

CONTENT NOTES
FLORIDA COMMISSION ON MENTAL HEALTH AND SUBSTANCE ABUSE
AUGUST 28, 2000
PENSACOLA, FL

The meeting was called to order at 9:15 a.m. by Chair David Shern.

Present:

Allen, Terry
Cohen, Jeri
Haines, John
Holmes, Patsy
Kang, Rodney
Lestage, Dan
Park, Sallie
Pomm, Ray
Schuck, Laura
Sharpe, Bob
Singleton, Jerry
Slate, Risdon
Sloyer, Phyllis
Steele, Dianne
Williams, Bob
Williams, Irv

Absent:

Clary, Charlie
McC Campbell, David
McKinnon, Mary
Morris, Charlie
Murman, Sandra
Spellman, Michael

A quorum was present.

Dr. Shern gave an overview of plans for the final report, due to the Governor and State Legislature on December 1, 2000. He described the body of the report, which will integrate common themes across populations that have emerged from meeting speakers, public testimony, literature, etc. as well as present overall findings and recommendations (approximately 30-40 pages). Four major appendices may contain reports of each of the four workgroups, written so that each report could stand alone and serve as a summary and reference for advocates of specific populations. The report will also have an executive summary and a bulleted list of recommendations for ready reference. These plans met with the approval of the other Commissioners.

Terry Allen asked if draft legislation based on the recommendations would be contained in the report. Dr. Shern responded that it had not been decided if draft legislation would be contained in the final report or if that would be submitted separately. Staff will consult with contacts in the State Legislature to determine the best way to handle this before that decision is made.

Dr. Shern went on to describe planned two-day fall Commission meetings: on September 22 and 23 in West Palm Beach at Hanley Hazelden; October 13-14 in Miami (exact site has not been determined); and November 17-18 in Tampa at the Florida Mental Health Institute. In September, three of the four workgroups (Data, Adults and Older Adults) will present their findings and recommendations, with time allotted for workgroup and Commission discussion and comment on these reports. The Children's Workgroup will present their report in October, and all findings and recommendations will continue to be discussed. In November, overall Commission findings and recommendations will be discussed and voted on, and a draft final report will be discussed. The report will be delivered on or before December 1, and legislation based on the Commission's recommendations will be written.

Dr. Shern mentioned that Commission meetings to date had not adequately dealt with three topics: prevention; quality and performance management; and jail diversion. Comments on inviting speakers to address these topics were as follows:

Dan Lestage: All public testimony should directly address these topics and not any issue the testifier wishes to talk about.

Dianne Steele: All three topics are important and we should invite excellent speakers who can offer suggested recommendations related to these subjects.

Sallie Parks: Because local jails currently act as a safety net for people with MHSA problems, perhaps a representative from the Sheriff's Association could speak to us.

Bob Williams: Speakers should be experts, and all three topics should be done in September.

Terry Allen: Agreed. We must get input early, before the report is written. All Commissioners agreed.

David Shern: Said we will invite national or state experts in these areas and give each approximately three hours to speak, answer questions and take relevant public testimony.

From 9:45 until 12:00, the four Workgroups (Data, Children, Adults, and Older Adults) met. After a break for lunch, the Workgroups presented the following status reports:

Data and Needs Assessment: **Terry Allen** reported that the group had a spirited meeting. They reacted to the draft workgroup report prepared by Dr. Kevin Kip, suggesting revisions. The areas their report will cover include: identification of problems, need, costs, and recommendations. They have concluded there is no way to follow a patient through the current system.

Children: **John Haines** said that Paul Rollings, PhD, ADM Program Supervisor in District 1, gave a presentation on their exemplary system of care. His presentation focused on lead agencies. The Children's workgroup continues to examine exemplary

systems. They looked at a second draft of their workgroup report and asked in more depth than previously, “What should the children’s system look like?” basing their thinking on examples of excellent programs they’ve looked at. Their recommendations will mirror concerns around the state regarding flexibility, accountability, coordination, and collaboration, especially related to funding.

Adults: Ray Pomm Their report, still in rough draft, is looking at prevention, public education and recommendations regarding consistency and access throughout Florida. They are asking, “What do we want?” and will develop a “core curriculum” to be used around the state. They need more work on ambulatory care and have spent considerable time on emergent care including eligibility and level of funding. Dr. Pomm noted the group’s understanding that the whole system cannot be fixed overnight but that a foundation for positive change can be built.

Older Adults: Sallie Parks reported that a draft is in progress. Their first priority is to recommend a clear policy statement regarding MHSA in older adults. They have discussed the best minimum age to suggest for older adults and are leaning toward age 60. They have looked at exemplary programs. They agree that services must have a focus on prevention and early intervention and the delivery of services where elders actually are. More outreach is needed to identify and treat people with problems. Outcomes are different in older adults. Funding challenges exist and there are long-term care needs. There is also a need for an overlay of services in nursing homes, ALFs, etc.

