LSF Health Systems Triennial Needs Assessment – October 2019

Introduction

A Community Health Needs Assessment serves as a systematic approach to collecting, analyzing and utilizing data to identify priority areas for improving health. LSF Health Systems contracted with WellFlorida Council and the Health Planning Council of Northeast Florida to conduct the triennial behavioral health needs assessment required by State and Federal statutes. LSFHS will use this report as a call to action, engaging providers, consumers, stakeholders and community members, in creating effective programs and policies and collaborating with other organizations to bring positive change to our communities. The long-term goal of a Community Health Needs Assessment is to identify health priorities and develop impact strategies with all health-related stakeholders in the community. This report will serve to inform the development of the LSF Health Systems Strategic Plan for 2020-2023 and the annual enhancement plans submitted to the Department of Children and Families to address unmet needs. Town Hall meetings with Providers and stakeholders will be scheduled in each of the circuits served by LSF Health Systems to discuss the results of the Triennial Needs Assessment.

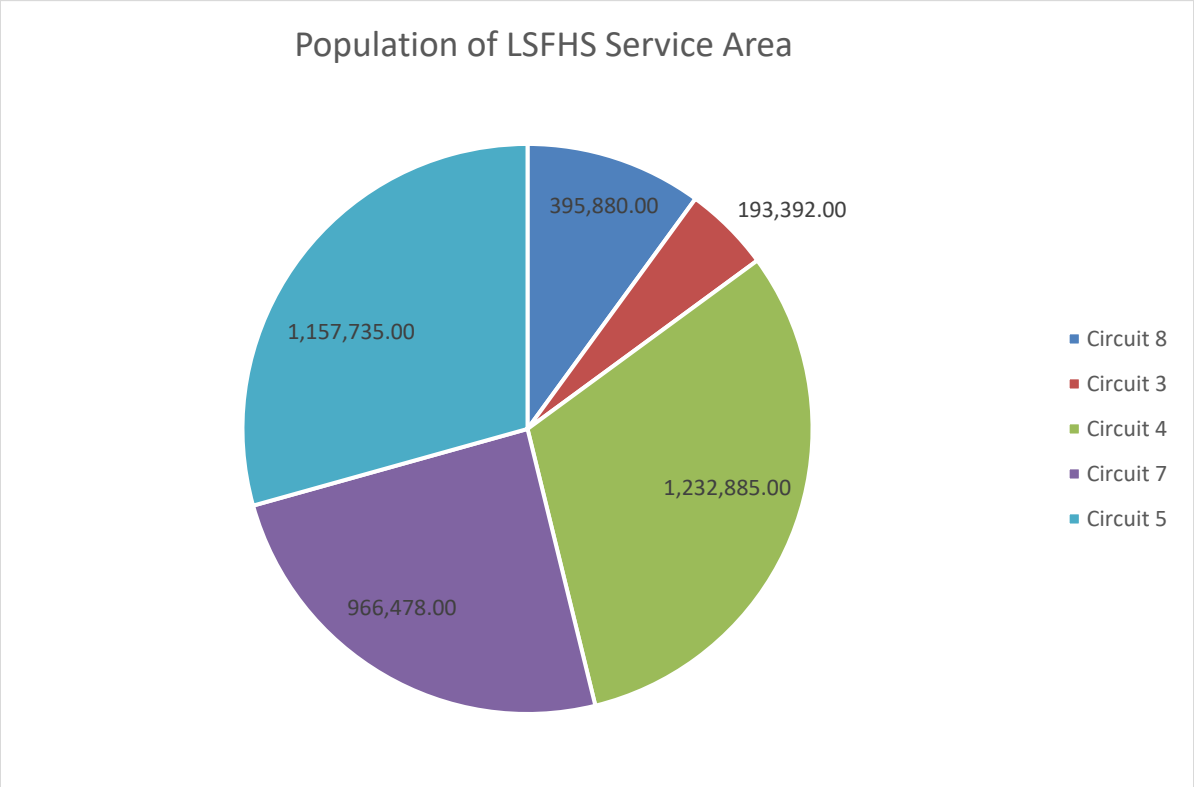
Methodology

Generally, the health of a community is measured by the physical, mental, environmental and social well-being of its residents. Due to the complex determinants of health, the Behavioral Health Needs Assessment is driven by both quantitative and qualitative data collecting and analysis from both primary and secondary data sources. Data collected and analyzed includes social determinants of health, community health status, and health system assessment. Social determinants of health include socioeconomic demographics, poverty rates, population demographics, uninsured population estimates and educational attainment levels and the like. The community health status assessment includes factors such as County Health Rankings, CDC's Behavioral Risk Factor Surveillance Survey, and hospital utilization data. Health system assessment includes data on insurance coverage (public and private), Medicaid eligibility, health care expenditures by payor source, hospital utilization data, and physician supply rate and health professional shortage areas.

In addition to the extensive review of secondary data, the LSF Health Systems Needs Assessment also included surveys of consumers, providers and stakeholders as well as focus groups in each Circuit. The data collected through these processes as well as LSFHS service utilization data were analyzed for trends and community priorities.

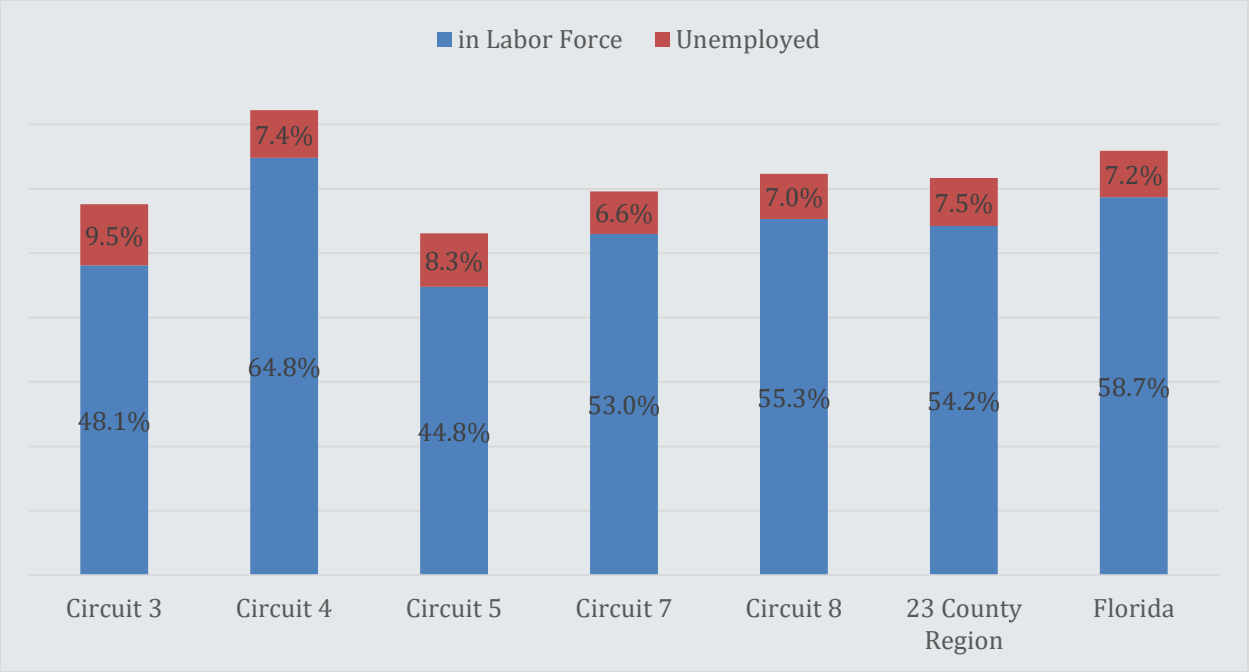
Secondary Data Findings

The LSF Health Systems catchment area, serving five Judicial Circuits, is comprised of 23 counties, with a total population of 3,946,370, or 18.6% of the state population based on 2017 census estimates.

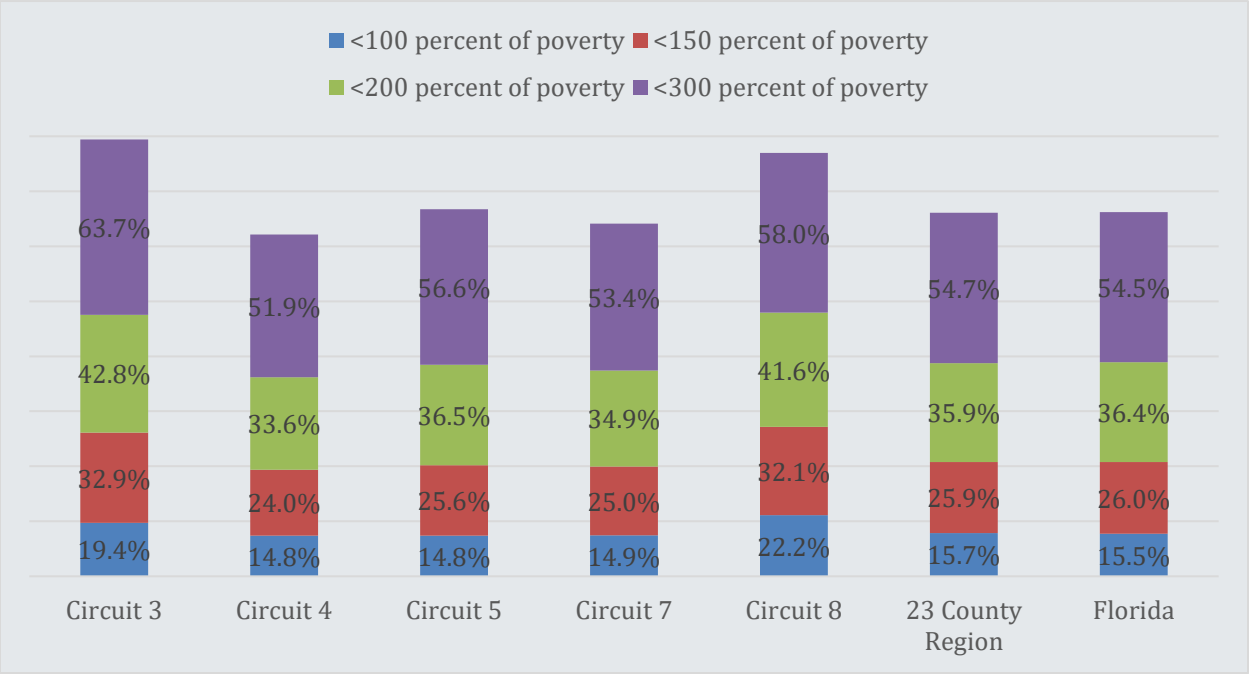


Counties in the LSFHS service area collectively scored slightly higher than the state of Florida for unemployment. Counties vary widely in the percentage of population that live in poverty, with some counties significantly higher than the state average.

EMPLOYMENT STATUS, 2013-2017.



ESTIMATED TOTAL POPULATION BY SELECTED RATIO OF INCOMES TO POVERTY LEVEL IN THE PAST 12 MONTHS, 2013-2017.



Based on the 2019 County Health Profiles, the ratios of healthcare providers to per capita population are higher in most counties in the LSFHS catchment area except for Alachua and Duval counties. For primary care physicians the ratio of providers to per capita population in Florida is 1387:1. In 19 out of 23 counties there are fewer primary care physicians per capita than the state average. For dentists the ratio of providers to per capita population in Florida is 1704:1. In 21 of 23 counties there are fewer dentists per capita than the state average. For mental health providers the ratio of providers to per capita population in Florida is 667:1. In 20 out 23 counties there are fewer mental health providers per capita than the state average.

Unemployment, poverty, poor physical health and lack of access to healthcare professionals impact behavioral health needs and the incidence of so-called “diseases of despair”; substance use disorder, overdose and suicide as evidenced in the data presented below.

Behavioral Risk Factor Surveillance System

The Florida Department of Health conducts the Behavioral Risk Factor Surveillance Survey (BRFSS) with financial and technical assistance from the Centers for Disease Control and Prevention (CDC). This statewide survey is conducted via telephone in order to collect self-reported data on individual risk behaviors and preventative health practices found to be related to the leading causes of morbidity and mortality in the United States. The current data available for the LSF service area is from 2016.

