Linking, Advocating, Treating, Transitioning, Empowering & Recovery Support (LATTERS)
Florida Assertive Community Treatment (FACT), Tier 2 Variation

I. LEVEL OF CARE DESCRIPTION

Linking, Advocating, Treating, Transitioning, Empowering & Recovery Support (LATTERS) services use a multidisciplinary approach to deliver care to adults with serious mental illness (SMI). LATTERS services deliver mental health rehabilitation interventions and supports necessary to assist participants to achieve and maintain rehabilitative, resiliency, and recovery goals. Clinical case management and recovery supports promote continuity of care and ease of service access until a full transition to community-based care.

Services may provide a step down for individuals who meet the Department's high utilization criteria and require an intensive array of services to prevent recurring admissions to acute care environments or residential treatment. Services may also support individuals who no longer need FACT Team services but may need support with transitioning to community-based car.

II. SCOPE OF SERVICES

LATTERS provides services to participants where they live or in an office setting, whichever is determined to be clinically appropriate, with an after-hours on-call system to provide crisis intervention services and support.

The recovery process is highly personal and may occur via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, or other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness, as well as managing setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

Program Goals

The goals of LATTERS services are to:

- decrease crisis episodes;
- promote independent functioning;
- increase community tenure;
- improve community involvement through increased time at work, in school, or with social contacts;
- maintain personal satisfaction and autonomy; and
- improve overall quality of life for program participants.

The ideal length of stay is 12 – 18 months. However, providers should determine whether the maximum benefit has been achieved based on clinical judgment, goal attainment, confirmed community-based service linkage, and the participant's input.

III. SERVICE DESCRIPTION

LATTERS is a clinical case management model with medical services, wellness management, and recovery support. The service array includes:

Psychiatric Services (via Psychiatric Advanced Practice Registered Nurse or Psychiatrist)

- Primary psychiatric care, if appropriate, or coordination with other psychiatric providers
- Psychiatric mental status assessment
- Medication and symptom management
- Brief supportive therapy
- Coordination with other providers for both physical and psychiatric care needs
- Service participants are seen on a regular schedule, preferrable at least every three months
- Consultation and support of the Team Coordinator

Nursing (via Licensed Practical Nurse or Registered Nurse)

- Medication coordination and delivery
- Provision of injectable antipsychotic medications
- Consultation and support of the clinical case management team

Clinical Case Management (via Team Coordinator, Behavioral Health Clinician, and Case Specialists)

- Aftercare/Follow-up
- Assessment
- Case Management, including community-based service linkage and monitoring
- Information and Referral Services
- In-Home and On-Site Services Overlay
- Intervention Services, including supportive therapy
- Outpatient – Individual and Group
- Recovery Support – Individual and Group
- Engagement of natural supports
- Supported Employment
- Supported Housing/Living, including tenancy supports
- Person-centered planning and crisis planning
- Family psychoeducation
- Advocacy and benefits management
- Wellness management and recovery, which includes “manualized” curricula, such as Illness Management and Recovery (IMR); Wellness Management and Recovery (WMR); Wellness Recovery Action Plans (WRAP); Psychiatric Advance Directives (PADs)

Staffing Requirements

LATTERS staffing configurations combine practitioners with varying backgrounds in education, training, and experience. This diverse range of skills and expertise enhances the team's ability to provide comprehensive care based on individual needs.

Hours of operation and staff coverage provide services Monday through Friday 8:00 a.m. – 5:00 p.m. The team also ensures an after-hours on-call system is available to provide crisis intervention services and support.

The minimum staffing patterns are:

# of Participants	Minimum Direct Service[1] FTE	Psychiatric Service Hours per Week	Nurse FTE	Minimum Total FTE
60	5	18.00	1.00	6

Within the guidelines of the prescribed staff-to-participant ratios presented in the staffing chart above, teams may exercise a degree of flexibility in team composition. However, LATTERS services must minimally include:

- One full-time Licensed Team Coordinator,
- One part-time[1] Psychiatric Advanced Registered Nurse Practitioner (ARNP) or
- Psychiatrist,
- One full-time Licensed Practical Nurse (LPN) or Registered Nurse (RN),
- One full-time Behavioral Health Clinician,
- Two full-time Case Specialists,
- One full-time[1] Administrative Assistant.

