BBHC Provider Contract Handbook

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I. Introduction

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

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II. Service Provision Detail (Attachment I)

A. SERVICES TO BE PROVIDED

1. Definition of Terms

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

2. General Description

a. General Statement

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

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

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

b. Scope of Services

The following scope of service applies to the Contract:

(1) The Provider is responsible for the administration and provision of services to the target population(s) indicated in Exhibit A-1, entitled “Target Populations Exhibit” and in accordance with the tasks outlined in this Contract. Services shall be delivered at the locations specified in and in accordance with the Provider’s ME-approved Application for Pre-Qualification and Program Description which are incorporated herein by reference.

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

c. Major Program Goals

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

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

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

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

d. Minimum Programmatic Requirements

The Provider shall maintain the following minimum programmatic requirements:

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

(a) Be driven by the needs and choices of the clients;

(b) Promote family and personal self-determination and choice;

(c) Be ethically, socially, and culturally/linguistically responsive and responsible; and

(d) Be dedicated to excellence and quality results.

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

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

(a) Include the client and families as full partners in the planning and delivery of services;

(b) Incorporate a broad array of service and support (e.g. physical, emotional, clinical, social, educational, and spiritual);

(c) Meet the client's individualized needs and strengths;

(d) Be provided in the least restrictive clinically appropriate setting;

(e) Be coordinated at the system and service delivery level to ensure multiple services are seamlessly provided;

(f) Be sensitive to cultural and linguistic needs of clients; and

(g) Be gender responsive, e.g., treatment services designed to meet the needs of women.

3. Clients to be Served

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Determination of Individuals Served

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

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

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

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

final and binding on all parties.

B. MANNER OF SERVICE PROVISION

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

a. Task List

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

(2) The Provider shall serve the number of persons indicated in Exhibit D, entitled "Substance Abuse & Mental Health Required Performance Outcomes & Outputs" within the activities specified in "Funding by Program and Activity**,** Exhibit G.

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

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

(a) Data Elements:

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

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

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

(5) For licensable services, the Provider shall maintain correct and current Florida Agency for Health Care Administration ("AHCA") licenses and only bill for services under those licenses. In the event any of the Provider's licenses are suspended, revoked, expired or terminated, the Provider shall provide immediate written notification to the ME's Contract Manager listed in Section 6 of this Contract. Payment shall be suspended for services delivered by the Provider under such license(s) until said license(s) are reinstated.

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

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

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

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

(10) **Recovery Oriented System of Care (ROSC):** The Provider shall participate in this initiative through the BBHC Clinical/Quality Improvement Committee which will include the integration of Mental Health and Substance Abuse services.

(11) **Cultural and Linguistic Competence:** The Provider shall adhere to its Cultural and Linguistic Plan submitted in its Application for Pre-Qualification and Program Description and approved by the ME. As required in the BBHC Procedures Manual, the Provider will maintain strategies to increase cultural competence among board members; staff; and family members, when appropriate and ensure client access that address cultural and linguistic needs and preferences, including but not limited to sign language, Spanish, Creole, translation, and interpretive services.

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

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

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

(15) **Access to Care:** The Provider shall ensure individuals needing treatment services will receive services, depending on the severity of individual need, consistent with industry standards for distance and travel time, and as specified in the ME Utilization Management ("UM") protocol BBHCOP 13-14 available in the ME's Operating Manual on the ME website at www.bbhcflorida.org, which is incorporated herein by reference. Non-compliance with timely access to care for services terms will result in a corrective action and may result in a financial penalty as specified in the Paragraph entitled "Financial Penalties for Failure to Take Corrective Action" of the Contract. Further, the Provider shall ensure the needs and preferences of clients and their families drive treatment planning and service delivery, and clients and their families (with consent) are involved in all aspects of treatment (pre, during and post); engage service clients, family members, and advocates in the design, development, and evaluation of services; provide clients with a choice of provider and services, whenever possible; and continuously assess and improve consumer satisfaction.

(16) **Clients with special needs:** The Provider shall assess the client

to identify whether specialty services apply including: employability skills training; victimization and trauma; infant mental health; elderly; family; recovery; blind, deaf, or hard of hearing; developmentally disabled; and criminally-involved/forensic. When specialty services are identified as a need and not delivered by the Provider, the Provider shall link the client to an appropriate service agency and engage the service agency in treatment planning and service delivery, as appropriate. As applicable, the Provider shall provide early diagnosis and treatment intervention to enhance recovery and prevent hospitalization and partner with the ME and other stakeholders to reduce the admissions and the length of stay for dependent children and adults with mental illness in residential treatment services. The Provider shall comply with the provisions of the ME's Procedures Manual related to "Assisted Living Facilities with a Limited Mental Health License," if services to such residents are offered and available for review on the ME website at www.bbhcflorida.org and is incorporated herein by reference.

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

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

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

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

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

(20) **Client Satisfaction Survey:** Pursuant to DCF Pamphlet 155-2 ("PAM 155-2"), Chapter 13, page 13-6, section V., the Provider shall conduct and submit quarterly Consumer Satisfaction Surveys of clients served. The ME will advise the Provider in writing by July 31st each contract year of the total number of Consumer Satisfaction Surveys that will be required to be submitted quarterly by the Provider for that contract year. Failure to provide the required number of surveys or ME-approved Survey, Exhibit Q, entitled "Consumer Satisfaction Survey" may result in a corrective action and an imposed financial penalty.

(21) **Utilization Management:** The Provider agrees to participate in all

of the requirements of the ME Utilization Management Program as detailed in BBHC Procedures Manual available at www.bbhcflorida.org, and incorporated herein by reference.

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

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

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

(23) Complaints and Grievances: The Provider shall adhere to its ME-approved Complaints and Grievances Policy and Procedures whereby clients may submit complaints and/or grieve concerns about contracted services delivered by the Provider through a progressive response within the Provider's organization that results in timely resolution and ultimately appeal to the ME for a final determination. The Provider shall ensure all written materials include the telephone number for the ME (1-877-698-7794) to which consumers, family members, employees, and the public may report grievances and clients and staff receive annual training topic evidenced through documentation of successful completion of training in the employee's Personnel File. Clients and client family members shall also be advised of the Provider Policy at intake for services.

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

(25) The Provider shall provide an annual update to the 2-1-1 Broward Information and Referral Call Center site directly, and within seven

(7) business days when program information changes. For instructions to update your agency's information, please contact 2-1-1 Broward or update online at http://www.211-broward.org. Updating provider program information is critical to ensure that a current and centralized information and referral point for services is available to the residents of Broward County. Provider must provide confirmation that 2-1-1 information has been updated annually prior contract execution.

b. Task Limits

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

2. Staffing Requirements

a. Staffing Levels

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

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

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

b. Professional Qualifications

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

standards set forth in Chapter 397, Florida Statutes. This requirement shall include all personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services.

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

3. Service Location and Equipment

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

b. Equipment
The Provider shall furnish all appropriate equipment necessary for the effective delivery of the services purchased. In the event the Provider is authorized to purchase any non-expendable property with funds under this Contract, the Provider will ensure compliance with PR006, Property Management, which can be located at www.bbhcflorida.org, and is incorporated herein by reference; DCF Operating procedures as outlined in CFOP 40-5, CFOP 80-2, and Rule 65E-14, F.A.C., as applicable, which are incorporated herein by reference and may be obtained from the ME.

4. Deliverables

a. Services
The Provider shall deliver the services specified in and described in the approved documents submitted in the Provider's Application for Pre-Qualification and Program Description submitted by the Provider and as set forth in "Funding by Program and Activity, Exhibit G.

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

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

(2) In addition to the modifiers to procedure codes currently required to be utilized as per DCF PAM 155-2, Appendix 2, the Provider is directed to utilize the following modifiers required for services funded by the following sources, where applicable:

Modifier 3 Code	Description
26	Clients involved in Child Welfare
49	Family Intensive Treatment (FIT) (Current Provider: Henderson)
50	Florida Assertive Community Treatment Teams (FACT) (Current Provider: Henderson)
97	Transition to Independence Program (TIP)
98	Family Engagement Program (FEP) (Current Provider: Henderson)
99	First Episode Team (Current Provider: Henderson)
V1	Power of Peers
V3	Undocumented Clients
V4	Supportive Housing Program (Current Provider: Henderson)
VE	Voucher - Employment
VT	Voucher - Transportation
VH	Voucher - Housing
VO	Voucher - Other
BK	Opioid Crisis Grant - STR

Modifier 4 Code	Description
DV	Care Coordination – Substance Abuse
DO	Care Coordination – Mental Health
CO	First Episode Team
B7	Florida Assertive Community Treatment Teams (FACT) Expenses (Current Provider: Henderson)
CB	Partners for Prevention
BH	Purchase of Residential Treatment Services for Emotionally Disturbed Children and Youth
BO	HIV Services – Adult Substance Abuse
BX	HIV Services – Children Substance Abuse
DM	ME Transition Vouchers Mental Health (MHTRV)
DS	ME Transition Vouchers Substance Abuse (MSTRV)
DX	Forensic Multidisciplinary Team (MHAFH) (Current Provider: Henderson)
EC	Central Receiving System
EK	Opioid Crisis Grant - STR

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

(4) Data shall be submitted electronically to the ME by the 7th of each month following the month of service into the DCF designated prevention database or other data reporting system designated by the ME (the "Portal"). As per the Subcontractor Financial

Responsibility Policy #BBHC.0045, Providers are responsible for the quality of their data; therefore, errors in authorizations/certifications and penalties due to exceptions or data errors will result in payment adjustments, regardless if the Provider has banked/excess units. The Provider shall also:

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

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

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

i. Alternative Method: As per PAM 155-2, an enrollment record is required for a client specific service records be accepted in the system, when funded by DCF. Since this requirement may disrupt the daily submission, the Provider Portal has a new funding source code named 'Z- Temp Crisis Svcs'. Using this code, client-specific service events does not require an enrollment record. However, providers will need to reconcile and update these records with the appropriate funding source code with the monthly submission of data. At this point, the Provider's Portal will enforce the enrollment requirement, if the selected code is a DCF-funded

type. As per the title of this section, this is an Alternative Method of data submission, Providers may prefer not to use this option and send enrollments records with the client specific services during the daily submission (recommended option).

ii. Non-DCF/ME funded services: Most Providers have been already uploading both DCF/SAMH funded acute services and Non-DCF/Other Funders acute services using Client Specific Services Form/File (recommended). Non-DCF/Other Funders acute services information is used to show aggregated numbers only and will not be shown in the system screen reports nor be sent to DCF. For Non-DCF/ME funded services only, Providers have the option to report the aggregate number of beds utilized on a specific date and funding source using the Non-Client Specific Service Event Form/File. Since these types of services are measured in days, the fields units and participants must match. In the case that these two fields do not match, CBH will consider that the 'units' field contains the valid number of occupied beds to be reported to DCF and to be used in the generation of reports. Note that ME has only approved reporting using the Non-Client Specific Form/File when the complete episode of care of the client is paid by 3rd party Funders. If a client has at least one service in the episode of care funded by the ME/DCF; the complete services dataset must be reported using the Client-Specific Form/File.

