



## Mental Health Advisory Committee Agenda

Promoting a Safer and Healthier Community Since 1854

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<b>Date of Meeting:</b>	September 15, 2016
<b>Time of Meeting:</b>	8:00 am – 10:00 am
<b>Location of Meeting:</b>	Winnebago County Health Department, 555 North Court; Room 115; Rockford, IL
<b>Committee Members:</b>	Phil Eaton, Angie Goral (Chair), Carol Klint, Richard Kunnert (Secretary), Charles Smith, MD, Matthew Toohey, Sandra Martell (ex officio)
<b>Committee Support:</b>	Mike Bacon, Harlan Johnson, Melissa Westphal, Karen Fiery, John Barlow (recorder)

<b>Agenda Item</b>	<b>Time</b>	<b>Sponsor/Presenter</b>
1. Introduction of Guests/Public Participation	10 min	A. Goral
2. Approval of Agenda: September 15, 2016	5 min	A. Goral
3. Approval of Minutes: August 18, 2016	5 min	All
4. Streamwood Behavioral Healthcare System	10 min	Guest - E. O'Brien
5. Team (Sub-Committee) Activity Reports/Action Plans	10 min	All
a. Data		D. Kunnert/M. Toohey
i. Community Health Survey Data – Posted on web September 7, 2016		
ii. Provider/Referral Data – December 2016		
b. Messaging/Marketing		M. Westphal/S. Martell
i. Media Plan		
ii. Outreach events		
c. Funding		M. Bacon/P. Eaton
6. Community Health Improvement Plan – Wellness Focused Winnebago		S. Martell
a. Review of plan including goals, indicators, and strategies		
7. Additions		
a. Class Action Suit – NB vs. Norwood	5 min	S. Martell
Enter comments at <a href="https://www.illinois.gov/hfs/info/legal/PublicNotices/Pages/default.aspx">https://www.illinois.gov/hfs/info/legal/PublicNotices/Pages/default.aspx</a> .		
b. League of Women Voters Event – <i>Shameful Criminalization of Mental Illness/Cook County Sheriff Tom Dart</i> October 25, 2016; 5:00 – 8:00 pm DEADLINE to register is September 25, 2016		
8. Next Meeting		
a. October 20, 2016		

**Minutes of the  
Winnebago County Mental Health Advisory Committee  
Monday, August 18, 2016 @ 8:00 a.m.  
Winnebago County Health Department,  
555 N. Court, Room 115, Rockford, IL**

**Present:** Charles Smith, Angie Goral (Chair), Richard Kunnert, Matthew Toohey, Philip Eaton, Carol Klint, Dr. Sandra Martell (ex officio)

**Support Staff Present:** Mike Bacon, Karen Fiery, Harlan Johnson, and John Barlow (recorder)

Angie Goral called the meeting to order at 8:05 a.m.

**Introduction of Guests / Public Participation:** No guests present.

**Approval of Agenda:** Angie Goral asked for a motion to approve the agenda. Dr. Richard Kunnert moved and Matthew Toohey seconded to set the agenda, all members voted aye, motion carried.

**Approval of Minutes:** Angie Goral asked for a motion to approve the July 21, 2016 minutes. Richard Kunnert moved and Matthew Toohey seconded to approve the minutes. With that, all members voted aye, motion carried.

**CEMP Overview:** A presentation was given by Theresa James providing a brief overview of Comprehensive Emergency Management Program (CEMP). CEMP is a web-based platform that will be utilized to store the IPLAN. Overview included how to navigate the system, links to current information, and how to edit and comment on documents. CEMP allows version control of documents to ensure all users are viewing the most up to date information / documentation and allows coordinating community groups to view what is happening with the other IPLAN priorities.

**Editorial Board Meeting Update:** Angie Goral and Richard Kunnert briefed the committee members regarding the meeting held with the Editorial Board on August 16, 2016. Discussion with the Editorial Board included present and past actions, the community support model, the priorities identified, and duplication of services and funding for services.

It was addressed that the mental health issues identified are a community problem that affects the entire community; the committee needs to continuously stress this point. 708 Board and creative funding options were also discussed. Well thought out action plans with community involvement will need to be created in order to continue to maintain focus and receive support on the issues. Individual case management is also a vital part of the community support model.

The Editorial Board is planning to produce a spread on the Mental Health findings for the August 21, 2016 Sunday paper.

**Press Conference:** Dr. Sandra Martell briefed that a press conference is scheduled for 11:00 a.m. on August 22, 2016 to be held at 555 N. Court Street in room 115. Sample agenda for the press conference along with speakers were discussed. A press release has also been drafted and will be released. Discussion was held regarding sound bites for the media and the key findings and strategic recommendations white paper. Sue Merchen (WCHD PIO) will assist committee members to prepare for press conference.

**Team (Sub-Committee) Activity Reports:**

**a. Data/Survey:** Nothing to report.

**b. Messaging/Marketing:**

**i. Approval of Minutes:** Angie Goral asked for a motion to approve the August 5, 2016 Messaging/Marketing Committee minutes. Matthew Toohey moved and Dr. Smith seconded to approve the minutes. With that, all members voted aye, motion carried.

Angie Goral asked for a motion to approve the August 12, 2016 Messaging/Marketing Committee minutes. Dr. Smith moved and Phillip Eaton seconded to approve the minutes. With that, all members voted aye, motion carried.

**ii. Media Plan:** Annual report and white paper will be placed on the WCHD website and distributed to media attending the press conference on August 22. Survey results will have to be requested separately as a data disclaimer is required before downloading.

A Rockford University Business College student has requested to look at Mental Health to determine the return on investment for prevention and intervention.

**c. Funding/Recommendations:** Nothing to report.

**Request – Community Advisory Group for IPLAN:** Dr. Sandra Martell requested that the Mental Health Advisory Committee serve as the Community Advisory Group for IPLAN Mental Health priority and Angie Goral asked for a motion. Richard Kunnert moved and Matthew Toohey seconded to for the MHAC to serve as the IPLAN Advisory Group. With that, all members voted aye, motion carried.

**Meeting Adjournment:** There being no further business, the meeting adjourned at 9:26 a.m. with a motion by Richard Kunnert and seconded by Matthew Toohey, all members voted aye in favor, motion carried.

