

ATTACHMENT I
to
Written testimony to HFSRB on August 6, 2012

Singer Mental Health Center
Re-balancing Meeting
July 9, 2012 1 pm – 4 pm
Swedish-American Hospital – Rockford
Minutes

1. **Introductions** - Please see attendance list attached. DHS/DMH Region 2 Executive Director Amparo Lopez noted that this will be the last Stakeholder/Rebalancing meeting before the release of the RFI.

2. **Budget update** – Michael Pelletier/Dan Wasmer:

The Governor has signed the Budget, with modifications. Money has been provided to operate State Operated Hospitals (SOH) or to provide transitional/rebalancing services so DHS/DMH will be operating SOHs as well as funding transition and rebalancing services for those areas where a SOH is closing. Twenty million dollars have been cut from the DHS/DMH budget for community services. \$13 million of the cuts will be accomplished by delaying FY '13 payments by one month; \$7 million of the cuts will come from three grant services, with agencies allowed to redistribute the cuts to other grants per their agency's needs.

3. **Recovery Services Items for RFI Inclusion** – Dan Wasmer asked for feedback from Advocacy and Consumer stakeholders regarding what Recovery foci should be included in the upcoming Request for Information (RFI). Michael Pelletier asked for specific services that would meet clients' needs. All RFI services must include how the service will respond to client/family needs and support Recovery.

Comments included:

- It is difficult to find Recovery Specialists to hire
- Peer support and engagement
- WRAP should be available to all clients
- Educate physicians of the need to include unfunded clients in their outpatient services in order to decrease hospitalizations
- Educate consumers regarding what services will be available
- Need for a triage center
- Need for crisis services
- Assistance in applying for entitlements
- Education and availability of transportation to service sites
- Emergency Room diversion service sites

4. **Agency Recommendations** – Amparo asked each agency to briefly summarize their recommendations for services to be included in the RFI. Agency responses included:

- Consumer Representatives; Mobile crisis outreach
- WRAP
- Safety initiatives such as CIT
- Crisis residential; Enhanced IOP; PSH; transitional PSR; increased psychiatric leadership; vocational education; transportation; mobile crisis services; Dartmouth self-management training
- Crisis residential
- ED diversion
- Mental Health consultants; Brief Intervention Linkage Teams (BILT); transportation
- Enhanced outpatient services; Recovery-focused Regional triage/Living Room; crisis residential; ED diversion
- Enhanced crisis response, including virtual assessment for EDs to deflect inpatient admissions

- Consumer Support Specialist; Continuity of Care; PSR through enhanced case management; BILT; tele-psychiatry; Mental Health Hospitalist
- ED triage; linkage between hospital and CMHC; Regional crisis residential
- Triage Center/Intercept model
- CHIPS beds; increased coordination with post-discharge provider
- Triage; CIT training; crisis beds; more assistance with obtaining entitlements; use NAMI as an educational tool, either independently or aligned with a CMHC; expand CIT training with police
- Increased crisis intervention

As no mention was made of substance abuse services, Rick Nance explained a MI/SA hybrid service that was created for the Tinley Park service area. For those individuals with substance abuse or co-occurring substance abuse disorders, medical and psychiatric services will be provided initially (3 – 10 days), then a referral will be made to DASA or MISA. Services will include detox. beds and treatment levels 1,2, and 3. Providers need to tell DASA what is needed.

To clarify, Michael explained that funding for rebalancing services will be via one year grants. Michael made note of a request for multi-year grant funding.

5. Focus Group – Dr. Beedle, Acting Clinical Director for DMH explained the composition and task of a Clinical Focus Group that would be meeting on Tuesday, July 10. Clinicians from a sampling of agencies and consumers affected by the Singer closing will review a sampling of Singer charts in order to identify the primary factors leading to hospitalization and to identify what services needed to be in place to divert a percentage of those hospitalizations. The Focus Group is being kept small to afford the greatest efficiency in the chart reviews. After their review, the Group will offer a service mix, below the intensity of hospitalization, to recommend for inclusion in the RFI.

6. Preliminary Timeline/Next Steps – Michael offered the following timeline:

After the Focus Group meets, DMH's Dr. Mary Smith will perform a statistical analysis of their conclusions and the RFI will be written. Release date target is the week of July 23. At the end of August, around the 24th, there will be a review of proposals with the Director and the Governor's office. Agencies that submitted the selected proposals will be contacted the last week in August and discussions with each agency will be held during the first two weeks of September. Training with selected agencies will occur from mid-September – mid-October. Singer is expected to close October 31, 2012.

Amparo thanked the stakeholders for their time

ATTACHMENT II
to
Written testimony to HFSRB on August 6, 2012

7/9/12 Singer Rebalancing Stakeholder's Meeting – attendance sheet:

DHS/DMH – Dr. Dennis Beedle; Michael Pelletier; Dan Wasmer; Jordan Litvak; Tom Miller;
Sally Davidson; Pat Lindquist; Eldon Wigget; Marvel Bodman
DHS/DASA – Rick Nance & Jane ? (per conference phone)
DeKalb County Community Mental Health Board – Donna Moulton
NAMI Illinois – Robin Garvey; Jean Morrow
Rockford Memorial Hospital – Deanna Murray; Carolyn Bengtson
RHC – Becky Cook Kindall
Sinnissippi – Larry Prindenville
Rosecrance – Mary Ann Abate; Kristin Hesselbacher; Phil Eaton (per conference phone)
FHN – Jennifer Aurand
NCBHS – John Reinert; Jodi Mahoney (per conference phone)
Mental Health Consultant – Dan Neal
Swedish American – Angeline Brechlin; Ann Gantzer
Mental Health Assoc. of Rock River Valley – Dick Kunnert
Stepping Stone – Steve Langley; Susan Schroeder
Ben Gordon Center – Michael Flora
Governor's Office – Mark Doyle
Bridgeway – Bill Nelson & Aimee Anderson (per conference phone)
DASA – Rick Nance and Jan (per conference phone)
CGH – Kristy Guile (per conference phone)
Pioneer Center for Human Services – James Carpenter, Chloe Jones, Stephen Sanders, Lawrence
Nichols; Ronald E. Smith, Brennan Suraszek, Brett Doyle

ATTACHMENT III
to
Written testimony to HFSRB on August 6, 2012
(see next pages

also found at
<http://www.dhs.state.il.us/page.aspx?item=61113>

IDHS REQUEST FOR INFORMATION

**Singer Mental Health Center (SMHC) Community Reinvestment
Request for Information (RFI)
Release date: July 26, 2012**

Information Due By Close of Business Monday, August 13, 2012

DMH plans to hold one technical assistance call concerning this RFI. Details will be sent out under separate notice.

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

dhs.mh@illinois.gov

Send one electronic copy (in Microsoft Word and Excel as indicated) of your response to this RFI by the due date and time to:

dhs.mh@illinois.gov

A single (1) paper copy of the proposal shall also be postdated Monday, August 13, 2012 and mailed to:

Jackie Manker, Associate Director
IDHS Division of Mental Health
319 E Madison, Ste 3B
Springfield, Illinois 62701

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 or 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.

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**Department of Human Services
Singer Mental Health Center (SMHC) Community Reinvestment
Request for Information**

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IDHS REQUEST FOR INFORMATION

I. Context

A. Background

The rebalancing of the mental health system of care highlights the Governor's commitment to providing community-based alternatives to institutional care that is consistent with current patient-focused standards of care as well as the Supreme Court's 1999 Olmstead ruling, mandating that persons in institutional settings be afforded greater opportunities for community living. Thus, on January 19, 2012 the Governor announced a plan to rebalance the state's approach to care for individuals with mental health conditions. In his annual budget address on February 22, 2012, the Governor announced the plan to close the Singer Mental Health Center (SMHC). The targeted projection date for closure is October 31, 2012.

This RFI is the formal mechanism through which IDHS/DMH is soliciting proposals from community mental health agencies, hospitals, and substance use disorder (SUD) providers to deliver the community-based alternative levels of care to replace the services historically provided at SMHC. The RFI reflects the input from community stakeholder through the Governor's Rebalancing Workgroup planning process, which began on January 19, 2012, and continued through the issuance of this document.

Important steps in the rebalancing and transition planning process include:

1. An analysis of the clinical needs of persons served at SMHC;
2. An analysis of the existing and potential community service capacity in the area served by SMHC (Regions 2 West and 3 North);
3. Preparing a "Plan Evolution" for moving the work with the community stakeholders forward.

The IDHS Divisions of Mental Health (DMH) and Division of Alcohol and Substance Abuse (DASA) began the formal planning for the rebalancing with the formation and empanelment of two strategic Committees. The committees and their mission/function are as follows:

Hospital Engagement - Mission: Assist the state in determining the scope, types, amounts, locations and rates for hospital based care.

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.

Co-Chairs for each of the above Committees were appointed and are clinical or regional experts from the Regions 2W and 3N communities. Subject matter experts from DMH, and DASA were appointed to be state liaisons and to provide support to the committee co-chairs.

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B. Guiding Principles for this RFI

The expectation of recovery is a foundational principle of DMH's mission, vision and values. Therefore, the importance of including recovery-oriented services cannot be over-emphasized. Participating providers are encouraged to review Appendix 1 titled "Guiding Principles for Rebalancing: New Models and New Directions" a document that highlights:

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

DMH will evaluate the level of inclusion of recovery services as one of the critical decision factors in the funding decisions.

C. Description of the Northwest Crisis Care Region

DMH Region 2 West - Counties Served

Residents of **DeKalb County** receive DMH funded behavioral health services predominantly from the Ben Gordon Center which is affiliated with Kishwaukee County, Valley West, and FHN Memorial Hospital providing coordination between inpatient and outpatient programming. The agency provides comprehensive mental health services, substance abuse services, and scattered site residential services for adults and children. The hospitals in this county are Kishwaukee County, a general medical surgical hospital; Valley West, another general medical surgical hospital; and FHN Memorial Hospital, a regional healthcare system.

For year 2010, the Census Bureau reported DeKalb County as having a population of 105,160 residents. In 2006 -2012, 14.6% of people were living below poverty level. Median household income was \$54,002. Medicaid Enrollment for DeKalb County in FY11 shows 987 Adults with Disabilities; 4,486 Other Adults; 308 seniors, totaling 5,781 adults.

Residents of **Stephenson County** receive DMH funded behavioral health services predominantly from FHN Family Counseling Center which is affiliated with FHN Memorial Hospital and Galena Hospital. The agency provides comprehensive mental health services and scattered site residential services for adults. The hospitals in this county are FHN Memorial Hospital, a regional healthcare system; and Galena Hospital, a general healthcare facility.

For year 2010, the Census Bureau reported Stephenson County as having a population of 47,711 residents. In 2006 -2012, 14.8% of people were living below poverty level. Median household income was \$43,304. Medicaid Enrollment for Stephenson County in FY11 shows 1089 Adults with Disabilities; 2,935 Other Adults; 517 seniors, totaling 4,541 adults.

Residents of **Jo Daviess County** receive DMH funded behavioral health services predominantly from FHN Family Counseling Center which is affiliated with FHN Memorial Hospital and Galena Hospital. The agency provides comprehensive mental health services and scattered site

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residential services for adults. The hospitals in this county are FHN Memorial Hospital, and Galena Hospital.

For year 2010, the Census Bureau reported Jo Daviess County as having a population of 22,678 residents. In 2006 -2012, 8.4% of people were living below poverty level. Median household income was \$50,279. Medicaid Enrollment for Jo Daviess County in FY11 shows 226 Adults with Disabilities; 858 Other Adults; 140 seniors, totaling 1,224 adults.

DeKalb, Stephenson and Jo Daviess counties are served by FHN, a comprehensive mental health center and provide Rule 132 services.

Residents of **Carroll County** receive DMH funded behavioral health services predominantly from Sinnissippi Center which is affiliated with KSB Medical Group providing coordination between inpatient and outpatient programming. The agency provides comprehensive mental health services, substance abuse services, and 12 crisis beds for persons of all ages. The hospital in this county is KSB Medical Group, offering inpatient and outpatient behavioral health care.

For year 2010, the Census Bureau reported Carroll County as having a population of 15,387 residents. In 2006 -2012, 11.7% of people were living below poverty level. Median household income was \$44,805. Medicaid Enrollment for Carroll County in FY11 shows 286 Adults with Disabilities; 896 Other Adults; 184 seniors, totaling 1,366 adults.

Residents of **Lee County** receive DMH funded behavioral health services predominantly from Sinnissippi Center which is affiliated with KSB Medical Group providing a long standing history of coordination between inpatient and outpatient programming. The agency provides comprehensive mental health services, substance abuse services, 12 crisis beds, and is geared to adults, children, and adolescents. The hospital in this county is KSB Medical Group, offering inpatient and outpatient behavioral health care.