Staff Roles and Credentials

The provider must maintain a current organizational chart indicating required staff and displaying organizational relationships and responsibilities, lines of administrative oversight, and clinical supervision.

Licensed Team Coordinator

The team coordinator must be a full-time employee with full clinical, administrative, and supervisory responsibility to the team with no responsibility to any other programs during the 40-hour workweek and possess a Florida license in one of the following professions:

- Licensed Clinical Social Worker, Marriage and Family Therapist, or Mental Health Counselor licensed in accordance with Chapter 491, Florida Statutes
- Psychiatrist licensed in accordance with Chapter 458, Florida Statutes
- Psychologist licensed in accordance with Chapter 490, Florida Statutes

The team coordinator is a practicing clinician providing services and clinical supervision

[1] Direct services staff does not include the psychiatric care provider or administrative staff.

at least 50 percent of the time. They are responsible for administrative, clinical, and quality oversight of the team. Preferably, the team coordinator is certified as a clinical supervisor. The team coordinator receives consultation from the psychiatric staff and administrative supervision from the Chief Executive Officer or designee.

Psychiatric Advanced Practice Registered Nurse (APRN) or Psychiatrist

The psychiatric APRN or psychiatrist provides clinical consultation to the entire team as well as psychopharmacological consultations for all participants, as needed. They also monitor non-psychiatric medical conditions and medications, provide brief therapy, and provide diagnostic and medication education to participants, with medication decisions based in a shared decision-making paradigm. If participants are hospitalized, they communicate directly with the inpatient psychiatric care provider to ensure continuity of care.

The psychiatric APRN or psychiatrist must have access to a board eligible psychiatrist for weekly consultation. A minimum of 0.30 hours of psychiatric services must be available for each participant per week (e.g., 18 hours for 60 participants). Participants must be seen by the psychiatric APRN or psychiatrist at least once every three months.

Licensed Practical Nurse or Registered Nurse

The nursing staff performs the following critical roles:

- Manage the medication system,
- Administer and document medication treatment,
- Screen and monitor participants for medical problems/side effects,
- Communicate and coordinate services with other medical providers,
- Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change related to their physical health),
- Educate other team members on monitoring of psychiatric symptoms and medication side effects, and
- With participant agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).

Behavioral Health Clinician

The Behavioral Health Clinician must be a Master's Level Clinician and hold a degree from an accredited university or college with a major in psychology, social work, counseling, or other behavioral science.

The Behavioral Health Clinician provides evidence-based therapeutic services and incorporates behavioral health goals. The Behavioral Health Clinician may also integrate treatment for co-occurring mental illness and substance use disorders to participants who have a history of substance abuse. This may include:

- Assessments that consider the relationship between substance use and mental health,

- Tracking of participants' stages of change readiness and stages of treatment,
- Outreach and motivational interviewing techniques,
- Cognitive behavioral approaches and relapse prevention, and
- Treatment approaches consistent with the participants' stage of change readiness.

The Behavioral Health Clinician also provides consultation and training to other team staff on integrated assessment and treatment skills relating to co-occurring disorders such as crisis intervention, individual and group sessions.

Case Specialists

This position requires a minimum of a bachelor's degree in a behavioral science, with preference for individuals also credentialed as a Certified Recovery Peer Specialist. Case specialists provide rehabilitation and support functions under clinical supervision and are integral members of individual treatment team. This includes social and communication skills training and training to enhance participant's independent living. Examples include on-going assessment, problem solving, assistance with activities of daily living, and coaching. Caseloads are determined by the Team Coordinator based on the needs of the individuals served but shall not exceed 20 participants.

Administrative Assistant

An administrative assistant is responsible for organizing, coordinating, and monitoring the non-clinical operations. Functions include direct support to staff, including monitoring and coordinating daily team schedules and supporting staff in both the office and field. Additionally, the administrative assistant serves as a liaison between participants and staff, including attending to the needs of office walk-ins and calls from participants and natural supports.

Target Population / Clinical Eligibility

LATTERS services are for individuals 18 years of age or older with serious mental illness who meet the following criteria:

- Individual is determined to need:
  - ongoing, community based psychiatric outreach and supports to ensure stability and avoid significant negative consequences such as death, victimization, hospitalization, homelessness, or violence that will compromise recovery, or
  - a strategic, titrated transition to minimize the risk of relapse and/or psychiatric decompensation.
- FACT Team (Tier 1) as a comprehensive, bundled service program is judged to be no longer medically necessary given the individual's person-centered goals.
- Determined to be the appropriate level of care compared to other available alternative interventions or programs within the Managing Entity service array.

