Commission on Mental Health and Substance Abuse

Commission on Mental Health and Substance Abuse Members

Sheriff Bill Prummell
Chair

Ann Berner
Speaker of the House Appointee

Representative Christine Hunschofsky
Speaker of the House Appointee

Clara Reynolds
Governor Appointee

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Florida Department of Children and Families

Secretary Simone Marstiller
Florida Agency for Health Care Administration

Dr. Uma Suryadevara
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Judge Ronald Ficarrotta
Governor Appointee

Wes Evans
President of the Senate Appointee

February 16, 2022 - 9:00 a.m. to 1:00 p.m.

Note: The following is a summary of the highlights of the proceedings and is not intended to be construed as a transcript. For information on the Commission, please visit the Commission website:
https://www.myflfamilies.com/service-programs/samh/commission/index.shtml

Attendance Summary

Members in Attendance

Chair, William Prummell
Ann Berner
Representative Christine Hunshofsky
Clara Reynolds
Doug Leonardo
Secretary Shevaun Harris
Dr. Jay Reeve
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Senator Darryl Rouson
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Dr. Uma Suryavevara
Wes Evans

Staff in Attendance

Pat Smith

Proceedings

Call to Order and Welcome

Chair William Prummell called the Commission on Mental Health and Substance Abuse meeting to order at 9:00 a.m. and welcomed commissioners.

Roll Call

The roll was called by Pat Smith and a quorum was confirmed.

Approval of December Meeting Minutes

Approved by Commissioner Jay Reeve and seconded by Commissioner Chief Judge Ronald Ficarrotta. All in favor, minutes were passed.

Overview of the Department of Education Role in Behavioral Health/Resiliency Toolkit

Jacob Oliva, Senior Chancellor with the Florida Department of Education, presented on what the Department of Education is doing to support mental health for students and a system of care. He shared that the state of Florida is one of the leaders to recognize the value of making sure schools were open through the pandemic, ensuring students had a safe place to go and be supported by peers and people who care about them. In last year's assessment period, they measured the impact COVID had on student learning, or what Mr. Oliva referred to as COVID learning loss, after there was a pivot to distance learning and hybrid learning. Mr. Oliva was happy to announce that 94% of students participated in their annual snapshot which means they came into school and participated, but the trends indicated that there was a decline in performance. In language arts and reading there was around a 3% loss and in math there was around a 10% loss, when compared to pre-pandemic 2019. There was also a 3% decrease in kindergarten readiness and statewide enrollment has been down statewide. They received Education Support Relief Funds, 9 billion to last over the next few years to support different programs to mitigate learning loss, and to address the emotional needs and mental health issues. The Department of Education looked to how they can support mental health education and what they can do to support access to mental health services. They can collect from districts annually how they have met this requirement. Many districts inquired about resources, best practices, and how to meet the mental health requirement. First Lady DeSantis urged state agencies to combine these resources to address those requests and there is now a website, CPALMS, where right on the front page is the resilience tool kit and its resources for teachers. There are nine different topics with sample lessons for different grades that they can pull to help meet that mental health education requirement. It's still a work in progress, the framework is there but this will be an ongoing effort to build that and ensure they have access to high quality materials to meet those requirements for education.

As to mental health services, the legislature has made some historic investments in providing access to school districts and how they can support students from a mental health aspect. There was 75 million earmarked mental health allocation that came through the school districts through the funding formula, should help not just with mental health education but also help with looking at the ratios of access to school counselors, SW, psychologist. When you looked at the national recommendations for schools, 1 school counselor for every 250 students, in Florida it is about 500 students. Those workloads are high and that identified a need to provide extra funds. Every student must have access to an adult that they can turn to. Fortunately, in 2019-2020 that allocation started at 75 and every year it has gone up. We are excited that the governor's recommendation was to increase it to 140 million dollars this year. They are training not just teachers, but all staff including bus drivers and maintenance staff, etc., in youth mental health first aid which is a training that teaches adults how to recognize signs and symptoms and gives them the skills to recognize a student who is in distress, and then making sure they have access to the school-based support they need. School-based mental health experts provide different levels of treatment that happen at the school-based level, called "tiers of support." Tier 1 around MH, what is every student in the school have access to? As you go up through

