

Rebalancing & Community Reinvestment Strategy  
For Tinley Park Mental Health Center  
&  
Region 1 South

Plan Elaboration

February 6, 2012

ILLINOIS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MENTAL HEALTH



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# Tinley Park Mental Health Center

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### Overview of the Tinley Park Mental Health Center

Tinley Park Mental Health Center serves patients from a geographic area that extends from the south side of Chicago to all southern Cook townships, as well as Will, Grundy and Kankakee counties (DHS/DMH Region 1 South). Tinley Park MHC was constructed 1953, and is located in the south suburban village of Tinley Park. It occupies 213 acres and is adjacent to the 62 acres of property vacated by Howe Development Center. Tinley currently utilizes 7 buildings, including one building for patient care. The other 6 buildings include the power house, water plant, transportation, administration, mechanical stores and Oak Hall. Oak Hall houses the kitchen responsible for preparing and distributing food to Tinley and Ludeman Developmental Center. It also houses a regional pharmacy hub that fills and distributes prescriptions to three DHS hospitals/facilities: Tinley Park MHC, Ludeman and Mabley Developmental Centers. Until January, 2012, another building housed one of three Cook County Mental Health Courts. Since January, the Court moved its operations from Tinley Park to Madden Mental Health Center. There are 9 buildings no longer in use by Tinley Park. Tinley staff remains responsible for continued maintenance and security of the buildings vacated by Howe. DHS is in the process of decommissioning the buildings on the Howe campus and expects to complete this project by mid-February.

### Tri-Hospital System

Tinley Park Mental Health Center is a 75 bed hospital, providing inpatient psychiatric hospitalization for persons 18 years or older. Tinley Park Mental Health Center is accredited through The Joint Commission (TJC). In 2007, Tinley lost its Centers for Medicare and Medicaid Services (CMMS) certification. Loss of CMMS certification prevents DHS from billing Medicaid for persons over 65 or participating in the federal DSH program. In 2005, DMH reorganized the three (3) hospitals within Cook County (Tinley Park, Madden and Chicago Read) into a regional, tri-hospital model. This tri-hospital system model allowed for the more efficient use of resources while maximizing bed capacity. By centralizing all referrals, DMH could quickly identify available beds within the system. Though the preference is to

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use the hospital within the person's own region, the tri-hospital system allows DMH to optimize resources while minimizing Emergency Department (ED) wait times.

### Population Served

Any individual, age 18 or over, who meets the criteria for voluntary or involuntary admission (as defined in the Mental Health & Developmental Disabilities Code) is eligible for admission to any of the state-operated, civil hospitals. In 2005, Tinley Park was designated as an acute care psychiatric inpatient hospital. Since the hospital lost CMMS certification, persons with insurance are directed to either Madden or Chicago Read. For several years, Tinley Park has served a consistent patient population possessing similar general characteristics. In FY 11, there were 1905 admissions with an average length of stay (ALOS) of 11.6 days. There were 1523 admissions (79%) from Region 1 South. Of those hospitalized in FY11, 54% were first time admissions to a State Operated Psychiatric Hospital (SOPH) and 98% did not have any form of insurance. The average daily census (ADC) was 68, realizing a 90% occupancy rate. For FY11, Tinley Park had an 11.7% 30-day readmission rate. The majority of those readmitted within 30 days had a primary substance abuse diagnosis. Seventy percent (70%) of patients admitted to Tinley are male. The most prevalent diagnoses were Depression and Bipolar spectrum disorders. Twenty four percent (24%) of admissions had a primary substance abuse (SA) diagnosis with no major mental illness. Sixty percent (60%) of all admissions had co-occurring and substance abuse diagnoses.

Typically, patients are discharged to home with medication for up to 14 days. If they have mental illnesses, they are provided a linkage appointment (ideally within 24 hours) with a Community Mental Health Clinic within 24 hours of discharge. Those with a primary substance abuse diagnosis are linked to substance abuse services.

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### Current Capacity

Currently, Tinley Park is operating 51 beds on 2 patient care units. Tinley Park does not have sufficient psychiatrists to open the remaining 25 bed unit. The recruitment of professional staff (psychiatrists and nurses in particular) has been complicated by general professional workforce shortages, salary limitations and the closure announcements.

