Community Action Treatment (CAT) Team

Requirement: Specific Appropriations of the General Appropriations Act

Frequency: Monthly and Quarterly

Due Date: 10th day of the month

Purpose

To ensure the implementation and administration of the Community Action Treatment (CAT) program, the CAT Network Service Providers shall adhere to the service delivery and reporting requirements herein. Best practice considerations and resources are provided to support continuous improvement of the CAT program; however, these are not contractually required.

Authority

Specific Appropriation 367 of the 2019-20 General Appropriations Act (GAA) directed the Department of Children and Families (Department) to " … contract with the following providers for the operation of Community Action Treatment (CAT) teams that provide community-based services to children ages 11 to 21 with a mental health or co-occurring substance abuse diagnosis with any accompanying characteristics such as being at-risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care; having two or more hospitalizations or repeated failures; involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement; or poor academic performance or suspensions. Children younger than 11 may be candidates if they display two or more of the aforementioned characteristics."

Agency	# of CAT Teams	Counties
Child Guidance Center, Inc.	1	Duval
Clay Behavioral Health Center, Inc.	1	Clay, Putnam
Halifax Hospital Medical Center	1	Volusia, Flagler
LifeStream Behavioral Center, Inc.	2	1. Lake, Sumter 2. Citrus, Hernando
Meridian Behavioral Healthcare, Inc.	3	1. Columbia, Hamilton, Lafayette, Suwannee, 2. Bradford, Baker, Union, Nassau 3. Gilchrist, Levy, Dixie
St. Augustine Youth Services, Inc.	1	St. Johns
The Chrysalis Center, Inc. d/b/a Chrysalis Health	1	Alachua
SMA Healthcare, Inc.	1	Marion

Network Service Provider Responsibilities

To ensure consistent statewide implementation and administration of this proviso project, the Network Service Provider responsibilities include:

1. Network Service Providers providing CAT services must adhere to the service delivery and reporting requirements described in this Guidance document,
2. Submit data (including encounter data), in accordance with the most recent version of the PAM 155-2, into the Managing Entity's Data System,
3. Submit **Appendix 1 - Persons Served and Performance Measure Report and Appendix 2 - Quarterly Supplemental Data Report, and Appendix 3 - CAT Return on Investment** (See the Required Reporting section for more details),
4. Participate in all CAT program conference calls, meetings or other oversight events scheduled by the Department,
5. Submit quarterly reporting of actual expenditures, fiscal year-end financial reconciliation of actual allowable expenditures to total payments, and prompt return of any unearned funds or overpayments (See the Required Reporting section for more details),
6. Network Service Providers will be paid on a monthly fixed rate payment methodology (in some instances, at the Managing Entity's discretion and approval, other payment methodologies may be utilized); therefore, the Network Service Providers must serve a minimum number of persons per team per month. Unless otherwise approved in advance by the Managing Entity, the Network Service Provider shall adopt a minimum service target of 35 children per month.
    - The Network Service Provider may request the Managing Entity's approval for an alternative target, taking into consideration a Network Service Provider's program-specific staffing capacity, historical funding utilization, estimated community needs, or unique geographic and demographic factors of the service location.
    - In the first year of services by a newly procured Network Service Provider, a phase-in period may be implemented to achieve the minimum service target as follows:
        - 10 children per month during the first month of services,
        - 20 children per month during the second month,
        - 25 children per month during the third month, and
        - 35 children per month thereafter.
7. Financial consequences may be applied in the event a Network Service Provider does not meet the monthly minimum service target. Financial consequences shall be established at a $2,000 reduction of the monthly invoice amount for each individual served less than the monthly service target.

Program Goals

CAT is intended to be a safe and effective alternative to out-of-home placement for children with serious behavioral health conditions. Upon successful completion, the family should have the skills and natural support system needed to maintain improvements made during services. The goals of the CAT program are to:

1. Strengthen the family and support systems for youth and young adults to assist them to live successfully in the community,

2. Improve school related outcomes such as attendance, grades, and graduation rates,
3. Decrease out-of-home placements,
4. Improve family and youth functioning,
5. Decrease substance use and abuse,
6. Decrease psychiatric hospitalizations,
7. Transition into age appropriate services; and
8. Increase health and wellness.