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

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

(f) Resubmit corrected records no later than the next monthly submission deadline. The failure to submit any data set or the Provider's total monthly submission per data set, which results in a rejection rate of 5% or higher of the number of

monthly records submitted will require the Provider to submit a corrective action plan describing how and when the missing data will be submitted or how and when the rejected records will be corrected and resubmitted; and

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

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

(5) A facility designated as a public receiving or treatment facility under this Contract shall report the following Payor Class data to the ME, unless such data are currently being submitted into the Portal. Public receiving or treatment facilities that do not submit data into the Portal, or other data reporting system designated by the ME, shall report these data annually as specified in the Required Reports, Exhibit C, even if such data are currently being submitted to AHCA:

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

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

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

(8) The Provider must subtract all units which are billable to other sources, including Social Security, Medicare payments, managed care, and funds eligible for local matching which include patient

fees from first, second, and third-party payers, from each monthly request for payment. Should an overpayment be detected upon reconciliation of payments, the Provider shall immediately refund any overpayment to the ME.

5. Performance Specifications

a. Performance Measures

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

b. Performance Evaluation Methodology

The Provider shall collect information and submit performance data and individual client outcomes, to the ME data system in compliance with PAM 155-2 requirements. The specific methodologies for each performance measure may be found at the following website: http://www.dcf.state.fl.us/performance/dashboard/. The Provider shall maintain the capability to engage in organized performance improvement activities, and to be able to participate in partnership with the ME in performance improvement projects related to system wide transformation and improvement of services for individuals and families. If the Provider fails to meet the Contract standards, the ME, at its exclusive option, may allow a reasonable period for the Provider to correct performance deficiencies. If performance deficiencies are not resolved to the satisfaction of the ME within the prescribed time the ME will terminate the Contract. Performance data information may be posted on DCF's web-based performance Dashboard located at: http://www.dcf.state.fl.us/performance/dashboard/

6. Provider Responsibilities

a. Provider Unique Activities

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

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

(3) If the Provider receives federal block grant funds from the Substance Abuse Prevention and Treatment or Community Mental Health Block Grants the Provider agrees to comply with Subparts I and II of Part B of Title XIX of the Public Health Service Act, 42 U.S.C. §300x-21, et seq. (as approved September 22, 2000) and the Health and Human Services (HHS) Block Grant regulations (45 CFR Part 96).

(4) If the Provider receives funding from the Substance Abuse Prevention and Treatment Block Grant ("SAPT") it shall maintain compliance with all of the requirements of the Substance Abuse and Mental Health Services Administration ("SAMHSA") Charitable Choice provisions and the implementing regulations of 42 CFR §54a.

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

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

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

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

(9) The Provider shall make available to the ME all evaluations, assessments, surveys, monitoring or other reports and any

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

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

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

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

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

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

b. Coordination with other Providers/Entities

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

2. Plan for Care Coordination

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

(ii) When indicated by the ME, the Provider will ensure substance abuse and/or mental health services are available to clients served by the Broward Sheriff's Office's ("BSO") Protective Investigators to support the principle of keeping children in the home whenever possible. As specified in the BBHC Procedures Manual regarding the "Behavioral Health and Child Welfare Integrated Recovery Initiative," located on the BBHC website at www.bbhcflorida.org, priority for behavioral health services shall be given to families with children determined to be "unsafe" by the BSO's child protective investigators. Such priority is limited to individuals who are not eligible for managed care, or who require services not included as reimbursable by managed care, as defined in Clients to Be Served, Exhibit A.

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

c. **Minimum Service Requirements:** See "Minimum Service Requirements" Exhibit F.

7. Managing Entity Responsibilities

a. Managing Entity Obligations

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

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

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

b. Monitoring Requirements

(1) The ME will monitor the Provider in accordance with this Contract and ME's monitoring Policy and related procedures entitled "CBH PR004 Contract Accountability Reviews (Onsite) & CBH PR005 Contract Accountability Reviews (Desk Review)", which can be located at www.bbhcflorida.org and is incorporated herein by reference. The Provider shall comply with any coordination or documentation required by the ME to successfully evaluate the programs, and shall provide complete access to all records, including budget and financial information, related to services provided under this Contract, regardless of the source of funds.

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

c. Training and Technical Assistance

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

(2) The ME will provide technical assistance and support to the Provider for the maintenance and reporting of data on the performance standards that are specified in Substance Abuse & Mental Health Required Performance Outcomes & Outputs, Exhibit D.

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

d. Review Compliance with Utilization Management Criteria

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

www.bbhcflorida.org and is incorporated herein by reference.

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

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

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

C. Compensation:

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

Exhibit B, entitled "Method of Payment"
Exhibit E, entitled "Invoice", which is located on the BBHC website located at www.bbhcflorida.org
Exhibit G, entitled "Funding by Program and Activity"
Exhibit H, entitled "Funding Detail"
Exhibit H-1, entitled "Local Match Plan"

D. Special Provisions

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

2. Incident Reports

a. The Provider shall submit incident reports that meet eligibility criteria to the ME and enter into the Incident Reporting and Analysis System ("IRAS") pursuant to the ME's Incident Reporting Policy and Procedure entitled, "QI001, Critical Incident Reporting" which is located at www.bbhcflorida.org and is incorporated herein by reference. The Provider and any subcontractor must comply with and inform its employees of the mandatory reporting requirements. The Provider is advised certain incidents may warrant additional follow-up by the ME which may include on-site investigations or requests for additional information or documentation. When additional information or documentation is requested, the Provider shall submit the information requested by the ME as required above. It is the responsibility of the Provider to maintain an Incident Reporting Logbook listing all incidents reported by the Provider, with the following information: client's initials, incident report tracking number from IRAS (if applicable),

incident report category, date and time of incident, and follow-up action taken.

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

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

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

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

http://www.dcf.state.fl.us/programs/samh/publications/FL-SAMH-PlanFY17-19.pdf.

Providers shall comply with the BBHC Procedures Manual regarding "Children's Mental Health Services", which is available at www.bbhcflorida.org.

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

(a) The Provider agrees to comply with the data submission requirements outlined in DCF PAM 155-2 and with the funding restrictions outlined in "SAMH OCA's And Funding Restrictions" which can be found at: http://www.dcf.state.fl.us/programs/samh/publications/155-2-v12/appendices/A5DataCodeTables-v12.pdf and which are incorporated herein by reference.

(b) The Provider is required to utilize the modifiers to procedure codes required for Block Grant funds as per DCF PAM 155-2, Appendix 2,: http://www.dcf.state.fl.us/programs/samh/publications/155-2-v12/appendices/A2ModifiersandDefinitions-v12.pdf.

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

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

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

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

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

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

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

11. **Medicaid Enrollment**

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

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

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

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

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

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

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

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

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

which the repayment period extends beyond the next scheduled pay period.

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

18. Property and Title to Vehicles

a. Property

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

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

accordance with DCF operating procedure CFOP 80-2.

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

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

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

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

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

(8) If the Provider replaces or disposes of property purchased by the Provider pursuant to this Contract, the Provider is required to provide accurate and complete information pertaining to replacement or disposition of the property as required on the Provider's annual inventory.

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

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

b. Title to Vehicles

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

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

19. **Certificates of Insurance:** Certificates of Insurance must comply with the requirements found in the Prime Contract including but not limited to, JH343: A-4.2.3, A-4.2.7, A-4.2.8, A-4.2.9, and A-4.2.10.

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E. List of Exhibits

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

Exhibit Title	Exhibit Number	Applicable Services	Location
Clients to be Served	A	All	Handbook
Target Populations	A-1	All	Contract
Method of Payment	B	All	Handbook
Required Reports	C	All	Handbook
Substance Abuse and Mental Health Required Performance Outcomes and Outputs	D	All	Contract
Request for Reimbursement (Invoice)	E	All	BBHC Website
Minimum Service Requirements	F	All	Handbook
Funding by Program and Activity	G	All	Contract
Purchased Beds	G-1	Residential; Room & Board; SRT; CSU; Detox	Contract
Funding Detail	H	All	Contract
Local Match Plan	H-1	All	Contract
Outreach/Prevention Activities Service Log	I	Outreach and Prevention Services	BBHC Website
National Voter Registration Monthly Report	J	Direct Service Providers	BBHC Website
~~SAMH Pre-Authorization Utilization Management Roster~~	~~K~~	~~Adult/Children's Residential (1 and 2); SRT; CSU; Detox~~	~~BBHC Website~~
TANF Program Participant Log	L	TANF-Funded	BBHC Website
Assessors Quarterly Roster (Form CR004-01)	M	Assessments	BBHC Website
Targeted Case Management Quarterly Roster	N	Case Management	BBHC Website
Incidental Fund Invoice and Expenditure Log	O	Providers with Incidental Funding	BBHC Website
Performance Measures - Continuous Quality Improvement Programs	P		Handbook
Consumer Satisfaction Survey	Q	Direct Service Providers	BBHC Website

III. Monitoring and Audits (Attachment II)

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

A. PART I: FEDERAL REQUIREMENTS

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

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

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

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

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

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

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

Single Audit Information for Recipients of Recovery Act Funds:

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

(b) For recipients covered by the Single Audit Act Amendments of 1996 and OMB Circular A–133, ''Audits of States, Local Governments, and Non-Profit Organizations,'' recipients agree to separately identify the expenditures for Federal awards under the Recovery Act on the Schedule of Expenditures of Federal Awards ("SEFA") and the Data Collection Form (SF–SAC) required by OMB Circular A–133. OMB Circular A–133 is available at https://www.whitehouse.gov/omb/circulars/a133_compliance_supplement_2014. This shall be accomplished by identifying expenditures for Federal awards made under the Recovery Act separately on the SEFA, and as separate rows under Item 9 of Part III on the SF–SAC by CFDA number, and inclusion of the prefix ''ARRA-'' in identifying the name of the Federal program on the SEFA and as the first characters in Item 9d of Part III on the SF–SAC.

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

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

B. PART II: STATE REQUIREMENTS

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

In the event the recipient expends $500,000 or more in state financial assistance during its fiscal year, the recipient must have a State single or project-specific audit conducted in accordance with §215.97, Florida Statutes; applicable rules of the Department of Financial Services; and Chapters

10.550 (local governmental entities) or 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General. The recipient agrees to provide a copy of the single audit to the ME and its contract manager. In the event the recipient expends less than $500,000 in State financial assistance during its fiscal year, the recipient agrees to provide certification to the ME and its contract manager that a single audit was not required. In determining the state financial assistance expended during its fiscal year, the recipient shall consider all sources of state financial assistance, including state financial assistance received from the ME, other state agencies, and other non-state entities. State financial assistance does not include Federal direct or pass-through awards and resources received by a non-state entity for Federal program matching requirements.

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

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

C. PART III: REPORT SUBMISSION

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

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

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

C. Copies of reporting packages required by Part II of this Contract shall be submitted by or on behalf of the recipient directly to the following address:

Auditor General
Local Government Audits/342
Claude Pepper Building, Room 401
111 West Madison Street
Tallahassee, Florida 32399-1450

Email address: flaudgen_localgovt@aud.state.fl.us

Providers, when submitting audit report packages to the ME for audits done in accordance with

Uniform Grant Guidance 2 CFR §200 or Chapters 10.550 (local governmental entities) or 10.650 (nonprofit or for-profit organizations), Rules of the Auditor General, should include, when available, correspondence from the auditor indicating the date the audit report package was delivered to them. When such correspondence is not available, the date that the audit report package was delivered by the auditor to the Provider must be indicated in correspondence submitted to the ME in accordance with Chapter 10.558(3) or Chapter 10.657(2), Rules of the Auditor General.

