THIRD AMENDMENT

This Amendment made and entered into this _____ day of _____, 2019, by and between Pinellas County, a political subdivision of the State of Florida, hereinafter referred to as "County," and Suncoast Center, Inc., St. Petersburg, FL hereinafter referred to as "Contractor," (individually referred to as "Party", collectively "Parties").

WITNESSETH:

WHEREAS, the County and the Contractor entered into an agreement on May 10 2016, pursuant to Pinellas County Contract No. 156-0045-LI (hereinafter "Agreement") pursuant to which the Contractor agreed to provide Behavioral Health High Utilizer Pilot Program for County; and

WHEREAS, Section Twenty-One (21) of the Agreement permits modification by mutual written agreement of the parties; and

WHEREAS, the County and the Contractor now wish to modify the Agreement in order extend the term pursuant to Section (4)(B),at the same prices, terms, and conditions;

NOW THEREFORE, the Parties agree that the Agreement is amended as follows:

1. This Agreement is hereby extended to include the amended and restated statement of work set out in Exhibit A, incorporated herein, beginning May 10, 2019 and continuing to May 9, 2020, unless terminated or canceled as provided therein, at a twelve (12) month budget of $650,862.00. The Parties may extend the term of this Agreement for an additional twelve (12) month period pursuant to the same terms, conditions, and pricing set forth in this Agreement by mutually executing an amendment to the Agreement, as provided herein.

2. Except as changed or modified herein, all provisions and conditions of the original Agreement and any amendments thereto shall remain in full force and effect.

Each Party to this Amendment represents and warrants that: (i) it has the full right and authority and has obtained all necessary approvals to enter into this Amendment; (ii) each person executing this Amendment on behalf of the Party is authorized to do so; (iii) this Amendment constitutes a valid and legally binding obligation of the Party, enforceable in accordance with its terms.

IN WITNESS WHEREOF the Parties herein have executed this Third Amendment as of the day and year first written above.

PINELLAS COUNTY, FLORIDA
by and through its
Board of County Commissioners

Chairman

ATTEST:
KEN BURKE

Deputy Clerk

CONTRACTOR: SUNCOAST CENTER, INC.

Barbara Daire
Authorized Signature

Barbara Daire
Printed Authorized Signature

CEO
Title Authorized Signature

APPROVED AS TO FORM

By: _____
Office of the County Attorney

EXHIBIT A

STATEMENT OF WORK

SUNCOAST CENTER, INC.
BEHAVIORAL HEALTH HIGH UTILIZER PILOT PROGRAM

Contractor will continue to lead the implementation of a Behavioral Health High Utilizer Pilot Program (Pilot), including planning, coordination, and provision of housing and other behavioral health and social services, for individuals who are most frequently admitted to the public Baker Act facility and frequent users of the Pinellas County jail and local health care providers.

Target Population:
The target population for the Behavioral Health High Utilizer Pilot (Pilot) program is a pre-identified subset of individuals who are frequent users of the County's public Baker Act facility and the County jail. These individuals are frequently homeless, often have co-occurring behavioral health and medical conditions, and are frequently involved with the criminal justice system. COUNTY may request adjustments to the target population, as necessary, to address community needs. Adjustments to the target population will require written authorization by Pinellas County Human Services.

Services to be Performed
Contractor will coordinate and provide all required services in accordance with the model developed by the Work Group including:

A. The Contractor will continue Pilot Team activities and manage the project to achieve documented objectives and outcomes.

i. Maintain a dedicated team of professionals to staff the Pilot comprised of a psychiatrist, case managers, a law enforcement representative, a nurse case manager, and a therapist (Pilot Team) to continue Pilot activities and management to achieve objectives and outcomes.

Deliverable: Report on names and qualifications of Pilot Team and associated staff upon hire/assignment. Any change to Pilot Team structure shall be submitted to COUNTY for written authorization

ii. Conduct individualized service planning with the client and identified service providers, monitor progress and outcomes of clients, and adjust housing and service plans, as necessary.

