Tab 3	**SB 282** by **Rouson (CO-INTRODUCERS) Jones, Book**; (Identical to H 00795) Mental Health and Substance Use Disorders
Tab 4	**SB 294** by **Garcia**; (Similar to H 00617) Public Records/Statewide Council on Human Trafficking
Tab 5	**SB 704** by **Harrell**; (Similar to H 00479) Substance Abuse Service Providers
Tab 6	**SB 756** by **Diaz**; Public Records/Human Trafficking Victims
Tab 7	**SB 764** by **Albritton**; (Similar to H 00757) Step Into Success Internship Program
Tab 8	**SB 792** by **Ausley (CO-INTRODUCERS) Garcia**; (Similar to H 00563) Children and Young Adults in Out-of-home Care
Tab 1	**SPB 7008** by **CF**; OGSR/Substance Abuse Impaired Persons
Tab 2	**SPB 7010** by **CF**; OGSR/Public and Professional Guardians

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Garcia, Chair
Senator Book, Vice Chair

MEETING DATE: Tuesday, November 30, 2021
TIME: 12:30—3:00 p.m.
PLACE: *Mallory Horne Committee Room,* 37 Senate Building

MEMBERS: Senator Garcia, Chair; Senator Book, Vice Chair; Senators Albritton, Brodeur, Harrell, Rouson, Torres, and Wright

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	Consideration of proposed bill:		
1	**SPB 7008**	OGSR/Substance Abuse Impaired Persons; Amending a provision relating to an exemption from public records requirements for involuntary assessment and stabilization, court orders, related records, and personal identifying information regarding substance abuse impaired persons; removing the scheduled repeal date of the exemption, etc.	Submitted and Reported Favorably as Committee Bill Yeas 7 Nays 0
	Consideration of proposed bill:		
2	**SPB 7010**	OGSR/Public and Professional Guardians; Amending a provision which provides an exemption from public records requirements for certain information held by the Department of Elderly Affairs in connection with a filed complaint or subsequently conducted investigation relating to public and professional guardians; removing the scheduled repeal of the exemption, etc.	Submitted and Reported Favorably as Committee Bill Yeas 7 Nays 0
3	**SB 282** Rouson	Mental Health and Substance Use Disorders; Providing that the use of peer specialists is an essential element of a coordinated system of care in recovery from a substance use disorder or mental illness; revising background screening requirements for certain peer specialists; requiring the Department of Children and Families to develop a training program for peer specialists and to give preference to trainers who are certified peer specialists; authorizing the department to certify peer specialists, either directly or by approving a third-party credentialing entity, etc. CF 11/30/2021 Favorable AHS AP	Favorable Yeas 7 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 294** Garcia (Similar H 617)	Public Records/Statewide Council on Human Trafficking; Creating an exemption from public records requirements for personal identifying information of a donor or prospective donor to the direct-support organization of the Statewide Council on Human Trafficking who desires to remain anonymous; providing an exemption from notice requirements for specified meetings; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity, etc. CF 11/30/2021 Favorable GO RC	Favorable Yeas 7 Nays 0
5	**SB 704** Harrell (Similar H 479)	Substance Abuse Service Providers; Requiring service provider applicants to include the names and locations of certain recovery residences in their license application; requiring service providers to record specified information in the Department of Children and Families' Provider Licensure and Designations System after a specified date; providing civil penalties; prohibiting certified recovery residence administrators from actively managing more than a specified number of residents; requiring service providers to return an individual's personal effects upon the individual's discharge, etc. CF 11/30/2021 Favorable CA RC	Favorable Yeas 7 Nays 0
6	**SB 756** Diaz	Public Records/Human Trafficking Victims; Providing that the personal identifying information of a victim of human trafficking in a petition for human trafficking victim expunction and in all pleadings and documents related to the petition is confidential and exempt from public records requirements; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity, etc. CF 11/30/2021 Temporarily Postponed GO RC	Temporarily Postponed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 764** Albritton (Similar H 757)	Step Into Success Internship Program; Designating the "Step Into Success Act"; establishing the Step Into Success internship program within the Department of Children and Families for eligible foster youth; requiring that eligible foster youth receive priority consideration for certain internship positions; requiring the department to publicize internship opportunities and inform foster youth of where to locate the information; requiring approved agencies to provide and monthly update a list of open employment opportunities for which eligible foster youth may apply; specifying requirements and conditions for foster youth to earn college credit for work performed in the internship program, etc. CF 11/30/2021 Favorable AHS AP	Favorable Yeas 7 Nays 0
8	**SB 792** Ausley (Similar H 563)	Children and Young Adults in Out-of-home Care; Specifying the rights of, rather than goals for, children and young adults in out-of-home care; providing the roles and responsibilities of the Department of Children and Families, community-based care lead agencies, and other agency staff; designating a children's ombudsman as an autonomous entity within the department; requiring the ombudsman, in consultation with the department and other specified entities and by a specified date, to develop standardized information explaining the rights of children and young adults placed in out-of-home care, etc. CF 11/30/2021 Favorable AHS AP	Favorable Yeas 7 Nays 0

Other Related Meeting Documents

By Senator Rouson

19-00096-22 2022282__

A bill to be entitled

An act relating to mental health and substance use disorders; amending s. 394.4573, F.S.; providing that the use of peer specialists is an essential element of a coordinated system of care in recovery from a substance use disorder or mental illness; making a technical change; amending s. 397.4073, F.S.; revising background screening requirements for certain peer specialists; revising authorizations relating to work by applicants who have committed disqualifying offenses; making a technical change; amending s. 397.417, F.S.; providing legislative findings and intent; revising requirements for certification as a peer specialist; requiring the Department of Children and Families to develop a training program for peer specialists and to give preference to trainers who are certified peer specialists; requiring the training program to coincide with a competency exam and be based on current practice standards; authorizing the department to certify peer specialists, either directly or by approving a third-party credentialing entity; prohibiting third-party credentialing entities from conducting background screenings for peer specialists; requiring that a person providing recovery support services be certified or be supervised by a licensed behavioral health care professional or a certain certified peer specialist; authorizing the department, a behavioral health managing entity, or the Medicaid program to reimburse

19-00096-22 2022282__

recovery support services as a recovery service; encouraging Medicaid managed care plans to use peer specialists in providing recovery services; requiring peer specialists and certain persons to meet the requirements of a background screening as a condition of employment and continued employment; requiring certain entities to forward fingerprints to specified entities; requiring the department to screen results to determine if the peer specialist meets the certification requirements; requiring that fees for state and federal fingerprint processing be borne by the peer specialist applying for employment; requiring that any arrest record identified through background screening be reported to the department; authorizing the department or the Agency for Health Care Administration to contract with certain vendors for fingerprinting; specifying requirements for vendors; specifying disqualifying offenses for a peer specialist who applies for certification; authorizing a person who does not meet background screening requirements to request an exemption from disqualification from the department or the agency; providing that a peer specialist certified as of the effective date of the act is deemed to satisfy the requirements of the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (l) of subsection (2) and subsection

(3) of section 394.4573, Florida Statutes, are amended to read:

394.4573 Coordinated system of care; annual assessment; essential elements; measures of performance; system improvement grants; reports.—On or before December 1 of each year, the department shall submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an assessment of the behavioral health services in this state. The assessment shall consider, at a minimum, the extent to which designated receiving systems function as no-wrong-door models, the availability of treatment and recovery services that use recovery-oriented and peer-involved approaches, the availability of less-restrictive services, and the use of evidence-informed practices. The assessment shall also consider the availability of and access to coordinated specialty care programs and identify any gaps in the availability of and access to such programs in the state. The department's assessment shall consider, at a minimum, the needs assessments conducted by the managing entities pursuant to s. 394.9082(5). Beginning in 2017, the department shall compile and include in the report all plans submitted by managing entities pursuant to s. 394.9082(8) and the department's evaluation of each plan.

(2) The essential elements of a coordinated system of care include:

(l) Recovery support, including, but not limited to, the use of peer specialists to assist in the individual's recovery from a substance use disorder or mental illness; support for competitive employment, educational attainment, independent living skills development, family support and education, wellness management, and self-care; and assistance in obtaining

housing that meets the individual's needs. Such housing may include mental health residential treatment facilities, limited mental health assisted living facilities, adult family care homes, and supportive housing. Housing provided using state funds must provide a safe and decent environment free from abuse and neglect.

(3) SYSTEM IMPROVEMENT GRANTS.—Subject to a specific appropriation by the Legislature, the department may award system improvement grants to managing entities based on a detailed plan to enhance services in accordance with the no-wrong-door model as defined in subsection (1) and to address specific needs identified in the assessment prepared by the department pursuant to this section. Such a grant must be awarded through a performance-based contract that links payments to the documented and measurable achievement of system improvements.

Section 2. Paragraphs (a) and (g) of subsection (1) of section 397.4073, Florida Statutes, are amended to read:

397.4073 Background checks of service provider personnel.—

(1) PERSONNEL BACKGROUND CHECKS; REQUIREMENTS AND EXCEPTIONS.—

(a) For all individuals screened on or after July 1, 2022 2019, background checks shall apply as follows:

1. All owners, directors, chief financial officers, and clinical supervisors of service providers are subject to level 2 background screening as provided under s. 408.809 and chapter 435. Inmate substance abuse programs operated directly or under contract with the Department of Corrections are exempt from this requirement.

2. All service provider personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services are subject to level 2 background screening as provided under s. 408.809 and chapter 435.

3. All peer specialists who have direct contact with individuals receiving services are subject to a background screening as provided in s. 397.417(5) ~~level 2 background screening as provided under s. 408.809 and chapter 435~~.

(g) If 5 years or more, or 3 years or more in the case of a certified peer specialist or an individual seeking certification as a peer specialist pursuant to s. 397.417, have elapsed since an applicant for an exemption from disqualification has completed or has been lawfully released from confinement, supervision, or a nonmonetary condition imposed by a court for the applicant's most recent disqualifying offense, the applicant may work with adults with substance use disorders, mental health disorders, or co-occurring disorders under the supervision of persons who meet all personnel requirements of this chapter for up to 180 ~~90~~ days after being notified of his or her disqualification or until the department makes a final determination regarding his or her request for an exemption from disqualification, whichever is earlier.

Section 3. Section 397.417, Florida Statutes, is amended to read:

397.417 Peer specialists.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that:

1. The ability to provide adequate behavioral health

services is limited by a shortage of professionals and paraprofessionals.

2. The state is experiencing an increase in opioid addictions, many of which prove fatal.

3. Peer specialists provide effective support services because they share common life experiences with the persons they assist.

4. Peer specialists promote a sense of community among those in recovery.

5. Research has shown that peer support facilitates recovery and reduces health care costs.

6. Persons who are otherwise qualified to serve as peer specialists may have a criminal history that prevents them from meeting background screening requirements.

(b) The Legislature intends to expand the use of peer specialists as a cost-effective means of providing services. The Legislature also intends to ensure that peer specialists meet specified qualifications and modified background screening requirements and are adequately reimbursed for their services.

(2) QUALIFICATIONS.—

(a) A person may seek certification as a peer specialist if he or she has been in recovery from a substance use disorder or mental illness for the past 2 years or if he or she is a family member or caregiver of a person with a substance use disorder or mental illness.

(b) To obtain certification as a peer specialist, a person must complete the training program developed under subsection (3), achieve a passing score on the competency exam described in paragraph (3)(a), and meet the background screening requirements

specified in subsection (5).

(3) DUTIES OF THE DEPARTMENT.—

(a) The department shall develop a training program for persons seeking certification as peer specialists. The department must give preference to trainers who are certified peer specialists. The training program must coincide with a competency exam and be based on current practice standards.

(b) The department may certify peer specialists directly or may approve one or more third-party credentialing entities for the purposes of certifying peer specialists, approving training programs for individuals seeking certification as peer specialists, approving continuing education programs, and establishing the minimum requirements and standards applicants must meet to maintain certification. Background screening required for achieving certification must be conducted as provided in subsection (5) and may not be conducted by third-party credentialing entities.

(c) The department shall require that a person providing recovery support services be certified; however, an individual who is not certified may provide recovery support services as a peer specialist for up to 1 year if he or she is working toward certification and is supervised by a qualified professional or by a certified peer specialist who has at least 2 years of full-time experience as a peer specialist at a licensed behavioral health organization.

(4) PAYMENT.—Recovery support services may be reimbursed as a recovery service through the department, a behavioral health managing entity, or the Medicaid program. Medicaid managed care plans are encouraged to use peer specialists in providing

recovery services.

(5) BACKGROUND SCREENING.—

(a) A peer specialist, or an individual who is working toward certification and providing recovery support services as provided in subsection (3), must have completed or have been lawfully released from confinement, supervision, or any nonmonetary condition imposed by the court for any felony and must undergo a background screening as a condition of initial and continued employment. The applicant must submit a full set of fingerprints to the department or to a vendor, an entity, or an agency that enters into an agreement with the Department of Law Enforcement as provided in s. 943.053(13). The department, vendor, entity, or agency shall forward the fingerprints to the Department of Law Enforcement for state processing and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing. The department shall screen the results to determine if a peer specialist meets certification requirements. The applicant is responsible for all fees charged in connection with state and federal fingerprint processing and retention. The state cost for fingerprint processing shall be as provided in s. 943.053(3)(e) for records provided to persons or entities other than those specified as exceptions therein. Fingerprints submitted to the Department of Law Enforcement pursuant to this paragraph shall be retained as provided in s. 435.12 and, when the Department of Law Enforcement begins participation in the program, enrolled in the Federal Bureau of Investigation's national retained fingerprint arrest notification program, as provided in s. 943.05(4). Any arrest record identified must be reported to the

department.

(b) The department or the Agency for Health Care Administration, as applicable, may contract with one or more vendors to perform all or part of the electronic fingerprinting pursuant to this section. Such contracts must ensure that the owners and personnel of the vendor performing the electronic fingerprinting are qualified and will ensure the integrity and security of all personal identifying information.

(c) Vendors who submit fingerprints on behalf of employers must:

1. Meet the requirements of s. 943.053; and

2. Have the ability to communicate electronically with the state agency accepting screening results from the Department of Law Enforcement and provide the applicant's full first name, middle initial, and last name; social security number or individual taxpayer identification number; date of birth; mailing address; sex; and race.

(d) The background screening conducted under this subsection must ensure that a peer specialist has not, during the previous 3 years, been arrested for and is awaiting final disposition of, been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or been adjudicated delinquent and the record has not been sealed or expunged for, any felony.

(e) The background screening conducted under this subsection must ensure that a peer specialist has not been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or been adjudicated delinquent and the record has not been sealed or expunged for, any offense

prohibited under any of the following state laws or similar laws of another jurisdiction:

1. Section 393.135, relating to sexual misconduct with certain developmentally disabled clients and reporting of such sexual misconduct.

2. Section 394.4593, relating to sexual misconduct with certain mental health patients and reporting of such sexual misconduct.

3. Section 409.920, relating to Medicaid provider fraud, if the offense was a felony of the first or second degree.

4. Section 415.111, relating to abuse, neglect, or exploitation of vulnerable adults.

5. Any offense that constitutes domestic violence as defined in s. 741.28.

6. Section 777.04, relating to attempts, solicitation, and conspiracy to commit an offense listed in this paragraph.

7. Section 782.04, relating to murder.

8. Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or a disabled adult, aggravated manslaughter of a child, or aggravated manslaughter of an officer, a firefighter, an emergency medical technician, or a paramedic.

9. Section 782.071, relating to vehicular homicide.

10. Section 782.09, relating to killing an unborn child by injury to the mother.

11. Chapter 784, relating to assault, battery, and culpable negligence, if the offense was a felony.

12. Section 787.01, relating to kidnapping.

13. Section 787.02, relating to false imprisonment.

14. Section 787.025, relating to luring or enticing a child.

15. Section 787.04(2), relating to leading, taking, enticing, or removing a minor beyond state limits, or concealing the location of a minor, with criminal intent pending custody proceedings.

16. Section 787.04(3), relating to leading, taking, enticing, or removing a minor beyond state limits, or concealing the location of a minor, with criminal intent pending dependency proceedings or proceedings concerning alleged abuse or neglect of a minor.

17. Section 790.115(1), relating to exhibiting firearms or weapons within 1,000 feet of a school.

18. Section 790.115(2)(b), relating to possessing an electric weapon or device, a destructive device, or any other weapon on school property.

19. Section 794.011, relating to sexual battery.

20. Former s. 794.041, relating to prohibited acts of persons in familial or custodial authority.

21. Section 794.05, relating to unlawful sexual activity with certain minors.

22. Section 794.08, relating to female genital mutilation.

23. Section 796.07, relating to procuring another to commit prostitution, except for those offenses expunged pursuant to s. 943.0583.

24. Section 798.02, relating to lewd and lascivious behavior.

25. Chapter 800, relating to lewdness and indecent exposure.

26. Section 806.01, relating to arson.

27. Section 810.02, relating to burglary, if the offense was a felony of the first degree.

28. Section 810.14, relating to voyeurism, if the offense was a felony.

29. Section 810.145, relating to video voyeurism, if the offense was a felony.

30. Section 812.13, relating to robbery.

31. Section 812.131, relating to robbery by sudden snatching.

32. Section 812.133, relating to carjacking.

33. Section 812.135, relating to home-invasion robbery.

34. Section 817.034, relating to communications fraud, if the offense was a felony of the first degree.

35. Section 817.234, relating to false and fraudulent insurance claims, if the offense was a felony of the first or second degree.

36. Section 817.50, relating to fraudulently obtaining goods or services from a health care provider and false reports of a communicable disease.

37. Section 817.505, relating to patient brokering.

38. Section 817.568, relating to fraudulent use of personal identification, if the offense was a felony of the first or second degree.

39. Section 825.102, relating to abuse, aggravated abuse, or neglect of an elderly person or a disabled adult.

40. Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or a disabled person.

41. Section 825.103, relating to exploitation of an elderly person or a disabled adult, if the offense was a felony.

42. Section 826.04, relating to incest.

43. Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

44. Section 827.04, relating to contributing to the delinquency or dependency of a child.

45. Former s. 827.05, relating to negligent treatment of children.

46. Section 827.071, relating to sexual performance by a child.

47. Section 831.30, relating to fraud in obtaining medicinal drugs.

48. Section 831.31, relating to the sale, manufacture, delivery, or possession with intent to sell, manufacture, or deliver of any counterfeit controlled substance, if the offense was a felony.

49. Section 843.01, relating to resisting arrest with violence.

50. Section 843.025, relating to depriving a law enforcement, correctional, or correctional probation officer of the means of protection or communication.

51. Section 843.12, relating to aiding in an escape.

52. Section 843.13, relating to aiding in the escape of juvenile inmates of correctional institutions.

53. Chapter 847, relating to obscenity.

54. Section 874.05, relating to encouraging or recruiting another to join a criminal gang.

55. Chapter 893, relating to drug abuse prevention and

control, if the offense was a felony of the second degree or greater severity.

56. Section 895.03, relating to racketeering and collection of unlawful debts.

57. Section 896.101, relating to the Florida Money Laundering Act.

58. Section 916.1075, relating to sexual misconduct with certain forensic clients and reporting of such sexual misconduct.

59. Section 944.35(3), relating to inflicting cruel or inhuman treatment on an inmate resulting in great bodily harm.

60. Section 944.40, relating to escape.

61. Section 944.46, relating to harboring, concealing, or aiding an escaped prisoner.

62. Section 944.47, relating to introduction of contraband into a correctional institution.

63. Section 985.701, relating to sexual misconduct in juvenile justice programs.

64. Section 985.711, relating to introduction of contraband into a detention facility.

(6) EXEMPTION REQUESTS.—A person who wishes to become a peer specialist and is disqualified under subsection (5) may request an exemption from disqualification pursuant to s. 435.07 from the department or the Agency for Health Care Administration, as applicable.

(7) GRANDFATHER CLAUSE.—A peer specialist certified as of July 1, 2022, is deemed to satisfy the requirements of this section.

~~(1) An individual may seek certification as a peer~~

~~specialist if he or she has been in recovery from a substance use disorder or mental illness for at least 2 years, or if he or she has at least 2 years of experience as a family member or caregiver of a person with a substance use disorder or mental illness.~~

~~(2) The department shall approve one or more third-party credentialing entities for the purposes of certifying peer specialists, approving training programs for individuals seeking certification as peer specialists, approving continuing education programs, and establishing the minimum requirements and standards that applicants must achieve to maintain certification. To obtain approval, the third party credentialing entity must demonstrate compliance with nationally recognized standards for developing and administering professional certification programs to certify peer specialists.~~

~~(3) An individual providing department-funded recovery support services as a peer specialist shall be certified pursuant to subsection (2). An individual who is not certified may provide recovery support services as a peer specialist for up to 1 year if he or she is working toward certification and is supervised by a qualified professional or by a certified peer specialist who has at least 3 years of full-time experience as a peer specialist at a licensed behavioral health organization.~~

Section 4. This act shall take effect July 1, 2022.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

BAKER ACT AND MARCHMAN ACT PROJECT TEAM REPORT

FOR FISCAL YEAR 2016-17

Department of Children and Families
Substance Abuse and Mental Health Program Office

November 24, 2015

Mike Carroll	Rick Scott
Secretary	Governor

Table of Contents

I. Executive Summary

I.A. PURPOSE

The following is a synthesis of the findings and recommendations of the Department of Children and Families (Department) Baker Act and Marchman Act Project Team (Project Team). It is important to note, that the Project does not recommend blending, or combining, the Baker Act and Marchman Act. The Project Team recommends the following:

- Legislative Intent language that focuses on mental and substance use disorders being diseases of the brain, and involving the local community in the planning process for behavioral health acute care services.
    - Shift to medical approach in the treatment of mental health and substance abuse.
    - Recognize that substance use and mental disorders are sub-specialties within the medical specialty health care arena.
    - Acknowledge that behavioral health disorders cause effects on individuals' ability to reason, exercise good judgment, recognize the need for services and sufficiently provide self-care, which require responsibility for their care to be relegated to third parties and/or vested in the authorities of behavioral health programs and practitioners.
    - Establish community based alternatives that include prevention, intervention and outreach to prevent need for higher levels of care and provide for care coordination and recovery oriented services upon discharge.
    - Provide funding of the community system resulting in cost savings and efficiencies across multiple systems.
    - Define specifications and minimum standards for access to care that will be available in each community.
    - Authorize licensed and certified behavioral health practitioners to exercise the full authority of their respective scopes of practice.
    - Provide the mechanism for communities in conjunction with others, to define their local behavioral health, emergency, acute care and treatment array of services.
    - Ensure that local systems of acute care services have standardized services and processes for access.
    - Ensure that local systems of care are designed to maximize available local resources, including health care services and managed care plans.
- Every county have access to either a central receiving facility, an access center, a triage center, a crisis stabilization unit or an addictions receiving facility, or have a plan that addresses accessibility.
- A transportation plan and local community plan should be developed by the managing entities for every county
    - Plans will provide exception to existing statutory requirements mandating law enforcement to transport to nearest receiving facility, to provide for consumer choice and meet specifications of the local transportation plan

- Align the statutory requirements in Chapters 394 and 397, F.S. so that the same qualified professionals are authorized to initiate involuntary examinations/assessments/stabilizations under the Baker Act and the Marchman Act.
- The requirements for the collection of data and the time frames for both the Baker Act and the Marchman Act should be aligned
- Require the collection, submission and reporting of the same data for the Marchman Act and the Baker Act, by all public receiving facilities and should be submitted to DCF using the CSU database.
- Timeframes should be standardized so that involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act must be completed within 72 hours. However, a physician or physician's assistant or psychiatric nurse acting under the physician may authorize up to an additional 48 hours based on a determination of need without court involvement.

Estimate of the cost to address the needs for expanded acute care capacity ranged from $133 million to $ 298 million. We recognize that those consensus estimates can result in the immediate discounting of the Project Team's recommendations based on the projected cost. (Appendix 2).

Instead, we would recommend the following:

- The Legislature should consider a multiple year approach to addressing the acute care service capacity within Florida's communities.
- This approach would reflect a commitment and investment in mental health and substance abuse services that would be designed to meet local behavioral health acute care needs over time.
- Appropriations should be targeted to those services that include acute care beds, but also place a premium of funding lower cost services designed to reduce demand on inpatient, crisis stabilization, and detoxification services; such as, mobile crisis response teams. In addition, improved care coordination across Medicaid, and other health plans and other funding sources to reduce demand on publically funded services and expand community treatment options.
- Building community residential and housing options for persons with a major mental or substance use disorders.
- Provide options for funding a community's treatment capacity to address the needs of the most in need and vulnerable. Only with a sustained commitment will these issues that have placed Florida's behavioral health system in "crisis," ultimately be successfully resolved.

I.B. INTRODUCTION

During the 2015 regular session of the Florida Legislature, proposed legislation aimed at making substantive changes to Part I of Chapter 394, F.S., which addresses the Baker Act. Senate Bill 7070 would have combined certain features of Chapter 397, F.S., or the Marchman Act, into one comprehensive statute that combines voluntary and involuntary treatment for persons with mental illness and substance use disorders into one comprehensive law.

Although the bill did not become law, it created considerable legislative, executive agency, and public interest in the current state of mental health and substance abuse services. Public discussion specifically

addressed public access to acute care services and the belief that current statutes do not adequately address issues of access, availability, and the organization of these essential services.

II. BACKGROUND

II.A. BAKER ACT

In 1971, the Florida Legislature enacted the Florida Mental Health Act (Part I of Chapter 394, F.S.), a comprehensive revision of the state's century-old mental health commitment laws. The law, commonly referred to as the "Baker Act," was designed to significantly strengthen and protect the due process and civil rights of individuals in mental health facilities and ensure public safety.

In 1978, through proviso, the Legislature authorized the creation of Crisis Stabilization Units (CSUs) and short-term residential treatment facilities (SRTs) to provide a less costly, less intensive, and less restrictive alternative to inpatient hospitalization for examination/crisis stabilization and also for placement/long-term treatment. The most recent major revision to the Baker Act was in 2004 when the Legislature created Involuntary Outpatient Placement as an involuntary treatment option (effective January 1, 2005).

Crisis services are defined in s. 394.67(3), F.S., as emergency interventions that are designed to prevent further deterioration of the individual's mental health. They include short-term evaluation, stabilization, and brief intervention. Once stabilized, individuals are redirected to the most appropriate and least restrictive treatment settings consistent with their needs. Most publically funded crisis services are provided in CSUs, which are located in receiving facilities for individuals on voluntary and involuntary status.

Receiving and treatment facilities are defined by the Florida Mental Health Act (ss. 394.451-47891, F.S.) and are designated by the Department to receive and hold individuals on involuntary status under emergency conditions or for psychiatric evaluation. These facilities, referred to as Baker Act Receiving Facilities, provide brief, intensive crisis services to individuals who require emergency mental health stabilization. (Appendix 3).

Section 394.461, F.S., authorizes the Department to designate community facilities as a receiving facility. Any other facility within the state, including a private or federal facility, may be so designated by the Department, provided such designation is agreed to by the governing body or authority of the facility.

II.B. MARCHMAN ACT

In 1970, the Florida Legislature enacted Chapter 397, F.S., governing the Treatment and Rehabilitation of Drug Dependents. The following year, it enacted Chapter 396, F.S., titled the Myers Act as the state's "Comprehensive Alcoholism Prevention, Control, and Treatment Act," modeled after the federal Hughes Act.

Since individuals with substance abuse issues often don't contain their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction did not address the problems faced by Florida's citizens.

In 1993, Representative Steven Wise introduced legislation to merge Chapters 396 and 397, F.S., into a single law, Chapter 397, F.S., that clearly outlined legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination, and children's substance abuse services. The chapter was named the "Hal S. Marchman Alcohol and Other Drug Services Act of 1993," and is commonly referred to as the Marchman Act.

Addiction receiving facilities are defined in Chapter 397, F.S., and are designated by the Department as secure, acute care facilities that provide, at a minimum, detoxification and stabilization services and are operated 24 hours per day, 7 days per week to serve individuals found to be substance use impaired.

Unlike the Baker Act that requires facilities to accept persons brought by law enforcement officers, the Marchman Act requires facilities to refuse acceptance of persons if it would cause the facility to go over licensed census, to accept responsibility for a person beyond the safe management of the program, or if the person is unable to pay the cost of a private program. However, if the facility is a licensed hospital and the officer believes the person has an emergency medical condition as a result of the substance abuse issues, a hospital must accept the person under the federal EMTALA law and perform a medical screening and stabilization prior to releasing the person or transferring him or her to another appropriate facility. (Appendix 4).

When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

II.C. EMERGENCY EXAMINATION AND TREATMENT OF INCAPACITATED PERSONS ACT

Section 401.445, F.S., governs the emergency examination and treatment when an emergency medical condition is life-threatening and the individual is unable to provide informed consent to examination, transport, or treatment.

II.D. ACCESS TO EMERGENCY SERVICES AND CARE

Section 395.1041, F.S., establishes state requirements equivalent to the federal EMTALA/COBRA law, which prohibits the denial of emergency services and care by hospitals and physicians, and enforcing the ability of individuals to get all necessary and appropriate emergency care within the capability and capacity of each hospital. This statute also requires hospitals to adhere to rights and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital is designated as a receiving or treatment facility. However, this is not a requirement for individuals being involuntarily assessed and stabilized under the Marchman Act.

III. PROCESS

In June 2015, the Department convened the Baker Act and Marchman Act Project Team (Project Team). This report builds upon the proposed changes to the court processes for the Baker Act and Marchman

Act considered by the Florida Supreme Court's Task Force on Substance Abuse and Mental Health Issues in the Courts. The Project Team was charged with developing recommendations and specifications to integrate access to the Baker Act and Marchman Act by defining a community system of behavioral health acute care services that:

1. Provides a single point of access to acute emergency care, intervention, and treatment services;
2. Ensures that individuals are determined to meet criteria for voluntary and involuntary examination and treatment for a mental illness or a substance use disorder have access to required services;
3. Ensures that each county or circuit has access to a designated receiving facility that, at a minimum, can screen, evaluate, and refer individuals to the appropriate level of care;
4. Ensures that individuals, their families, law enforcement agencies, judges and other court professionals, behavioral health professionals, and the public are aware of the locations of designated receiving facilities, access centers, or triage centers;
5. Determine the existing capacity for Addiction Receiving Facilities (ARFs), CSUs, and detoxification facilities;
6. Develops a standard or benchmark for determining the need for additional bed capacity over and above the capacity met through Medicaid, Medicare, and private insurance based on the number of beds per capita; and
7. Estimates the cost of the proposed recommendations based on several different models, or methods of calculation.

The composition of the Project Team included representatives of state agencies, community hospitals, non-profit substance abuse and mental health provider organizations, managing entities, professional trade and provider associations, court professionals and personnel, law enforcement, local government, Medicaid managed care organizations, consumers, and experienced practitioners and administrators from acute care service programs in the substance abuse and mental health system. Stakeholders from these diverse backgrounds participated in Project Team meetings that were conducted over the course of three months. This broad range of participation resulted in the recommendations that are presented in this report.

IV. RECOMMENDATIONS

Legislative Intent	
Relevant Statute(s)	ss. 394.453, 394.66, and 397.305, F.S.
Discussion	During the Project Team meetings, team members expressed concern for the need to revise current legislative intent in Chapters 394 and 397, F.S., to reflect the changes and advances in the behavioral health field, as well as clearly establish priorities, rights, and key policy statements. Most importantly, the current legislative intent language does not recognize substance use and mental disorders as diseases of the brain or as a medical sub-specialty.
Recommendations	Amend current legislative intent language in Chapters 394 and 397, F.S., to incorporate language that clearly and affirmatively establishes the Legislature's intent to:

	1. Shift to medical approach in the treatment of mental health and substance abuse recognizing that substance use and mental disorders are diseases of the brain, and are complex medical issues whose etiology and progression involve interactive biological, genetic, psychological, cultural, and social factors. 2. Recognize that Substance Use and Mental Disorders are sub-specialties within the medical specialty health care arena of Behavioral Health. Treatment saves lives, improves the health of the affected individuals and families, and reduces negative impacts to society. 3. State the importance of data collection and utilization to inform decisions regarding funding, client needs, access to services, and information regarding the behavioral health acute care system. 4. Establish and fund community-based alternatives that include prevention, intervention and outreach, as well as recovery-oriented services in the community to prevent the need for and use of higher levels of care. In addition, provide for the coordination of comprehensive care and recovery oriented services upon discharge from all levels of care. 5. Provide proper and appropriate funding of the community behavioral health system of care which will result in cost-savings and efficiencies across multiple systems, including criminal justice/law enforcement, healthcare, etc. 6. Define the specifications and minimum standards for access to care that will be available in or accessible by each community based on funding. 7. Authorize licensed and certified behavioral health practitioners to exercise the full authority of their respective Scopes of Practice in the performance of professional functions necessary to carry out the intent of this statute. 8. Provide the mechanism for communities in conjunction with the Department, local governments, law enforcement, courts, behavioral health managing entities, and consumers and families to define a local, accessible behavioral health system, including emergency, acute care and treatment array of services are: accessible, well defined, and readily understood in each community. 9. Ensure that local systems of behavioral health acute care services have standardized services and processes for accessing services. 10. Ensure that local systems of care are designed to maximize available local resources including health care services and managed care plans. 11. Expand the use of mobile crisis teams and other alternative intervention options in the community.

Single Point of Access	
Relevant Statute(s)	s. 394.461, F.S.
Discussion	The current Baker Act and Marchman Act differ in several key points related to receiving facilities, including who may provide assessments and evaluations, the time permitted to conduct an involuntary examination, authority to release individuals, and specific administrative functions such as notifications to other involved persons and data collection and reporting. Current statutes establish five routes to crisis services for individuals with mental or substance use disorders, four of them involuntary. The Baker Act and Marchman Act differ significantly in addressing involuntary assessment. This includes defining methods of initiation, criteria, time frames, and disposition alternatives. Revising the statutes to align the process, and standardize the forms for petitions and certificates, while retaining the ability to identify whether the primary basis is a mental or substance use disorder, would significantly reduce bureaucratic barriers to accessing crisis evaluations and still protect individual rights through due process in any involuntary proceedings.
Recommendations	The Department has provided a brief description of a central receiving facility, access center, and triage center as examples of single points of access for the purposes of this report. It is recommended that the Legislature authorize the Department to develop administrative rules to establish the specific standards, functions, and services for any facilities providing a single point of access. **Central Receiving Facility** The concept of a Central Receiving Facility (CRF) is an integrated mental health crisis stabilization unit and addictions receiving facility as currently described in s. 394.4612, F.S., and Rule 65E-12.110, F.A.C. The CRF can be a single point of entry with or without an Access Center or Triage Center into the mental health and substance abuse system for assessments, and appropriate placement of adults experiencing a mental health or substance abuse crisis. It is important to note that not all counties may have the financial resources or demand for acute care services to support a CRF as the single point of access. Counties need the flexibility and an availability of options to provide services. **Access Center** An Access Center (AC) may be available, at a minimum, 12 hours per day, seven days per week for individuals experiencing a low level substance abuse, mental health, or co-occurring crisis after receiving a standardized screening. This

	location can be a separate and freestanding facility. The primary purpose is to assist the public in accessing services. **Triage Center** A Triage Center (TC) is a community-based option that is an initial point of entry into the community mental health and substance abuse system. A TC should be integrated so that the facility and its staff have the ability, at a minimum, to assess, examine, and refer individuals to the appropriate level of care.

Transportation	
Relevant Statute(s)	ss. 394.462, 394.4685, 394.9082, 397.6772, 397.6793, 397.6795, F.S.
Discussion	Under the requirements of the Baker Act, regardless of how an examination is initiated, law enforcement must transport an individual to the nearest Baker Act receiving facility to be examined unless a Transportation Exception Plan has been approved by the Secretary of the Department. The designated law enforcement agency may decline to transport the individual to a receiving facility only if: 1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of individuals to receiving facilities pursuant to this section at the sole cost of the county; and 2. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the individual or others. However, when a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination under the Baker Act and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.[1]

[1] Section 394.462(1)(e), F.S.

	The current requirements for involuntary assessment and stabilization under the Marchman Act specify that law enforcement are only required to transport an individual in protective custody. For involuntary assessments and stabilization initiated by persons or means other than protective custody, the Marchman Act allows for, but does not require, the transportation of individuals and permits individuals other than law enforcement to provide the transportation. Specifically, for a court-ordered assessment and stabilization, the Court may order law enforcement to transport a person to nearest appropriate licensed service provider. Transportation for Emergency Admission may be provided by an applicant for a person's emergency admission, spouse or guardian, law enforcement officer, or health officer. Regardless of how the involuntary assessment and stabilization is initiated, the Marchman Act does not require an individual to be transported to the nearest receiving facility. Instead, depending on how the involuntary assessment and stabilization was initiated, an individual may be transported to a hospital, licensed detoxification facility, addiction receiving facility, jail, or a less intensive component of a licensed service provider for assessment only. Currently, the Baker Act and Marchman Act do not require any formal planning regarding the transportation of individuals who meet the criteria under these statutes. However, the Baker Act allows for the development of a Transportation Exception Plan, and also specifies that each law enforcement agency shall develop a memorandum of understanding with each receiving facility within the law enforcement agency's jurisdiction which reflects a single set of protocols for the safe and secure transportation of the individual and transfer of custody of the person.[2] These protocols must also address crisis intervention measures.
Recommendations	1. Establish requirements for the transportation of individuals for involuntary assessment/stabilization, and involuntary treatment, as well as, the transfer of individuals between facilities, under the Marchman Act that mirror and align with the corresponding requirements in the Baker Act.[3] 2. Require the Managing Entities, in consultation with the board of county commissioners and local law enforcement agencies, to develop a Transportation Plan for each county or circuit within the managing entity's assigned region that defines the specifications and

[2] Section 394.462(1)(k), F.S.

[3] Sections 394.462 and 394.4685, F.S.

	minimum standards for transportation and access to behavioral health acute care services that will be present or available in each community. 3. Each Transportation Plan must address, at a minimum, the following: a. Specify the models of Community Intervention options available and the roles, processes, and responsibilities of those programs in diverting individuals from acute care placements. b. Specify how local hospitals, designated receiving facilities, and acute care inpatient and detoxification providers will coordinate activities to screen, assess, examine, stabilize, and refer individuals presented on an involuntary basis under the Baker Act or Marchman Act. c. Specify the responsibility for, and the means by which, individuals in a behavioral health crisis will be transported to and between facilities for involuntary examinations and treatment, involuntary court proceedings and resulting commitments under the Baker Act and Marchman Act. d. The method of transferring individuals after law enforcement has relinquished physical custody of the individual at a designated receiving facility. The receiving facilities must provide or arrange for their transportation to another facility or appropriate placement. The managing entities must submit transportation plans to the Department for final review and approval. Plans must be submitted every three years and updated as needed.

Qualified Professionals	
Relevant Statute(s)	Part I of Chapter 394, Part V of Chapter 397, and s. 397.311, F.S.
Discussion	**Scope of Practice** There is significant variation in the authorized scope of practice for qualified professionals established in Chapters 394 and 397, F.S. This variation has created inconsistencies between the Baker Act and Marchman Act in how involuntary examinations (i.e. professional certificates) are initiated, and who has the authority to conduct assessments, examinations, and discharge of individuals. Furthermore, the limitations placed on certain qualified professionals under the Marchman Act to initiate professional certificates, and under the Baker Act, to assess, admit, and discharge individuals, restrict the privileges, or scope of practice that these professionals are statutorily granted under the purview of their license.

Qualified Professionals	
	Physician Shortage In February 2015, a study of physician supply and demand commissioned by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida found the physician shortage will grow to 7,000 physician specialists by 2025. This shortfall spans 19 specialties, with the largest areas of need in psychiatry, general surgery, rheumatology, and thoracic surgery.[4] The current supply of specialists in Florida is insufficient to provide a level of care consistent with the national average, after taking into consideration differences in the demographics and health risk factors between Florida and the nation. Of the specialties included in the projected shortage, psychiatry is expected to have the most severe physician specialty deficit with a 55 percent shortfall statewide by 2025.[5] **Access to Care** The disconnect between the authority to access, evaluate, and discharge individuals under the Baker Act and Marchman Act, along with the current and projected statewide shortage of psychiatrists will create significant barriers to accessing and initiating care.
Recommendations	1. Align statutory requirements in Chapters 394 and 397, F.S. so that the same qualified professionals authorized to initiate involuntary examinations under the Baker Act are also authorized to initiate involuntary assessments and stabilizations under the Marchman Act. 2. Authorize the following qualified professionals, as defined in their respective chapters, to initiate involuntary examination/assessment under the Marchman Act and Baker Act: a. Physician; b. Physician Assistant; c. Psychiatrist; d. Psychologist; e. Advanced Registered Nurse Practitioner;

[4] Study: Florida Facing Critical Shortage of Physician Specialists through 2025. PRNewswire. February 17, 2015. http://www.prnewswire.com/news-releases/study-florida-facing-critical-shortage-of-physician-specialists-through-2025-300037111.html site last accessed on October 14, 2015.

[5] *Florida Physician Workforce Analysis: Forecasting Supply and Demand.* IHS Global. Commissioned by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida. February 2015. http://mediad.publicbroadcasting.net/p/healthnewsfl/files/201502/SNHAF_Physicians_Workforce_Analysis_2015-v5.pdf site last accessed on October 14, 2015.

Qualified Professionals	
	f. Advanced Registered Nurse Practitioner having a specialty in psychiatry licensed under part I of chapter 464; g. Licensed Mental Health Counselor; h. Licensed Clinical Social Worker; and i. Licensed Marriage and Family Therapist 3. Provide an exception to limit the authority of Certified Addiction Professionals to initiate only involuntary assessment and stabilization under the Marchman Act. 4. All licensed health care professionals in Chapters 394 and 397, F.S., should have experience and be cross trained in both substance abuse and mental health.

Data	
Relevant Statute(s)	ss. 394.461, 394.463, 394.4655, 394.467, 394.9082, F.S.
Discussion	**Baker Act Data** The Baker Act (Part I of Chapter 394, F.S.), as well as Part IV of Chapter 394, F.S., contain several provisions requiring the submission, collection and reporting of Baker Act-related data for private and public receiving facilities to the Department and the Agency for Health Care Administration (AHCA). This has not only created confusion and increased the administrative burden on providers, but it has also resulted in inconsistent and siloed data due to incompatible and unintegrated data systems and processes. As a result, the meaningful use and analysis of this data is severely diminished. *(Please see the below table for a summary of data submission requirements).* Additionally, during the 2015 Regular Session, CS/HB 79 was passed and signed into law, amending Part IV of Chapter 394, F.S., directing the Department to develop, implement, and maintain a Crisis Stabilization Services Utilization Database (CSU Database) whereby behavioral health managing entities collect utilization data from psychiatric public receiving facilities.[6] Public receiving facilities within a managing entity's provider network are required to submit utilization data in real time, or at least daily, to the managing entity. This includes the number of indigent patients admitted and discharged, the current active

[6] These facilities operate under Department designation as crisis stabilization units where emergency mental health care is provided. General Revenue funding for community mental health services pays for space in receiving facilities to care for the indigent. Managing entities must comply with the bill's requirements for data collection by August 1, 2015

census of licensed beds, the number of beds purchased by the Department, and the number of unoccupied licensed beds regardless of payor source.

As a result, the establishment of data reporting requirements in both Part I and Part IV of Chapter 394, F.S., has unintentionally created conflicting statutory requirements for the submission of data to the Department.

Data Submitted to the Department
Facilities designated as public receiving or treatment facilities shall report to the Department on an annual basis the following data, *unless these data are currently being submitted to the Agency for Health Care Administration (AHCA)*: 1. Number of licensed beds. 2. Number of contract days. 3. Number of admissions by payor class and diagnoses. 4. Number of bed days by payor class. 5. Average length of stay by payor class. 6. Total revenues by payor class. "Payor class" means Medicare, Medicare HMO, Medicaid, Medicaid HMO, private-pay health insurance, private-pay health maintenance organization, private preferred provider organization, the Department of Children and Families, other government programs, self-pay patients, and charity care.[7]
A managing entity shall require a public receiving facility within its provider network to submit data, in real time or at least daily, to the managing entity for: 1. All admissions and discharges of clients receiving public receiving facility services who qualify as indigent, as defined in s. 394.4787; 2. Current active census of total licensed beds 3. Number of beds purchased by the Department 4. Number of clients qualifying as indigent occupying the Department-purchased beds 5. Total number of unoccupied licensed beds regardless of funding. The managing entities must report this data to the Department, using the CSU database, on a monthly and annual basis.[8]
The Office of Clerks of Court shall submit to the Department a copy of the following: 1. Petition for involuntary outpatient placement and individualize treatment

[7]Section 394.461(4), F.S.

[8] Section 394.9082(10), F.S.

	plan[9] 2. Continued involuntary outpatient placement certificate and treatment plan[10] 3. Petition for involuntary inpatient placement[11] **Data Submitted to the Agency for Health Care Administration** The Agency for Health Care Administration shall receive and maintain copies of the following: 1. Ex-parte orders for involuntary examination[12] 2. Mental Health Professional certificates for initiating involuntary examinations[13] 3. Law enforcement reports (involuntary examination)[14] 4. Involuntary outpatient placement orders[15] 5. Involuntary inpatient placement orders[16] *Note: The Baker Act Reporting Center at the Louis de la Parte Florida Mental Health Institute receives data on behalf of AHCA, which allows it to meet its statutorily required receipt and reporting of this information. Currently, Baker Act receiving facilities must mail the involuntary examination initiation forms and a coversheet with critical information about each examination initiated to the Baker Act Reporting Center. Staff at the Reporting Center must manually process and enter the data contained in the involuntary examination initiation forms.* **Marchman Act Data** Currently, there are no statutory requirements for the collection, submission, or reporting of Marchman Act-related to the Department. However, the Office of the State Courts Administrator publishes data on the number of Marchman Act and Baker Act petitions filed and disposed. The data are based on information received from the Clerks of Court and are extracted from a static database containing the official trial court statistics.[17]
Recommendations	1. Require the collection, submission, and reporting of the same data for the Marchman Act as currently required for the Baker Act by all designated receiving facilities, as well as any other licensed providers accepting

[9] Section 394.4655(3)(c), F.S.

[10] Section 394.4655(7)(a)(4), F.S.

[11] Section 394.467(3), F.S.

[12] Section 394.463(2)(e), F.S.

[13] Section 394.463 (2)(a)(3), F.S.

[14] Section 394.463 (2)(a)(2), F.S.

[15] Section 394.4655(6)(b)(2), F.S.

[16] Section 394.463(2)(e), F.S.

[17] http://trialstats.flcourts.org/TrialCourtStats.aspx Site last accessed on October 15, 2015.

	individuals under the Marchman Act (i.e. central receiving facilities, access centers, triage centers, CSUs, ARFs, and detoxification providers). 2. Require all Marchman Act data and all Baker Act data submitted by public and private receiving to Department and AHCA, to be submitted using the existing CSU Database established in s. 394.9082(10), F.S. The existing CSU database will need to be enhanced to allow for the collection, storage, submission, and analysis of Marchman Act data. The enhanced database should be renamed the Acute Care Database to accurately reflect the data being collected. 3. Revise requirements in s. 394.461(4), F.S., to remove exception for the submission of data to the Department if data is currently being submitted to AHCA. Instead, allow for the sharing of Baker Act data with AHCA. 4. Transfer statutory language and requirements pertaining to both the CSU database in s. 394.9082(10), F.S., and public receiving and treatment facilities data in s. 394.461(4)(a)-(b), F.S., to a new section in Part IV of Chapter 394, F.S. The new section in Part IV should blend the requirements in s. 394.9082(10), F.S., and s. 394.461(4)(a)-(b), F.S., and incorporate recommendations in this section for the reporting requirements for Marchman Act and Baker Act. 5. Require all Baker Act and Marchman Act Involuntary Petitions, Court Orders, Professional Certificates, Law Enforcement Reports, and treatment plans to be electronically submitted (or uploaded) using the Acute Care Database. Provide for the secure electronic transmission, and storage of all documents and data entered into the system consistent with 42 CFR Part II, HIPAA, and Chapters 394 and 397, F.S. AHCA would have access to all Baker Act-related data and documents, while the Department would have access to all Baker Act and Marchman Act-related data and documents.[18]

Additional Considerations	
Recommendations	1. In light of the recommendations in this report, the Department's methods of purchasing capacity for CSU, ARF, and residential detoxification beds warrants additional analysis of capacity versus utilization, and consideration of alternative methods of purchasing capacity for crisis services and payment methodologies. 2. The current Baker Act and Marchman Act differ substantially in who is authorized to initiate petitions for involuntary treatment, the criteria, placement options, the role of the state attorney and public defender, and time frames for orders. Alignment in the processes and

[18] The Department would not share Marchman Act-related data with the Agency for Health Care Administration due to the confidentiality requirements of 42 CFR Part II, HIPAA, and Chapter 397, F.S.

	documentation required by these statutes can reduce bureaucratic barriers to accessing court-ordered treatment, while retaining the important protections of due process. 3. Unlike the Baker Act, the Marchman Act does not include any provisions explicitly prohibiting the charging of fees for the filing of petitions for involuntary assessment and stabilization, or involuntary treatment. The charging of fees for the filing of a petition(s) creates a barrier to accessing services. 4. Standardize time frames so that hearings for involuntary treatment petitions must be held within five court working days of filing; orders for initial or continuing involuntary treatment are for 90-day increments, with an option for courts to order more frequent reviews. 5. Consider standardizing timeframes so that involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act must be completed within 72 hours. However, a physician or physician's assistant or psychiatric nurse acting under the physician may authorize up to an additional 48 hours based on a determination of need without court involvement. If admitted involuntarily, total time combined may not exceed 72 hours unless there is further court involvement or the physician identifies a need for the additional 48 hours.

V. Appendices

Appendix 1. Baker Act and Marchman Act Project Team Participants

Appendix 2. Baker Act and Marchman Act Project Team Fiscal Subcommittee's Cost Methodologies and the Public Consulting Group (PCG) Crisis Stabilization Reimbursement Transition Plan

Appendix 3. CSU-SRT Statewide Map

Appendix 4. Addiction Receiving Facilities Statewide Map

Appendix 5. Public and Private Receiving Facilities

Appendix 6. Mobile Crisis Teams

Appendix 1

Participant	Affiliation
John Bryant, Assistant Secretary for Substance Abuse and Mental Health **(Chair)**	Department of Children and Families, Office of Substance Abuse and Mental Health
Melanie Brown- Woofter	Florida Council for Community Mental Health
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Ashley Schwab	Department of Children and Families, Office of Substance Abuse and Mental Health
Jeffrey Cece	Department of Children and Families, Office of Substance Abuse and Mental Health
Mark Fontaine	Florida Alcohol and Drug Abuse Association
Tabitha McDonald	Florida Sheriffs Association
Matt Dunagan	Florida Sheriffs Association
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Mary Armstrong	Florida Mental Health Institute, Department of Mental Health Law and Policy, University of South Florida
Richard Brown	Agency for Community Treatment Services
Carali McLean	Agency for Community Treatment Services
Jack Plagge	Agency for Healthcare Administration, Bureau of Health Facility Regulation, Hospital & Outpatient Services Unit
Doug Leonardo	Baycare Behavioral Health
Jerry Kassab	Aspire Health Partners
Vicki Garner	Aspire Health Partners
Shannon Robinson	Aspire Health Partners
Margo Adams	Florida Psychiatric Society
Jennifer Grandal	Office of the State Courts Administrator, Office of Court Improvement
Rose Patterson	Office of the State Courts Administrator, Office of Court Improvement
The Honorable Mark A. Speiser	Circuit Court Judge, 17th Judicial Circuit
Jane Johnson	Department of Children and Families, Office of the Chief of Staff
Herb Helsel	Department of Children and Families, Northeast Region
Nicole Stookey	Department of Children and Families, Office of Legislative Affairs
Yamile Diaz	Department of Children and Families, Southern Region
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Susan Harbin, Esq.	Florida Association of Counties
Neal Dwyer	Central Florida Behavioral Health Network
Betty Hernandez	South Florida Behavioral Health Network
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Laurie Chesley	LSF Health Systems
Geovanna Dominguez	Central Florida Cares Health System, Inc.
Candy Hodgkins	Gateway Community Services, Inc.
Rich Rasmussen	Florida Hospital Association
Pamela Carter	Central Florida Behavioral Health Network
Sheriff Robert A. "Bob" Gualtieri	Pinellas County Sheriff's Office
Natalie Kelly	Florida Association of Managing Entities

Appendix 2

Baker Act and Marchman Act Project Team Fiscal Subcommittee's Cost Methodologies

In costing the Baker Act and Marchman Act three different methodologies were employed in an effort to triangulate results and to validate the projected cost to implement a "no wrong door" approach to mental health and substance abuse services statewide.

