House Bill 945
Managing Entity (ME) Plan

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

DeSoto County

Due Date: January 1, 2025
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CONTENTS

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 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.

SECTION 2: PLANNING PROCESSFOR A COORDINATED SYSTEM OF CARE

DEFINITIONS

The Managing Entities believe that 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 DeSoto County, we have determined a plan will be established for DeSoto 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 DeSoto County has services unique to them and thus separate plans are warranted.

PLANNING STRATEGY

In DeSoto County, it has been determined, HB 945 will be discussed and reviewed at DeSoto 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 will be completed in three phases

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

Phase 2 – CFBHN will participate in planning meetings with fellow Managing Entities (FAME), the goal of which will include development of a uniform and cohesive flow of information and format across each Managing Entities region and plan. In

addition, these planning meetings will allow for sharing of information, planning ideas, and development of cohesive thought processes across each region.

Phase 3 – CFBHN will conduct general community wide meetings with identified community stake holders and state funded agencies to discuss the purpose of the plan and roles of those involved review the plan framework, review the plans organization and flow, work to develop/analyze identified gaps within each community's system of care, and development of graphs and flow charts that provide a visual of how the system of care works. A general information meeting with all counties will occur, followed by bi-monthly county level meetings with identified stakeholders until the plan is completed.

Per statute, once finalized, CFBHN will reconvene with key community stakeholders every three years to review and amend the plan as necessary. In the interim, information contained in the Appendix section of the plan will continue to be updated without the need for assembly of stakeholders.

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 currently existing community-based plans such as the Mental Health plans for DeSoto County Schools along with the county's 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: DeSoto County Mental Health Assistance Allocation Plan

Appendix 3.2: DeSoto County Community Health Improvement Plan (CHIP)

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

Appendix 3.5: C12 Juvenile SIM Report

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.

CHILDREN AND YOUTH MH NEEDS OR SERVICE GAPS PRIORITIES

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

CHILDREN AND YOUTH SA NEEDS OR SERVICE GAPS PRIORITIES

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

COMMUNITY HEALTH ASSESSMENTS

The trending top priorities identified in needs assessments conducted in surrounding counties within the SunCoast region were access to and reducing stigma behavioral health, and access to health care services. Studies have shown that Florida mental, emotional, and behavioral disorders are common and begin early in life. Children and youth 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 the trauma and increase their likelihood of achieving positive health, social-emotional, and education 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, adolescence, and young adults were:

- 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 DeSoto County.

