REVISED EXHIBIT T

Children's Mental Health Services Model –
Families and Communities Empowered for Success (F.A.C.E.S.)

Thriving Mind through this contract funds a clinical model under Children's Mental Health services that enables youth with multiple and changing needs to remain in the least restrictive settings in their community and attain and maintain a physical-mental-emotional-spiritual recovery. The clinical model is known as Families and Communities Empowered for Success (F.A.C.E.S.) which was developed with the support of a System of Care SAMHSA Grant that was awarded to the Florida Department of Children and Families in 2009.

I. Description

The F.A.C.E.S. clinical team will provide a flexible array of intensive in-home services and supports to youth designed to maintain them in the least restrictive community setting. Services will be delivered utilizing a recovery-oriented model applying recovery management practices. These practices are accomplished by using Florida's Recovery-Oriented System of Care (ROSC) Framework as described in Exhibit BH, Recovery Management Practices. These services provide assistance to youth and their families in identifying goals and making choices that promote resiliency and facilitate recovery. Recovery is the personal process of overcoming the negative impact of a psychiatric and substance abuse/use despite its continued presence. As such, these services are intended to restore the functioning level of the individual and their participation in the community by reconnecting them with society and rebuilding skills in their identified roles within the community. The focus is on the strengths, resources, readiness and recovery phase of the child/ youth and their family. This team approach for delivery of services will be used to guide and support children/youth and their families with development of a recovery plan focusing on the areas of individual and family living, learning, working and socialization.

F.A.C.E.S. eligible youth are those 6 through 17 years of age at-risk of entering a more restrictive level of care within the Children's Mental Health service continuum, who present for services in Miami-Dade County and are identified by a full clinical assessment such as the bio-psychosocial with a serious emotional or emotional mental health diagnosis, substance abuse diagnosis, and co-occurring mental health and substance abuse diagnosis and are expected to carry such diagnosis for at least one (1) year. Exclusionary criteria include the functional and/ or behavioral problems primarily related to cognitive or developmental disabilities (including learned behavioral problems not associated with a mental health condition or if the youth lacks the cognitive ability to benefit from insight-oriented therapy). In addition, children/ youth will not be eligible for F.A.C.E.S. services when they are receiving similar therapeutic services of equal or greater intensity from another source; when the parent or caregiver does not voluntarily consent to the services; or when the parent, foster parent, caregiver, and/ or youth do not agree to actively participate in the program.

Based on a recovery-oriented model, it is expected that the type and frequency of services offered will be based on the treatment phase that the children/youth and their family are in and by their expressed needs. The treatment phases provided within the program and the expected service array are as follows:

1. **Engagement** - The youth and/ or family have expressed a desire to enter treatment and the provider is in the process of developing a therapeutic relationship during this phase. This is the initial stage of exploring the challenges that the child/ youth are experiencing that are associated with their mental health, substance abuse, or co-occurring disorder and the familial dynamics. This phase is associated

with a high intensity of clinical services and supports, in order to fully engage the child/ youth and family in treatment.

2. **Treatment** - The youth and family are fully engaged and are willing to discuss the problems that brought them to treatment and are working to address the symptoms associated with their diagnosis during this phase. This treatment phase is associated with a high intensity of clinical services and supports in order to address the symptoms in which the child/ youth and family present.
3. **Stabilization & Discharge** - The symptoms associated with the diagnosis that brought the youth into services are being managed sufficiently and the youth is stabilized. The youth and family are actively participating in treatment and have an increased awareness of their symptoms and the steps needed to manage them. This treatment phase is associated with a lower intensity of clinical services and supports that are aimed at assisting the youth and family to maintain recovery and prepare them for discharge into a lower level of care. It is anticipated that youth and their families stay in this treatment phase up to two months prior to their transition to a lower level of care.
4. A Warm Handoff should be utilized prior to discharge. "Warm Hand-off" as defined by the U.S. Department of Health and Human Services is a transfer of care between two members of the health care team, where the handoff occurs in front of the patient and family. This transparent handoff of care allows patients and families to hear what is said and engages patients and families in communication, giving them the opportunity to clarify or correct information or ask questions about their care. Warm handoffs engage the patient through structured communication and improve safety by helping prevent communication breakdowns.

