Commission on Mental Health and Substance Use Disorder
Annual Interim Report

January 1, 2024

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[1] Judge Ficarrotta resigned as of August 2023; seat remained vacant at date of publishing.

Message from the Chair

Thank you for taking the time to read the 2024 Interim Report by the State of Florida's Commission on Mental Health and Substance Use Disorder. The toll taken by untreated mental illness and substance use disorders in the state of Florida, and across the United States, is often devastating for families, communities, caregivers, and for individuals living with these conditions. Impacts range from loss of connection with families and friends, to impaired functioning at work and in life due to hospitalizations, severe injury, and in too many tragic cases, death. Understandably, families, individuals, and stakeholders can become frustrated and disheartened when faced with these challenges and conditions. Too often, that frustration can turn to feelings of helplessness, hopelessness, and a sense that there is no way forward. The Commission on Mental Health and Substance Use Disorder's (Commission) role, as defined by section 394.9086, Florida Statutes (F.S.), is to recommend a way forward at the state level.

The Commission was created in 2021 by the Florida Legislature, to review the mental health and substance use disorder treatment and delivery systems across the state and make specific recommendations to ensure that this state is providing the best possible behavioral healthcare for Floridians and their families. The first Commission report, issued in January 2023, presented the initial review results and made recommendations. During the 2023 legislative session, the Florida Legislature extended both the timeframe and scope of the Commission and asked for annual Interim Reports over the course of the next three years. This report is the first Interim Report. Over the course of the past year, the Commission has heard hundreds of hours of testimony and presentations regarding the variety of mental health and substance use disorder treatment systems, options, and philosophies in use across the state and the nation. Subject matter experts called by the Commission have tirelessly given their time collecting and presenting data for consideration. Family members and individuals living in recovery from mental illness and substance use disorder have been key participants, as appointed Commissioners, subject matter experts, and meeting attendees.

Throughout the Commission's 2023 meetings, it became clear that the state is currently home to some of the most innovative and effective mental health and substance use disorder treatment approaches anywhere in the country. In the last several years, with the unwavering championship of Governor Ron DeSantis, First Lady Casey DeSantis, and strong legislative leadership and support, Florida has seen the introduction of the 988 Suicide & Crisis Lifeline; Community Action Treatment Teams for children and youth; Central Receiving Facilities for individuals transported under the Baker Act and Marchman Act; Mobile Response Teams; an expansion of Florida Assertive Community Treatment Teams; school-based mental health initiatives; Coordinated Opioid Response (CORE) Network and bridge initiatives that connect services aimed at ensuring rapid treatment of opioid overdose; expansion of integrated mental health and primary care treatment programs; Certified Community Behavioral Health Center model programs;

opioid treatment programs; integrated response teams and residential programs that weave together law enforcement, judicial involvement and behavioral health; as well as a plethora of local solutions. The findings of the Commission inquiries are clear. Across Florida, state agencies, payors such as Managing Entities and Managed Care Organizations, local agencies such as law enforcement and schools, and service providers have all responded and continue to respond creatively and wholeheartedly to address behavioral health issues in the state. This flowering of support for, and creativity and innovation around behavioral health, are reasons for pride and excitement. The challenges in this field are enormous and the pain experienced by families and individuals is profound. Florida's leaders, stakeholders, content experts, funders, and providers are demonstrably eager to overcome the challenges.

In part because of the flowering of support, creativity, and concern from a wide variety of stakeholders, agencies, and communities, the Commission discussion and inquiry in 2023 has centered on questions of coordination and structure between various partners, and specifically how best to align systems, supports and services for maximum community access and quality of care. Feedback from the Legislature, and the DeSantis Administration has been unanimous in requesting that the Commission provide actionable recommendations that can be implemented to support best practices throughout the system of care. This report demonstrates a strong focus on solutions and on maximizing the strengths of the system, as well as coordinating those strengths.

The 12 recommendations made by the Commission this year fall into four general areas: Strengthening Community Networks and Cross-Agency Collaboration, Enhancing the Crisis Care Continuum, Improving Data Collection and Management Processes, and Optimizing the Financial Management of the Behavioral Health System of Care.

The Commission's recommendations are intended to respond to specific Legislative requests as outlined in section 394.9086, F.S., and to be concrete, detailed, and specific. Some recommendations involve substantial revisions to current practice, while some involve relatively small and easy to achieve goals that nonetheless will have significant impacts across the system. All recommendations have been vetted and approved by the full Commission and are offered to the Florida Legislature and Executive Office of the Governor for consideration in continuing the improvement of an already strong system of care.

I would like to express my strongest possible appreciation and gratitude to the Commission's subcommittee chairs: Secretary Shevaun Harris, Representative Christine Hunschofsky, Professor Kathleen Moore, Clara Reynolds, and Senator Darryl Rouson. As chairs of the Commission's subcommittees, these extraordinarily dedicated public servants and content experts have spent countless hours deeply engaged in leading the subcommittees through a dense, sometimes daunting, array of data, testimony, and strong opinions to craft recommendations that support Florida's continued journey

towards greater excellence in the delivery of behavioral health services. I am awed by the commitment, dedication, and brilliance of these leaders.

I would also like to thank all of my fellow Commissioners. The Commission consists of members from all walks of life – elected officials, secretaries of state agencies, department heads, family members and individuals with lived experience, representatives of Managing Entities and payor organizations, academic experts, and providers. Each brings perspective and experience to the table, but we all have one thing in common: an absolute passion and commitment to make the Florida system of behavioral health service delivery the best it can possibly be, and in doing so, improve the lives of millions of Florida citizens and families by ensuring that no one in the state goes without the behavioral health care they need. The brilliance, passion, and compassion of my fellow Commissioners has resulted in a year of very hard work and active meetings that have always been inspiring, productive, and highly engaged. Profound gratitude also goes to the Commission's team of subject matter experts, those individuals who are engaged with behavioral health, and in many cases leading behavioral health research and healthcare, who have committed to and volunteered so much of their time ensuring that the Commission considers the latest information, the most creative solutions, and the best practices. Thank you to the Governor's Deputy Chief of Staff, Katie Strickland, for always being available and supportive. Thank you to Secretary Shevaun Harris and the staff of the Department of Children and Families for providing Commission support, guidance, and structure and particularly to Department of Children and Families' Office of Substance Abuse and Mental Health Assistant Secretary Erica Floyd Thomas, who was crucial in helping to keep the Commission organized, staffed, and on track. Finally, the entire Commission owes an enormous debt to Aaron Platt, Government Operations Consultant within the Office of Substance Abuse and Mental Health. Mr. Platt has served as our guide, our companion, our timekeeper, and the right hand of the chair through evenings, weekends, holidays, and whenever called upon to make sure that the Commission's business was kept on track. Thank you, Mr. Platt!

In closing, and on a personal note, I have been working in the field of behavioral health since 1985. I am humbled and grateful to serve as chair of this Commission. I have rarely had the privilege of working with such a committed, brilliant, and engaged group, especially one with the heart and passion to support individuals dealing with behavioral health issues that this Commission and all those who attend meetings display in every meeting. I look forward with excitement and anticipation to continuing work in 2024 and to our continued journey towards unparalleled behavioral health excellence in Florida.

Jay Reeve, PhD
Chair
State of Florida Commission on Mental Health and Substance Use Disorder

Introduction

The Commission on Mental Health and Substance Use Disorder (Commission) is responsible for examining the current implementation of mental health and substance use disorder services in the state and determining how to improve the effectiveness of existing practices, procedures, programs, and initiatives; identifying any gaps or barriers in the delivery of services; assessing the adequacy of the current infrastructure of the 988 Florida Suicide & Crisis Lifeline system and other components of the state's crisis care continuum; and recommending changes to existing laws, rules, and policies necessary to implement the Commission's recommendations. The Commission meets quarterly or upon the call of the chair via teleconference or in-person.

Beginning on January 1 each year, the Commission presents an interim report on findings and evidence-based recommendations on how to best provide and facilitate mental health and substance use disorder services in the state. The interim report shall be submitted to President of the Senate, the Speaker of the House of Representatives, and the Governor annually through January 1, 2025, until the submission of the final report by September 1, 2026.

To achieve the Commission's objectives, the chairperson of the Commission designates subcommittees to evaluate specific aspects of the state's mental health and substance use disorder services and provides recommendations based on findings.

2023 Commission Subcommittees

The 2023 Commission subcommittee structure evolved over time to ensure membership is organized in a manner that supports the statutory purposes of the Commission and creates opportunities for effective engagement. To that end, and upon successful completion of the respective charge for the Business Operations and Criminal Justice subcommittees, those subcommittees were sunset in 2022.

In 2023, as the Commission embarked on building from the previous recommendations of the Commission, the need for three new subcommittees was identified. The three new subcommittees area of focus are System of Care, Children and Youth Behavioral Health, and Suicide Prevention. The additional subcommittees were added to the existing Commission structure. The Commission worked throughout the year with the five subcommittees dedicated to specific areas of focus, and under this structure, the Commission continues to examine and identify opportunities to enhance Florida's behavioral health system.

Description of the Commission's 2023 subcommittees:

System of Care

The System of Care subcommittee is responsible for conducting a review and evaluation of the publicly funded mental health and substance use disorder services within the Department of Children and Families (DCF), the Agency for Health Care Administration (AHCA), and all other departments or agencies that provide mental health and substance use disorder services as directed by section 394.9086(4)(a), F.S. Through monthly convenings, the subcommittee identified key themes: better coordination of care, enhanced real-time data sharing, need to address workforce challenges, enhance opportunities for data driven decision making, and the need to conduct a service gap analysis.

Children and Youth Behavioral Health

The Children and Youth Behavioral Health subcommittee is responsible for reviewing and evaluating the effectiveness of behavioral health services in the state, identifying barriers to care, assess priority population groups that can benefit from publicly funded care, and propose recommendations for the creation of a single state agency that will manage the delivery of these services. The subcommittee is tasked to identifying gaps in behavioral healthcare and assess current staffing levels and availability of services across Florida.

Suicide Prevention

The Suicide Prevention subcommittee is responsible for conducting a review of the infrastructure of the 988 Florida Suicide & Crisis Lifeline system, evaluating how behavioral health Managing Entities may fulfill their purpose of promoting service continuity and working with community stakeholders throughout the state to support the 988 Florida Suicide & Crisis Lifeline system and other crisis response services. The subcommittee will complete the necessary program evaluations and make recommendations to improve linkages between the 988 Florida Suicide & Crisis Lifeline infrastructure and crisis response services within the state.

Data Analysis

The Data Analysis subcommittee is responsible for reviewing data collection, reporting mechanisms, and other data resources related to behavioral health across all available data sets. The subcommittee is also responsible for making recommendations for the development of a searchable statewide behavioral health data repository to address the quality and effectiveness of the current mental health and substance use disorder service delivery systems, identify gaps in delivery systems, and recommend promising practices and data-based goals for and of current behavioral health systems.

Finance

The Finance subcommittee is responsible for conducting a review and evaluation of the financial management of the publicly funded mental health and substance use disorder

services within DCF, AHCA, and all other departments which administer mental health and substance use disorder services. This review shall include, at a minimum, a review of purchasing, contracting, financing, local government funding responsibility and accounting mechanisms.

Florida Behavioral Health System of Care

DCF and AHCA are a part of Florida's behavioral health system of care and are designed to provide mental health and substance abuse services, supports, and recovery-oriented care for children and adults. DCF is the single state authority on mental health and substance use disorder, the state opioid treatment authority, and are responsible for the designation of Baker Act receiving facilities. AHCA is the single state authority for Florida's Medicaid program and directs the state's health policy and planning. AHCA oversees the licensure of health care facilities, including Crisis Stabilization Units and inpatient psychiatric hospitals.

