SERVICE AGREEMENT

This Agreement, **AGR75**, between **Southeast Florida Behavioral Health Network, Inc.**, hereinafter referred to as SEFBHN, and the **Indian River County Board of County Commissioners**, hereinafter referred to as the Provider, shall be effective July 1, 2023 until June 30, 2024.

A. Scope of Work to be Performed

The scope of work will encompass the following areas and activities:

The Provider will provide substance use services to assist individuals struggling with opioid addiction.

B. Tasks

The major tasks to be performed by the Provider will encompass providing services for substance use disorder as further described in **Attachment A, Scope of Service**, herein incorporated by reference.

1. Budget and Compensation

The fees set by this Agreement are based upon the Scope of Work listed above, the description of the Scope of Services as detailed in **Attachment A, Scope of Service**, herein incorporated by reference**.**

The **Indian River County Board of County Commissioners** will receive **$1,841,140.00 for FY 23/24** for services rendered as described in **Attachment A, Scope of Service**. These funds will be released on a cost reimbursement basis as approved and split as a total of $825,000.00 for CORE Services and $1,016,140.00 for Non-Qualified County Services.

The Invoice must be submitted to SEFBHN and include purpose and description of the services performed. The Provider shall only invoice for services that are specified in **Attachment A, Scope of Service** and have been delivered during the agreement period.

For FY 23/24 SEFBHN will remit a total payment of $1,841,140.00, upon receipt of properly completed and approved cost reimbursement invoices by the 10th of each month.

2. Data Collection

a. Opioid Settlement (OS) providers will be required to report data directly to the Department through the Florida Opioid Implementation and Financial Reporting System (OIFRS) system. The planned OS data to be collected will include:

diagnosis(es), demographics, financial, and service provided.

SEFBHN's obligation to pay under this Agreement is contingent on the availability of funding for this project being received from the State of Florida through the Opioid Settlement again the three largest pharmaceutical distributors, McKesson, Cardinal Health and AmerisourceBergen ("Distributors"), and one manufacturer, Janssen Pharmaceuticals, Inc., and its parent company Johnson & Johnson (collectively, "Janssen"). The Provider will have no right of action against SEFBHN or the State as a result of lack of sufficient funding. If funds become unavailable, provisions of termination will apply.

b. Coordinated Opioid Recovery (CORE) Network of Addiction Care

This agreement will require compliance with the **Department of Children and Families' Guidance Document 41, Coordinated Opioid Recovery (CORE) Network of Addiction Care**, herein incorporated by reference. The current incorporated guidance document is effective as of October 1, 2023 and, any updates to the guidance document will also be incorporated.

C. Terms and Conditions

Any changes to dates and fees must be submitted and approved by SEFBHN. If circumstances arise that will require additional services and time, the Provider will notify SEFBHN and obtain written agreement prior to undertaking such activities. The Provider shall perform all services, tasks and provide deliverables, including the quarterly reconciliation, and reports, as specified in this agreement.

D. Business Associates

Pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, and Standards for the Privacy and Security of Individually Identifiable Health Information, found at 45 C.F.R. Parts 160, 162 and 164, 42 C.F.R. and as amended by the Health Information Technology for Economic and Clinical Health Act, (collectively, "**HIPAA**"), SEFBHN is required to protect certain individually identifiable health or other information ("**Protected Health Information"** or **"PHI**" including, but not limited to, PHI in an electronic form). Should SEFBHN request that the Provider share or disclose Client PHI with any of the other SEFBHN designated business associates, SEFBHN shall provide the Provider with written direction indicating the name of the entity, confirmation that such entity is a business associate with a written business associate agreement with SEFBHN and the specific information and/or data SEFBHN desires the Provider to disclose to or share with such other business associate and the Parties agree to execute any such additional agreements as necessary to complete such activities. For purposes of this Agreement, "Client" shall mean: any individual that is eligible to receive behavioral health services in accordance with DCF

eligibility policies in the Service Area.

E. Governing Law and Compliance

1. Governing Law

The validity, enforceability, and interpretation of this Agreement, including the Attachments, shall be determined and governed by the laws of the State of Florida, as well as applicable federal laws. The Parties agree that jurisdiction for any dispute, action, claim or alternative dispute resolution proceeding regarding this Agreement shall reside in Martin County, Florida.

2. Florida Regulatory Governance

This Agreement, the Attachments and the performance thereof, are subject to the requirements and regulations promulgated by and specific verbiage required by DCF.

3. Corporate Compliance

During the term of this Agreement, each Party shall: (i) ensure that it is duly organized, validly existing and in good standing under the laws of Florida; (ii) maintain all requisite federal, state and local authority, permits and licenses necessary or appropriate to operate and to carry out its obligations under this Agreement; (iii) monitor its performance of administrative functions on an ongoing basis to ensure compliance with applicable DCF performance standards and guidelines; and (iv) notwithstanding any term or provision in this Agreement to the contrary, remain ultimately responsible for assuring that it is operating in accordance with all applicable federal, state and local laws, rules, regulations and ordinances.

F. General Provisions

1. Notwithstanding anything in this Agreement to the contrary, the Parties acknowledge and agree that each Party is subject to the Florida Public Records Act under the Florida Contract and under Chapter 119, Florida Statutes. Nonetheless, in the event that a Party becomes legally compelled to disclose any of the Confidential Proprietary Information (the "Compelled Party"), the Compelled Party will provide the other Party with prompt notice thereof so that the other Party may seek a protective order or other appropriate remedy. In the event that such protective order or other remedy is not obtained by the other Party, the Compelled Party will furnish or cause to be furnished only that minimum portion of the Confidential Proprietary Information which the Compelled Party is legally required to furnish.