A variety of data sources were utilized in the development of the methodologies including the Department of Children and Families report on state funded CSU Beds, Detox beds, Addiction Receiving Facility (ARF) beds, hospital discharge data, and Managing Entity (ME) contractual information.

Assumptions:

The methodologies for cost of detox and ARF bed are based on reimbursement levels paid by the managing entities for the previous fiscal year. Cost methodology for the CSU beds is based on a study conducted by the Public Consulting Group (PCG) under contract with the Department of Children and Families based on a requirement included in the 2012 General Appropriations Act and issued on January 2013. These costs assume that beds are purchased on a bed availability model. If this is changed to a per diem reimbursement method, the costs would be higher.

There are no fixed capital outlay costs included.

The ratios are applied to the statewide population and the methodologies do not result in a projected cost by DCF Circuit, Medicaid region, or other geography.

Methodology 1: Beds Per Capita

Method 1: Beds per Capita Using DCF Funded Capacity					
	Total Beds Needed*	**DCF Funded Beds**	**Additional Beds Needed**	**CSU Unit Cost**	**Cost per Year for Additional Beds**
CSU Bed Need	1951	696	1255	$ 378.50**	$173,345,040
*DCF rule 65E-12.104(8), FAC, provides a guideline for planning CSU bed capacity of 10 beds per 100,000 people. Given the state population of 19,507,369, this generates a need of 1951 beds.					
**The $378.50 cost per bed was determined in the Public Consulting Group report commissioned by the Department of Children and Families titled: Department of Children and Families Crisis Stabilization Reimbursement Plan, 2013.					
	Total Beds Needed	**DCF Funded ARF and Detox Beds**	**Additional Beds Needed**	**Detox Unit Cost**	**Cost per Year for Additional Beds**
DCF Funded Detox Beds	975	377	598	$280.00	$61,153,256
The detox bed standard of 1 bed per 20,000 people is a proxy for discussion.					

				Grand Total Additional Cost	$234,498,295

This methodology calculates the number of beds that would be necessary statewide to meet the guideline of 10 beds per 100,000 population for CSU beds (per DCF Rule 65E-12.104(8) and the guideline of 5 beds per 100,000 population for Detox beds statewide (a proxy as no guideline exists in Rule at present). The cost is derived by projecting the cost per bed x the number of additional beds needed x 365 days (assuming that the beds are at capacity annually).

Detail:

DCF rule 65E-12.104(8) provides a guideline for Crisis Stabilization Unit (CSU) bed capacity of 10 beds per 100,000 population (or 1 bed per 10,000 people). According to the Bureau of Economic and Business Research the current population in Florida is 19,507,369. Applying the ratio of 1 bed: 10,000 population results in a total need of 1,951 CSU beds statewide.

Currently there are 696 DCF funded CSU beds (contracted CSU beds) statewide. Using a formula of (Total beds– Contracted beds= Additional bed need), 1,251 additional beds are needed statewide.

At a CSU Unit Cost of $378.50 per day (the bed cost reported in the Public Consulting Group (PCG) report of 2013) the cost per year for these additional beds is $173,345,040.

Research revealed that there is no standard in rule for Detox bed capacity. A standard of 1 bed per 20,000 population (5 beds per 100,000 population) was used in this Beds Per Capita methodology, and is a proxy for discussion. Applying the ratio of 1 bed: 20,000 population results in a total need of 975 Detox beds statewide. Currently there are 377 DCF funded Detox beds (DCF licensed and contracted Detox beds), resulting in a need of 598 additional Detox Beds.

The cost per day of Detox bed is $280.00 (the average current DCF reimbursement/contracted rate). The total cost per year for these additional beds is $61,153,256.

The grand total of the annual cost of the additional DCF funded CSU beds and DCF funded Detox beds needed statewide to meet the guidelines is $234,498,295.

Methodology 2: Central Receiving Facility Model

Method 2: Central Receiving Facility Model					
	Total Beds Needed	**AHCA Licensed CSU Beds and DCF Licensed**	**Additional Beds Needed**	**CSU Unit Cost**	**Cost per Year for Additional Beds**

		Detox Beds			
CSU/Detox Bed Need	3701	1541	2160	$ 378.50	$ 298,346,941
This system relies on flexible CSU, SRT, hospital, Detox, and Addictions Receiving Facility Beds. The combined total of all these beds equals 233, which based on a population of 1.2 million in Orange County results in a current capacity of 1.98 beds per 10,000 population.					
This system relies on funding from various sources: local, state, and private sources.					

The Orange County central receiving facility (CRF) has been operational for at least 10 years and is the result of an integrated model and funding system of service that brings together Law Enforcement, Mental Health and Substance Abuse providers, Justice and other stakeholders. The CRF is the single point of entry for mental health and substance abuse services in Orange County and provides services under both the Baker Act and Marchman Act.

Detail:

This model uses a variety of inpatient services including

Baker Act/Mental Health (193 beds):

87 Adult CSU beds, 20 Children CSU beds, 56 Hospital-contracted CSU beds, 30 Short Term Residential Treatment (SRT) beds; and Marchman Act/Substance Abuse (40 beds):

40 Detox beds

For a total of 233 beds. Note that 12 Addiction Receiving Facility beds are imbedded in the 87 Adult CSU beds and can be utilized based on demand.

According to the Bureau of Economic and Business Research the current population in Orange County is 1,227,995, resulting in a standard of 1.9 beds per 10,000 population. This is almost double the standard in the Bed Per Capita methodology. Applying this ratio to the statewide population (above) results in a need of 2,160 additional CSU and Detox beds statewide to bring the entire statewide system up to the central receiving facility model standard.

At a cost of $378.50 per day per bed, the annual additional cost is $298,346,941.

Methodology 3:

Method 3: 2014 Needs Assessment		
ME	**CSU Beds Unmet +**	**Detox Beds Unmet + Unfunded**

	Unfunded		
BBCBC	$2,427,836	$240,462	
BBHC	$7,803,999	$3,827,756	
CFBHN	$29,240,230	$5,209,649	
CFCHS	$25,264,316	$12,684,487	
LSF	$12,198,507	$2,028,571	
SEFBHN	$5,671,071	$2,577,580	
SFBHN	$21,629,091	$2,530,728	
Total	$104,235,052	$29,099,233	
		Grand Total	$133,334,285

Methodology 3 includes figures for unmet and unfunded need by managing entity according to self-reported data acquired by surveying Florida Council for Community Mental Health members in 2014. The survey included data regarding current utilization of services, wait list for services and current bed capacity and reimbursement rates compared to actual cost of providing the service.

The total additional annual funding necessary to meet the utilization need for CSU beds is $104,235,052 and $29,099,233 for Detox beds for a total of $133,334,285.

Actual Provider Cost:
This cost was generated on actual provider cost using figures developed by Public Consulting Group (PCG), an independent consultant contracted by the Department in 2013. According to PCG report entitled 'Department of Children and Families Crisis Stabilization Reimbursement Plan' the Average Cost per Bed Day is $378.50 for CSU beds.

In summary, costs for funding a "no wrong door" approach range from $133 - $298M, depending on which model is used. This represents total additional costs and should be funded between a partnership of state government, local governments, Medicaid and local communities.

State of Florida
Department of Children and Families
Crisis Stabilization Reimbursement Transition Plan

January 1, 2013

TABLE OF CONTENTS

1. INTRODUCTION

This *Crisis Stabilization Reimbursement Transition Plan* is presented by the Department of Children and Families to the Florida Legislature to fulfill the requirements of the legislative proviso found in Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346. This proviso mandates the Department to develop a plan to transition from capacity-based reimbursement to utilization-based ("per diem") reimbursement for mental health crisis stabilization services.

This section of the Transition Plan provides essential background information for understanding the proposed reimbursement model and its rationale, and the process that was used to develop it. Section 2 provides definitions of technical terms used throughout the document. Section 3 reports the results of a quantitative analysis of providers' costs of providing crisis stabilization services in Florida. Section 4 reports the results of a qualitative analysis of three of the state's local crisis stabilization systems of care. Section 5 describes the Department's proposed method of utilization-based reimbursement to meet the requirements of the legislative proviso. Section 6 describes the statutory and regulatory changes that would be required to implement the proposed method. Section 7 describes the steps the Department would need to take to implement the method. Section 8 discusses the potential impact of implementing the proposed reimbursement method.

Florida's Mental Health Crisis Services System

Florida's mental health crisis services system is governed by the Baker Act (Chapter 394, Part 1, Florida Statutes), which authorizes the Department to manage programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders through emergency rehabilitative services for persons requiring intensive short-term and continued treatment for recovery. The Baker Act provides for the involuntary examination of individuals who, due to mental illness, present a threat to themselves or others, or are unable to care for themselves on a basic level. The Baker Act also allows individuals who are competent to consent to be admitted for crisis services on a voluntary basis if they appear to have a mental illness and may benefit from treatment.

Requirements of the Legislative Proviso

In proviso of the 2012 General Appropriations Act, the Florida Legislature mandated that:

> "The department shall develop a plan to modify the method of expending funds for crisis stabilization services to establish per diem reimbursement for covered services provided to qualified patients. The department's recommended method shall be budget neutral and shall allow use of available funds to reimburse a variety of providers, including public

receiving facilities, community mental health programs, licensed acute care hospitals, or other approved facilities. The plan shall be submitted to the Legislature no later than January 1, 2013 and shall identify steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.)

Thus the essential requirements of the plan are that it:

a) Establish utilization-based ("per diem") reimbursement.
b) Maintain budget-neutrality.
c) Allow reimbursement of a variety of provider types to the extent possible.

The Department has decided to incorporate two additional major elements in the plan, which were not specifically mandated by the proviso:

d) Competitive procurement of Department-funded crisis stabilization services by managing entities (MEs).
e) Utilization management of Department-funded crisis stabilization services by MEs.

Crisis Stabilization Unit (CSU) Workgroup

The Crisis Stabilization Unit (CSU) Workgroup was convened by the Department and met monthly from May through November 2012 (except during July) to advise the Department on the development of this Transition Plan. Workgroup participants included executives of hospitals and CSU providers, representatives of the law enforcement community, and Department staff. The Workgroup was charged with advising on the following matters: the process and criteria to be used in the establishment of per diem reimbursement; criteria to be used in the competitive procurement process for crisis stabilization services; possible changes to the requirements for a facility to be designated as a Baker Act receiving facility; possible changes to the roles of public and private receiving facilities; and types of facilities that should be eligible to serve as receiving facilities.

Public Consulting Group (PCG)

Public Consulting Group (PCG) was contracted by the Department to facilitate the meetings of the CSU Workgroup and conduct related research. PCG conducted a quantitative analysis of utilization, funding and provider costs throughout the state's crisis stabilization system. PCG also evaluated the crisis stabilization service systems as they currently operate in three of the Department's regions, in order to provide background information for the development of this Transition Plan. PCG also collaborated with Department staff in the development of this Transition Plan document.

Managing Entities (MEs)

The Department is in the process of implementing managing entities (MEs) statewide. MEs are private, non-profit corporations contracted by the Department to take over many of the administrative responsibilities that had previously belonged to the regional or circuit offices of the Department. MEs are already operating in most of the state and are expected to cover the entire state by March 1, 2013. The central role of MEs is to subcontract with community mental health and substance abuse providers that are funded by the Department, including public receiving facilities. Thus, the reimbursement model described in Section 5 of this Transition Plan assigns MEs (rather than the Department) responsibility for competitively procuring public receiving facility contracts.

2. DEFINITIONS

This section defines key terms that are used throughout this Transition Plan.

1) **Baker Act:** Chapter 394, Part I, Florida Statutes; regulates mental health services; provides for the involuntary examination of individuals who, due to mental illness, present a threat to themselves or others, or are unable to care for themselves on a basic level; allows individuals who are competent to consent to be admitted for crisis services on a voluntary basis if they appear to have a mental illness and may benefit from treatment.

2) **Budget neutral:** Not requiring any legislative appropriations above the level appropriated for the most recent fiscal year.

3) **Capacity-based reimbursement (or funding):** A funding mechanism wherein the Department contracts with each public receiving facility for a certain number of beds to be available for Department clients, and provides the same amount of reimbursement to the facility each year regardless of the number of beds actually used by Department clients.

4) **Client:** Any individual receiving services in any substance abuse or mental health facility, program, or service, which facility, program, or service is operated, funded, or regulated by the department. (s. 394.67(2), F.S.)

5) **Crisis stabilization services:** Brief, intensive services provided twenty-four (24) hours per day, seven (7) days per week for individuals experiencing a mental health crisis. Crisis stabilization services include services associated with involuntary examination and voluntary admission under the Baker Act.

6) **Crisis stabilization unit (CSU):** A program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state. (s. 394.67(4), F.S.)

7) **Department client:** A client whose household income is below the Federal poverty guideline; who has no payor source available other than the Department; and who is receiving services from a Department-contracted provider. Department clients are eligible for Department-funded crisis stabilization services.

8) **Express and informed consent:** Consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to

enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. (s. 394.455(9), F.S.)

9) **Facility:** Any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness. (s. 394.455(10), F.S.)

10) **Incompetent to consent to treatment:** A person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. (s. 394.455(15), F.S.)

11) **Involuntary examination:** A mental health examination conducted by a receiving facility under the authority of the Baker Act and without the express and informed consent of the individual examined, for the purpose of determining whether the individual meets criteria for involuntary placement. An involuntary examination may be initiated by a licensed health care professional, a law enforcement officer, or by the circuit court upon petition from any party. The criteria for involuntary examination are that the individual appears to have a mental illness, presents a danger to self or others because of the mental illness, and that no less restrictive alternative is available to relieve the danger. (s. 394.463, F.S.)

12) **Private facility:** Any hospital or facility operated by a for-profit or not-for-profit corporation or association that provides mental health services and is not a public facility. (s. 394.455(22), F.S.)

13) **Public facility:** Any facility that has contracted with the Department to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose in accordance with contracts negotiated by the Department's Regional Office or by a Managing Entity (ME). All CSUs are public receiving facilities; hospitals may be either public or private receiving facilities. (s. 394.455(25), F.S.)

14) **Receiving facility:** Any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail. (s. 394.455(26), F.S.)

15) **Transportation exception plan (TEP):** A plan authorized by the Department and by a Board of County Commissioners pursuant to s. 394.462(4), F.S., allowing individuals

within a specific county to be transported to a receiving facility other than the nearest one under specified circumstances to improve service coordination and better meet clinical needs.

16) **Universal service requirement:** The requirement under s. 394.462(1) (j), F.S. that receiving facilities accept all individuals brought by law enforcement for involuntary examination.

17) **Utilization rate:** A ratio calculated for each facility providing crisis stabilization services by dividing the number of bed days actually utilized by Department clients during a year by the number of bed days contracted for by the Department.

18) **Utilization-based funding:** A funding mechanism wherein the Department reimburses providers on a per diem basis for the number of bed days actually used by Department clients.

19) **Utilization target**: In the reimbursement method proposed by this Transition Plan, the minimum number of bed days used by Department clients during a fiscal year which a crisis stabilization services provider must provide in order to receive the full value of the provider's contract with its managing entity (ME).

20) **Voluntary admission:** The admission of an individual to a facility with the individual's express and informed consent.

3. PROVIDER COSTS IN FLORIDA'S CRISIS STABILIZATION SYSTEM

A key component of any analysis of reimbursement methodologies for a system of care is a review of existing provider data. In this section, we have documented the analysis of the current crisis stabilization system in Florida on the basis of the provider costs of providing crisis stabilization services to Department clients. The following subsection will provide an overview of the methodology used to capture crisis stabilization service provider costs, the data collection process, and the analysis of the provider data. Limitations of the data are also discussed. It should be emphasized that the analyses reported here concern the providers' costs of providing services, not the cost to the Department.

In conducting the analysis, the data was reviewed in multiple ways to provide various perspectives on the system. The data was initially reviewed on a statewide basis and broken out by total cost per bed day for adult and children's units combined and then the cost per bed day by adults and by children's units discretely. The second analysis was done in a similar fashion; however the data was broken out based on Department region. The third analysis compared the cost per bed day for a crisis stabilization unit (CSU) versus a hospital receiving facility.

Data Collection Methodology

Public Consulting Group (PCG) initially set out to conduct a quantitative analysis of the crisis stabilization system in Florida with a focus on Department-funded providers (public receiving facilities) with the results of the analysis to be used to inform future rate development exercises. At the August, 2012 CSU Workgroup meeting, PCG initiated the discussion about the future data collection efforts to be completed. During this discussion, PCG staff identified the data they would seek to collect from crisis stabilization providers. PCG noted that, because Medicare and Medicaid cost reports were not available for all providers, this data collection effort would likely require the development of a survey to be completed by all crisis stabilization service providers. CSU Workgroup participants proposed using the data provided by the public receiving facilities in the Department's Agency Capacity Reports rather than developing a new survey tool and asking providers to duplicate existing efforts. One limitation of this option is that, in general, only the crisis stabilization providers designated as public receiving facilities have completed the Agency Capacity Reports; as a result, the private receiving facilities would still have needed to be asked to complete a survey in order to capture a comprehensive data set.

Following the August CSU Workgroup meeting, Department staff, in consultation with PCG, began developing utilization-based reimbursement models to be presented during the September CSU Workgroup meeting. Through these discussions, it became apparent that rates would be set in negotiations with the Managing Entities; therefore, there was no need for this Transition Plan

to specify rates or rate formulas. The Department agreed that PCG should proceed with the quantitative analysis using the Agency Capacity Report data for the public receiving facilities. The remainder of this section describes the data collection efforts and the analysis of the data obtained.

Data Collection Process

Prior to collecting data, PCG conducted initial research to better understand Agency Capacity Reports, the data included in them, limitations of this data, and the role of these reports in contract negotiations between the Department and the public receiving facilities. As part of these efforts, PCG interviewed staff of two managing entities (MEs): South Florida Behavioral Health Network and Lutheran Services of Florida. Some of the key conclusions follow.

- ***Reimbursement rates are calculated based on 100% utilization rates.*** One of the main limitations of the Agency Capacity Report data is that it assumes a utilization rate of 100 percent. While this assumption was acceptable under the capacity-based model, it presents a challenge in using the data to determine an appropriate rate for utilization-based funding. One ME staff member suggested that the maximum days be calculated using 85% as an estimate for the utilization rate. This alone, however, would not address the issue of different utilization rates for adults and children. In reviewing the analysis in the following pages it should be noted that all rates are based on this same assumption of 100% utilization as this is the representation of the actual data reported by providers.

- ***The Role of Agency Capacity Reports in contract negotiations varies by ME and Department region.*** The use of Agency Capacity Report data in contract negotiations varies across the state. Agency Capacity Reports are often not used in determining the rate the crisis stabilization providers receive. It was noted by one of the managing entities interviewed that due to the statewide maximum rates that are set in rule for both adult and child crisis stabilization services, there is little room for the negotiation of rates. Therefore, the Agency Capacity Report data is only used to determine rates for providers who are found to have rates below the statewide maximum rates, in which case those providers would receive a rate based on the costs identified in their Agency Capacity Report. In the rare event that the DCF Regional Office or Managing Entity makes the determination to appeal for a higher rate for a provider, the Agency Capacity Report data may be used to support that request.

Following PCG's research on the Agency Capacity Report data, PCG contacted the Department's regional contract managers to begin data collection. PCG, with the help of DCF Central Office, also reached out to the Department's Regional Managers and to the managing entities to assist in the collection of the Agency Capacity Report data. One of the greatest

challenges of this phase of the engagement has been the identification of the appropriate staff to provide the Agency Capacity Report data, since the Department's regions are in various stages of implementing the managing entities.

Analysis of Agency Capacity Reports

The analysis of the Department-funded crisis stabilization system presented in the following sections is based on the data reported by the public receiving facilities on their Agency Capacity Reports. The data was received through the Department's regional offices; the managing entities; and in some cases directly from the providers themselves. PCG has accepted the data as reported without any substantial audit efforts. In the preparation of the analysis, PCG would like to note the following major limitations:

- ***Data has been received for 28 public receiving facilities.*** At the time of this analysis, PCG has only received data for 28 public receiving facilities out of a total of 64 possible providers. In some cases, the data has been combined for a provider with multiple locations as was the case for the four PEMHS locations. While considering the providers that submitted one report for multiple locations does help to reduce the number of facilities for whom no data was received, there are still a significant number of facilities not included in this analysis.

- ***Some providers did not differentiate between adult and children's services.*** Another limitation of the analysis is that some providers that were identified as having both adult and children's services only provided data in the aggregate for all crisis stabilization services. Where possible, PCG attempted to separate the bed capacity data between adult and children's categories with the reported expense separated proportionally between the two. As a result, the analysis of the cost per bed day for the adult versus children's services may not provide as clear a distinction as might be expected.

The Appendix lists those public receiving facilities that have submitted Agency Capacity Report data included in the analyses. PCG also received data from Sarasota Memorial Hospital (Bayside Center for Behavioral Health) and Central Florida Behavioral Hospital (Baycare Behavioral Health). However, as private receiving facilities, their data was excluded from the analysis.

PCG has conducted three separate analyses on the cost per bed day as reported on the Agency Capacity Report by the public receiving facilities. The first analysis looks at the statewide cost per bed day, while the second analysis looks at the cost per bed day on a regional basis. The third and final analysis compares the cost per day for crisis stabilization units (CSUs) versus hospital providers. In each of the three analyses, we have examined the data in the aggregate (including both adult and children's services); for adult services only; and for children's services only.

Statewide Analysis

In the statewide analysis, the Agency Capacity Report data for all providers has been combined to identify the statewide average cost per bed day. Again, this analysis looks at adult and children's data both separately and in combination. The following table summarizes the results.

	Statewide
Total Bed Days Available	314,432
Total Expense	$ 119,013,554
Average Cost per Bed Day	**$ 378.50**
Total Bed Days Available - Adult	272,136
Total Expense - Adult	$ 102,597,490
Average Cost per Bed Day - Adult	**$ 377.01**
Total Bed Days Available - Child	42,296
Total Expense - Child	$ 16,416,063
Average Cost per Bed Day - Child	**$ 388.12**

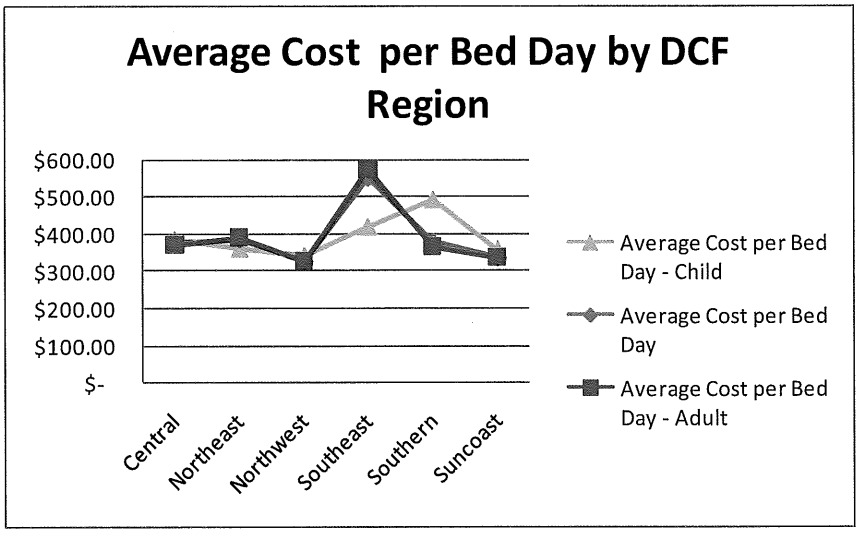
The analysis of the cost per bed day on the statewide basis illustrates two key points: first, the statewide average cost per bed day for crisis stabilization services ($378.50) is greater than the state's maximum rate of $291.24; second, the average cost per bed day for children's crisis stabilization services ($388.12) is higher than the cost per bed day for adult crisis stabilization services ($377.01).

Regional Analysis

The regional analysis, like the statewide analysis, includes the available bed days, the total expense and the cost per bed day. It should be noted that there are limitations to this analysis given the limited number of Agency Capacity Reports received. For example, Agency Capacity Report data was only received for three of the fifteen public receiving facilities in the Central region. Likewise, the data for the Southeast region includes only two of the eleven public receiving facilities.

	REGION					
	Central	Northeast	Northwest	Southeast	Southern	Suncoast
Total Bed Days Available	29,930	61,050	22,070	29,565	58,412	113,406
Total Expense	$ 11,210,965	$ 23,587,556	$ 7,263,521	$ 16,279,237	$ 22,229,902	$ 38,442,374
Average Cost per Bed Day	**$ 374.57**	**$ 386.37**	**$ 329.11**	**$ 550.63**	**$ 380.57**	**$ 338.98**
Total Bed Days Available - Adult	21,900	50,830	21,749	24,820	52,572	100,266
Total Expense - Adult	$ 8,112,871	$ 19,902,856	$ 7,153,600	$ 14,281,777	$ 19,354,605	$ 33,791,782
Average Cost per Bed Day - Adult	**$ 370.45**	**$ 391.56**	**$ 328.92**	**$ 575.41**	**$ 368.15**	**$ 337.02**
Total Bed Days Available - Child	8,030	10,220	321	4,745	5,840	13,140
Total Expense - Child	$ 3,098,094	$ 3,684,700	$ 109,921	$ 1,997,460	$ 2,875,296	$ 4,650,592
Average Cost per Bed Day - Child	**$ 385.81**	**$ 360.54**	**$ 342.43**	**$ 420.96**	**$ 492.35**	**$ 353.93**

The cost per bed day is quite variable across the different regions in the state. Further, given that a large number of beds included in the analysis were adult beds, the average cost per bed day for adults closely mirrors that of the aggregate average cost per bed day. The following chart depicts the variability in cost per bed day across the five regions of the state for which Agency Capacity Report data was received.



Crisis Stabilization Unit (CSU) vs. Hospital Analysis

The final component of the analysis was to look at the cost per bed day for the CSU providers against the cost per bed day for the hospital providers. Like the previous two analyses, this analysis compares the cost per bed day in the aggregate and then the cost per bed day for adults and children separately. One limitation of this analysis is that, of the thirteen public receiving facilities that are hospitals, only five submitted Agency Capacity Report data to be included in the analysis. A second limitation is that, of the five hospitals for which data was included in the

analysis, only one reported costs associated with children's beds. The following table presents the results of this analysis based on the data received from those five hospitals.

	CSU	Hospital
Total Bed Days Available	267,618	46,815
Total Expense	$ 94,351,606	$ 24,661,948
Average Cost per Bed Day	**$ 352.56**	**$ 526.80**
Total Bed Days Available - Adult	230,067	42,070
Total Expense - Adult	$ 79,933,003	$ 22,664,488
Average Cost per Bed Day - Adult	**$ 347.43**	**$ 538.73**
Total Bed Days Available - Child	37,551	4,745
Total Expense - Child	$ 14,418,603	$ 1,997,460
Average Cost per Bed Day - Child	**$ 383.97**	**$ 420.96**

The costs per bed day for crisis stabilization services in the hospital setting were significantly higher than the costs per bed day for crisis stabilization services in the stand-alone CSUs. This is consistent with the general understanding that CSUs provide a less costly alternative to hospitalization. While the table above shows that the average cost per bed day for adults is greater than that for children's, this may not be an accurate representation as the children's data includes only one hospital.

Conclusions

As the preceding analyses illustrate, the cost per day for crisis stabilization services in Florida are on average over $375 per day. While there are some providers whose cost per day is less than this figure, the preceding analyses clearly show that the existing maximum (model) rate of $291.24 per day, as defined in Florida Statute, does not cover the costs incurred by crisis stabilization providers in serving DCF clients. Given the language in the legislative proviso and the requirement to remain budget neutral within a utilization-based reimbursement approach it is safe to assume that providers will continue to realize reimbursement at rates below their costs in providing these services.

4. EVALUATION OF CRISIS STABILIZATION SYSTEMS OF CARE

To inform the development of the proposed reimbursement model, Public Consulting Group (PCG) conducted a qualitative evaluation of three of the state's existing local mental health crisis systems of care: Broward County, Circuit One, and Orange County. The findings of this evaluation are reported in this section.

The Broward County System of Care

Broward County, which includes Ft. Lauderdale, has three public receiving facilities, as well as five hospitals serving as private receiving facilities. The county uses a central receiving facility model that allows the burden of Department clients to be shared equitably, primarily across the three public receiving facilities and, when necessary, across the five private receiving facilities. Since a payment model that would be based on a central receiving facility structure is proposed in Section 5 of this plan, PCG interviewed staff from the Department's Southeast Regional Office familiar with Broward's system of care.

In the mid-1990s, the Department decided that Broward County had an excess of crisis stabilization beds; the Department reorganized the system with input from stakeholders, downsizing from 90 beds to 60 beds. All of the receiving facilities had been clustered in part of the county; new facilities were contracted in different areas of the county.

Currently, there are three CSUs in Broward County: one in the central area, one in the eastern area, and one in the southwestern area. Individuals are transported to the nearest receiving facility, whether public or private, and are transferred, if necessary, after being evaluated at that facility. Only one CSU admits children; all three admit adults.

By opening three sites, Broward increased the number of funded beds; yet there are still circumstances in which there is a significant amount of overflow. When overflow occurs and there are no publicly-funded beds available, there is a rotation between the private facilities that accept individuals for whom they know they will not be reimbursed for providing services. Private hospitals have been accepting individuals in this situation for the past few years. One of the Broward CSUs is located in a private hospital that has a larger capacity than can be funded; however, the hospital will provide additional beds without reimbursement when needed.

The three public facilities take turns acting as a central receiving facility by managing the system for transporting indigent patients to private facilities in overflow situations. Each month, a different public facility maintains the log that records which private facility is up on the rotation to accept an indigent patient. The individual is then sent to whichever facility is next on the

rotation, as long as they have an available bed, which is typically easy to determine as the availability of beds at each facility is recorded daily.

Law enforcement is not responsible for transporting individuals after they have been brought to a facility and evaluated; the facility is responsible for transporting them to another facility, if necessary.

Workgroup participants expressed concerns about the conflict of interest that could arise from a central receiving facility providing clinical services and determining transfer destinations. In Broward this problem is mitigated by the three public receiving facilities rotating the responsibility for determining transfer destination.

The Department regional staff interviewed noted that the system of care depends on positive relationships among the Department's Regional Office, the public facilities, and the private facilities, and on the commitment of the administration at the private facilities. Whenever there is a change in administration at the private facilities, there is cause for concern that the relationship may change.

The central receiving facility model used in Broward County has worked well in that community, and seems to function best in more densely populated areas. There are other aspects of Broward that make it unique: the county and other local stakeholders provide funding at a higher level than in most areas of the state; and outpatient services have been reduced in order to shift funding to crisis stabilization services. Thus, replicating the central receiving facility model that is used in Broward may not be feasible in other regions in the state due to the different levels of funding, community support, and population density.

Regional office staff also encouraged the workgroup to ensure that the Baker Act Task Force is maintained through the current changes to the CSU structure; they emphasized the importance of this group, consisting of essential stakeholders that have been meeting regularly since 1975, and its contributions to the success of the central receiving facility.

The Circuit One System of Care

The Department's Circuit One, identical in boundaries to the First Judicial Circuit, is located in the western portion of the Florida Panhandle and is comprised of four counties: Escambia, Okaloosa, Santa Rosa, and Walton. Circuit One is part of the Department's Northwest Region. The Circuit One system of care already functions under what may be called a "quasi-utilization-based" model. Thus it serves as an informative model for the transition to utilization-based funding. PCG interviewed staff of Lakeview Center, the managing entity responsible for Circuit One, about their system of care and the benefits and challenges associated with it.

Circuit One's quasi-utilization-based model was the result of a change in the payment methodology implemented by the ME a few years ago. The Northwest Region's public receiving facilities operate with a capitated model, but they also are required to show that their funding is reflective of the number of beds used. The facility maintains a data warehouse where information concerning utilization is collected from monthly reports; funding is based on this utilization data. The two CSUs in Circuit One, Lakeview Center and Bridgeway Center, submit annual utilization reports to the data warehouse and are subject to an annual contract negotiation to set target rates.

Currently, when a Department client is brought to a CSU that is at capacity, the client is transferred to another facility that has available beds. If there are no Department-funded beds left in any of the public facilities in Circuit One, clients are transported to a local hospital private receiving facility.

PCG asked ME staff about the advisability of implementing a tiered rate structure, wherein facilities would receive a higher rate for the first one to three days and a lower rate thereafter. Theoretically, such a rate structure could yield shorter stays by incentivizing more efficient treatment and discharge planning. The ME does not use tiered rates; staff explained this would not be necessary as there is no incentive to hold individuals overlong as it is: it would damage relations with law enforcement and other community stakeholders since there would be a lack of bed availability.

The Department's proposed reimbursement model (described in Section 5 of this Transition Plan) includes competitive procurement of public receiving facilities by MEs. Lakeview Center staff expressed some concerns about the introduction of competitive procurement for crisis stabilization services. CSUs are presently the lowest cost provider of these services (as discussed in Section 3); and Lakeview Center uses the maximum ("model") rate for it subcontracted providers. Lakeview Center staff report that if they had to use competitive procurement to award their contracts, the rates would likely increase. Providers would then increase their rates, which could detriment the whole system.

Lakeview Center's use of a quasi-utilization-based model in Circuit One has not resulted in any change of funding levels. There has been an increase in administrative workload as providers must now demonstrate they are providing a certain number of bed days of services in order to receive their contracted funding. However, facilities have had no difficulty meeting their utilization target. Nevertheless, utilization-based funding as it exists in the Northwest Region may not work for smaller CSUs elsewhere in the state that cannot rely on having their beds filled consistently.

The Orange County System of Care

In Orange County, which includes Orlando, a central receiving facility, the Central Receiving Center (CRC), has served individuals in need of substance abuse services as well as those in need of Baker Act crisis stabilization services since 2002. Law enforcement transports individuals to the CRC where, after an initial assessment, the individual is either released or transported to the most appropriate facility based on clinical needs, payor source, and bed availability.

Public and private receiving facilities (including CSUs and hospitals) work in cooperation with the CRC and accept transfers from it. Department clients are assigned to facilities on a rotating basis to ensure fair and efficient sharing of the burden of care. Members of the CRC staff manage the rotation list, which does not pose a conflict of interest as the CRC does not house any crisis stabilization beds. For the first few years of operation, in order to ensure fairness, an administrative service organization (ASO) was hired to manage the assignment of clients to facilities. Eventually, the facilities took over this task themselves, with responsibility for managing the process rotating among the facilities each month. Orange County has a Transportation Exception Plan (TEP), as authorized under s. 394.462(4), F.S., allowing law enforcement to bypass the nearest receiving facility and transport all individuals in crisis directly to the CRC.

Prior to the adoption of the central receiving facility model, Baker Act transportation had become a significant burden on law enforcement; officers were spending hours at a time in hospital emergency departments, monitoring individuals who were awaiting examination. Now, officers need only spend a few minutes at the CRC to drop off an individual for examination. As a result, the central receiving facility model has strong support from local law enforcement agencies.

Orange County's system of care has proven to work well and is arguably replicable in some other areas of the state. The facility has served to decrease the incarceration rate of individuals with mental illnesses and substance abuse issues in the region, by giving this population access to rapid assessments and appropriate referrals.

5. PROPOSED METHOD OF UTILIZATION-BASED REIMBURSEMENT

The legislative proviso mandating this plan states, in its entirety, that:

> "The department shall develop a plan to modify the method of expending funds for crisis stabilization services to establish per diem reimbursement for covered services provided to qualified patients. The department's recommended method shall be budget neutral and shall allow use of available funds to reimburse a variety of providers, including public receiving facilities, community mental health programs, licensed acute care hospitals, or other approved facilities. The plan shall be submitted to the Legislature no later than January 1, 2013 and shall identify steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.)

This section describes the proposed reimbursement model. The Basic Model would apply statewide while the Access Centers Option could be implemented in particular geographic areas at the discretion of the MEs. With or without the Access Centers Option, the Basic Model:

- Meets the requirements of the legislative proviso to implement utilization-based funding while remaining budget neutral.
- Introduces competitive procurement and utilization management.
- Maintains the universal service requirement.

The Basic Model

The features of the Basic Model would apply statewide. The managing entities (MEs) would be largely responsible for the implementation and operation of the approach. The ME would divide their geographic area into procurement areas and competitively procure one or more public receiving facilities for each procurement area. The procurement areas would be based on community need, location of existing facilities, and utilization history. Maps delineating procurement areas would be subject to final approval by the Department. Bids would be accepted from any crisis stabilization unit (CSU) or hospital licensed to provide psychiatric care, located within the procurement area, and able to demonstrate the ability to meet the Baker Act requirements for designation as a receiving facility. Analysis by Department staff and Public Consulting Group has determined that no other types of facilities would have the capability to provide Baker Act services; comments from the CSU Workgroup confirm this. Bidders would be eligible regardless of for-profit or non-profit status, and could include new entrants to the Baker

Act market. Integrated crisis stabilization unit/addictions receiving facilities (CSU-ARFs), which focus on co-occurring substance abuse and mental health disorders, would be eligible to bid.

MEs would establish criteria for competitive procurement, including quality of care indicators, costs, and strength of community partnerships. The MEs would have the option of formally eliciting public input on these procurement criteria, including feedback from key stakeholders such as local providers, law enforcement agencies, county and municipal governments, and consumer and family advocacy organizations. At the managing entity's discretion, this process could include public meetings. The contracts resulting from the procurement process would be awarded for a four year term, the same as the term of the Department's contracts with the MEs. As at present, facilities that were not awarded contracts, or did not bid for them, could still be designated by the Department as private receiving facilities.

The reimbursement for crisis stabilization services would be on a utilization (per diem) basis with the MEs negotiating rates with each public receiving facility in the procurement process. In order to maintain budget neutrality, the MEs would also negotiate monthly reimbursement caps with these providers, taking into consideration providers' costs and the number of licensed beds. Monies paid to providers by MEs could not exceed the monthly cap, which would be set to ensure the ME does not exceed its total budget for crisis stabilization services. The MEs would be required to report to the Department in a monthly or quarterly reconciliation process to ensure all Department funding is being expended in an appropriate manner. Public receiving facilities would continue to be required to accept individuals for examination, regardless of ability to pay, even after reaching their monthly reimbursement cap. The same requirement would apply to private receiving facilities.

Finally, the MEs would negotiate monthly utilization targets, in terms of the number of bed days utilized by Department clients. In setting utilization targets, MEs would have the option of using data reflecting utilization history for the region, circuit, county, or procurement area, as long as this was done consistently across the ME's subcontracted providers. MEs could use the Department's available historical utilization data, or data the MEs themselves have collected, or may collect in the future.

Reimbursement rates, reimbursement caps, and utilization targets would be set in such a way that a provider would earn the full value of the reimbursement cap as long as their utilization did not fall significantly (2 - 10%) below the historical norm for adult services. Children's services would have a larger cushion (15%). This would help providers adapt to the new system by giving them a cushion so that they would not lose revenue if there is a small decline in utilization. However, if utilization fell further, the provider would see a decline in revenue.

The following steps summarize the process for determining the utilization targets and reimbursement caps for adult units:

1. Negotiate a reimbursement cap dollar amount based on the number of licensed beds, available budget, and market conditions;
2. Select a utilization target for adult services that is between 90% and 98% of the number of bed–days expected to be utilized, based on historical data (85% for children's services);
3. Divide the reimbursement cap by the target number of bed days to calculate the bed-day rate; and
4. Reallocate reimbursement caps among providers annually, based on utilization patterns.

For adult units, providers may earn less than the value of their reimbursement cap, because actual utilization may fall below the utilization target. However, setting the target slightly below 100% would help providers adapt to the new system by giving them a cushion so that they would not lose revenue if there is a small decline in utilization. For children's units, rates and utilization targets would be set in a similar manner, except that the utilization target would be set at 85% of the historical norm, allowing children's crisis stabilization services providers to have a relatively stable revenue stream even though utilization may be highly variable. This would allow the MEs to accommodate the relatively low utilization levels for children's units that arise from the small number of beds in children's units and the high variability of utilization. This flexibility is necessary to ensure that children's beds are available when they are needed, even if they are at times unused.

In addition to the crisis stabilization services, MEs would have flexibility to include contract provisions for reimbursement for alternative services that reduce the need for crisis stabilization, including mobile crisis services and drop-in centers. The reimbursement for these services would, however, count toward the reimbursement cap for that provider. MEs would also have the option of building into subcontracts incentives for providers to divert individuals into less costly and less restrictive alternative crisis services, when appropriate.

Finally, under the Basic Model, MEs would provide utilization management for contracted providers. The utilization management function would include:

- Automatic preauthorization by the ME for reimbursement of three bed days for individuals admitted for involuntary examination, based on the facility's determination that the individual does not meet criteria for release in the "initial mandatory involuntary examination" required by Rule 65E-5.2801(1);

- Automatic preauthorization by the ME for additional days for individuals awaiting hearing for involuntary placement after the filing of the petition by the facility;
- Automatic preauthorization for individuals on a waiting list for admission to a state mental health treatment facility; and
- Concurrent review by the ME for reimbursement of voluntary admissions.

The Access Centers Option

The Access Centers Option uses competitive procurement to select the central receiving facility (access center), which would itself be a contracted receiving facility, as well as other contracted receiving facilities. As in the Basic Model, MEs would negotiate rates, reimbursement caps, and utilization targets with individual providers. Facilities not awarded contracts could still be designated as private receiving facilities. All public receiving facilities would be obligated by contract to accept transfers of individuals, as assigned by the access center, within the capability and licensed capacity of the destination facility.

The features of the Access Centers Option would be added on to the Basic Model in certain counties, or portions of counties, at the discretion of MEs. The Access Centers Option leverages the concept of central receiving facilities, which already exist and work well in some areas of the state.

The main features and functions of the access center under this option are listed below.

- The access center would receive and examine all individuals transported by law enforcement. The access center would complete the "initial mandatory involuntary examination" required by Rule 65E-5.2801(1), unless immediate transfer was needed for medical reasons. This would allow access centers to release individuals (when clinically appropriate) without transferring them to another facility. The initial exam includes the following elements:
    - A review of the individual's documented recent behavior that led to the exam being initiated;
    - A brief psychiatric history;
    - A face-to-face examination by a physician or clinical psychologist;

  - The ME could require by contract that the initial exam be done by a psychiatrist; and
  - The ME could require by contract that the initial exam be completed within a certain time frame, such 6 hours, in order to improve the efficiency of the system of care.

- The access center would provide brief crisis intervention and refer to outpatient services to avoid admissions when clinically appropriate.
- The access center would receive a standard rate negotiated with the ME for each individual examined.
- The access center would determine whether the individual met criteria for involuntary examination and release the individual promptly if the criteria were not met.
- The access center would transfer clients to another receiving facility if criteria were met, or if extended observation were necessary.
- The access center would approve reimbursement of bed days as in the Basic Model, except that no bed days would be needed if the individual were released directly from the access center.
- The access center would provide overflow capacity when all other local receiving facilities (public and private) were at licensed capacity.

The Access Center Option, like the Basic Model, would incorporate utilization management. Under this option, the ME would assign one of its own staff members to each access center to function as a utilization management specialist ensuring that clinical functions would be separated from utilization management functions. The ME utilization management specialist would determine transfer destination systematically, based on the clinical needs of the individual, payor source available, and bed availability. Basic protocols for determining transfer destination would be included in Transportation Exception Plans (TEPs), making them subject to public comment and approval by the Department. More detailed criteria for transfers – especially medical criteria - would be subject to ME discretion, but codified in written procedures.

6. REQUIRED STATUTORY AND REGULATORY REVISIONS

The Department, in consultation with Public Consulting Group (PCG), conducted an analysis to identify any changes to statute or rule that would be required in order to implement the reimbursement model proposed in Section 5 of this report. The only needed change identified is an amendment to Rule 65E-14.021 (Unit Cost Method of Payment), Florida Administrative Code, to eliminate the maximum ("model") rate ($291.24) for crisis stabilization services. This would give managing entities the flexibility they need to negotiate rates with each subcontracted public receiving facility based on market conditions and available budget. Under the proposed model, there would be no maximum, minimum, or "model" rate.

7. STEPS FOR IMPLEMENTATION OF THE PROPOSED REIMBURSEMENT METHOD

The legislative proviso mandating this Transition Plan required that the Plan identify "steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.) This section describes those steps.

Steps for Implementation

1) *The Department will complete the statewide implementation of managing entities (MEs).*

   This Department initiative has been in progress for several years and is expected to be completed by March 1, 2013. Since MEs play a central role in the proposed reimbursement method, it will not be possible to fully implement the method until the MEs are fully operational.

2) *The Department will amend Rule 65E-14.021 (Unit Cost Method of Payment), Florida Administrative Code, to eliminate the maximum "model" rate for crisis stabilization services.*

   The Department is presently reviewing Rule Chapter 65E-14, F.A.C., which governs reimbursement of Department-funded substance abuse and mental health services. The Department anticipates proposing extensive amendments to this rule chapter, including amendments to accommodate the expanding role of MEs. Elimination of the maximum "model" rate for crisis stabilization services will be included among the proposed amendments. The target date for adoption of these amendments is July 1, 2013.

3) *The Department will negotiate amendments to its contracts with MEs to require that the MEs implement the proposed reimbursement method, including competitive procurement of public receiving facilities.*

   Existing contracts between the Department and the MEs require MEs to competitively procure subcontracted services to the extent possible; however, these existing contracts provide minimal guidance on the procurement process. Contract amendments will provide more detailed guidance regarding public receiving facilities. The timeline for these contract amendments to take effect depends upon the stage of implementation of the ME. However, if the Department implements the proposed reimbursement method, these contract amendments are expected to take effect for all MEs by January 1, 2014.

4) *The MEs will competitively procure public receiving facility contracts and implement the proposed reimbursement method.*

   The timeline for implementation of the new reimbursement model depends on the implementation of the MEs and the effective dates of contract amendments with MEs. However, if the Department implements the proposed reimbursement method, it is expected to be in full effect statewide by July 1, 2014.

5) *The Department will review and approve competitive procurement criteria and procurement area maps proposed by MEs, and require revisions as needed.*

6) *The Department will provide ongoing technical assistance to the MEs and their subcontracted providers to implement the new reimbursement method.*

8. POTENTIAL IMPACT OF THE PROPOSED REIMBURSEMENT METHOD

The Department, in consultation with Public Consulting Group and the CSU Workgroup, has sought to develop the proposed reimbursement method to meet the requirements of the legislative proviso (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346) in a manner that is consistent with the Department's mission and beneficial to the Department's clients. However, some Workgroup participants representing providers of crisis stabilization services have expressed concerns about potential adverse impacts of the proposed reimbursement method. This section describes the potential benefits and potential adverse impacts of the proposed reimbursement method, and highlights provisions intended to mitigate the workgroup's concerns. This section also discusses other issues raised by the workgroup related to the Baker Act system of care.

Potential Benefits of the Proposed Reimbursement Model

The proposed reimbursement method will make the Baker Act system of care more flexible and responsive by requiring that reimbursement caps be reallocated annually on the basis of changes in utilization. This will mean that resources will be reallocated regularly from low utilization providers to high utilization providers. Under the current system, such reallocation occurs only sporadically. Moreover, the utilization management features of the proposed reimbursement method have the potential to increase efficiency in the system of care, reducing unnecessary admissions and reducing lengths of stay, especially for individuals with complex discharge planning requirements. This could reduce costs substantially.

The proposed reimbursement model may also make it possible to serve more clients within existing resources by increasing utilization rates. Historically, the statewide utilization rate for Department-funded beds is 90.2% for adults and 38.2% for children. If these utilization rates were to rise to 95% for adults and 85% for children (based on the utilization targets in the proposed reimbursement model), with statewide Department-funded bed capacity remaining the same, the number of bed days utilized by Department clients would increase by 9,500 for adults and 13,470 for children. Based on historical average lengths of stay, this would translate into services provided for an additional 1,803 adults and 4,388 children per year.[1] Recent history suggests a significant increase in crisis stabilization services may be needed in the coming years.

[1] Staff analysis based on *Bed Use in Public Receiving Facilities and Treatment Facilities Fiscal Year 2009-2010.* http://www.dcf.state.fl.us/programs/samh/publications/csu0910.pdf

The total number of Baker Act involuntary examinations grew steadily from 122,000 in 2007 to 143,000 in 2010, an increase of 17% in just three years.[2]

However, it is important to note that actual utilization levels are subject to the influence of many factors, and cannot be predicted with any confidence. Utilization of crisis stabilization services may not need to increase to the extent noted above; in particular such a large increase in utilization is not likely for children's beds. To the extent these additional services are not needed, cost savings could result or resources could be diverted to other areas. Managing entities will have the option of diverting resources to less costly, less restrictive, alternative crisis services that could reduce the need for involuntary examinations, such as mobile crisis services and drop-in centers.

Potential Adverse Impacts of Proposed Reimbursement Model

The major advantage of the existing, capacity-based reimbursement method is that it ensures the stability of the system of care; concerns expressed by the CSU Workgroup have centered on the possible loss of this stability. The lack of competitive procurement for crisis stabilization services has meant a relatively stable pool of public receiving facilities. Most providers have been operating in the crisis stabilization market for many years. There are only occasionally new entrants to - or exits from - the market. This stable tenure has allowed providers to develop strong relationships with key community stakeholders: law enforcement agencies, county governments, non-receiving facility hospitals, and the Department. Turnover of public receiving facility administrators is relatively low, making it easier to maintain these relationships. These relationships are critical to the functioning of the Baker Act system.

Some workgroup participants have expressed concerns that competitive procurement could push longstanding providers - particularly CSUs - out of the market, disrupting local systems of care that the Department has built over many years. The proposed reimbursement model tries to address this concern by allowing managing entities (MEs) to include strength of community partnerships as a possible criterion for competitive procurement, and by giving MEs the option of incorporating formal public input into the development of procurement criteria and procurement area maps. Moreover, the Department must give final approval of these criteria and maps.