D. PART IV: RECORD RETENTION

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

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IV. HIPAA (Attachment III)

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

A. Section 1. Definitions

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

1.2 Specific definitions:

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

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

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

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

B. Section 2. Obligations and Activities of Business Associate

2.1 Business Associate agrees to:

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

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

2.1.3 Acknowledge that (a) the foregoing safeguards, policies and procedures requirements shall apply to the Business Associate in the same manner that such requirements apply to the Department/Managing Entity and (b)

the Business Associate's and their Subcontractors are directly liable under the civil and criminal enforcement provisions set forth at Section 13404 of the HITECH Act and section 45 CFR §§164.500 and 164.502(E) of the Privacy Rule (42 U.S.C.1320d-5 and 1320d-6), as amended, for failure to comply with the safeguards, policies and procedures requirements and any guidance issued by the Secretary of Health and Human Services with respect to such requirements;

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

2.1.5 Notify the Managing Entity's Security Officer, Privacy Officer and the Contract Manager as soon as possible, but no later than three (3) business days following the determination of any breach or potential breach of personal and confidential departmental/Managing Entity data;

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

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

2.1.8 Provide at Business Associate's own cost notice to affected parties no later than 45 days following the determination of any potential breach of personal or confidential departmental/Managing Entity data as provided in §817.5681, Florida Statutes;

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

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

2.1 11 In accordance with 45 CFR §§164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information. Business Associate's must attain satisfactory assurance in the form of a written contract or other written agreement with their business associate's or subcontractor's that meets the applicable requirements of §164.504(e)(2) that the Business Associate or Subcontractor will appropriately safeguard the information. For prior contracts or other arrangements, the provider shall provide written certification that its implementation complies with the terms of 45 CFR §164.532(d);

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

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

entity's obligations under 45 CFR §164.526;

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

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

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

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

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

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

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

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

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

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

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

3.1.7 Follow guidance in the HIPAA Rule regarding marketing, fundraising and

research located at Sections 45 CFR § 164.501,45 CFR §164.506 and 45 CFR §164.514.

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

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

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

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

E. Section 5. Termination

5.1 Termination for Cause

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

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

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

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

5.2 Obligations of Business Associate Upon Termination

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

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

5.2.1.2 Return to covered entity, or other entity as specified by the Department/Managing Entity or, if permission is granted by the Department/Managing Entity, destroy the remaining protected health information that the Business Associate still maintains in any form;

5.2.1.3 Continue to use appropriate safeguards and comply with Subpart

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

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

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

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

F. Section 6. Miscellaneous

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

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

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

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V. Cost Reimbursement for Participants of Evidence Based Practice Trainings (Attachment IV)

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

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

The rates are as follows:

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

VI. Clients to be Served (Exhibit A)

A. General Description

The Provider shall furnish services funded by this Contract to the target population(s) as it appears on, Target Populations Exhibit (Exhibit A-1).

B. Client/Participant Eligibility

(1) The Provider agrees that all persons meeting the target population descriptions found in Exhibit A-1 are eligible for services based on the availability of resources. A detailed description of each target population is contained in §394.674, Florida Statutes, and as described in the PAM 155-2, based on the availability of resources. PAM 155-2 is available on the Department's website at http://www.myflfamilies.com/service-programs/substance-abuse/pamphlet-155-2l and is incorporated herein by reference.

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

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

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

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

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

C. Client/Participant Determination

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

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

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

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

D. Contract Limits

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

(2) The Provider agrees that funds provided in this Contract will not be used to serve persons outside the target population(s) specified in Exhibit A-1. NOTE: Prevention funds allocated to underage drinking programs and activities targeting eighteen (18) to twenty (20) year old individuals may be taken from Adult Substance Abuse Prevention funds.

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

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

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VII. Method of Payment (Exhibit B)

Invoices shall be submitted in sufficient detail for the completion of a pre-audit and post-audit.

A. Payment Clauses

1. **This is a fixed price (unit cost) contract**. The unit prices are listed on the document entitled "Funding by Program and Activity" (Exhibit G), included in the Contract. The ME shall pay for contracted services according to the terms and conditions of this Contract as it appears on the Funding Detail (Exhibit H). Performance will be determined by the Provider delivering and billing for services in excess of those units of service BBHC will be required to pay. Should the Provider receive any funding from the "Uncompensated Units Reimbursement Funds", then the amount of Local Match as it appears on the Funding Detail, will automatically change, utilizing the formula prescribed the Method of Payment section of this Contract. BBHC's obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature and the Contract JH343 between BBHC and the Florida Department of Children and Families ("DCF"). Any costs or services eligible to be paid for under any other contract or from any other source are not eligible for payment under this Contract.

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

3. Pursuant to §394.76(3), Florida Statutes, the Provider agrees to provide local matching funds in the amount stated in the Funding Detail. Should the Provider receive Uncompensated Units Reimbursement funds, the amount of Local Match as it appears on the Local Match Plan Document (Exhibit H-1), will automatically change, utilizing the formula: additional match required on the uncompensated units = uncompensated Substance Abuse Services not exempt from local match requirements x 16.67% + uncompensated Mental Health Services not exempt from local match requirements x 33.33%.

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

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

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

B. Additional Release of Funds

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

C. Medicaid Billing

1. The ME is the payor of last resort. The ME and the Provider agree DCF, through its contract with the ME, is not a liable as a third party for Medicaid eligible services provided to individuals that meet the eligibility criteria for Medicaid. Authorized Provider services shall be reimbursed in the following order of precedence:
   - **a.** Any liable first, second, and/or third party payors;
   - **b.** Medicaid, pursuant to §409.910, Florida Statutes, if the individual meets the eligibility criteria for Medicaid, and the service is Medicaid eligible; and
   - **c.** DCF through the ME (only if none of the above are available or eligible for payment)

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

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

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

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

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

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

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

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

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

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

1. The Provider's attention is directed to its obligations under applicable parts of Part A or Title IV of the Social Security Act and the Provider agrees TANF funds shall be expended for TANF participants as outlined in the Temporary Assistance to Needy Families (TANF) Guidelines. TANF Guidelines can be obtained from the ME, or can be found at the following web site:

   http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/temporary-assistance-needy-families-tanf-maintenance-effort-moe-resources

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

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

F. Invoice Requirements

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

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

3. The Provider shall request monthly reimbursement for services rendered via the completion of the Invoice for Services (Exhibit E), as required in this Contract and as specified in Required Reports (Exhibit C). The invoice template is located at concordia.iossolution.com.

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

twelve (12) month period, ME may exercise its termination clause.

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

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

7. Pursuant to Rule 65E-14.021(10)(a)2., F.A.C., any costs or service units paid pursuant to another contract or another source are not eligible for payment under this Contract. The Provider must subtract all units which are billable to Medicaid, and all units for client services paid from other sources, including Social Security, Medicare payments, and funds eligible for local matching which include patient fees from first, second, and third-party payers, from each monthly invoice. Services delivered on bed-day availability, shall be reported on the “Schedule of Bed-Day Availability” at the end of the fiscal year and refund any overpayment.

G. Supporting Documentation

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

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

H. Funding Sweeps

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

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VIII. Required Reports (Exhibit C)

Required Reports	Due Date	#of Copies	Send to:
PAM155-2 Monthly Service Data	Seventh (7) calendar day of the following month for which services were rendered	NA	Portal / SAMHIS / PBPS
Invoice/Request for Reimbursement and supporting documentation	Tenth (10) calendar day of the following month for which services were provided	1	Provider Portal - Invoices
Exhibit O, Incidental Log (As applicable)	Tenth (10) calendar day of the following month for which services were provided	1	Provider Portal - Invoices
Outreach/Prevention/TANF Services Log	As Requested	1	Provider Portal - Invoices
Incident Reports	As required in QI001, Incident Reporting Policy	1	IRAS and iras.bbhc@ concordiabh.com
Financial Statements (Balance Sheet and Statement of Activity)	Quarterly on October 7; January 7; April 7; July 7	1	Contract Manager
Ad-Hoc	As Requested	As Requested	As Requested
Voter Registration Report (As applicable)	Seventh (7) calendar day of the following month for which services were rendered	1	Provider Portal
Consumer Satisfaction Survey (As Applicable)	Quarterly on September 30; December 31; March 31; June 30	1	Director Of Quality via U.S. Mail
Year-End Financial Reports for Providers Not Requiring Audits Per Attachment II			
Schedule of State Earnings	45 calendar days after the end of the Provider's fiscal year.	1	Contract Manager
Schedule of Related Party Transaction Adjustments	45 calendar days after the end of the Provider's fiscal year.	1	Contract Manager
Projected Covered service Operating and Capital Budget Actual Expenses &Revenues Schedule	45 calendar days after the end of the Provider's fiscal year.	1	Contract Manager
Schedule of Bed-Day Availability Payments	45 calendar days after the end of the Provider's fiscal year.	1	Contract Manager
Agency Prepared Financial Statements (Balance Sheet and Statement of Activity)	45 calendar days after the end of the Provider's fiscal year.	1	Contract Manager

Year-End Financial Reports for Providers Requiring Audits Per Attachment II			
Financial & Compliance Audit to include the necessary schedules per **Attachment II**	170 calendar days after the end of the Provider's fiscal year or 30 calendar days after its completion, whichever comes first. (See **Attachment II**)	1	Contract Manager
Substance Abuse Providers			
Annual Report for HIV Early Intervention Services (SAPT Block Grant Set Aside Funded Services Only)	Upon Request	1	As Requested
Annual Report for Pregnant Women and Women with Dependent Children (SAPT Block Grant Set Aside Funded Services Only)	Upon Request	1	As Requested
Narrative Block Grant Report – as requested – once a year			
Miscellaneous			
PBPS Data Entry Training Report for Prevention Program Coordinator and any data entry staff, if applicable (Prevention Service Providers)	Upon Request	1	As Requested
Prevention Services Invoices Back-Up Report printed from PBPS (Prevention Services Providers)	7th calendar day of the following month for which services were rendered	1	Portal
Coalition Activities Report (Prevention Services Providers)	Quarterly on October 7; January 7; April 7; July 7	1	Portal
Final Invoice	By July10 of each fiscal year and/or 15 days after Contract end	1	Portal
Civil Rights Compliance Questionnaire	June 30	1	Contract Manager
Tangible Property Inventory Report (As applicable)	April 15	1	Portal
TANF SAMH Program Logs and Service Data (As applicable)	Upon Request	1	Portal
ADA Client Communication Assessment Auxiliary Aid Service Record Monthly Summary Report (As applicable)	By the 5th calendar day following the reporting month	1	Portal

External Quality Assurance Reviews, Monitoring Reports, Surveys & Corrective Action Plans	As specified in the Paragraph entitled "Inspections and Corrective Action" of the Contract	1	As Requested
Payer Class Data	7th calendar day for the following month for which services were rendered	1	Portal
Adult Mental Health			
PATH Annual Reports (As applicable)	Drafts to be submitted to ME for Southern Region SAMH Program Office	1	Contract Manager
Mental Health ALF Report (As applicable)	Quarterly on October 15; January 15; April 15; and July 15	1	Portal
Forensic Services			
Post Arrest Diversion Report	10th calendar day for the following month for which services were rendered	1	Director of Operations - SOC (BBHC)
Conditional Release Report (As applicable)	7th calendar day for the following month for which services were rendered	**1**	BBHC Forensic Services Coordinator Provider
Waitlist			
Wait List (As applicable)	As prescribed by Utilization Management Protocol	1	Portal

IX. Minimum Service Requirements (Exhibit F)

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

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

A. PROGRAMMATIC AUTHORITY (FEDERAL)

1. Mental Health

42 U.S.C. 300x to 300x-9 *(Block Grant for community Mental Health Services)*
http://www4.law.cornell.edu/uscode/42/ch6AschXVIIpB.html

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

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

42 U.S.C. 300x-21 to 300x-35 and 300x-51 to 300x-66*(SA Treatment & Prevention Block Grants)*
http://www4.law.cornell.edu/uscode/html/uscode42/usc_sup_01_42_10_6_A_20_XVII_30_B_40_ii.html

