Unlocking the pieces:
Community Mental Health in Northeast Florida

A JCCI Inquiry
presented by Baptist Health

FINAL IMPLEMENTATION REPORT

Pat Hogan
Implementation Task Force Chair

September 2016

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Marion Tischler
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Terri Wall

Jim Penrod
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**Mental Health**

**Implementation Task Force Members**

The following individuals participated in all or some portion of the advocacy work of the JCCI Mental Health Task Force. Their diligence and dedication are sincerely appreciated.

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<th>Jackie Nash</th>
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Summary from the Task Force Chair:

Next time you’re in a crowded restaurant or at a ball game, look around you and consider that one in every four to five people you see is living with a mental illness, they probably have not been diagnosed or treated, and may never be. Ignoring mental illness jeopardizes a person’s prospects for long-term recovery and increases the risk factor for other chronic diseases (e.g., cancer, diabetes, cardiovascular disease, asthma, stroke, etc.). The unnecessary toll this extracts on individuals and the community as a whole is significant and heartbreaking.

The stark reality, as identified in JCCI’s 2014 Mental Health Inquiry (*Unlocking the Pieces*), is that mental health is rarely discussed, people with mental illnesses are stigmatized in the community, there is a shortage of mental health professionals, the system of care is fragmented, and mental health in the public sector is severely underfunded.

Finding ways to improve the mental health system in Northeast Florida and destigmatizing mental illness were the primary objectives of the Mental Health Implementation Task Force when it came together for the first time in October 2014.

The 101-member Task Force, which I have been honored to chair, was formed after the release of the *Unlocking the Pieces* Inquiry, expertly led by Michelle Braun, President and CEO of United Way of Northeast Florida. The Task Force was composed of many mental health professionals, while others were simply concerned citizens interested in improving their community. This Final Implementation Report reflects the countless hours of hard work of these Task Force members over the last two-plus years. Their dedication to improving the life prospects of those living with mental illness has been extraordinary.

The Mental Health Inquiry committee developed 12 overall recommendations that fell into four main categories (advocacy and community engagement; coordination of care; building capacity; and public awareness and education). It was the role of our Task Force to advocate for the implementation of these recommendations to the applicable stakeholders and elected leaders in the community.

The Task Force was divided into seven subcommittees, each of which was assigned responsibility for one or more of the recommendations. The subcommittees were:

- Strategic Plan and Legislative Action
- Coordination of Care
- Funding
- Professional Training and Licensure
- Decriminalizing Mental Illness
- Managing Severe and Persistent Mental Illness
- Public Awareness and Early Identification
Over the two-year period, the subcommittees met separately on many occasions, and they came together periodically to share information and discuss strategies. Hundreds of advocacy meetings were held with stakeholders throughout the region, including prominent civic leaders and elected officials, and the first of what will be an annual Florida Mental Health Summit (coordinated by MHA of Northeast Florida) was held in Jacksonville in August 2015. A full recap of the advocacy progress made on each recommendation follows this summary.

We are pleased to report that of the 24 components of the 12 recommendations, eight were fully implemented, 14 were partially implemented, and only two not yet implemented at all. To be sure, we experienced some disappointments along the way, but even in those instances, we learned things that can be useful to the community going forward. As is often the case in JCCI implementation projects, many of the recommendations are simply not suited to completion in a two-year timeframe (e.g., eliminating the deeply-entrenched stigma associated with mental illness; integration of physical and mental health care which have traditionally been treated separately; etc.). We are confident, however, that work initiated during our implementation term and being carried forward in the years ahead will pay future dividends not yet realized.

As a Task Force, we are not so presumptuous as to suggest that all of the positive things that have occurred to help address the Inquiry’s recommendations are a direct result of our activities. We are convinced, however, that our work has elevated awareness throughout the community of the critical need to improve the mental health system in Northeast Florida and has served as a catalyst for sustained progress going forward.

Highlighting the successes of the last two years is the elevation of mental health as a priority of the State Legislature. Florida has long lagged the rest of the country in public funding for mental health, ranking 49th of 50 states. As a result of increased attention from vigorous advocacy efforts and the dedication of some individual House and Senate members, the Legislature appropriated funding in 2015 that provided incremental dollars for mental health for the first time in more than a decade. Then in 2016, mental health enjoyed a banner year in Tallahassee with the passage of multiple bills that represent progress on several issues of particular concern to our Task Force (e.g., prescribing rights for controlled substances by ARNP’s; codifying mental health courts across the state; creation of an advisory committee of health experts to explore telemedicine; etc.).

Of particular importance to me was our success in two other key areas. First, our project created an effective system-wide collaborative, bringing together organizations that had rarely, if ever, sat at the same table together. Solving the complex issues facing the mental health community requires the frequent exchange of ideas and opinions across the entire system, and our Task Force successfully demonstrated the significant benefit to be derived from regular collaboration. Also required is the willingness of every stakeholder to assist in breaking down silos that can impede progress. As we discovered, this is sometimes easier said than done since some organizations can be more interested in protecting their own interests than considering solutions that may better serve the common good.
Secondly, we established as a priority from the outset of the project to identify a way of sustaining the momentum developed during our implementation work. Too often in the past, JCCI implementation projects have been successful in laying the groundwork for future progress, only to see the momentum dissipate when the two-year project concludes. LSF Health Systems, which serves as the Managing Entity for publicly-funded mental health in our region, worked closely with us throughout the implementation process, assigning representatives to each of the seven subcommittees. As we conclude our term, LSF has agreed to assume the role of maintaining the basic structure of the Task Force subcommittees and keeping the collaboration intact beginning October 1, 2016. My thanks go to Dr. Christine Cauffield, Executive Director of LSF Health Systems, for her visionary leadership and confidence in our work. To know that the momentum established will be continued in the years ahead means that our work will have a lasting legacy and not soon be forgotten.

The *Unlocking the Pieces* inquiry and subsequent implementation process would not have been possible without the considerable financial support and collaboration of our presenting sponsor, Baptist Health. Our thanks go to Baptist Health for recognizing the need for this important work in our community.

Finally, I would like to re-emphasize how deeply gratified I am by the dedication of the impressive group of volunteers with whom I have been fortunate to work over the past two years. The success of JCCI projects depends totally on the efforts of community volunteers who often conduct their work in relative anonymity and receive little or no public acclaim for their efforts. Their satisfaction is derived solely from the knowledge that their efforts have made a positive difference in the community. The members of the Mental Health Implementation Task Force have clearly done that, and they are to be commended for helping make Northeast Florida a better place to live.

*Pat Hogan*
*Task Force Chair*
*September 2016*
Results of Advocacy Work:

SUBCOMMITTEE 1 (Strategic Plan and Legislative Action):

Subcommittee Chairs - Tina St. Clair and Marion Tischler

Recommendations Assigned:

Recommendation #1a, 1d, 1f:

Mental Health America of Northeast Florida (MHA), Lutheran Services Florida (LSF), and Behavioral Health Network of Northeast Florida should convene a coalition of mental health stakeholders to serve as an advocacy channel for the advancement of mental health policy in the region. The coalition should include people living with mental illness and their family members, business leaders, mental health agencies, providers of primary care and behavioral care services, representatives of the criminal justice system, Department of Children and Families, Jacksonville System of Care Initiative, the faith-based community, and other interested stakeholders.

