual disabilities; mental illness; and addictive disease. Furthermore, CFBHN commits to providing accessibility without regard to race, color, national origin, disability, age, gender, religious preference, marital status, physical appearance, sex or sexual orientation. CFBHN encourages organizations to understand and respond appropriately to the cultural needs of their clients.

SUICIDE PREVENTION

CFBHN and our community partners embrace the "Zero Suicide" approach to suicide care management. CFBHN provided training and technical assistance on suicide prevention best practices, including evidence-based screenings, assessment, safety planning, and lethal means restriction counseling. Provider contracts now include the requirement of evidence-based suicide practices and providers have updated their policies and procedures to include such prevention measures.

CFBHN participates in the Department of Children and Families' Suicide Prevention Coordinating Council. Individuals identified at risk for suicide are provided intensive suicide care coordination and enrolled in suicide care-specific treatment. CFBHN coordinates with community partners and local community stakeholders for community-based information sharing events on suicide prevention.

988 and Suicide Prevention Hotline

In August 2019, FCC staff, in consultation with the U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration, the Department of Veteran Affairs, and the North American Numbering Council, released a report recommending the use of 988 as the 3-digit code for the National Suicide Prevention Lifeline. In July 2020, the FCC adopted rules designating this new phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors. The transition has taken place resulting in phone service providers directing all 988 calls to the existing National Suicide Prevention Lifeline by July 16, 2022.

Appendix 4.9: 988 Suicide Prevention Hotline

TRAUMA INFORMED CARE

Behavioral Health agencies, as well as school personnel and social workers have been trained in Trauma Informed Care. Trauma Informed Care is the understanding of trauma and knowing that responses to trauma can induce additional, unintentional trauma.

For a list of Trauma Informed Care providers, refer to the County Community Service Array, Appendix 4.2.

SECTION 7: DATA SYSTEMS AND EVALUATION

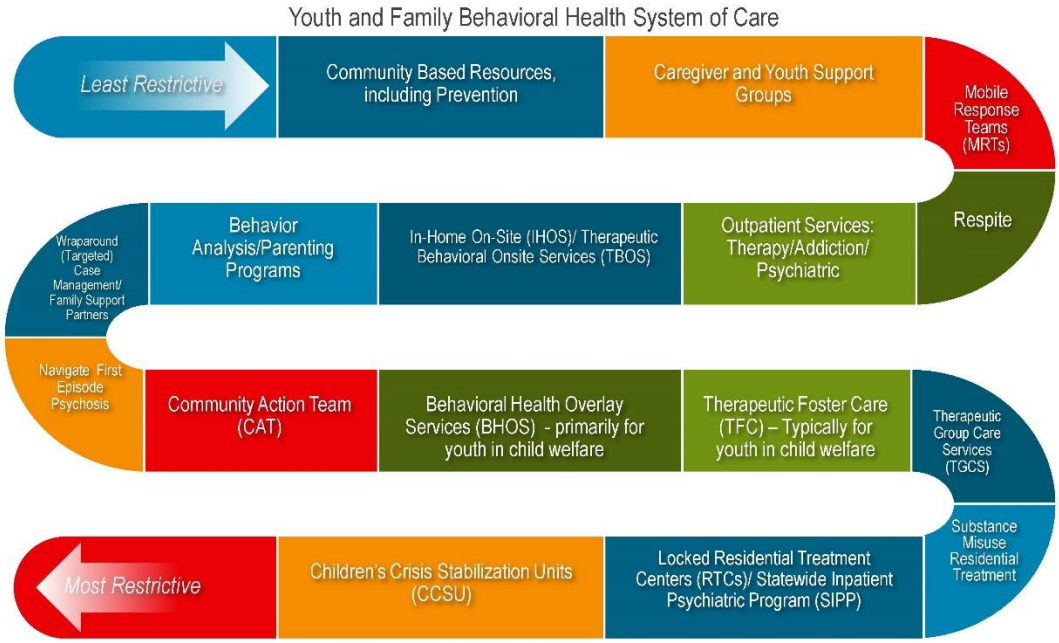
CONTINUOUS QUALITY IMPROVEMENT

The mission of Central Florida Behavioral Health Network (CFBHN) is to manage a quality behavioral health system of care that brings help and hope to individuals, families, and communities. Continuous quality improvement is an important component of the mission of the Network and helps to ensure the quality and consistency of the array of behavioral health services offered by community stakeholders.

