Active Community Care Transition:
Tinley Park Mental Health Center Community Reinvestment

Information Due By Close of Business Monday, April 16, 2012

Please direct all questions regarding the general procedures for responding to this Request for Information to:

dhs.mh@illinois.gov

Please send one electronic copy (in Microsoft Word) and one paper copy of your response to this Request for Information by the due date and time to:

Jackie Manker, Associate Director
IDHS Division of Mental Health
319 E Madison, Ste 3B
Springfield, Illinois 62701
Phone: 217-782-5700
e-mail: Jackie.manker@illinois.gov

We would like to thank your organization in advance for reviewing this Request for Information (RFI).[1]. Our community partners and other stakeholders have long constituted the bedrock of the public mental health services available for residents of Illinois. Illinois Department of Human Services Division of Mental Health (IDHS/DMH) appreciates your organization's ongoing efforts and values your input into the further evolution of our service model.

This RFI consists of two major sections. The first provides the context for this request, describing important background information, locations for obtaining additional background information and the current needs of IDHS/DMH leading to this RFI. The second section details the information being requested.

[1] This RFI does not constitute any commitment by the State to follow any particular procurement course of action. The RFI is for informational purposes only and may not necessarily result in an award of a contract or an increase in funding of an existing contract. The information provided in response to this RFI is considered the property of the IDHS/DMH and will be kept confidential by the IDHS/DMH to the extent permitted by law. Information that you provide that you consider to be a trade secret or you consider confidential/proprietary (See section 7(1)(g) of the Illinois Freedom of Information Act 5 ILCS 140/7) must be claimed as such at the time of submission. In addition, a detailed written justification explaining why the provided information is a trade secret or is confidential/proprietary must also be submitted. Please note that the IDHS/DMH cannot reimburse community service agencies or other entities for any expenses associated with responding to this RFI.

Department of Human Services

Request for Information

Active Community Care Transition:
Tinley Park Mental Health Center Community Reinvestment

Table of Contents

I. Context

A. Background

In the fall of 2011, a shortfall in the fiscal year 2012 budget made it necessary to begin actions to close several State of Illinois facilities by June 30, 2012. Local meetings were initiated to engage stakeholders who would be impacted by these closures. Subsequent action by the Illinois State Legislature provided the needed funding flexibility to keep all facilities open for the entire fiscal year. This extension has allowed the IDHS to work with community stakeholders to refine the plan for the transition of acute care services to local community providers.

This RFI is for the purchase of community-based inpatient and outpatient alternatives to services provided at Tinley Park Mental Health Center (TPMHC), which is now scheduled for closure as of June 30, 2012. It reflects community stakeholder input garnered from "Active Community Care Transition" (ACCT) planning process, which began on January 19, 2012, and continued through the issuance of this document. The ACCT design was detailed in a presentation to the Commission on Governmental Forecasting and Accountability (COGFA) on February 6, 2012, which can be found at:

http://www.ilga.gov/commission/cgfa2006/home.aspx

Some highlights from that presentation include the steps taken by the DMH to restart the TPMHC closure process. Important steps included:

1. An analysis of the clinical needs of persons served at TPMHC;
2. An analysis of the existing and potential community service capacity in the area served by TPMHC (Region 1 South);
3. Drafting a description of the core service elements identified by the community stakeholders in the fall of 2011; and,
4. Preparing a "Plan Evolution" for moving the work with the community stakeholders forward.

Plan Evolution. Immediately following the COGFA hearing, DMH conducted a series of clinical focus groups to gather expert opinion on the most appropriate service interventions for the new Crisis Care System in Region 1 South. On February 17, 2012 an expert panel of community hospital emergency department and inpatient psychiatric unit managers was assembled, and on March 20 and 26, a panel of state hospital clinical administrators, supervisors, and managers were convened. These groups reviewed clinical vignettes based on typical presentations for admission at TPMHC, and also reviewed a sample of actual admission records (with names and identifying information redacted). The focus groups were asked to: 1) determine what services would have been needed to avert SOH admission, and 2) to make recommendations for community stabilization service package. The list of the participants in this process can be found at Appendix 1 titled Rebalancing Mental Health Focus Group Agenda.

Simultaneous with this activity, the Governor's Office and DHS began the formal ACCT process. Six strategic ACCT Committees were formed and empanelled. The committees and their mission/function are as follows:

1. **Hospital Engagement** - Mission: Assist the state in determining the scope, types, amounts, locations and rates for hospital based care.
2. **Service Models & Innovations** - Mission: Assist the state in determining the appropriate scope, types, amounts and locations of services for enhancement in the region. In addition, assist the state in developing and planning for the implementation of innovative service interventions.
3. **Community Education & Support** - Mission: Assist the state in planning for the education of consumers and providers as the system changes, and to identify and plan for workforce development needs.
4. **Service Financing & Payment Methodology** - Mission: Assist the state in defining new payment models for financing the community service enhancements and innovations recommended by Committees 1 & 2.
5. **System Performance & Outcomes Assessment** - Mission: Assist the state in determining the most appropriate methodology and metrics for evaluating effectiveness of system reforms and restructuring efforts.
6. **Messaging, Media & Legislative Liaison** - Mission: Assist the state in developing appropriate messages, and interface with the members of the General Assembly on restructuring issues.

Co-Chairs for each of the above ACCT Committees were appointed. For all except the System Performance & Outcomes Assessment Committee, the co-chairs are leaders in the community stakeholder realm. Top executives from the Governor's Office, DMH, and the Division of Alcohol and Substance Abuse (DASA) were appointed to be state liaisons and to provide support to the committee co-chairs.

A list of the Committee members is attached to this RFI is contained at Appendix 2 titled ACCT Committee List.

Significant work by five (5) of the ACCT Committees has contributed to this RFI. The **Hospital Engagement** and **Service Models & Innovations Committees** have recommended the community crisis system enhancements contained in this RFI. The **Service Financing & Payment Methodology** and the **System Performance & Outcomes Assessment Committees** have explored approaches to financing enhancements and measuring their impact respectively. Work by the **Community Education & Support Committee** and the **Messaging Media & Legislative Liaison Committee** is underway and will play an important role once the system enhancements move forward. All committees are seen as essential to guiding the continued refinement of the new Region 1 South Crisis Care System in the future.

A record of to-date ACCT Committee Meetings is attached to this RFI is provided at Appendix 3 titled Master Schedule and Brief Status of ACCT Committee Meetings.

B. Focus of This RFI

Clinical Characteristics of the Individuals and Their Service and Support Needs

This RFI is aimed at meeting the needs of a specific and prescribed population of individuals. Specifically, we are targeting the approximately 1,900 individuals from Region 1 South area who, if not for the Tinley closure, would be seeking state-operated hospital (SOH) services in the twelve months beginning July 1, 2012. The basis for this forecast is shown in the table below, which details SOH admissions from the four community areas that make up Region 1 South during fiscal year 2011. The average length of stay for these admissions is about 11.6 days.

Table I.
FY11 State Hospital Admissions by
Region 1 South Community Areas

	Tinley Park MHC	Madden MHC	Chicago-Read MHC	Total	%
City of Chicago Southside	263	235	5	**503**	25.97%
South Suburban Cook	759	98	11	**868**	44.81%
Will County	383	50	2	**435**	22.46%
Grundy County	33	3	1	**37**	1.91%
Kankakee County	85	8	1	**94**	4.85%
Total Region 1 South	**1,523**	**394**	**20**	**1,937**	

Some of the significant characteristics of this population include the following features:

- About 98% of people admitted to TPMHC were referred from local community hospital emergency departments;
- For about 54% of people admitted, the admission was the first one to SOH services;
- About 24% of people admitted were given at least one Substance Use Disorder (SUD) diagnosis with no other major mental illness;
- About 60% of people were given a diagnosis of SUD that was co-occurring with other mental illnesses;
- About 98% of people did not have insurance and were not Medicaid eligible;
- About 17% of people admitted were experiencing homelessness;
- About 11.7% of people were being re-admitted to SOH services, with the majority of those being re-admitted having SUD.

The table below shows the hospital EDs in which RFI services will need to be targeted.

Table II.
FY11 Emergency Department Referrals TPMHC

TINLEY PARK MHC

Targeted High volume Hospital ED	Totals	City	South Suburban	Will / Grundy	Kankakee	Out of Region 1 S
Hospitals with Psychiatric Units						
INGALLS	222		222			
SILVER CROSS	173			173		
CHRIST	115		115			
PALOS COMM	81		81			
ST JOSEPH – Joliet	135			135		
ST BERNARD	66	66				
RIVERSIDE	58				58	
ST MARY Kankakee	53				53	
LITTLE CO OF MARY	47		47			
Totals for Hospitals with Psychiatric Units	**950**	**66**	**465**	**308**	**111**	**0**
% of Total Referrals (N=1,897)	50%	3%	25%	16%	6%	0%
Hospitals without Psychiatric Units						
ST JAMES	195		195			
SOUTH SUBURBAN	118		118			
METRO SOUTH	62		62			
BOLINGBROOK	55			55		
ROSELAND	46					46
MORRIS	33			33		
Totals for Hospitals without Psychiatric Units	**509**	**0**	**375**	**88**	**0**	**46**
% of Total Referrals (N=1,897)	27%	0%	20%	5%	0%	2%
Total Number of ED Referrals to TPMHC from Region 1 South area Hospitals	**1,459**	**66**	**840**	**396**	**111**	**46**
% of Total Number of Persons Referred (N=1,897)	77%	3%	44%	21%	6%	2%
Patients per day	4.00	0.18	2.30	1.08	0.30	0.13

Expert Clinical Focus Groups consisting of clinicians from area hospitals, community service providers and IDHS/DMH have been convened to review clinical information on representative samples of individuals admitted to TPMHC. The result of this group's work can be summarized as follows:

- About 53% of people did not meet admission criteria for inpatient level of care
  - About 5% of this group could have been successfully diverted to intensive levels of outpatient ambulatory care within the Rule 132 services array
  - About 11% of this group appeared to require specifically and solely substance abuse services (DASA)
  - About 37% of this group appeared to require observation (up to 48 hours), after which an intensive levels of outpatient ambulatory care (within the Rule 132 array) would have been appropriate to address their needs
- About 47% of persons would have needed inpatient level of care

To help responders to this RFI further understand the characteristics of the population targeted by this RFI, a report on the diagnoses of individuals discharged by TPMHC during FY11 is contained at Appendix 4 titled FY11 Discharges from Tinley Park with the Following Primary Discharge Diagnosis.

The work of the Expert Focus Groups has led IDHS to develop an RFI inviting three types of qualified providers to participate in developing the enhanced, Integrated Crisis System in Region 1 South. They are:

- Community hospitals that can provide inpatient and other hospital-based psychiatric services;
- Community mental health service providers; and,
- Community SUD providers.

Collaboration is encouraged across applicant provider agencies in order to maximize opportunities for integration of Crisis Care components.

C. Guiding Principles for this RFI

DHS would like to underscore the importance of recovery-oriented services. Participating providers are encouraged to review a monograph included at Appendix 5 titled Guiding Principles for Rebalancing: New Models and New Directions. This document highlights:

- Services are Recovery-Oriented
- Services are Trauma-Informed
- Services will be Outcome-Validated

II. The Vision for the Region 1 South Crisis System

IDHS will approach the development of an enhanced Crisis System in a two-phase process. In Phase I, acute care alternatives will focus on engaging individuals presenting at community hospital emergency departments (ED) in Region 1 South. Phase II is envisioned as a period of refining the system to intercept people before they present at the community ED.

This RFI seeks to quickly implement Phase I services by July 1, 2012. The ACCT Committees for **Hospital Engagement** and **Service Models & Innovations** agree that to adequately replace the acute inpatient services provided by TPMHC, the goals of the emerging Region 1 South Crisis System will be to:

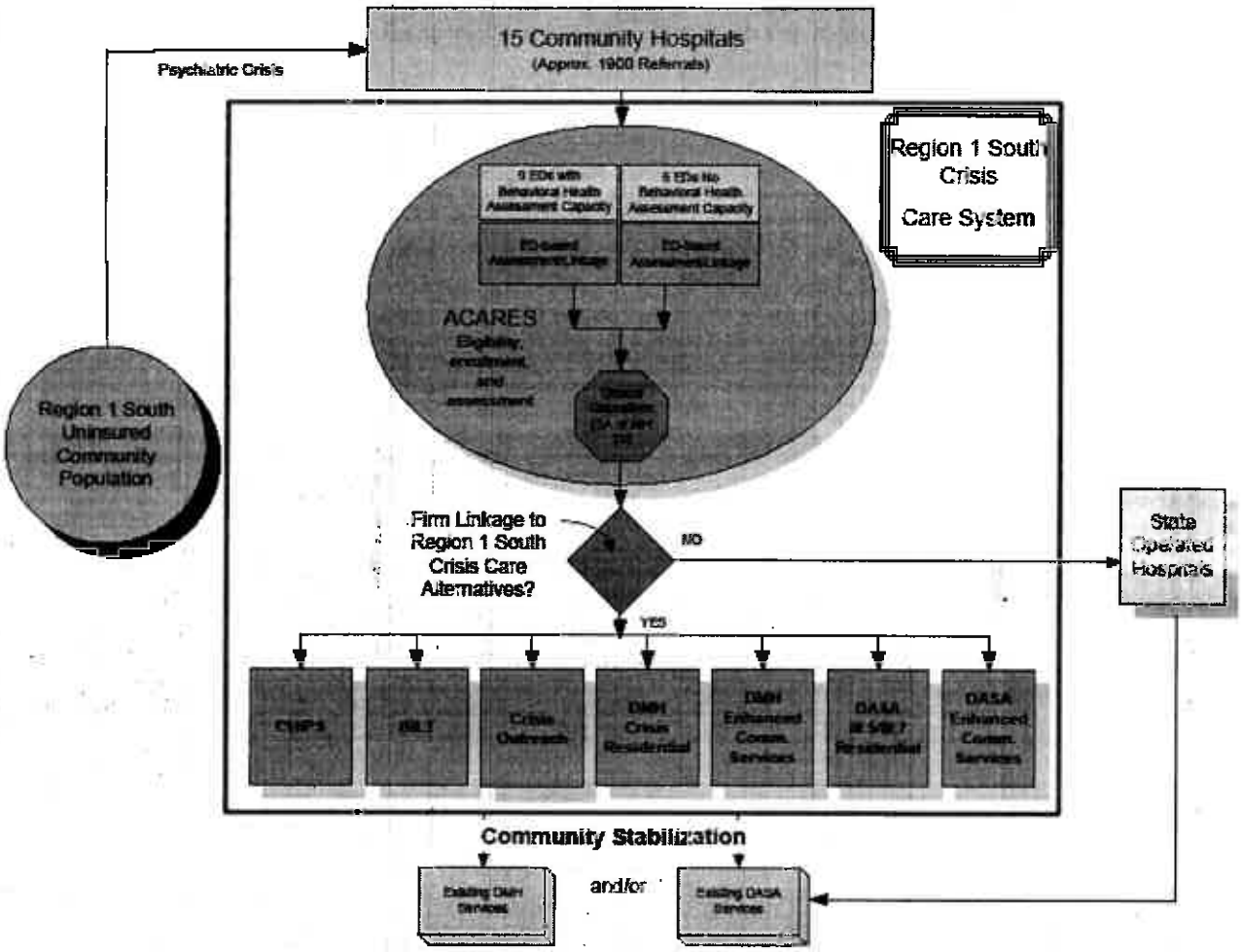
- Provide timely and accessible aid in the community emergency departments
- Provide access to a wide range of crisis stabilization options
- Help individuals achieve stability as quickly as possible
- Help people return to the community
- Assist people in a return to a pre-crisis level of functioning
- Provide community treatment alternatives to the ED
- Increase or improve recovery pathways using natural supports

To reach these goals, the Region 1 South Crisis System will:

- Deliver Crisis Intervention Services 24 hours a day, 7 days a week
- Be co-located or mobile, providing crisis services at the EDs
- Help resolve a wide array of presenting problems, such as access to medication, transportation, immediate housing, etc.
- Help people connect to the most appropriate level of DMH and/or DASA community services
- Incorporate evaluation protocols identified by IDHS to measure the effectiveness of the Region 1 South Crisis System

The diagram below illustrates the Region 1 South Crisis Care System design that has emerged from the ACCT Committee meeting process. Features appearing in green shaded boxes are those that will be funded through this RFI process. The functions contained within the blue shaded oval, will be provided by existing DHS structures. Together with the emergency departments currently operating in Region 1 South, this will become the new Region 1 South Crisis Care System.

Region 1 South Crisis Care System Flowchart



III. Services To Be Purchased Under This RFI

A. ED-Based Assessment/Linkage

Nine (9) of the Region 1 South EDs are within hospitals that have acute psychiatric inpatient units able to dispatch behavioral health specialists to the ED to perform crisis assessments, and to help make a linkage to an alternate care option. Six (6) hospitals do not have behavioral health specialists to attend to the person presenting with a psychiatric emergency.

This RFI seeks to augment the behavioral health assessment and linkage capacity at all 15 hospitals. For those not having internal behavioral health specialist, DHS will purchase a mobile outreach service from a community provider. The mobile assessment and linkage service will travel to the ED or co-locate there and perform these functions. For those nine (9) hospitals with behavioral health specialists, this RFI will seek to augment their work to provide the needed assessment and linkage function. Across all 15 EDs, the workers would conduct

interviews, complete assessments and make recommendations for alternative care. Entry into services would be authorized by the ACARES Line (described below) and the worker would then proceed to make the necessary linkage to the service, including needed transportation (also described below).

