Lake County
Health Department and
Community Health Center

Community Action Plan for Behavioral Health in Lake County, Illinois 2016- 2020

This report is the result of nine months of collaborative planning among leaders from many agencies and organizations in Lake County, facilitated by Leading Healthy Futures with direction and guidance from the Lake County Health Department. The report has been prepared by Leading Healthy Futures, presenting an action plan to address areas of unmet need in behavioral health in Lake County, Illinois.

The Action Plan identifies 13 strategies within 4 issue areas:
provider workforce, coordination/ continuum of care, access, and awareness.

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LHF

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Executive Summary

This report provides a recommended five-year action plan to address the unmet behavioral health needs in Lake County, IL. These needs were identified in a July 2014 report entitled "An Assessment of Behavioral Health Needs, Service Capacities, and Projected Trends in Northern Lake County" (Assessment). The action plan presented here is a result of a ten month project involving collaboration from behavioral health and social service providers and stakeholders from Northern Lake County, led by Leading Healthy Futures (LHF), and funded by the Healthcare Foundation of Northern Lake County.

Based on the tremendous behavioral needs identified, stakeholders in Lake County prioritized four population groups whose behavioral health needs would need to be addressed in any successful action plan: low income adults and youth who have non-severe mental health conditions; individuals who have substance abuse disorders and are not severely mentally ill; individuals who are severely mentally ill, do not require residential treatment, and are not homeless; and individuals who are severely mentally ill, and require residential treatment and/or are homeless. In addition to the four population groups, four main underlying issue areas to address were identified: provider workforce; coordination/continuum of care; awareness; and access. For all of these population groups and underlying issues, the need for improved linguistic, cultural, racial and ethnic competencies was held as a constant.

This report presents detailed discussions of 13 unique strategies, grouped according to the underlying four issue areas, which have great potential to meet the needs of these population groups over the next five years. Each strategy was researched by LHF and discussed in detail by groups of Northern Lake County stakeholders. The results of these conversations and research are presented here, including summaries of the strategies and more detailed considerations around scale, potential partners, expected outcomes, revenue potential, and cost assumptions.

The report outlines recommendations for successful implementation of the action plan. LHF's recommendation is to leverage the existing structure of *Live Well, Lake County* to serve as the convener for implementation. A Behavioral Health Action Team, with interdisciplinary representation, would be created under this existing structure, meeting for the first time between February and April of 2016. The Behavioral Health Action Team would guide decisions around which strategies to pursue in which order, with the recommendation of initially choosing one strategy per issue area to pursue in Year 1, and choosing additional strategies in Year 2 and beyond.

Pursuit of the strategies recommended and expounded upon in this report is expected to have a substantial impact on unmet behavioral health needs in Northern Lake County. Successful implementation of this action plan would create:

- Greater awareness of behavioral and mental health issues in the community;
- More effective referrals and care coordination between social service, health, and behavioral health agencies in the county;
- Greater access to services throughout the county; and
- Expansion of the provider work force and capacity to serve patients and clients in the county.

With careful and strategic implementation of these strategies, Northern Lake County has the potential to reduce the unmet behavioral health needs of its population, and become a model for other counties, communities, and collaboratives seeking to do the same.

How to Read This Report

This report begins with an explanation of the rationale for and need for change, as outlined in the 2014 Needs Assessment and in initial conversations with the Task Force as the planning phase began. This section, ***The Case for Change***, also details the four prioritized population groups identified.

The next section, ***Action Plan***, provides an overview of the 13 strategies that were identified, researched, and developed through this process. The four underlying issue areas that they fall within are also discussed, followed by recommendations for implementation and a possible timeline.

The rest of the report, ***Discussion of Individual Strategies***, provides an in-depth presentation of each of the 13 strategies, organized by issue area. Each strategy begins with a table identifying the populations it addresses, cost levels for implementation and the timeline for implementation. General background information and critical success factors are discussed, as well as an explanation of the intended impact and scale of the strategy. Interested partners that would participate in implementation are identified, as well as the strategy's impact on workforce. Finally, outcomes, revenue, and costs are presented to guide more detailed planning necessary for actual implementation.

Following the explanation of all 13 strategies, the report concludes with appendices that provide addition details regarding the project's methodology, participating partners, and more.

The Case for Change

In 2013, the Lake County Health Department embarked on a two year project generously funded by the Healthcare Foundation of Northern Lake County to assess and plan a response that would address unmet behavioral health needs in Northern Lake County. The first year of the project was devoted to a comprehensive needs assessment, and the second year to developing a five year action plan in response to identified needs.

The first phase of the project resulted in a July 2014 report entitled, "An Assessment of Behavioral Health Needs, Service Capacities, and Projected Trends in Northern Lake County" (Assessment). The Assessment identified tremendous behavioral health needs, limited capacity to address this need, and projections of growing and changing needs going forward. Leading Healthy Futures (LHF) was engaged for the second phase of work, which involved leaders from Lake County in a collaborative planning process to define an actionable five year plan to address the identified needs. See Appendix 1 for the full methodology used to develop the plan and Appendix 2 for the participating individuals and agencies.

The Need

Based on the Assessment, there is a need to increase capacity, as well as redesign and improve the way behavioral health services are offered in Northern Lake County. The Assessment's key findings were:[1]

The need is enormous.

Major depression, binge drinking, and use of illicit drugs are very prevalent. Large numbers of young adults use alcohol and tobacco, and young people are overrepresented in hospital emergency departments for behavioral health issues. In some areas, such as Waukegan, North Chicago, and the western portion of the county, the need is even greater. Some populations experienced specific types of unmet needs; for example, Latinos are dramatically underrepresented in hospital use data, while African Americans are overrepresented among those who use emergency services. Importantly, many critical behavioral health services are lacking and a significant number of professionals, including psychiatrists, counselors, and case managers, are needed.

Capacity is limited.

The Lake County Health Department and non-profit sector are at capacity, and cannot keep up with the demand for behavioral health services. Not enough providers accept Medicaid, and those that do often take only a few Medicaid patients. The Health Department's service capacity has shifted with many programs, such as case management, declining due to state funding. Child and Adolescent Behavioral Services are among the few programs to have risen slightly.

The need is expected to grow and to change going forward.

The Affordable Care Act is likely to dramatically improve access to service for low income individuals due to the increase in individuals who have health insurance; however, this insurance increase is likely to strain already limited behavioral health capacity. The diverse group of 12,000 individuals who are newly eligible for Medicaid may now be able to access services at a wide variety of places. Culturally and linguistically appropriate services are expected to be an increasing need in the future.

The Population Groups

During the planning process, four key population groups emerged:

Low income adults and youth who have non-severe mental health conditions

These include individuals experiencing episodic or mild depression, grief, family/marital conflict, anxiety, etc., who are not severely mentally ill, and do not have substance issues. One in eight individuals in Lake County lives in poverty and 14.5 percent are uninsured. This population often goes without care, particularly for non-severe mental health conditions, and uses the emergency room when behavioral health care is needed. Among hospital emergency department users, anxiety was the third most common mental health diagnosis, suggesting non-severe mental health conditions may be a prevalent unmet need. Affordable services for children and youth are also hard to secure; persons 15-24 years old are 14 percent of the population but 30 percent of emergency department behavioral health visits, suggesting young people disproportionately rely on emergency rooms for behavioral health care.

Individuals who have substance abuse disorders and are not severely mentally ill (SMI)

In Northern Lake County, the number of individuals reporting illicit drug use in the past month is 21,800, and 21,700 report needing but not receiving treatment for alcohol use in the past year. An estimated 79,500 individuals in Northern Lake County met the definition of binge alcohol use. This is a significant population with large amounts of unmet need. Nearly half of all non-profit and for-profit providers in Lake County said that when they need to refer a client for a service, they typically seek rehabilitation for substance abuse, or outpatient counseling for substance abuse.

Individuals who are severely mentally ill, do not require residential treatment, and are not homeless

This includes those dually diagnosed with SMI and substance abuse. Over 12,000 adults in Northern Lake County report have experienced SMI in the past year. About 6 percent of adults and nearly 8 percent of 18-25 year olds have had at least one major depressive episode in the past year. Almost 4 percent of adults and more than 6 percent of 18-25 year olds reported serious thoughts of suicide in the past year. Half of all non-profit and for-profit providers in Lake County said that when they need to refer a client for a service, they typically seek psychiatry services.

Individuals who are severely mentally ill, and require residential treatment and/or are homeless

This includes those dually diagnosed with SMI and substance abuse. Chronically mentally ill persons often cycle through temporary shelters, due to the shortage of residential facilities and affordable housing. There are almost no residential facilities for children in Lake County that accept Medicaid. Among non-profit and for-profit providers in Lake County, 62 percent said that when they need to refer a client for a service they typically seek inpatient psychiatric services; 44 percent of non-profit providers typically sought short-term shelter, and 26 percent typically sought long-term shelter.

While these population groups appear distinct, they do overlap as individuals may move between these groups over time. For example, a low income individual with non-severe mental health conditions may later develop a substance abuse disorder, or an individual who is severely mentally ill and living independently, over time, become homeless and need residential treatment.

The Action Plan

Major Issues and Related Strategies

Strategies were identified to address the unmet needs of these four broad populations, with many strategies applying to several populations. Of 28 original strategies, 13 were eventually prioritized as a "balanced set" to create optimal impact, addressing the different populations and needs, while also having a mix of strategies that have relatively short- and long-term planning requirements and relatively low and high costs.

All but one of these prioritized strategies addressed three or four of the population groups identified above. Thus, the 13 strategies came to be organized around the major underlying issues that impact all four populations: provider workforce, access, awareness, coordination/continuum of care, and provider workforce.

Provider Work Force

A lack of a sufficient provider workforce is a tremendous barrier to addressing behavioral health needs in all of the four target populations. Lake County currently has shortages in several professions, psychiatry the most notable. The Assessment noted an extreme shortage of psychiatric care available, with those that are available rarely accepting Medicaid. There is a need for persons to be able to see a psychiatrist immediately, but the provider shortage makes this impossible. Additionally, mental health counselors who accept Medicaid often do not specialize in services to children, and relatively few behavioral health providers speak Spanish.

Strategies to address provider work force challenges are:

> Strategy 1: Develop programs (internships, residencies) for behavioral health trainees: Develop practice sites and/or training programs for counseling professions (e.g. social work, psychology), medical professionals such as nurse practitioners (NP) and physician assistants (PA), and psychiatrists, to increase the workforce capacity and pipeline in Lake County.
>
> Strategy 2: Develop a program of international recruitment and joint recruitment of behavioral health professionals: Develop processes for international recruitment of behavioral health providers and J-1 visa waiver sponsorship, and develop a program of joint recruitment of psychiatrists including hospital affiliation and academic appointment.
>
> Strategy 3: Expand the use of telepsychiatry in Lake County: Use telepsychiatry to increase the quantity of psychiatric care available in Lake County by contracting with psychiatrists outside of Lake County to be available via telehealth technology.

Coordination/Continuum of Care

Services in Lake County are often fragmented and separated by geography, eligibility rules, and many other factors. Individuals often need help navigating the system, and providers are exploring ways to better coordinate services for those with multiple, complex needs, though coordination between

primary care and behavioral health services often does not occur. Many experts who participated in the 2014 Needs Assessment expressed that they had no database or guide for making effective referrals, or that they did not know where to find certain specialized services.

To address the need for better coordination across the continuum of care for all four populations, the selected strategies are:

Strategy 4: Integrate behavioral health services into primary care settings: Integrate behavioral health services into primary care settings including the presence of a Licensed Clinical Social Worker (LCSW) or Licensed Clinical Professional Counselor (LCPC) in the primary care office, universal screening of patients for behavioral health issues, and a consulting psychiatrist to support primary care providers in prescribing medication. Implementation of this strategy will increase access to behavioral health care, increase care provision by providers other than psychiatrists, increase coordination of care among behavioral health and primary care providers, all resulting in the more efficient and effective utilization of resources.

Strategy 5: Integrate primary care services into behavioral health settings: Develop fully-integrated behavioral health homes through collaboration and co-location of two agencies, and/or through single agencies integrating primary care services into existing behavioral health services. This strategy aims to increase quality of care for individuals with severe and chronic behavioral health needs, improve physical health outcomes and prevent premature deaths of individuals with severe mental illness.

Strategy 6: Develop a referral network among agencies in Lake County: A group of agencies in a geographic area would organize to develop a set of protocols through which referrals would be sent and received among agencies. This network should include regular meetings of the group. This strategy will increase coordination of care and collaboration among providers, improve system of referrals, increase efficiency of referral process, and address gaps in care. In addition, this strategy will lay the groundwork for technology-based referrals. This strategy could include medical, behavioral health and social service providers.

Strategy 7: Expand the use of technology to facilitate the continuum of care in Lake County, specifically the number of agencies that use technology to send and receive referrals: Use technology to facilitate the proposed referral network. The goal of this strategy is to increase coordination of care and collaboration among providers, improve system of referrals, increase efficiency of referral process, address gaps in care, and provide a basis for measuring effectiveness of referrals. This strategy is not specifically intended to include medical and behavioral health providers, given heightened requirements for confidential handling of client information. However, significant impact can be achieved through technology-based information, referral and potentially case management, among agencies whose services address the social determinants of health.

Access

Physical access to care in Lake County is a significant challenge, as the county is large in size, has limited public transportation options, and has areas with very few service providers. According to the 2014

Needs Assessment, needs are particularly acute in certain parts of the county, specifically the low-income areas in the Waukegan area, and the large portions of western Lake County that have almost no service providers. Strategies to address the issue of access across all four of these populations are:

Strategy 8: Co-locate behavioral health providers and other social service agencies in one location to improve access to services: This strategy plans to create a co-location site for services in Northwestern Lake County with eventual expansion to a second site in Northeastern Lake County. The intended impact of this strategy is to increase access to behavioral health services and all other social services for low income individuals in Northern Lake County.

Strategy 9: Expand supportive housing services for individuals with severe mental illness (SMI): Increase the number of case managers available to help individuals with SMI locate and remain stable in private housing. This strategy aims to provide increased access to housing and treatment for individuals with SMI.

Strategy 10: Develop school-based behavioral health services to increase access to services for youth: This strategy plans to develop a system of co-locating behavioral health services in high schools throughout northern Lake County. The goal of this strategy is to increase access to behavioral health services for children and adolescents with behavioral health needs, especially those whose parents have limited transportation.

Strategy 11: Develop a program to provide transportation to appointments for individuals with behavioral health needs: Develop a transportation service in Lake County available for individuals with behavioral health needs who lack access to behavioral health services due to limited resources, specifically transportation. The transportation program will be housed within a host agency and will provide transportation to behavioral health appointments. This strategy will increase access to behavioral health services for low income individuals.

Awareness

Awareness of mental health concerns and how to address them may be lacking in Lake County. Data on awareness is limited; however, there are indications that specific populations lack sufficient awareness of mental health concerns. For example, Latinos are highly underrepresented in emergency room visits and inpatient visits, suggesting that awareness may be a contributing factor. Veterans are another population of concern; many of the roughly 4,000 at-risk veterans in the county who need mental health and other assistance services are not connected to the Veterans Administration (VA), suggesting a need for better awareness and recognition of mental health concerns among veterans. There are also insufficient services to prevent behavioral health problems from becoming critical, so many go unrecognized until they reach crisis level. Strategies identified to address awareness are:

Strategy 12: Train individuals in Mental Health First Aid: This strategy will result in an increased understanding of what mental illness is, achieved through the training of individuals across different sectors (education, public safety, first responders, healthcare, social service, etc.) in mental health first aid. This could be accomplished by identifying a host agency to coordinate the training of

trainers throughout various agencies in various sectors in Lake County. Reliance on SAMHSA's evidenced-based practice guidelines for Mental Health First Aid is strongly encouraged.

Strategy 13: Design and implement a public awareness campaign: This strategy calls for the development and successful implementation of a sustainable public awareness plan for Lake County that provides consistent, visible messages aimed at decreasing the stigma of mental illness and increasing awareness of available resources. This strategy relies on the coordination of existing community awareness efforts to develop an effective plan with minimal redundancy.

Taken together, the 13 proposed strategies offer a comprehensive solution to address profound unmet needs identified in the Assessment, as well as serve the varied target populations. This report provides developed views into each strategy, how each strategy addresses these critical needs across the defined populations, and how each strategy can best create positive change in how behavioral health services are delivered in Lake County over the next five years.

Overview Tables of Strategies

The following tables provide snapshots of the 13 strategies. For each strategy, the table contains an overview of the strategy, a definition of success in 5 years, expected impact, types of partners that might be involved, anticipated costs, relevant age groups, cultural and linguistic competency considerations, and expected time to implement.

Please note that the organizations listed as indicating interest under "Partners" are organizations that have expressed potential interest at the time of this report's development. The list is not final or all-inclusive, and many other partner organizations are desired for the actual implementation of these strategies over the next five years.

The "Relevance for Age Groups" information contained within the table brings to light that while nearly all of the strategies are pertinent to both children and adults, a few do have greater relevance to one age group. For example, the school-based behavioral health services strategy (Strategy 10) will primarily impact children and adolescents while expanding supportive housing services for individuals with severe mental illness (Strategy 9) is expected to impact significantly more adults than children. The strategies are conceived as a "balanced set" to ensure that all age populations are reached.

Finally, the "Cultural and Linguistic Competencies" information in the table is meant to highlight the specific strategies most likely to close existing gaps in culturally- and linguistically-appropriate care for non-English speaking and non-White populations in Northern Lake County. While all strategies should be pursued in a linguistically- and culturally-competent manner, some strategies, such as international recruitment (Strategy 2), telepsychiatry (Strategy 3), and co-location of services (Strategy 8), have the greatest potential to close gaps in areas of cultural or linguistic need. As with "Relevance for Age Groups," this should be taken into consideration when planning which strategies to initially pursue.