MENTAL AND BEHAVIORAL HEALTH CONTINUUM

Overview: Mental & Behavioral Health Services and Supports in the Community			
PREVENTION	**Economic Stability** ❖ Homeless Coalitions ❖ Workforce Board ❖ DCF ESS & Care Coordination ❖ Social Security/ Disability ❖ HOPE Florida ❖ School Readiness Program - ELC	**Access to Health Care** ❖ Department of Health ❖ Federally Qualified Health Centers (FQHC) ❖ Health Insurance - Case Manager ❖ APD ❖ AHCA	**Social & Community – Protective Factors** ❖ Children's Alliance/ Councils / Taskforces ❖ Community Council Against Substance Abuse (CCASA) ❖ Parent-Teacher Groups ❖ Social / Community Groups ❖ Boys & Girls Clubs/ YMCAs ❖ CBC Neighborhood Projects ❖ Healthy Start/ Help Me Grow/ Healthy Families
SCREENING/ DIAGNOSIS	**Medical/ Developmental Assessments** ❖ Health Insurance – Private providers ❖ Department of Health ❖ Federally Qualified Health Centers FQHCs ❖ School System – Student Services (Nurse/Dental) ❖ Early Steps/ FDLRS ❖ Healthy Start/ Healthy Families ❖ Early Learning Coalition – Inclusion Specialists	**Educational Assessments** ❖ School System – Student Services and exceptional student services, FDLRS Family Diagnostic Learning Resource System ❖ Private Providers / Health Insurance– Psycho-Educational Testing ❖ Center for Autism Related Disabilities (CARD) ❖ Vocational Rehab	**Mental/ Behavioral Health Assessments** ❖ Health Insurance – Private Providers ❖ School System – Student Services – community health partners ❖ ME – Community Mental Health Centers ❖ DJJ – Comprehensive Evaluations ❖ DCF – Foster Care CBHA ❖ Center for Autism Related Disabilities (CARD)
TREATMENT	**Outpatient Services** ❖ Outpatient Counseling (Individual, Family, Group) ❖ Psychiatric – Medication Management ❖ Medication Assisted Treatment (MAT) ❖ Targeted Case Management ❖ Care Coordination	**Intensive Outpatient Services** ❖ Increased or Intensive Counseling/ Therapy ❖ CAT Team ❖ Wrap Around Teams ❖ FACT Team ❖ ABA ❖ CBC Diversion Programs ❖ Home Health/Personal Care Assistance ❖ Partial Hospitalization Programs (PHP) ❖ Family Wellbeing Treatment Team ❖ Family Support Team (FST) ❖ Twin Rivers Pathways	**Inpatient Treatment/ Residential Programs** ❖ Behavioral Health Overlay Services (BHOS) group home ❖ Specialized Therapeutic Group Home (STGH) ❖ Intermediate Care Facility (ICF) ❖ Inpatient Competency Restoration (JITP) ❖ State Mental Health Hospital ❖ Statewide Inpatient Psychiatric Placement (SIPP) / Residential Treatment Center (RTC) (Mental Health, Substance Abuse and Co-Occurring) ❖ Therapeutic Foster Home ❖ Therapeutic Foster Group Home ❖ Assisted Living Facility (ALF)
CRISIS/ ACUTE	**Hotlines/Triage** ❖ Mobile Response Teams ❖ Community Mental Health Centers -Crisis Lines ❖ 211 ❖ ME – Access to Care Line ❖ Law Enforcement Crisis Intervention Teams ❖ 988 Suicide Hotlines	**Emergency Treatment** ❖ Baker Act – Receiving Facility ❖ Marchman Act – ARF ❖ Hospital Emergency Room	**Emergency Placement** ❖ Mental Health Respite ❖ Florida Network of Youth Shelters ❖ Domestic Violence Shelter ❖ Homeless Emergency Shelter ❖ Foster Care (Abuse, Neglect, Abandonment) ❖ Better Together
RECOVERY/ SUPPORT	**Education & Training** ❖ ME Mental Health First Aid ❖ Community Coalitions/ Alliances ❖ Hospitals ❖ Awareness Groups	**Support Groups** ❖ Caregiver & Youth Support Groups ❖ CBC – Kinship Support Groups/ Foster & Adoptive Groups	**Peer Support** ❖ Community Clubhouses/Support Programs ❖ Share Spot Drop in Center

Less Intensive/Restrictive — More Intensive/Restrictive

COUNTY COMMUNITY SERVICE ARRAY

DeSoto 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
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	

Appendix 4.1: 65e-14, Service Definitions

Appendix 4.2: County Community Service Array

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 co- ordination, 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, providers, 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 and 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, youth, 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.

PREVENTION & EARLY INTERVENTION

Prevention refers to the proactive approach to preclude, forestall, or impeded 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 through

the use of 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.

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 result in better outcomes for children, adolescents and families and provides significant cost savings to a community.

*Note: not currently in Desoto

CARE COORDINATION (PER GUIDANCE DOCUMENT 4)

Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care.

This includes services and supports that affect a person's overall well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation and the justice systems. It is time- limited, with a heavy concentration on educating and empowering the person served and provides a single point of contact until a person is adequately connected to the care that meets their needs.

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. It is an approach that 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, interpersonal problems/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 person level, it incorporates shared decision making in planning and service determinations and emphasizes self-management. Persons served and family members should be the driver 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 person's needs and wishes, case management may be a service identified in the person's care plan that he or she will be referred to. Case management may be ongoing for those determined eligible for this service based on current standards. 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 by 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;
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and
- Focus on an individual's wellness and community integration.

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

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

Appendix 4.3: Guidance Document 4, Care Coordination

Appendix 4.4: Florida Service Navigation Worksheet

COMMUNICATION, COLLABORATION, AND COMMUNITY EDUCATION

It is important for Network Service 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). Network Service Providers should identify and coordinate efforts with other key community stakeholders.

MOBILE RESPONSE TEAMS – CRISIS SUPPORT

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him or her. 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 lessen trauma whenever possibly 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 with 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, ensure they engage in services, and assist them navigate 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

Community Action Treatment (CAT) teams provide community-based services to children and youth 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 and youth 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.

