APPENDIX C – COVER PAGE FOR GRANT APPLICATION

Criminal Justice, Mental Health and Substance Abuse Reinvestment Grant

PROPOSAL INFORMATION	
Type of Grant:	Planning Grant ☐ Implementation and Expansion Grant ☒
Project Title:	Alte r atives to Incarceration Pasco - Jail Reent r (ATIP-JR)
County(ies):	Pasco
Preferred Project Start Date:	July 1, 2021

APPLICANT INFORMATION	
	DGrants Ñ . &
Street Address	PO Box 428
e and Zip Code:	New Por Richey, FL 34653
Email:	deborah.antioco@baycare.org
Phone:	727-
	315-8663

ADDITIONAL CONTACT

Paricipating Organization Name:	BayCare Behavioral Health
Contact Name & Title:	Tracey Kaly, Director, Ambulatory Clinical Operations
Street Address	PO Box 428
City, State and Zip Code:	New Por Richey, FL 34653
Email:	tracey.kaly@baycare.org
Phone:	727-315-887

FUNDING REQUEST AND MATCHING FUNDS

	Total Amount of Grant Funds Requested	Total Matching
Program Year 1	$400,000	
Program Year 2	$400,000	
Program Year 3	$400,000	
Total Project Cost	$1,200,000	

CERTIFYING OFFICIAL

Cerifing Oficial's Name (printed):

Title: Vice-President, Behavioral Healt Se rices

Date: b - - 2

☐ 37918 Meridian Avenue, Dade City, Florida 33525
(352) 521-4111 – FAX (352) 521-4105

District 1 - Ron Oakley

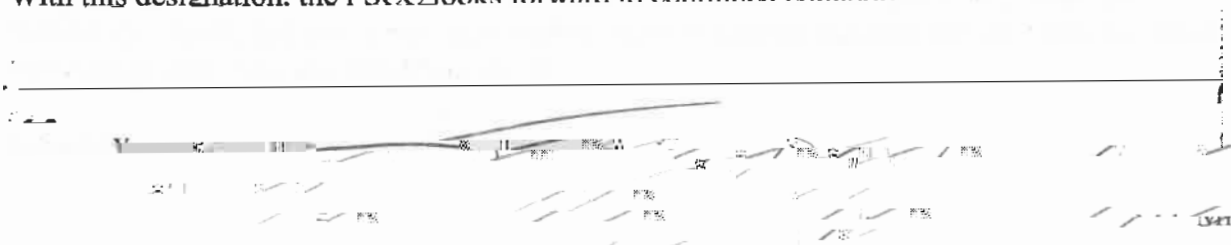
District 3 - Kathryn Starkey
District 4 - Mike Wells
District 5 - Jack Mariano

January 22, 2021

Gail Ryder
BayCare Behavioral Health

Clearwater, FL 33759

With this designation, the PSCC looks forward to continued collaboration with BayCare



e Moore, Chair
Public Safety Coordinating Council

3.7.2 Tab 2: Table of Contents

Tab	Section	Content	Page(s)
Tab 1	3.7.1	Cover Page	1
		Certified Designation Letter	
Tab 2	3.7.2	Table of Contents	
Tab 3	3.7		

3.7.3 Tab 3: Statement of Mandatory Assurances

3.7.4 Tab 4: Match Commitment and Summary Forms

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3.7.5 Tab 5: Statement of the Problem
3.7.5.1 Include a detailed description of the problem the project will address. The application should document the extent of the problem using local or state data

Center whose complex behavioral and rehabilitative needs are not well met through the current approach to care. As a result, these inmates often bounce from crisis to detox centers to residential programs to emergency departments to hospitals to jail, have multiple arrests, face possible institutionalization, or drop out of community-based treatment with no change in functioning; all costly, chaotic, and ineffective ways to provide care and improve outcomes. As these costs continue to consume an increasingly larger proportion of budgets; payers, health care providers, law enforcement, justice systems, and policymakers are looking towards “high utilizer” programs with a greater sense of urgency.

The project being proposed has developed a high-level understanding of the characteristics of the target population to create a high-utilizer definition and unique characteristics as well as identify specific criterion for enrollment. The target population of high utilizers will include inmates meeting clinical diagnostic criteria for severe mental illness and:

1. A minimum of one (1) arrest or violation of probation and two (2) Involuntary Examinations/Baker Act/Crisis Stabilization admits within a 12-month period; or
2. Discharged or awaiting placement at a State Mental Health Treatment Facility (STMHTF).