For year 2010, the Census Bureau reported a population of 36,031 residents. In 2006 -2012, 9.6% of people were living below poverty level. Median household income was \$48,502. Medicaid Enrollment detail for Lee County in FY11 shows 564 Adults with Disabilities; 974 Other Adults; 279 seniors, totaling 1,817 adults.

Residents of **Ogle County** receive DMH funded behavioral health services predominantly from Sinnissippi Center which is affiliated with KSB Medical Group providing a long standing history of coordination between inpatient and outpatient programming. The agency provides comprehensive mental health services, substance abuse services, 12 crisis beds, and is geared to adults, children, and adolescents. The hospital in this county is KSB Medical Group, offering inpatient and outpatient behavioral health care.

For year 2010, the Census Bureau reported a population of 53,497 residents. In 2006 -2012, 8.9% of people were living below poverty level. Median household income was \$44,805. Medicaid Enrollment detail for Ogle County in FY11 shows 836 Adults with Disabilities; 3,430 Other Adults; 529 seniors, totaling 4,795 adults.

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Residents of **Whiteside County** receive DMH funded behavioral health services predominantly from Sinnissippi Center which is affiliated with KSB Medical Group providing a long standing history of coordination between inpatient and outpatient programming. The agency provides comprehensive mental health services, substance abuse services, 12 crisis beds, and is geared to adults, children, and adolescents. The hospital in this county is KSB Medical Group, offering inpatient and outpatient behavioral health care.

For year 2010, the Census Bureau reported a population of 58,498 residents. In 2006 -2012, 11.2% of people were living below poverty level. Median household income was \$45,266. Medicaid Enrollment detail for Whiteside County in FY11 shows 1,378 Adults with Disabilities; 3,177 Other Adults; 575 seniors, totaling 5,130 adults.

Residents of **Winnebago County** receive DMH funded behavioral health services predominantly from Rosecrance Center and Stepping Stones, Inc. which is affiliated with Rockford Memorial Hospital, Swedish American Hospital, and OSF St. Anthony Medical Center providing a long standing history of coordination between inpatient and outpatient programming. Rosecrance Center provides comprehensive mental health services, inpatient and outpatient substance abuse services, is geared to adults, children, and adolescents, ACT, CILA (16), 4 crisis beds, and community resource center funded by Title XX. Stepping Stones provides residential and PSH. The hospitals in this county are Rockford Memorial Hospital, offering inpatient behavioral health care; Swedish American Hospital, also offering inpatient behavioral health care; and OSF St. Anthony Medical Center, a general medical surgical hospital.

For year 2010, the Census Bureau reported a population of 295,266 residents. In 2006 -2012, 15.9% of people were living below poverty level. Median household income was \$47,198. Medicaid Enrollment detail for Winnebago County in FY11 shows 7,406 Adults with Disabilities; 19,652 Other Adults; 3,308 seniors, totaling 30,366 adults.

Residents of **Boone County** receive DMH funded behavioral health services predominantly from Rosecrance Center and Stepping Stones, Inc. which is affiliated with Rockford Memorial Hospital, Swedish American Hospital, and OSF St. Anthony Medical Center providing a long standing history of coordination between inpatient and outpatient programming. Rosecrance Center provides comprehensive mental health services, inpatient and outpatient substance abuse services, is geared to adults, children, and adolescents, ACT, CILA (16), 4 crisis beds, and community resource center funded by Title XX. Stepping Stones provides residential and PSH. The hospitals in this county are Rockford Memorial Hospital, offering inpatient behavioral health care; Swedish American Hospital, also offering inpatient behavioral health care; and OSF St. Anthony Medical Center, a general medical surgical hospital.

For year 2010, the Census Bureau reported a population of 54,165 residents. In 2006 -2012, 10.4% of people were living below poverty level. Median household income was \$61,210. Medicaid Enrollment detail for Boone County in FY11 shows 408 Adults with Disabilities; 2,395 Other Adults; 239 seniors, totaling 3,042 adults.

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These counties are served by Rosecrance Center, a comprehensive mental health center and DASA provider, and Stepping Stones, Inc., a residential provider. Providers coordinate to provide both mental health Rule 132 and DASA services to their residents.

DMH Region 3 North – Counties Served

Bureau, LaSalle, Marshall, Putnam, and Stark Counties

The 172,610 residents of Bureau (35,503), LaSalle (111,509), Marshall (13,180), Putnam (6,086), and Stark (6,332) counties receive DMH funded behavioral health services predominantly from North Central Behavioral Health Systems, Inc. North Central Behavioral Health Systems, Inc. (NCBHS) is a comprehensive community mental health center providing both Mental Health and Substance Abuse services. Also NCBHS has for many years been committed to rural behavioral health care access through innovative programming including piloting computer technology to improve case management access for rural populations and the use of telepsychiatry. About 10.7 percent of the residents in these counties are living below the poverty level, and the median household income is approximately \$48,216. Perry Memorial and St Margaret's hospitals are in Bureau County and neither have inpatient psychiatric units. Illinois Valley Community, Mendota Community, St Mary's and OSF St. Elizabeth hospitals are in LaSalle County, and OSF St. Elizabeth has a 26 bed inpatient psychiatric unit. Marshall and Stark counties do not have hospitals.

Henderson, Henry, Knox, and Warren Counties

The 133,804 residents of Henderson (8,213), Henry (51,020), Knox (55,836), and Warren (18,735) counties receive DMH funded behavioral health services predominantly from Bridgeway, Inc. Bridgeway is a comprehensive mental health center providing both Mental Health and Substance Abuse services. Bridgeway also has an extensive residential capacity and is a leader in its commitment to Individual Placement and Support programming (rapid employment for mental health consumers). About 12.7 percent of the residents in these counties are living below the poverty level, and the median household income is approximately \$43,449. Hammond Henry and Kewanee hospitals are in Henry County and neither has an inpatient psychiatric unit. Cottage Hospital and OSF St. Mary Medical Center are in Knox County, and Cottage Hospital has a 12 bed inpatient geriatric psychiatric unit. OSF Holy Family Medical is in Warren County, and Henderson County does not have a hospital.

Peoria County

The 183,433 residents of Peoria County receive DMH funded behavioral health services predominantly from the Human Service Center. The Human Service Center (HSC) is a large comprehensive mental health center providing both Mental Health and Substance Abuse services. The only Assertive Community Treatment Program in Region 3 is provided by HSC which is also noted for a long standing commitment to Recovery values. Under a DMH contract, HSC is also serving Williams' class consumers choosing to leave IMDs for a more independent life in the community. About 14.5 percent of Peoria County residents are living below the poverty level, and the median household income is approximately \$49,747. OSF St.

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Francis Medical Center, Methodist Medical Center, and Proctor hospitals are in Peoria County. Methodist has a 68 bed inpatient psychiatric unit, expanded subsequent to the closure of Zeller Mental Health Center, Proctor has an 18 bed inpatient geriatric psychiatric unit, and OSF St. Francis tertiary treatment facility, offers psychiatric liaison, consultation, and Partial Hospitalization, but does not have an inpatient psychiatric unit.

Mercer and Rock Island Counties

The 166,331 residents of Mercer (16,957) and Rock Island (149,374) counties receive DMH funded behavioral health services predominantly from the Robert Young Center. The Robert Young Center is a comprehensive mental health center providing both Mental Health and Substance Abuse services. About 10.8 percent of the residents in these counties are living below the poverty level, and the median household income is approximately \$48,568. Genesis Medical Center and Trinity Medical Center are in Rock Island counties, and Trinity Medical Center has a 54 bed inpatient psychiatric unit. Mercer County Hospital is in Mercer County. The Robert Young Center affiliated with Trinity Medical Center has a long history of providing coordination between inpatient and outpatient programming. They are also developing a comprehensive network for the provision of primary and behavioral healthcare integration.

Summary of counties served:

- Persons served are from all economic backgrounds.
- Residents receive mental health and substance abuse treatment based on need.
- Counseling and case coordination to address child welfare problems and legal issues are available in most counties.
- There is evidence of a growing Hispanic population (some undocumented) resulting in a need for Spanish-speaking services,
- Extensive coordination occurs between affiliated area hospitals.
- In many communities, the agencies identified are the only certified, comprehensive provider of mental health Rule 132 and DASA services in the county.

Additional summary statistical information by County is in Appendix 2.

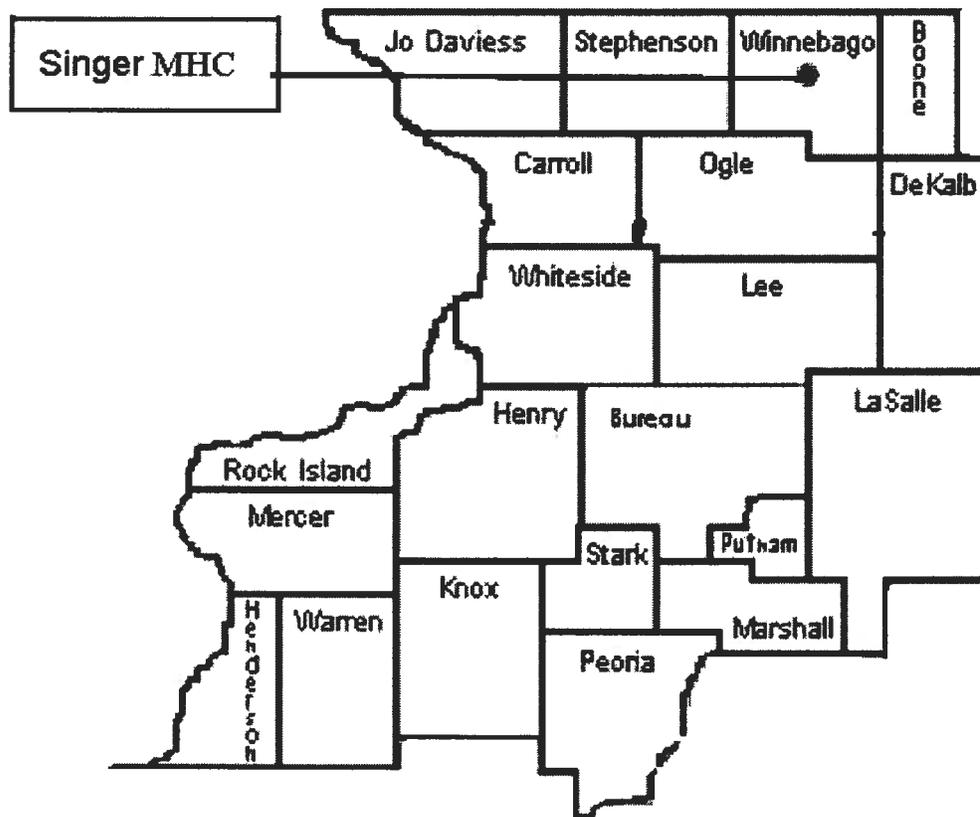
D. Clinical Characteristics of the Individuals and Their Service and Support Needs

This RFI is aimed at meeting the needs of a specific and prescribed population of unfunded individuals. The target population is approximately 845 individuals from the SMHC catchment area Regions 2W and 3N see Figure I below who, if not for the Singer closure, would be seeking state-operated hospital (SOH) services in the remaining eight months of FY13 (beginning November 1, 2012). The basis for this forecast is shown in Table I FY11 Emergency Department Referrals to SMHC below, which details SOH admissions from the Regions 2W and 3N counties. Some of the significant characteristics of this population include the following features:

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1. Approximately 90% of the people admitted to SMHC were referred from local community hospital emergency departments see Table I;
2. Approximately 51% of the people admitted, the admission was the first one to SOH services;
3. Approximately 14% of the people admitted had a substance use disorder or substance induced disorder as their primary discharge diagnosis;
4. Approximately 30% of the people admitted had a substance use disorder or substance induced disorder as a secondary discharge diagnosis.
5. Approximately 66% of the people did not have insurance or Medicaid ;
6. Approximately 14% of the people admitted were experiencing homelessness;

Figure I Singer Mental Health Center Catchment Area



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Table I FY11 Emergency Department Referrals to SMHC

FY11 Emergency Department Referrals to SMHC	Count
Swedish American Hospital (Winnebago)	364
Rockford Memorial Hospital (Winnebago)	14
St. Anthony Hospital (Winnebago)	12
Methodist (Peoria)	21
Trinity (Rock Island)	26
Kishwaukee (DeKalb)	52
Valley West (DeKalb)	5
Freeport (Stephenson)	64
Midwest (Jo Daviess)	7
Illinois Valley Community (LaSalle)	6
Mendota (LaSalle)	3
Ottawa Regional (LaSalle)	42
St. Margaret (Bureau)	2
St. Mary (LaSalle)	2
Perry Memorial (Bureau)	5
Centegra (McHenry)	53
Memorial West (McHenry)	1
Mercy Harvard (McHenry)	1
Cottage (Knox)	7
Kewanee (Henry)	5
St. Mary (Knox)	4
KSB (Lee)	37
CGH (Whiteside)	13
Morrison (Whiteside)	7
Rochelle Community (Ogle)	4
Other State Operated Hospitals	51
Forensic (county jails)	19
Other	18
Total	845

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D. Clinical Characteristics of the Individuals and Their Service and Support Needs (continued)

An Expert Clinical Focus Group was convened to review clinical information on representative samples of individuals admitted to SMHC. This expert panel consisted of clinicians from area hospitals, community service providers and IDHS/DMH. The result of this group's work can be summarized as follows:

Assessed need at the point of presenting crisis:

- 25% could benefit from long term inpatient hospital level of care
- 30% could benefit from short term inpatient hospital level of care CHIPS
- 40% could benefit from short intensive stabilization
- 5% could benefit from crisis residential

Assessed need at the point of presenting crisis or as discharge follow-up:

- 25% could benefit from ACT/CST
- 15% could benefit from DASA residential
- 25% could benefit from crisis residential post discharge
- 25% could benefit from supervised residential
- Follow-up with Acute Community Services (ACS) as indicated

To further understand the characteristics of the population targeted by this RFI, please refer to Appendices 3 and 4 for the FY11 SMHC discharge diagnoses.