AHCA and DCF coordinate with other state agencies such as the Department of Health (DOH), the Department of Education (DOE), the Agency for Persons with Disabilities (APD), and local governments in the delivery of mental health and substance use disorder services. These partnerships enhance the provision of prevention, crisis intervention, clinical treatment, and recovery support services for all Floridians. A comparative chart showing the available behavioral health services across Florida's state agencies and third-party insurers are in Appendix 1.

DCF contracts for behavioral health services through seven regional systems of care known as Managing Entities. Managing Entities plan, coordinate, and subcontract for the delivery of community mental health and substance use disorder services, improve access to care, promote service continuity, and support efficient and effective delivery of services. Behavioral health services coordinated by the Managing Entities include assessments, mental health and substance use disorder outpatient services, case management, care coordination, residential services, peer specialists, crisis stabilization services, Mobile Response Teams (MRTs), and other social supports such as supported housing and supported employment. A map of the seven Managing Entities and coverage areas are in Appendix 2.

The Florida Department of Corrections (FDC) provides comprehensive mental health services to inmates starting from the reception process up to a scheduled release. The various levels of mental health care are based upon the seriousness of the inmate's symptoms and associated impairment. Services provided include outpatient care and four levels of inpatient care. Following reception, in which all inmates receive comprehensive mental health evaluations and clinical interviews, inmates are assigned an initial mental health grade; S1 - Routine Care to S6 - Court-Ordered Treatment. As FDC has a no-

wrong-door approach to service access, inmates may change mental health grades over time as behavioral health needs change. For example, inmates that experience an acute crisis may have a brief admission for either Self-Harm Observation Status or Mental Health Observation Status. If the nature of the crisis persists, the inmate may be stepped up to a higher level of inpatient care or stepped down to outpatient services.

The Florida Department of Juvenile Justice (DJJ) serves youth who are at-risk or have come in contact with the juvenile justice system. Mental health and substance abuse services are offered throughout DJJ's continuum of care through prevention, detention, probation, and residential services. Chapter 985, F.S., grants authority to DJJ to establish mental health and substance abuse programs. Rule 63N-1, Florida Administrative Code, created by the DJJ's Office of Health Services establishes the requirements for delivery of mental health, substance abuse, and developmental disability services for youth in probation, intake screening, day treatment programs, secure detention facilities, or residential commitment programs.

The DJJ detention centers are staffed with full-time mental health clinical staff who are on-site daily to provide mental health and substance abuse treatment services. Based upon the individualized treatment needs, the youth in detention are provided services during their stay, and youth who are under probation supervision receive services from outpatient DJJ providers. Mental health and substance abuse treatment services in residential commitment programs range in intensity and include Mental Health Overlay Services; Substance Abuse Overlay Services; Juvenile Sexual Offender Treatment Services; Development Disability Treatment Services; Borderline Developmental Disability Treatment Services; Intensive Mental Health Treatment Services; and Comprehensive Treatment Services for Co-Occurring Disorders.

All youth in DJJ secure detention centers, day treatment programs, and residential commitment programs receive mental health and substance abuse services that are directly funded by DJJ. Some DJJ contracted prevention and probation outpatient community providers may seek Medicaid or private insurance funding before billing DJJ directly for services. All community youth who do not have insurance receive DJJ funded services.

Florida Medicaid Behavioral Health Services

AHCA is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. This authority includes establishing and maintaining a Medicaid state plan, and state plan waivers, approved by the federal Centers for Medicare and Medicaid Services. A Medicaid state plan and state plan waiver is an agreement between a state and the federal government describing how that state administers its Medicaid programs; it establishes groups of individuals covered

under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

As of October 2023, the Florida Medicaid program covers over five million low-income individuals, including over two million youth, or 67 percent, of the youth in Florida.
Florida Medicaid covers a broad array of inpatient and outpatient behavioral health services for a comprehensive approach to treatment and recovery. These services include assessments and evaluations, behavioral therapies, recovery support, case management services, and crisis management.

AHCA continually works to identify and implement new and innovative approaches to optimize access to and delivery of medically necessary behavioral health services for both mental health and substance abuse needs. In addition to a core set of services defined in Florida Medicaid's Medicaid State Plan, the Florida Medicaid Statewide Medicaid Managed Care offers additional services appropriate for individuals suffering from mental illness or substance use disorder, such as short-term residential treatment, inpatient and ambulatory detox, intensive outpatient treatment and partial hospitalization, and crisis management services, such as crisis stabilization and mobile response teams.

In administering the Florida Medicaid Statewide Medicaid Managed Care Program, AHCA has worked closely with Medicaid recipients, plans, providers, and other stakeholders to continuously enhance performance and improve the quality of outcomes and recipient satisfaction. AHCA has approved health plans to provide a variety of behavioral health and substance abuse benefits in addition to those covered under the state plan. In addition, AHCA partners with DCF on a regular basis to align policies and service fee coding for Medicaid with existing DCF guidance and rules for improved interagency cooperation.

AHCA continues to work with the Florida Legislature to fund or enhance the behavioral health service array or activities to support access. Recent examples include:

- Certified Community Behavioral Health Clinics (CCBHCs) are being implemented as a Medicaid covered service by AHCA, in collaboration with DCF, and community behavioral health providers. The implementation plan includes a process for certification, recommendations for Florida specific outcome measures and recommendations for a methodology for value-based payment. AHCA will be submitting a request for federal approval for Medicaid coverage of the CCBHC based on the plan by January 31, 2024.
- The Legislature provided an additional $29,747,679 to provide rate increases for Medicaid behavioral health services in the Medicaid Community Behavioral Health Fee Schedule, effective October 1, 2023.

- The Legislature provided additional funding of $4,400,000 for residency, fellow, or intern positions to address the deficit in mental health and behavioral health facilities. This funds up to $200,000 for each unweighted full-time resident, fellow, or intern position in an accredited program who rotates through mental health facilities to address the severe deficit of physicians trained in these specialties.
- The Legislature provided $1,344,447 in funding to Citrus Health Network for psychiatry residency slots in Federally Qualified Health Centers. This funds psychiatry residency slots for Federally Qualified Health Centers that hold continued institutional accreditation from the Accreditation Council for Graduate Medical Education in adult and child psychiatry.
- The Legislature provided an additional $15,000,000 for a Value-Based Pediatric Behavioral Health Services Reimbursement Increase. This increased reimbursement, effective October 1, 2023, for Value-Based Pediatric Behavioral Health Services provided in a pediatrician's office setting and for medically fragile youth receiving services in a nursing facility.
- The Legislature continued to provide $456,770 to address services for youth in the Statewide Inpatient Psychiatric Program. This program is designed to permit prior authorization of services, monitoring and quality assurance, discharge planning, and continuing stay reviews of all youth admitted to the program.

Florida Behavioral Health Data

The state supports Floridians contending with behavioral health challenges through investments in behavioral health funding across state agencies. During Fiscal Year (FY) 2020-2021, state agencies served over 1.6 million Floridians in need of behavioral health-related services and supports. The tables below display funding, the number of individuals served by state agency, and mental health and substance use disorder expenditures by the agency representing the larger payor in the behavioral health space, AHCA.

FY 2020-2021 Behavioral Health Funding and Number Served by Agency		
Agency	**Individuals Served**	**Funding**
Department of Health	-	$80,827
Department of Elder Affairs	96	$211,145
Department of Juvenile Justice	10,377	$81,595,036
Department of Education	226,087	$107,508,900
Department of Corrections	67,129	$119,779,232
Agency For Health Care Administration	1,123,725	$608,293,631
Department of Children and Families	237,606	$1,052,294,153
Total	**$1,969,762,924**	**1,665,020**

Source: 2022 Commission Data Request

AHCA - Children's Mental Health (MH) Expenditures by Service Type		
Service	**Distinct Claims**	**Total Expenditures**
Long Term Care Services with a Behavioral Health Primary Diagnosis	868	$9,747,930
MH Outpatient Hospital	222,012	$45,835,956
MH Inpatient Hospital	44,261	$171,093,058
Pharmacy	1,487,723	$198,175,864
MH Treatment Services	3,315,984	$253,001,487
Other Services with a Behavioral Health Primary Diagnosis	5,402,874	$458,578,987
Behavior Analysis	2,153,927	$1,078,065,535
Total	**12,610,521**	**$2,214,498,817**

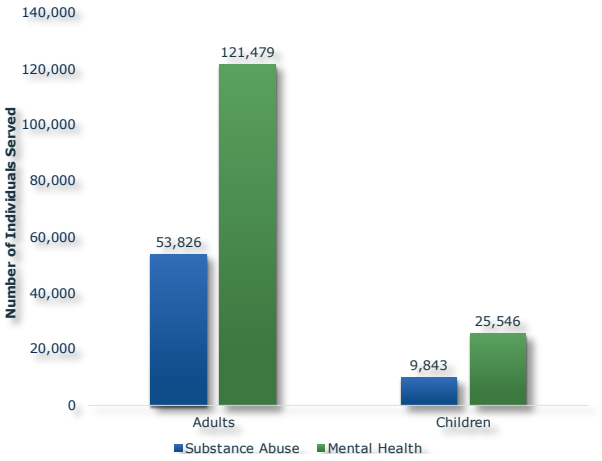
AHCA - Children's Substance Use Disorder (SUD) Expenditures by Service Type		
Service	**Distinct Claims**	**Total Expenditures**
SUD MAT Pharmacy	1,799	$97,922
SUD Treatment Services	5,718	$325,729
SUD Outpatient Hospital	3,431	$1,707,428
Other Services with an SUD Primary Diagnosis	46,981	$2,644,472
SUD Inpatient Hospital	922	$4,117,553
Total	**58,332**	**$8,893,103**

AHCA - Adult Mental Health (MH) Expenditures by Service Type		
Service	**Distinct Claims**	**Total Expenditures**
MH Outpatient Hospital	73,381	$13,637,731
MH Inpatient Hospital	44,986	$135,880,384
Pharmacy	2,244,126	$230,342,990
MH Treatment Services	2,360,898	$286,817,018
Other Services with a Behavioral Health Primary Diagnosis	1,829,288	$292,860,214
Long Term Care Services with a Behavioral Health Primary Diagnosis	74,187	$457,350,854
Total	**6,612,444**	**$1,416,889,190**

AHCA - Adult Substance Use Disorder (SUD) Expenditures by Service Type		
Service	**Distinct Claims**	**Total Expenditures**
SUD Outpatient Hospital	20,572	$7,597,706
SUD MAT Pharmacy	76,686	$16,901,196
Other Services with an SUD Primary Diagnosis	551,269	$24,219,223
SUD Treatment Services	413,993	$27,967,875
SUD Inpatient Hospital	11,234	$34,216,729
Total	**1,052,453**	**$110,902,730**

Individuals Served by the State of Florida

Data shows that in 2021, 725,329 Floridian adults contended with serious mental illness, and 12,568 students in kindergarten through 12th grade had an emotional or behavioral disability.[2] During the FY 2021-2022, DCF provided mental health and substance use disorder services to 210,694 individuals with 17 percent of those served being under the age of 18.



Source: Florida Department of Children and Families

There were over 1,200 distinct mental health diagnostic codes for the individuals served by DCF during FY 2021-2022. The top three mental health diagnoses were Generalized Anxiety Disorder, Post-Traumatic Stress Disorder (Unspecified), and Major Depressive Disorder (Recurrent, Moderate).