**** 2:10 p.m. Carol Bracy, Legislative Director, Florida Association of Counties** reviewed issues related to counties’ role in financing behavioral health care. She noted that Florida law requires county governments to participate in funding the state’s MHSA system. DCF determined that counties contributed some \$57 million in FY 1999-2000 for MHSA services. The law (Chapter 394, Part IV, Florida Statutes) clearly defines such terms as governing body and local matching funds. The law states that all other contracted MHSA services require local participation on a 75-to-25 state-to-local ratio. The following qualify for local match: third party fees, contributions, donations, in-kind, volunteer services, United Way, program income, interest income, and other local government participation such as cities, school boards, and special districts. Exempted from local match requirements are: residential deinstitutionalization; deinstitutionalization case management; ADM Block Grants; and children’s mental health.

Ms. Bracy recommended the following changes in local match requirements if counties continue to be required to make up the difference in what providers generate in other local sources to meet the 25% obligation:

- Eliminate statutory ambiguity; revise and update statutes; and avoid broadening programs that require local match.
- Improve local accountability and oversight; county governments should have more flexibility in funding use; a needs assessment should be done to properly allocate money and plan for services. Counties should have a say in funding allocation methodology; type and amount of services funding with combined state and local funds; provider selection; contract negotiation; and identification of target population.

[Also see “Briefing on Local Match Requirements” on the Website]

**** 2:25 p.m. Paul Rollings, PhD, ADM Program Supervisor, District 1** described major issues in MHSA financing. He first described categorical funding streams, explaining their client impact in terms of those with dual diagnosis, families in need of services, and lack of flexibility. He then discussed categorical funding in terms of its impact on administration regarding complex funding, contracting, tracking mechanisms and a lack of flexibility.

**** 2:40 p.m. Lucia Maxwell, Managed Care Consultant (clients include Florida Alcohol and Drug Abuse Association), Executive Director, Panhandle Area Health Network** reviewed the current state system for financing mental health and substance abuse services, saying purchasing is carried out according to capacity and is inflexible in terms of changing client needs. She also said there are inconsistent standards among numerous funding sources, a huge burden of required documentation, and unrealistic outcomes measures. She outlined four ways the current system should change, to include: blended funding, with flexibility and recognition of variations in client severity; strengthened systems of care; a single set of standards for accountability; and outcomes measures based on national norms. Ms. Maxwell said she does not favor capitation to accomplish these goals because a capitated system would require more money and infrastructure than exists in the current system. Capitation has not worked in other states, such as Texas, Arizona and Tennessee. Substance abuse also has no enrolled population nor defined eligibility. Any financial risk should be shared with the state, and community based care should be maintained.

2:45 p.m. Gary Bembry, Chief Financial Officer, Lakeview Center agreed that the system is very fragmented but said that funding is undeniably inadequate to meet current needs. Florida ranks somewhere between 35th and 47th in per capita behavioral health spending. “We must get a handle on unmet need; the data show this. The financial system is complex. Money drives clinical care more than it should.” He advocated the reduction of artificial categorization of funds. “At a district level, we must do a better job of this.” He advised the Commission to do “a goal realignment,” focusing on the goal of good clinical outcomes, then make the financial system match. Many treatment professionals are far removed from funding issues. “Financing needs to get into the hands of clinicians.” Customer satisfaction is very important, he said, and should not be overlooked.

**** 2:50 p.m. Ron Manasa, Executive Director, Manasa Consulting Group, represented the views of NAMI (National Alliance for the Mentally Ill).** On behalf of NAMI, he advocated changing the state’s current contracting system in which both DCF and AHCA provide mental health services and gave three reasons: 1) administrative duplication; 2) incompatibility of DCF and AHCA programs; and 3) wrong performance incentives. He said that both DCF and AHCA perform many similar functions that could be consolidated yet also have many differences, including different client and service eligibility, service documentation, definitions of service, units of measure, data requirements, invoicing procedures, monitoring protocols, and auditing requirements. Mr.

Manasa also noted that the current system is service-centered rather than client-centered (i.e., providers are paid for units of services delivered without regard to actual need or effectiveness). He cited a lack of service standards, treatment protocols, required client involvement and choice, client-specific performance measures, and financial incentives based on client outcomes. NAMI offered the following recommendations for change: 1) assign sole responsibility for community mental health to DCF, blending AHCA funding into DCF funding. This could entail either AHCA capitating to DCF or both DCF and AHCA capitating to a third party; 2) establish case rates or care level rates as the method of payment; 3) establish service standards and client treatment outcomes and link to payment system; and 4) set aside a portion of case or care rates for client choice to create provider competition. NAMI believes these changes will eliminate waste, serve more people, and achieve better outcomes through more client involvement.