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, which will take place over the next two years, will result 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

TELEHEALTH

Telehealth services can be provided via a multitude of platforms, allowing for diversity in meeting the needs of both the provider and clients 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 clients 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 clients in remote locations. Some providers provide clients with equipment, such as tablets and internet hot spots, to ensure the client's 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 to 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 a child's treatment.

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

SECTION 5: INTEGRATED SERVICE DELIVERY APPROACHES

INTEGRATED SERVICE DELIVERY SUPPORTS

Appendix 5.1: Circuit 12 Interagency Staffing Team Quick Reference Guide and System Map

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 substance misuse and/or mental 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, 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.

Child Welfare clients with substance use or co-occurring disorders 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.

Behavior Health Consultants (BHC) are Masters Level licensed clinicians supporting the Child Protective Investigators (CPI). BHCs act as substance misuse and mental health subject matter expert 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 5.2: FIT/FIS/BHC Team providers and locations

Appendix 5.3: Guidance Document 18, Family Intensive Services (FIT) Teams

Appendix 5.4: 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 directs 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 will work 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 will provide 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 age 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 aged 6 weeks to 60 months also have access to developmental screening to help identify needed affecting growth and learning early and prior to school entry. The ELCFH also administers the Voluntary Prekindergarten Program for the afore listed four county service area.

Handle With Care

Handle With Care is a multiagency collaborative effort to increase knowledge and awareness when a student has experienced a traumatic event in their home or community. Beginning with the 2017-2018 school year, the School District of DeSoto County partnered with all local law enforcement agencies to establish an immediate notification system when a student enrolled in a district school becomes involved with an active case. This system was designed to notify school principals, teachers, and counselors that a student may be experiencing some level of trauma and to simply be aware, if outward signs of problems begin to emerge. Beginning with the 2020-2021 school year, the DeSoto County HwC program will seek to become more proactive in identifying students who are involved with potentially traumatic events and exhibit academic, behavioral, or attendance-related issues, in order to connect the student and family with appropriate interventions

Appendix 5.5: Handle with Care Information

Appendix 5.6: 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 youth at risk staffings, children specific staffing team staffings, local review team staffings, and other interagency staffings to assist with provision of community resources to divert high risk youth from deeper end systems. CFBHN will collaborate 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

CFBHN will collaborate with the Agency for Persons with Disabilities (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 DeSoto 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

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 medical services, which include behavioral health, pharmacy, and transportation services. Sunshine Health operates both MMA Plans and other Managed Medicaid programs through specialty plans that serve unique populations. They are The Serious Mental Illness (SMI) Specialty Plan, the Child Welfare (CW) Specialty Plan, the Long-Term Care Plan, and the Children's Medical Services (CMS) Plan. In addition to covering basic Medicaid state plan services, the SMMC Health Plans and Specialty Plans also cover alternative In Lieu of Services (ILOS) that allow for behavioral health continuum of care services and all Sunshine Health Plans offer an array of Expanded Benefits. Furthermore, the Specialty Plans offer specialized programs, supports, Case Management, and Care Coordination services.

CFBHN's plan is to coordinate with local Medicaid Managed Care Health Plans for children enrolled in Medicaid, including the Specialty Plans. An example is collaboration with the Health Plans' Case Managers/Care Coordinators during CFBHN / System of Care local high risk children/SIPP/TGC staffing process. 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. Additionally, CFBHN will coordinate with Sunshine Health on opportunities to leverage Behavioral Health In Lieu of Services, expanded benefits, and case management programs offered when beneficial for Medicaid covered children. Through efforts to maximize Medicaid In Lieu of Services, CFBHN will collaborate with Sunshine Health for technical assistance on provider network credentialing, contracting, eligibility, and claims submissions for ILOS such as Wraparound, Mobile Crisis, and Peer Support. CFBHN will also partner with Sunshine Health for community and shared provider training opportunities on topics such as Trauma Informed Care and High-Fidelity Wraparound in the Suncoast Region and Circuit 10 Hillsborough County.

Sunshine Health will collaborate with CFBHN, County Crisis System of Care (mobile crisis), and 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 supports the children's mobile crisis assessment and intervention system and will contract and reimburse for crisis services for Medicaid covered members.

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.

