Healthy Illinois 2021 Behavioral Health Action Team Meeting

Wednesday, February 24, 2016 1:30 PM – 4:00 PM

Call info: 1-866-297-7906 Code: 631744

Present: *Maureen McDonnell, Karen Ayala, Posh Charles, Mary Dobbins, Mary Elsner, Josh Evans, Beth Fiorini, Jan Gambach, Vinetta Washington (for Judith Gethner), Vincent Keenan, Christina Koster, David McCurdy, Mark Mulroe, Leticia Reyes-Nash, Amy Sagen, Sue Ellen Shumacher, Sheryl Smith, Meryl Sosa, Amaal Tokars, Ron Weglarz*

Absent: *Krysta Heaney, Jeff Joy, Diana Knaebe, Colette Lueck, Sharon Post, Dan Rabbitt, Laurie Selvers, Mary Smith*

Public Guests: *Stacey Diggs*

UIC School of Public Health MidAmerica Center for Public Health Practice Staff: *Martina Coe, Guddi Kapadia, Geneva Porter*

Topic	Discussion/Updates	Action Items/Decisions Made	Responsibility/ Deadline
Welcome and Roll Call	Meeting is called to order by Maureen McDonnell. Introductions were made by members of Action Team, both in-person, as well as those on the conference line.		
Approval of Minutes	**Minutes from 2/10/2016 meeting** *Comments:* Provided clarification on notes where 'word association and meaning' was mentioned. **Meeting Purpose:** - Assess to see where all three small groups are with goals - Build upon and analyze goals and objectives - Propose short- and long-term outcomes	Move to approve minutes made by Amaal Tokars and seconded by David McCurdy.	
Small Group Presentations	Review through goals and objectives for agreement/disagreement and/or additional ideas. **Early Intervention Action Plan** **Objective 1** • Two parallel systems operating (direct care and supportive services): Making the linkage between the two would not		

	necessary rely solely on primary care but can gently refer patient to work with a professional that works with the family to engage them in the services recommended. • Look at health outcome measures to increase the number of healthcare providers. *Comments* Speaker - Provide information to family providers and help them meet the overall goal. A lot of primary care providers do not know what resources are available to them. *<u>Screening discussion</u>* Speaker - One of problems with screening is that [primary care physicians] do not get paid, so it is hard to integrate into their system. There is need for advocacy around this because insurances are not willing to pay. Speaker - From working in primary care, what we think is important for the patient may be different from others in practice. When we do this screening we open Pandora's box to other issues. This is a context to keep in mind as we discuss these issues. Speaker – How about commercial health plans or something to reimburse for screening? Speaker - A depression screening may be a reimbursement screening but Medicaid will not reimburse. An activity may not be reimbursed because they may see things early that would be an example of early intervention, or risks that may be presented. Speaker – What level of screening are we talking about? Speaker – The recommended reimbursement strategies at a lower cost. Speaker – It is an issue that if we cannot solve the problem of reimbursement, how do we get the information to another mental		

	health worker? Speaker – Develop an RFI as a form of integration because there are so many flavors of opportunities and we need to pull from all the available resources. We need to do so in a manner across the state that is not haphazard – there needs to be a training hub with integration of **Objective 1 and 2.** **Objective 2** *Comments* • An integrator who can work between primary care physician and a mental health specialty. Speaker – A number of primary care offices have case office in which there are mental health consultants. *Payment of services discussion* Speaker – Sustainability of billing through reimbursement. Speaker – FQHCs and rural offices get services paid through private insurance. Speaker – Provided an example • Pilot sites in Illinois can go on and on for generations and are never incorporated into regular, everyday practice. • There needs to be an integration of geography, age, and infrastructure. o It was decided that this is an issue for a later time, and will require revisiting. **Treatment Action Plan Goal 1** • Lowering the number of times emergency room is used as a form or treatment. o This is often the primary source of treatment, and the most expensive so needs alternatives.		

Comments

Group speaker - There needs to be an understanding of what is available because people do not know what is available, and that area needs to be addressed.

Speaker – In the general revenue fund (GRF) world, funding provided by state money that is in a report by NSAD each year of services, care, and outcomes since 1993. However, money in the GRF world is reduced which is shifted to Medicaid.

Metrics discussion

- Should there be a quantitative goal in reducing ER visit? Do we want to suggest a measure or not?
- Concern is that reduction could seem like the treatment issue is not being handled.
- The reduction of 50% is too high and could be unobtainable. Possibly reduce the percentage to 20%.
    - Factors to consider are the number of beds in the psych unit and the living room facilities and if people know about them.
- The timing is difficult to come up with another percentage. The environment in which mental health is occurring, especially on the children side may make delivery change.

Goal 4

- Reduction of duplication

Prevention Action Team
Goal 1

- Focus on having a measurable baseline for behavioral health literacy as a way to reduce stigma.
- Introduce mental health education by allowing for a test to see where individuals are to establish the baseline.

Comments

	Speaker – Reducing stigma is a positive; however, what we are focusing on appears to be a follow-over from everything else and not exclusively focusing on reducing stigma. Group speaker – Goal 2 is more focused on reducing stigma, especially with the Kennedy Campaign, Mental Health First Aid as well, etc. **Goal 2** Related to a number of goals in treatment section. This goal is especially important on the topic of jails and prisons – all could be tied together with the correction system, primary care, and first responder. Walgreens is mentioned as a pharmacy that will have NarCan. OTC availability is slightly different. **Goal 3** • A possible overlap in early intervention and prevention with a FEMA-like program. o Violence is not only gun violence, but suicide and abuse. o A team, similar to FEMA, helps to prevent mental health breakdowns such as PTSD, alcohol and substance abuse. ▪ This could result in a reduction in the number of people who progress to chronic mental illnesses. o Train community leaders, religious leaders, and community health workers – CHAMPS *Comments* Speaker – Existing models where this already done? Speaker – Between the United Way and Northwestern – training of 17 faith-based leaders to be first responders. NATEL in Israel, used in the Boston Bombing, have come over to assign with the startup of the model project.		• Sue Ellen will provide the press release about the OTC availability.

Next Steps	**Next Meeting: March 2, 2016 from 2:00 – 4:00 PM, possibly via Webinar** **Geneva will send an email to the group to ascertain thoughts around post submission of the SHIP and how to continue to work together. Questions will include:** 1. How would you envision a Behavioral Health Action Team working together in SHIP implementation? How could/should we work together (e.g., sharing information about best practices, partnerships)? 2. What would be examples of success? If we are successful, what might happen? 3. What do you think you/your organization could contribute to a Behavioral Health Action Team as a part of the SHIP implementation going forward? 4. Who's missing from the conversation? Who should be asked to join?	Geneva will email the group questions; response is requested by Monday, February 29. Members should also respond with their interest in being publicly listed as a contributor to this process as a member of the Behavioral Health Action Team.
Public Comment	None.	
Adjournment	Meeting adjourned at 4:00PM.	