PROVIDER WORKFORCE		
Strategy 1	**Overview**	**Definition of Success in 5 Years**
Develop programs (internships, residencies) for behavioral health trainees	Develop practice sites/ training programs for counseling professions (social work, psychology), mid-level medical professions (NP, PA), and psychiatrists	One new training program open with solid plans to open other training programs for other disciplines of providers within behavioral health
Impact	**Partners**	**Cost**
Increase workforce in Lake County	**Types of Partner Organizations** Universities and professional schools Federally Qualified Health Centers (FQHC) Community Mental Health Centers (CMHC) Behavioral health providers Other social service agencies **Initial Organizations Indicating Interest** Lake County Health Department Arden Shore Child and Family Services One Hope United Youth and Family Counseling Rosalind Franklin University Health System Vista Medical Center West Zacharias Sexual Abuse Center Mano a Mano Family Resource Center Nicasa Behavioral Health Services	Cost of the supervisor's time at the host agency Cost of staff and faculty necessary to oversee training programs at the university of professional school Cost of a stipend if determined appropriate for the training program
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	High opportunity to close gaps in areas of cultural or linguistic need	5+ years

PROVIDER WORKFORCE		
Strategy 2	**Overview**	**Definition of Success in 5 Years**
Develop a program of international recruitment and/or joint recruitment of behavioral health professionals	International recruitment of psychologists, visa sponsorship, joint recruitment (partner with a hospital for academic appointment and outpatient) of psychiatrists	Evidence of a successful track record of international hiring international providers. This could mean two successful hires and a feeling that the process has been worked out and/or, develop a joint recruitment relationship with a hospital in Lake County that results in the hiring of two psychiatrists
Impact	**Partners**	**Cost**
Increase workforce in Lake County	**Types of Partner Organizations** Universities and professional schools Hospitals Federally Qualified Health Centers (FQHC) Community Mental Health Centers (CMHC) Other behavioral health providers **Initial Organizations Indicating Interest** Lake County Health Department Arden Shore Child and Family Services Rosalind Franklin University Health System Vista Medical Center West Nicasa Behavioral Health Services	Cost to sponsor visa and visa application fee Potential travel costs for interviewing the candidate Staff time to develop the program
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups Strategy could potentially bring additional child psychiatrists to Lake County	High opportunity to close gaps in areas of cultural or linguistic need	3-4 years

PROVIDER WORKFORCE		
Strategy 3	**Overview**	**Definition of Success in 5 Years**
Expand the use of telepsychiatry in Lake County	Use telepsychiatry to increase the quantity of psychiatric care available in Lake County by contracting with a psychiatrist outside of Lake County to be available via telehealth technology	To fully and successfully implement a telepsychiatry program in Lake County at a minimum of two agencies reaching clients in at least two communities that are underserved by psychiatric services
Impact	**Partners**	**Cost**
Increase access to psychiatric care in Lake County	**Types of Partner Organizations** Psychiatrists outside of Lake County (licensed in IL) willing to provide telepsychiatry services Hospitals Federally Qualified Health Centers (FQHC) Community Mental Health Centers (CMHC) Other behavioral health providers **Initial Organizations Indicating Interest** Lake County Health Department Youth and Family Counseling PADS Rosalind Franklin University Health System Vista Medical Center West Advocate Condell Medical Center Mano a Mano Family Resource Center Nicasa Behavioral Health Services Arden Shore Child and Family Services	Cost to cover the gap between billing revenue and expenses – This includes the cost of having mental health professional in the room with the patient Cost of HIPAA-compliant technology for each patient site Cost of HIPAA-compliant technology for the psychiatrist's site if not already equipped
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups Strategy could potentially increase access to child psychiatry in Lake County	High opportunity to close gaps in areas of cultural or linguistic need	3-4 years

COORDINATION/ CONTINUUM OF CARE		
Strategy 4	**Overview**	**Definition of Success in 5 Years**
Integrate behavioral health services into primary care settings	Integrate behavioral health services into primary care settings including the presence of a LCSW or LCPC in the primary care office, universal screening of patients, and a consulting psychiatrist to support primary care providers in prescribing medication	Integration of behavioral health services into the primary care services of all safety net providers, including, at minimum, the universal screening of patients for depression
Impact	**Partners**	**Cost**
Increase access to behavioral health care, increase care provision by providers other than psychiatrists, increase coordination of care among behavioral health and primary care providers, all resulting in the more efficient and effective utilization of resources	**Types of Partner Organizations** Federally Qualified Health Centers (FQHC) Private primary care practices Hospitals Community Mental Health Centers (CMHC) Other behavioral health providers **Initial Organizations Indicating Interest** Lake County Health Department Catholic Charities One Hope United Rosalind Franklin University Health System Advocate Condell Medical Center Vista Medical Center West Nicasa Behavioral Health Services Arden Shore Child and Family Services	Cost the integration of screening tools into the existing EHR Cost of the LCSW or LCPC (best practice is 1 FTE LCSW or LCPC per 3-4 FTE PCP) Cost of the consulting psychiatrist (best practice is 0.05 FTE per 1,000 primary care panel) Cost of training MA on screening procedure Cost of training PCPs and LCSW or LCPC on integration model Cost of limited/ or loss of productivity during initial phases of implementation Cost of infrastructure changes to support integration
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	Medium opportunity to close gaps in areas of cultural or linguistic need	3-4 years

COORDINATION/ CONTINUUM OF CARE		
Strategy 5	**Overview**	**Definition of Success in 5 Years**
Integrate primary care into behavioral health	Develop fully-integrated behavioral health homes either through a collaboration and co-location of two agencies or through a single agency integrating primary care services into existing behavioral health services	Two fully functioning and successful behavioral health homes in Lake County
Impact	**Partners**	**Cost**
Increase quality of care for individuals with severe and chronic behavioral health needs. Improve physical health outcomes for individuals with severe behavioral health needs	**Types of Partner Organizations** Federally Qualified Health Centers (FQHC) Community Mental Health Centers (CMHC) Behavioral health providers Primary care providers **Initial Organizations Indicating Interest** Lake County Health Department Youth and Family Counseling One Hope United Rosalind Franklin University Health System Vista Medical Center West Zacharias Sexual Abuse Center Nicasa Behavioral Health Services Arden Shore Child and Family Services	Cost of training staff on the integrated model Cost of limited/ or loss of productivity during initial phases of implementation Cost of infrastructure changes to support integration
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	Medium opportunity to close gaps in areas of cultural or linguistic need	3-4 years

COORDINATION/ CONTINUUM OF CARE		
Strategy 6	**Overview**	**Definition of Success in 5 Years**
Develop a referral network among agencies in Lake County	A group of agencies in a geographic area organize to develop a structure and a set of protocols on which referrals are sent and received among one another. This structure should include regular meetings of the group.	The presence of an active and sustained network between agencies that provides a channel of communication about referral processes and procedures within the network
Impact	**Partners**	**Cost**
Increase coordination of care and collaboration among providers. Improve system of referrals. Increase efficiency of referral process. Address gaps in care.	**Types of Partner Organizations** Social service agencies Federally Qualified Health Centers (FQHC) Community Mental Health Centers (CMHC) Behavioral health providers Primary care providers Hospitals **Initial Organizations Indicating Interest** The Alliance for Human Services Youth and Family Counseling Catholic Charities One Hope United PADS Rosalind Franklin University Health System Vista Medical Center West Advocate Condell Medical Center Zacharias Sexual Abuse Center Mano a Mano Family Resource Center Nicasa Behavioral Health Services Arden Shore Child and Family Services	Staff time to attend meetings, to develop implement new practices
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	Medium opportunity to close gaps in areas of cultural or linguistic need	1-2 years

COORDINATION/ CONTINUUM OF CARE		
Strategy 7	**Overview**	**Definition of Success in 5 Years**
Expand the use of technology to facilitate the continuum of care in Lake County, specifically the number of agencies that use technology to send and receive referrals	The technology to facilitate a referral network	85% of human service agencies using ServicePoint or other chosen technology to send 90% or more of their referrals each
Impact	**Partners**	**Cost**
Increase coordination of care and collaboration among social service providers. Improve system of referrals. Increase efficiency of referral process. Address gaps in care.	**Types of Partner Organizations** Social service agencies **Initial Organizations Indicating Interest** The Alliance for Human Services Youth and Family Counseling Catholic Charities PADS Division of Adult Probation Services Rosalind Franklin University Health System Vista Medical Center West Advocate Condell Medical Center Zacharias Sexual Abuse Center Nicasa Behavioral Health Services	FTEs for system administration, FTEs in participating agencies
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	Low opportunity to close gaps in areas of cultural or linguistic need	1-2 years

ACCESS		
Strategy 8	**Overview**	**Definition of Success in 5 Years**
Co-locate behavioral health providers and other social service agencies in one location to improve access to services	Co-locate human services in northwest and northeast Lake County	The existence of a human services hub in Northwest Lake County and the active planning of a human services hub in Northeast Lake County
Impact	**Partners**	**Cost**
Increase access to behavioral health services and all other social services for low income individuals in Northwest Lake County	**Types of Partner Organizations** Social service agencies Federally Qualified Health Centers (FQHC) Community Mental Health Centers (CMHC) Behavioral health providers Pharmacies **Initial Organizations Indicating Interest** One Hope United Youth and Family Counseling Catholic Charities PADS Division of Adult Probation Services Rosalind Franklin University Health System Vista Medical Center West Nicasa Behavioral Health Services Arden Shore Child and Family Services	Cost of the physical space and any renovations necessary Cost of relocating agencies or opening additional sites for each agency
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	High opportunity to close gaps in areas of cultural or linguistic need	5+ years

<table>
<tr><th colspan="3">ACCESS</th></tr>
<tr><th>Strategy 9</th><th>Overview</th><th>Definition of Success in 5 Years</th></tr>
<tr><td>Expand supportive housing services for individuals with severe mental illness</td><td>Increase the number of case managers available to help individuals with SMI locate and remain stable in private housing</td><td>The potential to provide case management services to all chronically homeless individuals with severe mental illness who are willing to actively engage in treatment</td></tr>
<tr><th>Impact</th><th>Partners</th><th>Cost</th></tr>
<tr><td>Provides increased access to housing and treatment for individuals with severe mental illness</td><td><u>Types of Partner Organizations</u>
Existing homeless service providers, including those who have in the past or current utilize case managers to support clients, which include, but are not limited to the following:
• Lake County Health Department
• New Foundation Center
• Independence Center
• PADS Lake County
• Catholic Charities

<u>Initial Organizations Indicating Interest</u>
Lake County Health Department
Catholic Charities
Division of Adult Probation Services
Lake County Community Development</td><td>FTEs for case managers, potential supplementing of rent</td></tr>
<tr><th>Relevance for Age Groups</th><th>Cultural and Linguistic Competencies</th><th>Time to Implement</th></tr>
<tr><td>Especially relevant for adults</td><td><u>Medium</u> opportunity to close gaps in areas of cultural or linguistic need</td><td>3-4 years</td></tr>
</table>

ACCESS		
Strategy 10	**Overview**	**Definition of Success in 5 Years**
Develop school-based behavioral health services to increase access to services for youth	Provide access to BH services at schools	The availability of behavioral health services in the five largest high schools in Northern Lake County
Impact	**Partners**	**Cost**
Increase access to behavioral health services for children/adolescents with behavioral health needs, especially those whose parents have limited transportation	**Types of Partner Organizations** Local school districts Behavioral health providers Other social service providers **Initial Organizations Indicating Interest** One Hope United Nicasa Behavioral Health Services Youth and Family Counseling Rosalind Franklin University Health System Zacharias Sexual Abuse Center Mano a Mano Family Resource Center Arden Shore Child and Family Services	FTEs for coordination/ etc., potential coordinator
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
Especially relevant for school-aged children and adolescents	Medium opportunity to close gaps in areas of cultural or linguistic need	3-4 years

ACCESS		
Strategy 11	**Overview**	**Definition of Success in 5 Years**
Develop a program to provide transportation to appointments for individuals with behavioral health needs	Preferred model: paid drivers (one agency houses the drivers for all LC) Alternative model: a system in which agencies can book rides for clients using Uber or Lyft	Available, accessible, affordable transportation for behavioral health appointments for individuals with limited resources and behavioral health needs.
Impact	**Partners**	**Cost**
Increase access to behavioral health services for low income individuals	**Types of Partner Organizations** Behavioral health providers County government (e.g., Department of Transportation) **Initial Organizations Indicating Interest** Youth and Family Counseling The Alliance for Human Services Zacharias Sexual Abuse Center Nicasa Behavioral Health Services	FTEs for program coordination and driving Vehicle, insurance, gas, and maintenance Insurance to cover volunteers and mileage to reimburse volunteers
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	Low opportunity to close gaps in areas of cultural or linguistic need	3-4 years

AWARENESS		
Strategy 12	**Overview**	**Definition of Success in 5 Years**
Train individuals in Mental Health First Aid	Train community members in mental health first aid	An increased understanding of what mental illness is achieved through the training of individuals across different sectors (education, public safety, first responders, healthcare, social service, etc.) in mental health first aid. This can be measured by the increase in Mental Health First Aid trainers in Lake County from approximately 2 to 5+ and the availability of mental health first aid classes open to the public from approximately 1 per year to 1 per month.
Impact	**Partners**	**Cost**
Provides an increased awareness of what mental illness is and how to respond when witnessing a mental health crisis	**Types of Partner Organizations** Schools Libraries Social service agencies Healthcare providers First responders **Initial Organizations Indicating Interest** Catholic Charities PADS Youth and Family Counseling One Hope United Division of Adult Probation Services Vista Medical Center West Mano a Mano Family Resource Center Nicasa Behavioral Health Services Arden Shore Child and Family Services	$2,000 training fee per trainer, staff time of the trainer to train community
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	High opportunity to close gaps in areas of cultural or linguistic need	1-2 years

AWARENESS		
Strategy 13	**Overview**	**Definition of Success in 5 Years**
Design and implement a public awareness campaign	Coordinate existing community awareness efforts. Develop a public awareness campaign to decrease stigma and increase an awareness of available resources for behavioral health needs	The development and successful implementation of a sustainable public awareness plan for Lake County that provides regular visibility of messages aimed at decreasing the stigma of mental illness and increasing awareness of available resources.
Impact	**Partners**	**Cost**
Decreases stigma for individuals with behavioral health needs, increases an understanding of available resources	**Types of Partner Organizations** Behavioral health providers Community action groups **Initial Organizations Indicating Interest** Youth and Family Counseling The Alliance for Human Services One Hope United PADS Rosalind Franklin University Health System Vista Medical Center West Zacharias Sexual Abuse Center Mano a Mano Family Resource Center Arden Shore Child and Family Services Nicasa Behavioral Health Services	Cost of advertising time/space, including radio ads, Pace bus ads, newspaper ads Printing costs Staff time to coordinate existing efforts, plan campaign, put campaign into action
Relevance for Age Groups	**Cultural and Linguistic Competencies**	**Time to Implement**
All age groups	High opportunity to close gaps in areas of cultural or linguistic need	1-2 years

Recommended Structure for Implementation

Leading Healthy Futures recommended to the planning groups that an existing, low-cost, inclusive mechanism should be relied upon for the plan's oversight and implementation. After considering a few existing structures, the consensus that emerged from the planning groups is to leverage *Live Well, Lake County* as the convening group for implementation, and to create an action team for behavioral health. A graphic representation of Live Well, Lake County is shown in appendix 3, with this new action team shown in the lower right. LHF recommends that the Behavioral Health Action Team would convene for the first time between February and April of 2016, and at the first meeting, one strategy from each issue area would be prioritized for planning in 2016 and subsequent implementation. LHF also recommends that this plan and the opportunity to participate in implementation should be widely disseminated to all relevant organizations and agencies.

Potential Timeline for Implementation

As noted above, LHF's recommendation is to choose one strategy from each issue area for detailed planning in 2016, with implementation expectations in accordance with a reasonable planning window. The Chart below depicts the amount of time each strategy would likely take to implement should it be chosen for implementation in Year 1.

Area	Strategy	Year 1	Year 2	Year 3	Year 4	Year 5
Provider Workforce	1. Develop programs for behavioral health trainees	Select one from this set to plan in Year 1	Plan	Pilot	Pilot	Expand
	2. Recruitment and Retention of Behavioral Health Providers		Plan / Pilot	Pilot / Expand	Expand	Sustain
	3. Telepsychiatry		Plan	Pilot	Expand	Sustain
Continuum of Care	4. Integrate behavioral health services into primary care settings	Select one from this set to plan in Year 1. #6 or # 7 could be ready for pilots during Year 1.	Plan	Pilot	Expand	Sustain
	5. Integrate primary care services into behavioral health settings		Plan	Pilot	Expand	Sustain
	6. Referral Network	Pilot	Pilot / Expand	Expand	Sustain	Sustain
	7. Technology to facilitate referral network	Pilot	Pilot / Expand	Expand	Sustain	Sustain
Access	8. Co-location	Select one from this set to plan in Year 1	Plan	Plan	Pilot	Pilot
	9. Expand supportive housing for individuals with SMI		Pilot	Expand	Expand	Sustain
	10. School-Based Behavioral Health Services		Pilot	Expand	Expand	Sustain
	11. Transportation		Plan	Pilot	Expand	Sustain
Awareness	12. Mental Health First Aid	Select one to plan and pilot in Year 1. Pilot	Expand	Expand	Sustain	Sustain
	13. Public Awareness Campaign	Pilot	Pilot / Expand	Expand	Sustain	Sustain

Discussion of Individual Strategies

Provider Workforce

Strategy 1: Develop programs (internships, residencies) for behavioral health trainees

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
	✓	

Time to Implement		
1-2 Years	3-4 Years	5+ Years
		✓

Background

A common theme in conversations with Behavioral Health Action Plan Task Force members was concerns around an insufficient behavioral health workforce and pipeline in Lake County. This workforce shortage is characterized by extended vacancies in positions for psychiatrists, especially child psychiatrists and bilingual psychiatrists, trouble finding bilingual providers, and difficulty filling various other behavioral health positions. The workforce committee was tasked with addressing these concerns.

One promising strategy is to develop practice sites and training programs such as internships or residencies for behavioral health trainees. The goal of the program would be to create a behavioral health workforce pipeline for counseling professions such as social work and psychology, medical professionals such as nurse practitioners and physician assistants, and psychiatrists.

The programs would be developed as a collaboration between a graduate or professional school and the potential practice sites. The programs would aim to select residents or interns whose interests and career goals are in keeping with the areas of need in Lake County. These areas of need include bilingual professionals, culturally competent providers, and psychiatrists.

Critical Success Factors

The factors necessary for the success of any of the above models are:

- Graduate and professional school programs interested in developing new training sites
- Behavioral health providers interested in serving as a training site for behavioral health trainees
- Providers at training sites appropriately credentialed to provide supervision to behavioral health trainees
- Approval of the training site by the profession's accrediting body as necessary, for example, accreditation as an American Psychological Association-approved internship or post-doctoral residency program

- Behavioral health trainees interested in completing their training in Lake County

Impact

Increasing the number of behavioral health trainees in Lake County has the ability to increase the number of individuals served. Depending on the scope of the trainee's work and the modalities in which he or she is providing care, one social work or psychology intern who works 25 hours per week could potentially work with 20 clients per week. An intern who conducts numerous group sessions could potential even provide services to 40 or more clients per week. It should be noted that not all of this is billable work for interns. Often interns can provide a positive impact by seeing uninsured clients whom the agency would normally struggle to serve due to cost.