Medicaid (AHCA) Covered 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 5.8 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 crossover 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 utilizes an integrated service delivery support approach through The Youth At Risk Staffing Model developed by CFBHN which will be used in the SunCoast Region and Circuit 10 in early identification of children and youth with significant mental health impairment. This model allows community stakeholders across systems and funding sources to work together in collaboration to ensure coordination of care and

ensure continuity of care among high-risk youth to prevent deeper penetration into high levels of care. CFBHN provides technical assistance and oversite in the SunCoast Region and Circuit 10 for community stakeholders involved in the Youth At Risk Staffing process.

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 organizations (CBC) organizations on earlier identification of high risk youth through the integration of the Youth at Risk staffing model.

Appendix 5.9: Youth at Risk Staffing Model

Appendix 5.10: Medicaid's Role in Children's Staffings

Appendix 5.11: Child Staffing Process Framework

Appendix 5.12: Medicaid Child Staffing Process

Appendix 5.13: Medicaid Notification of Staffing Form

Appendix 5.14: DCF/AHCA Report and Flowchart

FAMILY FIRST PREVENTION SERVICES ACT

The Family First Prevention Services Act (FFPSA) 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.

Currently, there are no EBP or MDT programs in DeSoto County.

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

Appendix 5.15: FFPSA Information and Florida FFPP Information

Appendix 5.16: Child Removal Matrix

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 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

Appendix 6.2: YMS 2425 Goals and Plans

VOICE, CHOICE, AND INDIVIDUALIZATION OF SERVICES

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

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 result in better outcomes for children, adolescents and families and provides a significant cost savings to a community.

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

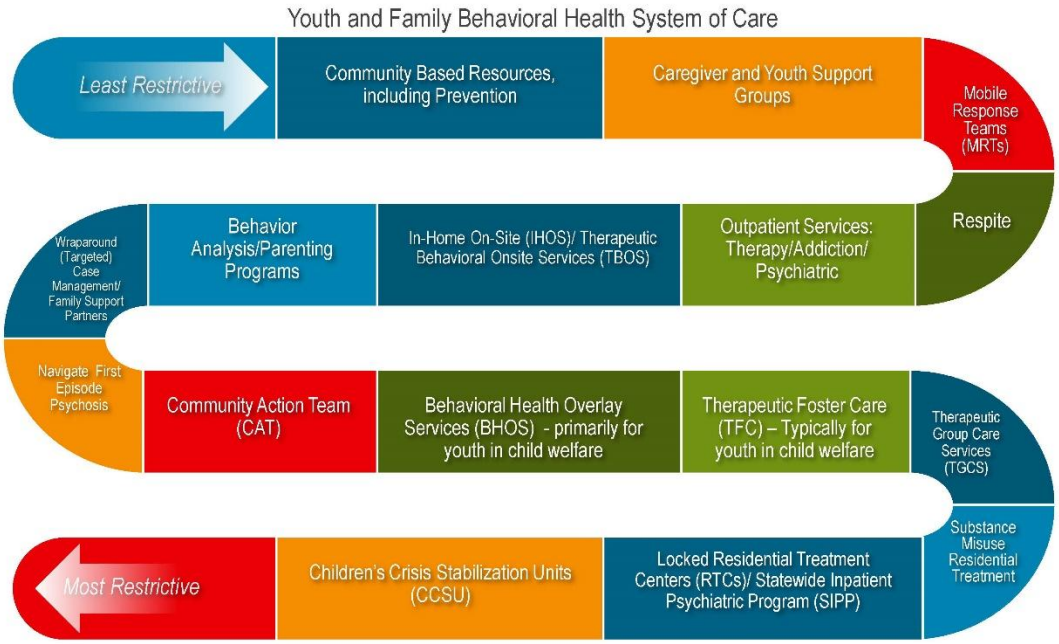
CONTINUOUS QUALITY IMPROVEMENT

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 stake holders.