Approved by the Mental Health Advisory Committee \_\_\_\_\_  
Date

\_\_\_\_\_  
Richard Kunnert, Secretary  
Winnebago County Mental Health Advisory Committee

Next Meeting: September 15, 2016 at 8:00 a.m.; Winnebago County Health, 555 N. Court St., Room 115, Rockford, IL



# Winnebago County Health Department IPLAN 2020



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## Phase 5 – Formulate Goals and Strategies

### Community Health Improvement Plan

#### Introduction

The Community Health Improvement Plan (CHIP) is developed to address the health priorities identified through the Community Health Assessment (Phases I – IV of the MAPP Process). With input from the community, the CHIP outlines the goals and strategies that will be implemented by the Winnebago County Health Department and its community partners over the next five years to improve the health of Winnebago County. It is population-based and prevention-focused through a lens of health equity. The CHIP is also a strategic initiative of the Winnebago County Health Department Strategic Plan to ensure that the health priorities are addressed.

The Community Health Assessment was presented to community members, elected officials, municipal/village department officials such as Fire/Police/Human Services, the Board of Health, and the Winnebago County Board. They were asked to prioritize general Strategic issues such as Access to Care and Aging Population. Prioritization was completed through use of a Prioritization Matrix based on Lean Six Sigma with the stated goal of identifying the top three (3) health priorities that should be prioritized with the resources of the Winnebago County Health Department including time, money, and manpower. Health Problems that were identified through the Community Themes and Strengths Assessment provided further refinement of the health priorities.

After reviewing the findings from the Community Health Status Assessment prioritization process and the strengths and weaknesses from the Community Themes and Strengths Assessment, the IPLAN Steering Committee ranked through a nominal process the following issues for development of plans and commitment of agency resources.

1. Maternal and Child Health
2. Mental/Behavioral Health
3. Violence

The IPLAN Steering Committee identified the strategic issues of health equity, families as infrastructure, and education for life for emphasis in the development of the goals, strategies, and actions for the health priorities. Each Health Priority has an identified community advisory group to assist in community engagement and participation; alignment of goals, programming, and resources; and provide input and feedback regarding the plans, implementation, and evaluation of outcomes.

Healthy People 2020 (HP2020) was used in the development of objectives, strategies, and actions. Opportunities for alignment with the state health improvement plan Healthy Illinois 2021 (SHIP2021) were reviewed and identified for inclusion.

Three community advisory groups were identified to provide input and assist in development of action plans to address the health priorities. These community groups had been organized around similar initiatives prior to the IPLAN assessment and shared similar organizational vision, mission, and goals. They were formally approached to serve as the Community Advisory Group by the Public Health Administrator of Winnebago County. The PHA provided an overview and presentation of the MAPP process, health priorities, and roles/responsibilities of the Community Advisory Group. The Early

Learning Council of the Rockford Area (ELCRA) agreed to participate through formal motions and adoption by their Executive Committee on August 12<sup>th</sup>; the Mental Health Advisory Committee approved their participation as a Community Advisory Group on August 18<sup>th</sup>; and the Leads of the Workgroup Addressing Youth Violence agreed to serve as the Community Advisory Group on August 25, 2016. The Rockford Regional Health Council Executive Director committed to participate on all three (3) health priorities. A formal MOU detailing roles and responsibilities has been drafted.

## Maternal and Child Health

**Goal 1:** Enhance the development of family infrastructure that supports the optimal development of children in all families especially families experiencing the negative social determinants of health.

### Issues and Trends

Maternal and Child Health (MCH) is also identified as a health priority for the state of Illinois in SHIP2021 with overarching goals of ensuring access to preventive, primary, and specialty care; supporting healthy pregnancy and infant outcomes; eliminating disparities; and strengthening data systems to support MCH.

While infant mortality declined in Winnebago County from 9.9 in 2000 to 7.7 in 2010 per 1,000, the rate of decline was not as steep as other communities in the state of Illinois and the overall infant mortality rate of 7.7 exceeds the goal for HP2020 of 6.0. In reviewing infant mortality rates by race and ethnicity, Black/African American infants (16.1) have approximately a 2.5 times the risk of dying in infancy as compared to white infants or Hispanic infants. Adequacy of prenatal care using the Kotelchuck index remained fairly constant over the past 10 years with no significant improvement in the rate of clients with inadequate care. More concerning is the increase in the rate of clients whose adequacy of prenatal care is unknown. Access to insurance coverage through the Affordable Care Act (ACA) and Medicaid Presumptive Eligibility does not translate in practice to access and use of prenatal care.

Low birth weight infants (babies weighing less than 2500 grams) were born disproportionately to mothers less than 20 years of age (11.72%) and aged 40 years or more (12.6%) exceeding national and state baseline of 8.2% similar to Winnebago County as a whole. Similar to the racial disparity in infant mortality, Black/African American infants were twice as likely to be born weighing less than 2500 grams. Like infant mortality, the percent of teen births has declined from 13.3% (2008) to 10.8% (2011) but continues to trend higher than state and national data. HP2020 focuses on adolescence as a time when risky health behaviors are initiated or peak including mental/behavioral health concerns such as substance use and abuse, unprotected sexual activity that can lead to STD/STI and unintended pregnancies, and violence. The increase in violence impacting youth and the teen pregnancy rate have similar root causes that can be addressed to strengthen and support family relationships and communication that can be reinforced in schools and the community.

The Forces of Change Assessment (FOCA) identified several threats related to social and family issues including disjointed family unit, urban flight, xenophobia, persistent racism, and lack of affordable social activities. Opportunities that were identified included a nationally recognized park system with social engagement and access to social services.

Areas for improvement in the local public health system identified through the Local Public Health System Assessment (LPHSA) specifically applicable to the concerns in Maternal and Child Health were in

the areas of mobilizing community partnerships and policy development. While there are many entities addressing (MCH) health, there continues to be fragmentation and lack of alignment resulting in a diffusion of impact. This health priority presents the opportunity for the local public health system to develop and implement policies that MCH concerns.

### Community Partners

Early Childhood Learning Council, Rockford Regional Health Council

### Outcome Objectives

O1.1: By 2020, reduce the rate of African American/Black infant deaths by 20%.

O1.2: By 2020, reduce the teen pregnancy rate by 10%.

### Impact Objectives

I1.1: By 2018, increase the proportion of pregnant women who receive early and adequate prenatal care as measured by the Kotelchuck index by 10%.

### Strategies:

- Increase access to early diagnosis of pregnancy and entry into care.
- Advocate for policies to support the development of a holistic, comprehensive system of prenatal care.
- Educate community on importance of a holistic, comprehensive system of prenatal care.

### Activities:

- Develop community-wide public information campaign to stress importance of early and ongoing prenatal care.
- Decrease barriers to prenatal care.
- Assess access to prenatal care throughout all regions of Winnebago County.
- Develop outreach to areas with transportation issues.
- Advocate for policies to support evidence-based home visiting and case management to at-risk families.
- Develop referral system to ensure pregnant women are identified and connected to systems of prenatal care promptly.
- Engage fathers in the prenatal care system.

