LSF Health Systems
FY 19/20 Enhancement Plan
Local Funding Request – Short Term Residential and Assisted Outpatient Treatment

Please complete the following form for each of the five priorities identified in your Managing Entities' Needs Assessment.

1. **Please describe the process by which the area(s) of priority were determined. What activities were conducted, who participated, etc.**

   Per SB12, LSFHS completed the initial triennial needs assessment in October 2016. This assessment was included a review of a variety of data elements including waitlist data, admission and discharge data, drive time to access services and access to care line call data. Stakeholder feedback was obtained and is obtained on an ongoing basis through regular participation in a wide variety of community meetings across the 23-county service area including but not limited to Behavioral Health Consortium meetings, Community Alliance meetings, Housing Continuum of Care meetings and collaborative meetings with DCF, CBC lead agencies and the ME. The needs assessment was also informed by the Prevention needs assessment conducted by our partner Community Coalition Alliance. In July 2017, and again in Jul/August 2018 stakeholder input was updated through Town Hall meetings in each circuit and a stakeholder survey distributed to over 1200 stakeholders in our service area. The 2018 survey had a 40% response rate with representation from consumers, family members of consumers, providers, and a variety of other stakeholders. . LSFHS is currently in the process of completing the 2019 Triennial Needs Assessment through a contract with the Northeast Florida Health Planning Council and WellFlorida Council. The assessment includes surveys of consumers, providers and stakeholders, provider focus groups, analysis of county level health data and county level LSF utilization data. The assessment will be completed in October 2019.

2. **Please describe:**

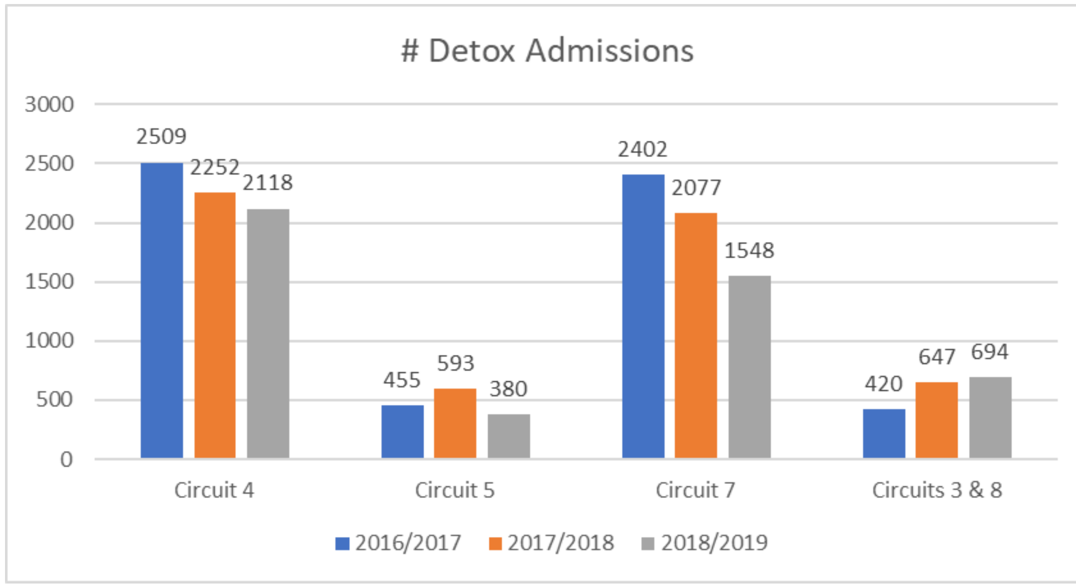
   a. **The problem or unmet need that this funding will address**

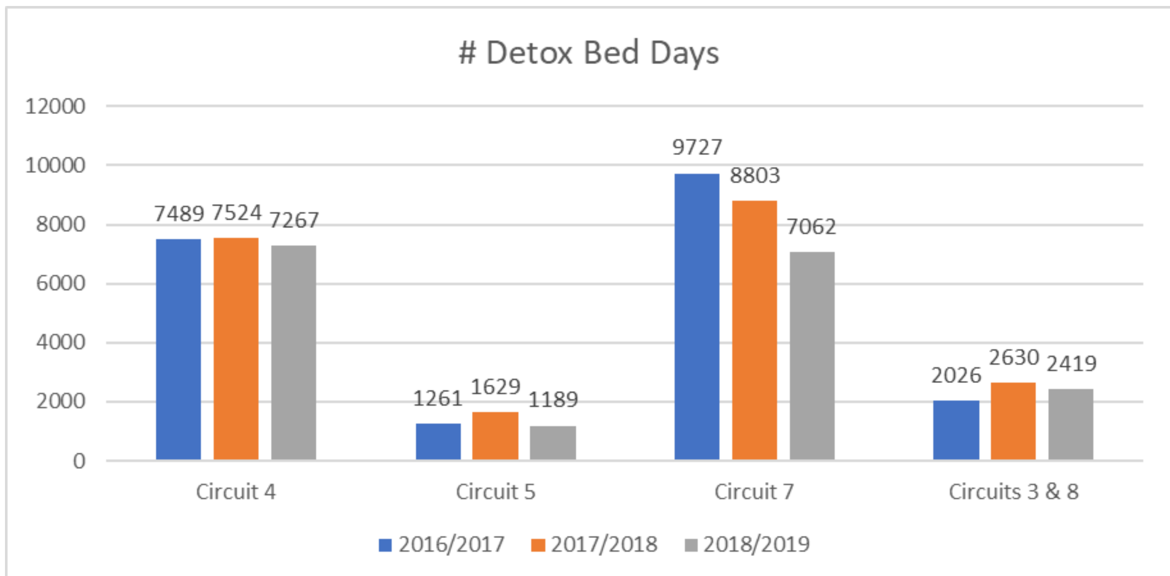
   Poorly managed care transitions for high-risk, high need individuals from acute services to lower levels of care negatively affect a person's health and well-being, potentially causing additional utilization of acute crisis services, avoidable re-hospitalization, or re-arrest. Many of these individuals cycle through jails, emergency rooms, and homeless facilities, leading to decompensation of the person's mental health and creating immense costs for multiple publically funded systems. With the development of a full range of services from crisis stabilization to high intensity, high structure residential programs and intensive community services transition from the crisis service to home or other post-acute care settings can be managed to avoid this cycling.

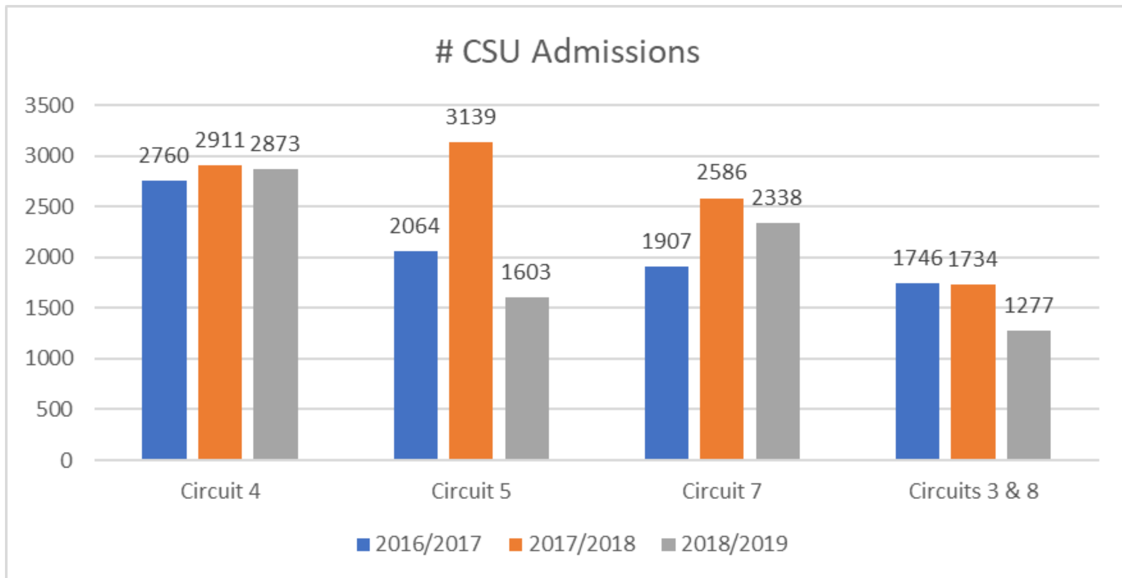
   Without the appropriate treatment, at the right time and in the right setting, people with behavioral health conditions will likely continue to cycle through jail or acute levels of care for their treatment. The judicial system has identified the lack of appropriate services and an intensive, coordinated and phased treatment system as a critical gap in services. Judges in specialty courts feel ham strung with inadequate community alternatives to jail and acute care. The evidence based, Assisted Outpatient Treatment (AOT) model has been successful in moving to a clinical, community response to behavioral health issues rather than a criminal justice response. Implementation of the AOT model, in conjunction with SRT beds will afford the Court alternatives to repeated

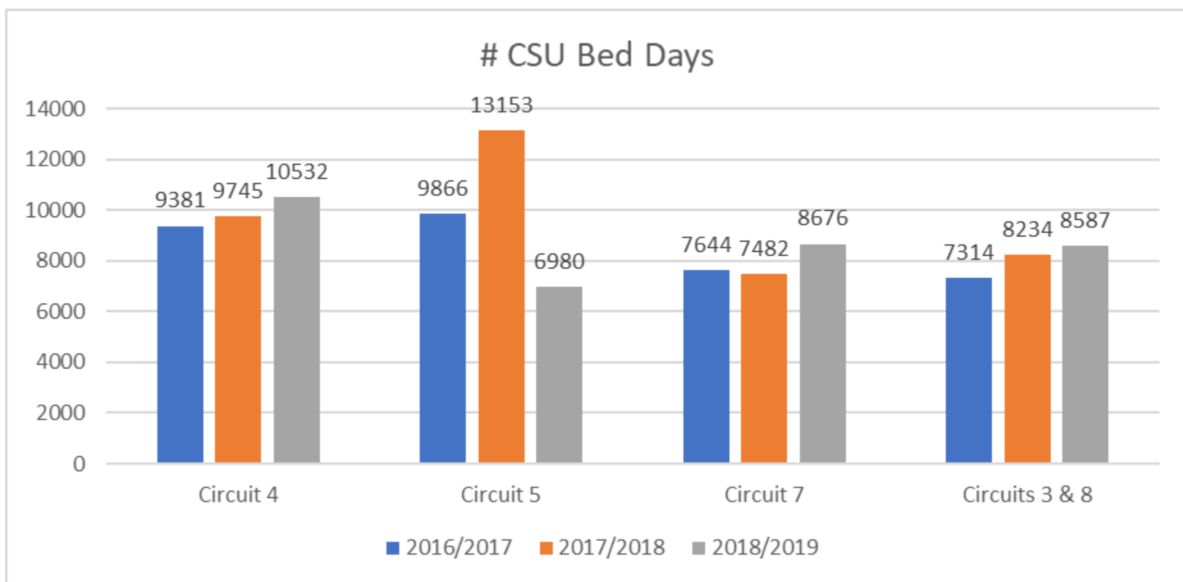
incarceration and Baker Acts for addressing the needs of individuals with serious mental illness, substance use and co-occurring disorders.