Examples of appropriate "augmentation" at the nine (9) EDs with behavioral health could include:

- Adding QMHP level staff to perform crisis assessment on less than a 24/7/365 basis
- Enhancing QMHP level staff to reach 24/7/365 coverage in the ED
- Enhancing QMHP level staff to obtain double coverage on typically busy shifts or days of the week
- The addition of face-to-face Psychiatry/APN for rapid assessment, consultation, and/or the immediate initiation of active treatment (including psychotropic medications)

With such enhancements, the ED could assume broader authority and responsibility for recommending the appropriate level of service in the Region 1 South Crisis Care Network, working in concert with the ACARES provider. Providers filling this system need will need to project the staff time needed to respond on a 24/7/365 basis to one or more of the EDs in Region 1 South. Please refer to the above charts to gauge the possible volume and flow of referrals from the various EDs in the area. During the ACCT Committee process, stakeholders likened this function to that already done for children and adolescents in the current screening, assessment and linkage functions under the SASS Program, so this may be a useful consideration to a proposal under this RFI.

Qualified responders for ED-Based Assessment/Linkage are community hospitals duly licensed as a hospital within the State of Illinois with specifically designated psychiatric inpatient hospitalization program(s) for adults; fully certified as a Medicaid/Medicare provider; fully in compliance with the State of Illinois Mental Health Code and Confidentiality Act; fully accredited by the Joint Commission on Accreditation for Healthcare Organizations (TJC) or by Healthcare Facilities Accreditation Program (HFAP). Qualified community providers are those presently under contract with IDHS Division of Mental Health or the Division of Alcohol and Substance Abuse.

B. Community Hospital Inpatient Psychiatric Services (CHIPS)

CHIPS, is a contractual program between the state and local community hospitals for the purchase of inpatient psychiatric bed capacity for admissions of "indigent" persons with mental illnesses in acute crisis. Active treatment should be expected to resolve the crisis within a 6 day average length of stay. The program has active concurrent review, is reimbursed on an all-inclusive bed and professional fee-for-service rate, and expects immediate coordination of care efforts with the next level of care providers for services following discharge. IDHS/DMH would be payer of last resort after expedited applications for Medicaid are filed and have received final determination.

The initial basic contract that will be used to purchase this service can be found at:

http://www.dhs.state.il.us/OneNetLibrary/27896/documents/Contracts/FY12/FY12-CSA-Amendment-9-9-11.pdf.

This contract will be supplemented by an addition that specifies the scope of service and payment. The CHIPS Scope of Services is attached at Appendix 6 titled Community Services Agreement Exhibit A Scope of Services.

The projected utilization of CHIPS for which DMH is proposing to receive for area hospitals is at Appendix 7 titled CHIPS Projections. DMH is wishing to contract with hospitals with existing inpatient Behavioral Health (BH) units for utilization numbers both from their ED but also to support portions of the other capacity from other area hospital EDs where no inpatient BH capacity exists. State hospital capacity will be available for safety net purposes. These numbers are for your consideration only. Contracts, with more specific targeted volumes will be let based upon submission of your proposals and subsequent negotiations with DMH.

Qualified responders for CHIPS services are community hospitals duly licensed as a hospital within the State of Illinois with specifically designated psychiatric inpatient hospitalization program(s) for adults; be fully certified as a Medicaid/ Medicare provider; fully in compliance with the State of Illinois Mental Health Code and Confidentiality Act; fully accredited by the Joint Commission on Accreditation for Healthcare Organizations (TJC) or by Healthcare Facilities Accreditation Program (HFAP). Providers certified to provide behavioral Medicaid services and under contract with IDHS/DASA or IDHS/DMH would also qualify.

C. Brief Intervention Linkage Teams (BILT)

BILTs are a version of a Crisis Stabilization Unit.[2] These units are based either within an ED or psychiatric unit as programs of 3-5 beds. These programs are for individuals who are in need of a safe, secure environment that is less restrictive than inpatient hospitalization. BILTs can be designed for both voluntary and involuntary individuals. The program is to provide immediate active treatment with the goal of stabilizing the individual and re-integrate him or her back into the community quickly. The typical length of stay in a BILT is expected to be 36-48 hours.

Multi-disciplinary teams of mental health professionals staff BILTs, and provide rapid psychiatric assessment, observation to assess suicidal intent and risk, medication, counseling, referrals, and linkage and coordination to the appropriate level of services to be received post-discharge.

[2] Adams, C.L. & El-Mallakh, R.S. (2009) Patient Outcome after Treatment in a Community-Based Crisis Stabilization Unit. *The Journal of Behavioral Health Services and Research, 36*, 396-399.

In some situations a BILT may also serve as a site for 24-hour walk-in crisis services for urgent situations, providing:

- Screening and assessment
- Crisis stabilization (including medication)
- Brief treatment
- Rapid linking with services

The BILT provider would have broader authority and responsibility for recommending a next level of service. Authorization for next level services may be the purview of the Region 1 South ACARES provider, but it is anticipated that close collaboration would make this a seamless effort between the two providers. A program description of an ED-based crisis stabilization service that reflects the model envisioned for this RFI is included at Appendix 8 titled Advocate Illinois Masonic Emergency Department-Behavioral Health.

Qualified responders for BILT services are community hospitals duly licensed as a hospital within the State of Illinois with specifically designated psychiatric inpatient hospitalization program(s) for adults; be fully certified as a Medicaid/Medicare provider; fully in compliance with the State of Illinois Mental Health Code and Confidentiality Act; fully accredited by the Joint Commission on Accreditation for Healthcare Organizations (TJC) or by Healthcare Facilities Accreditation Program (HFAP).

D. Crisis Outreach

Crisis Intervention is defined as: Activities or services provided to a person who is experiencing a psychiatric crisis. The services are designed to interrupt a crisis, and include: assessment, brief supportive therapy or counseling and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goal of crisis intervention is symptom reduction, stabilization and restoration to the previous level of functioning. (See *Community Mental Health Services Service Definition and Reimbursement Guide, page 29*, at:

http://www.hfs.illinois.gov/assets/cmhs.pdf

The Crisis Outreach service envisioned for this RFI is a total function that not only provides the services as described above, but also insures that the person served receives direct support necessary until a firm linkage to another service is in place or the crisis has been resolved. Service may need to be provided during a transitional period to facilitate the timely and rapid discharge from the Emergency Department once the next level of care is identified. Also, the service should provide access to other critical supports such as client transitional subsidies, options for temporary housing, transportation, Living Rooms, drop-in centers, etc. The crisis service may also be combined with the ED-base assessment/linkage described above.

In responding to this RFI providers should detail how they propose to establish a system to efficiently and effectively respond to referrals from one or more of the EDs in Region 1 South as part of Phase I of the Region 1 South Crisis Care System. However, the RFI response should also reflect how the provider's crisis response system may evolve to more flexibly respond to mental health crisis in other settings in the future, such as the development of a mobile crisis team.

The crisis outreach service may act as the primary mental health provider until it is appropriate to transition the individual into mainstream services. Qualified responders for crisis outreach would be providers certified to provide behavioral Medicaid services and under contract with IDHS/DASA or IDHS/DMH would also qualify.

E. DMH Crisis Residential

This level of residential care provides brief periods of care to consumers within a residential site when they are experiencing a psychiatric crisis to assist them to return to and maintain housing or residential stability in the community, continue with their recovery, and increase self-sufficiency and independence.[3] This service includes 24 hour seven days per week access to crisis beds and residential support activities designed to provide short-term continuous supervision, crisis interventions, assessment and treatment. These services are to be delivered in a provider controlled facility with 24 hour crisis beds that are a part of or linked to Crisis Intervention Services.

The intense, rapid response service is highly focused on assessment, diagnosis, therapeutic intervention and stabilization of the presenting psychiatric crisis. Responses to this RFI may expand existing crisis residential programs or proposed the creation of new programs by provider agencies in order to meet the needs of individuals previously served by TPMHC. Qualified responders for crisis outreach would be providers certified to provide behavioral Medicaid services and under contract with IDHS/DASA or IDHS/DMH would also qualify.

F. DMH Enhanced Community Services

Under the current DMH Non-MRO service package, individuals are eligible for:

- Unlimited crisis intervention
- Mental health assessment (4 hours)
- Treatment plan development , review and modification (2 hours)
- Various types case management (5 hours)
- LOCUS case management (1.5 hours)
- Psychotropic medication administration (3 hours)
- Psychotropic medication monitoring (2 hours)
- Psychotropic medication training-individual (2 hours)
- Oral interpretation and sign language (25 hours)

[3] Drawn from the draft Residential Rule 140 currently under development.

The table describing covered services is attached at Appendix 9 titled NonMedicaid Service Package per Fiscal Year.

Responses to this RFI should include proposals to enhance the above service package to address the need for psychiatry appointments; brief supportive counseling or therapy, or other Rule 132 services that could help to continue the stabilization process. Qualified responders for crisis outreach would be providers certified to provide behavioral Medicaid services and under contract with DMH.

F. DASA (ASAM) III.5 & III.7 Residential

Currently the DMH State Hospitals discharge about one quarter of all persons served with a primary diagnosis of substance use disorder. Participants in recent ACCT clinical focus groups reviewed a sample of such individuals to render an expert opinion on what may have effectively been used as an alternative to the SOH admission. DASA Level 3.5 Residential Rehabilitation Services is viewed as a solid alternative for people with an SUD presenting at a community ED.

Level III.7 is a structured inpatient program which is consistent with the American Society of Addictive Medicine Patient Placement criteria for treatment of Substance Use Disorders (ASAM PPC-2R 2001). This service site should provide clinical services via an interdisciplinary team which assesses and addresses the individual needs of a client. Services may be medical services, individual, group, family or personal activity/social skills services. The services are planned clinical services and program activities designed to stabilize acute symptoms and or non-medical or psychiatric symptoms. Activities may include medication assisted treatment, cognitive behavioral, psychosocial rehabilitation, and or other therapies which may be individual or group that address the individual's disorders, psychological development, individual recovery supports and stage of recovery.

Level III.5 Residential Rehabilitation is typically short term (21 day or less) residential care provided in a 24-hour structured, safe, stable and supervised recovery setting (i.e. halfway houses, recovery homes). Active services are scheduled for a minimum of 25 hours per week and may include individual/group/family therapy, medication management/ education, interpersonal and group living skills group. Programs currently in operation may need to be enhanced to allow a rapid transition of the person from a Region 1 South ED. New programs would need to be designed for this rapid transfer as well.

Enhancements to the **Level III.5 & III.7** need to consider access to a psychiatrist for medication assessment and administration, and the ability to safely monitor medication. Qualifying providers are licensed community substance abuse service providers certified to provide behavioral Medicaid services and under contract with DHS/DASA.

G. DASA Enhanced Community Services

A full continuum of services should be available to the clients deflected from the emergency departments, crisis intervention units, or referral sources. Such key services and new resources for these individuals should be for individuals with a substance abuse disorders who are in need of:

1. **Outpatient Services:** Access to existing/enhanced outpatient (individual and group, and family) from individual to intensive outpatient services should be made available for those individuals medically stabilized and residing within the community. Such services should be able to address issues of co-morbidity and the need for Services integration.
2. **Medications and Medication Assisted Treatment:** Access to necessary medications for the treatment of both psychiatric and substance use disorders for a designated time period defined by the department should be available.
3. **Recovery Coaches/Mentors:** These services should be made available for individuals who have repeated crisis engagements and/or difficulty with successfully accomplishing their addiction and or psychiatric recovery plans. These services should be available 24/7 to individuals in need and need to integrate with and as a part of all services being provided to the client.

Qualifying providers are licensed community substance abuse service providers certified to provide behavioral Medicaid services and under contract with DHS/DASA.

IV. Other DHS Contracting in Support of this RFI

A. Adult Care and Referral Entry Service (ACARES)

Similar to the Crisis and Referral Entry Service (CARES) design used for the Child and Adolescent System, the Department will purchase capacity for such a service for adults and create a single point of entry to the Region 1 South Crisis Care System for the person presenting with psychiatric emergencies at local EDs. ACARES would not be a provider of any other direct clinical services, and during Phase I, would be accessed only by the EDs in the Region 1 South area.

Due to limited resources it is important for responders to this RFI to note that DHS's initial priority is to ensure sufficient alternative services for Region 1 South residents that would have previously been served by Tinley Park Mental Health Center; that is, the equivalent of the 1,900 individuals served annually at TPMHC. Thus, during Phase I the focus will be to intercept individuals in crisis at the EDs. ACARES approval of access to the new Region 1 South Crisis System will be based on the following criteria:

- The person is a resident of the Region 1 South area, or is a person who is homeless from the Region 1 South area
- The referring ED has certified that the person is presenting based on a psychiatric crisis

- The outcome of the clinical assessment indicates that one of the Region 1 South Crisis System alternatives could be used to avoid SOH admission
- The person agrees to the alternative crisis care
- An appropriate alternate crisis care is available (e.g., bed at the III.7, bed at a CHIPS hospital, etc.)

During Phase I, EDs would contact ACARES when:

1. A person having neither private nor public insurance coverage presents to their EDs and needs assessment for or access to the psychiatric acute care options described in this document;
2. There is no capacity at the ED to provide the assessment required for entry into the Region 1 South Crisis Care System; or
3. A qualified assessment has been performed and the ED is seeking referral entry service into the Region 1 South Crisis Care System.

ACARES will be responsible for answering all incoming calls to an established 24/7/365 hot. NOTE: After the Region 1 South Crisis Care System established, the Department may negotiate a plan for opening the ACARES line for community referrals. Such refinements or "sequential intercepts," will be guided by the ongoing ACCT Committee Structure and DHS monitoring of the flow of people into and through the new Crisis Care System.

The ACARES Line Workers will provide the following services to the Region 1 South EDs:

1. Collect information to evaluate whether the ED patient meets eligibility criteria for the ACARES response (see 1-3 above);
2. Determine if the assessment done by the referring ED is sufficient to determine eligibility for one or more of the Region 1 South Crisis Care System services;
3. Where the assessment is determined to be insufficient for entry into the Region 1 South Crisis Care System, dispatch a qualified crisis assessment worker to perform the assessment;
4. Based on the assessment results, authorize the person for the most appropriate available Region 1 South Crisis Care service;
5. Where more than one Region 1 South Crisis Care service will be authorized for a person (i.e., CHIPS followed by Rule 132 services), the ACARES Line will assume responsibility for authorizing the transition between services;
6. Arrange for transportation of the person to (or between) the authorized Region 1 South Crisis Care System provider site(s); and,
7. Authorize payment for the cost of transportation and any Region 1 South Crisis Care service. This authorization will be provided upon certification that the provider of the service has been denied coverage under all other private and public health insurance programs, including the Medicaid program of the Illinois Department of Healthcare and Family Services. Denial of Medicaid must follow an adequate Medicaid application. The definition of an adequate Medicaid application will be developed by DMH.

B. Transportation

Transportation is an essential ingredient of a crisis system that ties all the service components together. The ability to safely transport individuals in need of crisis services in a timely and cost effective manner is critical to operations. The requirements for providers who are authorized to transport persons in crisis vary between communities and may be determined by the legal status (voluntary versus involuntary) of the individual in need of treatment.

For situations when staff cannot coordinate transport between Region 1 South Crisis Care sites using local law enforcement or emergency medical vehicles, or when public or private commercial means of transport, such as a taxi voucher program, are not feasible, IDHS/DMH proposes to issue a separate RFI for transportation services independent of the other clinical services described here, with the transportation service authorized by the ACARES entity.

NOTE: For Will, Grundy and Kankakee Counties, it is anticipated that supplementary transport services will be bid out under an Invitation for Bid or a Sole Source Contract. These services will be for the transport of consumers voluntarily seeking non-inpatient community services such as Crisis Residential, access to a Living Room model program or Level 3.5 DASA services. Transfers of patients from emergency rooms to psychiatric units on an involuntary basis is already provided by Illinois Patient Transport

Within Cook County, DMH proposes that within Region 1 South, three (3) newly funded transportation services will be developed. First would be car transport of involuntary patients being moved from emergency departments to hospitals with psychiatric units, second as necessary, funding to be provided for involuntary patients whose risk level and or clinical criteria requires the use of an ambulance. Lastly, in circumstances where no other transport means is available, car transport for consumers seeking non-inpatient services such as Crisis Residential, access to a Living Room model program or Level III.5 DASA services.

IDHS/DMH will arrange transportation alternatives that are:

- Reliable
- Consistently available
- Performed by individuals with the appropriate skill levels for managing the individual being transported

C. Emergency and Transition Medication

Accessing psychotropic medications is critical for averting unnecessary inpatient admissions or ED presentations and also for maintaining stability for some individuals post discharge. Stipends or grants to local CMHCs for accessing emergency medications and access to the DHS state-operated mail order pharmacy services (locally housed in Will County and with likely savings for non-emergency medications in the 25-30% range) for post discharge medications will both be available. ACARES will likely play a role in the certification of the need for emergency/transition medications for persons entering the Region 1 South Crisis Care System.

DMH plans to support the needs for discharge and emergency medication needs through a combination of mini-grants to providers under this RFI to support emergent prescriptive needs and a larger monetary accessibility to the IDHS Pharmacy (OCAPS). Providers would be able to access pharmaceuticals through a mail order prescription process from the locally situated IDHS Pharmacy hub in Joliet. Bidders should project the anticipated total cost necessary based on projected volumes.