SECTION 8: OPPORTUNITIES FOR IMPROVEMENT

- Managing Entities have been tasked to write the HB945 plan but have not been given authority to implement plan
- Enforcement of the plan
- Funding (flexible, non-specific and general revenue)
- CFBHN does not currently have access to AHCA data
- Need for universal release of information to allow communication across providers
- Care Coordination across multiple platforms and systems
- System navigation for children, youth, and families
- Transportation
- Services in county versus available in neighboring counties
- Need for high fidelity wraparound trained providers
- Recruitment of providers
- Access to internet/phone service reliability to do telehealth
- Decrease workforce capacity to fulfill contractual obligations
- Affordable/available housing for individuals and staff
- Specialized peer services support for youth and parents

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 of 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
FST	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:	DeSoto

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

Date	Milestone Title	Description or Activity
5/19/2021	Region Meeting	Meeting with SCR and C10
7/8/2021	DeSoto CHiP	Second meeting with DeSoto HB945 Stakeholders
8/12/2021	DeSoto CHiP	First meeting with DeSoto HB945 Stakeholders
10/14/2021	DeSoto CHiP	Third meeting with DeSoto HB945 Stakeholders
09/25/2024	Special HB 945 meeting	First meeting with DeSoto HB945 Stakeholders
10/14/2024	Special HB 945 meeting	Second meeting with DeSoto HB945 Stakeholders

Additional key dates and information, not included on timeline

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

HB945 Timeline DeSoto.xlsx

Appendix 2.4: HB 945 Required Attendee Tracking

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

County: DeSoto	Meeting #1	Date: 07/08/2021
Required Organization	**Name, Agency**	
Managing Entity Leadership	Alan Davidson, Stacy Payne, Rob Tabor, John Cornett, Luis Rivas	
Community Based Care	Kathleen Cowan, Monique Myers - SCC	
Medicaid MMA Plan		
SEDNET Manager		
School District Superintendent or designee	Gina Stafford	
Early Learning Coalition		
AHCA		
The Department of Children and Families, Child Welfare	Elida Mujic, CDA C12 Nekesha Nash, SAMH Robin Ragan Kim Kutch	
Department of Juvenile Justice	Virginia Donovan	
Behavioral Health Providers	Amanda Wood, CBHC	
Law Enforcement agencies		
Child/Adolescents/Families with Lived Experience	Beth Piecora, CFBHN	
APD	Debra Noel	

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

County: DeSoto	Meeting #2	Date: 08/12/2021
Required Organization	**Name, Agency**	
Managing Entity Leadership	Alan Davidson, Stacy Payne, Rob Tabor, Luis Rivas, John Cornet, Laura Gross	
Community Based Care		
Medicaid MMA Plan	Carole Matyas, Staywell/Sunshine	
SEDNET Manager		
School District Superintendent or designee	Gina Stafford	
Early Learning Coalition		
AHCA	Brittani Randolph	
The Department of Children and Families, Child Welfare	Nekesha Nash, SAMH Betsie Cieslal Elida Mujic	
Department of Juvenile Justice	Virginia Donovan	
Behavioral Health Providers	Amanda Wood, CBHC	
Law Enforcement agencies		
Child/Adolescents/Families with Lived Experience	Beth Piecora, CFBHN	
APD	Mike Lacey	

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

County: DeSoto	Meeting #3	Date: 10.14.2021
Required Organization	**Name, Agency**	
Managing Entity Leadership	Alan Davidson, Rob Tabor, John Cornett, Luis Rivas, Laura Gross	
Community Based Care		
Medicaid MMA Plan	Kelly Singleman Carol Matyas Kristie Sparks	
SEDNET Manager	Dave McCarron	
School District Superintendent or designee		
Early Learning Coalition	Anne Bouhebent	
AHCA	Margaret Dorceus	
The Department of Children and Families, Child Welfare	Kimberly Kutch	
Department of Juvenile Justice	Virginia Donovan	
Behavioral Health Providers	Amanda Wood	
Law Enforcement agencies	Major Andrew Proudfit	
Child/Adolescents/Families with Lived Experience	Beth Piecora	
APD	Mike Lacey	

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

County: DeSoto	Updated Meeting #1	Date:10.02.2024
Required Organization	**Name, Agency**	
Managing Entity Leadership	Luis Rivas Beth Piecora Shannon Kennedy LaTasha Cohen Misty Ross Jorge Villada Laura Gross	
Community Based Care		
Medicaid MMA Plan	Donna Nickel	
SEDNET Manager		
School District Superintendent or designee	Dr. Amy Bennett Dr. Gina Stafford	
Early Learning Coalition	Kelly Wertenbach	
AHCA		
The Department of Children and Families, Child Welfare	John Cornett	
Department of Juvenile Justice	Toni Latortue (GAL)	
Behavioral Health Providers	Vickie Scanlon Kylie Sumner	
Law Enforcement agencies		
Child/Adolescents/Families with Lived Experience	Beth Piecora Shannon Kennedy	
APD		