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### Description of the Initial Approach

We have long expected that rebalancing state-operated inpatient services in Region 1South will result in a more integrated, less restrictive service delivery system that enables people to receive services closer to their home community while promoting the principles of recovery and consumer-driven care.

Once Tinley Park Mental Health Center in Region 1South was initially identified for rebalancing, leadership staff from the DMH hospital and regional systems initiated an analysis of the clinical needs of the population served and the existing and potential provider capacity in the region. Considerable data were aggregated and analyzed, including but not limited to:

- Tinley Park Mental Health Center admissions by geocode
- Ten most frequent discharge diagnoses from Tinley Park
- Discharge diagnosis by geocode
- Number of existing community, inpatient psychiatric beds
- Number and types of existing community mental health and substance abuse services
- Admissions to Tinley Park by insurance status
- Impact of rebalancing on Region 1South and the larger, tri-hospital Cook County state hospital system

Through analysis of these data and consultation with hospital and region staff, DMH developed a plan for enhanced and expanded community-based services in Region 1South, if Tinley Park Mental Health Center closed. This initial plan called for a reinvestment in Region 1S community services and the addition of Region 1 substance abuse detoxification services (to deflect unnecessary and inappropriate admissions to both Madden and Chicago Read) thereby maximizing the capacity at the remaining Region 1 state-operated hospitals, to accept admissions from the Tinley Park catchment area.

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Following the Governor's closure announcement in September, DMH initiated a series of community stakeholder engagement meetings to solicit input from community providers on reinvestment strategies and explored opportunities for providers to actively participate in the rebalancing effort through new or enhanced service options. Over the course of several months, DMH held a dozen such community stakeholder meetings and documented, tabulated and analyzed the feedback provided and developed preliminary projections of Region 1S community service needs. DMH also began to informally solicit proposals for new service offerings in Region 1South including community-based, acute, inpatient services, crisis residential and substance abuse residential services.

In the months that followed, DMH worked with the Governor's Office and members of the General Assembly, to establish consensus around criteria to evaluate and determine which hospitals in the state system represented the best opportunities for rebalancing. Measureable and objective definitions for these criteria, were also developed and the criteria were presented to key mental health stakeholder groups<sup>1</sup>, for review and input. Based on these established, objective criteria Tinley Park Mental Health Center was again identified as presenting the greatest opportunity for rebalancing and system transformation.

DMH has intensified its planning efforts and continues to validate, revise and refine the rebalancing plan. In the weeks ahead, meetings with community partners and focus groups are scheduled, to confirm the clinical hypotheses on which the plan is based and identify any critical service gaps that need to be addressed. With input from providers, consumers and stakeholders, DMH will continue to further develop and enhance the Tinley Park rebalancing plan, to ensure that access is maintained and a comprehensive, community-based service system is available.

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<sup>1</sup> The criteria were reviewed by the Mental Health Summit and by the Mental Health Planning & Advisory Council

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### **The Core Plan Elements**

This plan elaborates and expands on the ideas proposed during the community engagement meetings held locally after the Governor's announcement and prior to the CGFA hearing.

The rebalancing plan is designed to:

- 1) Assure access to acute inpatient psychiatric care;
- 2) Redesign the service system – especially the crisis care component;
- 3) Be continually strengthened by stakeholder input

### Facts and Preliminary Analysis

Our plan is based on several data analyses most notably the statistical analysis of diagnostic code data (See Appendix A). During the early transition phase, DMH continues to project that the predominant treatment service needed will be focused towards a more acute care delivery package (e.g. acute inpatient psychiatric hospitalization). Additionally however, the diagnostic data clearly showcases the needs for expansion beyond the acute inpatient services into currently available but under-developed ambulatory options as based according to DMH Rule 132 and DASA Rule 2060. These services include expansion of crisis services, crisis residential care, emergency supported housing and a range of treatment options provided by substance abuse (SA) providers. In many cases, these services can actually more appropriately meet the clinical need of the consumer at the time of presentation at hospital emergency departments, hospital inpatient psychiatric units and state operated hospitals. Further, these enhanced ambulatory services will be instrumental in assuring longer term stabilization while promoting Recovery.