The American Psychological Association describes a variety of benefits to developing an internship or training program. These benefits extend beyond the intern and the agency to the community and to the profession as a whole. The benefits to developing an internship program include:

- Quality control for future professionals entering the field: The host agency is providing the intern with an unparalleled learning opportunity that will be influential long after the intern completes his or her graduate program and enters the field. This gives the agency the ability to influence and mold the future of the profession.
- Interns may remain in the community following completion of schooling: Many interns choose internships with the hope of getting their foot in the door in the community in which they hope to build a career. Other interns choose an internship based on what it offers and in turn develop a connection to the community and elect to seek permanent employment in the area following the completion of school.
- Can increase the amount of a specific service provided: For example, should an agency wish to offer more group sessions aimed at a particular population but there are not any providers with the time available to develop and plan for the group, the intern could be trained to lead the group with the supervision of a provider.
- Increase cultural and linguistic diversity: An agency can increase its ability to provide services in a client's native language if its intern is bilingual.
- Interns are often energetic and excited about work: The level of excitement that is often seen in interns and early career professionals can often remind staff of their passion for the field or even bring a new way of thinking about things to an existing team.
- Cost-effective way to increases staff and services: According to the American Psychological Association, "Developing an internship program is a cost-effective way of increasing staff and services in this tight economic climate."[2] This will be discussed further in the Cost Assumptions section of this document.
- An internship program can reflect well on the host agency: Interns carry their internship experiences with them back to their universities and on to future jobs.

Scale

The committee tasked with developing workforce strategies believes that this strategy has the potential to greatly impact the future of the behavioral health workforce in Lake County and that along with the great potential of the strategy comes an extensive planning process.

Plan: Determine champions; convene graduate and profession schools and potential practice sites; determine the structures of who should be involved based on the disciple of trainee; define an appropriate pilot.

Pilot: Successfully add practice sites to Lake County

- The pilot could include adding a rotation at a community mental health center in Lake County to an existing training program (i.e., a physician's assistant program adds a clinical rotation at Lake County Health Department's behavioral health home as an option to students)
- Or, accepting the first student into a newly developed training site relationship in Lake County (i.e. A social work program sends its first student to a newly developed internship at a community mental health center)

Spread: Increase the number of students who complete trainee experiences in Lake County; increase the number of practice sites; develop partnerships with additional professional/ graduate schools to create new practice sites for professional disciplines of behavioral health providers

Sustain: Maintain relationships with existing graduate and professional programs; continue to provide an excellent training experience for behavioral health trainees

Definition of Success in Five Years: One new training program open with solid plans to open other training programs for other disciplines of providers within behavioral health

Partners

Types of Partner Organizations

- Universities and professional schools
- Federally Qualified Health Centers (FQHC)
- Community Mental Health Centers (CMHC)
- Behavioral health providers
- Other social service agencies

Initial Organizations Indicating Interest

- Lake County Health Department
- Arden Shore Child and Family Services
- One Hope United
- Youth and Family Counseling
- Rosalind Franklin University Health System
- Vista Medical Center West
- Zacharias Sexual Abuse Center
- Mano a Mano Family Resource Center
- Nicasa Behavioral Health Services

Workforce

Staff at the training site:

- Administrative staff at the training site to coordinate the development of the program with the professional or graduate school
- Supervisor
    - Each intern would need to be assigned to a supervisor who would provide clinical supervision as dictated by the trainee's graduate program requirements
- Task supervisor
    - Should a model be chosen that allows the trainee to work at more than one site, the trainee would need a task supervisor at each site. This role would be filled by the primary supervisor when the trainee is at the primary supervisor's site.

- Other behavioral health/ medical staff
    - It is likely that the trainee will come in contact with and have the chance to learn from other providers in the agency. This could include activities such as co-facilitating a group with a provider or participating in a home visit with a case manager. These activities would require the agency staff member to spend time with the trainee prior to the task to prepare the trainee.
- Other agency staff
    - The trainee would potentially need to work with other staff members in the host agency such as a human resources staff member to complete any agency required training

Staff at the professional or graduate school:

- Administrative staff at the graduate or professional school to coordinate the development of the program with the accrediting body and with the training site
- Faculty time to provide a connection between the training experience and the coursework as required by the accrediting body

Measurable Outcomes

- The number of individuals served by each intern throughout the duration of the internship
- % of interns who remain in Lake County following the completion of the internship program (assuming they were completing their degree in the same year)
- % increase in applications for internship positions from year 1 to year 2

High Level Sources of Revenue

- ✓ New billing (specific estimates would depend on selected professions and the care setting)
- ✓ Federal grants
- ✓ State grants
- ✓ Private foundation dollars
- ✓ Financial investments from participating organizations/partners

Additional Revenue Notes:

- Cost savings from not replacing an open position
- Should the trainee already possess the qualifications necessary to be designated as a MHP (mental health professional) or QMHP (qualified mental health professional), it might be possible to bill Medicaid for certain services provided by the intern
- Community mental health centers can bill Medicaid for trainee's time as long as the supervisor is reviewing the documentation
- Residents' ability to generate revenue will be specific to each program.

Cost Assumptions

- Costs will vary significantly depending on specialty or profession (psychiatrists, social workers, etc.) Costs include:
    - Cost of the supervisor's time at the host agency – *could be up to .25 FTE*
    - Cost of staff and faculty necessary to oversee training programs at the university of professional school – *could be 1.0 or more FTE depending on scope of program*
    - Cost of a stipend, if determined appropriate for the training program – *could be anywhere from no or low-cost, such as many unpaid social work internships, to psychiatry residents who earn a salary of $52,000 in Chicago area programs*

The American Psychological Association developed a toolkit for agencies considering developing an internship program. This toolkit urges agencies to conduct a cost-benefit analysis of the proposed program. The toolkit suggests four models that could be used to complete this cost-benefit analysis[3].

1. "Cost vs. Revenue Model (Weiskopf & Newman, 1982) - this model, which was developed for a community mental health center, compares revenues generated by interns with costs of the internship training program. It is only applicable to settings where fees are collected for services.
2. Fees per Contact Model (Rosenberg et al., 1985) - this model proposes a graph whereby the "yearly cost per intern" is plotted against the "fees per contact". The goal is to determine how many contacts an intern must have per week to offset the cost of his/her training. This model is also only applicable to fee-generating settings.
3. Replacement Cost Model (Loucks et al., 1980) - this model assesses how much it would cost if services provided by interns were delivered by senior staff, minus the cost of the Training Program. This model is applicable to all internship programs, whether or not the center is fee-for-service.
4. Combined Model (Schauble et al., 1989) - this model proposes a complex mathematical formula to determine cost per service hour for interns vs. cost per service hour for senior staff replacement of interns. It is most applicable to programs where there is great variability in costs and numbers of trainees from year-to-year."

- Specific planning of a training or internship program would involve using one of the above models to test the cost-benefits of such a program.

Provider Workforce

Strategy 2: Develop a program of international recruitment and joint recruitment of behavioral health professionals

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
		✓

Time to Implement		
1-2 Years	3-4 Years	5+ Years
	✓	

Background

The shortage of behavioral health providers is perhaps the most pressing workforce issue in Lake County. Positions for psychiatrists are especially difficult to fill. While there is a notable shortage of psychiatrists in general, the need for child psychiatrists and bilingual psychiatrists is even greater. The Behavioral Health Task Force identified a need for expanded methods of recruiting in order to address the shortage of psychiatrists and other behavioral health providers.

Agencies in Lake County are currently offering various incentives, including competitive salaries, relocation costs, and attractive retirement plans, in an attempt to fill vacant positions for psychiatrists. Despite the various incentives, many vacancies remain due to the national shortage of psychiatrists.

To combat these difficulties in recruiting psychiatrists, the Workforce Committee proposed the following recruitment strategies:

- Recruitment of international behavioral health providers with visa sponsorship. This strategy is most successful for psychologists as international recruitment of post-residency medical doctors is difficult for licensure reasons.
- Sponsorship of a J-1 visa waiver for foreign nationals who are recent graduates of residency programs in the United States. This waiver is only available to Lake County Health Department and Erie HealthReach Waukegan because of their Health Professional Shortage Area (HPSA) designations
- Develop a mechanism for joint recruitment (partner with a hospital for academic appointment and outpatient) so that the prospective provider is willing to serve in the outpatient setting of a community mental health center without forfeiting the career benefits that come with academic appointment and hospital affiliation.

Critical Success Factors

- Funding to cover the cost of visa sponsorship for internationally recruited providers or to cover the cost of the J-1 visa waiver for international physicians graduating from United States residency programs

- Develop a relationship with medical schools and hospitals for the process of joint recruitment
- Being granted J-1 waiver by the Illinois Department of Public Health, the process is competitive

Impact
Successfully implementing some or all three of these recruitment strategies could help fill vacancies for psychiatrists in Lake County.

Scale
Plan: Identify champions and leaders of the strategy; develop relationships with hospitals; develop relationships with universities; determine what joint recruitment would look like for the hospital and for the university; determine the process and protocol for joint recruitment; simulations to work on joint recruitment, one or two agencies should work together on determining the process and procedures for international recruitment and for J-1 visa waiver sponsorship

Pilot: Logistics are worked out for joint recruitment, one or two positions are filled using joint recruitment and potentially international recruitment or a J-1 visa waiver

Spread: Joint recruitment and international recruitment or J-1 visa waiver sponsorship become commonly used tools in recruitment of psychiatrists by behavioral health providers throughout Lake County

Sustain: Continue to evaluate the process and the success of joint recruitment; stay current on the policies and procedures regarding international recruitment and J-1 visa waivers

Definition of Success in Five Years:

- Evidence of a successful track record of international recruitment of providers or securing a J-1 visa waiver for an early career foreign national psychiatrist.
- A successful track record might be defined as two successful hires and a feeling that the process has been worked out.
- The development of a joint recruitment relationship with a hospital in Lake County and a medical school that results in the hiring of two psychiatrists

Partners
Types of Partner Organizations

- Universities and professional schools (for joint recruitment or to reach international students seeking employment post-graduation)
- Hospitals (for joint recruitment)
- Federally Qualified Health Centers (FQHC)
- Community Mental Health Centers (CMHC)
- Other behavioral health providers

Initial Organizations Indicating Interest

- Lake County Health Department
- Arden Shore Child and Family Services
- Rosalind Franklin University Health System
- Vista Medical Center West
- Nicasa Behavioral Health Services

Workforce Requirements

- Administrative time at FQHCs recruiting foreign nationals and managing visa sponsorship or J-1 waiver process
- Administrative time at hospitals and medical schools coordinating the process of joint recruitment
- Administrative time at behavioral health agencies coordinating the process of joint recruitment

Measurable Outcomes

- The number of providers hired using any of these three recruiting strategies
- A decrease in the number of vacant positions for psychiatrists in Lake County

High Level Sources of Revenue

- ✓ New billing
- ✓ Private foundation dollars
- ✓ Financial investments from participating organizations/partners

Additional Revenue Notes:

- Participating organizations may be interested in financially investing the resources to recruit in order to ensure positions do not remain vacant.

Cost Assumptions

- Cost to sponsor visa: $1,500 for an employer with between 25 and 50 FTE, $2,000 for an employer with more than 50 FTE[4]
- Potential travel costs for interviewing the candidate: Approximately $1,500
    - Round trip airfare for in-person interview: $1,000
    - Hotel: $450 (approximately $150/night for 3 nights)
    - Transportation to/from interview and to/from the hotel: $150 - $100 round trip shared ride to/from airport, $10-$20/trip to interview or visit practice sites in Lake County
- Cost of J-I visa waiver application: $120 processing fee[5]
- Cost of staff time at FQHCs, hospitals, medical schools, and other behavioral health agencies to develop the program: Approximately 0.1 FTE per practice site, which could be $5,000 per site

Provider Workforce

Strategy 3: Expand the use of telepsychiatry in Lake County

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
	✓	

Time to Implement		
1-2 Years	3-4 Years	5+ Years
	✓	

Background

To address the shortage of psychiatrists in Lake County, this strategy proposes the use of telepsychiatry to increase the quantity of psychiatric care available in Lake County by contracting with a psychiatrist outside of Lake County to be available via telehealth technology.

Telepsychiatry is often organized in a hub and spoke fashion. In this model, the hub – henceforth referred to as the distance site to remain consistent with the terminology used by the State of Illinois Bureau of Comprehensive Health Services[6] – is where the psychiatrist is located. This site could be located anywhere in the U.S., including Lake County if there would be a psychiatrist in Lake County with the ability to take new patients. Given the current shortage of psychiatrists in Lake County, the distance site would more likely be in Chicago, elsewhere in Illinois, or potentially out of state. The distance site could be located in a Federally Qualified Health Center (FQHC) or a hospital, behavioral health clinic, or private practice. Each spoke – henceforth referred to as an originating site to remain consistent with Illinois Bureau of Comprehensive Health Services terminology[7] – is the location where a patient would attend the appointment. At the originating site, the client must be accompanied at all times by a physician, licensed healthcare professional, licensed clinician, qualified mental health professional (QMHP), or mental health professional (MHP).

Common Terminology	Hub	Spoke
Medicaid Terminology in Illinois	Distance Site	Originating Site
Who is located at the site?	Psychiatrist licensed in Illinois with a HFS 3882, Psychiatric Residency Certification form, on file with the Department of Healthcare and Family Services	Patient/Client and MHP
Where can the site be located?	FQHC, Hospital, or Psychiatrist's Office This could be outside of Lake County	Physician's Office, Local Health Department, Community Mental Health Centers, Outpatient Hospitals.

Critical Success Factors

- Identification of a psychiatrist, either in Lake County or elsewhere, who can take new patients.
- Secure funding to close the gap between the psychiatrist's cost and the reimbursement received by the distance site for the service
- Address potential gap between the cost of the MHP's time, the cost of the use of the facility, and the reimbursement received by the originating site
- Secure the technology required at each site for the telepsychiatry program to remain HIPAA compliant

Impact

Telepsychiatry has been proven to be a highly successful solution to the shortage of psychiatrists in various communities across the United States. While the provision of direct services via telehealth began in rural areas, it has since been expanded across many shortage areas: rural, suburban, and urban. Telepsychiatry is credited with providing increased access to high-quality care while providing a simulations cost savings. The Chicago Tribune cites a 2012 study: "The study found that psychiatric admissions to hospitals decreased by an average of 24.2 percent among patients six months after beginning remote videoconferencing compared with the six months before. In addition, the days of hospitalization dropped by an average of 26.6 percent for those who had to be admitted."[8]

Scale

Plan: Identify a distance site and an originating site, determine scheduling, billing, MOU, physical space, equipment

Pilot:

- Identify an agency to serve as the originating site.
- Originating site agency develops a partnership with psychiatrist who has the capacity to take on new patients and is prepared to work in telehealth environment
- Develop a Memorandum of Understanding (MOU) with the distance site. The MOU should detail topics such as a payment arrangement, appointment scheduling, confidentiality and other operational and risk management details.
- The distance site and the originating site may want to decide on a minimum schedule such as two days per month for appointments as possible.
- For HIPAA compliance, both sites need to have adequately encrypted internet, and a private office in which the appointments can be conducted. Then the appointment can be conducted through ordinary video calling software (such as FaceTime, Skype or GoToMeeting)

Spread: Multiple hubs and spokes as deemed appropriate and/or necessary

- Due to cost and complexity, full-scale implementation must be based on experiences in pilot
- If pilot is successful, full scale implementation could either expand telepsychiatry appointments available at the originating site used during the pilot, or expand into additional originating sites
- One of the largest barriers to full scale implementation will be the availability of psychiatrists willing and able to serve as a distance site

Sustain: Secure on-going funding sources

Definition of Success in Five Years: To fully and successfully implement a telepsychiatry program in Lake County at a minimum of two agencies reaching clients in at least two communities that are underserved by psychiatric services

Partners

Types of Partner Organizations

- Psychiatrists outside of Lake County (licensed in IL) with available capacity and willing to provide telepsychiatry services
- Hospitals
- Federally Qualified Health Centers (FQHCs)
- Community Mental Health Centers (CMHCs)
- Other behavioral health providers

Initial Organizations Indicating Interest

- Lake County Health Department
- Youth and Family Counseling
- PADS
- Rosalind Franklin University Health System
- Vista Medical Center West
- Advocate Condell Medical Center
- Mano a Mano Family Resource Center
- Nicasa Behavioral Health Services
- Arden Shore Child and Family Services

Workforce

- A psychiatrist willing and able to serve telepsychiatry patients
- A Mental Health Professional (MHP), or a person with any other approved credential, to oversee each appointment at the originating site. Professionals other than MHPs may be used, but the use of a MHP would most likely be the most cost-effective option.

Measurable Outcomes

The success of this program could be measured in the following ways:

- Number of appointments conducted
- Number of instances of hospitalizations of participants in the telepsychiatry program
- Length of stay in hospital of telepsychiatry patients
- Number of no show appointments
- Number of cancelled appointments
- Average reimbursement per service/visit
- Patient satisfaction
- Provider satisfaction

High Level Sources of Revenue

- ✓ New billing
- ✓ Federal grants
- ✓ Private foundation dollars

Additional Revenue Notes:

- The reimbursement scenarios for telepsychiatry vary according to the type of facility for the originating and distance sites. In most of these scenarios, there is likely to be a gap between the total costs for the service and total reimbursement. See Appendix 4 for details regarding Medicaid and Medicare reimbursement scenario examples.
- Private insurance: Illinois does not mandate that private insurance cover telehealth services, so this must be addressed for each health plan.
- Funding from grants may be available:
    - Federal opportunities:
        - Office for the Advancement of Telehealth
        - United States Department of Agriculture and Rural Development – Distance Learning and Telemedicine Grants
        - Health Resources and Services Administration – Telehealth Network Grant
    - Private Foundations

Cost Assumptions

- Staffing
    - Training
    - Development of new systems such as the scheduling process.
- Technology
    - Each site would need a computer. Best practice is to use a monitor that is large enough for the physician to appear life size to the patient. Approximate cost would be $2,000.
    - If site is using electronic medical records, it is likely the site is already using a WPA2 Enterprise wireless network, which should be adequately encrypted to allow video conferencing to be HIPAA compliant.[9] This should not add costs for most sites.
        - Cost of HIPAA-compliant technology for psychiatrist site if not already equipped
        - Cost of HIPAA-compliant technology for each patient site if not already equipped.
- May also be necessary for the originating site to pay a retainer to the distance site. While this is more common in telehealth for consult, it is sometimes seen in direct service as well. Retainers should be negotiated to close a reasonable gap in actual costs of services provided, billable revenue, and any grants or contracts that are supporting the project.
- Cost to cover the gap between billing revenue and expenses (this includes the cost of having mental health professional in the room with the patient)

Coordination/Continuum of Care

Strategy 4: Integrate behavioral health services into primary care settings

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
✓		

Time to Implement		
1-2 Years	3-4 Years	5+ Years
	✓	

Background

According to the Substance Abuse and Mental Health Services Administration, integrated care is, "the systematic coordination of general and behavioral healthcare."[10] Integrated healthcare addresses two common themes in behavioral health. Integrated care provides for the better management of chronic illnesses such as obesity and cardiovascular disease, which are often responsible for premature deaths of individuals with severe mental illness. Additionally, integrated care enables primary care providers to better fulfill their role as the first interaction with behavioral healthcare for many individuals.[11]

Behavioral health and primary care can be integrated in both primary care settings and behavioral health settings. This strategy focuses on integrating behavioral health into a primary care setting. The Milbank Memorial Fund details three levels of integration for primary care settings: coordinated, co-located, and fully-integrated.

