

DHS/DMH Community Expansion under PA 90-0104/SB 0026

Presentation to SMHR Act of 2013 Full Workgroup

October 16, 2013

SMHRF COMPARABLE SERVICES

- Development process:
 - Build upon work previously completed
 - Include a broad array of stakeholders
 - Use data to inform
 - Consider programs that provide increased choice

Illinois Mental Health Strategic Plan Goals/Objectives that were taken into account in planning the SMHRF Comparable Services:

GOAL 1: Ensure that **hospitals, residential and other treatment facilities** serving individuals with mental illnesses deliver services in a recovery-oriented manner with **clear plans and “pathways” to discharge.**

OBJECTIVES

- Reduce the rate of psychiatric hospitalizations and re-hospitalizations through **greater use of community crisis intervention teams and the development of short-term sub-acute units in non-hospital residential treatment settings.**
- **Provide more effective transition from residential settings to the community** with more deliberate and planned community living skills training before transition (such as promote “doing with” interventions rather than “doing for” interventions, for example, training a person with diabetes in illness self-management rather than managing it for that person) and with better linkages between community agencies and residential treatment settings.
- **Ensure greater integration of recovery-oriented approaches** into residential treatment settings.

Illinois Mental Health Strategic Plan Goals/Objectives that were taken into account in planning the SMHRF Comparable Services (cont.):

GOAL 2: Assess the current role of existing residential and other treatment facilities and **enhance the effectiveness, efficiency, and coordination of the service system** by encouraging and facilitating new roles and responsibilities for key components of the system.

OBJECTIVES

- Develop a plan to build on the **relationships that exist between facilities and other community providers to create joint treatment approaches, discharge planning.**
- Explore **expansion of focus of transitional housing sites** beyond just homeless individuals to include individuals with mental illness needing housing until a more permanent housing situation can be secured.
- Explore and plan for incorporation of **72-hour clinic observation beds** for stabilization and expedient referral to the most appropriate treatment site from hospital emergency departments.

Illinois Human Services Commission “Rebalancing”
Recommendations that were taken into account in planning the
SMHRF Comparable Services:

- **Recommendation:** Develop a plan to **build community capacity** and service delivery that outlines strategies to meet service and support needs of individuals with disabilities living in the community.
- **Recommendation:** Develop a strategic plan to clearly identify the **housing needs and goals**, the resource allocations, the accomplishments to date and gaps in the systems, and the strategies **to fill the gaps across the Rebalancing Initiatives.**

Stakeholder Input in Process

- Consumers
- PAS/RR agencies
- Hospital Discharge Planners
- DHS Contracted Providers
- Trade Associations
- Housing
- Labor
- Managed Care Entities
- State Departments

Major Findings from August 20, 2013 Focus Group of Former Nursing Home Mental Health Consumers

- Few were asked or given choice between admission to nursing facility or an alternative; all passively agreed
- Many felt their stay at nursing facility was helpful but also thought same could be accomplished in other settings with appropriate support
 - helped them to become more stabilized
 - would prefer more community-based settings
- **Services needed in the community:**
 - Peer support and socialization opportunities (people to talk to)
 - Transitional residential settings
 - Job support/coaching
- **Biggest challenges living in the community:**
 - Transportation (e.g., getting to the store)
 - Assimilating back to society; time-warp (time lost); do not know what is going on and how to fit in
 - Loneliness; not knowing how to branch out; want to hang out with “normal people”

Major Findings from August 21, 2013 Focus Group of Pre-Admission Screening (PAS) Mental Health Screeners

- Primary reason for referral to nursing homes is lack of a residence that provides high level of support, and continued need for stabilization
- Medication and service non-compliance a precipitating factor for many hospitalizations
- Although many individuals are beyond their first episode of mental illness, they are not linked to any provider or system
 - Insufficient follow-up and linkage to outpatient services
- Identified following needs:
 - more assertive outreach and bringing services to the consumer
 - short term emergency housing (many consumers homeless or cannot return to prior living situation)
 - dual diagnosis substance use services, especially residential that is longer than 28 days and includes assistance in skill development and housing search
 - longer term mental health residential treatment with 24 hour supervision
 - community provider stationed at emergency department to direct some individuals to crisis beds with mobile follow-up
 - Triage Center in emergency department