Priority as a Community Concern

Pasco County stakeholders have continuously supported the development and implementation of local multi-system responses that prevent or reduce the involvement of individuals with behavioral health disorders in the justice system. As evolving challenges have surfaced in multiple areas, these stakeholders have designed and deployed strategies and interventions at multiple Sequential Intercept Mapping Levels. However, an ongoing need for Pasco County is addressing incarcerated individuals with severe mental illness and their re-entry into the community, specifically at Intercept 3 (Jail) and Intercept 4 (Re-Entry).

The two critical priorities as a community concern for this target population are:

1. In jail comprehensive approach to screening, assessment, diagnostic formulation, treatment planning and intervention to identify clinical, supportive and risk needs of individuals with severe mental illness.
2. Continuity of care transitioning from jail to community through the implementation of re-entry strategies that focus on rapid accessibility, sharing of information, warm handoffs, adherence to treatment recommendations and follow along care coordination.

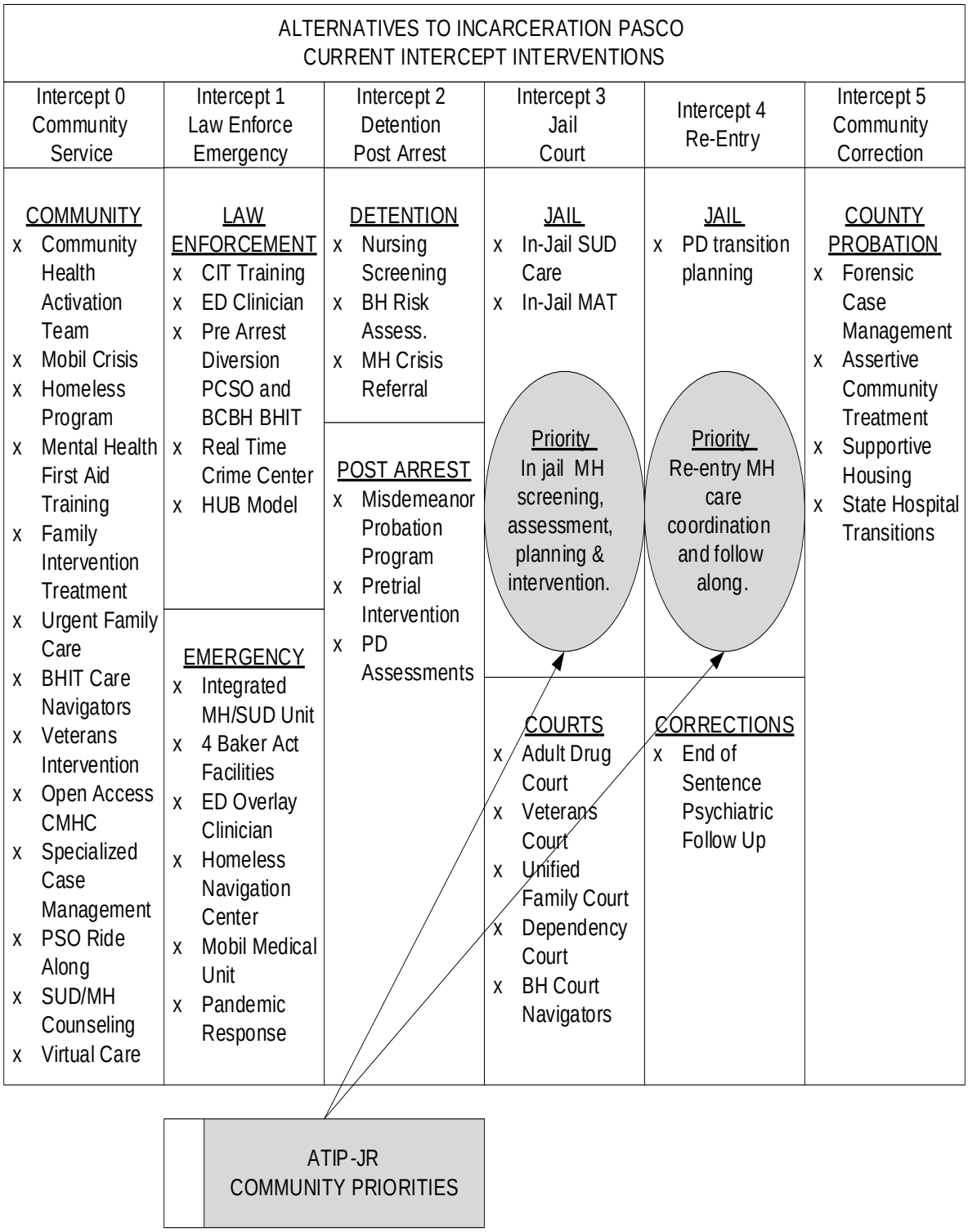
The proposed project would provide in jail services of Comprehensive Screening, Assessment , Diagnostic Formulation, Treatment Planning, and Intervention (Intercept 3) and Re-Entry Care Coordination (Intercept 4) by bringing together the local Managing Entity, Pasco County Sheriff, Pasco Central Detention Center, the Correctional Health Care Provider, the Circuit Court, Public Defender, and a Community Behavioral Health Center.