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### Initial Elements of the Restructuring Initiative

To implement our restructuring plan, DMH continues the engagement meetings with local providers to:

- 1) Purchase acute inpatient psychiatric bed days at the community hospitals in the Region 1 South area (CHIPS)

This service allows consumers to receive acute care in local hospitals that are closer to, and often formally linked and associated with, the individual's current mental health treatment providers. Research has affirmed that the proximity of other natural support networks (families, friends, employers, support groups) is critical to Recovery.

This service is achieved through the purchase of bed days from local community hospitals. The negotiated rate covers all cost of care including physician costs. In order to participate in the program, the hospital must demonstrate efforts to acquire coverage for care by submitting applications for recipients of care. DMH pays claims for stays following receipt of a denial disposition on the Medicaid application file for the recipient. All admissions to care through this service are pre-approved by a utilization review process managed by the state.

- 2) Purchase acute ambulatory crisis care from community providers in the Region 1 South area.

There is an array of crisis supports that can be considered, based on the specific needs of each community. These services include the following:

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Crisis Hotline: A crisis hotline is uniquely positioned to provide intervention before a crisis becomes an emergency. The utility of hotlines in the effort to save lives that might otherwise be lost to suicide is well known. Many of the best mental health providers across the country provide 24-hour accessibility of staff that are trained more broadly in crisis intervention. The ability of the mental health system to respond at the moment someone reaches out for help can mean the difference between a psychiatric emergency and an opportunity for positive change. The state of Georgia improved upon the crisis hotline model by giving crisis workers access to appointment times for CMHCs, so that if someone calls in crisis and does not need immediate hospitalization, s/he can be given a geographically accessible face-to-face appointment within 24 hours.

Mobile Crisis Response: This involves an assessment team that provides rapid community crisis intervention. Such teams provide intermediary service for people who are in crisis, and whose situations place them between the ability to be helped by telephone support or timely office-based crisis intervention, on one hand, and the need for treatment in an ED or similar setting, on the other. Mobile crisis response services (also known as Assertive Community Treatment - ACT - or Community Support Team - CST) are reimbursable under Rule 132 - our community mental health system's taxonomy of services. Mobile teams would likely be most frequently dispatched by crisis hotline personnel when the assessment yields the decision that the individual needs more intensive evaluation and intervention than can occur on the telephone.

Crisis Residential: This model is an intervention for people whose situations can't accommodate even the rapid pace of outpatient crisis interventions, but who do not require inpatient hospitalization. Crisis residential models can also be used to shorten the length of stay of a psychiatric hospitalization. When a person's situation has stabilized to the point that hospitalization is no longer

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necessary, but intensive support remains highly advisable, s/he can often benefit from the supportive services offered in crisis residential settings. Many settings with services similar to Crisis Residential are greatly enriched by utilization of Recovery Support Staff.

- 3) Purchase acute co-occurring and substance abuse services at community mental health and DASA providers in the Region 1 South area.

As noted above, many of the individuals who use our hospital services have either primary or secondary addictive illnesses. This is both a statewide and a national issue. With respect to Region One, however, the sheer number of people in our Chicagoland hospitals who have substance use disorders has an enormous impact on the service system and our ability to deliver the right treatment to people. One focus projected at this time will be short term (21 day) residential care known as Level 3.5. This level of residential extended care provides 24-hour structured and supervised recovery setting (i.e. halfway houses, recovery homes); Services may include individual/group/family therapy, medication management/education, interpersonal and group living skills group.) In addition, more traditional models of care, such as Individual Dual Diagnosis Treatment (IDDT) for serving individuals with co-morbid psychiatric and substance abuse disorders is contemplated.

- 4) Purchase transportation, for consumers discharged from the three acute levels of care from providers in the Region 1 South area.

Transportation: Consumers will need transportation services, most often ambulance services, to allow for their safe movement from an evaluating site (e.g. hospital emergency room) to the most appropriate, clinically determined treatment site. Additionally, transportation costs may include purchasing access to options for: 1) safe return to their community after completion of the acute care treatment or 2) transport to other care providers.

