

MEMBERS PRESENT

Springfield Location:

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|--------------------|----------------|----------------|---------------|
| Michele Carmichael | Alan Dietrich | David Elder | Seth Harkins |
| Debra Kinsey | Andrea Medley | Dee Ann Ryan | Gary Seelbach |
| Randy Staton | Julie Stremlau | Brooke Whitted | |

Chicago Location: (attending by Video conference)

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| Toni Hoy | Jason Johnson | Jane Kelly |
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MEMBERS ABSENT

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| Bob Bloom | Kathy Briseno | Bill Delgado | Kye Gaffey |
| Merlin Lehman | | | |

STAFF PRESENT

Springfield Location:

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| Mindy Miller | Lynn Lowder | Linda Prewitt | John Schornagel |
| Debbi Smith | | | |

Chicago Location: (attending by Video conference)

Robert Watts

LIAISONS PRESENT

None

GUESTS PRESENT

Springfield Location:

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| Barb Chatman, | Vermillion 708 Board |
| Susan Fonfa, | HFS |

Chicago Location: (attending by Video conference):

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| Linda Davis, | Illinois Collaborative |
| Marc Fagan, | Thresholds, |
| Jane Gantner, | DCFS |
| Dr. Todd Kasden, | Illinois Collaborative |
| Dr. Renee Mehlinger | Illinois Collaborative |
| Heather O'Donnell, | Thresholds |
| Pat Palmer, | Illinois Collaborative |
| Dr. Constance Williams, | Illinois Collaborative |

Attended by Teleconference

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| Jessica Masbaum, | Illinois Collaborative |
| Tammy Mayer, | Illinois Collaborative |
| Chris McConke, | Illinois Collaborative |
| Shawn Wilson, | Illinois Collaborative |
| Kathy Venke, | Springfield Service Center |

I. CALL TO ORDER

Chairperson Harkins called the meeting to order at 9:30 a.m. Members, CRSA staff and visitors in attendance and on the phone introduced themselves.

II. APPROVAL OF THE JUNE 13, 2013 MINUTES

The Authority reviewed the minutes of the June 13, 2013 Authority meeting.

MOTION: *Gary Seelbach moved and Brooke Whitted seconded that the minutes of the June 13, 2013 Authority meeting be approved as submitted. The motion carried unanimously.*

III. STAFF REPORT

Director Schornagel referenced the following informational handouts in member board packets:

- **Staff Activity Report** for June 2013. Director Schornagel commented that CRSA served 360 referents in FY12 and that this number of yearly referrals has stabilized in the last 5 years. He also noted that we have two cases that remain at Staff Review: one a former Dispute Resolution case that staff is monitoring and the other a case currently at the Technical Assistance staffing level.
- **Updated CRSA Membership List**
- One page sheet **listing newly selected Officers for FY 14** as well as the **newly elected Executive Committee**, both adopted at the June 2013 CRSA meeting.
- **CRSA FY 14 Meeting Schedules**
- Director Schornagel referenced several CRSA graphs identifying **CRSA referrals sources over a 5 year period** as well as a **breakdown of staffing and other case related meetings attended by CRSA staff over the last five fiscal years**. This had been requested by Gary Seelbach. Director Schornagel emphasized the “field-based” nature of what CRSA staff do, attending an average of 375 case related/client specific

staffings/meetings each year. He added that this might, in part account for the consistently high consumer satisfaction scores.

IV. DMH/COLLABORATIVE DIALOUGE WITH CRSA

Chairperson Seth Harkins welcomed the numerous participants from DHS/DMH Administration and the Collaborative for Options and Choice. Director Schornagel referenced an E-mail communication contained in the Board packets between himself and Doctors Renee Mehlinger and Constance Williams as well as with DMH's CRSA's Representative, Alan Dietrich. The E-memo briefly listed Authority concerns about the ICG program in advance of today's meeting and dialogue.

