Subcommittee Members Present:
Marvin Lindsey - Community Behavioral Healthcare Association
Gene Griffin - Illinois Children's Mental Health Partnership

Emily Miller - Illinois Association of Rehabilitation Facilities
Angie Hampton - Egyptian Public and Mental Health Department
Regina Crider - Youth and Family Peer Support Alliance
Eric Foster - Illinois Association for Behavioral Health
Dee Ann Ryan - Family Advocate
Tamara Doyle - Parent Advocate/ Haven Focused
Katrina Roberts - Parent Advocate/ Haven Focused
Eric Lenzo - Mt. Sinai Health System
Jason Keeler - Allendale Association
Deborah McCarrel - Illinois Collaboration on Youth (ICOY)
Michael Naylor - Illinois Psychiatric Society
Peter Nierman - Illinois Psychiatric Society
Michele Churchy-Mims - Metropolitan Family Services
Margo Roethlisberger - Ada S. McKinley

HFS Staff:
Kelly Cunningham
Kristine Herman
Jessica Johnson

Public:
Mikal Sutton - Blue Cross Blue Shield of Illinois
Anna Carvalho - representing CHOICES
Dr. Lorrie Jones - Next Level
Alma Stanton - Meridian Health Plan
Greg Lee - Meridian Health Plan
Nicole Lee - Harmony
Emily Gelber - Smart Policy Works
Tina Barksdale - Next Level
Paul Frank - Harmony/Wellcare
Michael Gerger - University of Illinois - Chicago
Felix Rodriguez - County Care
Kate Thierry - Blue Cross Blue Shield of IL
Meryl Sosa - Illinois Psychiatric Society
Rachel Engram-Sims - Meridian Health Plan
Amber Kirchhoff - Thresholds
Emily Cassidy - Harmony
Kenita Perry-Bell - University of Illinois - Chicago
Tom Wilson - Access Living
Kathy Chan - Cook County Health and Hospital Systems
Tony Smith - National Alliance on Mental Illness – Chicago
Brianna Lantz- IlliniCare
David Vinkler- Molina Healthcare
Debbi Smith- Community Residential Services Association
Lee Ann Reinert- DHS/DMH
Cyrus Winnett – Illinois Association of Medicaid Health Plans

1. Start time is **11:15am**

2. Topic: Continuity of Care
   - 1st half: Transitioning from youth to adult services
   - 2nd half: Transitioning from Fee-for-Service to Managed Care and vice-versa

3. The remaining NB Stakeholder Committee meeting date, time and topic:
   - Technical Support: Monday, August 6, 2018

4. Minutes from the Monday, July 9, 2018 meeting were reviewed. Two members of the public indicated that they were at the meeting but were not represented in the minutes. Minutes were approved with those edits.

5. Questions/Comments from Committee Members regarding:

Marvin Lindsey: Opened the meeting by outlining the two topics to be covered and asking that the committee members conduct their discussion first and then the public would be asked for their input.

Deb McCarrel: It would be helpful to discuss what adult services will look like, and what is currently there. Historically, there have been issues with adult services, so understanding what they will look like in the future would help assess if there will continue to be a cliff effect where services drop off once a youth moves into the adult system.

Margo Roethlisberger: Transition age youth often are not interested in continuing to engage in services, even Assertive Community Treatment (ACT) and Psychosocial Rehabilitation (PSR). These young adults often have different priorities and are not accustomed to having to go to a Community Mental Health Center (CMHC) to access services. They also often need vocational or daily living skills assistance, which does not always fit with a CMHC service array.

Dee Ann Ryan: Many of these young adults have Individualized Education Plans (IEP), so there should be coordination between the school and the mental health system starting at age 14 to ensure that the young adult has transition supports in place well before they transition to the adult system.

Gene Griffin: Many of the support systems for youth stop at age 21, while some end at 18.

Michelle Churchy-Mims: There is often a gap or disconnect between the children and adult systems because adult services have historically been funded under the Department of Human Services through various divisions without a specific transition age youth division to assist in coordination.