SECTION 8: OPPORTUNITIES FOR IMPROVEMENT

- Managing Entities have been tasked to write the HB945 plan but have not been given authority to implement plan.
- CFBHN does not currently have access to AHCA's Data.
- Need for universal release of information to allow communication across providers
- Care Coordination across multiple platforms and systems
- Enforcement of the plan
- Flexible, non-specific, and general revenue
- Affordable/Available housing for staff and individuals
- Transportation
- Lack of levels of care services available *within* county (i.e. day treatment/outpatient/FST/CAT – intense services)
- Need for high fidelity wraparound trained providers
- Recruitment of providers
- Specialized Peer Services support for youth and parents,
- Decrease workforce shortage to fulfill contractual obligations

SECTION 9: COORDINATED SYSTEM OF CARE PLAN



Please note that the infograph above is ideally how the Children's System of Care operates, moving a child/adolescent/young adult from the least restrictive to most restrictive levels of care.

FEEDBACK GATHERED FROM MEETINGS/SURVEYS/INDIVIDUALS AND FAMILIES SERVED

The purpose of the HB945 Managing Entity Plan is to serve as the foundation for addressing the key behavioral health gaps for children and youth as defined by consumers, community stakeholders, provider partners, and CFBHN staff. The plan will help inform, enhance, and drive children's system of care efforts for each child. Feedback from meetings and informal surveys was gathered to measure the effectiveness of the HB945 Managing Entity Plan. The feedback gathered will help to identify opportunities in the communities served while building on the many strengths within the current system.

PRIORITIES

"To facilitate parents and caregivers obtaining services and supports by making referrals to specialized treatment provides, if necessary, with follow-up to ensure services are received."

1. Comprehensive Coordinated System of Care

2. Integrated Service Delivery and Supports

3. Data Systems and Evaluation

APPENDIX

Appendix 2.1: HB 945 Definitions

Key Term	Shared Definition
Substance Use	Recovery-Oriented System of Care (ROSC) terminology previously referred to as "substance abuse". For the purpose of this plan, the term Substance Use will be used to highlight a recovery focused approach to treatment and needs.
Outreach	Contact of a mobile response team (MRT) either by 2-1-1 or direct call. The MRT will triage the request and to the extent possible, provide an in-person response. Response to a crisis in the location where the crisis is occurring is optimal.
Providers funded by the state's child-serving systems	Any behavioral health provider organization receiving funding by any of the child-serving systems (as defined below).
Child-serving systems	Early Learning Coalitions Public and Charter School systems Child welfare (Community based care and DCF (Department of Children and Families)) Department of Juvenile Justice Agency for Persons with Disabilities Agency for Healthcare Administration Medicaid Managed Medical Assistance Plans
High utilizers of crisis stabilization services "funded through the department"	Crisis stabilization services funded by the Managing Entities for individuals (up to age 25 years old) identified as person who has had three or more crisis placements
Available resources	As determined by the regional Managing Entity.
High utilizers	Youth/young adults up to 25 years old. With three (3) or more acute care admissions within 180 days; or with an acute care admission that lasts sixteen (16) days or longer.

Care Coordination	As per Guidance Document 4 to "mean the implementation of deliberate and planned organizational relationships and service procedures that improve the effectiveness and efficiency of the behavioral health system by engaging in purposeful interactions with individuals who are not yet effectively connected with services to ensure service linkage. Examples of care coordination activities include development of referral agreements, shared protocols, and information exchange procedures...."
The multiagency network for students with emotional or behavioral disabilities	Also known as SEDNET, which creates and facilitates a network of key stakeholders committed to assisting in the provision of a quality system of care for students with or at-risk of emotional and/or behavioral challenges.

Appendix 2.2: Common Acronyms

Acronym	Definition
AHCA	Agency for Health Care Administration
ALF	Assisted Living Facility
APD	Agency for Persons with Disabilities
BHC	Behavioral Health Consultant
BHOS	Behavioral Health Overlay Services
BHRS	Behavioral Health Receiving System
CARD	Center for Autism Related Disabilities
CAT	Community Action Team
CBC	Community Based Care
CCSU	Children's Crisis Stabilization Unit
CFBHN	Central Florida Behavioral Health Network
CM	Case Management/Manager
CPI	Child Protective Investigations/Investigator
CRS	Central Receiving System
CSST	Children Specific Staffing Team