Project partners include:

1. Sixth Judicial Circuit Court and Public Defenders Office
2. Wellpath
3. Central Florida Behavioral Health Network
4. Pasco Sheriff Office
5. Pasco County Detention Center
6. BayCare Behavioral Health, Inc.

This project entitled, Alternatives to Incarceration Pasco - Jail Reentry (ATIP-JR), would provide in jail services under the umbrella of the Alternatives to Incarceration Pasco (ATIP) current model at Intercept 3 (In-Jail) and Intercept 4 (Re-Entry).

Table 1


ALTERNATIVES TO INCARCERATION PASCO
CURRENT INTERCEPT INTERVENTIONS
Intercept 0 Community Service
Intercept 1 Law Enforce Emergency
Intercept 2 Detention Post Arrest
Intercept 3 Jail Court
Intercept 4 Re-Entry
Intercept 5 Community Correction
COMMUNITY
x Community Health Activation Team
x Mobil Crisis
x Homeless Program
x Mental Health First Aid Training
x Family Intervention Treatment
x Urgent Family Care
x BHIT Care Navigators
x Veterans Intervention
x Open Access CMHC
x Specialized Case Management
x PSO Ride Along
x SUD/MH Counseling
x Virtual Care
LAW ENFORCEMENT
x CIT Training
x ED Clinician
x Pre Arrest Diversion PCSO and BCBH BHIT
x Real Time Crime Center
x HUB Model
EMERGENCY
x Integrated MH/SUD Unit
x 4 Baker Act Facilities
x ED Overlay Clinician
x Homeless Navigation Center
x Mobil Medical Unit
x Pandemic Response
DETENTION
x Nursing Screening
x BH Risk Assess.
x MH Crisis Referral
POST ARREST
x Misdemeanor Probation Program
x Pretrial Intervention
x PD Assessments
JAIL
x In-Jail SUD Care
x In-Jail MAT
Priority
In jail MH screening, assessment, planning & intervention.
COURTS
x Adult Drug Court
x Veterans Court
x Unified Family Court
x Dependency Court
x BH Court Navigators
JAIL
x PD transition planning
Priority
Re-entry MH care coordination and follow along.
CORRECTIONS
x End of Sentence Psychiatric Follow Up
COUNTY PROBATION
x Forensic Case Management
x Assertive Community Treatment
x Supportive Housing
x State Hospital Transitions
ATIP-JR
COMMUNITY PRIORITIES

3.7.5.2 The applicant must provide an analysis of the current population of the jail in the county .
Data was obtained from the Pasco Sheriff's Office Report Management System (RMS), Jail Management System (JMS) and Wellpath in relation to arrests and mental health for calendar year 2020. During this twelve-month time frame, the Pasco Countya w

The high-utilizer data sets used for identification of the target population criteria takes a structured and collaborative approach to data collection and data sharing with stakeholders. Data analytics are critical for identification, ongoing measurement, and evolution. The main objective is to provide data driven real time response based on an

1. A minimum of one (1) arrest or violation of probation and two (2) Involuntary Examinations/Baker Act/Crisis Stabilization admits within a 12-month period; or
2. Discharged or awaiting placement at a State Mental Health Treatment Facility (STMHTF).

As the jail population of consumers with mental health needs increases within Pasco County the needs of these individuals are not currently being met for:

1. In-jail comprehensive approach to screening, assessment, diagnostic formulation and treatment planning to identify clinical, supportive and risk needs of individuals with severe mental illness.
2. Continuity of care transitioning from jail to community through the implementation of re-entry strategies that focus on rapid accessibility, sharing of information, warm handoffs, adherence to treatment recommendations and follow along care coordination.

The addition of these ATIP-JR interventions at Intercept 3 (Jail) and Intercept 4 (Re-entry) under the ATIP model, would align with the CJMHSA Strategic Plan for Pasco County by focusing on activities related to the following Plan objectives:

Objective 1.2 Provide an information system to track persons who consent to treatment during their involvement with the program(s) and for at least one year after discharge, including but not limited to, arrest, receipt of benefits, employment and stable housing.