I1.2: By 2018, reduce the percentage of low birth weight infants born to mothers less than 20 years of age by 10%.

#### Strategies:

- Decrease unhealthy/risky behaviors among adolescents.
- Increase access to age-appropriate contraceptive and prenatal care services.
- Improve pre-conception health status of adolescents.
- Advocate for policies that support reproductive health education to adolescents.
- 

#### Activities:

- Promote adoption of evidence-based sexual education curriculum in all school districts.
- Develop adolescent based services including contraception, mental/behavioral, and physical health.
- Encourage healthy eating and active living behaviors (HEAL).
- Develop and implement positive pre-conception health practices (e.g. alcohol, tobacco, folic acid, healthy weight).
- Increase collaboration with community partners and agencies addressing adolescent/youth such as Transform Rockford, Rockford Regional Health Council, Alignment Rockford/Rockford Public Schools, Rockford Police Department, YMCA, YWCA, YouthBuild, Youth Services Network, Boys and Girls Clubs, and Scouting Organizations to strengthen community assets and leverage resources.
- Increase access to confidential pregnancy testing and prenatal care for adolescents.

I1.3: By 2018, reduce the percentage of low birth weight Black/African American infants by 10%.

#### Strategies:

- Increase access to culturally competent prenatal care in Black/African American communities.
- Improve pre-conception health status of Black/African American women of reproductive age (15 – 45 years).
- Increase community support for healthy pregnancy behaviors and outcomes.
- Advocate for policies that support culturally competent care in Black/African American communities.

#### Activities:

- Conduct outreach in selected communities at increased risk for poor infant outcome to enroll and engage in ongoing prenatal care.
- Encourage healthy eating and active living behaviors (HEAL).
- Train providers on culturally competent prenatal care.
- Develop doula/community support system in selected communities.
- Develop role of fathers in supporting healthy pregnancy.
- Screen and refer clients for substance abuse including tobacco.
- Expand WIC (Women, Infants, and Children) Nutrition Education Program services in selected communities.
- Provide case management services to pregnant women at highest risk for low birth weight infants.
- Increase access to pregnancy testing for early diagnosis and referral to care.

## Mental/Behavioral Health

### Community Support System Framework

Goal 2: A Community Support System (CSS) will be developed and implemented to prevent, identify, and effectively support in managing mental health conditions to maximize the functioning, adaptability, and potential of the individual, the family, and the community, Figure 9.

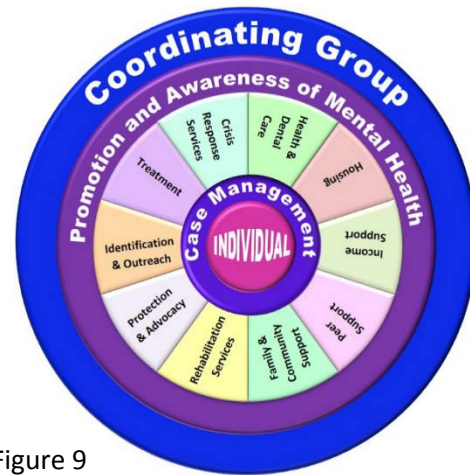


Figure 9

### Issues and Trends:

In December 2011, the Chairman of the Winnebago County Board appointed seven persons to the Winnebago County Mental Health Advisory Committee (MHAC) under the leadership of the Winnebago County Health Department (WCHD) to comply with Illinois State Statute (55 ILCS 5/5 – 25027). The charge of the MHAC was to 1) assess the current mental health services in the county, 2) monitor changes in the available mental health services, and 3) make recommendations for additional mental health services if deemed necessary. For purposes of the assessment, the Winnebago County MHAC defined mental health broadly to include mental, emotional, and personality disorders as detailed in the DSM 5 – Diagnostic and Statistical Manual of Mental Disorders 5<sup>th</sup> Edition; substance use disorders as defined in the DSM 5; and intellectual/developmental disabilities. The assessment was completed in 2016 and included four (4) surveys which elicited responses from 2,197 individuals; interviewed 20 expert key informants; reviewed the impact of the failure to pass an Illinois state budget on mental health services; synthesized all the information and held two strategic discussions to review and prioritize the findings. Major findings from this assessment concluded that over 80% of Winnebago County residents believe that mental illness continues to be stigmatized. Using the framework of the Community Support System (CSS) identified the following gaps in the CSS in Winnebago County:

#### Client Identification and Outreach

- Lack of outreach services. Many mentally ill persons are incapable of finding and accessing appropriate care because of the nature of the illness or other barriers including financial and insurance coverage. Winnebago County lacks a coordinated entry approach and a proactive outreach program.
- Difficulty being assessed/diagnosed in a timely manner. Families reported difficulties in knowing where to have a person assessed and long wait times when they were able to get an appointment. They reported that it was nearly impossible to have a comprehensive assessment for persons with multiple disorders (mental illness, substance use, and/or intellectual/developmental disabilities).

#### Mental Health Treatment

- Lack of services for children. Winnebago County has limited early childhood mental health services. There are no local hospital beds for mentally ill children under the age 12. Waiting lists for pediatric/adolescent services are exceptionally long.

- Lack of psychiatric care. Winnebago County has a long-term, critical need for additional psychiatrists who specialize in working with individuals in addition to medication management.
- Need for integrated care for persons with multiple mental health disorders. Winnebago County has severely limited capacity to treat a person with more than one disorder (mental illness, substance use disorder, and intellectual/developmental disabilities) using an evidence-based, integrated approach.

#### Crisis Response Services

- Lack of crisis care and stabilization. Winnebago County lacks crisis care for individuals who have been described as dangerous to themselves or others. Furthermore, the state budget impasse and reductions has negatively impacted the outpatient Triage Center operated by Rosecrance Health Network.

#### Family and Community Support

- Lack of services and supports for intellectual/developmental disabilities. In March 2016, 335 persons with intellectual/developmental disabilities in Winnebago County were on the Illinois Department of Human Services wait list with severe needs for crisis stabilization services in homes and facilities, psychiatric inpatient services, respite care for families, residential services for adults and seniors, medication management and monitoring, and/or transitional and supported employment.
- Lack of resources. Persons with mental illness, substance disorders, and intellectual/developmental disabilities have difficulty in securing supportive services such as dental care, transportation, and housing/shelter. The nature of the illness and disability requires special considerations and accommodations.

#### Case Management

- Frequent Users of Publicly-Funded Services. The “super utilizers” committee identified a group of persons who are heavy users of first-responder calls. In terms of the Community Support Systems model, this group needs intensive case management and all of the services in the model. Without that approach in place, we watch these homeless persons go from mental health crisis to mental health crisis with an increasing need for first-responder and other public resources. Housing First was established in Winnebago County to address their needs; however, the project lacks funding.