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- 5) Enhancement of the current traditional Rule 132 services package for non-Medicaid individuals:

Rule 132 Crisis Enhancement: Ready access to a psychiatrist for post-discharge follow-up, and the ability to manage and dispense discharge medications are both clinically verified as the best predictors of reduced likelihood of re-admissions. Additionally, expansion of the treatment services available under the current non-Medicaid service package will be significantly considered and developed, further and specifically by: 1) Continuing discussion with the stakeholders; and 2) implementing the recommendations proposed from the Governor's Advisory Workgroup, Service Models and Innovations Sub-Committee (see Attachment B). Housing options should include: 1) Traditional Rule 132 care - Supervised and Supportive care, 2) emergency housing, 3) permanent supportive housing slots, and 4) short-term housing assistance. Access to these services at one of the critical intercept points may, in fact, mitigate the use of more expensive acute care options as proposed above.

- 6) Facilitate and incentivize care coordination efforts:

It is now considered best practice to integrate mental health service delivery with primary care, specialty medical care, emergency housing and social service supports. It is anticipated that some of the models that are in use by area providers enrolled in HFS Integrated Care pilot as well as models identified in proposals submitted under the HFS' "Innovations" project can be used as templates for DMH to develop similar care coordination efforts for this project.

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- 7) Reduce admission pressure to Madden by creating bed capacity through the purchase of inpatient psychiatry and substance abuse treatment services from providers in the Region 1 South and 1 Central area.

Similar diagnostic profiles, as cited previously, are also seen at the Madden MHC. In order to remain an active regional safety net hospital for acute psychiatric care, Region 1 needs to assure the availability of these psychiatric beds. This will be achieved by both purchasing bed days (CHIPS) from local hospitals in Region 1C and investing in co-occurring and substance abuse treatment in proximate communities.

#### Summary of Provider Proposals:

Our previous and ongoing community engagement meetings as well as several informal meetings have prompted the submission of several working proposals to address the services as described above. Hospital collaborations have resulted in inpatient psychiatric services proposals from St. Bernard's Hospital (Chicago), Riverside Hospital (Kankakee), Loretto Hospital (Chicago) and St Mary's and Elizabeth's Hospital (Chicago). Exploratory meetings have been held with St Joseph's (Joliet) and St Mary's (Kankakee) Hospitals.

DMH has actively involved DASA as the technical expert in advising us on the substance abuse services models. Proposals for substance abuse care or letters of intent have been secured from Haymarket (Chicago), and HealthCare Alternatives, Inc. (Chicago). Cornell Interventions (Chicago) is in the processing of submitting a proposal.

The Will County Behavioral Health program, Thresholds and the Helen Wheeler MHC in Kankakee have allowed us to disclose their active interest in reviewing with DMH their previously submitted plans or concept papers for this transition. Other providers of care are choosing not to disclose their participation in preliminary discussions concerning their potential interest in the region's restructuring efforts. The state anticipates more

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transparency as the planning process evolves, and a more formal process to solicit proposals for new and or enhanced services for the region ensues.

Based on the current analysis of needs, and informed by actual proposals for the provision of care obtained by community providers to date, resources may be allocated in accordance with the proportions represented below (See Figure 1). It is anticipated that these proportions may change following broader stakeholder input.

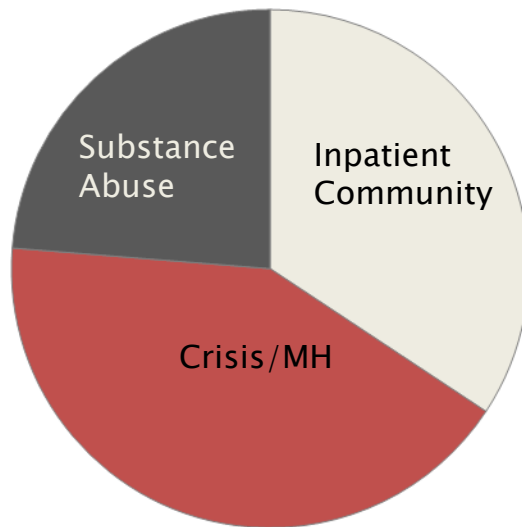


Figure 1

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### Plan Evolution – Moving Forward

We anticipate the following major goals as characterizing our work from here forward:

1. Review and analysis of characteristics of the population currently served
2. Review of assumptions about clinical service needs
3. Conduct service gap analysis
4. Develop innovative service models and structures
5. Ascertain which providers want to lead the implementation of the alternative models and structure
6. Complete and implement the service structure
7. Develop appropriate metrics with which to evaluate the effectiveness of the service changes and the system's performance

### Review and analysis of characteristics of the population currently served

The evolution of this plan was first informed by the review of relevant data. For example: An analysis of data showing the top fifteen most frequently diagnosed illnesses upon discharge from TPMHC in FY'11 shows the following:

- Fifty-five per cent of persons in this group had an affective illness. (Affective disorders can include depression, mania, or both, and can include psychotic affective illnesses.)
- Twenty-four percent of these people had psychotic illnesses unrelated to affective illness. (An example would be schizophrenia, paranoid type.)
- Twenty-two percent of this group had a substance-induced mood disorder (See Figure 2).

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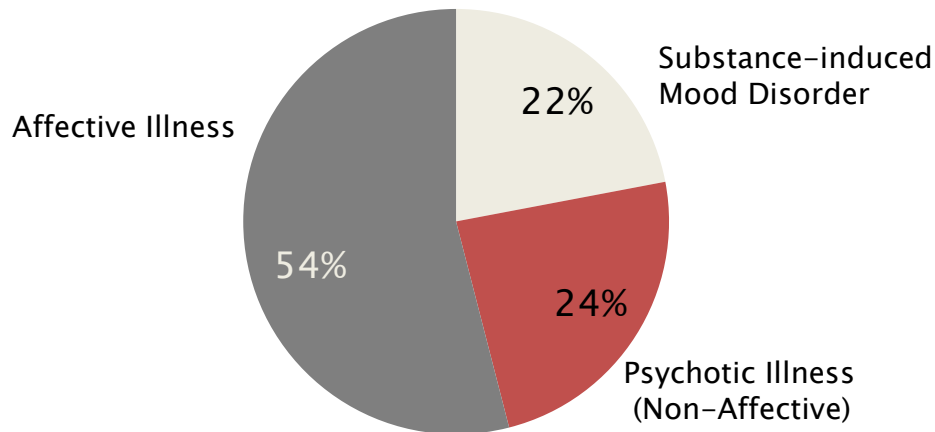


Figure 2

Additionally, up to 62% of the people who were discharged had a secondary illness that involved substance use disorders. This is consistent with national statistics that demonstrate the widespread degree of co-morbidity of substance use disorders that plague people who have serious mental illnesses. Another interesting fact is that over 100 people served at Tinley in the last fiscal year had conditions with strong social/environmental components, such as adjustment disorders and stress-related disorders. People with these types of mental illnesses are often particularly responsive to non-hospital interventions, if they are delivered before the difficulties are exacerbated to the point of emergency.

### Review of assumptions about clinical service needs of the TPMHC population

The service needs of people with mental health needs in Region 1S are very similar to needs identified across the country. While systems' structures and interventions vary from state to state, and from Mental Health Authority to Mental Health Authority, we know the needs of the individuals we serve are consistent with information from many other states. Nevertheless, because systemic interventions derive from our assessment of service needs,



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DMH intends to confirm (or disconfirm) detailed assumptions about the people we serve in Region 1S. The following system evaluative activities will be continued or conducted:

### Clinical focus Groups (in process):

DMH clinical executive staff members are organizing focus groups, consisting of psychiatric and emergency service providers throughout Region 1S. These service providers include, for example, hospitals whose emergency departments refer large numbers of people to DMH inpatient services, state hospital psychiatric leadership, as well as community service providers in Region 1S. Because Region 1S serves urban/suburban areas as well as less densely populated and rural areas, geographic heterogeneity will characterize these groups. Focus group participants will be given case studies typifying clinical and psychosocial issues associated with the top five–seven more frequently observed clinical presentations at TPMHC. The experienced clinician focus group participants will then be asked to identify the most appropriate service interventions for these situations.

These recommendations are not to be made based on services currently available in the continuum of care in Region 1S. Rather, the recommendations should reflect the most appropriate, evidence–based interventions that would lead to the best outcomes.