The F.A.C.E.S. clinical team is led by a Licensed Clinical Supervisor who provides administrative oversight and coordinates the services of the treatment teams comprised of the following staff:

- A Licensed Clinical Supervisor – 1 FTE
- Certified Recovery Peer Specialist (may include Family Coach or Peer Specialist) – 2 FTE
- A Care Coordinator/Targeted Case Manager – 2 FTE
- A Therapist/Clinician – 3 FTE

It is understood that individual and family therapy will be provided by different clinician from the Licensed Clinical Supervisor of the F.A.C.E.S. teams in keeping with best practices. If the need arises, members of the team can be added, such as a Certified Behavioral Analyst, Psychiatrist, etc. as determined by the individual needs of the child/ youth and their family. All clinical team members must meet at least one (1) time per week and staff must be trained and competent in utilizing evidence-based practices, recovery concepts and language. The family and youth voice and choice must be evident throughout all phases of treatment, from engagement through stabilization and discharge.

Moreover, in order to provide the full complement and quality of services and supports offered through F.A.C.E.S., each team must maintain a full staffing pattern as specified in the approved program description, incorporated herein by reference, which aligns with the allocation of contracted dollars. While Thriving Mind understands that staff turnover is common in the social service industry, it is the responsibility of the provider to ensure that all positions are filled within eight (8) weeks of vacancy. In addition, position(s) that remain vacant for extended periods of time will negatively impact the ability of the provider to draw down allocated funds meaning failure to maintain a full complement of staff may result in the reallocation of contracted dollars. It is expected that temporary staff trained in the services delivery model and implemented evidence-based practices will be re-assigned to vacant position(s) to

ensure that the full array of services and supports are provided to all children/ youth and their families. Vacant positions must be filled with permanent staff within three (3) months.

II. System of Care Values

A key principle of systems of care is that screening, assessment, evaluation, and service planning must be strengths and resources based and that they take into account both the child/youth and the strengths, resources, and needs of the family. The following system of care values must be embedded within all aspects of the F.A.C.E.S. service array provided through:

- Family Driven Care
- Youth Driven Care
- Cultural and Linguistic Competence
- Individualized
- Evidence-Based practices
- Streamlining and expediting access to services
- Continuous Quality Assurance
- Collaborative
- Community-Based
- Integrated Services
- Trauma Informed Care
- Trauma Specific Care

III. Comprehensive Community Service Team (CCST) Services Documentation

Services and supports provided are rendered through the Comprehensive Community Service Team (CCST) as defined in Rule 65E-14, F.A.C. CCST is a bundled service package designed to provide short-term assistance and guide individuals in rebuilding skills in identified roles in their environment through the engagement of natural supports, treatment services, and assistance of multiple agencies when indicated. Services provided under Comprehensive Community Service Teams may not be simultaneously reported to another Covered Service. Allowable bundled activities include the following Covered Services as defined in 65E-14, F.A.C. are as follows: Aftercare, Assessment, Case Management, Information and Referral, In-home/On-Site, Intensive Case Management, Intervention, Outpatient, Outreach, Prevention-Indicated, Recovery Support, Supported Employment, and Supportive Housing. Other transition, Therapeutic Recreational Activities (non-traditional support services), medications and other enhancement support services, as identified on the treatment plan, are considered allowable expenses and reimbursed using Incidental Expenses covered service pursuant to Rule 65E-14, F.A.C.

IV. Service Array

F.A.C.E.S. provides therapeutic services and supports to youth and their families with diverse and complex needs. Therefore, it is anticipated that caseloads will vary widely in intensity and the types of services and supports delivered. While some cases may involve the minimum required service type and frequency, others may warrant significantly more clinical services and supports in order to address their changing and complex needs. However, there should be no more than thirty (30) cases served at one time by a clinical team based on guidance and phases of treatment. Once the needs of the youth and family have been adequately stabilized, resulting in a reduction in either the frequency or type of required services, it is recommended that they be stepped down with adequate natural supports and

continue clinical services within the outpatient service continuum.

There must be evidence that staff is aware of the needs of the youth and family, and documentation in the service record that identified needs are addressed by the CCST and the person receiving services. Staff must assist families with obtaining benefits (insurance, Social Security and income) and must adhere to the requirements of Exhibit AN, Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery SOAR. Documentation in the service record must reflect efforts, progress, and barriers to individualized goals and treatment objectives, including school performance. Documentation is necessary to identify changes in services, supports, and continuity of those services and supports (i.e., treatment plan updates indicating new/revised/achieved goals). A safety plan must be developed with the youth and family and included within the case record.