those tiers of support some students need more intense services, you could say most are okay with an established school with mentors, but some students need more attention and care, and that school counselor might do small groups with identified individuals and work with the parents and providers. When you get into tier 3, that is super intensive layer of supports, that means partnering with outside supports and we have Managing Entities that work with the local health providers and communities in making sure that schools are collaborating with other mental health agencies. Mr. Oliva explained that part of their role is working with the districts on their mental health allocation plans and what they intend to do with those dollars. Department of Education posts them on their website and can provide to this group so that everyone can see what schools are doing at the different levels and how they are meeting the needs of their students across the network.

Reeve question – In reference to tier 3 students, could you say a word or two more about that and where it's going, where you would like to see it go? Overcome Inconsistencies?

- **Oliva response** – Some districts are doing really well, and others need a lot more layers of support. When we first started going down this conversation and building out this system of care, what are the roles of school and community-based providers and how do we provide access to the same info and not overlap services and ensure everyone is working toward the same goal. Often times children in distress have families in distress and more agencies become involved. Summer after MSD the legislature took swift action and we received more of those mental health allocations and we did a huge conference that summer with school districts and ME's and community providers and got everyone in the same room, to show if you were in "x" county these are the people who provide services in your community. One of the takeaways from that, is how many of them didn't know those agencies existed or worked in this space? It's really about those collaborative connections, in my opinion it is probably time to bring those groups back together. Let's get an update on where we are now and learn from each other because there are some districts who aren't as seamless as others. Part of those conversations reveal there are deserts and islands in Florida that do not have access, no licensed practitioner within 100 miles, and we must be creative. How do we partner with neighboring counties and support telehealth? We have made a lot of progress, but we will always be working to get better. There is value in getting the regional folks back together and ask did we take our foot off the gas or keep going?

Salamida question – One of our subcommittees has been established as a finance committee. One of the charges there is to look at how mental health and substance use services are funded across the state. With the funding formula that the schools use, how are resources allocated around the state to ensure they are done adequately? How does that money get allocated across the different school districts across the state?

- **Oliva response** – In the state of Florida Education and Finance Program, it is a model used and the easiest way to say is that it is categorical (MH Allocation) in that funding formula is based on the number of students in that school district determines the

number of dollars allocated. It could be very beneficial to large districts, but if you are in a smaller district and get a smaller share it may not be enough to hire a full-time person so you may need to partner with someone, some districts must partner with each other to share those dollars and resources. It is a topic worth digging into if we get those regions back together and identify those islands and deserts and how we can add an extra layer of support in those areas.

Reynolds question – In that formula, is every child the same or is a child with IEPS weighted differently?

- **Oliva response** – That formula, there is a based student allocation (BSA), so regardless of program or services you need as a student you start with a base and depending on the program, some have higher weights than others. Those weights get factored into that formula that would build on that base. Not every child generates the same number of funds, they get put in different matrixes and fields. Kindergarten through 3rd grade has a higher number than 6th to 8th grade. Class requirements are different. Those factors start weighting in.

Reynolds question – when you talk about behavioral health allocation, you are looking at all those factors in determining how much they will get?

- **Oliva response** – Not necessarily with those categoricals and that's where it gets complicated. Within those weights there are certain categoricals, there are so many different layers and the easiest way to say how it gets distributed is to say the number of students in the district.

Chair Prummell comment/question – All counties or school districts are not created equal. Can you go into more about what type of training they need to get? What are we teaching our school board members?

