WINNEBAGO MENTAL HEALTH BOARD AGENDA

DATE: Wednesday September 2nd, 2020

Time: 2:00 PM

Location: Virtual

Called by: Mary Ann Abate President

Members: Richard Kunnert Vice President, Rev. Dr. K. Edward Copeland Treasurer, Danielle Angileri Secretary, Dr. Bill Gorski, Dr Terry Giardini, Dr. Julie Morris, Tim Nabors, Linda Sandquist

Advisory Members: Wendy Larson Bennett, Jay Ware

Administrative Coordinator: Jason Holcomb, Region 1 Planning Council

Guests: Steve Chapman, Winnebago County

Agenda:

A. Call to Order

B. Roll call

C. Approval of August Meeting Minutes

D. Public comment

E. Budget – Update

F. Board Liability Insurance - Update

G. Board Legal Representation - Update

H. Environmental Scan - Update

I. Draft Charter Document (Vision, Mission, Values, Principles) – Discussion

J. 35 Day Work Plan – Action Required

K. NAMI Newsletter Public Update – Action Required

L. Youth Mental Health System of Care Grant Letter of Support – Action Required

M. Mercy Health Public Hearing Position – Action Required

N. Other matters

O. Adjournment

WINNEBAGO MENTAL HEALTH BOARD AGENDA

DATE: Wednesday August 5, 2020

Time: 2:00 PM

Location: Virtual, Zoom

Members: Mary Ann Abate President, Richard Kunnert Vice President, Rev. Dr. K. Edward Copeland Treasurer, Danielle Angileri Secretary, Dr. Bill Gorski, Dr. Terry Giardini, Dr. Julie Morris, Tim Nabors, Linda Sandquist

Advisory Members: Wendy Larson Bennett, Jay Ware

Agenda:

I. Call to Order: Called by Mary Ann Abate, President, at 2:00PM

II. Roll call

  a. Board members present: Richard Kunnert Vice President, Dr. Rev. Edward Copeland Treasurer, Danielle Angileri Secretary, Dr. Bill Gorski, Dr. Terry Giardini, Dr. Julie Morris, Tim Nabors, Linda Sandquist

  b. Advisory members present: Wendy Larson Bennett, Jay Ware

  c. Coordinator: Jason Holcomb

  d. Others present: Dan Magers, Paul Carpenter, Youth System of Care for Children's Mental Health Committee (Lori Poppen, Mary Ellen Commare, Jason Holcomb, Pamela Clark-Reidenbach, Joseph Kreul, Danielle Angileri)

III. Approval of Minutes: Motion to approve the July 1 minutes by Richard Kunnert. Second motion comes from Dr. Terry Giardini. Unanimous approval passed.

IV. Public comment: No public comment

V. Children's Mental Health Committee Presentation

  a. The Presenters: Pam Clark Reidenback of NICNE, Jason Holcomb of Region 1 Planning Council, Mary Ellen Commare of Youth Services Network, Lori Poppen of Children's Home & Aid Society, Joseph Kruel of Rosecrance, and Danielle Angileri of NAMI Northern Illinois

  b. In 2018 a community planning team led by Rosecrance submitted a proposal to the Illinois Children's Healthcare Foundation to develop the Youth Mental Health System of Care. The team includes many organizations from our community. Though this group was a finalist, but did not get selected because they were not far along enough in their planning stages. In the Fall of 2018 NICNE applied for a planning grant from the CFNIL to support a Community Planning Team's effort to analyze the current system of mental health for youth. The goal was to analyze the community's current system of mental healthcare for youth, including gaps and strengths in service provision, in order to create a new coordinated, integrated, comprehensive System of Care

addressing the mental health needs of our community's children and adolescents, ages 0 to 21, in Winnebago and Boone Counties. From January 2019 to present day, a planning team has worked together using a Collective Impact approach to convene diverse groups to transform the current system.

c. Trends & Research: Current Public Health research shows troubling trends, suggesting that since 2007, mental health for youth has continuously worsened. Worldwide, 10-20% of children experience mental health disorders. Half (50%) of all mental illness onsets by age 14; 75% by age 20. Only 25% of mental illness is adult-onset. Recent research demonstrates both the need and the high return-on-investment potential for investment in youth mental health.

d. Key Informant Survey Results: The key informants identify the following areas for improvement of the current children's mental healthcare system:

- Funding- across all areas
- Workforce Development- shortage of service providers, especially child Psychiatrists. It is stated that there are long waiting lists for services, and recruitment and retention of specialized staff is difficult due to low or stagnant wages in the area. Informants also see a need for existing staff to receive additional training including crisis intervention and trauma-informed trainings.
- Equity & Access- Current services are not affordable or accessible to all, especially for families who are Latino or African American, families who are low-income, of families in other underserved groups. There are few affordable providers, and a need for more multi-lingual providers and interpreters. There are transportation limitations and service provider locations results in barriers to access. There is a need for more home-based service options.
- Collaboration- Key informants think that there is a lack of coordinated and systemic approaches to service provision, and a lack of communication between organizations. A current lack of in-patient care options result in children leaving the community for treatment. Schools have limited support or resources needed to assist children with emotional or behavioral problems, and the formation of school-agency partnerships can help to address this issue.
- Engagement- Key informants discussed the importance of engaging and educating the community about children's mental health and the mental healthcare services available in the area. Engaging parents and families is essential, however cultural barriers exist which get in the way of accomplishing this.

e. The Model: The Community Support System (CSP) framework was developed in 2977 as the basis for planning and organizing services for adults living with mental illness. The means that all working parts 'wrap around' the individual

in need. After careful review of literature and best practices, the group has chosen this to apply to youth mental health care. The model includes:

- *Promotion and Awareness of Mental Health*- Stigma, self-care strategies, social-emotional learning, equity, workforce development, marketing
- *Case management*- education about available services, referrals, assessments, follow-up, navigation, education for care managers on available support, supporting the role of case managers
- *Identification & Outreach*: Client engagement and outreach, lack of funding*, transportation, prevention*, and early intervention* (*There is a very large gap in funding prevention and early intervention)
- *Protection & Advocacy*- Identifying root cause for issues, punitive model, access to legal services, enforcing safeguards, juvenile mental health code, patient bill of rights, human rights, civil rights
- *Crisis Response Services*- First responders, immediate access, short-term inpatient care, support and education regarding trauma, emergency mental health services
- *Treatment*- Individualized assessments, inpatient treatment, school-based treatment, psychiatric services, counseling, therapeutic foster care. A barrier here is a lack of child psychiatrists, tele-health services, and inpatient beds.
- *Rehabilitative Services*- Strategies for volunteer opportunities, play and recreation, experiential and therapeutic services, special education & 504 plans, before/after school programs, mentoring
- *Physical Health & Dental Care*- Primary care, specialty care, dental care, orthodontic care, travelling wellness checks, parent & family education. A barrier in this section is lack of consistent providers, or continuity of care
- *Family & Community Support*- Family education, interpreter services, school education, faith-based support, recreational programs, early childhood experiences, respite care. Barrier to this group include transportation and funding.
- *Peer Support*- Formal support groups, peer mentoring, prevention services, networks, group recreation, Certified Peer Support Specialists (CPSS), school initiatives, volunteer activities
- *Housing*- Foster care and respite, supported living, sober housing, in-home supports, group homes, shelter services, advocacy for tenant/housing rights

- *Income Support*- Support for families, education costs, job training, employment opportunities, assistance with benefits applications

f. The Importance of Lived Experience: In the recovery movement, the concept of lived experience, means that those who have lived with mental health conditions, are experts. This is just as valuable as the credentials people earn in the field and it is important that both providers and those with lived experience work together as partners. Those with lived experience actively challenge existing dynamics and promote the development of more equitable care. People with lived experience can empathize and advocate on behalf of those currently unable to do so and research indicates peer roles contribute to an improved sense of hope, empowerment and social inclusion for those accessing services. Lived experience should be included as a guiding force to shape the way services are designed and delivered. A personal example was shared here.

g. Next Steps:
   - The groups will continue to engage community providers to continually assess gaps in service and barriers for clients.
   - Engage the community through forums to learn about barriers.
   - Continually assess community needs.
   - Assess processes, impact, and outcome measures.
   - Future funding potential to continue the planning process.
   - The Youth Mental Health System of Care planning group is open, flexible, and willing to provide input or other assistance.

h. Questions and discussion: It is a goal to have those with lived experience help come up with solutions, not just gaps.