Workgroup participants have also emphasized that capacity-based funding has provided a reliable revenue stream for public receiving facilities, enabling them to remain in the market

[2] *Annual Report of Baker Act Data: Summary of 2010 Data.*
http://bakeract.fmhi.usf.edu/document/BA_Annual_Report_2010.pdf

though the maximum bed-day rate for crisis stabilization services ($291.64) has not increased for many years. As shown by the analysis reported in Section 3 of this Plan, the Department's bed-day rates are considerably lower than providers' actual costs of providing services. This is only possible because services for Department clients are effectively subsidized by other payor sources (such as Medicaid) which pay higher rates. Department funding has been a critical component of the crisis services funding system, despite the Department's low rates, simply because Department funding is stable from month to month, and usually from year to year. Some Workgroup participants have expressed concerns that the transition to utilization-based funding will force some CSU providers out of the market by depriving them of a stable revenue stream. The proposed reimbursement model attempts to address this issue by requiring MEs to set utilization targets for adult units 2-10% below historical utilization norms. This allows a cushion so that providers will not lose revenue if they experience a modest decline in utilization rates.

The concern about losing a reliable revenue stream is especially relevant to children's CSUs, which have smaller numbers of beds than adult CSUs (often only 2-4 beds) and, therefore, are more affected by fluctuations in utilization. Children's CSU have historically had low utilization rates; and the Department has generally accepted these low utilization rates to ensure that beds are available for children when they are needed. The proposed reimbursement model attempts to address this issue by requiring MEs to set utilization targets for children's units 15% below historical utilization norms.

Staffing Requirements for Crisis Stabilization Units (CSUs)

Staffing requirements for CSUs are governed by Rule 65E-12.105 (Minimum Staffing Standards), F.A.C. A certain number of registered nurses (one or two) and mental health treatment staff (one to three) are required to be available on-site at a CSU. The number depends on the number of licensed beds and the time of day.

Some Workgroup participants representing CSU providers suggested that Rule 65E-12.105 should be amended so that the number of staff required is proportional to the number of individuals actually receiving services at the time, rather than proportional to the number of licensed beds. Such a change may allow providers to use resources more efficiently without compromising clinical care standards. The Department intends to study this issue.

Transportation Exception Plans (TEPs)

Normally, an individual transported by law enforcement for involuntary examination under the Baker Act must be transported to the nearest receiving facility. Transportation Exception Plans (TEPs), authorized by s. 394.462(4), F.S., allow individuals within a specific county to be transported to a receiving facility other than the nearest under specified circumstances, in order to improve service coordination and better meet clinical needs. TEPs must be approved by the Department and by the Board of County Commissioners. TEPs currently exist in twelve of Florida's 67 counties. In some counties, such as Broward (as discussed in Section 4 of this

Transition Plan), a TEP is the foundation of a central receiving facility system of care model. In other counties, a TEP targets specific populations, such as minors or elderly people, allowing them to bypass the nearest receiving facility and be transported directly to the facility that can serve them best.

Some Workgroup participants suggested that many counties not currently served by a TEP would benefit from one. As the experiences of Broward and Orange Counties (described in Section 4) have shown, a TEP can greatly increase the efficiency of resource utilization within a system of care. The proposed reimbursement model includes an Access Centers Option which incorporates a central receiving facility; this would require a TEP to implement. Even counties where the ME chooses not to implement the Access Centers Option may benefit from a TEP. The Department intends to instruct its Regional Offices and MEs to study the issue of implementing TEPs where appropriate.

Funding Levels for Crisis Stabilization Services

There was a strong consensus among CSU Workgroup participants that current funding levels for mental health services in Florida are insufficient to meet the needs of individuals in need of these services. Most receiving facilities for adults operate at near 100% utilization. Legislative appropriations for mental health services, including crisis stabilization services, have not increased in many years; nor has the maximum ("model") rate ($291.64) for crisis stabilization services. As discussed in Section 3, providers' actual costs per bed day ($378.50) are much higher than the model rate. Crisis stabilization services for Department clients are effectively subsidized by other payor sources, especially Medicaid. This situation may not be sustainable as provider costs increase due to inflation and other factors impacting the cost of health care services. Moreover, insufficient funding for non-crisis services contributes to the need for crisis services. Individuals are less likely to experience mental health crises when they have access to outpatient mental health services and community supports such as supportive housing and drop-in centers. Therefore, CSU Workgroup participants urged that increased funding for mental health services, including crisis stabilization services, be considered.

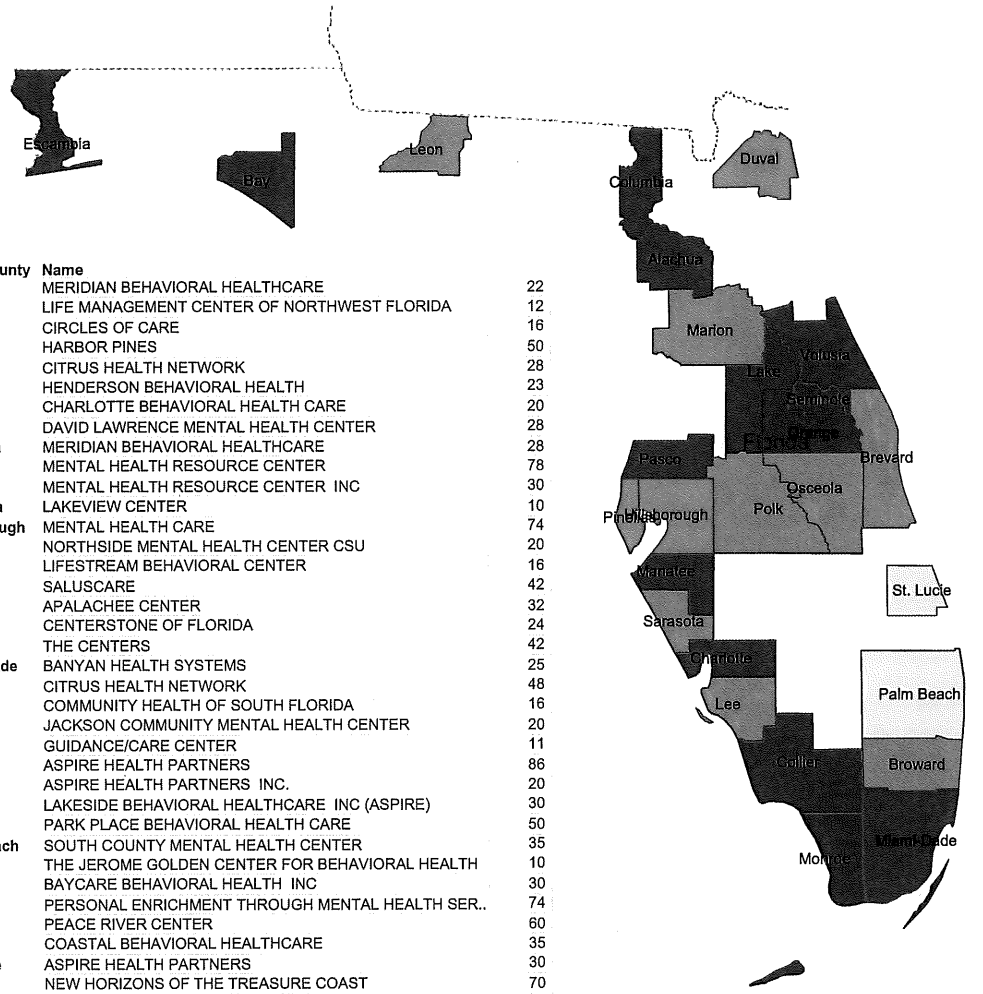
APPENDIX:
RECEIVING FACILITIES REPORTING DATA FOR PROVIDER COST ANALYSES

Apalachee Center, Inc.
Bridgeway Center
Centers, The
Charlotte Behavioral Health Care, Inc.
Citrus Health
Coastal Behavioral Health Care
Community Health of South Florida, Inc.
David Lawrence Center
Depoo Hospital
Flagler Hospital
Fort Lauderdale Hospital
Guidance Care Center, Inc.
Henderson Behavioral Health
Jackson Memorial Hospital
Jackson North Community Mental Health Center
Lakeview Center
Lee Mental Health Center, Inc.
Life Management Center of Northwest Florida
Lifestream Behavioral Center
Manatee Glens Corporation
Mental Health Care, Inc.
Mental Health Resource Center / Mental Health Center of Jacksonville
Meridian Behavioral Health Care
Miami Behavioral Health Center
New Horizons Community Mental Health Center
Northeast Florida State Hospital, Bldg. 57
Northside Mental Health Center, Inc.
Peace River Center for Personal Development
Personal Enrichment through Mental Health Services, Inc
SMA Behavioral Health Services


PUBLIC CONSULTING
GROUP

Appendix 3

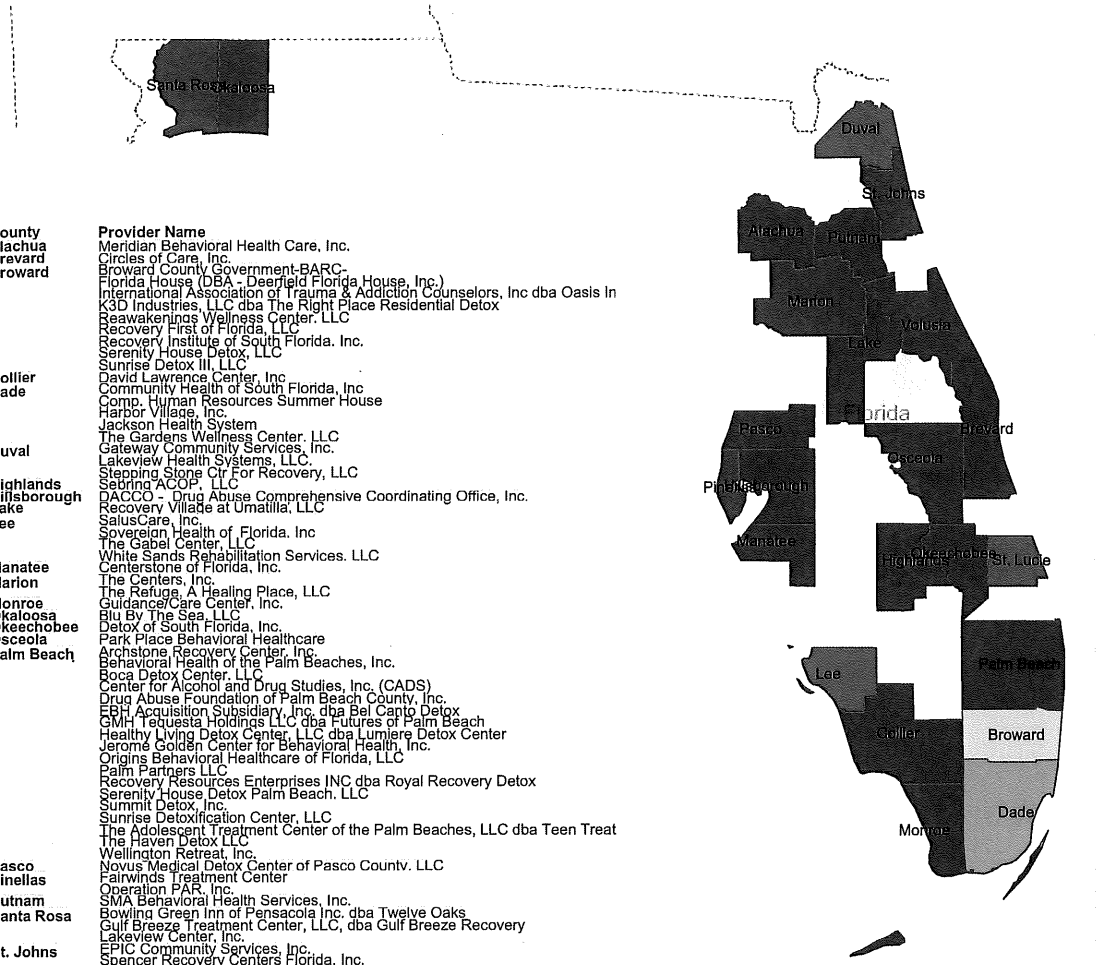
CSUs and SRTs



Street County	Name	
Alachua	MERIDIAN BEHAVIORAL HEALTHCARE	22
Bay	LIFE MANAGEMENT CENTER OF NORTHWEST FLORIDA	12
Brevard	CIRCLES OF CARE	16
	HARBOR PINES	50
Broward	CITRUS HEALTH NETWORK	28
	HENDERSON BEHAVIORAL HEALTH	23
Charlotte	CHARLOTTE BEHAVIORAL HEALTH CARE	20
Collier	DAVID LAWRENCE MENTAL HEALTH CENTER	28
Columbia	MERIDIAN BEHAVIORAL HEALTHCARE	28
Duval	MENTAL HEALTH RESOURCE CENTER	78
	MENTAL HEALTH RESOURCE CENTER INC	30
Escambia	LAKEVIEW CENTER	10
Hillsborough	MENTAL HEALTH CARE	74
	NORTHSIDE MENTAL HEALTH CENTER CSU	20
Lake	LIFESTREAM BEHAVIORAL CENTER	16
Lee	SALUSCARE	42
Leon	APALACHEE CENTER	32
Manatee	CENTERSTONE OF FLORIDA	24
Marion	THE CENTERS	42
Miami-Dade	BANYAN HEALTH SYSTEMS	25
	CITRUS HEALTH NETWORK	48
	COMMUNITY HEALTH OF SOUTH FLORIDA	16
	JACKSON COMMUNITY MENTAL HEALTH CENTER	20
Monroe	GUIDANCE/CARE CENTER	11
Orange	ASPIRE HEALTH PARTNERS	86
	ASPIRE HEALTH PARTNERS INC.	20
	LAKESIDE BEHAVIORAL HEALTHCARE INC (ASPIRE)	30
Osceola	PARK PLACE BEHAVIORAL HEALTH CARE	50
Palm Beach	SOUTH COUNTY MENTAL HEALTH CENTER	35
	THE JEROME GOLDEN CENTER FOR BEHAVIORAL HEALTH	10
Pasco	BAYCARE BEHAVIORAL HEALTH INC	30
Pinellas	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SER..	74
Polk	PEACE RIVER CENTER	60
Sarasota	COASTAL BEHAVIORAL HEALTHCARE	35
Seminole	ASPIRE HEALTH PARTNERS	30
St. Lucie	NEW HORIZONS OF THE TREASURE COAST	70
Volusia	SMA BEHAVIORAL HEALTH SERVICES	30

Appendix 4

Addiction Receiving Facilities



County	Provider Name
Alachua	Meridian Behavioral Health Care, Inc.
Brevard	Circles of Care, Inc.
Broward	Broward County Government-BARC-
	Florida House (DBA - Deerfield Florida House, Inc.)
	International Association of Trauma & Addiction Counselors, Inc dba Oasis In
	K3D Industries, LLC dba The Right Place Residential Detox
	Reawakenings Wellness Center, LLC
	Recovery First of Florida, LLC
	Recovery Institute of South Florida, Inc.
	Serenity House Detox, LLC
	Sunrise Detox III, LLC
Collier	David Lawrence Center, Inc
Dade	Community Health of South Florida, Inc
	Comp. Human Resources Summer House
	Harbor Village, Inc.
	Jackson Health System
	The Gardens Wellness Center, LLC
Duval	Gateway Community Services, Inc.
	Lakeview Health Systems, LLC.
	Stepping Stone Ctr For Recovery, LLC
Highlands	Sebring ACOP, LLC
Hillsborough	DACCO - Drug Abuse Comprehensive Coordinating Office, Inc.
Lake	Recovery Village at Umatilla, LLC
Lee	SalusCare, Inc.
	Sovereign Health of Florida, Inc
	The Gabel Center, LLC
	White Sands Rehabilitation Services, LLC
Manatee	Centerstone of Florida, Inc.
Marion	The Centers, Inc.
	The Refuge, A Healing Place, LLC
Monroe	GuidanceCare Center, Inc.
Okaloosa	Blu By The Sea, LLC
Okeechobee	Detox of South Florida, Inc.
Osceola	Park Place Behavioral Healthcare
Palm Beach	Archstone Recovery Center, Inc.
	Behavioral Health of the Palm Beaches, Inc.
	Boca Detox Center, LLC
	Center for Alcohol and Drug Studies, Inc. (CADS)
	Drug Abuse Foundation of Palm Beach County, Inc.
	EBH Acquisition Subsidiary, Inc. dba Bel Canto Detox
	GMH Tequesta Holdings LLC dba Futures of Palm Beach
	Healthy Living Detox Center, LLC dba Lumiere Detox Center
	Jerome Golden Center for Behavioral Health, Inc.
	Origins Behavioral Healthcare of Florida, LLC
	Palm Partners LLC
	Recovery Resources Enterprises INC dba Royal Recovery Detox
	Serenity House Detox Palm Beach, LLC
	Summit Detox, Inc.
	Sunrise Detoxification Center, LLC
	The Adolescent Treatment Center of the Palm Beaches, LLC dba Teen Treat
	The Haven Detox LLC
	Wellington Retreat, Inc.
Pasco	Novus Medical Detox Center of Pasco County, LLC
Pinellas	Fairwinds Treatment Center
	Operation PAR, Inc.
Putnam	SMA Behavioral Health Services, Inc.
Santa Rosa	Bowling Green Inn of Pensacola Inc. dba Twelve Oaks
	Gulf Breeze Treatment Center, LLC, dba Gulf Breeze Recovery
	Lakeview Center, Inc.
St. Johns	EPIC Community Services, Inc.
	Spencer Recovery Centers Florida, Inc.
St. Lucie	Florida Center For Recovery, Inc.
	New Horizons of the Treasure Coast, Inc.
	Starting Point Detox, LLC dba Unity Detox Center
	Unity Recovery Center, Inc.
Volusia	SMA Behavioral Health Services, Inc.

Appendix 5

Facility Type	Name	Street County	License Status	Total Licensed Beds	Adult	Child	Adult & Child
Crisis Stabilization Unit	APALACHEE CENTER	Leon	LICENSED	28	24	4	28
Crisis Stabilization Unit (ARF)	ASPIRE HEALTH PARTNERS	Orange	LICENSED	30	30		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS	Seminole	LICENSED	30	30		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS	Orange	LICENSED	27	27		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS INC.	Orange	LICENSED	20		20	
Crisis Stabilization Unit	BANYAN HEALTH SYSTEMS	Miami-Dade	LICENSED	25	25		
Crisis Stabilization Unit (ARF)	BAYCARE BEHAVIORAL HEALTH INC	Pasco	LICENSED	30	30		
Crisis Stabilization Unit	CENTERSTONE OF FLORIDA	Manatee	LICENSED	24			24
Crisis Stabilization Unit	CHARLOTTE BEHAVIORAL HEALTH CARE	Charlotte	LICENSED	20			20
Crisis Stabilization Unit	CIRCLES OF CARE	Brevard	LICENSED	16		16	
Crisis Stabilization Unit (JARF)	CITRUS HEALTH NETWORK	Miami-Dade	LICENSED	24		24	
Crisis Stabilization Unit	CITRUS HEALTH NETWORK	Miami-Dade	LICENSED	24	24		
Crisis Stabilization Unit	COASTAL BEHAVIORAL HEALTHCARE	Sarasota	LICENSED	20	20		
Crisis Stabilization Unit	COASTAL BEHAVIORAL HEALTHCARE	Sarasota	LICENSED	15	15		
Crisis Stabilization Unit	COMMUNITY HEALTH OF SOUTH FLORIDA	Miami-Dade	LICENSED	16	16		
Crisis Stabilization Unit	DAVID LAWRENCE MENTAL HEALTH CENTER	Collier	LICENSED	28			28
Crisis Stabilization Unit	GUIDANCE/CARE CENTER	Monroe	LICENSED	11	11		
Crisis Stabilization Unit	HARBOR PINES	Brevard	LICENSED	50	50		
Crisis Stabilization Unit	HENDERSON BEHAVIORAL HEALTH	Broward	LICENSED	23	23		
Crisis Stabilization Unit	JACKSON COMMUNITY MENTAL HEALTH CENTER	Miami-Dade	LICENSED	20	20		
Crisis Stabilization Unit	LAKESIDE BEHAVIORAL HEALTHCARE INC (ASPIRE)	Orange	LICENSED	30	30		
Crisis Stabilization Unit	LAKEVIEW CENTER	Escambia	LICENSED	10	10		
Crisis Stabilization Unit	LIFE MANAGEMENT CENTER OF NORTHWEST FLORIDA	Bay	LICENSED	12			12
Crisis Stabilization Unit	LIFESTREAM BEHAVIORAL CENTER	Lake	LICENSED	16			16
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	14		14	
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	30	30		
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	30	30		
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	24	24	0	24
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	24			24
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	30			30
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER INC	Duval	LICENSED	30	30		
Crisis Stabilization Unit	MERIDIAN BEHAVIORAL HEALTHCARE	Alachua	LICENSED	22			22
Crisis Stabilization Unit	MERIDIAN BEHAVIORAL HEALTHCARE	Columbia	LICENSED	28			28
Crisis Stabilization Unit	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	30	30		
Crisis Stabilization Unit (ARF)	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	20		20	
Crisis Stabilization Unit	NORTHSIDE MENTAL HEALTH CENTER CSU	Hillsborough	LICENSED	20	20		
Crisis Stabilization Unit	PARK PLACE BEHAVIORAL HEALTH CARE	Osceola	LICENSED	30	30		
Crisis Stabilization Unit	PARK PLACE BEHAVIORAL HEALTH CARE	Osceola	LICENSED	20		20	
Crisis Stabilization Unit	PEACE RIVER CENTER	Polk	LICENSED	30			30
Crisis Stabilization Unit (ARF)	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	15		15	
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	15	15		
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	30	30		
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	14	14		
Crisis Stabilization Unit	SALUSCARE	Lee	LICENSED	30	30		
Crisis Stabilization Unit (ARF)	SALUSCARE	Lee	LICENSED	12		12	
Crisis Stabilization Unit	SMA BEHAVIORAL HEALTH SERVICES	Volusia	LICENSED	30	30		
Crisis Stabilization Unit	SOUTH COUNTY MENTAL HEALTH CENTER	Palm Beach	LICENSED	20	20		
Crisis Stabilization Unit	SOUTH COUNTY MENTAL HEALTH CENTER	Palm Beach	LICENSED	15	15		
Crisis Stabilization Unit	THE CENTERS	Marion	LICENSED	30	30		
Crisis Stabilization Unit	THE CENTERS	Marion	LICENSED	12		12	
Crisis Stabilization Unit	THE JEROME GOLDEN CENTER FOR BEHAVIORAL HEALTH	Palm Beach	LICENSED	10			10
SRT	APALACHEE CENTER	Leon	LICENSED	4	4		
SRT	ASPIRE HEALTH PARTNERS	Orange	LICENSED	29	29		
SRT	CITRUS HEALTH NETWORK	Broward	LICENSED	28	28		
SRT	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	20	20		
SRT	PEACE RIVER CENTER	Polk	LICENSED	30	30		

Appendix 6

Mobile Crisis Teams Statewide

Northwest Region

- Youth Mobile Crisis Team- Duval- Child Guidance Center 904-448-4700 x308

Northeast Region

- None

SunCoast Region

- Mental Health Center – 819-239-8064 – Hillsborough County
- Peace River Center – 269-519-0575 – Polk County
- Manatee Glens – 941-782-4299 – Manatee County

Southeast Region

- New Horizons: Catchment area is the Treasure Coast & Okeechobee (St. Lucie, Martin, Indian River, & Okeechobee). Not West Palm Beach. Andrea Gates- 772-672-8476. Also, the direct number for our Mobile Crisis Response Team is 772-672-8470.
- South County Mental Health Center: Karyn Green (561) 637-1001 - Palm Beach Area (Adults and Children)
- The Jerome Golden Center : Donna Harris (561) 383-5841 - West Palm Beach Area (Children and Adults)
- Henderson Youth Emergency Services (YES): Ben Galloso (954) 713-5100 Ext 2402 - Broward County Area- (Children)
- Henderson Mobile Crisis Response Team: Elizabeth Rosonow (954)463-0911 - Broward County Area (Adults).

Southern Region

- Banyan Mobile Crisis Team, (305)774-3616 &(305)774-3617, serving Miami-Dade County

Central Region

- Mobile Crisis Team for Circuit 18 (Brevard)only 321-632-2737

November 30, 2021
Meeting Date

Children, Families, and Elder Affairs
Committee

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

SB 282
Bill Number or Topic

Amendment Barcode (if applicable)

Name Sean Burnfin

Phone (850) 922-0358

Address 500 South Duval Street
Street

Email burnfins@flcourts.org

Tallahassee — *City*
Florida — *State*
32399 — *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
State Courts System - Steering Committee on Problem-Solving Courts

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

11-30-21
Meeting Date

Children, Families, & Elder Affairs
Committee

SB 282
Bill Number or Topic

Amendment Barcode (if applicable)

Name Robert Cooper, Zero Hour Life Center

Phone 352-476-9061

Address 3070 West Cardinal Street
Street

Email rcooper@zerohourlifecenter.org

Lecanto FL 34461
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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11-30-2021
Meeting Date

Children, Families & Elder Affs
Committee

SB 282
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dawn T. Steward

Phone 407-645-0273

Address 1747 Orlando Central Pkway
Street

Email stw2130@aol.com

Orlando FL 32809
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by: Florida PTA

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

11/30/21
Meeting Date

Children, Family, Elders
Committee

282
Bill Number or Topic

Amendment Barcode (if applicable)

Name Natalie Kelly

Phone 850-895-1313

Address 122 S Calhoun St.
Street

Email natalie@flmanagingentities.com

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Association of managing Entities

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

Lowery, Nikki

From: Cox, Ryan
Sent: Wednesday, December 1, 2021 10:22 AM
To: Lowery, Nikki
Subject: FW: Sen Albritton Votes

Sincerely,

Ryan C. Cox
Staff Director
Senate Committee on Children, Families, and Elder Affairs
(850) 487-5340

From: Liebert, Andrew <Liebert.Andrew@flsenate.gov>
Sent: Wednesday, December 1, 2021 10:20 AM
To: Cox, Ryan <Cox.Ryan@flsenate.gov>
Cc: Hinchee, John <Hinchee.John@flsenate.gov>
Subject: Sen Albritton Votes

Ryan,

Please show Sen. Albritton voting in the affirmative on the following bills from the meeting yesterday:

SPB 7008
SPB 7010
SB 282
SB 294
SB 704

Let me know if you need anything else. Have a great day.

Best regards,

Andrew Liebert
Legislative Aide to Senator Ben Albritton
Senate District 26
150 North Central Avenue
Bartow, Florida 33830
850-487-5026 – Office
239-595-5990 – Cell

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Senate Committee on Children, Families, and Elder Affairs
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Andrew Liebert
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Senate District 26
150 North Central Avenue
Bartow, Florida 33830
850-487-5026 – Office
239-595-5990 – Cell

By Senator Harrell

25-00437A-22 2022704__

A bill to be entitled

An act relating to substance abuse service providers; amending s. 397.403, F.S.; requiring service provider applicants to include the names and locations of certain recovery residences in their license application; creating s. 397.4104, F.S.; requiring service providers to record specified information in the Department of Children and Families' Provider Licensure and Designations System after a specified date; requiring service providers to update the record with any changes within a specified timeframe; providing civil penalties; amending s. 397.4871, F.S.; requiring certified recovery residence administrators to demonstrate the ability to meet specified requirements; prohibiting certified recovery residence administrators from actively managing more than a specified number of residents; providing an exception; deleting a provision prohibiting certified recovery residence administrators from actively managing more than three recovery residences; amending s. 397.501, F.S.; requiring service providers to return an individual's personal effects upon the individual's discharge; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (j) is added to subsection (1) of section 397.403, Florida Statutes, to read:

397.403 License application.—

25-00437A-22 2022704__

(1) Applicants for a license under this chapter must apply to the department on forms provided by the department and in accordance with rules adopted by the department. Applications must include at a minimum:

(j) The names and locations of any recovery residences to which the applicant service provider plans to refer patients or from which the applicant service provider plans to accept patients.

Section 2. Section 397.4104, Florida Statutes, is created to read:

397.4104 Record of recovery residences used by service providers.—

(1) By July 1, 2022, a service provider shall record in the department's Provider Licensure and Designations System the name and location of each recovery residence that the service provider has referred patients to or received patients from and update the record with any changes that occur. A service provider must update such record within 30 business days after the change.

(2) Beginning July 1, 2022, a licensed service provider that violates this section is subject to an administrative fine of $1,000 per occurrence. The department may suspend or revoke a service provider's license pursuant to s. 397.415 for repeat violations of this section.

Section 3. Subsection (8) of section 397.4871, Florida Statutes, is amended to read:

397.4871 Recovery residence administrator certification.—

(8)(a) A certified recovery residence administrator must demonstrate the ability to effectively and appropriately respond

to the needs of residents, to maintain residence standards, and to meet the certification requirements of this section.

(b) A certified recovery residence administrator may not actively manage more than 50 residents at any given time unless written justification is provided to, and approved by, the credentialing entity as to how the administrator is able to effectively and appropriately respond to the needs of the residents, to maintain residence standards, and to meet the residence certification requirements of this section. However, a certified recovery residence administrator may not actively manage more than 100 residents ~~no more than three recovery residences~~ at any given time.

Section 4. Subsection (5) of section 397.501, Florida Statutes, is amended to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(5) RIGHT TO CARE AND CUSTODY OF PERSONAL EFFECTS.—An individual has the right to possess clothing and other personal effects. The service provider may take temporary custody of the individual's personal effects only when required for medical or safety reasons, with the reason for taking custody and a list of the personal effects recorded in the individual's clinical record. A service provider shall return an individual's personal effects upon the individual's discharge, even if the discharge is against medical advice.

Section 5. This act shall take effect upon becoming a law.

BAKER ACT AND MARCHMAN ACT PROJECT TEAM REPORT

FOR FISCAL YEAR 2016-17

Department of Children and Families
Substance Abuse and Mental Health Program Office

November 24, 2015

Mike Carroll	Rick Scott
Secretary	Governor

Table of Contents

I. Executive Summary

I.A. PURPOSE

The following is a synthesis of the findings and recommendations of the Department of Children and Families (Department) Baker Act and Marchman Act Project Team (Project Team). It is important to note, that the Project does not recommend blending, or combining, the Baker Act and Marchman Act. The Project Team recommends the following:

- Legislative Intent language that focuses on mental and substance use disorders being diseases of the brain, and involving the local community in the planning process for behavioral health acute care services.
    - Shift to medical approach in the treatment of mental health and substance abuse.
    - Recognize that substance use and mental disorders are sub-specialties within the medical specialty health care arena.
    - Acknowledge that behavioral health disorders cause effects on individuals' ability to reason, exercise good judgment, recognize the need for services and sufficiently provide self-care, which require responsibility for their care to be relegated to third parties and/or vested in the authorities of behavioral health programs and practitioners.
    - Establish community based alternatives that include prevention, intervention and outreach to prevent need for higher levels of care and provide for care coordination and recovery oriented services upon discharge.
    - Provide funding of the community system resulting in cost savings and efficiencies across multiple systems.
    - Define specifications and minimum standards for access to care that will be available in each community.
    - Authorize licensed and certified behavioral health practitioners to exercise the full authority of their respective scopes of practice.
    - Provide the mechanism for communities in conjunction with others, to define their local behavioral health, emergency, acute care and treatment array of services.
    - Ensure that local systems of acute care services have standardized services and processes for access.
    - Ensure that local systems of care are designed to maximize available local resources, including health care services and managed care plans.
- Every county have access to either a central receiving facility, an access center, a triage center, a crisis stabilization unit or an addictions receiving facility, or have a plan that addresses accessibility.
- A transportation plan and local community plan should be developed by the managing entities for every county
    - Plans will provide exception to existing statutory requirements mandating law enforcement to transport to nearest receiving facility, to provide for consumer choice and meet specifications of the local transportation plan

- Align the statutory requirements in Chapters 394 and 397, F.S. so that the same qualified professionals are authorized to initiate involuntary examinations/assessments/stabilizations under the Baker Act and the Marchman Act.
- The requirements for the collection of data and the time frames for both the Baker Act and the Marchman Act should be aligned
- Require the collection, submission and reporting of the same data for the Marchman Act and the Baker Act, by all public receiving facilities and should be submitted to DCF using the CSU database.
- Timeframes should be standardized so that involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act must be completed within 72 hours. However, a physician or physician's assistant or psychiatric nurse acting under the physician may authorize up to an additional 48 hours based on a determination of need without court involvement.

Estimate of the cost to address the needs for expanded acute care capacity ranged from $133 million to $ 298 million. We recognize that those consensus estimates can result in the immediate discounting of the Project Team's recommendations based on the projected cost. (Appendix 2).

Instead, we would recommend the following:

- The Legislature should consider a multiple year approach to addressing the acute care service capacity within Florida's communities.
- This approach would reflect a commitment and investment in mental health and substance abuse services that would be designed to meet local behavioral health acute care needs over time.
- Appropriations should be targeted to those services that include acute care beds, but also place a premium of funding lower cost services designed to reduce demand on inpatient, crisis stabilization, and detoxification services; such as, mobile crisis response teams. In addition, improved care coordination across Medicaid, and other health plans and other funding sources to reduce demand on publically funded services and expand community treatment options.
- Building community residential and housing options for persons with a major mental or substance use disorders.
- Provide options for funding a community's treatment capacity to address the needs of the most in need and vulnerable. Only with a sustained commitment will these issues that have placed Florida's behavioral health system in "crisis," ultimately be successfully resolved.

I.B. INTRODUCTION

During the 2015 regular session of the Florida Legislature, proposed legislation aimed at making substantive changes to Part I of Chapter 394, F.S., which addresses the Baker Act. Senate Bill 7070 would have combined certain features of Chapter 397, F.S., or the Marchman Act, into one comprehensive statute that combines voluntary and involuntary treatment for persons with mental illness and substance use disorders into one comprehensive law.

Although the bill did not become law, it created considerable legislative, executive agency, and public interest in the current state of mental health and substance abuse services. Public discussion specifically

addressed public access to acute care services and the belief that current statutes do not adequately address issues of access, availability, and the organization of these essential services.

II. BACKGROUND

II.A. BAKER ACT

In 1971, the Florida Legislature enacted the Florida Mental Health Act (Part I of Chapter 394, F.S.), a comprehensive revision of the state's century-old mental health commitment laws. The law, commonly referred to as the "Baker Act," was designed to significantly strengthen and protect the due process and civil rights of individuals in mental health facilities and ensure public safety.

In 1978, through proviso, the Legislature authorized the creation of Crisis Stabilization Units (CSUs) and short-term residential treatment facilities (SRTs) to provide a less costly, less intensive, and less restrictive alternative to inpatient hospitalization for examination/crisis stabilization and also for placement/long-term treatment. The most recent major revision to the Baker Act was in 2004 when the Legislature created Involuntary Outpatient Placement as an involuntary treatment option (effective January 1, 2005).

Crisis services are defined in s. 394.67(3), F.S., as emergency interventions that are designed to prevent further deterioration of the individual's mental health. They include short-term evaluation, stabilization, and brief intervention. Once stabilized, individuals are redirected to the most appropriate and least restrictive treatment settings consistent with their needs. Most publically funded crisis services are provided in CSUs, which are located in receiving facilities for individuals on voluntary and involuntary status.

Receiving and treatment facilities are defined by the Florida Mental Health Act (ss. 394.451-47891, F.S.) and are designated by the Department to receive and hold individuals on involuntary status under emergency conditions or for psychiatric evaluation. These facilities, referred to as Baker Act Receiving Facilities, provide brief, intensive crisis services to individuals who require emergency mental health stabilization. (Appendix 3).

Section 394.461, F.S., authorizes the Department to designate community facilities as a receiving facility. Any other facility within the state, including a private or federal facility, may be so designated by the Department, provided such designation is agreed to by the governing body or authority of the facility.

II.B. MARCHMAN ACT

In 1970, the Florida Legislature enacted Chapter 397, F.S., governing the Treatment and Rehabilitation of Drug Dependents. The following year, it enacted Chapter 396, F.S., titled the Myers Act as the state's "Comprehensive Alcoholism Prevention, Control, and Treatment Act," modeled after the federal Hughes Act.

Since individuals with substance abuse issues often don't contain their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction did not address the problems faced by Florida's citizens.

In 1993, Representative Steven Wise introduced legislation to merge Chapters 396 and 397, F.S., into a single law, Chapter 397, F.S., that clearly outlined legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination, and children's substance abuse services. The chapter was named the "Hal S. Marchman Alcohol and Other Drug Services Act of 1993," and is commonly referred to as the Marchman Act.

Addiction receiving facilities are defined in Chapter 397, F.S., and are designated by the Department as secure, acute care facilities that provide, at a minimum, detoxification and stabilization services and are operated 24 hours per day, 7 days per week to serve individuals found to be substance use impaired.

Unlike the Baker Act that requires facilities to accept persons brought by law enforcement officers, the Marchman Act requires facilities to refuse acceptance of persons if it would cause the facility to go over licensed census, to accept responsibility for a person beyond the safe management of the program, or if the person is unable to pay the cost of a private program. However, if the facility is a licensed hospital and the officer believes the person has an emergency medical condition as a result of the substance abuse issues, a hospital must accept the person under the federal EMTALA law and perform a medical screening and stabilization prior to releasing the person or transferring him or her to another appropriate facility. (Appendix 4).

When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

II.C. EMERGENCY EXAMINATION AND TREATMENT OF INCAPACITATED PERSONS ACT

Section 401.445, F.S., governs the emergency examination and treatment when an emergency medical condition is life-threatening and the individual is unable to provide informed consent to examination, transport, or treatment.

II.D. ACCESS TO EMERGENCY SERVICES AND CARE

Section 395.1041, F.S., establishes state requirements equivalent to the federal EMTALA/COBRA law, which prohibits the denial of emergency services and care by hospitals and physicians, and enforcing the ability of individuals to get all necessary and appropriate emergency care within the capability and capacity of each hospital. This statute also requires hospitals to adhere to rights and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital is designated as a receiving or treatment facility. However, this is not a requirement for individuals being involuntarily assessed and stabilized under the Marchman Act.

III. PROCESS

In June 2015, the Department convened the Baker Act and Marchman Act Project Team (Project Team). This report builds upon the proposed changes to the court processes for the Baker Act and Marchman

Act considered by the Florida Supreme Court's Task Force on Substance Abuse and Mental Health Issues in the Courts. The Project Team was charged with developing recommendations and specifications to integrate access to the Baker Act and Marchman Act by defining a community system of behavioral health acute care services that:

1. Provides a single point of access to acute emergency care, intervention, and treatment services;
2. Ensures that individuals are determined to meet criteria for voluntary and involuntary examination and treatment for a mental illness or a substance use disorder have access to required services;
3. Ensures that each county or circuit has access to a designated receiving facility that, at a minimum, can screen, evaluate, and refer individuals to the appropriate level of care;
4. Ensures that individuals, their families, law enforcement agencies, judges and other court professionals, behavioral health professionals, and the public are aware of the locations of designated receiving facilities, access centers, or triage centers;
5. Determine the existing capacity for Addiction Receiving Facilities (ARFs), CSUs, and detoxification facilities;
6. Develops a standard or benchmark for determining the need for additional bed capacity over and above the capacity met through Medicaid, Medicare, and private insurance based on the number of beds per capita; and
7. Estimates the cost of the proposed recommendations based on several different models, or methods of calculation.

The composition of the Project Team included representatives of state agencies, community hospitals, non-profit substance abuse and mental health provider organizations, managing entities, professional trade and provider associations, court professionals and personnel, law enforcement, local government, Medicaid managed care organizations, consumers, and experienced practitioners and administrators from acute care service programs in the substance abuse and mental health system. Stakeholders from these diverse backgrounds participated in Project Team meetings that were conducted over the course of three months. This broad range of participation resulted in the recommendations that are presented in this report.

IV. RECOMMENDATIONS

Legislative Intent	
Relevant Statute(s)	ss. 394.453, 394.66, and 397.305, F.S.
Discussion	During the Project Team meetings, team members expressed concern for the need to revise current legislative intent in Chapters 394 and 397, F.S., to reflect the changes and advances in the behavioral health field, as well as clearly establish priorities, rights, and key policy statements. Most importantly, the current legislative intent language does not recognize substance use and mental disorders as diseases of the brain or as a medical sub-specialty.
Recommendations	Amend current legislative intent language in Chapters 394 and 397, F.S., to incorporate language that clearly and affirmatively establishes the Legislature's intent to:

	1. Shift to medical approach in the treatment of mental health and substance abuse recognizing that substance use and mental disorders are diseases of the brain, and are complex medical issues whose etiology and progression involve interactive biological, genetic, psychological, cultural, and social factors. 2. Recognize that Substance Use and Mental Disorders are sub-specialties within the medical specialty health care arena of Behavioral Health. Treatment saves lives, improves the health of the affected individuals and families, and reduces negative impacts to society. 3. State the importance of data collection and utilization to inform decisions regarding funding, client needs, access to services, and information regarding the behavioral health acute care system. 4. Establish and fund community-based alternatives that include prevention, intervention and outreach, as well as recovery-oriented services in the community to prevent the need for and use of higher levels of care. In addition, provide for the coordination of comprehensive care and recovery oriented services upon discharge from all levels of care. 5. Provide proper and appropriate funding of the community behavioral health system of care which will result in cost-savings and efficiencies across multiple systems, including criminal justice/law enforcement, healthcare, etc. 6. Define the specifications and minimum standards for access to care that will be available in or accessible by each community based on funding. 7. Authorize licensed and certified behavioral health practitioners to exercise the full authority of their respective Scopes of Practice in the performance of professional functions necessary to carry out the intent of this statute. 8. Provide the mechanism for communities in conjunction with the Department, local governments, law enforcement, courts, behavioral health managing entities, and consumers and families to define a local, accessible behavioral health system, including emergency, acute care and treatment array of services are: accessible, well defined, and readily understood in each community. 9. Ensure that local systems of behavioral health acute care services have standardized services and processes for accessing services. 10. Ensure that local systems of care are designed to maximize available local resources including health care services and managed care plans. 11. Expand the use of mobile crisis teams and other alternative intervention options in the community.

Single Point of Access	
Relevant Statute(s)	s. 394.461, F.S.
Discussion	The current Baker Act and Marchman Act differ in several key points related to receiving facilities, including who may provide assessments and evaluations, the time permitted to conduct an involuntary examination, authority to release individuals, and specific administrative functions such as notifications to other involved persons and data collection and reporting. Current statutes establish five routes to crisis services for individuals with mental or substance use disorders, four of them involuntary. The Baker Act and Marchman Act differ significantly in addressing involuntary assessment. This includes defining methods of initiation, criteria, time frames, and disposition alternatives. Revising the statutes to align the process, and standardize the forms for petitions and certificates, while retaining the ability to identify whether the primary basis is a mental or substance use disorder, would significantly reduce bureaucratic barriers to accessing crisis evaluations and still protect individual rights through due process in any involuntary proceedings.
Recommendations	The Department has provided a brief description of a central receiving facility, access center, and triage center as examples of single points of access for the purposes of this report. It is recommended that the Legislature authorize the Department to develop administrative rules to establish the specific standards, functions, and services for any facilities providing a single point of access. **Central Receiving Facility** The concept of a Central Receiving Facility (CRF) is an integrated mental health crisis stabilization unit and addictions receiving facility as currently described in s. 394.4612, F.S., and Rule 65E-12.110, F.A.C. The CRF can be a single point of entry with or without an Access Center or Triage Center into the mental health and substance abuse system for assessments, and appropriate placement of adults experiencing a mental health or substance abuse crisis. It is important to note that not all counties may have the financial resources or demand for acute care services to support a CRF as the single point of access. Counties need the flexibility and an availability of options to provide services. **Access Center** An Access Center (AC) may be available, at a minimum, 12 hours per day, seven days per week for individuals experiencing a low level substance abuse, mental health, or co-occurring crisis after receiving a standardized screening. This

	location can be a separate and freestanding facility. The primary purpose is to assist the public in accessing services. **Triage Center** A Triage Center (TC) is a community-based option that is an initial point of entry into the community mental health and substance abuse system. A TC should be integrated so that the facility and its staff have the ability, at a minimum, to assess, examine, and refer individuals to the appropriate level of care.

Transportation	
Relevant Statute(s)	ss. 394.462, 394.4685, 394.9082, 397.6772, 397.6793, 397.6795, F.S.
Discussion	Under the requirements of the Baker Act, regardless of how an examination is initiated, law enforcement must transport an individual to the nearest Baker Act receiving facility to be examined unless a Transportation Exception Plan has been approved by the Secretary of the Department. The designated law enforcement agency may decline to transport the individual to a receiving facility only if: 1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of individuals to receiving facilities pursuant to this section at the sole cost of the county; and 2. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the individual or others. However, when a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination under the Baker Act and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.[1]

[1] Section 394.462(1)(e), F.S.

	The current requirements for involuntary assessment and stabilization under the Marchman Act specify that law enforcement are only required to transport an individual in protective custody. For involuntary assessments and stabilization initiated by persons or means other than protective custody, the Marchman Act allows for, but does not require, the transportation of individuals and permits individuals other than law enforcement to provide the transportation. Specifically, for a court-ordered assessment and stabilization, the Court may order law enforcement to transport a person to nearest appropriate licensed service provider. Transportation for Emergency Admission may be provided by an applicant for a person's emergency admission, spouse or guardian, law enforcement officer, or health officer. Regardless of how the involuntary assessment and stabilization is initiated, the Marchman Act does not require an individual to be transported to the nearest receiving facility. Instead, depending on how the involuntary assessment and stabilization was initiated, an individual may be transported to a hospital, licensed detoxification facility, addiction receiving facility, jail, or a less intensive component of a licensed service provider for assessment only. Currently, the Baker Act and Marchman Act do not require any formal planning regarding the transportation of individuals who meet the criteria under these statutes. However, the Baker Act allows for the development of a Transportation Exception Plan, and also specifies that each law enforcement agency shall develop a memorandum of understanding with each receiving facility within the law enforcement agency's jurisdiction which reflects a single set of protocols for the safe and secure transportation of the individual and transfer of custody of the person.[2] These protocols must also address crisis intervention measures.
Recommendations	1. Establish requirements for the transportation of individuals for involuntary assessment/stabilization, and involuntary treatment, as well as, the transfer of individuals between facilities, under the Marchman Act that mirror and align with the corresponding requirements in the Baker Act.[3] 2. Require the Managing Entities, in consultation with the board of county commissioners and local law enforcement agencies, to develop a Transportation Plan for each county or circuit within the managing entity's assigned region that defines the specifications and

[2] Section 394.462(1)(k), F.S.

[3] Sections 394.462 and 394.4685, F.S.

	minimum standards for transportation and access to behavioral health acute care services that will be present or available in each community. 3. Each Transportation Plan must address, at a minimum, the following: a. Specify the models of Community Intervention options available and the roles, processes, and responsibilities of those programs in diverting individuals from acute care placements. b. Specify how local hospitals, designated receiving facilities, and acute care inpatient and detoxification providers will coordinate activities to screen, assess, examine, stabilize, and refer individuals presented on an involuntary basis under the Baker Act or Marchman Act. c. Specify the responsibility for, and the means by which, individuals in a behavioral health crisis will be transported to and between facilities for involuntary examinations and treatment, involuntary court proceedings and resulting commitments under the Baker Act and Marchman Act. d. The method of transferring individuals after law enforcement has relinquished physical custody of the individual at a designated receiving facility. The receiving facilities must provide or arrange for their transportation to another facility or appropriate placement. The managing entities must submit transportation plans to the Department for final review and approval. Plans must be submitted every three years and updated as needed.

Qualified Professionals	
Relevant Statute(s)	Part I of Chapter 394, Part V of Chapter 397, and s. 397.311, F.S.
Discussion	**Scope of Practice** There is significant variation in the authorized scope of practice for qualified professionals established in Chapters 394 and 397, F.S. This variation has created inconsistencies between the Baker Act and Marchman Act in how involuntary examinations (i.e. professional certificates) are initiated, and who has the authority to conduct assessments, examinations, and discharge of individuals. Furthermore, the limitations placed on certain qualified professionals under the Marchman Act to initiate professional certificates, and under the Baker Act, to assess, admit, and discharge individuals, restrict the privileges, or scope of practice that these professionals are statutorily granted under the purview of their license.

Qualified Professionals	
	Physician Shortage In February 2015, a study of physician supply and demand commissioned by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida found the physician shortage will grow to 7,000 physician specialists by 2025. This shortfall spans 19 specialties, with the largest areas of need in psychiatry, general surgery, rheumatology, and thoracic surgery.[4] The current supply of specialists in Florida is insufficient to provide a level of care consistent with the national average, after taking into consideration differences in the demographics and health risk factors between Florida and the nation. Of the specialties included in the projected shortage, psychiatry is expected to have the most severe physician specialty deficit with a 55 percent shortfall statewide by 2025.[5] **Access to Care** The disconnect between the authority to access, evaluate, and discharge individuals under the Baker Act and Marchman Act, along with the current and projected statewide shortage of psychiatrists will create significant barriers to accessing and initiating care.
Recommendations	1. Align statutory requirements in Chapters 394 and 397, F.S. so that the same qualified professionals authorized to initiate involuntary examinations under the Baker Act are also authorized to initiate involuntary assessments and stabilizations under the Marchman Act. 2. Authorize the following qualified professionals, as defined in their respective chapters, to initiate involuntary examination/assessment under the Marchman Act and Baker Act: a. Physician; b. Physician Assistant; c. Psychiatrist; d. Psychologist; e. Advanced Registered Nurse Practitioner;

[4] Study: Florida Facing Critical Shortage of Physician Specialists through 2025. PRNewswire. February 17, 2015. http://www.prnewswire.com/news-releases/study-florida-facing-critical-shortage-of-physician-specialists-through-2025-300037111.html site last accessed on October 14, 2015.

[5] *Florida Physician Workforce Analysis: Forecasting Supply and Demand.* IHS Global. Commissioned by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida. February 2015. http://mediad.publicbroadcasting.net/p/healthnewsfl/files/201502/SNHAF_Physicians_Workforce_Analysis_2015-v5.pdf site last accessed on October 14, 2015.

Qualified Professionals	
	f. Advanced Registered Nurse Practitioner having a specialty in psychiatry licensed under part I of chapter 464; g. Licensed Mental Health Counselor; h. Licensed Clinical Social Worker; and i. Licensed Marriage and Family Therapist 3. Provide an exception to limit the authority of Certified Addiction Professionals to initiate only involuntary assessment and stabilization under the Marchman Act. 4. All licensed health care professionals in Chapters 394 and 397, F.S., should have experience and be cross trained in both substance abuse and mental health.

Data	
Relevant Statute(s)	ss. 394.461, 394.463, 394.4655, 394.467, 394.9082, F.S.
Discussion	**Baker Act Data** The Baker Act (Part I of Chapter 394, F.S.), as well as Part IV of Chapter 394, F.S., contain several provisions requiring the submission, collection and reporting of Baker Act-related data for private and public receiving facilities to the Department and the Agency for Health Care Administration (AHCA). This has not only created confusion and increased the administrative burden on providers, but it has also resulted in inconsistent and siloed data due to incompatible and unintegrated data systems and processes. As a result, the meaningful use and analysis of this data is severely diminished. *(Please see the below table for a summary of data submission requirements).* Additionally, during the 2015 Regular Session, CS/HB 79 was passed and signed into law, amending Part IV of Chapter 394, F.S., directing the Department to develop, implement, and maintain a Crisis Stabilization Services Utilization Database (CSU Database) whereby behavioral health managing entities collect utilization data from psychiatric public receiving facilities.[6] Public receiving facilities within a managing entity's provider network are required to submit utilization data in real time, or at least daily, to the managing entity. This includes the number of indigent patients admitted and discharged, the current active

[6] These facilities operate under Department designation as crisis stabilization units where emergency mental health care is provided. General Revenue funding for community mental health services pays for space in receiving facilities to care for the indigent. Managing entities must comply with the bill's requirements for data collection by August 1, 2015

census of licensed beds, the number of beds purchased by the Department, and the number of unoccupied licensed beds regardless of payor source.