We plan to provide generic medications in all of the categories. We will consider brand name behavioral health meds only on a case by case basis with prior authorization by both DMH and OCAPS. The categories to be covered are as follows:

- Antihypertensive medications (generics only)
- Hyperglycemic medications (generic only)
- Analgesics (generic only)
- Dyslipidemias (generic only)
- Antipsychotics (generic first)
- Antidepressants (generic first)
- Mood Stabilizers (generic first)

V. Instructions for Submitting Proposals

A significant amount of psychiatric acute care need is already addressed via existing services in the Region 1 South area. The Region 1 South Crisis Care System will build on existing community hospital emergency departments and inpatient psychiatric units, along with existing DHS community provider programs. Many of the existing hospitals and providers draw support from State funding streams. Going forward, it will be essential for applications to clearly define the existing resources to be built upon, as well as the new capacities being developed.

The RFI also strives to promote strategic systems integration by:

- building alliances among existing service providers;
- leveraging other funding streams; and,
- engaging stakeholders in system planning throughout Phase I and Phase II.

To promote good planning, this RFI contains a map of current key service providers in Region 1 South, inclusive of community mental health and SUD service providers, as well as community hospitals. To see map click on link below:

http://maps.google.com/maps/ms?msa=0&msid=201434494408819946232.0004bb4c0309650a7304b

Submissions that propose alliances between two or more providers shall contain a Memorandum of Understanding (MOU) or letters of intent for such collaborations. In describing your proposed program, both in the narrative and in the budget pages, please make sure to highlight any of the key components below, and explain how existing elements will be used in conjunction with the proposed enhancements or additions to your program array.

A. Crisis Telephone Services

Many IDHS providers provide some form of crisis telephone service. These will play an ongoing important role in the Region 1 South Crisis Care System. The telephone is often the first point of contact with the professional care system for a person in crisis or a member of his/her support system. During Phase One, these services will remain intact. However, during our planning for Phase Two, we will explore ways to use the new Region 1 South Crisis Care System to engage people before they reach the ED.

B. Crisis Intervention Services

Crisis Intervention is defined as: Activities or services provided to a person who is experiencing a psychiatric crisis. The services are designed to interrupt a crisis, and include: assessment, brief supportive therapy or counseling and referral and linkage to appropriate community services to avoid more restrictive levels of treatment. The goal of crisis intervention is symptom reduction, stabilization and restoration to the previous level of functioning. (See *Community Mental Health Services Service Definition and Reimbursement Guide, page 29*, at:

http://www.hfs.illinois.gov/assets/cmhs.pdf

Several IDHS providers in the Region 1 South catchment area already operate crisis intervention services, using a blend of state grant funding, fee for service billing, and other private or governmental funding streams to support the delivery of actual crisis intervention services. The program description appears at Appendix 10 titled Sample Prices Program and Budget Document features an example of crisis services attached to a crisis telephone line. This may be useful as a guide to designing your proposal.

C. Access to Community-based Rule 132 Services

Currently, individuals with serious mental illnesses who are not eligible for Medicaid have access to some of the community-base Rule 132 (Medicaid Community Mental Health Services Program) services. See: http://www.hfs.illinois.gov/assets/cmhs.pdf for the Rule 132 services definitions. Services now available for individuals who do not have Medicaid at funded DMH provider agencies in Region 1 South are detailed at Appendix 9.

D. Substance Use Disorder (SUD) Services

For the person with a qualifying diagnosis, a range of SUD services, from outpatient to residential, will be available. The services include:

- Case management
- Community intervention
- Detoxification
- Intensive outpatient services
- DASA early intervention
- Outpatient services
- Residential rehabilitation
- Residential rehabilitation—extended

- Toxicology

Useful information about DASA services can be found at:

http://www.dhs.state.il.us/OneNetLibrary/27896/documents/Manuals/FY12/DASA_Contractual_Policy_Manual_FY2012.pdf
and at:
http://www.ilga.gov/commission/jcar/admincode/077/07702090sections.html.

E. Client Transitional Subsidies

In order to effectively manage individuals in crisis and firmly link them to the appropriate level of service, a number of barriers and needs may be encountered that have to be efficiently and effectively managed. Emergency housing, food, clothing or transportation may be required, as well as medications. Accessing psychotropic and other medications is critical for averting unnecessary inpatient admissions or ED, presentations and also for maintaining stability for some individuals post discharge. We would like providers to consider the Client Transitional Subsidy needs that may be associated with the particular role they wish to play in the new Region 1 South Crisis Care System.

F. Access to Psychiatry

Several IDHS providers have grant funding that allows a measure of psychiatry services for uninsured individuals. This service will be vital feature to the Region 1 South Crisis Care System and will likely be enhanced by this RFI. Additions to this funding stream can be proposed to reflect the added needs of the ACARES certified Region 1 South Crisis Care System recipient.

G. Supportive Housing

The successful use of supportive housing to help people with mental illnesses stabilize their lives and reduce the use of costly inpatient psychiatric services is well documented. In an Illinois study of the effectiveness of supportive housing, the number of users and uses of mental health hospitals decreased 90% from pre- to post-supportive housing, and the use of Inpatient/Acute Medicaid services decreased 82%.[4] The Substance Abuse and Mental Health Services Administration recognizes only ten evidence-based practices for serving adults with mental illnesses. Supportive housing is one of the ten.

Many DMH and DASA providers already use supportive housing as part of a comprehensive approach to achieving better outcomes for the persons experiencing repeat mental health crises or for persons with dual disorders.

[4] Social IMPACT Research Center (2009). Supportive Housing in Illinois: A Wise Investment.

For Region 1 South Crisis Care System recipients who are homeless, participating providers will be expected to initiate contact with any available Continuum of Care (CoC) planning body. These committees come together to work on the issues surrounding homelessness, from prevention to permanent housing and everything in between. There are several Continua of Care that cover Region I South:

- Will County CoC
- The Alliance to End Homelessness in Suburban Cook County
- DeKalb CoC
- CoC of Kane County
- DuPage County CoC
- McHenry County CoC

These entities develop and operate homeless prevention programs, emergency shelters, transitional housing and permanent supportive housing, as well as other supportive services for persons experiencing homelessness

H. Warm Line[5]

IDHS/DMH currently operates a Warm Line for the state's public mental health service system. The Warm Line is staffed by peers, and it is designed to provide social support to callers in emerging, but not necessarily urgent, crisis situations. Peers are current or former consumers of services who are trained to provide non-crisis supportive counseling to callers. The Line focuses on the following:

- Building peer support networks and establishing relationships,
- Active listening and respect for consumer boundaries, and
- Making sure callers are safe for the night

Participating providers should consider weaving the Warm Line into their existing and expanded crisis care services.

[5] Pudlinski, P. Contrary Themes of Three Peer-Run Warm Lines: *Psychiatric Rehabilitation Journal*, Spring 2001.

I. Peer Support -Services (e.g., Living Room Models)[6]

Peer support services provide social connectedness and support by former or current consumers of mental health services in a home-like setting. In times of crisis, people feel alone with their anxiety, panic, anger, frustrations and depression. One of the goals of peer-run crisis respite is to provide connections and relationships that can lessen the intensity of these feelings. These non-medical alternative programs offer a comfortable, non-judgmental environment in which one might be able to process stresses as well as explore new options. The hope is that these interactions will result in fresh, short-term solutions and a wider array of options for handling future crises.

As people have an opportunity to stay connected to peers while moving through challenging thoughts, feelings and impulses, the need for external intervention is diminished. This alternative approach to handling crisis teaches people healthier attitudes about themselves and others. With increased skills, individuals can reduce or even eliminate their susceptibilities to the pressures that cause overwhelming emotional distress.

A peer respite site can include facilities for overnight stays of up to seven days. It is anticipated that on-line training program for certification as substance abuse recovery specialist being developed by Governor's State University may enhance the potential pool of peer support specialists.

---

[6] *Peer Respite Services: Transforming Crisis to Wellness.* Teleconference by Substance Abuse and Mental Health Services Administration's Resource Center to Promote Acceptance, Dignity and Social Inclusion Associated with Mental Health. August 4, 2011.

National Empowerment Center web site at: http://www.power2u.org/crisis-alternatives.html

VI. Information Requested

A. Provider Organization Information, complete Attachment A.

B. Capability and Plans for Delivery of Community Mental Health Medicaid Services complete Attachment B.

Include in your narrative a detailed description of the capability of your organization to deliver hospital-based or community-based mental health or substance abuse services, both existing service capacity (available open "slots") as well as proposed expansion of capacity for each service. In the "notes" column please reflect any special expertise (especially languages spoken and cultural competence), and description of hours of availability for each of the services. If applicable, include the number of teams/staff providing each service, number of individuals served and locations where this service is available for each service:

C. Development of additional service capacity, complete Attachment C.

Include in your narrative for Attachment C the expansion of capacity for exiting services and the development of any new services proposed, describe your plans and resources (head count and funding) needed to develop service and support capacity: (a) for FY 2012; and (b) in subsequent years.

The narrative shall include a description of how your organization will assure that services and supports are recovery-oriented, and will be delivered in a manner that is person-centered, and respects the individual's preferences and choices.

Propose options that can build on existing staff, teams or resources and options that require totally new development. Include an anticipated time frame for new/expanded services. Your response shall include at least the following infrastructure needs:

- Staff recruitment and selection
- Staff training and development
- Staff supervision
- Staff administrative support
- Additional office space
- Additional equipment

D. Capability and Plans for Securing and Maintaining Linkages with Other Necessary Supports and Services; complete Attachment D.

E. Describe the capability of your organization to provide integrated services for individuals with the dual disorders of mental illness and substance abuse, including the degree, if any, to which your organization's service delivery model corresponds to the fidelity of the evidenced-based models for this integrated service.

F. Describe the capability of your organization to provide integrated services for individuals with the dual disorders of mental illnesses and medical/physical problems, including all staffing, procedures, or other factors demonstrating integrated practice.

G. Geographic coverage

Community mental health service providers, please describe the geographic area currently served by your agency and any additional areas where your organization could expand geographically. Specifically list the Hospital EDs, from the Hospitals listed in Table II that you propose your agency would serve. Describe any conditions that would impact your organization's ability to expand into new areas, including but not limited to minimum number of clients in an area and resources needed to support geographic expansion.

H. Financial stability

- Provide a general assessment of the financial stability of your organization and its ability to sustain operations into the future of the next five years. This general assessment should be described in the context of the reality of existing rates, budget issues, and consequent payment timeliness currently being experienced in the state.

- Provide the following indicators reflecting the financial condition of your organization:

    - Number of days of operation possible with cash on hand
    - Current total amount of available lines of credit not currently being utilized
    - Ratio of total assets to total liabilities
    - Resources of any affiliated organizations that could be available to support the services described above

I. Capability and Plans to Assure the Ongoing Quality of Services and Continuous Improvement

- Describe the quality improvement and quality assurance processes currently in place within your organization and any plans to adjust or further develop these processes in the immediate future. Include specific example(s) of how these processes have improved outcomes, service, and/or minimized risk;
- Describe how your current and future quality improvement and assurance processes will benefit the Region 1 South Crisis Care recipients.

J. Capability and Plans to Provide Individual Outcome Data

Describe your organization's current use or immediate future plans to obtain and utilize individual consumer outcome data.

Attachments and Appendices

Attachments

Appendices

Attachment A
Provider Organization Information

Name:	
FEIN Number:	
Address: **City, State, Zip**	
Contact Person:	
Contact phone number:	
Contact email address:	
Locations of offices and sites of services delivery (address/services provided at the address):	
Number of unduplicated adult consumers served in FY11:	
Number of new patients/ consumers/case openings in FY11:	
Number of case closings/ terminations of services in FY11:	
Characteristics of adult consumers served in FY11:	
% male/female:	
% with serious mental illness:	
Staffing characteristics:	
Total number of staff supporting the provision of psychiatric, mental	

health or substance abuse services	
Number and percentage of total that are administrative and support staff (not providers of direct services).	
Number of prescribers of medications. Distinguish between MDs and other prescribers (please identify).	
Number of direct service staff board eligible or certified in psychiatry.	
Number and percentage of direct service staff qualified as an LPHA (i.e., licensed service providers, including psychiatrists).	
For community mental health providers, the number and percentage of direct service staff whose highest qualification is a QMHP.	
For community mental health providers, the number and percentage of direct service staff whose highest qualification is an MHP.	
For community mental health providers, the number and percentage of direct service staff who are self-identified consumers.	
For community mental health providers, the number and percentage of direct service staff who are Certified Recovery Support Specialists.	
List of languages spoken by direct service staff including number of staff by credential who speak each language.	
List of ethnic groups in which the agency has cultural competence including number of staff by credential with the demonstrated competence for each ethnic group.	

Attachment B
Proposed Budget

RFI Proposal Document

Program Title: _____
Provider Name: _____

Provider FEIN: _____
Street Address: _____
City: _____
Contact Person: _____
Contact Phone Number: _____
Contact Email Address: _____
Proposal Date: _____
Proposed Period of Service: _____

Personnel - FTE Base Salary (1.0 FTE = _____hours per week)	**# of FTEs**	**Monthly Amount**	**Annual Amount**	**Proposed Amount**	**Notes** *List applicable quantity, units, percentages, clarification, etc.*
Position Title 1:					
Position Title 2:					
Position Title 3:					
Position Title 4:					
Position Title 5:					
Position Title 6:					
Position Title 7:					
Position Title 8:					
Position Title 9:					
Position Title 10:					
Total		$0	$0	$0	
FICA @ 7.65%		$0	$0	$0	
Benefits					
Retirement					
Life & Health Insurance					
Other: _____					
Other: _____					
Personnel - FTE Base Salary (1.0 FTE = _____hours per week)	**# of FTEs**	**Monthly Amount**	**Annual Amount**	**Proposed Amount**	**Notes** *List applicable quantity,*

					units, percentages, clarification, etc.
Total		$0	$0	$0	
Total Personnel Cost		**$0**	**$0**	**$0**	
Indirect Cost (or detail by item below)					
Percentage:_____					
Contractual Services					
Training					
Other: _____					
Other: _____					
Total		$0	$0	$0	
Travel					
# Miles (cost per mile=					
Mileage costs		$0	$0	$0	
Other transportation					
Lodging					
Per diems/meals					
Other: _____					
Total		$0	$0	$0	
Commodities					
Office Supplies					
Other: _____					
Other: _____					
Total		$0	$0	$0	
Equipment/Furniture					
Desks					
Chairs					
Other: _____					
Personnel - FTE Base Salary (1.0 FTE = _____hours per week)	**# of FTEs**	**Monthly Amount**	**Annual Amount**	**Proposed Amount**	**Notes** *List applicable quantity, units, percentages, clarification, etc.*
Total		$0	$0	$0	
Information Technology					
Desktop Computer					
Laptop Computer					

Printer					
Software					
Internet Service					
Other: _____					
Total		$0	$0	$0	
Telecommunications					
Land Phone (equipment)					
Cell Phone (equipment)					
Installation					
Monthly Service for land phones					
Monthly Service for cell phones					
Total		$0	$0	$0	
Operation of Automotive Equipment					
Vehicle Lease					
Vehicle Purchase					
Gasoline					
Maintenance					
Licenses and fees					
Total		$0	$0	$0	
Occupancy					
Rent (Cost per sq ft = _____)					
Utilities					
Repairs & Maintenance					
Personnel - FTE Base Salary (1.0 FTE = _____hours per week)	**# of** **FTEs**	**Monthly** **Amount**	**Annual** **Amount**	**Proposed** **Amount**	**Notes** *List applicable quantity, units, percentages, clarification, etc.*
Insurance					
Taxes					
Total		$0	$0	$0	
Renovation Costs					
Other Start-up Costs					
_____					
_____					

_____					
Other Indirect Cost					
_____					
_____					
_____					
Total Non-Personnel Cost		$0	$0	$0	
Total Program Cost		$0	$0	$0	

Attachment C
Service Capacity Form

Services currently funded or readily available w/o capital development funding	Program Code	Annual Funding Amount	Current capacity	Estimated Average Number of Individuals Served per Month	Proposed new capacity	Proposed new costs	Estimated Available Capacity	Note
Inpatient Psychiatric								
BILT Model Behavioral Health Services in ED								
Psychiatric Leadership	350							
Special Projects	510							
Specialized Direct Clinical Services	515							
Psychiatric Medications	574							
PATH Grant	575							
Crisis Staffing	580							
Crisis Telephone Line								Hours c =

MH CILA	620
Outreach	710
Drop-In Center	720
Quality Administrator	730
Integrated Health Care	760
Supported Residential	820
Supervised Residential	830
Crisis Residential Care	860
Supportive/PSH Housing	
Non-Medicaid	NMR

Rule 132 Services

Crisis intervention
Crisis intervention, state operated facility screening
Crisis intervention--multiple staff
Mental health assessment
Treatment plan development
Case management--mental health

Case management--transition linkage and aftercare

Case management--mandated follow-up
Case management - LOCUS
Psychotropic medication administration
Psychotropic medication monitoring
Psychotropic medication training--Individual
Psychotropic medication training--group
Oral interpretation and sign language

Case management--client-centered consultation
Assertive community treatment
Community support, team
Assertive community treatment, group

Community support, individual	
Community support, group	
Community support, residential, individual	
Community support, residential, group	
Psychosocial rehabilitation, individual	
Psychosocial rehabilitation, group	
Therapy/counseling--Individual	
Therapy/counseling--group	
Therapy/counseling--family	
Mental health intensive outpatient--adult	

Level I - Methadone	5
Level III Rehabilitation - Adult (Medicaid only programs)	27

Recovery Home	40
Case Management	41
Intervention	42
Level I - Adult or Adult/Youth	43
Level II - Adult or Adult/Youth	44
Halfway House	45
Detoxification	46
Level III Rehabilitation - Adult	47
Assessment	48
Donated Funds Initiative (DFI)	49
Toxicology	52
Interpreter Referral Services	64
HIV	95
HIV Early Intervention Training	96
Enhanced DASA Substance Abuse 3.5 or 3.7 Residential Services	

Attachment D
Linkage Capability

Service or Support	# of unduplicated adult consumers linked last year	Comment on your organization's capability to provide effective linkages to this service. Include a description of the activities performed to complete the linkage
Housing		
Permanent Supportive Housing		
Primary/physical medical services and care		
Substance abuse services		
Vocational services		
Educational services		
Support groups		
Natural supports (churches, community groups, etc.)		
Other services or supports (please specify)		

APPENDIX #1

Rebalancing Mental Health Clinical Focus Group Agenda
February 17, 2012

Participants:

Lorrie Rickman Jones, Ph.D. Director, DHS Division of Mental Health

Theodora Taylor, Director, DHS, Division of Alcohol and Substance Abuse

Dennis Beedle M.D., Acting Clinical Director Illinois DMH

Shastri Swaminathan M.D., Chief of Psychiatry Advocate Illinois Masonic Medical Center, Past President of Illinois Medical Society and Illinois Psychiatric Society.