VI. Budget update: Dr. Copeland and Mr. Kunnert received an approval from the Winnebago county financial committee. August 13, Steve Chapman and Dr. Martell from the Winnebago County Health Department will meet with a small group from the Board to develop the total budget and speak about the preliminary budget amendment for 2020. Tax money will start being collected in October 2020. At the August 13 meeting, our group will ask about projections of dollars earned.

VII. R1 Service Agreement: The contract was signed by Mrs. Abate and Dr. Copeland to hire Jason Holcomb. Jason is process driven and believes that it is important to define the process we are using. The framework helps guide where our focus areas are. The planning process will determine how we prioritize. There are several best practice ideas to draw from to develop something unique to work for our community. Jason will set up phone calls with each board member individually to get their point of view on the process. Mrs. Abate suggests that all collective requests for Jason move through the President so there is one streamline for his direction.

VIII. Ordinance Update: The goal is to establish the freedom for our Board to utilize the money through our prioritized system and then report to the whole Winnebago County board on what we have done. Our Board was created on an ordinance and the verbiage is vague on how the money relates to us. Mrs. Larson Bennett suggests we ask the legislators that backed this idea up to ask them to help us insert an

update into the ordinance. It was also suggested that we wait until after the upcoming elections to move forward with this.

IX. Other Matters

a. Liability insurance- Mr. Carpenter checked with the HR directors who was optimistic that we could be added through the full County board with some type of insurance. He will continue to follow the issue.

b. Open Meetings Act Training: Please send Jason your certificates. If you have not taken the training, please do so as soon as possible.

c. If anyone has agenda item input, please send your comments to Jason. He will be taking over creating the agenda.

d. Sherriff Caruana meeting: Terry Giardini, Jay Ware, and Wendy Larson Bennett had an information sharing meeting with the Sherriff's department. The department has ideas and they are looking for more training in regards to mental health. It was made clear that our board was not going to supplant funds for existing services. The Sherriff's department is already examining new types of response for mental health crises. They are also reaching out to other local law enforcement and first-responders to collaborate.

e. As board members, we need to continue to remain objective when discussing the mental health tax. We can listen, but must be careful. We cannot guarantee anyone with funding. The board and our plan of action are the final say.

X. Adjournment: Linda Sandquist moves to adjourn at 3:45PM. Dr. Julie Morris has the second motion. All approved.

August 27, 2020

10:30 AM

Virtual Meeting – ZOOM

Re: Minutes of Winnebago County Mental Health Board meeting with Winnebago County Health Department

Call to Order: Mary Ann Abate called the meeting to order at approximately 10:40am Wednesday, August 27th

Members present - Mary Ann Abate (President), Richard (Dick) Kunnert VP, Reverend Dr. K Edward Copeland Treasurer

Members Absent: Danielle Angileri, Linda Sandquist, Tim Nabors, Dr. Terry Giardini, Dr. Bill Gorski, Dr. Julie Morris

Advisors Absent: Wendy Larson Bennet, Jay Ware

Other Present: Jason Holcomb, RPC; James Keeler, WCHD; Steve Chapman, Winnebago County; Sherriff Gary Caranua; Deputy Chief Rick Ciganek; Assistant States Attorney John Giliberti

Discussion:

Steve Chapman reported that Fund 196 was set-up for the mental health tax, department code 496 and that the board could forward their approved invoices to Winnebago County Health Department for payment

Jim Keeler reported approved invoices could be sent to him or to accounts payable email account

Steve Chapman noted that 2020 -2021 FY Budget and preliminary budget for 2020-2021 fiscal year would be laid over on the 3rd of September. He reported it would be a good idea for the mental health board to have a budget for the fiscal year by mid-September to present to the Winnebago County Board.

Mary Ann Abate expressed the difficulty in predicting the tax revenue due to COVID-19.

Steve Chapman reported that he projected approximately $13 million for the year.

Jason Holcomb asked with what frequency the budget would be updated and who a request for the balance of funds could be made to.

Mr. Chapman reported that Winnebago County Finance Department would be the appropriate department to request a balance from. He noted that IL revenue

Mary Ann Abate noted that most of the funds will be issued to through RFP's. She also noted the need for liability insurance for the board and asked if there had been any further clarification about that being provided by the County.

Steve Chapman reported that they would follow-up to get clarification on this point.