Objective 1.3 Implement strategies that support the Strategic Plan for diverting the target population from the criminal justice system.

Objective 3.1Abs (Ob)TjMCID 0 12 72 349.

3.7.6 Tab 6: Project Design and Implementation

3.7.6.1 The application must include a description of the planning council or committee, including:

3.7.6.1.1 A description of the composition of the planning council or committee,

Pending proposal award, the Steering Committee would be reconvened. Steering Committee membership by agency and title is outlined in Table 4.

Table 4

Steering Committee

2018 - 2020 Activities

- Finalized CIT class schedule.

- Reviewed plan for co-locating Care Navigators at county jail for reentry planning for inmates with addictions issues.
- Utilized PSO data sets for overdoses fatal and non-fatal.
- Designed Mental Health Unit proposal for Pasco Sheriff Office.
- Partnered with Pasco Sheriff Office to implement Behavioral Health Intervention Team (BHIT) to focus on community diversion 2019.
- Collaborated with DOH to secure $278,400 in funding to combat opioid epidemic.
- Received $40,000 in grant funding from Seminole County Florida to combat opioid epidemic.
- Secured funding to provide LEOs with Narcan Nasal Spray.
- Collaborated with DCF to provide Narcan Nasal Spray to those impacted by opioid overdoses.
- Committee members to Salt Lake City, Utah to gather information on co-response team, co-location between Behavioral Health and Law Enforcement and information sharing MOUs.

ponder unit, collaboration between Behavioral Health and Law Enforcement

courts, and the judiciary. Mark Engelhardt, Karen Mann, and Katelind Halldorsson from the University of South Florida (USF) Criminal Justice, Mental Health, and Substance Abuse Technical Assistance Center (CJMHSA TAC) facilitated the mapping. During the mapping, the facilitators guided participants to identify resources, gaps in services, and opportunities at each of the five distinct intercept points of the criminal justice system. Additionally, there was discussion regarding Intercept “0” or early intervention services, which addresses prevention and the civil, voluntary, and involuntary Baker Act and Marchman Act systems.

The SIM results provided the core for the Pasco County strategic plan to address adults with behavioral health disorders involved in the criminal justice system. Since that time, the SIM and the strategic plan have been used to assess resources, gaps, opportunities for diversion and alternative justice/behavioral health interventions]TJ 0 oc0.00207 (t)2 pded h iilunta

- Diversion program entitled Behavioral Health Intervention Team
- Diversion model for Addiction Screening & Intervention
-

Table 5

CJMHSA Pasco County Strategic Plan
Goal: Pasco County and key stakeholders will collaborate to develop, implement and sustain services

1.3.2	Identify available funding to dedicate a behavioral health professional to engage ILP identified individuals in services.

1.3.14	Divert 90% of State Hospital Referrals into community-based care over 3 Yrs.	BayCare Court System CFBHN	Pending

	identified, screened, assessed and engaged.		BayCare		
2.3.4	Establish process flow: BCBH obtains Universal Release of Information. Provides information of engaged enrollees to PSO to note in RMS/JMS systems to be viewed in real time by responding officers and dedicated program data analyst.		Sheriff's Office BayCare CFBHN	Within 60 days of award	
2.3.5	Quarterly pulls from RMS, CFBHN and BCBH on participants enrolled in ATIP-JR to track arrest and data sets for acute stabilization.	Quarterly Report	Sheriff Office CFBHN BayCare	Within 90 days of award	
2.3.6	Identify best practices for Data and Information Sharing across Justice systems of care.	Meeting Minutes	BayCare Sheriff's Office CFBHN	11/18	10/18
2.3.7	Implement Hub Model strategies as best				

Objective 4.0: Address Recovery Oriented Needs				
Task	Performance Measure	Lead Organization	Projected Complete Date	Complete Date
4.1	Adapt service capacity and models to ta5.4 (i)-1.1 (ql)2.2 (ul)2.2 (e6 425.12or)1.4 (eco)-17.5 (v imp7.64 6.9or2 672.96 01.1 (anc)-8.9e6 425.12oof u6 01.1 (i)-9 (l)3.2 (i)3.1 (z)-8.9ation of			

behavioral health strategies but also improving stakeholder functioning, shared communication, transparency, shared decision making, and shared outcomes.