Harold McGrath M.D., Chief of Psychiatry, Advocate Christ Medical Center, Neurosciences Institute Foundation Board Chairman

George Miller, M.D. Emergency Department, Medical Director, Advocate South Suburban Hospital

Tim Moore, LCPC, Grand Prairie Services, Director of Clinical Programs

John Galik, Ph.D. Franciscan St. James Hospital

Jackie Haas, MSW, LCSW, President & CEO, Helen Wheeler MHC

Susan Hudson, LCPC, RDDP, Grundy County, Director of Mental Health & Substance Abuse

Joe Troiani, Ph.D. Executive Director, Will County Behavioral Health

Richard Multack, D.O Vice President, Medical Management, Advocate South Suburban Hospital

Lisa Labiak, Vice President, Business Development and Corporate Communications, Grand Prairie Services

Rebalancing Mental Health Clinical Focus Group
March 20 and March 26, 2012

Participants:

Dennis Beedle M.D., Acting Clinical Director Illinois DMH

Patricia Reedy LCSW, DMH, Chief Social Worker

Mary E Smith, Ph.D. Associate Director Decision Support, Research and Evaluation

Scarline Jerome Kon, M.D. Tinley Park MHC. Medical Director

Tony Fletcher, Psy.D., ABPP/FP, Clinical Psychologist Elgin MHC

Denise Blumenthal, LCSW Social Work Director, Chicago-Read MHC

Katherine Burson, OTR/L, DMH, Chief of Rehabilitative Services DMH

Geri Staehle, R.N. Director of Nursing Chicago-Read MHC

Rob Petkofski, R.N., A.P.N., Director of Nursing, Madden MHC

Gordon Reiher, LCPC, Contract Manager, Region 1Central

Virginia Goldrick, Ph.D., Recovery Support Specialist Region 1 North

APPENDIX #2
ACCT Committee List

Transition of Care, Project Manager	Mark.Doyle@illinois.gov	312-343-4650
Director	LorrieRickman.Jones@illinois.gov	312-814-1115
Senior Dir. Health Care Policy & Regulation	mclarke@ihastaff.org	217-541-1154
Chief of Psychiatry	docshrink1@gmail.com	773-206-8977
	addie.anderson@lorettohospital.org	
Director, BH Service	christine-anthony@riversidehealthcare.net	
	ebeckman@metrosouthmedicalcenter.com	
	kbergmark@paloscomm.org	
	jbergren@ingalls.org	
Director AIR	jbosley@ingalls.org	708-915-6414
	dorothy_bourgeois@ghr.org	
Dir. Emergency Dept.	nancy.burke@ahss.org	
	mcaserta@psych.uic.edu	
	Patricia_cassidy@ghr.org	
Sr. VP/Chief Strategy Officer		815-300-7002
	nconnolly@mercy-chicago.org	
Interim CEO	dave.crane@ahss.org	
	mark-desilva@ghr.org	
	sducker@ameritech.net	
	bruce_elegant@rush.edu	
President	michael.englehart@advocatehealth.com	
	mfreyer@lcmh.org	708-229-5004
Director, BH	john.galik@franciscanalliance.org	
	cgillen@reshealthcare.ord	
Director	rgreenspan@ingalls.org	
VP Patient Care Services		
	kevin-hack@riversidehealthcare.net	
Facilitor	m-heyrman@uchicago.edu	773-753-4440
Director, BH	abigail.hornbogen@povena.org	
	beth.hughes@provena.org	
	kjohnson@ingalls.org	
	vjohnson@emp.com	
Dir, MH	douglas.jones@provena.org	
	khooshmand@mercy-chicago.org	
	phil-kambic@riversidehealthcare.net	
VP Patient Care Services, CNO	Maureen.Kelly@franciscanalliance.org	
VP, Dev. & Corp. Communication	llabiak@GPSBH.org	708-623-1504

	amy.lafine@provena.org	
President	kenneth.lukhard@advocatehealth.com	
CEO	rick.mace@ahhss.org	
	kmallo@lcmh.org	
Chief of Psychiatry	harold.mcgrath@advocatehealth.com	708-684-5844
Medical Director ED	george.miller@advocatehealth.com	
Dir. Med/Surg & Phych	michael.moonan@advocatehealth.com	
Medical Management VP	robert.multack@advocatehealth.com	
	DNeal@fhn.org	
	sharon.okeefe@uchospitals.edu	
Manager ED	shar_oshea@metrosouthmedicalcenter.com	708-824-4510
Patient Care Services	sharon.otten@advocatehealth.com	
Dir. Emergency Services	nancy.pasieta@advocatehealth.com	
	kperrino@lcmh.org	708-229-6136
Dir. of Impatient Behavioral Health	petersenmary@ihs.org	309-793-2031
	dpowell@roselandhospital.org	
Business Development	beth.purcell@advocatehealth.com	
Serv. Planning & Devel. Manager	jreinert@ncbhs.org	
Administrator, Dept of Psychiatry	rrobinson@cookcountyhhs.org	312-864-8020
	mroy@morrishospital.org	
	JimSarver@sinnissippi.com	
	cschneider@cookcountyhhs.org	
	jshaffer@roselandhospital.org	
Director, ED	jshere@lcmh.org	708-229-5710
Dir. Clinical Operations, BHS	emsmith@macneal.com	
Director, BH		
	msteadham@morrishospital.org	
Manager ED	staylor@lcmh.org	708-229-5606
LCSW	ethrun@morrishospital.org	815-942-2932
Director, Emergency Services	gayle_toscano@metrosouthmedicalcenter.com	708-824-4518
	btownsend@mercy-chicago.org	
Director of BH		
Consumer	Marti57@comcast.net	708-755-0414 630-278-9383
Asst. Medical Dir, LCMH ED	wpwdoc@hotmail.com	708-229-5765
President/CEO	seth.warren@franciscanalliance.org	
	david.wilson@sinai.org	
ER Director	augustus.ynares@provena.org	815-937-8749
	pzielske@ingalls.com	
	leslie.zun@sinai.org	
Dep. Dir. of Program Services	Patricia.Kates-Collins@illinois.gov	312-814-1895

Contract Manager	Gajef.McNeill@illinois.gov	618-241-6866
Acting Clinical Director	dennis.beedle@illinios.gov	312-814-8762
Special Assist. to the Director	michael.pelletier@illinois.gov	847-894-9877
Residential Care Worker	Susan.Pickett@illinois.gov	312-443-3144
Director of B/H	jtroiani@willcountyhealth.org	815-727-8516
Executive Director	l.baker@shpa-il.org	217-528-9814
MSW, CADC	mlindsey@CBHA.net	217-585-1600
CEO	mambrosino@swcsinc.org	708-429-1260 ext. 1234
	burf9905@aol.com	708-612-4227
Consumer	marti57@comcast.net	773-708-7456
	jcollord@hcenter.org	
Dir. of Behaviorla Health Services	tdykstra@trinity-services.org	815-717-1700
President & CEO	hwcjackie@ameritech.net	815-939-3543
Vice President/COO	dhespell@cornerstoneservices.org	815-741-7082
Director		
CEO		
CEO	jjohnson@hrdi.org	312-441-9009
Vice President of Clinical Serv.	DLustig1@aol.com	312-226-7984 ext. 488
Peer Specialist	c.martin@fayettecompanies.org	309-671-8000 ext. 2208
Executive Director	pmclenighan@steppingstonestreatment.com	815-744-4555
Associate Clinical Director	tmoore@gpsbh.org	630-333-5232
President/CEO	Loshea@the-assocation.org	630-966-4001
CCO		773-572-5440
	apizza@tasc-il.org	
Consumer	rawork1967@gmail.com	815-814-2341
President & CEO	allensandusky@ameritech.net	708-647-3300
Consumer	Marti57@comcast.net	708-755-0414 630-278-9383
CEO	sward@gpsbh.org	708-444-1501
Manager	Jayne.Antonacci@illinois.gov	217-785-7754
Project Manager & Block Grant Coordinator	Danielle.Kirby@illinois.gov	312-814-5815
Compliance Unit Manager	JOE.LOKAITIS@illinois.gov	217-785-7612
Administrator	RICK.NANCE@illinois.gov	217-557-6706
	CHRIS.POWER@illinois.gov	217-782-2498
Manager	Carmen.Townsend@illinois.gov	312-814-2307
Comm. Serv. Fiscal Pol. Specialist	Brock.Dunlap@illinois.gov	217-524-6996
Facility Director	GUSTAVO.ESPINOSA@illinois.gov	708-338-7202
Director, Recovery Support	Nanette.Larson@illinois.gov	309-693-5228

Serv.		
Assoc. Director	JACKIE.MANKER@illinois.gov	217-782-5700
Assoc. Dir. Region Serv	DAN.WASMER@illinois.gov	773-908-6267
	JimSarver@sinnissippi.com	
Director, BH		
	Jaurand@fhn.org	
	steffbrownfam@hotmail.com	309-973-6303
President	deopered@trinityqc.com	309-779-2041
	peaton@rosecrance.org	
	bgcmg@bengordoncenter.org	
Director of Operations	fredam@ihs.org	309-779-2051
	sel@ssrinc.org	
Peer Specialist	c.martin@fayettecompanies.org	309-671-8000 ext. 2208
CEO	dmiskowiec@ncbhs.org	
	murphyr@ihs.org	
	DNeal@fhn.org	
	billn@bway.org	309-344-4337
Consumer	no e-mail (see mailing address)	815-962-7866
	d ornelis@yahoo.com	309-428-9273
Consumer	rawork1967@gmail.com	815-814-2341
	zschamper@gmail.com	815-297-4374
Compliance Unit Manager	JOE.LOKAITIS@illinois.gov	217-785-7612
Region Executive Director	jordan.litvak@illinois.gov	217-786-6866
Region Executive Director	amparo.lopez@illinois.gov	847-742-1040 ext. 2002
	jshustitzky@thechicagoschool.edu	
Executive Director	thomas.lora@sbcglobal.net	217-522-1403
	JAurand1@fhn.org	
Consumer	marti57@comcast.net	773-708-7456
Outpatient Director	dukedr@ihs.org	309-779-2023
IOOV Coordinator	sacred.creations@thebridge.to	618-798-9788
Professor	Kathleen R Delaney@rush.edu	312-942-6208
	Jim.Sarver@sinnissippi.com	
Director of Services	sue@ssrinc.org	815-963-0683
Consumer	Marti57@comcast.net	708-755-0414 630-278-9383
Manager	Jayne.Antonacci@illinois.gov	217-785-7754
Coordinator	Kellie.Gage@illinois.gov	312-814-6415
Service Coordinator	Carolyn.Hartfield@illinois.gov	312-814-5809

Facility Director	GUSTAVO.ESPINOSA@illinois.gov	708-338-7202
Director, Recovery Support Serv.	Nanette.Larson@illinois.gov	309-693-5228
Vice Pres. - CAO	bstortz@cornerstoneservices.org	815-841-7042
President/CEO	loshea@the-association.org	630-966-4001
	burf9905@aol.com	708-612-4227
Sr. Dir, Health Policy & Reg.	mclarke@ihastaff.org	217-541-1150
	peaton@rosecrance.org	
CEO	bgcmf@bengordoncenter.org	
President & CEO	hwcjackie@ameritech.net	815-939-3543
	elliottjones@gmail.com	708-408-0242
MSC/CADC	mlindsey@cbha.net	217-585-1600
Chief Financial Officer	murphyr@ihs.org	309-793-2031
COO	billn@bway.org	309-344-4377
	Frank.Kopel@illinois.gov	217-524-7480
Serv. Planning & Devel. Manager	jreinert@ncbhs.org	
CEO	starnes@bway.org	309-837-4876
Administrator	RICK.NANCE@illinois.gov	217-557-6706
Manager	Joseph.Tracy@illinois.gov	312-814-6359
Business Administrator	Brock.Dunlap@illinois.gov	217-524-6996
Associate Director	Susan.Pickett@illinois.gov.	312-433-3144
Associate Director	MaryE.Smith@illinois.gov	312-814-4948
Outpatient Director	dukedr@ihs.org	309-779-2023
Director of Operations	fredam@ihs.org	309-779-2051
Executive Director	william@silcofillinos.org	217-744-7777
	sel@ssrinc.org	
COO	jmahoney@ncbhs.org	815-224-1610
Director	Theodora.Binion@illinois.org	312-814-6357
Deputy Director	Maria.Bruni@illinois.gov	312-814-2148
Manager	Richard.Sherman@illinios.gov	312-814-2290
President	jstover@iarf.org	217-753-1190 ext. 171
Transition of Care, Proj. Manager	Mark.Doyle@illinois.gov	312-343-4650
VP for Public Policy & Gen. Counsel	Karen@equipforequality.org	312-895-7330
President	deopered@trinityqc.com	309-779-2041
Director of Operations	fredam@ihs.org	309-779-2051
Legislation/Legal Lisaison	Pat.Knepler@illinois.gov	217-785-7612

Manager	JOE.LOKAITIS@illinois.gov	217-557-6706
Administrator	RICK.NANCE@illinois.gov	312-814-2436
Manager	Lillian.Pickup@illinois.gov	312-814-8944
Director	Debra.Ferguson@illinois.gov	

APPENDIX #3

Master Schedule and Brief Status of ACCT Committee Meetings

April 2, 2012

Compiled by: D. Wasmer; dan.wasmer@illinois.gov

Hospital Engagement [Tinley Park Area] Dennis Beedle & Michael Pelletier

Date of meeting	Agenda Items	Status
March 16, 2012, Christ Hospital with teleconference option	Explanation of the 3 hospital based services under consideration for RFI	Follow-up phone call for technical assistance questions scheduled for 3-23-2012
Teleconference 3-23-12	Follow-up call with the Committee to update on the draft Rebalancing Plan	Awaiting distribution of RFI

Hospital Engagement [Singer Area] Dennis Beedle & Michael Pelletier

Date of meeting	Agenda Items	Status
Conference call April 23, 2012	1. Brief chairs of committee on goals and purpose of committees; 2. seek further membership; 3. schedule face-to-face meetings	Pending completion
1st Meeting anticipated in weeks of April, 16th and 23rd 2012 with teleconference option	1. Review TPMHC for template; 2. Explanation of the 3 hospital based services under consideration for RFI	Pending Scheduling

Service Models & Innovations [Tinley Park Area] Dan Wasmer & Gustavo Espinosa

Date/type of meeting	Agenda Items	Status
March 14, 2012 In-person @ Will County Health Dept, with teleconference option	1. Discuss the ACCT process. 2. Mission of Committee. 3. Review draft of Rebalancing Plan for Crisis System Service Array. 4. Plan next steps	Done. Draft minutes, revised Rebalancing Plan (rev.3/19), and other supporting documents now on file with Sharon Lefferts Office at DHS.
March 21, 2012 In-person @ Will County Health Dept, with teleconference option	1. Review revised Rebalancing Plan (rev.3/19). 2. Make further refinements to plan. 3. Reach group agreement on the plan design and language. 4. Discuss possible next steps.	Meeting conducted. Minutes and new draft Rebalancing document being written.
TBA		

Service Models & Innovations [Singer Area] Amparo Lopez & Jordan Litvak

Date of meeting	Agenda Items	Status
1st Meeting anticipated in weeks of April, 16th and 23rd 2012 with teleconference option	1. Discuss the ACCT process. 2. Mission of Committee. 3. Review draft of Rebalancing Plan for Crisis System Service Array used for the Tinley area and discussion about changes to adapt for the Singer community area.	pending

Community Education & Support [Both Areas] Amparo Lopez & Gustavo Espinosa

Date of meeting	Agenda Items	Status
February 27,2012 teleconference with co-chairs	1. Introductions and welcome. 2. Mission of the Committee 3. Identifying members for committee 4. Review of Outline	Done. Draft minutes on file with Sharon Leffers. Next meeting 3/5/12
March 5, 2012, teleconference.	1. Introductions & Welcome. 2. Brief summary of the ACCT Committee Work. 3. Mission of the committee 4. Next Steps	Done. Draft minutes on file with Sharon Lefferts. Next meeting on 3/23, 2012. Committee requested copies of Rebalancing and Reinvestment Plan document as well as ACCT Draft
March 23, 2012, teleconference	1. Introductions &Welcome 2. Summary of the ACCT Committee Structure and work 3. Overview of ACCT Draft Plan 4. Next Steps	Committee requested copy of the updated ACCT Draft Plan
March 30, 2012 teleconference	1. Introductions 2. Review of Minutes 3. ACCT Plan Update 4. Community Education Plan Discussion	Audience and Mode of Communication table was reviewed

Service Financing & Payment Methodology [Both Areas] Brock Dunlap

Date of meeting	Agenda Items	Status
March 16, 2012, teleconference	1) Welcome 2) Mission 3) Discuss services document	Completed
March 23, 2012, teleconference	1) Walk thought changes to services document and applying estimated costs 2) Discuss possible Phase I and Phase II options 3) Discuss holdback of funds for unforeseen system needs 4) Discuss next steps	

System Performance & Outcomes Assessment [Both Areas] Sue Pickett & Mary Smith

Date of meeting	Agenda Items	Status
March 29, 2012 @ 2 pm (teleconference)	1. Welcome & introductions 2. Mission of ACCT Workgroups & Systems Performance & Outcomes Assessment Workgroup 3. Overview of proposed services 4. Discussion of draft performance metrics	Done. Minutes being compiled.
Tele-conference scheduled for April 12, 2012	Pending	Pending

Messaging Media & Legislative Liaison [Both Areas] Pat Knepler & Debra Ferguson

Date of meeting	Agenda Items	Status
No meeting scheduled yet.		