Similarly, there were over 700 distinct substance abuse diagnostic codes for individuals served by DCF during FY 2021-2022. The top three substance abuse diagnostic codes were Opioid Dependence (Uncomplicated), Alcohol Dependence (Uncomplicated), and Cannabis Dependence (Uncomplicated).

[2] Florida Department of Health, Mental Health Behaviors and Complications | CHARTS (flhealthcharts.gov)

The tables below display the top five mental health and substance abuse diagnoses for FY 2021-2022.

Top Ten Mental Health Diagnosis Codes, FY 2021-2022	
Diagnostic Code	**# of Individuals**
Generalized Anxiety Disorder	13,668
Post-Traumatic Stress Disorder (Unspecified)	13,126
Major Depressive Disorder (Recurrent, Moderate)	12,401
Major Depressive Disorder (Single Episode, Unspecified)	11,294
Schizoaffective Disorder (Bipolar Type)	8,835
Schizophrenia (Unspecified)	8,271
Bipolar Disorder (Unspecified)	7,861
Attention-Deficit Hyperactivity Disorder (Combined Type)	6,518
Major Depressive Disorder (Recurrent Severe without Psychotic Features)	5,279
Adjustment Disorder with Mixed Disturbance of Emotions and Conduct	4,621

Source: Florida Department of Children and Families

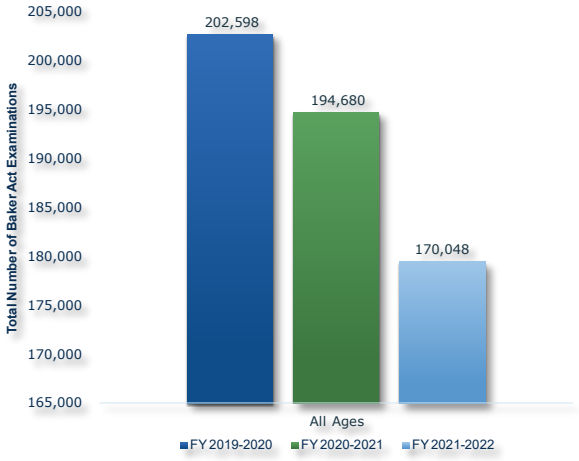
Top Ten Substance Use Diagnosis Codes, FY 2021-2022	
Diagnostic Code	**# of Individuals**
Opioid Dependence (Uncomplicated)	20,458
Alcohol Dependence (Uncomplicated)	9,454
Cannabis Dependence (Uncomplicated)	5,723
Other Stimulant Dependence (Uncomplicated)	4,232
Cannabis Abuse (Uncomplicated)	3,998
Cocaine Dependence (Uncomplicated)	3,936
Alcohol Abuse (Uncomplicated)	2,782
Generalized Anxiety Disorder	1,684
Opioid Dependence (In Remission)	1,624
Problem Related to Unspecified Psychosocial Circumstances	1,562

Source: Florida Department of Children and Families

During a panel presentation on behavioral health episodes at emergency departments, the Commission heard from Florida experts who reported that many overdose victims showing up at emergency departments have co-occurring mental health conditions and may be using substances to self-medicate. Emergency department physicians described the importance of administering buprenorphine and issuing “bridge” prescriptions that help address withdrawal, cravings, and overdose risk until individuals can connect to long-term community-based care. Peer specialists help engage treatment resistant individuals in conversations about medication-assisted treatment and help navigate them toward other needed services. Some patients find buprenorphine easier to transition onto than methadone, because it is less stigmatized and doesn’t require daily dosing at designated clinics.

Baker Act Data

The Florida Mental Health Act, commonly referenced as the Baker Act, is a Florida law that enables families, the court, and certain medical and mental health professionals to provide emergency mental health services and temporary detention for individuals who are impaired due to a mental illness and are unable to determine individual needs for treatment. Due to the nature of mental health diagnoses, individuals with mental illness may experience crisis episodes and require short-term evaluation and treatment.

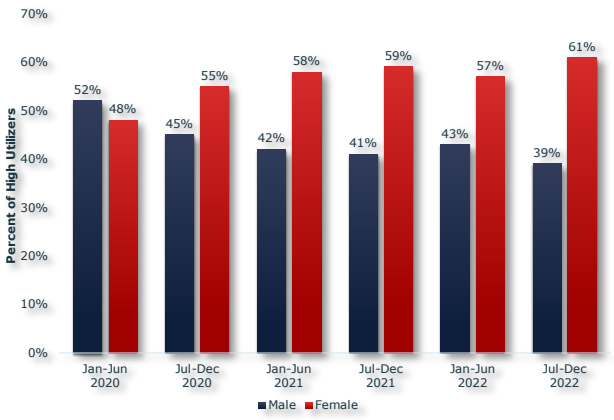


Source: Florida Department of Children and Families

During FY 2021-2022, there were 170,048 involuntary examinations (Baker Acts) for 115,239 individuals, marking a 13 percent decrease from the previous FY. This marks the third year reflecting a reduction in the number of Baker Acts statewide. The statewide decrease for FY 2021-2022 could be accounted for by a decrease in Baker Acts across all age groups, where an 11 to 13 percent decrease is observed depending on the age group. The FY 2021-2022 Baker Act Annual Report is available at: https://myflfamilies.com/services/samh/publications.

High Utilizers of Crisis Stabilization Services

House Bill 945 (2020), tasked AHCA and DCF with identifying children and adolescents who are the highest users of crisis stabilization services and collaboratively taking appropriate action within available resources to meet the behavioral health needs of such children and adolescents more effectively.



Source: Florida Agency for Healthcare Administration

A high utilizer is defined as someone 18 years of age or younger with 3 or more Crisis Stabilization Unit (CSU) admissions within 180 days. For 2022, the average number of admissions for high utilizers identified during July-December was 4.8.[3] During that same period, 61 percent of high utilizers were female.

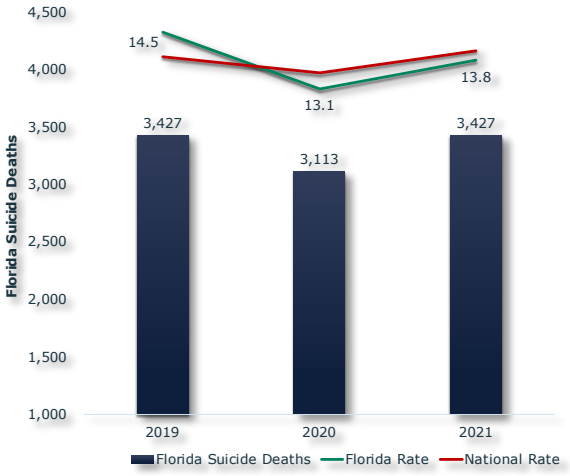
[3] Florida Agency for Healthcare Administration

Suicide Data

In 2021, suicide was the 12th leading cause of death in Florida, and 3,325 lives were lost to suicide, conferring a rate of 14.0 per 100,000 individuals which marks a 6.87 percent rate increase from 2020.[4]

In Florida, males experience more than three times the rate of suicide deaths compared to females, a trend that has persisted for over 50 years.

While 2021 data shows a slight increase in total suicide deaths, these numbers are a general decrease compared to national suicide data.



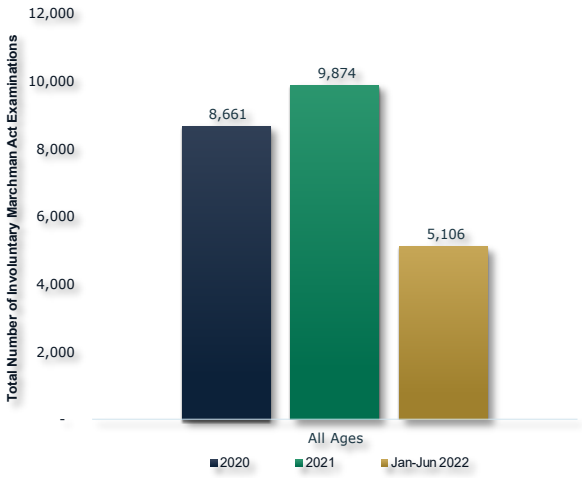
Source: Florida Agency for Healthcare Administration

Additional information on Florida's suicide data and initiatives are available on the Suicide Prevention Coordinating Council's Annual Report: https://myflfamilies.com/services/samh/publications.

Marchman Act Data

The Hal S. Marchman Act allows for voluntary admission and involuntary assessment, stabilization, and treatment of youth and adults who are seriously impaired due to substance use.

Data from the Office of the State Court Administrator shows a 14 percent increase in the number of involuntary Marchman Act examinations from calendar year 2020 to 2021. Provisional data shows that that over 5,100 involuntary Marchman Act cases were filed between January and June 2022.



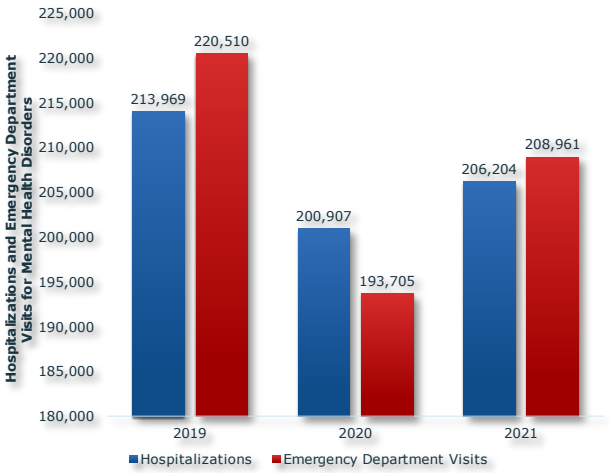
Source: Office of the State Court Administrator

[4] Florida Department of Health, Suicide and Intentional Self-Harm Deaths and Hospitalizations | CHARTS (flhealthcharts.gov)

Hospitalizations and Emergency Department Visits for Behavioral Health Disorders

In 2021, there 206,204 hospitalizations for mental disorders which includes, schizophrenia, mood disorders, intellectual disabilities, and drug and alcohol induced mental disorders. 46 percent of hospitalizations were for mood and depressive disorders.[5] 34 percent of mental health hospitalizations were for adults ages 25 to 44.[6]

There were 208,961 emergency department visits for mental disorders for 2021 which accounted for 3 percent of all emergency department visits.[7] Over 13,000 emergency department visits were due to intentional self-harm injuries in 2021.[8]



Source: Florida Agency for Healthcare Administration

Florida Department of Corrections Office of Health Services

FDC has over 85,000 inmates in its correctional facilities and supervises almost 140,000 offenders as part of its community supervision operation. On a daily basis, approximately 23 percent of the 85,000 active inmate population is diagnosed with a mental illness that affects their functioning, and up to 69 percent of the total population have accessed mental health services within the last year. Over the last decade, the percent of inmates diagnosed with a mental illness has steadily increased while the overall prison population has decreased.

Correctional Substance Use Treatment

FDC provides in-prison and community-based substance disorder treatment programs throughout the state. Substance use and dependence among the justice-involved population, as well as the general population, continues to be a pervasive and costly problem. Incarcerated individuals are seven times likelier than individuals in the general population to have a substance use disorder. More than two-thirds of individuals in jails are dependent on or have abused alcohol or drugs, with little difference in the overall prevalence between men (68 percent) and women (69 percent). Staggering recidivism rates further compound the issue, as more than half (52.2 percent) of all incarcerated substance-involved individuals have one or more previous incarcerations, compared with 31.2 percent who are not substance- involved.