These gaps have directly contributed to issues regarding suicide and substance abuse especially opiate abuse. The Behavioral Risk Factor Survey reported that 21.4% of adults in Winnebago County as compared to 20.4% in the state of Illinois lacked emotional support. Social isolation has been identified as a risk factor for violence at all levels – individual, family, and community. Alarming age adjusted rates of suicide continued at higher rates in Winnebago County (13.7) than the state of Illinois (10.5) and HP2020 target of 10.2. Males were impacted disproportionately with rates 4 times that of females.

Winnebago residents have consistently reported greater than average number of poor mental health days (3.5) as compared to state (3.3) and the nation’s top performers (2.3). Data from the Winnebago County Coroner continues to trend upward in the number of drug related deaths with heroin as the drug responsible for more than deaths than any other in the County.

Adoption and maintenance of healthy lifestyles are also linked to mental health. Poor nutrition, lack of physical activity, and substance use can contribute to deterioration while balanced nutrition, physical activity, and avoidance of drugs and tobacco supports positive functioning and coping.

In parallel, behavioral health has been prioritized in Healthy Illinois 2021 (HI2021) with overarching goals of building on and improving local system integration; reducing deaths due to behavioral crises; increasing behavioral health literacy and decreasing stigma; and improving response to community violence.

The Forces of Change assessment identified the Affordable Care Act (ACA) as both an opportunity and challenge for funding of healthcare in Winnebago County. Other challenges relevant to this health priority was the perceived lack of social activities/engagement, disjointed family unit, isolation, and lack of mental health services for adolescents. Opportunities included stronger community and neighborhood relationships, more social engagement and stronger social unit. The opportunity to educate health professionals was also identified as a community strength. Changes in leadership also provide the opportunity to pursue alternative funding options while at the same time create challenges related to the unknown.

The health priority also provides an opportunity for the LPHS to strengthen its ability to mobilize community partnerships for action to address the issue including the delivery of services and advocacy for policies and funding that support optimal individual functioning and community vibrancy.

#### Outcome Objective:

O2.1: By 2020, a Coordinating Agency for Community Support System in Winnebago County will be established and functioning to address mental health concerns.

O2.2: By 2020, decrease the rate of suicide in Winnebago County by 10%.

O2.3: By 2020, decrease the rate of deaths from opiate (heroin) overdose by 10%.

O2.4: By 2020, increase access to services that support the positive social emotional development of the pediatric population. (Increase the proportion of children with mental health issues that receive treatment – HP2020)

#### Impact Objectives:

I2.1: By 2017, the Mental Health Advisory Council (MHAC) will define the roles and responsibilities of the Coordinating Agency including succession and sustainability.

#### Strategies:

- Advocate for the establishment of a Coordinating Agency/entity responsible for the oversight of the Community Support System to address mental/behavioral health.
- Identify membership for the MHAC that is representative and inclusive of both providers, referral sources, and consumers to address mental health priorities on a community level.

#### Actions:

- Current appointed MHAC will review and revise By-laws.
- Recruit for vacancies on the MHAC.

I2.2a: By 2018, decrease the wait time in days by 50% for adults and adolescents seeking crisis stabilization.

#### Strategies:

- Advocate for policies that support funding for mental health services.
- Support expansion of crisis stabilization services.
- System development to monitor access to crisis stabilization services.

#### Actions:

- Reach out to the major health systems (Mercy Health, OSF – St. Anthony, Swedish American) to discuss use of trust funds to support pediatric mental health.
- Work with University of Illinois College of Medicine at Rockford to incorporate mental health in the new integrated curriculum
- Train primary care providers in the region to manage mental health issues within their panel of patients/clients.
- Identify potential resources for funding of mental health services.
- Review systems for implementation of system for access "control" to crisis stabilization similar to bed control in in-patient settings.

I2.2b: By 2017, adopt standardized assessment of suicidal behavior and guidelines for assessment to be used by all community providers.

#### Strategies:

- Decrease the rate of suicide through early identification and intervention.
- Decrease stigmatization of suicide through normalization of care process.
- Promote awareness in the community of risk factors and warning signs of suicide <https://afsp.org/about-suicide/risk-factors-and-warning-signs/>.
- Correlate risk factors for suicide with other health priorities – Violence and Maternal and child health.
  - Health Risk Factors:
    - Depression
    - Bi-polar
    - Schizophrenia
    - Conduct Disorder
    - Psychotic Disorders
    - Anxiety Disorders
    - Substance Abuse
    - Serious chronic health condition and/or pain
  - Environmental Risk Factors



- Stressful life events – job loss, divorce, death
- Prolonged stress – harassment, bullying, relationship problems, and unemployment
- Access to lethal means – firearms and drugs
- Exposure to another’s suicide or graphic or sensationalized accounts of suicide
- Historical Factors
  - Prior suicide attempts
  - Family history of suicide attempts
  - Adverse Childhood Events (ACEs)
- Integrate principles of healthy lifestyle behaviors to support positive mental health.

Actions:

- Assemble community subject matter experts in field of mental health to complete inventory of assessments currently in use by agencies addressing health conditions.
- Review current literature to determine evidence-based tool for use by community agencies.
- Identify developmentally-appropriate tools for use by agencies in Winnebago County that have access to the population including but not limited to workplace, schools and universities, clinics, criminal justice system, drug/alcohol treatment, homeless, specialty case management such as Ryan White, homeless, etc.
- Implement community-wide standardize assessment tool to assess for depression and suicide.
- Identify risk factors for suicide that place community at risk for other negative health consequences related to health priorities of Violence and Maternal and Child Health.
- Conduct community-wide public information campaign on risk factors and warning signs of suicide and association of risk factors.
- Conduct community-wide public information campaign on the benefits of healthy lifestyle on positive coping, stress management, and adaptation in support of mental health.

I2.3a: By 2018, increase the number of schools participating in the evidence-based All Star curriculum by 20%.

I2.3b: By 2017, increase access to prescription drug disposal in collaboration with the Winnebago County Sheriff.

I2.3c: By 2018, develop plan to train community members to recognize and reverse opiate overdose through the administration of naloxone.

Strategies:

- Advocate for policies that support prevention of drug abuse involving opiates.
- Advocate for inclusion of evidence-based substance abuse prevention education in schools.
- Early intervention to prevent deaths associated with opiate overdose.

Actions:

- Increase access to methods/treatments to reverse opiate overdose.