42 CFR, Part 54 *(Charitable choice)*
http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr54_03.html

45 CFR 96.120 – 137 *(SA Treatment & Prevention Block Grants)*
http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr96_03.html

Restrictions on expenditures of SAPT

45 CFR 96.135
http://www.access.gpo.gov/nara/cfr/waisidx_01/45cfr96_01.html

3. Substance Abuse-Confidentiality

42 CFR, Part 2
http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr2_03.html

4. Health Insurance Portability and Accountability Act (HIPAA)

45 CFR 164
http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr164_03.html

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

20 CFR 416
http://www.access.gpo.gov/nara/cfr/waisidx_03/20cfr416_03.html

6. Endorsement and Payment of Checks Drawn on the United States Treasury

31 CFR 240 relating to SSA
http://www.access.gpo.gov/nara/cfr/waisidx_03/31cfr240_03.html

7. Temporary Assistance to Needy Families (TANF)

Part A, Title IV of the Social Security Act

45 CFR, Part 260
http://www.access.gpo.gov/nara/cfr/waisidx_03/45cfr260_03.html

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

8. Positive Alternatives to Homelessness (PATH)

Public Health Services Act, Title V, Part C, Section 521, as amended
42 U.S.C. 290cc-21 et. seq.
http://www.law.cornell.edu/uscode/html/uscode42/usc_sup_01_42_10_6A_20_III-A_30_C.html

Stewart B. McKinney Homeless Assistance Amendments Act of 1990, Public Law 101-645
https://www.congress.gov/bill/101st-congress/house-bill/3789

42 CFR, Part 54
http://www.access.gpo.gov/nara/cfr/waisidx_03/42cfr54_03.html

9. Americans with Disabilities Act of 1990

42 U.S.C. 12101 et seq.
https://www.eeoc.gov/laws/statutes/ada.cfm

B. FLORIDA STATUTES

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

1. Child Welfare and Community Based Care

Chapter 39, F.S.	Proceedings Relating to Children
Chapter 119, F.S.	Public Records
Chapter 402, F.S.	Health and Human Services; Miscellaneous Provisions
Chapter 435, F.S.	Employment Screening
Chapter 490, F.S.	Psychological Services
Chapter 491, F.S.	Clinical, Counseling and Psychotherapy services
Chapter 1002, F.S.	Student and Parental Rights and Educational Choices
Section 402.3057, F.S.	Persons not required to be re-fingerprinted or rescreened
Section 414.295, F.S.	Temporary Cash Assistance; Public Records Exemptions

2. Substance Abuse and Mental Health Services

Chapter 381, F.S.	Public Health General Provisions
Chapter 386, F.S.	Particular Conditions Affecting Public Health
Chapter 395, F.S.	Hospital Licensing and Regulation

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

3. Developmental Disabilities

Chapter 393, F.S.	Developmental Disabilities

4. Adult Protective Services

Chapter 415, F.S.	Adult Protective Services

5. Forensics

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

6. Florida Assertive Community Treatment (FACT)

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

7. State Administrative Procedures and Services

Chapter 120, F.S.	Administrative Procedures Act
Chapter 287, F.S.	Procurement of Personal Property and Services
Chapter 815, F.S.	Computer - Related Crimes
Section 112.061, F.S.	Per diem and Travel Expenses*
Section 112.3185, F.S.	Additional Standards for State Agency Employees
Section 215.422, F.S.	Payments, Warrants & Invoices; Processing Times
Section 216.181(16)(b), F.S.	Advanced funds invested in interest bearing accounts

***Travel Expenses are specified in the DFS Reference Guide for State Expenditures**
http://www.myfloridacfo.com/Division/SFM/DOMSEC/documents/State_Travel_Manual_2011-01-15.pdf

C. FLORIDA ADMINISTRATIVE CODE (RULES)

1. Child Welfare and Community Based Care

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

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

2. Substance Abuse and Mental Health Services

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

3. Financial Penalties

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

4. Reduction/ Withholding of Funds

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

D. MISCELLANEOUS

1. Department of Children and Families Operating Procedures

CFOP 155-10, Services for Children with Mental Health & Any Co-occurring Substance Abuse Treatment Needs In Out of Home Care Placements
https://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20175-xx%20Family%20Safety/CFOP%20175-40,%20Services%20for%20Children%20with%20Mental%20Health%20and%20Any%20Co-Occurring%20Substance%20Abuse%20or%20Developmental%20Disability%20Treatment%20Needs%20in%20Out-of-Home%20Care%20Placements.pdf

CFOP 215-6, Incident Reporting and Client Risk Prevention
https://www.dcf.state.fl.us/admin/publications/cfops/CFOP%20215-xx%20Safety/CFOP%20215-6,%20Incident%20Reporting%20and%20Analysis%20System%20(IRAS).pdf

2. Federal Cost Principles

Uniform Grant Guidance
http://www.ecfr.gov/cgi-bin/text-idx?SID=6214841a79953f26c5c230d72d6b70a1&tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl

OMB Circular A-21, Cost Principles for Educational Institutions
http://www.whitehouse.gov/omb/circulars_a021_2004

OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments
http://www.k12.wa.us/TitleI/workshops/OMBCircularA-87CostPrinciplesforStateLocalandIndianTribalGovernments.pdf

OMB Circular A102, Grants and Cooperative Agreements with State and Local Governments
http://www.whitehouse.gov/omb/circulars_a102

OMB Circular A-122, Cost Principles for Non-profit Organizations
https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A122/a122_2004.pdf

3. Audits

Uniform Grant Guidance
http://www.ecfr.gov/cgi-bin/text-idx?SID=6214841a79953f26c5c230d72d6b70a1&tpl=/ecfrbrowse/Title02/2cfr200_main_02.tpl

OMB Circular A-133, Audits of States, Local Governments and Non-Profit Organizations
https://www.whitehouse.gov/sites/whitehouse.gov/files/omb/circulars/A133/a133.pdf

Section 215.97, F.S., Florida Single Audit Act
http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0200-0299/0215/Sections/0215.97.html

Comptrollers Memorandum #03 (1999-2000): Florida Single Audit Act Implementation
http://www.myfloridacfo.com/aadir/cm0/cm990003.htm

4. Administrative Requirements

45 CFR, Part 74 - Uniform Administration Requirements for Awards and Subawards to Institutions of Higher Education, Hospitals, other Non-Profit Organizations and Other Commercial Organizations
http://www.access.gpo.gov/nara/cfr/waisidx_06/45cfr74_06.html

45 CFR, Part 92 - Uniform Administration Requirements (State and Local Governments)\
http://www.access.gpo.gov/nara/cfr/waisidx_06/45cfr92_06.html

OMB Circular A110, Uniform Administrative Requirements for Grants and Other Agreements
https://www.whitehouse.gov/omb/circulars_a110

5. Data Collection and Reporting Requirements

Rule 65E-14.022, F.A.C.
https://www.flrules.org/gateway/ruleNo.asp?ID=65E-14.022

Section 397.321(3)(c), F.S., Data collection & dissemination system
http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0397/Sections/0397.321.html

Section 394.74(3)(e), F.S., Data Submission
http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.74.html

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

http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.77.html

CFP 155-2, Mental Health and Substance Abuse Data Measurement Handbook
http://www.dcf.state.fl.us/programs/samh/pubs_reports.shtml

X. PATH Broward

The Projects for Assistance in Transition from Homelessness (PATH) is funded by a formula grant authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990. PATH grants are distributed annually by SAMHSA to all 50 states, the District of Columbia, Puerto Rico, the Northern Mariana Islands, Guam, American Samoa, and the U.S. Virgin Islands. PATH, the first major federal legislative response to homelessness, is administered by and funded through the Center for Mental Health Services (CMHS), a division of SAMHSA, within the U.S. Department of Health and Human Services (HHS).

States and territories are referred to as PATH grantees. The Department of Children and Families SAMH Program Office is the PATH grantee for Florida, who works with the MEs to oversee the programs, Local Intended Use Plans (LIUP) and annual budgets.

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

PATH Providers:

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

1. PATH providers are expected to integrate SAMHSA's definition and principles of recovery into their programs to the greatest extent possible.
2. PATH providers are expected to integrate positive programmatic involvement of individuals with mental health issues and their family members when possible into the program design. This reconnection should be facilitated meaningfully, and span all aspects of the organization's activities as described below.
3. It is crucial for PATH providers to establish relationships with the local CoC, Housing Authorities, landlords, faith-based organizations, and other agencies/organizations providing services and supports to individuals who are experiencing homelessness.
4. PATH providers should ensure that individuals enrolled in PATH are transitioned to mainstream services, with the understanding that these services will remain available to the consumer after their transition out of homelessness. The PATH program encourages a focus on sustainable mental health services and housing. Other mainstream services of importance are services that provide health care, employment/vocational training, community connection, support, and resources for daily needs.
5. PATH providers are responsible for prioritizing PATH services to veterans and individuals experiencing chronic homelessness who meet PATH eligibility.
6. PATH outreach requires multiple contacts to build a trusting relationship and engage individuals eligible for PATH services. After becoming enrolled in PATH, continued contacts with the individual are needed to assist the individuals in meeting basic needs, medical care, benefits, housing, and mental health treatment and supports. Most of the staff work time is spent working directly with the individual. Work hours should be flexible and not necessarily 8:00 a.m. to 5:00 p.m. Staff should flex work hours to work early mornings, early evenings, and weekends because individuals who are experiencing homelessness may be more visible during these times, especially in camps or street locations.

7. PATH providers should hold team meetings frequently, even as often as weekly, to ensure good communication among team members. It is recommended that the team members work together and share caseloads so more than one staff member is familiar with the consumers and could provide SAMHSA's Homeless and Housing Resource Network PATH services. For example, it is crucial to take action as soon as individuals enrolled in PATH make the commitment to participate in mental health treatment because this opportunity may not last. If the primary staff member is not available, another staff member would need to assist the individual. Team meetings are also important for discussing challenges that staff may have during outreach or while engaging and providing services to individuals experiencing homelessness and serious mental illness.
8. PATH staff members work with the most vulnerable individuals in our communities. These are individuals who have active symptoms of mental illness and with whom it may be difficult to engage. It is crucial for staff to be supported in the work they do, to be offered opportunities for growth, and to feel satisfied with the work they are doing. Staff supervision is important to advancing these goals. Supervisors are responsible for providing the support necessary to identify instances of "burnout," identify the need for additional training to improve skills, and to assist staff with alternative methods for providing service to those individuals that may be a challenge to work with. Supervision should be scheduled as often as the individual staff member deems necessary.
9. PATH providers must ensure that PATH staff members receive the training necessary to perform the highest quality of work. It is recommended that all staff receive training in the following areas:
    a. Outreach and engagement
    b. Motivational interviewing
    c. Trauma-informed care (TIC)
    d. Cultural and linguistic competency
    e. Recovery
    f. Person-centered thinking
    g. Crisis response and suicide prevention (e.g., applied suicide intervention skills training)
    h. Housing First
    i. Critical time intervention (CTI)

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

1. Ensure the accuracy of data submitted for the PATH Annual Report.
2. Enter data into the PDX portal for final review by the ME.
3. Ensure timely submission of the PATH Annual Report to the ME.
4. Participate in monitoring at least annually to ensure the minimum program priorities indicated above are provided, PATH funds are expended appropriately, and data is collected and reported for the PATH Annual Report.
5. Participate in any local, state or national calls, trainings or learning collaboratives.