Dick Kunnert noted the potential need for legal services.

Mary Ann Abate asked the representative from the State's Attorney's Office if the State's Attorney felt there was any conflict of interest to represent them to represent the Mental Health Board and if the Mental Health Board needed independent representation.

The representative from the State's Attorney's Office reported that he would follow-up on this item and provide clarification.

Mr. Chapman offered to attend the next Mental Health Board meeting.

Mary Ann asked Jason Holcomb to add the budget to the agenda and to include Mr. Chapman on the meting invitation.

Mr. Holcomb responded that he would do so.

Mary Ann motioned to adjourn the meeting. Dick Kunnert seconded. All board members in attendance were in favor and none opposed.

Vison

Our hope for our community

We want a robust community where residents are knowledgeable about mental health and have access to high quality mental health services when they need them.

Mission

What we are doing about it

We are an appointed group of passionate community leaders who coordinate and improve mental health services in Winnebago County through planning, funding, evaluation, and communication.

Values

Why we do what we do

Wellness– We believe people need more than medication and counseling to be well so we promote a multi-disciplinary approach across a continuum of care using the Community Support System Framework

Collaboration – We believe that relationships are foundational to coordination so we practice teamwork

Transparency – We believe the best way to gain trust is to be truthful so we practice open and consistent communication about our work

Diversity – We believe complex problems require perspectives from all areas of the community so we practice listening

Client-Centeredness – We believe that people with mental illness are important members of our community so we promote services that support them with compassion and unconditional positive regard

Intersectionality - We believe that mental health is interconnected with other parts of community life and personal identity so we promote solutions that address a combination of factors.

Trauma-Informed: We believe that no one who has experienced trauma should ever be re-traumatized during the process of seeking out or receiving mental health or substance abuse services so we promote trauma-informed care in all areas of service delivery.

Awareness – We believe mental illness can occur at any age and can affect individuals across all domains including race, gender, economic class, age and circumstance, so we strive to educate all members of our community about mental health, developmental health, and mental hygiene to increase mental health literacy and prevent mental illness.

Principles

How we operate

Evidence-Based: Our decisions are driven by the best available evidence and data.

Process-Oriented: We use best-practice processes to guide planning, funding, evaluation, and communications.

Outcomes-Informed: We evaluate the results of our efforts by collecting and analyzing data in order to continuously improve and maximize impact.

Equitable: We measure results with equity in mind, analyzing needs and outcomes by racial, ethnic, geographic, gender, or other demographic breakdown.

Urgent: We operate with a sense of urgency knowing that gaps in care affect real people.

Emergent: We stay flexible in order to identify and address new issues in the service delivery system as they are developing.

Network-Driven: We work diligently to establish a broad and diverse coalition of community stakeholders dedicated to improving the mental wellbeing of our community.

35 Day Work Plan DRAFT

Goals: To identify best-practices, timeline, dependencies, required coordination, and resources needed from October 1, 2020 to September 30, 2021 in the areas of planning, request for proposals (RFP), evaluation, communications, and coordination.

Process Area	Action Item	Target Date	Responsible	Supportive	Consulted
Planning	Best Practices Identified	09/16	JH	DA, EC, JW	MAA, DK
Planning	Dependencies/coordination needs Identified	09/16	JH	DA, EC, JW	MAA, DK
Planning	Resource Needs/Budget Developed	09/16	JH	DA, EC, JW	MAA, DK
Planning	Timeline/Work Plan Developed	09/23	JH	DA, EC, JW	MAA, DK
RFP	Best Practices Identified	09/16	JH	LS, JM	MAA, DK
RFP	Dependencies/coordination needs Identified	09/16	JH	LS, JM	MAA, DK
RFP	Resource Needs/Budget Developed	09/16	JH	LS, JM	MAA, DK
RPF	Timeline/Work Plan Developed	09/23	JH	LS, JM	MAA, DK
Evaluation	Best Practices Identified	09/16	JH	BG	MAA, DK
Evaluation	Dependencies/coordination needs Identified	09/16	JH	BG	MAA, DK
Evaluation	Resource Needs/Budget Developed	09/16	JH	BG	MAA, DK
Evaluation	Timeline/Work Plan Developed	09/23	JH	BG	MAA, DK
Communication	Best Practices Identified	09/16	JH	TG, TN, WL	MAA, DK
Communication	Dependencies/coordination needs Identified	09/16	JH	TG, TN, WL	MAA, DK
Communication	Resource Needs/Budget Developed	09/16	JH	TG, TN, WL	MAA, DK
Communication	Timeline/Work Plan Developed	09/23	JH	TG, TN, WL	MAA, DK
Coordination	FY2021 coordinated budget developed	09/18	EC	JH, BG	MAA, DK, DA
Coordination	FY2021 budget approved	09/18	WCMHB	N/A	N/A
Coordination	FY2021 coordinated work plan developed	10/02	MAA, DK	JH	DA, EC
Coordination	FY2021 service agreement drafted	10/02	JH	MAA, DK	EC, DA
Coordination	FY2021 work plan & service agreement approved	10/07	WCMHB	N/A	N/A