The Coalition should establish and implement a regional strategic plan for mental health that includes, but is not limited to, the following:

- 1a. Establish advocacy priorities at the local, state, and federal levels for mental health.
- 1d. Advocate (with support from the Florida Council of Community Mental Health and Northeast Florida Nursing Association) for passage of pending legislation increasing the scope of practices of Advanced Registered Nurse Practitioners (ARNP) by the Florida Legislature, allowing for writing prescriptions for controlled substances and signing certificates of involuntary examinations under the Baker Act.
- 1f. Work with the Florida Council of Community Mental Health, local criminal justice entities, NAMI, and persons living with mental illness to review involuntary commitment laws in other states and develop an advocacy plan to modify the Baker Act to include a broader range of criteria for compulsory psychiatric treatment.

Results: Over-arching Recommendation 1 - Perhaps the overriding priority of the JCCI Mental Health Implementation project was to identify an organization capable of and willing to assume responsibility for carrying forward the work of the Task Force at the completion of its two-year term. Recognizing that most of the recommendations established by the Unlocking the Pieces Inquiry Committee were long-term in nature and did not lend themselves to full implementation in a two-year window, members of Subcommittee 1 were committed to establishing an ongoing collaborative that would sustain the momentum created over the life of the JCCI project in the years ahead.

LSF Health Systems, the Managing Entity for public mental health in Northeast Florida and prominently represented on each of the seven subcommittees, graciously volunteered to assume this role beginning October 1, 2016. The significance of this development cannot be overstated since it represents the first
time a formal process has been identified for continuing the work of a JCCI implementation project after its two-year term has expired. This will ensure that the collaborative spirit established during the past two years across all components of the mental health system in Northeast Florida will be sustained.

1a. As the Mental Health Implementation Task Force began its work in October 2014, the Florida Legislature had largely ignored mental health for more than a decade. Florida ranked an appalling 49th of 50 states in public funding for mental health, and no incremental dollars had been appropriated since 2003. What little funding was available was necessarily exhausted on costly emergency care, leaving little for prevention and supportive services. Compounding the problem was Florida’s unwillingness to expand Medicaid, an important component of the Affordable Care Act that would provide health coverage for all of the state’s most vulnerable individuals and families.

Through the consistent and coordinated lobbying efforts of mental health advocacy organizations throughout the state, things began to change in 2015. On February 6, 2015, Behavioral Health Network of Northeast Florida convened a legislative panel forum to initiate discussion among its members on issues of concern to be advanced to the State Legislature. Mental Health America of Northeast Florida (MHA), through the leadership of CEO Denise Marzullo, embraced and increased their role as the most recognizable state lobbyist for mental health representing Northeast Florida. Ms. Marzullo devoted a significant percentage of her time to developing and strengthening relationships with state legislators in Tallahassee and advocating for increased attention to mental health.

Through these and other efforts of sustained lobbying and education directed at our state’s legislators, a number of prominent legislators, including Duval Delegation Members Senator Aaron Bean and Representatives Charles McBurney and Mia Jones, stepped forward during the 2015 Legislative Session to propose and advocate for new mental health legislation. While few mental health bills were ultimately passed, the 2015 Legislative Session did produce some noteworthy incremental funding for mental health. A total of $39 million in new funding was appropriated across the state for the first time in more than a decade, though it came through Federal block grants and not state funding sources.

In August 2015, MHA of Northeast Florida staged the first statewide Mental Health Summit in Jacksonville, bringing together more than 200 mental health professionals, advocates, and elected leaders to highlight the need for increased attention to mental health. One of the primary objectives of the Summit was to reach consensus on a set of legislative priorities to be advanced for the 2016 Legislative Session.

In preparation for the Summit, Subcommittee 1 developed its list of priorities to be considered at the Summit. The Subcommittee 1 priorities included: prescribing privileges for ARNP’s (Advanced Registered Nurse Practitioners); codifying Mental Health Court to increase its effectiveness; increasing the number of SOAR processors to assist individuals with mental illness who are incarcerated in regaining their Social Security disability benefits; and revisions to the Baker and Marchman Acts to improve Florida’s process of involuntary commitment of individuals with severe and persistent mental illness).

The Mental Health Reform Legislative Agenda ultimately approved at the Summit largely mirrored the recommendations of Subcommittee 1.
The 2016 Legislative Session did not disappoint, resulting in the most successful year for mental health legislation in Florida in decades. The 2016 State Budget included $53 million in new funding for mental health, including funding for central receiving facilities; Crisis Assessment and Treatment Teams (CAT); Family Intensive Treatment Teams (FIT); substance abuse; and forensics. In addition, other legislation was passed successfully addressing several key priorities identified at the Mental Health Summit the previous August:

- House Bill 423 granted prescribing privileges of controlled substances to ARNP’s and Physician Assistants for patients at health facilities such as hospitals and nursing homes, albeit with some restrictions;
- House Bill 439 authorized the creation of treatment based courts and established a forensic state hospital diversion program. While no funding was allocated to this bill, it still represents a welcome first step.
- Senate Bill 12 incorporates a wide-ranging number of provisions for improving the mental health system, including one that more closely aligns the Baker Act (mental illness) and Marchman Act (substance abuse) by modifying legal procedures and timelines, as well as processes for assessment, evaluation, and provision of services.

1d. As noted above, House Bill 423 extended prescribing privileges for controlled substances to ARNP’s and Physician Assistants, but the list of restrictions is substantial, so this should be viewed as a step in the right direction but not a final resolution. A more substantial bill without restrictions passed through the House, but it was later modified in a compromise required to gain Senate approval.

1f. Per above, Senate Bill 12 successfully addressed better alignment of provisions of the Baker Act and Marchman Act, but it did not specifically focus on considering a broader range of criteria for compulsory psychiatric treatment. This is progress, but additional attention to improving the decades old Baker Act will be required in future Legislative Sessions.

Evaluation:  Over-Arching Recommendation 1  Implemented
Recommendation 1a  Implemented
Recommendation 1d  Partially Implemented
Recommendation 1f  Partially Implemented
SUBCOMMITTEE 2 (Coordination of Care):

Subcommittee Chair - Ashley Smith Juarez

Recommendations Assigned:

Recommendation #4:

The Clinton Health Matters Initiative in Northeast Florida should convene a group of stakeholders to investigate, develop and implement a community-wide coordinated system of intake, referrals, and case management that incorporates mental health treatment.

Results: Clinton Health Matters Initiative in Northeast Florida successfully convened an impressive list of stakeholders, including physicians, hospital administrators, clinicians, and other advocates to consider opportunities for developing a coordinated health information sharing system in Jacksonville. The group met monthly throughout the two-year implementation term, exploring ways to establish a health records portal.

Long-time Duval County Health Department official, Dr. William Livingood, addressed the subcommittee to provide background information on a previous effort he spearheaded ten years ago to establish an electronic records system in Northeast Florida. Significant challenges (e.g., federal HIPPA laws; incompatible electronic software systems among hospitals; financial resources to implement; etc.) were identified at that time, and the project did not move forward.

A potential model information sharing system – The Greater Houston Healthconnect – addressed the subcommittee to provide background on their opt-in health information exchange, one of the few in existence across the country. A non-profit organization launched in 2010, the Greater Houston Health Information Exchange (GHHIE) was created to develop and implement an electronic health information exchange for the greater Houston region enabling all patients and health care and wellness service providers to easily access patient records for true continuity of care. Healthconnect is supported by a federal grant administered through the Texas Health Services Authority and by contributions from area organizations.