[5] Florida Agency for Healthcare Administration, Hospitalizations From Mental Disorders - FL Health CHARTS
[6] Florida Agency for Healthcare Administration, Hospitalizations for Mental and Behavioral Health Disorders - FL Health CHARTS
[7] Florida Agency for Healthcare Administration, Emergency Department Visits - FL Health CHARTS
[8] Florida Department of Health, Suicide and Intentional Self-Harm Deaths and Hospitalizations - FL Health CHARTS

FDC estimates that at least 58 percent of approximately 85,174 incarcerated individuals (prison status population on June 30, 2023) meet the screening criteria for substance use treatment. Therefore, there are approximately 49,719 individuals currently incarcerated in need of substance use assessment and treatment. However, only approximately 38 percent of these individuals receive services. While approximately 59 percent of 84,034 individuals on active community supervision have an identified substance use disorder history. As of June 30, 2023, approximately 43,665 individuals needed community-based outpatient substance use treatment. However, only approximately 47 percent of individuals receive these services.

Florida Behavioral Health Initiatives

Expansion of Behavioral Health Services

DCF has been working steadfastly to bolster the state's system of behavioral health care. Over the previous five years, more than $5.3 billion has been invested in behavioral health services for youth and adults. During the last FY year, that resulted in nearly 80,000 individuals receiving substance use disorder services and more than 179,000 individuals receiving mental health services through DCF.

During FY 2022-2023, DCF received over $100 million to expand access to behavioral health services throughout the state and reduce waitlists for services that support individuals, youth, and families with complex needs through treatment teaming approaches, residential services, and recovery supports, including: Florida Assertive Community Treatment teams, Community Action Treatment teams, Family Intensive Treatment, Respite Care, and MRTs.

988 Florida Suicide & Crisis Lifeline

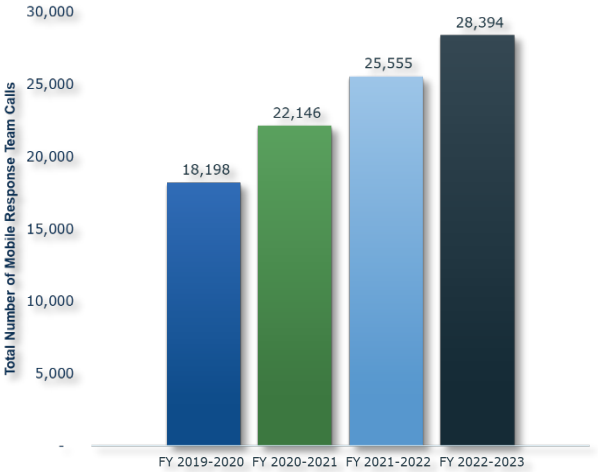
The National Suicide Hotline Designation Act of 2020 amended the Communications Act of 1934 to designate 988 as the easy to remember three-digit dialing code for individuals experiencing a mental health or substance use crisis, including suicidal thoughts and feelings. Serving as an expansion of the 11-digit predecessor, the National Suicide Prevention Lifeline, 988 provides a single-point-of-entry into the crisis care continuum. The nationwide 988 Suicide & Crisis Lifeline went live on July 16, 2022.

Florida has a 988 network of 13 Lifeline Centers to properly serve the state. A 988 caller in Florida is routed to one of the 13 Lifeline Centers through a routing algorithm using designated county coverage areas. If a center is unable to answer a call within 120 seconds, the call is then routed to an in-state backup center. This provides two levels of localized support before a call is routed to the national backup that, while serviceable, may be unaware of the nuances within the crisis care landscape of a given state or region.

The 988 Florida Suicide & Crisis Lifeline served 173,520 individuals through calls, chat, and text in the first year, July 2022 through July 2023. The 988 Lifeline Centers reported a 97 percent diversion rate, or crisis calls that did not require an in-person response after telephonic support. In-state answer rates improved by 21 percent, rising from 54 percent in July 2022 to 75 percent in June 2023. From the time data collection began in October of 2022, through June of 2023, there were 786 suicide attempts in progress averted by Florida's 988 Lifeline Centers.

Mobile Response Teams

MRTs are available 24 hours a day, 365 days per year, to help diffuse crisis and avoid the need for crisis services such as involuntary Baker Act examinations. Historically, MRTs focused on individuals under 25 years old. During FY 2022-2023, DCF funded additional MRTs and expanded capacity of existing MRTs. With the additional capacity, MRTs expanded focus to serve individuals of all ages.



Source: Florida Department of Children and Families

The total calls received by MRTs over the last four FYs has steadily increased as there has been a 59 percent increase in the total number of calls received since FY 2019-2020, highlighting the need for expanded mobile crisis services. Even with the increase in the total call volume, the potential diversion rate from involuntary Baker Act examinations has remained over 80 percent since FY 2019-2020.[9] The implementation of MRTs in Florida has been one element cited as having a direct impact on reducing the number of Baker Acts, which have been trending down dramatically over the past three years.

Baker Act Data Collection System

DCF prioritizes analyzing data in ways that allows a deeper understanding of system challenges and improve outcomes in individuals served. DCF also acknowledges the importance of access to near real-time data in informing practice.

While Baker Act data is robust and provides insightful information about Baker Act examinations, DCF continues to identify methods to improve efficiency and strengthen services. As a result, DCF has developed a web-based system, the Baker Act Data Collection System (BADCS), to streamline data collection while enhancing data quality, accessibility, timeliness, and reporting through the development of a public facing dashboard.

[9] Florida Department of Children and Families

DCF anticipates that these enhancements will enable us to continue fulfilling our priorities as the state's mental health authority, while allowing partners and stakeholders to make community-level decisions regarding crisis care using near real-time data.

Naloxone Distribution

Since 2016, DCF's Overdose Prevention Program has been distributing naloxone to individuals at risk of witnessing or experiencing an opioid overdose and saving thousands of lives as a result. There would have been considerably more than 6,442 opioid-caused deaths in 2021 had it not been for the 7,859 reported overdose reversals using DCF's naloxone kits. The table below charts the growth in the Overdose Prevention Program from 2018 through 2022, for the number of organizations enrolled to distribute, the number of naloxone doses distributed, and the number of overdose reversals (which are voluntarily reported and therefore undercounted).

Naloxone Distribution			
Year	**Distributors Enrolled**	**Doses Distributed**	**Overdose Reversals Reported**
2018	58	35,338	1,466
2019	101	73,406	1,737
2020	164	139,114	4,434
2021	256	264,538	7,859
2022	396	348,186	11,196

Source: Florida Department of Children and Families

The FY 2023-2024 General Appropriations Act specifies that $250,000 from the Opioid Settlement Trust Fund be used to provide the Florida College System and State University System with a supply of emergency opioid antagonists with an auto-injection or intranasal application delivery system for an individual believed to be experiencing an opioid overdose. The intent is for an opioid antagonist delivery system to be in each residence hall or dormitory residence. DCF will transfer these recurring funds to DOE for the Florida College System and State University System to be administered by the Board of Governors.

Certified Community Behavioral Health Clinics

In May of 2023, the Commission heard a presentation by the National Council for Mental Wellbeing regarding the CCBHC model. CCBHCs are nonprofit clinics that meet certain standards for services, technology, partnerships, and data reporting to provide better access to services for more people. The model supports clinical protocols with effective financing to ensure accountability, promote effective clinical care and cover the actual cost of care. Florida has 23 providers implementing the CCBHC model.

Other states adopting the model report the following outcomes:

- Reduction in inpatient hospitalization;
- Increase in the number of individuals served with other behavioral health services;
- Reduction in time and costs incurred by law enforcement officers providing transportation; and
- Increase in the percentage of individuals receiving medication-assisted treatment.

Medicaid Health Plan Performance Improvement Projects

AHCA has contractually required the Medicaid health plans to conduct a Performance Improvement Project focused on improving follow-up visits within seven days after a hospitalization or emergency department visit related to behavioral health.
The three specific measures of focus are:

- Follow-up after hospitalization for a mental health disorder.
- Follow-up after emergency department visit for a mental health disorder.
- Follow-up after emergency department visit for a substance use disorder.

The health plans are implementing a variety of activities to improve performance in this area, including the following:

- Using Florida's Encounter Notification Service to timely identify health plan members with behavioral health-related hospitalizations and emergency department visits and provide outreach to the members to schedule follow-up visits.
- Conducting in-service trainings with discharge planning teams at behavioral health facilities that did not schedule seven-day follow-up appointments.
- Identifying and providing outreach to emergency departments and inpatient providers regarding assistance with scheduling follow-up appointments and the plans' coverage of behavioral health services.
- Offering Healthy Behaviors incentives to enrollees to for completing follow-up visits within seven days after discharge.
- Developing Pay-for-Performance programs to offer incentives to providers for meeting specified quality metrics.
- Enhancing discharge planning and care coordination/case management.
- Promoting telehealth utilization for seven-day follow-up appointments.

Under the current Florida Medicaid Statewide Medicaid Managed Care program re-procurement, one of the quality goals is to improve childhood and adolescent mental health for the upcoming new managed care contracts.

Youth Resiliency Initiative

An update on the initiative to build resiliency amongst students and the mental health allocation to the Children and Youth Behavioral Health subcommittee was presented by DOE in June. Resiliency is being prioritized by DOE through a toolkit that shares dynamic resources for students and parents/caregivers, educators, and community partners. School districts provide five hours of data-driven instruction related to resiliency, character development, and mental health to students in grades sixth to 12th annually. Additionally, more than 80 percent of school staff receive mental health awareness training and the mental health assistance allocation and Florida safe schools' assessment tool strengthen school safety and support training, services, and resources.

The purpose of the Mental Health Assistance Allocation funding is to support school-based mental health care, train staff in detecting and responding to student mental health issues, connect students to appropriate services and focus on delivering evidence based mental health care to students. Florida has made significant investments in the mental health and wellbeing of youth and since 2019-2020 the allocation has grown from $75 million to $160 million in 2023-2024.

Residential Continuum of Care

In 2018, the FDC launched the Residential Continuum of Care Program at Wakulla Correctional Institution Annex. This facility includes a Diversionary Treatment Unit, Secure Treatment Unit, and Cognitive Treatment Unit. A Diversionary Treatment Unit for women was later opened at the Florida Women's Reception Center. These specialized residential mental health treatment units provide enhanced protective housing and evidence-based treatment services to individuals with serious mental health concerns that have traditionally demonstrated difficulty adjusting to daily living in the general inmate population.

The Secure Treatment Unit is designed to serve inmates diagnosed with a serious mental illness who, due to behaviors, would otherwise be at or considered for a Close Management facility. The Diversionary Treatment Unit is designed to serve inmates who are unable to function in general population due to serious mental illness and are not in need of the inpatient level of care. The Cognitive Treatment Unit is designed to address the habilitation needs of inmates with moderate to severe impairment in cognitive functioning.

Mental Health Re-Entry Program

FDC arranges for continuity of post-release care for inmates who are receiving psychiatric care for the disabling symptoms of a mental disorder prior to end-of-sentence. In addition, FDC ensures that inmates with milder forms of mental disorder are counseled in preparation for their re-entry into the community. The Mental Health Re-Entry Program has established agreements with DCF, the Social Security Administration, and the

Veteran's Administration to assist in getting mental health patients the follow-up care and financial support they need as soon as possible after release from prison.

Department of Corrections' Office of Community Corrections

The Office of Community Corrections (OCC) is responsible for overseeing the supervision of over 140,000 adult offenders across Florida. The scope of supervision includes various categories such as parole, conditional release, conditional medical release, court-ordered supervision like regular probation, administrative probation, drug offender probation, sex offender probation, and community control. Correctional Probation Officers play a crucial role in enforcing standard and court-imposed conditions, conducting field contacts, investigations, and making referrals to assist offenders in successfully completing their terms of supervision.