Eligibility

The following participation criteria are established in proviso. The Network Service Provider must follow these standards for CAT services:

1. Otherwise eligible for publicly funded substance abuse and mental health services pursuant to s. 394.674, F.S., and
2. Individuals aged 11 to 21 with a mental health diagnosis or co-occurring substance abuse diagnosis with one or more of the following accompanying characteristics:
    - The individual is at-risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care,
    - The individual has had two or more periods of hospitalization or repeated failures,
    - The individual has had involvement with the Department of Juvenile Justice or multiple episodes involving law enforcement, or
    - The individual has poor academic performance or suspensions.
3. Children younger than 11 with a mental health diagnosis or co-occurring substance abuse diagnosis may be candidates if they meet two or more of the aforementioned characteristics.

Individuals residing in therapeutic placements such as hospitals, residential treatment centers, therapeutic group homes and therapeutic foster homes; and those receiving day treatment services are not eligible to receive CAT services.

Network Service Providers may serve families who exceed the financial eligibility while applying a sliding fee scale in accordance with 394.674 F.S. and Ch. 65E-14.018, F.A.C., if no other option for treatment at this level is available (i.e. rural areas).

Client treatment cannot exceed 9 months. Prior authorization is required for extension or readmission to the program at any point using LSF Health Systems' required form, **CAT Extension/Readmission Authorization Form**.

CAT Model

The CAT model is an integrated service delivery approach that utilizes a team of individuals to comprehensively address the needs of the young person, and their family, to include the following staff:

1. A full-time Team Leader,
2. Mental Health Clinicians,
3. A Psychiatrist or Advanced Practice Registered Nurse (part-time),
4. A Registered or Licensed Practical Nurse (part-time),
5. A Case Manager,
6. Therapeutic Mentors, or certified peer specialists, and
7. Support Staff

The Network Service Provider must have these staff as part of the team; however, the number of staff and the functions they perform may vary by team in response to local needs and as approved by the Managing Entity. CAT members work collaboratively to deliver the majority of behavioral health services, coordinate with other service providers when necessary, and assist the family in developing or strengthening their natural support system.

CAT funds are used to address the therapeutic needs of the eligible youth or young adult receiving services. However, the CAT model is based on a family-centered approach in which the CAT team assists parents or caregivers to obtain services and supports, which may include providing information and education about how to obtain services and supports, and assistance with referrals.

The number of sessions and the frequency with which they are provided is set through collaboration based on the needs of the individual and family rather than service limits. The team is available on nights, weekends, and holidays. In the event that interventions out of the scope of the team's expertise, qualifications, or licensure (i.e., eating disorder treatment, behavior analysis, psychological testing, substance abuse treatment, etc.) are required, referrals are made to specialists, with coordination from the individual, family and team. This flexibility in service delivery is intended to promote a "whatever it takes" approach to assisting young people and their families to achieve their goals.

The CAT team is required to utilize the High-Fidelity Wraparound Process as prescribed in Exhibit A. Additional resources can be found at the following link: https://www.nwi.pdx.edu

1. All members of the team must be trained in wraparound within three (3) months of employment or contract issuance, whichever is later.
2. For sustainability of the model, each team must have at least one coach who will certify additional team members as wraparound facilitators and champion the wraparound process in the agency. The following team members must be certified as a Wraparound Coach within 12 months of employment or contract issuance, whichever is later:
    a. Team Lead/Supervisor, and/or;
    b. Therapist
3. The following team members need to be certified as a Wraparound facilitator within 12 months of employment or contract issuance, whichever is later:
    a. Case Manager, and;
    b. Therapeutic Mentor

4. Wraparound coaches will participate in monthly coaching calls as provided by community wraparound champions.
5. Team Lead/Supervisor or designee shall attend Wraparound implementation or learning community meetings as offered or required.