E. Qualified Providers

The Expert Focus Group work has led IDHS to inviting three types of qualified providers to respond to the RFI and participate in developing the enhanced the NCCS.

- Licensed community hospitals enrolled with Medicaid (HFS) that provide:
 - Adult acute inpatient psychiatric services, or
 - Emergency department services, and/or
 - Other hospital-based psychiatric services
- Community Mental Health Service Providers currently contracted through DMH, who are Rule 132 certified and enrolled with Medicaid (HFS).
- Substance use disorder providers, currently contracted through DASA, who are licensed under Rule 2060/2090 and enrolled with Medicaid (HFS).

Collaboration is encouraged between provider agencies to maximize opportunities for integration of crisis care components. Proposals that include cross-collaboration across agencies and service types will be given strong consideration. However, DMH reserves the right to fund agencies or programs separately and independently.

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III. The Vision for the Northwest Crisis Care System (NCCS)

DMH envisions an enhanced Crisis Care System that provides acute care alternatives which will focus on engaging individuals presenting at community hospital emergency departments (ED) and at awarded selected community sites that maximize opportunities for diversion of the crisis incident to a less restrictive community based site rather than the historical use, solely or predominantly, of emergency departments.

This RFI seeks to implement services on or about October 1, 2012. The goals of the emerging NCCS will be to.

- Provide timely and accessible crisis intervention services in the hospital emergency departments and awarded selected community sites.
- Provide access to a wide range of crisis stabilization options most proximate to the consumer's geographic location.
- Help individuals achieve stability as quickly as possible.
- Provide and maintain crisis services within the local community to maximize existing support systems.
- Assist people in a return to a pre-crisis level of functioning.
- Provide community treatment alternatives to the crisis care situations.
- Increase or improve recovery pathways using natural supports.

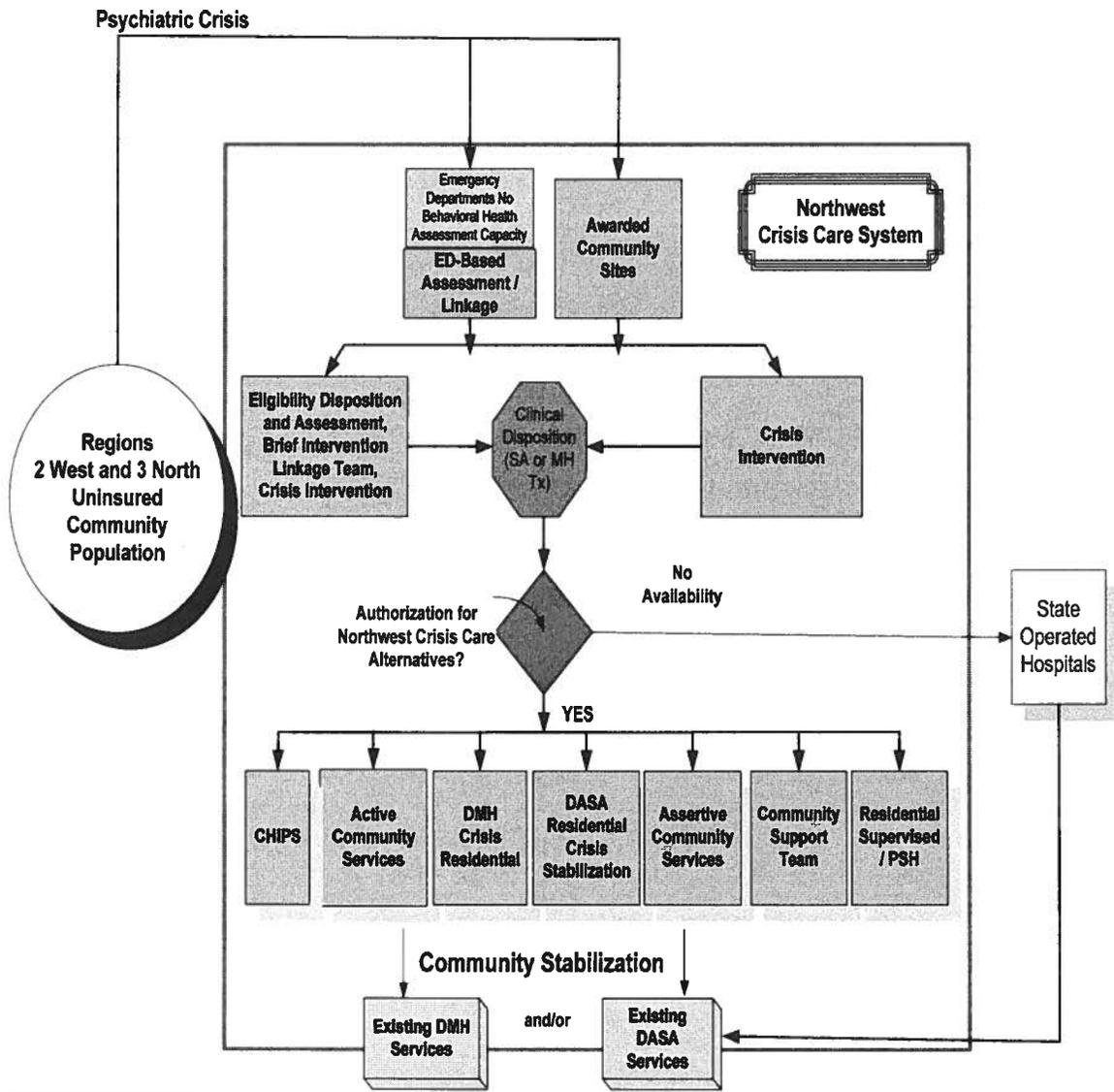
To reach these goals, the NCCS will:

- Deliver crisis intervention services 24 hours a day, 7 days a week;
- Provide crisis services at or for the EDs or
 - at awarded selected community sites or
 - provide telehealth capability to provide these services;
- 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 NCCS;

Figure II Northwest Crisis Care System Flowchart shown below illustrates the NCCS design that has emerged from the planning 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 DMH structures. Together with the hospital emergency departments and awarded selected community sites, this model will become the new NCCS.

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Figure II Northwest Crisis Care System (NCCS) Flowchart



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III. SERVICES TO BE PURCHASED UNDER THIS RFI

A. Crisis Intervention (Program 580)

Crisis Intervention is defined as those 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 the "Community Mental Health Services Service Definition and Reimbursement Guide", page 29, at:

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

The crisis services 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 the direct support necessary until a firm linkage to another service provider is in place or the crisis has been resolved.

Service(s) may need to be provided during a transitional period to facilitate the timely and rapid discharge from awarded selected community sites once the next level of care is identified.

Also, the service should provide access to other critical supports for the consumer. The crisis service may also be combined post discharge from awarded selected community sites, or to supplement or to act as a primary source of referral for crisis residential services as described below.

In responding to this RFI detail how you propose to establish a system to efficiently and effectively:

- a) Manage the historical volumes from emergency departments (see Table I) through crisis intervention services at awarded selected sites; and/or
- b) Shift the historical volumes at emergency departments from current hospital intervention points to other awarded selected community sites;
- c) Provide details on the projected referral volumes to other levels of purchased care, including transportation as outline in this RFI.

The crisis intervention provider would have broader authority and responsibility for recommending a next level of service similar to EDA evaluators. The crisis outreach service

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may act as the primary mental health provider until it is appropriate to transition the individual into mainstream services.

The request for such a service shall include a narrative that details how the service will combine the NCCS functions to intercept individuals and move them into the appropriate level of care. Details that need to be clearly articulated in the request include:

1. The location of the awarded selected community site within the NCCS;
2. The area served by the awarded selected community site and the hospital emergency departments within the defined area;
3. The number of NCCS individuals that would be served by the awarded selected community site;
4. The source of referrals, such as local police, CMHCs, hospital EDs, advocacy organizations, etc.;
5. The means/methods of transportation of unfunded referrals (see the Transportation Section below);
6. The hours of operation and minimum staffing of the awarded selected community site;
7. The credentials and qualifications of site staff, including detail on the credentials and qualifications of peer staff. "Evaluators" should be Qualified Mental Health Professional (QMHP) level staff, Licensed Practitioner of the Healing Arts (LPHA) preferred;
8. How the awarded selected community site staff will perform the following functions:
 - a. EDA Evaluation and Linkage to other levels of service in the NCCS
 - b. On-site Rule 132 crisis intervention services (See Community Mental Health Services Service Definition and Reimbursement Guide, page 29, at: <http://www.hfs.illinois.gov/assets/cmhs.pdf>)
 - c. On-site DASA services
 - d. Provide/arrange transportation to approved and authorized NCCS service sites.

B. ED Based Eligibility, Disposition, and Assessment (EDA)

This RFI seeks to augment the need for a behavioral health assessment and linkage capacity at all community hospitals in their emergency departments.

For those hospitals not having internal behavioral health specialist, or for those hospitals not seeking BILT funding, DHS will purchase a crisis intervention service for Eligibility, Disposition, and Assessment (EDA) from a community mental health provider. The EDA and linkage service may provide evaluation services either through an in-person face to face encounter or through telehealth technology in a manner consistent with existing Department of Healthcare and Family Services (HFS) guidelines.

For those hospitals with significant historical volumes and with behavioral health specialists, this RFI will seek to augment their work to provide the needed assessment and linkage

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function through BILT funding as outlined below, or EDA should the hospital not wish propose BILT services.

Across all EDs and awarded selected community sites the “Evaluators” (Qualified Mental Health Professional (QMHP) level staff, Licensed Practitioner of the Healing Arts (LPHA) preferred) would conduct interviews, complete assessments and make recommendations for alternative levels of care. Entry into services would be authorized by the ACCESS Line (described below) and the evaluator would then proceed to make the necessary linkage to that level of care (service), including needed transportation (also described below).

In responding to this RFI detail how you propose to establish a system to efficiently and effectively:

- a) Manage the historical volumes from emergency departments (see Table I) through crisis intervention services at awarded selected sites; and/or
- b) Shift the historical volumes at emergency departments from current hospital intervention points to other awarded selected community sites;
- c) Provide details on the projected referral volumes to other levels of purchased care, including transportation as outline in this RFI.

This function is similar to that already done for SOH pre-screening process and in the current screening, assessment and linkage functions under the Screening Assessment Support Services (SASS) Program for the children and adolescents.

The Eligibility, Disposition, and Assessment (EDA) Scope of Services is in Appendix 5.

C. Community Hospital Inpatient Psychiatric Services (CHIPS) (Program 550)

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 in Appendix 6.

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DMH is wishing to contract with hospitals with existing inpatient Behavioral Health (BH) units for admission utilization both from their ED but also to support portions of the other capacity from other area hospital ED where no inpatient BH capacity exists and from awarded selected community sites. State hospital capacity will be available for safety net purposes. 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 licensed community hospitals with category of service Acute Mental Illness (AMI) licensed beds for adults who are:

- Certified as a Medicaid/ Medicare provider and ;
- Assert to remain fully in compliance with the State of Illinois Mental Health Code and Confidentiality Act and ;
- Enrolled for Adult Medicaid (HFS) services and ;
- Accredited by The Joint Commission (TJC) or by Healthcare Facilities Accreditation Program (HFAP).