CSU	Crisis Stabilization Unit
CW	Child Welfare
DCF	Department of Children and Families
DJJ	Department of Juvenile Justice
EBP	Evidence-Based Practices
ELC	Early Learning Coalition
ESS	Economic Self-Sufficiency
FFPSA	Family First Prevention Services Act
FIS	Family Intervention Services
FIT	Family Intensive Treatment (team)
FMHI	Florida Mental Health Institute
FQHC	Federally Qualified Health Center
FSFN	Florida Safe Family Network
FSP	Family Support Team
FWTT	Family Wellbeing Treatment Team
HB	House Bill
HNHU	High Need High Utilizer
ICF	Intermediate Care Facility
LE or LEO	Law Enforcement/Law Enforcement Officer
MAT	Medication Assisted Treatment
MDT	Multidisciplinary Team
ME	Managing Entity
MH	Mental Health
MMA	Medicaid Managed Assistance
MRT	Mobile Response Team
NAMI	National Alliance on Mental Illness
NSP	Network Service Provider
NWD	No Wrong Door

PHP	Partial Hospitalization Program
QA/QI	Quality Assurance/Quality Improvement
RCO	Recovery Community Organization
ROSC	Recovery Oriented System of Care
RTC	Residential Treatment Center
SA	Substance Abuse (Use)
SAMSHA	Substance Abuse and Mental Health Services Administration
SEDNET	Multiagency Network for Students with Emotional/Behavioral Disabilities
SIPP	Statewide Inpatient Psychiatric Program
STGH	Specialized Therapeutic Group Home
TBRI	Trust Based Relational Intervention
TIC	Trauma Informed Care
WRAP	Wellness Recovery Action Plan
YAR	Youth at Risk

Appendix 2.3: HB 945 Meeting Timeline

HB945 Timeline

County:	Charlotte

Record date of meeting and all notable outcomes to be included on timeline

Date	Milestone Title	Description or Activity
5/15/2021	Region Meeting	Meeting with SCR and C10
08/05/221	Charlotte HB945 Meeting	First meeting with Charlotte HB945 Stakeholders
09/17/2021	Charlotte HB945 Meeting	Second meeting with Charlotte HB945 Stakeholders
10/13/2021	Charlotte HB945 Meeting	Third meeting with Charlotte HB945 Stakeholders
10/2/2024	Charlotte HB945 Meeting	First meeting with Charlotte HB945 Stakeholders
10/28/2024	Charlotte HB945 Meeting	Second meeting with Charlotte HB945 Stakeholders

Additional key dates and information, not included on timeline

Date	Description	Notes
12/1/2021	Clean up	Prepare notes

HB945 Timeline Charlotte.xlsx

Appendix 2.3: HB 945 Required Attendee Tracking

Use tracking sheet identify attendance by required organizations at all HB945 meetings.

County: Charlotte	Meeting #1	Date: 08/05/2021
Required Organization	**Name, Agency**	
Managing Entity Leadership	Alan Davidson, Stacy Payne, Rob Tabor	
Community Based Care	Maureen Coble, Children's Network Naderah Salim, Children's Network	
Medicaid MMA Plan		
SEDNET Manager		
School District Superintendent or designee	Rebecca Marazon, Coordinator of Psych Services,	
Early Learning Coalition		
AHCA	Cynthia Brandt	
The Department of Children and Families, Child Welfare	Nakesha Nash	
Department of Juvenile Justice	Margaret LaMarca	
Behavioral Health Providers	Sarah Wright, CBHC Stephanie Kerns, CBHC	
Law Enforcement agencies		
Child/Adolescents/Families with Lived Experience		
APD	Brett Gottschalk	

Use tracking sheet identify attendance by required organizations at all HB945 meetings.

County: Charlotte	Meeting #2	Date: 9.17.2021
Required Organization	**Name, Agency**	
Managing Entity Leadership	Alan Davidson, Rob Tabor, Laura Gross	
Community Based Care	Maureen Coble was sent a copy of the plan	
Medicaid MMA Plan	Christie Sparks, CMS Claudia Navaro, CCP Orlene Campbell, CCP	
SEDNET Manager		
School District Superintendent or designee	Rebecca Marazon	
Early Learning Coalition		
AHCA	Brittani Randolph	
The Department of Children and Families, Child Welfare	Melissa Leslie Aaron Stitt	
Department of Juvenile Justice		
Behavioral Health Providers	Stephanie Kerns Sarah Wright Rebecca Hansen	
Law Enforcement agencies		
Child/Adolescents/Families with Lived Experience	Beth Piecora	
APD		

Use tracking sheet identify attendance by required organizations at all HB945 meetings.