The following is data for acute care utilization for FY 16/17, FY 17/18 and FY 18/19









Transitional care for both civil and forensic populations at risk for admission to the state hospital, jail or acute care is significantly lacking. Large gaps in the system of care inhibit the ability of the community to treat the consumer in the least restrictive environment. Development of diversion options in the community will result in a decrease in the number of admissions to the State Mental Health Treatment Facilities (SMHTF). In the 23 county LSFHS service area there is one, 16 bed SRT facility. The data below summarizing the high need, high utilizers by Circuit, supports the need for an additional 20 beds of short-term residential treatment, 10 to serve Circuits 5, 3 and 8, and 10 to serve Duval, Volusia, Flagler.

Provider	Circuit	CSU HN/HU	Detox HN/HU	*Total*
Mental Health Resource Center	4	208	0	*208*
Gateway Community Services	4	1	109	*110*
Orange Park Medical Center (OPMC)	4	11	0	*11*
The Centers	5	43	17	*60*
Lifestream Behavioral Center	5	32	2	*34*
SMA Healthcare	7	119	71	*190*
BayCare Behavioral Health	7	3	1	*4*
EPIC Community Services	7	0	15	*15*
Halifax Hospital Medical Center	7	0	0	*0*
Flagler	7	23	0	*23*
Meridian Behavioral Healthcare	3 and 8	111	44	*155*
Total		**551**	**259**	***810***

b. The proposed strategy and specific services to be provided:

The purpose of Short-Term Residential Treatment (SRT) is to provide intensive short-term treatment, competency restoration and rehabilitative skills to individuals who need a 24-hour-a-day structured therapeutic setting in a less restrictive environment than a CSU or inpatient psychiatric unit. Steps of recovery will develop self-care skills, communication skills, and recovery orientation so that residents can be stepped down to a less restrictive environment in as short a time as possible. This unit is designed to assist individuals return as rapidly as possible to the community. The SRT will decrease avoidable hospitalizations, inpatient care, incarcerations, and homelessness. The SRT will focus on an individual's wellness and community integration. This program will focus on diversion and treatment in the community with the family's support. The SRT will reduce avoidable SMHTF and CSU readmissions using the following interventions:

- Patient/Family Engagement and Activation
- Medication Management
- Comprehensive Transition Planning
- Care Transition Support
- Transition Communication

LSFHS successfully applied for and was awarded a Criminal Justice Mental Health and Substance Abuse Reinvestment Implementation Grant for three year beginning FY 18/19 to implement a modified AOT program within the specialty courts in Marion County including Mental Health Court and Veterans Court. This grant will enable judges to order individuals into treatment rather than jail with confidence that they will receive the coordination and access to services necessary to keep themselves and the community safe. The model includes co-location of a care coordinator, housing resource navigator and Peer Support/Peer Recovery Specialist at the Courthouse, along with contracted psychiatric ARNP time weekly at the Courthouse to address medication needs to increase the integration of services and move individuals to a recovery rather than punishment focus. Additional short-term residential treatment

beds are an important piece of the continuum of care necessary to address the complex needs of individuals involved in the specialty courts. Other jurisdictions, including Volusia/Flagler counties, have requested the opportunity to implement an AOT model.

c. Target population to be served:

The target population includes those consumers, both civil and forensic who are at risk of admission to the State Mental Health Treatment Facilities (SMHTF) or who repeatedly cycle through the acute care, homelessness and criminal justice systems.

- Civil target population:
  - Person is at least 18 years old and diagnosed with a severe and persistent mental illness, with or without co-occurring disorders. Individuals must be continent, ambulatory or capable of self-transfer.
  - All individuals shall be admitted pursuant to Chapter 394 (voluntary or involuntary), Part I, F.S., and Chapter 65E-5, F.A.C., and only on the order of a physician.
  - Individuals must present as acutely mentally ill and in need of intensive staff supervision, support and assistance, as documented in a psychiatric or psychological evaluation.
  - Person is at risk of institutionalization or incarceration for mental health reasons.
  - The individual receives a psychiatric or psychological evaluation
  - The individual is referred from a CSU, inpatient psychiatric unit (including county jail psychiatric units.

- Forensic target population:
  - Individuals must be at least 18 years of age
  - Individuals shall be charged with a felony
  - Individuals shall be free of any major medical conditions or shall have stable medical conditions.
  - Individuals must be continent, ambulatory or capable of self-transfer
  - Individuals display with physically aggressive, suicidal, or homicidal behavior (past history will be evaluated on a case by case basis)
  - Individuals must present as acutely mentally ill and in need of intensive staff supervision, support and assistance, as documented in a psychiatric or psychological evaluation
  - All individuals shall be admitted pursuant to Chapter 916, F.S. (voluntary or involuntary), Part I, F.S., and Chapter 65E-5, F.A.C.,
  - Have received at least two psychiatric or psychological evaluations finding that the individual has a mental illness as defined by Chapter 916.106 (13), F.S. and with:
    - That at least two independent evaluators opine that the person is unable to proceed at any material state of a criminal proceeding and
    - That with treatment there is a probability that the defendant will attain competence to proceed in the foreseeable future.
  - Or found not guilty by reason of insanity and
    - Has been referred from a CSU, inpatient psychiatric unit, or a designated public or private receiving facility.

d. **County(ies) to be served (County is defined as county of residence of service recipients)**

Volusia/Flagler (AOT) Marion, Alachua, Levy, Duval, Volusia, Flagler and Putnam as well as residents from other counties in the LSFHS service area (SRT)

e. **Number of individuals to be served**

AOT – 125, SRT-80

3. **Please describe in detail the action steps to implement the strategy**

See attached excel workbook- action plan tab

4. **Identify the total amount of State funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.**

See attached excel workbook- budget tab

5. **Identify expected beneficial results and outcomes associated with addressing this unmet need.**

- Community based care which integrates natural supports
- Decrease in recidivism rate into acute levels of care due to stabilization of the consumer.
- Decrease in touchpoints with the criminal justice system due to stabilization of the consumer.
- Cost avoidance to the overall system of care.
- Increased medication compliance
- Increase in overall functioning as evidenced by FARS
- Increase in continuity of care
- Increase in positive outcomes due to phase-down approach in a structured environment
- Increased length of time between acute care episodes
- Reduced readmissions of high utilizers
- Improved time of linkage to next treatment appointment to within 7 days
- Increased diversion from SMHTF admission

6. **What specific measures will be used to document performance data for the project**

- Reduction in recidivism rates of the acute levels of care
- Increase in medication compliance
- Increase in overall functioning as evidenced by FARS
- Increase length of time between acute care episodes
- Improve time of linkage to next treatment appointment to within 7 days
- Reduce readmissions to SMHTFs
- Increased diversion from SMHTF admissions

LSF Health Systems
FY 19/20 Enhancement Plan
Local Funding Request

Substance Abuse Services: Addictions Receiving Facility, Outpatient and Residential Treatment

Please complete the following form for each of the five priorities identified in your Managing Entities' Needs Assessment.

1. **Please describe the process by which the area(s) of priority were determined. What activities were conducted, who participated, etc.**

   Per SB12, LSFHS completed the initial triennial needs assessment in October 2016. This assessment was included a review of a variety of data elements including waitlist data, admission and discharge data, drive time to access services and access to care line call data. Stakeholder feedback was obtained and is obtained on an ongoing basis through regular participation in a wide variety of community meetings across the 23-county service area including but not limited to Behavioral Health Consortium meetings, Community Alliance meetings, Housing Continuum of Care meetings and collaborative meetings with DCF, CBC lead agencies and the ME. The needs assessment was also informed by the Prevention needs assessment conducted by our partner Community Coalition Alliance. In July 2017, and again in Jul/August 2018 stakeholder input was updated through Town Hall meetings in each circuit and a stakeholder survey distributed to over 1200 stakeholders in our service area. The 2018 survey had a 40% response rate with representation from consumers, family members of consumers, providers, and a variety of other stakeholders. LSFHS is currently in the process of completing the 2019 Triennial Needs Assessment through a contract with the Northeast Florida Health Planning Council and WellFlorida Council. The assessment includes surveys of consumers, providers and stakeholders, provider focus groups, analysis of county level health data and county level LSF utilization data. The assessment will be completed in October 2019.

2. **Please describe:**

   a. **The problem or unmet need that this funding will address**

      Substance use continues to be a rising social concern, focus on the opioid crisis has driven new resources specific to individuals with an opioid use disorder, however many individuals suffer from addiction to substances other than opioids. New funds to treat opioid addiction have been heavily invested in outpatient MAT. Effective July 1, 2019, state funded outpatient MAT services are available in all 23 counties in the LSFHS service area. Service availability varies across the 23 county LSFHS service area. Largely rural, many counties are severely lacking in treatment resources. In Judicial Circuits 3 and 8, there are 6 publicly funded detox beds to serve indigent and uninsured individuals in 10 of the 12 counties. In Flagler County 215 adults were placed on a waitlist for residential substance abuse treatment in FY 18/19. The challenge however is not restricted to the rural counties. In Duval County, 132 individuals seeking residential substance abuse treatment were placed on a waitlist in FY 18/19.

      Reductions in Department of Corrections funding in FY 18/19 for residential Substance Abuse treatment beds exacerbated the symptoms of an underfunded system, resulting in even longer wait lists for individuals being released from jails and individuals with court ordered residential treatment. Even

though funding has been restored, there continues to be a significant waitlist for residential services in some counties.

SOR funding is in place for the 19/20 fiscal year and the first quarter of fiscal year 20/21. For LSFHS that is $11,065,762 in non-recurring revenue that provides outpatient, residential, hospital bridge and prevention services to thousands of individuals. In FY 18/19 2,436 individuals received services for the treatment of opioid use disorder through STR/SOR federal funding. If these federal funds are not renewed, thousands of individuals will be in need of ongoing treatment. In addition, even with the federal resources, the incidence of cocaine, methamphetamine and alcohol addiction is increasing across our counties. There is an ongoing need for funding that can be used to treat any substance use disorder.

From the patient family perspective:

- There is little information or support.
- Limited transportation is a barrier to treatment, especially in rural counties
- Follow-up is disjointed and hard to set up.
- There is limited continuity and high risk of bouncing between systems.