Service Requirements

- Services must be provided to participants or their family members (or significant natural support persons).
- A minimum of 60 percent of all interventions must be delivered in natural settings and out of the provider's office(s).
- Visits must occur during times, and at locations, that reasonably accommodate the participant's and family's needs in community locations and other natural settings.
- Visits must occur at times that do not interfere with work, educational, and other community activities.
- Documentation must demonstrate that more than one member of the team is actively engaged in the direct service to each participant.

Services and Supports

The LATTERS approach to performing services is based on recovery orientation and promotes empowerment. The guiding principles include participant choice, cultural competence, person-centered planning, rights of persons served, stakeholder inclusion, and voice.

At a minimum, the program must offer:

- Counseling and intervention including, but not limited to:
  - motivational interviewing;
  - stage-based interventions;
  - refusal skill development;
  - cognitive behavioral therapy; and
  - psychoeducational approaches.
- Development and support of skills used for coping with trauma.
- Assisting the participant in symptom self-monitoring, reduction, and management.
- Improving quality of life- identify and minimize the negative effects of the mental illness and co-occurring disorders, which interfere with their ability to succeed within community, home, school, and work settings.
- Support and consultation to participant's family and their support systems. Interventions must be directed primarily to the well-being and benefit of the participant.
- Psychoeducation, counseling, and skill building for participant's family and their support systems, when those interventions are directed primarily to the well-being and benefit of the participant, with or without the client being present. In all cases, the family or support system psychoeducation or skill building must relate to a need identified in the assessment.

Assessments and Recovery Plan

Initial Assessment and Recovery Plan

The Team Leader in coordination with the Psychiatrist or Psychiatric APRN performs an initial assessment and develops an initial plan of care on the day of the participant's

admission to the program. The participant and designated team members will be actively involved in the development of the plan. This is intended to ensure that immediate needs for medication, treatment, and basic needs are not delayed. The required components of an initial assessment, at a minimum, include:

- A brief mental status examination,
- Assessment of symptoms,
- An initial psychosocial history,
- An initial health/medical assessment,
- A review of previous clinical information obtained at the time of admission,
- A preliminary identification of the participant's housing, financial and employment status; and
- A preliminary review of the participant's strengths, challenges, and preferences.

Biopsychosocial Assessment

The team completes a biopsychosocial assessment as an expansion of the initial plan within 30 days of admission. The biopsychosocial assessment shall describe the biological, psychological, and social factors that may have contributed to the participant's need for services. The evaluation synthesizes the results of all assessments administered and include a brief mental status exam, diagnostic/clinical impression and preliminary service recommendations based on those results and interview of the participant and family. Refer to Chapter 65D-30, Florida Administrative Code for further requirements of the Biopsychosocial Assessment

Functional Assessment Rating Scale (FARS)

Complete the FARS to document impressions from clinical evaluations or mental status exams to assess cognitive, social and role functioning within 30 days of admission. To effectively monitor changes over time, the FARS shall be administered again 6 months after admission and then again annually after admission. A final administration of the FARS shall be completed at discharge, whether planned or an administrative discharge.

Daily Living Activities (DLA-20): Adult Mental Health

The DLA-20 will support the functional assessment data needs of service providers. In the first 30 days following admission, complete the DLA-20 to determine the parts of life impacted by a participant's mental illness. To effectively monitor changes over time, the DLA-20 shall be readministered within sixty (60) calendar days of initial completion and continue to be administered at 60-day intervals throughout the course of services. A final administration of the DLA-20 shall be completed at discharge, except in the case of unplanned discharge or disengagement.

Comprehensive Recovery Plan

The team completes a comprehensive recovery plan as an expansion of the initial plan within 90 days of admission, following completion of all assessments. The Comprehensive Recovery Plan shall adhere to the following guidelines:

- Planning is person-centered and actively involves the participant, guardian (if

any), and family members and significant others the participant wishes to participate.