County: Charlotte	Meeting #3	Date: 10.13.2021
Required Organization	**Name, Agency**	
Managing Entity Leadership	Alan Davidson, Rob Tabor, Laura Gross	
Community Based Care	Maureen Coble	
Medicaid MMA Plan	Kelly Singleman	
SEDNET Manager	Connie Tucker	
School District Superintendent or designee		
Early Learning Coalition		
AHCA	Brittani Randolph Cynthia Brandt	
The Department of Children and Families, Child Welfare	Aaron Stitt	
Department of Juvenile Justice		
Behavioral Health Providers	Heather Cross Sarah Wright Stephanie Kerns	
Law Enforcement agencies		
Child/Adolescents/Families with Lived Experience		
APD	Leah Watson	

Use tracking sheet identify attendance by required organizations at all HB945 meetings.

County: Charlotte	Updated Meeting #1	Date:10.02.2024
Required Organization	**Name, Agency**	
Managing Entity Leadership	Luis Rivas Beth Piecora LaTasha Cohen Shannon Kennedy Misty Ross Jorge Villada Laura Gross	
Community Based Care	Nadereh Salim	
Medicaid MMA Plan		
SEDNET Manager		
School District Superintendent or designee	Susan Flores	
Early Learning Coalition		
AHCA		
The Department of Children and Families, Child Welfare	John Cornett	
Department of Juvenile Justice		
Behavioral Health Providers	Vickie Scanlon	
Law Enforcement agencies		
Child/Adolescents/Families with Lived Experience	Beth Piecora Shannon Kennedy	
APD		

Use tracking sheet identify attendance by required organizations at all HB945 meetings.

County: Charlotte	Updated Meeting #2	Date:10.28.2024
Required Organization	**Name, Agency**	
Managing Entity Leadership	Luis Rivas Beth Piecora LaTasha Cohen Laura Gross	
Community Based Care		
Medicaid MMA Plan	Donna Nickel	
SEDNET Manager		
School District Superintendent or designee		
Early Learning Coalition		
AHCA	Miranda Johnson Ranada Howard	
The Department of Children and Families, Child Welfare	John Cornett	
Department of Juvenile Justice		
Behavioral Health Providers		
Law Enforcement agencies		
Child/Adolescents/Families with Lived Experience	Beth Piecora	
APD		

Appendix 3.1: Charlotte County Mental Health Assistance Allocation Plan

charlotte-2024-25-mha.pdf

Appendix 3.2: Charlotte County Community Health Improvement Plan

http://www.floridahealth.gov/provider-and-partner-resources/community-partnerships/floridamapp/state-and-community-reports/Charlotte-county/_documents/Charlotte_CHIP.pdf

Charlotte_CHIP4 2021-2025.pdf

Appendix 3.3: Behavioral Health Transportation/Behavioral Health Receiving System (BHRS)

Charlotte County Transportaion Plan

Appendix 3.4: Community Health Assessment

2020-Healthy-Charlotte-Community-He

Appendix 4.1: 65e-14, Service Definitions

65E-14 Updated 2023-03-08.pdf

Appendix 4.2: County Community Service Array

Charlotte County 2-1-1:
https://www.charlottecountyfl.gov/departments/human-services/faq-211.stml

Aunt Bertha
findhelp.org

HOPE Florida: https://www.myflfamilies.com/APathwaytoProsperity/

Appendix 4.3: Guidance Document 4, Care Coordination

Guidance 4 Care Coord 2023 07 01.p

Appendix 4.4: Florida Service Navigation Worksheet

Florida Service Navigation Workshe

Appendix 4.5: Mobile Response Teams; location and contact info

Charlotte
The Centers for Progress and Excellence
(Team A)
844-395-4432

DeSoto
Centerstone of Florida
941-782-4600

Hendry
The Centers for Progress and Excellence
(Team C)
844-395-4432

Hillsborough
Gracepoint
813-272-2958

Manatee
Centerstone of Florida
941-782-4600

Pinellas
Personal Enrichment Mental Health Services
727-362-4424

Sarasota
First Step of Sarasota
941-364-9355

Collier
The Centers for Progress and Excellence
(Team B)
844-395-4432

Glades
The Centers for Progress and Excellence
(Team C)
844-395-4432

Highlands
Peace River Center
863-519-3744
1-800-627-5906

Lee
The Centers for Progress and Excellence
(Team A)
844-395-4432

Pasco
Baycare Health System
/Baycare Behavioral Health
727-372-4357

Charlotte
Peace River Center
863-519-3744
1-800-627-5906

Appendix 4.6: Guidance Document 34, Mobile Response Teams (MRTs)