Best Practice Considerations: Models and Approaches for Working with Young People and Their Families

1. The Transition to Independence Process (TIP) model is an evidence-supported based on published studies that demonstrate improvements in real-life outcomes for youth and young adults with emotional/behavioral difficulties (EBD).

http://tipstars.org/Home.aspx

2. The Research and Training Center for Pathways to Positive Futures (Pathways) aims to improve the lives of youth and young adults with serious mental health conditions through rigorous research and effective training and dissemination. Their work is guided by the perspectives of young people and their families and based in a positive development framework.

http://www.pathwaysrtc.pdx.edu/about

3. National Wraparound Initiative - Wraparound is an evidence-supported practice that is intensive, holistic, strength based, individual and family driven and individualized care planning and management process that engages and supports individuals with complex needs (most typically children, youth, and their families) to live in the community and realize their hopes and dreams. The process is typically delivered through case management activities through a team supported approach.

https://nwi.pdx.edu/wraparound-basics/

4. Florida Wraparound model and toolkits available for providers and Managing Entities http://www.socflorida.com/wraparound.shtml

5. Strengthening Family Support for Young People: Tip sheet for strengthening family support. https://www.pathwaysrtc.pdx.edu/pdf/projPTTC-FamilySupportTipSheet.pdf

6. Positive Youth Development (PYD), Resilience and Recovery: Actively focuses on building strengthens and enhancing healthy development.

https://www.pathwaysrtc.pdx.edu/pdf/pbCmtyBasedApproaches09-2011.pdf

7. Section 394.491, F.S. – Guiding principles for the child and adolescent mental health treatment and support system.

http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.491.html

8. Youth M.O.V.E. National. Youth M.O.V.E is a youth led national organization devoted to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice,

education, and child welfare. There are chapters in Florida and opportunities for young people to learn leadership and advocacy skills and to get involved with peers.

https://youthmovenational.org/mission-and-vision/

Serving Young Adults

The CAT program serves young adults up to the age of twenty-one (21), which includes young adults ages eighteen (18) up to twenty (20) who are legally considered adults. Network Service Providers serving these young adults must consider their legal rights to make decisions about their treatment, who will be involved, and with whom information will be shared. In keeping with the focus of the CAT model, Network Service Providers should support the young person to enhance and develop relationships and supports within their family and community, guided by their preferences.

Coordination With Other Key Entities

It is important for Network Service Providers to address the provision of services and supports from a comprehensive approach, which includes coordination with other key entities providing services and supports to the individual receiving services. In collaboration with and based on the preferences of the individual receiving services and their parent/legal guardian (if applicable). Network Service Providers should identify and coordinate efforts with other key entities as part of their case management function, which include but are not limited to: primary health care, child welfare, juvenile justice, corrections, and special education. In addition, Network Service Providers should make all efforts to include natural support systems of the individual and community connections in service delivery.

If the individual receiving services is a minor served by child welfare, members of their treatment team shall include their child welfare Case Manager and guardian ad litem (if assigned). If and how the parent will be included in treatment should be determined in coordination with the dependency case manager, based on individual circumstances. Network Service Providers shall document efforts to identify and coordinate with the other key entities in the case notes.

Screening and Assessment

Within 45 days of an individual's admission to services, the Network Service Provider shall complete the North Carolina Family Assessment Scale for General Services and Reunification® (NCFAS-G+R) as the required initial assessment to assist in identifying areas of focus in treatment. The NCFAS-G+R and Plans of Care (Initial and Master) must be completed for all individuals served, to include those transferred from another program within the same agency.

Network Service Providers are encouraged to use a variety of reliable and valid screening and assessment tools in addition to the NCFAS-G+R as part of the assessment process, with focus on screening for co-occurring mental health and substance use disorder. Additionally, Network Service Providers are encouraged to gather collateral information in coordination with the individual served, their family and other system partners, to include such things as: school records; mental health and substance abuse evaluations and treatment history; and level of cognitive functioning to develop a comprehensive understanding of the young person's and their family's circumstances.

As with best practice approaches such as Systems of Care, Transition to Independence and Wraparound, the screening and assessment process should focus on identifying competencies and resources to be leveraged as well as needs across multiple life domains, such as education, vocation, mental health, substance use, primary health, and social connections. Please visit http://www.socflorida.com/wraparound.shtml for guidance on the Florida Wraparound model.