OCC actively collects and analyzes data related to mental health and substance use disorders within the supervised population. Through comprehensive assessments and ongoing monitoring, FDC gains insights into the prevalence, trends, and specific needs of individuals grappling with these issues within the correctional system. This data-driven approach is pivotal in tailoring targeted interventions and support mechanisms to address the complex challenges associated with mental health and substance use disorders among inmates. In alignment with a commitment to rehabilitation and public safety, OCC has undertaken various initiatives to enhance mental health and substance use disorder interventions. These initiatives involve collaboration with mental health professionals, addiction specialists, and community partners (e.g., Drug and Mental Health Courts).

FDC recognizes the interconnected nature of mental health and substance use issues and works towards implementing evidence-based practices that promote effective treatment modalities. Additionally, there is a focus on providing comprehensive training for probation staff to better identify, respond to, and support individuals with mental health and substance use disorders throughout their transition back into the community. Furthermore, OCC delivers yearly online training sessions on mental health supervision for probation officers. Additionally, OCC is in close collaboration with the Office of Health Services to develop an in-person training program specifically designed to address the supervision of offenders grappling with mental health issues.

OCC plays a pivotal role in supervising over 140,000 adult offenders through a network of probation officers. With a strong emphasis on data-driven strategies, collaborations, and specialized courts, FDC strives to address mental health and substance use disorders, reduce recidivism, and enhance rehabilitation outcomes. The commitment to evidence-based practices, comprehensive training, and community partnerships reflects a holistic approach to public safety and the successful reintegration of individuals into society.

Department of Juvenile Justice Initiatives

In 2023, DJJ's Office of Health Services partnered with DCF to provide an overview of DJJ's mental health and substance abuse system of care to Mobile Response Teams and Community Action Teams. The presentations were completed statewide to ensure effective collaboration and care coordination of mental health and substance abuse services.

In keeping with DJJ's guiding principle to use high-quality data to inform decision-making, the Office of Health Services began a six-month study of precipitating factors leading up to Baker Acts in juvenile detention and residential commitment programs.

DJJ has participated in all relevant aspects of Florida's State Health Improvement Plan. One area of emphasis in the past year has been to train and equip all secure juvenile detention facilities, residential commitment programs, and various juvenile probation offices/programs with Naloxone through the DOH's Helping Emergency Responders Obtain Support program.

Commission Recommendations

The Commission has put forth research-based and data-driven recommendations with measurements of impact in mind. Overarchingly, the goal is to arrive at a comprehensive, equitable behavioral health system of care that is interconnected and efficiently provides quality care and resources to the most vulnerable.

The recommendations have been constructed through extensive discussion, research, and are in alignment with the statutes that address the mission and objectives of state-supported mental health and substance use disorder services and the duties of the Commission. These recommendations directly address planning, management, staffing, financing, contracting, coordination, and accountability objectives.

To better inform the Commission's actions and future recommendations, the first recommendation is the execution of a gap analysis. A gap analysis will provide a clear picture of the state's behavioral health infrastructure and provide needed insight.

The remaining recommendations brought forth by the subcommittees were sorted into four thematic groups:

- Strengthening Community Networks and Cross-Agency Collaboration,
- Enhancing Crisis Care Continuum,
- Improving Data Collection and Management Processes, and
- Optimizing the Financial Management of the Behavioral Health System of Care.

Recommendation 1: Complete a Gap Analysis.

To better inform the Commission's actions and recommendations going forward the leading recommendation is the execution of a gap analysis. A gap analysis will allow for the Commission to have a clear picture of the state's behavioral health infrastructure and provide the needed insight to inform subsequent recommendations.

The Commission has recommended the development of a gap analysis to better understand the needs of consumers, providers, Managing Entities, and key stakeholders. A gap analysis will accomplish the following:

- The gap analysis will include a demographic profile of individuals served by each managing entity, the homeless population, individuals served by multiple systems, service units' availability and costs, consumer input, and other factors that will help the Commission evaluate the behavioral health system of care.

This analysis will assist in identifying key services that need expansion to address challenges and reduce the use of more costly services. To ensure the success of the analysis, regional representatives from various agencies will be involved, including DCF, the Florida Association of Managing Entities (FAME), AHCA, APD, DOE, DJJ, the Florida Sheriff's Association, Florida Hospital Association (FHA), Florida Behavioral Health Association (FBHA), and other local behavioral health providers.

Due to the complexity of the analysis, DCF has started researching the expertise and costs required for conducting a comprehensive gap analysis for the Florida behavioral health system of care. The first phase of research found that a multidisciplinary team of professionals is necessary for effective evaluation, combining expertise in both behavioral health services and healthcare system analysis. DCF has determined the type of professionals required for conducting an analysis of this scale, which includes healthcare analysts and health service researchers, behavioral health experts and clinicians, health policy analysts, community engagement specialists and advocates, individuals with lived experience, and project management professionals. This team can collectively address the different aspects of the system, from clinical quality to policy and community engagement, leading to a more comprehensive assessment and actionable recommendations for improvement. Currently, DCF is conducting the second phase of research to determine the estimated cost associated with the analysis.

An important note is that during FY 2021-2022 the legislature appropriated $500,000 to facilitate an assessment of cultural health disparities related to awareness of, and engagement with, mental health and substance use services. The resulting 2*022 Florida Cultural Health Disparity and Behavioral Health Needs Assessment* was a collaboration between the Managing Entities and nine Local Health Councils throughout the state. This

comprehensive assessment contains information on individuals served (including a demographic profile), community health, expenditures by covered service, and results of focus groups and surveys of consumers, providers, stakeholders, members of vulnerable communities, and Peer Recovery Support Specialists on topics like the No Wrong Door Model, awareness of resources, and barriers to accessing care.

The assessment highlighted survey fatigue as an important consideration for future assessments. Survey fatigue occurs when respondents lose interest or motivation to complete surveys which can impact the overall response rates or the quality of participant responses.[10] The report advised that, "Survey fatigue is a community issue which can prevent gathering information for future planning and policy making…The focus of many surveys can be redundant and the questions duplicative. Respondents are very weary of this process that requires valuable time, yet direct benefit may not be realized for several years." Although needs assessments and gap analyses produce different findings, the methods of gathering information are largely similar. Therefore, survey fatigue should be taken into consideration when conducting the gap analysis.

The Commission anticipates a fiscal impact for this recommendation to contract for an entity to perform the gap analysis. Based on the findings of the gap analysis there may be additional fiscal impacts that are currently unknown at the time of this report.

Strengthening Community Networks and Cross-Agency Collaboration

The behavioral health system of care approach intends to build a coordinated network of services to ensure that all Floridians receive individualized mental health and substance abuse support. These services are offered and maintained through the collaborative efforts of multiple agencies, private entities, and community-based service providers. This group of recommendations serves to strengthen the relationships and build the necessary agreements to bolster the current system of care.

Recommendation 2: Expand Patient Centered Behavioral Health Clinics.

The Commissions recommends developing a standardized framework for a Florida-specific CCBHC model. The CCBHC model is a framework designed to enable coordinated, comprehensive access to behavioral healthcare services. CCBHCs serve individuals seeking care for mental health or substance use, irrespective of their ability to pay, place of residence, or age. This includes the provision of developmentally appropriate care for children and youth. CCBHCs are required to comply with specific

[10] Brown, R. F., St. John, A., Hu, Y., & Sandhu, G. (2023). Differential Electronic Survey Response: Does Survey Fatigue Affect everyone equally? *Journal of Surgical Research*, 294, 191–197. https://doi.org/10.1016/j.jss.2023.09.072

service standards established by federal regulations and ensure expedited access to care.

There are 23 providers in Florida receiving funding to implement or expand the CCBHC model. In 2022, the National Council for Mental Wellbeing prepared a CCBHC Impact Report which found that Florida's CCBHCs served 23 percent more individuals than prior to CCBHC implementation, 87 percent of Florida's CCBHCs saw individuals for routine needs within 10 days of the initial referral compared to the national average of 48 days, and on average, Florida CCBHCs hired 27 new staff in 2022.[11]

Currently, DCF contracts with Managing Entities to plan and administer services included in the proposed Florida CCBHC model. Services include care coordination, crisis services, psychiatric rehabilitation services, peer specialists and family support services, and outpatient mental health and substance use services. If CCBHCs are implemented, the reimbursement of services bundled under the Medicaid rate will shift payment of certain services from DCF to Florida Medicaid. However, this shift does not eliminate the overall need for DCF to provide services as the CCBHC will not include all DCF's covered behavioral health services and supports. DCF will continue to contract with providers outside of the scope of CCBHCs' services and catchment area. This approach enables the prioritization of more intensive, evidence-based services to serve the population.

A key feature of the CCBHC model is the requirement that crisis services are available 24/7, thereby enabling individuals to access essential care during emergencies. CCBHCs also provide care coordination to facilitate patients' navigation of behavioral health care, physical health care, social services, and other pertinent systems.

At minimum, the standardized framework should address the following behavioral health challenges and barriers: staffing, accessibility, care coordination, service scope, quality and reporting, and organizational authority.

The 2023-2024 Florida General Appropriations Act included proviso language directing AHCA to develop an implementation plan to add CCBHC services as a Medicaid-covered service. AHCA developed the implementation plan which outlined the tasks, milestones, and responsibilities related to the execution of Florida CCBHC model. The implementation of the proposed framework will require collaboration among various organizations including DCF, AHCA, Managing Entities, FBHA, and other local behavioral health providers. The full implementation plan is available online through AHCA's website[12].

[11] National Council on Mental Wellbeing. (2022). (rep.). *2022 CCBHC Impact Report: Expanding Access to Comprehensive, Integrated Mental Health & Substance Use Care*. Retrieved November 29, 2023, from https://www.thenationalcouncil.org/resources/2022-ccbhc-impact-report/.

[12] CCBHC Implementation Plan | Agency for Healthcare Administration

This recommendation will have a fiscal impact on AHCA and DCF, the amount is indeterminate at the time of this report. CCBHC providers have begun to assess the fiscal impact to the Medicaid program for the first cohort of CCBHCs. The results of their assessment were not available at this time.

Recommendation 3: Establish Regional Collaboratives.

The Commission recommends establishing regional collaboratives that address ongoing challenges at the local level. The purpose of the regional collaborative is to facilitate enhanced interagency communication, promote the development of regional strategies tailored to address community-level challenges and create opportunities to improve the accessibility, availability, and quality of behavioral health services. The regional collaborative membership will be comprised of representatives from DCF, Managing Entities, AHCA, Medicaid health plans, APD, DOE, DOH, Florida Sheriff's Association, FHA, and FBHA.

This recommendation will have a fiscal impact. AHCA and DCF will lead the responsibility for organizing and facilitating meetings of the collaborative and all identified agencies will expend additional resources to participate. Costs will depend on details like the meeting format (in-person or virtual), number of participants or representatives from each agency and organization, frequency of meetings, and the involvement of personnel needed for logistics and for the development of regional strategies.

Recommendation 4: School District and Managing Entity Behavioral Health Memorandum of Understanding.

Section 394.491, F.S., outlines certain principles that guide the publicly funded child and adolescent mental health treatment and support system. These principles require that children and adolescents receive services that are integrated and linked with schools, residential child-care agencies, and other child-related agencies and programs. Services delivered in a coordinated manner allow for a child or adolescent to move through the system of care based on their changing needs. The provision of comprehensive and coordinated child and adolescent mental health services enhances the likelihood of positive outcomes and contributes to the child's or adolescent's ability to function effectively at home, school, and in the community.