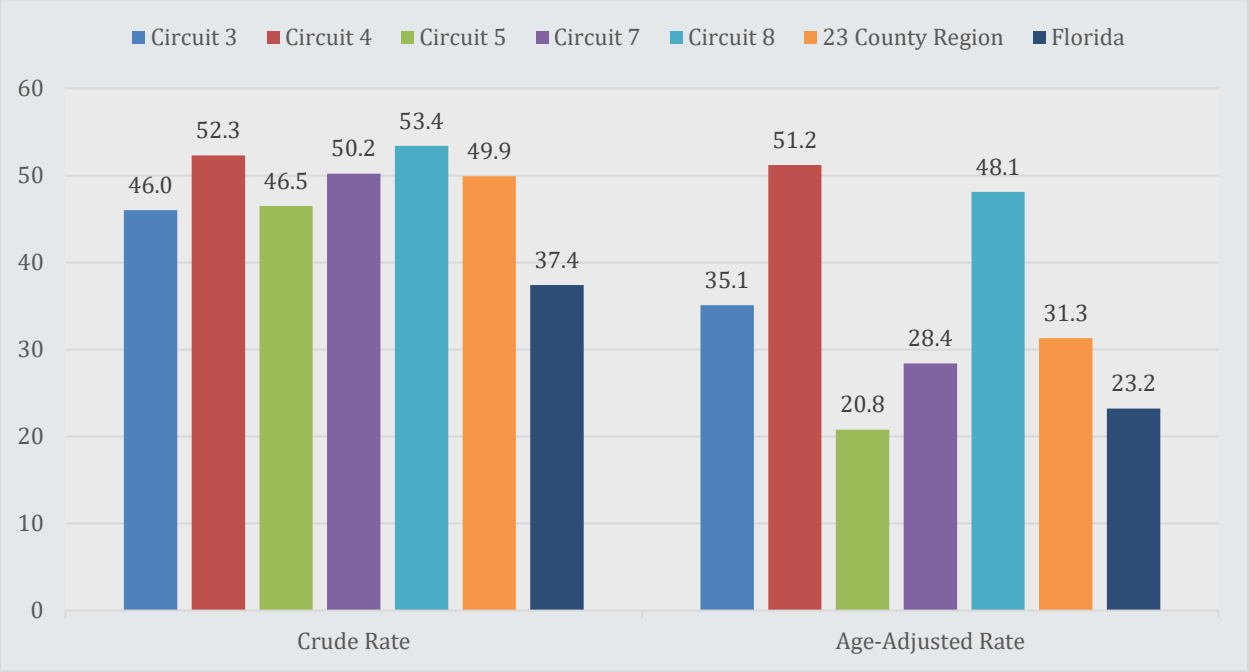
Mortality

The statistics in the following section are reported as crude as well as age-adjusted death rates. Crude rates are used to report the overall burden of disease in the total population irrespective of age, whereas age-adjusted rates are the most commonly utilized rates for public health data and are used to compare rates of health events affected by confounding factors in a population over time.

Mental Health Disorder Death Rates

The figure below shows death rates related to mental health disorders with ICD-10 code F01-09, F20-48, and F50-99. Both crude and age-adjusted death rates are higher in the LSF service area as well as in each circuit individually than in the state of Florida, with the exception of Circuit 5's age-adjusted death rate, which is lower than Florida's rate.

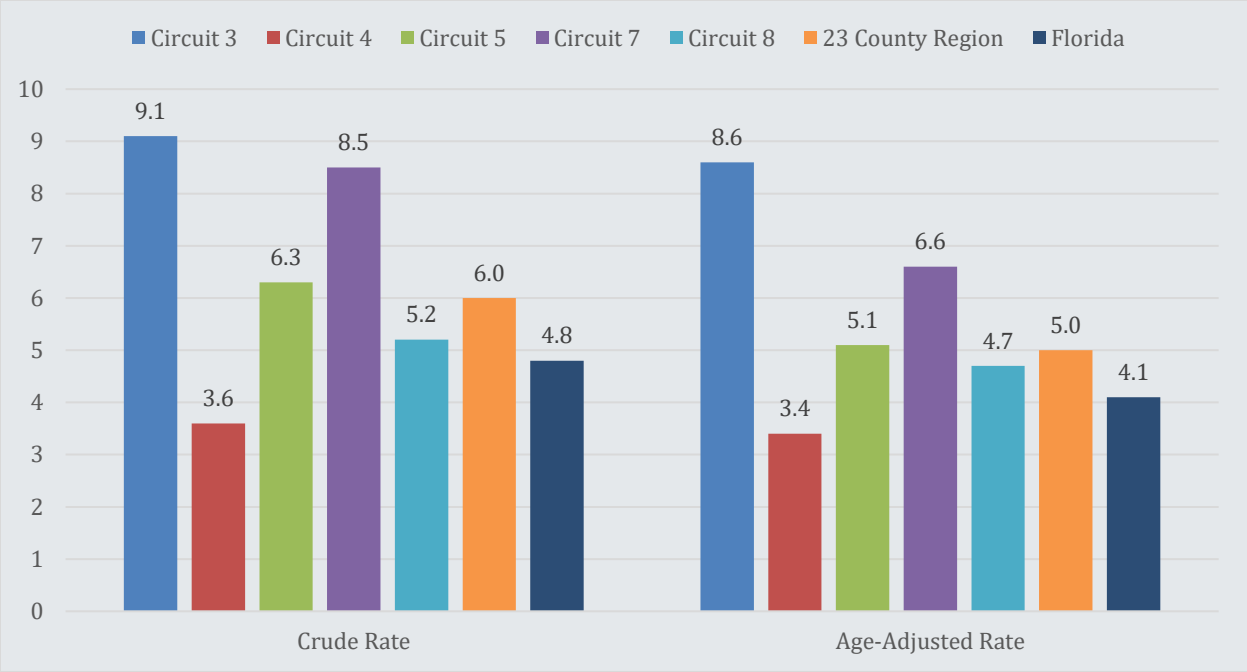
CRUDE AND AGE-ADJUSTED DEATH RATE PER 100,000 POPULATION FOR ALL RACES RELATED TO MENTAL HEALTH DISORDERS, 2017.



Mental Health Substance Abuse Death Rates

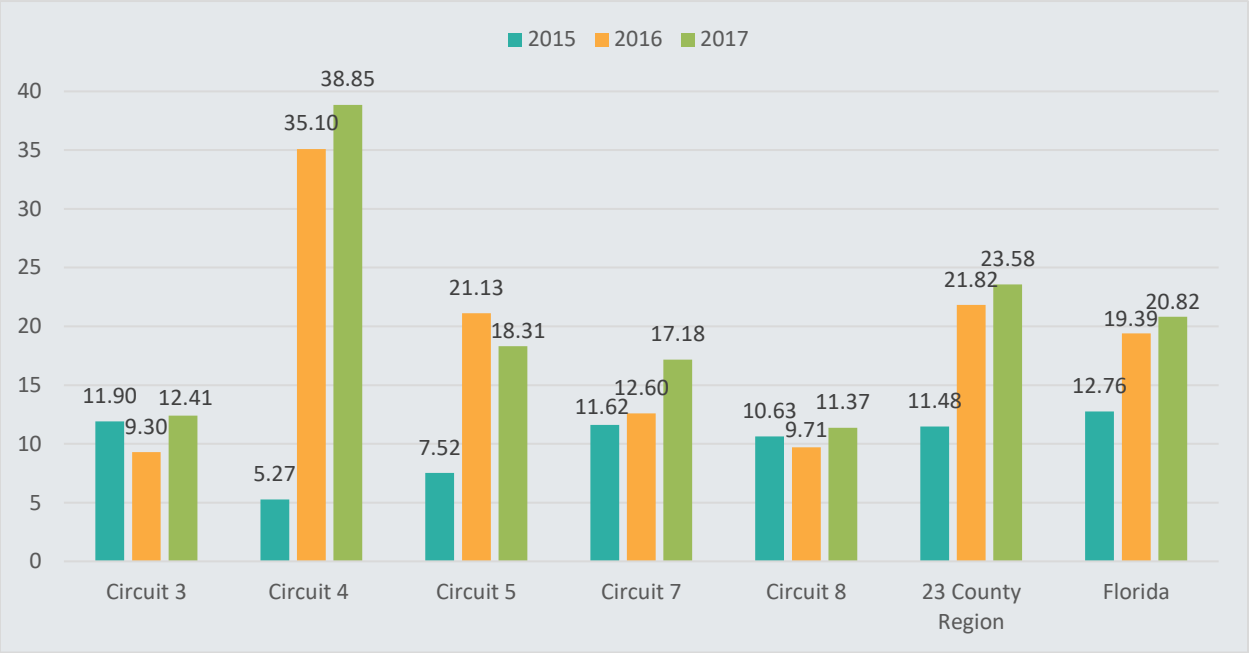
While death rates due to mental health disorders have roughly remained steady from 2015 to 2017, the rate of substance abuse related deaths among those with a mental or behavioral health disorder has been climbing steadily from 2015 to 2017 in both the LSF service area and in Florida. The LSF service area saw 133 of these deaths in 2015. This number rose to 202 in 2016, and 229 in 2017. The number of such deaths climbed steadily in Florida throughout these three years as well (807, 954, 985, respectively).

CRUDE AND AGE-ADJUSTED DEATH RATES PER 100,000 POPULATION FOR ALL RACES RELATED TO SUBSTANCE ABUSE DISORDERS, 2017.



The LSF Health Systems catchment area has been hard hit by the opioid crisis. The following figure shows the death rates where opioids were the cause of death for all ages and all races. Among all of LSF's five circuits, the service area as a whole, and Florida overall, mortality rates have increased from 2015 to 2017. In 2017, Circuit 4 had the highest mortality rate related to opioids (38.85 per 100,000 population) and Circuit 8 the lowest (11.37 per 100,000 population) (Technical Appendix, Table 186).

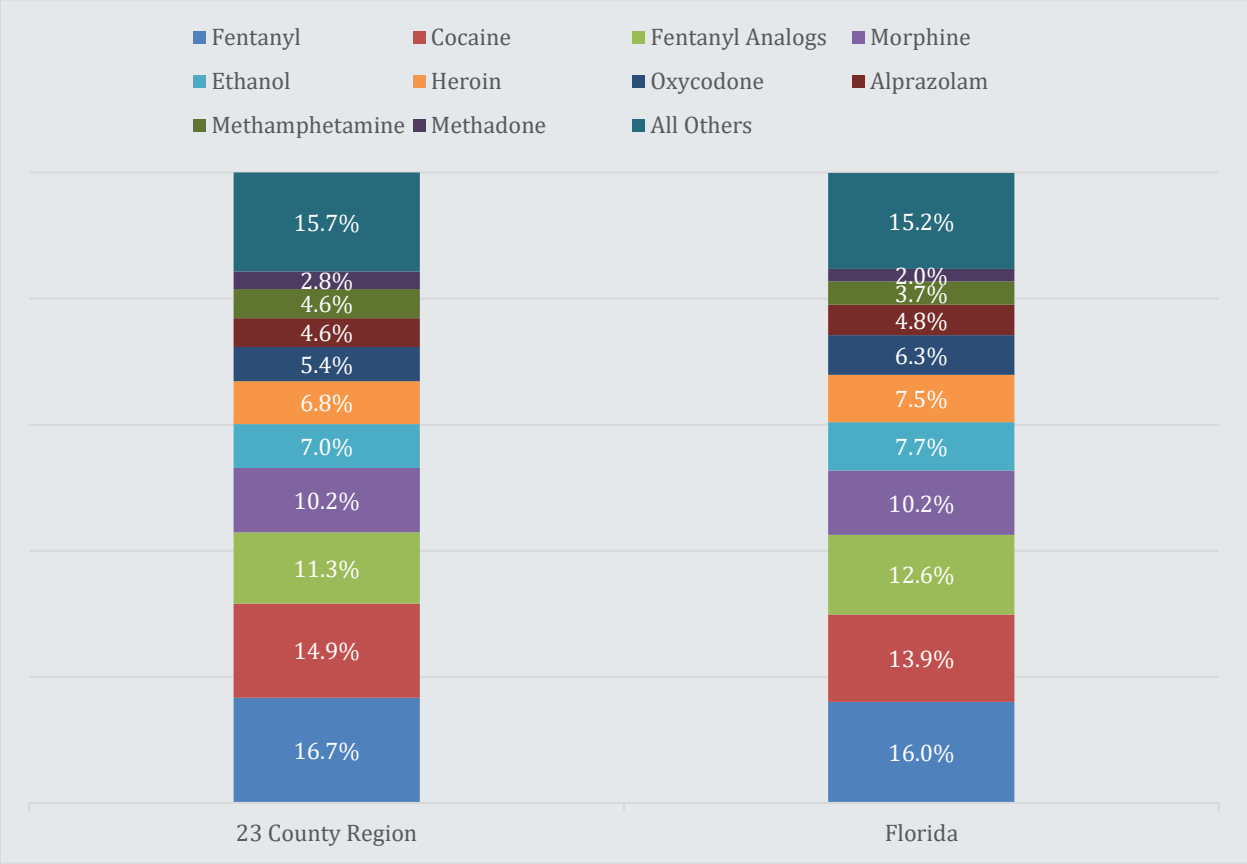
RATE PER 100,000 POPULATION WHERE "OPIOIDS" WERE THE CAUSE OF DEATH BY YEAR, 2015-2017.



Top 10 Substances That Were The Cause of Deaths

The figure below shows the top 10 substances that were the cause of death for all age groups in 2017. The substances were the same in 2017 as in 2016, although the ranking varied somewhat. Fentanyl Analogs and Morphine switched order from 2016 to 2017. In 2016, Fentanyl Analogs were ranked the number four substance that was the cause of death, and Morphine was ranked the number three substance. In 2017, Fentanyl Analogs were ranked number three, and Morphine was ranked number four. Methadone and Methamphetamines also switched ranks, Methadone was the number nine and Methamphetamines the number ten cause of death related to substances in 2016. In 2017, Methadone was the number ten and Methamphetamines the number nine cause of death among substances. Compared to Florida, the LSF service area had higher percentages of deaths caused by Fentanyl, Cocaine, Methamphetamines, and Methadone in 2017, and Florida had higher percentages of deaths caused by Fentanyl Analogs, Ethanol, Heroin, Oxycodone, and Alprazolam. Fentanyl caused the highest percentage of deaths among all substances and showed an increased percentage in both the LSF service area and Florida from 2016 to 2017 (the LSF service area: 15.7 percent in 2016 to 16.7 percent in 2017; Florida: 15.4 percent in 2016 to 16.0 percent in 2017). Cocaine was the number two substance that caused death in 2017, as well as in 2016, and showed an increased percentage for the LSF service area and Florida as a whole (LSF: 14.5 percent in 2016 to 14.9 percent in 2017; Florida: 12.1 percent in 2016 to 13.9 percent in 2017). Fentanyl Analogs show the third highest percentage among substances that were the cause of death in 2017 and also show an increased percentage from 2016 to 2017 (LSF: 7.4 percent in 2016 to 11.3 percent in 2017; Florida: 8.4 percent in 2016 to 12.6 percent in 2017) (Technical Appendix, Table 190).