SOURCE: https://www.pathpdx.org/UserFiles/PATH%20Program%20Guide%20-%20FINAL.pdf

XI. Statewide Inpatient Psychiatric Programs (SIPP) Services

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

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

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

Compensation. For the period of the Agreement, the Network Provider agrees to accept the compensation rate of $416.99 per day; for the "ME" pre-approved service, based on bed day utilization.

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

XII. First Episode Psychosis Program

- The First Episode Psychosis Program follows the NAVIGATE Model
- The program is designed to **teach you and your family the skills** and information you need to get back on your feet and work towards having a rich, full life.
- The program **involves a number of different interventions** including medication management, resiliency training, help getting back to work or school, and a family support/education program to increase the success of your recovery.
- These **interventions have been shown to be effective** in helping people get on with their lives even after they had experienced these kinds of problems.
- You will learn strategies that will help you to **pursue your goals** and get on with your life.
- You will **learn coping strategies** that will help you better manage your illness and psychotic symptoms.
- You will be **working with a team** to help you with your goals including a doctor, clinic director, a clinician for counseling and recovery training, family counselor, and an expert on work and school issues.

The NAVIGATE Model

TREATMENT	PROVIDER	AIMS
Medication Management	Psychiatrist, Nurse	• Monitor use of medication to reduce symptom distress. • Preventing relapses in order to help achieve desired goals.
Family Education	Program Director	• Teaching families about psychosis. • Provide skills to help families move forward in recovery. • Reducing family stress through improved communication and problem solving skills.
Individual Resiliency Training	Individual Resiliency Trainer (IRT) Clinician	• Teaching about psychosis and processing the experience. • Work collaboratively to make progress towards goals and improve functioning. • Reduce self-stigmatizing beliefs. • Help them learn social and resiliency skills.
Supported Employment/Education	Employment/ Education Specialist (SEE)	• Provide support and tips to help you get back to work/school or stay in work/school • Follow along support for those employed or in school.

XIII. Family Intensive Treatment Team (FITT)

I) *Philosophy of the Program:*

The Family Intensive Treatment (FITT) team model is designed to provide intensive team-based, family-focused, comprehensive services to families in the child welfare system with parental substance abuse.

II) *Program Description:*

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

III) *Admission Criteria:*

1. Have a substance use disorder;
2. Have at least one child between the ages of zero (0) and eight (8) years old;
3. Have been referred by a child protective investigator (CPI), dependency case manager, or community-based care (CBC) lead agency;
4. Are either under judicial supervision in dependency court (both in-home and out-of-home), but for out-of-home cases, only those parents with goal of reunification, or have been assessed as unsafe; and
5. Are willing to participate in the FITT Program, may be court ordered.

IV) *Program Goals:*

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

V) *Measurable Program Objectives:*

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

2. Within 48 hours of a family's referral to services, the Network Service Provider shall commence initial assessments to guide the development of a treatment plan. The

Network Service Provider shall ensure that the initial assessment process includes participation by the parent(s).

3. Complete behavioral health and parenting assessments within five (5) days of referral.

4. Assessments should include minimally the following elements:
   a. Parental substance use disorder assessment, such as the Global Appraisal of Individual Need – Individual (GAIN-I), or any other assessment tool designated by BBHC;
   b. Mental health assessment, if required;
   c. Parenting capacity;
   d. Family functioning.

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

6. Provide immediate access to substance use disorder treatment within 48 hours of the assessment being completed, if necessary.

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

8. On a monthly basis, provide a list of the families being served to the relevant community-based care lead agency.

VI) Discharge Criteria:

Persons may be discharged after they complete treatment goals or are provided with a "warm hand off" to an appropriate service provider. It is anticipated that at discharge 90% percent of parents served will be living in a stable housing environment and that 80% percent of parents served will have improved their level of functioning as measured by the Functional Assessment of Mental Health and Addiction (FAMHA)

FIT team providers shall engage all families, who have successfully completed their treatment goals, in aftercare services in an effort to foster continued positive outcomes and protective factors. Aftercare services may consist of, but are not limited to: support groups;

peer support services; home visits; telephone calls; and case management services. Incidental funds may also be used to assist families with aftercare expenses. Aftercare services may be provided for up to 6 months.

VII) Mechanisms to address the Needs of Special Populations:

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

VIII) Staffing Structure and Resources:

a. **1** Program Manager
b. **2** Behavioral Health Clinicians
c. **2** Specialized Care Coordinators
d. **2** Family Support/Peer Mentors

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

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

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

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

IX) Procedures to support Interdisciplinary Team Interaction:

One Child, One Family, One Team, One Plan

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

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

X). ***Training Activities for Staff Competency:***

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

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

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

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

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

XIV. Forensic Multidisciplinary Team (FMT)

The Forensic Multidisciplinary Team (FMT) is a service-delivery model for providing comprehensive community-based treatment to persons with severe and persistent mental illnesses and legal issues, considered to be in Chapter 916 known as ITP (Incompetent to Proceed) or NGI (Non Guilty for Insanity). The FMT team is the central point for delivering services required by each client to live successfully in the community by optimizing their independence. Delivering the needed level of support in an assertive manner, appropriate service planning and coordination, advocacy, flexibility, attention to medications and response during times of crisis are the hallmarks of this approach.

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

The Program admission criteria include:

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

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XV. Medication Assisted Treatment (MAT) Program

The Medication Assisted Treatment (MAT) Program includes a comprehensive care model to treat persons with opioid use disorders that features phased treatment: 1) an induction phase; 2) an intensive outpatient stabilization with integrated primary care services; 3) a maintenance phase with ongoing peer support, medication management and a compendium of supportive services and a detoxification. Peer support services are utilized throughout all phases of the program.

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

MAT programs utilize the following evidence-based models: 1) Emergency Initiation of MAT and Integrated Prenatal Care following the SAMSHA guidelines; 2) Medicaid Home Health Model for the Treatment of Opioid Use Disorders; and 3) Detoxification – Office-Based Opioid Treatment.

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

MAT services include:

- Aftercare
- Case Management
- Crisis Support/Emergency
- Day Treatment
- Incidental Expenses (excluding housing/rental assistance and direct payments to participants)
- In-Home and On-Site
- Medical Services
- Medication-Assisted Treatment (methadone maintenance, buprenorphine maintenance or oral naltrexone)
- Outpatient
- Outpatient Detoxification
- Outreach (to identify and link individuals with opioid use disorders to medication-assisted treatment providers)
- Recovery Support
- Supported Employment
- Supportive Housing/Living

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

MAT Programs will provide an integrated, phased program to promote long-term stability and recovery. Throughout each phase of treatment, medication assisted treatment services will be delivered in conjunction with psychopharmacology/medication management services, psychotherapy/counseling services, primary care services and peer recovery support services. The phases of treatment are induction, stabilization and maintenance. Consumers also have the option of detoxification. The phases of treatment include specific services as follows:

I. Induction Phase (One week induction period, includes Assessment and Medical Services):
   - Psychiatric evaluation
   - Physical
   - Biopsychosocial/ Initial treatment plan
   - Labs
   - Medication Reconciliation
   - Daily Clinic Visit
     - Medication Administration/Observation
     - Medication Management
     - Medication Education
     - Evidence Based Assessment
   - Individual Recovery Support

II. Stabilization or Detoxification Phase/ Intensive Outpatient (4-6 weeks)
   - Group Therapy
   - Psychiatric evaluation
   - Psychiatric follow up/medication management
   - Medication Assisted Treatment
   - Medications
   - Individual therapy
   - Labs (urine toxicology)
   - Recovery support (group and individual)
   - Primary Care Services

III. Maintenance Phase (6 - 8 months)
   - Medication Assisted Treatment
   - Intervention Services (individual therapy)
   - Aftercare groups & Individual Recovery Support
   - Labs (urine toxicology)
   - Medications
   - Vivitrol administration and management
   - Primary Care Services

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

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XVI. Adult Post-Arrest Diversion Program

Graduation and Discharge Criteria for Post-Arrest Diversion Program

Graduation from Intensive Phase:
The length of the *Intensive Phase* of the Post-Arrest Diversion program will be 6 months to a year depending on the individual's progress. The criteria for successful graduation from the Post-Arrest Diversion Program include:

1. A minimum of 6 months without re-arrest.
2. Completion of the Moral Reconation Therapy Program and behavioral demonstration of internalization of the MRT concepts.
3. Compliance with all aspects of the service/treatment plan collaboratively created upon admission into the program (BRHPC, Smith Community Mental Health).
4. Stability in housing and employment.

The Diversion Team will make every effort to provide the necessary support services to facilitate successful completion of the program. However, Diversion Program services are time limited. They are available to enrolled clients for a period of up to one year at which point they will be discharged and referred to another provider for continuity of care. That being said, clients **may** be discharged from the program prior to completion for the following reasons:

1. Failure to comply with the mutually agreed upon treatment/service plan.
2. A new arrest for a felony charge.
3. Admission to a state mental health treatment facility or state or federal prison.
4. Serious medical or mental health situation than precludes participation in the program.

Post-Diversion Step-Down Phase:
Clients who have met the criteria for graduation from the Diversion Program, but have not completed one year of supervision, will participate in the Post-Diversion *Step-Down Phase*, which will include:

1. Weekly phone contact with designated Case Manager
2. Completion of at least one more MRT workbook
3. Once monthly attendance at an MRT group
4. Continuation of therapy at BRHPC as needed
5. Continuation of medication management as scheduled
6. Monthly reports to the State Attorney will continue

Monthly progress reports will continue to be sent to the State Attorney and discharge will be recommended as soon as the client is ready. Discharge readiness will be evaluated on a month-to-month basis.

Discharge
Upon successful completion of the Intensive phase of the Post-Arrest Diversion Program, a letter recommending termination of relevant legal charges will be submitted on behalf of the client. We will also include a post-discharge plan that will include recommendations for continuation of medication, therapy and community case management as needed.

XVII. Juvenile Post-Arrest Diversion (JPAD) Program

Description:
This program was designed by BBHC in collaboration with the State Attorney and Public Defender Offices to serve youth with mental illness and/or co-occurring substance abuse disorders who have been arrested with 3rd degree non-violent felonies. The goal of this program is to meet the behavioral health needs of these youth to avoid further involvement with the criminal justice system, and at the same time have their charges dropped to keep them from having this negatively impact their futures. The length of the program is one year which includes graduated phases depending on the individual's progress.

Process:
Initially the youth processed through the Juvenile Assessment Center (JAC) will be identified by the Juvenile Assessment Team (JAT) as potential candidates based on their diagnosis and charges. The JAT will complete a biopsychosocial assessment, and if additional testing is indicated, the youth would be referred to Smith Community Mental Health to be seen by a psychologist or psychiatrist. When it is determined that the youth would be appropriate for the Juvenile Post-Arrest Diversion (JPAD) Program, a referral would be made to the State Attorney's Office (SAO). If the SAO approves the youth, a TIP Coach/Case Manager would be assigned and the youth would be referred to Broward County's Office of Justice Services for enrollment in the Moral Reconation Therapy (MRT). The individual will be linked to behavioral health services, as needed, and the family will be engaged in services, as well. Evidence Based Practice therapy sessions will be provided. Monthly reports will be sent to the SAO.

Graduation:
The criteria for successful graduation from the Juvenile Post-Arrest Diversion Program include:

5. A minimum of 6 months without re-arrest.
6. Completion of the Moral Reconation Therapy Program.
7. Participation in TIP (Transition to Independence) via a Life Coach.
8. Compliance with all aspects of the service/treatment plan collaboratively created upon admission into the program.
9. Involvement of the family, as appropriate.