*All board members are accountable and informed across all areas.

Initials Key	DA – Danielle Angileri	TG – Terry Giardini	EC – Edward Copeland	JH – Jason Holcomb
MAA – Mary Ann Abate	LS – Linda Sandquist	BG – Bill Gorski	WL – Wendy Larson	WCMHB – Winn. County Mental Health Board
DK – Dick Kunnert	TN – Tim Nabors	JM – Julie Morris	JW – Jay Ware	

Youth Mental Health System of Care Grant Proposal Info

WHO: This is a collaborative effort, comprised of partners from sectors such as education, primary care, mental health and the justice system; lead applicants on the grant are Rosecrance and Northern Illinois Center for Non-Profit Excellence (NICNE).

WHAT: The collaborative is requesting $850,000 from the Illinois Children's Healthcare Foundation for the *Coming Together for Healthy Children* initiative to develop and implement a plan for achieving a sustained, improved system of care for youth in Winnebago and Boone Counties.

WHERE: Winnebago County and Boone County

WHEN: This request is for four years of funding, starting January 1st 2021

WHY: Improving the System of Care for children is vital because "at any point in time, one in ten children in Illinois suffer from a mental illness severe enough to cause some level of impairment; yet, in any given year only about 20% of these children receive mental health services." (Illinois Children's Mental Health Partnership, FY 2017 Annual Report to the Governor). The current youth mental health system of care remains segmented. The community must work together to meet families' behavioral health needs in light of fewer resources, increased poverty, crisis calls, trauma, and admissions for mental healthcare services.

HOW: 1) Deep engagement of people with lived experience in order to refine our plan; 2) Heightened collaboration and coordinated care among partners and community-based organizations through the creation of a monthly community of practice; 3) Capacity-building of mental health service providers through workforce development and training; and 4) Systems development through the hiring of a Systems Navigator and creation of a central database of service providers.

August 21, 2020

Illinois Children’s Healthcare Foundation
1200 Jorie Boulevard, Suite 301
Oak Brook, IL 60523

Re: ***Letter of Interest for the Illinois Children’s Healthcare Foundation’s Children’s Mental Health System of Care Planning and Implementation Grant***

Dear Illinois Children’s Healthcare Foundation:

We are writing to express the support of the Winnebago County Mental Health Board for Rosecrance’s application on behalf of the Youth Mental Health System of Care collaborative for an Illnois Children’s Healthcare Foundation grant to plan and implement a children’s mental health system of care. The Community Mental Health Act (40 ILCS 20/) directs community mental health boards to “consult with other appropriate private and public agencies in the development of local plans for the most efficient delivery of mental health, developmental disorders, and disorder services.” Accordingly, the Winnebago County Mental Health Board is encourged by the efforts of the Youth Mental Health System of Care’s collabotaive efforts to promote more efficient and effective services and programs and sees opportunties for coordination of efforts.

Sincerely,

Mary Ann Abate
President, Winnebago County Mental Health Board

Mercy Health Position Statement – Data Review

Mercy Health Community Benefit Plan – FY 2021

Strategy: Improve behavioral health status of community members

Tactic: Continue to provide inpatient and outpatient behavioral medicine service to area residents

Measure: Adult psychiatric in-patient services; outpatient psychiatric medication management services

Behavioral Health Crisis Offenses Listed in NetRMS from 08/18/19 to 08/18/20 (City Of Rockford)

Pandhandling – 12; Drug overdose – 469; Transportation of mental patient – 121 (08/19 to 02/20 = 44; 03/20 to 08/20 = 77); Detention of mental patient = 1; Despondent/Suicidal Subject = 842; Suicide by firearm = 5; Suicide by hanging = 8; suicide by cutting = 2; suicide by drugs = 8; suicide by other means = 2

Medicare

Patients discharged on antipsychotic mediations who had a body mass index, blood pressure, blood sugar, and cholesterol level screenings in past year ***Higher** percentages are better.