Dr. Mehlinger walked the CRSA Board, staff and visitors in attendance through a Power Point presentation, asking that questions be saved until after the presentation. She added that the Power Point will be posted online on the DHS Website after finalization as will comments and questions from various stakeholders. Dr. Mehlinger referenced the Affordable Care Act and expressed a willingness to partner with various stakeholders to improve access to services for children with mental illness and their families.

An open question and comment dialogue ensued between all parties.

In the question and answer session there were numerous questions and comments about role of the Collaborative and inquiries regarding the specific roles for both the DMH and the Collaborative in the evolving ICG process and who is ultimately in control and responsible for outcomes. Director Schornagel commented that it has been a number of years since Value Option, Inc (VO) was brought into Illinois as an Administrative Service Organization and that there is a widespread public perception that consumer and provider input has not been sought nor welcomed as the ICG program has evolved since VO was brought in. Gary Seelbach asked Dr. Kasden about his clinical credentials as the lead clinician at the Collaborative and Dr. Kasden confirmed that he is not a board certified Child and Adolescent Psychiatrist but rather holds credentials in general psychiatry. Brooke Whitted asked Dr. Kasden about his employment status enquiring about for whom he and other members of the Collaborative work, Value Options Inc or the Department of Mental Health. After brief discussion, Dr. Kasden confirmed that his paychecks are sent from Value Options, Inc Mr. Whitted then referenced the CRSA's long-standing concern about the alarming and steadily declining numbers of kids found eligible for the ICG program since VO became involved in the ICG program as an administrative services organization. He inquired if the role of VO in the ICG program was really to incentivize the reductions of the number of kids getting ICGs in Illinois and ultimately to reduce ICG expenditures within DMH? He commented that the number of kids found ineligible ICGs since VO was brought to Illinois tend to support that view. Dr. Kasden denied that the role of VO, within the Collaborative, was to intentionally and dramatically reduce ICG eligibility to reduce program cost. Dr. Kasden stated that the ICG eligibility decision making process is multi-dimensional and that Secretary level appeals are conducted by two independent psychiatrists, who overturn about 2 % of ICG denials on appeal. He added that that "the ties go to the runners" indicating that with the ICG program, the Collaborative and DMH err on the side of the child rather than the agency. The CRSA board requested more information about

the psychiatrists who are involved in these appeals.

There were a stream of questions and concerns regarding how the ICG program interfaces with the Illinois Medicaid program and the Illinois Department of Healthcare and Family Services (HFS). CRSA Governor's Appointee, Dee Ann Ryan questioned why Medicaid eligible children ever need to apply for the ICG given their federally guaranteed eligibility through EPSDT, for both PRTFs and longer term residential treatment through HFS as well as for intensive community-based mental health services? She referenced the "medical necessity" guidelines and appeal process within the ICG program and wondered if there is a corollary appeal process within HFS, in the event that HFS denies placement or services under EPSDT? She added that children and families need the right treatment, at the right time, in the right place and that further data be collected and evaluated to coordinate efforts between, DMH's ICG program, the Collaborative and HFS. Debra Kinsey from HFS clarified that, at this time, EPSDT is not available to support and residential placements for kids with mental illness in Illinois and similarly that Medicaid paid PRTF's have not been developed within Illinois. Debbi Smith commented on the 94 (R) initiative, inquiring about how much money has been recouped from Medicaid for ICG residential kids since the 94 (R) was initiated five years ago and inquired about where the money has gone? She further inquired is there any 94 (R) money that could or should be re-directed to support more and better community-based services?