Best Practice Considerations: Screening and Assessment Resources

1. The California Evidenced-based Clearinghouse for Child Welfare – Assessment ratings and how to determine if an assessment is reliable and valid.

   http://www.cebc4cw.org/assessment-tools/assessment-ratings/

2. The REACH Institute offers a listing of mental health screening tools, assessments and tool kits. GLAD-PC Toolkit and T-MAY

3. Screening and assessment resources for co-occurring mental health and substance use disorders.

   - The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions and offers a compendium of validated screening and assessment instruments and tools for mental and substance use disorders.

     http://www.integration.samhsa.gov/clinical-practice/screening-tools

   - SAMHSA Co-occurring Center for Excellence – Integrated Screening and Assessment

     https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based- Practices-EBP-KIT/SMA08-4366

   - Alcohol & Drug Abuse Institute - University of Washington: Info Brief: Co-Occurring Disorders in Adolescents. Provides an extensive list of resources related to screening, assessment and integrated treatment.

     http://adai.uw.edu/pubs/infobriefs/ADAI-IB-2011-01.pdf

4. Casey Life Skills assessment is a free practice tool and framework developed for working with youth in foster care; however, it is beneficial for any young person. It is a self-assessment of independent living skills in eight areas that takes about 30 minutes to complete online and provides instant results.

   http://lifeskills.casey.org/

5. Youth Efficacy/Empowerment Scale and Youth Participation in Planning Scale - Portland Research and Training Center (Pathways RTC):

   https://www.pathwaysrtc.pdx.edu/pdf/pbCmtyBasedApproaches09-2011.pdf

6. Strengths, Needs and Culture Discovery Assessment - To explore individual and family strengths, needs, culture, and vision and to use these to develop a document that will serve as the starting point for planning.

   https://nwi.pdx.edu/

Treatment Planning Process

The treatment planning process serves to identify short-term objectives to build long-term stability, resilience, family unity and to promote wellness and illness management. A comprehensive, team-based approach is increasingly seen as the preferred mechanism for creating and monitoring treatment plans and is consistent with the CAT program.

There is evidence that outcomes improve when youth and families participate actively in treatment and their involvement is essential at every phase of the treatment process, including assessment, treatment planning, implementation, and monitoring and outcome evaluation.[1] Working as a team, the young person, family, natural supports, and professionals can effectively support individualized, strength-based, and culturally competent treatment.

Network Service Providers shall focus on engagement of the young person and their family as a critical first step in the treatment process, as well as the promotion of active participation as equal partners in the treatment planning process.

Best Practice Considerations: Treatment Planning for Young People with Behavioral Health Needs

1. Achieve My Plan (AMP) - The AMP study is testing a promising intervention that was developed by researchers at Portland State University, in collaboration with young people who have mental health conditions, service providers and caregivers. Tip sheets for meeting facilitators and young people, the Youth Self-efficacy/Empowerment Scale and Youth Participation in Planning Scale and a video entitled Youth Participation in Planning can be found at:

   http://www.pathwaysrtc.pdx.edu/proj-3-amp

2. Family and Youth Participation in Clinical Decision Making. American Academy of Child and Adolescent Psychiatry.

   http://www.aacap.org/aacap/Policy_Statements/2009/Family_and_Youth_Participation_in_Clinical_Decision_Making.aspx

3. Individual and Family Team meetings. The Wraparound process promotes Individual and Family team meetings that includes the individual, their family, professionals working with the family and their natural support systems. The initial Wraparound plan is developed during the initial Child and Family Team meetings. Individual and Family team meetings are held every 30 days to monitor the Wraparound plan to ensure effectiveness and to revise as needed to ensure the plan best matches the individual's and family's self-identified needs.

[1] See, http://www.aacap.org/aacap/Policy_Statements/2009/Family_and_Youth_Participation_in_Clinical_Decision_Making.aspx

https://nwi.pdx.edu/NWI-book/Chapters/SECTION-4.pdf

4. Florida Wraparound model and toolkits available for providers and Managing Entities http://www.socflorida.com/wraparound.shtml

Plan of Care

1. **Initial Plan of Care**

   Within 30 days of an individual's admission to services, the Network Service Provider shall complete an Initial Plan of Care to guide the provision of services by the CAT team. Services and supports by the CAT team are established in the Initial Plan of Care, which provides sufficient time to complete the NCFAS-G+R within the first 45 days. Review of the Initial Plan of Care is required to ensure that information gathered during the first 60 days is considered and that a Master Plan of Care is developed to articulate the provision of services and supports longer-term. The Network Service Provider must document that the Initial Plan of Care was reviewed with the individual being served and his or her parent or guardian and request that they sign the plan at the time of review. At a minimum, the Initial Plan of Care shall:

   - Be developed with the participation of the individual receiving services and his or her family, including caregivers and guardians,
   - Specify the CAT services and supports to be provided by CAT Team members, to include a focus on engagement, stabilization, and a safety planning if needed, and
   - Include a brief initial discharge planning discussion, to include the general goals to be accomplished prior to discharge.