The Commission recommends that school districts negotiate a Memorandum of Understanding (MOU) with local Managing Entities to set forth a defined process to engage a comprehensive coordinated approach that addresses students' behavioral health needs through effective planning, referral management, service provision, resource allocation, data collection and program performance monitoring.

The MOU should be developed and widely distributed among the school district's principals, the corresponding managing entity, and identified public or private community mental health service providers pursuant to House Bill 5101 (2023). House Bill 5101 (2023) created section 1006.041, F.S., to require each school district to develop and submit a plan detailing the district's mental health assistance program. Within this plan, the district must contract or establish agreements with local community behavioral health service providers to provide behavioral health services and support at the district's schools. The services provided can be provided on or off the school campus and may use telehealth services as needed.

The MOU will establish a framework for effective communication practices for addressing school mental health services and privacy considerations related to the exchange of information between the parties to this MOU and the relevant laws and regulations. DOE will oversee the local school districts' participation to ensure the MOU remains current, useful, and relevant.

The MOU should include the following components:

- Contact details of staff members from both parties responsible for implementing the MOU.
- A management plan for the needs assessment.
- Jointly developed protocols and contact points for Mobile Response Teams.
- Efforts to align DOE-approved suicide screening instruments.
- The conditions under which a referral for Managing Entity care coordination will be made.
- A plan to connect school districts to children's crisis units or hospitals to obtain child-specific information with signed parental/guardian release of information.
- A communication plan for evidence-informed trainings relevant to school district personnel and system alignment.
- A plan for sharing aggregated data on the behavioral health system as well as child-specific data for educational planning with appropriate release of information.

A proposed MOU Framework for the local school districts, Managing Entities, and public or private community mental health service providers can be found in Appendix 3.

The school districts, Managing Entities, and community mental health services providers will need budget and staffing resources to support operations and identify responsibilities related to the implementation of the MOU Framework and its requirements. The associated costs may vary at regional-level and are indeterminate at the time of this report.

Recommendation 5: A Multi-Agency Continuum of Care Collaborative.

Florida's behavioral health system of care is managed by a several entities which all play a vital role in the delivery of children's mental health and substance abuse services. For children with specialized treatment needs, navigating the system of care can be challenging for them and their families. Without the appropriate treatment, a youth's behavioral health symptoms may escalate resulting in the need for more intensive care.

The Commission recommends the designation of a single state agency to lead a collaborative effort between DCF, AHCA, Managing Entities, Community Based Care lead agencies, Medicaid health plans, service providers, youth, and families to create a Multi-Agency Continuum of Care Collaborative. The Collaborative will define, develop, and monitor the continuum of care for Florida's children with complex behavioral healthcare needs and challenges to improve the quality of and access to services.
The collaborative would be responsible for:

- Documenting, summarizing, and reporting to the legislature annually about statewide access, utilization, and effectiveness of both residential treatment services and those services that, if effective, could prevent and limit the need for more intensive residential treatment.
- Defining and developing an effective and sufficient continuum of care that includes:
    - Care Coordination to guide families towards appropriate, early, and non-residential treatment interventions and, when necessary, residential treatment.
    - Expanded residential options, including respite and short-term residential treatment.
    - An adequate and effective statewide inventory of specialized therapeutic group care programs.
    - Specialized therapeutic group care options for specific targeted populations, such as children with unique abilities and developmental delays, children with histories of aggressive or delinquent behavior, and children who are sexually reactive or human trafficking victims.
- Regularly reviewing and analyzing reimbursement rates to:
    - Recognize the complexity and variety of children's needs, acknowledging that one rate may not adequately cover specialized treatment needs.
    - Identify changing and emerging populations, problems, and needs, and facilitate adjustable and enhanced rates within each level of care to address gaps.
    - Adjust and respond to market, technology, and industry changes and advances.
- Reviewing and revising 65E-9, Florida Administrative Code to streamline the licensing process, remove outdated and potential barriers to obtaining licensure, and support the increase of statewide program capacity for residential treatment centers.

The Commission anticipates AHCA and DCF as the lead of the Collaborative. They will need budget and staffing resources to support operations and identify responsibilities, the amount is indeterminate at the time of this report.

Enhancing the Crisis Care Continuum

Access to necessary supports for mental health services is critical to the overall wellbeing and resiliency of Florida's families. The growing demand for the state's network of suicide, crisis, and emotional distress services supports the expansion of 988, MRTs, and CSUs. The key to developing a comprehensive and integrated crisis system of care is to ensure that all parts of the system are working together to effectively deliver services. This group of recommendations encourage strategies to further support the advancement of Florida's crisis care continuum.

Recommendation 6: Establish a policy recognizing 988 as a part of the behavioral health system of care and require Managing Entities to ensure and encourage communication and development of formal relationships between the 988 Florida Suicide & Crisis Lifelines and network providers, including Mobile Response Teams and Crisis Stabilization Units.

The 988 Florida Suicide & Crisis Lifeline offers confidential short-term counseling and aims to connect individuals in crisis with longer-term behavioral health services through referrals to providers in the community. In cases where telephonic de-escalation is not possible, in-person care may be required.

The Commission recommendation is to make policy changes that formally establishes that 988 is part of the behavioral health system and operates under the same guidelines for sharing client information as MRTs, CSUs, Care Coordination, etc. Presently, 988 providers are facing communication barriers with other entities due to their obligation to protect client data. These barriers can result in delaying care which can be detrimental, especially when an individual is experiencing a crisis and in need of immediate services.

Managing Entities should be directed to develop MOUs with the 988 Florida Suicide & Crisis Lifelines and network providers. The MOU will facilitate enhancements to the quality of crisis care provided within the continuum and establish standards that will guide providers. The Managing Entities can help develop partnerships and MOUs between 988 and providers in their network to facilitate referrals, follow-ups, and information sharing.

This recommendation has no known fiscal impact.

Recommendation 7: Proposes the engagement and expansion of peer participation throughout the crisis care continuum.

A peer specialist, as defined by section 397.311(30), F.S., is a person who has been in recovery from a substance use disorder or mental illness for at least 2 years and uses their lived experience to support others in a behavioral health setting. Individuals who have spent at least two years as family member or caregiver of an individual who has a substance use disorder or mental illness may also serve as a peer specialist.

The peer support model has been adopted to serve a variety of client groups including individuals with serious mental illness, substance use, older adults, youth and adolescents, and families[13]. Peer specialist services have been shown to impact those who receive the services by instilling hope, empowerment, and resilience through increased social functioning, social integration[14].

This can be achieved by developing a template to assess the performance of elements within the continuum. The template would enable the evaluation of the effectiveness of the crisis care continuum and facilitate the standardization of peers' involvement in crisis care.

To provide consistent care across the state, the assessment process will follow A Recovery Oriented System of Care (ROSC) initiative. The ROSC is a value-driven framework that serves to guide the behavioral health system of care in its delivery of services. This framework involves developing a network of clinical and nonclinical services and supports that sustain long-term, community-based recovery.

This recommendation will have a fiscal impact in order to certify and hire more peers throughout the system. As of July 2023, there were 914 Certified Recovery Peer Specialists in Florida. An estimated staffing bundle of $100,000 per Certified Recovery Peer Specialist would include fees for the certification, examination, reinstatement, renewal or upgrade, fees for required training as appropriate, salary and fringe benefits, and travel expenses. The number of peers needed to expand the peer specialist workforce will require further examination to determine the needs across the state.

Recommendation 8: Revise section 394.462, F.S., to require Transportation Plans to address the protocol for transitions between 988 providers, Mobile Response Teams, and Designated Receiving Facilities.

[13] Shalaby, R. A. H., & Agyapong, V. I. O. (2020). Peer Support in Mental Health: Literature Review. *JMIR mental health*, *7*(6), e15572. https://doi.org/10.2196/15572
[14] Shalaby, R. A. H., & Agyapong, V. I. O. (2020). Peer Support in Mental Health: Literature Review. *JMIR mental health*, *7*(6), e15572. https://doi.org/10.2196/15572

Transporting individuals experiencing an acute behavioral health crisis can be a traumatic event. Therefore, it is essential to make the transport humane and considerate. To facilitate this, a new language needs to be adopted for crisis transportation during the Baker Act and Marchman Act transportation. The aim should be to explore statewide solutions that avoid using police cars and handcuffs and rely on medical transport wherever possible.

Recommendations discussed include:

- Individuals in need of inter-hospital transport for an acute behavioral health crisis should be transported by medical professionals with the training and expertise to manage both mental health and medical conditions.
- Inter-hospital transport restraint guidelines should align with Centers for Medicare and Medicaid Services guidelines for hospital restraints. Patients should be transported in the least restrictive, safest means necessary.
- Individuals who are at high risk for violence or agitation due to underlying conditions such as dementia, traumatic brain injuries, delirium, substance use disorders, or psychiatric conditions should be managed according to medically indicated interventions such as medical restraints or medications.
- If necessary, law enforcement officers should accompany Emergency Medical Services (EMS) to provide support and ensure the safety of the patient and EMS professionals during transport.
- EMS professionals should receive training to manage acute psychiatric and substance use disorder conditions and should also be aware of the life-threatening medical complications that can result from substance use disorders and psychiatric conditions/medications.

This recommendation will have a fiscal impact to county-level transportation plans. These changes will impact counties that must pay transportation of individuals under the Baker Act, shifting costs from law enforcement agencies to medical transportation companies or other allowable options. The level of impact is indeterminate at the time of this report.

Improving Data Collection and Management Processes

Effective and meaningful behavioral health interventions require timely, accurate, and diversified data. Standardized tools are essential for state agencies to monitor the progress or decline of data during an intervention or episode of care. When behavioral health data is readily accessible, connected, and easy to understand, it becomes easier to produce better outcomes. This group of recommendations focus on actions to improve the quality and effectiveness of current mental health and substance abuse services delivery systems, identify delivery system gaps, and enhance current behavioral health systems with promising practices and data-based goals.

Recommendation 9: Enhance the state system of data collection and create a publicly accessible data dashboard for 988 services.

DCF collects statewide 988 data that includes: total calls answered, including short abandons; number of suicide attempts in progress; number of calls that resulted in either voluntary or involuntary emergency rescue; number of contacts referred to mental health or substance use services; number of contacts referred to Mobile Response Teams; number of staff hired and trained; number of additional staff needed; number of formal agreements between 988 and Mobile Response Teams, Crisis Stabilization Units, and 911 Public Service Answering Points.

However, there is a need to continue enhancing data collection and ensure the data is available to the public, in order to provide a true and full picture of 988 services in Florida. This must include explanations, disclaimers, and context when publishing this data, and include information about metrics collected by Vibrant Emotional Health, including methodologies that provide context when state level data differs from Vibrant's national metrics for the state. To measure and gauge the true quality and quantity of 988 services the data collected should be standardized across all centers.

This data collection initiative will need to provide context on:

- How one measure impacts another.
- Speed at which calls are answered.
- Data related to follow-up calls.
- State level data excluding short abandons where the call was disconnected.
- Capture crisis call data from 211 and other center lines to gain a truer picture of crisis needs and funding requirements.
- How to standardize data across centers.

This recommendation may have a fiscal impact based on required technology for enhanced data collection. DCF's Office of Information Technology Services is currently developing a public-facing dashboard with 988 data, so there are no additional costs associated with the dashboard. The implementation of an automated data collection system for 988 services may have added costs related to the startup, implementation, and sustainability of the system and cannot be estimated at the time of this report.

Recommendation 10: Explore Opportunities that Support Regionalized Expansion of Health Information Exchanges (HIE).