- Coordinated care is described as a close referral network between primary care and behavioral health providers, mental health screening in the primary care setting, routine exchange of information between primary care and behavioral health, and brief behavioral health interventions being provided in the primary care setting.
- Co-located care consists of behavioral health and primary care in the same setting, a standardized referral process for patients to be seen by behavioral health providers, and an enhanced collaboration between primary care and behavioral health providers including cross-training.
- Fully-integrated care is demonstrated by the development of a single treatment plan for patients with both behavioral and physical health elements, and a team approach to treatment with both behavioral health and primary care providers taking an active role in treatment planning.[12]

Critical Success Factors

- In order for this program to be successfully implemented in Lake County, it would be necessary to identify primary care providers and behavioral health providers that are willing to work together to develop systems to integrate their services.

- Should Lake County wish to implement a model that requires the hiring of additional personnel, securing funding will be a critical step in implementation.

Impact

Increase access to behavioral health care, increase care provision by providers other than psychiatrists, increase coordination of care among behavioral health and primary care providers, all resulting in the more efficient and effective utilization of resources

According to the report, *Economic Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry*, prepared by Milliman, Inc. for the American Psychiatric Association, "an estimated $26 - $48 billion can potentially be saved annually through effective integration of medical and behavioral services."[13] While this figure is impressive and incredibly convincing, it is only a snapshot of the impact of integration of primary care and behavioral health. According to Klein and Hostetter from the Commonwealth Fund, "Failure to recognize and appropriately treat behavioral health conditions has a significant impact on health outcomes and costs: patients with these diagnoses use more medical resources, are more likely to be hospitalized for medical conditions, and are readmitted to the hospital more frequently."[14] The Center for Health Care Strategies and Mathematica Policy Research states, "More than 70 randomized controlled trials have shown collaborative care for common mental disorders such a depression to be more effective and cost-effective than usual care, across diverse practice settings and patient populations."[15] Integrated care in Lake County could lead to more consistent access to medical care for individuals with severe mental illness, increased access to behavioral health care for individuals with an undiagnosed or newly diagnosed mental illness, and better health outcomes for all patients with any level of mental or behavioral health needs.

Scale

Plan: Identify primary care providers interested in integrating behavioral health services into the practice; identify behavioral health providers interested in contracting with primary care provider to provide behavioral health services in the integrated practice; meet with primary care settings that have already successfully integrated behavioral health into the primary care practice for guidance in planning, define roles, work flows, reimbursement expectations and contracting requirements between the two provider organizations.

Pilot: The implementation of an integrated care model will most likely be an extended process as systems are developed between providers and disciplines. To allow for the most seamless process possible, it might be advantageous to start with a small pilot program at one of the primary care settings in Lake County. Or, to the degree that pilots have already begun, either expansion or replication in other settings could be implemented, potentially with the expectation to monitor key performance indicators to support other future implementations. An example of a successful commitment to monitoring multiple clinics' integration of behavioral health comes from Austin, TX. Two clinics in Austin developed and implemented a plan to integrate behavioral health into the primary care setting. Following this implementation, an evaluation was conducted to assess whether the programs were implemented as planned, and whether the programs were accomplishing the goals that were set forth prior to implementation.[16]

The recommended integration model for the pilot in Lake County is organized around three main components. These components are as follows: 1) the primary care provider will prescribe psychotropic medications when appropriate, 2) a licensed therapist will be located in the primary care setting, and 3) a collaborative relationship will be developed with a psychiatrist. (The three components are expanded upon below.) In some cases it may be possible for a primary care practice to employ the behavioral

health staff directly, in other cases it may prove to be more cost effective to contract with a behavioral health provider to provide the behavioral health services.

Primary care physician will prescribe when appropriate.

- The medical assistant will screen all patients for depression and anxiety while taking vitals at each annual well-child or well-adult visit
    - One commonly used screening tool is the PHQ-2
- Should the results of the initial screening warrant additional information, the primary care provider will do a secondary screening during the appointment
    - The PHQ-9 has proven successful for this use
- When the results of the screenings warrant assessment or the patient requests behavioral health services, the patient will be assessed by the therapist in the office (LCSW or LCPC)
- Based on the assessment, the therapist will begin treatment
- Should medication be considered, the following sharing of information will take place
    - Therapist and primary care provider will discuss the patient's needs
    - If the primary care provider deems necessary, there will be consultation with psychiatrist

Locate a licensed therapist (LCSW or LCPC) in the primary care setting.

- Therapist will assess patients as necessary based on either the results of the primary care provider's screening or based on patient request
- Therapist should be able to diagnose (licensed)
- Therapist will develop a treatment plan for the patient with input from the primary care provider and, when necessary from the psychiatrist
- Therapist will provide follow-up and minor care coordination if the client is referred to the psychiatrist to assure that the patient sees the psychiatrist

Develop a collaborative relationship with a psychiatrist.

- The primary care provider will be able to consult with psychiatrist when necessary before prescribing
- The therapist will be able to consult with the psychiatrist if the therapist is experiencing challenges with the patient
- The primary care provider and therapist team will refer the patient to psychiatrist when necessary

Spread: Work towards the integration of additional primary care settings

Sustain: Continue to seek funding to maintain the integration model

Definition of Success in Five Years: Integration of behavioral health services into the primary care services of all safety net providers, including, at minimum, the universal screening of patients for depression

Partners
Types of Partner Organizations

- Federally Qualified Health Centers (FQHCs)

- Private primary care practices
- Hospitals
- Community Mental Health Centers (CMHCs)
- Other behavioral health providers

Initial Organizations Indicating Interest

- Lake County Health Department
- Catholic Charities
- One Hope United
- Rosalind Franklin University Health System
- Advocate Condell Medical Center
- Vista Medical Center West
- Nicasa Behavioral Health Services
- Arden Shore Child and Family Services

Workforce

For the proposed pilot, the primary care site would need to bring on a licensed behavioral health provider on staff. This position could be filled by a LCSW or LCPC. The reason for filling the position with a licensed clinician is so that the clinician is able to diagnose the patients that he or she sees, and so that the service provided is reimbursable.

In addition to a licensed clinician, the existing primary care staff will need to be able to devote time to developing, learning, and utilizing the systems necessary for integration. These systems would include a screening program, a protocol for referring patients to the psychiatrist, and an arrangement as to how consultation with the psychiatrist would work.

Measurable Outcomes

Should this program be implemented, it would be advisable to collect data for the following indicators:

- Changes in mental health as measured by scores on a depression questionnaire - the questionnaire could be completed at the first session and the eighth session for clients who are referred to the licensed clinician for therapy.
- Changes in physical health as measured by the number of visits to the primary care provider, urgent care clinics, and emergency departments following the completion of eight weeks of therapy as compared to a period of time before referral to the mental health clinician.
    - It should be noted that the number of visits to a primary care provider might increase or decrease based on the client's needs.
- Changes in costs for the primary care setting for the year following implementation compared to the year prior to implementation.

A clinic in Austin, TX implemented a program very similar to the program proposed for Lake County. The Integrated Behavioral Health (IBH) program at People's Community Clinic (PCC) consisted solely of the addition of a LCSW to the clinic. Based on the results experienced by PCC, the proposed program could lead to improvements in mental and physical health and a decrease in cost. PCC experienced dramatic improvements in mental health, "Approximately 61% of patients in the PCC IBH [Integrated Behavioral Health] program experienced a 50% or greater reduction in their depression scores over time."[17] The

decrease in cost was notable as well, "Compared to the year before the IBH program, patient costs were 17% lower in the second year and 56% lower in the third year of program operation."[18]

High Level Sources of Revenue

- ✓ New billing
- ✓ Federal grants
- ✓ Private foundation dollars

Additional Revenue Notes:

- SAMHSA details various funding sources on its website for the integration of behavioral health into primary care. These sources include the following:
  - Grant Opportunities
    - Health Resources and Services Administration – Behavioral Health Integration Grant
    - Health Resources and Services Administration – ACA Mental Health Service Expansion
    - Substance Abuse and Mental Health Services Administration – Primary and Behavioral Health Care Integration Grant
    - U. S. Department of Health and Human Services – multiple applicable grants
  - Medicare and Medicaid Reimbursement
    - SAMHSA has created a document with information on Medicaid and Medicare reimbursements. See Appendix 5.
  - Private Payer Insurance

Cost Assumptions

- Cost of the integration of screening tools into the existing EHR
- Cost of the LCSW or LCPC (best practice is 1 FTE LCSW per 3-4 FTE PCP) - $65,000
- Cost of the consulting psychiatrist (best practice is 0.05 FTE per 1,000 primary care panel) - $90 per hour
- Cost of training Medical Assistant on screening procedure - $15/hour
- Cost of training PCPs and LCSW on integration model
- Cost of limited/loss of productivity during initial phases of implementation
- Cost of infrastructure changes to support integration

Coordination/Continuum of Care

Strategy 5: Integrate primary care into behavioral health

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
✓		

Time to Implement		
1-2 Years	3-4 Years	5+ Years
	✓	

Background

According to Fagiolini, and Goracci (2009), "Although the association between mental disorders and physical health complications has long been recognized, medical conditions remain undertreated in clinical psychiatric practice, and the life expectancy for individuals with serious psychiatric disorders is approximately 30% shorter than that of the general US population."[19] Integration of primary care services into behavioral health settings is often cited as a successful strategy for addressing the issue of chronic physical health issues in patients with severe mental illness.

The Milbank Memorial Fund details three levels of integration for primary care settings: coordinated, co-located, and fully-integrated.[20] An example of coordinated care would be having a medical care coordinator on staff at the behavioral health organization. That care coordinator would be responsible for building relationships between patients and primary care providers, and helping clients understand and address their physical health needs. Co-location, in the case of integration, is defined as having behavioral and physical health providers under the same roof. Within the scope of co-location are several models and varying levels of integration. Finally, full integration has been reached when behavioral and physical health providers share the same location, systems and patient base. In a fully collaborative, fully integrated system, the typical boundaries between disciplines have been overcome and all providers operate seamlessly together.

Critical Success Factors

- Behavioral health providers interested in integrating their practices with primary care
- Funding to support integration
- Developing a partnership with a primary care provider, potentially a FQHC, to co-locate and integrate primary care services into the existing behavioral health agency

Impact

Increase quality of care for individuals with severe and chronic behavioral health needs, and improve physical health outcomes for individuals with severe behavioral health needs.

This program has the potential to positively impact the physical and behavioral health of individuals in Lake County with severe mental illness. By providing health screenings in behavioral health settings, the

Lewin Group believes that a cultural message will be sent to clients that physical health should be a priority. This program also has the ability to link individuals with severe mental illness to primary care and create a system for follow up communication between the PCP and the behavioral health provider.

According to the Lewin Group's report on the integration of primary care into behavioral health, "While some premature deaths among individuals with SMI are related to complex mental health issues, a significant proportion are due to comorbid conditions such as cardiovascular disease, diabetes, respiratory disease, or infectious diseases. At the same time, the mental illness itself may interfere with individuals' ability to receive appropriate care."[21]

Scale

Plan: Identify behavioral health providers interested in integrating primary care services into the practice; identify primary care providers interested in contracting with behavioral health providers to provide primary care services in the behavioral health home setting; meet with agencies who have already successfully developed integrated behavioral health homes for guidance in planning; define roles, work flows, reimbursement expectations and contracting requirements between two provider organizations.

Pilot:

- An interested behavioral health provider seeks out a partner, such as a FQHC, to contract with to develop a behavioral health home
- The primary care provider co-locates at least a care coordinator, and possibly primary care providers, within the behavioral health provider's site
- The primary care providers and staff are trained on the special health care needs of individuals with severe mental illness
- Policies and procedures are put in place to ensure the collaboration of primary care and behavioral health providers and staff
- Systems are developed to ensure the monitoring and improvement of health outcomes among clients with severe mental illness and co-occurring chronic disease; these systems include the process of developing an integrated care plan for each patient

Spread: Additional behavioral health home sites are developed

Sustain: Determine funding necessary to sustain the behavioral health home model in various sites throughout Lake County

Definition of Success in Five Years: Two fully functioning, successful behavioral health homes in Lake County

Partners

Types of Partner Organizations

- Federally Qualified Health Centers (FQHC)
- Community Mental Health Centers (CMHC)
- Behavioral health providers
- Primary care providers

Initial Organizations Indicating Interest

- Lake County Health Department
- Youth and Family Counseling
- One Hope United
- Rosalind Franklin University Health System

- Vista Medical Center West
- Zacharias Sexual Abuse Center
- Nicasa Behavioral Health Services
- Arden Shore Child and Family Services

Workforce

- At least 1 FTE of care coordinator. It is preferable for the care coordinator to have at least a bachelor's level degree in nursing, social work or similarly related field.
- If possible, primary care providers, estimate approximately 1 FTE per 1,000 – 1,500 behavioral health patients, depending on predicted intensity of primary care.
- 1 FTE of medical assistant per 1 FTE of primary care provider
- Staff time to learn new integration procedures
    - Primary care provider
    - Care coordinator
    - Medical assistant
    - Registered nurse
    - Behavioral health providers
- Training time for billing staff in behavioral health practice to learn billing related to primary care, unless the primary care practice will handle this themselves.

Measurable Outcomes

While some measures are dependent on the model chosen, results could include the following:

- Number of clients who receive their primary care at the behavioral health home
- Number of behavioral health clients on appropriate treatment plans for physical health issues
- Health outcomes for individuals who receive their primary care at the behavioral health home

High Level Sources of Revenue

- ✓ New billing
- ✓ Federal grants
- ✓ State grants
- ✓ Private foundation dollars

Additional Revenue Notes:

- Federal Grant Opportunities
    - Health Resources and Services Administration – Behavioral Health Integration Grant
    - Health Resources and Services Administration – ACA Mental Health Service Expansion
    - Substance Abuse and Mental Health Services Administration – Primary and Behavioral Health Care Integration Grant
    - U. S. Department of Health and Human Services – multiple applicable grants
- Medicare and Medicaid Reimbursement
    - SAMHSA has created a document with information on Medicaid and Medicare reimbursements. See Appendix 5
- Private Payer Insurance

Cost Assumptions

- Care Coordinator, approximately $50,000
- Primary care provider, range from $90,000 (nurse practitioner) to $160,000 (physician)

- Cost of training staff on the integrated model
- Cost of limited/loss of productivity during initial phases of implementation
- Cost of infrastructure changes to support integration

Coordination/Continuum of Care

Strategy 6: Develop a referral network among agencies in Lake County

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
		✓

Time to Implement		
1-2 Years	3-4 Years	5+ Years
✓		

Background

With the quantity and variety of human service organizations in Lake County, a county-wide referral network could greatly improve the efficacy and efficiency of service provision. Too often, clients needing additional social services are given a list of providers to call and are expected to follow-up on their own. For a variety of reasons, a client may not follow up despite his or her need for the service. A client may feel uncomfortable making a cold call, may not have access to a phone, or may not have a call back number in case a message is left. Should the client succeed in getting connected with an agency, the provider might turn out not to be an appropriate match for the client's needs, and the client may again receive a phone number, thus starting the process over again. Without a developed referral network even case managers can struggle to find appropriate care for each client.

Clients could benefit greatly from a unified referral process for human service agencies in the county. While technology such as ServicePoint software exists to aid in the referral process, this strategy is specifically about the referral relationships, procedures, and workflows that need to be developed independent of technology. (Strategy 7 refers to technology that can then further improve the efficiency and monitoring of such a referral network.)

Critical Success Factors

In order for a county-wide referral network to be successful, a host agency must be identified and a network coordinator hired within the host agency. Additionally, funding would need to be secured to cover the salary of the network coordinator. For these structural items to be addressed, buy-in from the participating human service agencies will also be necessary, as the agencies will make up the network.

According to Family Health International, the key elements to a referral network are as follows:

- A group of organizations provide services to a target population within a given geographic area
- An organization that coordinates and oversees the referral network
- Regular meetings of providers from each member organization
- A designated referral person at each organization
- A directory of services
- A standardized referral form

- A feedback loop to track referrals
- Accurate documentation of incoming and outgoing referrals at each agency.[22]

Impact

- Increase coordination of care and collaboration among providers
- Improve system of referrals
- Increase efficiency of referral process
- Address gaps in care

Agencies frequently encounter clients whose needs exceed the services provided by the agency. In these cases, it is common for agencies to give the client information such as where to go or who to call to access additional supports. As mentioned above, there are many reasons why a client may not successfully engage with these additional supports. For clients with mental and behavioral health needs, the likelihood of following through on or engaging with additional services is often further decreased by the manifestations of the client's illness. At the point of referral, there is both an opportunity to address a client's unmet needs and a potential danger of losing the client. Collaboration is crucial to prevent clients from "falling through the cracks" among independent and autonomous agencies.[23]

While quantitative data is limited on the impact of referral networks, those who have successfully instituted referral networks credit such networks with an increase in efficiency, a decrease in duplication of services, and an overall cost savings for the agencies involved. These positive outcomes for the participating agencies are often paired with increased success for clients. Should this strategy be chosen for implementation, data should be collected to monitor outcomes experienced by clients and by the participating organizations within the network.

Scale

Plan: The pilot could start by utilizing an existing structure within Lake County to serve as the host. Once a host agency is selected, it will work with community partners to develop the referral network.

Pilot: It is possible that the referral network would start with a small group of agencies and seek to expand once relationships and workflows are developed. Agencies involved in the pilot should be open to using technology to facilitate the referral network.

Once the host agency has identified or hired a program coordinator, the coordinator should begin the process of developing partnerships with other agencies, resource mapping, and aiding each agency in conducting an inventory of available services. When an agency commits to joining the referral network, a designated contact person should be identified within the agency. The person at each agency designated to handle referrals would most likely be best suited to attend the regular meetings, maintain the agency's information in the directory of services, follow up on referrals, and maintain records on all incoming and outgoing referrals.