The goals of these focus groups are:

- To ascertain the degree to which our statistics and DMH’s leadership’s understanding of the needs of the people we serve correspond with the clinical impressions of experienced clinicians throughout Region 1S who are involved in delivering or referring people to services.
- To identify the optimal services and intervention strategies to address the needs of the population to be served.

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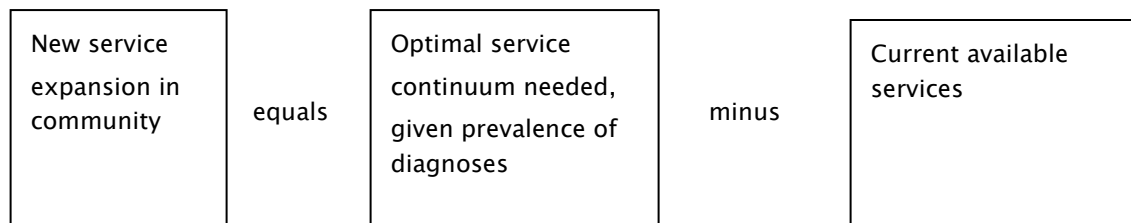
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### Service Gap Analysis (in process):

DMH leadership is in the process of coordinating and updating information about what services are available in the various geographic entities that comprise Region 1S. When this project is complete, we'll have an understanding of the degree of coverage of each section of Region 1S by services such as time-sensitive crisis services, crisis residential treatment, emergency departments, inpatient community psychiatric beds, substance use disorder services and primary care services.

We intend to compare existing service capacity against what has been identified by our clinical focus groups as optimal, appropriate services for this population. This comparison will inform decisions concerning the amount and types of services to be purchased across the region. The methodology will compare optimal service availability, given the prevalence of specific diagnostic groupings by geo code. More specifically, for any given community, service expansion will be informed by the following formula:



### Sequential Intercept Model

DMH intends to bring greater clarity to the region's systemic dynamics and vectors by adapting the Sequential Intercept Model, for use in analyzing the trajectory of persons in acute psychiatric distress to the most intensive, high acuity service levels.

Mental health and justice system providers across the country are learning from this model, which identifies multiple points at which persons with mental illnesses are inappropriately

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arrested, detained, tried, and sentenced for actions that occur as a result of psychiatric symptoms. The Sequential Intercept Model has defined interventions at each of these action points in order to prevent inappropriate incarceration.

DMH is designing an intercept model in Region 1S that incorporates the lessons from this major innovation into sequential situations that result in preventable hospitalizations. The development of the model thus far projects the following situations as sequential intercepts for crisis or other services that can prevent emergent admissions: Utilization of primary care centers, community mental health center appointments or crisis calls, utilization of SUD services, intervention of law enforcement, and presentations at hospital emergency departments or psychiatric inpatient settings (See Figure 3). We have confidence that our community partners will collaborate with us in constructing a robust sequential intercept model that confirms or disconfirms the need for many of the services discussed above. With service planning informed by such an analysis, the expected result is more targeted and efficient resource allocation resulting in desired outcomes, including more appropriate use of services such as inpatient hospitalization, and, more importantly, reduction of the disruption and trauma that often inheres in psychiatric hospitalization.

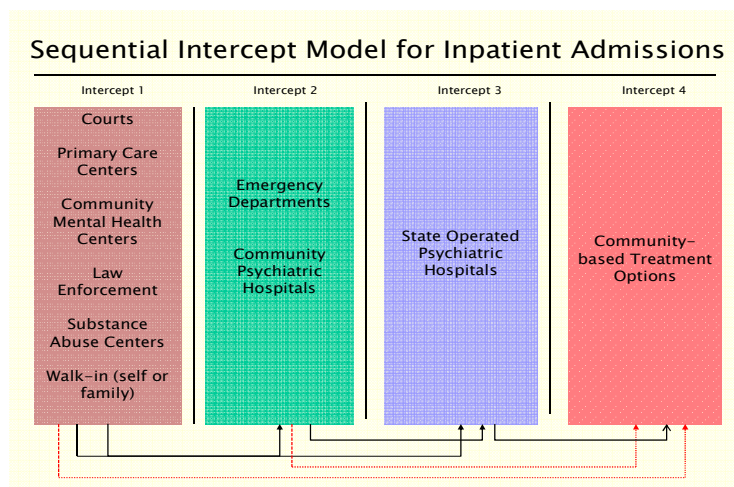


Figure 2

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### Innovative Service Models and Payment Methodologies