To that end, the CJMHSA Steering Committee has adopted a few of the principles of the Canadian Hub Model which is based upon the Scotland collaborative and community centric

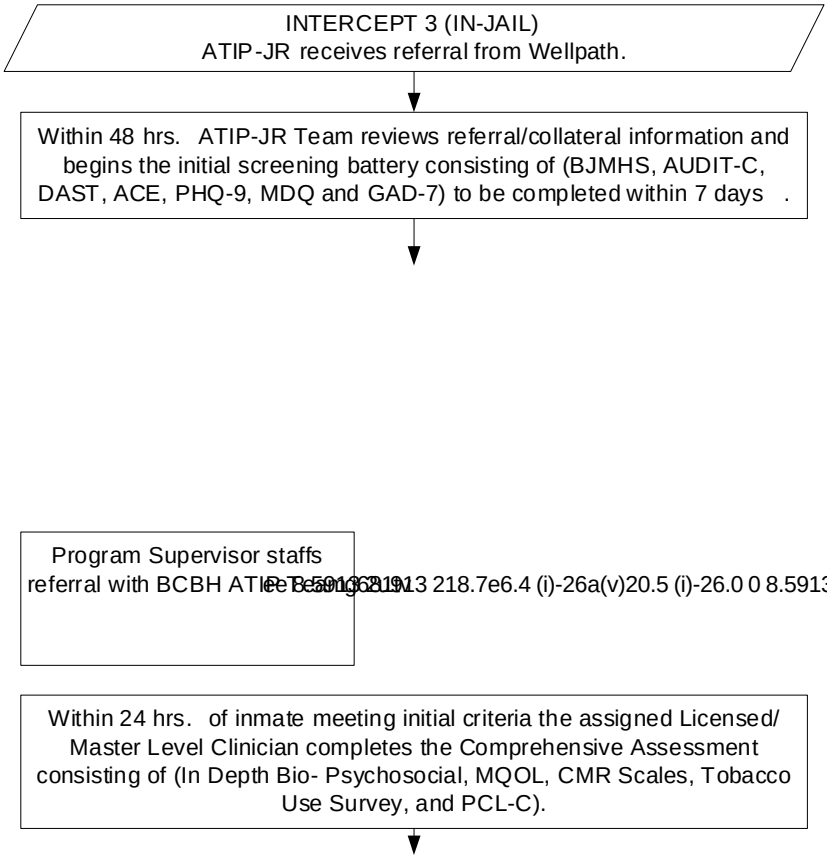
screening tool an immediate referral is made to ATIP-JR a

to address the needs. Areas of review include:

- Food/Clothing, Health and Medical Needs, Primary Health Care Benefits, Housing, Income Support/Benefits, Mental Health Services, Psychotropic Medication, Substance Use Services, Transportation

The Care Navigator and Peer Specialist will work with the community based ATIP Teams to eliminate any gaps in access to services between time of release and date of first outpatient (post release) behavioral health appointment. The Care Navigator and Peer Specialist will maintain contact with the inmate throughout the stay in-jail to continue to assess any changes in need, encourage engagement in services while incarcerated, and be the main point of contact post-release. ATIP has a comprehensive resource bank including agency names and points of contact for community resources including a minimum of temporary and permanent housing, shelters, medical and behavioral health services, transportation, SSI/SSDI, recovery and additional peer supports. The Team will anticipate that the periods following release (the first hours, days, and weeks) are critical and identify appropriate interventions as part of transition planning practices for individuals leaving the Detention Center. All ATIP team members engage in activities that facilitate continuity of care through the implementation of direct linkages and warm hand-offs. Incidental support funds for participants have been budgeted for utilization.

ATIP-JR team members will be trained in the SOAR process to expedite and increase access to SSI/SSDI benefits when appropriate. SOAR is a national program designed to increase access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder. Communities across the country are increasingly working to


INTERCEPT 3 (IN-JAIL)
ATIP-JR receives referral from Wellpath.
Within 48 hrs. ATIP-JR Team reviews referral/collateral information and begins the initial screening battery consisting of (BJMHS, AUDIT-C, DAST, ACE, PHQ-9, MDQ and GAD-7) to be completed within 7 days .
Program Supervisor staffs referral with BCBH ATIP Team
Within 24 hrs. of inmate meeting initial criteria the assigned Licensed/ Master Level Clinician completes the Comprehensive Assessment consisting of (In Depth Bio- Psychosocial, MQOL, CMR Scales, Tobacco Use Survey, and PCL-C).