Spread: Based on the results of the pilot, additional agencies should be invited to join the referral network.

Sustain: Regular evaluations of the referral network should take place to ensure that agencies are still finding the network beneficial; regular meetings should be sustained to ensure that agencies continue to update one another on changes in services, changes in referral process, and other relevant topics.

Definition of Success in Five Years: The presence of an active and sustained network between agencies that provides a channel of communication about referral processes and procedures within the network

Partners

Types of Partner Organizations

- Social service agencies
- Federally Qualified Health Centers (FQHC)
- Community Mental Health Centers (CMHC)
- Behavioral health providers
- Primary care providers
- Hospitals

Initial Organizations Indicating Interest

- The Alliance for Human Services
- Youth and Family Counseling
- Catholic Charities
- One Hope United
- PADS
- Rosalind Franklin University Health System
- Vista Medical Center West
- Advocate Condell Medical Center
- Zacharias Sexual Abuse Center
- Mano a Mano Family Resource Center
- Nicasa Behavioral Health Services
- Arden Shore Child and Family Services

Workforce

The success of this model for a referral network is very much contingent on the ability to employ a coordinator for the network. The coordinator would be on staff at the host agency and could potentially support the pilot on a part-time basis. The tasks associated in the position would most likely include: coordinate the initial resource mapping, develop and maintain the directory of services, create a common referral form, coordinate and lead monthly meetings for the network's agencies, work with providers to identify gaps and inefficiencies in the system, address issues within any single agency such as inappropriate referrals, and help agencies develop network protocols.[24]

In addition to the network coordinator, each agency would need to identify a staff member to serve as the liaison to the referral network. The agency could also benefit from assigning the same staff member to the tasks receiving all incoming referrals, sending out all outgoing referrals, documenting and maintaining data on all referrals, and attending the monthly network meetings.

Measurable Outcomes

In order to successfully monitor and evaluate the effectiveness of the referral network, data on the following items should be collected:

- Total number of outgoing referrals within the network (count individual referrals even if one client receives multiple referrals) – to be tracked by the network coordinator (using data from each agency)
- Number of referrals resulting in a client's engagement in a program within the network – to be tracked by the network coordinator (using data from each agency)

- Number of referrals made per agency – to be tracked within each agency
- Number of referrals received by the agency – to be tracked within each agency
- Number of received referrals resulting in a client's engagement in services – to be tracked within each agency

High Level Sources of Revenue

- ✓ Federal grants
- ✓ Private foundation dollars
- ✓ Financial investments from participating organizations/partners

Additional Revenue Notes:

- Federal Grant Opportunities
  - Dept. of Housing and Urban Development
  - Office of Community Services
- Grants from Private Foundations
  - Lake County Community Foundation (Local)
  - Healthcare Foundation of Northern Lake County
  - Other private foundations (local, state, and national)
- A membership fee from each organization for participation in the network

Cost Assumptions

Staff time to attend meetings, to develop and implement new practices. According to SAMHSA, "As an organization begins to engage in capacity building, it will find that its initial costs may be higher than under the old method. Programs and funders will need to be educated that in the short run, the new referral system will add costs. However, once the network is in place, it will maximize the use of funds by avoiding duplication of services and, most important, it will result in higher client rehabilitation success rates."[25]

For the proposed program, potential costs will include the following:

- Staffing Costs
  1. A program coordinator within the host agency (1 FTE) - $55,000
  2. A consistent contact person at each member agency (0.10) - $50,000 per 1 FTE, so approximately $5,000
  3. Cross training of staff members
  4. Provider time spent with clients explaining/discussing the referral process
- Non-Personnel Costs
  1. Technology for interagency communication – this could be via email, fax, phone
  2. A web-based service directory (could be within host agency's website). Note: Find Help Lake County already serves this purpose

Coordination/Continuum of Care

Strategy 7: Expand the use of technology to facilitate the continuum of care in Lake County, specifically the number of agencies that use technology to send and receive referrals

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
	✓	

Time to Implement		
1-2 Years	3-4 Years	5+ Years
✓		

Background

This strategy proposes that Lake County implement a technology to facilitate a county-wide referral network for social service providers. Much consideration has been given to the possibility of using ServicePoint to meet this need. Currently, ServicePoint remains a viable, appealing option to send and receive referrals between agencies that provide services that address the social determinants of health. For health provider organizations, however, ServicePoint does not appear viable for healthcare providers to send and receive referrals among health providers or social service providers. Health provider organizations are required to implement a wide range of information technology systems, each of which carries additional costs and impacts work flows among clinicians and support staff. Increasingly, health information systems provide electronic means of tracking referral completions and results. During the planning process for this strategy, health providers in Lake County expressed that the changes in workflow necessary to add an additional technology such as ServicePoint would exceed the benefit gained. Instead, health providers anticipate leveraging the existing referral tracking characteristics of their otherwise required health information technology to address this strategy.

This strategy will discuss how a technology, potentially but not necessarily ServicePoint, can be used to coordinate referrals between social service providers. The aim of this strategy is to better address the social determinants of behavioral health through better coordination of services.

During the five-year implementation, medical and behavioral health providers may be able to develop technology-based referral networks and processes. However at this writing, such a strategy or technology has not been defined.

What is ServicePoint?

ServicePoint is a web-based software developed by Bowman Systems that is capable of performing various case management functions both within a single agency and between agencies. Originally designed as an HMIS (Homeless Management Information System), ServicePoint is a flexible, web-based software system used by human services organizations to manage and coordinate services, guide resource allocation, and demonstrate effectiveness.[26] In addition to ServicePoint's various case and care

management functions, the program has privacy and security capabilities. Agencies have the ability to lock or share portions of a client's record. When deciding to share information, an agency can determine which other agencies will have access to the shared portion of the record.

How does Lake County currently use ServicePoint?

ServicePoint has been used in Lake County since as early as 1999 as a homeless management information system. According to Brenda O'Connell, the Continuum of Care Program Coordination for the Lake County Community Development Division, there are approximately 23 agencies who currently use ServicePoint for HMIS purposes as mandated by HUD, and an additional 9 agencies that are providing other human services.

Currently ServicePoint is being used by Lake County agencies to varying degrees. A comprehensive list of agencies using ServicePoint is included in Appendix 6. Some agencies use ServicePoint solely to send referrals to other agencies, while others use it just to receive referrals. In addition to its uses for referrals and as a HMIS, ServicePoint can be used as a client management tool. As a client management tool, ServicePoint allows agencies to track services provided, treatment outcomes, case management assignments and other tasks.

Critical Success Factors
For a technology to be used to facilitate a referral network, there are critical success factors that must be addressed. These factors include:

System-Wide Critical Success Factors

- Securing funding for system administrators to assist all agencies in securing licenses, creating accounts, technical support, and adjusting the system to meet each agency's needs
- Creating a "tipping point" where enough agencies are using the chosen system to send referrals, so that other organizations find it is a disadvantage not to participate.
- Developing agency-specific client consent for the release of information prior to sending a referral. A general consent that covers the client's information being placed in the system is not adequate for the sharing of information between agencies.

Agency-level Critical Success Factors

- Staff having time for technology training
- Designating a staff member in each agency to serve as a liaison to the referral network
- Willingness/ ability within each participating agency o devote time to the learning curve that comes along with implementing a new process or system

Impact
- Increase coordination of care and collaboration among providers.
- Improve system of referrals. Increase efficiency of referral process.
- Address gaps in care.

The expansion of ServicePoint for use as a referral tool (or the development of another technological solution) could provide a significant and positive impact to human service agencies in Lake County. As detailed in the Referral Network Strategy, the creation of a successful referral network among the providers in Lake County could lead to an increase in efficiency and efficacy of service provision. Using technology as a tool to facilitate this referral network would allow real-time sharing of information. Full-

scale implementation of technology in Lake County has the potential to improve client outcomes by improving coordination of care among agencies addressing the social determinants of health.

A technology such as ServicePoint also has the potential to positively impact the utilization of scarce resources in Lake County by identifying trends in resource utilization and allowing agencies to adjust accordingly. For example, if Agency A provides employment services in addition to its flagship service of housing assistance but it notices through ServicePoint that many of its clients enrolled in the employment services are already receiving job training and placement assistance from Agency B, then Agency A may wish to refer clients to Agency B for employment services instead of further allocating resources to its own small program.

Scale

Plan: Determine which technology is the most appropriate choice to facilitate the referral network for agencies whose services address the social determinants of health.

Pilot: According to O'Connell, agencies have reported that they do not use ServicePoint to send referrals because the other agencies they refer to are not using ServicePoint to accept referrals. O'Connell referred to this as a "tipping point" where enough agencies are using ServicePoint such that those who are not using ServicePoint decide to do so because it has become the commonly accepted practice. Regardless of the technology chosen, a go live date should be chosen to create such a "tipping point."

Spread: Once the first set of agencies are using the chosen technology, a second "go live" date should be chosen for agencies that have no yet begun using the technology.

Sustain: Continue to provide training; increased understanding of the potential of technology for the coordination of care

Definition of Success in Five Years: a technology will be employed as the primary mechanism of sending and receiving referrals for all social service agencies in Lake County

Partners

Types of Partner Organizations

- Social service agencies

Initial Organizations Indicating Interest

- The Alliance for Human Services
- Youth and Family Counseling
- Catholic Charities
- PADS
- Division of Adult Probation Services
- Rosalind Franklin University Health System
- Vista Medical Center West
- Advocate Condell Medical Center
- Zacharias Sexual Abuse Center
- Nicasa Behavioral Health Services

Workforce

- Workforce assumptions for ServicePoint

    - 1 FTE of system administrator to assist agencies that do not use ServicePoint for HMIS purposes
    - Maintain current FTE within LCCD
- Workforce assumptions for a different technology would need to be developed based on the system requirements

Measurable Outcomes
In order to successfully monitor and evaluate the effectiveness of Lake County's use of ServicePoint for referrals, data on the following items should be collected:

- Total number of outgoing referrals sent via technology (count individual referrals even if one client receives multiple referrals) – to be tracked by the host organization
- Number of referrals accepted within the program
- Number of referrals made per agency
- Number of referrals received per agency
- Number of referrals accepted per agency
- Number of received referrals resulting in a client's engagement in services – to be tracked within each agency
- Number of agencies using technology to receive referrals
- Number of agencies using technology to send referrals
- Number of clients in the program

High Level Sources of Revenue

- ✓ Federal grants
- ✓ State grants
- ✓ Private foundation dollars
- ✓ Financial investments from participating organizations/partners

<u>Additional Revenue Notes:</u>

- Federal Grant Opportunities
    - Dept. of Housing and Urban Development
    - Office of Community Services
- Grants from Private Foundations
    - Lake County Community Foundation (Local)
    - Healthcare Foundation of Northern Lake County
    - Other private foundations (local, state, and national)
- A membership fee from each organization for participation in the technology

Cost Assumptions
At a high level, implementation costs will include the following:

- 1 FTE system administrator - $55,000
- Staff time devoted to training at each partner agency
- A dedicated staff member at each agency to serve as the liaison to the referral network
- Non-personnel costs

$90 per user per year at each non-HMIS agency – exact charge from Bowman is passed along to the agency by LCCD

Access

Strategy 8: Co-locate behavioral health providers and other social service agencies in one location to improve access to services

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
✓		

Time to Implement		
1-2 Years	3-4 Years	5+ Years
		✓

Background

To increase access to services for individuals in Lake County, this strategy proposes the creation of a co-location site in northwestern Lake County. According Bradbury, Edwards, Laca, and Maher (2011), "Co-location is a type of collaboration in which two or more partner organizations share physical space on a regular basis, ranging from providing programming in a common space to sharing permanent offices. While some are connected by a shared service focus, co-location sites can house any number of organizations with widely different missions."[27]

A co-located site in Lake County would provide individuals with a single location for accessing a wide variety of services, including mental health and substance abuse treatment, and would make it more likely that they receive the full range of available supports. Case managers from one agency would be able to introduce clients to other providers, helping clients feel more comfortable in accessing new services. Additionally, appointments at various providers could be scheduled on one day at a single location leading to a higher likelihood that the appointments will be kept. Finally, clients may feel decreased stigma walking in the door of a co-located facility, as the reason for accessing the facility will be less identifiable.

The idea of co-location is not new to Lake County. In 2005, the Pearce Campus Community Resource Center in Zion, was formed. According to a summary written by the group in 2009, co-location proved successful initially: "We have found through the creation of Pearce Community Resource Center that savings are exponential, first, by the agency providing services. By renting space at a nominal cost one day a week, agencies are better able to assist their clients in the community in which they serve. There is also a significant cost savings to clients, in transportation, stress, and time, as they are able to access services much quicker. This, in turn, helps them to get on their feet sooner, conserving additional resources."[28] Unfortunately, the site closed due to factors such as limited outreach to other organizations and to the community, and there was no additional interest from other organizations to move into the space. The factors leading to the project's initial success, as well as to its eventual fading out should be taking into consideration when planning for future co-location projects in Lake County.

In addition, a few years prior to the development of this plan, the Lake County Community Foundation funded a study for Mano a Mano Family Resource Center, conducted by the Illinois Facilities Fund regarding the feasibility of a co-located site in Round Lake. That report and its findings should be reviewed during the planning process.

Many stakeholders within Lake County are already veterans at navigating the challenges and processes involved with co-location. At the time of writing, the Zacharias Sexual Abuse Center was in the process of opening a new branch in Skokie, Illinois in a shared space with the YMCA. The agency had received substantial dollars to build a beautiful facility, and sharing the space allows for cost-savings in maintaining it as well as synergies in serving the population, establishing new partnerships, and finding future foundation revenue. Amy Junge, CEO of the Zacharias Center, shared that finding the space and forming necessary agreements had taken two years, and was worthwhile, as it provided stakeholders time to process and make key decisions about operating and branding a joint facility. Her positive experiences indicate that co-location is a viable strategy to be pursued in Lake County and that organizations within the Lake County community can serve as in-house experts throughout the process.

Critical Success Factors

- Identification of a building in Northwest Lake County – the location should be close to a Pace bus route such as Route 570, Fox Lake.
- Funding to secure a building and to modify the building as necessary to meet the needs of the project
- Agencies willing to open an office at the co-located site or relocate an existing office to the co-located site

Impact

Increase access to behavioral health services and all other social services for low income individuals in Northwest Lake County. “Research indicates that co-location benefits both organizations and clients. Organizations benefit most from sharing spaces in terms of cost-effectiveness and increased service capacity. Clients experience access to many services in one place and higher quality service provision.”[29]

Scale

Plan: Determine partners; identify two agencies to lead the strategy; explore funding sources (or investors or corporate giving); find a location; plan further logistics such as renovations to the site, potential move-in date, each agency’s contribution to lease, and utilities.

Pilot: Open the Northwest Lake County Site

Spread: Expand hours and/or providers who operate from the site

Sustain: Continue to evaluate funding sources; continue to evaluate scope of co-location services

Definition of Success in Five Years: The existence of a human services hub in Northwest Lake County and the active planning of a human services hub in Northeast Lake County

Partners

Types of Partner Organizations

- Social service agencies
- Federally Qualified Health Centers (FQHCs)

- Community Mental Health Centers (CMHCs)
- Behavioral health providers
- Pharmacies

Initial Organizations Indicating Interest

- One Hope United
- Youth and Family Counseling
- Catholic Charities
- PADS
- Division of Adult Probation Services
- Rosalind Franklin University Health System
- Vista Medical Center West
- Nicasa Behavioral Health Services
- Arden Shore Child and Family Services

Workforce

- FTEs from two leading agencies for planning project
- FTEs from other partner agencies for planning project
- FTEs from each agency for addressing changes to agency structure to facilitate move to co-located site

Measurable Outcomes

- Number of agencies at co-located site
- Financial sustainability of co-located site
- Number of clients served
- Number of clients served by more than one
- Geographic spread of clients served (reach northwest of Lake County)

High Level Sources of Revenue

- ✓ Federal grants
- ✓ Private foundation dollars
- ✓ Financial investments from participating organizations/partners

Additional Revenue Notes:

- Agency contributions to rent and utilities
- Decreased overhead costs from shared space – rent, utilities, janitorial, etc.

Cost Assumptions

- Cost of the physical space – Average rental cost is $12.00 per square foot in Northern Lake County
- Cost of any necessary renovations
- Cost of relocating agencies or opening additional sites for each agency

Access

Strategy 9: Expand supportive housing services for individuals with severe mental illness

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
	✓	

Time to Implement		
1-2 Years	3-4 Years	5+ Years
	✓	

Background

In 2014, Lake County reported 275 people 18 years of age or older who experienced housing instability. Many of these individuals experience a severe mental illness and/or a substance use disorder. Housing stability has been shown to improve both physical and mental health outcomes and in the case of individuals with disabilities, such as significant behavioral health needs, supportive housing is often the most successful track to housing stability.

According to "Supportive Housing in Illinois: A Wise Investment" a report by Heartland Alliance, Supportive Housing Providers Association, and Corporation for Supportive Housing, an analysis of supportive housing residents showed a $2,414 reduction in the cost of services per client per year compared to the two year period before the residents entered supportive housing. Much of this cost savings is attributed to the decreased use of emergency services, in-patient services, and county jails by the residents once they entered supportive housing.[30]

This strategy proposes increasing the number of case managers in Lake County to support individuals in securing and maintaining housing with landlords in the community. According to Carol Craig, Housing Coordinator at the Lake County Health Department, the Health Department operates a HUD-funded housing program that can serve up to 50 households.

Unfortunately, the program does not always operate at capacity, because there has been difficulty matching households and individuals with the vacant housing units. Landlords are at times hesitant to rent to individuals with mental illness, but can be persuaded to do so if they are assured that the tenant will have a case manager to offer support. Craig hypothesizes that with additional case managers, the HUD-funded housing program would experience greater success in placing individuals and families in rental units throughout Lake County.

While different clients require different levels of support, and not all clients are able to live in a typical rental unit, increasing the number of case managers available to support individuals with SMI would allow for the best possible utilization of available housing. The addition of case managers would allow for individuals in need of less support to successfully transition into a rental unit in the community,

while individuals with greater need can be transitioned into existing agency-run units with on-site support.

Critical Success Factors

- Funding for case managers
- Funding for an increase in FTEs for supervision of case managers
- Ability to adapt to the changing Medicaid landscape in Illinois as billing for supportive housing services remains in flux

Impact

Currently, individuals with SMI and housing insecurity struggle to be successful in the community and often spend time in in-patient hospitals, emergency departments, and in custody. According to Gabe Conroe, Public Defender, the wait time between incarceration and housing is a notable issue for this population. Often, an inability to find housing can cause an individual to remain incarcerated. Others are released from jail without a plan and later struggle to find services.