A promising local effort already underway on a more limited scale involves a partnership between LSF Health Systems, the Managing Entity (M.E.) for public mental health and substance abuse in NE Florida, and RelayHealth, a national company that provides solutions to streamline communications between patients, providers, payers, pharmacies, pharmaceutical manufacturers, and financial institutions.

The Florida Department of Children and Families, which oversees the state’s M.E.’s, requires that each one implement a health information exchange system to provide data relating to efforts of Care Coordination to the Network Service Provider’s clients. To accomplish this, M.E.’s must (1) have the ability to exchange screening and assessment results among the Network Service Providers; (2) automate a referral and electronic consent for release of confidential information within and between Service Providers; and (3) have an integrated process for tracking and coordinating intake, admission, discharge and follow-up throughout the Network.
To meet the DCF requirements, LSF Health Systems and RelayHealth have partnered for a Health Information Exchange. The system allows participants to securely exchange Protected Health Information (PHI) through longitudinal patient/client records. The information sharing involves enrolled patients (those who agree to allow RelayHealth to record their PHI and enrolled participants (healthcare professionals, health workers, or staff). To access a patient’s information, enrolled participants must have appropriate patient/client consent as required by federal and state laws. The RelayHealth services are provided through a web-based communications platform.

While local providers in Jacksonville remain enthusiastic about creating a broader system similar to Greater Houston Healthconnect here, they recognize that significant financial resources must be identified and devoted to the implementation of a health records portal. The first steps must be: (a) to re-energize providers; and (b) identify funding sources. Creation of a vibrant and effective universal health information exchange is clearly regarded as an important step Jacksonville should take in the near future. We are confident that through continued collaboration of the community’s health care systems and other stakeholders established through this subcommittee, we will accomplish that objective sooner rather than later.

**Evaluation:** Partially Implemented (*Model identified but not yet applied.*)

**Recommendation #8b, 8c:**

The Clinton Health Matters Initiative in Northeast Florida should convene local hospitals, the Jacksonville System of Care Initiative (JSOCI), Nemours Children’s Clinic, and other health care stakeholders for the purpose of forming a coalition that expands existing programs to better integrate mental and primary health care across all age groups in the community. In order to accomplish these goals, the following solutions should be deployed:

- 8b. The pilot Collaborative Care Consultation Clinic (a partnership between Nemours and JSOCI) should be expanded to a community-wide initiative to more thoroughly train primary care physicians to identify mental health issues in children, adults, and senior citizens with consideration given to cultural competency.
- 8c. The coalition should discuss, identify and encourage the implementation of integration techniques utilizing new technology, including expanded use of telemedicine, to encourage consultation between primary care physicians and psychiatrists.

**Results:** The working group assembled by Clinton Health Matters Initiative referenced in Recommendation 4 spent considerable time during their deliberations focusing on ways to expand the integration of mental and physical health in Northeast Florida. All subcommittee members agree that a systematic coordination of general and behavioral healthcare is needed, but it is complicated to achieve and requires a willingness of health professionals to embrace changes in traditional methodologies.
The subcommittee established a connection with the Kennedy Forum, an organization founded by Patrick J. Kennedy in 2013, focused on identifying solutions for the future to improve the lives of individuals living with mental illness, particularly with regard to integration and coordination. It is hoped that a collaborative between the Kennedy Forum and Clinton Health Matters Initiative can create synergistic opportunities in the future.

Locally, Baptist Health has taken the lead on implementing integration strategies by initiating a process of embedding mental health providers in primary care physician clinics (PCP’s). Baptist has integrated behavioral health practitioners into five local medical practices:

a. Baptist MD Anderson Cancer Center has retained a clinical psychologist who serves patients receiving cancer treatment and their families;
b. The Baptist AgeWell Institute, which serves patients 65 and older, uses a team approach to medical care. The Institute brings together a gerontologist, several adjunct treatment modalities (e.g., physical therapy, speech therapy, etc.), and mental health services provided by a staff psychiatrist and a clinical psychologist.
c. Mental health practitioners have been integrated with primary care physicians at three Baptist Primary Care locations. The Regency and Lane Avenue locations each employ a full-time clinical psychologist, while the Airport location incorporates a clinical psychologist, a clinical social worker, and a licensed mental health counselor.

Baptist Health and UF Health Jacksonville have recently partnered to create the Wolfson Behavioral Health Center for Children which opened in July 2016. The Center will have a developmental pediatrician, as well as three psychiatrists, two psychologists, one neuropsychologist, one therapist, and one social worker. The pediatrician, social worker, and a psychiatrist are funded as part of the SAMHSA grant expansion awarded to Jacksonville System of Care Initiative (JSOCI) in collaboration with Baptist Health. Children who have co-existing mental and physical health conditions (e.g., diabetes and depression) will be able to obtain care at a single site to address their complex medical and mental health needs.

St. Vincent’s HealthCare began a concerted effort three years ago to more effectively incorporate behavioral health services into its integrated system of care. The St. Vincent’s Family Medicine Center launched a post-doctoral fellowship program in behavioral health in collaboration with the Family Medicine Residency Program. This program is designed to teach family medicine physicians and clinical psychologists to work collaboratively to address the physical and mental/psychosocial health needs of the patient. St. Vincent’s is also planning a new initiative that will place behavioral health providers of various levels in multidisciplinary ambulatory care clinics and primary care offices throughout the community.

In addition, local health systems that participate in the Community Health Needs Assessment are planning a Mental Health First Aid initiative, designed to teach anyone, from first responders to average citizens, to identify, understand and respond to signs of mental illness. The ultimate goal of this collaborative is to train 10,000 local Mental Health First Aid responders over the next three years.

Nemours Children’s Clinic operates a collaborative care model in partnership with JSOCI to provide specialized training for primary care physicians in adolescent depression and suicide risk assessment. In addition, the pilot Collaborative Care Consultation Clinic under the direction of Dr. Elise Falluco (Nemours), is a program in which primary care physicians and psychiatrists form a partnership. Primary care providers refer patients to a psychiatrist for a priority consultation which significantly reduces
waiting times. The patient then returns to the primary care physician for treatment. Hopes of expanding these programs would be accomplished by incorporating PCP clinics that have expressed an interest in participating to address adolescent depression. Additional funding and administrative support is required to take these models to the next level.

The subcommittee also focused on new technologies, particularly the use of telemedicine which is still in its relative infancy in Florida. While telemedicine is viewed as a promising health approach by many providers, there are significant obstacles that must be overcome. First, reimbursement issues must be addressed since most health insurers do not yet reimburse physicians for appointments not conducted in person. Second, licensure laws often preclude physicians from practicing across state lines. Finally, for telemedicine to be effective, physicians must be able to prescribe medications, but in most states (including Florida), a live physical examination is required before a medication can be prescribed.

Fortunately, the Florida Legislature now recognizes the potential of telemedicine, and with the passage of a law earlier this year, they have authorized the creation of an exploratory committee on telehealth. Advanced by State Senator Aaron Bean, the legislation establishes a 19-member panel of experts within the Florida Agency for Healthcare Administration. The panel’s membership should be finalized during the 2017 legislative session, and its deliberations will begin shortly thereafter. The committee is sure to recognize the barriers listed above early in its deliberations, and it is hoped they will offer specific recommendations to address them sometime in 2018.