Appendix 3.1: DeSoto County Mental Health Assistance Allocation Plan

DeSoto School MH Plan.pdf

https://www.fldoe.org/schools/k-12-public-schools/bosss/mental-health.stml

Appendix 3.2: DeSoto County Community Health Improvement Plan

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

DeSoto_CHIP5.pdf

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

DeSoto Transportation Plan 2

Appendix 3.4: Community Health Assessment

DeSoto_CHA2.pdf

Appendix 3.5: C12 Juvenile SIM Report

Circuit 12 Juvenile SIM Report.pdf

Appendix 4.1: 65e-14, Service Definitions

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

Appendix 4.2: County Community Service Array

2-1-1 Serving Sarasota, Manatee and DeSoto Counties: https://211.gs-humanservices.org/

Aunt Bertha:findhelp.org

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

Appendix 4.3: Guidance Document 4, Care Coordination


Guidance 4 Care Coord.pdf

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

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

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

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

Guidance 34 MRT.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
Polk, 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.pdf

Appendix 4.9: 988 Suicide Prevention Hotline

988-fact-sheet.pdf

Appendix 5.1: Circuit 12 Interagency Staffing Team Quick Reference Guide

Interagency Quick Guide.pdf

System Map 2020.pdf

Appendix 5.2: FIT/FIS/BHC Team locations and agency

BHC providers updated 11.2024.doc›

FIS providers-Updated 11

FIT providers updated 11.2024.doc›

Appendix 5.3: Guidance Document 18, Family Intensive Services (FIT) Teams

Guidance 18 FIT.pdf

Appendix 5.4: Guidance Document 19, Child Welfare

Guidance 19 Child Welfare.pdf

Appendix 5.5: Handle with Care


HwC Overview.docx


Handle with care info sheet.pdf


HWC Flyer.docx


FL HWC Process Flow - FINAL 04.16.2


HANDLE WITH CARE NOTICE.docx


HWC_Florida_School_8.5x11.pdf

Appendix 5.6: School District Mental Health Plan


desoto-2024-25-mha.pdf


012522 - (eBar #23494) SCMHNA Ta

Appendix 5.7: DCF/DJJ Crossover Youth Collaboration Protocol

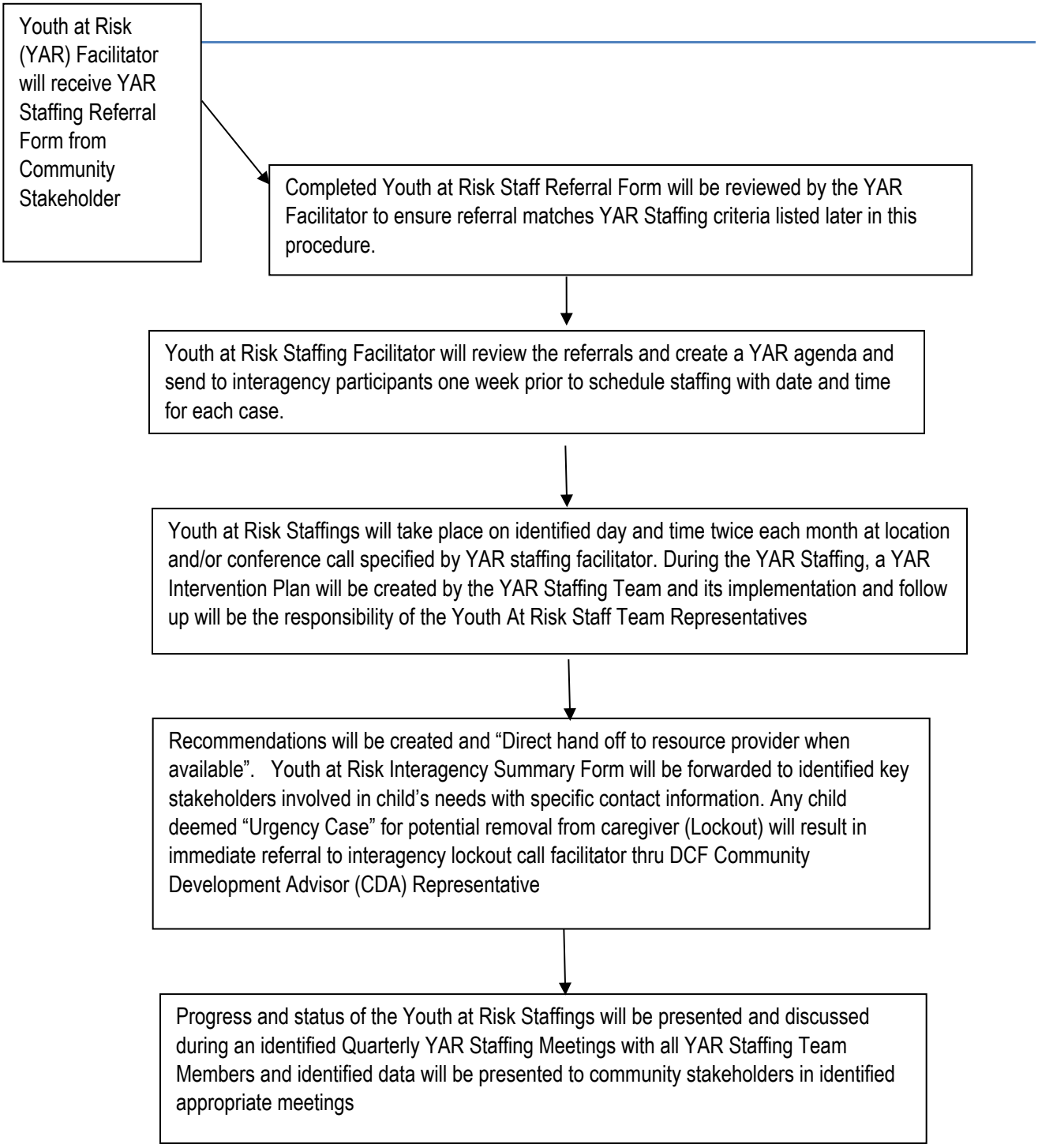

Circuit12 DCF_DJJ Crossover Youth Col

Appendix 5:8 Statewide Medicaid Managed Care Contact Info


SMMC_Brochure_CY19.pdf

Appendix 5.9: Youth at Risk Staffing Model (*Developed by CFBHN)*

Below is a flow chart of the Youth at Risk staffing Process