2. Public Records

a. SEFBHN and Provider shall comply with the provisions of Chapter 119, Fla. Stat. (Public Records Law), in connection with this Agreement and shall provide access to public records in accordance with §119.0701, Fla. Stat. and more specifically Provider shall:

b. Keep and maintain public records required by the County to perform the Agreement.

c. Upon request from the County's custodian of public records, provide the County with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Fla. Stat. or as otherwise provided by law.

d. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the Agreement term and following completion of the Agreement if SEFBHN does not transfer the records to the County.

e. Upon completion of the Agreement, transfer, at no cost, to the County all public records in possession of SEFBHN or keep and maintain public records required by the County to perform the Agreement. If the SEFBHN transfers all public records to the County upon completion of the Agreement, the SEFBHN shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the SEFBHN keeps and maintains public records upon completion of the Agreement, the SEFBHN shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the County, upon request from the County's custodian of public records, in a format that is compatible with the information technology systems of the County.

f. Chapter 119

(1) IF SEFBHN HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE SEFBHN'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS, MS. TAREE GLANVILLE, AT (772) 226-1424, TGLANVILLE@INDIANRIVER.GOV, 1801 27TH STREET, VERO BEACH, FL 32960.

(2) IF THE PROVIDER HAS QUESTIONS REGARDING THE APPLICATION OR CHAPTER 119, F.S., TO THE PROVIDER'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS AGREEMENT, CONTACT THE

CUSTODIAN OF PUBLIC RECORDS, MS. TRACEE DIAZ AT (561) 203-2485, OR BY EMAIL AT TRACEE.DIAZ@SEFBHN.ORG, OR BY MAIL AT: SEFBHN, 1070 INDIANTOWN ROAD, SUITE 408, JUPITER, FL 33477.

g. Failure to comply with the requirements of this Article shall be deemed a default as defined under the terms of this Agreement and constitute grounds for termination.

3. Severability

The illegality, unenforceability or ineffectiveness of any provision of this Agreement shall not affect the legality, enforceability or effectiveness of any other provision of this Agreement. If any provision of this Agreement, or the application thereof shall, for any reason and to any extent, be deemed invalid or unenforceable, neither the remainder of this Agreement, nor the application of the provision to other persons, entities or circumstances, nor any other instrument referred to in this Agreement shall be affected thereby, but instead shall be enforced to the maximum extent permitted by law.

4. The following Attachments are incorporated into this Agreement by reference:

a. Attachment A: Scope of Services

b. Statement of Funding

5. Authority to Bind

By signature below, each signatory represents and warrants that such person is duly-authorized to enter into this Agreement on the respective Party's behalf, and is duly authorized to bind such Party to the terms applicable to each.

6. Typewritten or Handwritten Provisions

Typewritten or handwritten provisions that are inserted, in this Agreement or attached to this Agreement as addenda or riders shall not be valid unless such provisions are initialed by both signatories to this Agreement.

7. Counterparts: Facsimile Execution and Captions

This Agreement may be executed and delivered: (a) in any number of counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument; and/or (b) by facsimile, in which case the instruments so executed and delivered shall be binding and effective for all purposes; and/or (c) by email communication to the parties identified in the Notice section. The captions in

this Agreement are for reference purposes only and shall not affect the meaning of terms and provisions herein.

8. Entire Agreement

This Agreement, including the Attachments A and B hereto, contains all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the Parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect.

IN WITNESS WHEREOF, the authorized representatives of the Parties hereto have executed this Agreement to be effective as of the Effective Date.

	THE INDIAN RIVER COUNTY BOARD OF COUNTY COMMISSIONERS	**SOUTHEAST FLORIDA BEHAVIORAL HEALTH NETWORK, INC.**
Signed by:		
Name:		Ann M. Berner
Title:		Chief Executive Officer
Date:		

The parties agree that any future amendment(s) replacing this page will not affect the above execution.

Federal Tax ID # (or SSN): ########## Provider FY Ending Date: ##/##

SERVICE AGREEMENT

Attachment A
Scope of Services

A. Florida Statewide Response for Opioid Abatement

The "**Children and Families Operating Procedure on Florida Statewide Response for Opioid Abatement**," is herein incorporated by reference and should be followed as per the most recent effective date available. At the time of this Agreement's execution, this document is still in draft form. When available, it will be shared from Southeast Florida Behavioral Health Network, Inc. staff.

B. Core Strategies

Non-Qualified Counties shall choose from the abatement strategies listed in the Core Strategies – Abatement Strategies section below. However, priority shall be given to the following core abatement strategies ("Core Strategies.")

1. **Naloxone or another FDA-approved drug to reverse opioid overdoses.**

   a. Expand training for first responders, schools, community support groups and families.

   b. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

2. **Medication-Assisted Treatment ("MAT") Distribution and other opioid-related treatment**

   a. Increase distribution of MAT to non-Medicaid eligible or uninsured individuals.

   b. Provide education to school-based and youth-focused programs that discourage or prevent misuse.

   c. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

   d. Treatment and Recovery Support Services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication with other support services.

3. **Pregnant & Postpartum Women**

   a. Expand Screening, Brief Intervention, and Referral to Treatment ("SBIRT") services to non-Medicaid eligible or uninsured pregnant women.

b. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("OUD") and other Substance Use Disorder ("SUD")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

c. Provide comprehensive wrap-around services to individuals with Opioid Use Disorder (OUD) including housing, transportation, job placement/training, and childcare.

4. Expanding Treatment for Neonatal Abstinence Syndrome

a. Expand comprehensive evidence-based and recovery support for NAS babies;

b. Expand services for better continuum of care with infant-need dyad; and

c. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Expansion of Warm Hand-off Programs and Recovery Services

a. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

b. Expand warm hand-off services to transition to recovery services;

c. Broaden scope of recovery services to include co-occurring SUD or mental health conditions.

d. Provide comprehensive wrap-around services to individuals in recovery including housing, transportation, job placement/training, and childcare; and

e. Hire additional social workers or other behavioral health workers to facilitate expansions above.

6. Treatment for Incarcerated Population

a. Provide evidence-based treatment and recovery support including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

b. Increase funding for jails to provide treatment to inmates with OUD.