- Conduct community-wide public information campaign on signs of opiate overdose and availability of methods/treatments to reverse overdose.
- Implement evidence based substance abuse education in elementary and middle-school grades.
- Partner with existent agencies currently providing interventions to reverse opiate overdose to expand access.
- WCHD to develop internal capacity to address access to naloxone.

12.3d: By 2017, increase the number of clients who receive treatment for opiate addiction by 10%.

Strategies:

- Early intervention to prevent deaths associated with opiate overdose.
- Advocate for policies and practices that increase access to treatment.

Actions:

- Train community providers on the identification of opiate abuse including school personnel, health care and social service providers.
- Review results of the assessment regarding addiction treatment and identify potential partners and resources for expansion for areas of stressed capacity.
- Develop referral system for opiate addiction treatment.
- Conduct public information campaign on addiction as a medical condition to destigmatize help seeking behavior.

12.3e: By 2019, advocate for policies to limit access to opiates and control quantities dispensed.

Strategies:

- Prevent drug addiction behaviors through education in early childhood.
- Increase early identification of individuals at risk for opiate abuse and refer for early intervention.
- Decrease access to prescription opiates in the community.

Actions:

- Educate school districts on the All Star curriculum to address substance abuse.
- Advocate for policies that support substance abuse education in the school system.
- Expand community access to safe drug disposal.
- Develop system for alternative pain management strategies.
- Conduct community-wide public information campaign on safe drug disposal.
- Advocate for policies that limit to opiates and control quantities dispensed.

## Violence Prevention

**Goal 3:** Decrease the incidence of personal, family, and community violence especially in areas suffering from unequal rates of violent acts.

### Issues and Trends

Violence continues to have an overall negative impact on the health of Winnebago County. The homicide mortality rate of 6.98/100,000 population is higher than the HP2020 Goal of 5.5/100,000. Minorities are impacted disproportionately by homicide. When comparing homicide rates by race and ethnicity, Black/African Americans were nearly 8 times more likely and Hispanics were 2 times more likely to die of homicide than Whites. While Winnebago County has traditionally had a lower incidence of domestic crimes committed by a family member or household member in the northern Illinois region, the rate increased 4 times from 2013 to 2014 (277.3/100,000). The impact of domestic crimes experienced by children contributes to a learned patterned of violence. HP2020 has set the goal of decreasing the percentage of children exposed to violence, crime, or abuse. Firearms kill more individuals in Winnebago than the state of Illinois and the rate of 10.4/100,000 exceeds the HP2020 threshold of 9.3/100,000. Suicide rates continued to rise over the past five years from a rate of 11.0 to 13.0 per 100,000 age-adjusted exceeding the HP2020 target of 11.3.

The City of Rockford representing the largest population base in Winnebago County had a violent crime rate including murder/non-negligent manslaughter, forcible rape, robbery, and aggravated assault of nearly 1400.00/100,000 population significantly higher than the state of Illinois at 400.00/100,000 in 2014. The issue of violence is not detailed for action HI2021. During the same time period, the rate of aggravated physical assault in Rockford was over four times greater than the state of Illinois (900 versus 200/100,000).

The Forces of Change Assessment identified several considerations for violence prevention included high unemployment rates, lack of job opportunities, and high cost of college education. Lack of funding to address health priorities has persisted. The cost in both financial and social terms continues to rise. Changes in governmental leadership (local and federal) also presents opportunities to work collectively on the issues.

The Office of Justice Programs (OJP) Diagnostic Center partnered with the City of Rockford to improve access to evidence-based information on prevention and controlling crime. Four priority areas were identified to address community violence in January 2016, Appendix M:

1. Coordinated Community Response to Youth Violence
2. Interagency Collaboration
3. Proactive Policing Strategies
4. Community-Police Relations

Interagency Collaboration and Coordinated Community Response to Youth Violence parallel the areas for strengthening in the LPHSA and again provide a framework for selection of strategies and actions.

As with the other priorities, violence as a public health issues relies on the mobilization and alignment of community partnerships to address the risk factors for collective impact. This issue also provides an opportunity for the community to develop policies impacting schools (discipline, bullying), justice (evidence-based sentencing, addressing recidivism), housing, and the workplace.

### Community Partners

The Workgroup addressing Youth Violence with Department of Justice (DOJ); Rockford Regional Health Council

### Outcome Objectives:

O1.1: By 2020, reduce the homicide rate by a minimum of 10%.

O1.2: By 2020, reduce the exposure of children to violence, crime, and/or abuse by a minimum of 10%.

O1.3: By 2020, reduce the incidence of fire-arm related deaths by a minimum of 10%.

### Impact Objectives

I1.1: By 2019, 80% of community areas impacted by violent acts will demonstrate a minimum of five community protective factors.

### Strategies:

- Encourage and support efforts to improve community resiliency and stability through community protective factors in partnership with residents, social service and youth agencies, and governmental entities incorporating policy, systems, and environment.
- Adopt set of community indicators to be used by agencies working to address community violence.
- Advocate for policies that support stronger purchasing and licensing requirements for handguns.

### Activities:

- Increase collaboration with community partners and agencies such as Transform Rockford, Rockford Regional Health Council, Alignment Rockford/Rockford Public Schools, Rockford Police Department, Rockford Housing Authority, and Winnebago County Sheriff to strengthen community assets and leverage resources.
- Work through United Way Strong Neighborhood Homes to foster sense of community.
- Work with Purpose Built Communities Project to address community protective factors.
  - Affordable housing
  - Educational attainment
  - Access to healthy foods
  - Recreational activities
  - Employment opportunities

I1.2: By 2017, 100% of community agencies and governmental entities will be knowledgeable about risk factors of violence in and to youth from individual, family, social/peer, and community perspective. <http://www.cdc.gov/violenceprevention/youthviolence/riskprotectivefactors.html>.

#### Strategies:

- Increase awareness of risk factors for violence from individual family, social/peer, and community perspective.
- Improve information sharing among community partners working with youth on evidence-based approach to violence prevention.
- Advocate for policies to support provider education and training regarding risk factors and mitigation techniques.

#### Activities:

- Conduct social media campaigns and trainings to increase awareness of contributing factors to violence and prevention approaches.
- Conduct provider and community training on family violence and bullying.
- Adopt community-wide family violence assessment tool to be used by agencies to promote early identification of risk.

I1.3: By 2018, 100% of community agencies and governmental entities will be active in the development of strategies to mitigate individual, social/peer, and family risk factors for violence.