Mercy = 5%; IL Average = 74%; National Average = 74%

Patients discharged from an inpatient psychiatric facility who received (or whose caregiver received) a complete record of inpatient psychiatric care and plans for follow-up ***Higher** percentages are better.
Mercy = 0%; IL Average = 72%; National Average = 63%

Patients whose follow-up care provider received a complete record of their inpatient psychiatric care and plans for follow-up within 24 hours of discharge ***Higher** percentages are better

Mercy = 0%; IL Average = 65%; National Average = 55%

Patients discharged from an inpatient psychiatric facility on 2 or more antipsychotic medications (medications to prevent individuals from experiencing hallucinations, delusions, extreme mood swings, or other issues), and whose multiple prescriptions were clinically appropriate ***Higher** percentages are better

Mercy = 95%; IL Average = 52%; National Average = 61%

Patients hospitalized for mental illness who received follow-up care from an outpatient mental health provider within 30 days of discharge ***Higher** percentages are better

Mercy = 38.8%; IL Average = 52.1%; National Average = 49.9%

Patients hospitalized for mental illness who received follow-up care from an outpatient mental healthcare provider within 7 days of discharge ***Higher** percentages are better

Mercy = 11.9%; IL Average = 25.8%; National Average = 27.7%

Patients readmitted to any hospital within 30 days of discharge from the inpatient psychiatric facility
*Lower percentages are better

Mercy – No Different Than National Rate; National Average = 20.1%

# of psychiatric facilities in each readmission rate category across the nation and the state:

- 70 inpatient psychiatric facilities in IL
- 1 inpatient facility was better than national average
- 52 were no different than national rate
- 13 were worse than national rate
- 4 did not have enough cases to reliably tell how they are performing

Community Health Collaborative, Healthy Community Survey

Access to Mental Health Providers

This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Report Area	Total Population (2017)	Primary Care Physicians, 2017	Primary Care Physicians, Rate per 100,000 Pop.
Report Location	338,252	232	68.6
Boone County, IL	53,512	30	56.06
Winnebago County, IL	284,740	202	70.94
Illinois	12,786,196	10,241	80.1
United States	325,147,121	249,103	76.6

Note: This indicator is compared to the state average.
Data Source: University of Wisconsin Population Health Institute, County Health Rankings. 2019. Source geography: County

Health Professional Shortage Areas

This indicator reports the number and location of health care facilities designated as "Health Professional Shortage Areas"(HPSAs), defined as having shortages of primary medical care, dental or mental health providers. This indicator is relevant because a shortage of health professionals contributes to access and health status issues.

Report Area	Primary Care Facilities	Mental Health Care Facilities	Dental Health Care Facilities	Total HPSA Facility Designations
Report Location	1	1	1	3
Boone County, IL	0	0	0	0
Winnebago County, IL	1	1	1	3
Illinois	114	93	88	295
United States	3,985	3,623	3,438	11,028

The 1 is 1200 West State Street Crusader

https://data.hrsa.gov/tools/shortage-area/hpsa-find

HPSA Designated Area Rockford Westside = HPSA

Data Source: US Department of Health & Human Services, Health Resources and Services Administration, Health Resources and Services Administration. February 2019. Source geography: Address

Depression (Medicare Population)

This indicator reports the percentage of the Medicare fee-for-service population with depression.

Report Area	Total Medicare Fee-for-Service Beneficiaries	Beneficiaries with Depression	Percent with Depression
Report Location	41,897	7,397	17.7%
Boone County, IL	6,335	1,020	16.1%
Winnebago County, IL	35,562	6,377	17.9%
Illinois	1,446,658	236,456	16.3%
United States	33,725,823	6,047,681	17.9%

Note: This indicator is compared to the state average.
Data Source: Centers for Medicare and Medicaid Services. 2017. Source geography: County

Percentage of Medicare Population with Depression by Year, 2011 through 2017

This indicator reports the percentage of the Medicare fee-for-service population with depression over time.