2. **Master Plan of Care**

   Within 60 days after admission, the Network Service Provider shall review the Initial Plan of Care and update it as needed to include the NCFAS-G+R initial assessment and other information gathered since admission. The Network Service Provider will implement the updated Initial Plan of Care as the Master Plan of Care. The Network Service Provide may adopt an unrevised Initial Plan of Care if it meets the requirements of the Master Plan of Care and includes the initial NCFAS-G+R assessment. At minimum the Master Plan of Care shall:

   - Be strength-based and built on the individual's assets and resources,
   - Be individualized and developmentally appropriate to age and functioning level,
   - Address needs in various life domains, as appropriate,
   - Integrate substance abuse and mental health treatment when indicated,
   - Specify measurable treatment goals and target dates for services and supports,
   - Specify team members responsible for completion of each treatment goal, and
   - Include a discharge plan and identify mechanisms for providing resources and tools for successful transition from services. At minimum, the Network Service Provider shall review and revise the Master Plan of Care every three months thereafter until discharge, or more frequently as needed to address changes in circumstances impacting treatment

and discharge planning. In each review, the Network Service Provider shall include active participation by the individual receiving services, and his or her family, caregivers, guardians, and other key entities serving the individual and natural supports, as appropriate.

Best Practice Considerations: Developing a Plan of Care

1. The Wraparound Approach in Systems of Care
   http://www.oregon.gov/oha/amh/wraparound/docs/wraparound-approach-soc.pdf
2. Florida Wraparound model and toolkits available for providers and Managing Entities
   http://www.socflorida.com/wraparound.shtml
3. Achieve My Plan (AMP): Youth participation in planning – provides tools, tip sheets for professionals and youth

   https://www.pathwaysrtc.pdx.edu/p3c-achieve-my-plan
4. Journal of Child and Family Studies (May 2017): Increasing Youth Participation in Team-Based Treatment Planning: The Achieve My Plan Enhancement for Wraparound:

   https://www.pathwaysrtc.pdx.edu/pdf/pbJCFS-Walker-AMP-Enhancement-for-Wraparound-05-2017.pdf
5. Community-based Approaches for Supporting Positive Development in Youth and Young Adults: RTC Pathways

   https://www.pathwaysrtc.pdx.edu/pdf/pbCmtyBasedApproaches09-2011.pdf

Services and Supports

The mix of services and supports provided should be dictated by individual needs and strengths, serve to strengthen their family, and provide older adolescents with supports and skills necessary in preparation for coping with life as an adult.[2] Services and supports and the manner of service provision should be developmentally appropriate for the individual. For older youth, services and supports may include supported employment and vocation certification, independent living skills training, and peer support services to assist in building social connections and learning new skills. It is important to discuss the roles and responsibilities of the CAT team members with the individual and family to ensure they understand the roles and responsibilities of each. This is especially important to clarify the role of the peer or mentor, as this person may promote social connectedness and assist in the development of a support network of friends outside of the CAT program.

Network Service Providers shall offer an array of formal treatment interventions and informal supports provided in the home or other community locations convenient and beneficial to the individual and family. Network Service Providers shall assist the individual and family to develop connections to natural supports within their own network of associates, such as friends and neighbors, through connections with

[2] Chapter 394. 491, F.S. - Guiding principles for the child and adolescent mental health treatment and support system.
http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.491.html

community, service and religious organizations, and participation in clubs and other civic activities. Natural supports ease the transition from formal services and provide ongoing support after discharge.[3] Formal treatment services may include evidenced-based practices appropriate to the circumstances of the young person and their family. Network Service Providers shall leverage resources and opportunities to implement evidenced-based practices with fidelity, which may include partnering with other CAT teams or organizations in the local system of care.