#### Individual risk factors:

- History of violent victimization
- Attention deficits, hyperactivity or learning disorders
- History of early aggressive behavior
- Involvement with drugs, alcohol or tobacco
- Low IQ
- Poor behavioral control
- Deficits in social cognitive or information-processing abilities
- High emotional distress
- History of treatment for emotional problems
- Antisocial beliefs and attitudes
- Exposure to violence and conflict in the family

#### Peer and Social risk factors:

- Association with delinquent peers
- Involvement in gangs
- Social rejection by peers
- Lack of involvement in conventional activities
- Poor academic performance
- Low commitment to school and school failure

## Family risk factors

- Authoritarian childrearing attitudes
- Harsh, lax or inconsistent disciplinary practices
- Low parental involvement
- Low emotional attachment to parents or caregivers
- Low parental education and income
- Parental substance abuse or criminality
- Poor family functioning
- Poor monitoring and supervision of children

## Strategies:

- Assess current assets in place to address youth violence.
- Address gaps in youth violence prevention activities.
- Adopt trauma informed care as a community standard to address adverse childhood events (ACE).
- Address environmental health risk factors associated with housing.
- Advocate for evidence-based home visiting initiatives for early childhood.
- Advocate for policies to provide early childhood development opportunities such as 0 to 3 early intervention and pre K schooling.

## Activities

- Conduct provider and community training on trauma informed care.
- Develop and/or provide resources on evidence-based interventions to prevent youth violence.
- Develop public information campaign on family violence/ACE and protective factors.
- Ensure that community 211 system has information on resources for trauma informed care.
- Develop Youth Community Advisory Panel to provide input on interventions to address youth violence.
- Address substance abuse issues in families.
- Mitigate environmental health hazards in housing that contribute to risk factors for violence.
- Enhance and expand MIECHV (Maternal and Infant Early Child Home Visiting) initiatives to support infant attachment and parenting skills in vulnerable families.
- Develop and implement standardized assessment for substance use in families with youth members.

**IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF ILLINOIS  
EASTERN DIVISION**

**N.B.** by and through his mother, ANGELA )  
BUCHANAN, **R.F.** by and through his mother, )  
DANIELLE FRAVEL, **J.J.** by and through his )  
mother, PHOEBE JOHNSON, **M.Wa.** by and through )  
his mother, DEBORAH WALTERS, **M.Wh.** by and )  
through his mother, PATRICIA WHEATFILL, )  
**M.B.** by and through her mother, MARY BAILEY, )  
**S.B.** by and through his parents, WALLACE BUSCH )  
and DAWNE BUSCH, **I.D.** by and through his mother,)  
MAGEN DREW, **S.M.** by and through his parents, )  
THOMAS MARATHALER and ERIN MARATHALER, )  
individually and on behalf of class, )

Plaintiffs, )

vs. )

**FELICIA F. NORWOOD**, in her official capacity )  
as Director of the Illinois Department of )  
Healthcare and Family Services, )

Defendant. )

No. 11 C 6866

Judge Jorge L. Alonso

Magistrate Judge Jeffrey Cole

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**NOTICE OF PROPOSED CLASS ACTION SETTLEMENT AND HEARING**

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**PLEASE READ THIS NOTICE CAREFULLY AND IN ITS ENTIRETY**

*A SETTLEMENT HAS BEEN PROPOSED THAT MAY AFFECT THE RIGHTS OF MEDICAID-ELIGIBLE PERSONS IN THE STATE OF ILLINOIS WHO ARE UNDER THE AGE OF 21, HAVE BEEN DIAGNOSED WITH A MENTAL HEALTH OR BEHAVIORAL DISORDER, AND HAVE BEEN RECOMMENDED TO RECEIVE HOME OR COMMUNITY SERVICES TO ADDRESS THEIR DISORDER.*

A Settlement Agreement has been proposed in this case, which may affect the rights of persons who are under the age of 21, Medicaid-eligible in the State of Illinois, have been diagnosed with a mental health or behavioral disorder, and for whom a licensed practitioner of the healing arts has recommended intensive home- or community-based services to correct or ameliorate their disorders.

This Notice explains the lawsuit and the key terms of the Settlement Agreement, tells you how to obtain more information, explains how to determine whether an individual is a Class Member in the lawsuit, and explains how Class Members (and/or their legal representatives) can tell the Court whether they disagree with the Settlement Agreement or some part of it.

The Settlement Agreement described in this Notice is subject to Court approval, and thus has not yet been made final. The Court has scheduled a hearing to determine the fairness, adequacy and reasonableness of the Settlement Agreement and to consider any objections Class Members may have to the Settlement Agreement.

## **1. WHAT IS THIS LAWSUIT ABOUT?**

The Court in charge of the lawsuit is the United States District Court for the Northern District of Illinois, and the case is known as *N.B. v. Norwood*, No. 11 C 6866. The people who sued are called the Plaintiffs, and the individual they sued is called the Defendant.

Plaintiffs filed this lawsuit on September 29, 2011, seeking to compel the State to provide services under the Early and Periodic Screening, Diagnostic, and Treatment (“EPSDT”) provisions of the Medicaid Act. The named Plaintiffs are children with mental health or behavioral disorders. The named Defendant is: Felicia F. Norwood, Director of the Illinois Department of Healthcare and Family Services. The Defendant is responsible for administering the State of Illinois’ Medicaid Program. The lawsuit seeks to compel the State of Illinois (through the Defendant) to comply with federal law by offering children with mental health or behavioral disorders access to certain Medicaid EPSDT services.

## **2. WHAT IS A SETTLEMENT AGREEMENT AND WHY IS IT BEING PROPOSED HERE?**

The Court in this case did not decide in favor of either Plaintiffs or Defendant. There was no trial or dispositive court ruling in the case. Instead, the Plaintiffs and Defendant negotiated a settlement of this dispute that is set out in the Settlement Agreement. Plaintiffs and Defendant have asked the Court to approve the Settlement Agreement. By settling this lawsuit, the parties avoid having to face the uncertainty of the outcome of a trial as well as the substantial cost of a trial. In addition, children with mental health or behavioral disorders will get relief from Defendant much sooner than if they had to wait for the resolution of the lawsuit through a trial and expected appeals. That process could take many years. The Plaintiffs who filed the lawsuit and their attorneys think the Settlement Agreement is the best outcome for the people who are Class Members.

## **3. WHO IS A CLASS MEMBER?**

The Court has certified the lawsuit as a class action and decided that everyone who fits this description is a Class Member: “All Medicaid-eligible children under the age of 21 in the State of Illinois: (1) who have been diagnosed with a mental health or behavioral disorder; and (2) for whom a licensed practitioner of the healing arts has recommended intensive home- and community-based services to correct or ameliorate their disorders.”