Margo Roethlisberger: It seems that the implementation of the Integrated Health Home model would be an ideal service for transition age youth ensuring that the coordination between youth and adult services is addressed as part of the care coordination model.

Michael Naylor: Having regional coordination offices that have a deep understanding of both youth and adult systems and that are also aware of what system the youth are coming from (e.g., DCFS, Juvenile System, etc.) will be absolutely critical.

Regina Crider: Treatment plans, IEPs and diagnoses all go hand-and-hand and should be integrated for youth to receive the best available services. It is not useful to anyone involved to start over, so clinical information related to the youth should be centrally collected for each youth, transition services should start at age 14 years and all clinical information should be utilized in coordination of services. Youth and families should also receive education regarding how to successfully navigate the youth and adult system and specific education on advocating for and representing their own needs.

Dee Ann Ryan: There needs to be a standardized assessment that is utilized in Child and Family Teams to enhance service planning and coordination through the Integrated Health Home. This process was part of the CHOICES pilot but that pilot was discontinued without clarification about what other system supports or coordination would be available.

Angie Hampton: There will be a “golden thread” with the new standardized assessment, the Illinois Medicaid+ Comprehensive Assessment for Needs and Strengths (IM+CANS). It will be used to assess individuals and then will flow into the four tiers of the Integrated Health Homes to be used by the Child and Family Teams for care coordination. There is also the Transition-to-Independence Process (TIP) evidence-based model that has been utilized with some success for individuals aged 14 – 29 years old. The model does require specialized training and developmental considerations. A handout regarding the model was provided to the co-chairs.

Jason Keeler: The universal assessment is going to be very important. However, there also has to be development awareness related to transition age youth’s functioning, not just a focus on their chronological age. Many of these young adults just want to be left alone and do not want to engage in any more “therapy”. They can experience “service fatigue” and need to be engaged differently and in accordance with their developmental needs.

Peter Nierman: In addition to developmental concerns, the Mental Health Code offers additional rights to youth who are 18 years old. They can refuse services, their guardians do not have to consent for services, and they can refuse to allow their parents/family to have any knowledge or participation in their services. While the youth is in school, the school through the IEP process is the entity accountable for services. Adults often do not have a person/entity accountable for services other than themselves. It will be crucial to create a single point of accountability for transition age youth to ensure service coordination and access. This accountability may lie with the

Integrated Health Home or not, but it must be a part of the system for transition age youth.

Marvin Lindsey asked if there were any additional comments from committee members and then opened the discussion for input from the public.

Public: Hospital transitions are difficult for plans to track in the adult system. So, understanding the responsibilities that the Integrated Health Homes and the health plans will have will be critical to ensuring that transition between systems is effective. There are pockets of services in the state that are focused on transition age youth, but only pockets. There needs to be education for youth and for families to understand where the existing services are, and there needs to be a concerted effort to develop more services. Both health plans and Integrated Health Homes have to play a role. Their respective roles should be clearly laid out in the health plans' contract and in the expectations for the Integrated Health Homes. There should be specific accountability for this population outlined in the contracts as well.

Public: Consideration of housing has to be a focus for this population as well. Establishing permanent housing when a youth transitions back to a community has to happen first because it is difficult to establish or maintain Medicaid eligibility without it. Redetermination requirements/announcements are mailed to recipients and if the youth does not have permanent housing, they do not receive the notices. In addition, services often require evidence of permanent housing in order to be eligible. Staff working for HFS/DHS should serve as the school-agency liaison and attend IEP meetings to assist youth/family with starting their treatment planning, including accessing resources for housing. The state must commit additional resources for establishing housing for this population.

Regina Crider & Katrina Roberts: We need to understand that currently some families are having negative interactions with the schools in the IEP process. Families need additional education and support regarding their role in the IEP and transition planning process. Families need more education and support in navigating the school and the mental health system (available services, rights, plan choices, coordinators, etc.).

Angie Hampton: We currently employ Family Resource Developers (FRD) who work in schools specifically with the IEP process. These FRDs offer peer support, education and help with navigation of the school system for the family. They have lived experience and specific training regarding working with families and youth. The school supports part of the FRDs salary, as they are seen as a valuable resource for the school as well as the family.