There was considerable conversation regarding the lack for transparency in the ICG program itself and how the ICG program interplays with other mental health programs at the community level and with ICG facility providers. There was comment regarding the seeming lack of integration between the children and adolescent program and adult services programs at the time of step down. HFS representative Debra Kinsey commented that if there were more Family Resource Developers within community agencies that the "incomplete packet rates" within the ICG program might be reduced. Gary Seelbach wondered about the level of direct technical assistance given by DHS of SASS workers at the community level and inquired about whether DMH and/or the Collaborative track data about SASS dysfunction and the related problem of high turnover among SASS providers in communities. He added that in his experience there is considerable variability in the amount and the quality of community-based mental health services available from one Illinois community to another. Marc Fagan from Thresholds commented on the need for better integration with community-based Mental Health Centers and ICG providers focusing on recipients needing more and better services to transition into the adult services realm. Dr. Mehlinger responded that Dr. Lorrie Jones had begun to address similar concerns in DMH's five year plan. Mr. Fagen also suggested that DMH do some outreach to mental health centers and facilities gather data on the experiences of those who are denied ICGs as well to approach ICG facilities which have to go through the licensure and certification process to gather provider feedback. He also commented on the need for improved Quality Control with respect to the timeliness of ICG application, eligibility and appeal processes. Dr. Mehlinger indicated that input from consumers, providers and other stakeholders are welcomed by DMH. Shawn Wilson with the Collaborative commented that more time could be spent to make the ICG access process more visible and to address training issues. He added that the Collaborative would be happy to come back and share statistics regarding how and when to help kids remain in their home communities and make solid clinical gains. Dr. Kasden commented that currently the Collaborative has four Clinical Care Managers

to oversee ICG recipients. Michele Carmichael from ISBE commented that the ISBE is looking at how many children need high treatment to address childhood trauma and are looking at best practices to support those children, including early intervention, coordinated prevention services to prevent the need for residential treatment. She questioned how many kids who need trauma-informed care who are failing to progress in other treatment modalities including ICG settings. She noted that there appears to be little collaboration among various entities to embrace the need for trauma-informed care, to develop of trauma-informed assessment tools and to create community-based infrastructure to treat children with early childhood trauma. She added that the ISBE will be providing training on this population.

There were numerous comments about perceived barriers built into the ICG application process that seem to fuel the increasing number of applications regarded as complete and the historically unprecedented drop in the percentage of applicants being denied eligibility for the ICG. Debbi Smith commented about the difficulties parents face in acquiring the required psychological evaluation which is often not payable through Medicaid. She also commented that the ICG eligibility cornerstone of “impaired reality testing” is ambiguous and does not appear to be supported by the DSM IV. She concluded that when combined, these barriers discourage application and fuel the high ICG denial rates. CRSA’s Linda Prewitt also commented on the numbers of ICG applicants with whom she has worked on ICG applications who seemingly meet the “impaired reality testing” requirement but who were ultimately denied an ICG because of failure to demonstrate impaired reality testing. She also commented on the shrinking number of approved ICG facilities, especially for out of state residential treatment facilities. Brooke Whitted asked for clarification regarding how new residential providers can become ICG approved providers? Mr. Whitted commented that he has been told that new ICG providers are not being considered at this time? Jane Kelly with DCFS commented that the ICG application is too long and too cumbersome and commented about the turnover of ICG coordinators in local mental health centers. She then commented on the critical importance of training more Family Resource Developers. Marc Fagan with Thresholds commented about there is an obvious need for the ICG application process to be revised noting the dramatic decline in ICG eligibility, as well as the increased numbers of ICG recipients losing their ICGs at around age 18 with no coherent/integrated step down process. Toni Hoy commented on the complexity of the ICG application process and that often parents find the process to be exhausting, only be denied an ICG 97 percent of the time.

There were comments made on the role of the CRSA and the ICG process. CRSA Chairperson Emeritus, David Elder, commented that that historically one of CRSA’s roles has been to affirmatively advocate for appropriate plans of services to be provided to children and their families, who otherwise fall between the cracks of the existing statewide service system. He also commented that in CRSA’s experience the primary reason for ICG denials centers around the inability of applicants being able to meet the clinical threshold of “impaired reality testing” which appears to vary greatly from year to year. He added the primary criticism of the ICG program within the CRSA has always been that the ICG program covers only the most severely mentally ill children in Illinois who require high end services and, as such, under-serve those children requiring residential treatment who have less severe forms of mental illness, as well as children who are diagnosed as Severally Emotionally Disturbed. He commented that that when there is obvious clinical need for intensive mental health services for a child and that child does

