

CONTENT NOTES
FLORIDA COMMISSION ON MENTAL HEALTH AND SUBSTANCE ABUSE
JULY 21, 2000
FORT MYERS, FL

(9:15 a.m.) The meeting was called to order by Commission Chair Dr. David Shern, who called the roll.

Present:

Allen, Terry
 Haines, John
 Haley, Ron (for Dan Lestage)
 Holmes, Patsy
 McCampbell, David
 McKinnon, Mary
 Murman, Sandra
 Parks, Sallie
 Pomm, Ray
 Schuck, Laura
 Singleton, Jeremiah
 Slate, Risdon

Spellman, Michael

Steele, Dianne
 Williams, Irv

Absent:

Clary, Charlie
 Cohen, Jeri
 Kang, Rodney
 Morris, Charlie
 Sharpe, Bob
 Sloyer, Phyllis
 Williams, Bob

A quorum was present. Diane Brady, Vice President of Operations and Chief of Nursing at Southwest Regional Medical Center, welcomed the Commissioners and others in attendance to her facility.

David Shern then introduced:

*****(9:30 a.m.)** Dr. Martin Cohen, president and CEO of MetroWest Community Healthcare Foundation of Framingham, MA. Dr. Cohen is a national consultant in mental health care systems architecture and financing. He has worked nationally with other state mental health Commissions and with hospital closings such as the upcoming closing of G. Pierce Woods State Hospital in Arcadia, FL.

Dr. Cohen began by reviewing his presentation's main topics: the structure of public health services, financing ("money drives the system, so think carefully about creating the right incentives"), and how structure and financing relate to the closure of state hospitals. He cautioned the Florida Commission to develop consensus around their recommendations, noting that in his experience with other state Commissions, those that did not have consensus and "buy in" around the major issues were not ultimately successful.

He urged awareness that mental illnesses also create significant disability. "We must be in the business of helping people cope with their disabilities in terms of housing, transportation, etc. [Persons with mental illnesses] usually have multiple needs and are often poor, so they may need financial assistance. Systems of care should respond to all

these issues, which is difficult because systems are often fragmented in terms of programs and funding sources. “Boundaries are created to limit access. We make it hard for people to move across boundaries. In fact, we ask the most vulnerable people in our society to negotiate boundaries.” He stated that we need to structure our mental health systems to better respond to individuals’ actual needs, creating mechanisms for multiple systems to work together. We also need to reward success while punishing failure (the opposite of what often happens).

Dr. Cohen advocated developing a single point of responsibility for each consumer’s care as well as a single point of responsibility and accountability within local communities (i.e., a central authority). He further suggested creating similar points of responsibility within the state bureaucracy (a cabinet cluster), then developing ways for these relationships to work, such as formal agreements and joint protocols, outsourcing staff, joint purchasing and decision making, and modeling behavior. “It is important to bring people together and give them money. If you want people to behave differently, give them money!” Reward systems that work well, and try to change those that don’t.

Regarding financing, Dr. Cohen pointed out the following problems:

- Many funding streams
- Little coordination among them
- Few financing incentives and many disincentives
- Existing financing systems are built around old treatment modalities
- Money should follow client needs, but the opposite is usually true

Possible solutions may include:

- Creating financial incentives
- Allowing for payment to nontraditional providers

When state hospitals are closed, it is important to consider what is being planned as the alternative, not necessarily in terms of beds but system capacity. “Who goes where often has more to do with perception than clinical reality.” Planners should consider what these new arrangements will mean for consumers, agencies, and staff and allow time for a phased-in approach. Former state hospital employees, he said, are valuable assets to new community care arrangements. “Issues of staff integration often overshadow the problems that clients have in integrating into the community.” Planners should additionally consider clinical coordination and accountability. There should be a single point of accountability for each client and clear clinical coordination to accommodate their individual needs.

The potential financial benefits of hospital closure always seem greater than they turn out to be, Dr. Cohen noted. “Some of the best benefits may be in terms of what’s left: redevelopment opportunities, housing, jobs, and long-term income. You also need to prime the pump. You can’t wait for the hospital to produce savings before you make investments in community systems.”