From the Private Provider perspective:

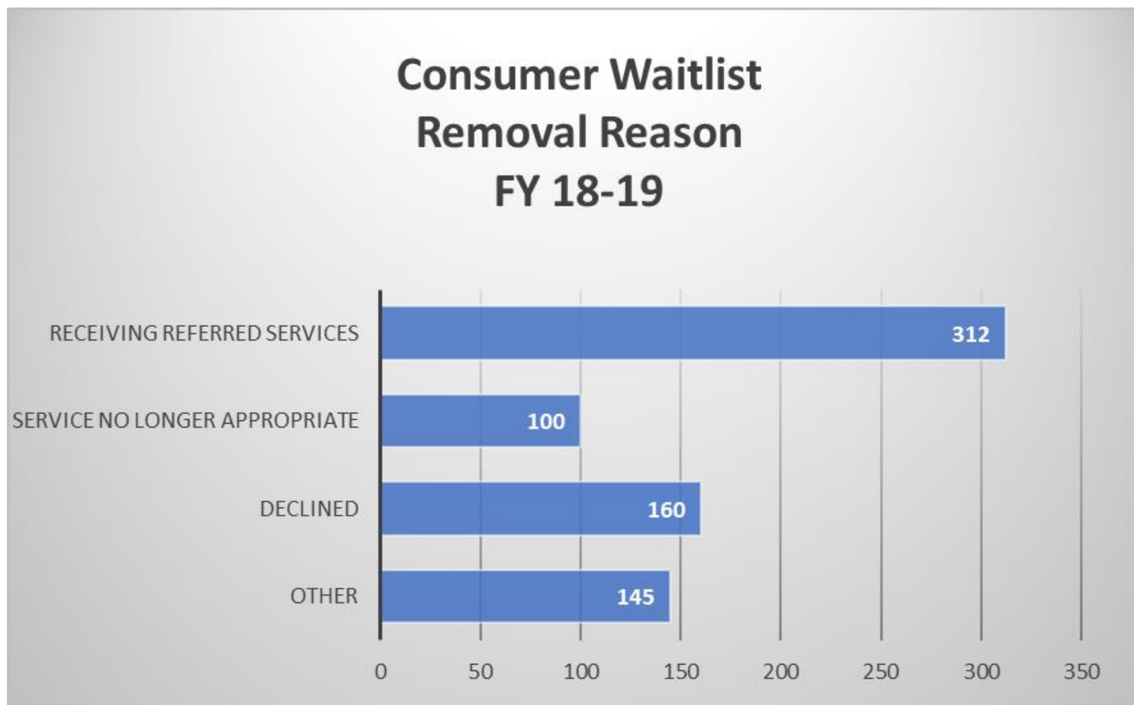
- There is a high cost to provide ED and inpatient care to indigent patients.
- The volume of MH/SUD involved patients who use the ED when a lower level of care would suffice is a burden and cost.
- They cannot easily arrange after care, particularly for indigent clients with serious mental illnesses who need more services than insurance covers (e.g., care coordination, family support, rehab, etc.)

From a community perspective:

- The system appears fragmented and inefficient.
- Patients bounce between different agencies with no coordinated approach.
- Criminal justice providers (LEO, courts, jails) have few options, particularly for substance abusing individuals who pose a community risk.

Waitlist data indicates 546 individuals seeking residential treatment services were placed on a wait list in 18/19. Despite the additional resources provided by the STR and SOR funds, the number of individuals placed on a waitlist for substance abuse treatement increased in FY 18/19, indicating an ongoing and increasing need for both residential and outpaitent treatment services.

ASA Residential Wait List	FY 18-19	FY 17-18
Number of Individuals Placed on the Wait List for ASA Residential Services that were successfully removed from the wait list	546 Individuals	409 individuals
Average Number of Days Waited for ASA Residential Services	57	Average of 62.28 days waiting
Number of Priority Consumers (IV Drug Users and/or Pregnant Women) That Waited for ASA Residential Services Due to Lack of Capacity that were successfully removed from the wait list during FY 17-18	109	30 individuals
Average Number of Days Priority Consumers (IV Drug Users or Pregnant Women) Waited for ASA Residential Services Due to Lack of Capacity	61.5	Average of 36.80 days waiting
Number of Individuals Placed on the Wait List for ASA Residential Services by Circuit Due to Lack of Capacity	Circuit 7- 407 individuals waited	Circuit 7- 276 individuals waited
	Circuit 5-6 Individuals waited	Circuit 5-15 Individuals waited
	Circuit 4- 132 individuals waited Circuit 8 – 1 individual waited	Circuit 4- 105 individuals waited
Reason Individuals Were Removed from The Waitlist	Receiving Referred Service-312 (44%)	Receiving Referred Service – 176 (34%)
	Declined Service-160 (22%)	Declined service -116 (23%)
	Service No Longer Appropriate-100 (14%)	Service No Longer Appropriate – 78 (15%)
	Other-145 (20%)	Other – 140 (27%)



b. The proposed strategy and specific services to be provided

The strategy is to increase needed substance abuse diagnosis and treatment options in underserved communities in the 23 county LSFHS service area through an addictions receiving facility, additional residential treatment beds and funding for outpatient treatment of substance abuse that is not limited to treatment of opioid use disorder.

The ARF provides a secure facility for a primary diagnosis of addiction. Services include:

- Single access for law enforcement, “drop off and go”
- 23-hour evaluation
- Immediate referral
- Initial medical clearance or referral
- Marchman Act or voluntary walk-in
- Hotline/Warmline for information, referral, consultation, with law enforcement, family/caregiver, community
- Care Coordination
- Assisted Outpatient

The 12-bed residential treatment programs provide residential level II SA treatment to individuals who require a more structured setting to effectively engage in treatment.

Funding to expand the availability of outpatient treatment for substance use disorder will enable the provider network to more effectively target resources to the specific needs of their community. Recurring funding is needed to stop treating addiction as a short-term condition. The availability of stable and consistent resources is essential to effectively treat addiction as the chronic condition that it is.

c. **Target population to be served:**

Individuals with substance use or co-occurring substance use and mental health conditions.

d. **County(ies) to be served (County is defined as county of residence of service recipients)**

Columbia, Hamilton, Lafayette, Baker, Union, Suwannee, Dixie, Gilchrist, Alachua, Levy, Putnam, Bradford – ARF

Volusia, Flagler, Putnam – residential treatment

Duval County – residential treatment

All Counties – outpatient SA treatment

e. **Number of individuals to be served**

ARF – 300 Residential Treatment - 200 Outpatient Treatment - 500

3. **Please describe in detail the action steps to implement the strategy**

See attached excel workbook- action plan tab

4. **Identify the total amount of State funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.**

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5. **Identify expected beneficial results and outcomes associated with addressing this unmet need.**
   - Medically supervised detoxification and stabilization
   - Ability to simultaneously address addiction and serious mental illness
   - Treatment is provided in a secure facility
   - Patient and family engagement designed to promote entry into follow-up care and reduce relapse
   - Referral into further treatment at an appropriate level of care based on thorough assessment
   - Admissions are voluntary, or under Marchman or Baker Act
   - Increase in the number of individuals with SUD who are engaged in treatment
   - Expanded access to services by reducing the number of individuals in need of treatment who must wait for services and reduction in the wait time to access services

6. **What specific measures will be used to document performance data for the project**

   - # of consumers placed on waitlist for SA residential treatment services
   - # of days from referral to service initiation
   - # of successful discharges from treatment
   - # of readmissions to detox, Emergency or other acute care settings
   - Cost reduction/return on investment

LSF Health Systems
FY 19/20 Enhancement Plan
Local Funding Request – Care Coordination/Housing Coordination

Please complete the following form for each of the five priorities identified in your Managing Entities' Needs Assessment.

1. **Please describe the process by which the area(s) of priority were determined. What activities were conducted, who participated, etc.**

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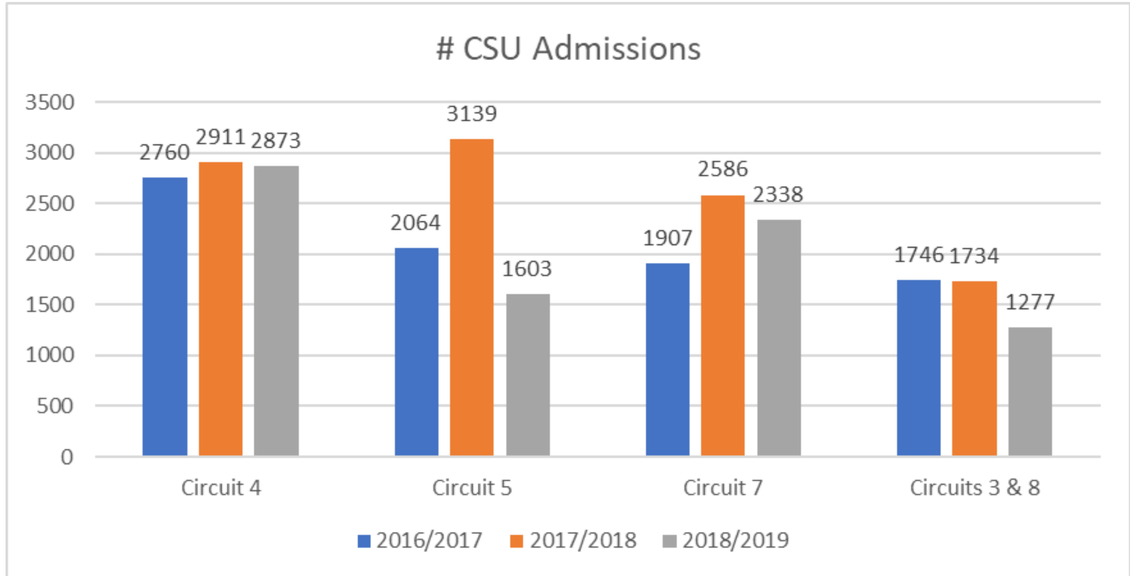
2. **Please describe:**

   a. **The problem or unmet need that this funding will address**

      In order for our system to function effectively and efficiently, a coordinated effort to connect high risk, high need individuals to appropriate services is critical. Absent this coordination, individuals with a serious mental illness, substance use disorder or co-occurring disorders are prone to cycle in and out of acute care settings, including CSU and inpatient detox, jails, emergency rooms and homeless facilities. A collaborative coordinated system to connect high risk, high need individuals to the right services at the right time can improve overall health, well-being and quality of life for individuals experiencing SMI, SUD or co-occurring conditions. In addition, reducing reliance on more costly acute care services or the criminal justice system to address ongoing behavioral health needs will ensure efficient use of public funds.

      The following is data for acute care utilization for FY16/17, FY 17/18 and FY 18/19.


CSU Admissions
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3000
2500
2000
1500
1000
500
0
2760
2911
2873
3139
2064
1603
1907
2586
2338
1746
1734
1277
Circuit 4
Circuit 5
Circuit 7
Circuits 3 & 8
2016/2017
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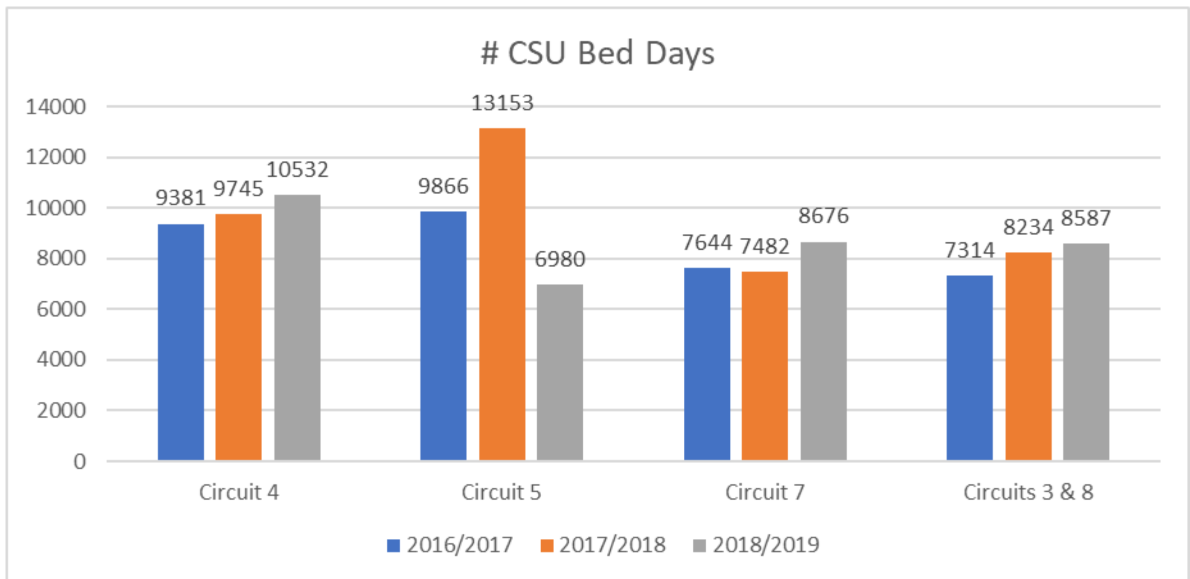
2018/2019