There must be evidence that the youth and family members receiving services, and supports were offered support in self-managing wellness via activities such as, but not limited to, education, supportive counseling, or skills training, and made aware of appropriate self-help or support groups. Evidence is required that those receiving services actively take part in achieving his/her service goal(s) and choose others who are involved in their recovery (as in Wellness Recovery Action Plan "WRAP Plans" Crisis Management tools). These persons could be family members, friends, or significant others. The F.A.C.E.S. Clinical Team, Certified Recovery Peer Specialist in particular, should have as a primary goal the creation of natural support systems. Documentation must reflect the use of natural supports. Furthermore, the Certified Recovery Peer Specialist must document all contact with the youth and family.

V. Data and Reporting Requirements

a. The Network Provider must submit all data, in accordance with 394.74(3)(e), F.S., and the DCF PAM 155-2, for the services reimbursed through this contract to the ME into Carisk or other data system designated by the ME and/or the Department.

b. F.A.C.E.S. Children's System of Care (CSOC) Monthly Census and Waitlist Report – To ensure consistency and accuracy in monitoring service availability and capacity, the Network Provider will submit the F.A.C.E.S. Children's System of Care Monthly Census and Waitlist Report in the template provided by the ME, by the due date and to the individuals listed in Exhibit C, Required Reports.

VI. Minimum Training & Certification Requirements

The following evidence-based practices must be utilized with children/youth enrolled in F.A.C.E.S.:

1) **Motivational Interviewing (MI)**. All F.A.C.E.S. clinical team members are required to complete MI training within six (6) months of joining the team. MI training is not required for those who completed the training within two (2) years prior to joining the F.A.C.E.S. clinical team. MI must be utilized with all children/youth enrolled in F.A.C.E.S.

2) **Wellness Recovery Action Planning (WRAP).** All F.A.C.E.S. clinical team members are required to complete the initial three (3) day WRAP training within six (6) months of joining the team. WRAP training is not required for those who completed the training within two (2) years prior to joining the F.A.C.E.S. clinical team. The WRAP facilitator five-day training is available to all F.A.C.E.S. clinical team members, however, this training is only required for those individuals who will be providing WRAP training within their organizations.

3) **High Fidelity Wraparound Best Practice (Wraparound).** All F.A.C.E.S. clinical team members are required to complete the (3) day Wraparound 101 training within six (6) months of joining the team and achieve certification within one (1) year of joining the team. In addition, all Case Management Supervisors are required to complete the two (2) day Supervisory Wraparound training and achieve certification within six (6) months of employment. Therapists are required to complete a half (1/2) day training designed for therapist working on the Wraparound team. Wraparound training is not required for those who completed the training within two (2) years prior to joining the F.A.C.E.S. clinical team. In addition, the Care Coordinator/Targeted Case Manager must complete all requirements for certification. Peer Support Specialist and Family Coaches are required to complete the Wraparound Family/Peer Support Training: a two (2) day training focused on the important and integral role of the Family and Peer Support partners in the Wraparound process. This training offers support and education to help these partners be successful as part of the Wraparound team. This evidence-based practice must be utilized with all children/youth enrolled in F.A.C.E.S.

4) **Recovery Peer Specialist Training & Certification.** All Peer Specialist are required to complete the Peer Specialist training as outlined by the Florida Certification Board within six (6) months of joining the F.A.C.E.S. clinical team and achieve certification within one (1) year of joining the team. The Peer Specialist training is not required for those who completed the training within two (2) years prior to joining the F.A.C.E.S. clinical team. This evidence-based practice must utilize with all children/youth enrolled in F.A.C.E.S.

5) **Certified Behavioral Health Case Manager (CBHCM).** The team is expected to have on staff a Certified Behavioral Health Case Manager. All targeted Case Managers must be certified as a Behavioral Health Case Manager by the Florida Certification Board within 90 days of employment.

6) All F.A.C.E.S. clinical team members must complete at least 20 hours of training during the orientation period, and annually thereafter, as required by Rule 65D-30, F.A.C., which includes two (2) hours of HIV/AIDS training, two (2) hours of aggression control techniques, and CPR training.

VII. Peer Services. The Network Provider must adhere to the terms and conditions pursuant to Exhibit AO, Peer Services.

VIII. Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR).

The Network Provider must process SOAR applications, as required by Exhibit AN, for the target population receiving services under this contract that have been screened and determined to be eligible for SOAR benefits.