His final thoughts included two warnings about structure and financing: it's not about reorganizing, and it's not about money. "It's about designing your system around the clinical and support needs of consumers and ensuring that your financing system is flexible enough to meet those needs."

(1:45 p.m.) Following workgroup meetings and lunch, workgroup chairs reported back to the Commission on their activities and progress as follows:

Data and Needs Assessment Workgroup (Michael Spellman)

The group discussed problems with data collection and integration, noting that a lot of data are collected but there is little integration. At this meeting, there was consensus about the need for uniform data sets that can be shared and used for providing necessary information for agencies. The group also feels that no new data systems should be created but current systems should be better integrated. Better use could also be made of existing data. The workgroup discussed looking into such technologies as a "Smart Card" that contains relevant data for consumer use when services are rendered.

Adult Workgroup (Ray Pomm)

"All members agree we have a broken system, but it has been hard to find a focus and direction for the workgroup. We are trying to look at the system in a new way. What is quality, and where in Florida should services be offered? We are now looking at a continuum of care. We have consensus about a single point of access, ongoing accountability, defined populations, and needed services. We need better infrastructure and oversight of care."

Older Adults Workgroup (Jeremiah Singleton)

"The problems are multiple, and the current system does not serve older adults. In fact, services 20 years ago were better than they are now. Currently, a real system does not really exist. People who need services are not being identified, and needed services are not available. How should they be accessed? We need elder-friendly services delivered where older adults find themselves (home, church, etc.). We also need to coordinate all services."

Children's Workgroup (John Haines)

"Many of the issues we have identified have been mentioned by the other workgroups. In our meetings, we have focused on models that have worked well in Florida and nationally. We have identified elements of these exemplary programs and identified major themes to explore and address in our report: systems issues, planning effective systems, identifying resources, inadequate system capacity, the importance of consumer choice, and the importance of involving families in treatment. We need to focus too on outcomes and the importance of prevention, which is too often forgotten."

**** (2:15 p.m.) John Bryant, Assistant Secretary, Mental Health Program Office, Department of Children and Families**

Mr. Bryant reviewed the financing and funding aspects of the upcoming closing of G. Pierce Woods Hospital. Within \$98 million in Medicaid money in community mental health care and targeted case management, there are four components: general revenue (taxes), federal grants to states, tobacco settlement money, and ADM block grants. Under mental health programs, 68% is general community support money, 3% is Indigent Drug Program (IDP), and 25% is Baker Act money (for emergency services, acute care, and crisis stabilization). In the latter group, DCF serves 50,000 people a year, and 1/3 are also served by other areas of the department's mental health budget (i.e., they are repeated rather than situational, or short term, users). Mental health special projects (3%) and continuity of care (1%) comprise the rest of the budget. In 1985, we had more services, and better services, in Florida than we do now, he said.

Under mental health institutional funding (total of \$263,487,429), civil beds account for 75% of the budget at \$180--\$215 a day, and forensic beds at \$150--160 a day (25%). "Ninety percent of funds for state hospitals used to be from general revenues," Mr. Bryant said. He defined disproportionate share as federal funds that in Florida have historically funded teaching hospitals and operations of general hospitals that provide indigent care. In 1997-98, disproportionate share accounted for 45% of DCF's hospital operating budget. "We relied on it," said Mr. Bryant, "but the federal government rethought the situation and reduced that money. We lost \$30 million in the last two years."

In addition to the funding reduction, the governor's budget, OPPAGA recommendations, and Senate appropriations all pointed to the closing of a 300-bed hospital. The Senate, according to Mr. Bryant, directed DCF to develop a plan to close a state hospital and transition patients to community-based care while minimizing economic impact on the local community. In the GPW closing, DCF is required to provide community services for approximately 600 people who would otherwise be hospitalized. Guiding principles include: serving patients in their home communities when possible; investing in community support; and individualizing treatment plans. Federal Medicaid disproportionate share money will not be replaced by General Revenue, Mr. Bryant stated. Bed capacities will have to be reduced to cover the loss, forensic beds will be maintained, and South Florida State Hospital's 350-bed capacity will not be reduced. Additionally, catchment areas will be realigned with emphasis on equity in access to beds, and other agencies such as AHCA, DOEA and DJJ will help with placement of patients and reducing community economic impact. Closing G. Pierce Woods without new community capacity was deemed not viable, and privatization would not produce enough cost savings.