7. Prevention Programs

a. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco).

b. Funding for evidence-based prevention programs in schools.;

c. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

d. Funding for community drug disposal programs; and

e. Funding and training for first responders to participate in pre-arrest diversion programs, post overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

8. Expanding Syringe Service Programs

Provide comprehensive syringe services programs with more wrap-around services including linkage to OUD treatment, access to sterile syringes, and linkage to care and treatment of infectious diseases.

9. Evidence-based data collection and research analyzing the effectiveness of the abatement strategies within the State.

10. Core Strategies – Abatement Strategies

a. Approved Uses – Part One: Treatment

(1) Treat Opioid Use Disorder (OUD)

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

(a) Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment (MAT) approved by the U.S. Food and Drug Administration.

(b) Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for OUD and any co-occurring SUD/MH conditions.

(c) Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

(d) Improve oversight of Opioid Treatment Programs (OTPs) to assure evidence-based or evidence informed practices such as adequate methadone dosing and low threshold approaches to treatment.

(e) Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

(f) Treatment of trauma for individuals with OUD (e.g., violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (e.g., surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

(g) Support evidence-based withdrawal management services for people with OUD and any cooccurring mental health conditions.

(h) Training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including tele mentoring to assist community-based providers in rural or underserved areas.

(i) Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

(j) Fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

(k) Scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD or mental health conditions, including but not limited to training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

(l) Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 (DATA 2000) to prescribe MAT for OUD and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

I. Dissemination of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service-Opioids web-based training curriculum and motivational interviewing.

II. Development and dissemination of new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication-Assisted Treatment.

(2) Support to People in Treatment and Recovery

Support people in treatment for or recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

(a) Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

(b) Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

(c) Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

(d) Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved medication with other support services.

(e) Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

(f) Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

(g) Provide or support transportation to treatment or recovery programs or

services for persons with OUD and any co-occurring SUD/MH conditions.

(h) Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

(i) Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

(j) Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

(k) Training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

(l) Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

(m) Create or support culturally appropriate services and programs for persons with OUD and any cooccurring SUD/MH conditions, including new Americans.

(n) Create and/or support recovery high schools.

(o) Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

(3) Connect People who Need Help to the Help they Need (Connections to Care)

Provide connections to care for people who have – or at risk of developing – OUD and any cooccurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

(a) Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

(b) Fund Screening, Brief Intervention and Referral to Treatment (SBIRT) programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

(c) Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

(d) Purchase automated versions of SBIRT and support ongoing costs of the technology.

(e) Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

(f) Training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

(g) Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

(h) Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

(i) Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid related adverse event.

(j) Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

(k) Expand warm hand-off services to transition to recovery services.

(l) Create or support school-based contacts that parents can engage with to

seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

(m) Develop and support best practices on addressing OUD in the workplace.

(n) Support assistance programs for health care providers with OUD.

(o) Engage non-profits and the faith community as a system to support outreach for treatment.

(p) Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

(4) Address the Needs of Criminal-Justice-Involved Persons

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

(a) Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

I. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery

II. Initiative (PAARI).

III. Active outreach strategies such as the Drug Abuse Response Team (DART) model.

IV. “Naloxone Plus” strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services.

V. Officer prevention strategies, such as the Law Enforcement Assisted Diversion (LEAD) model.

VI. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network, or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

VII. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

(b) Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

(c) Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

(d) Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

(e) Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

(f) Support critical time interventions (CTI), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

(g) Provide training on best practices for addressing the needs of criminal-justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

(5) Address the Needs of Pregnant Women and their Families, Including Babies with Neonatal Abstinence Syndrome

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome (NAS), through evidence-based

or evidence-informed programs or strategies that may include, but are not limited to, the following:

(a) Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women – or women who could become pregnant – who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

(b) Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

(c) Training for obstetricians or other healthcare personnel that work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

(d) Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; expand long-term treatment and services for medical monitoring of NAS babies and their families.

(e) Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with Neonatal Abstinence Syndrome get referred to appropriate services and receive a plan of safe care.

(f) Child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

(g) Enhanced family supports and childcare services for parents with OUD and any co-occurring SUD/MH conditions.

(h) Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

(i) Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including but not limited to parent skills training.

(j) Support for Children's Services – Fund additional positions and services, including supportive housing and other residential services, relating to

children being removed from the home and/or placed in foster care due to custodial opioid use.

b. Approved Uses – Part Two: Prevention

(1) Prevent Over-prescribing and Ensure Appropriate Prescribing and Dispensing of Opioids

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

(a) Fund medical provider education and outreach regarding best prescribing practices for opioids consistent with Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

(b) Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

(c) Continuing Medical Education (CME) on appropriate prescribing of opioids.

(d) Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

(e) Support enhancements or improvements to Prescription Drug Monitoring Programs (PDMPs), including but not limited to improvements that:

I. Increase the number of prescribers using PDMPs.

II. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

III. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

(f) Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

(g) Increase electronic prescribing to prevent diversion or forgery.

(h) Educate Dispensers on appropriate opioid dispensing.

(2) Prevent Misuse of Opioids

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence informed programs or strategies that may include, but are not limited to, the following:

(a) Fund media campaigns to prevent opioid misuse.

(b) Corrective advertising or affirmative public education campaigns based on evidence.

(c) Public education relating to drug disposal.

(d) Drug take-back disposal or destruction programs.

(e) Fund community anti-drug coalitions that engage in drug prevention efforts.

(f) Support community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction – including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

(g) Engage non-profits and faith-based communities as systems to support prevention.

(h) Fund evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

(i) School-based or youth-focused programs or strategies that have

demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

(j) Create of support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

I. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

II. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or other drug misuse.

(3) Prevent Overdose Deaths and Other Harms (Harm Reduction)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence based or evidence-informed programs or strategies that may include, but are not limited to, the following:

(a) Increase availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, individuals at high risk of overdose, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

(b) Public health entities provide free naloxone to anyone in the community.

(c) Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

(d) Enable school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

(e) Expand, improve, or develop data tracking software and applications for overdoses/naloxone revivals.