APPENDIX #4

FY11 Discharged from Tinley Park MHC with the following Primary Discharge Diagnosis

Dx Code	Description	# Discharged	Primary Substance Abuse
292.84	Drug-Induced Mood Disorder	215	215
296.90	Unspecified Episodic Mood Disorder	147	70
311	Depressive Disorder	135	
296.30	Major Depressive Disorder, Recurrent Episode, Unspecified	112	
298.9	Unspecified Psychosis	101	
295.70	Schizoaffective Disorder, Unspecified	92	
296.7	Bipolar I Disorder, Most Recent Episode Unspecified	79	
296.40	Bipolar I Disorder, Most Recent Episode Manic, Unspecifie	70	
296.20	Major Depressive Disorder, Single Episode, Unspecified	69	
295.30	Schizophrenia, Paranoid, Unspecified	69	
296.44	Bipolar I Disorder, Manic Episode, Severe With Psychotic	55	
291.89	Other Specified Alcohol-Induced Mental Disorders	52	52
296.60	Bipolar I Disorder, Mixed Episode, Unspecified	50	
296.33	Major Depressive Disorder,Recurrent,Severe Without Psycho	44	
295.90	Unspecified Schizophrenia, Unspecified	42	
296.64	Bipolar I Disorder, Mixed Episode, Severe With Psychotic	39	
V65.2	Person Feigning Illness	38	
309.0	Adjustment Disorder With Depressed Mood	33	
296.34	Major Depressive Disorder,Recurrent,Severe With Psychotic	30	
296.50	Bipolar I Disorder, Depressed Episode, Unspecified	29	
296.89	Other And Unspecified Bipolar Disorders, Other	25	
309.4	Adjustment Disorder With Mixed Disturbance Of Emotions An	24	
304.00	Opioid Type Dependence, Unspecified	24	24
296.23	Major Depressive Disorder, Single, Severe Without Psychot	21	
296.32	Major Depressive Disorder, Recurrent Episode, Moderate	20	
300.00	Anxiety State, Unspecified	19	
296.24	Major Depressive Disorder, Single, Severe With Psychotic	19	
303.90	Other And Unspecified Alcohol Dependence, Unspecified	18	18
295.62	Schizophrenic Disorders, Residual Type, Chronic	17	
296.04	Bipolar I Disorder,Single Manic Episode,Severe With Psych	15	
305.00	Alcohol Abuse, Unspecified	13	13

Dx Code	Description	# Discharged	Primary Substance Abuse
309.9	Unspecified Adjustment Reaction	12	
305.60	Cocaine Abuse, Unspecified	12	
295.32	Schizophrenia, Paranoid, Chronic	11	
303.00	Acute Alcoholic Intoxication, Unspecified	11	11
292.11	Drug-Induced Psychotic Disorder With Delusions	9	9
295.10	Schizophrenia, Disorganized, Unspecified	8	
309.28	Adjustment Disorder With Mixed Anxiety And Depressed Mood	8	
305.90	Other, Mixed Or Unspecified Drug Abuse, Unspecified	8	8
296.54	Bipolar I Disorder, Depressed Episode, Severe With Psycho	8	
297.1	Delusional Disorder	6	
304.20	Cocaine Dependence, Unspecified	6	6
296.63	Bipolar I Disorder, Mixed Episode, Severe Without Psychot	5	
304.80	Combinations Of Drug Dependence Excluding Opioid, Unspeci	5	5
292.12	Drug-Induced Psychotic Disorder With Hallucinations	5	5
309.81	Posttraumatic Stress Disorder	4	
304.70	Combinations Of Opioid Type Drug With Any Other, Unspecif	4	
300.01	Panic Disorder Without Agoraphobia	4	4
309.3	Adjustment Disorder With Disturbance Of Conduct	4	
296.43	Bipolar I Disorder, Manic Episode, Severe Without Psychot	3	
296.31	Major Depressive Disorder, Recurrent Episode, Mild	3	
305.50	Opioid Abuse, Unspecified	3	3
305.20	Cannabis Abuse, Unspecified	3	3
304.30	Cannabis Dependence, Unspecified	3	3
300.21	Agoraphobia With Panic Disorder	2	
295.60	Schizophrenic Disorders, Residual Type, Unspecified	2	
314.01	Attention Deficit Disorder With Hyperactivity	2	
295.73	Schizoaffective Disorder, Subchronic With Acute Exacerbat	2	
295.80	Other Specified Types Of Schizophrenia, Unspecified	2	
314.00	Attention Deficit Disorder Without Hyperactivity	2	
301.22	Schizotypal Personality Disorder	2	
296.53	Bipolar I Disorder, Depressed Episode, Severe Without Psy	2	
291.3	Alcohol-Induced Psychotic Disorder With Hallucinations	2	2
312.30	Impulse Control Disorder, Unspecified	2	
295.34	Schizophrenia, Paranoid, Chronic With Acute Exacerbation	2	
295.12	Schizophrenia, Disorganized, Chronic	1	
295.20	Schizophrenia, Catatonic, Unspecified	1	

Dx Code	Description	# Discharged	Primary Substance Abuse
648.44	Mental Disorders Complicating Pregnancy, Postpartum Condi	1	
305.70	Amphetamine Abuse, Unspecified	1	1
296.22	Major Depressive Disorder, Single Episode, Moderate	1	
291.2	Alcohol-Induced Persisting Dementia	1	
292.81	Drug-Induced Delirium	1	
V61.20	Counseling For Parent-Child Problem, Unspecified	1	
293.0	Delirium Due To Conditions Classified Elsewhere	1	
295.40	Schizophreniform Disorder, Unspecified	1	
295.74	Schizoaffective Disorder, Chronic With Acute Exacerbation	1	
295.92	Unspecified Schizophrenia, Chronic	1	
296.03	Bipolar I Disorder, Single Manic Episode, Severe	1	
296.21	Major Depressive Disorder, Single Episode, Mild	1	
301.13	Cyclothymic Disorder	1	
304.10	Sedative, Hypnotic Or Anxiolytic Dependence, Unspecified	1	1
289.9	Unspecified Diseases Of Blood And Blood-Forming Organs	1	
V71.09	Observation For Other Suspected Mental Condition	1	
296.80	Bipolar Disorder, Unspecified	1	
303.91	Other And Unspecified Alcohol Dependence, Continuous	1	1
308.3	Other Acute Reactions To Stress	1	
300.02	Generalized Anxiety Disorder	1	
312.34	Intermittent Explosive Disorder	1	
		1,906	454
			0.238195173

APPENDIX #5

Guiding Principles for Rebalancing: New Models and New Directions

Department of Human Services
Division of Mental Health

Nanette Larson, BA, CRSS, Director of Recovery Support Services
Jordan Litvak, LCSW, Regional Executive Director
Patricia Reedy, LCSW, Chief of Social Work Services

March 5, 2012

A. Introduction

The purpose of this paper is to propose a context, rationale and a set of guiding principles for the provision of services that will be needed to restructure the community healthcare/mental health service system in Illinois. This document is intended as a centering guidepost for our sister agencies and governmental partners, as well as the service provider community. As the landscape of healthcare service delivery is dramatically changing, the Department of Human Services/Division of Mental Health (IDHS/DMH) is at a crucial juncture. The advent of healthcare reform provides new opportunities for transforming and rebalancing the landscape of our system of care into one that is more consumer-driven and recovery-focused. Therefore, rebalancing will become essential to traverse that landscape. As a result, innovation will be required.

Multiple contemporary realities shape the context in which rebalancing and innovation must occur:

- The planned closures of mental health hospitals and developmental centers
- Increased access to and the integration of behavioral health and primary care (P.A. 097-0166)
- Increase in the amount of local oversight over public mental health services (P.A. 097-0439)
- The development of the legislatively sponsored Mental Health and Strategic Planning Task Force (P.A. 097-0438)
- Community needs assessments and service gaps analyses (P.A. 097-0381).
- Maximization community-based services and reduction of reliance on nursing home care for persons with mental illnesses (*Olmstead v. L.C. and E.W., Williams v. Quinn, Colbert v. Quinn*)

Given the above dynamics of change, our challenge is to deliver quality care in the context of these realities, most likely with fewer resources. Although we have transitioned to a fee-for-service system to maximize federal Medicaid dollars, providers continue to be challenged to: 1) Find more efficient ways of doing business in an effort to improve outcomes, and 2) Generate sufficient revenues to sustain viability. The challenge of rebalancing and improving services with fewer resources provides an additional impetus for innovation and the increasing use of recovery oriented services in our system.

In the midst of these turbulent times, significant creativity and collaboration have emerged from our many community partners. We have a window of time in which we can give serious thought and consideration to the rebalancing of the community healthcare system. The time for optimizing innovation has arrived. IDHS/DMH encourages all system partners to embrace new program and service delivery models and to bring innovative ideas to the table to assist in our rebalancing.

For example, when an individual faces an urgent situation associated with a mental illness, hospitalization is not necessarily the best or most effective intervention. However, a broader array of services must be offered if people in urgent, non-emergent situations are to be served appropriately. With this in mind, this brief is meant to offer some guiding principles about the types of services, and the characteristics of services, that we believe will be helpful for individuals in these situations. It is the delivery of such innovative services which IDHS/DMH is most interested in investing.

B. Three Guiding Principles for Innovation in Rebalancing: Recovery-Oriented, Trauma-Informed and Outcome-Validated

***1.* Recovery-Oriented**

The evidence is clear; the outcomes are validated. Recovery, while often perceived as a new concept in mental health, is actually not new at all. As the treatment centers that were available to persons with mental illnesses deteriorated in the late 19th and first half of the 20th century, perceptions about whether people could recover from these illnesses began to change. In the new millennia, we now know that recovery is, indeed, the expectation. Our service providers must fundamentally convey this.

Principles of Recovery:

- *Recovery emerges from hope:* The belief that recovery is real provides the essential and motivating message of a better future – that people can and do overcome the internal and external challenges, barriers, and obstacles that confront them.
- *Recovery is person-driven:* Self-determination and self-direction are the foundations for recovery. Individuals define their own life goals and design their unique paths.
- *Recovery occurs via many pathways:* Individuals are unique with distinct needs, strengths, preferences, goals, culture, and backgrounds, including trauma experiences. These trauma experiences that affect and determine their pathway to recovery.
- *Recovery is holistic:* Recovery encompasses an individual's whole life, including mind, body, spirit, and community. The array of services and supports available should be integrated and coordinated.
- *Recovery is supported by peers and allies:* Mutual support and mutual aid groups, including the sharing of experiential knowledge and skills, as well as social learning, play invaluable roles in recovery.
- *Recovery is supported through relationship and social networks:* An important factor in the recovery process is the presence and involvement of people who

believe in the person's ability to recover; who offer hope, support, and encouragement; and who also suggest strategies and resources for change.

- *Recovery is culturally-based and influenced:* Culture and cultural background in all of its diverse representations, including values, traditions, and beliefs are keys in determining a person's journey and unique pathway to recovery.
- *Recovery is supported by addressing trauma:* Services and supports should be trauma-informed to foster safety (physical and emotional) and trust, as well as promote choice, empowerment, and collaboration.
- *Recovery involves individual, family, and community strengths and responsibilities:* Individuals, families, and communities have strengths and resources that serve as a foundation for recovery.
- *Recovery is based on respect:* Community, systems, and societal acceptance and appreciation for people affected by mental health and substance use problems – including protecting their rights and eliminating discrimination – are crucial in achieving recovery.

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- *Health:* vercoming or managing one's disease(s), as well as living in a physically and emotionally healthy way;
- *Home:* a stable and safe place to live;
- *Purpose:* meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and,
- *Community:* relationships and social networks that provide support, friendship, love, and hope.

2. Trauma-Informed

The percentage of people who have mental illnesses who have also been traumatized is staggering (Goodman *et al*, 1997). Moreover, repeated studies have documented that various samples of people with schizophrenia have rates of co-occurring PTSD from between 29% to 43%. This means that, for a sizeable percentage of the people we serve, we must be mindful of the likelihood that s/he has been traumatized, and that we must guard against the possibility of individuals being re-traumatized.

Psychological trauma is a pivotal force that shapes a person's mental, emotional, spiritual and physical well-being. Because trauma can stem from violence, abuse, neglect, disaster, terrorism and war, nearly every family is impacted in some way. Trauma-informed care provides a new perspective. Support personnel shift from asking "What is wrong with you?" to "What has happened to you?" This change reduces the blame and shame that some people experience when seeking treatment and being diagnosed. It also builds an

understanding of how the past impacts the present. This can assist with connections that support progress toward healing and recovery.

Trauma-informed care takes a collaborative approach. Healing is led by the consumer, and *supported* by the service provider. Together, in a true partnership, people learn from each other. There is greater respect, progress toward healing, and greater effectiveness in services. Trauma-informed care in organizations impacts all aspects of service delivery–from how services are provided, to the environment or culture, to how the physical space is laid out. Trauma-informed care, if it is to be effective, also involves all members of the organization; from the receptionist at the front desk to the care provider and treatment team.

Ten Values of Trauma-Informed Care

- Understand the prevalence and impact of trauma
- Pursue the person's strength, choice and autonomy
- Providers must earn trust
- Healing happens in relationships
- Provide holistic care
- Share power
- Communicate with compassion
- Promote safety
- Respect human rights

3. Outcome-Validated

Routine outcome assessment involves either clinician or patient monitoring, and the rating of changes in health status and indicators of social functioning (including quality of life) (Slade, 2002). Significantly, an important distinction exists between the rating by the person receiving services, and the rating by the clinician. Most rating scales in mental health are completed by clinicians. The patient voice is often ignored in the development of various instruments to rate health outcomes (Jacobs, 2009). However, partnership and shared decision-making are essential for effective service delivery. Therefore, it is essential to collaborate with persons receiving services in the choice and development of appropriate outcome measures.

The issue of validity raises the question of how a 'good outcome' is defined in mental health. As previously discussed, one of the first issues becomes whose perspective is relevant, i.e., the person receiving services, or the clinician, or significant others. A second issue is the content of the measure, which has traditionally been based on symptoms. Beyond symptoms, there is also an interest in other aspects of outcome, such as social functioning, satisfaction and recovery.

It is universally recognized as imperative that the services provided lead to measurable positive outcomes for persons receiving those services. To that end, the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a searchable online

registry of more than 200 interventions supporting mental health promotion, substance abuse prevention, and mental health and substance abuse treatment (http://nrepp.samhsa.gov/) With such a treasury of outcome-validated interventions, it is no longer acceptable to provide services that are not informed by outcomes.

C. Innovation: A Working Definition

To satisfy the need for more integrated, recovery-oriented care as well as cost containment and efficiency requirements, public health care systems call for innovation. One simple definition of innovation is "the introduction of something new, a new idea, method or device" (Webster). Wikipedia defines Innovation as "the creation of better or more effective products, processes, services, technologies, or ideas that are accepted by markets, governments, and society. Innovation differs from invention in that innovation refers to the use of a new idea or method, whereas invention refers more directly to the creation of the idea or method itself." Thomas Edison, one of the world's greatest innovators said, "Innovation is 1% inspiration and 99% perspiration." Contemporary realities in public health care delivery systems call for innovation. Innovation is a concept that is almost universally relevant.

Within IDHS/DMH, we find ourselves promoting innovation to improve services, increase efficiencies and meet the challenges of new paradigms and payment systems. It is, therefore, helpful to have a common understanding of what we mean by innovation so that this concept can be consistently applied to our vision and mission. Our common understanding can also serve as a guide in promoting, developing and evaluating innovative programs and services. The next section of this paper describes what we mean by innovation and gives examples of the types of innovations we believe will positively impact the persons we serve.

Useful innovation requires the ability to be creative as well as the ability to execute. Creative ideas poorly executed lead to poor and wasteful programs. In this section, we look at excellence in execution as well as excellence in mental health service delivery.

Excellence at executing program operations is required for quality innovation, as evidenced by:

1. **An agency's ability to execute its operations efficiently and effectively.**

2. **Likelihood of program sustainability over time.**

   The risks vs. benefits of a program must be assessed in order to use limited dollars wisely. Many innovative programs often require start up money in the form of capacity grants or advances. A key measure for IDHS/DMH is the degree of financial viability of a program without the necessity of grants or cash infusions over the long term. This is not to say that there will never be services delivered that can't be purchased by third party payers. More services will be available if we conserve taxpayer dollars by ensuring that everything possible is done to maximize financial viability of program services.