Support services and natural supports are interventions developed on an individualized basis and tailored to address the individual's and family's unique needs, strengths, and preferences. Support services may include but are not limited to: Family Support Specialists; participation in recreational activities; youth development and leadership programs; temporary assistance in meeting and problem-solving basic needs that interfere with attaining treatment goals; and independent living skills training.

Best Practice Considerations:

1. Pathways Transition Training Collaborative (PTTC): Community of Practice Training: Provides training and TA materials for serving youth and young adults – Set of competencies; Transition Service Provider Competency Scale; On-line training modules focused on promoting positive pathways to adulthood.

   https://www.pathwaysrtc.pdx.edu/pathways-transition-training-collaborative

2. HHS: Office of Adolescent Health: Research, resources and training for providers, fact sheets, grant opportunities:

   https://www.hhs.gov/ash/oah/adolescent-development/mental-health/mental-health-disorders/index.html

3. RTC Pathways -Youth Peer Support

   https://www.pathwaysrtc.pdx.edu/pdf/proj-5-AMP-what-is-peer-support.pdf

Discharge

As part of the discharge planning process, CAT teams assist in identification of additional resources that help individuals and families maintain progress made in treatment. Throughout treatment, the Network Service Provider should focus on successful transition from services. As the individual moves into the discharge phase of treatment, the CAT Team may determine the need to modify the service array or frequency of services to ease transition to less intensive services and supports.

Network Service Providers are encouraged to implement a discharge planning process that:

1. Begins at admission,
2. Includes ongoing discussion as part of the Plan of Care review,
3. Includes active involvement of the individual and family,

[3] Transition Youth with Serious Mental Illness: http://www.apa.org/about/gr/issues/cyf/transition-youth.pdf

4. Includes transition to the adult mental health and other systems, as appropriate, and
5. Includes a transition plan submitted to and developed in collaboration with the individual and family that leverages available community services and supports.

Within seven calendar days of an individual's discharge from services, the Provider shall complete a Discharge Summary containing the following items, at a minimum:

1. The reason for the discharge,
2. A summary of CAT services and supports provided to the individual,
3. A summary of resource linkages or referrals made to other services or supports on behalf of the individual, and
4. A summary of the individual's progress toward each treatment goal in the Master Plan of Care.

Incidental Expenses

Pursuant to chapter 65E-14.021, F.A.C., temporary expenses may be incurred to facilitate continuing treatment and community stabilization when no other resources are available. Allowable uses of incidental funds include transportation, childcare, housing assistance, clothing, educational services, vocational services, medical care, housing subsidies, pharmaceuticals, and other incidentals that can demonstrate support of individual's treatment plan or other allowable uses.

Network Service Providers shall follow state purchasing guidelines and any established process for review and approval; however, Network Service Providers are encouraged to be creative in using these funds within the limits of what is allowable and to consult the Managing Entity regarding allowable purchases.

Prior authorization is required for incidental requests in excess of $1,000.00 using LSF Health Systems' required form.

Third-Party Services

Services provided by the core CAT Team staff and funded by CAT contract dollars cannot be billed to any third-party payers. Services provided outside of the core CAT Team staff may be billed to Medicaid or private insurance, to the extent allowable under these programs. If there is an imperative need to provide these services or supports sooner than later, the CAT team should use CAT funds to meet this need, while pursuing third-party billing.

If an individual requires interventions outside the scope of a team's expertise, qualifications or licensure (i.e., eating disorder treatment, behavior analysis, psychological testing, substance abuse treatment, etc.), the team may refer to a qualified service provider. The CAT team shall work in concert with any referral providers, the individual and the family to integrate referral services into overall treatment and to monitor progress toward treatment goals

In accordance with chapter 65D-30.003, F.A.C., all substance abuse services, as defined in subsection 65D-30.002(16), F.A.C., must be provided by persons or entities that are licensed by the department pursuant to Section 397.401, F.S., unless otherwise exempt from licensing under Section 397.405, F.S., prior to initiating the provision of services.