(f) Public education relating to emergency responses to overdoses.

(g) Public education relating to immunity and Good Samaritan laws.

(h) Educate first responders regarding the existence and operation of immunity and Good Samaritan laws.

(i) Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

(j) Expand access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

(k) Support mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

(l) Provide training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

(m) Support screening for fentanyl in routine clinical toxicology testing.

c. Approved Uses – Part Three: Other Strategies

(1) First Responders

In addition to items in previous sections relating to first responders, support the following:

(a) Educate law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

(b) Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

(2) Leadership, Planning and Coordination

Support efforts to provide leadership, planning, coordination, facilitation, training, and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

(a) Statewide, regional, local, or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment intervention services; to support training and technical assistance; or to support other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

(b) A dashboard to share reports, recommendations, or plans to spend opioid settlement funds; to show how opioid settlement funds have been spent; to report program or strategy outcomes; or to track, share, or visualize key opioid-related or health-related indicators and supports as identified through collaborative statewide, regional, local, or community processes.

(c) Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

(d) Provide resources to staff government oversight and management of opioid abatement programs.

(3) Training

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

(a) Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

(b) Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat

those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (e.g., health care, primary care, pharmacies, PDMPs, etc.).

(4) Research

Support opioid abatement research that may include, but is not limited to, the following:

(a) Monitoring, surveillance, data collection, and evaluation of programs and strategies described in this opioid abatement strategy list.

(b) Research non-opioid treatment of chronic pain.

(c) Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

(d) Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

(e) Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

(f) Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (e.g., Hawaii HOPE and Dakota 24/7).

(g) Epidemiological surveillance of OUD-related behaviors in critical populations including individuals entering the criminal justice system, including but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring (ADAM) system.

(h) Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

(i) Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

C. Covered Services as defined in Florida Administrative Code 65E-14.021

The covered services and project codes listed below are based on those eligible to access MSONQ as per the DCF FASAMS Pamphlet 155-2 with a last revision date of 2/23/24, herein incorporated by reference. If the OCA associated with this program changes, or the list of eligible services are changed, Southeast Florida Behavioral Health Network, Inc. staff will inform the Martin County Board of County Commissioners in an email which will include a the DCF FASAMS Pamphlet 155-2 and a revised Statement of Funding, herein incorporated by reference, if applicable.

1. Funding is currently available for the Non-Qualified County programs under MSONQ, the current Other Cost Accumulator (OCA), associated with this Agreement for ME Opioid TF Non-Qualified Counties funding.

2. Funding is currently available for the CORE programs under MSOCR, the current Other Cost Accumulator (OCA), associated with this Agreement for ME Opioid TF Coord Opioid Recovery Care funding.

D. Covered Services as defined in Florida Administrative Code 65E-14.021

1. 1 – Assessment (Eligible OCAs: MSOCR, MSONQ)

This Covered Service includes the systematic collection and integrated review of individual-specific data, such as examinations and evaluations. This data is gathered, analyzed, monitored and documented to develop the person's individualized plan of care and to monitor recovery. Assessment specifically includes efforts to identify the person's key medical and psychological needs, competency to consent to treatment, history of mental illness or substance use and indicators of co-occurring conditions, as well as clinically significant neurological deficits, traumatic brain injury, organicity, physical disability, developmental disability, need for assistive devices, physical or sexual abuse, and trauma.

2. 2 – Case Management (Eligible OCAs: MSOCR)

Case management services consist of activities that identify the recipient's needs, plan services, link the service system with the person, coordinate the various system components, monitor service delivery, and evaluate the effect of the services received. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.

3. 3 – Crisis Stabilization (Eligible OCAs: MSONQ)

These acute care services, offered twenty-four hours per day, seven days per week,

provide brief, intensive mental health residential treatment services. These services meet the needs of individuals who are experiencing an acute crisis and who, in the absence of a suitable alternative, would require hospitalization.

4. **4 – Crisis Support/Emergency (Eligible OCAs: MSOCR, MSONQ)**

This non-residential care is generally available twenty-four hours per day, seven days per week, or some other specific time period, to intervene in a crisis or provide emergency care. Examples include: crisis/emergency screening, mobile response, telephone or telehealth crisis support, and emergency walk-in.

5. **5 – Day Care (Eligible OCAs: MSONQ)**

Day care services, in a non-residential group setting, provide for the care of children of persons who are participating in mental health or substance use treatment services. In a residential setting, day care services provide for the residential and care-related costs of a child living with a parent receiving residential services. This covered service must be provided in conjunction with another Covered Service provided to a person 18 years of age or older.

6. **6 – Day Treatment (Eligible OCAs: MSOCR, MSONQ)**

Day Treatment services provide a structured schedule of non-residential interventions to assist individuals to attain skills and behaviors needed to function successfully in living, learning, work, and social environments. Activities emphasize rehabilitation, treatment, activities of daily living, and education services, using multidisciplinary teams to provide integrated programs of academic, therapeutic, and family services. For mental health programs, day treatment services must be provided for four or more consecutive hours per day. Substance abuse programs must follow the standards set forth in Rules 65D-30.0081 and 65D-30.009, F.A.C.

7. **8 – In-Home and On-Site (Eligible OCAs: MSOCR, MSONQ)**

Therapeutic services and supports, including early childhood mental health consultation, are rendered for individuals and their families in non-provider settings such as nursing homes, assisted living facilities, residences, schools, detention centers, commitment settings, foster homes, daycare centers, and other community settings.

8. **9 – Inpatient (Eligible OCAs: MSONQ)**

Inpatient services provided in psychiatric units within hospitals licensed as general hospitals and psychiatric hospitals under Chapter 395, F.S. They provide intensive treatment and stabilization to persons exhibiting behaviors that may result in harm to

self or others due to mental illness or co-occurring mental illness and substance use disorder.