Deliverable: Report on project and client progress as detailed in Outcomes and Evaluation section below.

iii. Assess each client's needs and goals through the use of the Level of Care Utilization System (LOCUS) standard assessment or other bio-psychosocial assessment instrument acceptable to COUNTY.

Deliverable: Reporting on assessments performed.

iv. Procure and deliver identified services to clients that are necessary to achieve the client's service plan goals.

Deliverable: Report on services engaged by client noting successful connection to services.

v. Re-engage clients who exit the Pilot or who fail to complete, or deviate from, housing and service plans.

Deliverable: Report on client status in program and efforts for re-engagement.

vi. Coordinate client engagement in the Pinellas County Health Program (PCHP) for all eligible clients participating in the Pilot.

Deliverable: Report on number of individuals currently enrolled in PCHP and/or connected by Pilot Team.

vii. Respond to client crises 24 hours/day, 7 days/week.

Deliverable: Provide staff schedule and after hour engagement as requested by COUNTY.

viii. Coordinate with service providers to ensure continuity and avoid duplication of effort.

Deliverable: Report on coordination efforts.

ix. Manage Pilot client data and ensure proper tracking of services, service connections, and client outcomes.

Deliverable: Report on data system and ongoing information management across providers.

x. Develop criteria that determine when a project participant is deemed ready to transition to sustainable community resources and services.

Deliverable: Discuss criteria at monthly meeting and submit transition criteria to COUNTY.

B. Identify an additional high utilizers to participate in the project within three (3) months of the Agreement start date.

i. Add new clients and provide intensive interventions to support a transition to recovery;

Deliverable: Report on new client engagement and progress.

ii. Develop a new client participation strategy that acknowledges shorter treatment timeframe of nine (9) months, but still provides critical supportive services and promotes future client stability;

Deliverable: Report on and document participation strategy.

C. The Contractor will implement their strategy that leverages community partnerships, promotes cost-saving measures, and is based on principles of long-term project sustainability. Implement long-term care strategy for the high utilizer population that is focused on maintaining client stability as well as leveraging existing community resources to provide client services, when possible. This should include, but is not limited to:

i. Identify activities/services for this population to utilize as they transition to sustainable community resources and treatment services (i.e. counseling groups, housing support, health services, substance abuse services, disability advocates, SOAR, and or vocational programs).

Deliverable: Report on activities/services utilized.

ii. Leverage partnerships with community agencies to secure housing and wraparound services for clients.

Deliverable: Report on agencies used and housing/services utilized by clients.

iii. Collaborate with community agencies to reduce barriers that may prohibit this population from accessing these services and agencies.

Deliverable: Report on barriers faced.

iv. Identify the current and potential future gaps that may prevent this population from achieving long-term stability.

Deliverable: Report on current and future gaps in care.

v. Document evidence of collaboration with community partners that demonstrates the service needs of the target population have been met. Facilitate agreements, memorandums of understandings, public-private partnerships, and subcontracts with additional providers to meet client needs.

Deliverable: Report on collaborations and provide COUNTY copies of all Piot related agreements, memoranda, partnerships, and subcontracts.

vi. Document leveraged community partnerships which achieve project cost savings (e.g. second year spending compared to savings from new partnerships). Include opportunities to maximize additional community resources that could be used to supplement and sustain Pilot activities (i.e. identify connections to rapid rehousing opportunities; food banks; etc.).

Deliverable: Provide a report highlighting these cost savings.

vii. Facilitate the coordination of cross-system communication and data sharing with local providers and entities by holding monthly system coordination meetings and establishing necessary data sharing agreements.

Deliverable: Report on meetings held and copies of data sharing agreements.

viii. Participate in program evaluation to aid in informing future system activities.

Deliverable: Participation in evaluation meetings by phone and/or in person.

ix. Address the top five (5) system issues impeding the reduction in number of system high utilizers.

Deliverable: Report on top five (5) system issues monthly.

x. Explore and implement coordinated system-wide release forms to aid in service connections. At a minimum, incorporate participation from behavioral health, medical, forensic and local supportive service providers (i.e., housing, vocational services, transportation, etc.); Coordinated release meeting.