- **Oliva response** – Crisis intervention training. The youth mental health first aid training is kind of a gold seal training by a group SAMHSA. It is a 3-day face-to-face training, you must be qualified like a school counselor or something along those lines. To give that training, it is a 6-hour training and can only do 20-30 people at a time, its time sensitive and its moving slower than expected. In year 1 we provided access to a virtual 2-hour training via Cognito, an introductory module to youth mental health first aid training. It doesn't meet the full scope, but we had over 200,000 people participated so they have something until we can get them in to be fully trained. The team is working on a virtual model that they hope to roll out in the summer, then they will be able to scale up the number of individuals who receive this training at a faster pace. Its time intensive, and not necessarily training teachers on how to provide the services but how to recognize the symptoms and then knowing who to call.

Harris comment – We welcome the opportunity to partner with Department of Education and local school districts in a regional meeting to get everyone back to the table.

- **Olivia response** – We can get together and start making that happen.

Chair Prummell Question –What is the Department of Education doing to follow the recommendations of the Marjory Stoneman Douglas School Safety Bill and meet those standards?

- **Oliva response** – If you know of a district that is not following the law we need to talk. We have the Office of Safe Schools, it's not just for training and support, but also oversight and compliance. If it comes to our attention that some of those components… there are requirements that school resource officer be always on campus when children are on school and we may find out that's not taking place for some reason and that requirement wasn't met if we find out about that, we have folks who sit down with them and ask how this happened and how can we prevent it from happening again. We can bring them in front of our state board if need be. If that's not happening, we have a team of folks who are onsite providing those layers of support, even in the last four years, that office has expanded to about 17. 6-7 of those individuals are regionally located throughout the state and doing onsite monitoring and making sure we implement all those laws.

Chair Prummell question – What are you doing to be proactive to make sure they are following what they need to be?

- **Oliva response** – There are technical lenses we look at monitoring through, one level is desktop monitoring. As we receive data, they are looking for patterns or inconsistencies. There is a term called Sessor, safety and incident reporting. We can tier them into priority districts and that could result in an onsite monitoring. Also do spot checks at a school to ensure those best practices are being implemented.

Chair Prummell question – Things I hear from dealing with school districts, SW or clinicians respond at a different level. You have one clinician saying they may need months of data, or another clinician may say they need weeks of data to do something. How do we clarify those inconsistencies?

- **Oliva response** – Probably not a simple answer, depending on the situation. Those dynamics between one child and teacher, it's never a one size fits all approach. Part of it is training, we have done some work with rolling out some model best practices, we need to continue engaging in that work. We have not met the threshold where everyone understands their roles and responsibilities because its different in every school. There are comprehensive school threat assessment guidelines and best practices that we continue to train schools and mental health providers on how to implement and some uniform checklists. When looking at those investments in mental health allocation to get those school social workers or counselors, we must also make sure those workloads are realistic. With training, continuing this dialogue to ensure everyone knows their role, ensuring those students and teachers have access to provide them the support they need.

Senator Rouson comment – Leaving for the Appropriations Committee. They will be voting on an amendment to allow this commission to meet in person and to be reimbursed per diem for cost. It also delays the reporting date from September 2022 to January of 2023.

Chair Prummell comment – If it goes through it will allow the commission to do and hear some things that are privileged, closed, areas that are private. So please vote yes.

Dr. Suryadevara comment – Talking about the clinical differences, clinicians come with their own baggage, some do not need a lot of data, and some are more reluctant. It is hard to make it more uniform because there are some children with a lot more risk factors, like background with the family. That is some of the difficulty in making it more uniform.