Performance Measures

The Network Service Provider shall include the following performance measures in each subcontract for CAT services:

1. **School Attendance**

   Individuals receiving services shall attend an average of 80% percent of school days, according to the following methodology:

   a. Calculate the percentage of available school days attended by all individuals served during the reporting period.

   - Include all individuals served age 15 and younger.
   - Include only those individuals age 16 and older who are actually enrolled in a school or vocational program.
   - For individuals in alternative school settings, such as virtual and home school, school attendance may be estimated based on specific requirements applicable to the setting. Examples include the percentage of work completed within a specified time-period; adherence to a schedule as reported by the parent, caregiver or legal guardian or documentation of a reporting mechanism.
   - Do not include individuals for whom school attendance in an alternative education setting cannot be determined.
   - Do not include any days an individual is considered medically excused as a result which in a crisis stabilization unit.

   b. The numerator is the sum of the total number of school days attended for all individuals.

   c. The denominator is the sum of the total number of school days available for all individuals.

2. **Children's Functional Assessment Rating Scales (CFARS) and Functional Assessment Rating Scale (FARS)**

   Effective once the Network Service Provider discharges a minimum of 10 individuals each fiscal year, 80% of individuals receiving services shall improve their level of functioning between admission to discharge, as determined by:

   a. The Children's Functional Assessment Rating Scales (CFARS) if the individual is under 18 years of age; or

   b. The Functional Assessment Rating Scale (FARS), if the individual is 18 years of age or older.

   - Measure improvement is based on the change between the admission and discharge assessment scores completed using the CFARS or FARS, as determined by the age of the individual.

   c. The numerator is the total number of individuals whose discharge score is less than their admission assessment score. Scores are calculated by summing the score for all questions

for each person discharged during the current fiscal year-to-date. A decrease in score from the admission score to the discharge score indicates that the level of functioning has improved.

d. The denominator is the total number of individuals discharged with an admission and discharge assessment during the current fiscal year-to-date.

3. Living in a Community Setting:

Individuals served will spend a minimum of 90% of days living in a community setting:

a. The numerator is the sum of all days in which all individuals receiving services qualify as living in a community setting.

- "Living in a community setting" excludes any days spent in jail, detention, a crisis stabilization unit, homeless, a short-term residential treatment program, a psychiatric inpatient facility or any other state mental health treatment facility.
- Individuals living in foster homes and group homes are considered living in a community setting.
- For children under 18 years of age, days spent on runaway status, in a residential level one treatment facility, or in a wilderness camp are not considered living in a community setting.

b. The denominator is the sum of all days in the reporting period during which all individuals were enrolled for services.

4. North Carolina Family Assessment Scale for General Services and Reunification (NCFAS-G+R)

Effective once the Provider discharges a minimum of 10 individuals each fiscal year, 65% of individuals and families receiving services shall demonstrate improved family functioning as demonstrated by an improvement in the Child Well-Being domain between admission and discharge, as determined by the North Carolina Family Assessment Rating Scale for General Services and Reunification (NCFAS- G+R), if the individual is under eighteen (18). The NCFAS-G+R is not required for individuals ages 18 or older.

a. Calculate the percentage of individuals who increased their family functioning in the Child Well-Being Domain by at least one point from admission to discharge, as measured by the NCFAS-G+R.

b. The numerator is the number of individuals whose score on the Child Well-Being domain at discharge is at least one point higher than their score on the Child Well-Being domain at admission during the current fiscal year-to-date.

c. The denominator is the total number of individuals receiving services who were discharged during the current fiscal year-to-date and for whom the NCFAS-G+R was used at admission.

Note: If an admission NCFAS assessment has been completed on a child and parent/caregiver and the child moves to a different home with a different caregiver, a NCFAS discharge assessment should be completed at that time to ensure the same parent/caregiver is assessed at admission and discharge. Additional consideration should be given to the following:

- If CAT services are continued in the new placement with the new parent/caregiver, an admission and discharge NCFAS assessment should be completed for the new parent/caregiver.
- If a child changes placements multiple times, the provider and ME should discuss how to report on the NCFAS performance measure for that child, keeping in mind that the NCFAS measures family functioning in the context of services received, so we need to know who received services to determine the level of improvement in functioning.

Appendix 2 Guidance

The following guidelines shall be used by CAT Network Service Providers when reporting the required quarterly data using **Appendix 2**.

