Minutes of the Behavioral Health Coordinating Council

The Behavioral Health Coordinating Council Committee met on Friday, September 9, 2016, at 7:30 AM in Room 400 of the Government Center, 115 East Washington Street, Bloomington, IL.

Members Present: Chairperson John McIntyre; Honorable Elizabeth Robb, retired Chief Circuit Judge; Mr. Steve Denault, Country Financial; Ms. Stephanie Barisch, Center of Youth and Family Service; Ms. Diane Schultz, The Baby Fold; Mr. Joni Painter, City of Bloomington; Mr. Mark Jontry, Regional Office of Education; Ms. Sonja Reece, McLean County Board of Health; Ms. Laurette Stiles, State Farm; Ms. Karen Zangerle, PATH; Mr. Tom Barr, Center for Human Services; Ms. Laura Furlong, MARC First; Colleen Kannady, Advocate Bromenn

Members Absent: Mr. Chad Boore, OSF St. Joseph's Hospital; Mr. Kevin McCarthy, Town of Normal, Mr. Russ Hagen, Chestnut Health Systems

Staff Present: Mr. Bill Wasson, County Administrator; Ms. Hannah Eisner, Assistant County Administrator; Ms. Amy Brooke, Recording Secretary, County Administrator's Office; Mr. Don Knapp, Assistant Civil State's Attorney

Department Heads/ Elected Officials Present: None

Others Present: Ms. Meredith Nelson, OSF St. Joseph's Hospital; Mr. Dave Sharar, Chestnut Health Systems; Ms. Judy Buchanan, Board of Health; Ms. Susan Shafer, McLean County Board; Ms. Megan Moser, Center for Human Services; Ms. Sue Pirtle, Center for Human Services

Chairperson McIntyre called the meeting to order at 7:35 AM and declared a quorum. Ms. Meredith Nelson stood in for Mr. Chad Boore and Mr. Dave Sharar stood in for Mr. Russ Hagen.

Ms. Reece motioned for approval of the June 6, 2016 minutes. Mr. Denault seconded. Motion passed.

Chairman McIntyre provided an overview of who the Behavioral Coordinating Council was established. The recommendation for the Behavioral Coordinating Council came out of

two working groups: Mental Health Needs Assessment and Mental Health Best Practices.

Chairman McIntyre shared that there has been progress in fulfilling the need for an extension of the Law and Justice Center. This will help to meet the needs of the female inmates as well as the needs of the mentally ill inmates.

Chairman McIntyre shared that a variety of subgroups have formed looking at different aspects of mental health (youth, housing, crisis stabilization, homelessness, etc.). One of the stumbling blocks has been the lack of data and the inability to share data across organizations.

Chairman McIntyre shared that there have been Chairman round tables which have been meeting. Two roundtables have met each month that the BHCC does not meet. The first one was in July and was a meeting with agencies dealing with homelessness and the Veteran's Administration. The August group was primarily made up of chiefs of first responders: fire chiefs, sheriff, police chief, director of EMS, etc. This was to give feedback on better use of the Crisis Stabilization Unit.

Mr. Dave Sharar presented on the Crisis Stabilization Unit (CSU).

The Crisis Stabilization Unit opened in April 2015. It is geared towards those in mental health crisis or substance withdrawal. It is not designed for those who need hospitalization. It is a voluntary unit designed for short term residential stay. There are 14 beds and it is staffed primarily by nurses, counselors, and social workers. Prescribers work out of the Federal Qualified Health Center.

The intent is to make it a welcoming, therapeutic, and supportive place for those in crisis. The goal is to stabilize individuals so they can return to the community.

The unit is funded primarily through Medicaid and managed Medicaid. Occasionally there are those who have never participated in ACA and have no means to pay. There is also a small percent of those who pay through private pay/commercial insurance. Unfortunately, very few private health plans recognize a nonhospital placement.

Mr. Sharar presented an overview of admission over the past year.

- 38% of admissions (201) had a primary mental health diagnosis
- 62% of admission (570) were detox admissions
- 75% of the all of the mental health cases come from McLean County
    - Many with the mental health diagnosis also need detox
    - They often have short term stay in detox and then transfer to the mental health program.
- The average length of stay is 8 day for mental health and 4.7 days for detox

The top 3 mental health diagnoses are depression, bi-polar depression, and anxiety/PTSD.

Individuals are referred with through a variety of avenues:

- Detox conversion to mental health program (42%)
- Self-referral (23%)
- Crisis Team (19%)
- Local hospitals (9%)
- Other (PATH, probation, various agencies – 7%)

Mr. Sharar shared about a safe passage program. The police can bring an individual in with no consequence. McLean County does not currently have this. Those that are coming through a safe passage program come from other counties: Pekin, Dixon, Pontiac. These counties do not have detox.