## **4. WHAT DOES THE SETTLEMENT AGREEMENT IN THIS CASE PROVIDE?**

The Settlement Agreement in this case, if approved by the Court, would provide certain rights and benefits to eligible Class Members as defined above. If the Settlement Agreement is



not approved, it will be withdrawn and the lawsuit will continue. A copy of the entire Settlement Agreement is available on the following websites:  
<https://www.illinois.gov/hfs/info/legal/PublicNotices>; [www.farley1.com](http://www.farley1.com); and [www.nbclassaction.com](http://www.nbclassaction.com).

Plaintiffs and Defendant in this case believe that the Settlement Agreement is fair, reasonable and provides adequate and appropriate relief to all eligible Class Members. The parties believe the Settlement Agreement provides eligible Class Members the opportunity to access a continuum of medically necessary mental and behavioral health services authorized and required by the Medicaid EPSDT requirement..

The following is a brief summary of key terms in the Settlement Agreement:

#### **A. Development and Delivery of Services**

The Settlement Agreement requires Defendant to ensure the availability of services, supports and other resources of sufficient quality, scope and variety to meet her obligations under the Settlement Agreement. More specifically, the Settlement Agreement requires Defendant to develop a Medicaid behavioral health delivery model that will provide a continuum of medically necessary mental and behavioral health services authorized and required by the EPSDT requirement of the Medicaid Act (sometimes referred to as a “continuum of care”).

The continuum of care will include all medically necessary home- and community-based services and supports, as well as inpatient psychiatric services in a Psychiatric Residential Treatment Facility (“PRTF”), including the following:

- a structure to link Class Members to medically necessary services on the continuum of care;
- statewide medically necessary mental and behavioral health services and supports required and authorized under the EPSDT requirement of the Medicaid Act that are sufficient in intensity and scope and appropriate to each Class Member’s needs consistent with applicable law;
- notice to HFS-enrolled Primary Care Physicians (“PCPs”) who perform periodic and medically necessary inter-periodic screenings to offer Class Members and families the opportunity to receive a mental and behavioral health screening during all periodic and inter-periodic screenings;
- a standardized assessment process, including an assessment tool that shall be utilized statewide, for the purpose of determining Class Members’ strengths and needs and informing treatment planning, medical necessity, intensity of service, and, as applicable, appropriate services for Class Members;
- a stratification methodology of identifying which Class Members qualify for particular services (including sub-acute care), the intensity of service delivery,

and the intensity of care coordination, based upon the standardized assessment process and consistent with the requirements of the Settlement Agreement;

- tiers of care coordination, with caseloads and service intensity consistent with the stratification and assessment process, including, where appropriate, intensive care coordination, such as High Fidelity Wraparound services, as defined by the National Wraparound Initiative (<http://nwi.pdx.edu/>);
- individual plans of care to serve the Class Member in the least restrictive setting appropriate to meet the Class Member’s treatment goals;
- child and family teams including the group of people chosen by the Class Member and family with the aid of the care coordinator to assist with the treatment planning process;
- a Mobile Crisis Response (“MCR”) model, including the development of crisis stabilizers, to provide behavioral health crisis response on a twenty-four hour a day, seven day a week basis;
- a plan to coordinate among providers the delivery of services and supports to Class Members in order to improve the effectiveness of services and improve outcomes;
- a process to communicate with Class Members, families, and stakeholders about service delivery and service eligibility; and
- procedures to minimize unnecessary hospitalizations and out-of-home placements.

## **B. Monitoring and Compliance**

Under the Settlement Agreement, Defendant will provide Class Counsel with a written annual report with information necessary for Class Counsel to evaluate Defendant’s compliance with the terms of the Settlement Agreement. The Settlement Agreement also provides a dispute resolution mechanism to allow the court to resolve any issues of alleged non-compliance with the Settlement Agreement.

## **C. Attorneys’ Fees and Costs**

The Settlement Agreement requires the State of Illinois to pay class counsel the total amount of \$1.275 million for their fees and costs associated with all litigation related to this Settlement Agreement and for compliance with the Settlement Agreement.

## **5. WHAT ARE “EPSDT SERVICES”?**

In the Settlement Agreement, “EPSDT Services” means those services provided to children with mental health and behavioral disorders under the Early and Periodic Screening,

Diagnostic, and Treatment services requirement of Title XIX of the Social Security Act, which provides that, for Medicaid-eligible children under the age of 21, a State must provide “screening services ... [and] necessary health care, diagnostic services, treatment, and other measures described in subsection [1396d(a)] to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services, whether or not such services are covered under the State plan.” 42 U.S.C. § 1396d(r)(1),(5). In subsection 1396d(a), medical assistance is defined to include “other diagnostic, screening, preventive, and rehabilitative services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law, for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.”

**6. WILL CLASS MEMBERS RECEIVE MONEY FROM THE SETTLEMENT AGREEMENT?**

No. There is no money awarded to any Class Member as part of the Settlement Agreement.

**7. HOW DO YOU TELL THE COURT THAT YOU AGREE OR DISAGREE WITH ALL OR PART OF THE SETTLEMENT AGREEMENT?**

All Class Members have the right to state any objection they may have to the Settlement Agreement and to give reasons why they believe the Court should not approve it. All Class Members have the right to state their approval of the Settlement Agreement, although they are under no obligation to do so.

The Court and the Parties will consider those opinions submitted by Class Members in the following manner:

- The statement must include the name and number of the case (*N.B. v. Norwood*, Case No. 11-6866);
- The statement must include a statement of the reasons why the Court should or should not approve the Settlement Agreement;
- The statement must be no longer than 15 pages in length;
- The statement must include the name, address, telephone number, and signature of the individual submitting it; and
- The statement must be submitted by U.S. Mail and postmarked no later than Wednesday, November 9, 2016, to

Robert H. Farley, Jr.  
Robert H. Farley, Jr. Ltd.  
1155 S. Washington St., Suite 201  
Naperville, IL 60540

Attorney Robert Farley, co-counsel for the Class, will provide the Court and other counsel for the Plaintiffs and Defendant with the statements that he receives and that Class Members want presented to the Court. Please note that it is not sufficient to simply state that you object. Objections must state the reasons why the Settlement Agreement should not be approved.

**8. WHEN AND WHERE WILL THE COURT DECIDE WHETHER TO APPROVE THE SETTLEMENT AGREEMENT?**

The Fairness Hearing will be held before the Honorable Jorge L. Alonso, United States District Judge, in the Dirksen Federal Building, 219 S. Dearborn Street, Room 1219, Chicago, Illinois 60604, on Tuesday, December 20, 2016, at 11:00 a.m. At this hearing, the Court will consider whether the Settlement Agreement is fair, reasonable, and adequate. The Court will consider any objections made according to the procedures described above.