CSU Bed Days
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12000
10000
8000
6000
4000
2000
0
9381
9745
10532
9866
13153
6980
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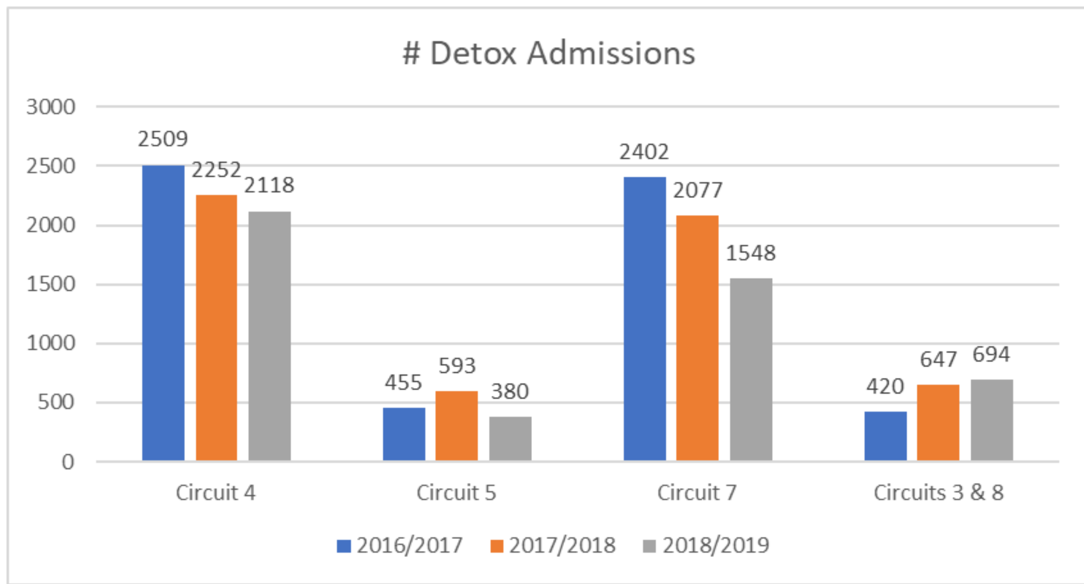
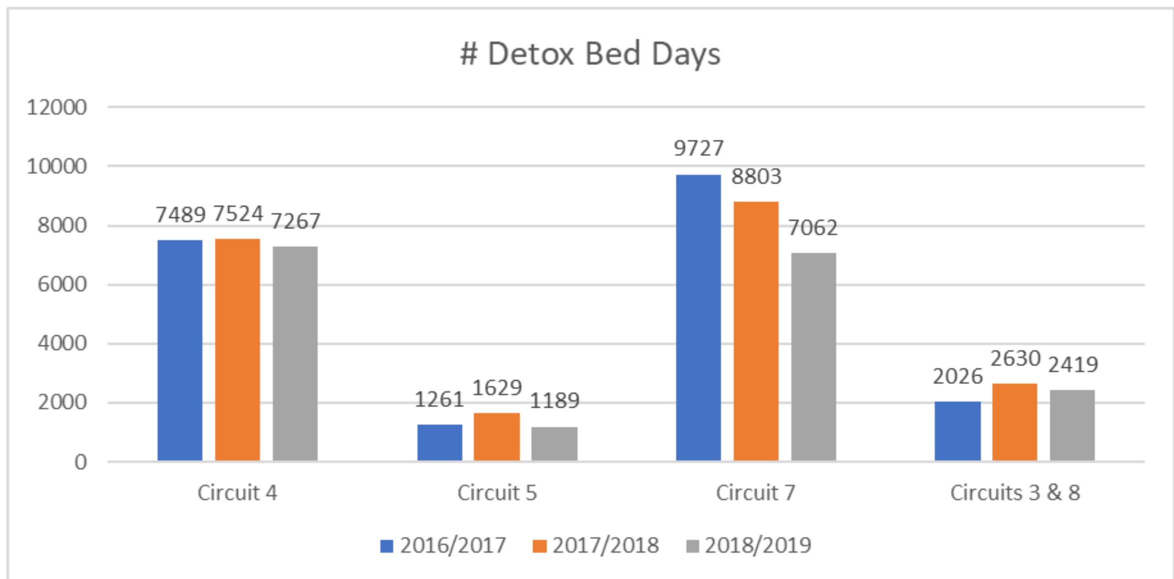
2016/2017
2017/2018
2018/2019





Safe, stable housing is a critical piece of an integrated service coordination effort in a Recovery Oriented System of Care. Permanent Supportive Housing is defined as "an evidence-based housing intervention that combines non-time limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities" (United States Interagency Council on Homelessness, 2016.) Data from the LSFHS Housing Needs Assessment tool estimates that approximately 6,484 individuals with mental health and/or substance use disorders (including family members) are in need of permanent supportive housing. DCF POE data indicates insufficient community housing options as the most significant barrier to discharge from a State Mental Health Treatment Facility (SMHTF) within 30 days. Stakeholder survey input also ranks inadequate housing options as a significant community resource gap. High risk, high need individuals with serious mental illness,

substance use disorder or co-occurring conditions are more likely to be disproportionately represented in acute care and criminal justice settings when they do not have stable housing. Preliminary data from FY 18/19 indicates annual service costs can be as much as 50% less for housed vs unhoused individuals.

b. The proposed strategy and specific services to be provided

LSFHS has implemented the care coordination initiative in accordance with DCF program guidance to the extent possible with existing resources. In order to obtain full benefit of this effort it is critical to ensure adequate resources to fully implement a robust care coordination effort at both the systemic (Managing Entity) level and the service (Provider) level. In order to promote community collaboration and ownership of responsibility for high risk, high need individuals, LSFHS has adopted a community-based model. The model requires a care coordinator for each Judicial Circuit and a single Care Coordinator for the State Hospital population. The LSFHS 23 catchment area requires 5 care coordinators, one each for Circuit 4, Circuit 5, Circuit 7, Circuits 3/8 and the State Hospital care coordinator. The current funding for Care Coordination and Housing Coordination at the ME level is non-recurring, putting in jeopardy the ability of the ME to continue to manage this critical process.

At the provider level there are 10 providers who serve the majority of consumers who meet the criteria for high risk, high need:

- Adults with 3 or more acute care admissions within 180 days or acute care admissions that last 16 days or longer, or
- Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF to the community

The appropriation of Care Coordination funding in FY 18/19 enabled LSFHS to invest in a number of innovative provider pilot programs to reduce acute care and SMHTF admissions and readmissions, for example, wraparound services including supportive housing, case management and therapeutic services, comprehensive, individualized services to provide options for individuals ready for discharge from the SMHTF, collaborations with law enforcement to reduce arrests related to behavioral health issues, and pairing care coordinators with children's CSU facilities to identify children with multiple Baker Act admissions and engage families in community services. Availability of resources has required enrolling the most needy, highest priority consumers in care coordination services. There continues to be a large number of individuals who are high need/high utilizers or are one admission away from meeting the definition as such who would benefit from care coordination if resources were available. Investing additional resources in care coordinators at the provider level can help improve outcomes for consumers and reduce costs to the system by meeting the needs of individuals in the community rather than in acute care settings.

Assuming an appropriate case load for a provider level care coordinator of 15 people, with an average length of service of 3 months, one care coordinator can serve 60 individuals in a 12-month period.

Data for the LSFHS service area identifies 665 (see chart below) individuals in FY 17/18 that meet the criteria, taking into account areas with significant geography, the need for care coordinators at the provider level is 15 FTEs.

Provider	Circuit	CSU HN/HU	Detox HN/HU	*Total*
Mental Health Resource Center	4	208	0	*208*
Gateway Community Services	4	1	109	*110*
Orange Park Medical Center (OPMC)	4	11	0	*11*
The Centers	5	43	17	*60*
Lifestream Behavioral Center	5	32	2	*34*
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BayCare Behavioral Health	7	3	1	*4*
EPIC Community Services	7	0	15	*15*
Halifax Hospital Medical Center	7	0	0	*0*
Flagler	7	23	0	*23*
Meridian Behavioral Healthcare	3 and 8	111	44	*155*
Total		**551**	**259**	***810***

LSFHS has implemented a robust housing coordination initiative. The FY 18/19 goals included:

- Increase the number of SAMH clients housed, with an emphasis on the highest cost high utilizers and individuals transitioning out of State Mental Health Treatment Facilities (SMHTF) and jail/prison systems.
- Strengthen the Continuum of Care and Housing Provider Network

The following charts summarize outcomes related to these goals.

Increase # of individuals Housed

Housing Care Coordinator and Mental Health Court Outcomes	FY 18/19	FY 17/18	YTD 16/17
# people housed through Housing Care Coordination	**158**	**75**	**144**
# people housed by Marion County Mental Health Court Housing Care Coordinator	**33**	**n/a**	**n/a**
Circuit distribution of people housed	**C4: 65** **C7: 63** **C3/8: 30** **C5: 35**	**C4:29** **C7:20** **C3/8:24** **C5:2**	

PATH Outcomes	FY 18/19
MHRC – C4	55
SMA – C7	75
UWSV – C3	59
Meridian – C8	31
Mid Florida – C5	30
# of total people housed	250
Type of Housing	In: 74 IS: 14 TH: 24 TGH: 6 ALF: 4 PSH: 27 O: 17

Type of Housing

IN (Independent Living, Non-subsidized)
PSH (Permanent Supportive Housing)
TH (Transitional Housing)
TGH (Therapeutic Group Home)
IS (Independent Living, Subsidized)
RRH (Rapid Re-Housing)
ALF (Assisted Living Facility)
O (Other)

Strengthen the Continuum of Care and Housing Provider Network

Meetings Attended	FY 18/19	FY 17/18	FY 16/17
# of CoC meetings attended	**255**	**315**	**349**
# Meetings with PATH staff	**25**	**35**	**60**
# Meetings with Community Agencies and Housing Providers	**200**	**186**	**287**
# Meetings with DCF and LSFHS contracted providers	**118**	**118**	**216**
# Meetings with Landlords/Property Managers	**18**	**0**	**10**
# Meetings related to SOAR	**25**	**54**	**39**
# of New Housing Contacts Mapped	**29**		

Trainings Provided	FY 18/19	YTD 17/18	YTD 16/17
# of people trained in **SOAR/ SSI/SSDI Simple 6**	**14**	**74**	**114**
# of people trained in **Motivational Interviewing**	**194**	**359**	**303**
# of people trained in **SPDAT/VI-SPDAT**	**40**	**14**	**92**
# of people training in **Adult Targeted Case Management**	**0**	**0**	**46**

The proposed model to meet needs is community based following judicial circuits and includes one housing care coordinator for Circuits 3/8 and one each for Circuits 4, 5, 7. The model also includes two housing resource development specialists to increase the availability of housing options across the service area, focusing on areas with a dearth of options and options for individuals with special needs such as skilled nursing care. Additionally, the model includes a SOAR Subject Matter Expert/Manager to provide training and technical assistance as well as programmatic oversight to SOAR processors in the provider network. A well-trained and proficient corps of SOAR processors will ensure benefit eligible individuals are assisted in applying for and receiving entitlement benefits in a timely manner, improving their ability to be self sufficient and reducing their reliance on other public funding.