In Peoria they have recently tried to get referrals from law enforcement. That can be tricky. If their crisis team responds with the police, sometimes they will bring an individual directly to the unit instead of the emergency department. They are also trying to work out EMS and ambulance services transporting directly to the unit rather than an emergency department. There is legislation that allows for that with a physician's approval.

Mr. Sharar shared the following goals for the unit:

- Co-locate a crisis center with the CSU – an alternative to the emergency department where the Crisis Team can conduct evaluations.
- Increase CSU referrals from paramedics and law enforcement
- Increase CSU referrals as a step down for hospitalized patients.

Mr. Sharar shared that there is a staff social worker who does discharge planning with every person admitted to the unit. This typically occurs within the first day or two that they are admitted to the unit. Part of the process is identifying resources. Resources may be very limited with someone who has unstable housing or is homeless. Another difficulty is when someone needs prescriptions and does not have the money needed to get them filled. They may end up going off their medication.

Due to a lack of resources, intensive case management is not available through the CSU. Some people may get case management through other agencies.

Ms. Kannady asked if the CSU tracks patients that return to the CSU.

Mr. Sharar stated that with addiction being such a chronic illness, they often see these clients return. In the detox portion of the program they are mainly seeing heroin and alcohol.

Mr. Sharar shared that in August the CSU was full. In the month of August 51 detox cases were turned away due to lack of space.

Ms. Reece inquired about the scope of services at the CSU and how they determine whom they will not accept.

Mr. Sharar shared that there is a set of admission criterion. Things that prohibit admission include medical issues requiring a hospital, being actively suicidal, and violence.

Ms. Meredith Nelson presented on the mental health services through OSF St. Joseph.

In the last 12 months, the Emergency Department at OSF St. Joseph had about 900 visits that could be classified as psychiatric using mental health diagnostic codes. About 1/3 of those involved alcohol or chemical dependency. Two-thirds involved mental health.

Patients that come to the Emergency Department go through a screening process that addresses mental health concerns. Many of the OSF hospitals – including OSF St. Joseph - are looking into creating safe rooms in the Emergency Departments. This is a room that has been modified and has all items removed that the patient could potentially use to harm themselves as well as other modifications. OSF St. Joseph also has an ED navigator. The navigator works with patients who present to the ED for a variety of different issues. The navigator does not currently do behavioral health evaluations but works with a broader population. However, she does assist the Crisis Team in making calls and on substance abuse referrals.

Tele-health is another area OSF St. Joseph is looking at and expanding. Currently, there is some access to tele-psychiatry through the OSF clinics. It is available to behavioral health providers and primary care providers. The virtual psychiatrists do not interact directly with patients but are a resource for providers.

Care Transformation is a program being piloted at the College Ave clinic. This is a team based care approach involving a primary care physician, behavioral health, pharmacy, and dietary. They evaluate patients as a team.

As an organization, each region was asked to identify top concerns/requests. For the eastern region these included providers, resources for behavioral health, psychiatrists to treat clients across the age spectrum, advanced practice support in the current psychiatric practices, looking at a resource for inpatient consultations, access to inpatient psychiatric beds, and increasing tele-health resources.

Ms. Kannaday spoke about the programs at Advocate BroMenn. At Advocate BroMenn they built out 3 safe rooms in part of the Emergency Department. Security monitors that area. There is an ED navigator available during the higher volume time frames to help connect patients with needed resources. They are about a year and half away from a more robust tele-health program. Currently, the ED has access to a tele-psychiatry through Advocate Christ Hospital in the Chicago area.

Some patients need to be transferred to places like McFarland. McFarland is always full. There is always a wait to get patients admitted. Those patients may end up being in the

ED for several days or even a week. They are being treated in the ED because places like McFarland pull from emergency departments first. If the patients do not qualify for Advocate BroMenn's inpatient unit because of their complexities or other reasons, they may be put in the intensive care without a medical diagnosis. They are put there because they have the highest level of security and staffing. Some patients have lived in the ICU for 2-3 months. They will get no reimbursement because they cannot find a place for them to go.

Advocate BroMenn has the 12 patient inpatient unit. They are working on getting funding to expand. The outpatient behavioral center has been moved out past the airport. They have recruited another adult psychiatrist and there are now two pediatric/adolescent psychiatrist. Recruiting providers is a challenge and there is an extensive waiting.

Ms. Reece shared that they run into difficulties with the state deciding if the patient is developmentally disabled of if the patient has a mental illness. The state agencies don't agree and no one want to take them. They have had to call state representatives for assistance in cutting through the red tape around the issues.

Chairman McIntyre shared that one of the issues that came out of the roundtable with first responders was diversion. There is a reluctance to transfer anywhere but to hospitals. Part of the reason for this is insurance reimbursement. This is a state wide issue.