Peer Specialist will complete the evidenced-based GAINS Re-Entry Checklist and Transition Plan identifying appropriate levels of engagement, services and treatment, available community resources, locations, and providers. Identified needs, recommendations and contact information will be documented on the individualized transition plan and a copy of the plan will be kept in the electronic health record. The Care Navigator or Peer Specialist will directly link the individual to the community-based outpatient ATIP Team Care Navigator. To best service the target population, ATIP-JR team members will be trained in:

- Co-Occurring Complex Disorders
- Trauma Informed Care
- APIC Model: which provides guidance to assist jurisdictions in this task. The acronym APIC stands for Assess, Plan, Identify, and Coordinate.
- GAINS Re-entry Checklist and Transition Plan

3.7.6.3.3.9 Linkages to community -based, evidence -based treatment programs for the served Target Population .

and

3.7.6.3.3.10 Community services and programs designed to prevent high -risk populations from becoming involved in the criminal justice system.

All ATIP team members have a comprehensive resource bank including agency name and point of contact for community resources including a minimum of temporary and permanent housing, shelters, medical and behavioral health services transportation, SSI/SSDI, recovery and peer supports. The Care Navigator and Peer Specialist will anticipate that the periods following release (the first hours and) are critical and identify appropriate interventions as part of transition planning practices for individuals with severe mental illness leaving the Detention Center.

When the release date of the inmate is known to ATIP-JR, they will te isp(t)2.1ase intTw 3.4526.96ntic

ATIP will monitor participants for 12 months following program enrollment. The following programs are a few of the best practice treatment levels within the Pasco continuum of care offered by BayCare that have been identified for rapid access and placement of the target population.

- x ATIP - Community Based (ATIP -CB)
  Behavioral Health Intervention Team (BHIT): Community based high quality and convenient behavioral health recovery services for justice involved clients focused on linkage to service needs through care coordination, brief intervention, system navigation and follow along services. Focus on populations with issues needing complex navigation, timely access, and diversion from high-cost services.
- x Family Intensive Treatment Team (FIT): Designed to provide an intensive team-based, family-focused, comprehensive service continuum to families in the child welfare system deemed "unsafe", specifically for parents with substance abuse/co-occurring issues. Program targeted to selected communities with high rates of child abuse cases.
- x Urgent Family Care (UFC): Moderate term, solution based, family systems in-home clinical team that offers child welfare families.
- x Forensic and Adult Case Management: Partnership program designed to intercept individuals in need of behavioral healthcare at the point of discharge from jail.
- x Project for Assistance in Transition from Homelessness (PATH): Case management and navigation for people with serious mental illness or with and a co-occurring substance use disorder, who are experiencing homelessness or at imminent risk of becoming homeless with high priority on Veterans.
- x Veteran Treatment Court (VTC): Veterans with a substance use disorder that were arrested and charged with non-violent third degree felony crimes related to their substance use. Work with Veterans Court to screen, assess and treat veterans in need.
- x Veteran Resource Center (VRC): Navigation and linkage to care for veterans and their families. Outreach, outpatient and residential services provided through the Center.
- x Treatment Alternatives to Needy Families (TANF): TAd l seats s]TJ-6 (at)7 e Tc -0.002 Tw 1

and support services that persons with severe mental illnesses need to successfully live in the community.

- x Outpatient Mental Health and Addiction Counseling: rapid access to care through Open Access program and linkage to group, individual and family counseling.
- x Enhanced Outpatient Substance Abuse Counseling: A level of care between residential and traditional outpatient for individuals in need of a more intense service level including development of a personal support network and re-establishment of healthy roles involving, work, education, relationships and quality of life.
- x Medication Assisted Treatment Opioid Program: P

social security or other benefits for which they may be eligible but were not receiving at their program start date with obtaining benefits through ATIP-JR.		on each individual served and stored in the separate qualitative and quantitative excel database maintained by ATIP-JR as mentioned in response to 3.7.6.4.1.
Percent diverted from a State Mental Health Treatment Facility.	90%	

3.7.6.4.3 At least one additional proposed performance measure unique to the tasks outlined in the application, including proposed targets and methodologies.

Table 7

Performance Measures	Target	Methodology
Percent who have completed a Comprehensive Assessment battery within 14 days of acceptance into program.	90%	Data sets will be collected on each individual served and stored in the separate qualitative and quantitative excel database maintained by ATIP-JR as mentioned in response to 3.7.6.4.1.
Percent who successfully re-enter and are enrolled in ambulatory Justice Integration services post release from incarceration.	75%	

3.7.6.5 Capability and Experience. The applicant must include a description of the Agency ’s capability and experience in providing similar services, including:

3.7.6.5.1 Capability and experience of the applicant and other participating organizations, including law enforcement agencies, to meet the objectives detailed in this RFA .