Summary of Youth at Risk (YAR) Staffings Model Process:

Purpose: To assist in diversion of high-risk youth entering deeper end services aeb residential, DJJ involvement, crisis centers, child welfare etc. and to assist in improving youth at risk system of care with involvement with available community resources.

Description: The identified Circuit or County will host a bi-monthly interagency staffing called the *Youth at Risk Staffing* facilitated by an identified staffing facilitator and a Youth At Risk Staffing Team and other identified key community stakeholders. During the YAR Staffings, an intervention plan will be created by the YAR Staffing Team for implementation. In addition, each participating community stakeholder will assist in identifying other community resource leaders who can assist in creating an individual and need specific resource plan to assist in diversion of these identified youth entering deeper end systems.

Procedures:

- *Youth at Risk Staffings* would be held twice a month on an identified day and time each month thru the Youth at Risk Staffing Facilitator.
- Youth at Risk Staffing Facilitator will receive YAR Staffing Referral Form from identified community stakeholders regarding youth who meet specific criteria to be staffed during the YAR Staffings (this criteria will be listed later in the procedures).
- Once received, the completed Youth at Risk Staff Referral Form will be reviewed by the Youth at Risk Staffing Facilitator to ensure the referral matches the YAR Staffing criteria.
- Youth at Risk Staffing Facilitator will review the referral forms and create a YAR agenda and send to interagency participants one week prior to schedule staffing with date and time for each case. During the YAR Staffing, a YAR Intervention Plan will be created by the YAR Staffing Team and its implementation and follow up will be the responsibility of the Youth at Risk Staffing Team Identified Representatives
- Recommendations will be created and "Direct hand off to resource provider when available". After completion of the YAR Staffings, the Youth at Risk Interagency Summary Form will be forwarded to identified key stakeholders involved in child's needs with specific contact information. Any child deemed "Urgency Case" for potential removal from caregiver (Lockout) will result in referral to interagency lockout call facilitator thru DCF Community Development Advisor (CDA) Representative.