Deliverable: Copies of coordinated release form examples. Recommendations for coordinated release form enhancement and list of community agencies/providers utilizing the form.

D. Educate and inform the COUNTY and collaborative partners of progress, successes, barriers, future opportunities, needs, and other program-related impacts as requested by the COUNTY.

Deliverable: Pilot meetings with Workgroup and the COUNTY held at least monthly (more frequent meetings may be requested by the County as needed to ensure proper implementation of the Pilot agreement). Presentations at meetings of the Homeless Leadership Board, Health and Human Services Leadership Board, and Board of County Commissioners at six (6) monthly intervals or as requested by COUNTY.

E. Reporting to the COUNTY will include:

Narrative report of each deliverable outlined in the services to be performed above, on a quarterly basis, unless otherwise noted and a Program Outcomes Report that will include information as detailed in Outcomes and Evaluation section below.

Deliverable: Submit a narrative report within thirty (15) days of the end of each quarter and a "Program Outcomes Report" to the COUNTY within ten (10) days of the end of each month. Other reporting can be requested by COUNTY as deemed necessary for effective administration of the Pilot.

PILOT MODEL:

Pilot Model will continue using the "Housing First" approach. This evidence-based practice centers on providing stable housing first, then providing other services as needed. Housing is viewed as an important tool rather than a reward for compliance or recovery. This approach to ending homelessness incorporates engagement, housing, intensive treatment and other social services to stabilize individuals so they can live independently in the community in permanent or supported housing that they do not have to leave.

The Pilot Model requires a dedicated staff (the Pilot Team) that works closely with system liaisons to identify and locate individuals who are high users. These individuals may already be a client of or may be entering one of the systems (i.e. jail, hospital, Baker Act facility, etc.). In these instances, the Pilot Team will attempt to engage individuals during their incarceration/ hospitalization prior to their release. The Pilot Team will also identify and use methods to incentivize entry into the Pilot, including offering housing assistance, and will continually work to engage clients reluctant to participate.

Upon reaching out to a literally homeless client, CONTRACTOR will ensure that the VI-SPDAT (Vulnerability Index of the Service Prioritization Decision Assessment Tool) is completed by a SPDAT/PHMIS-trained organization, unless documentation is submitted that the client has already been assessed via VI-SPDAT. Once housed, CONTRACTOR will ensure that the full-length SPDAT is administered by any SPDAT-trained, HUD-funded housing providers who may be housing these clients at approximately the 30, 90, 180, 270 and 365 day intervals.

Upon an individual's entry into the program, CONTRACTOR will conduct assessments of each participant using the LOCUS (Level of Care Utilization System Assessment) or other bio-psychosocial assessment instrument acceptable to the COUNTY.

Results of these assessments will guide development of individualized housing and service plans with the client. CONTRACTOR will be responsible for individually linking each participant to housing and other services identified by the assessments, and will follow up with providers and the client to ensure that services are acceptable, accessible and integrated. This ensures that the services indicated in the client's plans offer the greatest opportunity for success and that any barriers are addressed immediately. CONTRACTOR will rapidly respond to crises 24 hours per day, 7 days per week, and will monitor enrolled clients' hospitalizations, ER visits, Baker Acts and arrests in order to resume Pilot services as quickly as possible.

Collaborating with community partners, the Pilot Team will obtain other services based on identified need including, but not limited to financial assistance, employment assistance, benefit access assistance, ongoing medical and behavioral health care, and self-sufficiency assistance, such as life skills (hygiene, food preparation, budgeting, etc.), transportation, family/social relations, family reunification, legal assistance, parenting skills, or other need as identified. Access to financial benefits (e.g., Medicaid, Medicare, Supplemental Security Income (SSI), Supplemental Security Disability Income (SSDI), Food Stamps, the County Adult Emergency Financial Assistance Program, and the Pinellas County Health Program) will provide clients the opportunity to achieve and maintain self-sufficiency and to remain engaged in meaningful and productive activity such as school, day services, employment or volunteer work. Homeless clients will be referred to the System-Wide Outreach, Access and Recovery (SOAR) program for assistance with benefits applications when appropriate. Behavioral health services may be required to ensure ongoing stabilization and positive outcomes. It is anticipated that participants will receive ongoing behavioral health services through public funding streams for which they qualify.