- The plan is reviewed and updated, at minimum, every six (6) months during planned meetings, unless clinically indicated earlier, by the treatment team and the participant.
- The plan is based on assessment findings and:
    - Identifies the participant's strengths, resources, needs and limitations,
    - Identifies short and long-term goals with timelines,
    - Identifies participant's preferences for services,
    - Outlines measurable treatment objectives and the services and activities necessary to meet the objectives and needs of the participant, and
    - Targets a range of life domains such as symptom management, education, transportation, housing, activities of daily living, employment, daily structure, and family and social relationships, should the assessment identify a need and the participant agrees to identify a goal in that area.

Expected Outcomes

Given the provision of LATTERS services, it is expected that participants will demonstrate continued stabilization within the community, for example, absence or very limited use of psychiatric inpatient service and growth in life areas identified in the treatment plan, which may include:

- Maintenance of current areas of functioning and wellness, as desired and valued by the participant
- Increased use of wellness self-management and recovery tools, which includes independence around medication management
- Vocational/educational gains
- Increased length of stay in independent, community residence
- Increased functioning in activities of daily living, such as independence around money management and transportation
- Increased use of natural supports and development of meaningful personal relationships
- Improved physical health

Staff Communication and Planning

Similar to the FACT model (Tier 1), the team must conduct daily organizational staff meetings at regularly scheduled times as established by the Team Leader. The team completes the following tasks during the daily meeting:

- Conduct a brief, clinically relevant review of all participants at least weekly.
- Document any contacts (i.e., phone calls, home visits, transporting, etc.) in the past 24 hours.

- Maintain a schedule for each participant including all treatment and service contacts to be carried out to reach the goals and objectives in the participant's recovery plan.
- Maintain a central file of all schedules.
- Develop a daily staff schedule consisting of a written timetable for all treatment and service contacts to be divided and shared by the staff working that day based on:
    - schedule for each participant;
    - emerging needs;
    - need for pro-active contacts to prevent future crises; and
    - revision of recovery plans as needed and add service contacts to the daily staff assignment schedule per the revised recovery plans.

Active Engagement

As LATTERS services are voluntary, efforts should be made to actively engage participants throughout the treatment process. Engagement needs to be an ongoing process and the effort and importance of engagement put forth should remain present during the duration of treatment. Engagement strategies should be varied, thoughtful, and directed to the specific needs of each participant.

LATTERS services should utilize techniques such as Motivational Interviewing to maintain engagement and relationships with participants. LATTERS services should also look for markers or behavior that might indicate a member would need more assertive engagement. These signs could include missing appointments, lack of good rapport or trust in the therapeutic relationship, inpatient placement, increased or frequent crisis situations, homelessness or risk of homelessness, loss of natural supports, high risk behaviors, or substance use that may be interfering with ability to engage in treatment.

Treatment planning and subsequent therapeutic interventions must reflect appropriate, adequate, and timely implementation of all treatment interventions in response to the individually changing needs. The participant should be assessed consistently for transition and continues to meet admission criteria showing a need for this level of intervention.

Waiting List

Waiting list records are created when an individual has been determined eligible for LATTERS services but is at maximum capacity and access is not immediately available. Consent to participate in LATTERS services by an individual must be obtained to add them to a waiting list.

Administrative Tasks

Administrative tasks that include:

- Establishment and maintenance of written policies and procedures for:
    - Personnel,
    - Program organization,
    - Admission and discharge criteria and procedures,
    - Assessments and recovery planning,

  - Provision of services,
  - Medical records management,
  - Quality assurance/quality improvement,
  - Risk management, and
  - Rights of persons served.
- Accurate record keeping reflecting specific services offered to and provided for each participant, available for review by the Managing Entity and Department staff,
- Coordination of services with other entities to ensure the needs of the participant are addressed,
- Providing staff training and supervision to ensure staff are aware of their obligations as an employee, and
- A plan for supporting participants in the event of a disaster including contingencies for staff, provision of needed services, medications, and post-disaster related activities.

IV. DISCHARGE PLANNING AND TRANSITIONS

Discharge planning should begin immediately upon intake and the expectations and course of treatment should be discussed with the participant during the admission process. Long-term achievement of goals and markers for discharge should be discussed at each treatment plan update and participants should be consistently assessed for discharge readiness throughout the duration of engagement with services, including barriers to discharge, progress of discharge planning, and any changes to discharge plans.