Public: The care coordinator from the MCO or the Integrated Health Home could participate in the IEP to ensure that transition services are provided, and also help with system navigation and developmental issues. Care Coordinators should also have knowledge of all of the systems that could help support the youth.

Marvin Lindsey asked the committee and the public if they were aware of any other states that had best practices or strong supportive services for transition age youth.

Public: Minnesota recently had a state plan amendment approved for Community Support Team-like services that included peer support, therapy and family monitoring.

Public: Community Residential Services Association has a white paper on services for transition age youth and will submit it to the email address for the group. Minnesota information will also be sent.

Margo Roethlisberger: Living skills, mock apartments, vocational skills are critical for this population and are not necessarily therapy or Medicaid services. Engaging transition age youth in these services means helping them connect anger management to the ability to have a job and having a job to living independently. Any service provided to this population has to be framed in terms of their "regular" life goals (e.g., having my own place, having a decent job, having friends to hang out with, etc.).

Marvin Lindsey then directed the committee to begin discussion regarding the second topic for the meeting: What are the best ways to ensure Continuity of Care when transitioning between Fee-for-Service and Managed Care? What is the state's role in making sure there are smooth transitions without disruption of services?

Michelle Churchy-Mims: Knowing when youth are actually transitioning in real time can be a challenge. MEDI currently has real-time issues and as a result, a provider does not find out the eligibility status until 45-50 days later at times. It would help to get the plans involved, but we need to know about the transition right away.

Michael Naylor: Pharmacy transition can be problematic as well due to lack of knowledge with transitions. Some individuals have not been able to access medication in the transition between Fee-for-Service and Managed Care or between Managed Care plans. Medication should be continued through transition periods.

Peter Nierman: Psychiatric availability is a challenge today with what doctors are paid. The low rate creates burdens for psychiatrists and individuals, because psychiatrists cannot effectively transition individuals. In addition, CMHCs are losing money by hiring a psychiatrist. This is even more challenging when the youth has to transition from an adolescent to an adult psychiatrist. The state should look at what it can do to better support psychiatrists.

Public: We have not yet talked about transitions between levels of care, which is also a very important aspect of care for youth transitioning to the adult system.

Eric Lenzo: Utilization of tele-health could assist with creating additional resources, enhancing medication compliance, transitioning from adolescent to adult psychiatrists and should be fully supported by the state and fully implemented by Managed Care plans.

Margo Roethlisberger: There has to be attention paid to the time that it take providers to get information about the individual's enrollment in Managed Care or transition back into fee-for-service. Provider must know this information so that they can submit billing to the appropriate payer and not end up with more administrative headaches.

Public: The state just issued an RFP for Admission, Discharge and Transition real-time alterations. There should be a statewide electronic system in place soon that will tell providers, plans and Integrated Health Homes if a person is admitted to the hospital, goes to the ER, is transitioned from the hospital, etc. This real-time information will be very helpful.

Margo Roethlisberger: That will be helpful. But, MEDI also needs to be real-time. Now it only tells us if an individual is eligible for Medicaid but does not tell us what plan the individual is enrolled in. Providers need additional real-time information.

Peter Nierman: More real-time information is needed. However, more funds for services are also needed. MCOs pay for additional services out of their bottom lines and therefore do not often cover services such as flex funds or other supportive services. The state needs to offer additional funding in both Fee-for-Service and Managed Care to ensure that additional supportive services are available for families, not just Medicaid state plan services.

Public: In addition, the state needs to fund evidence-based services so that providers can be innovative and create better outcomes for individuals served.

Public: Psychiatrists should receive an add-on rate since the grant funding was discontinued but the psychiatric rate was not increased.

Marvin Lindsey then asked if the committee could review the NB Implementation Plan prior to it being submitted to the court.

HFS indicated that legal staff would need to review that request.

6. Marvin and Gene again asked the committee members and members of the public to send additional comments to the HFS email at: HFS.NBsubcommittee@illinois.gov.

7. Meeting was adjourned at 12:30pm. The next meeting will be held on August 6, 2018, from 11:00am – 12:30pm on **Technical Assistance**.