According to "Supportive Housing in Illinois: A Wise Investment", supportive housing yields a decrease in the use of in-patient psychiatric care. "None of the 11 people who used state mental health hospitals in their pre-supportive housing time period used them in their post-supportive housing time period."[31] An equally significant result was seen in the time spent in state prisons and county jails. The report shows a 100% decrease in the use of state prisons and an 86% decrease in the use of county jails from pre- to post-supportive housing.

Scale

Plan: Determine the current Medicaid environment for reimbursement of supportive housing services; identify additional funding sources; determine which agencies could benefit from additional case managers; determine the exact amount of case managers to be hired based on funding available

Pilot: Hire additional case managers as funding permits; continue to monitor the changing Medicaid environment to determine if additional reimbursement opportunities exist

Spread: Continue to seek and secure funding; expand the number of case managers should funding and need allow

Sustain: Advocate to Springfield for Medicaid reimbursement for supportive housing services

Definition of Success in Five Years: The potential to provide case management services to all chronically homeless individuals with severe mental illness who are willing to actively engage in treatment

Partners

Types of Partner Organizations

- Existing homeless service providers who currently or have in the past utilized case managers to support clients in housing
    - Lake County Health Department
    - New Foundation Center
    - Independence Center
    - PADS Lake County
    - Catholic Charities

Initial Organizations Indicating Interest

- Lake County Health Department
- Catholic Charities
- Division of Adult Probation Services
- Lake County Community Development

Workforce

- Approximately 15 additional case managers across agencies who provide this service
- FTEs to supervise case managers

Measurable Outcomes

- Number of individuals housed
- Measures of client success based on each client's treatment plan

High Level Sources of Revenue

- ✓ New billing
- ✓ Private foundation dollars

Additional Revenue Notes:

- Medicaid, details will depend on emerging Medicaid reform policies and Medicaid managed care contracting.
- Private foundations

Cost Assumptions

- 15 FTE of case managers - salary range per FTE: $30,000-$38,000 plus fringe benefits
- Addition of 0.5 – 1 FTE of supervision of case managers per agency
- Costs associated with an increase in case management clients
    - Mileage for case managers ($0.57 per mile, IRS 2015 Rate)
    - Small amount of resources per client for items such as a bus pass or having a replacement key made for an apartment or other client needs that the case manager may find if appropriate for the agency to cover
- Vehicles for transporting clients: 1 vehicle (pre-owned minivan) costs approximately $25,000
    - Insurance coverage for the agency vehicle: approximately $1,500
    - Gas for the agency vehicle
    - Maintenance per vehicle: approximately $1,100

Access

Strategy 10: Develop school-based behavioral health services to increase access to services for youth

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓		✓

Cost to Implement		
High	Medium	Low
	✓	

Time to Implement		
1-2 Years	3-4 Years	5+ Years
	✓	

Background

According to the National Association of School Psychologists, "In selected school districts across the country, community mental health providers working in the schools through inter-agency agreements provide some school-based mental health services."[32] The Lake County Behavioral Health Action Plan has proposed that such a strategy be considered in Lake County to improve access to behavioral health care for children and youth. Currently, school-based behavioral health services are being provided by One Hope United in a group setting in Zion Elementary School District 6.

There are two primary ways in which a community-based agency can provide school-based behavioral health services:

1. Behavioral health services can be provided at a school as part of a school-based health center. In Illinois all school-based health centers are required to provide behavioral health services. School-based health centers can receive payment through Medicaid, private insurance, or patient fees. Currently Round Lake High School's Health and Wellness Center is the only school-based health center in Lake County.
2. A community-based agency can also provide behavioral health services at a school without a permanent location such as a school-based health center. In this scenario, an outside agency would provide services in space provided by the school with all billing, scheduling, administration provided by the agency. This model is in essence an off-site provision of services with the off-site location being a school.

Should this strategy be implemented, an agency could develop a program to provide individual and group counseling to students at schools in Lake County.

Critical Success Factors

For this strategy to be successfully implemented, there are several critical success factors that will need to be met. Possibly the most important step in implementing this strategy would be to develop a memorandum of understanding between the agency and the school and school district where the program is to take place. This MOU should address scheduling, for example, what times should the

agency refrain from scheduling sessions to avoid disrupting the child's education. The MOU should also cover space usage; where the agency can conduct sessions, and on what days and for how long can the agency occupy that space. Finally, the MOU should describe the roles of the agency staff and the school person in referring students, scheduling appointments, and obtaining consent from guardians for the provision of services.

In addition to collaboration among the agency, the school and the school district, client and guardian participation are critical to the success of this proposed strategy. The client must be appropriate for school-based services, or be able to transition to agency-located services should it be determined that school-based is not appropriate. An example of a client appropriate for school-based services might be a client who is struggling with mild anxiety around his or her performance in school. The client would be appropriate for school-based treatment if his/her needs can be addressed in a limited number of sessions and s/he is able to successfully return to class after each session without too much emotional spill-over from the session into class. A client presenting with longer-term needs, a client with a need for additional family involvement, or a client who has difficulty transitioning back to class after his or her session might need to be transitioned to the agency's location for treatment.

Additionally, for clients under the age of 12, the parent or guardian must be willing to consent to the services. For clients ages 12-17, a maximum of 5 sessions of 45 minutes each can be provided before consent is obtained from the guardian.

Finally, the agency providing the services must be able to bill each client's health insurance for the service despite the off-site nature. According to Bruce Johnson, Executive Director of Nicasa Behavioral Health, agencies potentially are only able to bill 15 hours per week of off-site services.

Impact

Increase access to behavioral health services for children/adolescents with behavioral health needs, especially those whose parents have limited transportation

According to the National Adolescent Health Information Center, 20 percent of adolescents show signs of significant emotional distress but only a small portion receive treatment.[33]

Child Trends finds that, "The mental health needs of adolescents are often first identified in schools, where students spend so much of their time."[34] Because of this, the proposed strategy has the potential to have a significant impact on the children and youth in Lake County. The National Association of School Psychologists states, "Schools offer an ideal context for prevention, intervention, positive development, and regular communication between school and families. Parents and children are familiar with the environment and staff. In fact, students are more likely to seek counseling when services are available in schools (Slade, 2002)."[35]

Clients often miss behavioral health appointments for reasons ranging from logistical barriers (lack of transportation, inconvenient appointment times), to emotional barriers (uncertainty about the process or lack of clinical bond). Both sorts of barriers can be addressed by providing appointments at schools. Transportation issues and appointment time conflicts are mitigated because the student will already be at the location during the appointment time, assuming he or she has shown up for school that day. Emotional barriers can also be more readily addressed by leveraging the child's relationship with school staff and his or her comfort in the school environment to introduce the student to his or her therapist.

Scale

Plan: Determine model, identify pilot school(s) and districts, identify providers, determine billing ramifications, determine costs, and determine funding sources.

Pilot: One large high school that meets criteria.

According to Jill Novacek, One Hope United has recently completed a pilot of its group counseling program in Zion Elementary School District 6. Information from the development and implementation of this program should be used to inform any future programs developed in Lake County. One Hope United's program did not collect revenue from billing.

If a model is chosen that provides individual counseling at a school site, an agency willing to provide this service should be identified. A potential pilot for this model could consist of an agency sending a clinician to a middle school or high school for one day per week for one academic semester. During this time, the clinician could take referrals from school administrators and school social workers for students who need services. The clinician would then assess the student (student must be at least 12 years old) and determine if the student is appropriate for school-based services or if the student would be better served at the agency's location.

Spread: Spread to other schools in same district, or other districts. Or, add other providers to the first school. Choose according to students' needs, schools' capacity, and providers' capacity.

The possibilities for a full-scale implementation of this strategy are vast. Multiple agencies could be providing an array of behavioral health services including individual counseling, substance abuse counseling, bilingual services, and group counseling. These services could eventually be made available at any school in Lake County whose students exhibit a need for access to behavioral health services at the school location.

Sustain: Continued funding, continued interest

Definition of Success in Five Years: Increased availability of behavioral health services in the five largest high schools in Northern Lake County

Partners

Types of Partner Organizations

- Local school districts
- Behavioral health providers
- Other social service providers

Initial Organizations Indicating Interest

- One Hope United
- Nicasa Behavioral Health Service
- Youth and Family Counseling
- Rosalind Franklin University Health System
- Zacharias Sexual Abuse Center
- Mano a Mano Family Resource Center
- Arden Shore Child and Family Services

Workforce

This strategy would require workforce commitments from the host school and the agency. Based on the decisions made as part of the MOU, the school would need to provide staff to escort the child to and from the appointment, allow staff the time necessary to facilitate the referral process, and obtain consent from the parent.

The agency would need a clinician, most likely a LCSW or LCPC level clinician, available to go off-site one day per week for the appointments. In addition to the clinician, agency staff would be needed to facilitate administrative tasks such as scheduling appointments for students who are being referred to the agency's location and billing.

Measurable Outcomes

The success of this program could be measured in the following ways:

- Number of students referred to clinician
- Number of students receiving school-based treatment
- Number of students referred to the agency for services
- No-show rate for students receiving treatment at the school
- No-show rate for students referred to the agency's location
- Number of appointments conducted
- Average reimbursement per service/visit
- Patient satisfaction
- Provider satisfaction

High Level Sources of Revenue

- ✓ New billing
- ✓ Federal grants
- ✓ State grants
- ✓ Private foundation dollars

Additional Revenue Notes:

- Grant Opportunities
    - Federal Grants
        - Grants for the Integration of Schools and Mental Health Systems (Department of Education)
        - Grants to Improve the Mental Health of Children (Department of Education)
        - Healthy School, Healthy Communities program (Bureau of Primary Care)
        - Safe Schools/Healthy Students Initiative (Departments of Education, Justice and Health and Human Services)
    - State Grants – though state grants are currently not listed publicly due to the budget impasse, the following types of grants are usually available:
        - Preventive Health and Health Services Grants
        - Maternal and Child Health Grants
    - Grants from Private Foundations
- Private Payer Insurance
- Medicaid/ MCO

Cost Assumptions

To implement a pilot of the individual counseling approach, the following cost assumptions should be considered.

- Agency staff:
    1. Staff time spent coordinating with school
    2. 0.2 FTE masters-level clinician – licensed (LCSW or LCPC) per school
- School staff:
    1. Time spent collecting parent releases

2. Time spent coordinating with agency around logistics

- Non-personnel – mileage
- Potential costs related to use of school space

Access

Strategy 11: Develop a program to provide transportation to appointments for individuals with behavioral health needs

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
✓		

Time to Implement		
1-2 Years	3-4 Years	5+ Years
	✓	

Background
Preferred model: paid drivers (one agency houses the drivers for all LC)
Alternative model: a system in which trained volunteers provide transportation for stable patients.

There is a need for services to transport individuals to mental health and substance abuse treatment appointments and on related trips such as to the local pharmacy to fill a prescription. Meeting this need through a combination of paid drivers, volunteer drivers and travel vouchers is a viable option for Lake County. The proposed strategy relies on one Lake County-based agency to be responsible for coordinating this service for all eligible consumers. That agency would employ a program coordinator who would be responsible for overall program quality, dispatch, data collection, and staff and volunteer training and supervision. Additionally, the program coordinator would link consumers with travel vouchers in situations where a driver is unavailable.

Critical Success Factors
In order for Lake County to be successful in developing and operating a transportation program, all of the critical success factors must be met. The primary critical success factor is funding. Appropriate funding would be necessary to cover the salary of the program coordinator and paid drivers as well as the cost of fuel and insurance for the program-owned vehicle. The host agency might be able to secure a donated vehicle, but if this proves to be difficult, the agency would also need to purchase a vehicle for the program. Additionally, all volunteers would be eligible to receive mileage reimbursement for the miles driven in their personal vehicles while performing volunteer duties. The agency would also need to provide additional liability insurance for all volunteer drivers to supplement each driver's car insurance. In addition to funding, critical success factors include the ability to identify a willing host agency and the hiring of a program coordinator and a driver.

Impact
Increase access to behavioral health services for low income individuals

Developing a transportation program in Lake County for individuals with behavioral health needs would greatly increase access to care for these individuals. According to Hughes-Cromwick et. al. (2005), "An

analysis of nationally representative healthcare datasets revealed that about 3.6 million Americans miss or delay non-emergency medical care each year because of transportation issues."[36] According to SAMHSA, mental health consumers in the United States are found to be disproportionately represented in the lowest income groups.[37] Many individuals with disabilities in Lake County, about 7,725 in 2013,[38] rely on the Supplemental Security Income Program (SSI) as a primary source of income. At this income level it is often cost-prohibitive to own a vehicle. Due to the lack of public transportation in areas of Lake County, and the high cost of owning and maintaining a personal vehicle, many Lake County residents lack reliable transportation. According to Syed, Gerber, and Sharp (2013), "…in a study of 698 low-income adult patients, Silver et al. found that 25 percent of missed appointments/rescheduling needs were due to transportation problems, and bus users were twice as likely to miss their appointments compared to car users."[39]

Increased access to non-emergency medical transportation for individuals with behavioral health needs is shown to have a positive impact on health outcomes. According to Syed, Gerber, and Sharp (2013), "Ultimately, transportation barriers may mean the difference between worse clinical outcomes that could trigger more emergency department visits and timely care that can lead to improved outcomes."[40] An increase in access to transportation is correlated with an increased ability to schedule and keep appointments. Individuals who are able to schedule and keep mental health and substance abuse treatment appointments exhibit better health outcomes such as a decreased number of emergency department visits.

Scale

Plan: Planning for the creation of a transportation program should include conversations with the Lake County Division of Transportation and the Lake County Coordination Transportation Services Committee. Advocacy should be done to make both organizations aware of the impact that transportation has the health outcomes of individuals with behavioral health needs.

The planning team should identify an organization willing to lead the strategy, including being the host of the staff and the vehicles. Once a host agency is determined, logistics of the pilot should be worked out.

Pilot: Lake County could institute a pilot of the behavioral health transportation program before developing and initiating a full scale program. A pilot program could consist of 1 part-time paid driver and 1-3 volunteers covering Waukegan and North Chicago, or northwest Lake County.

The paid driver would work on a part-time schedule during the pilot program. Background checks would be performed on all potential staff and volunteers before training begins. The pilot program could aim to provide 10 rides per week. The host agency would secure a vehicle and all necessary insurance. Rides would be scheduled for the paid driver and the volunteers by the program coordinator. The program coordinator could also designate any scheduling criteria for clients such as 1 week notice for all appointments.

To the maximum extent possible, volunteers could cover defined geographies when the paid driver is already committed to a different client or on days that the paid driver is not working. Volunteers chosen for the program should complete a waiver before beginning to provide transportation. The host agency should secure additional vehicle insurance coverage as necessary to cover the volunteer driver, the occupant(s) and the vehicle while it is being used in conjunction with the program. Volunteers would be eligible for either mileage reimbursement from the agency at the appropriate IRS rate, or a tax deduction for miles driven. The program coordinator would be responsible for recording miles driven

and reimbursements issued. Statements could be issued to each volunteer at the end of each calendar year for the number of miles driven less reimbursements paid.

Spread: To all providers of direct BH services (psychiatry and counseling)

The full scale program could be developed based on the results of the pilot program. The expectation of the full scale program would be to provide up to 40 rides per week, with a minimum of 20 of these rides covered by a full-time paid driver. Once the transportation program is fully functional, consumers would be able to obtain travel vouchers when a driver, paid or volunteer, is not available. The travel vouchers become necessary as the goal is for consumers to feel confident that transportation will be available when they are scheduling appointments. Travel vouchers should be available for use for local Dial-a-Ride services through local jurisdictions, and if necessary, a taxi service. Most Dial-a-Ride services require that appointments are scheduled 1 day in advance. Should the paid driver call out sick on the day of, the program coordinator should assist that day's clients in scheduling rides with a taxi service.

Sustain: Determine sustainable sources of funding

Definition of Success in Five Years: Available, accessible, affordable transportation for behavioral health appointments for individuals with limited resources and behavioral health needs.

Partners

Types of Partner Organizations

- Behavioral health providers
- Bodies of government responsible for transportation (e.g. Lake County Division of Transportation)

Initial Organizations Indicating Interest

- Youth and Family Counseling
- The Alliance for Human Services
- Zacharias Sexual Abuse Center
- Nicasa Behavioral Health Services

Workforce

The success of this program would rely on the ability to hire a paid driver and a full-time program coordinator. The program coordinator will be responsible for the following tasks:

- Program management
    - Collect and address feedback from consumers through surveys and as grievances arise
    - Collect and address feedback from volunteer drivers through surveys and as grievances arise
    - Develop and maintain relationships with community partners
    - Maintain program records such as mileage reimbursements, a volunteer database, and a record of clients
- Data collection: maintain an accurate record of the number of rides given, number of consumers served, and number of hours volunteered, etc.
- Volunteer recruitment
- Volunteer training and supervision
- Explore further funding options

In addition to the program coordinator and the paid driver, the transportation program could benefit greatly from volunteer drivers. It may prove to be difficult to find volunteers due to real or perceived safety concerns of transporting individuals with severe mental illness. Because of this, a paid driver is an important part of the program. Should volunteer drivers be used, care should be taken to appropriately choose and train volunteers, and screen clients before placing clients with volunteers.

Measurable Outcomes

Should this program be implemented, it would be advisable to collect data for use in evaluating the program's success as well as for potential grant applications. The data collected should include:

- Number of rides given (one-way) per day, per week, per month
- What percentage of requested rides are scheduled? (How many rides were turned down due to a lack of resources?)
- Number of no-shows for scheduled rides
- Number of times driver was late
- Number of times client was late to appointment due to scheduling issue, driver error, etc.
- Number of volunteers
- Number of volunteer hours/miles logged

High Level Sources of Revenue

- ✓ New billing
- ✓ Federal grants
- ✓ State grants
- ✓ Private foundation dollars
- ✓ Financial investments from participating organizations/partners

Additional Revenue Notes:

- Federal grants:
  - SAMHSA mental health grants
  - Transportation department grants
- State or county funds or tax levies
- Billing/insurance
  - Medicaid – may be possible depending on Medicaid reforms and the ability to bill for supportive services.
  - Managed care organizations
- Other private foundation sources
- Rider co-payments or membership fees
- Donated vehicles

Cost Assumptions

The following are the costs that would most likely be associated with a full scale transportation program during its initial stages. These costs would increase should the program expand, as there would be a need to employ additional paid drivers and to the costs of additional volunteers.

