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

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
Deborah McCarrel - Illinois Collaboration on Youth (ICOY)
Michael Naylor - Illinois Psychiatric Society
Peter Nierman - Illinois Psychiatric Society
Michele Churchy-Mims - Metropolitan Family Services
Jen McGowan-Tomke – National Alliance for Mental Illness Chicago
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
Jessica Pickens- Next Level Health
Jill Hayden- Meridian
Meryl Sosa - Illinois Psychiatric Society
Amber Kirchhoff - Thresholds
Heather O' Donnell- Thresholds
Dr. O'Rourke- Illinois Chapter, American Academy of Pediatrics
Alli Shuck- ICMHP
Paul Bennet- Next Level Health

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1. Start time is 11:07 am

2. Topic: **Technical Support**

3. Minutes from the Monday, July 23, 2018 meeting were reviewed and approved with two corrections.

4. Questions/Comments from Committee Members regarding:

Marvin opened the meeting with an overview of the topic for the meeting. Discussed all of the BH Transformation Initiatives that are currently rolling out and asked the committee to consider how all of the initiatives will impact NB. Marvin also asked the committee members to think about implementation of all of the initiatives and give the State feedback on what providers

really need to support them in the transition, including a learning collaborative and ongoing technical assistance and resources that will be needed.

Margo Roethlisberger: Providers need a well laid out plan with information made available as soon as possible. Staff members have many questions about how to operationalize new services and supports. Administrators at agencies need to be able to give staff specific guidance, so concrete information is critical. Providers need additional training and information. Webinar sessions are preferable so that staff do not have to travel to training. A train-the-trainer model would also be beneficial.

Jen McGowan-Tomke: A centralized technical assistance entity would be a very beneficial investment for the State. Providers need one place to contact to receive information, ongoing technical assistance and training. A Center of Excellence model with a university partner would be ideal.

Dee Ann Ryan: Workforce development is not occurring and is critical to the success of the entire system and for compliance with NB. Licensed clinical staff needs to be trained to do behavioral health assessments that give support staff all of the information that they need to work with the family. Support staff / paraprofessional staff need to be trained to work in families' homes with parents and with children to implement the clinical staff's recommendations. Without this critical workforce development component, services will not be available or effective. There should be a dedicated workforce development project that starts now.

Deb McCarrel: A technical assistance entity was previously proposed and development was begun. The entity helped with financial mapping, outreach to the public, communications and could have been utilized for fidelity monitoring. This was also a very strong recommendation from the Children's Services Subcommittee under the previous administration. The Office of Medicaid Innovation at the University of Illinois – Urbana Champaign should be where the Center of Excellence is built. This would also allow for Medicaid matching funds to be sought for sustainability.

*Marvin asked if Deb would submit the Children's Services Subcommittee recommendations to the NB email inbox. Deb indicated that she would.

Marvin Lindsey: CBHA wrote a bill last session that required the creation of the Behavioral Health Workforce Center though a university partner. The Center was based on an initiative

from Nebraska that worked as a pipeline for clinicians from school into the workforce. The bill number is HB5111.

Public: It has to be noted that any changes that the State makes often take staff time and financial resources. The State does not offer capacity grants or any other financial compensation for providers to implement these changes. Updating electronic health records can be very costly. Information about how new systems will interact with existing systems is crucial. Conflicting information coming from multiple sources only makes it more difficult to implement. The State needs to provide clear information on the technical specifications of the IM-CANS system as soon as possible so that providers can get the technical work done. The State must also ensure that rates are sufficient for providers to ensure that services can be done. Providers have to be able to hire clinically trained staff.

Public: Psychiatric rates were cut from $47 million to $21 million. Rate add-ons were then provided but did not go to psychiatrists. This has led many psychiatrists to stop seeing Medicaid eligible individuals. This is really problematic for transitions in levels of care particularly when patients are discharged from hospitalization. Patients lose psychiatric care when they are discharged, and there are very few residential settings in Illinois where they can continue to receive care. There need to be more Psychiatric Residential Treatment Facilities in state so that children can receive care in-state. Right now most of the Individual Care Grant providers are out of state and that is not good for families. Children who are out of state cannot maintain adequate contact with their families and often struggle with transitioning home. Parents also need training and support to navigate the various systems in which their children are involved such as education. There is more work needed to train staff on proper transitions of care for children.

Dee Ann Ryan: Current residential facilities could be converted to PRTFs, but the belief is that if they are built then they will always be full, unless community services are built out first. But, right now, we do not have PRTFs, and we do not have additional community supports.

Peter Nierman: There also needs to be a proper array of services for children with autism. There are currently very few effective services for this population. They often end up being served in the traditional mental health system that has nothing to offer the children and families in terms of effective services.

We also have to think about sustainability. A key principle of Systems of Care is that the system must be sustainable. There has to be someone at the gubernatorial level that is a champion for the System of Care. That person had to have oversight of all the child-serving systems to ensure that the systems collaborate to serve children in a coordinated manner. That person has to have a longer view of the implementation and sustainability of the system. In addition, prevention must be emphasized. Children must be identified and must receive effective treatments before their behaviors lead them to involvement with Department of Juvenile Justice or Child Welfare.