**Evaluation:**

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<td>Recommendation 8c</td>
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**SUBCOMMITTEE #3 (Funding):**

**Subcommittee Chair - Laureen Pagel**

**Recommendations Assigned:**

**Recommendations #1b, 1c, 1g:**

- **1b.** Develop a strategy to secure funding from multiple sources (local, state, federal) for mental health prevention, diagnosis, and treatment for people of all ages.
- **1c.** Advocate for expansion of Medicaid in the State of Florida.
- **1g.** Work with professional associations to close loopholes in the Mental Health Parity Act, which are currently used by insurers to bypass the intent of the law.

**Results:**

**1b.** Perhaps the most challenging work of all 7 subcommittees was that of the Funding group under the leadership of Laureen Pagel. Florida ranks a dismal 49th of 50 states in public funding for mental health, spending less than one-third the per capita average in the USA. Funding in Northeast Florida has historically lagged other portions of the state, and it has actually lost ground since 2001.

Fortunately, a vocal and influential group of Florida legislators began recognizing in 2014 that the status quo is no longer acceptable, and they began to view mental health as more of a priority in Tallahassee. Accordingly, the 2015 Legislative session produced incremental funding for mental health in the state for the first time in more than a decade, though the new dollars ($39 million) were from Federal block grants and went largely to substance abuse rather than mental health. While the incremental dollars were not enough to nudge Florida from its standing as next-to-last among the 50 states in mental health funding, any new funding was viewed as progress, and several of the priorities identified by Subcommittee 3 were funded by the incremental dollars (e.g., high fidelity wrap-around services, case management, SOAR processing, integrated care, etc.). *(See Appendix 1)*

**1c.** Added to the funding challenge was the intransigence of the Governor and Florida Legislature throughout the implementation term to even consider expanding Medicaid, even though the vast majority of expansion costs would be funded by the Federal Government. In states that do not expand Medicaid, the effect is to leave many of our poorest citizens without health care because their incomes are too high for Medicaid eligibility but not high enough to qualify for federal health care subsidies. Sadly, there appears to be little chance of Florida adopting Medicaid expansion in the near term. Expansion must be approved on a state-by-state basis, but because it is a component of the Affordable Care Act, the prevailing ideological point of view of the majority in Tallahassee has been to oppose expansion just as they do the whole concept of Obamacare. The result is that nearly one million of the state’s most vulnerable individuals remain uninsured.

**1g.** In regard to perceived loopholes in the Mental Health Parity Act, the Subcommittee learned through discussions with Florida Blue executives and others that the Mental Health Parity Act and subsequent addendums have effectively brought parity among insurers to *coverage*, but not to *treatment*. Since 2013, all large group plans offered by health insurers have been required to come into compliance with the provisions of the Act, and they have done so.
The real parity issue is that mental health treatment is fundamentally different from medical/surgical treatment and will remain so. First, there is no medical diagnosis that requires a patient to see the same practitioner on a weekly or monthly basis for years, even decades. In addition, most medical diagnoses have an accepted course of treatment, while mental health diagnoses offer no standardization and often no agreement from one professional to the next.

**Evaluation:**

- **Recommendation 1b**  Partially Implemented
- **Recommendation 1c**  Not Implemented
- **Recommendation 1g**  Partially Implemented
SUBCOMMITTEE #4 (Professional Training/Board Licensure)

Subcommittee Chairs - Terri Wall and Jim Penrod

Recommendations Assigned:

Recommendations #1e, 1h:

- 1e. Advocate for an increase in the number of mental health professionals who accept one or more forms of health insurance, including Medicaid and Medicare, to make health care more affordable and increase patient access to treatment.
- 1h. Continue to evaluate evidence-based practices and expand their use in Northeast Florida.

Results: 1e. Subcommittee 4 members conducted a fact-finding market analysis over the first several months of their activity to attempt to determine the number of mental health professionals of all types in Northeast Florida. No universal clearing house for accessing mental health professionals exists in this area, and it became increasingly apparent as barriers were reached that assembling a data base on such a scale, particularly for those operating in private practice, was beyond the scope of this volunteer group. The subcommittee also quickly learned that as difficult as it is to assemble a comprehensive list of mental health professionals, it is even more challenging to determine the types of reimbursements they accept for services.

Clearly, there is a shortage of mental health providers in Northeast Florida, particularly psychiatrists. We know this because waiting lists for services in Northeast Florida often range from one to several months. The demand for services vastly exceeds the supply of practitioners. The problem is compounded for low-income individuals since it is estimated that only about one-third of the practicing psychiatrists in the region accept Medicaid as a form of payment for services. Low reimbursement rates by Medicaid often make it impossible for providers to cover their expenses, so most psychiatrists are reluctant and usually unwilling to accept it.

Medicaid reimbursement modifications require federal and state legislative action, so continued consistent advocacy efforts must be applied if improvements are to be realized. MHA of Northeast Florida and LSF Health Systems have adopted Medicaid issues (i.e., expansion of Medicaid in Florida; and reimbursement rates to providers) as advocacy priorities at the state level, but it will take persistence and perseverance to convince a heretofore inflexible state legislature.

1h. Following several months of background work designed to develop a survey to ascertain the use of “evidence-based practices” by mental health professionals in the region, Subcommittee 4 members concluded that there is no commonly accepted definition of the term, resulting in a large gray area. Some providers consider basic treatment practices as evidence-based, whether or not there is any external scientific evidence to support the practices.

As a result, Subcommittee 4 decided to exercise caution in surveying providers since it was beyond the group’s purview to make determinations about what meets the definition of evidence-based practices.
LSF Health Systems, represented on Subcommittee 4, explained that providers who receive public funds are required by contract to demonstrate the use of one or more evidence-based practices as defined by LSF using SAMHSA and other national registries for same. LSF surveys their providers and maintains a summary of evidence-based practices being utilized in the area, albeit only for those providers who receive public funding.

Since the LSF survey and summary were already available, Subcommittee 4 concluded it would be duplicating efforts to do another survey. The larger issue is to increase awareness among providers of what evidence-based practices are being used by their colleagues and encourage them to expand their own use. Accordingly, Subcommittee 4 requested that LSF publish a utilization summary and use their communication vehicles to encourage broader use of evidence-based practices by the providers. LSF subsequently published in their February 2016 newsletter a listing of evidence-based practices in use in Northeast Florida and a letter encouraging their providers to consider adopting additional practices.

**Evaluation:**

- Recommendation 1e Not Yet Implemented
- Recommendation 1h Partially Implemented

**Recommendation #7:**

In order to improve diagnosis and treatment for mental illness, more access should be created to mental health professionals who are well-trained, reimbursed fairly, able to work collaboratively, and are technologically savvy. Specific actions include:

- 7a. UF Health Jacksonville should expand the number of psychiatric residency slots it offers.
- 7b. The coalition referred to in Recommendation 1 should meet with mental health professional associations to identify a strategy for increasing licensing reciprocity for physicians and other mental health providers to make it easier to practice in Florida.
- 7c. The Florida chapter of the National Association of Social Workers should identify funding streams for loan forgiveness and scholarships for education and training of mental health providers who will commit to working in the region.

**Results:**

7a. During the implementation phase of the Mental Health project, it was determined in speaking with Dr. Steven Cuffe, Program Director of the Psychiatric Residency program at UF Health Jacksonville, that one psychiatric residency slot was added in 2015, raising the number of annual slots from three to four. This is a step in the right direction because physicians often settle permanently in the cities where they complete their residency.

7b. The research conducted by Subcommittee 4 revealed that mental health professionals who relocate from other states generally have licensing privileges in Florida as prescribed in the Florida Statutes. For psychologists and LMHC’s, there is one additional step that requires them to pass that portion of the licensing exam pertaining to the laws and rules related to their practice in Florida.