9. 10 – Intensive Case Management (Eligible OCAs: MSOCR)

These services are typically offered to persons who are being discharged from an acute care setting, and need more professional care, and have contingency needs to remain in a less restrictive setting. The services include the same components as case management as described in subparagraph (4)(d)1., of this rule, but are provided at a higher intensity and frequency, and with lower caseloads per case manager sufficient to meet the needs of the individuals in treatment.

10. 11 – Intervention – Individual and 42 – Intervention – Group (Eligible OCAs: MSOCR, MSONQ)

Intervention services focus on reducing risk factors generally associated with the progression of substance misuse and mental health problems. Intervention is accomplished through early identification of persons at risk, performing basic individual assessments, and providing supportive services, which emphasize short-term counseling and referral. These services are targeted toward individuals and families. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.

11. 12 – Medical Services (Eligible OCAs: MSOCR, MSONQ)

Medical services provide primary psychiatric care, therapy, and medication administration provided by an individual licensed under the state of Florida to provide the specific service rendered. Medical services improve the functioning or prevent further deterioration of persons with mental health or substance abuse problems, including mental status assessment. Medical services are usually provided on a regular schedule, with arrangements for non-scheduled visits during times of increased stress or crisis.

12. 13 – Medication Assisted Treatment (Eligible OCAs: MSOCR, MSONQ)

This Covered Service provides for the delivery of medications for the treatment of substance use disorders which are prescribed by a licensed health care professional. Services must be based upon a clinical assessment, and treatment and support services must be available for and offered to individuals receiving medications to support their ongoing recovery.

13. 14 – Outpatient – Individual and 35 – Outpatient – Group (Eligible OCAs: MSOCR, MSONQ)

Outpatient services provide clinical interventions to improve the functioning or prevent further deterioration of persons with mental health and/or substance abuse use disorders. These services are usually provided on a regularly scheduled basis by appointment, with arrangements made for non-scheduled visits during times of increased stress or crisis. Outpatient services may be provided to an individual or in a group setting. The maximum number of individuals allowed in a group session is 15. This covered service shall include clinical supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service.

14. 15 – Outreach (Eligible OCAs: MSOCR, MSONQ)

Outreach services are provided through a formal program to both individuals and the community. Community services include education, identification, and linkage with high-risk groups. Outreach services for individuals: encourage, educate, and engage prospective individuals who show an indication of substance misuse and mental health problems or needs. Individual enrollment is not included in Outreach services.

15. 18 – Residential Level I (Eligible OCAs: MSONQ)

These licensed services provide a structured, live-in, non-hospital setting with supervision on a twenty-four hours per day, seven days per week basis. For adult mental health, Residential Treatment Facilities Level IA and IB, as defined in Rule 65E-4.016, F.A.C., are reported under this Covered Service. For children with serious emotional disturbances, Level 1 services are the most intensive and restrictive level of residential therapeutic intervention provided in a non-hospital or non-crisis stabilization setting. Residential Treatment Centers, as defined in Rule 65E-9.002, F.A.C. are reported under this Covered Service. For substance use treatment, Residential Level 1, as defined in Rule 65D-30.007, F.A.C., provides a range of assessment, treatment, rehabilitation, and ancillary services in an intensive therapeutic environment, with an emphasis on treatment, and may include formal school and adult education programs.

16. 19 – Residential Level II (Eligible OCAs: MSONQ)

Level II facilities are licensed, structured rehabilitation-oriented group facilities that have twenty-four hours per day, seven days per week, supervision. Level II facilities house persons who have significant deficits in independent living skills and need extensive support and supervision. For adults with a mental illness, Residential Treatment Facilities Level II, as defined in Rule 65E-4.016, F.A.C., are reported under this Covered Service. For children with serious emotional disturbances, Level II services provide intensive therapeutic behavioral and treatment interventions.

Therapeutic Foster Homes are reported under this Covered Service. For substance use treatment, Level II, as defined in Rule 65D-30.007, F.A.C., services provide a range of assessment, treatment, rehabilitation, and ancillary services in a less intensive therapeutic environment with an emphasis on rehabilitation and may include formal school and adult educational programs.

17. 20 – Residential Level III (Eligible OCAs: MSONQ)

These licensed facilities provide twenty-four hours per day, seven days per week supervised residential alternatives to persons who have developed a moderate functional capacity for independent living. For adults with a mental illness, Residential Treatment Facilities Level III, as defined in Rule 65E-4.016, F.A.C., are reported under this Covered Service. For substance use treatment, Level III, as defined in Rule 65D-30.007, F.A.C., provides a range of assessment, rehabilitation, treatment and ancillary services on a long-term, continuing care basis where, depending upon the characteristics of the individuals served, the emphasis is on rehabilitation or treatment.

18. 21 – Residential Level IV (Eligible OCAs: MSONQ)

This type of facility may have less than twenty-four hours per day, seven days per week on-premise supervision. It is primarily a support service and, as such, treatment services are not included in this Covered Service, although such treatment services may be provided as needed through other Covered Services. Level IV includes satellite apartments, satellite group homes, and therapeutic foster homes. For adults with a mental illness, Residential Treatment Facilities Level IV, as defined in paragraph 65E-4.016, F.A.C., are reported under this Covered Service. For substance use treatment, Level IV, as defined in Rule 65D-30.007, F.A.C., provides a range of assessment, rehabilitation, treatment, and ancillary services on a long-term, continuing care basis where, depending upon the characteristics of the individuals served, the emphasis is on rehabilitation or treatment.

19. 22 – Respite Services (Eligible OCAs: MSOCR, MSONQ)

Respite care services support the family or other primary care giver by providing time-limited, temporary relief, including overnight stays, from the ongoing responsibility of care giving.

20. 24 – Substance Abuse Inpatient Detoxification (Eligible OCAs: MSOCR, MSONQ)

These programs utilize medical and clinical procedures to assist adults, and adolescents with substance use disorders in their efforts to withdraw from the physical effects of substance use. Residential detoxification and addiction receiving facilities provide emergency screening, evaluation, short-term stabilization, and treatment in a medically supervised.