In addition to the traditional services that we expect to proliferate in accordance with regional needs, DMH is looking to partner with community providers to develop new models that directly address the needs of the communities. These innovations in service delivery may be staggered in implementation. Although we have been planning implementation of services such as those outlined below, they are not all likely to be available by the end of FY 12. New models for consideration include, but are not limited, to:

1. Emergency Department Crisis Intervention: Emergency departments have become the default destination for people who are in crisis, and not all of these crises are medical in nature. Emergency departments often employ social workers or other crisis workers who can provide a variety of psychological and social supports, such as family interventions or services for individuals experiencing homelessness or lack of food. Such staffing decisions can decrease hospitalizations, as well as provide services that more closely fit the nature of the crises for which people are seeking help.
2. Brief Intervention, Linkage Treatment (BILT): This is conceptualized as a hospital-based unit with a short-term (24–48 hour) stay. BILT will facilitate the use of highly focused mental health assessment and supportive measures, including peer support, to help individuals stabilize their situations quickly, and to provide timely, validated referral and linkage to recovery-oriented community services.

The respondent hospital will operate a small inpatient unit to admit individuals whose situations are assessed as able to benefit from short term clinical observation and treatment. The goals of these brief stays would be rapid assessment and triage of individuals' situations and rapid formulation, with the individual, of a treatment plan that addresses urgent, as well as longer-term recovery needs. This is a model from which advantages to the healthcare system, the emergency healthcare system, the state budget, and, most importantly, people with urgent mental health issues will accrue.

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3. Peer Support: Most of the systemic interventions being planned by DMH Region 1S are likely to be greatly enhanced by Intentional Peer Support. Peer support personnel are persons who have lived experience with mental illnesses, who are willing to disclose their experiences for the benefit of others, and who are trained in counseling strategies that foster hope and utilize the peers' own experiences in order to do so.
- *Emergency Departments*: EDs are excellent places to offer peer support. Even EDs that don't board psychiatric patients will be encouraged to add peer support to the services they offer individuals with mental illnesses. Peer counselors can make the emergency department experience far less aversive to individuals whose illnesses, by definition, decrease the ability to manage stress. Additionally, support by a peer counselor at the beginning of a help-seeking process conveys the powerful expectation of recovery in multiple ways.
  - *'Living Room'*: This dramatic innovation in recovery-oriented services is exemplified by the living room models in Maricopa County, Arizona. These home-like environments are primarily staffed with recovery support specialists, with psychiatric services available. People with mental health concerns are welcome, free of charge. Although the living room in one of the cities reduced monthly ED visits from the local clinic by 23%, the philosophy and approach in a living room is quite different than in an ED. Individuals are encouraged to focus on their strengths rather than only on their problems. Unlike many hospital environments, the expectation of recovery is conveyed throughout the living room experience.

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### Payment Methodologies

Payment strategies have yet to be finalized for inpatient and outpatient services. In the past, DMH has purchased private hospital services via the Community Hospital Inpatient Psychiatric Services (CHIPS) model. Discussions have been under way for some time with interested inpatient service providers, some of whom prefer another model. A DMH team has been formed to conduct these negotiations.

The Department of Healthcare and Family Services (HFS) has, and is, implementing multiple Medicaid reforms. One of these, for example, involves coordinated care management: people are, essentially, rated on parameters such as the severity of their illnesses and ability to collaborate with their healthcare providers. They are then matched with support models such as reminder calls, liaison with primary care doctors, monitoring of prescription refills, etc. Payment methodologies can be explored that could add per member/per month payments for this coordinated care activity. Another widely used tool involves capitation models. DMH has solicited and received several proposals that use case rate or capitation models. Payment models that utilize blended funding strategies from DHS sister divisions – especially DMH and DASA – may be proposed.

Cook County Health System has initiated a process that could result in an early Medicaid expansion for Cook. We plan to meet with them to model our analyses and our system interventions in such a way as to accommodate this expansion. It may occur as early as CY 2012.