TOP 10 SUBSTANCES THAT WERE THE CAUSE OF DEATH FOR ALL AGES, 2017.



All of the data tables are presented in the appendices attached to this report.

Based on the Florida Health Charts 2018 data, 19 of the 23 counties in the LSFHS catchment area have suicide rates that are higher than the state average.

Suicide Age-Adjusted Death Rate, Single Year Per 100,000, 2018		
County	**Count**	**Rate**
Florida	**3552**	**15.3**
Lafayette	0	0
Hamilton	1	6.1
Dixie	3	9.7
Sumter	21	11.1
Bradford	5	16
Alachua	42	16.5
Duval	164	16.9
Hernando	33	17.4
Clay	39	18
Baker	5	18.4
Suwannee	9	19.3
Volusia	125	19.4
Union	3	20
Gilchrist	5	20.2
Lake	77	21.3
Nassau	18	21.7
St. Johns	56	22
Columbia	18	23.1
Flagler	29	24.8
Levy	11	24.9
Marion	91	25
Putnam	24	29.6
Citrus	51	30.9

LSF Health Systems continues to be engaged in suicide prevention initiatives throughout the 23-county area, including the Florida LINC (Linking Individuals in Need of Care) suicide prevention grant and Zero Suicide. We used existing funds to purchase a movie and curriculum designed to open the discussion about suicide with young adults, their parents and teachers. We will be partnering with the youth-driven My Life groups in the counties to conduct meetings and town halls to show the movie and bring the community into the effort to reduce suicides. We have hosted suicide prevention conferences with well known national experts. Through our Training Institute, we continue to provide suicide prevention trainings including QPR and other best practice offerings.

I. Waitlist Information

The completed Tables for Needs Assessment file, including the "Special Populations on Waitlist" tab is included at the end of this report as Appendix 1. Within the LSF Health Systems catchment area, the services reported as having the greatest number of individuals placed on a waitlist are residential and outpatient substance abuse services for adults. In FY 18-19, 372 adults were placed on a waitlist for residential substance abuse services and 367 adults were placed on a waitlist for outpatient substance abuse services. There were no reported individuals placed on a waitlist for acute care services in FY18-19 however we have started to see a waitlist for detox services in FY 19-20. Providers reported no individuals placed on a waitlist for mental health services in FY 18-19. We have identified an underlying belief on the part of providers that if they indicate they are placing individuals on a waitlist that they are not meeting community needs and it will reflect negatively upon them and the system. We have been diligent in requiring consistent reporting of waitlist information for substance abuse due to the Block Grant reporting requirements. We have identified an opportunity to provide TA to develop more consistent and accurate reporting of waitlist information for Mental Health services in our network.

B. Redirection of Existing Resources to address waitlist for Substance Use Treatment

LSF Health Systems has strived to strategically mix recurring treatment funds such as Community-Based Substance Abuse Services with project specific funding like SOR to build sustainable capacity where most needed. Using the additional recurring Community-Based Substance Abuse Services funding, we added residential treatment beds to Circuit 4 – 3 beds to Gateway, Circuit 7- 3 beds to SMA and Circuit 5 –5 beds to Phoenix House, a new network service provider, to expand the diversity of services in Marion County. Likewise, we added the recurring, Community-Based Substance Abuse Services funds to our providers of substance abuse treatment services to increase the outpatient treatment capacity, particularly for individuals who need treatment for conditions other than Opioid Use Disorder, as well as to build outpatient capacity to sustain individuals with OUD in the event the federal funds are no longer available.

C. Redirection of Existing Resources to address waitlist for Mental Health Services

Providers reported no individuals placed on waitlists for mental health services in FY 18-19. We have implemented care coordination initiatives both at the Managing Entity and Provider level to help ensure the most efficient use of resources and the most effective treatment in the least restrictive environment. Care Coordination resources have been utilized to fund teams in the Children's CSU at MHRC and in Volusia County to reduce the number of readmissions for children and adolescents with multiple Baker Acts. The teams include a care coordinator and a

peer specialist to work with the child and family. In addition, LSF Health Systems has utilized bundled services projects to facilitate individualized, all inclusive care coordination/supported housing options for individuals being discharged from the State Mental Health Treatment Facility. These options include adult family care homes, and supported housing programs to provide an individualized program of six to nine months, focused on building life skills, engaging individuals in community treatment and support activities and linking them with community landlords when they are ready to move to a more independent setting.

II. Community Feedback

A. For each of the groups listed below, please describe any unmet needs identified, the process or methodology used to identify the unmet needs, and response rates and the number of respondents for any surveys or focus groups.

- **Individuals served and their family members**
- **Providers of behavioral health services**
- **Other community stakeholders (particularly those from the child welfare, criminal justice, and school systems)**

As part of their 23-county service area assessment, LSF Health Systems, engaged the services of WellFlorida Council to facilitate the design, implementation and analysis of primary data collection through surveying. Three distinct surveys were developed and implemented. The consumer survey collected opinions and perspectives from LSF Health Systems' clients throughout the service area. Healthcare professionals from LSF Health Systems Network Service Providers, including therapists, counselors, prevention specialists, executives and other behavioral health care specialists participated in the provider survey. Community stakeholders and partners throughout the service area responded to a third survey WellFlorida Council is the statutorily designated (F.S. 408.033) local health council that serves 16 north central Florida counties. To more effectively reach the remaining counties in LSF Health Systems service area, WellFlorida partnered with the Health Planning Council of Northeast Florida, another statutorily designed health council, that serves the northernmost Florida region. WellFlorida Council and the Health Planning Council of Northeast Florida share the mission to provide communities with health information, tools, and analyses while partnering in planning, assessment, research to improve health outcomes and resources.

In addition to the survey data, WellFlorida and the Health Planning Council of Northeast Florida also conducted provider focus groups to better understand and assess the network's implementation of the No Wrong Door Model and a Recovery Oriented System of Care.

Survey Methodology

Process

WellFlorida Council and the Health Planning Council of Northeast Florida, in conjunction with LSF Health Systems leaders, collaboratively developed the three surveys to gather input, perspectives, and feedback from the distinct audiences.

Consumer Survey

To be eligible to participate in the survey, a consumer was required to be 18 years of age or older and have used services in the past 12 months for either a mental health condition or substance use problem, or both. In addition, adults 18 years of age and older who had served as the primary caregiver or guardian of an adult or child who had received services in the past 12 months for a mental health condition and/or substance use issue were also eligible to participate. Responses from individuals who did not meet the aforementioned criteria were not included in the data analysis. The survey included 21 questions and nine (9) demographic items. The Qualtrics® web-based surveying platform was used to deliver the survey and collect responses. The Flesch-Kincaid readability score for the survey instrument was grade level eight (8). Prior to deployment, the electronic version of the survey was pre-tested for functionality and ease of use.

A convenience sampling approach was utilized for collecting survey responses; i.e., respondents were selected based on accessibility and willingness to participate. The survey went live on August 6, 2019 and remained available through September 20, 2019. The survey was available electronically on WellFlorida's website with the link shared by LSF Health Systems providers with clients. In addition, survey marketing paper and electronic flyers were distributed, e-mail promotional messages were sent to health care providers and community partner agencies, and LSF Health Systems website postings were made.

Provider Survey

An electronic eight (8) item survey for mental health and substance use treatment and prevention providers was launched on August 6 and closed on September 20, 2019. Providers included mental health and/or substance use treatment and prevention professionals, including but not limited to CEO's, psychiatrists, therapists, counselors, case workers, outreach staff and community health workers. The survey sought to collect information on the types of mental health and/or substance use treatment and prevention services offered in LSF Health Systems' 23-county service area, the extent of the use of evidence-based or evidence-informed services, the range of diagnoses being treated, as well as information on perceived gaps in services and barriers to providing and receiving services for both providers and consumers. The provider survey also included five (5) demographic items. As with the consumer survey, the provider survey was readability tested, scoring a grade level of nine (9). The electronic survey was pre-tested for content and functionality.

Once again, the convenience sampling approach was used. LSF Health Systems providers received multiple reminders to complete the survey throughout the survey period, in both electronic and paper formats. LSF Health Systems providers also were offered paper flyers and sample email messages to distribute to their colleagues and peers in the 23-county service area to invite and encourage broad participation by behavioral healthcare professionals.

Stakeholder Survey

Input from stakeholders in law enforcement, juvenile justice, criminal justice, local government, elected officials, healthcare providers, and social and community service agencies was sought to inform LSF Health Systems of current and projected needs and gaps, barriers and shortfalls, as well as progress and promising approaches to addressing mental health and substance use treatment and prevention issues. An electronic 18-item survey that also included five (5) demographic items was widely distributed and promoted in the service area. The survey link was posted on many LSF Health Systems community partner agencies' websites and distributed via email, listserv and social media. The stakeholder survey scored grade 11 on the Flesch-Kincaid readability test and was pre-tested for functionality and content. This survey also employed the convenience sampling method and was open from August 6 through September 30, 2019.

Survey Limitations

Using the convenience sampling method to collect input for a system-wide health assessment process, has its advantages, disadvantages and limitations. Surveys collected using this method can yield rich qualitative data for assessment and planning in a cost-efficient manner. Data are available relatively quickly to match the pace of a system-wide assessment and are useful to signal the beginning of changes or shifts in attitudes, behaviors and outcomes. Among the disadvantages of collecting assessment data via convenience sampling are the potential for bias in data collection and sampling errors that could introduce inaccuracies. Surveying that uses the convenience sampling method has its limitations. In LSF Health Systems 23-county service area survey participants were self-selected which introduced selection bias. As such, the results are not generalizable to the entire population. Even with these limitations, valuable insights and perspectives, opinions and attitudes about behavioral health needs and issues were generated and will contribute to assessing and identifying priority concerns in the service area.

Survey Results

Consumer Survey

At the time it closed there had been 303 logins to the consumer survey on the Qualtrics® platform. Of those, 232 were categorized as complete surveys. The survey completion rate was calculated at 76.6 percent which falls within the expected range for a survey of this length and complexity. However, 55 surveys were excluded from the analysis because, although complete, there were no pertinent data as the survey respondents had indicated that none of the conditions applied to them. The 177 eligible surveys were analyzed, and a summary of the results follows below. Note that survey respondents could answer as both personal service user and as guardian or primary caregiver of an adult or child who received services. The demographic factors for those who personally received services were tabulated separately from the demographic factors of those under a guardian or primary caregiver's care. Full survey results are presented in Appendix 2.

Consumer Survey Participant Profile

The consumer survey gathered information from an array of respondents. Survey respondents resided in 14 of the 23 counties in the LSF Health Systems service area. More than two-thirds of respondents were female. Most of the survey respondents were non-Hispanic (87 percent) and identified as heterosexual (80.8 percent). The racial diversity profile of survey respondents included 76.8 percent Whites, 11.3 percent Blacks and about 6.8 percent of two or more races. Of those who indicated they had personally received services in the 23-county area, 15.5 percent said they were affected only by a mental health condition, 29.0 percent were affected only by a substance use problem and more than half (55.5 percent) were affected by both mental health and substance use problems. Among the 22 survey respondents who were guardians or primary caregivers of adults or children, 20 (91.0 percent) reported the adult or child in their care had a mental health condition and two (2) had both a mental health condition and substance use problem. Demographic information was collected about the adults or children under the guardianship or in the care of the survey respondent. Eight (8) individuals indicated they were both guardians or primary caregivers and had personally used mental health and/or substance use treatment services. Their demographic information is included with that of survey respondents personally affected by these conditions.

Consumer Survey Key Findings

Survey respondents with a mental health condition were most commonly in treatment for one (1) to three (3) months (35.5 percent), had been self-referred (32.7 percent) or court-referred (23.6 percent) to treatment, and sought treatment as a result of alcohol or other drug-dependency (41.8 percent). Those with substance use problems also most frequently reported having been in treatment for one (1) to three (3) months, were court-referred (31.3 percent),

and sought care because of alcohol or other drug dependency (56.6 percent). Survey respondents with mental health conditions most frequently received care at Gateway Community Services (31.8 percent). Rating the provider organization where they most frequently received mental health services, 76.3 percent of respondents said that they were always or most times satisfied with the care received, felt they could schedule an appointment soon enough to meet needs always or most times (67.3 percent) , and believed they were getting better (79 percent, always or most times). For survey respondents with substance use problems, Gateway Community Services was reported as the location where they most frequently received services. About 82.4 percent were always or most times satisfied with the care they received, felt they could always, or most times schedule an appointment soon enough to meet needs (82.4 percent) and 95.3 percent said they were always or most times getting better. Survey respondents with a mental health condition and respondents with a substance use problem agreed that individual counseling is the most important service for their treatment. Both groups of respondents also agreed that the most common barriers to getting mental health and substance use treatment services were cost, insurance coverage, and transportation (23.9 percent, 29.0 percent, 23.2 percent, respectively for mental health services; 27.0 percent, 23.9 percent, 27.7 percent, respectively, for substance use treatment services). Only 20.9 percent of survey respondents with a mental health condition reported they had used a hospital emergency room for care in the past 12 months. Those with a substance use problem said that 32.8 percent had used an emergency room for services in that timeframe. Cash, self-pay or no pay was reported as the most frequent payment method for services for both those with a mental health condition and those with a substance use problem (30.0 percent and 35.1 percent, respectively). With transportation reported as a barrier, 37.4 percent and 35.9 percent of those with a mental health condition and those with a substance use problem, respectively, had a roundtrip travel distance of five (5) to 15 miles to their service provider. About 38.0 percent of survey respondents with a mental health condition, substance use problem or both used a personal vehicle as transportation to their service provider location, 30.3 percent were transported by family or friends while 26.5 percent used public transportation. Homelessness in the last 12 months was reported by 48.2 percent of survey respondents with a mental health condition. Similarly, 48.9 percent of those with a substance use problem said they had been homeless in the last 12 months.