The Diversion Team (consisting of a Case Manager/TIP Coach, and Therapist) will make every effort to provide/link the necessary clinical and support services to facilitate successful completion of the program. However, Diversion Program services are time limited. They are available to enrolled clients for a period of up to one year at which point they will be discharged and continue to receive services as needed. Clients **may** be discharged from the program prior to completion for the following reasons:

5. Failure to comply with the mutually agreed upon treatment/service plan.
6. A new arrest for a felony charge.
7. Admission to a SIPP, detention, or state/federal prison.
8. Serious medical or mental health situation than precludes participation in the program.

Post-Diversion Aftercare:
Clients who have met the criteria for graduation from the Diversion Program, but have not completed one year of supervision, will participate in aftercare which will include:

7. Weekly phone contact with designated Case Manager/TIP Coach
8. Completion of at least one more MRT workbook
9. Once monthly attendance at an MRT group
10. Continuation of therapy, as needed
11. Continuation of medication management as scheduled

12. Monthly reports to the State Attorney will continue

Upon successful completion of the Diversion Program and the Aftercare Program or 12 months, whichever comes first, a letter indicating successful completion of the program and recommending termination of legal charges, as per agreement, will be sent to the State Attorney's Office. The SAO will either drop the charges or not file the charges.

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XVIII. SOAR Requirements

OUTREACH, ACCESS, AND RECOVERY (SOAR)
Requirement: Contract
Frequency: Monthly Reporting of SOAR data

SOAR is a national project funded by the Substance Abuse and Mental Health Service Administration (SAMHSA) that is designed to increase access to SSI/SSDI for eligible adults with mental illnesses who are homeless or at risk of homelessness. BBHC, as part of a mandated DCF Statewide Initiative, is responsible to assure that the SOAR model is implemented within our region in collaboration with key stakeholders. Access to SSI/SSDI is a major tool in recovery from mental illness and homelessness. Without these benefits, it is extraordinarily difficult for individuals we serve to engage in treatment, to keep appointments, to maintain housing, enter the workforce, and to meet other basic needs.

To this end, BBHC has assigned a SOAR Lead that is a certified SOAR trainer and is available to provide technical assistance in collaboration with DCF and the SAMHSA funded SOAR Technical Assistance Center. The ME Soar Lead also identifies other local team leads and trainers available in the area to assist as needed.

The SOAR Online training course (derived from SAMHSA's Stepping Stones to Recovery model) provides all SOAR processors an opportunity to practice what they learn in the course by completing an SSI and SSDI application packet using SOAR techniques and key components. The training focuses on the initial application and thorough documentation of the disability using a Medical Summary Report to avoid appeals, reduce the need for consultative exams, increase approval rates, and reduce times to decisions. Staff who use the SOAR model to apply for benefits are hereby referred to as "SOAR Processors".

PROVIDER REQUIREMENTS:

1. SOAR Processors: If the network service provider offers adult case management, outreach, or related direct service under a BBHC contract, the provider shall employ at least one full-time staff to be utilized as a dedicated SOAR processor whose sole duty is to process SOAR applications for SAMH clients <u>or</u> ensure that relevant direct service staff (i.e., case managers, peer specialists, etc.) are trained in SOAR and designate one employee as a point of contact for the SOAR initiative.
2. Training: All SOAR processors must take the online course. Documentation of the processor's SOAR training must be maintained in the personnel file.
   a. Staff who supervise SOAR processors must also take the online SOAR training to aid in supervision and to manage the Online Application Tracking System.
   b. The agency must ensure that the most recent training certifications or refresher training certifications are no more than two (2) years old. The SOAR dedicated processor should seek refresher courses through BBHC if this requirement is not satisfied.
3. Each dedicated SOAR processor is required to complete **at least ten (10) SSI/SSDI applications per year** or a number relative to the agency capacity (a determination of appropriate outcomes must be made between the BBHC SOAR Coordinator and the agency).
4. The dedicated SOAR processor will maintain a **minimum approval rating of at least 65%** during each calendar year.

5. The agency must report data and outcomes to the BBHC Soar Lead and SOAR Technical Assistance Center using the **Online Application Tracking (OAT) system** including:
    a. Number of SOAR-assisted SSI/SSDI applications;
    b. Decisions on applications, including appeals; and
    c. Numbers of days until applications are approved from date of application submission to date of decision.
6. The agency SOAR designee **must attend the regularly convened local SOAR Initiative meetings** to explore and identify funding and sustainability as well as develop a collaborative effort to implement the SOAR model in Broward.
7. The agency ensures that resources and tools used are from the national SOAR TA website: https://soarworks.prainc.com/

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XIX. Transition to Independence (TIP)

Organizations providing TIP services must adhere to the Provider Implementation Agreement (updated 2016) and utilize the Implementation Drivers Action Plan (both attached).

Providers must complete OCP2 Referral Forms on all clients receiving TIP who may be eligible for the evaluation. The forms must be completed and send to the Clinical Integration Coordinator within 7 days of starting TIP services. As part of TIP expansion across the system of care, CSC and Broward County funded clients will also be referred to OCP2 as applicable to provide information on quality or services and practice improvement.

Providers agree to attend relevant OCP2 committees, participate in monthly consultation sessions with BBHC staff, provide rosters on clients served as requested, and participate in TIP Solutions Review calls as scheduled. All services must be entered into the Concordia portal using the TIP modifier.

Transition to Independence Process (TIP) Initiative

Provider Implementation Agreement

INTRODUCTION:

THE OCP2 TRANSITION TO INDEPENDENT PROCESS (TIP) INITIATIVE is a collaborative learning and implementation project for the One Community Partnership 2 (OCP2) System of Care Expansion Grant administered by the Broward County Human Services Department's Community Partnerships Division in collaboration with the Broward Behavioral Health Coalition (BBHC) and the Children's Services Council (CSC). TIP training and fidelity implementation is being provided by the Stars Behavioral Health Group and the National Network on Youth Transition.

This Initiative will require a dedicated group of professionals and organizations who, like you, are committed to ensuring that youth and emerging adults who experience difficulties with transition due to mental health and co-occurring issues receive effective, evidence-supported services to successfully transition into adulthood. This initiative is facilitating Broward's System of Care implementation of effective transitional supports for emerging adults on their way towards resiliency, recovery, and wellness.

THE NATIONAL NETWORK ON YOUTH TRANSITION is responsible for defining and applying fidelity and certification standards for implementation and sustainability of the TIP Model. The National Network on Youth Transition involves: 1) certifications of TIP Model site-based trainers, 2) certification of TIP-Informed sites and TIP Model sites 3) managing and conducting TIP Model Fidelity Assessments of sites, and 4) conceptualizing, conducting and collaborating with evaluation and research on transitions topics.

THE STARS TRAINING ACADEMY is the official purveyor of the TIP Model and collaborates with community agencies across the Nation to provide training and customized consultation to achieve programs with high fidelity and sustainable implementation of evidence-supported and evidence-based practices. Read more on their website: www.tipstars.org

Broward TIP Collaborative

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

Agency Interest, Readiness, and Commitment

OCP2 is looking to confirm the level of interest and commitment across partner agencies for adopting the Transition to Independence Process (TIP) Model. Your agency is a key partner within the system of care for implementation of the TIP Model and we need each organization to complete this Provider Implementation Agreement.

OCP2 Feedback/Evaluation

As your agency joins this cohort, you will have TIP Trained Transition Facilitators to support youth in their recovery goals that align with the OCP2 system of care grant. As such, youth served and their families will have the opportunity to provide feedback about services by participating and enrolling in the evaluation. Incentives are provided for their time and participation. BBHC Peer Evaluators will meet with youth who agree to participate and ask about the effectiveness and satisfaction in services. Youth and family participation in the evaluation is fully voluntary and based on informed consent. OCP 2 staff will provide training as well as information about the evaluation that participating agencies can share with youth and families. Agencies participating in the TIP Initiative agree to collaborate with the voluntary National Evaluation process.

Benefits of Participation

- Tracking of progress and recovery outcomes for youth and young adults with emotional/behavioral difficulties (EBD).
- Feedback about TIP Model competency informing targeted technical assistance provided by NNYT Certified TIP Model Consultants at Cross-Site Forums in our community.
- Enhanced staff and supervisor competencies for working with youth and their families
- Development of high fidelity TIP through participation in fidelity evaluation and technical assistance for the agency.

TIP Training and Fidelity Requirements

The TIP Initiative requires providers to attend **three 3-day trainings** throughout one year, monthly case reviews, and participate in ongoing implementation activities that include areas identified below:

Participating agencies will commit to:

- Securing senior leader support for implementing the TIP Model.
- Identifying one person to lead the TIP Model implementation at their agency. This person will also serve as the primary liaison to the Broward TIP Collaborative.
- Selecting and/or hiring personnel who will serve on the agency's Transition Team and be trained in TIP (e.g., personnel serving functions such as: Transition Facilitators with support from, for example, Peer Support Specialists, and Supervisors/Program Managers, Family/Youth partners, others).

  - **Selected Staff must be available to attend all days of TIP Training.**

- Sending selected Transition Team members to the TIP training events as relevant to each to advance their application of the TIP Model. These events include: TIP Model Orientation Workshops, TIP Model Cross-Site Forums, Teleconferences, etc.
- Presentations and Discussions (e.g., webinars, TIP Solutions Review process), periodic Supervisory Team Leadership meetings and calls (local TIP Community of Practice or with TIP Model Consultant).
- Providing support to the implementation of TIP Model (e.g., personnel time to devote to supervision, implementing changes at your agency, designing and collecting progress and outcome data, utilizing information, data, and feedback to improve services and supports)
- Sharing "lessons learned" on TIP Model implementation with others in the Broward TIP Collaborative.
- Considering contributing to building the Broward TIP collaborative sustainability and capacity building through such roles as: having one of your Team Members being mentored and ultimately certified as a TIP Model Site-Based Trainer; having a Supervisor or Quality Assurance Manager mentored and certified as a Regional TIP Model Fidelity QI Assessor.
- Supporting opportunities for youth and young adults voice, choice, and leadership (e.g., encouraging youth participation in Youth M.O.V.E. Broward, hiring a Young Adult as a Peer Support Specialist as part of the team, having a young person serving on your TIP Community Steering Committee).

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XX. Individual Placement Support (IPS)

For Providers Offering IPS Services:
Provider should prioritize transition age youth from TIP providers in outreach / engagement efforts as part of the OCP2 initiative. Organizations providing IPS services must meet fidelity by adhering to the Supported Employment Fidelity Scale found on the www.IPSworks.org website. Providers agree to attend relevant OCP2 committees, participate in monthly consultation sessions with BBHC staff, provide rosters on clients served as requested, and participate in trainings as scheduled. All services must be entered into the Concordia portal using the Supported Employment code.

For Providers Who Have Clients Eligible for the Workforce:
Providers must review eligible clients and refer to IPS agencies within 30 days. The IPS team can outreach client prior to referral for clarification of services and engagement. The Provider continues to be part of the IPS treatment team as the behavioral health provider. Both agencies collaborate and establish MOUs/Agreements as necessary to share clients and documentation accordingly. Further Technical Assistance will be provided by BBHC per the IPS Fidelity Scale.

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XXI. Permanent Supportive Housing (PSH)

Provider should prioritize transition age youth from TIP providers in outreach / engagement efforts as part of the OCP2 initiative funding allows.

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

Providers agree to attend relevant OCP2 committees, participate in monthly consultation sessions with BBHC staff, provide rosters on clients served as requested, and participate in TIP Solutions Review calls as scheduled. All services must be entered into the Concordia portal using the Supportive Housing Code.