D. Brief Intervention Linkage Team (BILT)

DMH is soliciting proposals that propose other levels of crisis treatment. BILTs are the staffing component of a what might typically be a considered a crisis stabilization unit. These units may typically be based within an ED and be of minimal size (3-8 beds). These programs are often distinct service areas in the ED strictly for persons with mental illnesses presenting in acute crisis and 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 typical length of stay in a BILT setting is expected to be 24-36 hours.

DMH is seeking proposals from hospital providers who can develop multi-disciplinary teams of mental health professionals to staff BILTs. The BILT will 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.

Examples of appropriate BILT Team development or augmentation at the EDs:

- A. Qualified Mental Health Professional (QMHP) level staff, Licensed Practitioner of the Healing Arts (LPHA) preferred :
 1. To perform crisis assessment based on documented mental health crisis volumes and projected to respond on a 24/7/365 basis and /or ;
 2. Enhancing staff to reach 24/7/365 coverage in the ED and /or ;
 3. Enhancing staff to obtain coverage necessary on typically busy shifts or days of the week;
- B. Face-to-face Psychiatry/APN for rapid assessment, consultation, and/or the immediate initiation of active treatment (including psychotropic medications).

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- C. Consultation by a practitioner qualified under Administrative Rule 2060 to assess, diagnose, and treat persons with substance use disorders. Please see the Professional Staff Qualifications at the following link.

<http://www.ilga.gov/commission/jcar/admincode/077/077020600C03090R.html>

The BILT provider would have broader authority and responsibility for recommending a next level of service similar to EDA evaluators. Authorization for next level services will be the purview of the ACCESS provider.

Qualified responders for BILT services are licensed community hospitals who are:

1. Certified as a Medicaid/Medicare provider;
2. Assert to maintain full compliance with the State of Illinois Mental Health Code and Confidentiality Act;
3. Accredited by The Joint Commission (TJC) or by Healthcare Facilities Accreditation Program (HFAP).

Please refer to Table I to gauge the historical volume and flow of referrals from the various EDs in the area. This function is similar to that already done for SOH pre-screening process and in the current screening, assessment and linkage functions under the SASS Program for the children and adolescents.

In responding to this RFI detail how you propose to establish a system to efficiently and effectively:

- a) Manage the historical volumes from emergency departments (see Table I) through crisis intervention services at awarded selected sites; and/or
- b) Shift the historical volumes at emergency departments from current hospital intervention points to other awarded selected community sites;
- c) Provide details on the projected referral volumes to other levels of purchased care, including transportation as outline in this RFI.

E. DMH Crisis Residential (Program #860)

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.² 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.

² Drawn from the draft Residential Rule 140 currently under development.

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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 to meet the needs of individuals previously served by SMHC. Qualified responders for crisis residential would be providers certified to provide behavioral Medicaid services and under contract with IDHS/DMH would also qualify.

Respondents proposing this level of care acknowledge and assert that upon contract initiation this service will be:

- fully compliant with all standards within the proposed Rule 140 and;
- may be converted to Fee for Service (FFS) reimbursement in manner and time frame consistent with DMH's actions with other currently funded Crisis Residential programs (Program #580) and ;
- understand that DMH may, at its sole discretion, institute utilization authorization, concurrent review and reauthorization standards in manner and time frame consistent with DMH's actions with other currently funded Crisis Residential programs

F. Residential Services

DMH is receptive to receiving proposals that propose other levels of residential support consistent with the currently identified Supervised Residential service (program #830) and Permanent Supportive Housing (PSH) program.

Respondents proposing this level of care acknowledge and assert that upon contract initiation this service will be:

- Fully compliant with all standards within the proposed Rule 140 or Rule 150; and
- May be converted to Fee for Service (FFS) reimbursement in manner and time frame consistent with DMH's actions with other currently funded Supervised Residential programs (Program #830) and
- Understand that DMH may, at its sole discretion, institute utilization authorization, concurrent review and reauthorization standards in manner and time frame consistent with DMH's actions with other currently funded Residential programs.

It is incumbent on the respondent to provide convincing evidence that:

- The current level of existing capacity is not adequate to support the historical level of state operated participants, and supports the levels of services requested;
- That these levels of residential supports will be significantly used for NCCS participants, are critical for the recovery of NCCS participants; and

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- Without this service the crisis incident would likely result in an admission to a state operated hospital.

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G. The NGRI Community Conditional Release Program

Respondents should advise DMH of their interest and intent for serving eight to ten NGRI consumers who are adjudicated for conditional release to the community. DMH has developed a pilot program and is developing accompanying Policies and Procedures. Any new community conditional release programs would be supported by the risk management and community safety knowledge gained to date by experience with the current pilot program as well as the Forensics Bureau's general knowledge of monitoring these types of consumers. Such a service would necessarily require collaboration between the DMH Forensic Bureau, the local DMH Regional Office and the community mental health center provider. The goal of this partnership would be to provide a safe and structured environment for forensic mental health clients transitioning from inpatient hospitalization to independent community living. Such a program would target NGRI status clients who are found to possess the functionality and stability necessary to live successfully outside an inpatient setting and who are granted a Conditional Discharge by their court. The goal of the program is to provide clients an intermediate step between inpatient hospitalization and independent community living.

The program requires a gradual, supervised transitional experience from a supervised residential setting (current existing capacity) with case management, recovery focused services and clinical treatment in accordance with the Terms of Conditional Release provided by the court. The privileges of unsupervised client movement are earned gradually as clients demonstrate stability and compliance with the program. In the final phase of the program clients are allowed to move into the community to live independently. During this phase, clients continue to receive psychiatric services, court reporting and as-needed case management.

A Summary of Not Guilty by Reason of Insanity (NGRI) and Conditional Release Finding is in Appendix 7.

H. Acute Community Care Services (ACS)

For individuals from NCCS being discharged from an ED, CHIPS, crisis residential or a DHS/DMH Hospital, and for those discharged from DASA residential services with a co-occurring disorder, the contracted community mental health centers must provide Acute Community Services, and must:

- Initiate treatment within 24 hours of discharge from an ED and within 48 hours of discharge from a hospital or residential service;
- Evaluate and serve individuals consistent with Rule 132 services;
- Assist the individual with the Medicaid application process.

It is assumed that the services and supports funded by these contracts will consist primarily of the services of the Medicaid Community Mental Health Services Program (Rule 132), including psychiatric services as mental health assessment and psychotropic medication administration,

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monitoring and training. Providers may also include any other services or supports they determine will be needed to achieve the recovery goals of the individual, which may include medications, transportation or substance abuse services, to avoid more restrictive and expensive services. That is, the provider has the flexibility to determine and enhance the range of services and supports that are best tailored to meet the needs of the individual eligible for the NCCS as indicated by the mental health assessment. The ACS provider shall assist the residential provider or individual in locating and facilitating a hard hand-off referral to another ACS provider if the individual chooses.

To ensure timely access to needed services, the provider will:

- Make arrangements to ensure that the Evaluators completing eligibility and disposition determinations in the NCCS hospital emergency departments or from BILTs or awarded selected community sites can immediately schedule an appointment with a qualified mental health staff member within 24 hours (e.g., provider supplies Evaluators with the times and locations made available for such appointments) These arrangements will include availability of services appropriate to the needs of the individual. For example, if the individual requires psychiatric medication monitoring or evaluation, the appointment scheduled will be with a practitioner who is professionally able to address such needs;
- Make arrangements to ensure that individuals eligible for the NCCS needing aftercare or follow-up services after being discharged from CHIPS, Mental Health Crisis Residential, DASA Residential or DHS/DMH hospitalization can be scheduled for appointment with a qualified mental health staff member within 48 hours These arrangements will include availability of services appropriate to the needs of the individual. For example, if the individual requires psychiatric medication monitoring or evaluation, the appointment scheduled will be with a practitioner who is professionally able to address such needs. It is strongly recommended that the provider begin active collaboration for discharge linkage planning with residential service providers as soon as possible after admission to those settings.

For each individual identified as eligible for NCCS, the Acute Community Services contracted provider remains responsible for services and supports for the individual for the twelve month period following the provider's initial assessment of the individual. Individuals who are determined to be Medicaid eligible should convert to regular Medicaid services as soon as possible and will no longer be eligible for the NCCS.

Providers are also required to submit reports on expenses, deliverables and performance measures as outlined in the DHS Contract Exhibit for this program.

The community mental health services provider ensures that each individual determined to be eligible for NCCS and to receive enhanced Acute Community Services is appropriately registered with the designated identifier in the DHS/DMH consumer individual registration/enrollment information system.

The Acute Community Care Services (ACS) Scope of Services is in Appendix 8.

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I. Substance Use Disorder (SUD) services, Division of Alcoholism and Substance Abuse (DASA)

DMH is accepting proposals from DASA providers able to deliver crisis stabilization services to patients referred from the EDAs or as outlined in the DASA Residential Crisis Stabilization Criteria in Appendix 9.

It is incumbent on the respondent to provide convincing evidence that:

- Demonstrates the ability to deliver the services requested;
- Demonstrates that these levels of residential supports will be used for only NCCS participants;
- Demonstrates that these services are critical for the recovery of NCCS participants;
- Demonstrates that without these services the crisis situation would likely result in an admission to a state operated hospital and
- Will assess all consumers using the ASAM PPC2-R and Locus assessment in order to make a firm referral and linkage to all recommended existing licensed substance abuse, Mental Health, and/or recovery support services upon discharge.

DMH will coordinate the analysis, review and awarding of such proposals with the DHS Division of Alcohol and Substance Abuse (DASA) who will act as contractor for such services.

Useful information about DASA services can be found in the following links:

http://www.dhs.state.il.us/OneNetLibrary/27896/documents/Manuals/FY12/DASA_Contractual_Policy_Manual_FY2012.pdf

<http://www.ilga.gov/commission/jcar/admincode/077/07702090sections.html>

J. Assertive Community Treatment (ACT) and Community Support Team (CST)

Input from the Clinical Focus Group pointed to the value of Assertive Community Treatment (ACT) and Community Support Team (CST) service models for the stabilization of persons experiencing a psychiatric emergency. The emphasis on “in-vivo” interventions of these models makes them uniquely valuable for addressing and resolving the type of community living challenges that can result in an emergency department presentation.

A description of ACT and CST services can be found the Community Mental Health Services Service Definition and Reimbursement Guide, page 20 and 28 respectively, at:

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

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There are two ways DMH can support the expanded use of these models in the NCCS area. First, formally incorporate existing ACT and CST programs into the NCCS, and establish the procedures needed to authorize program services for unfunded individuals for the period of time needed to help the person stabilize the presenting crisis. It is the expectation that those unfunded persons referred to such programs are likely to meet the eligibility requirements for Medicaid.

Second, DMH can help expand ACT and CST resources in the NCCS area by helping existing Community Support service providers with start-up costs related to creating new ACT or CST services from existing and newly hired staff. Accordingly, a grant for up to 3 months to cover the added administrative and operational costs, including staff recruitment, orientation, and training, can be requested under this RFI. However, it will be crucial that the applicant demonstrate that the new Team will be able to sustain itself on FFS revenue streams from the existing volume of funded (i.e., Medicaid) individuals and the volume of authorized NCCS individuals.

For any proposal under each of the above two scenarios, details that need to be clearly articulated in the request would include:

- The location within the NCCS of the expanded or new Team;
- The defined area and the hospital emergency departments served by the Team;
- The Team's total capacity and the portion (number) of NCCS individuals that the Team would serve; and,
- The source of NCCS participants when not referred for EDA after presentation at one of the hospital emergency departments in the area, such as local police, CMHCs, hospital EDs, advocacy organizations, etc.
- Commitment to undertake disability benefits applications including Medicaid application according to best practices.

Like all other higher level services in the NCCS, ACT or CST services would need to be available for referrals 24/7/365.

K. Peer Recovery Support Services

The DMH is receptive to receiving proposals that reflect projected levels of peer recovery support services and/or augmentation of other services to include peer delivered services. Peer recovery support services are founded on the use of a peer recovery support specialist's personal recovery experience, and are designed to inspire hope, provide encouragement, explore strengths and challenges, and identify resources with, and for, persons served. Peer recovery support services are based upon the principle of mutuality, which creates the foundation for the development of trusting, supportive relationships.

Peer recovery support specialists focus on promoting individual choice and self-determination. They are uniquely adept at helping others learn how to effectively self-advocate. By role-modeling a lifestyle of recovery, they are able to mentor, teach and model life skills for individuals at all stages in the recovery process.

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One of the goals of peer recovery support services is to provide connections and relationships which decrease the experience of isolation so often felt by individuals with mental illnesses. By talking with others who are willing to share openly about their own experiences in recovery, individuals receiving services develop a stronger sense of hope for their own recovery. These interactions often result in fresh, short-term solutions and a wider array of options for managing future crises and/or sustaining wellness over time.