Adjustments of the defined Pilot model may be made by mutual written agreement of the COUNTY, through its Director of Human Services, and the AGENCY through an authorized representative.

Outcomes and Evaluation

Success of the Pilot will show positive outcomes for enrolled clients, leading to an end to the costly cycle of recidivism for these individuals in jails, hospitals and public Baker Act facilities. Short-term, intermediate, and long-term performance measures are attached in the draft Logic Model. **CONTRACTOR** must submit a Quarterly Narrative Report within fifteen (15) days of the end of each quarter and a Program Outcomes Report to the COUNTY within ten (10) days of the end of each month. The Quarterly Narrative Report of each deliverable outlined in the services to be performed above, on a quarterly basis, unless otherwise noted, and a Program Outcomes Report that will include information as detailed in Outcomes and Evaluation section below**.** COUNTY reserves the right to amend data elements, performance measures, or reports as necessary to ensure that the overall programmatic purpose is demonstrated, quantified, and achieved. Reporting will include:

Short-term:

Number and percentage of:

a. Clients engaged and enrolled in Pilot program
b. Homeless clients housed within one week of entry, by type of housing (transitional, permanent, permanent supportive housing, etc.)
c. Clients receiving LOCUS or other approved assessment within one week of entry
d. Clients receiving VI-SPDAT from trained provider within one week of identification in the community
e. Clients receiving housing plans and service plans within one week of entry
f. Clients receiving treatment as indicated in their service plan
g. Clients receiving indicated wrap-around services:
h. Financial Assistance
i. Self-Sufficiency Skill training
j. Employment training
k. Budgeting and financial literacy training
l. # of system issues documented
m. # of community partnerships developed
n. Amount of project cost savings achieved as a result of leveraging community
o. partnerships and resources

Intermediate

a. Reduction in#/% of clients arrested one (1) and three (3) months post pilot entry
b. Reduction of# of jail bed days one (1) and three (3) months post pilot entry
c. Reduction in#/% of clients with Baker Acts one (1) and three (3) months post pilot
d. entry
e. Reduction in total # of Baker Acts 1 and 3 months post pilot entry
f. Reduction in #/ % of clients hospitalized one (1) and three (3) months post entry
g. Reduction in #/ % of clients with emergency room visits one (1) and three (3) months post entry
h. #and% of clients enrolled in training/skills programs (e.g. Vincent House)

Long-term Results

a. Number and percentage of clients who successfully complete treatment as indicated in the service plan
b. Increase in# and % of clients in permanent or permanently supported housing longer than six (6) months
c. Reduction in #/ % of clients arrested six (6) months post entry

d. Reduction in #/ % of clients with Baker Acts six (6) months post entry
e. Reduction in clients admitted to detox at (6) months post entry
f. Reduction in #/ % of clients hospitalized six (6) months post entry (to be defined)
g. Increase in#/% of clients stable in community/self-sufficient (e.g. receiving Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI))
h. Increase in#/% of clients employed in paid positions
i. Increase in# I% of clients engaged in meaningful, productive activity (e.g., school, day services, volunteer work)

NOTE: Required measures may be amended to ensure compliance and achievement of County and community goals

Contractor Qualifications:

a. CONTRACTOR must be a 501(C)(3) non-profit organization, incorporated for at least one (1) year and provide proof of current status with the State of Florida as a licensed non-profit organization.
b. CONTRACTOR must ensure that any housing service provider is an active participant in the Pinellas Homeless Management Information System (PHMIS) and that a SPDAT/PHMIS-trained organization conducts the VI-SPDAT with the client upon identification.
c. CONTRACTOR must sign a HIPAA Business Associate Agreement (Exhibit F).
d. CONTRACTOR must execute a Data Sharing Agreement (Exhibit G) and provide program and other information in an electronic format to the Pinellas County Data Collaborative for the purpose of research and policy development.
e. CONTRACTOR must be licensed by the State of Florida for the provision of mental health and/or substance abuse treatment.