- Program coordinator – salary and benefits
- 1 paid driver – salary and benefits
- 1 vehicle (pre-owned minivan): approximately $25,000
- Insurance coverage for the agency vehicle: approximately $1,500
- Supplemental insurance coverage for volunteer drivers

    - One current volunteer driver program in Illinois stated that insurance is $2,500 per year for $3 million for major liability/loss for 100-150 volunteer drivers
    - Another volunteer driver program in Illinois reported that insurance for volunteers is $450 per volunteer per year
- Gas for the agency vehicle: approximately $4,500
- Mileage reimbursement for volunteers: $300 at the 2015 IRS volunteer rate of $0.14 per mile
- Maintenance for the agency vehicle: approximately $1,100

Awareness

Strategy 12: Train individuals in Mental Health First Aid

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
		✓

Time to Implement		
1-2 Years	3-4 Years	5+ Years
✓		

Background

Considered by SAMHSA as best practice, Mental Health First Aid is gaining traction in the United States as a way to equip the general population with the skills to respond to a variety mental health emergencies and assist individuals in need to appropriate resources. The *Boston Globe* quotes Linda Rosenberg, CEO of the National Council for Community Behavioral Health, "'What's appealing about this is that it's for everybody, like first aid.'"[41]

This strategy is based on various successful implementations in other communities across the nation, including Palm Beach County, Florida. In Palm Beach County, The Alpert Jewish Family & Children's Services (AJFCS) partnered with the Palm Beach County Action Alliance for Mental Health to put into action a communitywide initiative to train citizens in Mental Health First Aid. AJFCS used grant funding to hire a countywide Mental Health First Aid coordinator who coordinates classes for citizens and oversees the training of instructors from various agencies throughout the county.[42]

The Behavioral Health Action Plan proposes a model similar to that of Palm Beach County.

<u>Model in Lake County</u>

- Identify a host agency
- Identify 0.5 FTE coordination within the host agency
- Train instructors in various agencies
- Agencies who have instructors trained through this project might be required to host a certain number of classes open to the public
- Coordinator works with the following sectors to assure that vital community members are trained
    - Schools
    - EMTs
    - Fire fighters
    - Safety net medical providers
    - Librarians
    - Lay people in social service agencies

Note: Law enforcement agencies in Lake County are being trained in other mental health response programs that are more robust than MHFA.

Critical Success Factors

- Identification of a host agency
- Securing of funding for the coordinator
- Securing of funding for the training of instructors
- Interest from additional agencies to have staff members trained as instructors

Impact

This strategy hopes to accomplish the dual tasks of decreasing the stigma associated with mental illness and preparing citizens to respond in mental health emergencies. According to The RAND Cooperation report developed for CalMHSA (2012), "Strategic targeted trainings aimed at "key power groups" such as employers, landlords, criminal justice, health care providers, policymakers, and the media have been posited as a potentially effective way to reduce stigma (Corrigan, 2004, 2011)."[43]

Scale

Plan: Identify a host agency to oversee the implementation of this strategy; identify funding to cover the cost of training trainers; identify funding to cover the cost of 0.5 FTE coordinator

Pilot: Identify a program coordinator; program coordinator will become trained as an instructor of Mental Health First Aid; program coordinator will begin to train individuals from various sectors;

Spread: Program coordinator will identify agencies who are interesting in having a staff member trained as an instructor; assure that individuals in the following sectors are receiving training: police, library, teachers, EMT/fire, and others who regularly come in contact with the public.

Sustain: on-going training to keep certifications current

Definition of Success in Five Years: An increased understanding of what mental illness is, achieved through the training of individuals across different sectors (education, public safety, first responders, healthcare, social service, etc.) in mental health first aid. This can be measured by the increase in Mental Health First Aid trainers in Lake County from approximately 2 to 5+ and the availability of mental health first aid classes open to the public from approximately 1 per year to 1 per month.

Partners

Types of Partner Organizations

- Schools
- Libraries
- Social service agencies
- Healthcare providers
- First responders

Initial Organizations Indicating Interest

- Catholic Charities
- PADS
- Youth and Family Counseling
- One Hope United

- Division of Adult Probation Services
- Vista Medical Center West
- Mano a Mano Family Resource Center
- Nicasa Behavioral Health Services
- Arden Shore Child and Family Services

Workforce

- 0.5 FTE program coordinator
- Less than 0.1 FTE for each agency's trainer to conduct trainings for the public

Measurable Outcomes

- Number of citizens in Lake County trained in Mental Health First Aid
- Number of Mental Health First Aid classes offered per year in Lake County
- Number of Mental Health First Aid trainers in Lake County

High Level Sources of Revenue

- ✓ Federal grants
- ✓ Private foundation dollars
- ✓ Financial investments from participating organizations/partners

Additional Revenue Notes:

- Federal grants include SAMHSA and other federal grants
- Private foundation grants
  - http://www.activeminds.org/mental-health-first-aid
- Some insurance companies are offering corporate funding
- Charge $25 material fee for classes open to the public

Cost Assumptions

- $2,000 training fee per trainer, staff time of the trainer to train community
- $25 material fee for those being trained (covered by agency for agency staff members)

Awareness

Strategy 13: Design and implement a public awareness campaign

Populations			
Substance Abuse Disorder, not Mentally Ill	Severely Mentally Ill, not Residentially Placed or Homeless	Severely Mentally Ill, Living in Residential Program or Homeless	Non-Severely Mentally Ill, Not-Substance Abusing, Low Income Adults and Youth
✓	✓	✓	✓

Cost to Implement		
High	Medium	Low
		✓

Time to Implement		
1-2 Years	3-4 Years	5+ Years
✓		

Background

Designing and implementing a public awareness campaign to (1) combat the stigma surrounding mental illness and (2) publicize available behavioral health resources is an important component of this Behavioral Health Action Plan. According to a study by The RAND Cooperation, "…reducing this stigma may be a critical step in prevention and early intervention for mental disorders; stigma reduction should also improve the quality of life for people experiencing mental health problems."[44]

To develop a public awareness campaign, a group should be convened that consists of all existing collaborative groups, task force groups, initiatives, agencies, etc. that are addressing public awareness, specifically stigma reduction and awareness of existing resources to create a unified public awareness campaign development team.

The team described above should be convened by a host agency. This host agency should have staff available to devote the time to convening the participants and scheduling the meetings. The team could work together to align existing public awareness efforts. Additionally, team members should develop a county-wide plan for a new public awareness campaign for the reduction of stigma surrounding mental health needs and to raise awareness about existing resources for behavioral health care in Lake County. This plan should be based on the model described in SAMHSA's "Developing a Stigma Reduction Initiative" tool kit.[45]

The Amherst H. Wilder Foundation (2009) cites the U.S. Department of Health and Human Services as offering the following recommendations for developing a social marking campaign:

- Conducting a situational analysis to determine prevailing needs, attitudes, environments, and barriers.
- Developing and implementing a marketing plan, including selection of audiences and an implementation timeline.
- Convening partners and stakeholders, including adult and youth consumers of mental health services, early and throughout the process to help develop and implement activities and materials.
- Evaluating the effectiveness of the implemented strategies and refine as necessary.

- Investing both human and financial resources.
- Knowing your message, and emphasizing messages that are strength-based and focused on recovery.
- Developing a compelling and memorable theme.
- Watching your language, such as emphasizing "mental health" rather than "mental illness."
- Establishing spokespeople, especially consumers of mental health services[46]

Strategies that could be considered in the plan include a radio advertisement and an advertisement on the back of Pace buses. It is possible that raising awareness of existing resources might be linked in some way to Find Help Lake County, a program of the United Way of Lake County.

Critical Success Factors

- Development of a multi-agency and multi-group initiative to develop a plan for the campaign
- Staff time at the host agency to convene the members of the initiative
- Staff time at each agency/ group to work on the projects of the initiative
- Funding for the costs of materials, advertising space/ time, etc.

Impact

The goal of this strategy is to decrease stigma for individuals with behavioral health needs and increase an understanding of available resources. According to Penn and Couture (2002), "This suggests that providing individuals with factual information about SMI, in particular regarding dangerousness and SMI, would reduce stigmatization."[47]

Scale

Plan: Convene a group of community organizations; evaluate current public awareness strategies in Lake County; align existing efforts; develop a marketing plan for a new public awareness campaign around stigma reduction and the publicizing of resources.

Pilot: Launch the public awareness campaign.

Spread: Expand the campaign into different sorts of media; continue to expand and adjust the strategy for optimal impact.

Sustain: Secure on-going funding to sustain the program; monitor the effectiveness of the program; involve additional stakeholders in the process of developing social marketing material as appropriate.

Definition of Success in Five Years: The development and successful implementation of a sustainable public awareness plan for Lake County that provides regular visibility of messages aimed at decreasing the stigma of mental illness and increasing awareness of available resources.

Partners

Types of Partner Organizations

- Behavioral health providers
- Community action groups

Initial Organizations Indicating Interest

- Youth and Family Counseling
- The Alliance for Human Services
- One Hope United

- PADS
- Rosalind Franklin University Health System
- Vista Medical Center West
- Zacharias Sexual Abuse Center
- Mano a Mano Family Resource Center
- Nicasa Behavioral Health Services
- Arden Shore Child and Family Services

Workforce

FTEs from the host agency to organize the participating groups

FTEs from participating groups to develop the plan

Measurable Outcomes

- Development of a multi-approach public awareness campaign
- Number of agencies and groups participating in the development of the campaign
- Number of ads placed at the end of Year 1
    - Radio ads
    - Bus ads
    - Print ads
- Number of press releases issued at the end of Year 1
- Number of articles/ news stories picked up from press releases at the end of Year 1

High Level Sources of Revenue

- ✓ Private foundation dollars
- ✓ Financial investments from participating organizations/partners

Additional Revenue Notes:

- In-kind donations
    - Radio ad time
    - Donations from design firms to create print advertising
- Private foundation grants

Cost Assumptions

- Cost of advertising time/space
    - Radio ads
    - Pace bus ads
    - Newspaper ads
- Print costs
- Staff time
    - Coordinating existing efforts
    - Planning campaign
    - Putting campaign into action

Appendices

Appendix 1: Methodology/Approach

The action plan phase began in January 2015 with a prioritization of issues that were identified in the Assessment. This prioritization was completed by a small group of stakeholders including members of the Lake County Health Department, and leaders from mental health and social service organizations in the community. LHF took the prioritized issues and researched evidence-based practices to develop an initial list of proposed strategies to address each issue.

Once a large number of issues and affected populations were pulled from the assessment, a larger group of Lake County stakeholders, organized by affected population, were convened. Four main populations were the focus of the action plan:

- *Low income adults and youth who have non-severe mental health conditions* such as episodic or mild depression, grief, family/marital conflict, anxiety, etc., are not severely mentally ill, and do not have substance issues
- *Individuals who have substance abuse disorders and are not severely mentally ill*
- *Individuals who are severely mentally ill, do not require residential treatment and are not homeless.* Includes dually diagnosed (SMI and substance abuse).
- *Individuals who are severely mentally ill, and require residential treatment and/or are homeless.* Includes dually diagnosed (SMI and substance abuse).

Each planning group focused on population-specific issues, as well as issues that affected all populations. Issues were prioritized and strategies were suggested. After this meeting, LHF condensed the list of suggested strategies from each group into one list, and organized them by underlying issue.

At the next meeting, each planning group focused on prioritized populations was asked to prioritize the strategies, and come up with ten that they felt would: address the needs of their population; fit the criteria recommended (see Appendix 7); and that the total ten represented a balanced set. The final set was determined to be a balanced set that addresses all populations and fits the criteria of achievability, large impact, financial viability, and appropriateness for the timing. The balance came in ensuring that the needs of all populations would be addressed, that some strategies would be simple while others would be more complex, that key gaps and underlying issues would be addressed, and that optimal impact would be achieved.

The resulting priorities were combined to create the final list of strategies presented in this document. With one exception, each strategy was determined to be applicable to all four populations. Thus, at this point in the process, the groups were rearranged so that experts from each population group were spread across the strategies. This ensured that each issue was examined through the lens of several different populations and that the robust strategies that emerged would meet the needs of different populations.

The final version of the strategies presented here emerged out of these group meetings, supported by best practices and research conducted by the LHF team. Strategy design was discussed and tested with group members and subject matter experts to ensure feasibility and acceptability.

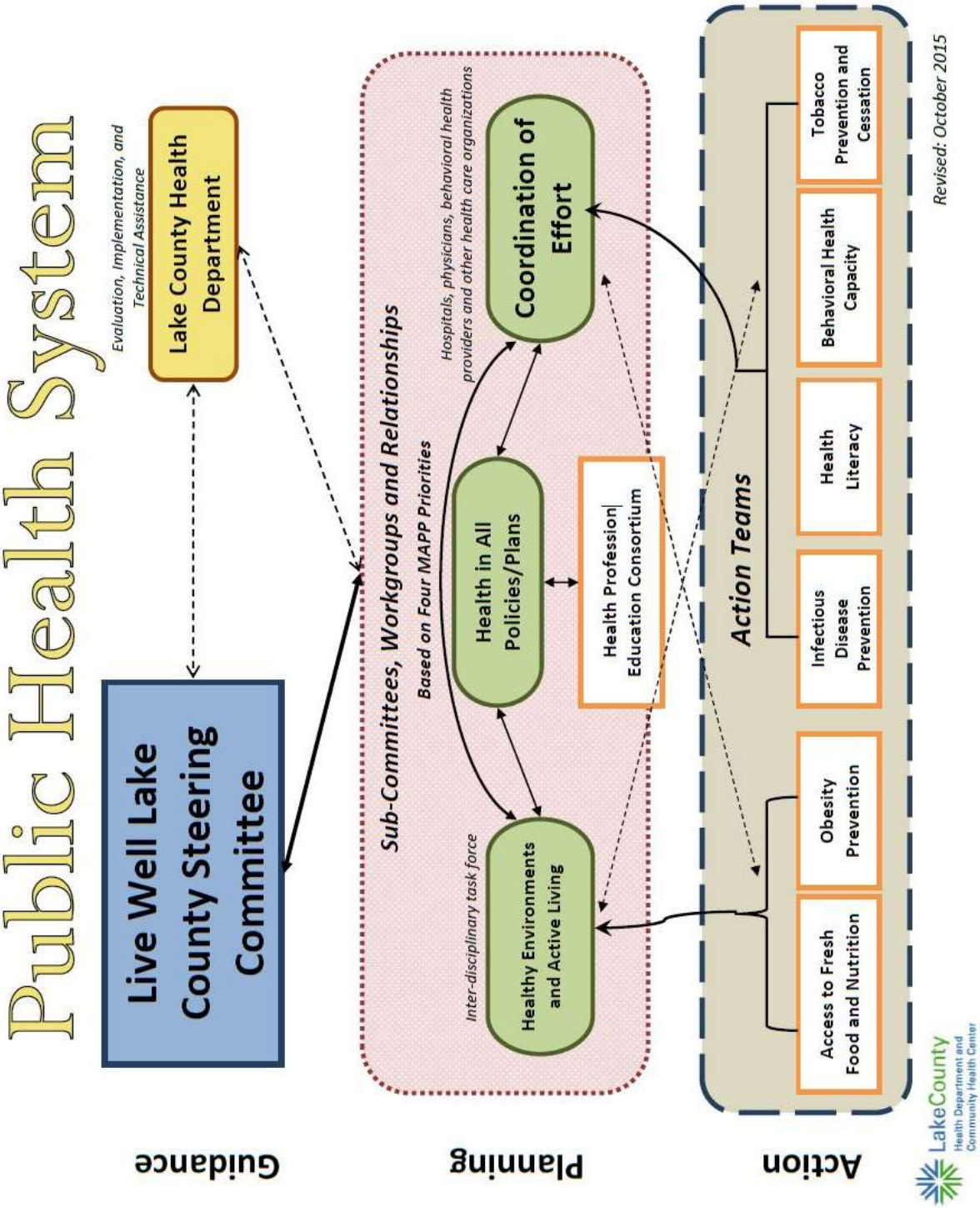
Appendix 2: Participating Individuals and Agencies

The planning process would not have been possible without participation from a wide variety of community leaders. LHF thanks those who made this work possible, including the members of the Project Task Force and the project groups that met regularly throughout 2015. These individuals and organizations include:

Angela Baran	Program Officer	Healthcare Fnd. of Northern Lake County
Maryanne Bajgrowicz	Dir. of Nursing, Emergency, Trauma, EMS, Critical Care	Advocate Condell Medical Center
Tony Beltran	Executive Director	Lake County Health Department
Nick Caputa	Assoc. Director, Behavioral Health Services	Lake County Health Department
Gabriel Conroe	Public Defender	Lake County Public Defender's Office
Barbara Cornew	Executive Director	The Alliance for Human Services
Carol Craig	Housing Coordinator	Lake County Health Department
Pat Davenport	Executive Director	A Safe Place
Paul Dean	Former Executive Director	Family Service of Lake County
Andy Duran	Executive Director	LEAD (Linking Efforts Against Drugs)
Katherine Hatch	Public Defender	Lake County Public Defender's Office
Dr. Carol Hincker	Assist. Superintendent, Special Services	Zion 6 School District
Angel Jackson	Director of Community Schools	Zion 6 School District
Bruce Johnson	CEO	Nicasa Behavioral Health Services
Sam Johnson-Maurello	Assoc. Director, Behavioral Health Services	Lake County Health Department
Amy Junge	CEO	Zacharias Sexual Abuse Center
Dr. Patti Kimbel	Director of Psychiatry	Vista Medical Center West
Rudy Martin	Senior Probation Officer	Division of Adult Probation Services
Dr. Dora Maya	President and CEO	Arden Shore Child and Family Services
Megan McKenna Mejia	Executive Director	Mano a Mano Family Resource Center
Kathy Mitsuuchi	Antioch Area Program Director	Kindred Life Ministries
Janelle Moravek	Executive Director	Youth and Family Counseling
Alan Moy	Director of Psychiatry	Vista Health Center
Maureen Murphy	Associate Vice President	Catholic Charities
Jill Novacek	Director of Programs	One Hope United
Brenda O'Connell	Continuum of Care Program Coordinator	Lake County Community Development
Dennis Skolnik	Interim Executive Director	Family Service of Lake County
Dr. Ted Testa	Psychologist	Private practice
Dr. David Ventrelle	Practice Manager	Rosalind Franklin University
Gail Weil	Executive Director	Community Youth Network
Joel Williams	Executive Director	PADS Lake County

Special thanks go to Tony Beltran, Sam Johnson-Maurello, Jennifer Keel, Jennifer Bernabei of the Lake County Health Department, and Angela Baran of the Healthcare Foundation of Northern Lake County.