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XXII. BBHC Housing Initiative

Requirement: Contract
Frequency: Monthly Reporting of Housing Referral/HMIS data

BBHC began implementing its Housing Initiative as part of a state requirement from DCF for all Managing Entities, per Incorporated Document 37 (Effective 1/12/16)
Mission: to address accessibility, sustainability, and wrap-around supports for persons with mental illness and substance use issues who are homeless, at-risk or homelessness or are exiting institutional care and need on-going supports to live independently.
Purpose:

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

PROVIDER REQUIREMENTS:

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

Referral Process

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

BBHC's ROLE: Through this initiative, BBHC has hired a **Housing Team** that includes a Housing Coordinator, Housing Navigator and SOAR/Entitlements Coordinator to support implementation and technical assistance for the network. The Housing Staff will:

1. Evaluate applications, confirming eligibility according to HUD's definition of homeless categories.

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

Please refer to the Housing Manual on the BBHC website for full details. http://www.bbhcflorida.org/?q=housing

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XXIII. BBHC Care Coordination

For Additional Information please see:
INCORPORATED DOCUMENT-Guidance Document #4

PURPOSE AND GOALS

Care Coordination serves to assist individuals who are not effectively connected with the services and supports they need to transition successfully from higher levels of care to effective community-based care. This includes services and supports that affect a person's overall well-being, such as primary physical health care, housing, and social connectedness. Care Coordination connects systems including behavioral health, primary care, peer and natural supports, housing, education, vocation and the justice systems. It is time-limited, with a heavy concentration on educating and empowering the person served, and provides a single point of contact until a person is adequately connected to the care that meets their needs.

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

- Improve transitions from acute and restrictive to less restrictive community-based levels of care;
- Increase diversions from state mental health treatment facility admissions;
- Decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness; and
- Focus on an individual's wellness and community integration.

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

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

PRIORITY POPULATIONS

Pursuant to s. 394.9082(3)(c), F.S., the Department has defined several priority populations to potentially benefit from Care Coordination. Managing entities and provider agencies are expected to minimally serve the following two populations:

1. Adults with a serious mental illness (SMI), substance use disorder (SUD), or co-occurring disorders who demonstrate high utilization of acute care services, including crisis stabilization, inpatient, and inpatient detoxification services. For the purposes of this document, high utilization is defined as:
   a. Adults with three (3) or more acute care admissions within 180 days; or
   b. Adults with acute care admissions that last 16 days or longer.

2. Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF back to the community.

Populations identified to potentially benefit from Care Coordination that may be served in addition to the two required groups include:

1. Persons with a SMI, SUD, or co-occurring disorders who have a history of multiple arrests, involuntary placements, or violations of parole leading to institutionalization or incarceration.

2. Caretakers and parents with a SMI, SUD, or co-occurring disorders involved with child welfare.

3. Individuals identified by the Department, managing entities, or network providers as potentially high risk due to concerns that warrant Care Coordination, as approved by the Department.

NETWORK SERVICE PROVIDER RESPONSIBILITIES

Network Service Provider responsibilities include:

1. Assess organizational culture and develop mechanisms to incorporate the core values and competencies of Care Coordination into daily practice.

2. Utilize a standardized level of care tool and assessments to identify service needs and choice of the individual served.

3. Serve as single point of accountability for the coordination of an individual's care with all involved parties (i.e., criminal or juvenile justice, child welfare, primary care, behavioral health care, housing, etc.).

4. Engage the individual in their current setting, such as the crisis stabilization unit (CSU), SMHTF, homeless shelter, detoxification unit, etc. Individuals served should not be expected to come to the care coordinator.

5. Develop a care plan with the individual based on shared decision making that emphasizes self-management, recovery and wellness. This must include transition to community based services and/or supports.

6. Provide daily contact for the first 30 days of services. This includes telephone contact or face-to-face contact (which may be conducted electronically). Leaving a voicemail is not considered contact. If the individual served is not responding to attempted contacts, the provider must document this in the clinical record and make active attempts to locate and engage the individual.

7. Provide 24/7 on-call availability.

8. Coordinate care across systems, to include behavioral and primary health care as well as other services and supports that impact the social determinants of health.

9. Assess the individual for eligibility of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Veteran's Administration benefits, housing benefits, and public benefits, and assist them in obtaining eligible benefits. When applying for SSI or SSDI benefits, providers must use the SSI/SSDI Outreach, Access, and Recovery (SOAR) application process. Free training is available at: https://soarworks.prainc.com/course/ssissdi-outreach-access-and-recovery-soar-online-training

10. For individuals who require medications, ensure linkage to psychiatric services within 7 days of discharge from higher levels of care. If no appointments are available, document this in the medical record and notify the managing entity.

11. Coordinate with the managing entity to identify service gaps and request purchase of needed services not available in the existing system of care.

12. Develop partnerships and agreements with community partners (i.e., managed care organizations, criminal and juvenile justice, community based care organizations, housing providers, federally qualified health centers, etc.) to leverage resources and share data.

CARE COORDINATION ALLOWABLE COVERED SERVICES

Care Coordination is a bundled service approach that is reported through an expenditure Other Cost Accumulator in accordance with Pamphlet 155-2. Pursuant to ch. 65E-14.014, F.A.C., providers may not bill for services for individuals who have third party insurance coverage when the services provided are paid under the insurance plan or recipients of Medicaid, or another publically funded health benefits assistance program, when the services provided are paid by said program. The following is a list of allowable covered services as defined in ch. 65E-14.021, F.A.C.

1. Outreach
2. Assessment
3. Crisis Support/Emergency
4. Recovery Support
5. Case Management
6. Intensive Case Management
7. In-Home and On-Site
8. Supportive Housing
9. Intervention

For additional information please refer to the BBHC Care Coordination Manual.

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XXIV. Transitional Voucher Procedure

Purpose:
The Transitional Vouchers are designed to help bridge the gap for persons with behavioral health disorders as they transition from acute or restrictive levels of care to lower levels of care. The intent is to provide financial assistance and facilitate individuals' ability to live independently in the community with treatment and support services based on need and choices and help them build a support system to improve their community involvement and overall quality of life which will sustain their independence, recovery, and overall well-being. The aim is to also help prevent recurrent hospitalization, incarceration, provide safe, affordable, and stable housing opportunities and increase individuals choice and self-determination in their treatment and support service selection.

The service is time limited financial assistance based on the individuals' needs and care plan objectives. Individuals have limited resources available or they have exhausted other financial resources including insurance; and have complex needs which may require multi-agency involvement.

All transitional voucher requests must receive formal agency approval/denial utilizing the authorized form and approval by the designated BBHC Care Coordinator.

Agencies will continue to utilize internal policies and procedures in accordance with Broward Behavioral Health Coalition's (BBHC).

Eligibility (All funds are time-limited):
Individuals must be receiving substance abuse and/or mental health services and be served by a Care Coordination Team funded by BBHC.

Examples for use of Transitional Voucher Funds (If other resources are not available):

- Employment related expenses
- Housing assistance/subsidies
- Educational/Vocational services
- Transportation
- Day Treatment/Recovery Support
- Medical Care/Services/Pharmaceuticals
- Clothing
- Childcare
- Respite Services
- Other incidentals as approved by BBHC in compliance with Rule 65E-14.021, F.A.C.

Restrictions and Limitations:

- Voucher funds are the payer of last resort
- Directly support documented treatment/service goals of the client
- Receipts must be maintained by the agency
- Invoice for requested service must be attached to the application
- Individuals should increasingly demonstrate the ability to self-manage and/or transition to other fund sources based on access to disability benefits, insurance, employment, and/or housing vouchers

Agency Responsibilities:

It is the responsibility of the agency to develop an agency-specific policy and procedure to ensure accuracy, accountability, and responsibility for the funds requested and approved.

- The information will include initials or record identifier of individuals served
- Amount expended, service/item purchased, date of purchase, case manager involved
- The justification for a particular expenditure should be included in the client's treatment plan

Procedure for Accessing Transitional Voucher Funds:

- Case Manager/Agency Designee will complete a Transitional Voucher Request/Application Form on behalf of the individual being served
- The Transitional Voucher Request/Application will be submitted internally to the agency supervisor or designee for signature
- After being signed by the supervisor or agency designee the following must be submitted to the corresponding BBHC Care Coordinator overseeing the client's Care Coordination Team:
    - Transitional Voucher Request/Application Form
    - Copy of the current treatment plan justifying the need for the requested service
    - Copy of Invoice for requested service
- BBHC Care Coordinator will approve and return signed form to the Case Manager/Agency Designee
- Case Manager/Agency Designee is responsible for following their agency's internal policy in order to obtain and disburse the requested funds
- The Agency Designee is responsible for documenting and maintaining records of the Transitional Voucher funds provided on behalf of their clients
- BBHC Care Coordinators will also maintain a monthly tracking log of Transitional Voucher funds that have been approved

Attachment: Transitional Voucher Request/ Approval Form

Transitional Voucher Request/Approval Form

Shall be submitted for proposed expense along with documentation, Treatment Plan, and justification for the expense. All costs shall be consistent with the requirements of the contract, the State of Florida Reference Guide for State Expenditures, and applicable Florida statutes, rules, and regulations.

Case Manager/Requestor:	Request Date**:**
Provider:	

Section A: **Request for Voucher Funding Authorization**

1. Recipient's Name:	2. SS#:
3. DOB:	4. Sex: M ☐ or F ☐
5. Annual Income: $	6. SA☐ MH☐ CO☐
7. Client Benefits:	
8. Description of Goods/Services requested:	
9. Reason for request/benefit to participant:	
10. Alternative explored:	
11. Make check payable to:	
12. Funding amount requested:	

$ _______________	For ___________days	For the month of:______________

Requestor Signature	Date	Supervisor Signature	Date

To be completed by BBHC

Section B:

Action Taken:	☐Approved ☐Denied	Funding Allocation: MH ☐ SA ☐ Voucher Type: ☐ Employment ☐ Housing ☐ Transportation ☐ Other
$ Amount Approved:		
Reason for Denial:		
Care Coordinator Name	Signature	Date

XXV. Cultural and Linguistic Competency Plans

Broward Behavioral Health Coalition, as part of the OCP2 system of care initiative, requires all its network providers to comply with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS Standards). The CLAS Standards are utilized as the benchmark for evaluation because they are aligned with the U.S. Department of Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities (HHS, 2010) and the National Stakeholder Strategy for Achieving Health Equity (National Partnership for Action to End Health Disparities, 2011), which aim to promote health equity by providing clear plans and strategies to guide efforts to improve cultural and linguistic competence.

A CLC assessment tool below was created with the SAMHSA TA Network using the CLAS Standards as benchmarks. This tool can serve as a guide for agencies to improve CLC plans and better serve their target populations.

The tool includes the 4 themes that the CLAS Standards focus on: 1) Introduction: Principal Standard; 2) Governance, Leadership, and Workforce; 3) Communication and Language Assistance; and 4) Engagement, Continuous Improvement, and Accountability. Researchers decided to add two additional themes: 5) Family Involvement and 6) Service Delivery: Intake, Treatment, and Discharge. The family involvement theme centers around taking an individual approach to service delivery, and values the importance of the family during treatment and discharge. The CLC plan should include several statements on how the agency values the individual and their familial preferences. Lastly, the service delivery theme centers on how the cultural and spiritual preferences of the individual are recognized during intake, service, and discharge. These two themes are an integral part of culturally appropriate practices to care that go beyond linguistically appropriate practices that is covered in CLAS standards 1-15.

BBHC requires all network providers to maintain a CLC Action Plan based on the Assessment tool. Updates to CLC plans must be submitted annually when requested by Concordia/CQI Department.