Participants of this *Youth at Risk Interagency Staffing* should include County School System Representatives including SEDNET, Managing Entity Representative, AHCA and/or MMA Plan Representative, CAT Team Representative, DJJ and Court Representative (Court Psychologist, Diversion Team Representative, Etc.) if court involved, Guardian, Child if applicable, Targeted Case Manager if applicable, NAMI Representative or Peer Specialist, APD if applicable, Child Welfare Agency of that circuit, Adoption Support Specialist if applicable and any other stakeholder identified.

Each child presented on staffing would have approximately 15 minute slot for this interagency intervention. The purpose of this Youth At Risk Staffing would be to assist in provision of identified community resources utilizing a “direct hand off approach” and to prevent entrance into child welfare or other deeper end systems of care. If a child is considered an "urgent case" if child is in jeopardy of lockout (Guardian refusing to allow back into the living home environment) the case should be referred to the DCF Community Development Advisor (CDA) in the county for initiation of a critical case staffing\lockout call prior to referral to the YAR Staffings.

Criteria to be referred to the YAR Staffing

- ✓ One or more of the following issues must be met to be referred to YAR Staffing:
    - *A child completed a SIPP (State Inpatient Psychiatric Program) level of care or other similar residential level of care within last 6 months and guardian and/or other community stakeholders are recommending residential level of care again.*
    - *A child has been Baker Acted at least 2 times in a 30-day period.*
    - *Parents/Guardians are looking to place their child in a residential facility.*
    - *Two or more attempts to intervene with a parent who is refusing to take their child back home which could lead to a lockout out*
    - *Child is being charged with a domestic battery (21 days in DJJ) and is returning into the school system.*
    - *Child is exhibiting sexual offender or sexual reactive issues.*
    - *Chronic unsafe behavior i.e. arson, violence towards others that cause concern for safety towards self or others*
    - *A child who is a frequent runner causing concern for safety of self.*
    - *A child who is exhibiting severe mental health or other concerning symptoms creating child to identified as a “risk” in the school system*

Start Up Needs

1. Identification of Youth At Risk Staffing Team Facilitator
2. Identification of YAR Staffing Team
3. Finalization of Youth at Risk Staffing Criteria
4. Development of Youth At Risk Staffing Form
5. Identification of YAR notification process (who has the forms, where do they get sent, how does information get back to the YAR Team of when staffing will occur)
6. Creation of Outreach Strategies for community engagement in process
7. Identification of YAR Start Date

Other possible areas to develop as supportive services for YAR Referred Clients

1. *Development of a Youth At Risk Parent Support Group*
2. *Development of utilization of Parent Peer Support*

3. *Identification of communication outreach strategies to schools and other community areas involved for utilization of the YAR and alert system strategies*
4. *Utilization of additional Incidental Dollars to provide engagement targeted strategies (example=use incidental dollars to pay for mentor needs, token award system for students with cognitive deficits etc..)-what will lead the student to engage in healthy behaviors?*
5. *Identification of utilization of Youth at Risk screening tools (ACE, Trauma tools, substance use, physical health)*
6. *Utilization of Telehealth when possible for students more immediate access to mental health screenings*
7. *Development of a Youth At Risk Community Resource Guide*

Appendix 5.10: Medicaid's Role in Children's Staffings

Medicaid's Role in Child Staffings_upd

Appendix 5.11: Child Staffing Process Framework

Child Staffing Process Framework_

Appendix 5.12: Medicaid Child Staffing Process

Florida Medicaid Child Staffing Proce

Appendix 5.13: Medicaid Notification of Staffing Form

Florida Medicaid Notice of Staffing Fo

Appendix 5.14: 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 5.15: Family First Prevention Services Act and Florida Family First Prevention Plan information

FFPSA_one page overview.pdf

FL FFP Plan 2021-2026 (002).pdf

Appendix 5.16: Child Removal Matrix

Child Removal Matrix.pdf

Appendix 6.1: Guidance Document 35, Recovery Management Practices

Guidance 35 Recovery Mgmt FY23.

Appendix 6.2: YMS 2425 Goals and Plans

YMS 24-25 Goals and Plans.pdf