21. 25 – Supportive Employment (Eligible OCAs: MSOCR, MSONQ)

Supported employment is an evidence-based approach that assists individuals with gaining competitive integrated employment. Supported employment can be a team-based approach and focuses on the full range of community jobs that match the job seeker's strengths and preferences. Job supports are individualized and include: job development, job placement, and long-term job coaching.

22. 26 – Supported Housing/Living (Eligible OCAs: MSOCR, MSONQ)

Supported housing/living is an evidence-based approach to assist persons with substance use and mental illness in the selection of permanent housing of their choice. These services also provide the necessary supports to transition into independent community living and assure continued successful living in the community. For children with mental health challenges, supported living services are a process which assist adolescents in selecting and maintaining housing arrangements and provides services, such as training in independent living skills, to assure successful transition to independent living or with roommates in the community. For substance use treatment, services provide for the housing and monitoring of recipients who are participating in non-residential services, recipients who have completed or are completing substance use treatment, and those recipients who need assistance and support in independent or supervised living within a "live-in" environment.

23. 27 – Treatment Alternative for Safer Community (Eligible OCAs: MSOCR, MSONQ)

TASC provides for identification, screening, court liaison, referral and tracking of persons in the criminal justice system with a history of substance use or addiction.

24. 28 – Incidental Expenses (Eligible OCAs: MSOCR, MSONQ)

This Covered Service reports temporary expenses incurred to facilitate continuing treatment and community stabilization when no other resources are available. All incidental expenses shall be authorized by the Managing Entity. Allowable purchases under this Covered Service includes: transportation, childcare, housing assistance clothing, educational services, vocational services, medical care, housing subsidies, pharmaceuticals and other incidentals as approved by the Department or Managing Entity.

25. 29 – Aftercare – Individual and 43 – Aftercare – Group (Eligible OCAs: MSONQ)

Aftercare activities occur after a treatment level of care is completed and include activities such as supportive counseling, life skills training, and relapse prevention for

individuals with mental illness or substance use disorders to assist in their ongoing recovery. Aftercare services help individuals, families, and pro-social support systems reinforce a healthy living environment.

26. 30 – Information and Referral (Eligible OCAs: MSOCR, MSONQ)

These services maintain information about resources in the community, link people who need assistance with appropriate service providers, and provide information about agencies and organizations that offer services. The information and referral process is comprised of: being readily available for contact by the individual, assisting the individual with determining which resources are needed, providing referral to appropriate resources, and following up to ensure the individual's needs have been met, where appropriate.

27. 32 – Substance Abuse Outpatient Detoxification (Eligible OCAs: MSONQ)

These services utilize medication or a psychosocial counseling regimen that assists recipients in their efforts to withdraw from the physiological and psychological effects of addictive substances.

28. 36 – Room and Board with Supervision Level I (Eligible OCAs: MSONQ)

This Covered Service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Residential Level I as defined in F.A.C. 65E-14.021.

29. 37 – Room and Board with Supervision Level II (Eligible OCAs: MSONQ)

This Covered Service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Residential Level II as defined in F.A.C. 65E-14.021. This Covered Service is not applicable for provider facilities which meet the definition of an Institute for Mental Disease as defined by Title 42 CFR, Part 435.1010.

30. 38 – Room and Board with Supervision Level III (Eligible OCAs: MSONQ)

This Covered Service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Residential Level III as defined in F.A.C. 65E-14.021.

31. 39 – Short-term Residential Treatment (Eligible OCAs: MSONQ)

These individualized, stabilizing acute and immediately sub-acute care services provide short and intermediate duration intensive mental health residential services on

a twenty-four hours per day, seven days per week basis, as provided for in Rule Chapter 65E-12, F.A.C. These services shall meet the needs of individuals who are experiencing an acute or immediately sub-acute crisis and who, in the absence of a suitable alternative, would require hospitalization.

32. 40 – Mental Health Clubhouse Services (Eligible OCAs: MSONQ)

Structured, evidence-based services both strengthen and/or regain the individual's interpersonal skills, provide psycho-social support, develop the environmental supports necessary to help the individual thrive in the community and meet employment and other life goals, and promote recovery from mental illness. Services are typically provided in a community-based program with trained staff and members working as teams to address the individual's life goals and to perform the tasks necessary for the operations of the program. The emphasis is on a holistic approach focusing on the individual's strengths and abilities while challenging the individual to pursue those life goals. This service would include, but not be limited to, clubhouses certified under the International Center for Clubhouse Development. This covered service may not be provided to a person less than 18 years old.

33. 44 – Comprehensive Community Service Team – Individual and 45 – Comprehensive Community Service Team - Group (Eligible OCAs: MSONQ)

This Covered Service is a bundled service package designed to provide short-term assistance and guide individuals to rebuild skills in identified roles in their environment through the engagement of natural supports, treatment services, and assistance of multiple agencies when indicated. Services provided under Comprehensive Community Service Teams may not be simultaneously reported to another Covered Service. Allowable bundled activities include the following Covered Services as defined in subsection (4) of F.A.C. 65E-14.021: Aftercare, Assessment, Care Coordination, Case Management, Information and Referral, In-home/Onsite, Intensive Case Management, Intervention, Outpatient, Outreach, Prevention – Indicated, Recovery Support, Supported Employment, and Supportive Housing.

34. 46 – Recovery Support – Individual and 47 – Recovery Support - Group (Eligible OCAs: MSOCR, MSONQ)

This Covered Service is comprised of nonclinical activities that assist individuals and families in recovering from substance use and mental health conditions. Activities include social support, linkage to and coordination among service providers, life skills training, recovery planning, coaching, education on mental illness and substance use disorders, assisting individuals using digital therapeutics approved by the United States Food and Drug Administration, and other supports that facilitate increasing recovery capital and wellness contributing to an improved quality of life. Recovery capital is the personal, family, social, community resources and natural supports that promote

recovery. These activities may be provided prior to, during, and after treatment. These services support and coach an adult or child and family to regain or develop skills to live, work and learn successfully in the community. This Covered Service shall include supervision provided to a service provider's personnel by a professional qualified by degree, licensure, certification, or specialized training in the implementation of this service, or by a certified peer specialist who has at least 2 years of fill-time experience as a peer specialist at a licensed behavioral health organization. This Covered Service must be provided by a Certified Recovery Peer Specialist pursuant to Section 397.417, F.S. These services exclude twelve-step programs such as Alcoholics Anonymous and Narcotics Anonymous.