In addition to the survey process specific to the needs assessment, LSF Health Systems also regularly collects consumer satisfaction surveys from service recipients For FY 18-19 a total of 4464 surveys were submitted through the LSFHS system.

The survey elicits responses from the consumer on seven domains of satisfaction;

- General Satisfaction
- Access to Care
- Involvement in Treatment
- Functional Satisfaction
- Quality of Care
- Outcome of Care
- Social Connectedness.

The satisfaction scores ranged from 84.18% to 92.58%, with an overall satisfaction score of 88%. The summary of consumer satisfaction surveys is presented in Appendix 3

Provider Survey

At the time it closed there had been 403 logins to the provider survey on the SurveyMonkey® platform. There were 37 surveys that were deemed ineligible because the survey respondent was not a provider of mental health and/or substance abuse treatment or prevention services in the 23-county LSF Health Systems service area. There were 333 eligible, complete surveys included in the analysis. A summary of the survey results is presented below. Full survey results are presented in Appendix 2

Provider Survey Participant Profile

The provider survey collected input and information from many mental health and substance abuse treatment and prevention professionals from all five (5) of the circuits in the LSF Health Systems service area. Almost three-quarters of respondents were female (74.5 percent). Most of the survey respondents were non-Hispanic (89.5 percent) and identified as White (74.5 percent) and Black or African American (12.3 percent). More than half (51.0 percent) were between the ages of 30 to 59 years of age. The most common job titles of survey respondents were nurse, case manager, behavioral health technician, and director and administrator. The largest proportion of provider survey respondents had been in their professions less than five (5) years at 30.9 percent, followed by those who had been in their professions for more than 20 years at 23.8 percent.

Provider Survey Key Findings

Mental health and substance abuse treatment and prevention professionals reported providing a wide variety of services in the LSF Health Systems 23-county service area. About 61.4 percent of survey respondents indicated that they provide both mental and substance abuse treatment services while 21.7 percent provide mental health services exclusively, 9.3 percent provide substance abuse treatment services exclusively, and 7.6 percent focus on prevention services exclusively. The diagnoses most commonly treated by provider survey respondents included Schizophrenia and psychotic disorders (39.3 percent), depressive disorders (39.3 percent), opioid-related disorders (37.2 percent), bipolar disorders (34.5 percent), and alcohol-related disorders (24.9 percent). Among the most commonly provided services were adult mental health case management (70.6 percent) and outpatient services (68.5 percent), adult substance abuse outpatient (65.8) and case management (63.4 percent) services, adult substance abuse medication-assisted treatment (MAT, 58.3 percent), and adult mental health crisis stabilization (56.8 percent). Prevention services were offered by more than half (55.9 percent) of survey respondents or their organizations. Provider survey respondents indicated that numerous evidence-based or evidence-informed services are provided by their facilities including Cognitive Behavioral Therapy (CBT, 59.2 percent), motivational interviewing (50.8 percent), trauma-informed care (36.6 percent), Dialectical Behavior Therapy (DBT, 35.7 percent), and relapse prevention therapy (29.4 percent). Services that need to be increased or expanded to meet community need according to survey respondents include individual counseling for mental health (44.1 percent), psychiatry services (36.6 percent), individual counseling for substance abuse (32.4 percent), case management (27.0 percent) and inpatient (overnight) treatment (24.0 percent). About 42.7 percent of providers reported that there are waiting lists for services at their facilities or organizations; another 30.3 percent indicated there are no waiting lists. Of those facilities or organizations with waiting lists, the most common services on such lists include residential treatment (6.9 percent), adult detoxification (4.5 percent), and MAT (3.9 percent).

Survey findings point to the barriers providers face in providing mental health and substance abuse treatment services to clients. At the same time, clients experience barriers in accessing services as reported by providers. Among the reported impediments to delivering mental health and substance abuse treatment services were funding issues (72.0 percent), adequate staffing (41.1 percent), client issues with housing (32.7 percent) and payment source (27.9 percent) and ensuring client access to needed services (26.1 percent). Provider survey respondents indicated that the most frequently experienced barriers by clients included transportation to services (49.8 percent), insurance issues (43.5 percent), motivation or desire to get services (39.6), availability of services when needed (35.4) and cost (34.2 percent).

Stakeholder Survey

The stakeholder survey gathered 186 completed surveys on the SurveyMonkey® platform. The electronic 18-item survey also included five (5) demographic items and was widely distributed and promoted in the service area among stakeholders in law enforcement, juvenile justice, criminal justice, local government, elected officials, healthcare providers, and social and community service agencies. The 186 eligible surveys were analyzed, and a summary of the results is shared below. Full survey results are presented in Appendix 2

Stakeholder Survey Participant Profile

The stakeholders who responded to the survey were an experienced group of concerned professionals. Demographic data from the 186 completed surveys indicate that most of the stakeholder survey respondents were female (75.9 percent), White (81.8 percent) and non-Hispanic (85.5 percent). More than 40 percent had 20 or more years in their professions and 75.7 percent of stakeholder survey respondents were between the ages of 35-64 years. Stakeholders from all five (5) of the circuits in the LSF Health Systems service area responded to the survey. While 35.5 percent of the stakeholders who participated were from Circuit 8 (Alachua, Baker, Bradford, Gilchrist, Levy and Union Counties), the remaining circuits had similar representation at 22.0 percent for Circuit 3 (Columbia, Dixie, Hamilton, Lafayette and Suwannee Counties), 26.3 percent for both Circuit 4 (Clay, Duval and Nassau Counties) and Circuit 7 (Flagler, Putnam, St. Johns and Volusia Counties, and 26.9 percent for Circuit 5 (Citrus, Hernando, Lake, Marion and Sumter Counties). The areas of expertise stakeholders most commonly brought to the survey included education (43.0 percent), social services (33.3 percent), health care (30.1 percent), adult, child and family welfare (24.2 percent) and government (16.1 percent).

Stakeholder Survey Key Findings

In the area of mental health, 33.9 percent of stakeholder survey respondents said that addressing mental health issues in the region was somewhat a priority; another 27.4 percent felt it was a high priority. About 84.4 percent of stakeholder survey respondents said that the mental health needs of residents were partially or slightly met with the most common barriers to meeting those needs being funding (66.1 percent), growing demand (53.2 percent) and

insurance issues (47.8 percent). Stakeholders rated the top barriers that residents face in accessing mental health services as insurance issues (47.8 percent), cost (47.3 percent), and transportation (45.7 percent). Awareness of available mental health services seemed to be lacking by both stakeholders and residents. Stakeholders who replied to the survey said that 47.2 percent of stakeholders were fully or moderately aware while only 15.0 percent of residents were fully or moderately aware of the mental health services available in their area. Among the positive changes or progress in the area of mental health in the past 12 months, stakeholders most frequently mentioned there were new or expanded services, more funding for school-based programs and services, and more awareness of mental health problems and their impact. Stakeholders attributed these changes to collaboration among partners (46.2 percent), community interest or demand (38.7 percent), and funding changes (26.9 percent).

For their geographic area, stakeholder survey respondents said that addressing substance abuse was somewhat (36.6 percent) or a high (30.6 percent) priority. About 80 percent of stakeholders felt that the substance use treatment and prevention needs of residents were partially or slightly met. Common barriers to meeting those needs, according to survey respondents, included funding (66.1 percent), keeping up with demand and need (57.5 percent), and insurance-related issues (45.2 percent). As rated by stakeholders, barriers that residents face in accessing substance use treatment services included cost (54.3 percent), insurance issues (46.2 percent), and transportation (37.0 percent). To varying extents both stakeholders and residents lacked awareness of the substance use treatment services available in their area. About 41.4 percent of stakeholders and 19.9 percent of residents were rated as being fully or moderately aware of services. Some progress or positive change was noted by the stakeholders who responded to the survey. These most frequently included more funding, resources and focus on opioid use, a general increase in funding, an increase in the availability of Medication Assisted Treatment (MAT), and more awareness of substance abuse problems. Stakeholders attributed these changes to collaboration among partners (34.9 percent) and community interest or demand (31.2 percent).

Community Input - Provider Focus Groups

Listening to and gauging perspectives of the community are essential to any community-wide initiatives. The impressions and thoughts of community residents can help pinpoint important issues, highlight possible solutions, and feed into identification of strategic issues. To gain a better understanding of these issues, this needs assessment employed the following two approaches: focus groups and surveys.

Focus groups were held with CEOs and/or their designated representatives from providers in LSF's service area to better understand and assess the availability of programs and services under the No Wrong Door Model and Recovery Oriented System of Care (ROSC) as well as other evidence-based programs used by these providers.

This section includes the following components of the Provider Focus Groups:

- **Methodology of Provider Focus Groups**
- **Demographics of Focus Group Participants**
- **Results of Provider Focus Groups**

Provider Focus Group Methodology

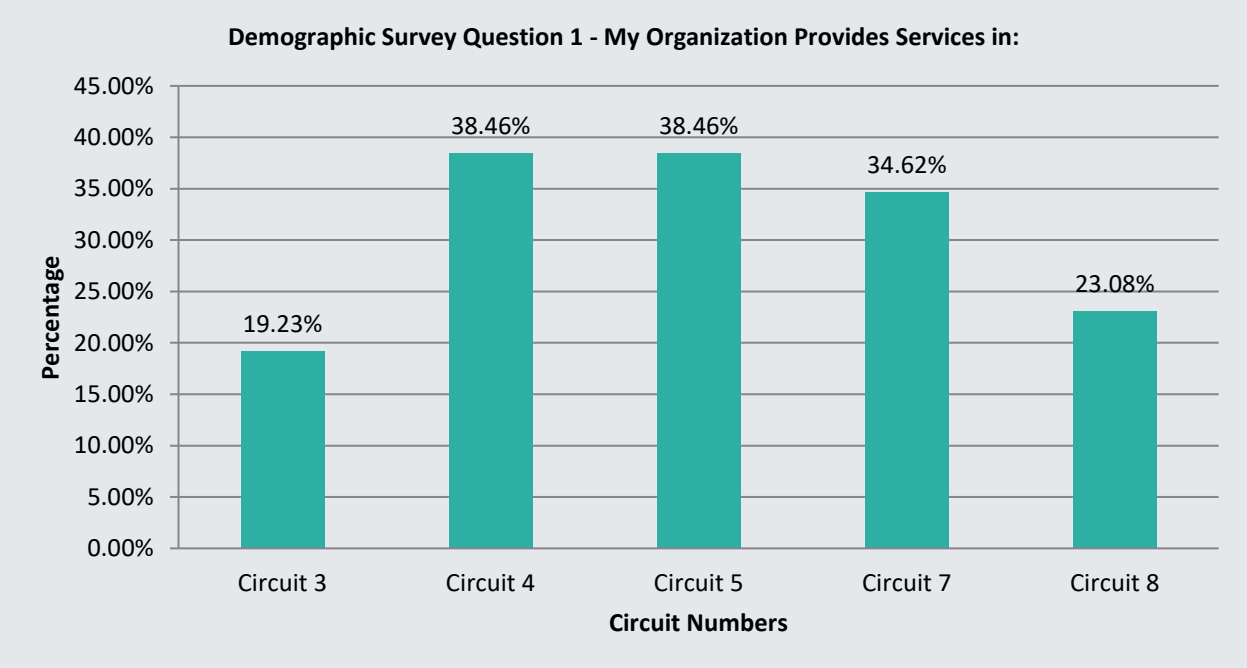
Trained facilitators conducted four virtual focus groups with LSF Health Systems providers during the months of August and September of 2019. Providers were placed into focus groups based on the circuit areas covered by their organizations: Circuit 4, Circuit 5, Circuit 7, and a combined focus group which included Circuits 3 and 8 as well as those providers who covered multiple circuits in LSF's service area.

A virtual operator and one facilitator guided the focus group discussion using an approved script. Focus group questions were related to the No Wrong Door Model and Recovery-Oriented System of Care Model. The focus group questions were read aloud by the facilitator and also shared electronically for providers to view during the telephone-based focus group.