1. **Discharge placements for individuals identified as admission as at risk of out of home placement**

   A primary CAT program goal is diverting these individuals from placement within the juvenile justice, corrections, residential mental health treatment or child welfare systems, and enabling them to live effectively in the community. The considerations below are non-exhaustive guidelines by which CAT Network Service Providers can determine if an individual is at high risk of out of home placement at the time of admission.

   a. Residential Mental Health Treatment, including therapeutic group homes

   - Has a recommendation from a psychologist/psychiatrist for placement in residential mental health treatment center?
   - Has a recommendation from a Qualified Evaluator for placement in residential treatment (child welfare)?
   - Has previously been placed in residential treatment?
   - Is the parent/legal guardian is requesting placement in a residential mental health treatment center?

   b. Department of Juvenile Justice (DJJ) Placement

   - Are there current DJJ charges or is there a long history of charges?
   - Was there previous DJJ commitment placement?
   - Does a child aged 12 and under have current or previous DJJ charges?

   c. Child Welfare Out of Home Placement

   - Is there an open Child Welfare case or investigation?
   - Were there previous child welfare cases, investigations or services?
   - Were there any previous out-of-home Child Welfare placements?

2. **Gainful Activity for Individuals Not Enrolled in School or Vocational Program**

Participation in gainful activities by individuals aged sixteen and older who are not enrolled in school or vocational programs is an indicators of program success in fostering self-sufficiency. These activities should focus on employment, continued education, vocation training and certification, work readiness, career planning, and skill development related to obtaining and keeping a job. These activities are opportunities for a therapeutic mentor to assist individuals in identifying personal goals and developing plans.

Examples of enrichment activities include, but are not limited to, employment and supported employment; internships and apprenticeships; linkage to and services from entities such as Vocational Rehabilitation; and activities that support career planning, occupational research and assessment

Required Reporting:

- **Appendix 1 - Persons Served and Performance Measure Report**: A report submitted monthly by the 10th of the month, on the Department's template. The Network Service Provider shall submit the report electronically to the LSF Health Systems Network Manager and Director of Program Operations and include the following attestation: "I hereby attest the information provided herein is accurate, reflects services provided in accordance with the terms and conditions of this contract, and is supported by client documentation records maintained by this agency."
- **Appendix 2 - Quarterly Supplemental Data Report**: In order to assist the Department with system-wide programmatic analysis of the CAT model, the Network Service Providers must submit quarterly supplemental data, by the 10th of the month after the completion of each state fiscal year quarter, (10/10, 1/10, 4/10, 7/10), to the LSF Health Systems Network Manager and Director of Program Operations, submitted on the Department's template.
- **Appendix 3 – CAT Return on Investment Quarterly Report**: The Network Service Provider must submit a quarterly report to the LSF Health Systems Network Manager and Director of Program Operations by the 10th of the month after the completion of each state fiscal year quarter, (10/10, 1/10, 4/10, 7/10), documenting the actual return on investment achieved and describing the methodology by which the return on investment amount was determined. The report should be submitted on the Department's template.
- **Exhibit O - Expenditure Reconciliation Report**: A quarterly detailed cumulative reports of program expenses submitted on the Managing Entity's template by the 10th of the month after the completion of each state fiscal year quarter, (10/10, 1/10, 4/10, 7/10), to the LSF Health Systems Network Manager and Director of Program Operations which are used to track all expenses associated with the grant and reconcile these expenditures with the payments made to the grantee. The financial reports track both grant award-funded and match-funded expenses and encourages program expenditure planning and projection.
    - The Managing Entity reserves the right to request monthly **Exhibit O - Expenditure Reconciliation** reports after the third quarter depending on the Network Service Providers rate of spending.
- **Waitlist Report**: In order to assist the Department with system-wide programmatic analysis of the CAT model, the Network Service Providers must submit monthly waitlist data by the 10th of the month to the LSF Health Systems Network Manager and Director of Program Operations on the Managing Entity's template.

- Ad Hoc and additional reporting may be required as determined necessary by LSF Health Systems or the Department of Children and Families.

Community Action Treatment (CAT) Teams will be administered according to DCF Guidance 32, which can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities/.