7c. Research conducted by Subcommittee 4 regarding loan forgiveness programs determined that the National Health Service Corps (NHSC), a division of the US Health and Human Services Department, offers tax-free loan repayment assistance to support qualified health care providers who choose to
practice in parts of the country where they are most needed (i.e., designated Health Professional Shortage Areas). Licensed health care providers, including mental health professionals, may earn up to $50,000 toward student loans in exchange for a two-year commitment to practice in a Health Professional Shortage Area. In addition, current medical students may earn up to $120,000 in their final year of school through the Student Loan Repayment Program if they commit to serving at least three years in an approved Health Professional Shortage Area. Eligibility requirements are stiff to qualify for these loans, so not all applicants are approved.

NHSC also has a State Loan Repayment Program, under which mental health professionals receive loan repayment assistance for qualified education debt. Unfortunately, Florida is one of only 14 states that does not offer a State Loan Repayment Program, but it is hoped that additional advocacy efforts will be successful in influencing the state to participate.

Evaluation:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Status</th>
</tr>
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<tbody>
<tr>
<td>7a</td>
<td>Implemented</td>
</tr>
<tr>
<td>7b</td>
<td>Implemented (Licensing reciprocity for mental health professionals is generally provided for in Florida.)</td>
</tr>
<tr>
<td>7c</td>
<td>Partially Implemented (The federal Student Loan Repayment Program is available to Florida applicants, but Florida does not participate in the State Loan Repayment Program)</td>
</tr>
</tbody>
</table>

**Recommendation #8a:**

8a. The local residency programs in primary care and psychiatry should establish a working relationship to cross-train their residents to have a stronger foundation in mental health diagnosis and treatment

**Results:** UF Health Jacksonville is the only local medical facility to offer psychiatric residencies. The relatively small number of faculty members limits the ability of UF Health to train/supervise residents from other programs, but they have initiated some efforts to improve understanding of mental health in other medical specialties. UF Health provides periodic lectures on mental health to residents in internal medicine and OB/GYN, and they have pediatric and OB/GYN residents training in their psychiatric clinic. Recently, UF Health has initiated discussions with St. Vincent’s family medicine residency about creating a clinical experience designed to cross-train physicians. While it remains a goal, there is not yet a program in place to place internal medicine residents in clinical experiences with the UF Health psychiatric residents.

**Evaluation:** Partially Implemented (Efforts are underway to cross-train physicians but are currently limited by the size of faculty staff)
**Recommendation #10:**

*Mental Health America of Northeast Florida, River Region Human Services, Daniel Inc., and others should convene a task force to coordinate training efforts for licensed and non-licensed mental health professionals. The trainings should be scheduled regularly, presented in multiple platforms for maximum access (i.e., web-based, in person, by phone, and an annual conference of providers), and be based on evidence-based practices.*

**Results:** LSF Health Systems has established a Training Institute for those interested in participating in mental health training offerings. This database provides listings for quality evidence based training, technical assistance and education opportunities for mental health professionals. The Training Institute can be easily accessed by clicking on Trainings at the LSF website ([http://samh.lsfnet.org/Pages/default.aspx](http://samh.lsfnet.org/Pages/default.aspx)). In order to broaden the reach of these training opportunities, MHA of Northeast Florida provides a link on their website.

To address the portion of Recommendation 10 suggesting an annual conference of providers, MHA of Northeast Florida stepped forward to stage a first-ever statewide Mental Health Summit in Jacksonville August 25-26, 2015. The Summit brought together more than 200 mental health professionals, advocates and concerned citizens throughout Florida with the common goal of exploring ways to improve the lives of people living with mental illness.

The Summit’s keynote speakers included the Honorable Judge Steve Leifman (11th Judicial Court) and Dr. Michael DeLaHunt, Chief of Psychiatry at Nemours Children’s Clinic in Jacksonville. Judge Leifman addressed the intersection of mental illness with the criminal justice system, focusing on the impressive progress made under his leadership in Miami-Dade County over the past 15 years. Dr. DeLaHunt spoke about one of the major themes of the two-day Summit – the importance of integration of physical and mental healthcare.

A series of thought-provoking workshops over the two days covered a wide range of topics, including several issues directly related to the work of the JCCI Mental Health Task Force (e.g., creation of a Central Receiving Facility; integrating physical and mental health; mental health and the homeless; children’s mental health and the role of schools; telebehavioral health; etc.).

The Summit concluded with attendees identifying a number of priorities that subsequently framed MHA’s mental health legislative agenda for the 2016 Florida Legislative Session. It is envisioned that the Florida Mental Health Summit will become an annual event; this year’s Summit will be held in Jacksonville on October 4-5, 2016.

**Evaluation:** *Implemented*
SUBCOMMITTEE 5 (*Decriminalizing Mental Illness*)

*Subcommittee Chairs - Ellen Williams and Greg Frazier*

**Recommendations Assigned:**

**Recommendation #3:**

*Renaissance Behavioral Health and River Region Human Services should lead a group of stakeholders (including community mental health centers, law enforcement, the State Attorney, Public Defender, and the local judicial system) to:*

- **3a.** Evaluate Assisted Outpatient Treatment for its applicability to Northeast Florida. If deemed germane to Northeast Florida, this stakeholder group should advocate for the judicial system and law enforcement to utilize Assisted Outpatient Treatment in Northeast Florida as has been done successfully in Seminole County, Florida.
- **3b.** Strengthen and expand the Mental Health Court to reduce the criminalization of mental illness in Northeast Florida.

**Results:**

**3a.** Assisted Outpatient Treatment (AOT) allows courts to order treatment for some individuals with severe and persistent mental illness while living in the community. AOT has been used effectively in some places across the country to help individuals with mental illness and their families avoid involuntary commitment to a mental health institution, but it carries with it certain civil liberties issues that opponents point to as sufficient reasons not to utilize it. While AOT is legal in Florida, it has seldom been used except in Seminole County where it has reportedly met with some success.

After discussing the advisability of promoting AOT for Northeast Florida, Subcommittee 5 members reached consensus that more research is needed. Subcommittee 5 clearly recognizes that AOT can represent a positive advancement for individuals who have a history of medication noncompliance. Once more evidence of its potential success is established and questions regarding civil rights issues are resolved, it could well be time to advocate for AOT in our community.

**3b.** With regard to Mental Health Court, representatives of Subcommittee 5 were invited by Circuit Court Judge Karen Cole, a strong advocate of decriminalization of mental illness, to attend and observe the Duval County Mental Health Court.

The voluntary Duval County Mental Health Court program was developed and implemented under the direction of the Fourth Judicial Circuit in 2008. Its mission is to provide constructive and innovative court supervision to ensure compliance, reduce recidivism and to offer a cost-effective alternative to incarceration. Mental Health Court, overseen by a Magistrate, links offenders who would ordinarily be prison-bound to long-term community-based treatment. The one-year program relies on mental health assessments, individualized treatment plans, and ongoing judicial monitoring to address both the mental health needs of the offender and the public safety concerns of the community. The criteria for Mental Health Court is to have an active criminal charge of a misdemeanor or 3rd or 2nd degree felony and a mental health diagnosis.
Since Mental Health Court has not historically been codified and funded as an official component of the Duval County judicial system, its effectiveness is limited. Some candidates for Mental Health Court, for example, would rather accept a short-term jail sentence than subject themselves to weekly appearances before the magistrate and frequent drug tests over the course of an entire year. Others intentionally fail the one-year program at its conclusion in order not to lose the security of the case management that accompanies Mental Health Court.