As a result, the establishment of data reporting requirements in both Part I and Part IV of Chapter 394, F.S., has unintentionally created conflicting statutory requirements for the submission of data to the Department.

Data Submitted to the Department
Facilities designated as public receiving or treatment facilities shall report to the Department on an annual basis the following data, *unless these data are currently being submitted to the Agency for Health Care Administration (AHCA)*: 1. Number of licensed beds. 2. Number of contract days. 3. Number of admissions by payor class and diagnoses. 4. Number of bed days by payor class. 5. Average length of stay by payor class. 6. Total revenues by payor class. "Payor class" means Medicare, Medicare HMO, Medicaid, Medicaid HMO, private-pay health insurance, private-pay health maintenance organization, private preferred provider organization, the Department of Children and Families, other government programs, self-pay patients, and charity care.[7]
A managing entity shall require a public receiving facility within its provider network to submit data, in real time or at least daily, to the managing entity for: 1. All admissions and discharges of clients receiving public receiving facility services who qualify as indigent, as defined in s. 394.4787; 2. Current active census of total licensed beds 3. Number of beds purchased by the Department 4. Number of clients qualifying as indigent occupying the Department-purchased beds 5. Total number of unoccupied licensed beds regardless of funding. The managing entities must report this data to the Department, using the CSU database, on a monthly and annual basis.[8]
The Office of Clerks of Court shall submit to the Department a copy of the following: 1. Petition for involuntary outpatient placement and individualize treatment

[7]Section 394.461(4), F.S.

[8] Section 394.9082(10), F.S.

	plan[9] 2. Continued involuntary outpatient placement certificate and treatment plan[10] 3. Petition for involuntary inpatient placement[11] **Data Submitted to the Agency for Health Care Administration** The Agency for Health Care Administration shall receive and maintain copies of the following: 1. Ex-parte orders for involuntary examination[12] 2. Mental Health Professional certificates for initiating involuntary examinations[13] 3. Law enforcement reports (involuntary examination)[14] 4. Involuntary outpatient placement orders[15] 5. Involuntary inpatient placement orders[16] *Note: The Baker Act Reporting Center at the Louis de la Parte Florida Mental Health Institute receives data on behalf of AHCA, which allows it to meet its statutorily required receipt and reporting of this information. Currently, Baker Act receiving facilities must mail the involuntary examination initiation forms and a coversheet with critical information about each examination initiated to the Baker Act Reporting Center. Staff at the Reporting Center must manually process and enter the data contained in the involuntary examination initiation forms.* **Marchman Act Data** Currently, there are no statutory requirements for the collection, submission, or reporting of Marchman Act-related to the Department. However, the Office of the State Courts Administrator publishes data on the number of Marchman Act and Baker Act petitions filed and disposed. The data are based on information received from the Clerks of Court and are extracted from a static database containing the official trial court statistics.[17]
Recommendations	1. Require the collection, submission, and reporting of the same data for the Marchman Act as currently required for the Baker Act by all designated receiving facilities, as well as any other licensed providers accepting

[9] Section 394.4655(3)(c), F.S.

[10] Section 394.4655(7)(a)(4), F.S.

[11] Section 394.467(3), F.S.

[12] Section 394.463(2)(e), F.S.

[13] Section 394.463 (2)(a)(3), F.S.

[14] Section 394.463 (2)(a)(2), F.S.

[15] Section 394.4655(6)(b)(2), F.S.

[16] Section 394.463(2)(e), F.S.

[17] http://trialstats.flcourts.org/TrialCourtStats.aspx Site last accessed on October 15, 2015.

	individuals under the Marchman Act (i.e. central receiving facilities, access centers, triage centers, CSUs, ARFs, and detoxification providers). 2. Require all Marchman Act data and all Baker Act data submitted by public and private receiving to Department and AHCA, to be submitted using the existing CSU Database established in s. 394.9082(10), F.S. The existing CSU database will need to be enhanced to allow for the collection, storage, submission, and analysis of Marchman Act data. The enhanced database should be renamed the Acute Care Database to accurately reflect the data being collected. 3. Revise requirements in s. 394.461(4), F.S., to remove exception for the submission of data to the Department if data is currently being submitted to AHCA. Instead, allow for the sharing of Baker Act data with AHCA. 4. Transfer statutory language and requirements pertaining to both the CSU database in s. 394.9082(10), F.S., and public receiving and treatment facilities data in s. 394.461(4)(a)-(b), F.S., to a new section in Part IV of Chapter 394, F.S. The new section in Part IV should blend the requirements in s. 394.9082(10), F.S., and s. 394.461(4)(a)-(b), F.S., and incorporate recommendations in this section for the reporting requirements for Marchman Act and Baker Act. 5. Require all Baker Act and Marchman Act Involuntary Petitions, Court Orders, Professional Certificates, Law Enforcement Reports, and treatment plans to be electronically submitted (or uploaded) using the Acute Care Database. Provide for the secure electronic transmission, and storage of all documents and data entered into the system consistent with 42 CFR Part II, HIPAA, and Chapters 394 and 397, F.S. AHCA would have access to all Baker Act-related data and documents, while the Department would have access to all Baker Act and Marchman Act-related data and documents.[18]

Additional Considerations	
Recommendations	1. In light of the recommendations in this report, the Department's methods of purchasing capacity for CSU, ARF, and residential detoxification beds warrants additional analysis of capacity versus utilization, and consideration of alternative methods of purchasing capacity for crisis services and payment methodologies. 2. The current Baker Act and Marchman Act differ substantially in who is authorized to initiate petitions for involuntary treatment, the criteria, placement options, the role of the state attorney and public defender, and time frames for orders. Alignment in the processes and

[18] The Department would not share Marchman Act-related data with the Agency for Health Care Administration due to the confidentiality requirements of 42 CFR Part II, HIPAA, and Chapter 397, F.S.

	documentation required by these statutes can reduce bureaucratic barriers to accessing court-ordered treatment, while retaining the important protections of due process. 3. Unlike the Baker Act, the Marchman Act does not include any provisions explicitly prohibiting the charging of fees for the filing of petitions for involuntary assessment and stabilization, or involuntary treatment. The charging of fees for the filing of a petition(s) creates a barrier to accessing services. 4. Standardize time frames so that hearings for involuntary treatment petitions must be held within five court working days of filing; orders for initial or continuing involuntary treatment are for 90-day increments, with an option for courts to order more frequent reviews. 5. Consider standardizing timeframes so that involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act must be completed within 72 hours. However, a physician or physician's assistant or psychiatric nurse acting under the physician may authorize up to an additional 48 hours based on a determination of need without court involvement. If admitted involuntarily, total time combined may not exceed 72 hours unless there is further court involvement or the physician identifies a need for the additional 48 hours.

V. Appendices

Appendix 1. Baker Act and Marchman Act Project Team Participants

Appendix 2. Baker Act and Marchman Act Project Team Fiscal Subcommittee's Cost Methodologies and the Public Consulting Group (PCG) Crisis Stabilization Reimbursement Transition Plan

Appendix 3. CSU-SRT Statewide Map

Appendix 4. Addiction Receiving Facilities Statewide Map

Appendix 5. Public and Private Receiving Facilities

Appendix 6. Mobile Crisis Teams

Appendix 1

Participant	Affiliation
John Bryant, Assistant Secretary for Substance Abuse and Mental Health **(Chair)**	Department of Children and Families, Office of Substance Abuse and Mental Health
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Vicki Garner	Aspire Health Partners
Shannon Robinson	Aspire Health Partners
Margo Adams	Florida Psychiatric Society
Jennifer Grandal	Office of the State Courts Administrator, Office of Court Improvement
Rose Patterson	Office of the State Courts Administrator, Office of Court Improvement
The Honorable Mark A. Speiser	Circuit Court Judge, 17th Judicial Circuit
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Nicole Stookey	Department of Children and Families, Office of Legislative Affairs
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Laurie Chesley	LSF Health Systems
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Candy Hodgkins	Gateway Community Services, Inc.
Rich Rasmussen	Florida Hospital Association
Pamela Carter	Central Florida Behavioral Health Network
Sheriff Robert A. "Bob" Gualtieri	Pinellas County Sheriff's Office
Natalie Kelly	Florida Association of Managing Entities

Appendix 2

Baker Act and Marchman Act Project Team Fiscal Subcommittee's Cost Methodologies

In costing the Baker Act and Marchman Act three different methodologies were employed in an effort to triangulate results and to validate the projected cost to implement a "no wrong door" approach to mental health and substance abuse services statewide.

A variety of data sources were utilized in the development of the methodologies including the Department of Children and Families report on state funded CSU Beds, Detox beds, Addiction Receiving Facility (ARF) beds, hospital discharge data, and Managing Entity (ME) contractual information.

Assumptions:

The methodologies for cost of detox and ARF bed are based on reimbursement levels paid by the managing entities for the previous fiscal year. Cost methodology for the CSU beds is based on a study conducted by the Public Consulting Group (PCG) under contract with the Department of Children and Families based on a requirement included in the 2012 General Appropriations Act and issued on January 2013. These costs assume that beds are purchased on a bed availability model. If this is changed to a per diem reimbursement method, the costs would be higher.

There are no fixed capital outlay costs included.

The ratios are applied to the statewide population and the methodologies do not result in a projected cost by DCF Circuit, Medicaid region, or other geography.

Methodology 1: Beds Per Capita

Method 1: Beds per Capita Using DCF Funded Capacity					
	Total Beds Needed*	**DCF Funded Beds**	**Additional Beds Needed**	**CSU Unit Cost**	**Cost per Year for Additional Beds**
CSU Bed Need	1951	696	1255	$ 378.50**	$173,345,040
*DCF rule 65E-12.104(8), FAC, provides a guideline for planning CSU bed capacity of 10 beds per 100,000 people. Given the state population of 19,507,369, this generates a need of 1951 beds.					
**The $378.50 cost per bed was determined in the Public Consulting Group report commissioned by the Department of Children and Families titled: Department of Children and Families Crisis Stabilization Reimbursement Plan, 2013.					
	Total Beds Needed	**DCF Funded ARF and Detox Beds**	**Additional Beds Needed**	**Detox Unit Cost**	**Cost per Year for Additional Beds**
DCF Funded Detox Beds	975	377	598	$280.00	$61,153,256
The detox bed standard of 1 bed per 20,000 people is a proxy for discussion.					

				Grand Total Additional Cost	$234,498,295

This methodology calculates the number of beds that would be necessary statewide to meet the guideline of 10 beds per 100,000 population for CSU beds (per DCF Rule 65E-12.104(8) and the guideline of 5 beds per 100,000 population for Detox beds statewide (a proxy as no guideline exists in Rule at present). The cost is derived by projecting the cost per bed x the number of additional beds needed x 365 days (assuming that the beds are at capacity annually).

Detail:

DCF rule 65E-12.104(8) provides a guideline for Crisis Stabilization Unit (CSU) bed capacity of 10 beds per 100,000 population (or 1 bed per 10,000 people). According to the Bureau of Economic and Business Research the current population in Florida is 19,507,369. Applying the ratio of 1 bed: 10,000 population results in a total need of 1,951 CSU beds statewide.

Currently there are 696 DCF funded CSU beds (contracted CSU beds) statewide. Using a formula of (Total beds– Contracted beds= Additional bed need), 1,251 additional beds are needed statewide.

At a CSU Unit Cost of $378.50 per day (the bed cost reported in the Public Consulting Group (PCG) report of 2013) the cost per year for these additional beds is $173,345,040.

Research revealed that there is no standard in rule for Detox bed capacity. A standard of 1 bed per 20,000 population (5 beds per 100,000 population) was used in this Beds Per Capita methodology, and is a proxy for discussion. Applying the ratio of 1 bed: 20,000 population results in a total need of 975 Detox beds statewide. Currently there are 377 DCF funded Detox beds (DCF licensed and contracted Detox beds), resulting in a need of 598 additional Detox Beds.

The cost per day of Detox bed is $280.00 (the average current DCF reimbursement/contracted rate). The total cost per year for these additional beds is $61,153,256.

The grand total of the annual cost of the additional DCF funded CSU beds and DCF funded Detox beds needed statewide to meet the guidelines is $234,498,295.

Methodology 2: Central Receiving Facility Model

Method 2: Central Receiving Facility Model					
	Total Beds Needed	**AHCA Licensed CSU Beds and DCF Licensed**	**Additional Beds Needed**	**CSU Unit Cost**	**Cost per Year for Additional Beds**

		Detox Beds			
CSU/Detox Bed Need	3701	1541	2160	$ 378.50	$ 298,346,941
This system relies on flexible CSU, SRT, hospital, Detox, and Addictions Receiving Facility Beds. The combined total of all these beds equals 233, which based on a population of 1.2 million in Orange County results in a current capacity of 1.98 beds per 10,000 population.					
This system relies on funding from various sources: local, state, and private sources.					

The Orange County central receiving facility (CRF) has been operational for at least 10 years and is the result of an integrated model and funding system of service that brings together Law Enforcement, Mental Health and Substance Abuse providers, Justice and other stakeholders. The CRF is the single point of entry for mental health and substance abuse services in Orange County and provides services under both the Baker Act and Marchman Act.

Detail:

This model uses a variety of inpatient services including

Baker Act/Mental Health (193 beds):

87 Adult CSU beds, 20 Children CSU beds, 56 Hospital-contracted CSU beds, 30 Short Term Residential Treatment (SRT) beds; and Marchman Act/Substance Abuse (40 beds):

40 Detox beds

For a total of 233 beds. Note that 12 Addiction Receiving Facility beds are imbedded in the 87 Adult CSU beds and can be utilized based on demand.

According to the Bureau of Economic and Business Research the current population in Orange County is 1,227,995, resulting in a standard of 1.9 beds per 10,000 population. This is almost double the standard in the Bed Per Capita methodology. Applying this ratio to the statewide population (above) results in a need of 2,160 additional CSU and Detox beds statewide to bring the entire statewide system up to the central receiving facility model standard.

At a cost of $378.50 per day per bed, the annual additional cost is $298,346,941.

Methodology 3:

Method 3: 2014 Needs Assessment		
ME	**CSU Beds Unmet +**	**Detox Beds Unmet + Unfunded**

	Unfunded		
BBCBC	$2,427,836	$240,462	
BBHC	$7,803,999	$3,827,756	
CFBHN	$29,240,230	$5,209,649	
CFCHS	$25,264,316	$12,684,487	
LSF	$12,198,507	$2,028,571	
SEFBHN	$5,671,071	$2,577,580	
SFBHN	$21,629,091	$2,530,728	
Total	$104,235,052	$29,099,233	
		Grand Total	$133,334,285

Methodology 3 includes figures for unmet and unfunded need by managing entity according to self-reported data acquired by surveying Florida Council for Community Mental Health members in 2014. The survey included data regarding current utilization of services, wait list for services and current bed capacity and reimbursement rates compared to actual cost of providing the service.

The total additional annual funding necessary to meet the utilization need for CSU beds is $104,235,052 and $29,099,233 for Detox beds for a total of $133,334,285.

Actual Provider Cost:
This cost was generated on actual provider cost using figures developed by Public Consulting Group (PCG), an independent consultant contracted by the Department in 2013. According to PCG report entitled 'Department of Children and Families Crisis Stabilization Reimbursement Plan' the Average Cost per Bed Day is $378.50 for CSU beds.

In summary, costs for funding a "no wrong door" approach range from $133 - $298M, depending on which model is used. This represents total additional costs and should be funded between a partnership of state government, local governments, Medicaid and local communities.

State of Florida
Department of Children and Families
Crisis Stabilization Reimbursement Transition Plan

January 1, 2013

TABLE OF CONTENTS

1. INTRODUCTION

This *Crisis Stabilization Reimbursement Transition Plan* is presented by the Department of Children and Families to the Florida Legislature to fulfill the requirements of the legislative proviso found in Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346. This proviso mandates the Department to develop a plan to transition from capacity-based reimbursement to utilization-based ("per diem") reimbursement for mental health crisis stabilization services.

This section of the Transition Plan provides essential background information for understanding the proposed reimbursement model and its rationale, and the process that was used to develop it. Section 2 provides definitions of technical terms used throughout the document. Section 3 reports the results of a quantitative analysis of providers' costs of providing crisis stabilization services in Florida. Section 4 reports the results of a qualitative analysis of three of the state's local crisis stabilization systems of care. Section 5 describes the Department's proposed method of utilization-based reimbursement to meet the requirements of the legislative proviso. Section 6 describes the statutory and regulatory changes that would be required to implement the proposed method. Section 7 describes the steps the Department would need to take to implement the method. Section 8 discusses the potential impact of implementing the proposed reimbursement method.

Florida's Mental Health Crisis Services System

Florida's mental health crisis services system is governed by the Baker Act (Chapter 394, Part 1, Florida Statutes), which authorizes the Department to manage programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders through emergency rehabilitative services for persons requiring intensive short-term and continued treatment for recovery. The Baker Act provides for the involuntary examination of individuals who, due to mental illness, present a threat to themselves or others, or are unable to care for themselves on a basic level. The Baker Act also allows individuals who are competent to consent to be admitted for crisis services on a voluntary basis if they appear to have a mental illness and may benefit from treatment.

Requirements of the Legislative Proviso

In proviso of the 2012 General Appropriations Act, the Florida Legislature mandated that:

> "The department shall develop a plan to modify the method of expending funds for crisis stabilization services to establish per diem reimbursement for covered services provided to qualified patients. The department's recommended method shall be budget neutral and shall allow use of available funds to reimburse a variety of providers, including public

receiving facilities, community mental health programs, licensed acute care hospitals, or other approved facilities. The plan shall be submitted to the Legislature no later than January 1, 2013 and shall identify steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.)

Thus the essential requirements of the plan are that it:

a) Establish utilization-based ("per diem") reimbursement.
b) Maintain budget-neutrality.
c) Allow reimbursement of a variety of provider types to the extent possible.

The Department has decided to incorporate two additional major elements in the plan, which were not specifically mandated by the proviso:

d) Competitive procurement of Department-funded crisis stabilization services by managing entities (MEs).
e) Utilization management of Department-funded crisis stabilization services by MEs.

Crisis Stabilization Unit (CSU) Workgroup

The Crisis Stabilization Unit (CSU) Workgroup was convened by the Department and met monthly from May through November 2012 (except during July) to advise the Department on the development of this Transition Plan. Workgroup participants included executives of hospitals and CSU providers, representatives of the law enforcement community, and Department staff. The Workgroup was charged with advising on the following matters: the process and criteria to be used in the establishment of per diem reimbursement; criteria to be used in the competitive procurement process for crisis stabilization services; possible changes to the requirements for a facility to be designated as a Baker Act receiving facility; possible changes to the roles of public and private receiving facilities; and types of facilities that should be eligible to serve as receiving facilities.

Public Consulting Group (PCG)

Public Consulting Group (PCG) was contracted by the Department to facilitate the meetings of the CSU Workgroup and conduct related research. PCG conducted a quantitative analysis of utilization, funding and provider costs throughout the state's crisis stabilization system. PCG also evaluated the crisis stabilization service systems as they currently operate in three of the Department's regions, in order to provide background information for the development of this Transition Plan. PCG also collaborated with Department staff in the development of this Transition Plan document.

Managing Entities (MEs)

The Department is in the process of implementing managing entities (MEs) statewide. MEs are private, non-profit corporations contracted by the Department to take over many of the administrative responsibilities that had previously belonged to the regional or circuit offices of the Department. MEs are already operating in most of the state and are expected to cover the entire state by March 1, 2013. The central role of MEs is to subcontract with community mental health and substance abuse providers that are funded by the Department, including public receiving facilities. Thus, the reimbursement model described in Section 5 of this Transition Plan assigns MEs (rather than the Department) responsibility for competitively procuring public receiving facility contracts.

2. DEFINITIONS

This section defines key terms that are used throughout this Transition Plan.

1) **Baker Act:** Chapter 394, Part I, Florida Statutes; regulates mental health services; provides for the involuntary examination of individuals who, due to mental illness, present a threat to themselves or others, or are unable to care for themselves on a basic level; allows individuals who are competent to consent to be admitted for crisis services on a voluntary basis if they appear to have a mental illness and may benefit from treatment.

2) **Budget neutral:** Not requiring any legislative appropriations above the level appropriated for the most recent fiscal year.

3) **Capacity-based reimbursement (or funding):** A funding mechanism wherein the Department contracts with each public receiving facility for a certain number of beds to be available for Department clients, and provides the same amount of reimbursement to the facility each year regardless of the number of beds actually used by Department clients.

4) **Client:** Any individual receiving services in any substance abuse or mental health facility, program, or service, which facility, program, or service is operated, funded, or regulated by the department. (s. 394.67(2), F.S.)

5) **Crisis stabilization services:** Brief, intensive services provided twenty-four (24) hours per day, seven (7) days per week for individuals experiencing a mental health crisis. Crisis stabilization services include services associated with involuntary examination and voluntary admission under the Baker Act.

6) **Crisis stabilization unit (CSU):** A program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state. (s. 394.67(4), F.S.)

7) **Department client:** A client whose household income is below the Federal poverty guideline; who has no payor source available other than the Department; and who is receiving services from a Department-contracted provider. Department clients are eligible for Department-funded crisis stabilization services.

8) **Express and informed consent:** Consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to

enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. (s. 394.455(9), F.S.)

9) **Facility:** Any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness. (s. 394.455(10), F.S.)

10) **Incompetent to consent to treatment:** A person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. (s. 394.455(15), F.S.)

11) **Involuntary examination:** A mental health examination conducted by a receiving facility under the authority of the Baker Act and without the express and informed consent of the individual examined, for the purpose of determining whether the individual meets criteria for involuntary placement. An involuntary examination may be initiated by a licensed health care professional, a law enforcement officer, or by the circuit court upon petition from any party. The criteria for involuntary examination are that the individual appears to have a mental illness, presents a danger to self or others because of the mental illness, and that no less restrictive alternative is available to relieve the danger. (s. 394.463, F.S.)

12) **Private facility:** Any hospital or facility operated by a for-profit or not-for-profit corporation or association that provides mental health services and is not a public facility. (s. 394.455(22), F.S.)

13) **Public facility:** Any facility that has contracted with the Department to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose in accordance with contracts negotiated by the Department's Regional Office or by a Managing Entity (ME). All CSUs are public receiving facilities; hospitals may be either public or private receiving facilities. (s. 394.455(25), F.S.)

14) **Receiving facility:** Any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail. (s. 394.455(26), F.S.)

15) **Transportation exception plan (TEP):** A plan authorized by the Department and by a Board of County Commissioners pursuant to s. 394.462(4), F.S., allowing individuals

within a specific county to be transported to a receiving facility other than the nearest one under specified circumstances to improve service coordination and better meet clinical needs.

16) **Universal service requirement:** The requirement under s. 394.462(1) (j), F.S. that receiving facilities accept all individuals brought by law enforcement for involuntary examination.

17) **Utilization rate:** A ratio calculated for each facility providing crisis stabilization services by dividing the number of bed days actually utilized by Department clients during a year by the number of bed days contracted for by the Department.

18) **Utilization-based funding:** A funding mechanism wherein the Department reimburses providers on a per diem basis for the number of bed days actually used by Department clients.

19) **Utilization target**: In the reimbursement method proposed by this Transition Plan, the minimum number of bed days used by Department clients during a fiscal year which a crisis stabilization services provider must provide in order to receive the full value of the provider's contract with its managing entity (ME).

20) **Voluntary admission:** The admission of an individual to a facility with the individual's express and informed consent.

3. PROVIDER COSTS IN FLORIDA'S CRISIS STABILIZATION SYSTEM

A key component of any analysis of reimbursement methodologies for a system of care is a review of existing provider data. In this section, we have documented the analysis of the current crisis stabilization system in Florida on the basis of the provider costs of providing crisis stabilization services to Department clients. The following subsection will provide an overview of the methodology used to capture crisis stabilization service provider costs, the data collection process, and the analysis of the provider data. Limitations of the data are also discussed. It should be emphasized that the analyses reported here concern the providers' costs of providing services, not the cost to the Department.

In conducting the analysis, the data was reviewed in multiple ways to provide various perspectives on the system. The data was initially reviewed on a statewide basis and broken out by total cost per bed day for adult and children's units combined and then the cost per bed day by adults and by children's units discretely. The second analysis was done in a similar fashion; however the data was broken out based on Department region. The third analysis compared the cost per bed day for a crisis stabilization unit (CSU) versus a hospital receiving facility.

Data Collection Methodology

Public Consulting Group (PCG) initially set out to conduct a quantitative analysis of the crisis stabilization system in Florida with a focus on Department-funded providers (public receiving facilities) with the results of the analysis to be used to inform future rate development exercises. At the August, 2012 CSU Workgroup meeting, PCG initiated the discussion about the future data collection efforts to be completed. During this discussion, PCG staff identified the data they would seek to collect from crisis stabilization providers. PCG noted that, because Medicare and Medicaid cost reports were not available for all providers, this data collection effort would likely require the development of a survey to be completed by all crisis stabilization service providers. CSU Workgroup participants proposed using the data provided by the public receiving facilities in the Department's Agency Capacity Reports rather than developing a new survey tool and asking providers to duplicate existing efforts. One limitation of this option is that, in general, only the crisis stabilization providers designated as public receiving facilities have completed the Agency Capacity Reports; as a result, the private receiving facilities would still have needed to be asked to complete a survey in order to capture a comprehensive data set.

Following the August CSU Workgroup meeting, Department staff, in consultation with PCG, began developing utilization-based reimbursement models to be presented during the September CSU Workgroup meeting. Through these discussions, it became apparent that rates would be set in negotiations with the Managing Entities; therefore, there was no need for this Transition Plan

to specify rates or rate formulas. The Department agreed that PCG should proceed with the quantitative analysis using the Agency Capacity Report data for the public receiving facilities. The remainder of this section describes the data collection efforts and the analysis of the data obtained.

Data Collection Process

Prior to collecting data, PCG conducted initial research to better understand Agency Capacity Reports, the data included in them, limitations of this data, and the role of these reports in contract negotiations between the Department and the public receiving facilities. As part of these efforts, PCG interviewed staff of two managing entities (MEs): South Florida Behavioral Health Network and Lutheran Services of Florida. Some of the key conclusions follow.

- ***Reimbursement rates are calculated based on 100% utilization rates.*** One of the main limitations of the Agency Capacity Report data is that it assumes a utilization rate of 100 percent. While this assumption was acceptable under the capacity-based model, it presents a challenge in using the data to determine an appropriate rate for utilization-based funding. One ME staff member suggested that the maximum days be calculated using 85% as an estimate for the utilization rate. This alone, however, would not address the issue of different utilization rates for adults and children. In reviewing the analysis in the following pages it should be noted that all rates are based on this same assumption of 100% utilization as this is the representation of the actual data reported by providers.

- ***The Role of Agency Capacity Reports in contract negotiations varies by ME and Department region.*** The use of Agency Capacity Report data in contract negotiations varies across the state. Agency Capacity Reports are often not used in determining the rate the crisis stabilization providers receive. It was noted by one of the managing entities interviewed that due to the statewide maximum rates that are set in rule for both adult and child crisis stabilization services, there is little room for the negotiation of rates. Therefore, the Agency Capacity Report data is only used to determine rates for providers who are found to have rates below the statewide maximum rates, in which case those providers would receive a rate based on the costs identified in their Agency Capacity Report. In the rare event that the DCF Regional Office or Managing Entity makes the determination to appeal for a higher rate for a provider, the Agency Capacity Report data may be used to support that request.

Following PCG's research on the Agency Capacity Report data, PCG contacted the Department's regional contract managers to begin data collection. PCG, with the help of DCF Central Office, also reached out to the Department's Regional Managers and to the managing entities to assist in the collection of the Agency Capacity Report data. One of the greatest

challenges of this phase of the engagement has been the identification of the appropriate staff to provide the Agency Capacity Report data, since the Department's regions are in various stages of implementing the managing entities.

Analysis of Agency Capacity Reports

The analysis of the Department-funded crisis stabilization system presented in the following sections is based on the data reported by the public receiving facilities on their Agency Capacity Reports. The data was received through the Department's regional offices; the managing entities; and in some cases directly from the providers themselves. PCG has accepted the data as reported without any substantial audit efforts. In the preparation of the analysis, PCG would like to note the following major limitations:

- ***Data has been received for 28 public receiving facilities.*** At the time of this analysis, PCG has only received data for 28 public receiving facilities out of a total of 64 possible providers. In some cases, the data has been combined for a provider with multiple locations as was the case for the four PEMHS locations. While considering the providers that submitted one report for multiple locations does help to reduce the number of facilities for whom no data was received, there are still a significant number of facilities not included in this analysis.

- ***Some providers did not differentiate between adult and children's services.*** Another limitation of the analysis is that some providers that were identified as having both adult and children's services only provided data in the aggregate for all crisis stabilization services. Where possible, PCG attempted to separate the bed capacity data between adult and children's categories with the reported expense separated proportionally between the two. As a result, the analysis of the cost per bed day for the adult versus children's services may not provide as clear a distinction as might be expected.

The Appendix lists those public receiving facilities that have submitted Agency Capacity Report data included in the analyses. PCG also received data from Sarasota Memorial Hospital (Bayside Center for Behavioral Health) and Central Florida Behavioral Hospital (Baycare Behavioral Health). However, as private receiving facilities, their data was excluded from the analysis.

PCG has conducted three separate analyses on the cost per bed day as reported on the Agency Capacity Report by the public receiving facilities. The first analysis looks at the statewide cost per bed day, while the second analysis looks at the cost per bed day on a regional basis. The third and final analysis compares the cost per day for crisis stabilization units (CSUs) versus hospital providers. In each of the three analyses, we have examined the data in the aggregate (including both adult and children's services); for adult services only; and for children's services only.

Statewide Analysis

In the statewide analysis, the Agency Capacity Report data for all providers has been combined to identify the statewide average cost per bed day. Again, this analysis looks at adult and children's data both separately and in combination. The following table summarizes the results.

	Statewide
Total Bed Days Available	314,432
Total Expense	$ 119,013,554
Average Cost per Bed Day	**$ 378.50**
Total Bed Days Available - Adult	272,136
Total Expense - Adult	$ 102,597,490
Average Cost per Bed Day - Adult	**$ 377.01**
Total Bed Days Available - Child	42,296
Total Expense - Child	$ 16,416,063
Average Cost per Bed Day - Child	**$ 388.12**

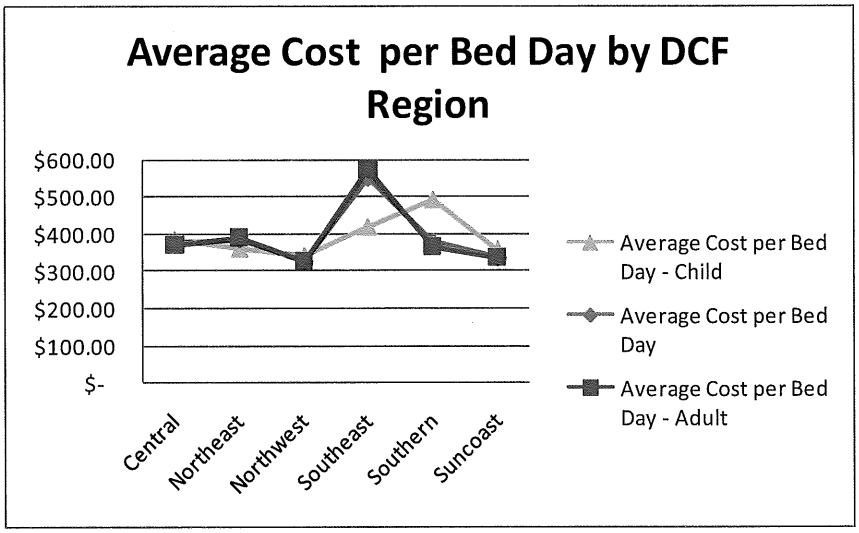
The analysis of the cost per bed day on the statewide basis illustrates two key points: first, the statewide average cost per bed day for crisis stabilization services ($378.50) is greater than the state's maximum rate of $291.24; second, the average cost per bed day for children's crisis stabilization services ($388.12) is higher than the cost per bed day for adult crisis stabilization services ($377.01).

Regional Analysis

The regional analysis, like the statewide analysis, includes the available bed days, the total expense and the cost per bed day. It should be noted that there are limitations to this analysis given the limited number of Agency Capacity Reports received. For example, Agency Capacity Report data was only received for three of the fifteen public receiving facilities in the Central region. Likewise, the data for the Southeast region includes only two of the eleven public receiving facilities.

	REGION					
	Central	Northeast	Northwest	Southeast	Southern	Suncoast
Total Bed Days Available	29,930	61,050	22,070	29,565	58,412	113,406
Total Expense	$ 11,210,965	$ 23,587,556	$ 7,263,521	$ 16,279,237	$ 22,229,902	$ 38,442,374
Average Cost per Bed Day	**$ 374.57**	**$ 386.37**	**$ 329.11**	**$ 550.63**	**$ 380.57**	**$ 338.98**
Total Bed Days Available - Adult	21,900	50,830	21,749	24,820	52,572	100,266
Total Expense - Adult	$ 8,112,871	$ 19,902,856	$ 7,153,600	$ 14,281,777	$ 19,354,605	$ 33,791,782
Average Cost per Bed Day - Adult	**$ 370.45**	**$ 391.56**	**$ 328.92**	**$ 575.41**	**$ 368.15**	**$ 337.02**
Total Bed Days Available - Child	8,030	10,220	321	4,745	5,840	13,140
Total Expense - Child	$ 3,098,094	$ 3,684,700	$ 109,921	$ 1,997,460	$ 2,875,296	$ 4,650,592
Average Cost per Bed Day - Child	**$ 385.81**	**$ 360.54**	**$ 342.43**	**$ 420.96**	**$ 492.35**	**$ 353.93**

The cost per bed day is quite variable across the different regions in the state. Further, given that a large number of beds included in the analysis were adult beds, the average cost per bed day for adults closely mirrors that of the aggregate average cost per bed day. The following chart depicts the variability in cost per bed day across the five regions of the state for which Agency Capacity Report data was received.



Crisis Stabilization Unit (CSU) vs. Hospital Analysis

The final component of the analysis was to look at the cost per bed day for the CSU providers against the cost per bed day for the hospital providers. Like the previous two analyses, this analysis compares the cost per bed day in the aggregate and then the cost per bed day for adults and children separately. One limitation of this analysis is that, of the thirteen public receiving facilities that are hospitals, only five submitted Agency Capacity Report data to be included in the analysis. A second limitation is that, of the five hospitals for which data was included in the

analysis, only one reported costs associated with children's beds. The following table presents the results of this analysis based on the data received from those five hospitals.

	CSU	Hospital
Total Bed Days Available	267,618	46,815
Total Expense	$ 94,351,606	$ 24,661,948
Average Cost per Bed Day	**$ 352.56**	**$ 526.80**
Total Bed Days Available - Adult	230,067	42,070
Total Expense - Adult	$ 79,933,003	$ 22,664,488
Average Cost per Bed Day - Adult	**$ 347.43**	**$ 538.73**
Total Bed Days Available - Child	37,551	4,745
Total Expense - Child	$ 14,418,603	$ 1,997,460
Average Cost per Bed Day - Child	**$ 383.97**	**$ 420.96**

The costs per bed day for crisis stabilization services in the hospital setting were significantly higher than the costs per bed day for crisis stabilization services in the stand-alone CSUs. This is consistent with the general understanding that CSUs provide a less costly alternative to hospitalization. While the table above shows that the average cost per bed day for adults is greater than that for children's, this may not be an accurate representation as the children's data includes only one hospital.

Conclusions

As the preceding analyses illustrate, the cost per day for crisis stabilization services in Florida are on average over $375 per day. While there are some providers whose cost per day is less than this figure, the preceding analyses clearly show that the existing maximum (model) rate of $291.24 per day, as defined in Florida Statute, does not cover the costs incurred by crisis stabilization providers in serving DCF clients. Given the language in the legislative proviso and the requirement to remain budget neutral within a utilization-based reimbursement approach it is safe to assume that providers will continue to realize reimbursement at rates below their costs in providing these services.

4. EVALUATION OF CRISIS STABILIZATION SYSTEMS OF CARE

To inform the development of the proposed reimbursement model, Public Consulting Group (PCG) conducted a qualitative evaluation of three of the state's existing local mental health crisis systems of care: Broward County, Circuit One, and Orange County. The findings of this evaluation are reported in this section.

The Broward County System of Care

Broward County, which includes Ft. Lauderdale, has three public receiving facilities, as well as five hospitals serving as private receiving facilities. The county uses a central receiving facility model that allows the burden of Department clients to be shared equitably, primarily across the three public receiving facilities and, when necessary, across the five private receiving facilities. Since a payment model that would be based on a central receiving facility structure is proposed in Section 5 of this plan, PCG interviewed staff from the Department's Southeast Regional Office familiar with Broward's system of care.

In the mid-1990s, the Department decided that Broward County had an excess of crisis stabilization beds; the Department reorganized the system with input from stakeholders, downsizing from 90 beds to 60 beds. All of the receiving facilities had been clustered in part of the county; new facilities were contracted in different areas of the county.

Currently, there are three CSUs in Broward County: one in the central area, one in the eastern area, and one in the southwestern area. Individuals are transported to the nearest receiving facility, whether public or private, and are transferred, if necessary, after being evaluated at that facility. Only one CSU admits children; all three admit adults.

By opening three sites, Broward increased the number of funded beds; yet there are still circumstances in which there is a significant amount of overflow. When overflow occurs and there are no publicly-funded beds available, there is a rotation between the private facilities that accept individuals for whom they know they will not be reimbursed for providing services. Private hospitals have been accepting individuals in this situation for the past few years. One of the Broward CSUs is located in a private hospital that has a larger capacity than can be funded; however, the hospital will provide additional beds without reimbursement when needed.

The three public facilities take turns acting as a central receiving facility by managing the system for transporting indigent patients to private facilities in overflow situations. Each month, a different public facility maintains the log that records which private facility is up on the rotation to accept an indigent patient. The individual is then sent to whichever facility is next on the

rotation, as long as they have an available bed, which is typically easy to determine as the availability of beds at each facility is recorded daily.

Law enforcement is not responsible for transporting individuals after they have been brought to a facility and evaluated; the facility is responsible for transporting them to another facility, if necessary.

Workgroup participants expressed concerns about the conflict of interest that could arise from a central receiving facility providing clinical services and determining transfer destinations. In Broward this problem is mitigated by the three public receiving facilities rotating the responsibility for determining transfer destination.

The Department regional staff interviewed noted that the system of care depends on positive relationships among the Department's Regional Office, the public facilities, and the private facilities, and on the commitment of the administration at the private facilities. Whenever there is a change in administration at the private facilities, there is cause for concern that the relationship may change.

The central receiving facility model used in Broward County has worked well in that community, and seems to function best in more densely populated areas. There are other aspects of Broward that make it unique: the county and other local stakeholders provide funding at a higher level than in most areas of the state; and outpatient services have been reduced in order to shift funding to crisis stabilization services. Thus, replicating the central receiving facility model that is used in Broward may not be feasible in other regions in the state due to the different levels of funding, community support, and population density.

Regional office staff also encouraged the workgroup to ensure that the Baker Act Task Force is maintained through the current changes to the CSU structure; they emphasized the importance of this group, consisting of essential stakeholders that have been meeting regularly since 1975, and its contributions to the success of the central receiving facility.

The Circuit One System of Care

The Department's Circuit One, identical in boundaries to the First Judicial Circuit, is located in the western portion of the Florida Panhandle and is comprised of four counties: Escambia, Okaloosa, Santa Rosa, and Walton. Circuit One is part of the Department's Northwest Region. The Circuit One system of care already functions under what may be called a "quasi-utilization-based" model. Thus it serves as an informative model for the transition to utilization-based funding. PCG interviewed staff of Lakeview Center, the managing entity responsible for Circuit One, about their system of care and the benefits and challenges associated with it.

Circuit One's quasi-utilization-based model was the result of a change in the payment methodology implemented by the ME a few years ago. The Northwest Region's public receiving facilities operate with a capitated model, but they also are required to show that their funding is reflective of the number of beds used. The facility maintains a data warehouse where information concerning utilization is collected from monthly reports; funding is based on this utilization data. The two CSUs in Circuit One, Lakeview Center and Bridgeway Center, submit annual utilization reports to the data warehouse and are subject to an annual contract negotiation to set target rates.

Currently, when a Department client is brought to a CSU that is at capacity, the client is transferred to another facility that has available beds. If there are no Department-funded beds left in any of the public facilities in Circuit One, clients are transported to a local hospital private receiving facility.

PCG asked ME staff about the advisability of implementing a tiered rate structure, wherein facilities would receive a higher rate for the first one to three days and a lower rate thereafter. Theoretically, such a rate structure could yield shorter stays by incentivizing more efficient treatment and discharge planning. The ME does not use tiered rates; staff explained this would not be necessary as there is no incentive to hold individuals overlong as it is: it would damage relations with law enforcement and other community stakeholders since there would be a lack of bed availability.

The Department's proposed reimbursement model (described in Section 5 of this Transition Plan) includes competitive procurement of public receiving facilities by MEs. Lakeview Center staff expressed some concerns about the introduction of competitive procurement for crisis stabilization services. CSUs are presently the lowest cost provider of these services (as discussed in Section 3); and Lakeview Center uses the maximum ("model") rate for it subcontracted providers. Lakeview Center staff report that if they had to use competitive procurement to award their contracts, the rates would likely increase. Providers would then increase their rates, which could detriment the whole system.

Lakeview Center's use of a quasi-utilization-based model in Circuit One has not resulted in any change of funding levels. There has been an increase in administrative workload as providers must now demonstrate they are providing a certain number of bed days of services in order to receive their contracted funding. However, facilities have had no difficulty meeting their utilization target. Nevertheless, utilization-based funding as it exists in the Northwest Region may not work for smaller CSUs elsewhere in the state that cannot rely on having their beds filled consistently.

The Orange County System of Care

In Orange County, which includes Orlando, a central receiving facility, the Central Receiving Center (CRC), has served individuals in need of substance abuse services as well as those in need of Baker Act crisis stabilization services since 2002. Law enforcement transports individuals to the CRC where, after an initial assessment, the individual is either released or transported to the most appropriate facility based on clinical needs, payor source, and bed availability.

Public and private receiving facilities (including CSUs and hospitals) work in cooperation with the CRC and accept transfers from it. Department clients are assigned to facilities on a rotating basis to ensure fair and efficient sharing of the burden of care. Members of the CRC staff manage the rotation list, which does not pose a conflict of interest as the CRC does not house any crisis stabilization beds. For the first few years of operation, in order to ensure fairness, an administrative service organization (ASO) was hired to manage the assignment of clients to facilities. Eventually, the facilities took over this task themselves, with responsibility for managing the process rotating among the facilities each month. Orange County has a Transportation Exception Plan (TEP), as authorized under s. 394.462(4), F.S., allowing law enforcement to bypass the nearest receiving facility and transport all individuals in crisis directly to the CRC.

Prior to the adoption of the central receiving facility model, Baker Act transportation had become a significant burden on law enforcement; officers were spending hours at a time in hospital emergency departments, monitoring individuals who were awaiting examination. Now, officers need only spend a few minutes at the CRC to drop off an individual for examination. As a result, the central receiving facility model has strong support from local law enforcement agencies.

Orange County's system of care has proven to work well and is arguably replicable in some other areas of the state. The facility has served to decrease the incarceration rate of individuals with mental illnesses and substance abuse issues in the region, by giving this population access to rapid assessments and appropriate referrals.

5. PROPOSED METHOD OF UTILIZATION-BASED REIMBURSEMENT

The legislative proviso mandating this plan states, in its entirety, that:

> "The department shall develop a plan to modify the method of expending funds for crisis stabilization services to establish per diem reimbursement for covered services provided to qualified patients. The department's recommended method shall be budget neutral and shall allow use of available funds to reimburse a variety of providers, including public receiving facilities, community mental health programs, licensed acute care hospitals, or other approved facilities. The plan shall be submitted to the Legislature no later than January 1, 2013 and shall identify steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.)

This section describes the proposed reimbursement model. The Basic Model would apply statewide while the Access Centers Option could be implemented in particular geographic areas at the discretion of the MEs. With or without the Access Centers Option, the Basic Model:

- Meets the requirements of the legislative proviso to implement utilization-based funding while remaining budget neutral.
- Introduces competitive procurement and utilization management.
- Maintains the universal service requirement.

The Basic Model

The features of the Basic Model would apply statewide. The managing entities (MEs) would be largely responsible for the implementation and operation of the approach. The ME would divide their geographic area into procurement areas and competitively procure one or more public receiving facilities for each procurement area. The procurement areas would be based on community need, location of existing facilities, and utilization history. Maps delineating procurement areas would be subject to final approval by the Department. Bids would be accepted from any crisis stabilization unit (CSU) or hospital licensed to provide psychiatric care, located within the procurement area, and able to demonstrate the ability to meet the Baker Act requirements for designation as a receiving facility. Analysis by Department staff and Public Consulting Group has determined that no other types of facilities would have the capability to provide Baker Act services; comments from the CSU Workgroup confirm this. Bidders would be eligible regardless of for-profit or non-profit status, and could include new entrants to the Baker

Act market. Integrated crisis stabilization unit/addictions receiving facilities (CSU-ARFs), which focus on co-occurring substance abuse and mental health disorders, would be eligible to bid.

MEs would establish criteria for competitive procurement, including quality of care indicators, costs, and strength of community partnerships. The MEs would have the option of formally eliciting public input on these procurement criteria, including feedback from key stakeholders such as local providers, law enforcement agencies, county and municipal governments, and consumer and family advocacy organizations. At the managing entity's discretion, this process could include public meetings. The contracts resulting from the procurement process would be awarded for a four year term, the same as the term of the Department's contracts with the MEs. As at present, facilities that were not awarded contracts, or did not bid for them, could still be designated by the Department as private receiving facilities.

The reimbursement for crisis stabilization services would be on a utilization (per diem) basis with the MEs negotiating rates with each public receiving facility in the procurement process. In order to maintain budget neutrality, the MEs would also negotiate monthly reimbursement caps with these providers, taking into consideration providers' costs and the number of licensed beds. Monies paid to providers by MEs could not exceed the monthly cap, which would be set to ensure the ME does not exceed its total budget for crisis stabilization services. The MEs would be required to report to the Department in a monthly or quarterly reconciliation process to ensure all Department funding is being expended in an appropriate manner. Public receiving facilities would continue to be required to accept individuals for examination, regardless of ability to pay, even after reaching their monthly reimbursement cap. The same requirement would apply to private receiving facilities.

Finally, the MEs would negotiate monthly utilization targets, in terms of the number of bed days utilized by Department clients. In setting utilization targets, MEs would have the option of using data reflecting utilization history for the region, circuit, county, or procurement area, as long as this was done consistently across the ME's subcontracted providers. MEs could use the Department's available historical utilization data, or data the MEs themselves have collected, or may collect in the future.

Reimbursement rates, reimbursement caps, and utilization targets would be set in such a way that a provider would earn the full value of the reimbursement cap as long as their utilization did not fall significantly (2 - 10%) below the historical norm for adult services. Children's services would have a larger cushion (15%). This would help providers adapt to the new system by giving them a cushion so that they would not lose revenue if there is a small decline in utilization. However, if utilization fell further, the provider would see a decline in revenue.

The following steps summarize the process for determining the utilization targets and reimbursement caps for adult units:

1. Negotiate a reimbursement cap dollar amount based on the number of licensed beds, available budget, and market conditions;
2. Select a utilization target for adult services that is between 90% and 98% of the number of bed–days expected to be utilized, based on historical data (85% for children's services);
3. Divide the reimbursement cap by the target number of bed days to calculate the bed-day rate; and
4. Reallocate reimbursement caps among providers annually, based on utilization patterns.

For adult units, providers may earn less than the value of their reimbursement cap, because actual utilization may fall below the utilization target. However, setting the target slightly below 100% would help providers adapt to the new system by giving them a cushion so that they would not lose revenue if there is a small decline in utilization. For children's units, rates and utilization targets would be set in a similar manner, except that the utilization target would be set at 85% of the historical norm, allowing children's crisis stabilization services providers to have a relatively stable revenue stream even though utilization may be highly variable. This would allow the MEs to accommodate the relatively low utilization levels for children's units that arise from the small number of beds in children's units and the high variability of utilization. This flexibility is necessary to ensure that children's beds are available when they are needed, even if they are at times unused.

In addition to the crisis stabilization services, MEs would have flexibility to include contract provisions for reimbursement for alternative services that reduce the need for crisis stabilization, including mobile crisis services and drop-in centers. The reimbursement for these services would, however, count toward the reimbursement cap for that provider. MEs would also have the option of building into subcontracts incentives for providers to divert individuals into less costly and less restrictive alternative crisis services, when appropriate.

Finally, under the Basic Model, MEs would provide utilization management for contracted providers. The utilization management function would include:

- Automatic preauthorization by the ME for reimbursement of three bed days for individuals admitted for involuntary examination, based on the facility's determination that the individual does not meet criteria for release in the "initial mandatory involuntary examination" required by Rule 65E-5.2801(1);

- Automatic preauthorization by the ME for additional days for individuals awaiting hearing for involuntary placement after the filing of the petition by the facility;
- Automatic preauthorization for individuals on a waiting list for admission to a state mental health treatment facility; and
- Concurrent review by the ME for reimbursement of voluntary admissions.

The Access Centers Option

The Access Centers Option uses competitive procurement to select the central receiving facility (access center), which would itself be a contracted receiving facility, as well as other contracted receiving facilities. As in the Basic Model, MEs would negotiate rates, reimbursement caps, and utilization targets with individual providers. Facilities not awarded contracts could still be designated as private receiving facilities. All public receiving facilities would be obligated by contract to accept transfers of individuals, as assigned by the access center, within the capability and licensed capacity of the destination facility.

The features of the Access Centers Option would be added on to the Basic Model in certain counties, or portions of counties, at the discretion of MEs. The Access Centers Option leverages the concept of central receiving facilities, which already exist and work well in some areas of the state.

The main features and functions of the access center under this option are listed below.

- The access center would receive and examine all individuals transported by law enforcement. The access center would complete the "initial mandatory involuntary examination" required by Rule 65E-5.2801(1), unless immediate transfer was needed for medical reasons. This would allow access centers to release individuals (when clinically appropriate) without transferring them to another facility. The initial exam includes the following elements:
    - A review of the individual's documented recent behavior that led to the exam being initiated;
    - A brief psychiatric history;
    - A face-to-face examination by a physician or clinical psychologist;

  - The ME could require by contract that the initial exam be done by a psychiatrist; and
  - The ME could require by contract that the initial exam be completed within a certain time frame, such 6 hours, in order to improve the efficiency of the system of care.