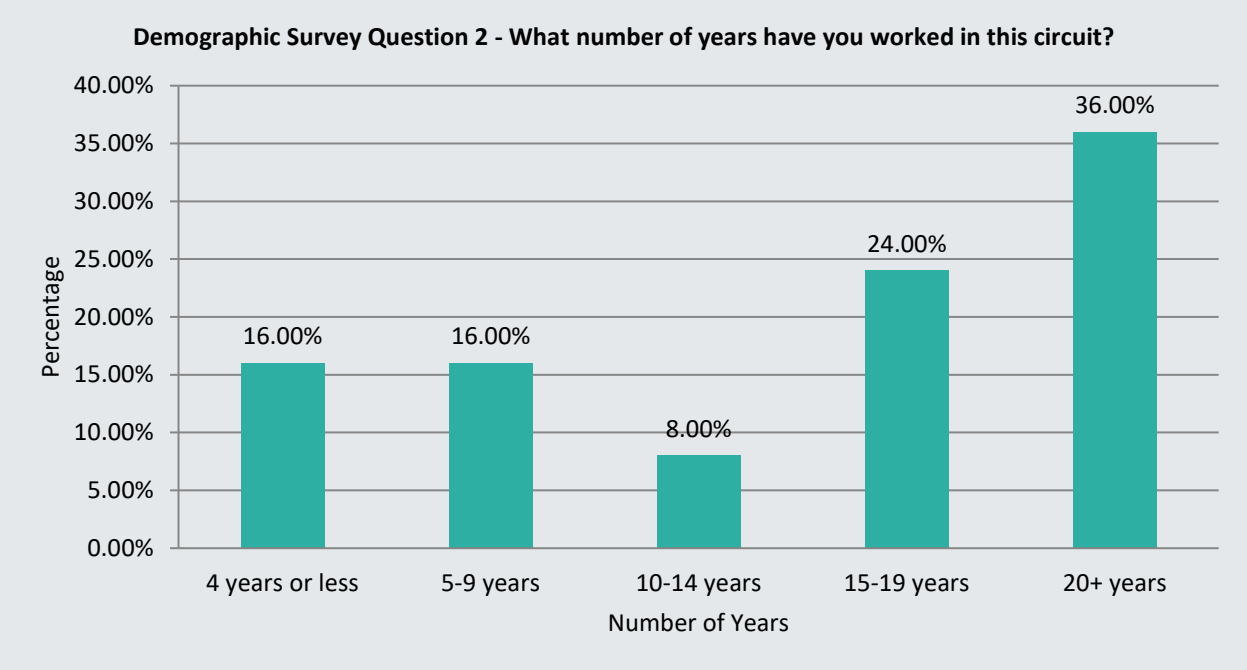
Demographics of Focus Group Participants

A brief demographic questionnaire was shared electronically with providers to complete at the end of the focus group discussion. Figure 1 shows the representation of focus group participants by the circuits their organizations represented. Over a third of focus group participants had worked for 20 or more years in their current circuit (Figure 2) and nearly half of participants (46 percent) had worked for 20 or more years in the behavioral health field (Figure 3). Nearly 70 percent of participating organizations provide mental health services, 50 percent provide substance abuse treatment services, and 43 percent report being involved in prevention, case management and/or social services as shown in Figure 4. Over half of focus group participants (52 percent) were CEOs or other executive-level position within their organizations (Figure 5).

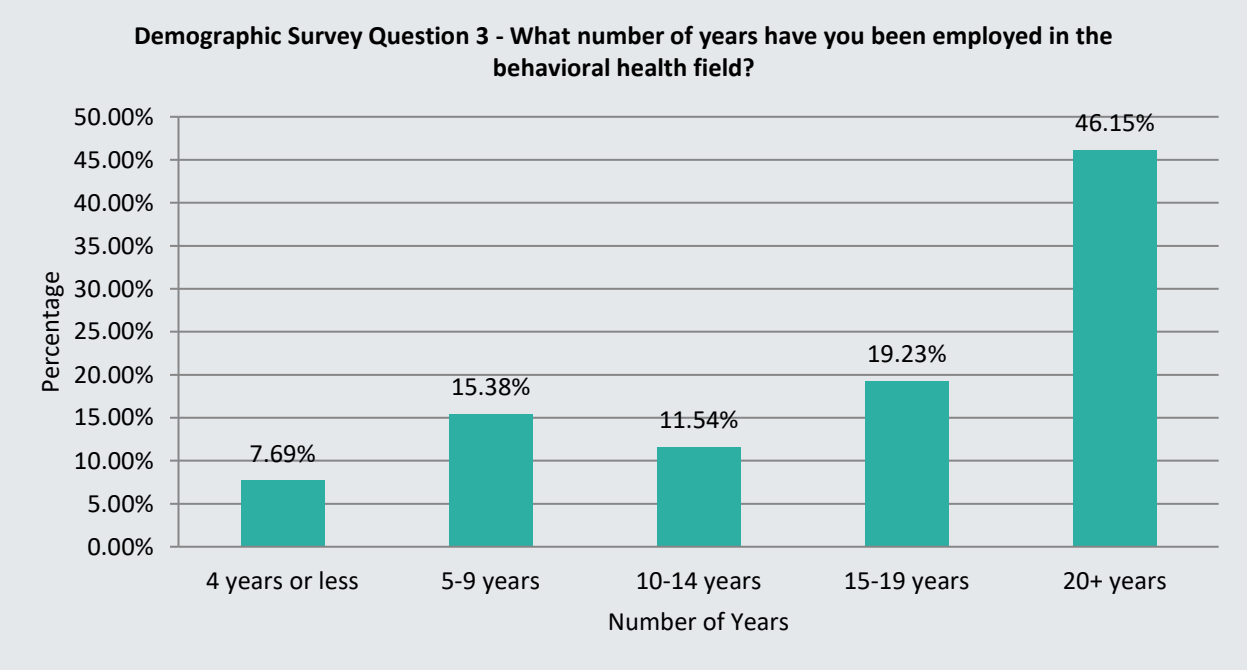
DEMOGRAPHIC QUESTION 1 – AREA OF SERVICES



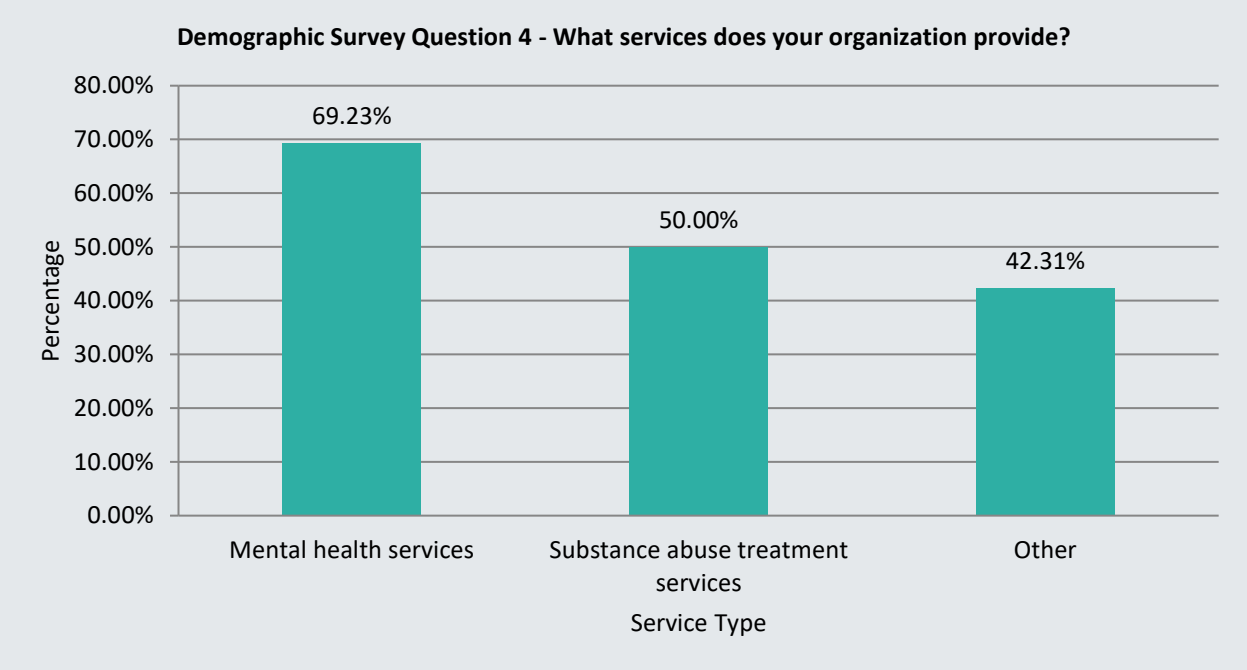
DEMOGRAPHIC QUESTION 2 – YEARS WORKED IN CIRCUIT



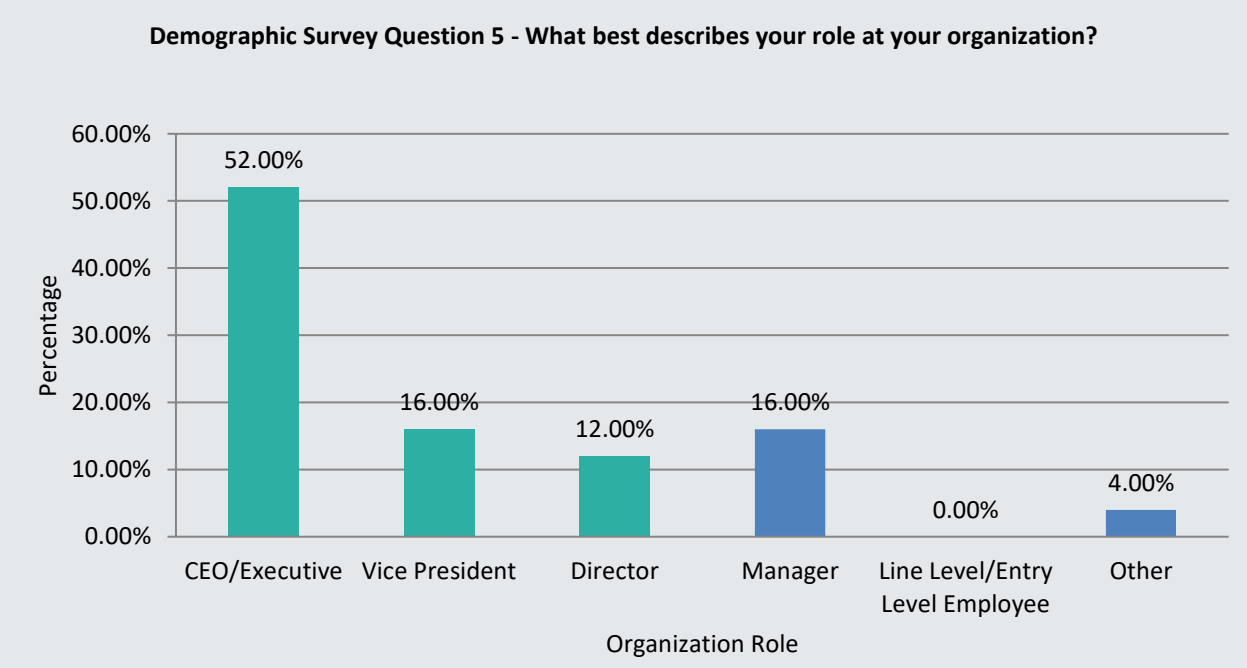
DEMOGRAPHIC QUESTION 3 – YEARS EMPLOYED IN THE FIELD



DEMOGRAPHIC QUESTION 4 –SERVICES PROVIDED BY ORGANIZATION



DEMOGRAPHIC QUESTION 5 – ROLE IN ORGANIZATION



RESULTS OF PROVIDER FOCUS GROUPS

The full summary of each of the focus group discussions is presented in Appendix 4.

SUMMARY OF KEY FINDINGS FROM PROVIDER FOCUS GROUPS

Focus group participants shared a wide range of perspectives on the No Wrong Door Model and Recovery-Oriented Systems of Care (RSOC) Model as they related to their own organizations, but the overall consensus is that both are used widely and daily. Participants who represent behavioral health organizations providing direct services had different insights to share from those participants who represent organizations focused on community awareness and prevention strategies. The most common challenges shared by all focus groups was the lack of adequate funding for behavioral health resources and services in the state of Florida, and the difficulty in finding qualified licensed behavioral health professionals to fill the needed positions within their organizations. Many participants also discussed the lack of capacity to serve clients needing specific services, such as the limited availability of detox treatment beds in many of their communities. Several participants also brought up that a shared data platform would help improve coordination and delivery among providers.

B. For each of the groups listed below, please describe how existing resources will be redirected to address their unmet needs.

- **Individuals served and their family members**

The services cited most often by consumers and their families as valued and in need of increased capacity were Outpatient Services, Residential Services, Housing, Medication Management and Support Group services.

Outpatient Services

LSFHS has aggressively adopted a Care Coordination philosophy to direct consumers to the most effective and efficient services. We have reviewed acute care data and reallocated the underutilized funding for children's CSU beds to other services including children's diversion and care coordination services and adult diversion. Children's CSU services are largely funded through Medicaid and other third-party payers, so reducing the number of beds paid on availability for children's acute care has made resources available to provide some of the services identified as having need that exceeds capacity. Funding streams for providers have been diversified to create a baseline of capacity for services with recurring funding to help sustain services when specialized funding is reduced or eliminated. Through a 3-year grant from Florida Blue, LSF Health Systems has expanded the capacity of community healthcare providers including Primary Care Physicians, to use the SBIRT (Screening, Brief Intervention & Referral to Treatment) to screen and refer individuals in need for treatment related to substance use. Additionally, the grant funds peer support services to assist referral sources and individuals in facilitating a seamless admission to treatment and increased engagement in services.

Through training, technical assistance and oversight of our provider network's fulfillment of the requirements to utilize the SOAR process to assist individuals in applying for and being approved for public benefits, LSFHS has continued to help eligible individuals obtain ongoing resources to provide health coverage through Medicaid and monthly income, freeing up resources for other individuals who do not qualify for benefits.

Residential

As stated previously, we have added residential beds to our network as resources have allowed. We have identified the need for additional residential beds through our enhancement plans for the past three years.