Mr. Sharar reiterated that there is legislation which allows patients to be diverted with physician approval. For this to work, the paramedics would need access to a physician through their organization to rule out medical complications which would necessitate going to a hospital.

Mr. Barr shared that they currently still have the mobile crisis team for McLean County. At a minimum there are two people on call at all times. The maximum call back time is 15 minutes. The team may prioritize call backs based on the assessed risk to the client. For example, someone in the community may be prioritized over someone who is currently in the emergency department. The client in the emergency department would be seen as being in a more secure setting.

Chairman McIntyre shared about diversion by law enforcement. In speaking with law enforcement officers, there is a mindset about what their mission is to begin with. It is primarily incarceration. The question becomes when to decide if there is a diversion that can be done. CIT can help with that process. The chiefs also expressed that there is often no space for detox. Other thoughts included the possibility of a special triage area for law enforcement or the possibility of a co-responder system who can help make the decisions on diversion.

Mr. Sharar shared that if they received a referral, the CSU could hold a bed for law enforcement.

Mr. Wasson provided that the following challenges came out of the Public Safety Round Table:

- There is a need to work around the mindset of needing to transport to a full service hospital.
- From a law enforcement perspective, there are individuals who are a safety risk to the community and need to go to jail. This is why the County has taken steps to increase capacity and address mental health needs in the correctional facility.
- There is a willingness from the Chiefs at the roundtable to work through the issues of diverting from the hospital or jail when appropriate.
- Crisis Intervention Training is very important.
    - There is very limited training provided in basic training that law enforcement officers go through.
    - There is a willingness to see CIT training in the basic training of law enforcement officers. This will take some legislative work.
    - The Crisis Intervention Training Grant application to the Bureau of Justice has passed peer review. The grant would increase the ability to train law enforcement, telecommunicators, and EMS personnel. Feedback was that the Mental Health First Aid training is good for people in the community but public safety personnel need more comprehensive training like CIT to meet the needs of the community.
    - There is investigation of the possibility of using Medicaid funding to help cover the cost of CIT training.

Mr. Wasson shared information about the Call for Service Data. This is part of the White House Initiative on data driven justice and behavioral health. This is being provided to the County free of charge for doing analytics for law enforcement initially and then expanding to cover a broader spectrum of services. CFS Analytics looks at call volume, officer allocations and attempts to identify super-utilizers. We currently do some basic analytical work with the Stevenson Center. CFS Analytics takes it to an entirely different level with thousands and thousands of data elements.

Currently, the County legal staff is working on an agreement with the University of Chicago to provide our criminal justice data and the health data that we have related to those in the criminal justice system in an anonymized way. This will allow the University of Chicago to begin analysis and help the County identify the data we would like on super utilizers and identify the needed services while minimizing overall cost.

The County will be speaking with local organizations about data sharing and what that would look like. There is significant value to the community in sharing data. Data is critical for making informed decisions.

Mr. Wasson shared that there are a few co-responder programs across the country where a case manager is sent with an officer or with EMS to a site. He stated that a co-responder

may make senses in one part of the County but not in every part of the County. In some parts of the County, it may make sense for EMS to transport somewhere to meet the co-responder for evaluation. The CFS Analytics aid in looking at those types of situations and what makes sense. However, it is dependent on getting the data needed to put into this tool.

Other areas CFS Analytics can aid with is looking at the use of personnel, the areas of needs, and the geography of those needs. It can drill down to specific addresses. That kind of information would not be available publicly but would be utilized by law enforcement and EMS in their planning processes.

APPRISS is another company that has volunteered to provide services. It provides reporting on crimes across the United States. It also records prescription data for approximately half the states. This does not currently include Illinois.

The goal is to begin with data analysis on an anonymized basis so that we can find the factors that are the most important for identifying the super utilizers for trying to be predictive. Fewer factors make sharing the data easier. Getting through an anonymized review will help to identify those factors and lead to sharing of actionable data. There are legal issues that need to be addressed with HIPPA and the Illinois Mental Health Code.

Health Information Exchanges do exist. The County has had several meetings with the Central Illinois Health Information Exchange. It is an example of how we can get to an information sharing process. Both BroMenn Advocate and OSF have seats on the board of the Central Illinois Health Information Exchange. The Central Illinois Health Information Exchange has a grant to expand health information exchanged to expand information exchange to entities like EMS and the County. This is a model that would allow data sharing through queries rather than requiring everyone to be on the same system. This will take both technical resources as well as legislative work.

Chairman McIntyre shared that the one that from interacting with different entities as part of the Data Driven Justice Initiative, the key seems to be a willingness for private and public entities and service providers to work together.

Meeting adjourned at 9:10 AM.

Respectfully submitted,

Amy L. Brooke
Recording Secretary