The phased closure of GPW by April 2002 with increased community capacity is expected to minimize bed loss, yield maximum savings, allow \$10.9 million to be reinvested in the community, and offer the highest potential for alternative facility use and replacement jobs. Five Assertive Community Treatment (ACT) teams will be assigned to the GPW catchment area in 1999-2000 and another five the next year to serve

a total of 1000 people. One hundred short-term residential beds will serve 300 people a year, and expanded residential care and housing will provide 189 beds in 2001-2002.

Public Testimony

(3:30 p.m.) Harold Maio, who identified himself as a person with a cognitive disability, told Commissioners about the “virus of prejudice” that infects every level of society. He read a racist quote and noted that we now reject such thinking but do not examine the research process behind it. He asked if any Commissioners had ever been institutionalized [for a mental health problem] and two raised their hands. He indicated he was glad to know there were those on the Commission who had had this first-hand experience. He urged the Commissioners to work together with persons with mental health disabilities, saying the experts are not researchers but consumers. “I’ve experienced the system and know my own needs.” Mr. Maio recounted his experience with Lee Memorial Hospital’s Patient Bill of Rights and his request that a mention of disabilities include mental as well as physical disabilities. He noted that he and other mental health services consumers want equal access to health care.

(3:40 p.m.) Jim Nathan, CEO of Lee Memorial Health System in Fort Myers, told Commissioners that Lee County and Southwest Florida are in “serious disarray” in their capacity to treat cognitive/mental health disabilities. “Since 1980, the United States has given elected officials signals that citizens want less taxation and less government. The result has been marketplace economics and a marketplace that does not respond to social issues. With new societal wealth, the feds have turned to states to deal with these problems, and the states have turned to counties, and counties are saying, Where’s the money?” Consumers are saying, “Who cares about us?” Mr. Nathan stated that people need to come together, lead by a Commission such as this one. He asked the Commission to advocate for a strategic planning grant for Southwest Florida to build on public/private partnerships and make Southwest Florida a leader in change.

Public Testimony

Closing of G. Pierce Woods State Hospital

(3:45 p.m.) Luke Wilson stated that it is “atrocious” to close GPW, which, he said, serves more than 50% of Florida state hospital patients. “It is not fair because GPW is more cost effective than other hospitals, serving 1.8 persons per bed versus 1.3 in other state hospitals.” He said that GPW is also at the forefront of treatment, citing dialectical therapy as an example. “This can’t be replaced by community programs or ACT teams.

(3:50 p.m.) Liew Wicker agreed that the hospital closing would not work, and people won’t get proper care in the community. He told of his son’s serious health crises and current success in a doctoral program in physics. GPW was instrumental in his son’s recovery. It provided help that no other institution was able to offer. Through his

problems, they had hope. “GPW represents this kind of hope [to persons with serious mental illnesses]. Please keep it open.”

(3:55 p.m.) Dick Durstein of the State Human Rights Advocacy Committee (SHRAC) said he had monitored 2008 Baker Act hearings in St. Petersburg so was qualified to “report from the trenches.” He said SHRAC is concerned about the planned GPW closing and questioned whether their patients are ready for independent living. He asked how these patients would be housed. He commented that DCF is making too many changes at once.

(4:00 p.m.) Robert McGuire said he was confused by John Bryant’s comments. No plans seemed to have been made for patients once the hospital closes. He asked if crime would not go up. “To do so much for so many with so little money...” Mr. McGuire questioned why the closure decision had been made without any county input. “The State alone is dictating policy.”

(4:02 p.m.) Karen Smith stated that she had been sick for a long time and community help is not available, specifically counseling. She said she had been out of the hospital for “a miraculous” 10 months. “You don’t plan on having a crisis.” She said she might have been able to avoid hospitalization if she had had community resources to rely on.