BayCare Behavioral Health (BCBH) - Applicant
As the behavioral health service line for BayCare Health System (BHS), BCBH is one of the largest and most comprehensive mental health and substance abuse treatment centers in Florida. BCBH is a tobacco-free workplace and promotes abstinence from all tobacco products. Service options include a full continuum of outpatient, residential, intervention, prevention, employee/student assistance programs, recovery programs,

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Pasco Sherriff Office

education and training, advocacy, research and development, and knowledge sharing of best-practices.

3.7.6.5.2 Availability of resources for the proposed project .
All resources and operational needs are in place to start In Jail programming according to RFA timelines.

3.7.6.5.3 Anticipated role of advocates, peer specialists, family members, and responsible partners .
The addition of ATIP-JR to the ATIP model will afford the opportunity to continue examining the way Pasco County collaborates to design a recovery-oriented system of care that delivers the right care, at the right place, and at the right time. Involving advocates, family members, consumers and stakeholders in the evaluation, planning, designing and delivery is integral to being more responsive to the targeted populations needs and will ensure a smooth transition for them across the continuum. The project will continue to promote a collaborative, integrated and effective engagement practice for all participatory levels within the context of wider engagement with Local and State Government. The framework and roles for this shared approach is established with all partners/stakeholders and the expected core competencies that align with the concepts of a recovery-oriented approach that includes:

Table 8

Core Competencies for Stakeholder Roles	
Steering Committee	Recovery Oriented System of Care
Collaboration/Communication/Peer Supports	Person/Family Centered Holistic Approach
Cross Training	Evidenced Based Promising Practices
Shared Accountability	Trauma Informed
Flexible Business Model	Rapid Access and Engagement
Flexible Payer Strategies	Innovative Model
Continuous Quality Improvement	Based on Diversity and Respect
Coordination at all Levels	Comprehensive Screening/Assessment
Data Driven Decisions	Comprehensive and Integrated Services
Vertical and Horizontal Buy In	Sustainable
Shared Data	Flexible Funding
Measure Community Impact	Integrated System of Care

3.7.6.5.4 Proposed staff, including Project Director, key personnel, and subcontractors who will participate in the project, showing the role of each and their level of effort and qualifications. Briefly discuss the responsibilities of each participating organization and how the Applicant proposes to fill staff positions and select subcontractors.

Table 9

Staff	FTE	Qualifications
Project Director (In Kind)	.50	3 yrs. management experience with justice integration and high-risk individuals, persons with co-occurring issues, substance use and domestic violence. Leadership experience with project management launch, analytics, and community-based care and development of innovative program design. Florida licensure.
Project Supervisor	1.0	5 yrs. management experience working with justice integration and high-risk individuals, including forensic 916 persons, homeless population, individuals with co-occurring issues. Leadership experience with case management, recovery-oriented systems, community-based care and local service system. Florida licensure.
Quality Manager (In Kind)	.25	Experience with program monitoring, high utilizer tracking, system evaluation, data analysis, return on investment reporting, priority Pblafoordmanagercdr populations and Florida state reporting. Florida licensure.

Steering Committee

The Project Director will lead the Steering Committee and meet monthly to provide governance, oversee program deliverables, identify barriers, discuss developments and trends, strategize sustainability and expansion activities, and monitor outcomes. The Committee will report quarterly to the Public Safety Planning Council.

3.7.6.6 Evaluation and Sustainability

3.7.6.6.1 Evaluation - D escribe how the project's effectiveness will be demonstrated, including assessments of implementation outcomes. Discuss how variables like stakeholder support and service coordination will be defined and measured. Describe the process for collecting performance measurement data, and any other state or local outcome data to measure project effectiveness in promoting public safety, reduction of recidivism and access to services and support s for the Target Population(s). If using an external evaluator, identify the individual or entity conducting the evaluation.

The program evaluation and data collection will be conducted by a team of individuals including, Project Director, Project Supervisor, Data Support Specialist, Quality Manager, PSO Systems Analyst and the Managing Entity. The performance measures include the required metrics outlined in the RFA as well as additional measures noted in the response. All measures will be carefully compiled on a monthly basis and information will be disseminated at the Public Safety Coordinating Council, Steering Committee, and at Multi-Disciplinary Team Meetings to be used as a management tool to gauge impact and performance.