Services provided include:

Care Coordination

- Identification of eligible individuals through data surveillance, information sharing, developing and facilitating partnerships, purchase of services and supports (ME)
- Assessment of needs including level of care determination, active engagement with consumer and natural supports, shared decision-making, linking with appropriate services and supports, monitoring progress and planning for transition to less intensive case management services when consumers are appropriately stable (Provider)
- Transitional Vouchers allow for individuals to have flexibility in addressing their behavioral health needs in the least restrictive, community-based setting and allow for the opportunity to implement service delivery in alignment with the principles of ROSC.

Housing Coordination

- Identification of eligible individuals through data surveillance, information sharing, developing and facilitating partnerships, identifying ways to increase housing resources, oversight of housing providers, training and technical assistance for SOAR processors to increase the number of individuals with benefits, purchase of services and supports through voucher system (ME)
- Assessment of needs, active engagement with consumer and natural supports, shared decision-making, linking with appropriate services and supports, facilitate successful application for

benefits through the SOAR model, monitoring progress and planning for transition to less intensive case management services when consumers are appropriately stable (Provider)

- Housing Vouchers: By utilizing flexible vouchers similar to the Community Transition Voucher program underway in the LSFHS Region, providers would have the capacity to offer housing subsidies and support for related housing expenses to place individuals with serious SA and/or MH disorders in stable housing as quickly as possible. The vouchers may also be used to cover incidental expenses such as medications not covered by third party payers. Priority for the vouchers will be given to those individuals who are being discharged from state hospitals, jails or prisons. Any remaining funds will be made available to SAMH consumers in the region in need of support to maintain housing stability and avoid repeat hospitalizations. Increased availability of flexible resources through transitional vouchers will enable the system to expand the reach of care coordination and housing coordination to be more proactive, reaching high risk, high need individuals sooner to reduce recidivism rates and improve quality of life outcomes.

c. Target population to be served:

- Adults with 3 or more acute care admissions within 180 days or acute care admissions that last 16 days or longer, or
- Adults with a SMI awaiting placement in a state mental health treatment facility (SMHTF) or awaiting discharge from a SMHTF to the community
- High risk, high service utilizers with serious mental illness, substance use disorder or co-occurring conditions who are homeless or at risk of homelessness

d. County(ies) to be served (County is defined as county of residence of service recipients)

Duval, Nassau, St Johns, Clay, Baker, Volusia, Flagler, Putnam, Baker, Union, Levy, Dixie, Gilchrist, Suwannee, Hamilton, Lafayette, Columbia, Alachua, Lake, Marion, Sumter, Citrus, Hernando,

e. Number of individuals to be served

665

3. Please describe in detail the action steps to implement the strategy

See attached excel workbook- action plan tab

4. Identify the total amount of State funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.

See attached excel workbook- budget tab

5. Identify expected beneficial results and outcomes associated with addressing this unmet need.

- Properly resourced, care coordination has the potential to reduce the reliance on acute care and criminal justice systems to address ongoing behavioral health needs, saving public dollars as these interventions come with significantly higher cost than community-based services.
- Improved overall health, well-being and quality of life for individuals with SMI, SUD or co-occurring conditions through improved engagement, coordination of assessment, and linking to needed services and supports.
- Individuals with stable supportive housing are less likely to cycle in and out of acute care and criminal justice systems resulting in more efficient use of public funds.
- Improved overall health, well-being and quality of life for individuals with SMI, SUD or co-occurring conditions through a Housing First focus.

6. What specific measures will be used to document performance data for the project

- % of readmissions to CSU within 30 days
- % of detox readmissions within 30 days
- Length of time between admissions
- % of discharge from a civil facility within 30 days
- # of individuals housed
- Length of time on Seeking Placement List for discharge from SMHTF
- Time from referral to housed
- New housing resources identified
- System cost for individual pre and post housing
- Increase in individuals receiving benefits

LSF Health Systems
FY 19/20 Enhancement Plan
Local Funding Request – Behavioral Health/Law Enforcement Co-Responder Teams

Please complete the following form for each of the five priorities identified in your Managing Entities' Needs Assessment.

1. **Please describe the process by which the area(s) of priority were determined. What activities were conducted, who participated, etc.**

Per SB12, LSFHS completed the initial triennial needs assessment in October 2016. This assessment was included a review of a variety of data elements including waitlist data, admission and discharge data, drive time to access services and access to care line call data. Stakeholder feedback was obtained and is obtained on an ongoing basis through regular participation in a wide variety of community meetings across the 23-county service area including but not limited to Behavioral Health Consortium meetings, Community Alliance meetings, Housing Continuum of Care meetings and collaborative meetings with DCF, CBC lead agencies and the ME. The needs assessment was also informed by the Prevention needs assessment conducted by our partner Community Coalition Alliance. In July 2017, and again in Jul/August 2018 stakeholder input was updated through Town Hall meetings in each circuit and a stakeholder survey distributed to over 1200 stakeholders in our service area. The 2018 survey had a 40% response rate with representation from consumers, family members of consumers, providers, and a variety of other stakeholders. . LSFHS is currently in the process of completing the 2019 Triennial Needs Assessment through a contract with the Northeast Florida Health Planning Council and WellFlorida Council. The assessment includes surveys of consumers, providers and stakeholders, provider focus groups, analysis of county level health data and county level LSF utilization data. The assessment will be completed in October 2019.

2. **Please describe:**

   a. **The problem or unmet need that this funding will address**

A call to law enforcement is often the community response to Individuals experiencing a behavioral health crisis due to mental health, substance abuse or co-occurring conditions. These calls frequently result in involuntary admission to the Crisis Unit or jail when there are no other suitable community responses available. Beginning in November 2016 Gainesville Police Department and Meridian piloted a small scale co-responder team that worked up to 4 hours per week in the Grace and Dignity Village homeless shelter, specifically in the area known locally as "tent city". The team utlized a community engagement model, interviewing residents and developing rapport, using a questionnaire to help gather information to inform expansion of the pilot. The team interviewed 77 individuals of whom 33.7% stated they suffered from mental illness or had been diagnosed with a mental illness. This information was volunteered and not expressly asked in the questionnaire. Of the individuals interviewed, 35% had been arrested by the Gainesville Police Department in the last 5 years. An additional 41.6% had other contact with the Gainesville Police Department.

In FY 2018/19, through funding by a Gainesville Police Department and LSF Health Systems/DCF, a pilot was funded consisting of a team of a CIT trained officer and Masters level mental health clinician to partner as a team to respond to calls for service involving persons with mental illness, a mental health crisis and emotionally

charged situations. The ream will address issues at the Intercept 0 and Intercept 1 points in the Sequential Intercept Model, focusing on individuals identified as high utilizers of crisis stabilization units, emergency rooms and the Alachua County Jail, intervening in a proactive and preventive manner either before a situation becomes a crisis or at the earliest stage of system involvement, thereby increasing jail diversion and crisis unit admissions. The team will free up other law enforcement officers to focus on more tradtional police concerns.

The attached data reports provided by Meridian highlight the first-year outcomes for the pilot. Several communities have expressed interest in implementing a co-responder program and Alachua County would like to expand their program to build on their success.

b. The proposed strategy and specific services to be provided

The Co-Responder model includes two full time employees; a CIT trained officer and a master's level mental health clinician. The team rides together in a marked police vehicle and responds to calls for service involving persons with mental illness, a mental health crisis, substance use and emotionally charged situations. 70% of the team's time is spent responding to calls in the community and conducting follow up visits as appropriate. The remaining 30% of the time is dedicated to leading and facilitating high utilizer case staffings, which include numerous multi-disciplinary community providers who have agreed to collaborate on solutions for individuals who are high utilizers of the criminal justice and behavioral health systems.

c. Target population to be served:

Individuals involved in law enforcement calls for service related to mental health and/or substance use

d. County(ies) to be served (County is defined as county of residence of service recipients)

Alachua, Clay, others TBD

e. Number of individuals to be served

2,000

3. Please describe in detail the action steps to implement the strategy

See attached excel workbook- action plan tab

4. Identify the total amount of State funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.

See attached excel workbook- budget tab

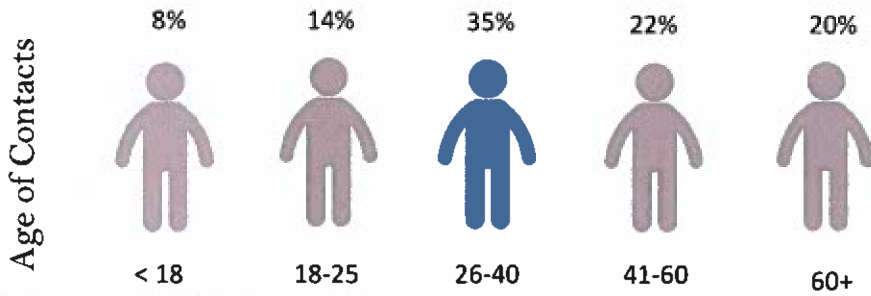
5. Identify expected beneficial results and outcomes associated with addressing this unmet need.

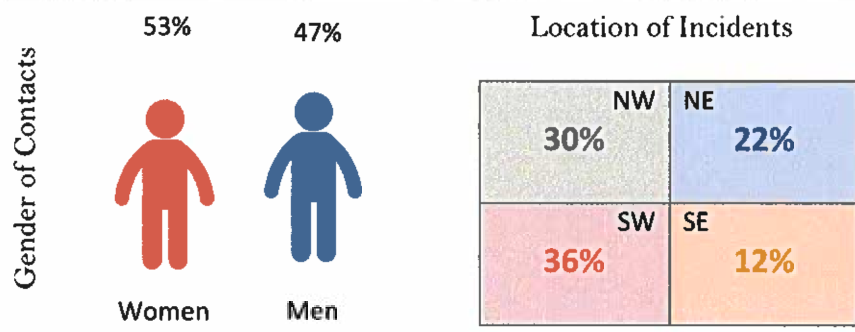
Better coordination of care for individuals who have frequent interactions with law enforcement due to behavioral health conditions, resulting in fewer repeat calls, earlier engagement in services, reduced expense for jail days and crisis unit admissions.