The Health Information Exchange (HIE) is a platform that allows healthcare professionals and patients to access a patient's medical records electronically. This helps to improve the speed, quality, safety, coordination, and cost of patient care. Currently, there are

multiple HIE platforms in the state that are not integrated and function independently. To address this issue, it is recommended that a regional HIE be established that facilitates data sharing among healthcare providers and partners. This will help to improve care coordination and service delivery. The use of HIEs among behavioral health and physical care teams can foster the exchange of critical health data, which can lead to better health outcomes for patients. Effective communication between behavioral health and physical healthcare teams can also help to reduce the stigma associated with mental health disorders and enable greater care coordination to meet the patient's healthcare needs comprehensively. Key partners for this initiative include AHCA, DCF, Managing Entities, FHA, FBHA, DJJ, and local behavioral health providers.

This recommendation may have a fiscal impact based on required technology for enhanced data collection. The costs associated with developing the regional HIEs will need to consider the expenses related to the startup, implementation, and sustainability of the platform and cannot be estimated at the time of this report.

Recommendation 11: Establish a Florida Behavioral Healthcare Data Repository.

To encourage data harmonization and the cleaning of specific data sources, the Commission recommends a Florida Behavioral Healthcare Data Repository (FBHDR). A data repository is a centralized location where data is stored and maintained for data analysis, sharing, and reporting. A FBHDR would enable standardized data entry, better data organization, facilitate increased accessibility and timeliness with data sharing, and encourage future research as more data becomes available. The Data Analysis subcommittee convened a meeting of policymakers and practitioners from across the country with expertise in bringing together various organizations to develop a statewide behavioral health data repository. The group identified the following necessary steps to mobilize the effort.

- Step 1: Establish a data analysis workgroup.
- Step 2: Secure administrative authority and commitment from stakeholders and state agencies.
- Step 3: Determine the structure of the repository, as well as policies and protocols for data standardization, security, access, and resources.
- Step 4: Implement a pilot.
- Step 5: Identify and evaluate areas of necessary improvement.

Additional information detailing the recommended steps to establish the FBHDR are available in Appendix 4.

The FBHDR will aid in connecting to local partners and coalitions which adds expertise, expansion of networks, and accesses locally available resources. Low-cost or no-cost solutions can be generated that maximize local resources, and a larger number of diverse partners can be activated, including cultural artists, peer specialists, co-researchers, and advocates.

The FBHDR will allow for:

- Building infrastructure and connectivity for local data use to maximize state resources.
- Local conversations and participatory research about experiences (e.g., dehumanizing, criminalizing, and traumatizing) can help to generate responsive solutions and practice/narrative/perspective change more quickly in the community.
- Peer specialists, co-researching, and advocacy can generate healing for participants, system professionals, and researchers.
- Knowing the history of behavioral health policy, narratives, research, and corresponding community conditions and how community conditions interact with policy and/or impact the effectiveness of service delivery.
- Integrate data science best practices with contextualizing information to deliver higher quality insights (i.e., living experiences, qualitative data, etc.).

This recommendation may have a fiscal impact based on required technology for enhanced data collection and the suggested data analysis workgroup. The costs associated with developing the FBHDR will need to consider the expenses related to the startup, implementation, and sustainability of the platform and cannot be estimated at the time of this report. Cost related to the data analysis workgroup will depend on details like the format of meetings (in-person or virtual), number of participants or representatives from each agency and organization, frequency of meetings, and the involvement of personnel needed for logistics and for the development of regional strategies.

Desired Outcomes of Recommendations:

- Development of legal data-sharing MOU templates that can provide uniformity among various community settings and may inform other state agencies' MOUs.
- Accelerated sharing of best practices innovation related to data sharing, implementation, and results.
- Access and integrate the expertise of individuals with lived experience to shape and improve service delivery and policies.
- Generate rich feedback loops with customizable state and local partners/coalitions on potential new pathways and possibilities.
- Determine specific questions to ask and answer.

- Obtain key, actionable information on the user experiences.
- Gain further recommendations on enhancement of the Integrated Data System based on the pilot with a specific use case that includes outcomes that are actionable based on a stakeholder determined purpose.

Optimizing Financial Management of the Behavioral Health System of Care

The financial management and funding of publicly supported mental health and substance use disorder systems and services by DCF, AHCA, DOE, and other relevant entities is a complex undertaking. The coverage and degree of involvement of these entities vary, leading to a wide variance in how different state agencies assess the need and adequacy of behavioral health services, how those services are procured, and what accountability mechanisms exist.

The Finance Committee has developed two information requests which were sent to state agencies related to review and evaluation of the financial management and funding of the existing publicly supported mental health and substance use disorder abuse systems and services. These requests included quantitative information related to funding amounts, as well as information about needs assessment, budget authorization, method of payment, and outcomes/accountability for each state agency. Responses were reviewed by the Finance Committee. The review of responses is ongoing.

The Finance Subcommittee of the Commission will continue to examine Florida's system for opportunities to purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.

Recommendation 12: Review the statutory requirements that direct the fiscal management process for behavioral health services.

A thorough review of all statutory language governing financial processes of the publicly funded behavioral health services system is required to identify opportunities for streamlining financial processes.

This recommendation is not expected to have a fiscal impact.

Conclusion

Florida's behavioral health system of care is an intricate network of partners, programs and services that are continuously adapting to meet the needs of individuals, families, and communities. The Commission is comprised of leaders, subject matter experts, and individuals with lived experience who possess unwavering commitments to improving the lives of Floridians contending with behavioral health challenges. The recommendations put forth by the Commission aim to address these challenges by prioritizing community

networks and cross-agency collaboration, enhancing the crisis care continuum, improving data collection and management processes, and optimizing the financial management of the behavioral health system of care.

Appendix

Appendix 1. Comparison of Behavioral Health Services State Agencies and Third-Party Insurers

Multiple state agencies and third-party insurers reimburse for behavioral health services in Florida. The following entities have legislative authorities to provide substance abuse and mental health services.

- Medicaid – Section 409.906, F.S., identifies community behavioral health services as optional Medicaid services.
- Department of Children and Families (DCF) – Chapters 394 and 397, F.S., designates DCF as single state authority for mental health and substance abuse and provides rulemaking authority for behavioral health policies.
- Department of Juvenile Justice (DJJ) – Section 985.601, F.S., requires the juvenile justice rehabilitation continuum to include substance abuse and mental health services.
- School Districts – Section 1011.62(13), F.S., created the mental health assistance allocation to provide funding that assists school districts in implementing their school-based mental health assistance program as required by section 1006.41, F.S.
- Florida's Children Health Insurance Program (CHIP) – Section 627.668, F.S., requires every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation to make available necessary care and treatment of mental and nervous disorders.
- Department of Corrections (DOC) – Sections 948.01 and 948.035, F.S., identifies outpatient and residential treatment as one of the conditions for placing individuals on probation or community control.
- Agency for Persons with Disabilities (APD) – Sections 393.066 and 393.0662, F.S., authorizes, respectively, medically necessary rehabilitative services as needed and the iBudget system under APD for administering this Home and Community Based Services waiver.
- Medicare – 42 United States Code (USC) §1395(d) and 42 USC §1395(k) – Federal code under the Social Security Act that proscribes inpatient (Part A) and outpatient (Part B) benefits that include substance abuse and mental health services under Medicare.
- Commercial Group Plans – Section 627.668, F.S., requires every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation to make available necessary care and treatment of mental and nervous disorders.

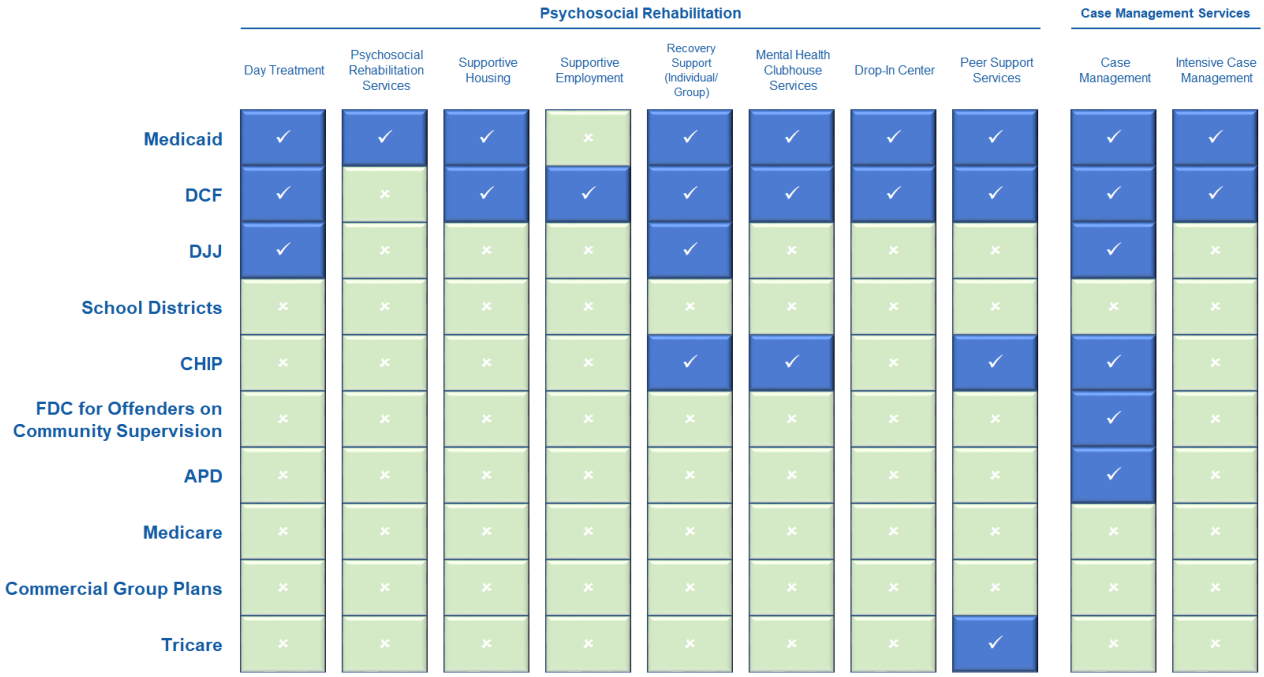
- Tricare – 32 Code of Federal Regulations section 199.17 describes Tricare benefits that include substance use and mental health treatment.

The following tables display the available behavioral health services for each of the specified entities.