- The access center would provide brief crisis intervention and refer to outpatient services to avoid admissions when clinically appropriate.
- The access center would receive a standard rate negotiated with the ME for each individual examined.
- The access center would determine whether the individual met criteria for involuntary examination and release the individual promptly if the criteria were not met.
- The access center would transfer clients to another receiving facility if criteria were met, or if extended observation were necessary.
- The access center would approve reimbursement of bed days as in the Basic Model, except that no bed days would be needed if the individual were released directly from the access center.
- The access center would provide overflow capacity when all other local receiving facilities (public and private) were at licensed capacity.

The Access Center Option, like the Basic Model, would incorporate utilization management. Under this option, the ME would assign one of its own staff members to each access center to function as a utilization management specialist ensuring that clinical functions would be separated from utilization management functions. The ME utilization management specialist would determine transfer destination systematically, based on the clinical needs of the individual, payor source available, and bed availability. Basic protocols for determining transfer destination would be included in Transportation Exception Plans (TEPs), making them subject to public comment and approval by the Department. More detailed criteria for transfers – especially medical criteria - would be subject to ME discretion, but codified in written procedures.

6. REQUIRED STATUTORY AND REGULATORY REVISIONS

The Department, in consultation with Public Consulting Group (PCG), conducted an analysis to identify any changes to statute or rule that would be required in order to implement the reimbursement model proposed in Section 5 of this report. The only needed change identified is an amendment to Rule 65E-14.021 (Unit Cost Method of Payment), Florida Administrative Code, to eliminate the maximum ("model") rate ($291.24) for crisis stabilization services. This would give managing entities the flexibility they need to negotiate rates with each subcontracted public receiving facility based on market conditions and available budget. Under the proposed model, there would be no maximum, minimum, or "model" rate.

7. STEPS FOR IMPLEMENTATION OF THE PROPOSED REIMBURSEMENT METHOD

The legislative proviso mandating this Transition Plan required that the Plan identify "steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.) This section describes those steps.

Steps for Implementation

1) *The Department will complete the statewide implementation of managing entities (MEs).*

   This Department initiative has been in progress for several years and is expected to be completed by March 1, 2013. Since MEs play a central role in the proposed reimbursement method, it will not be possible to fully implement the method until the MEs are fully operational.

2) *The Department will amend Rule 65E-14.021 (Unit Cost Method of Payment), Florida Administrative Code, to eliminate the maximum "model" rate for crisis stabilization services.*

   The Department is presently reviewing Rule Chapter 65E-14, F.A.C., which governs reimbursement of Department-funded substance abuse and mental health services. The Department anticipates proposing extensive amendments to this rule chapter, including amendments to accommodate the expanding role of MEs. Elimination of the maximum "model" rate for crisis stabilization services will be included among the proposed amendments. The target date for adoption of these amendments is July 1, 2013.

3) *The Department will negotiate amendments to its contracts with MEs to require that the MEs implement the proposed reimbursement method, including competitive procurement of public receiving facilities.*

   Existing contracts between the Department and the MEs require MEs to competitively procure subcontracted services to the extent possible; however, these existing contracts provide minimal guidance on the procurement process. Contract amendments will provide more detailed guidance regarding public receiving facilities. The timeline for these contract amendments to take effect depends upon the stage of implementation of the ME. However, if the Department implements the proposed reimbursement method, these contract amendments are expected to take effect for all MEs by January 1, 2014.

4) *The MEs will competitively procure public receiving facility contracts and implement the proposed reimbursement method.*

   The timeline for implementation of the new reimbursement model depends on the implementation of the MEs and the effective dates of contract amendments with MEs. However, if the Department implements the proposed reimbursement method, it is expected to be in full effect statewide by July 1, 2014.

5) *The Department will review and approve competitive procurement criteria and procurement area maps proposed by MEs, and require revisions as needed.*

6) *The Department will provide ongoing technical assistance to the MEs and their subcontracted providers to implement the new reimbursement method.*

8. POTENTIAL IMPACT OF THE PROPOSED REIMBURSEMENT METHOD

The Department, in consultation with Public Consulting Group and the CSU Workgroup, has sought to develop the proposed reimbursement method to meet the requirements of the legislative proviso (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346) in a manner that is consistent with the Department's mission and beneficial to the Department's clients. However, some Workgroup participants representing providers of crisis stabilization services have expressed concerns about potential adverse impacts of the proposed reimbursement method. This section describes the potential benefits and potential adverse impacts of the proposed reimbursement method, and highlights provisions intended to mitigate the workgroup's concerns. This section also discusses other issues raised by the workgroup related to the Baker Act system of care.

Potential Benefits of the Proposed Reimbursement Model

The proposed reimbursement method will make the Baker Act system of care more flexible and responsive by requiring that reimbursement caps be reallocated annually on the basis of changes in utilization. This will mean that resources will be reallocated regularly from low utilization providers to high utilization providers. Under the current system, such reallocation occurs only sporadically. Moreover, the utilization management features of the proposed reimbursement method have the potential to increase efficiency in the system of care, reducing unnecessary admissions and reducing lengths of stay, especially for individuals with complex discharge planning requirements. This could reduce costs substantially.

The proposed reimbursement model may also make it possible to serve more clients within existing resources by increasing utilization rates. Historically, the statewide utilization rate for Department-funded beds is 90.2% for adults and 38.2% for children. If these utilization rates were to rise to 95% for adults and 85% for children (based on the utilization targets in the proposed reimbursement model), with statewide Department-funded bed capacity remaining the same, the number of bed days utilized by Department clients would increase by 9,500 for adults and 13,470 for children. Based on historical average lengths of stay, this would translate into services provided for an additional 1,803 adults and 4,388 children per year.[1] Recent history suggests a significant increase in crisis stabilization services may be needed in the coming years.

[1] Staff analysis based on *Bed Use in Public Receiving Facilities and Treatment Facilities Fiscal Year 2009-2010.* http://www.dcf.state.fl.us/programs/samh/publications/csu0910.pdf

The total number of Baker Act involuntary examinations grew steadily from 122,000 in 2007 to 143,000 in 2010, an increase of 17% in just three years.[2]

However, it is important to note that actual utilization levels are subject to the influence of many factors, and cannot be predicted with any confidence. Utilization of crisis stabilization services may not need to increase to the extent noted above; in particular such a large increase in utilization is not likely for children's beds. To the extent these additional services are not needed, cost savings could result or resources could be diverted to other areas. Managing entities will have the option of diverting resources to less costly, less restrictive, alternative crisis services that could reduce the need for involuntary examinations, such as mobile crisis services and drop-in centers.

Potential Adverse Impacts of Proposed Reimbursement Model

The major advantage of the existing, capacity-based reimbursement method is that it ensures the stability of the system of care; concerns expressed by the CSU Workgroup have centered on the possible loss of this stability. The lack of competitive procurement for crisis stabilization services has meant a relatively stable pool of public receiving facilities. Most providers have been operating in the crisis stabilization market for many years. There are only occasionally new entrants to - or exits from - the market. This stable tenure has allowed providers to develop strong relationships with key community stakeholders: law enforcement agencies, county governments, non-receiving facility hospitals, and the Department. Turnover of public receiving facility administrators is relatively low, making it easier to maintain these relationships. These relationships are critical to the functioning of the Baker Act system.

Some workgroup participants have expressed concerns that competitive procurement could push longstanding providers - particularly CSUs - out of the market, disrupting local systems of care that the Department has built over many years. The proposed reimbursement model tries to address this concern by allowing managing entities (MEs) to include strength of community partnerships as a possible criterion for competitive procurement, and by giving MEs the option of incorporating formal public input into the development of procurement criteria and procurement area maps. Moreover, the Department must give final approval of these criteria and maps.

Workgroup participants have also emphasized that capacity-based funding has provided a reliable revenue stream for public receiving facilities, enabling them to remain in the market

[2] *Annual Report of Baker Act Data: Summary of 2010 Data.*
http://bakeract.fmhi.usf.edu/document/BA_Annual_Report_2010.pdf

though the maximum bed-day rate for crisis stabilization services ($291.64) has not increased for many years. As shown by the analysis reported in Section 3 of this Plan, the Department's bed-day rates are considerably lower than providers' actual costs of providing services. This is only possible because services for Department clients are effectively subsidized by other payor sources (such as Medicaid) which pay higher rates. Department funding has been a critical component of the crisis services funding system, despite the Department's low rates, simply because Department funding is stable from month to month, and usually from year to year. Some Workgroup participants have expressed concerns that the transition to utilization-based funding will force some CSU providers out of the market by depriving them of a stable revenue stream. The proposed reimbursement model attempts to address this issue by requiring MEs to set utilization targets for adult units 2-10% below historical utilization norms. This allows a cushion so that providers will not lose revenue if they experience a modest decline in utilization rates.

The concern about losing a reliable revenue stream is especially relevant to children's CSUs, which have smaller numbers of beds than adult CSUs (often only 2-4 beds) and, therefore, are more affected by fluctuations in utilization. Children's CSU have historically had low utilization rates; and the Department has generally accepted these low utilization rates to ensure that beds are available for children when they are needed. The proposed reimbursement model attempts to address this issue by requiring MEs to set utilization targets for children's units 15% below historical utilization norms.

Staffing Requirements for Crisis Stabilization Units (CSUs)

Staffing requirements for CSUs are governed by Rule 65E-12.105 (Minimum Staffing Standards), F.A.C. A certain number of registered nurses (one or two) and mental health treatment staff (one to three) are required to be available on-site at a CSU. The number depends on the number of licensed beds and the time of day.

Some Workgroup participants representing CSU providers suggested that Rule 65E-12.105 should be amended so that the number of staff required is proportional to the number of individuals actually receiving services at the time, rather than proportional to the number of licensed beds. Such a change may allow providers to use resources more efficiently without compromising clinical care standards. The Department intends to study this issue.

Transportation Exception Plans (TEPs)

Normally, an individual transported by law enforcement for involuntary examination under the Baker Act must be transported to the nearest receiving facility. Transportation Exception Plans (TEPs), authorized by s. 394.462(4), F.S., allow individuals within a specific county to be transported to a receiving facility other than the nearest under specified circumstances, in order to improve service coordination and better meet clinical needs. TEPs must be approved by the Department and by the Board of County Commissioners. TEPs currently exist in twelve of Florida's 67 counties. In some counties, such as Broward (as discussed in Section 4 of this

Transition Plan), a TEP is the foundation of a central receiving facility system of care model. In other counties, a TEP targets specific populations, such as minors or elderly people, allowing them to bypass the nearest receiving facility and be transported directly to the facility that can serve them best.

Some Workgroup participants suggested that many counties not currently served by a TEP would benefit from one. As the experiences of Broward and Orange Counties (described in Section 4) have shown, a TEP can greatly increase the efficiency of resource utilization within a system of care. The proposed reimbursement model includes an Access Centers Option which incorporates a central receiving facility; this would require a TEP to implement. Even counties where the ME chooses not to implement the Access Centers Option may benefit from a TEP. The Department intends to instruct its Regional Offices and MEs to study the issue of implementing TEPs where appropriate.

Funding Levels for Crisis Stabilization Services

There was a strong consensus among CSU Workgroup participants that current funding levels for mental health services in Florida are insufficient to meet the needs of individuals in need of these services. Most receiving facilities for adults operate at near 100% utilization. Legislative appropriations for mental health services, including crisis stabilization services, have not increased in many years; nor has the maximum ("model") rate ($291.64) for crisis stabilization services. As discussed in Section 3, providers' actual costs per bed day ($378.50) are much higher than the model rate. Crisis stabilization services for Department clients are effectively subsidized by other payor sources, especially Medicaid. This situation may not be sustainable as provider costs increase due to inflation and other factors impacting the cost of health care services. Moreover, insufficient funding for non-crisis services contributes to the need for crisis services. Individuals are less likely to experience mental health crises when they have access to outpatient mental health services and community supports such as supportive housing and drop-in centers. Therefore, CSU Workgroup participants urged that increased funding for mental health services, including crisis stabilization services, be considered.

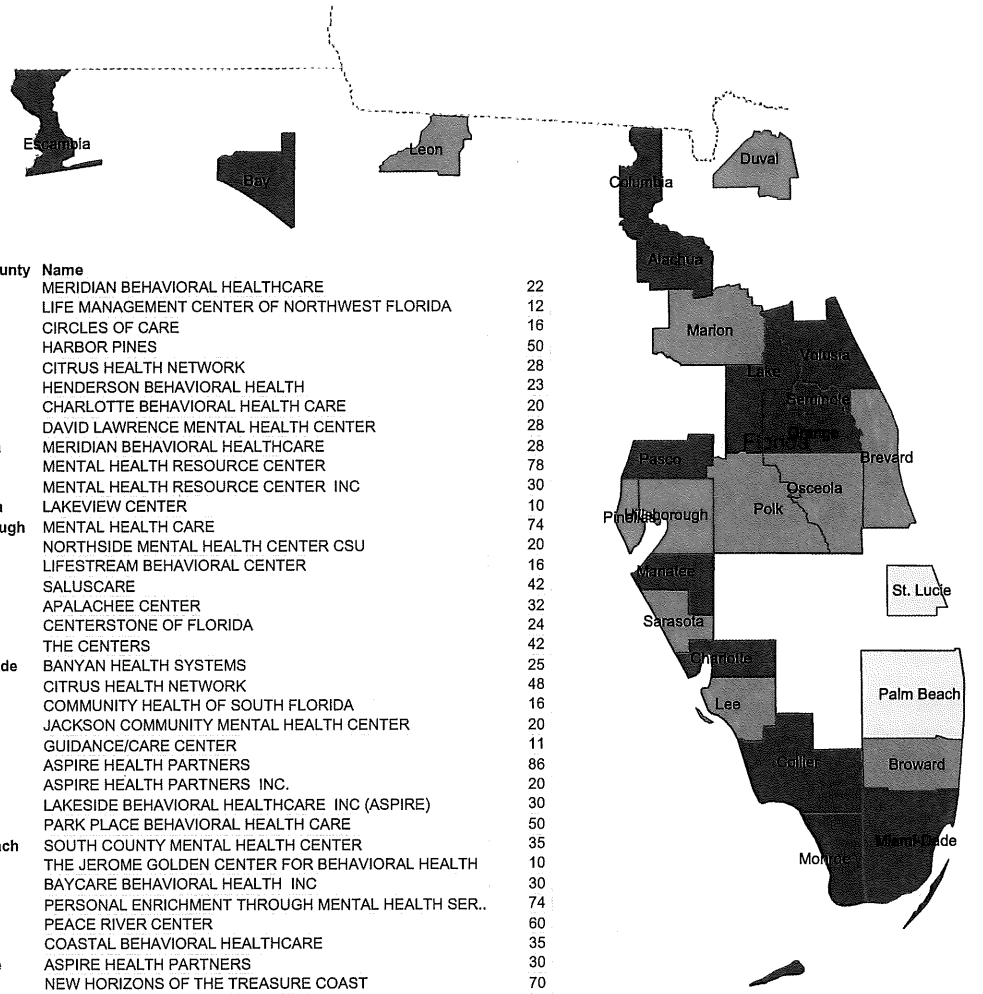
APPENDIX:
RECEIVING FACILITIES REPORTING DATA FOR PROVIDER COST ANALYSES

Apalachee Center, Inc.
Bridgeway Center
Centers, The
Charlotte Behavioral Health Care, Inc.
Citrus Health
Coastal Behavioral Health Care
Community Health of South Florida, Inc.
David Lawrence Center
Depoo Hospital
Flagler Hospital
Fort Lauderdale Hospital
Guidance Care Center, Inc.
Henderson Behavioral Health
Jackson Memorial Hospital
Jackson North Community Mental Health Center
Lakeview Center
Lee Mental Health Center, Inc.
Life Management Center of Northwest Florida
Lifestream Behavioral Center
Manatee Glens Corporation
Mental Health Care, Inc.
Mental Health Resource Center / Mental Health Center of Jacksonville
Meridian Behavioral Health Care
Miami Behavioral Health Center
New Horizons Community Mental Health Center
Northeast Florida State Hospital, Bldg. 57
Northside Mental Health Center, Inc.
Peace River Center for Personal Development
Personal Enrichment through Mental Health Services, Inc
SMA Behavioral Health Services


PUBLIC CONSULTING
GROUP

Appendix 3

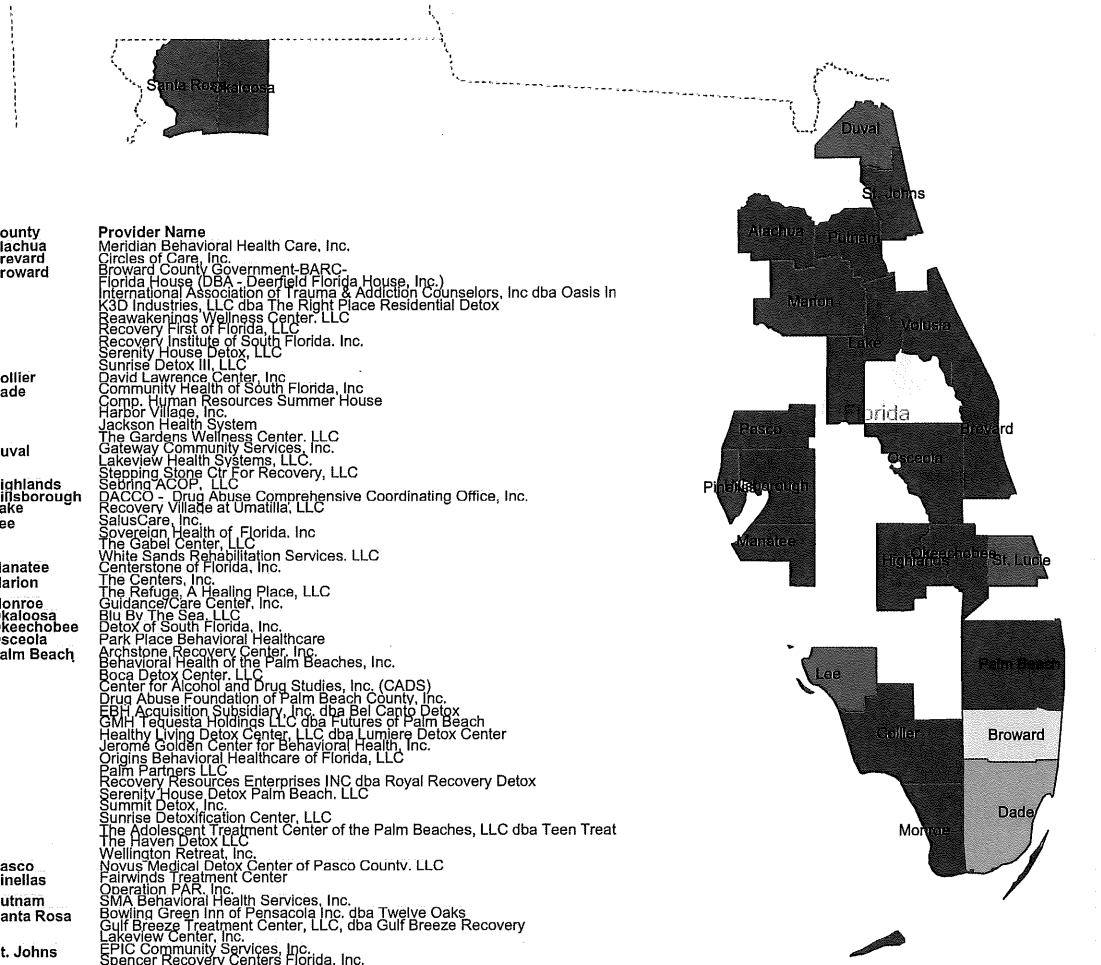
CSUs and SRTs



Street County	Name	
Alachua	MERIDIAN BEHAVIORAL HEALTHCARE	22
Bay	LIFE MANAGEMENT CENTER OF NORTHWEST FLORIDA	12
Brevard	CIRCLES OF CARE	16
	HARBOR PINES	50
Broward	CITRUS HEALTH NETWORK	28
	HENDERSON BEHAVIORAL HEALTH	23
Charlotte	CHARLOTTE BEHAVIORAL HEALTH CARE	20
Collier	DAVID LAWRENCE MENTAL HEALTH CENTER	28
Columbia	MERIDIAN BEHAVIORAL HEALTHCARE	28
Duval	MENTAL HEALTH RESOURCE CENTER	78
	MENTAL HEALTH RESOURCE CENTER INC	30
Escambia	LAKEVIEW CENTER	10
Hillsborough	MENTAL HEALTH CARE	74
	NORTHSIDE MENTAL HEALTH CENTER CSU	20
Lake	LIFESTREAM BEHAVIORAL CENTER	16
Lee	SALUSCARE	42
Leon	APALACHEE CENTER	32
Manatee	CENTERSTONE OF FLORIDA	24
Marion	THE CENTERS	42
Miami-Dade	BANYAN HEALTH SYSTEMS	25
	CITRUS HEALTH NETWORK	48
	COMMUNITY HEALTH OF SOUTH FLORIDA	16
	JACKSON COMMUNITY MENTAL HEALTH CENTER	20
Monroe	GUIDANCE/CARE CENTER	11
Orange	ASPIRE HEALTH PARTNERS	86
	ASPIRE HEALTH PARTNERS INC.	20
	LAKESIDE BEHAVIORAL HEALTHCARE INC (ASPIRE)	30
Osceola	PARK PLACE BEHAVIORAL HEALTH CARE	50
Palm Beach	SOUTH COUNTY MENTAL HEALTH CENTER	35
	THE JEROME GOLDEN CENTER FOR BEHAVIORAL HEALTH	10
Pasco	BAYCARE BEHAVIORAL HEALTH INC	30
Pinellas	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SER..	74
Polk	PEACE RIVER CENTER	60
Sarasota	COASTAL BEHAVIORAL HEALTHCARE	35
Seminole	ASPIRE HEALTH PARTNERS	30
St. Lucie	NEW HORIZONS OF THE TREASURE COAST	70
Volusia	SMA BEHAVIORAL HEALTH SERVICES	30

Appendix 4

Addiction Receiving Facilities



County	Provider Name
Alachua	Meridian Behavioral Health Care, Inc.
Brevard	Circles of Care, Inc.
Broward	Broward County Government-BARC-
	Florida House (DBA - Deerfield Florida House, Inc.)
	International Association of Trauma & Addiction Counselors, Inc dba Oasis In
	K3D Industries, LLC dba The Right Place Residential Detox
	Reawakenings Wellness Center, LLC
	Recovery First of Florida, LLC
	Recovery Institute of South Florida, Inc.
	Serenity House Detox, LLC
	Sunrise Detox III, LLC
Collier	David Lawrence Center, Inc
Dade	Community Health of South Florida, Inc
	Comp. Human Resources Summer House
	Harbor Village, Inc.
	Jackson Health System
	The Gardens Wellness Center, LLC
Duval	Gateway Community Services, Inc.
	Lakeview Health Systems, LLC.
	Stepping Stone Ctr For Recovery, LLC
Highlands	Sebring ACOP, LLC
Hillsborough	DACCO - Drug Abuse Comprehensive Coordinating Office, Inc.
Lake	Recovery Village at Umatilla, LLC
Lee	SalusCare, Inc.
	Sovereign Health of Florida, Inc
	The Gabel Center, LLC
	White Sands Rehabilitation Services, LLC
Manatee	Centerstone of Florida, Inc.
Marion	The Centers, Inc.
	The Refuge, A Healing Place, LLC
Monroe	GuidanceCare Center, Inc.
Okaloosa	Blu By The Sea, LLC
Okeechobee	Detox of South Florida, Inc.
Osceola	Park Place Behavioral Healthcare
Palm Beach	Archstone Recovery Center, Inc.
	Behavioral Health of the Palm Beaches, Inc.
	Boca Detox Center, LLC
	Center for Alcohol and Drug Studies, Inc. (CADS)
	Drug Abuse Foundation of Palm Beach County, Inc.
	EBH Acquisition Subsidiary, Inc. dba Bel Canto Detox
	GMH Tequesta Holdings LLC dba Futures of Palm Beach
	Healthy Living Detox Center, LLC dba Lumiere Detox Center
	Jerome Golden Center for Behavioral Health, Inc.
	Origins Behavioral Healthcare of Florida, LLC
	Palm Partners LLC
	Recovery Resources Enterprises INC dba Royal Recovery Detox
	Serenity House Detox Palm Beach, LLC
	Summit Detox, Inc.
	Sunrise Detoxification Center, LLC
	The Adolescent Treatment Center of the Palm Beaches, LLC dba Teen Treat
	The Haven Detox LLC
	Wellington Retreat, Inc.
Pasco	Novus Medical Detox Center of Pasco County, LLC
Pinellas	Fairwinds Treatment Center
	Operation PAR, Inc.
Putnam	SMA Behavioral Health Services, Inc.
Santa Rosa	Bowling Green Inn of Pensacola Inc. dba Twelve Oaks
	Gulf Breeze Treatment Center, LLC, dba Gulf Breeze Recovery
	Lakeview Center, Inc.
St. Johns	EPIC Community Services, Inc.
	Spencer Recovery Centers Florida, Inc.
St. Lucie	Florida Center For Recovery, Inc.
	New Horizons of the Treasure Coast, Inc.
	Starting Point Detox, LLC dba Unity Detox Center
	Unity Recovery Center, Inc.
Volusia	SMA Behavioral Health Services, Inc.

Appendix 5

Facility Type	Name	Street County	License Status	Total Licensed Beds	Adult	Child	Adult & Child
Crisis Stabilization Unit	APALACHEE CENTER	Leon	LICENSED	28	24	4	28
Crisis Stabilization Unit (ARF)	ASPIRE HEALTH PARTNERS	Orange	LICENSED	30	30		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS	Seminole	LICENSED	30	30		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS	Orange	LICENSED	27	27		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS INC.	Orange	LICENSED	20		20	
Crisis Stabilization Unit	BANYAN HEALTH SYSTEMS	Miami-Dade	LICENSED	25	25		
Crisis Stabilization Unit (ARF)	BAYCARE BEHAVIORAL HEALTH INC	Pasco	LICENSED	30	30		
Crisis Stabilization Unit	CENTERSTONE OF FLORIDA	Manatee	LICENSED	24			24
Crisis Stabilization Unit	CHARLOTTE BEHAVIORAL HEALTH CARE	Charlotte	LICENSED	20			20
Crisis Stabilization Unit	CIRCLES OF CARE	Brevard	LICENSED	16		16	
Crisis Stabilization Unit (JARF)	CITRUS HEALTH NETWORK	Miami-Dade	LICENSED	24		24	
Crisis Stabilization Unit	CITRUS HEALTH NETWORK	Miami-Dade	LICENSED	24	24		
Crisis Stabilization Unit	COASTAL BEHAVIORAL HEALTHCARE	Sarasota	LICENSED	20	20		
Crisis Stabilization Unit	COASTAL BEHAVIORAL HEALTHCARE	Sarasota	LICENSED	15	15		
Crisis Stabilization Unit	COMMUNITY HEALTH OF SOUTH FLORIDA	Miami-Dade	LICENSED	16	16		
Crisis Stabilization Unit	DAVID LAWRENCE MENTAL HEALTH CENTER	Collier	LICENSED	28			28
Crisis Stabilization Unit	GUIDANCE/CARE CENTER	Monroe	LICENSED	11	11		
Crisis Stabilization Unit	HARBOR PINES	Brevard	LICENSED	50	50		
Crisis Stabilization Unit	HENDERSON BEHAVIORAL HEALTH	Broward	LICENSED	23	23		
Crisis Stabilization Unit	JACKSON COMMUNITY MENTAL HEALTH CENTER	Miami-Dade	LICENSED	20	20		
Crisis Stabilization Unit	LAKESIDE BEHAVIORAL HEALTHCARE INC (ASPIRE)	Orange	LICENSED	30	30		
Crisis Stabilization Unit	LAKEVIEW CENTER	Escambia	LICENSED	10	10		
Crisis Stabilization Unit	LIFE MANAGEMENT CENTER OF NORTHWEST FLORIDA	Bay	LICENSED	12			12
Crisis Stabilization Unit	LIFESTREAM BEHAVIORAL CENTER	Lake	LICENSED	16			16
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	14		14	
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	30	30		
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	30	30		
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	24	24	0	24
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	24			24
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	30			30
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER INC	Duval	LICENSED	30	30		
Crisis Stabilization Unit	MERIDIAN BEHAVIORAL HEALTHCARE	Alachua	LICENSED	22			22
Crisis Stabilization Unit	MERIDIAN BEHAVIORAL HEALTHCARE	Columbia	LICENSED	28			28
Crisis Stabilization Unit	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	30	30		
Crisis Stabilization Unit (ARF)	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	20		20	
Crisis Stabilization Unit	NORTHSIDE MENTAL HEALTH CENTER CSU	Hillsborough	LICENSED	20	20		
Crisis Stabilization Unit	PARK PLACE BEHAVIORAL HEALTH CARE	Osceola	LICENSED	30	30		
Crisis Stabilization Unit	PARK PLACE BEHAVIORAL HEALTH CARE	Osceola	LICENSED	20		20	
Crisis Stabilization Unit	PEACE RIVER CENTER	Polk	LICENSED	30			30
Crisis Stabilization Unit (ARF)	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	15		15	
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	15	15		
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	30	30		
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	14	14		
Crisis Stabilization Unit	SALUSCARE	Lee	LICENSED	30	30		
Crisis Stabilization Unit (ARF)	SALUSCARE	Lee	LICENSED	12		12	
Crisis Stabilization Unit	SMA BEHAVIORAL HEALTH SERVICES	Volusia	LICENSED	30	30		
Crisis Stabilization Unit	SOUTH COUNTY MENTAL HEALTH CENTER	Palm Beach	LICENSED	20	20		
Crisis Stabilization Unit	SOUTH COUNTY MENTAL HEALTH CENTER	Palm Beach	LICENSED	15	15		
Crisis Stabilization Unit	THE CENTERS	Marion	LICENSED	30	30		
Crisis Stabilization Unit	THE CENTERS	Marion	LICENSED	12		12	
Crisis Stabilization Unit	THE JEROME GOLDEN CENTER FOR BEHAVIORAL HEALTH	Palm Beach	LICENSED	10			10
SRT	APALACHEE CENTER	Leon	LICENSED	4	4		
SRT	ASPIRE HEALTH PARTNERS	Orange	LICENSED	29	29		
SRT	CITRUS HEALTH NETWORK	Broward	LICENSED	28	28		
SRT	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	20	20		
SRT	PEACE RIVER CENTER	Polk	LICENSED	30	30		

Appendix 6

Mobile Crisis Teams Statewide

Northwest Region

- Youth Mobile Crisis Team- Duval- Child Guidance Center 904-448-4700 x308

Northeast Region

- None

SunCoast Region

- Mental Health Center – 819-239-8064 – Hillsborough County
- Peace River Center – 269-519-0575 – Polk County
- Manatee Glens – 941-782-4299 – Manatee County

Southeast Region

- New Horizons: Catchment area is the Treasure Coast & Okeechobee (St. Lucie, Martin, Indian River, & Okeechobee). Not West Palm Beach. Andrea Gates- 772-672-8476. Also, the direct number for our Mobile Crisis Response Team is 772-672-8470.
- South County Mental Health Center: Karyn Green (561) 637-1001 - Palm Beach Area (Adults and Children)
- The Jerome Golden Center : Donna Harris (561) 383-5841 - West Palm Beach Area (Children and Adults)
- Henderson Youth Emergency Services (YES): Ben Galloso (954) 713-5100 Ext 2402 - Broward County Area- (Children)
- Henderson Mobile Crisis Response Team: Elizabeth Rosonow (954)463-0911 - Broward County Area (Adults).

Southern Region

- Banyan Mobile Crisis Team, (305)774-3616 &(305)774-3617, serving Miami-Dade County

Central Region

- Mobile Crisis Team for Circuit 18 (Brevard)only 321-632-2737

11/30/21
Meeting Date

Children, Family, Elders
Committee

The Florida Senate
APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

704
Bill Number or Topic

Amendment Barcode (if applicable)

Name Natalie Kelly

Phone 850-895-1313

Address 122 S Calhoun St.
Street

Email natalie@flmanagingentities.com

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: FL Association of Managing Entities

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

Lowery, Nikki

From: Cox, Ryan
Sent: Wednesday, December 1, 2021 10:22 AM
To: Lowery, Nikki
Subject: FW: Sen Albritton Votes

Sincerely,

Ryan C. Cox
Staff Director
Senate Committee on Children, Families, and Elder Affairs
(850) 487-5340

From: Liebert, Andrew <Liebert.Andrew@flsenate.gov>
Sent: Wednesday, December 1, 2021 10:20 AM
To: Cox, Ryan <Cox.Ryan@flsenate.gov>
Cc: Hinchee, John <Hinchee.John@flsenate.gov>
Subject: Sen Albritton Votes

Ryan,

Please show Sen. Albritton voting in the affirmative on the following bills from the meeting yesterday:

SPB 7008
SPB 7010
SB 282
SB 294
SB 704

Let me know if you need anything else. Have a great day.

Best regards,

Andrew Liebert
Legislative Aide to Senator Ben Albritton
Senate District 26
150 North Central Avenue
Bartow, Florida 33830
850-487-5026 – Office
239-595-5990 – Cell

By Senator Albritton

26-00653B-22 2022764__

A bill to be entitled

An act relating to the Step Into Success internship program; creating s. 409.1455, F.S.; providing a short title; establishing the Step Into Success internship program within the Department of Children and Families for eligible foster youth; requiring the program to include qualified designated personnel who are responsible for specified services; requiring that eligible foster youth receive priority consideration for certain internship positions; defining terms; requiring the department to establish an internship program by a specified date; requiring the department to designate and ensure sufficient qualified staff to implement and maintain the program; requiring the department to prepare written educational and training materials by a specified date and update the materials at least annually; requiring the department to provide training and written materials to designated personnel; requiring the department to provide certain written materials to foster youth; requiring lead agencies to ensure such materials are provided to subcontracted providers; requiring the department to advertise and promote the program; requiring the department to provide specified training to foster youth; requiring such training to be provided in addition to other specified training; authorizing the development of such training by or in collaboration with specified entities; providing construction; requiring the department to develop and provide

26-00653B-22 2022764__

trauma-informed training to mentors; requiring the department to provide assistance with the program's administrative and procedural requirements to interested foster youth; requiring the department to publicize internship opportunities and inform foster youth of where to locate the information; requiring the department to assess the career interests of foster youth; requiring the department to ensure internships comply with the Fair Labor Standards Act; requiring the department to collaborate with specified entities to establish a system by a specified date for secondary institutions to award college credits; requiring the department to conduct follow-up interviews with participating foster youth within a specified timeframe and for a specified purpose; requiring the department to submit data from such interviews by a specified date annually for inclusion in a specified report; requiring the department to gather and compile feedback from mentors assigned to participating foster youth or personnel from participating agencies for a specified purpose; requiring the department to submit compiled mentor feedback by a specified date annually for inclusion in a specified report; requiring the department to collaborate with the Florida Institute of Child Welfare in preparation of an annual report; requiring approved agencies to provide and monthly update a list of open employment opportunities for which eligible foster youth may apply; requiring approved agencies to

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

offer foster youth priority consideration under certain circumstances; requiring approved agencies to recruit mentors to work with participating foster youth employed through the program; providing requirements for such mentors; specifying payment procedures and requirements for mentors; requiring approved agencies to implement certain procedures before discharging foster youth; requiring approved agencies to provide feedback and collaborate in preparation of a specified report; limiting the timeframe for foster youth participation in the internship program; authorizing the continued employment of foster youth under certain conditions; specifying conditions of employment for foster youth as interns; requiring a foster youth to meet eligibility requirements at the time of applying for an internship position; requiring foster youth to complete specified training within certain timeframes; authorizing the department or designated lead agencies or subcontracted providers to determine if an interested foster youth needs to complete training before applying; requiring that foster youth be classified as other-personal-services employees; specifying prerequisite conditions for discharging a foster youth intern; limiting the number of hours per week a foster youth may work; requiring foster youth to spend certain stipend funds for specific purposes and comply with certain dress code requirements; applying employment protections to foster youth

employed through the internship program; excluding compensation earned under the internship program from the definition of earned income for calculating economic self-sufficiency benefits; specifying requirements and conditions for foster youth to earn college credit for work performed in the internship program; granting postsecondary educational institutions with discretion to determine administrative compliance requirements; requiring approved agencies to cooperate with postsecondary educational institutions to provide specified information; requiring the Florida Institute for Child Welfare to submit an annual report to the Governor and the Legislature within a certain timeframe; providing requirements for the report; requiring the department and approved agencies to adopt rules; amending s. 414.56, F.S.; revising the duties of the Office of Continuing Care to include establishing and operating an internship program; providing appropriations; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 409.1455, Florida Statutes, is created to read:

409.1455 Internship program for foster youth.—

(1) SHORT TITLE.—This section may be cited as the "Step Into Success Act."

(2) CREATION.—There is established the Step Into Success

internship program to be administered by the department for eligible foster youth to develop essential workforce and professional skills in furtherance of their careers, to transition from the custody of the department to independent living, and to become best prepared for an independent and successful future. The establishment of this program must include qualified designated personnel whose responsibilities are to provide the required services to approved agency liaison personnel and eligible foster youth in accordance with this section. An eligible foster youth must receive priority consideration for any internship positions as provided under this section.

(3) DEFINITIONS.—For purposes of this section, the term:

(a) "Approved agency" means one of the following agencies that may participate in the internship program by employing eligible foster youth:

1. The Department of Children and Families;

2. The Department of Health;

3. The Agency for Health Care Administration;

4. The Department of Education;

5. The Department of Environmental Protection;

6. The Fish and Wildlife Conservation Commission; and

7. The Office of the State Fire Marshal within the Department of Financial Services.

(b) "Community-based care lead agency" has the same meaning as in s. 409.986(3)(d).

(c) "Foster youth" means an individual older than 16 years of age but younger than 26 years of age who is currently or was previously placed in foster care within this state.

(d) "Priority consideration" means the approved agency must invite a foster youth who is eligible to participate in the internship program to be interviewed for any position for which he or she meets the minimum qualifications.

(4) PROGRAM REQUIREMENTS OF THE DEPARTMENT.—The department shall establish an internship program for foster youth which begins operations on or before January 1, 2023, and complies with all of the following requirements:

(a) Designate and ensure that there is sufficient qualified staff to implement and maintain operation of the internship program.

(b) By November 1, 2022, prepare written educational and training materials for foster youth, including a toolkit to explain the internship program process, resources to assist in participating in the internship and entering the professional workforce, and guidance on securing an internship position and update the material thereafter at least once annually. Resources may include, but are not limited to, workshops and materials to assist with preparing resumes and staff assistance with securing internship positions.

(c) Provide all relevant training and written materials on the internship program to designated personnel within the approved agencies and any other relevant tools to such agencies to ensure successful participation in the program.

(d) Provide written materials to foster youth to ensure that all such youth are informed of the requirements for participating in the program and the contact information for the program office. All community-based care lead agencies shall ensure that any subcontracted providers that directly serve

youth are also provided with the training and written materials.

(e) Advertise and promote the availability of the internship program to engage as many eligible foster youths as possible.

(f) Provide to eligible foster youth a minimum of 2 hours of training relating to interview skills and a minimum of 4 hours of training relating to professional and leadership development skills that are relevant to performing the functions required of the positions offered by participating approved agencies. The training required in this paragraph must be provided in addition to any other life skills or employment training required by law and may be developed or administered by the department, community-based care lead agencies, or the lead agencies' subcontracted providers or through collaboration with the approved agencies, colleges or universities, or non-profit organizations in the community that have workforce training resources. This paragraph may not be construed to limit the number of hours of training offered in which a foster youth may participate.

(g) Develop and provide a minimum of 1 hour of trauma-informed training to mentors who serve under this section to ensure that they have the skills necessary to engage with participating foster youth.

(h) Provide assistance with the program's administrative and procedural requirements to foster youth interested in participating in the internship program, including, but not limited to, identifying and monitoring internship opportunities offered by approved agencies, being knowledgeable of the training and skills needed to match eligible foster youth to

appropriate roles offered by approved agencies, and assisting eligible foster youth with applying for employment positions in which they meet the minimum required qualifications.

(i) Publicize specific opportunities for internship positions offered by approved agencies in an easily accessible manner and inform foster youth who may be eligible for the program of where to locate such information.

(j) Assess each foster youth's career interests and determine the most appropriate internship opportunities based on his or her expressed interests.

(k) Ensure that internships under this section comply with the Fair Labor Standards Act.

(l) By November 1, 2022, facilitate and work with the Department of Education, the Board of Governors of the State University System, the Independent Colleges and Universities of Florida, the Commission for Independent Education, and approved agencies to establish a system for secondary institutions to award college credit toward a degree for internship positions held by foster youth through the internship program.

(m) Conduct follow-up interviews with participating foster youth within 3 months after their employment start date to ensure participants transition successfully into the work environment and to gather feedback on how to improve the experience for future participants. Such data must be submitted to the Institute for Child Welfare by August 1, 2023, and by August 1 annually thereafter for inclusion in the report required under subsection (8).

(n) Gather and compile feedback from mentors assigned to participating foster youth or from other personnel who are

employed by participating agencies on how to improve the experience for both foster youth participants and the approved agencies that participate in the program. Such data must be submitted to the Institute for Child Welfare by August 1, 2023, and by August 1 annually thereafter for inclusion in the report required under subsection (8).

(o) Collaborate with the Florida Institute of Child Welfare to provide any requested information necessary to prepare each annual report required under subsection (8).

(5) PROGRAM REQUIREMENTS OF APPROVED AGENCIES.—Each approved agency shall:

(a) Provide the department, or the community-based care lead agencies or the lead agencies' subcontracted providers, with a list, updated at least monthly, of open employment opportunities for which an eligible foster youth may apply to seek employment through the internship program.

(b) Offer priority consideration, including an interview, to any eligible foster youth who applies for an open other-personal-services position pursuant to this section, provided he or she meets all the minimum qualifications for employment in such position.

(c) Recruit employees within approved agencies to serve as mentors for foster youth employed with such agencies through the internship program.

1. To serve as a mentor, employees must:

a. Have worked for the approved agency for a minimum of 1 year;

b. Have experience relevant to the employment responsibilities of the intern;

c. Complete a minimum of 1 hour of trauma-informed training to gain skills critical for successfully engaging youth who have been involved in the foster care system; and

d. Pass a level 2 background screening as provided in s. 435.04 if the employee will be assigned to a foster youth who is younger than 18 years old and if the employee has not passed such a screening within the previous 3 years or is not exempt from such requirement pursuant to s. 435.07. An employee required to pass a level 2 background screening pursuant to this sub-subparagraph must submit a full set of his or her fingerprints to his or her employing approved agency. The approved agency shall forward the fingerprints to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing. The department shall pay the fees for state and federal fingerprint processing. The fee per each name submitted for processing shall be set at the same amount as prescribed in s. 943.053(3)(e); however, if any exceptions in that paragraph for a reduced fee are applicable, the department may pay the reduced fee under such circumstances.

2. Employees who serve as mentors for a minimum of 6 consecutive months are eligible for a maximum payment of $1,000 per intern per fiscal year, to be issued as follows:

a. At the conclusion of the first 6 consecutive months of service, $500.

b. At the conclusion of an additional 6 consecutive months of service, $500.

3. An employee may serve as a mentor for a maximum of three

interns at one time, but may not receive more than $3,000 in compensation per fiscal year for serving as a mentor. Any time spent serving as a mentor to an intern under this section counts toward the required minimum service to be eligible for payments pursuant to subparagraph 2.

(d) Engage an intern's assigned mentor and the approved agency's internship program liaison and, if applicable, document the intern's failure to comply with a corrective action plan after being given a reasonable opportunity to do so before discharging a foster youth employed pursuant to this section.

(e) Provide relevant feedback to the department at least annually for the department to comply with paragraphs (4)(m) and (n).

(f) Collaborate with the Florida Institute of Child Welfare to provide any requested information necessary to prepare each annual report required under subsection (8).

(6) TIME LIMITATIONS FOR PARTICIPATION.—A foster youth who obtains employment with an approved agency may participate in the internship program for no more than 1 year from his or her start date of employment as an other-personal-services employee with an approved agency pursuant to this section. A foster youth may be employed as an intern under the internship program by more than one approved agency, but may not be employed by more than one approved agency at the same time. However, an approved agency may extend the employment of a foster youth beyond the 1-year internship program in his or her capacity as an other-personal-services employee or may hire the foster youth as a full-time employee, but the extension of employment or hiring of a foster youth may not be as an intern pursuant to this section.

(7) CONDITIONS OF EMPLOYMENT.—As conditions of employment as an intern under the internship program, a foster youth shall be subject to all of the following:

(a) A participant must meet the definition of foster youth as defined in paragraph (3)(c) at the time such youth applies for an internship position with an approved agency.

(b) A foster youth must complete the minimum training requirements provided in paragraph (4)(f) related to interviewing before an interview with an approved agency and must complete all other training before commencement of work within the approved agency. The department, or, if designated, the community-based care lead agencies or the lead agencies' subcontracted providers, may determine on a case-by-case basis if an eligible foster youth needs to complete training before he or she applies for an internship position.

(c) If offered employment as an intern, a foster youth must be classified as an other-personal-services employee. Foster youth who have accepted employment with an approved agency pursuant to this section may be discharged after the approved agency has engaged the intern's assigned mentor and the approved agency's internship program staff to assist the intern and has documented the intern's failure to comply with a corrective action plan after being given a reasonable opportunity to do so.

(d) A foster youth may work a maximum of 20 hours per week.

(e) A foster youth shall spend all stipend funds received for the specific purpose of purchasing business attire or clothing that is in compliance with the dress code requirements of the approved agency with which the foster youth is employed. Notwithstanding any limitation on funds provided to purchase

clothing, foster youth shall comply with any dress code requirements of the approved agency with which he or she is employed.

(f) A foster youth shall be afforded the employee protections of all relevant and applicable federal and state laws, including compensation at minimum wage for any work performed. Compensation earned pursuant to employment gained through the internship program may not be considered earned income for purposes of computing eligibility for federal or state benefits, including, but not limited to, the Supplemental Nutrition Assistance Program, a housing choice assistance voucher program, the Temporary Cash Assistance Program, the Medicaid program, or the school readiness program.

(g) A foster youth may, at the discretion of a postsecondary institution within this state in which such youth is enrolled, earn college credits toward a degree for work performed as an intern under the internship program. College credits earned for work performed under the internship program may be in addition to any compensation earned for the same work performed under the internship program and may be awarded for completion of the whole or any part of the internship program. An institution has the discretion to determine whether the foster youth must comply with administrative requirements to be eligible for college credit, but must treat such positions the same as if a student obtained employment through a means other than the internship program. Approved agencies shall cooperate with postsecondary educational institutions to provide any information about internship positions which is necessary to enable the institutions to determine whether to grant the

participating foster youth credit toward his or her degree.

(8) REPORTS.—By October 1, 2023, and annually thereafter, the Florida Institute for Child Welfare shall submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which evaluates the internship program, including, but not limited to, whether the program is in compliance with this section; the outcomes of foster youth who obtain employment through the internship program; a summary of the feedback received pursuant to paragraphs (4)(m) and (n) from participating foster youth and mentors from approved agencies who have participated in the program; and recommendations, if any, for actions necessary to improve the effectiveness and outcomes of the program.

(9) RULEMAKING.—The department and approved agencies shall adopt rules to implement this section.

Section 2. Subsection (5) is added to section 414.56, Florida Statutes, to read:

414.56 Office of Continuing Care.—The department shall establish an Office of Continuing Care to ensure young adults who age out of the foster care system between 18 and 21 years of age, or 22 years of age with a documented disability, have a point of contact until the young adult reaches the age of 26 in order to receive ongoing support and care coordination needed to achieve self-sufficiency. Duties of the office include, but are not limited to:

(5) Establishing and operating an internship program for foster youth and complying with the requirements of s. 409.1455(4).

Section 3. For the 2022-2023 fiscal year, the sums of

$1,292,378 in recurring funds and $350,376 in nonrecurring funds are appropriated from the General Revenue Fund to the Department of Children and Families to implement this act.

Section 4. This act shall take effect July 1, 2022.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

11-30-2021
Meeting Date

Children Fam Affairs
Committee

SB 764
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dawn Steward

Phone 407-645-0273

Address 1747 Orlando Central Parkway
Street

Email stu2130@aol.com

Orlando Fl 32809
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:
FLBTA

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

By Senator Ausley

3-00735-22 2022792__

A bill to be entitled

An act relating to children and young adults in out-of-home care; amending s. 39.4085, F.S.; revising legislative findings and providing legislative intent; providing construction; specifying the rights of, rather than goals for, children and young adults in out-of-home care; providing the roles and responsibilities of the Department of Children and Families, community-based care lead agencies, and other agency staff; authorizing and encouraging district school boards to establish certain educational programs; requiring the department to adopt rules; creating s. 39.4088, F.S.; designating a children's ombudsman as an autonomous entity within the department; providing responsibilities of the ombudsman; requiring the ombudsman to collect and post on the department's website certain data; requiring the ombudsman, in consultation with the department and other specified entities and by a specified date, to develop standardized information explaining the rights of children and young adults placed in out-of-home care; requiring the department, community-based care lead agencies, and agency staff to use the information provided by the ombudsman in carrying out specified responsibilities; requiring the department to establish a statewide toll-free telephone number for the ombudsman; requiring the department to adopt rules; providing an effective date.

3-00735-22 2022792__

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 39.4085, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 39.4085, F.S., for present text.)

39.4085 Foster Children's Bill of Rights.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that the design and delivery of child welfare services should be directed by the principle that the health and safety of children, including freedom from abuse, abandonment, or neglect, is of paramount concern.

(b) The Legislature also finds that emotional trauma, separation from family, frequent changes in placement, and frequent changes in school enrollment, as well as dependency upon the state to make decisions regarding current and future life options, may contribute to feelings of limited control over life circumstances in children and young adults in out-of-home care.

(c) Therefore, it is the intent of the Legislature to empower these children and young adults by helping them become better informed of their rights so they can become stronger self-advocates.

(2) CONSTRUCTION.—This section may not be used for any purpose in any civil or administrative action and does not expand or limit any rights or remedies provided under any other law.

(3) BILL OF RIGHTS.—Except as otherwise provided in this chapter, the rights of a child or young adult placed in out-of-

home care are:

(a) To live in a safe, healthful, and comfortable home where he or she is treated with respect and provided with healthy food, appropriate clothing, and adequate storage space for personal use and where the caregiver is aware of and understands the child's or young adult's history, needs, and risk factors and respects his or her preferences for attending religious services and activities.

(b) To be free from physical, sexual, emotional, or other abuse or corporal punishment. This includes the child's or young adult's right to be placed away from other children or young adults who are known to pose a threat of harm.

(c) To receive medical, dental, vision, and mental health services as needed; to be free of the administration of psychotropic medication or chemical substances unless the administration of such medication or substances is authorized by a parent or the court; and to be free from being confined in any room, building, or facility unless placed by court order in a residential treatment center.

(d) To be able to have contact and visitation with his or her parents, other family members, and fictive kin and to be placed with his or her siblings or, if not placed with his or her siblings, to have frequent visitation and ongoing contact with his or her siblings, unless prohibited by court order; and to be provided with the location of and contact information for siblings and to have the court consider the appropriateness of continued communication with siblings who have left care.