Volusia County Pilot

Heather Allman, Policy Unit Manager for Florida Department of Children and Families, provided an overview of our children's care coordination pilot and Maggie Cveticanin presented on the Volusia teaming pilot. AHCA and the Department were tasked with working together to look at children who are utilizing crisis stabilization services at a high rate and they set out to define what that meant for purposes of this project. With the funding they received, there are several children's care coordination positions across the state. It is a highly intensive specialized activity that often includes engagement with children and their families particularly when they are experiencing a crisis or at a pivotal time in their journey through behavioral health services. Managing Entities share in the responsibility by providing oversight for the implementation and management for the community system of care and they offer services to everyone regardless of ability to pay. The goal of children's care coordination is to overcome systemic barriers to services and enable information sharing across systems, and to engage in joint planning for successful transitions between care and access to care. They have started to collect data on children's care coordination and the number of families impacted and served through care coordination and have about 500 families who have been assisted thus far since the data started to be collected which was October 2021. To highlight some of the differences between other services someone might have through another funding source or entity, this can be face to face and the care coordinators are familiar with services and supports that are offered through the Managing Entities such as CAT, Recovery supports and series, access to peers, things that may not be available through other funding sources. They ensure they are getting more than a referral or a phone number to call and engage other partners in the system. For example, if the child is experiencing some type of a situation where they have been arrested and there is need for coordination with DJJ or a probation officer, or they have an intellectual disability or developmental disability and there is a need for coordination with APD, they can bring them on board while working very closely with AHCA and the health plans so that they are aware and attending any kind of staffings and services available through Medicaid.

Maggie Cveticanin, Director of Substance Abuse and Mental Health for the Northeast region, encompassing Volusia County, shared that in September the Volusia County Sheriff held

meetings to identify needs in the community. Deputies had concerns over having to return to the same home over and over again and the Deputies only know of a couple of resources. The Department (DCF) contacted his staff and proposed a teaming pilot to address those concerns. They were recently funded for a childcare coordinator, and they identified the best avenue to support the sheriff would be to have the children's care coordinator work with the deputies when they go out to these homes and provide more intensive resources, warm hand offs to providers, other avenues the deputies may not be aware of, and help with their insurance. The deputy will speak with the family, find out the insurance, and ask if it's okay if they reach out to children's care coordinator. If the family agrees, they have an email address that goes directly to the children's care coordinator, and she reaches out within 24 hours to the family and provides MRT and several other resources and works with them if there are school issues. They also refer them to Integrated Practice Team, where a group of professionals come around the table and meet with the family to work out all the barriers this family has. They follow-up within 2 weeks to determine if they were successfully connected with services.

As of September 27, 2021, they have reached out to 85 families, 47 of those families are engaged in services. It has reduced the number of calls deputies received for those families and it has been very successful. Recently, they had a child in the community that was placed in foster care, the children's care coordinator worked with the integrated team and identified two caregivers that work there to provide 24-hour care. Furthermore, the children's care coordinator made sure this family had wraparound services, connecting them with a targeted CM and connected them with APD. This was a true success of our staff coordinating all these providers together and ensuring their staff had the proper outcomes.

Reynolds question – One of the things working with the ME that we often struggle with is income requirements, family makes too much or not enough and does not qualify for the resources. Are there income requirements?

- **Allman response** – No, not for care coordination itself. For services, the care coordinator would work to identify the most appropriate payor for services. It could be through the Managing Entity or through another agency like APD or DOE or through private insurance.

Reynolds question – Even if there is a waitlist or third party insurance that doesn't have the type of coverage this child needs, they still couldn't access managing entity dollars to get that level of support?

- **Allman response** – It depends, the children's care coordination could be utilized. The Department is paying for the positions, and then what they would do is look at the financial situation of the family and figure out what avenue is available to them for services.
- **Maggie Cveticanin clarification** – There is no financial requirement for that Volusia pilot program. The children's care coordinator works with the family on income requirements

and lines up what services will meet the family's needs and then identifies what services are available or connect with ME and providers.

Reynolds comment – When we are talking about third party commercial insurance, there is a limited ability. We have kids who need more then outpatient, and yet we do not have a continuum of care. We have that with the Managing Entity, but they do not meet their income requirement. Only certain kids who meet criteria can get those services and this is something we will need to figure out as a commission.

- **Allman response** – The income requirement for services through the ME is in statute and that would be something the commission could look at.

Harris comment – As the Secretary of the Department, it is important we ensure kids aren't following through the cracks and we set up the children's care coordinator to make sure they don't. We are trying to wrap our arms around these families and half the battle is making sure the parents know where to access those services and making sure those services are accessible because there are stringent requirements. Hopefully as we progress through the pilot, we can share more info with the commission and help them form more legislative items in how we break down some of those barriers. The goal of the Department is to serve the uninsured and under insured, but I think we need a bit more data to support any legislative items or proposals moving forward.