**9. DO YOU HAVE TO COME TO THE HEARING?**

All Class Members are welcome to attend the Fairness Hearing if they choose to do so, but no one is required to attend the Fairness Hearing. Plaintiffs' and Defendant's lawyers will be available to answer questions Judge Alonso may have. If you submit a statement or objection in accordance with the procedures described in paragraph 7 above, you are not required to come to Court to talk about it. As long as you mailed your written statement or objection in accordance with the procedures described in paragraph 7 above, the Court will consider it.

**10. WHO CAN SPEAK AT THE FAIRNESS HEARING?**

You may ask the Court for permission to speak at the Fairness Hearing. The Judge will decide whether you are permitted to do so. To request permission to speak at the Fairness Hearing, you must send a request to Class Counsel as directed below. Class Counsel will provide the necessary documents to the Court.

- The request must be entitled: "Notice of Intention to Appear in *N.B. v. Norwood*, Case No. 11-6866"
- You must send one copy of your "Notice of Intention to Appear" to the attorney listed below via U.S. mail, postmarked no later than Wednesday, November 9, 2016:

Robert H. Farley, Jr.  
Robert H. Farley, Jr. Ltd.  
1155 S. Washington St., Suite 201  
Naperville, IL 60540.

- Be sure to include your name, address, telephone number, and your signature on your "Notice of Intention to Appear."
- If you file a statement or objection and also want to ask for permission to speak at the Fairness Hearing, you can include the "Notice of Intention to Appear" in the same document as the statement/objection that is sent to Mr. Farley. Mr. Farley will

provide copies of these “Notices of Intention to Appear” to the Court and to other counsel for the parties.

**11. WHO ARE THE CLASS MEMBERS’ LAWYERS IN THE CASE?**

The Court ordered that the following attorneys represent the Class Members. These lawyers are called “Class Counsel.”

Robert H. Farley, Jr.  
Robert H. Farley, Jr. Ltd.  
1155 S. Washington St., Suite 201  
Naperville, IL 60540  
Tel: 630-369-0103  
email: [fareylaw@aol.com](mailto:fareylaw@aol.com)

Michelle N. Schneiderheinze  
Hunziker Heck & Schneiderheinze LLC  
Commerce Bank Building  
416 Main St., 16<sup>th</sup> Floor  
Peoria, IL 61602

Mary Denise Cahill  
Cahill & Associates  
1155 S. Washington St., Suite 106  
Naperville, IL 60540

Class Members will not be charged for these lawyers’ fees or expenses.

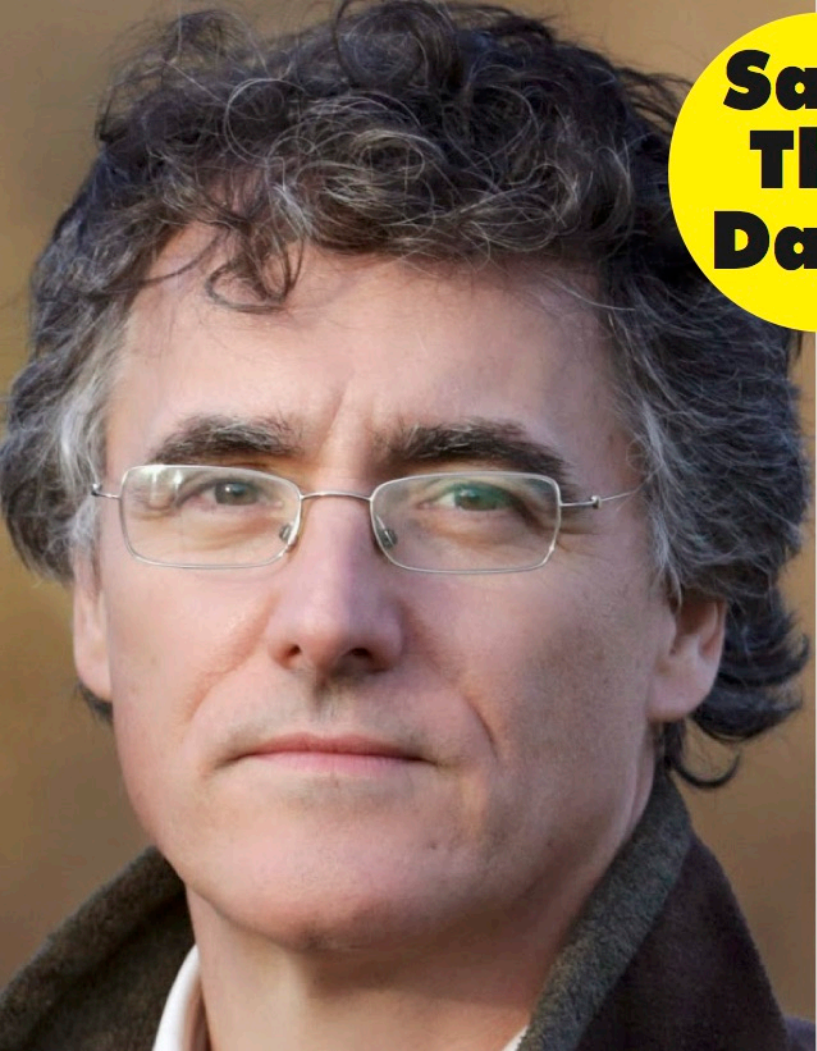
**12. HOW DO YOU GET MORE INFORMATION ABOUT THE SETTLEMENT AGREEMENT?**

A copy of the entire Settlement Agreement is available on the following websites: <https://www.illinois.gov/hfs/info/legal/PublicNotices>; [www.farley1.com](http://www.farley1.com); and [www.nbclassaction.com](http://www.nbclassaction.com).

If you have any questions for Plaintiffs’ lawyers or want to request that a copy of the Settlement Agreement be mailed to you, you may contact Attorney Robert H. Farley, Jr. at [fareylaw@aol.com](mailto:fareylaw@aol.com) or 630-369-0103.

Dated: September 6, 2016

The Honorable Jorge L. Alonso  
United States District Court Judge



**Save  
The  
Date!**

Cook County Sheriff

**Tom Dart**

Speaks on

**The Shameful  
Criminalization  
of Mental Illness**

Tuesday, October 25, 2016

5:00 p.m. – 8:00 p.m.

Radisson Hotel and Conference Center

200 South Bell School Road

Rockford, Illinois 61108

A Fundraiser for the  
League of Women Voters of Greater Rockford

[http://www.lwvgr.net/lwvgr\\_fundraiser16](http://www.lwvgr.net/lwvgr_fundraiser16)

**LWV**  
*of Greater Rockford*