Major Findings from August 30, 2013 Focus Group of Hospital Discharge Planners

- Relatively few individuals are experiencing their first psychiatric episode or hospitalization
 - Estimated 50% have Substance Use issues, and
 - Of those, 25-30% need primary Substance Use services
- Need to have post-hospital options for placement/housing
- Would be helpful to have post-discharge providers do their “intake” and meet the individual before discharge from the hospital
 - Should not place these individuals on “waiting lists” for community services
- Need for more supervision of the individuals post-discharge
 - Follow-up to ensure keep appointments, get and take medications
 - Intervene prior to any problematic issues arising or decompensation
- Estimate that approximately 30% will still need longer term care even with more robust community placements and services available, i.e., these individuals need longer term stabilization
 - Would be useful to have placement option available that is between outpatient community services in Permanent Supportive Housing and long-term institutional care
- A triage center within or near the hospital to permit additional observation of the individual to assess their real needs would be helpful

Needed Services from SMHRF Community Stakeholder Group:

- Housing and housing subsidies, Housing First Model
- Transitional housing that is immediately available, provides short term housing, skill development, staff available on-site 24/7
- Model of Substance Abuse Recovery Homes capable to address mental health issues in addition to substance use issues
- Strong relationship between hospitals and primary intercept point
- Co-location of provider at hospital E.D.s to assess appropriateness for alternative treatment settings
- Community based triage centers and Living Room models operated by peers
- Length of stay in residential programs determined by individual need

Data tells us:

- Referrals Made to Nursing Facilities by Screening Location
 - FY13 DHS/DMH PAS/MH data
 - Referrals to Nursing Facilities
 - 74% were from private hospitals' psychiatric units
 - 11% were from Private Hospitals' general units

Data tells us:

- Psychiatric Admissions to Hospitals by Zip Codes in areas of SMHRFs
 - FY12 HFS Claims Data based on Primary Diagnosis
 - Individuals with primary psychiatric diagnoses accounted for approximately 25% of admissions to general hospitals
 - 19% of all psychiatric admissions in zip code 60622
 - Humboldt Park, Ukrainian Village, West Town
 - Borders: Ashland (east), Kedzie (west), North Ave (north), Kinzie (south)
 - Next highest zip code 60640 with 7%
 - Uptown, Andersonville, parts of Edgewater
 - Borders: Lake Michigan (east), Damen (west), Bryn Mawr (north), Montrose (south)
 - Primary psychiatric diagnosis:
 - Substance-Related Disorders – 27%
 - Bipolar Disorders – 25%
 - Schizophrenia – 24%

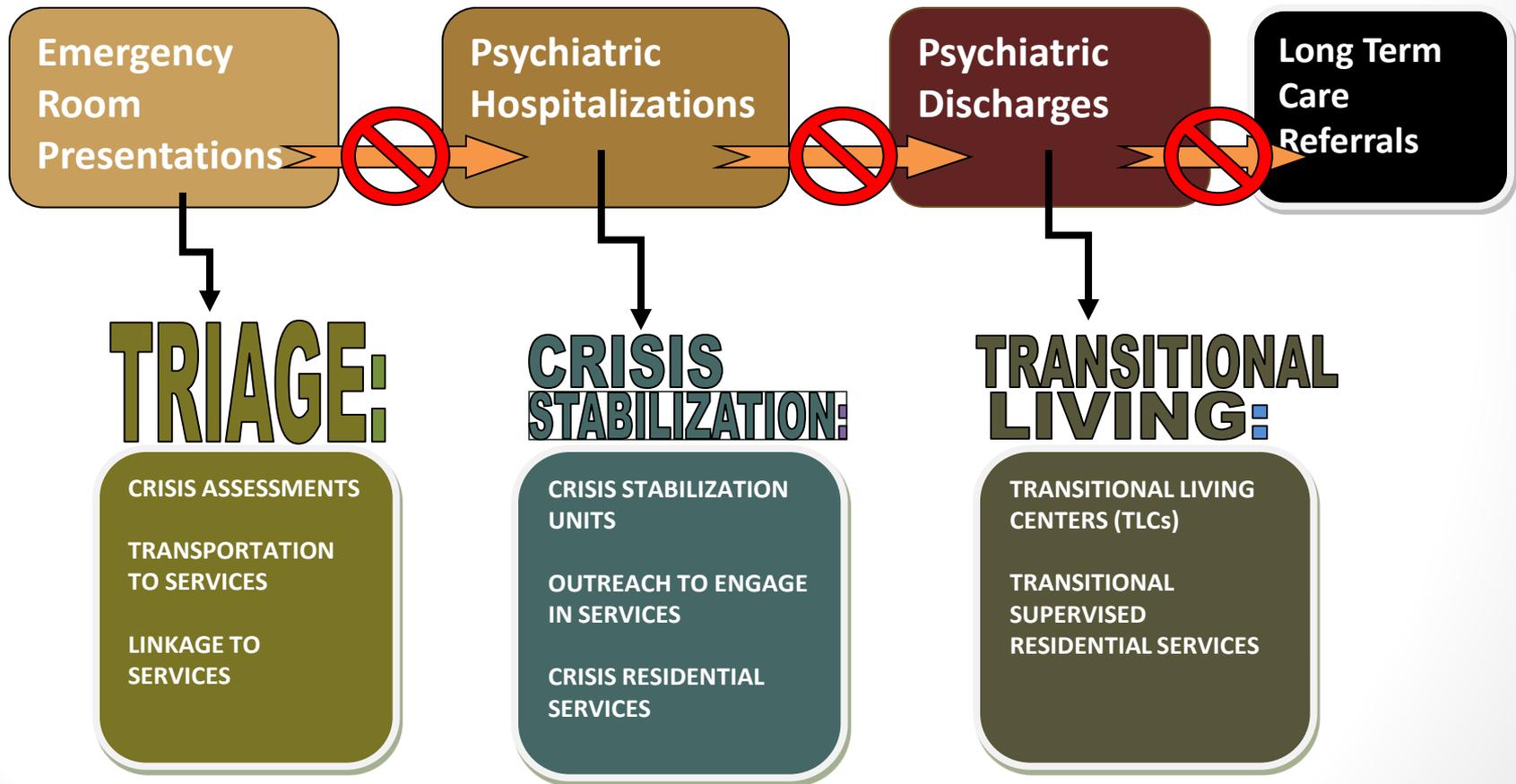
Data tells us:

- Emergency Room Visits of Individuals with a Primary Psychiatric Diagnosis by Zip Codes in areas of SMHRFs
 - FY12 HFS Claims Data by Zip Code
 - Individuals with primary psychiatric diagnoses accounted for approximately 4.3% of ER visits
 - 11% of ER visits occurred in zip code 60622
 - Next highest zip code 60649 with 11%
 - Primary Psychiatric Diagnostic Grouping:
 - Substance-Related Disorder – 23%
 - Mental Disorders – 22%
 - Schizophrenia – 15%
 - Bipolar Disorders – 12%
 - Anxiety Disorders – 11%

Sequential Intercept Analysis

- Analysis to understand the trajectory of individuals into long term care
- Two critical intercepts identified
 - Majority of referrals to long term care come from psychiatric hospitalizations
 - Most psychiatric hospitalizations are the result of emergency room referrals
- DHS/DMH has identified several services within Triage, Crisis Stabilization and Transitional Living which is believed to be useful in intercepting these trajectories

SERVICES FOR CRITICAL INTERCEPTS TO LONG TERM CARE REFERRALS



TRIAGE SERVICES

- CRISIS ASSESSMENT
 - Skilled professional assessment of individuals presenting in emergency rooms
 - Brief Crisis Intervention Strategies to reduce need for referral to higher level of care
- LINKAGE TO SERVICES
 - Immediate referral and assistance in obtaining necessary services and supports
- TRANSPORTATION BETWEEN LEVELS OF CARE
 - Safe, secure transportation to the most appropriate site for care when needed

CRISIS STABILIZATION

- DISCHARGE LINKAGE AND COORDINATION OF SERVICES
 - Immediate access to all necessary aftercare services
 - Assertive outreach for individuals who fail aftercare appointments
- OUTREACH TO INDIVIDUALS TO ENGAGE IN SERVICES
 - Active engagement of individuals referred from a crisis assessment to facilitate participation in services
- RESIDENTIAL CRISIS BEDS
 - For individuals in need of 24 hour supervision and support due to a psychiatric crisis

TRANSITIONAL LIVING

- TRANSITIONAL LIVING CENTERS
 - For individuals who lack a safe living environment and meet clinical criteria for need for high intensity community based services
 - Housing for no more than 16 individuals at a time, with access to treatment services and supports necessary to the individual's recovery
- TRANSITIONAL SUPERVISED RESIDENTIAL SETTINGS
 - For individuals in need of 24 hour services and supports in a supervised living arrangement
 - Programs are to be transitional in nature, with a focus on assisting the individual in developing the skills necessary to transition to permanent supportive housing

Thank You

- Are there any questions?