Chair Prummell question – Requested a copy of the statute for the Finance Committee

- **Allman response** – Will follow-up and send to Pat.

Marstiller comment – In the fall, the agency is moving into a large procurement of the Medicaid program. As we build out the ITN for this, we put in some stringent requirements, requiring the plans to be at the table every single time and we are working hard to ensure the Medicaid health plans are involved when these kids are in crisis and need supports. Second, I am hopeful that one of the things that comes out of this pilot is an ability to provide our court system with some additional tools to be able to place those children in the right environment for them. There are a number of kids in the deep end of the juvenile justice system with mental health issues that cannot be dealt with in the juvenile justice system. Third, I would suggest Mr. Chair that this commission might want to consider getting a presentation from Florida Healthy Kids because they offer insurance options for families who do not qualify for Medicaid. I am hoping there is a way for us to use this pilot and care coordination to inform these families that there is other insurance, state subsidized options for them, outside of Medicaid.

Dr. Gray-Eurom comment/question – Are there thoughts or plans on trying this pilot in a different area? Second, you spoke about the underinsured and the patient that has insurance that creates an underinsured scenario, that is where you are getting into the true cross-team collaboration to bring every potential service to the person who needs it and then finally, the fact that you are already bringing the insurers to the table is really big.

- **Harris response** – In terms of expansion, yes, we are super pleased with the outcomes in Volusia, and we have had conversations about expanding into the Tampa Bay area by March and considering expanding into the Suncoast area as well. Our goal is ultimately to see if we can do this statewide, but we want to be sure we are being measured and learning from our experiences.

In terms of the underinsured, we will use this as an opportunity to determine where we need to be and if there are statutory restraints. We do have money through substance use and block grant funding that we want to maximize, and with AHCA we can see if there are other insurances they may qualify for and with Secretary Marstiller we can see how we can supplement particular gaps.

Larkin – Skinner comment – Couple of things regarding the pilot, CAT team started as a pilot years ago and one way we got funding was through data. Getting the data for this pilot and the next pilot is really important. In our very first meeting we need to see data not just anecdotes. We committed as a commission to look at data and consider the data, as a reminder. It also highlights what we struggle with in funding and the funding silos. This is mostly funded through the county of Volusia and the sheriff is a powerhouse behind it. Every county has a sheriff, and all their relationships are different. We need to make sure we consider that and I'm really glad to hear AHCA will be including this in the RFPs for the plans coming out on managed care. If this does work and the data shows it the kids covered by Medicaid will have this service. Care coordination is important because it brings all the pieces together for the families.

- **Allman clarification** – The Volusia pilot with the children's care coordinator is a DCF funded position. We started collecting data in September 2021, and the managing entity collects data statewide. We will be able to share that as we get further into the pilot.
- **Larkin-Skinner comment** – Why is this one thing set aside and comes down through DCF and why are some things come down through the ME? It's not a criticism, its simply to highlight for the commission some of the confusion and all the different funding sources that come into the community.
- **Allman clarification** – Children's care coordination is available statewide, through the children coordinator positions at every regional office and through each managing entity. The Volusia pilot is specific to that area.

Gadd comment – After Parkland, Pasco County school system partnered with Central Florida Behavioral Health Network, the Managing Entity, to provide behavior health services to children. It has helped us get services to those children who are uninsured or underinsured. I would like to suggest we allow our managing entity to do a presentation on how this program is working. It is in Pasco and Hillsborough County.

Berner comment – We have child care coordinators around the state and we are also building on MRT in the schools and working with our school resource officers. In Martin County, working with the school resource officers, Mobile Response Teams and child care coordination and

targeted services. Last year this time, Martin County school resource officers conducted 52 Baker Acts in schools and this year they have 2. We attribute a lot of that to a fundamental change in resources, providing targeted education to school resource officers, and making Mobile Response Team available. The child care coordination position that the Department added this year has been instrumental, we now have multiple staff supporting children's care coordination. It has been an important component that has enhanced our system.