A bill passed during the 2016 Florida Legislative Session (HB 439) co-sponsored by House Judiciary Chairman Charles McBurney and Senate Judiciary Chairman Miguel Diaz de la Portilla allows for communities across the state to set up publicly-supported uniform mental health courts. No funding was appropriated at this time, but a formal legal structure is now in place that moves the needle in a positive direction.

**Evaluation:**

*Recommendation 3a – N/A (Assisted Outpatient Treatment was viewed positively for future application in NE Florida, but civil rights issues objections must be addressed first.)*

*Recommendation 3b - Partially Implemented (Mental Health Court has now been codified across the state but not yet funded.)*

**Recommendation #5:**

The City of Jacksonville, Jacksonville Sheriff’s Office, and community mental health providers should work with Ability Housing of Northeast Florida to implement a pilot to demonstrate the efficacy of providing permanent supportive housing for high utilizers of crisis services. The data derived from this pilot should be used to develop sustainable systems to enable chronically homeless individuals with mental illness to stop cycling through costly systems of care. This will reduce the community’s costs of incarceration and medical care while improving the quality of life for homeless individuals living with mental illness.

**Results:** In 2014, Ability Housing Inc. introduced a statewide pilot program called *The Solution that Saves*. A collaborative effort with area nonprofits and governmental entities, *The Solution that Saves* is designed to demonstrate that permanent affordable housing linked with support services is the most effective way to provide improved outcomes at less cost. The program has the support of the Jacksonville Sheriff’s Office and other key stakeholders. Assisting people who experience chronic homelessness to lead stable lives in the community can be challenging due to the complexity of their underlying conditions and disorders.

Ability Housing has long recognized that persons with housing instability and chronic health conditions are more likely to experience serious health issues (including mental illness) that impact costly systems of care. Many become caught in a recurrent cycle of costly emergency medical care, institutionalization in psychiatric hospitals and facilities, jails and prisons, and living on the streets or in homeless shelters.

National research supports this premise, but until *The Solution that Saves*, no Florida-specific data has been compiled, making it difficult to demonstrate the impact of permanent supportive housing to potential funders. This pilot was created to assess the impact of supportive housing on homeless
individuals, as well as conduct a cost-benefit analysis. Health Tech Consultants, Inc. was selected to conduct the analysis which is designed to lead to systemic changes at the local and state levels.

Since the program began in 2015, Ability Housing Inc. has enrolled 85 individuals in the pilot, 40 men and 45 women ranging in age from 22-62. All but three of those enrolled meet the HUD definition of chronically homeless (long-term homeless with a documented disability), the majority of whom have a diagnosable mental illness; 40% are covered by Medicaid, while about half have no health insurance. 55% of participants identify as African American and 45% as White.

The first cost-benefit analysis will be conducted once all participants have been in housing for a minimum of 12 months. Of those housed to date as part of the pilot program, 95% remain in housing as of August 2016. The first report is expected to be released early in 2017.

**Evaluation:** **Implemented**

**Over-Arching Progress on Decriminalization Efforts:**

In addition to the specific issues discussed in Recommendations 3 and 5, additional significant progress has been realized over the past two years in the local effort to decriminalize mental illness.

Under the direction of LSF Health Systems, *Sequential Intercept Mapping (SIM)* was introduced in 2015 as an outgrowth of the JCCI Mental Health project. SIM represents a comprehensive and organized way to look at the entire mental health system with the goal of reducing the number of individuals with mental illness who become involved with the criminal justice system.

Decriminalizing mental illness crosses many functions in the law enforcement, judicial, and mental health arenas. SIM provides a tool for developing criminal justice/mental health partnerships for the community to assess its resources, gaps, and opportunities at each of five “intercept points.” The mapping exercise is designed to identify potential opportunities for diversion, or alternative justice and behavioral health interventions for persons with mental illness, within each of the five intercepts. The SIM project enlists the support and commitment of the key stakeholders in this arena (Baker Act receiving facilities; community mental health centers; law enforcement; the State Attorney; Public Defender; the local judicial system, representatives of the JCCI Mental Health Task Force, and others).

As the SIM analysis concluded, a formal collaborative was established under which a consistent effort is to be maintained with the goal of changing those systemic factors that contribute to the criminalization of mental illness. The *Jacksonville Criminal Justice Behavioral Health Collaborative (JCJBHC)* was introduced in 2015 with strong initial support of members representing each of the critical sectors identified above. Since its inception, many new members have been added.

Four work groups were established under JCJBHC to address various facets of the relationship between mental health and the criminal justice system. The full Collaborative meets quarterly, while the work groups meet as needed. The four work groups are:

- Developing a Central Receiving Facility
- Information Sharing & Jail After Care
- Developing SOAR Processors (SSDI/SSI Benefits Specialists)
- Pre-Trial Mental Health Diversion
Each work group has realized some success in their first year, but it is clear that there are few quick fixes to a system as complicated and multi-faceted as the intersection between mental health and criminal justice.

In recent years, a number of progressive communities across the country have implemented Central Receiving Facilities to provide convenient and comprehensive services to individuals with mental illness. The Central Receiving Facilities provide assessment and treatment services, and are also used as an option for diverting individuals from jail. Orlando, which has operated a Central Receiving Facility since 2003, estimates that it has saved local taxpayers and hospitals $50 million since its creation.

In 2015, Mental Health Resource Center (MHRC) was awarded a grant from the Department of Children and Families to develop and implement a Central Receiving Facility in Jacksonville. The state grant requires 50% in local match funding, and it is hoped that sufficient financial support from the community will be obtained in the coming months to allow the project to proceed in the near future. MHRC and key stakeholders are charged with developing a formal plan that is broadly supported and meets the needs of the community.

Significant progress has also been realized by the SOAR Processors work group of the JCJBHC. The Managing Entity (LSF Health Systems) has amended its contractual requirements for all provider agencies receiving Adult Mental Health Case Management funding to include SOAR Dedicated Processors. Along with other community efforts, this has resulted in an increase over the past year in the number of SOAR Dedicated Processors and a corresponding increase in the number of SOAR applications completed. Currently, there are 11 SOAR processors in Northeast Florida with plans already under way to add more. As recently as 2014 when the JCCI Mental Health Inquiry was conducted, there were only four.

With the formation of the JCJBHC, it became apparent to members of Subcommittee 5 in the summer of 2015 that the LSF-coordinated effort is well organized and inclusive of all the appropriate stakeholders, most of whom had been involved in the JCCI project from its inception. It was therefore agreed that the most useful role of Subcommittee 5 would be to monitor the progress of JCJBHC and offer assistance as appropriate.

**Evaluation:**  
*Partially Implemented (The Jacksonville Criminal Justice Behavioral Health Collaborative provides a well-organized forum of key stakeholders to improve the lives of individuals with mental illness.)*
SUBCOMMITTEE 6 (Managing Severe and Persistent Mental Illness)

Subcommittee Chair - Eileen Briggs

Recommendations Assigned:

Recommendation #2:

Lutheran Services Florida and We Care should convene a broad coalition of providers that serve individuals living with chronic mental illness, including the criminal justice system, to develop a mechanism for coordinating care, medication management, and wrap-around services. The goals should be to ensure follow-up care, reduce homelessness, and lessen the frequency of emergency issues for those who are living with severe and persistent mental illness.