3. **Clear and specific deliverables coupled with measurable outcomes necessary for program evaluation.**

   Program innovators must be clear about desired outcomes and develop credible and reliable systems for collecting and measuring supporting data.

4. **Ability to replicate such programs elsewhere in the state.**

   While solutions to access and service are unique from community to community, the ability to replicate effective programs creates its own efficiencies and support systems, such as unified training programs, common quality indicators and Learning Collaborative programs.

5. **Improved continuity of care.**

   Good continuity of care enhances recovery and reduces recidivism, thereby reducing costs. Improved service coordination among multidisciplinary providers supports contemporary trends toward integrated care.

6. **Use of best practices and/or evidence based practices.**

   Applying best and evidenced based practices shows that service providers are operating within high quality practice standards and are more likely to achieve good outcomes.

7. **Excellent quality improvement plans.**
   Continuous quality improvement requires relevant thresholds, timely incident report/review and the ability to adjust and refine programming based upon good data.

8. **Excellence in information systems.**

   An agency's information system and billing infrastructure must be sufficiently capable of supporting expanded operations, data collection and effective claiming.

9. **Excellence in administrative systems.**

   An agency's administrative structure must be able to support program development through effective hiring, training and provision of sufficient supervision for implementation of innovative programs.

10. **Commitment to a recovery orientation.**

    Building upon individual strengths and addressing individual needs, agencies that provide recovery-oriented services are effective. Through a commitment to a recovery orientation, both staff and the healthcare environments inspire hope and empower individuals. This inspiration and empowerment supports skill acquisition that enables people to live, work, learn and participate fully in their communities.

D. Examples of Program Innovation

There are many sectors of mental health service delivery that provide the opportunity for program innovation. The examples below describe several such programs. The list below is not intended to be all-inclusive.

Integrated Care

Publicly funded primary care/behavioral health integration is likely to be one of the most significant trends in health care delivery over the next ten years and beyond. Both federal and state initiatives are actively funding pilots; several initiatives in the state have also been funded through Title XX dollars. Seed dollars, when made available, are used to underwrite the initial costs of system redesign, training and administrative expense, with the expectation that these programs will become self-sustaining through innovative or traditional revenue generation models.

Recovery Support Specialist Services

Within Illinois and across the country, more programs are utilizing services delivered by peers. Proper recruitment, selection and training of peers, supported by the Certified Recovery Support Specialist (CRSS) credential, help to ensure service quality for innovative programming in a variety of service sectors, such as: Permanent Supportive Housing, Mental Health Courts, Crisis Respite Centers (e.g. Living Room models), services for individuals experiencing homelessness, and Individual Placement and Support programs (Supported Employment) – to name a few.

Use of Technology

The use of tele-pschiatry has expanded across Illinois. Psychiatric shortages, especially in rural areas, have made this service a pragmatic reality. Additional experimentation with use of technology for case management and primary care delivery show promising outcomes. Use of computers and other digital devices allow for improved communications across long distances providing improved continuity of care. Courses in Wellness Recovery Action Planning (WRAP) can now be found on line, making this invaluable service available across transportation barriers.

Use of Prevention Services

We have seen a number of communities make good use of prevention services (e.g., Mental Health First Aid) in conjunction with other forms of outreach. Utilization of this spectrum of services supports the general population as well as those in greater need. Knowing who to call for what service may prevent bigger problems down the road. Coordinated outreach and multiple communication strategies reduce isolation, especially across the many rural areas in Illinois.

Hospital Based Services

Hospital service innovation is emerging in many areas. More psychiatric inpatient units utilize - oriented programming, including Wellness Recovery Action Planning (WRAP). A number of community hospitals have created flexible unit capacity to accommodate changing needs. Multiple hospitals have created separate psychiatric emergency areas. These have the following advantages: 1) They help to minimize overcrowding in EDs for people with other medical conditions. 2) They can concentrate and develop staff with mental health expertise. 3) One important effect of the concentrated mental health expertise is an improved understanding of community options; this promotes suitable dispositions, when clinically appropriate, that avoid unnecessary hospitalizations.

Community Based Services

Some of the most impressive innovations we have seen in community agencies have been services experienced when people come to agencies for the first time. Warm and welcoming receiving facilities, coupled with minimal delays for service access, go a long way towards impacting consumers' recovery. Some agencies have deployed groups led by peers for orientation to services, while others have offered one on one peer support for consumers who may be ambivalent about getting involved in treatment.

Innovative Crisis Services

Alternatives to inpatient care need to effectively manage risk, ensure safety, and direct initial services on to a recovery oriented trajectory. In order to do so, each community needs to identify the right level of intensity of crisis services to meet the needs of its citizens. Crisis services can range from residential to mobile, with enhancements such as use of technology, peer supports or clinically managed detoxification. The effective crisis program will be embedded into its community and take into account complementary services and resources.

These examples are not intended to be an all-inclusive list of innovations. However, changing service delivery trends and requirements for increased efficiency strongly suggest that some of the best opportunities for innovation will involve many of the elements described above.

E. Meeting the Challenge

Agencies that can collaborate and partner to combine purpose and mission will be those who develop the critical mass to meet the many fiscal and operational challenges of the future. Competency in weaving braided funding approaches will become a necessity to remain viable and sufficiently fluid during these times of rapid change. Contingency planning met by budgetary discipline, combined with focus on mission and vision, will be the challenge of the day.

The informed reader will realize that the parameters listed above are not mutually exclusive. Indeed, many of the concepts presented overlap quite naturally. We hope that these guiding principles and examples of program innovation provoke, motivate, and lead to increased

innovation. The resulting restructured delivery system may well be characterized by enhanced outcomes, and progress toward our goal of a truly facilitative, recovery-oriented system of care.

BIBLIOGRAPHY

Andrews, G. and Peters, L. (1994) Measurement of consumer outcome in mental health, in A report to the National Mental Health Information Strategy Committee, CRUFAD, Editor.

Goodman, Rosenberg, Mueser, Drake. Physical and Sexual Assault History in Women with Serious Mental Illness: Prevalence, Correlates, Treatment, and Future Research Directions. Schizophrenia Bulletin, Vol. 23, No. 4, 1997

Jacobs, Rowena. 2009. Investigating Patient Outcome Measures in Mental Health. Centre for Health Economics, University of York.

Keilman, John. 'Living Room' offers ER alternative for mental illnesses. Chicago Tribune, December 1, 2011.

Lysaker, Outcalt, & Ringer, 2010. Clinical and psychosocial significance of trauma history in schizophrenia spectrum disorders. Expert Review of Neurotherapeutics, 10(7), 1143–51.

Mueser, *et al.*, 2004. Interpersonal Trauma and Posttraumatic Stress Disorder in Patients With Severe Mental Illness: Demographic, Clinical, and Health Correlates.

Schizophrenia Bulletin, 30(l):45-57, 2004.

Pinel, P., 2008. Medico–philosophical treatise on mental alienation (G. Hickish, D. Healy, & L. C. Chardland, Trans.). (Second ed.). Oxford: Wiley–Blackwell.

RachBeisel, 1999. Co-Occurring Severe Mental Illness and Substance Use Disorders: A Review of Recent Research. Psychiatric Services, Vol. 50 No. 11

SAMHSA Recovery Support Strategic Initiative; Guiding Principles of Recovery

Slade, M. (2002) What outcomes to measure in routine mental health services, and how to assess them: a systematic review, Australian & New Zealand Journal of Psychiatry, 36(6): 743-53.

Legislative Summaries

Public Act 097-0166 adds a new Community Behavioral Health Care section that tasks IDHS to strive to guarantee persons suffering mental illness, substance abuse, and other behavioral disorders access to locally accessible behavioral health care providers who have the ability to treat these conditions in a cost effective, outcome-based manner. IDHS is to designate essential community behavioral health care providers as essential providers for 5 year terms, to ensure continuity and quality of care that is integrated with the person's overall medical care through the following:

- Promote the co-location of primary and behavioral health care services centers.
- Promote access to necessary behavioral health care services in the State's Health Insurance Exchange policies.
- Promote continuity of care for persons moving between Medicaid, SCHIP, and programs administered by the Department that provide behavioral health care services.
- Promote continuity of care for persons not yet eligible for Medicaid or who are without insurance coverage for their conditions.
- Work toward improving access in Illinois' underserved and health professional shortage areas.

A Designated Essential Provider must be not for profit or a governmental entity that:

- Demonstrates a commitment to serving low-income and underserved populations.
- Provides outcome-based community behavioral health care treatment or services.
- Does not restrict access or services because of a client's financial limitation.
- Is a community behavioral health care provider certified by the Department or a licensed community behavioral health care provider holding a purchase of care contract with the State under the State's Medicaid program.

Public Act 097-0438 adds a new 23 member Mental Health Services Strategic Planning Task Force composed of a broad range of legislative, provider, consumer, advocacy, union and academic behavioral health stakeholders to: 1) Develop, within 18 months, a 5-year comprehensive strategic plan for the State's mental health services. 2) To monitor progress during the plan implementation quarterly and make recommendations to the Governor and General Assembly to determine if the recommendations will become law.

The plan shall address the following topics:

- Provide sufficient home and community-based services to give consumers real options in care settings.
- Improve access to care.
- Reduce regulatory redundancy.
- Maintain financial viability for providers in a cost-effective manner to the State.
- Ensure care is effective, efficient, and appropriate regardless of the setting in which it is provided.
- Ensure quality of care in all care settings via the use of appropriate clinical outcomes.
- Ensure hospitalizations and institutional care, when necessary, are available to meet demand now and in the future.

Public Act 097-0439 for counties with a population of less than 3 million amends The Counties Code, adding a new 7 member volunteer mental health advisory committee if the county has a health department but no approved mental health program. The advisory committee shall identify and assess current mental health services in its respective jurisdiction, monitor any expansion or contraction and report to the county board.

Also, for counties with populations of less than 3 million, amends The Community Mental Health Act adding a new 7 member volunteer mental health advisory committee if no community mental health board has been established— unless mental health services are provided. The advisory committee shall identify and assess current mental health services in its jurisdiction, monitor any expansion or contraction, and report to the county board.

The committees shall have no taxing authority and the sections are repealed December 31, 2018.

Public Act 097-0381 - Legislative Findings
By recognizing in Legislative Findings an already deteriorating mental and behavioral health treatment system, exacerbated by the recent fiscal crisis, and characterized by fragmentation, geographic disparities, inadequate funding, workforce shortages, lack of transportation, and overuse of acute and emergency care, where many of an estimated 25% of Illinoisans with serious mental illness go without treatment because it is not available or accessible, an organized and integrated system of care is needed.

Regional Integrated Behavioral Health Networks
The Act requires IDHS to facilitate the creation of Regional Integrated Behavioral Health Networks to:

- Provide a platform for the organization of all relevant health, mental health, substance abuse, and other community entities.
- Provide a mechanism to channel financial and other resources efficiently and effectively.

Goals
The goals are:
- Particularly in rural areas, access to appropriate evidence-based services
- To improve access to behavioral health services throughout Illinois, but especially in rural Illinois communities, by fostering innovative financing and collaboration among a variety of service providers
- To support the development of region-specific planning and strategies
- To facilitate the integration of behavioral health, and primary, and other medical services.
- To advance opportunities under federal health reform initiatives
- Ensure actual or technologically-assisted access to the entire continuum of integrated care
- Identify funding for persons without insurance or who do not qualify for governmental programs; and
- Improve access to transportation in rural areas

Regional Integrated Behavioral Health Networks Steering Committee
To achieve the Act's goals the IDHS shall convene a Regional Integrated Behavioral Health Networks Steering Committee composed of responsible State agencies, including a member of each Network to
- Work collaboratively providing consultation, advice, and leadership to the Networks
- Facilitate communication within and across multiple agencies
- Remove regulatory barriers that may prevent Networks from accomplishing the goals
- Collectively or through one of its member agencies provide technical assistance to the Networks

Regional Networks Councils
In each of IDHS's regions Regional Networks Councils shall be convened comprised of community stakeholders.

Network Plans
Each Network shall, within 6 months, develop a comprehensive Regional Plan to address
- An inventory of services
- Identification of unmet needs
- Identification of opportunities to improve access through integrated care
- Development of a comprehensive plan to address community needs
- Development of a specific timeline to implement specific objectives and evaluation measures
- Include the complete continuum of services

Annual Report to the Governor and General Assembly
Report status of each Regional Plan including recommendations of the Regional Networks Councils to accomplish their goals and improve access to services.
- Include performance measures
- Changes to services capacity
- Waiting lists
- Volume and wait times in emergency departments
- Development of care integration partnerships or barriers to their formation
- Funding challenges and opportunities

Appendix 6

Community Service Agreement (CSA)

Exhibit A
Scope of Services

The Community Hospitalization Inpatient Psychiatric Services (CHIPS) program is intended to serve those persons with serious mental illness (SMI) and predominately those with serious and persistent mental illness (SPMI) as defined by IDHS (available at http://www.dhs.state.il.us/page.aspx?item=32632) who exhibit acute behaviors or symptoms requiring the services of an immediate inpatient setting. To maximize State resources, funds used to reimburse these services are used only after all other appropriate sources of reimbursement have been exhausted, and only for those persons in specific

financial need as defined as under 200% Federal poverty level (FPL) as found at http://aspe.hhs.gov/poverty/12poverty.shtml.

1. Inpatient psychiatric hospital services for the treatment of an adult (18 years of age and older) may only be provided as medically necessary for active treatment and which can reasonably be expected to improve the patient's condition. To be eligible for reimbursement by the CHIPS program, the guidelines in Attachment 1 must be followed.

2. The Provider shall cooperate with the IIDHS/DMH Region Utilization Review process, with treatment limited to continuous inpatient hospitalization, as authorized, per episode. The concurrent approval by the IIDHS/DMH Region Office is needed to qualify for consideration for payment under this CHIPS program. Requests for extensions of hospitalization must include the clinical rationale from the Provider.

3. The Provider will provide all of the following services:

   A. Inpatient Psychiatric Services, which includes:

      1. Daily Room and Board;
      2. Admitting physical examination and medical history;
      3. Routine assessments including nursing, social service and functional assessments;
      4. Routine laboratory and diagnostic evaluations;
      5. Individual treatment plan development and implementation;
      6. All inpatient therapies and services, including pharmaceutical treatments, under the direction of the attending psychiatrist or hospitalist resulting from the initial comprehensive psychiatric evaluation, diagnosis, and daily assessments;
      7. All inpatient therapies, programs and services that are part of the ongoing schedule of the provider's Psychiatric Services Inpatient Unit.
      8. A staffing within 72 hours of admission with participation of a psychiatric unit representative, a designated IIDHS/DMH funded community mental health service provider representative, and the consumer and legal guardian as indicated (and family, if authorized);
      9. Documented discharge planning with participation of a psychiatric unit representative and a designated IIDHS/DMH funded community mental health service provider representative, and the consumer and legal guardian as indicated (and family, if desired).

   B. Attending Psychiatric Physician Services, which includes the provision of medical coverage by psychiatrists credentialed and privileged by the Provider and minimally providing:

      1. Completion of an admission psychiatric evaluation within 24 hours of admission;
      2. Direction of inpatient therapies and services, including pharmaceutical treatments;
      3. Daily care with the patient, consisting of at least six face-to-face visits per seven day period is minimally expected;
      4. Completion of all documentation requirements for medical records in accordance to the Provider's policies, procedures or Medical Staff By-Laws.

C. Exceptional Psychiatric-related Medical Services: Upon written request and prior approval, the IIDHS/DMH Region Office may also authorize payment at currently established IDHFS rates for those exceptional psychiatrically-related medical services such as: non-routine medically prescribed evaluations, assessments and treatments, physician or professional consultative services necessary to diagnose or treat the consumer's presenting psychiatric symptoms. Services may be performed on an emergency basis, but approval by the IIDHS/DMH Region Office is still required for consideration of payment for such services.

D. Transportation: The hospital provider may request reimbursement for the safe and secure transport of a patient (consumer) to court, related to any involuntary admission or involuntary treatment or medication requests. IIDHS/DMH, at its sole discretion, may provide such transport through its contracted vendor.

E. Psychiatrist Court Appearance: Should it be required that the attending psychiatrist appear in court regarding an Involuntary Admission or Involuntary Treatment or Medication request, the psychiatrist may request reimbursement for that court appearance time at the rate of $75.00 per hour or part thereof.

4. Immediately following admission, the Provider, in collaboration with the designated IIDHS/DMH-funded community mental health service provider, must begin the process of identifying and planning for the appropriate aftercare resources for continuity of care.

5. The Provider must ensure that:

A. A complete application for Medicaid, AllKids or all other eligibility programs administered by the IDHS or IDHFS has been filed for consumer(s) under this program, and

B. It has received documentation that the application for eligibility has been denied under categories Type Action Reason (TAR) 17 (applicant determined not disabled by the Social Security Administration (SSA), TAR 18, applicant determined not disabled by IDHS Client Assessment Unit (CAU); and/or for specific cases as identified prior to discharge, the IIDHS/DMH Region Office may also consider TAR Category 07 (applicant not an Illinois resident) or TAR 05 (applicant does not meet citizen Immigration and Naturalization Service (INS) requirements) as a qualifying denial.