- **Harris clarification** – Responding to a comment in the chat as to why the managing entities cannot contract with health plans. There are ongoing conversations about how the ME can better support the health plans. There are a lot of moving parts and it's a complex system. These types of models are needed while we work toward the optimal model. Natalie Kelly would be happy to share the data they have been providing to the legislature and Department.

Chair Prummell question – A lot of these different pilot programs and overall programs being implemented either at the county or region are all larger areas with more resources and money. Have we thought about more rural and poor areas with less resources to see how this will work?

- **Harris response** – We would welcome the opportunity to have that conversation. We can follow-up with you offline and Florida Sheriffs Association to see what parts of the state might be ready for something like this pilot. We want to tap into the population cycling in to the DJJ system, so it is important to work with the Sherriff's office.

Chair Prummell question – These rural areas are very fiscally restrained, and you will see more of those uninsured or underinsured, it would be nice to know how these programs will work in smaller areas? We need to look at all these different pilot programs, look at what is successful, and how can we implement these success stories statewide.

- **Harris response** – We did expand into Franklin County, but that doesn't mean we cannot go further.

Chair Prummell question – How long have you been operating in Franklin?

- **Harris response** – December/January.

Chair Prummell comment – Anybody have questions comments or concerns. We can take a break and see everyone at 10:50.

Chair Prummell – Called meeting to order at 10:50.

Chair Prummell question – Commissioner Reynolds and Reeves, you were discussing some funding I am unfamiliar with. Can you please discuss what you were talking about?
Reynolds question – When Secretary Marstiller was talking about Medicaid plans going back out for bid and having a stronger connection, could there be a requirement to have those plans contract directly with the MEs?

- **Reeve response** – There are states where that happen, with braided funded streams. Let me clarify my concern, it has to do with the way DCF contracts are written and the way DCF understands their contracts. There is a very different approach to DCF contracting in comparison to Medicaid contracting. There is a different set of requirements for subcontractors versus vendors. There are arguments to be made on both sides which one is better for the community, but one problem is that traditionally subcontractors are viewed as operating zero sum contracts in other words if there is overage that reverts to the funding agency. Unfortunately, what you don't have is if the funding runs out before that the funding is made up for by the funding agency. Medicaid is a different entity, there are different kinds of contracts where the vendor, i.e. the provider, is expected to manage the funding in such a way they can end up with a novel loss at the end of the year. Two very different models. The issue for me and a lot of providers who contract with both the Department and Agency is if you endure a loss that's on you and anything over can be seized. My concern about that is that DCF methodology would be applied to all funding that flows through them.

Commissioner Leonardo comment – Less than 5-6% of the kids in Florida are uninsured and less than that have behavioral health needs. If we were looking to really do something, then the proposition would be to put all behavioral health regardless of payor through the Managing Entity which is not practical. We have multiple payors who have multiple eligibly requirements and provide a significant variation in terms of services covered. A child in school with a commercial insurance, will benefit from a certain set of services for a certain period of time, and that's true for all funding sources. Unless we say every child in Florida gets these services regardless of who pays, we are going to continue to have a variety of services, access points, programs, etc. At same time, these kids have parents that are not entitled to the same benefits as to the child that is needed to treat the family.

Ideally, we also want to treat the family, both child and parent. We come back to funding as a core challenge, and what we hope to do is improve coordination of services, communication, where there are true gaps in care, and being thoughtful and strategic in addressing gaps rather than capacity. The other thing to think about it is the Managing Entities will have to become managed care plans.

Harris comment – About contracting structure, the Department is making strides and progress in that regard with behavioral health. We are working with AHCA to address the funding issue.

Pat Smith comment – Commissioner Hunschofsky has to go to a committee meeting and wanted to know if she should share her report.