35. 48 – Prevention - Indicated (Eligible OCAs: MSONQ)

Indicated prevention services are provided to at-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental health or substance use disorders. Target recipients of indicated prevention services are at-risk individuals who do not meet clinical criteria for mental health or substance use disorders. Indicated prevention services preclude, forestall, or impede the development of mental health or substance use disorders. These services shall address the following specific prevention strategies, as defined in rule 65D-30.013, F.A.C.: education, alternative and problem identification and referral services.

36. 49 – Prevention - Selective (Eligible OCAs: MSONQ)

Selective prevention services are provided to a population subgroup whose risk of developing mental health or substance use disorders is higher than average. Target recipients of selective prevention services do not meet clinical criteria for mental health or substance use disorders. Selective prevention services preclude, forestall, or impede the development of mental health or substance use disorders. These services shall address the following specific prevention strategies, as defined in Rule 65D-30.013, F.A.C.: information dissemination, education, alternatives, and problem identification and referral services.

37. 50 – Prevention – Universal Direct (Eligible OCAs: MSONQ)

Universal direct prevention services are provided to the general public or a whole population that has not been identified on the basis of individual risk. These services preclude, forestall, or impede the development of mental health or substance use disorders. Universal direct services directly serve an identifiable group of participants who have not been identified on the basis of individual risk. This includes interventions involving interpersonal and ongoing or repeated contact such as curricula, programs, and classes. These services shall address the following specific prevention strategies, as defined in rule 65D-30.013, F.A.C.: information dissemination, education, alternatives, or problem identification and referral services.

38. 51 – Prevention – Universal Indirect (Eligible OCAs: MSONQ)

Universal indirect prevention services are provided to the general public or a whole population that has not been identified on the basis of individual risk. These services preclude, forestall, or impede the development of mental health or substance use disorders. Universal indirect services support population-based programs and environmental strategies such as changing laws and policies. These services can include programs and policies implemented by coalitions. These services can also include meetings and events related to the design and implementation of components of the strategic prevention framework, including needs assessments, logic models, and comprehensive community action plans. These services shall address the following specific prevention strategies, as defined in Rule 65D-30.013, F.A.C.: information dissemination, education, community-based processes, and environmental strategies.

39. 52 – Care Coordination (Eligible OCAs: MSOCR, MSONQ)

Care Coordination is a time-limited service that assists individuals with behavioral health conditions who are not effectively engaged with case management or other behavioral health services and supports for a successful transition to appropriate levels of care. Once engagement in the necessary community-based services is verified, care coordination services are terminated.

40. 53 – HIV Early Intervention Services (Eligible OCAs: MSOCR)

This Covered Service is a bundled service package to provide Human Immunodeficiency Virus (HIV) Early Intervention Services in accordance with 65D-30.004, F.A.C. Allowable HIV Early Intervention Services may include one or any combination of the following activities: pretest counseling; posttest counseling; tests to confirm the presence of HIV; tests to diagnose the extent of the deficiency in the immune system; tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from HIV, including tests for hepatitis C (when provided to individuals with HIV); therapeutic measures for preventing and treating the deterioration of the immune system and conditions arising from HIV; and, linkages to diagnostic tests, therapeutic measures, and HIV specific support services.

41. 54 – Room and Board with Supervision Level IV (Eligible OCAs: MSONQ)

This Covered Service solely provides for room and board with supervision on a twenty-four hours per day, seven days per week basis. It corresponds to Respite Services as defined in F.A.C. 65E-14.021.

E. Project Codes

1. A2 – FIT Team (Eligible OCAs: MSONQ)

Bundled rate expenditures for Family Intensive Treatment teams. Allowable covered services within the bundled rate must be reported in FASAMS as the actual covered service (i.e., case management, medical services, etc.)

2. A3 – Central Receiving System (Eligible OCAs: MSONQ)

Bundled rate expenditures for Central Receiving System grants. Allowable covered services within the bundled rate must be reported in FASAMS as the actual covered service (i.e., case management, medical services, etc.)

3. A4 – Care Coordination (Eligible OCAs: MSONQ)

Bundled rate expenditures for Care Coordination. Allowable covered services within the bundled rate must be reported in FASAMS as the actual covered service (i.e., case management, incidentals, etc.

4. A8 – Local Diversion Forensic Project (Eligible OCAs: MSONQ)

Bundled rate expenditures for Outpatient Forensic Mental Health Services as described in Guidance 6 of the ME contract. Allowable covered services within the bundled rate must be reported in FASAMS as the actual covered service (i.e., case management, medical services, etc.)

5. B1 – Network Evaluation and Development (Eligible OCAs: MSOCR, MSONQ)

Allowable expenditures of network service provider funding necessary to evaluate, develop, or expand the capacity of the regional network of care. This includes fidelity monitoring, independent quality assessment, workforce development, training, and related initiatives

6. B3 – Cost Reimbursement (Eligible OCAs: MSOCR, MSONQ)

Expenditures paid on an actual cost reimbursement method of payment, as defined in rule 65E-14.019, F.A.C., for necessary staffing, supplies and related expenditures to establish operational start-up capacity for new programs or services. Allowable costs are limited to those expenditures directly related to new services; to service contracts when required by statute, grant or funding source; or to specific fixed capital outlay projects appropriated by the legislature.