C. A complete application completed and filed by the provider consists minimally of the following components:

i) DHS forms 183A and 183B completed in detail as directed by IDHS/Human Capital Development (HCD)/Family Community Resource Center (FCRC) /Client Assessment Unit (CAU) notification; Form 183A is best completed at time of discharge.
ii) The initial history and physical and relevant labs and diagnostic reports - may use provider's Form;
iii) The initial psychiatric evaluation (if not included in the history and physical

evaluation) - may use provider's Form;

iv) The social history (or psycho-social evaluation)- may use provider's form;

v) Progress notes reflecting the consumer's disabling conditions- may use provider's form(s);

vi) A Physician Discharge Summary, including the aftercare or post-discharge plan, completed as required by the Hospital - may use provider's form;

viii) Social Services discharge planning record including names, titles/credentials, addresses, and phone numbers of all follow up providers;

ix) Outpatient progress notes of community mental health service providers from the 12 month period prior to the CAU review;

x) Responses by provider to any and all requests for subsequent information from DHS and/or CAU within required DHS timeframes (DHS form 267);

xi) The authorization for release of information to the Department of Human Services' Client Assessment Unit and the consumer's or hospital's local DHS office. Either the provider's release form or DHS' form may be used;

xii) The completion of Authorized Representative form (Il 444-2998) including designation of the Provider hospital or its designee and or designated discharge community provider as an authorized representative is strongly recommended.

Note that refusal of a Consumer or family to complete the Medicaid or AllKids application is not considered an acceptable reason for a denied application qualifying for payment. Similarly, denials based on insufficiency of information or denials made at the request of the hospital or its agents are not considered an acceptable reason for a denied application and thus not qualifying for payment. Provider acknowledges that the failure to ensure that a complete application for Medicaid, AllKids, Veterans' Care or all other IDHFS eligibility programs, may result in the certification of payment being denied or delayed by IIDHS/DMH.

Exhibit B
Deliverables

1. All admissions under the CHIPS program are to be reported by the Provider to the IIDHS/DMH Region Office within 24 hours of admission. These reports will include, but not be limited to, the Consumer's name or Illinois Department of Healthcare and Family Services (IDHFS) recipient identification number (RIN) or both, address, date of birth, provisional diagnosis and anticipated length of stay, unless such information is restricted by law.

2. A copy of the Provider's Initial Psychiatric Evaluation is to be provided to the IIDHS/DMH within 24 hours after completion by the Provider's physician.

3. The Patient (Consumer) Discharge Instruction Sheet (hospital-specific nursing discharge form) or Discharge Staff Note (hospital-specific form) or Discharge Staffing Form (Region-specific form) shall be provided to the designated after care providers (likely an IIDHS/DMH-funded community mental health service provider) and the IIDHS/DMH Region Office within 24 hours of discharge.

4. A Physician Discharge Summary will be provided to the designated IIDHS/DMH-funded community mental health service provider and the IIDHS/DMH Region Office as soon as possible, after completion per Providers' policy or Provider's Medical Staff by-laws.

5. The Provider will maintain, and upon request provide, verification of financial need as defined as the persons under 200% federal poverty level (FPL) as found at:

   http://aspe.hhs.gov/poverty/12poverty.shtml

6. The Provider will submit a payment voucher (Form C-13) to the respective DMH Region Offices for payment processing by IDHS that is reflective of CHIPS service activity (persons discharged) by the Provider for the previous month within 15 business days of the last day of the month.

Exhibit C
PAYMENT

Provider shall receive an estimated total compensation of $_____ for services under this Agreement.

Enter specific terms of payment here:

a) Inpatient psychiatric services and attending psychiatric physician services are reimbursed at $650.00 per day.

b) Payments for exceptional psychiatrically-related medical services (as identified above) that have been requested by the Provider and have received prior approval by the IIDHS/DMH Region Office or that were required on an emergency basis and later approved. Payment will be based on the rates of the Illinois Department of Healthcare and Family Services (IDHFS) for such procedures.

c) Payments will be based upon payment vouchers (Form C-13) being produced by the respective DMH Region Offices for payment processing by IDHS. The payment voucher amounts will be reflective of service activity by the Provider for the previous month.
d) Payment will not be authorized or released until these forms are on file with IIDHS/DMH Region Office.
e) Out-of-hospital passes or overnight passes off premises are not allowed. If either is issued, the day is not reimbursable under the terms of this Agreement.
f) It is not the intent or purpose of this Agreement to displace or reimburse services for all or part of indigent or non-insured psychiatric services historically provided by this Provider.

Estimated Annual Contract Amount: $

NOTE: The estimated figures are merely an objective means of computing the contract amount and should not be construed as a guaranteed amount that will be spent on the contract during the fiscal year.

ATTACHMENT 1

GUIDELINES FOR ADULT PSYCHIATRIC INPATIENT TREATMENT FOR CHIPS PATIENTS

To be eligible for the CHIPS program, the guidelines below must be followed.

A. GUIDELINES FOR ADMISSION FOR ACUTE HOSPITAL SERVICES

The provider will maintain written documentation that the admission for acute hospital services is provided as active treatment, including that:

1. The patient's condition affirms the need for required specialized resources and/or a structured environment in a selected facility for diagnosis, evaluation, or treatment and/or
2. The patient's response to current treatment reflects that a less intensive or less restrictive psychiatric treatment program would not be adequate to provide safety for the patient or others or to improve the patient's functioning and
3. An individualized treatment program is completed and on file that specifically addresses the therapeutic needs of the patient and, where appropriate, family involvement and
4. Care is supervised and evaluated by a licensed physician who has completed an accredited psychiatric residency i.e., Accreditation Council for Graduate Medical Education or Accreditation of Colleges of Osteopathic Medicine and
5. An expectation that the resources and techniques associated with this level of care will lead to successful discharge into the community or transfer to a less intensive or restrictive treatment program.

B. GUIDELINES FOR CONTINUED STAY:

The provider will maintain written documentation that the Severity of Illness (SI) and Intensity of Service (IS) criteria are met as indicated below:

SEVERITY OF ILLNESS (SI) (At a minimum, two criteria must be met.)

1. The patient requires continuous skilled psychiatric observation, planned Psycho-therapeutic services, planned and controlled psychotropic drug management, and/or electro-convulsive therapy.
2. The patient exhibits an inability to care for self due to an interaction of mental and other physical disorders creating incapacitating symptoms or behaviors.
3. The patient poses a significant suicide risk, including meeting any of the following:

   - feeling hopelessness and/or worthlessness; or,
   - history of unpredictable behavior, agitation, impulsivity, or poor judgment; or,
   - patient history of previous suicide attempts; or,
   - persistent insomnia with deterioration in mood or cognition; or,
   - patient history of noncompliance with treatment recommendations in the past; or,

- family history of suicide attempts or completed suicide; or,
- patient history of abusing drugs that could lead to impulsiveness or poor judgment; or,
- significant changes in mood or behavior; or,
- patient history of recent loss (e.g., job, relationship, family member); or,
- preoccupation with suicidal thoughts; or,
- whether or not there is a suicide plan; or,
- presence of a suicide plan with reasonable expectation for completion.

4. The patient shows a history of assaultive or self-mutilative behavior or reported evidence of danger to self or others.
5. The patient exhibits homicidal ideation accompanied by psychiatric disorder.
6. The patient exhibits impaired reality testing accompanied by disordered behavior (e.g., bizarre, delusional, illogical thinking, hallucinations, manic behavior).

INTENSITY OF SERVICE (IS) (At a minimum, two criteria must be met.)

1. Complex treatment necessitated by co-existing conditions requiring concurrent treatment (e.g., an insulin-dependent diabetic who is neglecting diabetic care due to major depression, chronic respiratory or cardiovascular insufficiency, etc.).
2. A need for a controlled environment to protect self and others (e.g., suicide precautions, instituted isolation, etc.)
3. Special treatment modalities available only in the hospital due to need for special environment, equipment, or ancillary services (e.g., planned and controlled psychotropic drug management). The need for inpatient electroconvulsive therapy will be evaluated on an individual basis and be based upon medical necessity.
4. For patients with a high potential for near-term readmission [within 30 days] (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.

C. GUIDELINES FOR DISCHARGE

The provider will maintain written documentation that the criteria for discharge as indicated below is met. (One of the following must be met.)

1. The patient no longer poses a risk of harm to self or others.
2. As indicated by a psychiatrist the presence of signs and symptoms sufficient to allow for functioning outside of the acute setting.
3. The patient shows no evidence prompting a reasonable expectation of significant psychiatric improvement with continued inpatient treatment.
4. Failure to initiate an initial therapeutic plan by the attending physician within 24 hours of admission and the multidisciplinary treatment plan if the patient remains in the hospital two days or longer, or both.

5. No weekly revision to multidisciplinary treatment plan exists.

D. DOCUMENTATION GUIDELINES

The following components of a patient's medical record have been defined to assist the admitting psychiatrist and ancillary staff in providing the necessary documentation indicative of active psychiatric care of intensity of service. The record must contain sufficient documentation for each item.

1. Within 24 hours of admission, a psychiatric assessment (including the reason for admission, mental status examination, determination of diagnosis and identification of behavior/symptoms that need clinical intervention, and initial therapeutic plan based on identified needs) must be documented in the medical record by an attending physician.
2. Other medical history and physical examination must also be completed within 24 hours of admission.
3. If a patient remains in the hospital more than two days, a multidisciplinary treatment plan should be documented in the medical record by the attending physician, with input from other members of the treatment team on the 2nd day of hospitalization. The multidisciplinary treatment plan should be implemented on the 2nd day of hospitalization and include:
   - Clinical activities designed to enhance the patient's functioning sufficient for the patient to be transferred to a less restrictive care environment with a decreased likelihood of readmission.
   - Estimated timeframes to achieve goals including a re-evaluation if goals are not met, and changes needed; a new plan formulated if necessary.
4. If a multidisciplinary treatment plan is warranted, multidisciplinary treatment plan/progress must be documented at least weekly.
5. Regular progress notes should be completed by non-nursing, non-physician clinicians at least weekly.
6. Physician involvement consistent with the acuity/complexity of the case. Physician involvement requires documentation in the form of a progress note. Attending physician's orders (written or verbal) or signature on the treatment plan are not substitutions for adequate physician involvement and documentation. The usual and customary standard is 6 progress notes per 7 day period/week. In order to reflect adequate attending physician involvement, resident physician documentation must reflect the patient was seen, and clinical interventions discussed with the attending physician.
7. Skilled psychiatric nursing must be reflected in the medical record daily and must contain an appropriate sample of clinical nursing observations and interchanges between the patient and nursing staff. In addition, an assessment of the patient for therapeutic and side effects of medications should be documented.
8. Discharge planning needs/efforts must be documented weekly in the medical record and should be part of the team's weekly evaluation of achievable goals. In addition, appropriate and timely follow-up arrangements should be documented and include a scheduled follow-up appointment.

9. An explanation at the time of discharge should be documented if an appointment cannot be arranged. Patient refusal of suggested follow-up arrangements should be documented.
10. Treatment may necessitate discontinuance of therapy for a period of time, or a period of observation as preparation for therapy, or as a follow-up to therapy, while maintenance or protective services are provided. If these are essential to the overall plan, they are part of active treatment.
11. For patients with a high potential for near-term readmission within 30 days (e.g., documented history of recent admission or high risk behavior, poor adherence to last hospitalization's discharge plan, family's capacity to maintain the treatment plan, or identified need for specialized outpatient milieu), the medical record must reflect efforts taken to address these issues to prevent further readmissions.

Appendix 7

CHIPS Projections

Attached below please find the projected Utilization of CHIPS for which DMH is proposing to receive from area hospitals. DMH is wishing to contract with hospitals with existing inpatient BH units for utilization numbers both from their ED but also to support portions of the other capacity from other area hospital EDs where no inpatient BH capacity exists. State hospital capacity will be available for safety net purposes. These numbers are for your consideration only. Contracts, with more specific targeted volumes will be let based upon submission of your proposals and subsequent negotiations with DMH.

CHIPs Projections per Hospital

Tinley Park MHC **Region 1 South -Tinley Park**	**Hx FY11 ED referrals**	**CHIPs @ 60%**	**Projected Inpt Days**	**Projected ADC**
Ingalls	222	133	799	2.2
Silver Cross	195	117	702	1.9
Provena St Joseph	135	81	486	1.3
Advocate Christ	115	69	414	1.1
Palos	81	49	292	0.8
St Bernard's	66	40	238	0.7
Riverside	58	35	209	0.6
St. Mary's	53	32	191	0.5
Little Company	47	28	169	0.5
TOTALS	**972**	**583**	**3499**	**9.6**
NON CHIPS TPMHC Hospitals				
St. James	195	117	702	1.9
South Suburban	118	71	425	1.2
Stoger	69	41	248	0.7
Metro South	62	37	223	0.6
Bolingbrook	56	34	202	0.6
Roseland	46	28	166	0.5
Non Psych coverage	**546**	**328**	**1966**	**5.4**
TARGETED Region 1South Numbers	**1518**	**911**	**5465**	**15.0**
Region 1C Madden				
St Bernard's	325	195	1170	3.2
Mt Sinai	137	82	493	1.4
St.Mary & Elizabeth's	225	135	810	2.2
Loretto	200	120	720	2.0

UIC	63	38	227	0.6
MacNeil	92	55	331	0.9
St Anthony	53	32	191	0.5
TOTALS	**1095**	**657**	**3942**	**10.8**
TPMHC / Madden Psych GRAND TOTALS	**2613**	**1568**	**9407**	**25.8**

APPENDIX 8

Advocate Illinois Masonic Emergency Department - Behavioral Health

Advocate Illinois Masonic has a committee that we have fondly named the ED-BH (Emergency Department – Behavioral Health) Committee which meets for one and half hours monthly chaired by the Chair of Emergency Medicine. Members of the Committee include ED and Behavioral Health leadership as well as leadership and direct line staff representing the inpatient psychiatric unit, pharmacy, consult liaison service, behavioral health, emergency department, public safety and care management. This committee tracks data about our performance with behavioral health patients in the emergency room (length of stay, # and length of standbys, # and length of restraints, compliance with seclusion and restraint orders, etc.). This is also the venue where concerns, missteps, and process improvements are discussed, developed and implemented.

The Emergency Department is staffed 24/7 by a DMH-funded Crisis team comprised of licensed clinicians. The Crisis Team also sponsors 9 – 12 masters and doctoral level trainees each year. We have "non-traditional: practicum schedules so trainees are scheduled to work with their Crisis Supervisors, days, evenings and weekends (this helps to increase the depth of the Crisis Team, and is particularly helpful in those times when the number of behavioral health patients is high). The Emergency Department has a three room wing (the "EDP": Emergency Department-Psychiatric) for the most acutely ill psychiatric patients. Because the Department often has 6-12 behavioral health patients, less acute patients are put in a designated section of the main ED. The Crisis Worker and the Nurse frequently "huddle" (consult with one another) to ensure that the placement of patients in optimal (e.g., who needs a private room, in which area). When the police bring in a behavioral health patient an overhead code is made on the PA system. A representative from medicine, nursing, the crisis team and public safety greet the police officers and the patient who is asked to sit in a comfortable chair in the EDP. A brief assessment is done at that time which includes an assessment as to whether medication is needed. The emphasis is on starting treatment within 1 hour of arrival.

The Emergency Department is stocked with two DVD players, a range of movies, English and Spanish language magazines, playing cards, journaling materials, lists of AA meetings, psycho educational materials and an i-pod which plays calming music on docking system. The Crisis Worker reviews the Safety Plan with each patient and this plan is kept with the chart so that each of the providers (nursing, medicine and crisis) are aware of the patient's stated preferences for how to remain calm and safe during the ED stay.

Each morning a psychiatrist rounds on behavioral health patients with longer lengths of stay in the Emergency Department. The psychiatrist consults with the Emergency Department attendings around issues of medication, continuing stabilization and care planning. The Crisis Clinicians provide frequent bedside interventions for the behavioral health patients. For those patients with longer lengths of stay, the combination of intensive therapeutic and medication stabilization and contact with collaterals sometimes provides sufficient improvement so that the patient can be discharged from the Emergency Department with a plan for follow up care which always includes an appointment with Behavioral Health Services or another community-based mental health organization within one week and medication script (for up to four weeks of medication depending on the patient's unique situation). The first month

of medication for indigent patients is paid for out of the medication fund provided by DMH. A psychiatric appointment is given within two weeks of the intake appointment and indigent patients can access entitlements advocacy at their intake appointment so that a longer term plan for accessing ongoing medication can be made.

USING THE "SAFETY PLAN"

1. Introduce the Safety Plan upon medical clearance when it has been determined that our patient will need a transfer to inpatient psychiatry for safety and protection.

2. Educate the patient on the possible LOS when being transferred and our concerns for them taking and active role in self care by participating in behavioral health care advance directives.

4. Answer any questions the patient may have about the Safety Plan. In addition explain the benefits of soothing activities when anxious. Our goal is to help them during this moment of Crisis.

4. Respond quickly to requests for supportive items to encourage success.

5. Before the patient leaves, the Crisis Worker may encourage the patient to educate others about which therapeutic strategies or activities are most helpful.

SAFETY PLAN

for Patient:_____

What would make you feel better?

Talking to someone? **Please circle all that apply**
Crisis Worker Clergy Nurse Physician

Someone else? Who? _____ phone number
_____

What Medications have helped you calm down in the past?
_____

How do you prefer to get the medicine? Take a pill Get a shot IV

Do you smoke cigarettes? YES NO **If yes, how many per day?**
_____

With Physician consent would a nicotine patch help? YES NO

Something to eat or drink? Food Drink Ice Chips

Would you like? Warm, moist cloth Shower TV
Playing Cards
Magazine DVD movie Journaling materials
Bible

Other Suggestion for Feeling Better?