(e) To be able to contact the children's ombudsman, as described in s. 39.4088, regarding violations of rights; to

speak to the ombudsman confidentially; and to be free from threats or punishment for making complaints.

(f) To maintain a bank account, to work, and to manage personal income, including any allowance, consistent with his or her age and developmental level, unless prohibited by the case plan, and to be informed about any funds being held in the master trust on behalf of the child or young adult.

(g) To attend school and participate in extracurricular, cultural, and personal enrichment activities consistent with his or her age and developmental level and to have social contact with people outside of the foster care system, such as teachers, church members, mentors, and friends.

(h) To attend all court hearings and address the court.

(i) To have fair and equal access to all available services, placement, care, treatment, and benefits and to be free from discrimination on the basis of race, national origin, color, religion, sex, mental or physical disability, age, or pregnancy.

(j) If he or she is 14 years of age or older or, if younger, is of an appropriate age and capacity, to participate in creating and reviewing his or her case plan and receive information about his or her out-of-home placement and case plan, including being told of changes to the plan, and to have the ability to object to provisions of the case plan; and, if he or she is 16 years of age or older, to provide assistance in developing a transition plan.

(k) To participate in activities that will help develop the necessary life skills to make the transition to independent living and self-sufficiency as adults; and, for older youth, to

be informed of available independent living services and community resources and how to apply for such services and access resources.

(l) To be free from removal from an out-of-home placement by the department or a community-based care lead agency unless the caregiver becomes unable to care for the child, the child achieves permanency, or the move is otherwise in the child's best interest and, if removed, to a transition under s. 39.4023 which respects his or her relationships and personal belongings.

(m) To have a guardian ad litem appointed to represent his or her best interests and, if appropriate, to have an attorney appointed to represent his or her legal interests.

(4) ROLES AND RESPONSIBILITIES OF THE DEPARTMENT, COMMUNITY-BASED CARE LEAD AGENCIES, AND OTHER AGENCY STAFF; AUTHORITY OF DISTRICT SCHOOL BOARDS.—

(a) The department shall operate with the understanding that the rights of children in out-of-home care are critical to their safety, permanency, and well-being. The department shall work with all stakeholders to help such children become knowledgeable about their rights.

(b) The case manager or other agency staff shall provide verbal and written instructions to a child entering out-of-home care to educate the child on identifying and reporting abuse, abandonment, or neglect and shall explain and provide a copy of the Bill of Rights established in subsection (3). The verbal and written instructions and explanation must use words and phrasing that the child can understand and must occur in a manner that is most effective for that child. The written instructions and Bill of Rights are required only if the child is of a sufficient age

and understanding to receive such instructions and rights. The case manager or other agency staff shall afford each child the opportunity to ask questions about his or her rights and how to identify and report abuse, abandonment, or neglect. The case manager or other agency staff shall document in court reports and case notes the date that such instructions and the Bill of Rights were provided to the child. The case manager or other agency staff must review the information with the child every 6 months and upon every placement change until the child leaves shelter or foster care.

(c) District school boards are authorized and encouraged to establish educational programs for students ages 5 through 18 years relating to identifying and reporting abuse, abandonment, or neglect and the effects of such abuse, abandonment, or neglect on a child. The district school boards may provide such programs in conjunction with the youth mental health awareness and assistance training program required under s. 1012.584, any other mental health education program offered by the school district, or any of the educational instruction required under s. 1003.42(2).

(5) RULEMAKING.—The department shall adopt rules to implement this section.

Section 2. Section 39.4088, Florida Statutes, is created to read:

39.4088 Children's ombudsman.—The children's ombudsman shall serve as an autonomous entity within the department for the purpose of providing children and young adults placed in out-of-home care with a means to resolve issues related to their care, placement, or services without fear of retribution. The

ombudsman must be given access to any record of a state or local agency which is necessary to carry out his or her responsibilities and may meet or communicate with any child or young adult in the child or young adult's placement.

(1) GENERAL RESPONSIBILITIES OF THE OMBUDSMAN.—The ombudsman shall:

(a) Disseminate information on the rights of children and young adults in out-of-home care established under s. 39.4085 and the services provided by the ombudsman.

(b) Attempt to resolve complaints informally.

(c) Conduct whatever investigation he or she determines is necessary to resolve a complaint.

(d) Update the complainant on the progress of the investigation and notify the complainant of the final outcome.

The ombudsman may not investigate, challenge, or overturn a court order or decision.

(2) DATA COLLECTION.—The ombudsman shall:

(a) Document the number, source, origin, location, and nature of all complaints.

(b) Compile all data collected over the course of the year, including, but not limited to, the number of contacts to the children's ombudsman toll-free telephone number; the number of complaints made, including the type and source of those complaints; the number of investigations performed by the ombudsman; the trends and issues that arose in the course of investigating complaints; the number of referrals made; and the number of pending complaints.

(c) Post the compiled data on the department's website.

(3) DEVELOPMENT AND DISSEMINATION OF INFORMATION.—

(a) By January 1, 2023, the ombudsman, in consultation with the department, children's advocacy and support groups, and children and young adults in, or persons previously in, out-of-home care, shall develop standardized information explaining the rights granted under s. 39.4085. The information must be age-appropriate, reviewed and updated by the ombudsman annually, and made available through a variety of formats.

(b) The department, community-based care lead agencies, and other agency staff must use the information provided by the ombudsman to carry out their responsibilities to inform children and young adults in out-of-home care of their rights pursuant to the duties established under this section.

(c) The department shall establish a toll-free telephone number for the children's ombudsman and post the number on the homepage of the department's website.

(4) RULEMAKING.—The department shall adopt rules to implement this section.

Section 3. This act shall take effect October 1, 2022.

2021 AGENCY LEGISLATIVE BILL ANALYSIS
Department of Children and Families

BILL INFORMATION	
BILL NUMBER:	SB 1100
BILL TITLE:	**Child Welfare (Foster Children Bill of Rights)**
BILL SPONSOR:	Senator Book
EFFECTIVE DATE:	October 1, 2021

COMMITTEES OF REFERENCE
1) Children, Families, and Elder Affairs
2) Appropriations Subcommittee on Health and Human Services
3) Appropriations
4)
5)

CURRENT COMMITTEE
Children, Families, and Elder Affairs

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

IDENTICAL BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

PREVIOUS LEGISLATION	
BILL NUMBER:	2020: SB 496, HB 1045 2019: SB 646, HB 823
SPONSOR:	2020: Sen. Book, Rep. Diamond 2019: Sen. Book, Rep. Ausley
YEAR:	2020, 2019
LAST ACTION:	2020: SB 496 – Died in Appropriations Subcom. HHS. HB 1045 – Died in Children, Families and Seniors Subcom. 2019: SB 646 - Died in Appropriations Subcommittee on Health and Human Services HB 823 - Died in Health and Human Services Committee

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 12, 2021 For further information, please contact John Paul Fiore at (850)488-9410.
LEAD AGENCY ANALYST:	Vanessa Snoddy, OCW Cal Walton, III, OCW
ADDITIONAL ANALYST(S):	Heather Rosenberg – Children's Ombudsman Teanna Houston, OCW Monique McCaskill, OCW
LEGAL ANALYST:	Stefanie Camfield, OGC

FISCAL ANALYST:	Sue Zwirz, Budget

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

This bill amends nine sections of Florida Statutes (F.S.) and creates one section, specifying the rights of children and young adults in out-of-home care. It also requires the Florida Children's Ombudsman to serve as an autonomous entity within the Department of Children and Families (Department) for certain purposes. A case plan is required to be developed in a face-to-face conference with a caregiver and child when appropriate. A caseworker is required to provide information about subsidies provided by early learning coalitions to caregivers of certain children. Lastly, the bill provides additional requirements for the licensure and operation of family foster homes, residential child-caring agencies, and child-placing agencies.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Section 1., s. 39.4085, F.S., - Foster Children's Bill of Rights. -

Public Law 113-183, Preventing Sex Trafficking and Strengthening Families Act, approved September 29, 2014, amended Section 475A of the Social Security Act, requires that the case plan for children in foster care beginning at age 14, has a document that describes the rights of the child with respect to safety, exploitation, education, health, visitation, and court participation, along with the right to be provided certain specific documents such as copies of consumer credit reports. Children are to sign an acknowledgement that they have been provided a copy of their rights and other relevant required documents at such time.

Section 39.4085, F.S., declares the legislative intent for the design and delivery of child welfare services for dependent children, establishing 23 "goals," guided by the principle of achieving safety and wellbeing for children in shelter or foster care. This section of the statutes further specifies that dependent children receive a copy of this section and that the goals are fully explained when they are placed in the custody of the Department. The language is explicit that the intent is to create goals, not rights, and that no person shall have a cause of action against the state or any of its subdivisions, agencies, contractors, subcontractors, or agents, based upon the adoption of or failure to provide adequate funding for the achievement of the goals by the Legislature. The goals are synchronized with various requirements found in Chapters 39 and 409, F.S., (see additional comments) to ensure compliance.

Section 409.145, F.S. empowers all caregivers of children in foster care to provide quality parenting, including approving or disproving a children's participation in activities based on the caregiver's assessment. It outlines the roles and responsibilities of caregivers defines reasonable prudent parent and gives the application of standard of care.

Section 409.1451, F.S, provides that it is the Legislature's intent for young adults who choose to participate in road to independence program receive the skills, education, and support necessary to become self-sufficient and leave foster care with a lifelong connection to a supportive adult through the Road-to-Independence Program, either through postsecondary education services and support (PESS) or aftercare services.

Currently, the Department provides preservice and in-service training to child protective investigators, case managers, and other child welfare professionals related to the goals established in s. 39.4085, F.S. In addition, the Department published a universal document sometime in 2007-2008 titled "Rights and Expectations for Children and Youth in Shelter or Foster Care" in collaboration with Florida Youth SHINE. The brochure has not been updated since that time; however, community-based care (CBCs) lead agencies are contracted to administer this section of the law. They are provided the funds and flexibility to develop and enhance training and learning tools to ensure the children and young adults understand the services and supports that they are entitled to.

Throughout sections of the statutes, Florida Administrative Code (F.A.C.), and Children and Families Operating Procedures, federal requirements with respect to a child's right to safety, exploitation, education, health, visitation, court participation, attending religious services and activities, prevention from misdiagnosis for purposes of placement in a higher level of care, and access to certain documents are addressed through child welfare professional and caregiver mandated activities. Additionally, Florida's child welfare policies are more detailed with regard to specific actions and when those actions should occur.

Section 2., s. 39.4088, F.S., - Florida Children's Ombudsman. –
The Department created an ombudsman position in September of 2016 with the intent to listen and be a voice for children and youth involved in the child welfare system. The ombudsman receives complaints about placement, care, and services, and assists in mediating concerns. The ombudsman is a resource to identify and explain relevant polices or procedures to children, young adults, and their caregivers. In addition, in September of 2016, the Department established a toll-free number to be used for children in the system who have concerns, questions, or complaints.

Section 3., s. 39.6011, F.S., - Case plan development. –
Section 39.6011, F.S., outlines that a case plan be developed in a face-to-face conference with the parent of the child, any court-appointed Guardian ad Litem, and if appropriate, the child, and temporary custodian of the child. All parties including caregivers are required to be notified timely of meetings, and hearings. As a responsibility of the Department, CBCs and other agency staff must request active participation in developing the case plan for the child which includes the caregiver as outlined in s. 409.145, F.S.

Section 39.6011(3), F.S., further outlines that before all parties sign the case plan, the Department shall explain provisions of the plan to all persons involved in its implementation, which include the child if appropriate.

In addition, two Department informational memos were published in 2015, providing updated federal requirements, pursuant to Public Law 113-183. The new provisions specific to children 14 years of age and their right to choose up to two members of the case planning team who are not foster parents or case managers to assist in the development stages of the case plan were reflected in the memos. The memos also captured the requirements to obtain credit reports from each of the three reporting agencies, Transunion, Equifax, and Experian. The results are to be provided to youth and any discrepancies must be addressed. To further monitor credit reporting requirements, Florida Safe Families Network (FSFN) received enhancements to capture data on the credit check for youth in out-of-home care with the release on January 4, 2019.

Effective July 29, 2019, Rule 65C-28.009, F.A.C., titled "Transition to Adulthood", was substantially rewritten to incorporate the information previously published in the Department's memos with regard to specific case planning for children 14 years of age and older, child's rights, transition planning, credit reporting requirements, and a multitude of other special requirements for children 13 years of age and older.

Section 4., s. 39.604, F.S., - Rilya Wilson Act; short title; legislative intent; childcare; early education; preschool. –
Section 39.604(2), F.S., the Rilya Wilson Act, addresses children in care being provided age-appropriate education to help ameliorate the negative consequences of abuse, neglect, or abandonment and for educational stability. The Legislature recognizes that children who are in the care of the state due to abuse, neglect, or abandonment are at increased risk of poor school performance and other behavioral and social problems.

Section 39.604(3), F.S., mandates the attendance of children from birth to school age if they are enrolled in an early education or childcare program. Currently, child protective investigators and case managers provide referrals to local early learning coalitions (ELC) for caregivers. Caregivers are informed of the additional cost, if any, by the ELC at their appointment.

Section 5., s. 39.701, F.S., - Judicial review. –
Section 39.701, F.S., addresses the general provisions of the judicial review and the requirements of the review hearings relevant to proceedings relating to dependent children. Before every judicial review hearing, the Department shares a written social study report to the court that includes specific information pertaining to the child as outlined in this section.

Section 6., s. 409.1415, F.S., - PARENTING PARTNERSHIPS. –
Section 409.145, F.S., requires the Department to coordinate a system of care that empowers caregivers for children in foster care to provide quality parenting and exercise a "reasonable and prudent parent standard" when approving or disapproving a child's participation in activities. This section highlights seven goals, in addition to goals established in s. 39.4085, F.S., outlining roles and responsibilities of caregivers, the Department, CBCs, and other agency staff relevant to ensuring the appropriate care of children in foster care.

Section 7., s. 409.175, F.S., Licensure of family foster homes, residential child-caring agencies, and child placing agencies; public records exemption. –
Section 409.175, F.S., requires licensure of family foster homes, residential child caring agencies, and child placing agencies. This section outlines the general training requirements for foster parents and their responsibilities as it pertains to the care of children, and to safeguard the legal rights of children served. This section also details the requirements for conditions of the home environment for all licensed homes and facilities.

Section 8., s. 409.1753, F.S., - Foster care; duties. –
Section 409.1753, F.S., requires the Department to ensure, within each district, that each foster home is given a telephone number to call during normal working hours whenever immediate assistance is needed and the child's caseworker is unavailable. The number must be staffed and answered by individuals possessing the knowledge and authority necessary to assist foster parents.

Section 9., s. 409.988, F.S., - Lead agency duties; general provisions. –
Section 409.988, F.S., outlines CBC's duties and general provisions pertaining to serving children in the child welfare system or children at risk of entering the system. The provisions include that each CBC shall be licensed as a child-caring or child-placing agency. Rule 65C-45.018(5), F.A.C., specifies that the supervising agency shall conduct an exit interview with licensed out-of-home caregivers who are closing voluntarily. This interview is an opportunity to explore any recommendations for improvement that the licensed out-of-home caregiver may be willing to share.

Section 10., s. 39.6013, - Case plan amendments. –
Section 39.6013, F.S., outlines requirements for amending the case plan. Copies of the amended plan must be immediately given to the persons identified in the case plan development.

2. EFFECT OF THE BILL:

Section 1., s. 39.4085, F.S., - Foster Children's Bill of Rights. -
This section amends s. 39.4085, F.S., establishing "*The Foster Children's Bill of Rights" (Bill of Rights)*. Section 39.4085(1), F.S., outlines legislative findings and intent. The findings include the challenges children in out-of-home care and young adults leaving out-of-home care face developmentally, psychosocially, and economically as compared to their peers outside of the child welfare system. The Legislature also recognizes that children and young adults in out-of-home care have additional rights that they should be aware of to better advocate for themselves. It is the intent of the Legislature to empower these children and young adults to become self-advocates.

Section 39.4085(2), F.S., establishes the *rights* of children and young adults in out-of-home care, replacing the existing *goals* language. The rewording of this section expands the intent of the provisions to all children and young adults in out-of-home care, not just children in the legal custody of the Department or in licensed foster care and is a more prescriptive interpretation of the federal requirements. The Bill of Rights specifies the legal entitlement of 14 distinct privileges that are critical to the children and young adult's safety, permanence, well-being, and empowerment as self-advocates.

The bill of rights entitles the youth to participate in extracurricular, cultural, and personal enrichment activities consistent with his or her age. This conflicts with s. 409.145, F.S., which empowers the caregiver to use prudent parenting when making decision to approve or disapprove the youth's participation in activities.

Young adults, ages 18 and older, are referred to as being in out-of-home care in this section. This conflicts with s. 39.6251(4)(a), F.S., which requires young adults ages 18 to 21, or age 22 if the young has a documented disability, to reside in a supervised living environment.

Section 39.4085(3), F.S., outlines the roles and responsibilities of the Department including development of training, related to the rights of children and young adults in out-of-home care. All child protective investigators, case managers, and other appropriate staff must complete the training annually. The Department is required to provide a copy of the Bill of Rights to all children and young adults entering out-of-home care, to provide an explanation of the Bill of Rights in language that is appropriate for the child. The caseworker or other appropriate agency staff shall document in court reports and case notes the date the Bill of Rights was reviewed in age appropriate language, and the Bill of Rights must be reviewed with the child or young adult every six months until the child or young adult leaves care. Licensed facilities that care for six or more children and young adults must post information about the rights of children and young adults in a prominent place in the facility.

Section 39.4085(4), F.S., outlines the roles and responsibilities of caregivers, including ensuring that the child or young adult in their care understands his or her rights. Also, the caregiver must assist children and young adults in their care in contacting the Florida Children's Ombudsman, if necessary.

Section 39.4085(5), F.S., requires the Department to adopt rules to implement this section.

Section 39.4085(6), F.S., addresses applicability of 39.4085, F.S., in any civil or administrative action. Outlining that this section does not expand or limit any rights or remedies provided under any other law.

Section 2., s. 39.4088, F.S., - Florida Children's Ombudsman. –
This section creates s. 39.4088, F.S., defining the ombudsmen role, outlining responsibilities, allowing the person that holds the position to have the freedom to self-govern and have access to any state or local record necessary to carry out their responsibilities. The present text provides the ombudsmen full autonomy when investigating complaints or concerns on behalf of children and young adults. The ombudsmen may not investigate, challenge, or overturn court-ordered decisions.

Section 39.4088(2), F.S., outlines the ombudsmen will also be required to collect data regarding complaints, develop standardized information, and disseminate to all stakeholders.

Section 39.4088(3), F.S., explains that the ombudsmen, in consultation with the Department and stakeholders shall develop standardized information explaining the Bill of Rights by January 1, 2022. Requires the Department, CBC, and other agency staff to use the information provided by the ombudsmen to inform children and children in out-of-home care of their rights.

Section 39.4088(4), F.S., requires the Department to establish a statewide toll-free telephone number for the ombudsman, and have it posted on the Department's website.

Section 3., s. 39.6011, F.S., - Case plan development. –
This section adds language in s. 39.6011, F.S., to require each case plan to include the following information if the child has attained 14 years of age or is otherwise of an appropriate age and capacity:

- A document that describes the rights of children in s. 39.4085, F.S., and the right to provide them with the documents pursuant to s. 39.701, F.S.;
- A signed acknowledgement by the child or young adult, or the caregiver if the child is too young or otherwise unable to sign and that the rights were explained to the child in a way that the child understands; and
- Documentation that a consumer credit report for the child was requested from at least one reputable credit reporting agency at no charge to the child, any results were provided to the child, any barriers to obtaining the credit reports were documented, details of how the Department ensured the child received assistance with interpreting the report and resolving any inaccuracies including any referrals made for assistance;
- The language also requires that if a child has reached age 14 or if younger, is of an appropriate age and capacity, the child must be consulted on the development of the case plan;
- Have an opportunity to attend a face-to-face conference;
- Have an opportunity to express a placement preference;
- Have the option to choose up to two members of the case planning team who are not foster parents or case managers to assist in the development stages. These individuals may be rejected at any time if there is good cause to believe that the individuals would not act within the best interests of the child. The child may not be included if information revealed or discussed which is of a nature that would best be presented to the child in a therapeutic setting; and
- Sign the case plan, receive an explanation of the provisions of the plan, and receive a copy of the plan.

This section also adds language to allow caregivers of the child to be part of the case plan development, if appropriate, and allows caregivers licensed as a foster home to receive a copy of the case plan.

Section 4., s. 39.604, F.S., - Rilya Wilson Act; short title; legislative intent; childcare; early education; preschool. –
This section amends s. 39.604, F.S., to add the requirement that caseworkers inform the caregiver of the amount of the subsidy provided by an ELC, that the amount may not be enough to pay the full child care program costs, and that the caregiver will be responsible for the difference. Determining the subsidy amount for all childcare and early education centers in advance and knowing the difference in subsidy and total costs will require the collaboration of the Department of Education, Office of Early Learning, and the ELCs throughout the state.

Section 5., s. 39.701, F.S., - Judicial review. –
This section amends s. 39.701, F.S., to add specific items that need to be included in the child's social study report to the court. Those items are the documentation of the Bill of Rights and the signed acknowledgement by the child or

caregiver in the event the child is too young. These same items are repeated at the special 17-year old judicial review that occurs 90 days after the child's 17th birthday. The effects are the same as referenced in Section 1.

Section 6., s. 409.1415, F.S., - PARENTING PARTNERSHIPS. –
This section amends s. 409.145, F.S., to add language to the caregiver's roles and responsibilities as follows:

- Requires foster parents to pay the difference in childcare fees that are not covered by the subsidy from ELC. This language codifies the Department's current practice;
- Requires the caregiver to ensure the child understands their rights; and
- Assists the child in contacting the Florida Children's Ombudsman, if necessary.

The caregiver is to receive any medical, dental, or psychological treatment plans and information on how to support the plan and information on how to manage any behavioral issues.

Section 7., s. 409.175, F.S., Licensure of family foster homes, residential child-caring agencies, and child placing agencies; public records exemption. –
This section amends s. 409.175, F.S., to add language to incorporate the Bill of Rights. This requirement would be in addition to current licensing provisions to safeguard the legal rights of children.

Section 8., s. 409.1753, F.S., - Foster care; duties. –
This section amends s. 409.1753, F.S., by striking language "within each district," and replacing it with "each lead agency provides each foster home with a telephone number to call for assistance when the child's caseworker is unavailable."

Section 9., s. 409.988, F.S., - Lead agency duties; general provisions. –
This section amends s. 409.988, F.S., to add specific duties for CBCs requiring the recruitment and retention of foster homes. The new language requires CBCs to:

- Develop a plan for accomplishing the recruitment and retention of foster homes;
- Use best practices;
- Submit their plans to the Department annually;
- Provide quarterly reports to the Department detailing the number of licensed foster homes and beds and occupancy rate; and
- Conduct exit interviews with foster parents who voluntarily give up their license to determine reasons and identify suggestions for how to better recruit and retain homes. Interviews must be summarized and submitted to the Department for quarterly review.

Section 10., s. 39.6013, - Case plan amendments. –
This section amends s. 39.6013, F.S., to conform a cross-reference to s. 39.6011(8)(c), F.S.

Section 11.
This section provides an effective date of October 1, 2021.

3. DOES THE LEGISLATION DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES?

If yes, explain:	Section 1. – s. 39.4085(5), F.S., requires the Department to adopt rules to implement this section. Section 2. – s. 39.4088(4), F.S., requires the Department to adopt rules to implement this section
What is the expected impact to the agency's core mission?	None
Rule(s) impacted (provide references to F.A.C., etc.):	65C-28, Out-of-Home Care, 65C-30, General Child Welfare Provisions, 65C-, 65C-45 Levels of Licensure, 65C-14 Group Care Licensing, 65C-15 Child-Placing Agencies, 65C-41, Extended Foster Care, 65C-33 Child Welfare Training and Certification, 65C-35 Psychotropic Medication for Children in Out-Home-Care,65C-43 Placement and Services for Sexually Exploited Children.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

List any known proponents and opponents:	Unknown
Provide a summary of the proponents' and opponents' positions:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL?

If yes, provide a description:	No
Date Due:	N/A
Bill Section Number(s):	N/A

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC. REQUIRED BY THIS BILL? NO

Board:	N/A
Board Purpose:	N/A
Who Appoints:	N/A
Appointee Term:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. WHAT IS THE FISCAL IMPACT TO LOCAL GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Office of Administrative Services finds that there are no expenditures generated by this bill.
Does the legislation increase local taxes or fees?	The Department's Office of Administrative Services finds that this bill does not increase local taxes or fees.
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	The Department's Office of Administrative Services finds that this section is not applicable.

2. WHAT IS THE FISCAL IMPACT TO STATE GOVERNMENT?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	The Department's Ombudsman, with the Office of Operations, currently performs some of the duties that are listed under the responsibilities connected to the Children's Ombudsman created by the bill. If this language is adopted, the Department would need to reassess the expectation and responsibilities of the current position, which would require enhanced qualifications, greater degree requirements, and more in-depth experience. The Department would have to determine any additional costs required to support the position, structure of the office within the organization chart, and the possibility of advertising for interested candidates for the revised job description. The Department currently has a toll-free number for the Florida Children's Ombudsman. Please see the Technology Impact section for additional fiscal impact resulting from technology needs.

Does the legislation contain a State Government appropriation?	The Department's Office of Administrative Services finds that this bill does not contain a State Government Appropriation.
If yes, was this appropriated last year?	The Department's Office of Administrative Services finds that this section is not applicable.

3. WHAT IS THE FISCAL IMPACT TO THE PRIVATE SECTOR?

Revenues:	The Department's Office of Administrative Services finds that there are no revenues generated by this bill.
Expenditures:	Caregivers are required to pay any balance the ELC subsidy does not cover. This already takes place, but the language will require the caseworker to inform the caregiver of this requirement.
Other:	The Department's Office of Administrative Services finds that this section is not applicable.

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES?

Does the bill increase taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not increase taxes, fees, or fines.
Does the bill decrease taxes, fees or fines?	The Department's Office of Administrative Services finds that this bill does not decrease taxes, fees, or fines.
What is the impact of the increase or decrease?	The Department's Office of Administrative Services finds that this section is not applicable.
Bill Section Number:	The Department's Office of Administrative Services finds that this section is not applicable.

TECHNOLOGY IMPACT

Does the legislation impact the agency's technology systems (i.e., IT support, licensing software, data storage, etc.)?	Yes
If yes, describe the anticipated impact to the agency including any fiscal impact.	Section 3., s. 39.6011, F.S., will require changes to FSFN to ensure data fields are appropriately created and mapped to populate the FSFN generated case plan template. Below are the requirements and the corresponding changes that need to be made to FSFN. • Requirement: A signed acknowledgement by the child or young adult, or the caregiver if the child is too young or otherwise unable to sign and that the rights were explained to the child in a way that the child understands; - FSFN Change: Add a signature line and check box section for question on the Case Plan. •Requirement: Documentation that a consumer credit report for the child was requested from at least one reputable credit reporting agency at no charge to the child, any results were provided to the child, any barriers to obtaining the credit reports were documented, details of how the Department ensured the child received assistance with interpreting the report and resolving any inaccuracies including any referrals made for assistance; - FSFN Change: Add the Credit Report information to the Case Plan template. Assumes credit check will be extracted from Assets & Employment information within FSFN.

• Requirement: The language also requires that if a child has reached age 14 or if younger, is of an appropriate age and capacity, the child must be consulted on the development of the case plan;
- FSFN Change: Add question to FSFN and update template.
• Requirement: Have an opportunity to attend a face-to-face conference;
- FSFN Change: Add question to FSFN and update template.
• Requirement: Have an opportunity to express a placement preference;
- FSFN Change: Add question to FSFN and update template.
• Requirement: Have the option to choose up to two members of the case planning team who are not foster parents or case managers to assist in the development stages. These individuals may be rejected at any time if there is good cause to believe that the individuals would not act in the best interest of the child;
- FSFN Change: Update Family Support sections.
• Requirement: Sign the case plan, receive an explanation of the provisions of the plan, and receive a copy of the plan.
- FSFN Change: Add signature line and maybe a documentation section.

To address the requirements of SB1100, the functional changes described above have been estimated as system changes to FSFN, described and estimated below:

Case Plan Changes to meet requirements of Section 3 (s. 39.6011, F.S.)

System development is required to include documentation of the Bill of Rights in the Case Plan within FSFN, with acknowledgement and signature. This is not currently in the Case Plan. The current template does not include a specific section for child and care giver. Changes include modifying the case plan template related to the Bill of Rights and the credit report, as well as allowing the child & care giver signature (non- digital). In the modified template, the signature section will be specified for child and care giver separately.

Based on the high-level requirements provided by the Office of Child Welfare, the FSFN support vendor has estimated:

Estimated Costs for FSFN Case Plan Changes for SB 1100		
Hours	Rate/Hour	Estimated Cost
600	$100	$60,000

Judicial Review Changes to meet requirements of Section 5 (s. 39.701, F.S.)

Documentation within the Judicial Review module of FSFN of the Bill of Rights, with acknowledgement and signature, is new functionality. Since it does not currently exist in Judicial Review, and the existing templates do not have specific sections for child and caregiver, this functionality must be developed. Necessary changes include modifying the case plan template related to the Bill of Rights, as well as allowing non-digital child and caregiver signatures. In the modified template, the signature section will specify separate child and caregiver signatures.

Based on the high-level requirements provided by the Office of Child Welfare, the FSFN support vendor has estimated:

Estimated Costs for FSFN Judicial Review Changes for SB 1100		
Hours	Rate/Hour	Estimated Cost
600	$100	$60,000

	Summary of Cost of FSFN Changes to meet requirements of SB 1100 Based on the high-level requirements provided by the Office of Child Welfare, the FSFN support vendor has estimated total costs for changes to **FSFN Case Plan and Judicial Review** as follows:

Total Estimated Costs for FSFN Case Plan and Judicial Review Changes for SB 1100		
Hours	Rate/Hour	Estimated Cost
1,200	$100	$120,000

FEDERAL IMPACT

Does the legislation have a federal impact (i.e. federal compliance, federal funding, federal agency involvement, etc.)?	No
If yes, describe the anticipated impact including any fiscal impact.	N/A

ADDITIONAL COMMENTS

Section 1

Section 39.407(3)(c), F.S., requires that the Department file a motion seeking the court's authorization to initially provide or continue to provide psychotropic medication to a child in its legal custody except under circumstances. The first exception to administration in the absence of a court order is in s. 39.407(3)(b), F.S., which allows the Department to take possession of any prescribed psychotropic medication the child is receiving at the time of removal and may continue to provide the medication as prescribed until the shelter hearing if parental authorization to continue to provide the medication cannot be obtained. The second exception to administration in the absence of a court order is in s. 39.407(3)(e), F.S., which allows the medication to be provided in advance of the issuance of a court order if the child's prescribing physician certifies in the signed medical report that delay in providing a prescribed psychotropic medication would more likely than not cause significant harm to the child. Lines 113-115 of the bill would conflict with these two statutory exceptions and to a court order. It also does not address how to handle emergency management of prescribed cannabis which is controlled by s. 381.986, F.S. It is unclear if this is considered to be a standard psychotropic as there are special conditions in the statute for possession by a caregiver.

Lines 120-123 of the bill require the child to be placed together with his or her siblings, unless prohibited by court order. The court only has jurisdiction to determine the placement of a child under its supervision. If a child's sibling, as defined in s. 39.01(8), F.S., is not under the court's jurisdiction, the court will be unable to satisfy the requirements in proposed s. 39.4085(2)(d), F.S., of placing the siblings together or ordering that contact or visitation.

Lines 100-102 propose that children in out-of-home care have the right to live in a comfortable home. The effect of the specific language may lead to unnecessary placement changes as children and young adults exercise their right to be placed in a home that achieves their required level of "comfort". The word comfortable is subjective and some children may never feel comfortable residing away from home even though the placement is in their best interest.

All youth and young adults are afforded the opportunity to receive financial and educational services. Although they are made aware of each service, they may not qualify for a specific program based on eligibility criteria. The transition plan that is developed at 16 is the foundation where all information related to eligible programs are discussed and provided to the youth as they prepare to transition to adulthood.

The Department places children in facilities licensed by other state agencies such as Agency for Person with Disability (APD) or Agency for Health Care Administration (AHCA) for 6 or more children. The Department does not have authority over the facilities; therefore it cannot require the provider post the rights of children and young adults in a prominent place in the facility.

Section 8
Each CBC currently has an on-call contact that allows for licensed providers to contact staff as needed 24 hours 7 days a week.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments and recommended action:	The language proposed for section 39.4085(6), F.S., is not as strong as that provided for in the current language regarding the potential for a cause of action against the Department. Multiple sections of the proposed language create legal liability for the Department which will likely increase litigation. The language proposed for section 39.4088, FS., does not address which office the ombudsman would be accountable to. Other than indicating that the position would be "an autonomous entity", this language is silent as to which office would appoint, manage, and pay for the ombudsman position. For examples of other ombudsman positions, see ss. 288.7015, 400.0063, and 1006.51, F.S.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

11/30/21
Meeting Date

Children, Families, & Elder Affairs
Committee

792
Bill Number or Topic

Amendment Barcode (if applicable)

Name Marty Lowrey

Phone

Address
Street

Email

Orlando FL
City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☑ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:
Florida Youth SHINE

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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The Florida Senate

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11/30/21
Meeting Date

Children, Families, & Elder Affairs
Committee

792
Bill Number or Topic

Amendment Barcode (if applicable)

Name Brian Thompson

Phone

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Email Brian36Thompson@gmail.com

Coral Springs FL
City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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11/30/21
Meeting Date

Children, Families, & Elder Affairs
Committee

792
Bill Number or Topic

Amendment Barcode (if applicable)

Name Rebekka Behr

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Tallahassee FL

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Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☑ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

792

Meeting Date

Deliver both copies of this form to
Senate professional staff conducting the meeting

Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name CANDICE BROWER Public Interest Law Section Of Florida Bar Phone

Address Email

Street

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

11-30-2021
Meeting Date

SB 792
Bill Number or Topic

Children Fam Affairs
Committee

Amendment Barcode (if applicable)

Name Dawn Steward

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Email stu2130@aol.com

021 Fl 32809
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:
Fl PTA

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

FOR CONSIDERATION By the Committee on Children, Families, and Elder Affairs

586-00942-22 20227008pb

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act; amending s. 397.6760, F.S., relating to an exemption from public records requirements for involuntary assessment and stabilization, court orders, related records, and personal identifying information regarding substance abuse impaired persons; removing the scheduled repeal date of the exemption; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 397.6760, Florida Statutes, is amended to read:

397.6760 Court records; confidentiality.—

(1) All petitions for involuntary assessment and stabilization, court orders, and related records that are filed with or by a court under this part are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Pleadings and other documents made confidential and exempt by this section may be disclosed by the clerk of the court, upon request, to any of the following:

(a) The petitioner.

(b) The petitioner's attorney.

(c) The respondent.

(d) The respondent's attorney.

(e) The respondent's guardian or guardian advocate, if applicable.

(f) In the case of a minor respondent, the respondent's

586-00942-22 20227008pb

parent, guardian, legal custodian, or guardian advocate.

(g) The respondent's treating health care practitioner.

(h) The respondent's health care surrogate or proxy.

(i) The Department of Children and Families, without charge.

(j) The Department of Corrections, without charge, if the respondent is committed or is to be returned to the custody of the Department of Corrections from the Department of Children and Families.

(k) A person or entity authorized to view records upon a court order for good cause. In determining if there is good cause for the disclosure of records, the court must weigh the person or entity's need for the information against potential harm to the respondent from the disclosure.

(2) This section does not preclude the clerk of the court from submitting the information required by s. 790.065 to the Department of Law Enforcement.

(3) The clerk of the court may not publish personal identifying information on a court docket or in a publicly accessible file.

(4) A person or entity receiving information pursuant to this section shall maintain that information as confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(5) The exemption under this section applies to all documents filed with a court before, on, or after July 1, 2017.

~~(6) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal~~

~~through reenactment by the Legislature.~~

Section 2. This act shall take effect October 1, 2022.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

BAKER ACT AND MARCHMAN ACT PROJECT TEAM REPORT

FOR FISCAL YEAR 2016-17

Department of Children and Families
Substance Abuse and Mental Health Program Office

November 24, 2015

Mike Carroll	Rick Scott
Secretary	Governor

Table of Contents

I. Executive Summary

I.A. PURPOSE

The following is a synthesis of the findings and recommendations of the Department of Children and Families (Department) Baker Act and Marchman Act Project Team (Project Team). It is important to note, that the Project does not recommend blending, or combining, the Baker Act and Marchman Act. The Project Team recommends the following:

- Legislative Intent language that focuses on mental and substance use disorders being diseases of the brain, and involving the local community in the planning process for behavioral health acute care services.
    - Shift to medical approach in the treatment of mental health and substance abuse.
    - Recognize that substance use and mental disorders are sub-specialties within the medical specialty health care arena.
    - Acknowledge that behavioral health disorders cause effects on individuals' ability to reason, exercise good judgment, recognize the need for services and sufficiently provide self-care, which require responsibility for their care to be relegated to third parties and/or vested in the authorities of behavioral health programs and practitioners.
    - Establish community based alternatives that include prevention, intervention and outreach to prevent need for higher levels of care and provide for care coordination and recovery oriented services upon discharge.
    - Provide funding of the community system resulting in cost savings and efficiencies across multiple systems.
    - Define specifications and minimum standards for access to care that will be available in each community.
    - Authorize licensed and certified behavioral health practitioners to exercise the full authority of their respective scopes of practice.
    - Provide the mechanism for communities in conjunction with others, to define their local behavioral health, emergency, acute care and treatment array of services.
    - Ensure that local systems of acute care services have standardized services and processes for access.
    - Ensure that local systems of care are designed to maximize available local resources, including health care services and managed care plans.
- Every county have access to either a central receiving facility, an access center, a triage center, a crisis stabilization unit or an addictions receiving facility, or have a plan that addresses accessibility.
- A transportation plan and local community plan should be developed by the managing entities for every county
    - Plans will provide exception to existing statutory requirements mandating law enforcement to transport to nearest receiving facility, to provide for consumer choice and meet specifications of the local transportation plan

- Align the statutory requirements in Chapters 394 and 397, F.S. so that the same qualified professionals are authorized to initiate involuntary examinations/assessments/stabilizations under the Baker Act and the Marchman Act.
- The requirements for the collection of data and the time frames for both the Baker Act and the Marchman Act should be aligned
- Require the collection, submission and reporting of the same data for the Marchman Act and the Baker Act, by all public receiving facilities and should be submitted to DCF using the CSU database.
- Timeframes should be standardized so that involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act must be completed within 72 hours. However, a physician or physician's assistant or psychiatric nurse acting under the physician may authorize up to an additional 48 hours based on a determination of need without court involvement.

Estimate of the cost to address the needs for expanded acute care capacity ranged from $133 million to $ 298 million. We recognize that those consensus estimates can result in the immediate discounting of the Project Team's recommendations based on the projected cost. (Appendix 2).

Instead, we would recommend the following:

- The Legislature should consider a multiple year approach to addressing the acute care service capacity within Florida's communities.
- This approach would reflect a commitment and investment in mental health and substance abuse services that would be designed to meet local behavioral health acute care needs over time.
- Appropriations should be targeted to those services that include acute care beds, but also place a premium of funding lower cost services designed to reduce demand on inpatient, crisis stabilization, and detoxification services; such as, mobile crisis response teams. In addition, improved care coordination across Medicaid, and other health plans and other funding sources to reduce demand on publically funded services and expand community treatment options.
- Building community residential and housing options for persons with a major mental or substance use disorders.
- Provide options for funding a community's treatment capacity to address the needs of the most in need and vulnerable. Only with a sustained commitment will these issues that have placed Florida's behavioral health system in "crisis," ultimately be successfully resolved.

I.B. INTRODUCTION

During the 2015 regular session of the Florida Legislature, proposed legislation aimed at making substantive changes to Part I of Chapter 394, F.S., which addresses the Baker Act. Senate Bill 7070 would have combined certain features of Chapter 397, F.S., or the Marchman Act, into one comprehensive statute that combines voluntary and involuntary treatment for persons with mental illness and substance use disorders into one comprehensive law.

Although the bill did not become law, it created considerable legislative, executive agency, and public interest in the current state of mental health and substance abuse services. Public discussion specifically

addressed public access to acute care services and the belief that current statutes do not adequately address issues of access, availability, and the organization of these essential services.

II. BACKGROUND

II.A. BAKER ACT

In 1971, the Florida Legislature enacted the Florida Mental Health Act (Part I of Chapter 394, F.S.), a comprehensive revision of the state's century-old mental health commitment laws. The law, commonly referred to as the "Baker Act," was designed to significantly strengthen and protect the due process and civil rights of individuals in mental health facilities and ensure public safety.

In 1978, through proviso, the Legislature authorized the creation of Crisis Stabilization Units (CSUs) and short-term residential treatment facilities (SRTs) to provide a less costly, less intensive, and less restrictive alternative to inpatient hospitalization for examination/crisis stabilization and also for placement/long-term treatment. The most recent major revision to the Baker Act was in 2004 when the Legislature created Involuntary Outpatient Placement as an involuntary treatment option (effective January 1, 2005).

Crisis services are defined in s. 394.67(3), F.S., as emergency interventions that are designed to prevent further deterioration of the individual's mental health. They include short-term evaluation, stabilization, and brief intervention. Once stabilized, individuals are redirected to the most appropriate and least restrictive treatment settings consistent with their needs. Most publically funded crisis services are provided in CSUs, which are located in receiving facilities for individuals on voluntary and involuntary status.

Receiving and treatment facilities are defined by the Florida Mental Health Act (ss. 394.451-47891, F.S.) and are designated by the Department to receive and hold individuals on involuntary status under emergency conditions or for psychiatric evaluation. These facilities, referred to as Baker Act Receiving Facilities, provide brief, intensive crisis services to individuals who require emergency mental health stabilization. (Appendix 3).

Section 394.461, F.S., authorizes the Department to designate community facilities as a receiving facility. Any other facility within the state, including a private or federal facility, may be so designated by the Department, provided such designation is agreed to by the governing body or authority of the facility.

II.B. MARCHMAN ACT

In 1970, the Florida Legislature enacted Chapter 397, F.S., governing the Treatment and Rehabilitation of Drug Dependents. The following year, it enacted Chapter 396, F.S., titled the Myers Act as the state's "Comprehensive Alcoholism Prevention, Control, and Treatment Act," modeled after the federal Hughes Act.

Since individuals with substance abuse issues often don't contain their misuse to one substance or another, having two separate laws dealing with the prevention and treatment of addiction did not address the problems faced by Florida's citizens.

In 1993, Representative Steven Wise introduced legislation to merge Chapters 396 and 397, F.S., into a single law, Chapter 397, F.S., that clearly outlined legislative intent, licensure of service providers, client rights, voluntary and involuntary admissions, offender and inmate programs, service coordination, and children's substance abuse services. The chapter was named the "Hal S. Marchman Alcohol and Other Drug Services Act of 1993," and is commonly referred to as the Marchman Act.

Addiction receiving facilities are defined in Chapter 397, F.S., and are designated by the Department as secure, acute care facilities that provide, at a minimum, detoxification and stabilization services and are operated 24 hours per day, 7 days per week to serve individuals found to be substance use impaired.

Unlike the Baker Act that requires facilities to accept persons brought by law enforcement officers, the Marchman Act requires facilities to refuse acceptance of persons if it would cause the facility to go over licensed census, to accept responsibility for a person beyond the safe management of the program, or if the person is unable to pay the cost of a private program. However, if the facility is a licensed hospital and the officer believes the person has an emergency medical condition as a result of the substance abuse issues, a hospital must accept the person under the federal EMTALA law and perform a medical screening and stabilization prior to releasing the person or transferring him or her to another appropriate facility. (Appendix 4).

When, in the judgment of the service provider, the person who is being presented for involuntary admission should not be admitted because of his or her failure to meet admission criteria, because his or her medical or behavioral conditions are beyond the safe management capabilities of the service provider, or because of a lack of available space, services, or financial resources to pay for his or her care, the service provider, in accordance with federal confidentiality regulations, must attempt to contact the referral source, which may be a law enforcement officer, physician, parent, legal guardian if applicable, court and petitioner, or other referring party, to discuss the circumstances and assist in arranging for alternative interventions.

II.C. EMERGENCY EXAMINATION AND TREATMENT OF INCAPACITATED PERSONS ACT

Section 401.445, F.S., governs the emergency examination and treatment when an emergency medical condition is life-threatening and the individual is unable to provide informed consent to examination, transport, or treatment.

II.D. ACCESS TO EMERGENCY SERVICES AND CARE

Section 395.1041, F.S., establishes state requirements equivalent to the federal EMTALA/COBRA law, which prohibits the denial of emergency services and care by hospitals and physicians, and enforcing the ability of individuals to get all necessary and appropriate emergency care within the capability and capacity of each hospital. This statute also requires hospitals to adhere to rights and involuntary examination procedures provided by the Baker Act, regardless of whether the hospital is designated as a receiving or treatment facility. However, this is not a requirement for individuals being involuntarily assessed and stabilized under the Marchman Act.

III. PROCESS

In June 2015, the Department convened the Baker Act and Marchman Act Project Team (Project Team). This report builds upon the proposed changes to the court processes for the Baker Act and Marchman

Act considered by the Florida Supreme Court's Task Force on Substance Abuse and Mental Health Issues in the Courts. The Project Team was charged with developing recommendations and specifications to integrate access to the Baker Act and Marchman Act by defining a community system of behavioral health acute care services that:

1. Provides a single point of access to acute emergency care, intervention, and treatment services;
2. Ensures that individuals are determined to meet criteria for voluntary and involuntary examination and treatment for a mental illness or a substance use disorder have access to required services;
3. Ensures that each county or circuit has access to a designated receiving facility that, at a minimum, can screen, evaluate, and refer individuals to the appropriate level of care;
4. Ensures that individuals, their families, law enforcement agencies, judges and other court professionals, behavioral health professionals, and the public are aware of the locations of designated receiving facilities, access centers, or triage centers;
5. Determine the existing capacity for Addiction Receiving Facilities (ARFs), CSUs, and detoxification facilities;
6. Develops a standard or benchmark for determining the need for additional bed capacity over and above the capacity met through Medicaid, Medicare, and private insurance based on the number of beds per capita; and
7. Estimates the cost of the proposed recommendations based on several different models, or methods of calculation.

The composition of the Project Team included representatives of state agencies, community hospitals, non-profit substance abuse and mental health provider organizations, managing entities, professional trade and provider associations, court professionals and personnel, law enforcement, local government, Medicaid managed care organizations, consumers, and experienced practitioners and administrators from acute care service programs in the substance abuse and mental health system. Stakeholders from these diverse backgrounds participated in Project Team meetings that were conducted over the course of three months. This broad range of participation resulted in the recommendations that are presented in this report.

IV. RECOMMENDATIONS

Legislative Intent	
Relevant Statute(s)	ss. 394.453, 394.66, and 397.305, F.S.
Discussion	During the Project Team meetings, team members expressed concern for the need to revise current legislative intent in Chapters 394 and 397, F.S., to reflect the changes and advances in the behavioral health field, as well as clearly establish priorities, rights, and key policy statements. Most importantly, the current legislative intent language does not recognize substance use and mental disorders as diseases of the brain or as a medical sub-specialty.
Recommendations	Amend current legislative intent language in Chapters 394 and 397, F.S., to incorporate language that clearly and affirmatively establishes the Legislature's intent to:

	1. Shift to medical approach in the treatment of mental health and substance abuse recognizing that substance use and mental disorders are diseases of the brain, and are complex medical issues whose etiology and progression involve interactive biological, genetic, psychological, cultural, and social factors. 2. Recognize that Substance Use and Mental Disorders are sub-specialties within the medical specialty health care arena of Behavioral Health. Treatment saves lives, improves the health of the affected individuals and families, and reduces negative impacts to society. 3. State the importance of data collection and utilization to inform decisions regarding funding, client needs, access to services, and information regarding the behavioral health acute care system. 4. Establish and fund community-based alternatives that include prevention, intervention and outreach, as well as recovery-oriented services in the community to prevent the need for and use of higher levels of care. In addition, provide for the coordination of comprehensive care and recovery oriented services upon discharge from all levels of care. 5. Provide proper and appropriate funding of the community behavioral health system of care which will result in cost-savings and efficiencies across multiple systems, including criminal justice/law enforcement, healthcare, etc. 6. Define the specifications and minimum standards for access to care that will be available in or accessible by each community based on funding. 7. Authorize licensed and certified behavioral health practitioners to exercise the full authority of their respective Scopes of Practice in the performance of professional functions necessary to carry out the intent of this statute. 8. Provide the mechanism for communities in conjunction with the Department, local governments, law enforcement, courts, behavioral health managing entities, and consumers and families to define a local, accessible behavioral health system, including emergency, acute care and treatment array of services are: accessible, well defined, and readily understood in each community. 9. Ensure that local systems of behavioral health acute care services have standardized services and processes for accessing services. 10. Ensure that local systems of care are designed to maximize available local resources including health care services and managed care plans. 11. Expand the use of mobile crisis teams and other alternative intervention options in the community.

Single Point of Access	
Relevant Statute(s)	s. 394.461, F.S.
Discussion	The current Baker Act and Marchman Act differ in several key points related to receiving facilities, including who may provide assessments and evaluations, the time permitted to conduct an involuntary examination, authority to release individuals, and specific administrative functions such as notifications to other involved persons and data collection and reporting. Current statutes establish five routes to crisis services for individuals with mental or substance use disorders, four of them involuntary. The Baker Act and Marchman Act differ significantly in addressing involuntary assessment. This includes defining methods of initiation, criteria, time frames, and disposition alternatives. Revising the statutes to align the process, and standardize the forms for petitions and certificates, while retaining the ability to identify whether the primary basis is a mental or substance use disorder, would significantly reduce bureaucratic barriers to accessing crisis evaluations and still protect individual rights through due process in any involuntary proceedings.
Recommendations	The Department has provided a brief description of a central receiving facility, access center, and triage center as examples of single points of access for the purposes of this report. It is recommended that the Legislature authorize the Department to develop administrative rules to establish the specific standards, functions, and services for any facilities providing a single point of access. **Central Receiving Facility** The concept of a Central Receiving Facility (CRF) is an integrated mental health crisis stabilization unit and addictions receiving facility as currently described in s. 394.4612, F.S., and Rule 65E-12.110, F.A.C. The CRF can be a single point of entry with or without an Access Center or Triage Center into the mental health and substance abuse system for assessments, and appropriate placement of adults experiencing a mental health or substance abuse crisis. It is important to note that not all counties may have the financial resources or demand for acute care services to support a CRF as the single point of access. Counties need the flexibility and an availability of options to provide services. **Access Center** An Access Center (AC) may be available, at a minimum, 12 hours per day, seven days per week for individuals experiencing a low level substance abuse, mental health, or co-occurring crisis after receiving a standardized screening. This

	location can be a separate and freestanding facility. The primary purpose is to assist the public in accessing services. **Triage Center** A Triage Center (TC) is a community-based option that is an initial point of entry into the community mental health and substance abuse system. A TC should be integrated so that the facility and its staff have the ability, at a minimum, to assess, examine, and refer individuals to the appropriate level of care.