Housing

Housing is frequently identified as an unmet need by consumers in with both mental health and substance use conditions. It is also cited as an unmet need by providers and community stakeholders. LSF Health Systems established a Housing and SOAR Division in 2014 embracing "Housing is Healthcare" mission. LSF Health Systems has elected to aggressively pursue grants to expand resources for safe, stable and affordable housing options for our consumers, either as a lead applicant, or as a partner with our providers. We have been the successful awardee of several grants to expand housing resources including;

- Marion County Criminal Justice Mental Health Substance Abuse Reinvestment Grant – LSFHS lead applicant. $1.2M over 3 years, 2018-2021. Provides for peer support services, care coordination services, outpatient treatment, medication management and housing support.
- Hernando County SAMHSA Drug Court grant – Hernando County Board of County Commissioners lead applicant. LSFHS provided grant writing support and will provide a housing navigator.
- CDC Overdose Data to Action grant – partnered with the Florida Department of Health. DOH is lead applicant. LSFHS will provide a housing navigator as well as providing evidence-based trainings to ER staff, first responders, law enforcement and other key staff involved with the target population.
- LSF Health Systems has also utilized a portion of the federal SOR grant to create a housing specialist position for individuals receiving MAT through the SOR grant. Expanding a resource list of landlords who are accepting of individuals with SUD and the issued they frequently experience, as well as serving as a liaison with the Oxford House representatives in the catchment area will create capacity that is expected to endure, even if the federal funds are not renewed.

Support Groups/ Recovery Services

LSFHS has redirected funds, primarily through funds allocated to providers and not fully expended, to recovery services and peer organizations including two NAMI chapters, Gainesville Peer Respite and clubhouses to provide support group and recovery support services. We have worked closely with our provider network to hire and support a robust peer workforce to engage individuals in treatment and support long term recovery.

LSFHS has been the successful applicant in two Health Resources Services Administration grants, most recently a grant of $1,148,296 over 4 years to provide an enhanced, two-tiered recovery Certified Recovery Peer Specialist (CRPS**)** training program for up to 70 individuals per year who will serve rural and medically underserved areas throughout LSF Health Systems' 23-county region. LSF Health Systems recognized the dearth of certified Peer Specialists available to our Provider organizations, as well as the need for best practice training curriculum to insure Peers were prepared to provide services.

Barriers to Treatment

The barriers to treatment most often cited by consumers and family members are the cost of services, insurance issues and transportation. Through the SOAR process we are able to assist some individuals removing barriers

related to insurance and cost of service. We now require our Provider Organizations to employ SOAR Processors to insure they are helping individuals who qualify for SSI/SSDI benefits to obtain these benefits, thereby freeing up additional dollars for the system of care. Most of our providers are now delivering some services through telehealth to help reduce the barriers related to transportation.

- **Providers of behavioral health services**

Providers have found it increasingly difficult to recruit and retain qualified staff to deliver services. Static rates have not allowed providers to keep pace with the market for staff at both the entry level positions like case managers and behavioral health technicians and the professional level positions such as licensed clinicians, nurses, ARNPs and psychiatrists. Vacant positions mean reductions in capacity to deliver services. LSFHS is working with the provider network to determine the resources necessary to provide a level of compensation that will allow for a stable workforce and the rates necessary to support that investment. Without additional resources it will be necessary to reduce the system capacity.

LSF Health Systems redirects resources to where they are most needed through the reallocation of lapse funds. When providers are unable to draw down their full contract amount, the unspent funds are shifted to providers who are able to draw down more service units thereby rebalancing the resources based on where the services are being delivered. Part of the process is to work with the providers who do not utilize all of their funds to provide technical assistance and identify barriers to help maintain equity in funding across the system.

LSFHS collaborates with providers in identifying and applying for grant opportunities and supporting legislative member projects to bring additional resources into the system of care,

- **Other community stakeholders (particularly those from the child welfare, criminal justice, and school systems)**

LSFHS, in collaboration with DCF has implemented Behavioral Health Consortia in each of the Circuits in the catchment area. These groups include stakeholders from across systems and communities including law enforcement, the schools and child welfare. Ideas on how to address unmet needs and improve cross system collaboration are prioritized for resources as they are available. Currently LSFHS is working with Jacksonville Sheriff's Office, DCF and local providers to redirect resources to fund a law enforcement Co-Responder program, a specialized team of law enforcement officer and clinician to intervene and follow-up with individuals who have frequent interactions with law enforcement due to behavioral health issues with the goal of diverting individuals from jail and crisis units to community services and supports.

III. Training and Technical Assistance Needs

LSF Health Systems assesses the training needs through a variety of means including survey of community service providers, including providers both within and outside the LSFHS network. Our Training Institute was established in 2014 to offer Providers, Stakeholders, and communities trainings on a myriad of key behavioral health care topics. CEUs are provide and the trainings serve to raise awareness on key issues. LSFHS staff participate in a variety of meetings and task forces monthly in each Circuit in our catchment area including Behavioral Health Consortiums, Human Trafficking Task Forces and Opioid Task Forces that bring together a variety of partners including DCF, providers, law enforcement and schools. In addition, through the monitoring process, areas in which providers would benefit from technical assistance are identified and the Network Management and Clinical Teams provide the TA as needed.

The LSFHS training survey results for 2019 are summarized below. The full survey report is presented in Appendix 5.

A total of 91 survey responses were received, representing staff at all levels, from front line staff to executive level. Responses were received from all 23 counties in the LSFHS catchment area. The top 10 areas identified as training needs were:

1. Baker Act and/or Marchman Act
   De-Escalation Strategies
   Suicide Prevention – QPRT (Question, Persuade, Refer, Treatment)
4. Trauma Informed/Trauma Focused Care
5. Certified Recovery Peer Specialist
6. Wellness Recovery Action Plan (WRAP)
7. Integrating Behavioral Health Care
   SOAR (Social Security & Disability Access, Outreach, Access & Recovery) for Homeless Adults
9. Care Coordination
10. Professional Peer Development

The aforementioned trainings, and many others are offered through the LSFHS Training Institute. The vast majority of respondents (92.68%) found on-site, face-to face training to be the most effective. The respondents identified the 3 greatest barriers to participation in training as:

1. Cost
2. Capacity of workforce to attend and still fulfill existing duties
3. Geography and location of venue

To expand capacity to provide needed training to our provider network and to the community, LSF Health Systems has pursued several grants either as the lead applicant or in partnership with our providers. The Health Related Services Administration grant secured by LSF Health Systems provides training for peer specialists to work with individuals with mental health and/or substance use conditions and prepare for certification. LSFHS also partnered with Clay County providers on a SAMHSA Mental Health Awareness grant to deliver Adult MHFA training, verbal de-escalation and High-Fidelity Wraparound training to prepare and train a diverse group of community members in Clay County on how to appropriately and safely respond to individuals with mental disorders, particularly individuals with serious mental illness (SMI) and/or serious emotional disturbance (SED). The training is intended to help identify, refer and link high risk populations, specifically, veterans and transition-aged youth (16-23) to the right resources in the community.

The Florida Blue Grant secured by LSF Health Systems provides training to community health providers, including Primary Care Physicians, on using the SBIRT model to screen individuals for substance use disorder and refer them to treatment. The grant provides Train the Trainer training to build community capacity to effectively screen individuals even after the grant period expires. Paired with Motivational Interviewing training the grant is creating capacity in the community to identify individuals and refer them to appropriate services.

LSFHS will also be hiring an additional trainer with the SOR funds to increase training related to opioid use disorder, treatment modalities and engagement strategies.

IV. System of Care

A. Top 5 Unmet Needs

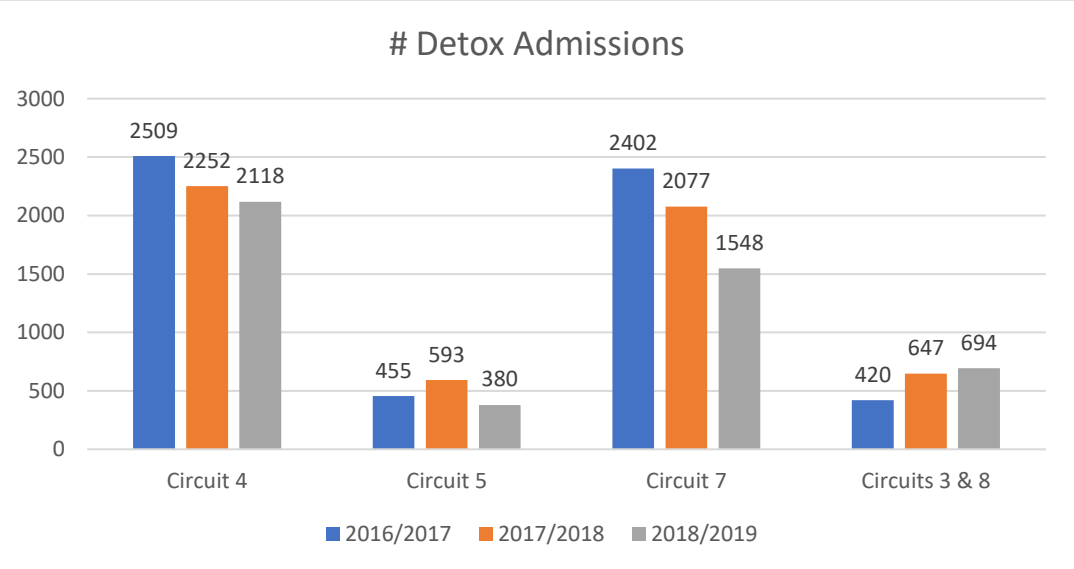
Based on the aggregate analysis of primary and secondary data, the top five unmet needs have been identified:

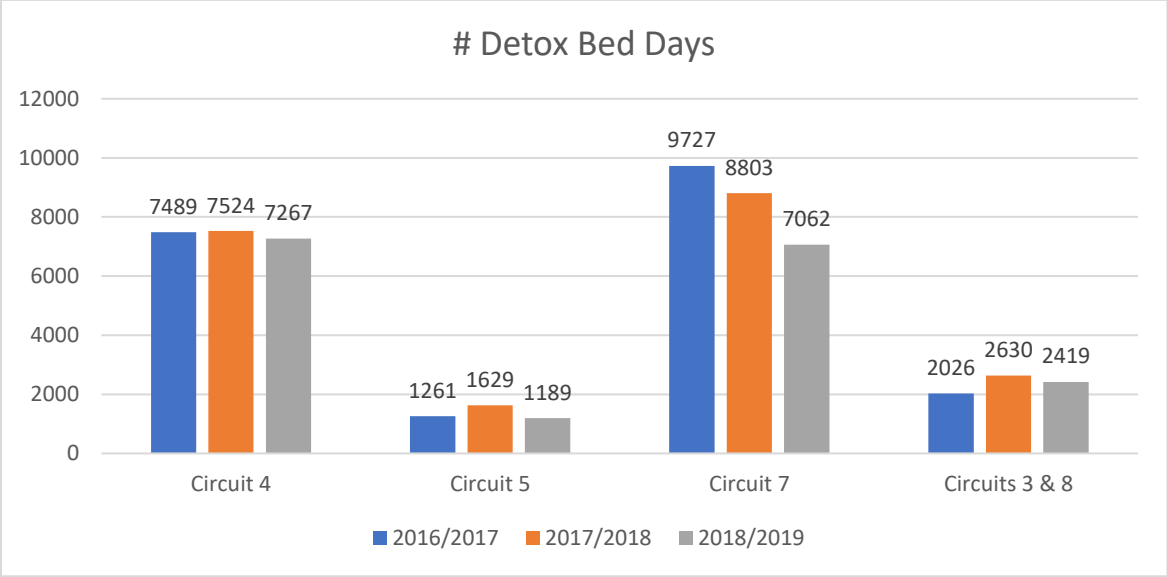
- **Short-term Residential Treatment and Assisted Outpatient Treatment**

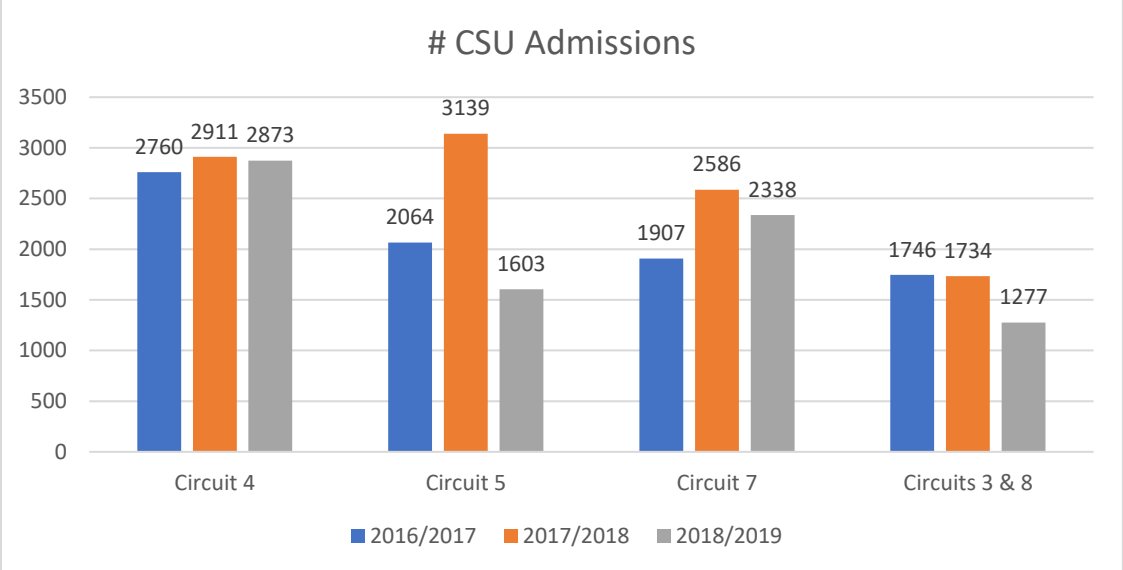
Poorly managed care transitions for high-risk, high need individuals from acute services to lower levels of care negatively affect a person's health and well-being, potentially causing additional utilization of acute crisis services, avoidable re-hospitalization, or re-arrest. Many of these individuals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