Report Area	2011	2012	2013	2014	2015	2016	2017
Report Location	15.79%	16.16%	16.98%	16.78%	17.55%	17.86%	17.66%
Boone County, IL	13.75%	14.42%	14.83%	14.82%	16.06%	16.09%	16.10%
Winnebago County, IL	16.11%	16.44%	17.32%	17.11%	17.81%	18.17%	17.93%
Illinois	14.49%	15.00%	15.34%	15.41%	15.95%	15.94%	16.35%
United States	15.28%	15.81%	16.22%	16.72%	17.41%	17.40%	17.93%

Mortality - Suicide

This indicator reports the rate of death due to intentional self-harm (suicide) per 100,000 population. Figures are reported ascrude rates, and as rates age-adjusted to year 2000 standard. Rates are resummarized for report areas from county level data,only where data is available. This indicator is relevant because suicide is an indicator of poor mental health.

Report Area	Total Population	Average Annual Deaths, 2012 - 2016	Crude Death Rate (Per 100,000 Pop.)	Age - Adjusted Death Rate (Per 100,000 Pop.)
Report Location	341,073	45	13.3	13.0
Boone County, IL	53,685	5	10.1	10.0
Winnebago County, IL	287,387	40	13.8	13.6
Illinois	12,845,254	1,394	10.85	10.53
United States	321,050,281	44,061	13.7	13.3

Note: This indicator is compared to the state average.

Data Source: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2013 - 17. Source geography: County

Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Gender

Report Area	Male	Female
Report Location	20.2	6.7
Boone County, IL	16.28	Suppressed
Winnebago County, IL	20.94	6.71
Illinois	16.96	4.52
United States	21.17	5.90

Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Race / Ethnicity

Report Area	Non - Hispanic White	Non - Hispanic Black	Asian or Pacific Islander	American Indian / Alaskan Native	Hispanic or Latino
Report Location	15.1	No data	No data	No data	No data
Boone County, IL	11.30	No data	No data	No data	No data
Winnebago County, IL	15.86	No data	No data	No data	Suppressed
Illinois	13.44	5.33	4.58	Suppressed	4.58
United States	16.82	6.06	6.32	12.47	6.39

Suicide Mortality, Age-Adjusted Rate (Per 100,000 Pop.) by Year, 2004 through 2016

Report Area	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Illinois	8.12	8.57	7.92	8.63	9.25	9.08	8.97	9.29	9.80	9.90	10.50	10.29	10.75
United States	10.99	10.93	11.00	11.29	11.60	11.76	12.11	12.34	12.60	12.60	13.00	13.28	13.47

Report Area	Total Population	Average Annual Deaths, 2012 - 2016	Crude Death Rate (Per 100,000 Pop.)	Age - Adjusted Death Rate (Per 100,000 Pop.)
Report Location	341,073	45	13.3	13.0
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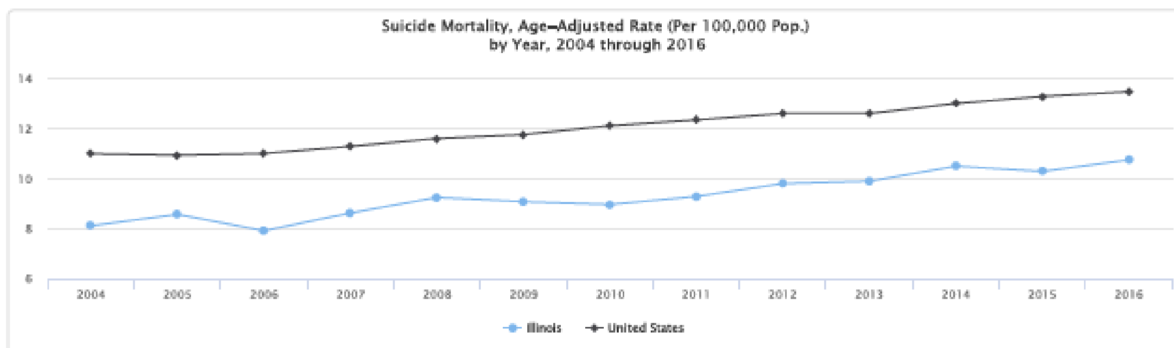
Winnebago County, IL	287,387	40	13.8	13.6
Illinois	12,845,254	1,394	10.85	10.53
United States	321,050,281	44,061	13.7	13.3