Transportation	
Relevant Statute(s)	ss. 394.462, 394.4685, 394.9082, 397.6772, 397.6793, 397.6795, F.S.
Discussion	Under the requirements of the Baker Act, regardless of how an examination is initiated, law enforcement must transport an individual to the nearest Baker Act receiving facility to be examined unless a Transportation Exception Plan has been approved by the Secretary of the Department. The designated law enforcement agency may decline to transport the individual to a receiving facility only if: 1. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service or private transport company for transportation of individuals to receiving facilities pursuant to this section at the sole cost of the county; and 2. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the individual or others. However, when a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination under the Baker Act and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.[1]

[1] Section 394.462(1)(e), F.S.

	The current requirements for involuntary assessment and stabilization under the Marchman Act specify that law enforcement are only required to transport an individual in protective custody. For involuntary assessments and stabilization initiated by persons or means other than protective custody, the Marchman Act allows for, but does not require, the transportation of individuals and permits individuals other than law enforcement to provide the transportation. Specifically, for a court-ordered assessment and stabilization, the Court may order law enforcement to transport a person to nearest appropriate licensed service provider. Transportation for Emergency Admission may be provided by an applicant for a person's emergency admission, spouse or guardian, law enforcement officer, or health officer. Regardless of how the involuntary assessment and stabilization is initiated, the Marchman Act does not require an individual to be transported to the nearest receiving facility. Instead, depending on how the involuntary assessment and stabilization was initiated, an individual may be transported to a hospital, licensed detoxification facility, addiction receiving facility, jail, or a less intensive component of a licensed service provider for assessment only. Currently, the Baker Act and Marchman Act do not require any formal planning regarding the transportation of individuals who meet the criteria under these statutes. However, the Baker Act allows for the development of a Transportation Exception Plan, and also specifies that each law enforcement agency shall develop a memorandum of understanding with each receiving facility within the law enforcement agency's jurisdiction which reflects a single set of protocols for the safe and secure transportation of the individual and transfer of custody of the person.[2] These protocols must also address crisis intervention measures.
Recommendations	1. Establish requirements for the transportation of individuals for involuntary assessment/stabilization, and involuntary treatment, as well as, the transfer of individuals between facilities, under the Marchman Act that mirror and align with the corresponding requirements in the Baker Act.[3] 2. Require the Managing Entities, in consultation with the board of county commissioners and local law enforcement agencies, to develop a Transportation Plan for each county or circuit within the managing entity's assigned region that defines the specifications and

[2] Section 394.462(1)(k), F.S.

[3] Sections 394.462 and 394.4685, F.S.

	minimum standards for transportation and access to behavioral health acute care services that will be present or available in each community. 3. Each Transportation Plan must address, at a minimum, the following: a. Specify the models of Community Intervention options available and the roles, processes, and responsibilities of those programs in diverting individuals from acute care placements. b. Specify how local hospitals, designated receiving facilities, and acute care inpatient and detoxification providers will coordinate activities to screen, assess, examine, stabilize, and refer individuals presented on an involuntary basis under the Baker Act or Marchman Act. c. Specify the responsibility for, and the means by which, individuals in a behavioral health crisis will be transported to and between facilities for involuntary examinations and treatment, involuntary court proceedings and resulting commitments under the Baker Act and Marchman Act. d. The method of transferring individuals after law enforcement has relinquished physical custody of the individual at a designated receiving facility. The receiving facilities must provide or arrange for their transportation to another facility or appropriate placement. The managing entities must submit transportation plans to the Department for final review and approval. Plans must be submitted every three years and updated as needed.

Qualified Professionals	
Relevant Statute(s)	Part I of Chapter 394, Part V of Chapter 397, and s. 397.311, F.S.
Discussion	**Scope of Practice** There is significant variation in the authorized scope of practice for qualified professionals established in Chapters 394 and 397, F.S. This variation has created inconsistencies between the Baker Act and Marchman Act in how involuntary examinations (i.e. professional certificates) are initiated, and who has the authority to conduct assessments, examinations, and discharge of individuals. Furthermore, the limitations placed on certain qualified professionals under the Marchman Act to initiate professional certificates, and under the Baker Act, to assess, admit, and discharge individuals, restrict the privileges, or scope of practice that these professionals are statutorily granted under the purview of their license.

Qualified Professionals	
	Physician Shortage In February 2015, a study of physician supply and demand commissioned by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida found the physician shortage will grow to 7,000 physician specialists by 2025. This shortfall spans 19 specialties, with the largest areas of need in psychiatry, general surgery, rheumatology, and thoracic surgery.[4] The current supply of specialists in Florida is insufficient to provide a level of care consistent with the national average, after taking into consideration differences in the demographics and health risk factors between Florida and the nation. Of the specialties included in the projected shortage, psychiatry is expected to have the most severe physician specialty deficit with a 55 percent shortfall statewide by 2025.[5] **Access to Care** The disconnect between the authority to access, evaluate, and discharge individuals under the Baker Act and Marchman Act, along with the current and projected statewide shortage of psychiatrists will create significant barriers to accessing and initiating care.
Recommendations	1. Align statutory requirements in Chapters 394 and 397, F.S. so that the same qualified professionals authorized to initiate involuntary examinations under the Baker Act are also authorized to initiate involuntary assessments and stabilizations under the Marchman Act. 2. Authorize the following qualified professionals, as defined in their respective chapters, to initiate involuntary examination/assessment under the Marchman Act and Baker Act: a. Physician; b. Physician Assistant; c. Psychiatrist; d. Psychologist; e. Advanced Registered Nurse Practitioner;

[4] Study: Florida Facing Critical Shortage of Physician Specialists through 2025. PRNewswire. February 17, 2015. http://www.prnewswire.com/news-releases/study-florida-facing-critical-shortage-of-physician-specialists-through-2025-300037111.html site last accessed on October 14, 2015.

[5] *Florida Physician Workforce Analysis: Forecasting Supply and Demand.* IHS Global. Commissioned by the Teaching Hospital Council of Florida and the Safety Net Hospital Alliance of Florida. February 2015. http://mediad.publicbroadcasting.net/p/healthnewsfl/files/201502/SNHAF_Physicians_Workforce_Analysis_2015-v5.pdf site last accessed on October 14, 2015.

Qualified Professionals	
	f. Advanced Registered Nurse Practitioner having a specialty in psychiatry licensed under part I of chapter 464; g. Licensed Mental Health Counselor; h. Licensed Clinical Social Worker; and i. Licensed Marriage and Family Therapist 3. Provide an exception to limit the authority of Certified Addiction Professionals to initiate only involuntary assessment and stabilization under the Marchman Act. 4. All licensed health care professionals in Chapters 394 and 397, F.S., should have experience and be cross trained in both substance abuse and mental health.

Data	
Relevant Statute(s)	ss. 394.461, 394.463, 394.4655, 394.467, 394.9082, F.S.
Discussion	**Baker Act Data** The Baker Act (Part I of Chapter 394, F.S.), as well as Part IV of Chapter 394, F.S., contain several provisions requiring the submission, collection and reporting of Baker Act-related data for private and public receiving facilities to the Department and the Agency for Health Care Administration (AHCA). This has not only created confusion and increased the administrative burden on providers, but it has also resulted in inconsistent and siloed data due to incompatible and unintegrated data systems and processes. As a result, the meaningful use and analysis of this data is severely diminished. *(Please see the below table for a summary of data submission requirements).* Additionally, during the 2015 Regular Session, CS/HB 79 was passed and signed into law, amending Part IV of Chapter 394, F.S., directing the Department to develop, implement, and maintain a Crisis Stabilization Services Utilization Database (CSU Database) whereby behavioral health managing entities collect utilization data from psychiatric public receiving facilities.[6] Public receiving facilities within a managing entity's provider network are required to submit utilization data in real time, or at least daily, to the managing entity. This includes the number of indigent patients admitted and discharged, the current active

[6] These facilities operate under Department designation as crisis stabilization units where emergency mental health care is provided. General Revenue funding for community mental health services pays for space in receiving facilities to care for the indigent. Managing entities must comply with the bill's requirements for data collection by August 1, 2015

census of licensed beds, the number of beds purchased by the Department, and the number of unoccupied licensed beds regardless of payor source.

As a result, the establishment of data reporting requirements in both Part I and Part IV of Chapter 394, F.S., has unintentionally created conflicting statutory requirements for the submission of data to the Department.

Data Submitted to the Department
Facilities designated as public receiving or treatment facilities shall report to the Department on an annual basis the following data, *unless these data are currently being submitted to the Agency for Health Care Administration (AHCA)*: 1. Number of licensed beds. 2. Number of contract days. 3. Number of admissions by payor class and diagnoses. 4. Number of bed days by payor class. 5. Average length of stay by payor class. 6. Total revenues by payor class. "Payor class" means Medicare, Medicare HMO, Medicaid, Medicaid HMO, private-pay health insurance, private-pay health maintenance organization, private preferred provider organization, the Department of Children and Families, other government programs, self-pay patients, and charity care.[7]
A managing entity shall require a public receiving facility within its provider network to submit data, in real time or at least daily, to the managing entity for: 1. All admissions and discharges of clients receiving public receiving facility services who qualify as indigent, as defined in s. 394.4787; 2. Current active census of total licensed beds 3. Number of beds purchased by the Department 4. Number of clients qualifying as indigent occupying the Department-purchased beds 5. Total number of unoccupied licensed beds regardless of funding. The managing entities must report this data to the Department, using the CSU database, on a monthly and annual basis.[8]
The Office of Clerks of Court shall submit to the Department a copy of the following: 1. Petition for involuntary outpatient placement and individualize treatment

[7]Section 394.461(4), F.S.

[8] Section 394.9082(10), F.S.

	plan[9] 2. Continued involuntary outpatient placement certificate and treatment plan[10] 3. Petition for involuntary inpatient placement[11] **Data Submitted to the Agency for Health Care Administration** The Agency for Health Care Administration shall receive and maintain copies of the following: 1. Ex-parte orders for involuntary examination[12] 2. Mental Health Professional certificates for initiating involuntary examinations[13] 3. Law enforcement reports (involuntary examination)[14] 4. Involuntary outpatient placement orders[15] 5. Involuntary inpatient placement orders[16] *Note: The Baker Act Reporting Center at the Louis de la Parte Florida Mental Health Institute receives data on behalf of AHCA, which allows it to meet its statutorily required receipt and reporting of this information. Currently, Baker Act receiving facilities must mail the involuntary examination initiation forms and a coversheet with critical information about each examination initiated to the Baker Act Reporting Center. Staff at the Reporting Center must manually process and enter the data contained in the involuntary examination initiation forms.* **Marchman Act Data** Currently, there are no statutory requirements for the collection, submission, or reporting of Marchman Act-related to the Department. However, the Office of the State Courts Administrator publishes data on the number of Marchman Act and Baker Act petitions filed and disposed. The data are based on information received from the Clerks of Court and are extracted from a static database containing the official trial court statistics.[17]
Recommendations	1. Require the collection, submission, and reporting of the same data for the Marchman Act as currently required for the Baker Act by all designated receiving facilities, as well as any other licensed providers accepting

[9] Section 394.4655(3)(c), F.S.

[10] Section 394.4655(7)(a)(4), F.S.

[11] Section 394.467(3), F.S.

[12] Section 394.463(2)(e), F.S.

[13] Section 394.463 (2)(a)(3), F.S.

[14] Section 394.463 (2)(a)(2), F.S.

[15] Section 394.4655(6)(b)(2), F.S.

[16] Section 394.463(2)(e), F.S.

[17] http://trialstats.flcourts.org/TrialCourtStats.aspx Site last accessed on October 15, 2015.

	individuals under the Marchman Act (i.e. central receiving facilities, access centers, triage centers, CSUs, ARFs, and detoxification providers). 2. Require all Marchman Act data and all Baker Act data submitted by public and private receiving to Department and AHCA, to be submitted using the existing CSU Database established in s. 394.9082(10), F.S. The existing CSU database will need to be enhanced to allow for the collection, storage, submission, and analysis of Marchman Act data. The enhanced database should be renamed the Acute Care Database to accurately reflect the data being collected. 3. Revise requirements in s. 394.461(4), F.S., to remove exception for the submission of data to the Department if data is currently being submitted to AHCA. Instead, allow for the sharing of Baker Act data with AHCA. 4. Transfer statutory language and requirements pertaining to both the CSU database in s. 394.9082(10), F.S., and public receiving and treatment facilities data in s. 394.461(4)(a)-(b), F.S., to a new section in Part IV of Chapter 394, F.S. The new section in Part IV should blend the requirements in s. 394.9082(10), F.S., and s. 394.461(4)(a)-(b), F.S., and incorporate recommendations in this section for the reporting requirements for Marchman Act and Baker Act. 5. Require all Baker Act and Marchman Act Involuntary Petitions, Court Orders, Professional Certificates, Law Enforcement Reports, and treatment plans to be electronically submitted (or uploaded) using the Acute Care Database. Provide for the secure electronic transmission, and storage of all documents and data entered into the system consistent with 42 CFR Part II, HIPAA, and Chapters 394 and 397, F.S. AHCA would have access to all Baker Act-related data and documents, while the Department would have access to all Baker Act and Marchman Act-related data and documents.[18]

Additional Considerations	
Recommendations	1. In light of the recommendations in this report, the Department's methods of purchasing capacity for CSU, ARF, and residential detoxification beds warrants additional analysis of capacity versus utilization, and consideration of alternative methods of purchasing capacity for crisis services and payment methodologies. 2. The current Baker Act and Marchman Act differ substantially in who is authorized to initiate petitions for involuntary treatment, the criteria, placement options, the role of the state attorney and public defender, and time frames for orders. Alignment in the processes and

[18] The Department would not share Marchman Act-related data with the Agency for Health Care Administration due to the confidentiality requirements of 42 CFR Part II, HIPAA, and Chapter 397, F.S.

	documentation required by these statutes can reduce bureaucratic barriers to accessing court-ordered treatment, while retaining the important protections of due process. 3. Unlike the Baker Act, the Marchman Act does not include any provisions explicitly prohibiting the charging of fees for the filing of petitions for involuntary assessment and stabilization, or involuntary treatment. The charging of fees for the filing of a petition(s) creates a barrier to accessing services. 4. Standardize time frames so that hearings for involuntary treatment petitions must be held within five court working days of filing; orders for initial or continuing involuntary treatment are for 90-day increments, with an option for courts to order more frequent reviews. 5. Consider standardizing timeframes so that involuntary examination under the Baker Act and involuntary assessment and stabilization under the Marchman Act must be completed within 72 hours. However, a physician or physician's assistant or psychiatric nurse acting under the physician may authorize up to an additional 48 hours based on a determination of need without court involvement. If admitted involuntarily, total time combined may not exceed 72 hours unless there is further court involvement or the physician identifies a need for the additional 48 hours.

V. Appendices

Appendix 1. Baker Act and Marchman Act Project Team Participants

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Appendix 3. CSU-SRT Statewide Map

Appendix 4. Addiction Receiving Facilities Statewide Map

Appendix 5. Public and Private Receiving Facilities

Appendix 6. Mobile Crisis Teams

Appendix 1

Participant	Affiliation
John Bryant, Assistant Secretary for Substance Abuse and Mental Health **(Chair)**	Department of Children and Families, Office of Substance Abuse and Mental Health
Melanie Brown- Woofter	Florida Council for Community Mental Health
Elizabeth Hockensmith	Department of Children and Families, Office of Substance Abuse and Mental Health
Ashley Schwab	Department of Children and Families, Office of Substance Abuse and Mental Health
Jeffrey Cece	Department of Children and Families, Office of Substance Abuse and Mental Health
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Annette Christy, Ph.D.	Florida Mental Health Institute, Department of Mental Health Law and Policy, University of South Florida
Mary Armstrong	Florida Mental Health Institute, Department of Mental Health Law and Policy, University of South Florida
Richard Brown	Agency for Community Treatment Services
Carali McLean	Agency for Community Treatment Services
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Doug Leonardo	Baycare Behavioral Health
Jerry Kassab	Aspire Health Partners
Vicki Garner	Aspire Health Partners
Shannon Robinson	Aspire Health Partners
Margo Adams	Florida Psychiatric Society
Jennifer Grandal	Office of the State Courts Administrator, Office of Court Improvement
Rose Patterson	Office of the State Courts Administrator, Office of Court Improvement
The Honorable Mark A. Speiser	Circuit Court Judge, 17th Judicial Circuit
Jane Johnson	Department of Children and Families, Office of the Chief of Staff
Herb Helsel	Department of Children and Families, Northeast Region
Nicole Stookey	Department of Children and Families, Office of Legislative Affairs
Yamile Diaz	Department of Children and Families, Southern Region
Silvia Quintana	Broward Behavioral Health Coalition
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Suzette Fleischmann	Cenpatico
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Susan E. Anderson, Esq.	FLORIDA ALFA (Florida Assisted Living Federation of

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Gail Matillo	FLORIDA ALFA (Florida Assisted Living Federation of America)
Susan Daurie	FLORIDA ALFA (Florida Assisted Living Federation of America)
Susan Harbin, Esq.	Florida Association of Counties
Neal Dwyer	Central Florida Behavioral Health Network
Betty Hernandez	South Florida Behavioral Health Network
Nicklaus J. Curley, Esq.	Real Property, Probate and Trust Law Section, The Florida Bar
Laurie Chesley	LSF Health Systems
Geovanna Dominguez	Central Florida Cares Health System, Inc.
Candy Hodgkins	Gateway Community Services, Inc.
Rich Rasmussen	Florida Hospital Association
Pamela Carter	Central Florida Behavioral Health Network
Sheriff Robert A. "Bob" Gualtieri	Pinellas County Sheriff's Office
Natalie Kelly	Florida Association of Managing Entities

Appendix 2

Baker Act and Marchman Act Project Team Fiscal Subcommittee's Cost Methodologies

In costing the Baker Act and Marchman Act three different methodologies were employed in an effort to triangulate results and to validate the projected cost to implement a "no wrong door" approach to mental health and substance abuse services statewide.

A variety of data sources were utilized in the development of the methodologies including the Department of Children and Families report on state funded CSU Beds, Detox beds, Addiction Receiving Facility (ARF) beds, hospital discharge data, and Managing Entity (ME) contractual information.

Assumptions:

The methodologies for cost of detox and ARF bed are based on reimbursement levels paid by the managing entities for the previous fiscal year. Cost methodology for the CSU beds is based on a study conducted by the Public Consulting Group (PCG) under contract with the Department of Children and Families based on a requirement included in the 2012 General Appropriations Act and issued on January 2013. These costs assume that beds are purchased on a bed availability model. If this is changed to a per diem reimbursement method, the costs would be higher.

There are no fixed capital outlay costs included.

The ratios are applied to the statewide population and the methodologies do not result in a projected cost by DCF Circuit, Medicaid region, or other geography.

Methodology 1: Beds Per Capita

Method 1: Beds per Capita Using DCF Funded Capacity					
	Total Beds Needed*	**DCF Funded Beds**	**Additional Beds Needed**	**CSU Unit Cost**	**Cost per Year for Additional Beds**
CSU Bed Need	1951	696	1255	$ 378.50**	$173,345,040
*DCF rule 65E-12.104(8), FAC, provides a guideline for planning CSU bed capacity of 10 beds per 100,000 people. Given the state population of 19,507,369, this generates a need of 1951 beds.					
**The $378.50 cost per bed was determined in the Public Consulting Group report commissioned by the Department of Children and Families titled: Department of Children and Families Crisis Stabilization Reimbursement Plan, 2013.					
	Total Beds Needed	**DCF Funded ARF and Detox Beds**	**Additional Beds Needed**	**Detox Unit Cost**	**Cost per Year for Additional Beds**
DCF Funded Detox Beds	975	377	598	$280.00	$61,153,256
The detox bed standard of 1 bed per 20,000 people is a proxy for discussion.					

				Grand Total Additional Cost	$234,498,295

This methodology calculates the number of beds that would be necessary statewide to meet the guideline of 10 beds per 100,000 population for CSU beds (per DCF Rule 65E-12.104(8) and the guideline of 5 beds per 100,000 population for Detox beds statewide (a proxy as no guideline exists in Rule at present). The cost is derived by projecting the cost per bed x the number of additional beds needed x 365 days (assuming that the beds are at capacity annually).

Detail:

DCF rule 65E-12.104(8) provides a guideline for Crisis Stabilization Unit (CSU) bed capacity of 10 beds per 100,000 population (or 1 bed per 10,000 people). According to the Bureau of Economic and Business Research the current population in Florida is 19,507,369. Applying the ratio of 1 bed: 10,000 population results in a total need of 1,951 CSU beds statewide.

Currently there are 696 DCF funded CSU beds (contracted CSU beds) statewide. Using a formula of (Total beds– Contracted beds= Additional bed need), 1,251 additional beds are needed statewide.

At a CSU Unit Cost of $378.50 per day (the bed cost reported in the Public Consulting Group (PCG) report of 2013) the cost per year for these additional beds is $173,345,040.

Research revealed that there is no standard in rule for Detox bed capacity. A standard of 1 bed per 20,000 population (5 beds per 100,000 population) was used in this Beds Per Capita methodology, and is a proxy for discussion. Applying the ratio of 1 bed: 20,000 population results in a total need of 975 Detox beds statewide. Currently there are 377 DCF funded Detox beds (DCF licensed and contracted Detox beds), resulting in a need of 598 additional Detox Beds.

The cost per day of Detox bed is $280.00 (the average current DCF reimbursement/contracted rate). The total cost per year for these additional beds is $61,153,256.

The grand total of the annual cost of the additional DCF funded CSU beds and DCF funded Detox beds needed statewide to meet the guidelines is $234,498,295.

Methodology 2: Central Receiving Facility Model

Method 2: Central Receiving Facility Model					
	Total Beds Needed	**AHCA Licensed CSU Beds and DCF Licensed**	**Additional Beds Needed**	**CSU Unit Cost**	**Cost per Year for Additional Beds**

		Detox Beds			
CSU/Detox Bed Need	3701	1541	2160	$ 378.50	$ 298,346,941
This system relies on flexible CSU, SRT, hospital, Detox, and Addictions Receiving Facility Beds. The combined total of all these beds equals 233, which based on a population of 1.2 million in Orange County results in a current capacity of 1.98 beds per 10,000 population.					
This system relies on funding from various sources: local, state, and private sources.					

The Orange County central receiving facility (CRF) has been operational for at least 10 years and is the result of an integrated model and funding system of service that brings together Law Enforcement, Mental Health and Substance Abuse providers, Justice and other stakeholders. The CRF is the single point of entry for mental health and substance abuse services in Orange County and provides services under both the Baker Act and Marchman Act.

Detail:

This model uses a variety of inpatient services including

Baker Act/Mental Health (193 beds):

87 Adult CSU beds, 20 Children CSU beds, 56 Hospital-contracted CSU beds, 30 Short Term Residential Treatment (SRT) beds; and Marchman Act/Substance Abuse (40 beds):

40 Detox beds

For a total of 233 beds. Note that 12 Addiction Receiving Facility beds are imbedded in the 87 Adult CSU beds and can be utilized based on demand.

According to the Bureau of Economic and Business Research the current population in Orange County is 1,227,995, resulting in a standard of 1.9 beds per 10,000 population. This is almost double the standard in the Bed Per Capita methodology. Applying this ratio to the statewide population (above) results in a need of 2,160 additional CSU and Detox beds statewide to bring the entire statewide system up to the central receiving facility model standard.

At a cost of $378.50 per day per bed, the annual additional cost is $298,346,941.

Methodology 3:

Method 3: 2014 Needs Assessment		
ME	**CSU Beds Unmet +**	**Detox Beds Unmet + Unfunded**

	Unfunded		
BBCBC	$2,427,836	$240,462	
BBHC	$7,803,999	$3,827,756	
CFBHN	$29,240,230	$5,209,649	
CFCHS	$25,264,316	$12,684,487	
LSF	$12,198,507	$2,028,571	
SEFBHN	$5,671,071	$2,577,580	
SFBHN	$21,629,091	$2,530,728	
Total	$104,235,052	$29,099,233	
		Grand Total	$133,334,285

Methodology 3 includes figures for unmet and unfunded need by managing entity according to self-reported data acquired by surveying Florida Council for Community Mental Health members in 2014. The survey included data regarding current utilization of services, wait list for services and current bed capacity and reimbursement rates compared to actual cost of providing the service.

The total additional annual funding necessary to meet the utilization need for CSU beds is $104,235,052 and $29,099,233 for Detox beds for a total of $133,334,285.

Actual Provider Cost:
This cost was generated on actual provider cost using figures developed by Public Consulting Group (PCG), an independent consultant contracted by the Department in 2013. According to PCG report entitled 'Department of Children and Families Crisis Stabilization Reimbursement Plan' the Average Cost per Bed Day is $378.50 for CSU beds.

In summary, costs for funding a "no wrong door" approach range from $133 - $298M, depending on which model is used. This represents total additional costs and should be funded between a partnership of state government, local governments, Medicaid and local communities.

State of Florida
Department of Children and Families
Crisis Stabilization Reimbursement Transition Plan

January 1, 2013

TABLE OF CONTENTS

1. INTRODUCTION

This *Crisis Stabilization Reimbursement Transition Plan* is presented by the Department of Children and Families to the Florida Legislature to fulfill the requirements of the legislative proviso found in Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346. This proviso mandates the Department to develop a plan to transition from capacity-based reimbursement to utilization-based ("per diem") reimbursement for mental health crisis stabilization services.

This section of the Transition Plan provides essential background information for understanding the proposed reimbursement model and its rationale, and the process that was used to develop it. Section 2 provides definitions of technical terms used throughout the document. Section 3 reports the results of a quantitative analysis of providers' costs of providing crisis stabilization services in Florida. Section 4 reports the results of a qualitative analysis of three of the state's local crisis stabilization systems of care. Section 5 describes the Department's proposed method of utilization-based reimbursement to meet the requirements of the legislative proviso. Section 6 describes the statutory and regulatory changes that would be required to implement the proposed method. Section 7 describes the steps the Department would need to take to implement the method. Section 8 discusses the potential impact of implementing the proposed reimbursement method.

Florida's Mental Health Crisis Services System

Florida's mental health crisis services system is governed by the Baker Act (Chapter 394, Part 1, Florida Statutes), which authorizes the Department to manage programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders through emergency rehabilitative services for persons requiring intensive short-term and continued treatment for recovery. The Baker Act provides for the involuntary examination of individuals who, due to mental illness, present a threat to themselves or others, or are unable to care for themselves on a basic level. The Baker Act also allows individuals who are competent to consent to be admitted for crisis services on a voluntary basis if they appear to have a mental illness and may benefit from treatment.

Requirements of the Legislative Proviso

In proviso of the 2012 General Appropriations Act, the Florida Legislature mandated that:

> "The department shall develop a plan to modify the method of expending funds for crisis stabilization services to establish per diem reimbursement for covered services provided to qualified patients. The department's recommended method shall be budget neutral and shall allow use of available funds to reimburse a variety of providers, including public

receiving facilities, community mental health programs, licensed acute care hospitals, or other approved facilities. The plan shall be submitted to the Legislature no later than January 1, 2013 and shall identify steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.)

Thus the essential requirements of the plan are that it:

a) Establish utilization-based ("per diem") reimbursement.
b) Maintain budget-neutrality.
c) Allow reimbursement of a variety of provider types to the extent possible.

The Department has decided to incorporate two additional major elements in the plan, which were not specifically mandated by the proviso:

d) Competitive procurement of Department-funded crisis stabilization services by managing entities (MEs).
e) Utilization management of Department-funded crisis stabilization services by MEs.

Crisis Stabilization Unit (CSU) Workgroup

The Crisis Stabilization Unit (CSU) Workgroup was convened by the Department and met monthly from May through November 2012 (except during July) to advise the Department on the development of this Transition Plan. Workgroup participants included executives of hospitals and CSU providers, representatives of the law enforcement community, and Department staff. The Workgroup was charged with advising on the following matters: the process and criteria to be used in the establishment of per diem reimbursement; criteria to be used in the competitive procurement process for crisis stabilization services; possible changes to the requirements for a facility to be designated as a Baker Act receiving facility; possible changes to the roles of public and private receiving facilities; and types of facilities that should be eligible to serve as receiving facilities.

Public Consulting Group (PCG)

Public Consulting Group (PCG) was contracted by the Department to facilitate the meetings of the CSU Workgroup and conduct related research. PCG conducted a quantitative analysis of utilization, funding and provider costs throughout the state's crisis stabilization system. PCG also evaluated the crisis stabilization service systems as they currently operate in three of the Department's regions, in order to provide background information for the development of this Transition Plan. PCG also collaborated with Department staff in the development of this Transition Plan document.

Managing Entities (MEs)

The Department is in the process of implementing managing entities (MEs) statewide. MEs are private, non-profit corporations contracted by the Department to take over many of the administrative responsibilities that had previously belonged to the regional or circuit offices of the Department. MEs are already operating in most of the state and are expected to cover the entire state by March 1, 2013. The central role of MEs is to subcontract with community mental health and substance abuse providers that are funded by the Department, including public receiving facilities. Thus, the reimbursement model described in Section 5 of this Transition Plan assigns MEs (rather than the Department) responsibility for competitively procuring public receiving facility contracts.

2. DEFINITIONS

This section defines key terms that are used throughout this Transition Plan.

1) **Baker Act:** Chapter 394, Part I, Florida Statutes; regulates mental health services; provides for the involuntary examination of individuals who, due to mental illness, present a threat to themselves or others, or are unable to care for themselves on a basic level; allows individuals who are competent to consent to be admitted for crisis services on a voluntary basis if they appear to have a mental illness and may benefit from treatment.

2) **Budget neutral:** Not requiring any legislative appropriations above the level appropriated for the most recent fiscal year.

3) **Capacity-based reimbursement (or funding):** A funding mechanism wherein the Department contracts with each public receiving facility for a certain number of beds to be available for Department clients, and provides the same amount of reimbursement to the facility each year regardless of the number of beds actually used by Department clients.

4) **Client:** Any individual receiving services in any substance abuse or mental health facility, program, or service, which facility, program, or service is operated, funded, or regulated by the department. (s. 394.67(2), F.S.)

5) **Crisis stabilization services:** Brief, intensive services provided twenty-four (24) hours per day, seven (7) days per week for individuals experiencing a mental health crisis. Crisis stabilization services include services associated with involuntary examination and voluntary admission under the Baker Act.

6) **Crisis stabilization unit (CSU):** A program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state. (s. 394.67(4), F.S.)

7) **Department client:** A client whose household income is below the Federal poverty guideline; who has no payor source available other than the Department; and who is receiving services from a Department-contracted provider. Department clients are eligible for Department-funded crisis stabilization services.

8) **Express and informed consent:** Consent voluntarily given in writing, by a competent person, after sufficient explanation and disclosure of the subject matter involved to

enable the person to make a knowing and willful decision without any element of force, fraud, deceit, duress, or other form of constraint or coercion. (s. 394.455(9), F.S.)

9) **Facility:** Any hospital, community facility, public or private facility, or receiving or treatment facility providing for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who appear to have a mental illness or have been diagnosed as having a mental illness. (s. 394.455(10), F.S.)

10) **Incompetent to consent to treatment:** A person's judgment is so affected by his or her mental illness that the person lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. (s. 394.455(15), F.S.)

11) **Involuntary examination:** A mental health examination conducted by a receiving facility under the authority of the Baker Act and without the express and informed consent of the individual examined, for the purpose of determining whether the individual meets criteria for involuntary placement. An involuntary examination may be initiated by a licensed health care professional, a law enforcement officer, or by the circuit court upon petition from any party. The criteria for involuntary examination are that the individual appears to have a mental illness, presents a danger to self or others because of the mental illness, and that no less restrictive alternative is available to relieve the danger. (s. 394.463, F.S.)

12) **Private facility:** Any hospital or facility operated by a for-profit or not-for-profit corporation or association that provides mental health services and is not a public facility. (s. 394.455(22), F.S.)

13) **Public facility:** Any facility that has contracted with the Department to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such purpose in accordance with contracts negotiated by the Department's Regional Office or by a Managing Entity (ME). All CSUs are public receiving facilities; hospitals may be either public or private receiving facilities. (s. 394.455(25), F.S.)

14) **Receiving facility:** Any public or private facility designated by the department to receive and hold involuntary patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment. The term does not include a county jail. (s. 394.455(26), F.S.)

15) **Transportation exception plan (TEP):** A plan authorized by the Department and by a Board of County Commissioners pursuant to s. 394.462(4), F.S., allowing individuals

within a specific county to be transported to a receiving facility other than the nearest one under specified circumstances to improve service coordination and better meet clinical needs.

16) **Universal service requirement:** The requirement under s. 394.462(1) (j), F.S. that receiving facilities accept all individuals brought by law enforcement for involuntary examination.

17) **Utilization rate:** A ratio calculated for each facility providing crisis stabilization services by dividing the number of bed days actually utilized by Department clients during a year by the number of bed days contracted for by the Department.

18) **Utilization-based funding:** A funding mechanism wherein the Department reimburses providers on a per diem basis for the number of bed days actually used by Department clients.

19) **Utilization target**: In the reimbursement method proposed by this Transition Plan, the minimum number of bed days used by Department clients during a fiscal year which a crisis stabilization services provider must provide in order to receive the full value of the provider's contract with its managing entity (ME).

20) **Voluntary admission:** The admission of an individual to a facility with the individual's express and informed consent.

3. PROVIDER COSTS IN FLORIDA'S CRISIS STABILIZATION SYSTEM

A key component of any analysis of reimbursement methodologies for a system of care is a review of existing provider data. In this section, we have documented the analysis of the current crisis stabilization system in Florida on the basis of the provider costs of providing crisis stabilization services to Department clients. The following subsection will provide an overview of the methodology used to capture crisis stabilization service provider costs, the data collection process, and the analysis of the provider data. Limitations of the data are also discussed. It should be emphasized that the analyses reported here concern the providers' costs of providing services, not the cost to the Department.

In conducting the analysis, the data was reviewed in multiple ways to provide various perspectives on the system. The data was initially reviewed on a statewide basis and broken out by total cost per bed day for adult and children's units combined and then the cost per bed day by adults and by children's units discretely. The second analysis was done in a similar fashion; however the data was broken out based on Department region. The third analysis compared the cost per bed day for a crisis stabilization unit (CSU) versus a hospital receiving facility.

Data Collection Methodology

Public Consulting Group (PCG) initially set out to conduct a quantitative analysis of the crisis stabilization system in Florida with a focus on Department-funded providers (public receiving facilities) with the results of the analysis to be used to inform future rate development exercises. At the August, 2012 CSU Workgroup meeting, PCG initiated the discussion about the future data collection efforts to be completed. During this discussion, PCG staff identified the data they would seek to collect from crisis stabilization providers. PCG noted that, because Medicare and Medicaid cost reports were not available for all providers, this data collection effort would likely require the development of a survey to be completed by all crisis stabilization service providers. CSU Workgroup participants proposed using the data provided by the public receiving facilities in the Department's Agency Capacity Reports rather than developing a new survey tool and asking providers to duplicate existing efforts. One limitation of this option is that, in general, only the crisis stabilization providers designated as public receiving facilities have completed the Agency Capacity Reports; as a result, the private receiving facilities would still have needed to be asked to complete a survey in order to capture a comprehensive data set.

Following the August CSU Workgroup meeting, Department staff, in consultation with PCG, began developing utilization-based reimbursement models to be presented during the September CSU Workgroup meeting. Through these discussions, it became apparent that rates would be set in negotiations with the Managing Entities; therefore, there was no need for this Transition Plan

to specify rates or rate formulas. The Department agreed that PCG should proceed with the quantitative analysis using the Agency Capacity Report data for the public receiving facilities. The remainder of this section describes the data collection efforts and the analysis of the data obtained.

Data Collection Process

Prior to collecting data, PCG conducted initial research to better understand Agency Capacity Reports, the data included in them, limitations of this data, and the role of these reports in contract negotiations between the Department and the public receiving facilities. As part of these efforts, PCG interviewed staff of two managing entities (MEs): South Florida Behavioral Health Network and Lutheran Services of Florida. Some of the key conclusions follow.

- ***Reimbursement rates are calculated based on 100% utilization rates.*** One of the main limitations of the Agency Capacity Report data is that it assumes a utilization rate of 100 percent. While this assumption was acceptable under the capacity-based model, it presents a challenge in using the data to determine an appropriate rate for utilization-based funding. One ME staff member suggested that the maximum days be calculated using 85% as an estimate for the utilization rate. This alone, however, would not address the issue of different utilization rates for adults and children. In reviewing the analysis in the following pages it should be noted that all rates are based on this same assumption of 100% utilization as this is the representation of the actual data reported by providers.

- ***The Role of Agency Capacity Reports in contract negotiations varies by ME and Department region.*** The use of Agency Capacity Report data in contract negotiations varies across the state. Agency Capacity Reports are often not used in determining the rate the crisis stabilization providers receive. It was noted by one of the managing entities interviewed that due to the statewide maximum rates that are set in rule for both adult and child crisis stabilization services, there is little room for the negotiation of rates. Therefore, the Agency Capacity Report data is only used to determine rates for providers who are found to have rates below the statewide maximum rates, in which case those providers would receive a rate based on the costs identified in their Agency Capacity Report. In the rare event that the DCF Regional Office or Managing Entity makes the determination to appeal for a higher rate for a provider, the Agency Capacity Report data may be used to support that request.

Following PCG's research on the Agency Capacity Report data, PCG contacted the Department's regional contract managers to begin data collection. PCG, with the help of DCF Central Office, also reached out to the Department's Regional Managers and to the managing entities to assist in the collection of the Agency Capacity Report data. One of the greatest

challenges of this phase of the engagement has been the identification of the appropriate staff to provide the Agency Capacity Report data, since the Department's regions are in various stages of implementing the managing entities.

Analysis of Agency Capacity Reports

The analysis of the Department-funded crisis stabilization system presented in the following sections is based on the data reported by the public receiving facilities on their Agency Capacity Reports. The data was received through the Department's regional offices; the managing entities; and in some cases directly from the providers themselves. PCG has accepted the data as reported without any substantial audit efforts. In the preparation of the analysis, PCG would like to note the following major limitations:

- ***Data has been received for 28 public receiving facilities.*** At the time of this analysis, PCG has only received data for 28 public receiving facilities out of a total of 64 possible providers. In some cases, the data has been combined for a provider with multiple locations as was the case for the four PEMHS locations. While considering the providers that submitted one report for multiple locations does help to reduce the number of facilities for whom no data was received, there are still a significant number of facilities not included in this analysis.

- ***Some providers did not differentiate between adult and children's services.*** Another limitation of the analysis is that some providers that were identified as having both adult and children's services only provided data in the aggregate for all crisis stabilization services. Where possible, PCG attempted to separate the bed capacity data between adult and children's categories with the reported expense separated proportionally between the two. As a result, the analysis of the cost per bed day for the adult versus children's services may not provide as clear a distinction as might be expected.

The Appendix lists those public receiving facilities that have submitted Agency Capacity Report data included in the analyses. PCG also received data from Sarasota Memorial Hospital (Bayside Center for Behavioral Health) and Central Florida Behavioral Hospital (Baycare Behavioral Health). However, as private receiving facilities, their data was excluded from the analysis.

PCG has conducted three separate analyses on the cost per bed day as reported on the Agency Capacity Report by the public receiving facilities. The first analysis looks at the statewide cost per bed day, while the second analysis looks at the cost per bed day on a regional basis. The third and final analysis compares the cost per day for crisis stabilization units (CSUs) versus hospital providers. In each of the three analyses, we have examined the data in the aggregate (including both adult and children's services); for adult services only; and for children's services only.

Statewide Analysis

In the statewide analysis, the Agency Capacity Report data for all providers has been combined to identify the statewide average cost per bed day. Again, this analysis looks at adult and children's data both separately and in combination. The following table summarizes the results.

	Statewide
Total Bed Days Available	314,432
Total Expense	$ 119,013,554
Average Cost per Bed Day	**$ 378.50**
Total Bed Days Available - Adult	272,136
Total Expense - Adult	$ 102,597,490
Average Cost per Bed Day - Adult	**$ 377.01**
Total Bed Days Available - Child	42,296
Total Expense - Child	$ 16,416,063
Average Cost per Bed Day - Child	**$ 388.12**

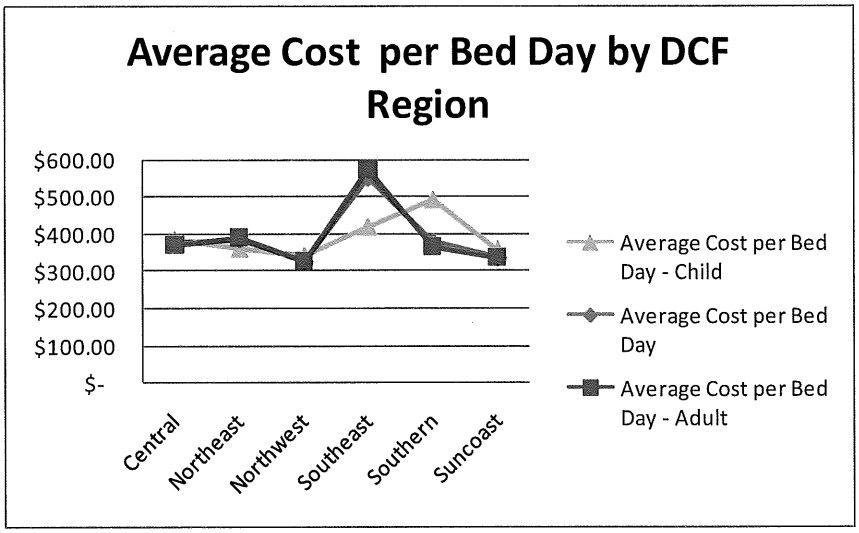
The analysis of the cost per bed day on the statewide basis illustrates two key points: first, the statewide average cost per bed day for crisis stabilization services ($378.50) is greater than the state's maximum rate of $291.24; second, the average cost per bed day for children's crisis stabilization services ($388.12) is higher than the cost per bed day for adult crisis stabilization services ($377.01).

Regional Analysis

The regional analysis, like the statewide analysis, includes the available bed days, the total expense and the cost per bed day. It should be noted that there are limitations to this analysis given the limited number of Agency Capacity Reports received. For example, Agency Capacity Report data was only received for three of the fifteen public receiving facilities in the Central region. Likewise, the data for the Southeast region includes only two of the eleven public receiving facilities.

	REGION					
	Central	Northeast	Northwest	Southeast	Southern	Suncoast
Total Bed Days Available	29,930	61,050	22,070	29,565	58,412	113,406
Total Expense	$ 11,210,965	$ 23,587,556	$ 7,263,521	$ 16,279,237	$ 22,229,902	$ 38,442,374
Average Cost per Bed Day	**$ 374.57**	**$ 386.37**	**$ 329.11**	**$ 550.63**	**$ 380.57**	**$ 338.98**
Total Bed Days Available - Adult	21,900	50,830	21,749	24,820	52,572	100,266
Total Expense - Adult	$ 8,112,871	$ 19,902,856	$ 7,153,600	$ 14,281,777	$ 19,354,605	$ 33,791,782
Average Cost per Bed Day - Adult	**$ 370.45**	**$ 391.56**	**$ 328.92**	**$ 575.41**	**$ 368.15**	**$ 337.02**
Total Bed Days Available - Child	8,030	10,220	321	4,745	5,840	13,140
Total Expense - Child	$ 3,098,094	$ 3,684,700	$ 109,921	$ 1,997,460	$ 2,875,296	$ 4,650,592
Average Cost per Bed Day - Child	**$ 385.81**	**$ 360.54**	**$ 342.43**	**$ 420.96**	**$ 492.35**	**$ 353.93**

The cost per bed day is quite variable across the different regions in the state. Further, given that a large number of beds included in the analysis were adult beds, the average cost per bed day for adults closely mirrors that of the aggregate average cost per bed day. The following chart depicts the variability in cost per bed day across the five regions of the state for which Agency Capacity Report data was received.



Crisis Stabilization Unit (CSU) vs. Hospital Analysis

The final component of the analysis was to look at the cost per bed day for the CSU providers against the cost per bed day for the hospital providers. Like the previous two analyses, this analysis compares the cost per bed day in the aggregate and then the cost per bed day for adults and children separately. One limitation of this analysis is that, of the thirteen public receiving facilities that are hospitals, only five submitted Agency Capacity Report data to be included in the analysis. A second limitation is that, of the five hospitals for which data was included in the

analysis, only one reported costs associated with children's beds. The following table presents the results of this analysis based on the data received from those five hospitals.

	CSU	Hospital
Total Bed Days Available	267,618	46,815
Total Expense	$ 94,351,606	$ 24,661,948
Average Cost per Bed Day	**$ 352.56**	**$ 526.80**
Total Bed Days Available - Adult	230,067	42,070
Total Expense - Adult	$ 79,933,003	$ 22,664,488
Average Cost per Bed Day - Adult	**$ 347.43**	**$ 538.73**
Total Bed Days Available - Child	37,551	4,745
Total Expense - Child	$ 14,418,603	$ 1,997,460
Average Cost per Bed Day - Child	**$ 383.97**	**$ 420.96**

The costs per bed day for crisis stabilization services in the hospital setting were significantly higher than the costs per bed day for crisis stabilization services in the stand-alone CSUs. This is consistent with the general understanding that CSUs provide a less costly alternative to hospitalization. While the table above shows that the average cost per bed day for adults is greater than that for children's, this may not be an accurate representation as the children's data includes only one hospital.

Conclusions

As the preceding analyses illustrate, the cost per day for crisis stabilization services in Florida are on average over $375 per day. While there are some providers whose cost per day is less than this figure, the preceding analyses clearly show that the existing maximum (model) rate of $291.24 per day, as defined in Florida Statute, does not cover the costs incurred by crisis stabilization providers in serving DCF clients. Given the language in the legislative proviso and the requirement to remain budget neutral within a utilization-based reimbursement approach it is safe to assume that providers will continue to realize reimbursement at rates below their costs in providing these services.

4. EVALUATION OF CRISIS STABILIZATION SYSTEMS OF CARE

To inform the development of the proposed reimbursement model, Public Consulting Group (PCG) conducted a qualitative evaluation of three of the state's existing local mental health crisis systems of care: Broward County, Circuit One, and Orange County. The findings of this evaluation are reported in this section.

The Broward County System of Care

Broward County, which includes Ft. Lauderdale, has three public receiving facilities, as well as five hospitals serving as private receiving facilities. The county uses a central receiving facility model that allows the burden of Department clients to be shared equitably, primarily across the three public receiving facilities and, when necessary, across the five private receiving facilities. Since a payment model that would be based on a central receiving facility structure is proposed in Section 5 of this plan, PCG interviewed staff from the Department's Southeast Regional Office familiar with Broward's system of care.

In the mid-1990s, the Department decided that Broward County had an excess of crisis stabilization beds; the Department reorganized the system with input from stakeholders, downsizing from 90 beds to 60 beds. All of the receiving facilities had been clustered in part of the county; new facilities were contracted in different areas of the county.

Currently, there are three CSUs in Broward County: one in the central area, one in the eastern area, and one in the southwestern area. Individuals are transported to the nearest receiving facility, whether public or private, and are transferred, if necessary, after being evaluated at that facility. Only one CSU admits children; all three admit adults.

By opening three sites, Broward increased the number of funded beds; yet there are still circumstances in which there is a significant amount of overflow. When overflow occurs and there are no publicly-funded beds available, there is a rotation between the private facilities that accept individuals for whom they know they will not be reimbursed for providing services. Private hospitals have been accepting individuals in this situation for the past few years. One of the Broward CSUs is located in a private hospital that has a larger capacity than can be funded; however, the hospital will provide additional beds without reimbursement when needed.

The three public facilities take turns acting as a central receiving facility by managing the system for transporting indigent patients to private facilities in overflow situations. Each month, a different public facility maintains the log that records which private facility is up on the rotation to accept an indigent patient. The individual is then sent to whichever facility is next on the

rotation, as long as they have an available bed, which is typically easy to determine as the availability of beds at each facility is recorded daily.

Law enforcement is not responsible for transporting individuals after they have been brought to a facility and evaluated; the facility is responsible for transporting them to another facility, if necessary.

Workgroup participants expressed concerns about the conflict of interest that could arise from a central receiving facility providing clinical services and determining transfer destinations. In Broward this problem is mitigated by the three public receiving facilities rotating the responsibility for determining transfer destination.

The Department regional staff interviewed noted that the system of care depends on positive relationships among the Department's Regional Office, the public facilities, and the private facilities, and on the commitment of the administration at the private facilities. Whenever there is a change in administration at the private facilities, there is cause for concern that the relationship may change.

The central receiving facility model used in Broward County has worked well in that community, and seems to function best in more densely populated areas. There are other aspects of Broward that make it unique: the county and other local stakeholders provide funding at a higher level than in most areas of the state; and outpatient services have been reduced in order to shift funding to crisis stabilization services. Thus, replicating the central receiving facility model that is used in Broward may not be feasible in other regions in the state due to the different levels of funding, community support, and population density.

Regional office staff also encouraged the workgroup to ensure that the Baker Act Task Force is maintained through the current changes to the CSU structure; they emphasized the importance of this group, consisting of essential stakeholders that have been meeting regularly since 1975, and its contributions to the success of the central receiving facility.

The Circuit One System of Care

The Department's Circuit One, identical in boundaries to the First Judicial Circuit, is located in the western portion of the Florida Panhandle and is comprised of four counties: Escambia, Okaloosa, Santa Rosa, and Walton. Circuit One is part of the Department's Northwest Region. The Circuit One system of care already functions under what may be called a "quasi-utilization-based" model. Thus it serves as an informative model for the transition to utilization-based funding. PCG interviewed staff of Lakeview Center, the managing entity responsible for Circuit One, about their system of care and the benefits and challenges associated with it.

Circuit One's quasi-utilization-based model was the result of a change in the payment methodology implemented by the ME a few years ago. The Northwest Region's public receiving facilities operate with a capitated model, but they also are required to show that their funding is reflective of the number of beds used. The facility maintains a data warehouse where information concerning utilization is collected from monthly reports; funding is based on this utilization data. The two CSUs in Circuit One, Lakeview Center and Bridgeway Center, submit annual utilization reports to the data warehouse and are subject to an annual contract negotiation to set target rates.

Currently, when a Department client is brought to a CSU that is at capacity, the client is transferred to another facility that has available beds. If there are no Department-funded beds left in any of the public facilities in Circuit One, clients are transported to a local hospital private receiving facility.

PCG asked ME staff about the advisability of implementing a tiered rate structure, wherein facilities would receive a higher rate for the first one to three days and a lower rate thereafter. Theoretically, such a rate structure could yield shorter stays by incentivizing more efficient treatment and discharge planning. The ME does not use tiered rates; staff explained this would not be necessary as there is no incentive to hold individuals overlong as it is: it would damage relations with law enforcement and other community stakeholders since there would be a lack of bed availability.

The Department's proposed reimbursement model (described in Section 5 of this Transition Plan) includes competitive procurement of public receiving facilities by MEs. Lakeview Center staff expressed some concerns about the introduction of competitive procurement for crisis stabilization services. CSUs are presently the lowest cost provider of these services (as discussed in Section 3); and Lakeview Center uses the maximum ("model") rate for it subcontracted providers. Lakeview Center staff report that if they had to use competitive procurement to award their contracts, the rates would likely increase. Providers would then increase their rates, which could detriment the whole system.