6. What specific measures will be used to document performance data for the project

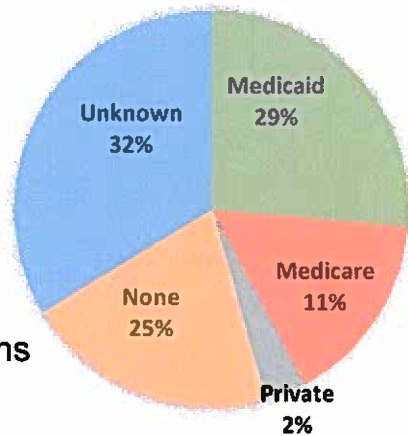
- # of diversions from acute care and criminal justice systems
- # of repeat calls
- % of individuals engaged in services
- System cost savings

Mental Health Team Calls for Service (Co-Responder)





Only 36% of individuals that called for service are in treatment at the time of initial contact.



64 Jail Diversions

71 Baker Act Diversions

Of the calls for service received, 67% had a current mental health and/or substance use diagnosis.

Statistics
April - November 2018

- Calls for Service: 434
- Contacts: 402
- Repeat Contacts: 86
- Follow Up's: 265
- Baker/Marchman Acts: 37
- Voluntary: 39
- Receiving Facility:
  - Meridian: 22
  - Other: 54

Statistics

April - November 2018

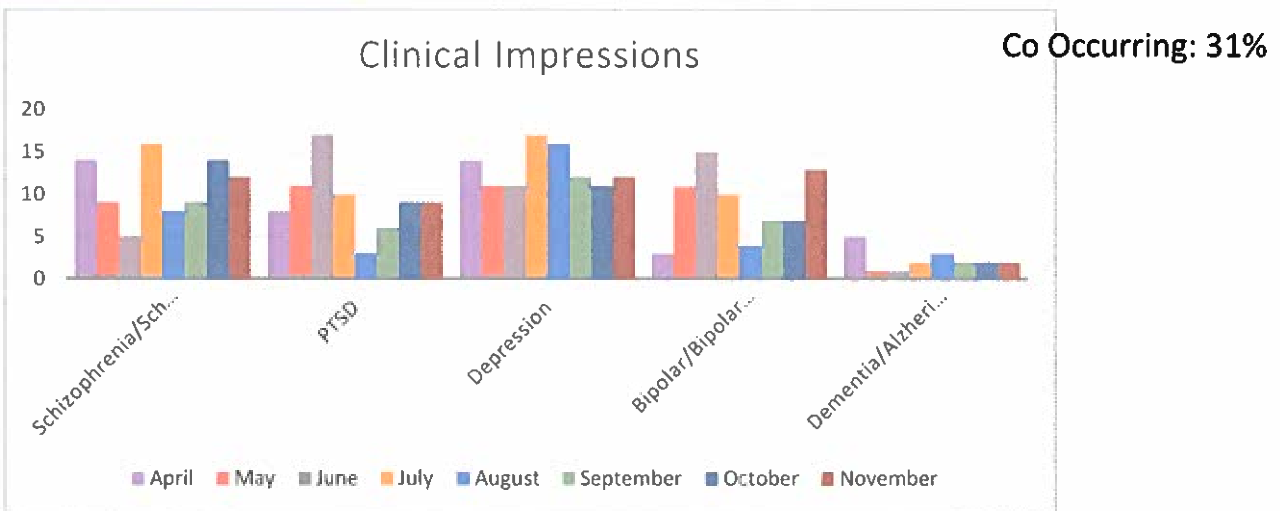
- Highest Call Volume:

  Afternoon

- Average Duration: 51 min
- Homeless: 21%
- Veterans: 10%

Mental Health Team was able to divert **75%** of individuals contacted who would have been Baker Acted and were able to refer them to mental health outpatient treatment or admit them on a voluntary basis for inpatient treatment.

Mental Health Team was also able to divert **92%** of individuals contacted that could have been arrested on scene. This saved the jail approximately $222,270.



Co Occurring: 31%

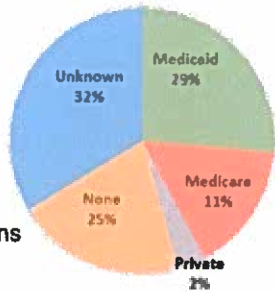
Gainesville.
Citizen centered
People empowered

The Co-responder program is sponsored by Meridian Behavioral Healthcare, the City of Gainesville, Gainesville Police Department, LSF Health Systems LLC, and the State of Florida, Department of Children and Families.

Mental Health Team Calls for Service Explainer (Co-Responder)

Age of Contacts- The age of individuals contacted during calls for service.
Gender of Contacts- The gender of individuals contacted during calls for service.
Location of Incident- The area of town where incident occurred.

Only **36%** of individuals that called for service are in treatment at the time of initial contact.



64 Jail Diversions

71 Baker Act Diversions

Of the calls for service received, **67%** had a current mental health and/or substance use diagnosis.

Current Diagnosis- Reported diagnosis verified by Meridian docs – or - If not a client of Meridian, then self-reported with supportive information, or with other documentation from hospitals, etc. is included.

Calls for Service- Number of calls requesting Team.

36% of Individuals in treatment- Self-reported. Not all were Meridian clients, but stated that have private counselors and/or go to other community resources for treatment.

Insurance- Self-reported. High percentage of unknown due to inability to ask during a crisis situation.

Jail Diversions- People who could have been arrested on scene for a crime if intervention was not available at the time of incident.

Baker Act Diversions- People who could have been Baker Acted if intervention was not available at time of incident. Referrals made to outpatient resource alternatives; which addressed the crisis without a need for inpatient treatment.

Statistics
April – November 2018

- Calls for Service: 434
- Contacts: 402
- Repeat Contacts: 86
- Follow Up's: 265

Contacts- # of contacts made on calls for service. Did not make contact with individual on every call. Some were UTL.

Repeat Contacts- Individuals who had contact with Team on prior calls for service. Some repeats were 2 or 3 calls and others were 8 or 9.

Follow Up's- Number of times follow up was conducted from calls for service. Most people who were not contacted were unable to be located or did not return phone calls, etc.

- Baker/Marchman Acts: 37
- Voluntary: 39
- Receiving Facility:
  - Meridian: 22
  - Other: 54

Baker/Marchman Acts- # of individuals Baker or Marchman Acted by Team due to immediate need for inpatient treatment.

Voluntary- # of individuals who were taken by the Team to a facility for voluntary inpatient treatment without necessity of Baker Act. (Person knew they were suicidal/homicidal and wanted treatment)

Receiving Facility- Aside from Meridian receiving facilities used were North Florida ER, VISTA, Shands ER, and VA.

- Highest Call Volume: Afternoon
- Average Duration: 51 min
- Homeless: 21%
- Veterans: 10%

Call Volume- Afternoon considered between 12:00 pm and 3:30 pm for our purposes. Team only works 9a to 7p.

Average Duration- Some calls took 15 minutes and others over 2 hours, but the average was 51 minutes.

Homeless- Only 21% of the calls for service involved homeless individuals. 22% of the homeless individuals we made contact with requested voluntary transport to Meridian for suicidal ideations or homicidal ideations.

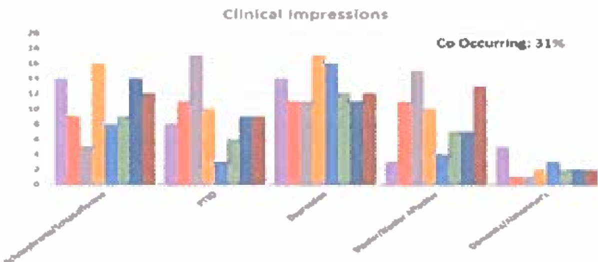
Veterans- This number is only individuals being contacted by our team.

Mental Health Team was able to divert **75%** of individuals contacted who would have been Baker Acted and were able to refer them to mental health outpatient treatment or admit them on a voluntary basis for inpatient treatment.

This number indicates the 75% of individuals who would/could have been Baker Acted by LEO, not that 75% of individuals could have been Baker Acted. These individuals were provided referrals for outpatient treatment. Some were provided transport for immediate outpatient assistance.

Mental Health Team was also able to divert **92%** of individuals contacted that could have been arrested on scene. This saved the jail approximately $222,270.

The number indicates that 92% of individuals contacted who could have been arrested on scene were not, it does not indicate that 92% of people contacted could have been arrested. The only people who were arrested on scene committed serious violent crimes. The amount of money saved by the jail due to diversions came from the average number of days spent in jail after being booked and the amount of money that the jail spends daily on individuals with mental health needs.



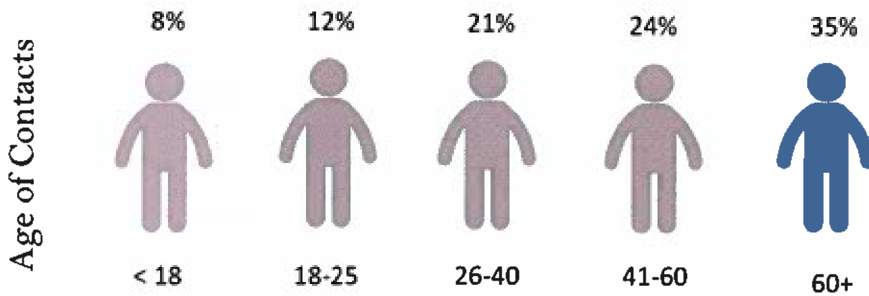
Reported diagnosis verified by Meridian docs – or - If not a client of Meridian, then self-reported with supportive information, or with other documentation from hospitals, etc. is included. The same holds true for Co-Occurring %.

The Co-responder program is sponsored by Meridian Behavioral Healthcare, the City of Gainesville, Gainesville Police Department, LSF Health Systems LLC, and the State of Florida, Department of Children and Families.

Meridian Media Contact:
Joy Riddle, SVP Marketing,
Communications, and Advancement
joy_riddle@mbhci.org
352.374.5600 x8218 * 352.262.2103

Mental Health Team Calls for Service

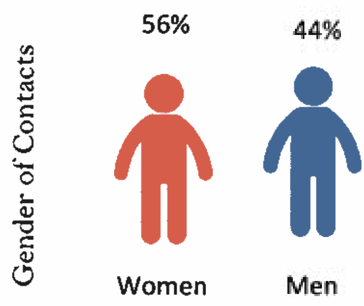
Age of Contacts



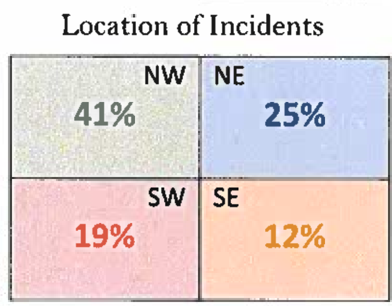
Annual Statistics

- Calls for Service: 333
- Contacts: 314
- Repeat Contacts: 92
- Homeless: 19%
- Veterans: 8%

Gender of Contacts

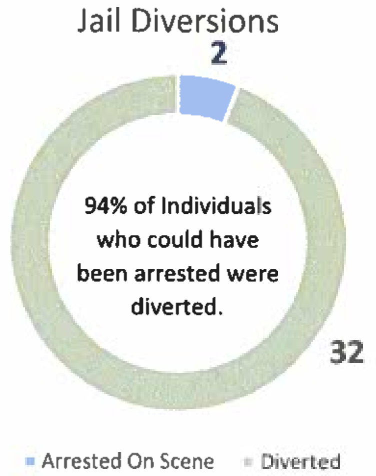


Location of Incidents

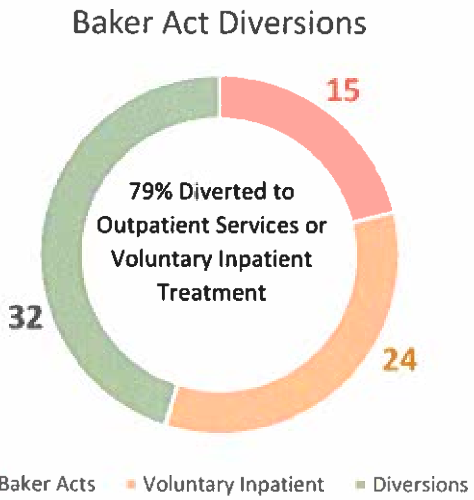


Only **34%** of individuals contacted by the Team reported being in treatment at the time of initial contact.