Subcommittee Updates

Business Operations, Commissioner Christine Hunshofsky - provided an update on the business operations subcommittee. Picked a few certain areas they thought they needed to address and had some people volunteer to be the lead on those issues and look at other states that must comply with federal requirements. We also wanted to look at these other agencies and the previous mapping of the Baker Act from House Bill 945. We want to put together a history of how we got to where we are, what legislation got us where we are today, what does the current landscape look like, and what are some best practices we want to adopt.

Commissioner Prummell comment – Want to return to previous conversation. Commissioner Berner has hand up.

Berner comment – ME's have a very flexible payment methodology, and there are a lot of opportunities to look at how the ME's ability to work with individuals eligible for Medicaid and looking at providers who are not enrolled in the Medicaid plans. Keeping an open mind to those possibilities is what I wanted to suggest. There really is an opportunity to dig a little deeper and have a much more appropriately funded behavioral health system. I welcome an opportunity to discuss further but beyond the scope of today's meeting.

Chair Prummell comment – Something the finance committee can dive into as well. Will go to subcommittee updates.

Criminal Justice, Commissioner Mark Mahon – We had a robust meeting, went to our allotted time, and we were very fortunate to have Judge Liefman join as a resource to rely on. The two areas we talked about focusing on were initially the Marchman Act and Baker Act, that is a concern throughout the court system. It's a stabilization and no ongoing treatment. The impact of these individuals on the court system is significant. Another item is restoration of competency. There is apparently a situation in Florida, the State spends about spends about 25% of its mental health budget to restoring competency to individuals. We are trying to look at a system that can improve the restoration of competency and if we can come out with a blueprint or an action plan that will reduce the dollars and improve the system, we could have a huge impact on the mental health service system.

Data Analysis, Commissioner Jay Reeve – We had a productive meeting, talked about the large landscape of gathering data statewide and ensuring we had something that looks like a prevalence map for different psychiatric and substance use issues which should help in terms of resource allocation and targeted intervention in different regions. We were fortunate enough to have friends from USF, The Art Institute, UF, and FSU, who spent their lives looking at data volunteered to form a sub-group. They will look at data from DCF and AHCA which is the

biggest set of data and will look at Juvenile Justice and private insurance. I think through that initial effort we will get a good idea of what we are talking about with prevalence and should be able to feed into a scientific needs assessment.

Chair Prummell – Senator Rouson not currently back on yet. Finance subcommittee had a brief meeting trying to set up their structure and what they will tackle. They will go over major funding sources, identify challenges and opportunities, committee will make recommendations for improvement on how to streamline the process, address priority groups for mental health and substance abuse services, needs assessment, planning activities, and local government mental health and substance abuse activities. They were going to review their roadmap and timeline and stated that members have some latitude to pick the direction because the scope is so broad. There are a lot of different funding sources and that will be a large undertake for that committee. Thank you to those that have worked on multiple subcommittees.

I did attend all subcommittee meetings, I listened to the previous meetings, and started to put bullet points together. I looked at what we are to accomplish under statute and identified what potential subcommittees those questions or concerns need to be addressed by. Will work on fine tuning this and send out to the different subcommittees. It will outline the statute and what your subcommittee needs to address, and if your subcommittee identifies any additional issues we have not covered, please add those to your list of things. I have done field trips to different parts of the state to see programs and taken notes. This has been a much larger undertaking than originally thought and that is why they are looking to push the initial report to January. If the bill Senator Rouson mentioned does go through, we will have two more subcommittee meetings and two more commission meetings before we have a rough draft for our first report. I am hoping to start meeting in person. If it doesn't go, been working with Pat and Mallory, to at least have a draft done in June to present at that meeting but will hopefully have it to you before then. Looking at data sharing and being able to view somebody who is going through the system with a 360-degree view and all the different entities being able to share this individual's treatment plan. Right now, we truly lack that. Recommended Commissioner Reeve and Dr. Sinpatico set up a meeting regarding another pilot program they will be doing down in Miami Dade and then we can bring back to the commission with your recommendations. Thanked DCF staff, Pat and Mallory for all their help.