Guidance 34 MRT
2023 07 01.pdf

Appendix 4.7: CAT teams; location and contact info

BayCare Behavioral Health
Pasco
7809 Massachusetts Avenue, New Port Richey, FL 34653
727-315-8638

Centerstone
Manatee County
383 6th Ave West, Bradenton, FL, 34205
941-782-4158

Sarasota/Desoto County
4010 Sawyer Road, Sarasota, FL, 34233
941-782-4272

Hendry/Glades County
813 E. Hickpochee Ave, Suite 500, Labelle, FL, 33935
813-342-4221

Lee County
4350 Fowler Ave, Suite 15, Ft. Myers, FL, 33901
615-815-6853

David Lawrence Centers for Behavioral Health
Collier
2806 South Horseshoe Drive, Naples FL 34104
239-263-4013, Fax 239-643-7278

Gracepoint
Hillsborough County
2815 E. Henry Ave Suite B4 Tampa, FL 33610
813-239-8228 Main Line 813-239-8453

Peace River Center
Charlotte, Highlands, and Hardee
1831 N. Crystal Lake Dr., Lakeland, FL, 33801
863-500-3780 / Fax #: 863-733-4497

Appendix 4.8: Guidance Document 32, Community Action Treatment (CAT) Teams

Guidance 32 CAT 2024 02 06.pdf

Appendix 4.9: 988 Suicide Prevention

988-fact-sheet.pdf

Appendix 5.0: FIT/FIS/BHC Team locations and agency

FIT

Circuit 13
DACCO

Circuit 6
Pasco – Baycare
Pinellas – Directions for Living

Circuit 12
Manatee – Centerstone

Circuit 20
Charlotte - Charlotte Behavioral
Lee – Charlotte Behavioral

Circuit 10
Charlotte, Highlands, Charlotte – Peace River Center

FIS

Circuit 13
DACCO

Circuit 6
Pinellas – Operation PAR

Circuit 12
Manatee – Centerstone
Sarasota – First Step of Sarasota

Circuit 20
Charlotte - Charlotte Behavioral
Lee – Charlotte Behavioral
Collier – David Lawrence Center

Circuit 10
Charlotte, Highlands, Charlotte –
Tri-County Human Services

BHC

Circuit 12
Manatee – Centerstone
Sarasota – First Step of Sarasota

Circuit 20
Charlotte - Charlotte Behavioral
Lee – Charlotte Behavioral
Charlotte – David Lawrence Center

Circuit 10
Highlands, Charlotte –
Tri-County Human Services

Appendix 5.1: Guidance Document 18, Family Intensive Services (FIT) Teams

Guidance 18 FIT 2024 01.pdf

Appendix 5.2: Guidance Document 19, Child Welfare

Guidance 19 Child Welfare 2021 07 01.p

Appendix 5.3: School District Mental Health Plan

charlotte-2024-25-mha.pdf

Appendix 5.4 Statewide Medicaid Managed Care Contact Info

SMMC_Brochure_CY 19.pdf

Appendix 5.5: Medicaid's Role in Children's Staffings

Medical Neglect.pdf

Appendix 5.6: Child Staffing Process Framework

Child Staff Process Framework.pdf

Appendix 5.7: Medicaid Child Staffing Process

Florida Medicaid Child Staffing Proce

Appendix 5.8: Medicaid Notification of Staffing Form

Florida Medicaid
Notice of Staffing F

Appendix 5.9: DCF/AHCA Report and Flowchart

Publications - Substance Abuse and Mental Health - Florida Department of Children and Families (myflfamilies.com)

HB945 Section 14
report.pdf

Appendix 5.10: Family First Prevention Services Act and Florida Family First Prevention Plan information

FFPSA_one page
overview.pdf

FL Family First
Prevention Plan_202

Appendix 5.12: Guidance Document 39

Guidance Document
39 23-24.pdf

Appendix 5.11: Guidance Document 35, Recovery Management Practices

Guidance 35
Recovery Mgmt FY23