Advocate Illinois Masonic Medical Center

Appendix 9

Non-Medicaid Service Package – Per Fiscal Year

Each unit = 15 minutes

Service	Service Limits
Crisis Intervention - one staff	Unlimited
Mental health assessment	4 hours /20 units
Treatment plan,development,review and modification	2 hours/ 8 units
Case Management -Mental Health -Transition Linkage and Aftercare -Mandated followup	5 hours/20 units total
Casemanagement- LOCUS	1.5 hours / 3 units
Psychotropic medication administration	3 hours/12 units
Psychotropic medication monitoring	2 hours/8 units
Psychotropic medication training-individual	2 hours/8 units
Oral interpretation & sign language	25 hours/100 units

Appendix 10

ASSOCIATION FOR INDIVIDUAL DEVELOPMENT

309 W. New Indian Trail Court
Aurora, IL 60506
Tel: 630-966-4000 Fax: 630-844-9884

Crisis Line and Crisis Intervention Services

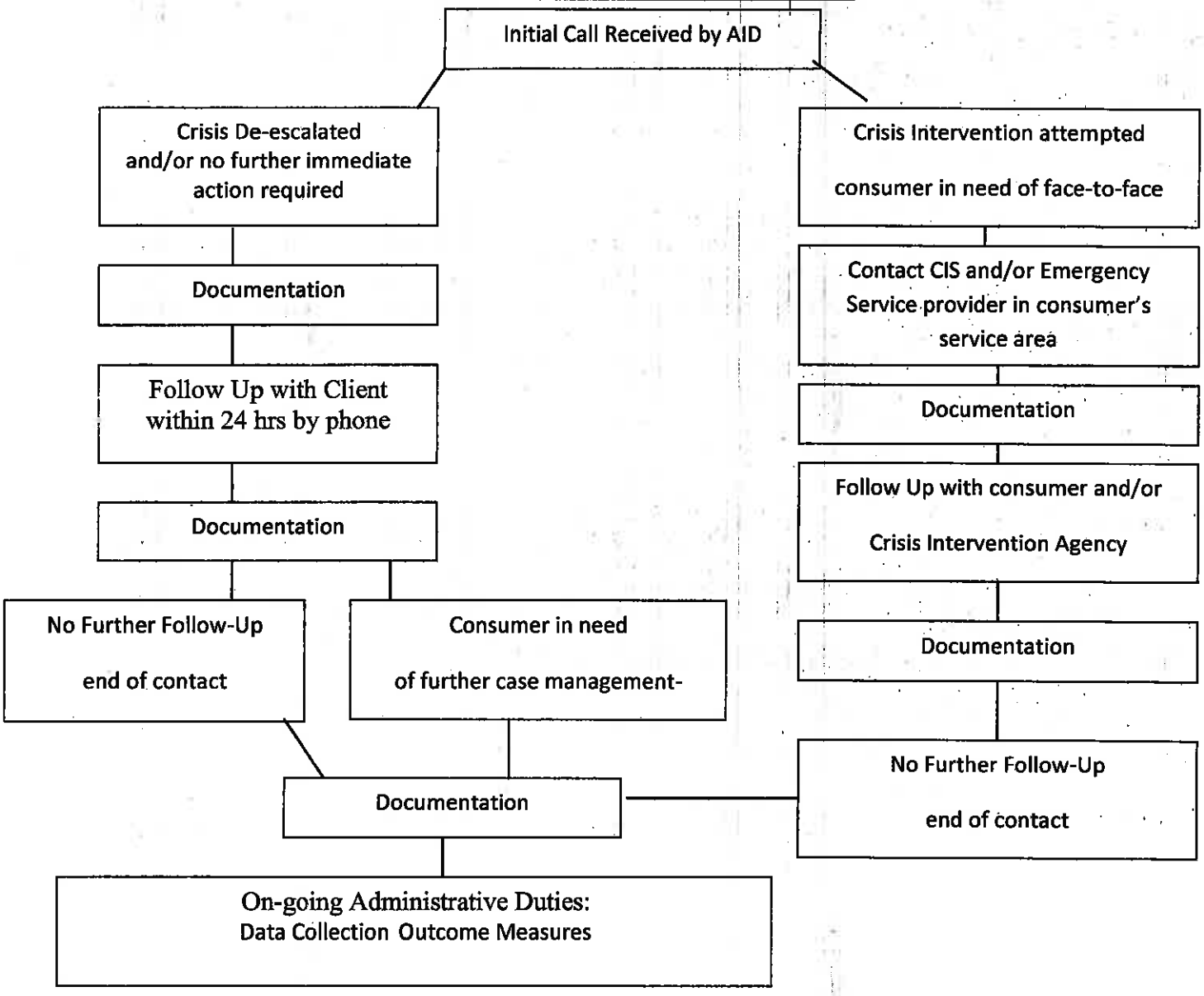
Agency Description:

The Association for Individual Development (AID) serves individuals with developmental, physical and/or mental disabilities, those who have suffered a trauma or are at risk. It was incorporated in 1961 by a small group of parents, serving 8 individuals with disabilities. Today, AID annually serves more than 5,100 individuals in 45 communities. It has a workforce of over 400 employees. AID provides quality services throughout the entire lifespan of an individual and utilizes a person-centered approach coupled with innovative practices to ensure the highest level of accomplishment. Our mission is to empower individuals with disabilities, mental illness and special needs to achieve independence and community inclusion.

Strength of Services:

- Array of services in the areas of Behavioral Health, Developmental Disabilities and Alcohol and Substance Abuse
- Comprehensive services –Prevention, Intervention and Rehabilitation Health Care Services
- Both Outpatient and Residential Treatment Services
- Both On and Off site services
- Services for all age groups
- State & Medicare approved "Community Mental Health Center"
- Primary prevention and intervention services of Crisis Line of Fox Valley and Crisis Intervention Services to prevent more intensive ER or hospitalization services
- Services provided with the philosophy of "resiliency focused", "empowering individuals", "recovery based" and on "evidence based practices"
- Licensure
    - Illinois Department of Human Services
        - Division of Mental Health
        - Division of Alcohol and Substance Abuse
        - Division of Developmental Disabilities
        - Division of Rehabilitation Services
        - Division of Community Health and Prevention
    - Illinois Department of Public Health
    - Illinois Department of Health Care and Family Services
    - Illinois Department of Children and Family Services
    - Illinois Department of Financial and Professional Regulation
- Accreditation
    - Commission of Accreditation of Rehabilitation Facilities (CARF)
    - American Association of Suicidology

Crisis Line Service Delivery Flow Chart



Crisis Line counselors not only provide crisis assessment but follow a Five Step Crisis Intervention Model:

1. Assessment: Active Listening, Psychosocial Factors, Past Coping Successes, evaluation of Current Supports.
2. Engaging the client: Become a Source of Support to the consumer, Normalize the client's Feelings, Non-judgmental.

3. Uncover Options: Refute the "no options" belief system, Utilize the three options available: Situational (People), Coping Mechanisms (Actions/Behaviors) and Constructive Thinking Patterns (Cognitive).
4. Planning: Restore consumer's equilibrium by providing a plan that is: Concrete, Positive, Active vs. Passive, and Engages Supports.
5. Obtaining Commitment: Consumer is Engaged in the Process, can Verbally Summarize their Plan, Expresses Relief (De-escalation), and is Willing to Involve Collaterals.

Appropriate referrals is provided to assist the caller with follow up care. These include referrals to: mental health outpatient services, substance abuse services, domestic violence, sexual assault, suicide prevention, pastoral, and finance. If it is determined that a face- to-face assessment and intervention is needed our Crisis Line dispatches a Crisis Intervention Services Counselor to do an on-site evaluation and intervention to prevent the need for more intensive treatment or hospitalization.

AID Service Descriptions

1.) Crisis Line of Fox Valley:

The Crisis Line of the Fox Valley is a 24-hour program that provides emergency intervention and dispatch, telephone counseling, information/referral and Sunshine (well-being) calls. The purpose of the Crisis Line is to de-escalate consumers, preventing the need for hospitalization. Appropriate follow-up care is provided or referred taking into account the consumers' resources and geographic location.

Services Include:

- **Information and Referral:**
  Counselors provide information about and referral to all human service agencies in the area for needs such as mental health, financial, health care, legal problems, shelter, support groups, and more. **Goal:** to link individuals to services prior to escalation of symptoms.
- **Sunshine Calls:**
  Counselors make calls to persons who may be elderly, isolated, disabled, or ill. **Goal:** contact and monitor individuals with known symptoms in order to avoid emergency room visits and/or hospitalization. (includes 16 part time, trained volunteer callers)
- **Emergency Services:**
  Counselors are trained to help with such emergencies as attempted suicide, drug overdose, and psychotic episodes. Incoming calls/requests come from numerous entities: individuals, family members, law enforcement and other emergency personnel.
- **Telephone Counseling/Crisis Counseling:**
  Counselors are trained to provide free, confidential counseling for any type of personal problem; alcohol, family, school, sex, loneliness, and depression. **Goal:** de-escalate and provide referrals to prevent the need for emergency intervention(s).

Consumers served:

The Crisis Line of the Fox Valley serves a varied population. Over 90% of incoming calls are from individuals seeking mental health intervention for themselves or a family member. As shown in the table below, requests for services has increased over 10% in the past year:

Fiscal Year of Program	# Of Calls Received	# Of Sunshine Calls Made	Dispatch (CIS)	Dispatch (Victims Services)
2009	29,346	34,878	1,161	268
2010	33,632	32,232	1,212	291
2011	38,178	31,378	667	293
2012 (YTD – Feb. 29)	31,233	25,166	360	221

2.) Crisis Intervention Services:

Crisis Intervention Services consist of face-to-face interactions with consumers following a traumatic event, death or request for a psychiatric evaluation. AID currently provides these services in the majority of the pilot area (parts of Kane, DuPage, Will and Cook Counties) and would sub-contract with providers outside our current service area.

Services include:

- **Crisis Intervention Services (CIS):**
  Clinicians are dispatched, via the Crisis Line, to complete mental health assessments at area hospitals, homes and police departments for those at risk of self-harm. **Goal:** to prevent hospitalization by involving collaterals, psychiatrists and all available resources. A.I.D. offers intake appointments for CIS consumers within 24 hours in order to promptly link them to services outside the hospital setting

- **Victims Services:**
  Advocates are dispatched, via the Crisis Line, to assist individuals who are victims of crime and/or trauma. **Goal:** to interact immediately following an incident in order to link victim to services outside the hospital setting and to prevent the development of Post Traumatic Stress Disorder (PTSD).

Consumers served:

Crisis Intervention Services and Victims Services receives response requests from area hospitals, police and fire departments as well as citizens and businesses. Crisis Intervention Services is called to assess an individual who may be suicidal; Victims Services responds to traumatic incidents such as completed suicides, homicides and unexpected deaths and may interact with a single individual or numerous witnesses/family members.

Fiscal Year of the Program	# of CIS Callouts	# of CIS Consumers	# of Victims Services Cases	# of Victims Services Consumers
2009	2294	2139	268	1804
2010	1879	1616	291	2187
2011	1922	1646	293	1762
2012 (YTD – Feb. 29)	1485	1376	221	1273

Service Outcomes:
AID's outcome measures are gathered, analyzed and reviewed on a regular basis by the Quality Improvement Committee. Exclusively, in the area of mental health, AID has produced the following outcomes:

- 75% of Mental Health Calls to the Crisis Line are successful in preventing the need for face-to-face interventions at an Emergency Department
- Crisis Intervention Services very successful in achieving state hospital deflection to less intensive services (93%).
- Consumers involved in AID Outpatient services- 91% stay out of the hospital.
- 85% of consumers seen face to face in our Crisis Intervention Services do not present at the Emergency Department for Psychiatric reasons within one year
- 100% of those suicidal consumers seen face to face do not go on to complete a suicide.

Testimonials from consumers served by AID's Crisis Line also demonstrate the effectiveness of crisis intervention in de-escalating consumers, minimizing the need for hospitalization:

- A seriously mentally ill Crisis Line caller attributes her increased socialization to the encouragement and support that Crisis Line workers provided.
- A parent reported that her daughter's 15 year old friend was very depressed and was contemplating suicide. The Crisis Line contacted the School Social Worker and (despite not knowing the student's last name) the school was able to identify the student and provide an intervention. The school contacted the Crisis Line to express their appreciation.
- Positive Intervention: A suicidal caller later stated she experienced hope and relief by speaking to a worker. She was able to tell her story, rather than be rushed to referrals. The caller went from high to low lethality and avoided hospitalization.

Staffing and Training:

The Crisis Line of the Fox Valley is staffed by full time Counselors with a Bachelor Degree or above in the Human Services field. Training is an intensive ten week process that includes classroom and crisis line room training with a supervisor for a minimum of two weeks before an employee is allowed to accept

incoming calls independently. Classroom instruction consists of instruction in: Suicide Prevention & Intervention, Crisis Intervention, Introduction to Mental Illness, Communication Skills, Domestic Violence, Sexual Assault as well as attaining knowledge in available community resources. Testing is done on a weekly basis to measure the employee's comprehension of the material. De-escalation of the caller is the primary goal, and employees are instructed in active listening as well as asking open-ended questions in order to obtain the necessary information to best assist the client. Training is also provided to assist the employee in coping with the challenges of the job: Stress Management, Compassion Fatigue and Debriefing.

Crisis Intervention Services counselors are also required to have attained a minimum of a Bachelor's Degree (Masters preferred) with extensive experience in a clinical setting. Training is completed over a thirty day period consisting of classroom instruction in Crisis Intervention, to prevent the need for hospitalization, and Diagnostic Skills. The clinician is required to job-shadow for the thirty day period with responsibilities gradually being turned over to the new recruit. The employee must prove their competencies throughout the month to their supervisor before being allowed to work independently

Current staff includes:

1.) **Joanne Furnas,** MA QMHP Director of the program, holds a Masters Degree in Emergency and Disaster Management, Bachelors in Behavioral Science and an Associate in Applied Science in Criminal Justice. Ms. Furnas is a former emergency police dispatcher and law enforcement officer who graduated from the Illinois State Police Academy. Trained since 2005 in Crisis Intervention and Stress Management (CISM), Ms. Furnas also provides debriefings for area law enforcement and fire departments following critical incidents. She is also the Incident Commander in charge of Emergency Management between AID and the Kane County Health Department.

2.) **Michelle McMullin** MA, LCPC is the Director of Behavioral Health. She graduated from Wheaton Graduate School in 1988 with a Master's Degree in Clinical Psychology. She worked for another agency for 15 years managing their Crisis programs prior to coming to AID. Michelle served for several years as a Red Cross volunteer and on the Northern Illinois Critical Incident Stress Management (CISM) Team. She has taken part in relief efforts for the Plainfield and Lemont Tornados as well as plane crashes and other disasters. In Elgin Illinios, she started the Community Emergency Response Team that responded to requests from the community for assistance following a trauma. These included bank robberies, death of a co-worker and death of students in schools. Michelle has also worked with Dr. Jeff Mitchell on the relief efforts following Hurricane Andrew in Florida and has taught and trained staff in Critical Incident Stress throughout the Midwest.

3.) **Sue Quillin** RN, MS, CDDN is the Director of Health Services and Quality Assurance at AID. Sue has a Master's Degree in Nursing Administration from DePaul University, and certification as a Developmental Disabilities Nurse. In her present role, Sue is responsible for supervision of clinical health services at AID as well as the oversight for AID's quality initiatives, including facilitation of regulatory and accreditation surveys, and chairing the agency's Quality Improvement Committee. Sue's clinical expertise includes psychiatric nursing, developmental disabilities, and crisis intervention.

4.) **Marja R. Huzevka,** MSEd, BCBA is a Board Certified Behavior Analyst and is the Director of Behavioral Services with AID. She completed her education at Northern Illinois University,

DeKalb, IL and Southern Illinois University, Carbondale, IL. She has a strong background in the field of Behavior Analysis due to her training under well-known behaviorists and at IABA. Additionally, she has 30 years of experience working with adults and children in crises, with developmental disabilities, psychiatric diagnoses, and /or substance abuse, in various capacities, both in The Netherlands and the United States.

5.) **Cheryl Brown**, BA, Program Manager of the Crisis Line, educational background includes degrees in social sciences, education and business administration and masters classes in counseling/educational psychology. Her 18 years of experience at AID benefits the Crisis Line of the Fox Valley with her expertise in training, supervision, supportive counseling for staff members and managing the technological side of a 24 hour program.

6.) **Danielle Joynes**, QMHP, MS, L.P.C. has a Masters Degree in Community Counseling, specializing in providing Crisis Intervention to both adolescents and adults. Ms. Joynes manages a team of over 15 clinicians, and has an extensive background in intensive outpatient services for women with addiction, prenatal depression screenings and indigent populations facing basic need emergencies. CISM trained in both individual and group crisis intervention, Danielle has facilitated numerous debriefings in our service area to emergency personnel following a traumatic incident.

7.) **Crisis Line MHP/QMHP:** This position requires a minimum of a Bachelor's Degree (Masters preferred) in the Human Services field and 5 years experience. Excellent communication skills are essential in order to assess, counsel and, most often, de-escalate a caller to prevent the need for further intervention(s).

8.) **Crisis Intervention Services MHP/QMHP**: This position requires a minimum of a Bachelor's Degree (Masters preferred) in the Human Services field and 5 years experience in a clinical setting. Requires the ability to work under stressful conditions to properly assess a consumer's mental health status to ensure accurate and thorough assessments and the capability to intervene in times of crisis in order to provide alternatives to more intensive treatment and/or hospitalizations.

Managerial Flow Chart for Crisis Services