Transfer Determination to A Higher Level of Care

Throughout LATTERS services provision, despite best clinical and medical efforts, a higher level of care may be needed. In this instance, participants may require admission to FACT services (Tier 1) and thereby increase the intensity of services, as well as full breadth of services.

This determination must be judged by the psychiatric APRN or psychiatrist on staff to be medically necessary, given an acute exacerbation of illness or significant reduction in functional status that is not adequately addressed within 4 weeks and for which FACT (Tier 1) is medically necessary to address. In such cases, the goal will be for FACT (Tier 1) to stabilize the participant and return to LATTERS services, once determined medically appropriate.

Discharge Categories

Discharges shall be based on the following categories:

- SUCCESSFUL COMPLETION: Participant made significant progress toward rehabilitation goals and engagement in community-based care is optimal. Participant no longer requires this level of care.
- TRANSFER TO A HIGHER LEVEL OF CARE: Participant requires transfer to a higher level of care (such as FACT Tier 1 or SMHTF). This reflects that maximum benefit has been achieved at current level of care and yet a higher level of care is needed. If the participant refuses transfer and disengages, the discharge will be defined as disengaged.
- MOVED: Participant moved out of the service area.

- JAIL/PRISON: Participant is discharged due to incarceration.
- DISENGAGED: Participant requests discharge or chooses not to participate, despite repeated efforts to engage.
- DEATH: Participant is discharged due to death.

Discharge Documentation

The following must be included in the participant's medical record at discharge:

- The reason(s) for discharge.
- The participant's status and condition at discharge.
- A final evaluation summary of the participant's progress toward the outcomes and goals.
- A plan developed in conjunction with the participant and their support system for an ongoing mental health crisis plan upon discharge
- A summary of referral information made while receiving services
- Documentation that the participant was advised they may return to LATRS services if they desire, and space is available.

V. REPORTS

The Network Service Provider shall submit the following reports monthly by the 10th of the month to the Managing Entity:

- **LATTERS Tracking Worksheet**

  This displays the team's client data, including demographic information, service data, assessment data, and any mental health disorder and/or substance use disorder diagnoses.

- **Monthly Census Worksheet**

  This monthly report displays the team's aggregate monthly census information. This report also captures waiting list totals as of the last day of the reporting month.

- **Vacant Position Report**

  This monthly report displays positions required by this program and whether the positions were filled or vacant for the reporting month.

VI. OUTCOME MEASURES

The Network Service Provider shall meet the following outcome measures:

- Percent of adults with severe mental illnesses who live in stable housing environment that is equal to or greater than 90 percent or the most current General Appropriations Act working papers transmitted to the Department of Children and Families; and,
- Average annual days worked for pay for adults with a severe mental illness that is equal to or greater than 40 days worked for pay or the most current General Appropriations Act working papers transmitted to the Department of Children and Families.
- While enrolled, fewer than 15 percent of all individuals will be admitted to a Baker Act Receiving Facility.

- While enrolled and upon completion, 75 percent of all individuals will either maintain or show improvement in their level of functioning, as measured by the Functional Assessment Rating Scale (FARS).
- Upon successful completion, 95 percent of individuals served will be living in a stable housing environment.
- Upon successful completion, 90 percent of individuals served will maintain or improve the parts of life impacted by mental illness, as measured by the Daily Living Activities (DLA-20): Adult Mental Health Assessment.
- Upon successful completion, fewer than 10 percent of all individuals will be admitted to a Baker Act Receiving Facility within three (3) months of discharge.

The Network Service Provider shall meet the following process measures:

- 90 percent of all initial assessments shall be completed on the day of the person's enrollment with written documentation of the service occurrence in the clinical record.
- 90 percent of all biopsychosocial assessments shall be completed within 30 days of the person's admission with written documentation of the service occurrence in the clinical record.
- 90 percent of all individuals enrolled shall have an individualized, comprehensive recovery plan within 90 days of admission with written documentation of the service occurrence in the clinical record.
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Linking, Advocating, Treating, Transitioning, Empowering & Recovery Support (LATTERS), Florida Assertive Community Treatment (FACT), Tier 2 Variation will be administered according to DCF Guidance 36, which can be found at following link using the applicable fiscal year: http://www.myflfamilies.com/service-programs/samh/managing-entities/.