7. B7 - Wraparound (Eligible OCAs: MSONQ)

Bundled rate expenditures for Wraparound. This project code should only be used when implementing the evidence-based Wraparound approach to care management, as defined by the National Wraparound Initiative (https://nwi.pdx.edu/). Expenditures for Wraparound may be billed as case management, CCST, or a bundled rate to include allowable covered services of assessment, case management, recovery support, CCST, medical, incidentals, and in-home/on-site.

8. C0 – Other Bundled Projects (Eligible OCAs: MSOCR, MSONQ)

Bundled rate expenditures for local community behavioral health initiatives not otherwise reportable under other project codes.

9. C1 – Sustainability Payment for Emergency Response (Eligible OCAs: MSONQ)

Lump sum payments to support provider sustainability during declared public emergencies. This code may only be used once per OCA per Provider each month to report the difference between the Total YTD ME General Ledger payments to the provider and the Total YTD Actual Payable reported for all other Covered Service and Project Codes for that OCA.

Southeast Florida Behavioral Health Network

Certification Regarding Eligibility to Contract

A. The Managing Entity shall not subcontract for Behavioral Health Services with any person or entity which:

1. Is barred, suspended, or otherwise prohibited from doing business with any government entity, or has been barred, suspended, or otherwise prohibited from doing business with any government entity in accordance with s. 287.133, F.S.;

2. Is under investigation or indictment for criminal conduct, or has been convicted of any crime which would adversely reflect on its ability to provide services, or which adversely reflects its ability to properly handle public funds;

3. Has had a contract terminated by the Department for failure to satisfactorily perform or for cause;

4. Has failed to implement a corrective action plan approved by the Department or any other governmental entity, after having received due notice; or

5. Is ineligible for contracting pursuant to the standards in s. 215.473(2), F.S.

B. Regardless of the amount of the subcontract, the Managing Entity shall immediately terminate the subcontract for cause, if at any time during the lifetime of the subcontract, the Provider is:

1. Found to have submitted a false certification under s. 287.135, F.S., or

2. Is placed on the Scrutinized Companies with Activities in Sudan List or

3. Is placed on the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, or

4. Is placed on the Scrutinized Companies that Boycott Israel List or is engaged in a boycott of Israel.

C. The undersigned certifies their agency is qualified and eligible to enter into or maintain a contract with the Managing Entity and none of the criteria listed for disqualification or termination have been met:

Signature	**Date**
Name of Authorized Individual	AGR75 **Application or Contract Number**

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Contracts/Subcontracts

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987 Federal Register (52 Fed. Reg., pages 20360 - 20369).

A. Instructions

1. Each provider whose contract/subcontract equals or exceeds $25,000 in federal moneys must sign this certification prior to execution of each contract/subcontract. Additionally, providers who audit federal programs must also sign, regardless of the contract amount. The Southeast Florida Behavioral Health Network ("ME") cannot contract with these types of providers if they are debarred or suspended by the federal government.

2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.

3. The provider shall provide immediate written notice to the ME at any time the provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the ME's assigned Compliance Administrator for assistance in obtaining a copy of those regulations.

5. The provider agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.

6. The provider further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal moneys, to submit a signed copy of this certification.

7. The ME may rely upon a certification of a provider that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.

8. This signed certification must be kept in the ME contract file. Subcontractor's certification must be kept at the provider's business location.

B. Certification

1. The prospective provider certifies, by signing this certification, that neither he nor his principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

2. Where the prospective provider is unable to certify to any of the statements in this certification, such prospective provider shall attach an explanation to this certification.

Signature	**Date**
Indian River County Board of County Commissioners	
Company	**Title**

Certification Regarding Lobbying for Contracts, Grants, Loans, and Cooperative Agreements

A. The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure Form to Report Lobbying,” in accordance with its instructions.

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

INTENTIONALLY LEFT BLANK

B. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Signature	**Date**
Name of Authorized Individual	AGR75 **Application or Contract Number**
Indian River County Board of County Commissioners **Name of Organization**	
Address of Organization	

Internal Statement of Funding Request

Agency:	**Indian River County Board of County Commissioners**
Negotiation Date:	**Ongoing through 3/8/24**
Fiscal Year:	**23/24**

General Information	
TAX ID / FEIN	
NPI Number	N/A
County Administrator	
Proposed Agreement Number	AGR75
Proposed Agreement Length	July 1, 2023 - June 30, 2024
Proposed Agreement Term	1 Year

SEFBHN Attendees	Provider Attendees
Becky Walker, Chief Operating Officer	
Amanda Busbin, Director of Program Innovation	

Financial Section

CIRCUIT 19			
OCA	**Description**	**FY 23/24 Original Allocation**	**Note**
MSOCR	ME Opioid TF Coord Opioid Recovery Care	$ 825,000.00	
MSONQ	ME Opioid TF Non-Qualified Counties	$ 1,016,140.00	
Total C19 FY 23/24 Mental Health		**$ 1,841,140.00**	

Rates and Funding Limitations

Circuit 19						
Program	**# - Covered Service**	**Eligible OCAs**	**Payment Methodology**	**Unit of Measure**	**FY 23/24 Rate**	**Note**
MH	B3 - Cost Reimbursement	MSOCR, MSONQ	Cost Reimbursement	Cumulative	$ 1.00	

Internal Statement of Funding Request

Agency:	**Indian River County Board of County Commissioners**
Negotiation Date:	**Ongoing through 3/8/24**
Fiscal Year:	**23/24**

Service Capacity

Circuit 19					
Program	**# / Covered Service**	**# Licensed Beds**	**# Purchased Beds**	**# of FTEs Providing Service**	**# of FTEs Applied to SEFBHN**
MH	B3 - Cost Reimbursement	N/A	N/A	Subcontracted Services.	

Provider Name: Indian River County Board of County Commissioners	
Signature of Agreement	
Printed Name of Signer	
Title of Signer	
Date Signed	

Managing Entity: Southeast Florida Behavioral Health Network, Inc.	
Signature of Agreement	
Printed Name of Signer	Ann Berner
Title of Signer	Chief Executive Officer
Date Signed	