To focus on prevention and sustainability there has to be a business model that incentivizes providers to offer the right amount of services at the right time to effectively treat children and families. Managed Care Organizations currently reject all inpatient detox services. They push providers to offer outpatient detox regardless of the medical necessity of inpatient. This is how their business model works. They restrict care to the least restrictive setting without any regard for what is best for the patient. While they may say money, we need to know where that money goes. Is it reinvested into the mental health system, or does it leave the mental health system to go to shareholders? MCOs are also only authorizing three or four days of hospitalization and children need much longer to stabilize. MCOs have said that there are too many providers with too many beds, and this seems to be the way that they are addressing that issue.

This could be construed as discrimination against mental health patients. To ensure that this does not become a wide-spread problem, there needs to be a tracking system to ensure that the level of services children are receiving now are not drastically reduced under managed care. The State needs to know the volume of services and the volume of denials on an ongoing basis. The State and MCOs must be accountable for the quality of care provided to youth and families. It is so bad that MCOs are recommending that parents relinquish custody of their children to DCFS just so that the MCO does not have to continue to pay for the child's care. This has been reported on multiple occasions and cannot continue.

Public: We are also really talking about the broken pieces of the system that need to be addressed. This is really about the children and families that are in need. Psychiatric hospitalizations are not long enough. Children need additional time to stabilize and many of them are being discharged while they are still experiencing psychosis. These types of system wide issues will ultimately impact the NB Consent Decree. Prevention and Early Intervention is crucial and was supported in a bill that established the Early Intervention Pilot designed to

provide Community Support Team services to children before they are diagnosed with major mental illnesses and before they are eligible for Assertive Community Treatment and Community Support Team under current rules.

Dee Ann Ryan: We definitely need PRTF services in state and will be able to afford them when early intervention services start keeping children out of hospitals and residential and keeping them at home and in the community. This cost shift will allow us to develop a more robust community system along with PRTFs to actually serve children and families.

Tamara Doyle: This will also help reduce trauma in children. Children being removed from their families or placed in residential causes an immense amount of trauma.

Angie Hampton: System of Care has been shown to provide better clinical outcomes along with cost savings, so it should be the focus of the implementation plan for NB. HFS should also have a division or bureau that is specific to children.

Kelly Cunningham: HFS does have a new Bureau of Behavioral Health. Kristine is the Bureau Chief.

Eric Foster: But we are still treating children as little adults. There needs to be a specific focus within HFS on the specific needs of children and adolescents.

Angie Hampton: The Integrated Health Homes should also be separated into children and adult to ensure that children's needs are addressed.

Deb McCarrel: Look at the Technical Assistance Center of Innovation at a university, since that would be eligible for federal match.

Public: Medicaid has taken ownership of behavioral health, and HFS has taken the lead on the transformation. HFS needs to really beef up child and adolescent staffing. There needs to be a "bench" or "sub-bureau" built of knowledgeable policy makers who can also be strong liaisons with the other departments.

Public: It would help to have a gubernatorial policy office to coalesce all of the children's behavioral health policy and then push the implementation of the policy to the various state

agencies. This would help to pull together all of the pieces of the children's behavioral health system including policy and dollars.

Jen McGowen: For there to really be a focus on prevention, we need a broader definition of crisis, including family and behavioral crises like Comprehensive Community Based Youth Services (CCBYS) responds to.

Public: The IM-CANS data platform brings up privacy concerns. Where will the data be stored? How will it be accessed? How do we know that data will be protected according to HIPAA requirements? Risk spikes in the first couple of months of treatment, because clients disclose more information due to building trust. Risk also spikes right before discharge. The IM-CANS is broad and "invasive". How will data be used? How will providers receive information?

Gene Griffin: Trauma informed services are required and will also require technical support from the State and communication with providers along with communication with families.

Dee Ann Ryan: This stakeholder process makes me feel like it is "token". It must be ongoing if it is going to have any impact.

Tamara Doyle: Trauma ties into other physical health issues, so we need to continue to educate families to support family engagement. Educating families about how the new system functions is essential. We need specific ways to engage families and could use the Family Leadership Councils to do this.

Regina Crider: Peer support is absolutely critical. We need this to increase and support the existing workforce, to properly engage families allowing them to increase participation in services. Peer Supporters can speak to families in ways that professionals will not be able to.

Public: Most pediatricians do not receive any training or education in mental health. There should be residency programs to give them basic mental health information so that they can be the front line for mental health referrals. Also, is peer support a Medicaid billable service?

Margo Roethlisberger: Peer supporters can bill for community support and other services as a Mental Health Professional, if they get credentialed.

Regina Crider: Many reports on children's mental health indicate that peer support should be a covered service, and many states cover this service. Family Resource Developers need more support and supervision as peer supporters. They are often isolated and utilized in different roles by CMHCs.

Jen McGowan-Tomke: There needs to be ongoing family engagement through a network of family leaders. NAMI used a train-the-trainer model for family engagement and focused on navigation of the system.

Peter Neirman: There needs to be a technical assistance unit to help develop a better array of services for the developmental disabilities and autism population. They need specific services that are more like Occupational / Physical Therapy and other specific therapies developed for this population.

Public: There needs to be cross system collaboration that understands that schools are the focal point for children. Schools need to understand that services are available through tight communication.

Angie Hampton: The Opioid Helpline could be a model that we look at for mental health awareness.

Tamara Doyle: There is also DocAssist available as another resource.

Marvin and Gene discussed next steps for the committee. The email will be open for the next two weeks to ensure that comments can be submitted. Final minutes will be emailed to the committee for approval and then posted on the website. The Implementation Plan will be posted once it has been approved by all parties. Ongoing stakeholder engagement will be developed in conjunction with the Court Monitor.

The meeting was adjourned at 12:35pm.