Appendix 3: Graphic Representation of Live Well, Lake County



Appendix 4: Medicaid and Medicare Reimbursement Scenarios

Medicaid

The following examples are provided by IDHFS.

Example 1:
Originating Site – Physician's office
Bill HCPCS Code Q3014
Reimbursement is $25.00
Distant Site – Physician who has completed an approved general or child/adolescent psychiatry residency program
Bill the appropriate CPT code for services provided
Reimbursement will be the fee schedule rate for the CPT code billed

Example 2:
Originating Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT
Reimbursement will be the facility's medical encounter rate
Distant Site – Encounter clinic
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program

Example 3:
Originating Site – Physician's office
Bill HCPCS Code Q3014
Reimbursement will be $25.00
Distant Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program
Reimbursement will be the facility's medical encounter rate

Example 4:
Originating Site – Encounter clinic
Bill the encounter HCPCS Code T1015 and any appropriate detail code(s) with modifier GT
Reimbursement will be the facility's medical encounter rate
Distant Site – Physician's office
There is no billable service; the Originating Encounter clinic is responsible for payment to the Distant Encounter clinic provider.
Provider rendering the service must be a physician who has completed an approved general or child/adolescent psychiatry residency program

Medicare

- Client must be located in a designated rural health professional shortage area.[48] In Lake County, low income clients in the Waukegan/Zion/Benton Service Area are eligible for telehealth services based on the federal designation, while none of Lake County is covered by state designation.[49]
- Originating site receives 20% of the appropriate fee schedule amount
- Distance site receives 80% of the appropriate fee schedule amount

	FQHC (non-Medicare)	**Medicare**	**CMHC (plus MD office, podiatrist office, health departments, outpatient hospitals)**
Originating Site (patient location)	Yes. Use T1015 + CPT code with modifier GT Qualified professional must be present at all times with the patient NOT eligible for the $25 Facility Fee	Only eligible if in a rural health professional shortage area (HPSA) or county not included in Metropolitan Statistical Area Bill using same method as FQHC?	May bill Q3014 to receive the $25 Facility Fee Qualified professional must be present at all times with the patient
Distant Site (provider location)	Must be MD Cannot bill	MDs in addition to nurse practitioners Can bill	Must be MD Can bill using CPT with modifier GT

Appendix 5: SAMHSA Medicare/Medicaid Reimbursement

CPT Code		Diagnostic Code	Community Health Center					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New Pt	May be used for behavioral health or physical health services	Yes	MD, PA, ANP	Yes	T1015 plus CPT code	MD, PA, ANP, Nurse Midwife	
	99211 - 99215 Est. Pt.					T1015 plus CPT code		
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	PhD Psychologist at this time; excludes LMSW	No			
	96151 Reassessment		Yes		No			
	96152 Individual TX		Yes		No			
	96153 Group TX		Yes		No			
	96154 Family TX w/ PT		Yes		No			
	96155 Family TX w/o PT		No		No			
Tele-medicine	90791 GT Psych eval w/o medical services	Psychiatric diagnosis	Yes	Physician, NP, PA, CNS, Clinical Psychologist, Clinical Social Worker	Yes	T1015 GT Psych eval w/o medical services	Physician, APN	No originating fee (Q3014) if originating site in FQHC. For telepsychiatry services, a physician, licensed health care professional or other licensed clinician, mental health professional (MHP), or qualified mental health professional (QMHP), as defined in 59 IL Admin Code 132.25, must be present at all times with the patient at the Originating Site.
	90792 Psych eval w/ medical services			Physician, NP, PA, CNS				
	90832-38 GT Therapy Services			Psychiatrist, CNP, Clinical Psychologist,	Yes	T1015 GT Therapy Services	See comments	
	99201-99215 Office or other OP services	Both MH & PH diagnosis	Yes	Physician, NP, PA, CNS	Yes	T1015 GT Office or other OP services		
Alcohol & Substance Services	96150-54 HABI Codes	Physical health diagnosis	No	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	No			Eligible originating site providers include: Physicians, Podiatrists, Local health departments, Community mental health centers, Outpatient hospitals, Encounter Rate Clinics, Federally Qualified Health Center (FQHC), and Rural Health Clinics. Tele-psychiatry providers include physicians, other licensed
	G0459 GT Pharmacological Management				No			
	G0406-G0408 GT Inpatient Consultation		Yes					
	G0442 GT Annual Alcohol Misuse Screen	1 per year	Yes	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	No			
	G0443 GT Brief Face to Face Counseling for alcohol misuse	4- 15 minute interventions within the 11			No			
	G0444 Annual Depression Screening			Physician, Nurse, PA				

CPT Code		Diagnostic Code	Community Health Center					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
Health, Obesity and Tobacco Counseling (Face to Face & Telemedicine	G0108, G0109 Ind-Group Diabetes Tx	Use GT for Telemedicine;	See Behavioral Health section	Physician or certified provider	No			healthcare professional or other licensed clinician, mental health professional, and qualified mental health professional.
	G0447 Behavioral Counseling for Obesity			Physician, NP, PA				
	G0436-37, 99406-07 Smoking Cessation			Physician, NP, PA				
	G0446 Behavioral Counseling for cardiovascular			Physician, Clinical Nurse Specialist, Certified Nurse-				
Substance Use Codes / SBIRT	G0442 Annual Alcohol Misuse Screen	1 per year	Yes	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	Yes	H0001 - AOD Assessment		
	G0443 Brief Face to Face Counseling for alcohol misuse	4- 15 minute interventions within the 11 months after a positive screening				H0002 BH Screen H0004 BH Counseling H0005 AOD Group		
Mental Health	90791 Psych eval w/o medical services	Use with BH diagnosis codes	Billable in and by primary care clinics - check your state's FQHC manual for billability in your state.	Physician, NP, PA, CNS	Yes	T1015	Psychiatrist MD/ DO, Clinical Psychologist (Doctoral), ARNP/APRN/PA/CNS /NP	
	90792 Psych eval w/ medical services					T1015		
	90832-38 Therapy Services			Physician, NP, PA, CNS, Psychologist, LCSW		T1015 individual and group	Clinical Psychologist, Clinical Social Worker, LPC	Must be enrolled to be a behavioral health provider. Modifiers AJ (CSW), AH (Clinical Psychologist) HO (LCPC and LMFT)
	H0031 Mental Health Assessment				No			
	90863 Group Therapy							
	H2011 Crisis Intervention							
	T1017 Case Management		No					
Two services in one day billable at FQHC?				**Yes**				

Yes - An FQHC or RHC may bill only one (1) medical encounter per patient per day and, if enrolled with the Department to provide dental services, one (1) dental encounter per patient per day. FQHCs and RHCs who enroll with the Department to provide behavioral health services may, in addition, bill one (1) behavioral health encounter per patient per day.

SBIRT	Grant Funded: This program works through screening, brief intervention, and referral services introduced into settings where people naturally seek medical help, including hospitals, trauma centers, emergency departments, community clinics, Federally Qualified Health Centers, and school clinics.

CPT Code		Diagnostic Code	Community Mental Health Centers (CMH)					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
E & M Codes	99201-99205 New Pt 99211 - 99215 Est. Pt.	May be used for behavioral health or physical health services	Yes	MD, PA, ANP	Yes	99201-99205 New Pt 99211 - 99215 Est. Pt.	MD, PA, ANP	Add on 90833, 90836, 90838 for therapy w/ E&M
Health and Behavior (HABI)	96150 Assessment	Services are secondary to a physical health diagnosis	Yes	PhD Psychologist at this time; excludes LMSW	Yes	96150 Assessment		Part of Harmony Health Plus Medicaid Coverage only - to be used in a medical setting
	96151 Reassessment		Yes			96151 Reassessment		
	96152 Individual TX		Yes			96152 Individual TX		
	96153 Group TX		Yes			96153 Group TX		
	96154 Family TX w/ PT		Yes			96154 Family TX w/ PT		
	96155 Family TX w/o PT		No			96155 Family TX w/o PT		
Tele-medicine	90791 GT Psych eval w/o medical services	Psychiatric diagnosis	Yes	Psychiatrist, CNP, Clinical Psychologist, Clinical Social	Yes	90791 GT Psych eval w/o medical services	Psychiatrist, PA, APRN, Clinical Psychologist, LCSW	For telepsychiatry services, a physician, licensed health care professional or other licensed clinician, mental health professional (MHP), or qualified mental health. Eligible originating site providers include: Physicians, Podiatrists, Local health departments, Community mental health centers, Outpatient hospitals, Encounter Rate Clinics, Federally Qualified Health Center (FQHC), and Rural Health Clinics. Tele-psychiatry providers include physicians, other licensed healthcare professional or other licensed clinician, mental health professional, and qualified mental health professional. professional (QMHP), as defined in 59 IL Admin Code 132.25, must be present at all times with the patient at the Originating Site.
	90792 GT Psych eval w/ medical services			Psychiatrist, CNP, CNS		90792 GT Psych eval w/ medical services	Psychiatrist, PA, APRN, Clinical Psychologist	
	90832-38 GT Therapy Services			Psychiatrist, CNP, Clinical Psychologist,	Yes	90832-38 GT Therapy Services	Psychiatrist, PA, APRN, Clinical Psychologist, LCSW	
	99201-99215 GT Office or other OP services	Both MH & PH diagnosis	Yes	Physician, NP, PA, CNS	Yes	99201-99215 GT Office or other OP services	Physician, PA, Clinical Psychologist, NP, CNS	
	96150-54 GT HABI Codes	Physical health diagnosis	No		No			
	G0459 GT Pharmacological Management							
	G0406-G0408 GT Inpatient Consultation		Yes		Yes			
Alcohol & Substance Services	G0442 GT Annual Alcohol Misuse	1 per year	Yes	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA				
	GT Brie to Face Counseling for alcohol misuse	4- 15 minute interventions within the 11						
	G0444 Annual Depression Screening							
Health, Obesity and Tobacco Counseling	G0108, G0109 Ind-Group Diabetes Tx	Codes are reimbursed by Medicare and	Yes	Physician, Clinical Nurse Specialist,	No			

CPT Code		Diagnostic Code	Community Mental Health Centers (CMH)					
			Medicare		State Medicaid			
			Paid?	Credentials	Paid?	Code	Credentials	Comments
(Telemedicine and Face to Face)	G0436-37, 99406 07 Smoking Cessation	other insurances in a primary clinic. Use GT for telemedicine		Certified Nurse-Wife, NP, PA, LMSW, LP				
	G0446 Behavioral Counseling for cardiovascular disease							
Substance Use Codes / SBIRT	G0442 Annual Alcohol Misuse Screen	1 per year in a primary care clinic	Yes	Physician, Clinical Nurse Specialist, Certified Nurse-Wife, NP, PA	Yes	H0004 AOD Ind Tx H0005 AOD Group	CADC, LPC, LCPC, MD, Licensed Psychologist, LSW, LCSW	Providers qualify for Medicaid reimbursement by having their programs certified by DHS/DASA and enrolled by the Illinois Department of Healthcare and Family Services. Starting in FY 2014, DASA will reimburse funded organizations for video counseling.
	G0443 Brief Face to Face Counseling for alcohol misuse	4- 15 minute interventions in a primary care clinic within the 11 months after a positive screening				H0001 AOD Assessment		
Mental Health	90791 Psych eval w/o medical services	Use with BH diagnosis codes	Yes	Physician, NP, PA, CNS	Yes	90791 Psych eval w/o medical services	Psychiatrist MD/ DO, Clinical Psychologist (Doctoral), ARNP/APRN/PA/CNS /NP, LPHA	add on 90785 for Interactive Complexity for psych eval and therapy codes
	90792 Psych eval w/ medical services					90792 Psych eval w/ medical services	Psychiatrist MD/ DO, ARNP/APRN/PA/CNS /NP	
	90832-38 Therapy Services			Physician, NP, PA, CNS, Psychologist, LCSW		H0031, H0032, H2011, H0004, H0004 HQ (group)	MHP, QMHP, LPHA	LPHA - LSW, LCSW, LPC, LCPC, RN-Psych, OT, Physician, APRN-Psych, Clinical Psychologist, LMFT MHP - Bachelor's Degree working under the supervision of an LPHA - reference Section 132.25 Definitions TITLE 59: MENTAL HEALTH CHAPTER IV: DEPARTMENT OF HUMAN SERVICES PART 132 MEDICAID COMMUNITY MENTAL HEALTH SERVICES PROGRAM SECTION 132.25
	H0031 Mental Health Assessment							
	90863 Group Therapy							
	H2011 Crisis Intervention					H2015 Community Support		
	T1017 Case Management		No			H2014 Group Skills Training		
	T1016 Supports Coordination					T1016 Supports Coordination	RSA	RSA - HS Graduate w/ training in MH; CRSS An individual who is certified and in good standing as a Recovery Support Specialist by IAODAPCA.
Peer Support	H0038 Peer Support		No			H0038 Peer Services, Ind & Group (HQ), Whole Health & Wellness Coach	Certified Recovery Support Specialist or CRSS –	
	H0038 Peer Support Group							

References:

Medicare Billing Information www.cms.gov

Medicare Telemedicine: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

FQHC Information: http://www.hfs.illinois.gov/assets/0708d200.pdf

Telemedicine: http://www.umtrc.org/clientuploads/directory/Resources/Illinois%202013.pdf

Illinois DASA Manual 2014: http://www.dhs.state.il.us/OneNetLibrary/27896/documents/Manuals/FY14/DASA-

Mental Health -CMH : http://www.hfs.illinois.gov/assets/cmhs.pdf

MH Credential Definitions: http://www.ilga.gov/commission/jcar/admincode/059/059001320A00250R.html

Mental Health- Harmony HABI CPT codes:https://www.harmonyhpi.com/auth_lookup

Appendix 6: Organizations Using ServicePoint

Referral Only

- Nicasa Behavioral Health Services
- Rosalind Franklin University

HUD Basic

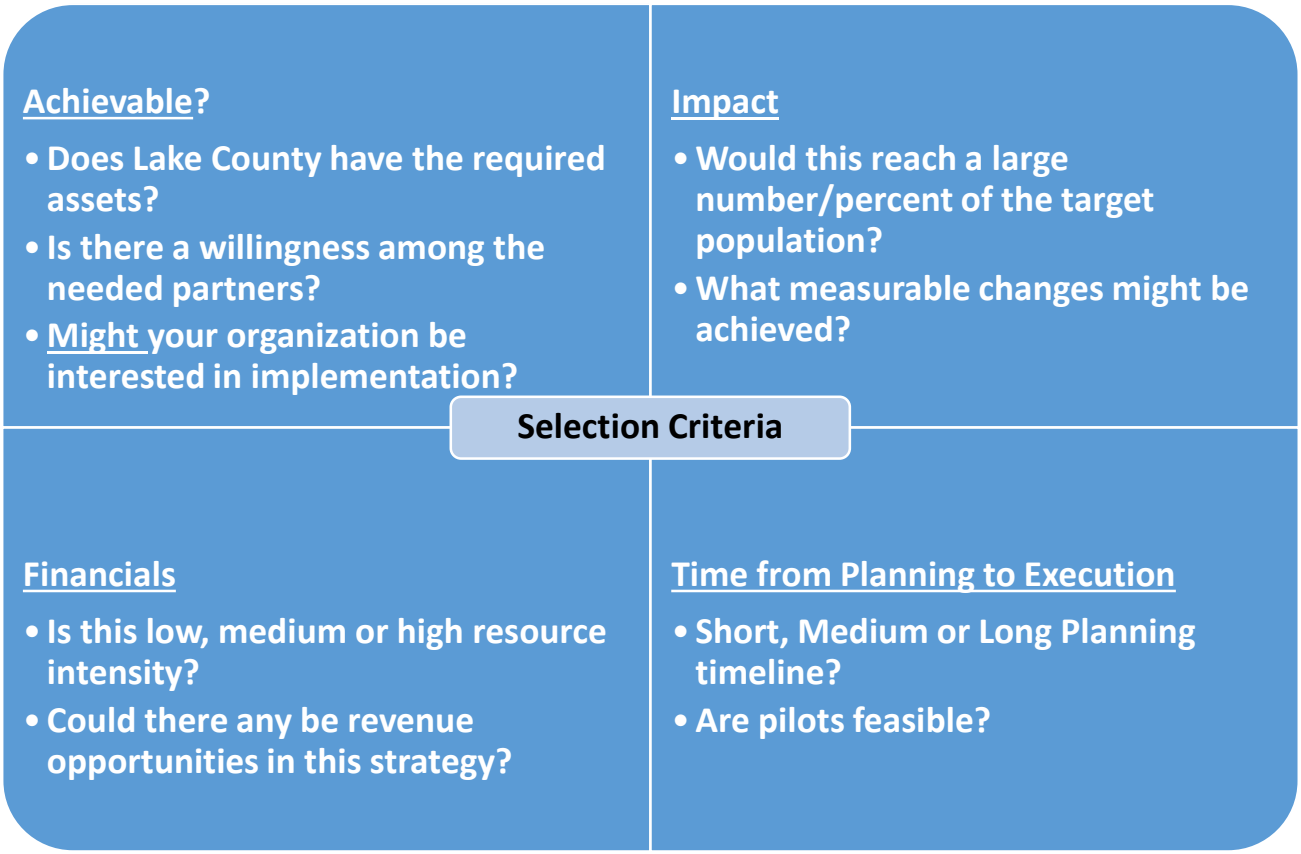
- Alexian Brothers Housing and Health Alliance
- Independence Center
- Lake County Haven
- I-Plus
- Waukegan Township
- New Foundation Center
- Prairie State Legal Services
- One Hope United
- OMNI Youth Services
- Community Youth Network
- Maristella
- Lake County Health Department

Client Management

- Arden Shore Child and Family Services
- Warren Township Center
- Catholic Charities
- Mano a Mano
- COOL Ministries
- PADS Lake County
- Lake County Public Defender's Office
- Waukegan Public Library
- Zion Township
- United Way of Lake County*

* United Way of Lake County is the administrator of Community Point/ Find Help Lake County. This program is fully integrated with ServicePoint and serves as the point of access to services in Lake County for the public.

Appendix 7: Criteria for Strategies



Citations

[1] An Assessment of Behavioral Health Needs, Service Capacities and Projected Trends in Northern Lake County, by Rob Paral and Associates. 2014.
[2] http://www.apa.org/education/grad/internship-toolkit.pdf
[3] http://www.apa.org/education/grad/internship-toolkit.pdf
[4] http://www.uscis.gov/forms/h-and-l-filing-fees-form-i-129-petition-nonimmigrant-worker
[5] http://travel.state.gov/content/visas/en/study-exchange/student/residency-waiver/fee.html
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