Lakeview Center's use of a quasi-utilization-based model in Circuit One has not resulted in any change of funding levels. There has been an increase in administrative workload as providers must now demonstrate they are providing a certain number of bed days of services in order to receive their contracted funding. However, facilities have had no difficulty meeting their utilization target. Nevertheless, utilization-based funding as it exists in the Northwest Region may not work for smaller CSUs elsewhere in the state that cannot rely on having their beds filled consistently.

The Orange County System of Care

In Orange County, which includes Orlando, a central receiving facility, the Central Receiving Center (CRC), has served individuals in need of substance abuse services as well as those in need of Baker Act crisis stabilization services since 2002. Law enforcement transports individuals to the CRC where, after an initial assessment, the individual is either released or transported to the most appropriate facility based on clinical needs, payor source, and bed availability.

Public and private receiving facilities (including CSUs and hospitals) work in cooperation with the CRC and accept transfers from it. Department clients are assigned to facilities on a rotating basis to ensure fair and efficient sharing of the burden of care. Members of the CRC staff manage the rotation list, which does not pose a conflict of interest as the CRC does not house any crisis stabilization beds. For the first few years of operation, in order to ensure fairness, an administrative service organization (ASO) was hired to manage the assignment of clients to facilities. Eventually, the facilities took over this task themselves, with responsibility for managing the process rotating among the facilities each month. Orange County has a Transportation Exception Plan (TEP), as authorized under s. 394.462(4), F.S., allowing law enforcement to bypass the nearest receiving facility and transport all individuals in crisis directly to the CRC.

Prior to the adoption of the central receiving facility model, Baker Act transportation had become a significant burden on law enforcement; officers were spending hours at a time in hospital emergency departments, monitoring individuals who were awaiting examination. Now, officers need only spend a few minutes at the CRC to drop off an individual for examination. As a result, the central receiving facility model has strong support from local law enforcement agencies.

Orange County's system of care has proven to work well and is arguably replicable in some other areas of the state. The facility has served to decrease the incarceration rate of individuals with mental illnesses and substance abuse issues in the region, by giving this population access to rapid assessments and appropriate referrals.

5. PROPOSED METHOD OF UTILIZATION-BASED REIMBURSEMENT

The legislative proviso mandating this plan states, in its entirety, that:

> "The department shall develop a plan to modify the method of expending funds for crisis stabilization services to establish per diem reimbursement for covered services provided to qualified patients. The department's recommended method shall be budget neutral and shall allow use of available funds to reimburse a variety of providers, including public receiving facilities, community mental health programs, licensed acute care hospitals, or other approved facilities. The plan shall be submitted to the Legislature no later than January 1, 2013 and shall identify steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.)

This section describes the proposed reimbursement model. The Basic Model would apply statewide while the Access Centers Option could be implemented in particular geographic areas at the discretion of the MEs. With or without the Access Centers Option, the Basic Model:

- Meets the requirements of the legislative proviso to implement utilization-based funding while remaining budget neutral.
- Introduces competitive procurement and utilization management.
- Maintains the universal service requirement.

The Basic Model

The features of the Basic Model would apply statewide. The managing entities (MEs) would be largely responsible for the implementation and operation of the approach. The ME would divide their geographic area into procurement areas and competitively procure one or more public receiving facilities for each procurement area. The procurement areas would be based on community need, location of existing facilities, and utilization history. Maps delineating procurement areas would be subject to final approval by the Department. Bids would be accepted from any crisis stabilization unit (CSU) or hospital licensed to provide psychiatric care, located within the procurement area, and able to demonstrate the ability to meet the Baker Act requirements for designation as a receiving facility. Analysis by Department staff and Public Consulting Group has determined that no other types of facilities would have the capability to provide Baker Act services; comments from the CSU Workgroup confirm this. Bidders would be eligible regardless of for-profit or non-profit status, and could include new entrants to the Baker

Act market. Integrated crisis stabilization unit/addictions receiving facilities (CSU-ARFs), which focus on co-occurring substance abuse and mental health disorders, would be eligible to bid.

MEs would establish criteria for competitive procurement, including quality of care indicators, costs, and strength of community partnerships. The MEs would have the option of formally eliciting public input on these procurement criteria, including feedback from key stakeholders such as local providers, law enforcement agencies, county and municipal governments, and consumer and family advocacy organizations. At the managing entity's discretion, this process could include public meetings. The contracts resulting from the procurement process would be awarded for a four year term, the same as the term of the Department's contracts with the MEs. As at present, facilities that were not awarded contracts, or did not bid for them, could still be designated by the Department as private receiving facilities.

The reimbursement for crisis stabilization services would be on a utilization (per diem) basis with the MEs negotiating rates with each public receiving facility in the procurement process. In order to maintain budget neutrality, the MEs would also negotiate monthly reimbursement caps with these providers, taking into consideration providers' costs and the number of licensed beds. Monies paid to providers by MEs could not exceed the monthly cap, which would be set to ensure the ME does not exceed its total budget for crisis stabilization services. The MEs would be required to report to the Department in a monthly or quarterly reconciliation process to ensure all Department funding is being expended in an appropriate manner. Public receiving facilities would continue to be required to accept individuals for examination, regardless of ability to pay, even after reaching their monthly reimbursement cap. The same requirement would apply to private receiving facilities.

Finally, the MEs would negotiate monthly utilization targets, in terms of the number of bed days utilized by Department clients. In setting utilization targets, MEs would have the option of using data reflecting utilization history for the region, circuit, county, or procurement area, as long as this was done consistently across the ME's subcontracted providers. MEs could use the Department's available historical utilization data, or data the MEs themselves have collected, or may collect in the future.

Reimbursement rates, reimbursement caps, and utilization targets would be set in such a way that a provider would earn the full value of the reimbursement cap as long as their utilization did not fall significantly (2 - 10%) below the historical norm for adult services. Children's services would have a larger cushion (15%). This would help providers adapt to the new system by giving them a cushion so that they would not lose revenue if there is a small decline in utilization. However, if utilization fell further, the provider would see a decline in revenue.

The following steps summarize the process for determining the utilization targets and reimbursement caps for adult units:

1. Negotiate a reimbursement cap dollar amount based on the number of licensed beds, available budget, and market conditions;
2. Select a utilization target for adult services that is between 90% and 98% of the number of bed–days expected to be utilized, based on historical data (85% for children's services);
3. Divide the reimbursement cap by the target number of bed days to calculate the bed-day rate; and
4. Reallocate reimbursement caps among providers annually, based on utilization patterns.

For adult units, providers may earn less than the value of their reimbursement cap, because actual utilization may fall below the utilization target. However, setting the target slightly below 100% would help providers adapt to the new system by giving them a cushion so that they would not lose revenue if there is a small decline in utilization. For children's units, rates and utilization targets would be set in a similar manner, except that the utilization target would be set at 85% of the historical norm, allowing children's crisis stabilization services providers to have a relatively stable revenue stream even though utilization may be highly variable. This would allow the MEs to accommodate the relatively low utilization levels for children's units that arise from the small number of beds in children's units and the high variability of utilization. This flexibility is necessary to ensure that children's beds are available when they are needed, even if they are at times unused.

In addition to the crisis stabilization services, MEs would have flexibility to include contract provisions for reimbursement for alternative services that reduce the need for crisis stabilization, including mobile crisis services and drop-in centers. The reimbursement for these services would, however, count toward the reimbursement cap for that provider. MEs would also have the option of building into subcontracts incentives for providers to divert individuals into less costly and less restrictive alternative crisis services, when appropriate.

Finally, under the Basic Model, MEs would provide utilization management for contracted providers. The utilization management function would include:

- Automatic preauthorization by the ME for reimbursement of three bed days for individuals admitted for involuntary examination, based on the facility's determination that the individual does not meet criteria for release in the "initial mandatory involuntary examination" required by Rule 65E-5.2801(1);

- Automatic preauthorization by the ME for additional days for individuals awaiting hearing for involuntary placement after the filing of the petition by the facility;
- Automatic preauthorization for individuals on a waiting list for admission to a state mental health treatment facility; and
- Concurrent review by the ME for reimbursement of voluntary admissions.

The Access Centers Option

The Access Centers Option uses competitive procurement to select the central receiving facility (access center), which would itself be a contracted receiving facility, as well as other contracted receiving facilities. As in the Basic Model, MEs would negotiate rates, reimbursement caps, and utilization targets with individual providers. Facilities not awarded contracts could still be designated as private receiving facilities. All public receiving facilities would be obligated by contract to accept transfers of individuals, as assigned by the access center, within the capability and licensed capacity of the destination facility.

The features of the Access Centers Option would be added on to the Basic Model in certain counties, or portions of counties, at the discretion of MEs. The Access Centers Option leverages the concept of central receiving facilities, which already exist and work well in some areas of the state.

The main features and functions of the access center under this option are listed below.

- The access center would receive and examine all individuals transported by law enforcement. The access center would complete the "initial mandatory involuntary examination" required by Rule 65E-5.2801(1), unless immediate transfer was needed for medical reasons. This would allow access centers to release individuals (when clinically appropriate) without transferring them to another facility. The initial exam includes the following elements:
    - A review of the individual's documented recent behavior that led to the exam being initiated;
    - A brief psychiatric history;
    - A face-to-face examination by a physician or clinical psychologist;

  - The ME could require by contract that the initial exam be done by a psychiatrist; and
  - The ME could require by contract that the initial exam be completed within a certain time frame, such 6 hours, in order to improve the efficiency of the system of care.

- The access center would provide brief crisis intervention and refer to outpatient services to avoid admissions when clinically appropriate.
- The access center would receive a standard rate negotiated with the ME for each individual examined.
- The access center would determine whether the individual met criteria for involuntary examination and release the individual promptly if the criteria were not met.
- The access center would transfer clients to another receiving facility if criteria were met, or if extended observation were necessary.
- The access center would approve reimbursement of bed days as in the Basic Model, except that no bed days would be needed if the individual were released directly from the access center.
- The access center would provide overflow capacity when all other local receiving facilities (public and private) were at licensed capacity.

The Access Center Option, like the Basic Model, would incorporate utilization management. Under this option, the ME would assign one of its own staff members to each access center to function as a utilization management specialist ensuring that clinical functions would be separated from utilization management functions. The ME utilization management specialist would determine transfer destination systematically, based on the clinical needs of the individual, payor source available, and bed availability. Basic protocols for determining transfer destination would be included in Transportation Exception Plans (TEPs), making them subject to public comment and approval by the Department. More detailed criteria for transfers – especially medical criteria - would be subject to ME discretion, but codified in written procedures.

6. REQUIRED STATUTORY AND REGULATORY REVISIONS

The Department, in consultation with Public Consulting Group (PCG), conducted an analysis to identify any changes to statute or rule that would be required in order to implement the reimbursement model proposed in Section 5 of this report. The only needed change identified is an amendment to Rule 65E-14.021 (Unit Cost Method of Payment), Florida Administrative Code, to eliminate the maximum ("model") rate ($291.24) for crisis stabilization services. This would give managing entities the flexibility they need to negotiate rates with each subcontracted public receiving facility based on market conditions and available budget. Under the proposed model, there would be no maximum, minimum, or "model" rate.

7. STEPS FOR IMPLEMENTATION OF THE PROPOSED REIMBURSEMENT METHOD

The legislative proviso mandating this Transition Plan required that the Plan identify "steps necessary to transition to the new payment system." (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346.) This section describes those steps.

Steps for Implementation

1) *The Department will complete the statewide implementation of managing entities (MEs).*

   This Department initiative has been in progress for several years and is expected to be completed by March 1, 2013. Since MEs play a central role in the proposed reimbursement method, it will not be possible to fully implement the method until the MEs are fully operational.

2) *The Department will amend Rule 65E-14.021 (Unit Cost Method of Payment), Florida Administrative Code, to eliminate the maximum "model" rate for crisis stabilization services.*

   The Department is presently reviewing Rule Chapter 65E-14, F.A.C., which governs reimbursement of Department-funded substance abuse and mental health services. The Department anticipates proposing extensive amendments to this rule chapter, including amendments to accommodate the expanding role of MEs. Elimination of the maximum "model" rate for crisis stabilization services will be included among the proposed amendments. The target date for adoption of these amendments is July 1, 2013.

3) *The Department will negotiate amendments to its contracts with MEs to require that the MEs implement the proposed reimbursement method, including competitive procurement of public receiving facilities.*

   Existing contracts between the Department and the MEs require MEs to competitively procure subcontracted services to the extent possible; however, these existing contracts provide minimal guidance on the procurement process. Contract amendments will provide more detailed guidance regarding public receiving facilities. The timeline for these contract amendments to take effect depends upon the stage of implementation of the ME. However, if the Department implements the proposed reimbursement method, these contract amendments are expected to take effect for all MEs by January 1, 2014.

4) *The MEs will competitively procure public receiving facility contracts and implement the proposed reimbursement method.*

   The timeline for implementation of the new reimbursement model depends on the implementation of the MEs and the effective dates of contract amendments with MEs. However, if the Department implements the proposed reimbursement method, it is expected to be in full effect statewide by July 1, 2014.

5) *The Department will review and approve competitive procurement criteria and procurement area maps proposed by MEs, and require revisions as needed.*

6) *The Department will provide ongoing technical assistance to the MEs and their subcontracted providers to implement the new reimbursement method.*

8. POTENTIAL IMPACT OF THE PROPOSED REIMBURSEMENT METHOD

The Department, in consultation with Public Consulting Group and the CSU Workgroup, has sought to develop the proposed reimbursement method to meet the requirements of the legislative proviso (Chapter 2012-118, Laws of Florida, Section 3, Appropriation 346) in a manner that is consistent with the Department's mission and beneficial to the Department's clients. However, some Workgroup participants representing providers of crisis stabilization services have expressed concerns about potential adverse impacts of the proposed reimbursement method. This section describes the potential benefits and potential adverse impacts of the proposed reimbursement method, and highlights provisions intended to mitigate the workgroup's concerns. This section also discusses other issues raised by the workgroup related to the Baker Act system of care.

Potential Benefits of the Proposed Reimbursement Model

The proposed reimbursement method will make the Baker Act system of care more flexible and responsive by requiring that reimbursement caps be reallocated annually on the basis of changes in utilization. This will mean that resources will be reallocated regularly from low utilization providers to high utilization providers. Under the current system, such reallocation occurs only sporadically. Moreover, the utilization management features of the proposed reimbursement method have the potential to increase efficiency in the system of care, reducing unnecessary admissions and reducing lengths of stay, especially for individuals with complex discharge planning requirements. This could reduce costs substantially.

The proposed reimbursement model may also make it possible to serve more clients within existing resources by increasing utilization rates. Historically, the statewide utilization rate for Department-funded beds is 90.2% for adults and 38.2% for children. If these utilization rates were to rise to 95% for adults and 85% for children (based on the utilization targets in the proposed reimbursement model), with statewide Department-funded bed capacity remaining the same, the number of bed days utilized by Department clients would increase by 9,500 for adults and 13,470 for children. Based on historical average lengths of stay, this would translate into services provided for an additional 1,803 adults and 4,388 children per year.[1] Recent history suggests a significant increase in crisis stabilization services may be needed in the coming years.

[1] Staff analysis based on *Bed Use in Public Receiving Facilities and Treatment Facilities Fiscal Year 2009-2010.* http://www.dcf.state.fl.us/programs/samh/publications/csu0910.pdf

The total number of Baker Act involuntary examinations grew steadily from 122,000 in 2007 to 143,000 in 2010, an increase of 17% in just three years.[2]

However, it is important to note that actual utilization levels are subject to the influence of many factors, and cannot be predicted with any confidence. Utilization of crisis stabilization services may not need to increase to the extent noted above; in particular such a large increase in utilization is not likely for children's beds. To the extent these additional services are not needed, cost savings could result or resources could be diverted to other areas. Managing entities will have the option of diverting resources to less costly, less restrictive, alternative crisis services that could reduce the need for involuntary examinations, such as mobile crisis services and drop-in centers.

Potential Adverse Impacts of Proposed Reimbursement Model

The major advantage of the existing, capacity-based reimbursement method is that it ensures the stability of the system of care; concerns expressed by the CSU Workgroup have centered on the possible loss of this stability. The lack of competitive procurement for crisis stabilization services has meant a relatively stable pool of public receiving facilities. Most providers have been operating in the crisis stabilization market for many years. There are only occasionally new entrants to - or exits from - the market. This stable tenure has allowed providers to develop strong relationships with key community stakeholders: law enforcement agencies, county governments, non-receiving facility hospitals, and the Department. Turnover of public receiving facility administrators is relatively low, making it easier to maintain these relationships. These relationships are critical to the functioning of the Baker Act system.

Some workgroup participants have expressed concerns that competitive procurement could push longstanding providers - particularly CSUs - out of the market, disrupting local systems of care that the Department has built over many years. The proposed reimbursement model tries to address this concern by allowing managing entities (MEs) to include strength of community partnerships as a possible criterion for competitive procurement, and by giving MEs the option of incorporating formal public input into the development of procurement criteria and procurement area maps. Moreover, the Department must give final approval of these criteria and maps.

Workgroup participants have also emphasized that capacity-based funding has provided a reliable revenue stream for public receiving facilities, enabling them to remain in the market

[2] *Annual Report of Baker Act Data: Summary of 2010 Data.*
http://bakeract.fmhi.usf.edu/document/BA_Annual_Report_2010.pdf

though the maximum bed-day rate for crisis stabilization services ($291.64) has not increased for many years. As shown by the analysis reported in Section 3 of this Plan, the Department's bed-day rates are considerably lower than providers' actual costs of providing services. This is only possible because services for Department clients are effectively subsidized by other payor sources (such as Medicaid) which pay higher rates. Department funding has been a critical component of the crisis services funding system, despite the Department's low rates, simply because Department funding is stable from month to month, and usually from year to year. Some Workgroup participants have expressed concerns that the transition to utilization-based funding will force some CSU providers out of the market by depriving them of a stable revenue stream. The proposed reimbursement model attempts to address this issue by requiring MEs to set utilization targets for adult units 2-10% below historical utilization norms. This allows a cushion so that providers will not lose revenue if they experience a modest decline in utilization rates.

The concern about losing a reliable revenue stream is especially relevant to children's CSUs, which have smaller numbers of beds than adult CSUs (often only 2-4 beds) and, therefore, are more affected by fluctuations in utilization. Children's CSU have historically had low utilization rates; and the Department has generally accepted these low utilization rates to ensure that beds are available for children when they are needed. The proposed reimbursement model attempts to address this issue by requiring MEs to set utilization targets for children's units 15% below historical utilization norms.

Staffing Requirements for Crisis Stabilization Units (CSUs)

Staffing requirements for CSUs are governed by Rule 65E-12.105 (Minimum Staffing Standards), F.A.C. A certain number of registered nurses (one or two) and mental health treatment staff (one to three) are required to be available on-site at a CSU. The number depends on the number of licensed beds and the time of day.

Some Workgroup participants representing CSU providers suggested that Rule 65E-12.105 should be amended so that the number of staff required is proportional to the number of individuals actually receiving services at the time, rather than proportional to the number of licensed beds. Such a change may allow providers to use resources more efficiently without compromising clinical care standards. The Department intends to study this issue.

Transportation Exception Plans (TEPs)

Normally, an individual transported by law enforcement for involuntary examination under the Baker Act must be transported to the nearest receiving facility. Transportation Exception Plans (TEPs), authorized by s. 394.462(4), F.S., allow individuals within a specific county to be transported to a receiving facility other than the nearest under specified circumstances, in order to improve service coordination and better meet clinical needs. TEPs must be approved by the Department and by the Board of County Commissioners. TEPs currently exist in twelve of Florida's 67 counties. In some counties, such as Broward (as discussed in Section 4 of this

Transition Plan), a TEP is the foundation of a central receiving facility system of care model. In other counties, a TEP targets specific populations, such as minors or elderly people, allowing them to bypass the nearest receiving facility and be transported directly to the facility that can serve them best.

Some Workgroup participants suggested that many counties not currently served by a TEP would benefit from one. As the experiences of Broward and Orange Counties (described in Section 4) have shown, a TEP can greatly increase the efficiency of resource utilization within a system of care. The proposed reimbursement model includes an Access Centers Option which incorporates a central receiving facility; this would require a TEP to implement. Even counties where the ME chooses not to implement the Access Centers Option may benefit from a TEP. The Department intends to instruct its Regional Offices and MEs to study the issue of implementing TEPs where appropriate.

Funding Levels for Crisis Stabilization Services

There was a strong consensus among CSU Workgroup participants that current funding levels for mental health services in Florida are insufficient to meet the needs of individuals in need of these services. Most receiving facilities for adults operate at near 100% utilization. Legislative appropriations for mental health services, including crisis stabilization services, have not increased in many years; nor has the maximum ("model") rate ($291.64) for crisis stabilization services. As discussed in Section 3, providers' actual costs per bed day ($378.50) are much higher than the model rate. Crisis stabilization services for Department clients are effectively subsidized by other payor sources, especially Medicaid. This situation may not be sustainable as provider costs increase due to inflation and other factors impacting the cost of health care services. Moreover, insufficient funding for non-crisis services contributes to the need for crisis services. Individuals are less likely to experience mental health crises when they have access to outpatient mental health services and community supports such as supportive housing and drop-in centers. Therefore, CSU Workgroup participants urged that increased funding for mental health services, including crisis stabilization services, be considered.

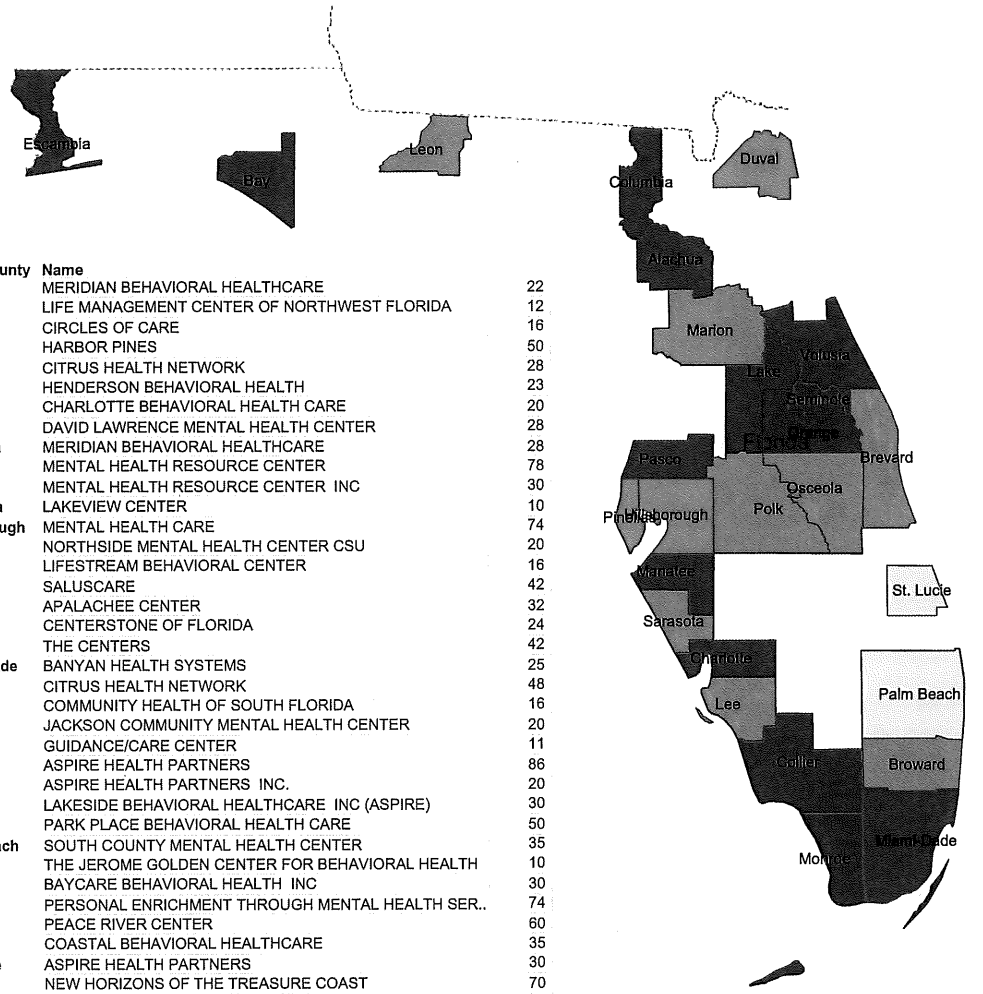
APPENDIX:
RECEIVING FACILITIES REPORTING DATA FOR PROVIDER COST ANALYSES

Apalachee Center, Inc.
Bridgeway Center
Centers, The
Charlotte Behavioral Health Care, Inc.
Citrus Health
Coastal Behavioral Health Care
Community Health of South Florida, Inc.
David Lawrence Center
Depoo Hospital
Flagler Hospital
Fort Lauderdale Hospital
Guidance Care Center, Inc.
Henderson Behavioral Health
Jackson Memorial Hospital
Jackson North Community Mental Health Center
Lakeview Center
Lee Mental Health Center, Inc.
Life Management Center of Northwest Florida
Lifestream Behavioral Center
Manatee Glens Corporation
Mental Health Care, Inc.
Mental Health Resource Center / Mental Health Center of Jacksonville
Meridian Behavioral Health Care
Miami Behavioral Health Center
New Horizons Community Mental Health Center
Northeast Florida State Hospital, Bldg. 57
Northside Mental Health Center, Inc.
Peace River Center for Personal Development
Personal Enrichment through Mental Health Services, Inc
SMA Behavioral Health Services


PUBLIC CONSULTING
GROUP

Appendix 3

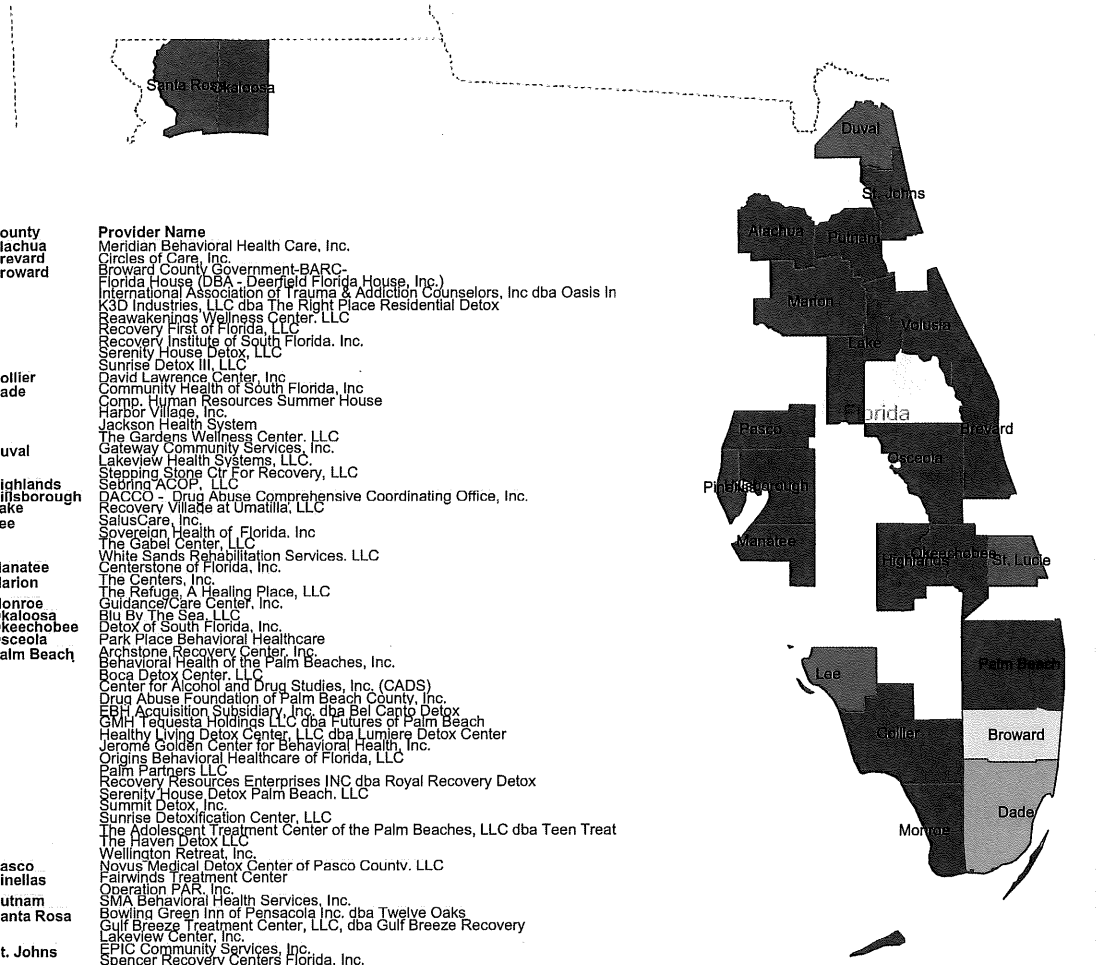
CSUs and SRTs



Street County	Name	
Alachua	MERIDIAN BEHAVIORAL HEALTHCARE	22
Bay	LIFE MANAGEMENT CENTER OF NORTHWEST FLORIDA	12
Brevard	CIRCLES OF CARE	16
	HARBOR PINES	50
Broward	CITRUS HEALTH NETWORK	28
	HENDERSON BEHAVIORAL HEALTH	23
Charlotte	CHARLOTTE BEHAVIORAL HEALTH CARE	20
Collier	DAVID LAWRENCE MENTAL HEALTH CENTER	28
Columbia	MERIDIAN BEHAVIORAL HEALTHCARE	28
Duval	MENTAL HEALTH RESOURCE CENTER	78
	MENTAL HEALTH RESOURCE CENTER INC	30
Escambia	LAKEVIEW CENTER	10
Hillsborough	MENTAL HEALTH CARE	74
	NORTHSIDE MENTAL HEALTH CENTER CSU	20
Lake	LIFESTREAM BEHAVIORAL CENTER	16
Lee	SALUSCARE	42
Leon	APALACHEE CENTER	32
Manatee	CENTERSTONE OF FLORIDA	24
Marion	THE CENTERS	42
Miami-Dade	BANYAN HEALTH SYSTEMS	25
	CITRUS HEALTH NETWORK	48
	COMMUNITY HEALTH OF SOUTH FLORIDA	16
	JACKSON COMMUNITY MENTAL HEALTH CENTER	20
Monroe	GUIDANCE/CARE CENTER	11
Orange	ASPIRE HEALTH PARTNERS	86
	ASPIRE HEALTH PARTNERS INC.	20
	LAKESIDE BEHAVIORAL HEALTHCARE INC (ASPIRE)	30
Osceola	PARK PLACE BEHAVIORAL HEALTH CARE	50
Palm Beach	SOUTH COUNTY MENTAL HEALTH CENTER	35
	THE JEROME GOLDEN CENTER FOR BEHAVIORAL HEALTH	10
Pasco	BAYCARE BEHAVIORAL HEALTH INC	30
Pinellas	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SER..	74
Polk	PEACE RIVER CENTER	60
Sarasota	COASTAL BEHAVIORAL HEALTHCARE	35
Seminole	ASPIRE HEALTH PARTNERS	30
St. Lucie	NEW HORIZONS OF THE TREASURE COAST	70
Volusia	SMA BEHAVIORAL HEALTH SERVICES	30

Appendix 4

Addiction Receiving Facilities



County	Provider Name
Alachua	Meridian Behavioral Health Care, Inc.
Brevard	Circles of Care, Inc.
Broward	Broward County Government-BARC-
	Florida House (DBA - Deerfield Florida House, Inc.)
	International Association of Trauma & Addiction Counselors, Inc dba Oasis In
	K3D Industries, LLC dba The Right Place Residential Detox
	Reawakenings Wellness Center, LLC
	Recovery First of Florida, LLC
	Recovery Institute of South Florida, Inc.
	Serenity House Detox, LLC
	Sunrise Detox III, LLC
Collier	David Lawrence Center, Inc
Dade	Community Health of South Florida, Inc
	Comp. Human Resources Summer House
	Harbor Village, Inc.
	Jackson Health System
	The Gardens Wellness Center, LLC
Duval	Gateway Community Services, Inc.
	Lakeview Health Systems, LLC.
	Stepping Stone Ctr For Recovery, LLC
Highlands	Sebring ACOP, LLC
Hillsborough	DACCO - Drug Abuse Comprehensive Coordinating Office, Inc.
Lake	Recovery Village at Umatilla, LLC
Lee	SalusCare, Inc.
	Sovereign Health of Florida, Inc
	The Gabel Center, LLC
	White Sands Rehabilitation Services, LLC
Manatee	Centerstone of Florida, Inc.
Marion	The Centers, Inc.
	The Refuge, A Healing Place, LLC
Monroe	GuidanceCare Center, Inc.
Okaloosa	Blu By The Sea, LLC
Okeechobee	Detox of South Florida, Inc.
Osceola	Park Place Behavioral Healthcare
Palm Beach	Archstone Recovery Center, Inc.
	Behavioral Health of the Palm Beaches, Inc.
	Boca Detox Center, LLC
	Center for Alcohol and Drug Studies, Inc. (CADS)
	Drug Abuse Foundation of Palm Beach County, Inc.
	EBH Acquisition Subsidiary, Inc. dba Bel Canto Detox
	GMH Tequesta Holdings LLC dba Futures of Palm Beach
	Healthy Living Detox Center, LLC dba Lumiere Detox Center
	Jerome Golden Center for Behavioral Health, Inc.
	Origins Behavioral Healthcare of Florida, LLC
	Palm Partners LLC
	Recovery Resources Enterprises INC dba Royal Recovery Detox
	Serenity House Detox Palm Beach, LLC
	Summit Detox, Inc.
	Sunrise Detoxification Center, LLC
	The Adolescent Treatment Center of the Palm Beaches, LLC dba Teen Treat
	The Haven Detox LLC
	Wellington Retreat, Inc.
Pasco	Novus Medical Detox Center of Pasco County, LLC
Pinellas	Fairwinds Treatment Center
	Operation PAR, Inc.
Putnam	SMA Behavioral Health Services, Inc.
Santa Rosa	Bowling Green Inn of Pensacola Inc. dba Twelve Oaks
	Gulf Breeze Treatment Center, LLC, dba Gulf Breeze Recovery
	Lakeview Center, Inc.
St. Johns	EPIC Community Services, Inc.
	Spencer Recovery Centers Florida, Inc.
St. Lucie	Florida Center For Recovery, Inc.
	New Horizons of the Treasure Coast, Inc.
	Starting Point Detox, LLC dba Unity Detox Center
	Unity Recovery Center, Inc.
Volusia	SMA Behavioral Health Services, Inc.

Appendix 5

Facility Type	Name	Street County	License Status	Total Licensed Beds	Adult	Child	Adult & Child
Crisis Stabilization Unit	APALACHEE CENTER	Leon	LICENSED	28	24	4	28
Crisis Stabilization Unit (ARF)	ASPIRE HEALTH PARTNERS	Orange	LICENSED	30	30		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS	Seminole	LICENSED	30	30		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS	Orange	LICENSED	27	27		
Crisis Stabilization Unit	ASPIRE HEALTH PARTNERS INC.	Orange	LICENSED	20		20	
Crisis Stabilization Unit	BANYAN HEALTH SYSTEMS	Miami-Dade	LICENSED	25	25		
Crisis Stabilization Unit (ARF)	BAYCARE BEHAVIORAL HEALTH INC	Pasco	LICENSED	30	30		
Crisis Stabilization Unit	CENTERSTONE OF FLORIDA	Manatee	LICENSED	24			24
Crisis Stabilization Unit	CHARLOTTE BEHAVIORAL HEALTH CARE	Charlotte	LICENSED	20			20
Crisis Stabilization Unit	CIRCLES OF CARE	Brevard	LICENSED	16		16	
Crisis Stabilization Unit (JARF)	CITRUS HEALTH NETWORK	Miami-Dade	LICENSED	24		24	
Crisis Stabilization Unit	CITRUS HEALTH NETWORK	Miami-Dade	LICENSED	24	24		
Crisis Stabilization Unit	COASTAL BEHAVIORAL HEALTHCARE	Sarasota	LICENSED	20	20		
Crisis Stabilization Unit	COASTAL BEHAVIORAL HEALTHCARE	Sarasota	LICENSED	15	15		
Crisis Stabilization Unit	COMMUNITY HEALTH OF SOUTH FLORIDA	Miami-Dade	LICENSED	16	16		
Crisis Stabilization Unit	DAVID LAWRENCE MENTAL HEALTH CENTER	Collier	LICENSED	28			28
Crisis Stabilization Unit	GUIDANCE/CARE CENTER	Monroe	LICENSED	11	11		
Crisis Stabilization Unit	HARBOR PINES	Brevard	LICENSED	50	50		
Crisis Stabilization Unit	HENDERSON BEHAVIORAL HEALTH	Broward	LICENSED	23	23		
Crisis Stabilization Unit	JACKSON COMMUNITY MENTAL HEALTH CENTER	Miami-Dade	LICENSED	20	20		
Crisis Stabilization Unit	LAKESIDE BEHAVIORAL HEALTHCARE INC (ASPIRE)	Orange	LICENSED	30	30		
Crisis Stabilization Unit	LAKEVIEW CENTER	Escambia	LICENSED	10	10		
Crisis Stabilization Unit	LIFE MANAGEMENT CENTER OF NORTHWEST FLORIDA	Bay	LICENSED	12			12
Crisis Stabilization Unit	LIFESTREAM BEHAVIORAL CENTER	Lake	LICENSED	16			16
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	14		14	
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	30	30		
Crisis Stabilization Unit	MENTAL HEALTH CARE	Hillsborough	LICENSED	30	30		
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	24	24	0	24
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	24			24
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER	Duval	LICENSED	30			30
Crisis Stabilization Unit	MENTAL HEALTH RESOURCE CENTER INC	Duval	LICENSED	30	30		
Crisis Stabilization Unit	MERIDIAN BEHAVIORAL HEALTHCARE	Alachua	LICENSED	22			22
Crisis Stabilization Unit	MERIDIAN BEHAVIORAL HEALTHCARE	Columbia	LICENSED	28			28
Crisis Stabilization Unit	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	30	30		
Crisis Stabilization Unit (ARF)	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	20		20	
Crisis Stabilization Unit	NORTHSIDE MENTAL HEALTH CENTER CSU	Hillsborough	LICENSED	20	20		
Crisis Stabilization Unit	PARK PLACE BEHAVIORAL HEALTH CARE	Osceola	LICENSED	30	30		
Crisis Stabilization Unit	PARK PLACE BEHAVIORAL HEALTH CARE	Osceola	LICENSED	20		20	
Crisis Stabilization Unit	PEACE RIVER CENTER	Polk	LICENSED	30			30
Crisis Stabilization Unit (ARF)	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	15		15	
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	15	15		
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	30	30		
Crisis Stabilization Unit	PERSONAL ENRICHMENT THROUGH MENTAL HEALTH SERVICES	Pinellas	LICENSED	14	14		
Crisis Stabilization Unit	SALUSCARE	Lee	LICENSED	30	30		
Crisis Stabilization Unit (ARF)	SALUSCARE	Lee	LICENSED	12		12	
Crisis Stabilization Unit	SMA BEHAVIORAL HEALTH SERVICES	Volusia	LICENSED	30	30		
Crisis Stabilization Unit	SOUTH COUNTY MENTAL HEALTH CENTER	Palm Beach	LICENSED	20	20		
Crisis Stabilization Unit	SOUTH COUNTY MENTAL HEALTH CENTER	Palm Beach	LICENSED	15	15		
Crisis Stabilization Unit	THE CENTERS	Marion	LICENSED	30	30		
Crisis Stabilization Unit	THE CENTERS	Marion	LICENSED	12		12	
Crisis Stabilization Unit	THE JEROME GOLDEN CENTER FOR BEHAVIORAL HEALTH	Palm Beach	LICENSED	10			10
SRT	APALACHEE CENTER	Leon	LICENSED	4	4		
SRT	ASPIRE HEALTH PARTNERS	Orange	LICENSED	29	29		
SRT	CITRUS HEALTH NETWORK	Broward	LICENSED	28	28		
SRT	NEW HORIZONS OF THE TREASURE COAST	St. Lucie	LICENSED	20	20		
SRT	PEACE RIVER CENTER	Polk	LICENSED	30	30		

Appendix 6

Mobile Crisis Teams Statewide

Northwest Region

- Youth Mobile Crisis Team- Duval- Child Guidance Center 904-448-4700 x308

Northeast Region

- None

SunCoast Region

- Mental Health Center – 819-239-8064 – Hillsborough County
- Peace River Center – 269-519-0575 – Polk County
- Manatee Glens – 941-782-4299 – Manatee County

Southeast Region

- New Horizons: Catchment area is the Treasure Coast & Okeechobee (St. Lucie, Martin, Indian River, & Okeechobee). Not West Palm Beach. Andrea Gates- 772-672-8476. Also, the direct number for our Mobile Crisis Response Team is 772-672-8470.
- South County Mental Health Center: Karyn Green (561) 637-1001 - Palm Beach Area (Adults and Children)
- The Jerome Golden Center : Donna Harris (561) 383-5841 - West Palm Beach Area (Children and Adults)
- Henderson Youth Emergency Services (YES): Ben Galloso (954) 713-5100 Ext 2402 - Broward County Area- (Children)
- Henderson Mobile Crisis Response Team: Elizabeth Rosonow (954)463-0911 - Broward County Area (Adults).

Southern Region

- Banyan Mobile Crisis Team, (305)774-3616 &(305)774-3617, serving Miami-Dade County

Central Region

- Mobile Crisis Team for Circuit 18 (Brevard)only 321-632-2737

Lowery, Nikki

From: Cox, Ryan
Sent: Wednesday, December 1, 2021 10:22 AM
To: Lowery, Nikki
Subject: FW: Sen Albritton Votes

Sincerely,

Ryan C. Cox
Staff Director
Senate Committee on Children, Families, and Elder Affairs
(850) 487-5340

From: Liebert, Andrew <Liebert.Andrew@flsenate.gov>
Sent: Wednesday, December 1, 2021 10:20 AM
To: Cox, Ryan <Cox.Ryan@flsenate.gov>
Cc: Hinchee, John <Hinchee.John@flsenate.gov>
Subject: Sen Albritton Votes

Ryan,

Please show Sen. Albritton voting in the affirmative on the following bills from the meeting yesterday:

SPB 7008
SPB 7010
SB 282
SB 294
SB 704

Let me know if you need anything else. Have a great day.

Best regards,

Andrew Liebert
Legislative Aide to Senator Ben Albritton
Senate District 26
150 North Central Avenue
Bartow, Florida 33830
850-487-5026 – Office
239-595-5990 – Cell

FOR CONSIDERATION By the Committee on Children, Families, and Elder Affairs

586-00941-22 20227010pb

A bill to be entitled

An act relating to a review under the Open Government Sunset Review Act; amending s. 744.2111, F.S., which provides an exemption from public records requirements for certain information held by the Department of Elderly Affairs in connection with a filed complaint or subsequently conducted investigation relating to public and professional guardians; removing the scheduled repeal of the exemption; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 744.2111, Florida Statutes, is amended to read:

744.2111 Confidentiality.—

(1) The following are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, when held by the Department of Elderly Affairs in connection with a complaint filed and any subsequent investigation conducted pursuant to this part, unless the disclosure is required by court order:

(a) Personal identifying information of a complainant or ward.

(b) All personal health and financial records of a ward.

(c) All photographs and video recordings.

(2) Except as otherwise provided in this section, information held by the department, is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution

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until the investigation is completed or ceases to be active, unless the disclosure is required by court order.

(3) This section does not prohibit the department from providing such information to any law enforcement agency, any other regulatory agency in the performance of its official duties and responsibilities, or the clerk of the circuit court pursuant to s. 744.368.

(4) The exemption under this section applies to all documents received by the department in connection with a complaint before, on, or after July 1, 2017.

~~(5) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2022, unless reviewed and saved from repeal through reenactment by the Legislature.~~

Section 2. This act shall take effect October 1, 2022.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

From: Delia, Peter
To: Lowery, Nikki
Subject: FW: OSGR- OPPG - S.744.2111, F.S.
Date: Monday, November 29, 2021 9:23:46 AM

Nikki, below is an email I have referenced on file for SB 7010. This is the only doc on file for SB 7010. Let me know if you have any questions or concerns. Thanks!

Peter Delia
Senior Attorney
Florida Senate
Committee on Children, Families,
And Elder Affairs
404 South Monroe Street
520 Knott Building
Tallahassee, Florida 32399-1100
delia.peter@flsenate.gov
(850) 487-5343

From: Derek Miller <millerd@elderaffairs.org>
Sent: Thursday, August 26, 2021 10:58 AM
To: Toliver, Lance <Lance.Toliver@myfloridahouse.gov>; Landry, Jeanne <Jeanne.Landry@myfloridahouse.gov>; Delia, Peter <Delia.Peter@flsenate.gov>
Subject: OSGR- OPPG - S.744.2111, F.S.

Lance, Peter, and Jeanne,

I hope today is treating you well. As promised, below are the stats you all inquired about from last week's call:

1. The total number of complaints received at DOEA/OPPG that were initially believed to be against a guardian and/or involving a guardianship for each of these 5 years –
    a. 2016: 183
    b. 2017: 132
    c. 2018: 56
    d. 2019: 113
    e. 2020: 169
    f. first 6-months of 2021: 89

2. A breakdown of how many of these complaints received were attended to entirely within DOEA/OPPG and disposed of, and how many were assigned to the Clerk of Courts' Statewide Investigative Alliance (SIA) for review and further investigation.

a. 2016: Referred SIA: 22
b. 2017: Referred SIA: 83
c. 2018: Referred SIA: 47
d. 2019: Referred SIA: 128
e. 2020: Handled by OPPG 109; Referred SIA: 63
f. first 6-months of 2021: Handled by OPPG: 39; Referred SIA

3. The approximate total number of public record requests received by the DOEA regarding OPPG complaints since 2017 is 170.
    a. 2017: 17
    b. 2018: 11
    c. 2019: 63
    d. 2020: 31
    e. first 8-months of 2021: 48

If you have any other questions, please do not hesitate to call me or send me an email.

Best,
Derek

Department of ELDER AFFAIRS
STATE OF FLORIDA

Derek Miller | Director of Legislative Affairs
Florida Department of Elder Affairs
4040 Esplanade Way, Tallahassee, Florida 32399
Office: (850) 414-2130 | Cell: (850) 274-6026

Lowery, Nikki

From: Cox, Ryan
Sent: Wednesday, December 1, 2021 10:22 AM
To: Lowery, Nikki
Subject: FW: Sen Albritton Votes

Sincerely,

Ryan C. Cox
Staff Director
Senate Committee on Children, Families, and Elder Affairs
(850) 487-5340

From: Liebert, Andrew <Liebert.Andrew@flsenate.gov>
Sent: Wednesday, December 1, 2021 10:20 AM
To: Cox, Ryan <Cox.Ryan@flsenate.gov>
Cc: Hinchee, John <Hinchee.John@flsenate.gov>
Subject: Sen Albritton Votes

Ryan,

Please show Sen. Albritton voting in the affirmative on the following bills from the meeting yesterday:

SPB 7008
SPB 7010
SB 282
SB 294
SB 704

Let me know if you need anything else. Have a great day.

Best regards,

Andrew Liebert
Legislative Aide to Senator Ben Albritton
Senate District 26
150 North Central Avenue
Bartow, Florida 33830
850-487-5026 – Office
239-595-5990 – Cell

CourtSmart Tag Report

Room: SB 37 **Case No.:** **Type:**
Caption: Senate Committee on Children, Families, and Elder Affairs **Judge:**

Started: 11/30/2021 12:31:19 PM
Ends: 11/30/2021 1:21:02 PM Length: 00:49:44

12:31:19 PM Meeting Called to Order
12:31:27 PM
12:31:38 PM Roll Call
12:31:44 PM Comments by Chair
12:33:04 PM SB 792
12:33:14 PM Senator Ausley presents SB 792
12:35:02 PM Rebekka Behr
12:39:07 PM Brian Thompson
12:39:14 PM Marty Lowrey
12:40:20 PM Questions on the bill
12:41:03 PM Appearances - Candice Brower Waive in Support
12:41:46 PM Debate
12:42:46 PM Senator Book
12:42:49 PM Senator Torres
12:43:25 PM Comments by Chair
12:44:42 PM Senator Ausley Closes
12:44:50 PM Vote
12:44:57 PM SB 764
12:45:32 PM Senator Albritton presents SB 764
12:46:58 PM Questions
12:47:01 PM Appearances - Dawn Steward Waive in Support
12:47:19 PM Debate
12:47:21 PM Senator Wright
12:47:42 PM Senator Albritton Waive Closed
12:47:51 PM Vote
12:48:01 PM SPB 7008
12:48:14 PM Committee Staff Presents SPB 7008
12:48:54 PM Questions
12:49:54 PM Appearances
12:49:57 PM Debate
12:50:01 PM Senator Wright Motion
12:50:14 PM Objection?
12:50:17 PM Motion Adopted
12:50:20 PM Vote
12:50:47 PM SPB 7010
12:50:55 PM Committee Staff Presents SPB 7010
12:51:15 PM Questions
12:52:16 PM Senator Torres
12:52:30 PM Committee Staff Responds
12:52:43 PM Follow up by Senator Torres
12:52:50 PM Committee Staff Responds
12:53:06 PM Follow up by Senator Torres

12:53:20 PM Committee Staff Responds
12:53:47 PM Appearances
12:53:52 PM Debate
12:53:59 PM Senator Brodeur Motion
12:54:07 PM Objection?
12:54:11 PM Motion Adopted
12:54:14 PM Vote
12:54:35 PM SB 282
12:54:40 PM Senator Rouson Presents SB 282
12:55:43 PM Questions
12:56:47 PM Appearances
12:56:50 PM Natalie Kelly - Waive in Support
12:56:58 PM Dawn Stewart - Waive in Support
12:57:05 PM Robert Cooper - Proponent
12:57:53 PM Sean Burnfin - Waive in Support
12:58:04 PM Debate
12:58:17 PM Senator Book
12:58:41 PM Senator Ruson Close
12:58:58 PM Vote
12:59:24 PM Gavel Pass to Senator Book
12:59:41 PM SB 294
12:59:48 PM Senator Garcia Presents SB 294
1:00:16 PM Questions
1:00:22 PM Appearances
1:00:30 PM Debate
1:00:35 PM Senator Garcia Close
1:00:42 PM Vote
1:00:57 PM SB 704
1:01:04 PM Recess
1:01:28 PM Recording Paused
1:08:16 PM Recording Resumed
1:10:17 PM Meeting called to order
1:11:20 PM SB 704
1:11:26 PM Senator Harrell Presents SB 704
1:14:11 PM Questions
1:15:13 PM Appearances
1:15:17 PM Natalie Kelly - Waive in Support
1:15:22 PM Debate
1:15:26 PM Senator Harrell Close
1:15:45 PM Vote
1:16:10 PM Comments by Chair Garcia
1:16:22 PM Questions by Senator Torres about Baker Act
1:18:24 PM Chair Garcia Responds
1:19:50 PM Senator Harrell records votes after roll call
1:20:06 PM SB 792 Yes
1:20:10 PM SB 764 Yes
1:20:16 PM SPB 7008 Yes
1:20:21 PM SPB 7010 Yes
1:20:25 PM SB 282 Yes
1:20:34 PM SB 792 Yes
1:20:47 PM Senator Torres Moves to Adjourn