Examples of appropriate development or augmentation of services to provide peer recovery support services, could include:

- Enhancement/augmentation of any other aspects of service delivery to include peer recovery support services (i.e., crisis intervention, CHIPS, BILT, crisis residential, residential, ACS, SUD, ACT, CST)
- Inclusion of peer-led recovery education groups
- Inclusion of peer-provided Wellness Recovery Action Plan (WRAP) classes
- Development of a peer-run crisis respite center
- Inclusion of individual (1:1) peer recovery support services (i.e., mentoring, wellness coaching, outreach & engagement)

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IV. OTHER CONTRACTED SUPPORT SERVICES FOR THIS RFI

A. Adult Care and Referral Entry Service (ACCESS)

DMH has contracted with the Illinois Collaborative for Access and Choice (Collaborative) to provide registration, authorization, concurrent review and re-authorization functions for participants in the Northwest Crisis Care System. Once the Evaluator has completed an evaluation and is prepared with a recommendation for the appropriate level of service for the individual, he should contact the Collaborative to obtain authorization and the name, address and contact information of a service provider with availability that is most convenient to the individual's home.

Procedure:

1. The Evaluator calls The Collaborative at 866-359-7953 to request authorization for the recommended level of care.
2. The Evaluator will provide the ACCESS Clinical Care Manager (CCM) at the Collaborative with all necessary information to complete a temporary registration and an authorization, including:
 - a. Demographic information (coordinate with Collaborative):
 - i. First and last name;
 - ii. RIN if applicable;
 - iii. Date of Birth;
 - iv. Address (last known address or current location if homeless);
 - v. Gender;
 - vi. Ethnicity.
 - b. Response Time indicators:
 - i. Time of admission of individual to ED;
 - ii. Start time of initial face-to-face contact between the individual and Evaluator.
 - c. Clinical Presentation:
 - i. Presenting problem/crisis;
 - ii. Five Axes Diagnosis;
 - iii. LOCUS dimensions and LOCUS Recommended Level of Care;
 - iv. ASAM dimensions assessments and the Patient Placement Criteria that have been met, if applicable.
 - d. Recommended Disposition – funded treatment options include:
 - i. Community Hospital Inpatient Psychiatric Services (CHIPS);
 - ii. Mental Health Crisis Residential;
 - iii. DASA Residential Treatment;
 - iv. Acute Community Services (ACS).
 - e. Existing SOH will serve as the safety net for instances when the above services are not available or not appropriate for the needs of the individual.

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3. The CCM reviews for medical necessity. If present, then the CCM will authorize care and will provide the Evaluator with:
 - a. A single authorization number which will be used to authorize the medically necessary level of care and (if necessary to access inpatient or residential services) payment for the transportation service for the individual;
 - b. The location and contact information for the provider with service availability at the approved level of care.
4. In the event that there is no available capacity for the recommended level of a care, the CCM will provide information about available capacity at other levels of care for consideration by the Evaluator, the individual and the ED physician.

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. By State law PA 93-770 DHS is required to arrange for the transportation of persons (outside of Cook County) who are involuntarily admitted into psychiatric facilities or hospitals and for those who are ordered by the court to be remanded for involuntary admission. ".....In making such arrangements and agreements with other public or private entities, the Department shall include provisions to ensure (i) the provision of trained personnel and the use of an appropriate vehicle for the safe transport of the recipient ..." DHS is currently contracted with a statewide provider for the purpose of achieving needed 'involuntary admission' transport services.

When necessary, IDHS/DMH will arrange involuntary patient transportation alternatives that are:

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

DMH expects that proposals including EDA, BILT, or crisis intervention require volume and cost projections which offer alternate arrangements for the transport of unfunded persons moving voluntarily from their location to another destination to receive approved and authorized services. The requirements for providers who may be selected to provide voluntary transport of persons in crisis may differ between communities and will be determined by the legal, voluntary status of the individual in need of treatment. It is required that any such proposal substantiate cost on a fee for service basis as well as demonstrate the ability of such transport services to move patients from location to destination in a safe and dignified manner.

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C. Emergency and Transition Medication

DMH plans to offer support to agencies for access to the IDHS Pharmacy (OCAPS) for the needs for discharge and emergency medication. Providers would be able to access pharmaceuticals through a mail order prescription process from the locally situated IDHS Pharmacy hub. Bidders should project the anticipated total cost necessary based on projected volumes.

This service is 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:

- 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 existing service area. Respondents to the Northwest Crisis Care System should build on existing capacity at community hospitals, emergency departments, inpatient psychiatric units, and 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

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

C. 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.

D. All proposals will be judged independently solely on the merits of that particular respondent's presentation in response to the needs for the Northwest Crisis Care System as outlined in this RFI.

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- E. Data or information supplied in this RFI use FY11 as the base year for planning purposes since this data provides the greatest amount of details and volume consistent with the projected needs of the Northwest Crisis Care System. DMH will consider both FY 11 and FY12 data in its final determination and contracting negotiations with respondents.
- F. Respondents with existing capacity in DMH or DASA funded programming shall fully document how the proposed services or programs augment, supplement build on and use.

VI. Information Requested

- A. Respondents with existing capacity in DMH or DASA funded programming shall fully document how the proposed services or programs augment, supplement build on and use:
 - 1. Access to existing Crisis Intervention Services;
 - 2. Access to all existing Community-based Rule 132 Services and other DMH contracted programs and services held by the agency;
 - 3. Access to existing Substance Use Disorder (SUD) Rule 2060 2090 services though DASA contracts;
- B. In responding to this RFI, providers should detail how they propose to establish and implement sustainable peer recovery support services, to be integrated within the currently established service delivery system. Distinctly for each service or program proposed the respondent must clearly detail in the narrative and supporting financial (budget) information and forms how the proposed program or service will support the mission of recovery The RFI respondent should include:
 - 1. Organization's vision for including peer recovery support services as part of the overall service delivery system
 - 2. Expected outcomes of the peer recovery support program
 - 3. Where/how peer recovery support services will fit within the organization's structure
 - 4. Description of the peer recovery support services/program to be developed
 - 5. Description of how the peer recovery support services/program will respond to the needs reflected under this RFI
 - 6. Plan for sustainability of peer recovery support services/program
 - 7. Job titles, duties and responsibilities for peer recovery support specialists
 - 8. Qualifications of peer recovery support specialists
 - 9. Process for hiring peer recovery support specialists
 - 10. Plan for training peer recovery support specialists
 - 11. Plan for training other staff regarding the new peer recovery support program
 - 12. Process for integrating the peer recovery support specialists into the treatment delivery team
 - 13. Supervision of peer recovery support specialists
 - 14. Administrative support of peer recovery support services

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- C. Provider Organization Information, complete Attachment A.
- D. Proposed Budget Information, complete Attachment B.
- E. Capability and Plans for Delivery of Community Mental Health Medicaid Services complete Attachment C.

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.

- F. 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.

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

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

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- J. **Geographic coverage** - For each service or program proposed the respondent shall describe the geographic area currently served by your agency and any additional areas where your organization could expand geographically and the geographic area to be served by each program or service. As appropriate, 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.
- K. **Financial stability**
1. 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.
 2. 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
- L. **Capability and Plans to Assure the Ongoing Quality of Services and Continuous Improvement**
1. 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;
 2. Describe how your current and future quality improvement and assurance processes will benefit the Northwest Crisis Care recipients.
- M. **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.

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Attachments and Appendices

Attachments

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Attachment A Provider Organizational Information

1. Provider Name:	
2. Address:	
3. Name and Title of Chief Executive:	
Telephone:	
Fax Number:	
Email Address:	
4. Primary Program Contact Person and Title:	
Telephone:	
Email Address:	
5. Fiscal Contact Person and Title:	
Telephone:	
Email Address:	
6. Remittance Address:	
7. Tax Payer I.D. (FEIN) Number: (FEIN number to be used with any resulting contract using official IRS name) <u>Include an IRS Form W-9 in your response.</u>	
8. Identify your Congressional District (by number):	
Identify your Illinois Senate District (by number)	
Identify your Illinois House District (by number)	
9. Identify your local IDHS office (s) that you link with, by name and number. Refer to the IDHS web site as follows: http://www.dhs.state.il.us/officeLocator/	
<p>Note: The above organizational information will be used to develop any resulting contract through the Illinois Department of Human Services (IDHS) Office of Contract Administration (OCA) so the information shall include executive level information of individuals authorized to execute contracts with IDHS. Further, if the organization is already registered with IDHS OCA or has multiple IDHS contracts please use the FEIN</p>	

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that the individual executing any resulting contract can access through the following IDHS OCA Community Services Agreement (CSA) Contract Tracking System internet site.

<https://grants.dhs.illinois.gov/gtsecure/gtp>

Please check the site to ensure your organization is registered. Please direct any contracting questions to DHS.dhsoca@illinois.gov

Include an IRS Form W-9 Request for Taxpayer Identification Number and Certification in your response.

Provider Service Delivery Capacity	
Locations of offices and sites of service delivery (include the address and the 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:	
<i>Characteristics of adult consumers served in FY11:</i>	
% male/female:	
% with serious mental illness:	
<i>Staffing characteristics:</i>	
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. (Please distinguish between MDs and other prescriber types).	
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 QMHP.	
For community mental health providers, the number and percentage of direct service staff whose highest qualification is MHP.	

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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 that 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.	

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Attachment B Proposed Budget (Not required for CHIPS)

Singer Mental Health Center RFI Proposal Budget Document

Program Title: _____ *The name of your proposed program*

Provider Official Name: _____ *Official IRS Name
Provider shall also submit an IRS Form W-9 to ensure any subsequent contract is structured correctly*

Provider FEIN: _____

Street Address: _____

City: _____

Contact Person: _____ *Organizational Official authorized to negotiate with the State and shall be one of the persons identified on Attachment A.
Complete all requested information and do not leave any blanks*

Contact Phone Number: _____

Contact Email Address: _____

Proposal Date: _____

Proposed Period of Service: _____

Personnel - FTE Base Salary	# of	Monthly	Annual	Proposed	Explanation (Use a separate Narrative as necessary)
(1.0 FTE = _____ hours per week)	FTEs	Amount	Amount	Amount	<i>Explanation of your proposed costs including a list of applicable quantity, units, percentages, clarification, etc. Explain your FTE calculations</i>
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	

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Benefits				
Retirement				
Life & Health Insurance				
Other: _____				
Other: _____				
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: _____				
Total		\$0	\$0	\$0

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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					
Insurance					
Taxes					
Total		\$0	\$0	\$0	
Renovation Costs					
Other Start-up Costs					

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Other Indirect Cost					

Total Non-Personnel Cost		\$0	\$0	\$0	
Total Program Cost		\$0	\$0	\$0	

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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	Notes/Detail
Hospitals									
	Inpatient Psychiatric								
	BILT								
	Behavioral Health Services in ED								
Community Mental Health									
	Psychiatric Leadership	350							
	Special Projects	510							
	Specialized Direct Clinical Services	515							
	Psychiatric Medications	574							
	PATH Grant	575							
	Crisis Staffing	580							
	Crisis Telephone Line								Hours of operation =

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	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	Notes/Detail
	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								

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	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	Notes/Detail
	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								

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	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	Notes/Detail
	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								

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	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	Notes/Detail
	Therapy/counseling--group								
	Therapy/counseling--family								
	Mental health intensive outpatient--adult								
Community Substance Abuse									
	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							

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	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	Notes/Detail
	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								

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Attachment D Linkage Capability

Service or Support	Number 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)		

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APPENDIX 1

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.

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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

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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:* overcoming 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

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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

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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.

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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.

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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 telepsychiatry 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.

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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

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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.