Recommendation #6:

Baptist Health and We Care should convene other area hospitals and psychiatric inpatient providers to identify persons who are frequent users of mental health services in order to evaluate the current cost of treatment, and examine alternative treatment plans and protocols that could reduce repeated hospitalizations and improve patient outcomes.

Results: Early in the Subcommittee 6 deliberations, it was recognized that the two recommendations (#2 and #6) are wholly inter-related and should be addressed together, not separately. They were therefore approached concurrently so that the Subcommittee effectively viewed them as one recommendation, not two.

The subcommittee initially focused its work on identifying the scope of the problem with respect to frequent utilizers of emergency mental health services. Unfortunately, no data existed across providers, so the initial effort of the Subcommittee was to convene all eight Crisis Stabilization Unit service providers (CSU’s) in Northeast Florida to begin a process of collaboration and information gathering. The crisis service providers who participated were:

- Mental Health Resource Center (MHRC)
- Baptist Health
- UF Health Jacksonville
- Riverpoint Behavioral Health
• Flagler Hospital
• Wekiva Springs
• Memorial Hospital
• Orange Park Medical Center

Each provider reported individually that their agency had mechanisms in place for identifying frequent users of emergency care; however, attempts to address these clients with innovative or alternative interventions were limited and not coordinated across providers. Those clients with private insurance are often provided with Care Coordination services by their insurance companies; but those with public insurance or none at all (indigent) do not have access to this level of care. This results in a revolving door of individuals with severe and persistent mental illness cycling through local CSU’s with fragmented care at very high costs to the community.

In order to gain some sense of the scope of the problem, the group agreed that each provider would be asked to gather and share data from their own facility on clients who are referred to as High Need, High Utilizers, defined as any individual with three or more CSU admissions within a 12-month period. In lieu of HIPPA-protected identifying information, the providers were asked to include the last four digits of each client’s social security number in order to generate an unduplicated count. Due to varying levels of concern in each provider’s legal department, most were not permitted to submit client identification information. Two facilities did not provide any data at all. The data gathered was as follows:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Clients with 3 or More Admissions within 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHRC</td>
<td>285</td>
</tr>
<tr>
<td>Baptist</td>
<td>145 (no client ID)</td>
</tr>
<tr>
<td>UF Health Jacksonville</td>
<td>91</td>
</tr>
<tr>
<td>Riverpoint</td>
<td>35</td>
</tr>
<tr>
<td>Flagler</td>
<td>29 (no client ID)</td>
</tr>
<tr>
<td>Wekiva</td>
<td>10 (no client ID)</td>
</tr>
<tr>
<td>OPMC</td>
<td>did not provide</td>
</tr>
<tr>
<td>Memorial</td>
<td>did not provide</td>
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</tbody>
</table>

From the data submitted above, a quasi-unduplicated count of high-need, high-utilizers of CSU services in NE FL was generated.

<table>
<thead>
<tr>
<th>Number of High-Need, High-Utilizers of CSU Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Quasi-Unduplicated Count</td>
</tr>
<tr>
<td>Total Individuals Identified at Multiple Facilities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HN/HU by Number of Admissions</th>
</tr>
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### Working Toward Information Sharing:

As the data above shows, the majority of HN/HU clients access services at either MHRC or Baptist Hospital. Both providers report that common identifiers for this population are homelessness and lack of connection with any outpatient care. Sulzbacher Center was identified as an important entity for this population since they ultimately come in contact with many of the same HN/HU clients passing through MHRC and/or Baptist. These three organizations agreed to work together to develop an effective information sharing plan and care coordination that, if successful, could represent a good starting point for addressing the needs of this group of high need individuals.

This smaller group agreed to share information through a process as follows:

1. Continually maintain a list of the 10 highest utilizers of CSU services;
2. Request ROIs from these individuals to share information; and
3. Work with MHRC’s LINK program to obtain housing and benefits needed.

Once this process is established, the group intends to grow upon the success of the initiative by expanding the reach of the partnership to law enforcement and other service providers.

### What we learned along the way:

1. In Northeast Florida, approximately 563 persons annually fall into the category of High-Need/High-Utilizers of Crisis Stabilization Units. Efforts toward addressing the unique needs of this population are fragmented and not well funded;
2. The Crisis Stabilization providers lack a centralized mechanism for sharing information or coordinating care for the HN/HU population;
3. HIPPA concerns prevent providers from sharing information or coordinating care;
4. The majority of SPMI HN/HU clients cycle through three main providers: Baptist, MHRC and the Sulzbacher Center; and
5. Increased funding and alternative interventions are needed to address the unique needs of this population.
6. While the committee was able to convene a broad coalition of providers, most were not able to participate in information sharing due to legal concerns;
7. Increased funding and alternative interventions are needed to address the unique needs of this population.

In summary, Subcommittee 6 was successful in forming a collaborative partnership with the two major providers of crisis services for the HN/HU population (MHRC and Baptist Health). The two had not previously worked together on addressing this shared population. Working in concert with Sulzbacher Center, the leading homeless services organization in the region, these collaborative partners have...
identified a potentially effective model to address the unique needs of this population through the sharing of information and coordinated care.

**Evaluation:** Partially Implemented (It is hoped that the pilot program identified above can be expanded to include both law enforcement and the broader array of service providers.)
SUBCOMMITTEE 7 (Public Awareness and Early Identification)

Subcommittee Chair – Kristi Krug

Recommendations Assigned:

Recommendation #9:

In order to promote wellness and assess, identify and treat early signs of mental illness in children, the Full Service Schools collaboration (led by United Way of Northeast Florida, Duval County Public Schools, Jacksonville Children’s Commission, Duval County Health Department, and others) should work to increase private and public funding for early interventions, treatment, and case management services to ensure that all children in Duval County have access to needed health services. This will require additional nurses, school psychologists, and other mental health professionals working in schools (i.e., Florida Certified School Social Workers and Licensed Clinical Social Workers) in sufficient quantity to meet or exceed national best practice staffing ratios.

Results:

Full Service Schools, a program coordinated by United Way of Northeast Florida, is a collaboration of Duval County Public Schools, Jacksonville Children’s Commission, Duval County Health Department, and St. Vincent’s Mobile Health, the goal of which is to connect DCPS students and families to a range of therapeutic, health and social services and address non-academic barriers to success in school. It has shown significant success since its founding in 1991, but its impact in the behavioral health arena has been limited by the shortage of mental health professionals working in schools.

“Children are coming to school with mental health issues, and the school system is not really equipped to deal with them,” said DCPS Superintendent Nikolai Vitti. “You’d be hard-pressed to talk to teachers today, especially in certain communities, and them not talk about the challenges children bring with them to the classroom, regarding behavior, sickness, and mental health.”

Full Service Schools Plus, a pilot program introduced in the 2015-2016 school year, is designed to help address this problem. A supplement to the existing Full Service Schools collaboration, Full Service Schools Plus embeds a therapist in each of the 12 schools within the Ribault High School Feeder pattern in order to increase students’ access to mental health services. The new program is designed to eliminate some of the gaps in mental health services in public schools. At the end of the school year in 2016, results were impressive with 935 referrals made and 61% of the students actually receiving services, as compared to 426 referrals and 22% receiving services during the 2014-15 school year. Full Service Schools Plus is a successful public-private partnership with the addition of the Chartrand Family Fund at The Community Foundation for Northeast Florida, Children’s Home Society, and the Jacksonville Public Education Fund.
If the pilot continues to demonstrate favorable results, the objective will be to expand it well beyond the 12 schools initially participating. “Ideally, the Plus model would be in every school, or at least expanded enough that each community is touched,” said Superintendent Vitti.