CLC Assessment Tool

Theme 1: Introduction: Principal Standard (Goal of the CLC Plan)

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 1: Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	The plan states that the organization offers effective quality care responsive to diverse cultural and health beliefs and practices.				
	The plan states that the organization offers understandable quality care responsive to diverse cultural and health beliefs and practices.				
	The plan states that the organization offers respectful quality care responsive to diverse cultural and health beliefs and practices.				
	The plan states how the organization collects and recognizes cultural health beliefs.				
	The plan states that the care provided will be provided in the client's preferred language, recognizing their health literacy and other communication needs.				
	The plan acknowledges health literacy and other communication needs, and defines what those are or may be for the organization.				

Theme 2: Governance, Leadership, and Workforce

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 2: Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	The plan states that the organization annually allocates resources to meeting the diverse cultural and linguistic needs of its clients.				
	The plan revisits its policies and management strategies on an annual basis to determine needs that may need addressing or added.				
	The plan states how often that the CEO and Board meets to set goals to improve diversity and offer continual cultural competence care and training as a part of the strategic plan.				
	The plan details how and when staff members can provide feedback on interactions with LEP and minority populations, to improve interactions and services.				
CLAS Standard 3: Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	The plan has protocols in place for recruiting diverse staff members including leadership and governance positions.				
	The plan specifies how organizations place priority on hiring members of staff with added bilingual or multilingual qualifications.				
	The plan specifies how the organization will recruit staff members that represent the service population, which includes advertising job opportunities in foreign languages in various outlets (social media networks, publications, professional organizations' email listservs, job boards, local schools, faith based organizations, training programs, minority health fairs, etc.).				
	The plan states that the organization recognizes staff who continue to meet the diverse needs of clients by offering the individuals internal promotions and other opportunities for upward mobility before seeking external candidates.				
	The plan states that the organization recognizes the diverse cultural beliefs of its employees.				
CLAS Standard 4: Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	The plan discusses how staff (workforce, leadership and governance positions) are trained on cultural norms, and how they vary by family (such as youth alcohol consumption or physical punishment).				
	The plan states that the organization supports the staff development of its employees, and how it places value on continued education and training in diversity and leadership.				
	The plan states how often staff and leaders receive training.				
	The plan states that the staff is trained on recognizing and responding to cultural health beliefs.				
	The plan states how both internal and external resources are used to educate the governance, leadership, and workforce on cultural beliefs that they may encounter.				
	The plan states that cultural competence in incorporated into staff evaluations and performance reviews.				
	The plan states what is included in the staff training, and how the training is evaluated.				

Theme 3: Communication and Language Assistance

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 5: Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	The plan states that the organization offers language assistance to LEP individuals and/or other communication needs at no cost to the client.				
	The plan details the way that clients are made aware of no cost language assistance.				
	The plan states that the organization offers language assistance to LEP individuals and/or other communication needs for access to services in a timely manner.				
	The plan states how program directors, "point of contact staff" or agency's appointed "gatekeeper" are made aware of and trained in language assistance services, policies, and procedures.				
	The plan identifies how language needs are noted in records for individuals seeking care (which may include language needs, "I speak" cards, etc.).				
	The plan states the maximum time that it will take to provide an interpreter and the maximum amount of time for service delivery using a certified interpreter.				
CLAS Standard 6: Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	The plan states that the organization has the availability of language assistance services clearly displayed.				
	The plan states what language assistance services are available at all times.				
	The plan states how the organization translates appropriate material.				
	The plan states that there is a protocol for verbally informing clients of the availability of services in their preferred language.				
CLAS Standard 7: Ensure competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors should be avoided.	The plan states the protocol for ensuring language assistance providers are certified.				
	The plan states how the organization ensures interpreter competence, including the interpreter's active listening skills, message conversion skills, and clear and understandable speech delivery.				
	The plan states if community brokers are used within the organization.				
	The plan states that untrained individuals and minors should NOT be used as interpreters.				
CLAS Standard 8: Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	The plan states that the organization has clear, easy to understand multimedia materials and signage in the languages used within the service community.				
	The plan states what multimedia materials are available in various languages.				
	The plan states that there is a formalized process and what the process is for translating materials into languages when the materials are not readily available.				
	The plan notes that the materials have been tested with members of the target audience (such as through focus groups, where members may identify content that may be embarrassing or offensive, suggest cultural practices that may be more appropriate examples, and assess whether the graphics are appropriate and reflect the diversity of the community).				
	The plan states that easily understandable signage is posted throughout the service area (including, but not limited to diverse languages, minority representation, and responsive to LGBTQ+ (safe space sign), and youth populations).				

Theme 4: Engagement, Continuous Improvement, and Accountability

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
CLAS Standard 9: Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	The plan states that the organization will regularly review organizational planning and operations with the purpose of identifying cultural and linguistic needs that are not being met.				
	The plan states how the annual organizational diversity goals will be created and discussed in meetings throughout the year.				
	The plan states that cultural and linguistic goals created by the organization will be included in the strategic plan, and will regularly be included as agenda items in staff meetings.				
CLAS Standard 10: Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and CQI activities.	The plan ensures that there is an ongoing evaluation of CLAS standards and how they are implemented within the organization.				
	The plan states that all staff are provided with CLAS-oriented feedback in their performance reviews.				
	The plan states how often CLAS standards are evaluated and revisited for quality improvement.				
CLAS Standard 11: Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	The plan details how and when demographic data will be obtained from the target community, and where the information will be updated and posted within the organization.				
	The plan discusses how the community demographic data will be used in program planning and service delivery.				
	The plan discusses how the community demographic data will be used to guide translated material and signage in the organization.				
	The plan discusses how the community demographic data will highlight any apparent disparities that may exist.				
	The plan states that the community demographic data and disparities will be presented to the governance and leadership of the organization annually.				
CLAS Standard 12: Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.	The plan details how and when community health assets and needs are performed.				
	The plan will discuss when and if qualitative data will be collected and used (such as focus groups or interviews) to enhance the community health assets and needs.				
	The plan discusses how findings from the community health needs assessments are utilized within the organization.				
	The plan offers opportunities for collaboration with other community based partners and stakeholders in discussing assets and challenges of the community and sharing best practices related to: 1) meeting needs; 2) capturing community demographics; and 3) strategies on the dissemination of findings.				
	The plan discusses how findings from the community health needs assessments are used in program development.				
CLAS Standard 13: Partner with the community to design, implement, and evaluate policies, practices, and services to	The plan details the method of targeting and communicating with other community based organizations that offer services that clients would benefit from.				
	The plan recognizes the success of cross-system collaborative efforts and the use of multidisciplinary teams in working with children and families.				

ensure cultural and linguistic appropriateness.	The plan states the organization's policies on ensuring collaborative agencies practice culturally and linguistically appropriate services and adhere to the CLAS standards.				
CLAS Standard 14: Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	The plan states the organization's strategies for LEP and others with communication needs to fill out conflict and/or grievances with the organization.				
	The plan offers conflict and grievance forms in various languages, including all of the languages that are represented within the target community.				
	The plan details the grievance resolution process, and the maximum length of time that grievances will be addressed.				
CLAS Standard 15: Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.	The plan details where the organization's diversity and linguistic policies are posted for the public.				
	The plan specifies that information collected from stakeholders is used in training, meetings, and for quality improvement.				
	The plan states the organization's policies on open communication to raise concerns of cultural and linguistic needs.				
	The plan states the protocol for a clear communication plan that is discussed with the individual seeking behavioral health care services and their family during discharge.				

Suggested Themes 5 and 6

	Statements	Yes/No	Date of Implementation	Data Source	Responsible Party
Family Acknowledgement	The plan states the organization's policy for including family in the service delivery, including the treatment and discharge of the client.				
	The plan details the organization's efforts and strategies towards coordinated, individualized, family-driven and youth guided services.				
	The plan should detail how the organization identifies familial preferences for and availability of traditional healers, religious and spiritual resources, alternative or complementary healing practices, natural supports, bilingual services, self-help groups, and consultation from culturally and linguistically competent independent providers, except when clinically or culturally contraindicated.				
	The plan acknowledges that treatment plans do not always match family values, and that improved listening to family and youth is suggested.				
Spiritual and Cultural Beliefs in Treatment & Discharge	The plan states that cultural and spiritual beliefs are recognized during the intake assessment.				
	The plan states that cultural and spiritual beliefs are recognized during the service treatment.				
	The plan states that cultural and spiritual beliefs are recognized during discharge of the individual.				
	The plan recognizes that traditional and natural supports may be necessary for treatment and interactions with individuals seeking behavioral health care.				

CLAS STANDARDS SOURCE: https://www.thinkculturalhealth.hhs.gov/

XXVI. Minimum Accreditation Standards

As part of a statewide initiative to promote the highest standards of quality, ethics, effectiveness, and accountability in nonprofit mental health and substance use services, BBHC is requiring that all its network providers obtain and maintain national accreditation through any of the associations below:

- Council on Accreditation (COA)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Joint Commission (JAHCO)

By the end of Fiscal Year 16-17:

- All currently accredited agencies must submit evidence of accreditation with expiration dates.
- Agencies not currently accredited must submit a plan to obtain accreditation with timelines, associated fees, and any concerns/barriers. These agencies must start the accreditation process by July 2017, as appropriate.
- All Agencies must comply, at a minimum, with accreditation standards of a designated accreditation body, if not accredited.

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XXVII. Performance Measures - CQI Programs (Exhibit P)

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

The Provider shall track by Program, as applicable, the following performance measures and report as part of its Quality Assurance ("QA")/Quality Improvement ("QI"). This information shall be made available to BBHC upon request.

Mental Health Services (Admission type):

Covered Services

01-Assessment	19- Residential Level 2
03- Crisis Stabilization Unit	20- Residential Level 3
06 Day/Night	21 Residential Level 4
08- In Home/ On-Site	34- FACT
09-Inpatient	35- Outpatient Group
12-Medical Services (psychiatric)	39-Short-term Residential Treatment
14-Outpatient Individual	Miscellaneous - Peer Support Services
18- Residential Level 1	

A. Average number of calendar days between a request for service and the date of the initially scheduled face-to-face appointment, tracked by intake, assessment, counseling/psychotherapy and psychiatric appointments.

B. Percent of clients who do not appear for their initial appointment tracked by intake, assessments, counseling/psychotherapy and psychiatric appointments.

C. Percent of appointments cancelled by the client tracked for all initial appointments by intake, assessments, counseling/psychotherapy and psychiatric services.

D. Percent of appointments cancelled by the staff for all initial appointments for intake, assessment, counseling/psychotherapy and psychiatric services.

E. When funded for Medical Services - Medication error percentage, as documented during the reporting period including: wrong medication, wrong dose or wrong time of administration as reported in inpatient/CSU and residential settings.

XXVIII. Forms (For form refer to BBHC Website: http://www.bbhcflorida.org/)

- Invoice (Exhibit E)
- ~~SAMH PRE-AUTHORIZATION UTILIZATION MANAGEMENT ROSTER (Exhibit K)~~
- Outreach / Prevention Activities Service Log (Exhibit I)
- National Voter Registration Monthly Report (Exhibit J)
- TANF Program Participant Log (Exhibit L)
- TANF Incidental Request Form
- TANF Monthly Income Verification
- Incidental Fund Invoice and Expenditure Log (Exhibit O)
- DCF Client Satisfaction Survey Template (Exhibit Q)
- DCF General (FY 17-18 Exhibits and Guidance Documents) http://www.myflfamilies.com/service-programs/substance-abuse/managing-entities/2017-contract-docs

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