It will be important to review from the initial kick off meeting the outline of the project metrics to estimate and follow which steps should be taken in order to meet baselines and then capture project data during execution at planned intervals. As part of the evaluation, the project will compare and apply variance analysis and other analysis methods to establish project progression at timeline intervals. Qualitative and quantitative data sets will be collected from multiple sources. The outcome evaluation will utilize a repeated measure, longitudinal design. Baseline measures will be collected immediately after the inmate is accepted into the program. Thus, these baseline measures will be assessed before they are exposed to the

- Resource Allocations (e.g. number of binding agreements, Committee attendance, participation, sustainability efforts, etc.)

The qualitative data will be collected through interviews. This will be used to understand perceptions. This will include monitoring of:

- Participant Quality of Life Measurement and Tobacco Use
- Participant Satisfaction
- Steering Committee/Stakeholder Feedback
- Innovations and Modifications to Practice Model
- Social Determinant Factors Impacting Service Coordination (access, recidivism,

In addition, inmates admitted to the ATIP-JR in jail project would also have expenditures of:

- x $1,100 per inmate Baker Act transports x minimum of 2 psychiatric admissions ($550 x 2)

these accomplishments has been the willingness and adeptness at creating long lasting collaboration and buy-in from community stakeholders serving Pasco County.

Sustainability of the current and future state service lines of the ATIP model have and will be accomplished by:

- Maintaining and expanding the current working partnerships and binding agreements that currently exist;
- Expanding partnership selection and recruitment efforts to focus on ensuring a commitment to develop a comprehensive service array that holistically addresses needs while reinforcing key community partnerships. Selection considerations include; involvement with the population to be served, an expressed interest in participation and the ability to deliver high-quality, innovative, responsive input that addresses the needs of the targeted populations based on a set of core competencies;
- All partners prioritizing rapid access to services for a recovery-oriented system of care;
- Ongoing and collateral assessment of potential growth opportunities to assure the potential for continuing support will be a key part of the Steering Committee

neline
ide a realistic and detailed timeline for each funding year proposed, indicating goals,
, milestones, and responsible partners. The timeline must include anticipated start and
ch milestone, be nchmark, and goal .

sks uly 1, 2021	Partners Responsible	Yr. 1 Months												Yr. 2*	Yr. 3*
		1	2	3	4	5	6	7	8	9	10	11	12		

Ms. Gail Ryder, Executive Director
BayCare Behavioral Health, Inc.h</MCID 0 >>BDC -0.50Top95c 0.07 T.3 </MCID 0 >>BDC -0.004 Tc 0.0

Wellpath
1283 Murfreesboro Road
Suite 500
Nashville, TN 37217

www.wellpathcare.com

Chris Nocco, Sheriff

TEAMWORK • PROFESSIONALISM • SERVICE

Dear Mr. Ryder,

The Pasco Sheriff Office supports the grant project entitled

makes a fundamental commitment to

Sincerely,

Chris Nocco, Sheriff

727-847-5878 727-847-5878 352-518-5000 727-372-5920 813-996-69

Alliance for Substance Addiction Prevention

Powered by Alliance for Healthy Communities

727-315-8658
asap@empoweredcommunities.org
www.empoweredcommunities.org/asap
7809 Massachusetts Ave
New Port Richey, FL 34653

February 16, 2021

Ms. Gail Ryder, Executive Director
BayCare Behavioral Health, Inc.
P.O. Box 428
New Port Richey, FL 34656

Re: Department of Children and Families Criminal Justice Mental Health and Substance Abuse Reinvestment Implementation Grant, Request For Application # RFA 2021 001.

[redacted]

With this letter, ***Pasco Alliance for Substance Addiction Prevention*** supports the grant [redacted]

Pasco Alliance for Substance Addiction Prevention makes a fundamental commitment to:

- Be a participant in the Pasco County CJMHSA Reinvestment Steering Committee as part of RFA 2021 001, submitted by BayCare Behavioral Health, Inc. on behalf of [redacted]
- [redacted]

understand the commitment to the Pasco County CJMHSA Reinvestment Steering Committee will be for a thirty-six-month period and will include project review, establishing and expanding diversion programming, increasing collaboration, implementing evidence-based [redacted] necessary services and resources to the individuals with severe mental illness.

Sincerely,

Christine Parris
President, Pasco Alliance for Substance Addiction Prevention

[redacted]

2985 Drew St. (MS 1014)

[redacted]

March 5, 2021

Re: Department of Children and Families Criminal Justice Mental Health and Substance Abuse

[redacted]

Reinvestment Implementation Grant. #RFA 2021 001.