(4:05 p.m.) Debbie Benjamin told of her hospitalization in the recently closed Charter Glades Hospital and how the shock treatments that have helped her depression have caused memory loss. “We need help in an out-of-hospital setting! I don’t realize when I’m backsliding. Thank God I have family here to tell me when I do. So many people sweep mental illness under the carpet, but we need help.”

(4:09 p.m.) Hugo Santiago-Ramos, LMHC, said he had been in the mental health field for 30 years and was on staff at GPW. “What shocks me is that the decision was made [to close GPW] then rationalized after the fact. Do we need a Jimmy Ryce facility? If they had a money shortfall, why not look at how to reduce beds in all the hospitals rather than focus on closing one hospital completely?” A needs assessment, he said, should have been done before. “There was no input asked from the medical associations in our 18 counties.”

(4:15 p.m.) Dr. Jane Zarzecki, a psychologist and division director at Coastal Recovery Centers of DeSoto and Sarasota Counties, said her concern with the GPW closing was that there are no ACT teams in DeSoto County. Sarasota County has helped out in the past. “DeSoto is an indigent county and we expect a lot of GPW patients to come there, and we are already underserved. It is difficult, she stated, to provide services in rural areas because there are few qualified professionals. “People are frightened of GPW patients, so housing them will be a huge problem.” She often has nowhere to send discharged patients but the Salvation Army. She urged that the communities that patients return to be given adequate support and resources to deal with their needs.

(4:20 p.m.) Norris W. Johnson said that people with mental illnesses need to be protected [by being in state hospitals], and they may need to sacrifice their freedom to get that protection. “The government and DCF want to avoid lawsuits, so they are closing this hospital.”

(4:22 p.m.) Ann Arnall, Deputy Director of Lee County Human Services, talked about local government financing responsibility for mental health care. She said that changes in statutory language regarding local match should not broaden local responsibility. Counties should insist that their money be spent in their own county. “Counties now have a limited role in ADM planning. There should be a strong partnership between state and local funding sources.”

(4:26 p.m.) Kevin Lewis, President of the Florida Alcohol and Drug Association, told of concern by the Florida Alcohol and Drug Abuse Association (FADAA) with lost resources. “We only have 19 beds four 4 counties. We just can’t meet people’s needs. Please don’t just plan – act! We’ve studied the problem numerous times. We know we need more resources and this Commission’s leadership. “Ask the people of Florida, ‘What are you willing to pay for? If you are only willing to fund help for one in five people, say so.’”

(4:30 p.m.) Jan Eustis, CEO of Ruth Cooper Center, told the Commission that Lee County is in a mental health crisis, with no crisis services for children, who must be sent to West Palm Beach or Tampa. She asked that the Commission focus on the whole continuum of care and look at the best way to keep people in the community.

(4:43 p.m.) Peter Schleh, Director of Specialized Services for Charlotte Community Mental Health, Inc., stated that there are good programs in Florida where the money follows the client. “I’m involved in adult therapeutic foster care homes, and that’s a very successful program. It should be used as a model for others.”

(4:45 p.m.) Frederick Schaerf, MD, PhD, a psychiatrist, talked about improving quality by utilizing data to determine the most efficient use of resources. He advocated more public/private partnerships and using quality improvement and performance standards to provide the best care and the best medications.

(4:48 p.m.) Nancy Grant, President of For the People, an advocate for mentally ill persons, told of her involvement in mobilizing citizens in 19 counties against the GPW closing. She also told of acting as an unpaid guardian for a man with a mental illness, who believes the state is trying to take his money.

(5:00 p.m.) State Representative Lindsay Harrington, District 72, said “Closing G. Pierce Woods is wrong! They’ve made the decision and now they’re trying to justify it. I’ll continue to advocate for keeping it open.” He noted that California is now moving away from community-based care and back to institutionalization. “They said the problem was poor planning, and the same is true here. We need to stop, look, and repair the system. We need fewer bureaucrats and more citizen involvement.”