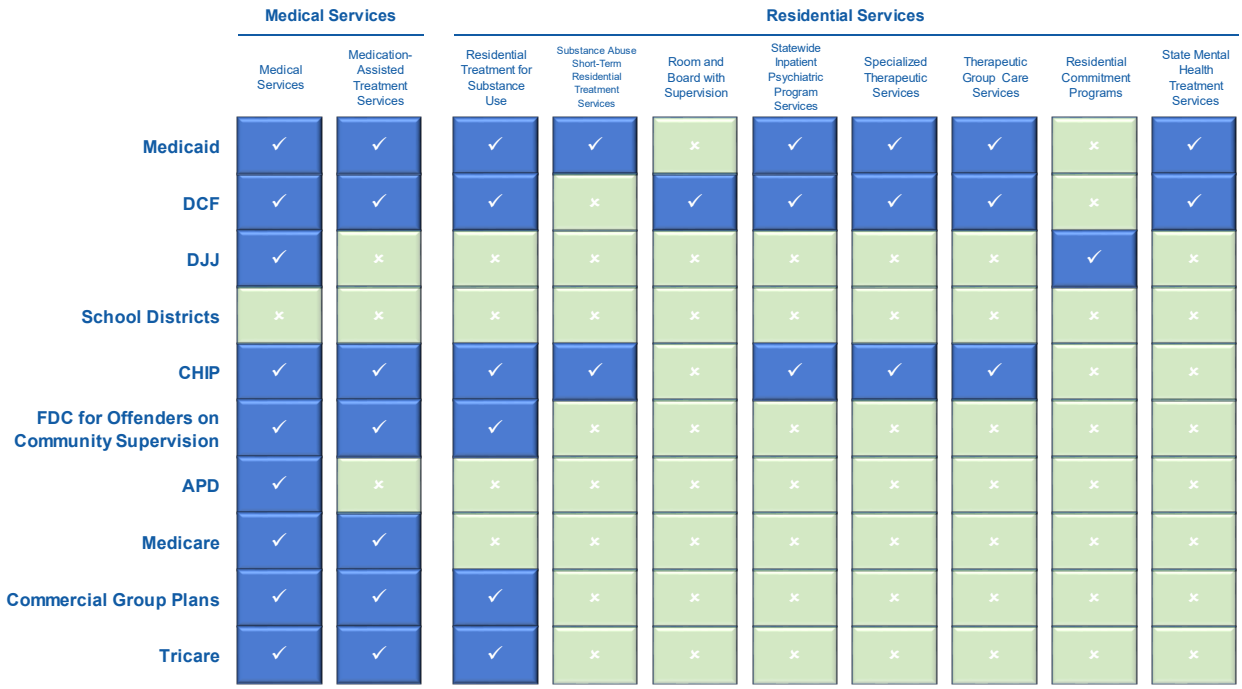
Behavioral Health Services Available Across Florida State Agencies and Third-Party Insurers

	Assessment and Treatment Plans			Therapy Services			Crisis Management				
	Assessment	Treatment Plan Development	Treatment Plan Review	Group Therapy	Individual Therapy	Family Therapy	Crisis Stabilization	Crisis Support/Mobile Response Teams	Substance Abuse Inpatient Detoxification	Inpatient Hospital Services	Addictions Receiving Facility Services
Medicaid	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DCF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DJJ	✓	✓	✓	✓	✓	✓	×	×	×	×	✓
School Districts	✓	✓	✓	✓	✓	✓	×	×	×	×	×
CHIP	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
FDC for Offenders on Community Supervision	✓	×	✓	✓	✓	×	×	×	×	×	×
APD	✓	✓	✓	✓	✓	✓	×	×	×	×	×
Medicare	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓
Commercial Group Plans	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	✓
Tricare	✓	✓	✓	✓	✓	✓	✓	×	✓	✓	×

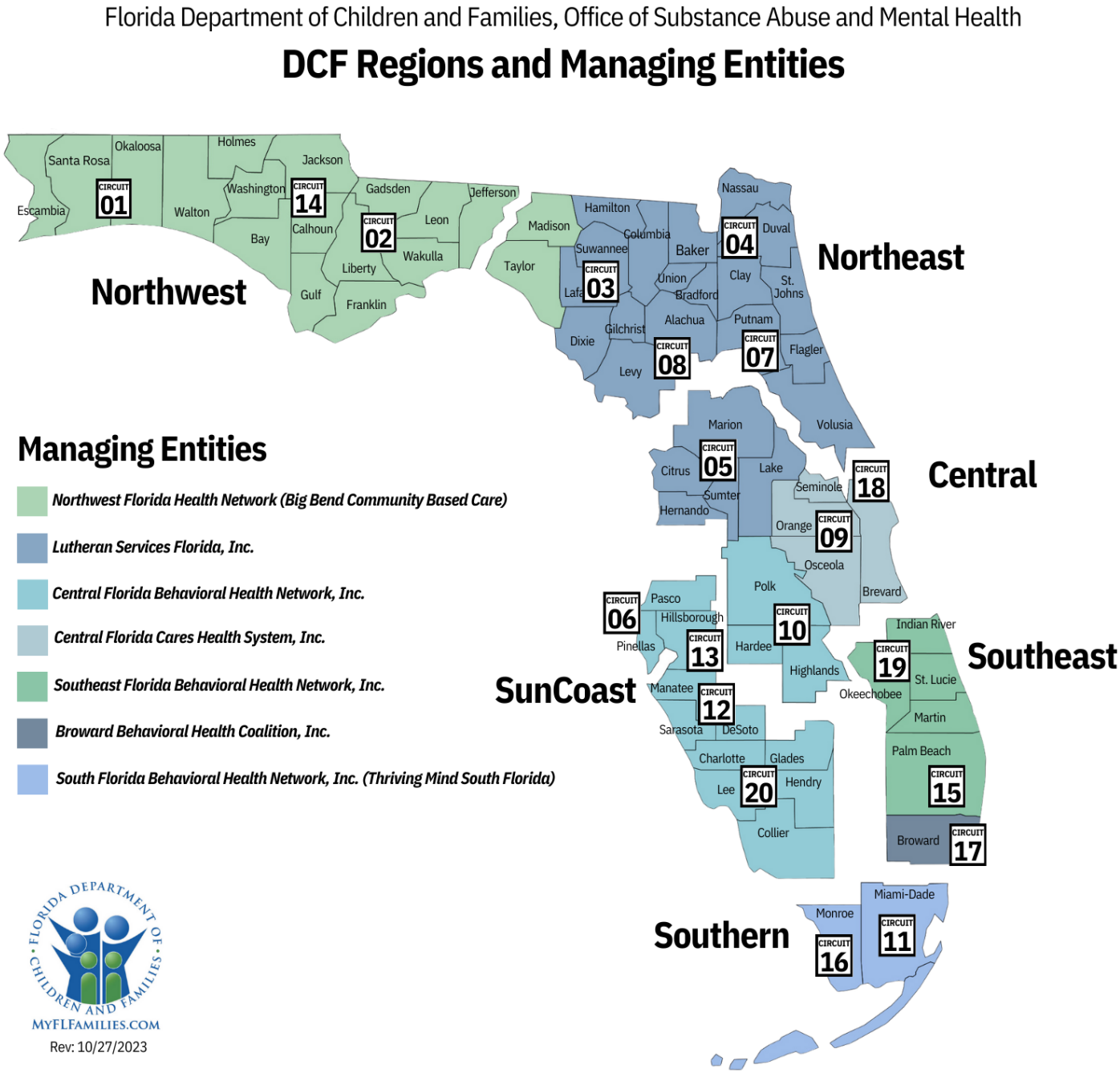
Behavioral Health Services Available Across Florida State Agencies and Third-Party Insurers



Behavioral Health Services Available Across Florida State Agencies and Third-Party Insurers



Appendix 2. Map of DCF Regions and Managing Entities



Appendix 3. MOU Framework for Recommendation 4

The MOU Framework between the local school districts, Managing Entities, and public or private community mental health services providers shall at a minimum include:

1. The local school district will convene a workgroup that includes school district representation, managing entity, and public or private community mental health services provider, if applicable. This workgroup will be referred to as the Youth Mental Health Collaborative (YMHC).
2. The local school district will facilitate community meetings each year that focus on the development, implementation, and management of the approved school mental health program plan. The school district will ensure the local Managing Entity and public or private community mental health services provider is an active participant.
3. The local school district, in collaboration with Managing Entity and a public or private community mental health services provider, will develop and enter into a business associate agreement that addresses the Health Insurance Portability and Accountability Act, Family Educational Rights and Privacy Act, confidentiality, etc.
4. The YMHC will research the various school mental health program models and compile a report that identifies the models with best outcomes and practices for implementation.
5. In addition to the outcomes outlined in House Bill 5101, the YMHC will agree on additional performance metrics and outcomes that focus on student success. Examples may include reducing the number of absences, increasing academic performance, decreasing disciplinary referrals, among other metrics, as agreed upon.
6. The YMHC shall ensure the plans include equitable funding for the administrative functions for all parties involved in administering the school mental health program.
7. Organizations associated with the MOU shall seek legal counsel to ensure that parameters are within the agency's jurisdiction and relevant laws and regulations.
8. By September 1st of each FY, each school district shall submit its approved plan to the DOE, as established in House Bill 5101.
9. By September 30th each school district shall submit a report on its program's outcomes and expenditures for the previous FY, as established in House Bill 5101, that includes:
    a. Students who receive screenings or assessments.
    b. Students who are referred to school-based or community-based providers for services or assistance.
    c. Students who receive school-based or community-based interventions, services, or assistance.
    d. School based or community-based mental health providers, including licensure type.
    e. Contract-based or interagency agreement-based collaborative efforts or partnerships with community based mental health programs, agencies, or providers.

10. The annual report will be made available by the DOE to the YMHC for program analysis and planning as necessary.
11. YMHC members shall establish clear roles and responsibilities specific to their region that enhances the MOU for the school mental health program.

Appendix 4. Florida Behavioral Healthcare Data Repository Action Steps

Figure 1: Florida Behavioral Healthcare Data Repository Action Steps

Step 1: Establish a data analysis workgroup.

This workgroup will maximize and multiply the value and use of the FBHDR through meaningful and substantive connections with local community partners. Members will convene meetings with service coalition partners to discuss local integrated data systems, focusing on improving outcomes for people who are high utilizers of services through connecting state and local initiatives.

- This workgroup will meet four times per year with one in-person meeting. A funding source is necessary for this function and may be acquired through grant opportunities focused on data expansion.
- Proposed agenda items for meetings to include:
  - Key behavioral health metrics and research findings.
  - Integration of expertise and experience of individuals with lived experience, frontline staff, and community members.
  - Data needs and opportunities.
  - What is currently working and potential challenges.
- Online portal for resources, engagement, and coordination.

This workgroup will engage in an effort to survey various data-holding agencies across the state to assess the types of data being collected. These discussions will establish a partnership with stakeholders to gain insight into views on acceptance and community leverage in the development and implementation of the FBHDR. For the pilot program, determine initial 1) questions to answer from the database based on 2) specific, achievable, and relevant use case. The initial, specific use case (and data needed to address these questions) will be actionable and provide information on accessibility and for what purposes. The coalition working group will guide this pilot process.

Step 2: Secure administrative authority and commitment from stakeholders and state agencies (DCF, AHCA, etc.).

Bring data together safely and responsibly. Policymakers and practitioners are better equipped to understand complex needs, allocate resources, measure the impacts of

policies and programs, engage in shared decision-making about data use, and institutionalize regulatory compliance.

Step 3: Determine the structure of the repository (centralized, federated, etc.), as well as policies and protocols for data standardization, security, access, and resources.

The Commission recommends development and ongoing enhancement of the FBHDR be housed within a university to allow for subject matter experts to have longitudinal opportunities to maintain an effective and evolving system.

- Subject matter experts at the universities will house and maintain the Integrated Data System and will work in conjunction with the full workgroup and all stakeholders for optimal and responsible use of the Integrated Data System.
- Secure resources/funding (preferably a commitment of recurring funding).

Step 4: Implement a pilot.

Collect data already aggregated and merged between AHCA and DCF or other relevant datasets to create a roadmap for an analytic plan before expanding statewide.

Step 5: Identify and evaluate areas of necessary improvement.

Provide information on behavioral health data sources in Florida for high-risk individuals and evaluate key questions related to cost, access, quality, and outcomes for behavioral health.

A data integration and expansion initiative such as this has potential impact at the state and local level. Intentionally designing a state and local behavioral health data infrastructure and partnership from inception will allow following:

- Improvement of behavioral health outcomes.
- Maximization of state resources.
- Acceleration of innovation and incubation.
- Building capacity to leverage and use data grounded in science.