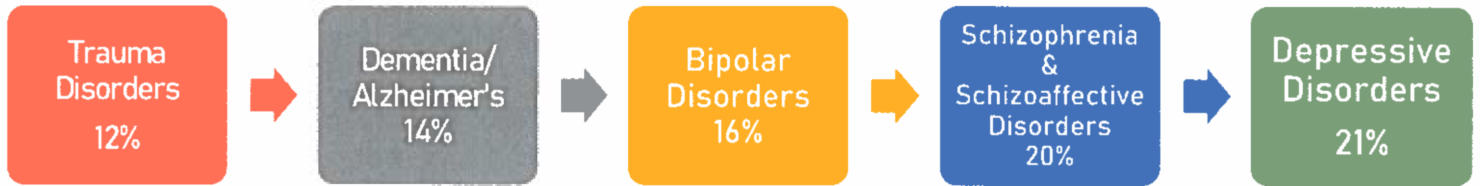
Jail Diversions



Baker Act Diversions



Of the individuals contacted on calls, **59%** had a current mental health and/or substance use diagnosis.

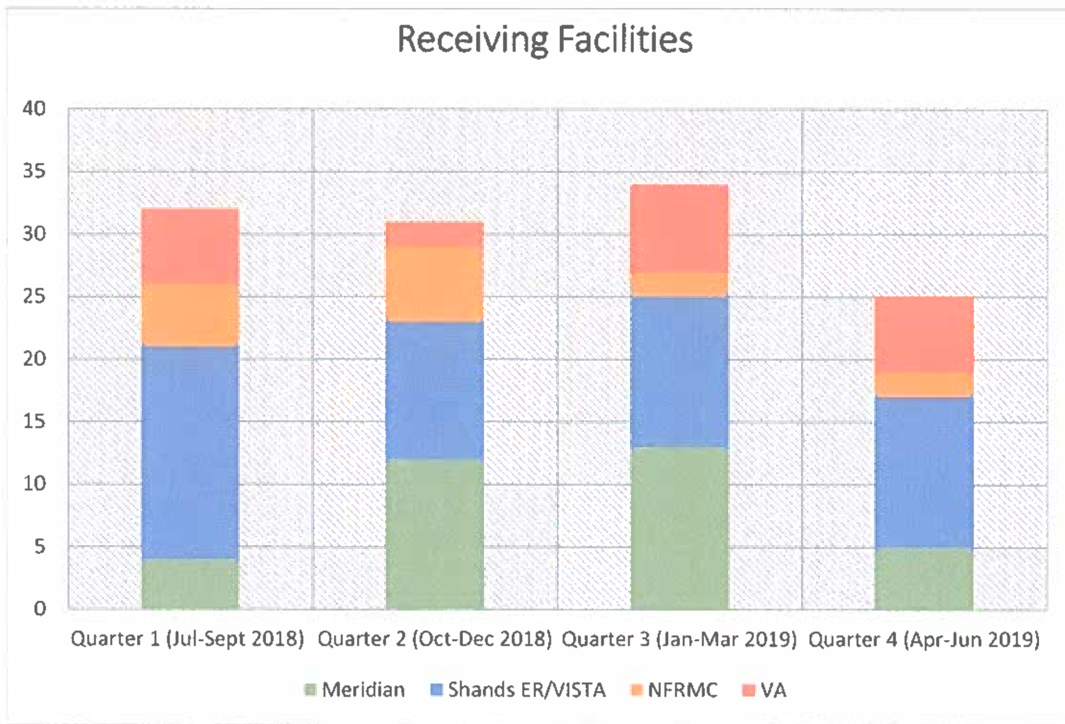


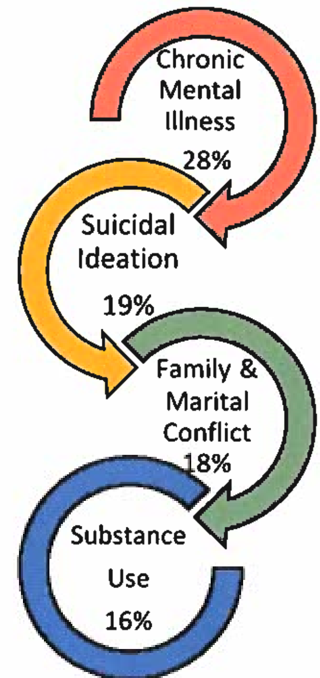
Clinical Impressions

Trauma Disorders 12% → Dementia/ Alzheimer's 14% → Bipolar Disorders 16% → Schizophrenia & Schizoaffective Disorders 20% → Depressive Disorders 21%

Co-Occuring: 26%

Identified Causations of Crisis





Mental Health Team Top Utilizers

Schizophrenia

Schizoaffective Disorder

Depressive Disorder

PTSD

Bi-polar Disorder

Bi-polar Affective Disorder

Personality Disorder

63% of Top Utilizers have a reported substance use concern

Total Arrests: **14**

Total number of Jail Days: **1,122**

Total Costs of Jail Days this month: **$134,640**

Total CSU/Detox Admissions: **11**

Total number of CSU/Detox days: **278**

Total number of documented Police Contacts: **40**

Total number of State Hospital Admissions: **5**

Discharge/Standby End of Year: **24**

LSF Health Systems
FY 19/20 Enhancement Plan
Local Funding Request – Central Receiving System

Please complete the following form for each of the five priorities identified in your Managing Entities' Needs Assessment.

1. **Please describe the process by which the area(s) of priority were determined. What activities were conducted, who participated, etc.**

Per SB12, LSFHS completed the initial triennial needs assessment in October 2016. This assessment was included a review of a variety of data elements including waitlist data, admission and discharge data, drive time to access services and access to care line call data. Stakeholder feedback was obtained and is obtained on an ongoing basis through regular participation in a wide variety of community meetings across the 23-county service area including but not limited to Behavioral Health Consortium meetings, Community Alliance meetings, Housing Continuum of Care meetings and collaborative meetings with DCF, CBC lead agencies and the ME. The needs assessment was also informed by the Prevention needs assessment conducted by our partner Community Coalition Alliance. In July 2017, and again in Jul/August 2018 stakeholder input was updated through Town Hall meetings in each circuit and a stakeholder survey distributed to over 1200 stakeholders in our service area. The 2018 survey had a 40% response rate with representation from consumers, family members of consumers, providers, and a variety of other stakeholders. . LSFHS is currently in the process of completing the 2019 Triennial Needs Assessment through a contract with the Northeast Florida Health Planning Council and WellFlorida Council. The assessment includes surveys of consumers, providers and stakeholders, provider focus groups, analysis of county level health data and county level LSF utilization data. The assessment will be completed in October 2019.

2. **Please describe:**

   a. **The problem or unmet need that this funding will address**

During the 2016 legislative session, the Florida State Legislature passed SB12 which included the mandate to establish a coordinated system of care, defined as "a system that assures, within available resources, that clients have access to the full array of behavioral and related services in a region or community offered by all service providers, whether participating under contract with the managing entity or another method of community partnership or mutual agreement within the mental health services delivery system. "The coordinated system of care is to function as a "No Wrong Door model", defined as "a model for the delivery of acute care services to persons who have mental health or substance abuse disorders, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system. The essential elements of a coordinated system of care include:

(a) Community interventions, such as prevention, primary care for behavioral health needs, therapeutic and supportive services, crisis response services, and diversion programs.

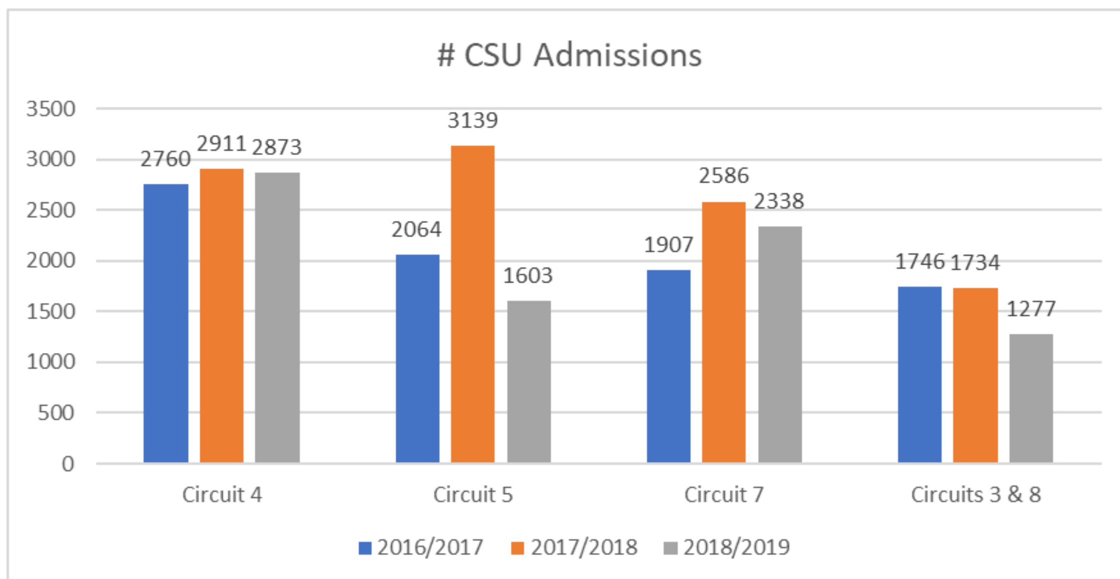
(b) A designated receiving system shall consist of one or more facilities serving a defined geographic area and responsible for assessment and evaluation, both voluntary and with mental illness, substance abuse disorder, or

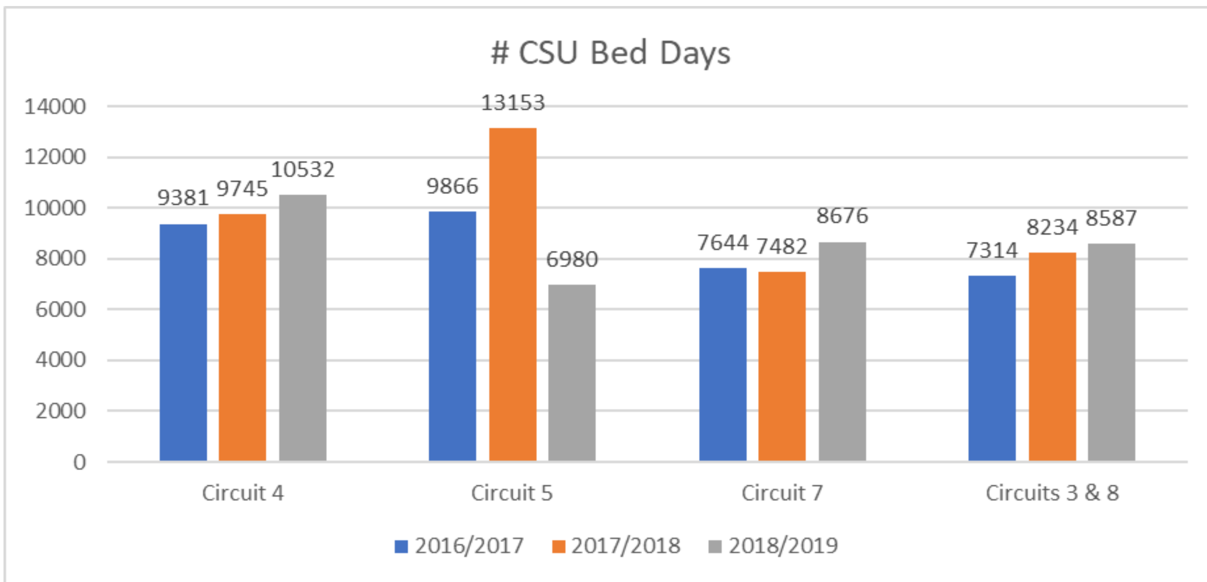
co-occurring disorders. A county or several counties shall plan the designated receiving system through an inclusive process that includes the managing entity and is open to participation from individuals with behavioral health needs, their families, providers, law enforcement, and other parties. The county or counties, in collaboration with the managing entity, shall document the designated receiving system through memorandum of agreement or other binding arrangements."