Data Summaries

Access to Mental Health Providers
Estimated Population 337,658 25,431,629
Number of Mental Health Providers 564 58,504
Ratio of Mental Health Providers to Population(1 Provider per x Persons)
598.7 434.7
Mental Health Care Provider Rate (Per 100,000 Population) 167 230

Health Professional Shortage Areas
Primary Care Facilities 1 114
Mental Health Care Facilities 1 93
Dental Health Care Facilities 1 88
Total HPSA Facility Designations 3 295

Depression (Medicare Population)
Total Medicare Fee-for-Service Beneficiaries 41,897 1,446,658
Beneficiaries with Depression 7,397 236,456
Percent with Depression 17.7% 16.3%

Mortality - Suicide
Total Population 341,073 12,845,254
Average Annual Deaths, 2012-2016 45 1,394
Crude Death Rate (Per 100,000 Pop.) 13.3 10.85
Age-Adjusted Death Rate (Per 100,000 Pop.) 13.0 10.53

September 3, 2020

Illinois Health Facilities and Services Review Board

525 W. Jefferson St., Second Floor

Springfield, IL 62761

Dear Review Board,

The Winnebago County Mental Health Board is disheartened by Mercy Health's request and subsequent actions to close their mental health beds. We find this inconsistent with mental health trends and community need.

Mental Health Trends

A growing body of evidence suggests increasing rates of mental illness. For example, depression among Medicare users has increased from 15.28% to 17.93% from 2011 to 2017 on a national level and from 16.11% to 17.93% in Winnebago County[1]. From 2004 to 2016, suicide mortality (age-adjusted) rates have increased more than 20% nationally and more than 30% in the State of Illinois[2]. Children's mental health trends are also concerning with suicide rates for children ages ten to fourteen tripling from 2007 to 2017[3]

While mental illness was already on the rise prior to the COVID-19 pandemic, recent research suggests greater psychological distress during the pandemic for people with serious mental illness,[4] a trend which can be predicted to increase the number of psychiatric crises and, in turn, the need for mental health hospital beds. These trends suggest a need for more community mental health beds, not less. In fact, research has demonstrated the need for 50 psychiatric beds per 100,000 people[5]. With only 34 available beds in the region (before Mercy's recent closure), this would only adequately support an adult population of less than 100,000 people. In absence of adequate community beds, individuals in psychiatric crisis fill up our emergency rooms, jails, and prisons.

Community Need

Consistent with mental health trends, Mercy has seen an increase in admissions for acute mental illness – up to 593 in 2018 from 570 in 2015. It is only because the average length of stay has decreased that the average daily census has decreased. It would be troubling to think that length of stay was being influenced intentionally to show a decreasing trend to support a preempted request for closure. Yet, it is hard to understand how this request fits with Mercy's own assessment of community need.

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[1] Centers for Medicare and Medicaid Services. 2017.
[2] Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. 2013-17.
[3] https://sites.nationalacademies.org/cs/groups/dbassesite/documents/webpage/dbasse_196552.pdf
[4] https://www.cebm.net/covid-19/severe-mental-illness-and-risks-from-covid-19/
[5] https://www.treatmentadvocacycenter.org/storage/documents/no_room_at_the_inn-2012.pdf

According to Mercy Health's FY2021 Community Benefit Plan[6] a key area of community need includes improving the behavioral health status of community members with a noted tactic to "continue to provide inpatient and outpatient medicine service to area residents."

It is worth noting that Mercy Health's North Rockton Ave Campus does not reside in a designated Health Professional Shortage Area (HPSA) for mental health[7]. While we understand the overall difficulty of attracting psychiatrist to the region, we find it unconvincing that this is an impossible task or a legitimate reason for closing down a much needed service in our community.

We ask that you please take into consideration the preceding information and rule in favor of keeping these much needed beds in our community.

Sincerely,

Mary Ann Abate

Winnebago County Mental Health Board President on behalf Winnebago County Mental Health Board

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[6] https://mercyhealthsystem.org/wp-content/uploads/2020/06/Winnebago-County-6.9.20.pdf

[7] https://data.hrsa.gov/tools/shortage-area/hpsa-find