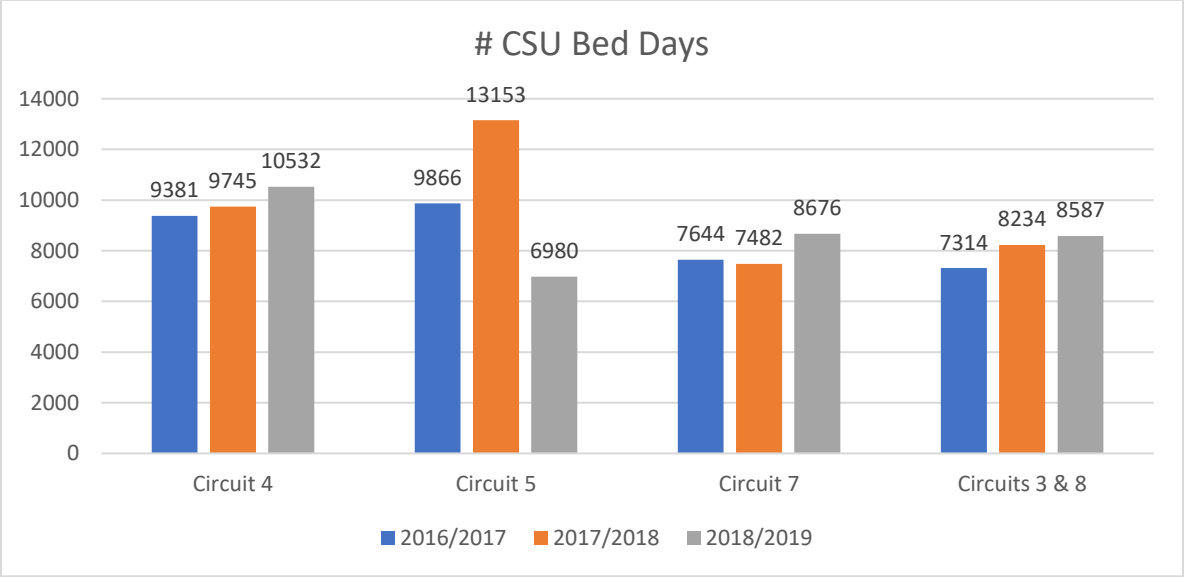
Without the appropriate treatment, at the right time and in the right setting, people with behavioral health conditions will likely continue to cycle through jail or acute levels of care for their treatment. The judicial system has identified the lack of appropriate services and an intensive, coordinated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

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




Detox Bed Days
12000
10000
8000
6000
4000
2000
0
7489 7524 7267
1261 1629 1189
9727 8803 7062
2026 2630 2419
Circuit 4
Circuit 5
Circuit 7
Circuits 3 & 8
2016/2017
2017/2018
2018/2019


CSU Admissions
3500
3000
2500
2000
1500
1000
500
0
2760 2911 2873
2064 3139 1603
1907 2586 2338
1746 1734 1277
Circuit 4
Circuit 5
Circuit 7
Circuits 3 & 8
2016/2017
2017/2018
2018/2019



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

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

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

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

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

Target population to be served:

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

- Civil target population:
  - Person is at least 18 years old and diagnosed with a severe and persistent mental illness, with or without co-occurring disorders. Individuals must be continent, ambulatory or capable of self-transfer.

- All individuals shall be admitted pursuant to Chapter 394 (voluntary or involuntary), Part I, F.S., and Chapter 65E-5, F.A.C., and only on the order of a physician.
- Individuals must present as acutely mentally ill and in need of intensive staff supervision, support and assistance, as documented in a psychiatric or psychological evaluation.
- Person is at risk of institutionalization or incarceration for mental health reasons.
- The individual receives a psychiatric or psychological evaluation
- The individual is referred from a CSU, inpatient psychiatric unit (including county jail psychiatric units).

• Forensic target population:

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

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

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

Number of individuals to be served

AOT – 125, SRT-80

- **Addictions Receiving Facility and Substance Abuse Treatment services**

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

  Reductions in Department of Corrections funding in FY 18/19 for residential Substance Abuse treatment beds exacerbated the symptoms of an underfunded system, resulting in even longer wait lists for individuals being released from jails and individuals with court ordered residential treatment. Even though funding has been restored, there continues to be a significant waitlist for residential services in some counties.

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

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

  The proposed strategy to address this need is to increase needed substance abuse diagnosis and treatment options in underserved communities in the 23 county LSFHS service area through an addictions receiving facility, additional residential treatment beds and funding for outpatient treatment of substance abuse that is not limited to treatment of opioid use disorder.
  The ARF provides a secure facility for a primary diagnosis of addiction. Services include:
    - Single access for law enforcement, “drop off and go”
    - 23-hour evaluation
    - Immediate referral
    - Initial medical clearance or referral

- Marchman Act or voluntary walk-in
- Hotline/Warmline for information, referral, consultation, with law enforcement, family/caregiver, community
- Care Coordination
- Assisted Outpatient

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

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

Target population to be served:

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

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

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

Volusia, Flagler, Putnam – residential treatment

Duval County – residential treatment

All Counties – outpatient SA treatment

Number of individuals to be served

ARF – 300 Residential Treatment - 200 Outpatient Treatment - 500

- **Housing and Care Coordination**
  In order for our system to function effectively and efficiently, a coordinated effort to connect high risk, high need individuals to appropriate services is critical. Absent this coordination, individuals with a serious mental illness, substance use disorder or co-occurring disorders are prone to cycle in and out of acute care settings, including CSU and inpatient detox, jails, emergency rooms and homeless facilities. A collaborative coordinated system to connect high risk, high need individuals to the right services at the right time can improve overall health, well-being and quality of life for individuals experiencing SMI,

SUD or co-occurring conditions. In addition, reducing reliance on more costly acute care services or the criminal justice system to address ongoing behavioral health needs will ensure efficient use of public funds.

Safe, stable housing is a critical piece of an integrated service coordination effort in a Recovery Oriented System of Care. Permanent Supportive Housing is defined as "an evidence-based housing intervention that combines non-time limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities" (United States Interagency Council on Homelessness, 2016.) Data from the LSFHS Housing Needs Assessment tool estimates that approximately 6,484 individuals with mental health and/or substance use disorders (including family members) need permanent supportive housing. DCF POE data indicates insufficient community housing options as the most significant barrier to discharge from a State Mental Health Treatment Facility (SMHTF) within 30 days. Stakeholder survey input also ranks inadequate housing options as a significant community resource gap. High risk, high need individuals with serious mental illness, substance use disorder or co-occurring conditions are more likely to be disproportionately represented in acute care and criminal justice settings when they do not have stable housing. Preliminary data from FY 18/19 indicates annual service costs can be as much as 50% less for housed vs unhoused individuals.

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

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

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

The appropriation of Care Coordination funding in FY 18/19 enabled LSFHS to invest in a number of innovative provider pilot programs to reduce acute care and SMHTF admissions and readmissions, for example, wraparound services including supportive housing, case management and therapeutic services, comprehensive, individualized services to provide options for individuals ready for discharge from the SMHTF, collaborations with law enforcement to reduce arrests related to behavioral health

issues, and pairing care coordinators with children's CSU facilities to identify children with multiple Baker Act admissions and engage families in community services. Availability of resources has required enrolling the most needy, highest priority consumers in care coordination services. There continues to be a large number of individuals who are high need/high utilizers or are one admission away from meeting the definition as such who would benefit from care coordination if resources were available. Investing additional resources in care coordinators at the provider level can help improve outcomes for consumers and reduce costs to the system by meeting the needs of individuals in the community rather than in acute care settings.

Proposed Strategies and Services to meet unmet need include:

Care Coordination

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

Housing Coordination

- Identification of eligible individuals through data surveillance, information sharing, developing and facilitating partnerships, identifying ways to increase housing resources, oversight of housing providers, training and technical assistance for SOAR processors to increase the number of individuals with benefits, purchase of services and supports through voucher system (ME)
- Assessment of needs, active engagement with consumer and natural supports, shared decision-making, linking with appropriate services and supports, facilitate successful application for benefits through the SOAR model, monitoring progress and planning for transition to less intensive case management services when consumers are appropriately stable (Provider)
- Housing Vouchers: By utilizing flexible vouchers similar to the Community Transition Voucher program underway in the LSFHS Region, providers would have the capacity to offer housing subsidies and support for related housing expenses to place individuals with serious SA and/or MH disorders in stable housing as quickly as possible. The vouchers may also be used to cover incidental expenses such as medications not covered by third party payers. Priority for the vouchers will be given to those individuals who are being

discharged from state hospitals, jails or prisons. Any remaining funds will be made available to SAMH consumers in the region in need of support to maintain housing stability and avoid repeat hospitalizations. Increased availability of flexible resources through transitional vouchers will enable the system to expand the reach of care coordination and housing coordination to be more proactive, reaching high risk, high need individuals sooner to reduce recidivism rates and improve quality of life outcomes.

Target population to be served:

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

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

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

Number of individuals to be served

665

- **Community-Based diversion from acute care**

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

In FY 2018/19, through funding by a Gainesville Police Department and LSF Health Systems/DCF, a pilot was funded consisting of a team of a CIT trained officer and Masters level mental health clinician to partner as a team to respond to calls for service involving persons with mental illness, a mental health crisis and emotionally charged situations. The ream will address issues at the Intercept 0 and Intercept 1 points in the Sequential Intercept Model, focusing on individuals identified as high utilizers of crisis stabilization units, emergency rooms and the Alachua County Jail, intervening in a proactive and preventive manner either before a situation becomes a crisis or at the earliest stage of system involvement, thereby increasing jail diversion and crisis unit admissions. The team will free up other law enforcement officers to focus on more tradtional police concerns.

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

Target population to be served:

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

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

Alachua, Clay, others TBD

Number of individuals to be served

2,000

- **Ability to attract and retain adequate qualified staff to deliver services of high quality and with fidelity to evidence-based services**

With the exception of additional funding, the ability to recruit and retain qualified staff was the greatest unmet need cited in provider survey responses. Stagnant reimbursement rates and increasing competition for licensed staff from employers who can pay higher salaries are making it difficult for providers to fill key positions such as licensed clinicians, behavioral health technicians, LPNs, ARNPs and psychiatrists. Turnover as staff seek higher paying opportunities creates drops in service capacity and lack of continuity of care for consumers in treatment. The current average starting salary for licensed clinicians reported by network service providers in the LSFHS network is $42,861. Governor DeSantis recently announced an anticipated increase to the starting base pay for teachers in Florida to $47,500.

The system will require additional resources to increase rates to a level that will support salaries that keep up with the market, or it will be necessary to increase rates with existing resources, which will decrease capacity. LSFHS supports investment in a stable, qualified workforce to maintain accountability in service delivery, use of evidence-based practices and quality supervision; all essential to the ability to deliver high quality services. LSFHS has implemented a work group involving key provider leadership to develop a plan to address this critical personnel issue.

B. No Wrong Door

Implementation of the No Wrong Door philosophy was assessed through focus groups in each of the five Circuits in the LSFHS catchment area. The summary of the implementation for each Circuit is presented below. The full focus group summaries are available in Appendix 4.

No Wrong Door Model – Effectiveness and Use

Circuit 4

Focus group participants report that the No Wrong Door Model is effective at increasing collaboration and communication between providers, and to provide assistance or referrals to an appropriate agency for anyone who comes through their doors. No Wrong Door is used widely and daily within their organizations; one participant referred to it as part of their culture.

Participants emphasized their use of **quality assurance/quality improvement** (conducting monthly meetings to ensure standards are met, and conducting focus groups to gain feedback from clients), **person-centered counseling** (peer specialists and care coordinators help establish client transition support services), and **community awareness** as key to the success of this model. A limitation mentioned by one organization's representative was that due to the high volume of calls they receive, they have found it necessary to emphasize referring clients elsewhere.

Circuit 7

Organizations represented in this focus group all reported that the No Wrong Door Model is a key part of their service philosophy – it is used widely and daily. Providers stressed that anyone who comes to them needing help will be connected to available services, whether in house or by appropriate referral. They spoke in great detail about their robust community referral system and how the Behavioral Health Consortium in St John's County has provided the opportunity to establish great relationships between all the provider agencies in their community, the school district and the sheriff's office.

A number of agencies have open access centers that are designed to connect families with a variety of needed services. Some are open 24 hours a day, seven days a week. Others have a call center clients can call to receive information about local services. One agency highlighted their mobile crisis team, which intervenes before a mental health issue reaches the level of a Baker Act, and works in collaboration with area schools, law enforcement, and mental health providers to respond to crisis calls and link families to needed services. Another agency trains their

staff in High Fidelity Wraparound which parallels aspects of **person-centered counseling** and **person-centered transition support**. Anyone experiencing homelessness is entered into the Homeless Management Information System or referred to an agency that can enter them in the system.