The legislature provided a number of system improvement grants to facilitate the implementation of the legislatively mandated model. Three grants were awarded in the LSFHS service area. The grants were awarded by competitive procurement. Applications developed were the result of many months of community planning and investment by a wide array of stakeholders including but not limited to county government, law enforcement and local service providers. Initial grants were for a five year period. In the 2017 legislative session the grant funding was reduced by approximately 40%, however funding was restored in the 2018 session.

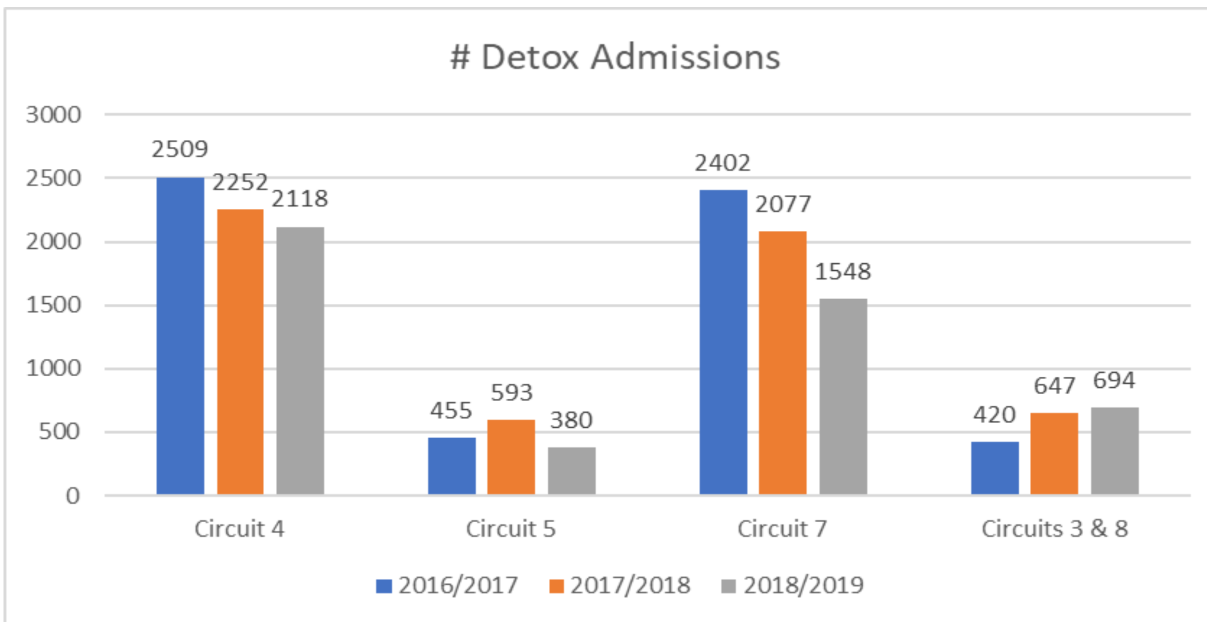
The service area covered by LSF Health Systems is comprised of 23 largely rural counties. Many counties have limited resources to invest in the enhancement of behavioral health services for their citizens. Economies of scale and shared resources have resulted in citizens in multiple counties having to travel significant distances for services, particularly for residential or inpatient treatment and acute care services such as crisis stabilization and detox. System Improvement grants have enabled three areas in the LSF Health Systems catchment area to develop comprehensive central receiving systems. Those areas include Duval County, Volusia/Flagler Counties and Lake/Sumter Counties. In judicial circuit 5, Marion County houses the acute care services for Marion and Citrus Counties. Hernando County is served largely out of the acute care system in the Tampa Bay area. Baker Act patients are transported long distances for assessment, presenting challenges for law enforcement, family members and the individuals themselves. A similar situation is present in judicial circuits 3/8 where the only acute care facilities are located in Gainesville (serving Dixie, Gilchrist, Alachua, Levy, Putnam and Bradford counties) and Lake City (serving Columbia, Hamilton, Lafayette, Baker, Union and Suwannee counties) .

Communities have developed transportation plans and service arrays to comply with the requirements of SB 12 to the best of their abilities within available resources. Additional System Improvement grants to provide the resources to more fully develop and enhance the basic systems in place are a priority for LSF Health Systems and our stakeholders. Acute Care data for the 5 Circuits in the LSF Health Systems service area for FY 16/17 and 17/18 is reflected in the following charts:

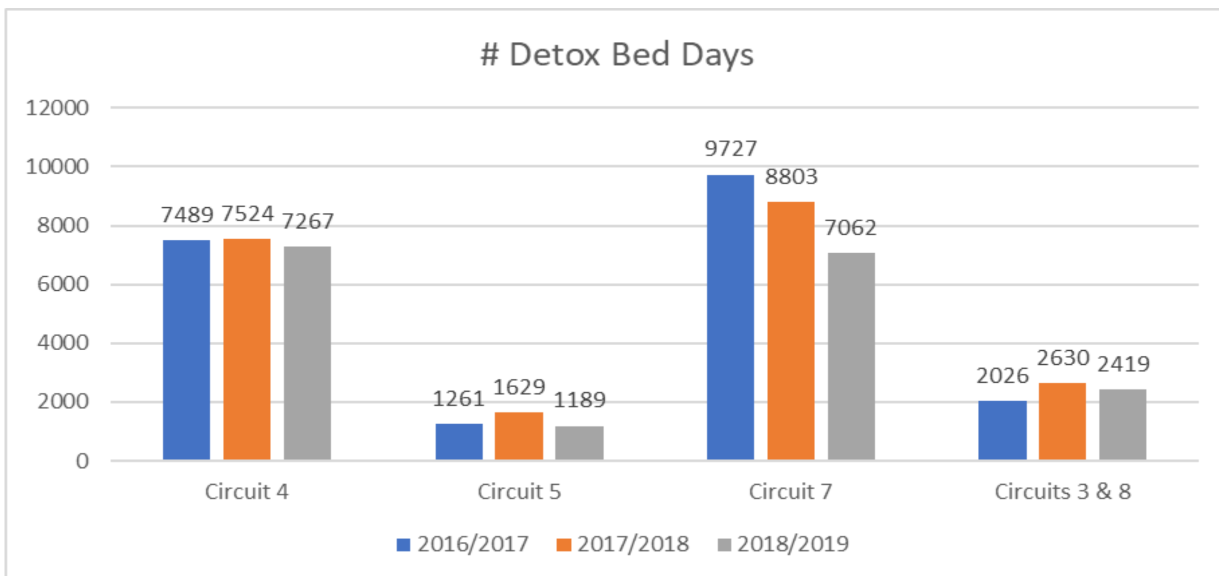




CSU Bed Days
14000
12000
10000
8000
6000
4000
2000
0
9381
9745
10532
9866
13153
6980
7644
7482
8676
7314
8234
8587
Circuit 4
Circuit 5
Circuit 7
Circuits 3 & 8
2016/2017
2017/2018
2018/2019



Detox Admissions
3000
2500
2000
1500
1000
500
0
2509
2252
2118
455
593
380
2402
2077
1548
420
647
694
Circuit 4
Circuit 5
Circuit 7
Circuits 3 & 8
2016/2017
2017/2018
2018/2019



The needs of High Need/High Utilizers are more effectively managed within a coordinated Central Receiving System. The chart below shows the 18/19 High Need/High Utilizer data by Provider and Circuit.

Provider	Circuit	CSU HN/HU	Detox HN/HU	*Total*
Mental Health Resource Center	4	208	0	*208*
Gateway Community Services	4	1	109	*110*
Orange Park Medical Center (OPMC)	4	11	0	*11*
The Centers	5	43	17	*60*
Lifestream Behavioral Center	5	32	2	*34*
SMA Healthcare	7	119	71	*190*
BayCare Behavioral Health	7	3	1	*4*
EPIC Community Services	7	0	15	*15*
Halifax Hospital Medical Center	7	0	0	*0*
Flagler	7	23	0	*23*
Meridian Behavioral Healthcare	3 and 8	111	44	*155*
Total		**551**	**259**	***810***

b. The proposed strategy and specific services to be provided

Full implementation of community specific, approved central receiving system projects to include added capacity in crisis stabilization beds, added capacity in residential treatment beds, added capacity in assessment, care coordination, intervention to effectively triage and serve individuals through the no wrong door model in a manner that most efficiently meets their needs in the least restrictive environment and reduces the ineffective and costly use of hospitals and jails to treat mental health and substance use disorders. LSF Health Systems will collaborate with system stakeholders in local

communities to conduct a robust planning process and application for additional resources should they become available.

c. **Target population to be served:**

Adults and children in need of assessment, community and crisis/emergency services

d. **County(ies) to be served (County is defined as county of residence of service recipients)**

Marion, Citrus, Hernando, Alachua, Dixie, Gilchrist, Levy, Putnam, Bradford, Columbia, Hamilton, Lafayette, Baker, Union, Suwannee

e. **Number of individuals to be served**

2500

3. **Please describe in detail the action steps to implement the strategy**

See attached excel workbook- action plan tab

4. **Identify the total amount of State funds requested to address the unmet need and provide a brief budget narrative. Please identify any other sources of state and county funding that will contribute to the proposal.**

See attached excel workbook- budget tab

5. **Identify expected beneficial results and outcomes associated with addressing this unmet need.**

Improved triage, assessment and coordination of a wide array of services will result in a system that is able to more effectively and efficiently meet the needs of individuals with mental health, substance use and co-occurring conditions and make the most efficient use of limited state resources.

6. **What specific measures will be used to document performance data for the project**

- % of readmissions to CSU within 30 days
- % of detox readmissions within 30 days
- # of diversions from acute care and criminal justice systems
- Time for Law Enforcement to connect Baker Act and Marchman Act patients to treatment
- Time from referral to initial service appointment
- # of successful completion and discharge from treatment