not qualify for ICG services, that it is the responsibility of DMH and other state agencies to actively collaborate and to find a solution to the service shortfall. Dr. Mehlinger agreed that the ICG is focused on only a narrow band of children with mental illness. CRSA Director Schornagel commented that historically, when CRSA gets a case involving an ICG application that might be easily addressed that he and his predecessor are accustomed to having an administrative contact within the ICG program leadership with whom to consult to explore solutions. He commented that such a contact person has not been available since Dr. Harkins left the ICG program. Dr. Mehlinger indicated that Dr. Williams would be available for that sort of consultation. Gary Seelbach commented on the need for an increased focus on quality assurance and more transparency. Chairperson Harkins echoed that concern saying that requests for better quality assurance and transparency within the ICG program is not new and has been requested for more than a decade.

CRSA Director Schornagel shared his opinion that Rule 135 needs to be revised through the JCAR process soon, commenting that it has been almost 15 years since Rule 135 was revised through the JCAR process which incorporated input from consumers, providers and other stakeholder groups like the CRSA. Dr. Kasden and Dr. Mehlinger reiterated the intentions of both DHS' and the Collaborative to seat various ICG Advisory Committees who would then make recommendations to both that would inform potential revisions to Rule 135 and that would go to JCAR for review and potential adoption. Revisions would include changes in the appeal process and increased training for Community Mental Health Centers, SASS providers and community-based ICG Coordinators. Dr. Mehlinger added that the run up to the JCAR review will be transparent and available online.

V. OLD BUSINESS

A. Vermilion County Complex Service Planning Process.

Director Schornagel commented on handouts in the packets outlining Vermilion County's Complex Service Planning Process, overseen by Vermilion County 708 Board Director, Dee Ann Ryan, Chairperson and her associate, Barb Chatman, both in attendance at today's meeting. He added that the Vermilion County Complex Service Planning process is one of the few decision making processes in the state that attempts to do true multiple-agency service planning around high end kids and families and the only such process in the state that explicitly dovetails with CRSA's Dispute Resolution process, if and when service delivery and/or coordinated funding breaks down. Dee Ann Ryan commented that it is often difficult to get all of the right agencies to table at such deliberations and made comment that the CRSA Dispute Resolution process is often too cumbersome and time consuming to be responsive to children and families who are in-crisis today needing resolutions in the shorter term.

B. Other

None

VI. NEW BUSINESS

None

VII. EXECUTIVE COMMITTEE REPORT

None

VIII. PUBLIC PARTICIPATION

None

IX. COMMENTS AND ANNOUNCEMENTS

Alan Dietrich commented that Dessie Trohoalides, Director of the ICG program is currently on extended medical leave and the DHS/DMH is in the process of appointing an interim Acting Director of the ICG program. Dr. Mehlinger offered a “get well shout out” to Ms. Trohoalides who is in a rehabilitation facility at Northwestern.

Director Schornagel commented that CRSA Regional Coordinator is still undergoing extensive medical treatment and that Mr. DeAngelo’s attitude remains strong and his outlook remains positive. Members expressed support to Jude and his family.

Debra Kinsey announced that there is movement within HFS Administration and that she is moving to another position with HFS. In following, Susan Fonfa will soon be appointed as the HFS Designee to CRSA. Ms. Kinsey indicated that she has enjoyed her time as a CRSA Board member and expressed confidence that Ms. Fonfa would be a primary designee from HFS. Director Schornagel commented that Debra Kinsey has been on the CRSA Board since early 2009 and that there has been considerable pressure on the HFS designee during that time both on CRSA related issues Like EPSDT and PRFF development as well as HFS involvement in Dispute Resolution cases, one of which went all the way to Director Review. The board thanked Ms. Kinsey for her participation and welcomed Ms. Fonfa to the Authority.

Michele Charmicheal announced that Cynthia Ward is soon leaving the ISBE and as such will not be appointed as an representative to CRSA from ISBE, as was previously planned.

X. OPEN DIALOUGE

None

XI. ADJOURNMENT

MOTION: *Brooke Whitted moved and Gary Seelbach seconded that the meeting be adjourned at 11:48 a.m. The motion carried unanimously.*