Clearly, the community partners in the Full Service Schools collaboration have embraced the challenge of improving mental health services in Duval County Public Schools. The Plus pilot program is an innovative solution that is working. Its expansion across the entire school district will improve the health and well-being of children throughout Jacksonville.

Evaluation:  Implemented

**Recommendation #11:**

United Way of Northeast Florida should convene community members and decision-makers to implement research-support strategies to decrease stigma related to mental illness and change the conversation about mental health. Strategies should include:

- Identifying community influencers to serve as champions and speak out publicly against prejudice and discrimination of persons with mental illness.
- Framing public messaging and information to cultivate a community-wide sense of responsibility and commitment to a healthier region and recognition that every person falls somewhere on the continuum of mental health; and
- Collaborating with the Florida Times-Union and other media sources to produce a specific community education campaign regarding mental health issues that includes a website, print, digital and broadcast stories of mental health.

**Results:** As the JCCI Mental Health Inquiry reported, the stigma associated with mental illness is both pervasive and firmly entrenched in our society. It results in those living with mental illness and their family members being unwilling to speak openly about their problem, often tragically keeping them from seeking the diagnosis and treatment that could improve their lives. Eradicating stigma is a long-term proposition that will take generations, and Subcommittee 7 members recognized it could never be accomplished in the two-year window of the JCCI implementation project.

In 2015, United Way of Northeast Florida commissioned a consultant to review stigma reduction campaigns in use elsewhere, and to explore similar opportunities for Jacksonville. The resulting document — *Deploying a Mental Illness Stigma and Discrimination Reduction Initiative in Duval County* — was presented to a group of key community stakeholders in January 2016.

Significant findings of the research included:

- Contact needs to be targeted. Rather than focusing on the population as a whole, contact is more effective when it targets key groups such as employers, landlords, health care providers, legislators, school personnel, media outlets, community leaders, etc. Efforts should be directed at those audiences whose knowledge, attitudes, and behavior must be changed in order to impact stigma reduction goals.
• “Local” contact programs are more effective. For example, employers in impoverished parts of a city and in wealthy suburbs will require different approaches. A one-size-fits-all approach typically results in limited and non-lasting impact.

• Contacts must be credible: a. The individual in the contact role should be similar in ethnicity, religion, and socioeconomic status to the target group; b. Those making the contact should have similar roles to those they are addressing (e.g., employers, police officers, health care providers; etc.); and c. Interactions are most effective when the consumer contact is in recovery rather than actively psychotic or homeless.

• The contact must be continuous. While a one-time contact may have some positive effects, they are likely to be fleeting.

Once the white paper was completed, United Way convened a group of key stakeholders in January 2016 to begin the process of identifying the best way to proceed with a stigma-reduction initiative in Northeast Florida. The meeting focused on how to define success and next steps for moving the discussions forward. It was generally agreed that a targeted approach to a specific audience (e.g., individuals living with mental illness who experience stigma first-hand) might be the most effective approach.

A smaller planning group consisting of some of the original stakeholders has met several times to chart a course for the campaign. Special Project Partners, a local consulting firm, was retained by United Way in June 2016 to conduct focus groups involving persons with mental illness and their families. The goal is to determine how much of an impact stigma has on seeking treatment and on the quality of life for those affected. The focus groups, scheduled for August 2016 are also designed to gather input of what an effective stigma reduction initiative might look like in Northeast Florida. Results will be discussed with United Way and its partners to determine the next steps.

Inputs from these United Way partners, the focus groups, and the report referred to above will provide a rich source of information for developing a stigma initiative that directly impacts those individuals who live with mental illness in Northeast Florida.

**Evaluation:**  
*Partially Implemented*

**Recommendation #12:**

*Mental Health America of Northeast Florida, United Way 2-1-1, and the Non-Profit Center of Northeast Florida should work together to develop a web-based data system for individual organizations/agencies to post primary services, events, group self-help programs, calendars of events, and training opportunities. This consumer and provider-friendly data system should be accessible by internet, telephone, face-to-face contact with agency staff, and other technologies.*

**Results:** A successful collaboration involving MHA of Northeast Florida and United Way 2-1-1 has resulted in a web-based data system available on the MHA website (mhajax.org) that provides a simple way to access mental health information, a list of mental health providers, screening tools, a calendar of events, and related articles and research.
The provider list helps an individual find licensed mental health practitioners. It can either be accessed by requesting contact information for specifically identified providers; or it can list providers who offer requested services. Sorting can be done either alphabetically or by location. Currently, 110 different providers are included on the site.

The site also includes screening tools which provide quick, easy-to-use questionnaires on eight different screening options (Depression screening; Anxiety; Bipolar; PTSD; Alcohol or Substance Abuse; Youth; Parent; and Psychosis). Once the responses are submitted, the individual is provided a summary based on the clinically recognized Patient Health Questionnaire (PHQ-9) instrument for diagnosing and measuring the severity of depression.

**Evaluation:** Implemented
APPENDIX 1

June 30, 2015

Christine Cauffield, Ph. D
Executive Director
LSF Health Systems
10450 San Jose Blvd., Unit A
Jacksonville, FL 32257

Dear Dr. Cauffield:

We understand that for the first time in a number of years, there will be dollars available for additional funding of substance abuse and mental health in the State of Florida. This is obviously a favorable and long overdue occurrence, and we are communicating with you to encourage LSF Health Systems to consider expanding the distribution of this incremental funding for uses beyond emergency services.

As you know, the JCCI Mental Health Inquiry emphasized the importance of utilizing some portion of new dollars to fund services that are less costly and provide a broader impact across the mental health system, rather than concentrating nearly all available dollars on deep-end care and crisis stabilization services that are the costliest. We recognize that heretofore not enough public funding has been available to do much more than cover emergency services, but we are hopeful that with these new dollars, LSF can expand its funding philosophy to cover some services that are more cost effective and have broader impact.

Two of the committees of the JCCI Mental Health Implementation Task Force (Funding; Strategic Plan) recently convened to discuss funding priorities. As you are aware, our Inquiry Committee and Implementation group have included a wide range of stakeholders throughout the mental health community in Northeast Florida, and the deliberations of these committees provided the following recommendation for LSF consideration as you develop a distribution plan for the new funds.

We recommend that the majority of the newly allocated funding in Northeast Florida be directed to services that reduce the need for deep-end services and emergency care. Specifically, we suggest that funding be provided for high-fidelity wrap-around services, case management, SOAR processing, integrated care, and other forms of care coordination. Further, we recommend that funded programs should demonstrate evidence of success, be client and family driven, and be culturally and linguistically competent. We also suggest that some portion of the incremental funding should support coalitions that engage children and families in services.

While we all recognize the new funding falls far short of the amount needed to provide a comprehensive publicly funded mental health system in our region, it at least represents a positive direction. We believe it should be viewed as an opportunity to begin the process of expanding funding into areas that can provide necessary services that can ultimately lead to more productive lives for individuals living with mental illness.
Don’t hesitate to contact us if we can provide additional information. Thank you for your consideration of our recommendation.

Sincerely,

Pat Hogan
Chair, JCCI Implementation Task Force

Laureen Pagel
Chair, Task Force Funding Subcommittee