Beverly Seiple, consumer spoke of her struggle with clinical depression and other family members similar battles. A son with mental illnesses committed suicide. She stated that consumers should be invited to participate more in mental health decision-making processes, perhaps in a question and answer panel format where consumers could be asked direct questions about their illnesses, experiences and views. “Ask adults with mental illness what they want! Florida is one of just a few states without an office of consumer affairs, yet we are large and growing.” She also expressed the belief that DCF should not be paying for the treatment of sexual predators, who should more appropriately be in criminal justice or juvenile justice systems. She said the system needs more money. “The Commission should ask the State Legislature for at least \$500 million.” ACT teams in particular should be more comprehensive and accessible. “I am able to speak up for others with mental illnesses, but many are not as fortunate as I am.”

Panel Discussion

Paul Rollings: It would be a leap of faith for the Legislature to integrate funding [per NAMI’s recommendation]. It is more important to allow for flexible movement within the budget. Mental health financing is the most complicated part of the government budget. Part of the reason for this is mistrust. A lot can be done with case rate funding. [Regarding capitation], certain services must be funded, and acute care is one. Perhaps a cafeteria approach to different kinds of funding would work.

Ron Manasa: Repeated NAMI’s recommendation that DCF should be in charge of funding.

Carol Bracy: Where do local governments (e.g., counties) fit into the blended funding model? Counties want flexibility.

Lucia Maxwell: Combining DCF and AHCA funding is a frightening concept. It would be better to combine funding on a regional or local level. Don’t move too quickly to a new funding system such as capitation or case rate. The burden may then fall on counties.

**** 4:00 Brent Taylor, Director of Policy, Advocacy Center for Persons with Disabilities, Inc.** Mr. Taylor explained that the Advocacy Center is the federally mandated agency that provides advocacy services on behalf of eligible Floridians with disabilities [including mental illnesses]. They investigate abuse, neglect and rights violations, pursue legal and other remedies, and provide information and referrals to persons in need. They are often best known as a public interest law firm that files class action lawsuits against the state on behalf of persons with disabilities. They also employ other methods of advocacy and work with the Legislature. Florida, he said, is failing particularly those adults and children with psychiatric disabilities.

Mr. Taylor asked the Commission to pay attention to the Olmstead Case. He also pointed out a great need for housing and employment for persons with mental health and substance abuse problems. “New systems need to be holistic. There is also little coordination of agencies and multiple funding streams. We get little cooperation from state housing and transportation agencies.”

Mr. Taylor said the system needs more money; reordering current appropriations is simply not going to be enough. “Honest, comprehensive and quality reform will require a commitment by the Legislature, the administration, and the public to fully fund what is truly needed. Helping individuals with psychiatric disabilities is a statewide challenge, not a localized crisis. While implementation of any system should be flexible enough to accommodate local idiosyncrasies, the system itself must be the product of state policy, planning, funding, technical assistance and monitoring.”

**** Bruce Jones, PhD., Administrator, Hendry Glades Mental Health Center** spoke about rural mental health and substance abuse needs. He pointed out that “rural” is defined as a county having 25 or fewer people per square mile. Fourteen Florida counties meet this criteria, with per capita incomes 20% to 30% less than the state average. Therefore, providers in these counties don’t have the same resources as wealthier more urban counties. Outside providers don’t find it fiscally viable to come into rural areas to work. He asked the Commission to consider the needs of rural areas, which have no advocacy group. Perhaps Medicaid could cover rural costs.

Public Testimony

****4:15 p.m. Jim Akin, Executive Director, National Association of Social Workers, Inc., Florida Chapter,** shared a letter he had written to Chair David Shern regarding an interpretation several years ago by the state Medicaid office of Senate Bill 484 that eliminated Licensed Clinical Social Workers and Psychologists from receiving crossover payments from Medicaid for mental health services. NASW-FL has been unsuccessful in working with the Medicaid office to restore these payments, resulting in the poorest of the elderly not having copayments covered. He pointed out that the interpretation in question did not remove crossover payments for physicians, psychiatrists, or nurse practitioners, although these professionals do not deliver mental health services to the elderly nearly as often as LCSWs and psychologists.

****Anita Capes, consumer, Family Trauma Survivors Network** asked the Commission to intervene politically for trauma survivors, citing need for more “client sensitive” services, research about trauma survivors, reimbursement for clinicians, supported

employment and volunteer opportunities, and other issues that would help this vulnerable population live stable, productive and satisfying lives.

****Chris Echsner, President of New Beginnings Group, Inc. Pensacola** addressed inadequate funding for halfway houses and other treatment, rehabilitative and support services such as housing, supported employment, vocational rehabilitation, continued counseling and case management. These are, he said, essential parts of the continuum of care. Recovery homes services such as New Beginnings are an exemplary program, he said. They have submitted their program as a model for change to District 1.

The meeting was adjourned at approximately 4:30 p.m.