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**APPENDIX 2
Singer RFI Providers and Statistical Summary by County**

COUNTY	DMH FUNDED PROVIDER(S)	POPULATION	% BELOW POVERTY LEVEL	MEDIAN HOUSEHOLD INCOME	MEDICAID ENROLLMENT			
					Adults w/ Disabilities	Other Adults	Seniors	Total
Boone (2)	Rosecrance Stepping Stones	54,167	10.4%	\$61,210	408	2,395	239	3,042
Carroll (2)	NCBHS	15,388	11.7%	\$44,805	286	896	184	1,366
DeKalb (2)	Ben Gordon	105,160	14.6%	\$54,002	987	4,486	308	5,781
Jo Daviess (2)	FHN Counseling	22,677	8.4%	\$50,279	226	858	140	1,224
Lee (2)	Sinnissippi	36,031	9.6%	\$45,502	564	974	279	1,817
Ogle (2)	Sinnissippi	53,497	8.9%	\$55,733	836	3,430	529	4,795
Stephenson (2)	Jane Addams	47,711	14.8%	\$43,304	10,898	2,935	517	4,541
Whiteside (2)	Sinnissippi	58,498	11.2%	\$45,266	1,378	3,177	575	5,130
Winnebago (2)	Rosecrance Stepping Stones	295,264	15.9%	\$47,198	7,406	19,652	3,308	30,366
Bureau (3)	North Central Behavioral Health Systems	34,978	11.1%	\$45,692	515	1,895	414	2,824
Henderson (3)	Bridgeway	7,331	11.4%	\$43,450	80	259	74	413
Henry (3)	Bridgeway	50,486	10.4%	\$49,164	758	2,484	409	3,651
Knox (3)	Bridgeway	52,919	15.5%	\$39,545	1,525	3,396	849	5,770
LaSalle (3)	North Central Behavioral Health Systems	113,924	10.8%	\$51,705	1,861	7,139	1,172	10,172

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COUNTY	DMH FUNDED PROVIDER(S)	POPULATION	% BELOW POVERTY LEVEL	MEDIAN HOUSEHOLD INCOME	MEDICAID ENROLLMENT			
					Adults w/ Disabilities	Other Adults	Seniors	Total
Marshall (3)	North Central Behavioral Health Systems	12,640	9.5%	\$49,116	185	713	145	1,043
Mercer (3)	Robert Young	16,434	9.3%	\$50,909	0	35	0	35
Peoria (3)	Children's Home Assoc. Community Workshop and Training Center Human Service Center Side Side Office of Concern	186,494	14.5%	\$49,747	5,094	11,223	1,830	18,147
Putnam (3)	North Central Behavioral Health Systems	6,006	10.9%	\$56,458	50	237	21	308
Rock Island (3)	Robert Young Transitions NFP	147,546	12.3%	\$46,226	3,026	8,593	1,503	13,122
Stark (3)	North Central Behavioral Health Systems	5,994	11.2%	\$49,196	58	254	55	367
Warren (3)	Bridgeway	17,707	13.4%	\$41,636	558	1,855	324	2,737

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APPENDIX 3 FY11 Discharges from Singer MHC with Primary Discharge Diagnosis

Dx Code	Description	Count	S/A Dx
298.9	UNSPECIFIED PSYCHOSIS	72	
295.70	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	69	
311	DEPRESSIVE DISORDER	51	
296.90	UNSPECIFIED EPISODIC MOOD DISORDER	50	
296.89	OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER	45	
296.80	BIPOLAR DISORDER, UNSPECIFIED	34	
309.0	ADJUSTMENT DISORDER WITH DEPRESSED MOOD	33	
295.30	SCHIZOPHRENIA, PARANOID, UNSPECIFIED	31	
296.33	MAJOR DEPRESSIVE DISORDER, RECURRENT, SEVERE WITHOUT PSYCHO	28	
303.90	OTHER AND UNSPECIFIED ALCOHOL DEPENDENCE, UNSPECIFIED	25	25
295.92	UNSPECIFIED SCHIZOPHRENIA, CHRONIC	22	
296.30	MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, UNSPECIFIED	21	
296.32	MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, MODERATE	20	
296.44	BIPOLAR I DISORDER, MANIC EPISODE, SEVERE WITH PSYCHOTIC	20	
304.90	UNSPECIFIED DRUG DEPENDENCE, UNSPECIFIED	19	19
295.90	UNSPECIFIED SCHIZOPHRENIA, UNSPECIFIED	17	
291.89	OTHER SPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS	17	17
295.32	SCHIZOPHRENIA, PARANOID, CHRONIC	16	
292.84	DRUG-INDUCED MOOD DISORDER	15	15
300.4	DYSTHYMIC DISORDER	12	
296.20	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED	12	
309.81	POSTTRAUMATIC STRESS DISORDER	11	
296.34	MAJOR DEPRESSIVE DISORDER, RECURRENT, SEVERE WITH PSYCHOTIC	10	
296.00	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, UNSPECIFIED	9	
296.7	BIPOLAR I DISORDER, MOST RECENT EPISODE UNSPECIFIED	9	
305.00	ALCOHOL ABUSE, UNSPECIFIED	9	9
296.40	BIPOLAR I DISORDER, MOST RECENT EPISODE MANIC, UNSPECIFIED	8	
296.23	MAJOR DEPRESSIVE DISORDER, SINGLE, SEVERE WITHOUT PSYCHOT	8	
296.50	BIPOLAR I DISORDER, DEPRESSED EPISODE, UNSPECIFIED	8	
305.90	OTHER, MIXED OR UNSPECIFIED DRUG ABUSE, UNSPECIFIED	8	8
296.24	MAJOR DEPRESSIVE DISORDER, SINGLE, SEVERE WITH PSYCHOTIC	7	
309.4	ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF EMOTIONS AN	7	
304.20	COCAINE DEPENDENCE, UNSPECIFIED	7	7
295.00	SCHIZOPHRENIA, SIMPLE, UNSPECIFIED	6	
296.53	BIPOLAR I DISORDER, DEPRESSED EPISODE, SEVERE WITHOUT PSY	5	
V65.2	PERSON FEIGNING ILLNESS	5	
309.28	ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD	5	
296.22	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE	4	
304.00	OPIOID TYPE DEPENDENCE, UNSPECIFIED	4	4
309.9	UNSPECIFIED ADJUSTMENT REACTION	4	
305.20	CANNABIS ABUSE, UNSPECIFIED	4	4
297.1	DELUSIONAL DISORDER	4	
296.43	BIPOLAR I DISORDER, MANIC EPISODE, SEVERE WITHOUT PSYCHOT	4	
295.10	SCHIZOPHRENIA, DISORGANIZED, UNSPECIFIED	3	
312.34	INTERMITTENT EXPLOSIVE DISORDER	3	
292.11	DRUG-INDUCED PSYCHOTIC DISORDER WITH DELUSIONS	3	3
300.00	ANXIETY STATE, UNSPECIFIED	3	
295.34	SCHIZOPHRENIA, PARANOID, CHRONIC WITH ACUTE EXACERBATION	3	
296.54	BIPOLAR I DISORDER, DEPRESSED EPISODE, SEVERE WITH PSYCHO	3	
296.60	BIPOLAR I DISORDER, MIXED EPISODE, UNSPECIFIED	3	
296.64	BIPOLAR I DISORDER, MIXED EPISODE, SEVERE WITH PSYCHOTIC	3	
292.12	DRUG-INDUCED PSYCHOTIC DISORDER WITH HALLUCINATIONS	3	3

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300.01	PANIC DISORDER WITHOUT AGORAPHOBIA	2	
292.9	UNSPECIFIED DRUG-INDUCED MENTAL DISORDER	2	2
299.80	OTHER SPECIFIED PERVASIVE DEVELOPMENTAL DISORDERS, CURREN	2	
291.9	UNSPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS	2	2
296.21	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MILD	2	
310.1	PERSONALITY CHANGE DUE TO CONDITIONS CLASSIFIED ELSEWHERE	1	
295.40	SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1	
312.30	IMPULSE CONTROL DISORDER, UNSPECIFIED	1	
295.12	SCHIZOPHRENIA, DISORGANIZED, CHRONIC	1	
293.9	UNSPECIFIED TRANSIENT ORGANIC MENTAL DISORDER	1	
296.03	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE	1	
314.01	ATTENTION DEFICIT DISORDER WITH HYPERACTIVITY	1	
V62.81	INTERPERSONAL PROBLEMS	1	
291.5	ALCOHOL-INDUCED PSYCHOTIC DISORDER WITH DELUSIONS	1	1
294.8	OTHER PERSISTENT MENTAL DISORDERS	1	
296.25	MAJOR DEPRESSIVE DISORDER, SINGLE, IN PARTIAL/UNSPECIFIED	1	
296.56	BIPOLAR I DISORDER, DEPRESSED EPISODE, IN FULL REMISSION	1	
297.8	OTHER SPECIFIED PARANOID STATES	1	
298.0	DEPRESSIVE TYPE PSYCHOSIS	1	
296.36	MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, IN FULL REMI	1	
300.02	GENERALIZED ANXIETY DISORDER	1	
300.13	DISSOCIATIVE FUGUE	1	
295.94	UNSPECIFIED SCHIZOPHRENIA, CHRONIC WITH ACUTE EXACERBATIO	1	
300.3	OBSESSIVE-COMPULSIVE DISORDERS	1	
295.50	LATENT SCHIZOPHRENIA, UNSPECIFIED	1	
301.83	BORDERLINE PERSONALITY DISORDER	1	
304.10	SEDATIVE, HYPNOTIC OR ANXIOLYTIC DEPENDENCE, UNSPECIFIED	1	
296.04	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, SEVERE WITH PSYCH	1	
304.30	CANNABIS DEPENDENCE, UNSPECIFIED	1	1
296.46	BIPOLAR I DISORDER, MANIC EPISODE, IN FULL REMISSION	1	
295.80	OTHER SPECIFIED TYPES OF SCHIZOPHRENIA, UNSPECIFIED	1	
295.75	SCHIZOAFFECTIVE DISORDER, IN REMISSION	1	
300.14	DISSOCIATIVE IDENTITY DISORDER	1	
		851	120
			14.10%

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APPENDIX 4 FY11 Discharges from Singer MHC with Secondary Discharge Diagnosis

Dx Code	Description	Count	S/A Dx
		204	
303.90	OTHER AND UNSPECIFIED ALCOHOL DEPENDENCE, UNSPECIFIED	41	41
304.90	UNSPECIFIED DRUG DEPENDENCE, UNSPECIFIED	38	38
301.83	BORDERLINE PERSONALITY DISORDER	33	
309.81	POSTTRAUMATIC STRESS DISORDER	33	
278.00	OBESITY, UNSPECIFIED	29	
305.20	CANNABIS ABUSE, UNSPECIFIED	27	27
305.00	ALCOHOL ABUSE, UNSPECIFIED	25	25
305.90	OTHER, MIXED OR UNSPECIFIED DRUG ABUSE, UNSPECIFIED	25	25
304.30	CANNABIS DEPENDENCE, UNSPECIFIED	21	21
292.84	DRUG-INDUCED MOOD DISORDER	20	20
305.1	TOBACCO USE DISORDER	18	
301.7	ANTISOCIAL PERSONALITY DISORDER	17	
301.9	UNSPECIFIED PERSONALITY DISORDER	17	
291.89	OTHER SPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS	16	16
401.9	ESSENTIAL HYPERTENSION, UNSPECIFIED	14	
314.01	ATTENTION DEFICIT DISORDER WITH HYPERACTIVITY	11	
304.20	COCAINE DEPENDENCE, UNSPECIFIED	10	10
300.4	DYSTHYMIC DISORDER	10	
312.34	INTERMITTENT EXPLOSIVE DISORDER	9	
309.0	ADJUSTMENT DISORDER WITH DEPRESSED MOOD	9	
301.6	DEPENDENT PERSONALITY DISORDER	8	
493.90	ASTHMA, UNSPECIFIED, UNSPECIFIED	8	
305.60	COCAINE ABUSE, UNSPECIFIED	7	7
521.00	DENTAL CARIES, UNSPECIFIED	7	
300.02	GENERALIZED ANXIETY DISORDER	7	
V62.89	OTHER PSYCHOLOGICAL OR PHYSICAL STRESS	6	
296.80	BIPOLAR DISORDER, UNSPECIFIED	6	
244.9	UNSPECIFIED HYPOTHYROIDISM	5	
300.3	OBSESSIVE-COMPULSIVE DISORDERS	5	
295.70	SCHIZOAFFECTIVE DISORDER, UNSPECIFIED	5	
304.80	COMBINATIONS OF DRUG DEPENDENCE EXCLUDING OPIOID, UNSPECIFIED	5	5
311	DEPRESSIVE DISORDER	4	
297.1	DELUSIONAL DISORDER	4	
298.9	UNSPECIFIED PSYCHOSIS	4	
300.00	ANXIETY STATE, UNSPECIFIED	4	
724.5	BACKACHE, UNSPECIFIED	4	
304.00	OPIOID TYPE DEPENDENCE, UNSPECIFIED	4	4
301.81	NARCISSISTIC PERSONALITY DISORDER	4	
530.81	ESOPHAGEAL REFLUX	4	
305.50	OPIOID ABUSE, UNSPECIFIED	4	4
496	CHRONIC AIRWAY OBSTRUCTION	3	
296.90	UNSPECIFIED EPISODIC MOOD DISORDER	3	
564.00	CONSTIPATION, UNSPECIFIED	3	
291.9	UNSPECIFIED ALCOHOL-INDUCED MENTAL DISORDERS	3	3
301.4	OBSESSIVE-COMPULSIVE PERSONALITY DISORDER	3	
296.30	MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, UNSPECIFIED	3	
272.4	OTHER AND UNSPECIFIED HYPERLIPIDEMIA	3	
317	MILD MENTAL RETARDATION	3	
318.0	MODERATE MENTAL RETARDATION	3	
250.00	DIABETES MELLITUS WITHOUT COMPLICATION, TYPE II OR UNSPECIFIED	3	