Commissioner Rein comment – With Southeast Florida Behavioral Health Network, SEFBHN, we saw for the first time a very effective and important sharing of AHCA information with the Managing Entity as part of a pilot project. I encourage Commissioner Reeve, as I join your subcommittee, perhaps Anne Berner could share some info on that. It was incredibly impressive and for the first time we saw common clients of Medicaid and the Managing Entity.

Public Comment

Chair Prummell – Any listeners who would like to make a comment or statement? None. Motion to close public comment, first motion by Jay Reeve and seconded by Clara Reynolds. All those in favor. None opposed.

Will continue to add public comment to commission meetings from here on. Thanked everyone for their participation. If and when we are able to meet in person, I am hoping we will go a bit longer and have some substantive conversations. Before we close, Pat or Mallory is there anything I missed we need to cover? None.

Salamida comment – In addition to some of the complexities, the workforce issues we are having in behavioral health are particularly burning because as we talk about models, pilots, and best practices, it is with the assumption we can hire to populate those programs. We are struggling to staff our existing programs; the wage competition is fierce and there are challenges to have flexibility to increase pay levels to get people to come on board and to stay on board. With the amount of funding in the schools they have some competition. Telehealth, private telehealth providers that are offering qualified clinical staff to work from home, we need their talent here. We are looking for data on this so we can have some discussions and be informed. Would like to touch on at the next meeting.

Chair Prummell question – Commissioner Suryadevara, I recall a program you discussing that is fully staffed?

- **Dr. Suryadevara response** – We have been increasing the training programs in Florida a lot, but other states have been offering more wages. On the other hand, because the training has increased, we are able to keep more residents here.

Chair Prummell question – any recommendations?

- **Dr. Suryadevara response** – Identifying the big stakeholders and where the money can come from, but the bigger challenge has been keeping all of them in Florida.

Salamida comment – When we talk about funding and reimbursement models and the challenges of how funding is allocated and access, it limits our flexibility of what we can do to solve these issues. It is a reality that is impacting our system of care.

Dr. Suryadevara question – Where are the other states getting the money from? Is it just funding or are we doing something wrong?

- **Chair Prummell response** – We see our population increasing and people are flocking here, but I can't answer that.

Salamida comment – What models are used to determine the necessary funding? If it's not adequate funding, it doesn't matter how it is allocated. At some point you must ask what is the

true need? My interest on the finance subcommittee is to push that question. How do we know what is the adequate level of funding and how do we know we are allocating it right based on factors that drive cost? I am curious if that model has ever been explored, but it seems like especially for community mental health centers it is getting harder and harder to keep up with. I think it is an issue for the finance committee to tackle and that is my intent to get us to push that question. What are we doing right and what can we do better?

Chair Prummell comment – Our very first meeting I brought up a similar question, how is funding decided and at that time Natalie Kelly was going over that and there is no set formula. If you guys and finance committee can come up with one that's awesome.

Reeve comment – My hope is that part of what we are doing in the data analysis subcommittee will speak to that and help the work the subcommittee is doing. You must have some sense of the prevalence rate in order to actually say we have x need in y community to see what we can do.

Reynolds comment – Many of the funding models we currently use are ones the state has dictated. We can change that if we have the fortitude and base it upon the data. Once we get the data in place then we can make the case and recommend other changes. I'm going to be hopeful that we can make those changes. As we look at prevalence, we are going to struggle to get data post COVID and the world is going to look very different in populations that never experienced behavioral health that are now asking for resources. We may need to add additional information to it.

Chair Prummell comment – Based on the conversations we had here and going over my notes, a lot of these topics will cross sub-committees. If you come up with a topic and need to have a joint meeting, have those conversations. We want to open up those silos.

Rein comment – Agree with both Commissioner Reeve and Reynolds, letting need define what we create and how we fund it. It starts with defining what that need is.

Closing Remarks

Chair Prummell – Motion to adjourn, first by Commissioner Clara Reynolds and second by Dr. Suryadevara. All in favor to adjourn.

Meeting was adjourned at 11:34 a.m.