Participants emphasized their use of person-centered counseling, participant engagement, person-centered transition support, engaging with the family as a whole, and hiring former clients as staff members as reasons for their successful use of this model. One agency spoke about how they provide aftercare after clients leave their facility, utilize peers, and work on transition plans from treatment.

Circuit 3&8

Focus group participants reported that the No Wrong Door Model is effective in providing assistance to their clients or referring those clients to an appropriate agency. For participants who provide direct care, they reported utilizing the No Wrong Door Model on a daily basis and commonly viewed it as their access to care model. Several focus group participants were not direct service providers and emphasized their organization's focus on community awareness, universal prevention strategies, and linking clients to services. For those participants who were not direct service providers, their use of the No Wrong Door Model is in connecting anyone who contacts their organization to an appropriate agency who can best help them. One participant's organization has a unique perspective of being a "Clubhouse Model." The Clubhouse Model provides a community of support and an opportunity for those with mental illness to work, make relationships, find housing, etc., and they link members to the outside services they need to maintain their long-term recovery.

Of the six aspects, participants emphasized their use of **community awareness** by engaging in numerous outreach activities, educational programs and events. Providers also highlighted **person-centered treatment and person-centered counseling** with an emphasis on the importance of peer support and consumer involvement in their treatment programs. The majority of participants reported have ongoing mechanisms in place at their organizations to ensure **quality assurance and quality improvement,** such as conducting focus groups and satisfaction surveys with their consumers, stakeholders and community partners.

Circuit 5

Focus group participants who were direct providers of care reported similar responses: that their organizations provide services or assistance with referrals to an appropriate agency to anyone coming through their doors. For those participants whose organizations do not provide direct services, they help in connecting clients to an appropriate agency that will best meet their needs. One participant reported utilizing peer support services to assist their clients. Another participant emphasized that while their organization's focus is on universal prevention strategies for substance abuse, they will refer anyone who contacts their agency to an appropriate resource to best help them. Overall, for those participants who provide direct care, they agreed that the No Wrong Door Model is their organization's philosophy and is used on a daily basis. Others noted they could not adequately answer how widely or frequently this model is used without reviewing data at their organizations.

Of the six aspects, all participants emphasized their use of **community awareness,** regardless of whether they provide direct services or are more focused on prevention. Examples of community awareness discussed by several participants included a variety of outreach and education initiatives as well as advisory groups to help raise awareness. Participants also emphasized their use of **consumer/stakeholder involvement,** such as having consumers or peers serving as liaisons on their organization's boards and committees. They also discussed their organization's focus on **person-centered counseling** and **person-centered transition support** through the use of case managers and peer specialists who work with their clients to make their transitions as smooth as possible. The

majority of focus group participants emphasized their organization's use of **quality assurance** and **quality improvement** measures to ensure their standards of care are monitored on an ongoing basis (i.e. consumer feedback surveys and focus groups). One participant noted their organization utilizes a scorecard approach to track these indicators.

C. Recovery Oriented Systems of Care

Implementation of the Recovery Oriented System of Care was assessed through focus groups in each of the five Circuits in the LSFHS catchment area. The summary of the implementation for each Circuit is presented below. The full focus group summaries are available in Appendix 4.

Circuit 4

Focus group participants incorporate elements of ROSC into various policies and procedures across their agencies. Some examples mentioned were recruiting people to their Board of Directors who are in recovery or who have family members in recovery, incorporating a parent model with wrap around services, involving clients in their own treatment plans, and using peer specialists who can better relate to clients, thereby increasing the number of people who decide to enter treatment plans. Externally, participants report partnering with other agencies to give their clients access to a wider variety of services by either co-locating services or by strengthening existing partnerships. A few participants have worked to create a collaborative group of area providers that meet bi-monthly to improve care coordination and talk about best practices and how to resolve barriers and share resources.

Outcomes and Effectiveness of ROSC

All providers in this group agreed that this model is widely used, and that ROSC improves outcomes for individuals, families and communities. One participant stated that, "There is always more buy-in when clients are part of their recovery," and another that, "They are more invested when they are part of the solution."

Circuit 7

Recovery-Oriented System of Care (ROSC)

The majority of focus group participants viewed the ROSC Model as one that is widely used throughout their organizations and stated that they incorporate various elements of this model into many of their programs. Several participants noted their organizations rely heavily on their partnerships with other agencies to help meet their clients' needs. A shared goal for many participants was connecting their clients to support systems within their communities and working towards full independence. A few participants discussed how their organizations have worked on High Fidelity Wraparound Plans (Wellness Recovery Action Plan) as examples of how they utilize a recovery-oriented system of care program with aspects of person-centered counseling and person-focused transition support. Another participant highlighted how their organization is continuing their efforts to develop a rich care coordination program that works with family members, caregivers and peer support to assist their clients in recovery. It was noted by another focus group participant that their organization's Mobile Response Team (MRT) program was a good example of how they utilize the ROSC.

Several focus group participants shared examples of how their organizations utilize specific elements of ROSC. One participant noted their origination recently expanded their program to be more culturally responsive, incorporating peers and ensuring their programs are evidence-based and providing research-based training. Another participant noted their organization is focused on patient-centered aspects and being family strength-based and culturally responsive in all of their programs. Several participants discussed how their organizations use system-wide education and training for all of their staff members. Another participant reported their organization tries to be culturally sensitive to best meet their clients' needs – such as providing translators to assist with language barriers – but would like to become more culturally responsive to the needs of the LBGTQ population.

Outcomes and Effectiveness of ROSC

Many focus group participants reported that ROSC improves outcomes for many individuals, families and communities. One participant emphasized the challenges faced when working with the homeless population who often do not have strong support networks. Another participant emphasized the importance of the work their organization does in assisting clients who transition out of hospital settings and linking them with the appropriate services in their community, so they have the best system of support. It was noted that the ROSC model can be helpful in soliciting feedback from consumers and encouraging family and community involvement, so their clients have a higher chance of success in achieving their goals. One participant reported their organization utilizes peers because "people with lived experiences are extremely helpful in recovery." One participant also emphasized that all staff in their organization is trained in ROSC to help them work better as a team on a common mission.

Circuit 3&8
Recovery-Oriented System of Care (ROSC)

Focus group participants agreed that recovery to the highest level is the shared goal for all of their clients. They reported their organizations utilize the 17 elements of ROSC in a variety of ways depending on their agency's focus. Those organizations providing direct services highlighted how peer support plays an important role in their treatment programs, such as in criminal diversion programs. For those participants whose organizations do not provide direct services, they discussed different ways they utilize community awareness and prevention strategies.

All participants emphasized that the ability of their recovery-oriented programs to be successful is dependent on funding. The majority of participants mentioned that their biggest programmatic challenge is not being adequately and flexibly financed. A limitation mentioned by one representative was their organization's ongoing reliance on grants which do not provide long-term support once that funding source ends. Another participant mentioned their organization's loss of funding to continue to provide peer support specialists for their clients which is an important component of recovery. All participants agreed that the ROSC model is used as widely as the funding permits.

Outcomes and Effectiveness of ROSC

Participants agreed that the ROSC model improves outcomes for individuals, families and the community. However, its effectiveness relates directly back to having the adequate funding to fully support all elements of these programs. It was noted by one participant that rural communities face much bigger funding challenges because they do not have the revenue base to get locally matched dollars required for many grants. Another participant discussed the limitations of this model's effectiveness due to the fact that the current health care system is driven by medical symptoms and not the social determinants of health. It was noted that it can be especially challenging to have a measurable impact on these social determinants. Another limitation of recovery-oriented programs mentioned was the challenge of recruiting peer support specialists for their mental health and substance abuse programs.

It was also emphasized that the Mental Health Clubhouse is a perfect example of a recovery-oriented model and has a great success rate of returning people back into their communities as well as preventing hospitalizations and interactions with law enforcement. With only 11 mental health clubhouses available in the 67 counties of Florida, access was identified as a huge barrier to the accessibility of this program.

Circuit 5

Recovery-Oriented System of Care (ROSC)

Many of the focus group participants who were direct service providers reported that the ROSC model is widely used at their organizations and they operate under the elements of this model on an ongoing basis. One participant noted that ROSC is embedded into all of their organization's policies, procedures, and practices and emphasized that everything they do is consumer and family driven. Another participant discussed how all of their organization's policies and processes are tested by data and outcomes. It was reported by several participants that their organizations do some elements of the ROSC model better than others and they are addressing those areas that need improvement. One participant mentioned their organization is working towards adopting the ROSC model throughout their agency, but they encountered some challenges and are working with a consultant to assist them in being more consistent with this model across their entire organization. Another participant mentioned their organization is working on increasing the number of peer support individuals and partnering with other organizations who have certification in the ROSC model.

The majority of participants agreed that the biggest challenge to implementing all elements of the ROSC model at their organization is related to behavioral health not being adequately and flexibility financed. Many emphasized that they are doing the best they can to meet their clients' needs within the funding limitations in Florida. Another issue they reported was the difficulty in finding quality behavioral health employees and feel it is a systemic problem. One participant also noted that substance abuse prevention is funded at lower levels than mental health prevention and that they must stretch their resources in this area.

Outcomes and Effectiveness of ROSC

It was agreed by the majority of focus group participants that the ROSC model improves outcomes for individuals, clients, and families and encourages communities to work together. One participant noted that they see their clients become more committed to their treatment when they work with peers and then later want to become part of the peer support system to help others as well. It was also emphasized by one participant that this model only improves outcomes when that individual is motivated for treatment and embraces the recovery-oriented system of care; it is by no means "a magic bullet". One participant also emphasized that while ROSC may improve outcomes for families and communities, it does not always result in improved outcomes with the state and it is dependent on what specific outcomes are being measured. It was also mentioned by one participant that the peer support aspect of the ROSC model can be especially challenging when working with the homeless population who often do not have a strong family or other support system.

D. Providers Employing Peer Specialists

Network Service Provider	(If applicable, # Peer Specialist)
The Centers	2
EPIC Behavioral	1
Mental Health America East of Central Florida	3
House Next Door	2
Clay Behavioral	4
Northwest Behavioral Health Services	1
LifeStream Behavioral Center	8
BayCare Behavioral	1
Gateway Community Services	19
Healthy Start Coalition	3
Ability Housing of Northeast Florida	2
Mental Health Resource Center	1
Cathedral Foundation d/b/a Aging True	2
I.M. Sulzbacher Center for the Homeless	1
SMA Healthcare	8
Meridian Behavioral	18
Gainesville Peer Respite	3
NAMI Hernando	

E. Evidence Informed Practices

LSF Health Systems supports and fosters the use of evidence-based and evidence-informed practices. We provide training on EBPs through our Training Institute and monitor for fidelity in practice through our clinical team's

participation in the provider monitoring process. A list of evidence-based practices employed in the network is below. Focus group summaries in Appendix 4. outline EBPs as described by the network service providers.

Evidence Based Practices

1 2 3 Magic Parenting
12 Step Facilitation
Active Parenting
Be Smart Rx
Botvin Life Skills
Brief Strategic Family Therapy (BSFT)
Celebrating Families
Character Counts
Circle of Security
Cognitive Behavioral Therapy (CBT)
Creating Lasting Family Connections
Dialectical Behavior Therapy (DBT)
Eight to Great
Eye Movement Desensitization and Reprocessing therapy (EMDR)
Family Behavior Therapy
Family Psychoeducation
Friday Night Done Right
Hidden in Plain Sight
I Steer Clear
Illness Management and Recovery
Incredible Years
Infant Mental Health evidence-based interventions
InShape Prevention Plus Wellness
Know the Law
Lily Recovery Wellness
Living in Balance
Mental Health First Aid
Motivational Enhancement Therapy
Motivational Interviewing (MI)
Natural High
No Joke
No One's House
Non-Abusive Psychological and Physical Intervention (NAPPI)
Nonviolent Crisis Intervention (CPI)
Nurturing Parent
Parent Child Interaction Therapy (PCIT)
Parenting Inside Out

Parents Who Host
Project Alert
Project Success
QPR Gatekeeper Model - Question, Persuade, and Refer
Rational Emotive Behavioral Therapy (REBT)
Relapse Prevention Therapy
Responsible Vendor Training
SAMHSA Anger Management
Screening, Brief Intervention and Referral to Treatment (SBIRT)
Second Step
Seeking Safety
Seven Challenges
Solution Focused Therapy
SPORT Prevention Plus Wellness
SSI/SSDI Outreach, Access, and Recovery Technical Assistance (SOAR)
Structural Family Therapy and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
The Matrix Model
The Power of Positive Parenting
The Voices
Too Good for Drugs
Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
Trauma Informed Care
Wellness Recovery Action Planning (WRAP)
Women in Recovery
Youth and Family Approach

F. Services requiring travel of over 1 hour

Short term residential requires travel of more than 1 hour for much of the LSF Health Systems catchment area as we have one facility located in Lake County. We have identified additional short-term residential beds as an unmet need in our enhancement plans for the past three years,

G. Unmet needs identified through coordination of care activities

Safe, stable and affordable housing and suitable placements for individuals being discharged from the State Hospital continue to be services where need outpaces capacity. These issues have been addressed through pilot programs, reallocation of resources and proposed investments through annual enhancement plans.

The completion of this Needs Assessment is the first step in the development of the LSF Health Systems Strategic Plan for 2020-2023. Results of the Needs Assessment will be presented to the community at Town Hall Meetings in each Circuit and in Behavioral Health Consortium meetings. LSF Health Systems will hold a strategic planning retreat to identify priorities and strategies for the next three years.