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783.22	UNDERWEIGHT	2	
303.93	OTHER AND UNSPECIFIED ALCOHOL DEPENDENCE, IN REMISSION	2	
296.54	BIPOLAR I DISORDER, DEPRESSED EPISODE, SEVERE WITH PSYCHO	2	
V65.2	PERSON FEIGNING ILLNESS	2	
523.9	UNSPECIFIED GINGIVAL AND PERIODONTAL DISEASE	2	
301.22	SCHIZOTYPAL PERSONALITY DISORDER	2	
345.90	EPILEPSY, UNSPECIFIED, WITHOUT MENTION OF INTRACTABLE EPI	2	
465.9	ACUTE UPPER RESPIRATORY INFECTIONS OF UNSPECIFIED SITE	2	
280.9	IRON DEFICIENCY ANEMIA, UNSPECIFIED	2	
305.93	OTHER, MIXED OR UNSPECIFIED DRUG ABUSE, IN REMISSION	2	2
309.4	ADJUSTMENT DISORDER WITH MIXED DISTURBANCE OF EMOTIONS AN	2	
296.50	BIPOLAR I DISORDER, DEPRESSED EPISODE, UNSPECIFIED	1	
285.9	ANEMIA, UNSPECIFIED	1	
296.20	MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, UNSPECIFIED	1	
V15.89	PERSONAL HISTORY OF OTHER HEALTH HAZARDS	1	
296.33	MAJOR DEPRESSIVE DISORDER, RECURRENT, SEVERE WITHOUT PSYCHO	1	
296.00	BIPOLAR I DISORDER, SINGLE MANIC EPISODE, UNSPECIFIED	1	
296.44	BIPOLAR I DISORDER, MANIC EPISODE, SEVERE WITH PSYCHOTIC	1	
295.40	SCHIZOPHRENIFORM DISORDER, UNSPECIFIED	1	
250.50	DIABETES WITH OPHTHALMIC MANIFESTATIONS, TYPE II OR UNSPE	1	
783.21	LOSS OF WEIGHT	1	
V62.81	INTERPERSONAL PROBLEMS	1	
296.89	OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER	1	
244.0	POSTSURGICAL HYPOTHYROIDISM	1	
251.2	HYPOGLYCEMIA, UNSPECIFIED	1	
294.8	OTHER PERSISTENT MENTAL DISORDERS	1	
820.8	FRACTURE OF NECK OF FEMUR, UNSPECIFIED PART, CLOSED	1	
292.82	DRUG-INDUCED PERSISTING DEMENTIA	1	
292.9	UNSPECIFIED DRUG-INDUCED MENTAL DISORDER	1	1
301.20	SCHIZOID PERSONALITY DISORDER, UNSPECIFIED	1	
292.2	PATHOLOGICAL DRUG INTOXICATION	1	1
290.40	VASCULAR DEMENTIA, UNCOMPLICATED	1	
292.11	DRUG-INDUCED PSYCHOTIC DISORDER WITH DELUSIONS	1	1
293.0	DELIRIUM DUE TO CONDITIONS CLASSIFIED ELSEWHERE	1	
294.9	UNSPECIFIED PERSISTENT MENTAL DISORDERS	1	
295.00	SCHIZOPHRENIA, SIMPLE, UNSPECIFIED	1	
944.07	BURN OF WRIST, UNSPECIFIED DEGREE	1	
295.30	SCHIZOPHRENIA, PARANOID, UNSPECIFIED	1	
295.32	SCHIZOPHRENIA, PARANOID, CHRONIC	1	
291.5	ALCOHOL-INDUCED PSYCHOTIC DISORDER WITH DELUSIONS	1	1
294.11	DEMENTIA IN OTHER CONDITIONS WITH BEHAVIORAL DISTURBANCE	1	
312.39	OTHER DISORDERS OF IMPULSE CONTROL	1	
429.3	CARDIOMEGALY	1	
307.51	BULIMIA NERVOSA	1	
307.81	TENSION HEADACHE	1	
396.3	MITRAL VALVE INSUFFICIENCY AND AORTIC VALVE INSUFFICIENCY	1	
309.28	ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD	1	
388.30	TINNITUS, UNSPECIFIED	1	
719.46	PAIN IN JOINT, LOWER LEG	1	
380.10	INFECTIVE OTITIS EXTERNA, UNSPECIFIED	1	
304.93	UNSPECIFIED DRUG DEPENDENCE, IN REMISSION	1	1
314.00	ATTENTION DEFICIT DISORDER WITHOUT HYPERACTIVITY	1	
368.00	AMBLYOPIA, UNSPECIFIED	1	
315.2	OTHER SPECIFIC LEARNING DIFFICULTIES	1	
333.90	UNSPECIFIED EXTRAPYRAMIDAL DISEASE AND ABNORMAL MOVEMENT	1	
338.4	CHRONIC PAIN SYNDROME	1	
343.9	INFANTILE CEREBRAL PALSY, UNSPECIFIED	1	
353.9	UNSPECIFIED NERVE ROOT AND PLEXUS DISORDER	1	
310.1	PERSONALITY CHANGE DUE TO CONDITIONS CLASSIFIED ELSEWHERE	1	
696.1	OTHER PSORIASIS	1	

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728.85	SPASM OF MUSCLE	1	
300.09	OTHER ANXIETY STATES	1	
300.19	OTHER AND UNSPECIFIED FACTITIOUS ILLNESS	1	
300.21	AGORAPHOBIA WITH PANIC DISORDER	1	
304.50	HALLUCINOGEN DEPENDENCE, UNSPECIFIED	1	
301.0	PARANOID PERSONALITY DISORDER	1	
367.1	MYOPIA	1	
305.63	COCAINE ABUSE, IN REMISSION	1	1
706.1	OTHER ACNE	1	
525.9	UNSPECIFIED DISORDER OF TEETH AND SUPPORTING STRUCTURES	1	
626.0	ABSENCE OF MENSTRUATION	1	
599.0	URINARY TRACT INFECTION, SITE NOT SPECIFIED	1	
304.10	SEDATIVE, HYPNOTIC OR ANXIOLYTIC DEPENDENCE, UNSPECIFIED	1	
592.0	CALCULUS OF KIDNEY	1	
304.23	COCAINE DEPENDENCE, IN REMISSION	1	1
550.90	INGUINAL HERNIA, UNILATERAL OR UNSPECIFIED	1	
299.80	OTHER SPECIFIED PERVASIVE DEVELOPMENTAL DISORDERS, CURREN	1	
715.90	OSTEOARTHRISIS, UNSPECIFIED IF GENERALIZED/LOCALIZED,SITE	1	
		851	255
			29.96%

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Appendix 5 Eligibility Disposition and Assessment (EDA)

Eligibility Disposition and Assessment Program 420 – ED Evaluation

Exhibit A – Scope

Funded community mental health service providers and hospitals are to:

1. Provide the services of a mental health professional at or above the level of a Qualified Mental Health Professional, Licensed Practitioner of the Healing Arts (LPHA) preferred (as defined in the “Medicaid Community Mental Health Services” Rule 132, available at: <http://www.dhs.state.il.us/page.aspx?item=56754> with availability on a 24 hour/seven day per week basis.
2. Receive calls requesting a NCCS Eligibility and Disposition Assessment and document the response time.
3. Ensure that priority responses are provided to the Emergency Departments of community hospitals in NCCS.
4. Ensure that the qualified professional includes all DMH prescribed assessment elements when determining the eligibility of the individual for NCCS.
5. Ensures that the assessment includes the prescribed clinical evaluation of the individual.
6. Based on the determination of eligibility and clinical evaluation, determines the most appropriate and available level of care and secures authorization for same.
7. Ensures firm linkage of the individual with the authorization level of care.
8. Ensure documentation of the evaluation, recommendations and disposition outcome for the individual.
9. Submit required registrations and encounters per DHS/DMH policy.

Exhibit B – Deliverables

Provider will document of all evaluations completed and maintain these in a clinical record for the individual.

The provider ensures that each individual determined to be eligible for NCCS is appropriately registered with the designated identifier in the DHS/DMH consumer registration/enrollment information system. Per grant reporting requirements, providers submit on a quarterly basis their expenses in the DHS prescribed format.

In addition, providers also submit on a quarterly basis to the DHS/DMH Regional Office indicators of the quality and effectiveness of services and supports, including:

1. Number of NCCS eligible individuals who have presented at a community hospital emergency department or elsewhere due to a mental health crisis
2. Number of dispositions to each level of care (e.g., CHIPS, Substance abuse residential, mental health crisis residential, capitated community care, other)
3. Number of referrals that were actually linked to the recommended service

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Exhibit C – Payment

The payments to the providers are administered in the form of a state grant to the provider, to be reconciled on the basis of allowable expenses per Administrative Rule 511. Payments are based on an annualized amount paid on a monthly basis.

Exhibit E – Performance Measures

1. Percentage of the calls for the evaluation of an individual are responded to on-site (at the community hospital emergency department or other locations) within one hour/60 minutes and documented as such.
2. Percentage of the evaluations documented and completed as a clinical record for the individual prior to the departure from the ED.
3. Percentage of individuals with successful linkages to the recommended level of services.

Exhibit F – Performance Standards

1. Percentage of the calls for the evaluation of an individual are responded to on-site (at the community hospital emergency department or other locations) within one hour/60 minutes and documented as such.
2. Percentage of the evaluations documented and completed as a clinical record for the individual prior to the departure from the ED.
3. Percentage of individuals with successful linkages to the recommended level of services

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Appendix 6

Community Service Agreement (CSA)

Program 550 - CHIPS

Exhibit A – Scope

The Community Hospitalization Inpatient Psychiatric Services (CHIPS) program is intended to serve those persons experiencing a psychiatric crisis diagnosed with serious mental illnesses (SMI) 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 Illinois residents meeting clinical eligibility requirements and in specific financial need as defined as under 200% Federal poverty level (FPL) as found at <http://aspe.hhs.gov/poverty/12poverty.shtml>

Exhibit B – Deliverables

1. The Provider will provide all of the following services:
 - A. Inpatient Psychiatric Services, which includes:
 - i. Daily Room and Board;
 - ii. Admitting physical examination and medical history;
 - iii. Routine assessments including nursing, social service and functional assessments;
 - iv. Routine laboratory and diagnostic evaluations;
 - v. Individual treatment plan development and implementation;
 - vi. 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;
 - vii. All inpatient therapies, programs and services that are part of the ongoing schedule of the provider's Psychiatric Services Inpatient Unit.
 - viii. A staffing within 72 hours of admission with participation of a psychiatric unit representative, a designated IDHS/DMH funded community mental health service provider representative, and the consumer and legal guardian as indicated (and family, if authorized);
 - ix. Documented discharge planning with participation of a psychiatric unit representative and a designated IDHS/DMH funded community mental health service provider representative, and the consumer and legal guardian as indicated (and family, if desired).
 - x. Submission of DMH required reporting which includes registration for services within DMH specified timelines.

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- B. Attending Psychiatric Physician Services, which includes the provision of medical coverage by psychiatrists credentialed and privileged by the Provider and minimally providing:
 - i. Completion of an admission psychiatric evaluation within 24 hours of admission;
 - ii. Direction of inpatient therapies and services, including pharmaceutical treatments;
 - iii. Daily care with the patient, consisting of at least six face-to-face visits per seven day period is minimally expected;
 - iv. Completion of all documentation requirements for medical records in accordance to the Provider's policies, procedures or Medical Staff By-Laws.
 - C. 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. IDHS/DMH, at its sole discretion, may provide such transport through its contracted vendor.
 - D. 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.
2. Immediately following admission, the Provider, in collaboration with the designated IDHS/DMH-funded community mental health service provider, must begin the process of identifying and planning for the appropriate aftercare resources for continuity of care.
3. 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)
 - 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/Division of Family and Community Services (DFCS)/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;

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- 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;
- vii. Social Services discharge planning record including names, titles/credentials, addresses, and phone numbers of all follow up providers;
- viii. Outpatient progress notes of community mental health service providers from the 12 month period prior to the CAU review;
- ix. Responses by provider to any and all requests for subsequent information from DHS and / or CAU within required DHS timeframes (DHS form 267);
- x. The authorization for release of information to the Department of Human Services' Client Assessment Unit and the consumer's or the hospital's local DHS office. Either the provider's release form or DHS' form may be used.
- xi. 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

Exhibit C – Payment

1. Inpatient psychiatric services and attending psychiatric physician services are reimbursed at \$650.00 per day.
2. The Provider will submit a form as determined 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.
3. Payment will not be authorized or released until these forms are on file with the DMH contractor.
4. 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.
5. 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

Exhibit E – Performance Measures

The Provider will maintain data and will report on a quarterly basis:

- Percentage (%) of completed applications for eligibility assistance on each individual served,
- % of individuals with a length of stay of 6 days or less
- % discharge diagnosis meeting criteria% of readmissions within 30 days

Exhibit F – Performance Standards

- 100% eligibility assistance applications completed
- 100% Length of stay of 6 days or less
- 100% of Diagnoses will be on DHS/DMH target list as described at http://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/britan2/ConsumerEligBenefitsforProviderManual060911.pdf
- Zero Readmissions within

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Appendix 7 Summary of Not Guilty by Reason of Insanity (NGRI) and Conditional Release Finding

Not Guilty by Reason of Insanity

In criminal trials, an NGRI (Not Guilty by Reason of Insanity) Acquittal results when the court establishes that a person is not criminally responsible for conduct if at the time of such conduct, as a result of mental disease or mental defect, the person lacks substantial capacity to appreciate the criminality of their conduct. A person who, at the time of the commission of a criminal offense, was not insane but was suffering from a mental illness, is not relieved of criminal responsibility for their conduct and may be found guilty but mentally ill.

After a finding or verdict of not guilty by reason of insanity under Sections 104-25, 115-3 or 115-4 of The Code of Criminal Procedure of 1963, the defendant shall be ordered to the Department of Human Services for an evaluation as to whether they are in need of mental health services. The order shall specify whether the evaluation shall be conducted on an inpatient or outpatient basis. If the evaluation is to be conducted on an inpatient basis, the defendant shall be placed in a secure setting unless the Court determines that there are compelling reasons why such placement is not necessary.

After the evaluation and during the period of time required to determine the appropriate placement, the defendant shall remain in jail. If the defendant is found to be in need of mental health services on an inpatient care basis, the Court shall order the defendant to the Department of Human Services. The defendant shall be placed in a secure setting unless the Court determines that there are compelling reasons why such placement is not necessary. Such defendants placed in a secure setting shall not be permitted outside the facility's housing unit unless escorted or accompanied by personnel of the Department of Human Services or with the prior approval of the Court for unsupervised on-grounds privileges as provided herein.

Clients whose illness becomes stabilized in the secure inpatient setting are eligible to gain more freedoms and privileges. Psychiatric behavior and stability can result in clients moving to non-secure units and gaining unsupervised on grounds and off grounds privileges. When a client demonstrates a sizable period of stability, the client and the client's lawyer or hospital staff can initiate a recommendation to the court that the individual be allowed to living outside the hospital with case management supports. The recommendation often includes a detailed aftercare plan for the client's treatment after the client leaves the hospital. This arrangement is referred to by the courts as a Conditional Release and is issued as a court order with specific requirements of the client to continue treatment in the community that addresses the client's continual recovery as well as manages any risk factors related to the clients NGRI index offense.

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Conditional Release

Conditional Release means the release from either the custody of the Department of Human Services or the custody of the Court of a person who has been found not guilty by reason of insanity under such conditions as the Court may impose which reasonably assure the defendant's satisfactory progress in treatment or habilitation and the safety of the defendant and others. The Court shall consider such terms and conditions which may include, but need not be limited to, outpatient care, alcoholic and drug rehabilitation programs, community adjustment programs, individual, group, family, and chemotherapy, random testing to ensure the defendant's timely and continuous taking of any medicines prescribed to control or manage his or her conduct or mental state, and periodic checks with the legal authorities and/or the Department of Human Services.

The Court may order the Department of Human Services to provide care to any person conditionally released under the section cited in the code of criminal procedure.. The Department may contract with any public or private agency in order to discharge any responsibilities imposed under the section. The Department shall monitor the provision of services to persons conditionally released and provide periodic reports to the Court concerning the services and the condition of the defendant. Whenever a person is conditionally released, the State's Attorney for the county in which the hearing is held shall designate in writing the name, telephone number, and address of an employee who shall be notified in the event that either the reporting agency or the Department decides that the conditional release of the defendant should be revoked or modified.

Conditional release shall be for a period of five years. However, the defendant, the person or facility rendering the treatment, therapy, program or outpatient care, the Department, or the State's Attorney may petition the Court for an extension of the conditional release period for an additional 5 years. Upon receipt of such a petition, the Court shall hold a hearing, shall determine whether the defendant should continue to be subject to the terms of conditional release, and shall enter an order either extending the defendant's period of conditional release for an additional 5 year period or discharging the defendant. Additional 5-year periods of conditional release may be ordered following a hearing as provided in this Section. However, in no event shall the defendant's period of conditional release continue beyond the maximum period of commitment ordered by the Court.

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Appendix 8 Acute Community Care Services (ACS)

Acute Community Care Services (ACS) Program 410

Exhibit A – Scope

The services and supports funded by these contracts consist primarily of the services of the Medicaid Community Mental Health Services Program (Rule 132), but can also include any other services or supports the community mental health providers determine will be needed to achieve the recovery goals of the individual and avoid more restrictive and expensive services. That is, the provider has the flexibility to determine the range of services and supports that are best tailored to meet the needs of the individual eligible for the Northwest Crisis Care System (NCCS).

Exhibit B – Deliverables

The community mental health services provider ensures that each individual determined to be eligible for NCCS is appropriately registered with the designated identifier in the DHS/DMH consumer registration/enrollment information system and is required to abide by DMH claiming policy which may include submission of electronic encounter claims.

For each month, by the 10th of the following month, the provider submits to their DHS/DMH Regional Office a summary of the services and supports provided to each individual determined to be eligible for NCCS, including identification of those individuals served that were direct deflections from community hospital emergency departments and individuals discharged from other levels of care and specification of which level of care (such as CHIPS, state hospital, crisis residential, substance abuse residential).

Per grant reporting requirements, providers also submit on a quarterly basis their expenses in the DHS prescribed format.

In addition, providers also submit on a quarterly basis to the DHS/DMH Regional Office indicators of the quality and effectiveness of services and supports, such as:

- Number of NCCS eligible individuals who presented at a community hospital emergency department due to a mental health crisis
- Number of NCCS eligible individuals who have been admitted to a state hospital or community hospital psychiatric unit
- The total number of appointments or contacts scheduled with NCCS eligible individuals and the percentage of those that were not kept by either the consumer or the provider
- The total number of linkages or transitions to other providers for NCCS eligible individuals and the percentage of those that were not successfully achieved

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Exhibit C – Payment

The payments to the providers are administered in the form of a state grant, to be reconciled on the basis of allowable expenses per Administrative Rule 511. A minimum of 80% of these funds should be toward payment of expenses related to provision of services in the State's plan for medical services. Payments are based on an annualized amount paid on a monthly basis.

Exhibit E – Performance Measures

Performance measures include the following:

1. Percentage of individuals seen face-to-face within 24 hours of referral.
2. Percentage of individuals screened for Medicaid eligibility.
3. Percentage of required reporting/data submitted by DMH specified timelines
4. Percentage and number of admissions to hospital (sorted by State Hospital/CHIPS) for psychiatric care at the following intervals– 30 days, 90 days, 180 days, 1 year
5. Percentage of individuals transitioned to appropriate services or DHS/DMH service benefit packages
6. Number of individuals referred to DMH crisis beds during FY2013.
7. Number of crisis residential and DASA 3.5 days used per individual in FY2013

Exhibit F – Performance Standards

1. 100% of individuals seen face-to-face within 24 hours of referral.
2. 100% of individuals screened for Medicaid eligibility.
3. Submission of 90% of all required reporting by the prescribed timeline
4. A 30 day "readmission" rate (i.e., no presentations to a state hospital or community hospital emergency department or psychiatric unit) that is less than or equal to 6.7% which is 5% less than the 11.7% readmission rate of TPMHC for FY 2011.
5. Transition of 100% of NCCS eligible consumers to appropriate services of DHS/DMH benefit packages following twelve months of services and supports (presumes consumer acceptance).

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APPENDIX 9 DASA Residential Crisis Stabilization Criteria

DASA Residential Crisis Stabilization

The DASA Residential Crisis Stabilization (RCS) program is designed to meet the unique needs of individuals with Substance Use Disorders (SUD's) seeking assistance at an emergency department (ED), state hospital, or other healthcare facility. In addition to active SUD's, these patients are often experiencing acute distress associated with mental illness, medical conditions, and psychosocial/environmental problems. While retaining the six dimensional assessment format described in the 2001 ASAM PPC-2R, the primary goals of DASA RCS are assessing, stabilizing and preparing patients for necessary follow-up treatment or ancillary services upon discharge. The short term nature of RCS (approximately 5-10 days) targets the stabilization of problems related to detoxification, biomedical, emotional, behavior, or cognitive conditions as described in ASAM Dimensions 1-3. Problems associated with readiness to change, relapse or continued use, and recovery environment (ASAM Dimensions 4-6) should be addressed in the RCS treatment planning process, but are generally not justification for continued stay once the patient is stable and able to be referred to additional alcohol and other substance abuse treatment services.

DASA Residential Crisis Stabilization providers are to submit to DHS/DMH or its agent on a daily basis:

- (a) The number of beds filled, and
- (b) The number of beds vacant and available.

When requesting authorization for services and if approved, the Collaborative will refer the patient to the most appropriate RCS program based on the clinical needs of the patient and the program location. The RCS is responsible for planning and executing follow-up services, including contacting follow-up service providers upon discharge from the residential program.

Admission Criteria for DASA Residential Crisis Stabilization

The patient must be assessed by the designated Evaluator from a community mental health center or community hospital, determined appropriate for admission to RCS, and agrees to engage in this level of care and treatment process. Specifically:

1. The patient has symptoms consistent with the diagnosis of a SUD.
2. The individual has been assessed with a LOCUS score of 4 or higher.
3. The patient's condition requires the need for continuous monitoring and supervision. A less intensive service would not provide adequate stabilization from their SUD.
4. Chronic medical problems are sufficiently stable and acute medical problems have been adequately treated to allow the patient to participate in the RCS program.
5. It is expected that the resources and techniques associated with this RCS will lead to successful discharge and referral for additional needed services.

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Continued Stay/Discharge Criteria for DASA Residential Crisis Stabilization

Continued stay in RCS is indicated as long as the patient continues to meet admission criteria justifying placement in the RCS. The patient will be discharged from the RCS when admission criteria are no longer met.

Exclusionary Criteria for DASA Residential Crisis Stabilization

An individual is not eligible for DASA RCS as part of the R1S/CCS if:

1. Assessment indicates the patient may experience acute substance withdrawal that cannot be managed safely by the provider at this level of care (i.e. acute or unstable medical or psychiatric symptoms of withdrawal not yet stabilized by medical treatment).
2. Assessment indicates the patient may experience acute medical symptoms that cannot be managed safely by the provider at this level of care (i.e. medical instability of acute or chronic medical conditions).
3. Assessment indicates the patient may experience acute psychiatric symptoms that cannot be managed safely by the provider at this level of care (i.e. acute psychosis, acute risk of danger to self or others, marked functional impairment, marked cognitive impairment).

Programmatic Requirements for DASA Residential Crisis Stabilization

1. A current physical examination must be completed and forwarded to the RCS program from a qualified medical professional or one must be completed within 24 hours of admission to the RCS.
2. If the patient has a confirmed psychiatric diagnosis or the patient begins to displays psychiatric symptoms, an initial psychiatric assessment must be completed by a licensed physician, clinical psychologist, clinical social worker, or clinical professional counselor within 48 hours of admission to the RCS or no later than 24 hours after the symptoms present. This assessment will be used in treatment planning, determining the need for further assessment by a licensed psychiatrist, and discharge planning.
3. An initial treatment plan must be developed by professional staff trained and credentialed to assess and monitor the medical and psychiatric status of patients admitted to the RCS. At a minimum, the initial treatment plan must address the presenting problems justifying admission (ASAM Dimensions 1, 2, and 3) and be confirmed by a physician within 48 hours of admission to the RCS.
4. Each patient shall have a planned regimen of care of at least 3 hours of treatment services per day if assessed as capable. This shall include at least one individual contact per day with a professional staff. Treatment services must focus on stabilization of the patient's presenting problems as well as engagement and motivation for additional needed services
5. Discharge/Transition planning shall begin at admission and must include coordination with follow-up providers to ensure a firm referral and linkage to additional services.

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Appendix 10

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 follow-up	5 hours/20 units total
Case management- 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