### System Performance Measurement/Outcome Assessment

With any system change effort, it is important to develop measures to assess the system's performance throughout the change process. In addition to traditional consumer satisfaction surveys and various outcome measures, the following indicators are examples of the metrics that may be collected to monitor the performance of the innovative service models:

1. Decreased wait times in Emergency Departments (ED): Patients presenting with mental health problems in EDs will have wait times of less than 24 hours;

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2. Decreased “stranding” times: Patients “stranded” in inappropriate treatment settings (i.e., general hospital units, EDs) will be transferred to appropriate treatment settings in 24 hours or less;
3. Decreased use of ED services: Consumers experiencing a mental health crisis will seek and use the innovative, community-based services (i.e., mobile crisis response, BAIL), thereby decreasing use of ED services;
4. Decreased criminalization of mental illnesses: The number of mental health consumers detained at Cook County Jail will decrease.

DMH will collect baseline data on these performance metrics through DataLink and data requests. Performance metric data will then be collected quarterly in order to capture how the system is evolving over time.

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### Community and Stakeholder Engagement

DMH recognizes that all planning is strengthened by input from stakeholders who are directly involved and impacted by the service delivery system. A number of opportunities to solicit stakeholder input will be crucial to continued planning and review of our progress. These include:

- Focus groups:
  - 1) Input on the strengths and limitations of what will continue to be an evolving service system; and
  - 2) Ideas for systemic responses to address the identified limitations. Current plans involve the formation of future focus groups constructed to combine the different types of expertise that inhere in people who use our services, providers of various types of community services, community hospital psychiatric units, community hospital emergency services, the advocacy community, state hospital clinical personnel, and other stakeholders.
- Proposal Solicitation: DMH is fortunate to have a community service system that includes community mental health providers with perspicacious clinicians and leaders. We have received, over the months, numerous very carefully thought out proposals in response to a variety of formal, semi-formal, and informal communications. DMH has never had to wait until a formal solicitation occurred to get innovative ideas from our dedicated community partners. DMH and its sister agencies have long encouraged providers to think 'outside the box' about how they could serve the people with whom they worked. Although not all of these ideas could be implemented, we have, because of these factors, no dearth of very well constructed ideas, suggestions, and models. We have had multiple recent proposals for rebalancing Region 1S from hospital and community service providers.



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- Solicitation of feedback from formal entities: DMH/DHS has a wide array of stakeholders who have a passionate interest in our work and upon whose input we depend in multiple situations. Our plan includes solicitation of input regarding the Active Community Care Transition from the following existing entities:
  - Region 1S Advisory Council
  - Region One Consumer Groups
  - Region One Central Advisory Council
  - Illinois Mental Health Planning and Advisory Council

In addition to the groups listed above, the Governor Office will convene the Mental Health Rebalancing Advisory Workgroup to provide ongoing input and consultation. The Advisory Workgroup's committees and their respective missions are listed below (See also Appendix B). It will be co-chaired by the leaders from the Governor's Office and DMH.

Committees are proposed as follows:

### 1. **Hospital Engagement**

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

### 2. **Service Models and Innovation**

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.

# Tinley Park Mental Health Center

## Rebalancing & Community Reinvestment Strategy

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### 3. **Community Education Support**

Mission: Assist the state in planning for the education of consumers and providers as the system changes and identify and plan for the workforce development needs.

### 4. **Service Financing and Payment Methodology**

Mission: Assist the state in defining new payment models for financing service delivery. Representatives from this committee should also participate with hospital engagement and innovation and service models groups to assure direct lines of communications between these committees.

### 5. **System Performance and Outcomes Assessment**

Mission: Assist the state in determining the most appropriate methodology and metrics for evaluating effectiveness of system reforms and restructuring efforts.

### 6. **Messaging, Media & Legislative Liaison**

Mission: Assist the state in developing appropriate messages, and interface with the members of the General Assembly on restructuring issues.

Tinley Park Mental Health Center  
Rebalancing & Community Reinvestment Strategy

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APPENDICES



## Appendix A

### Facts Sheet: Tinley Park MHC and Region 1South

FY11 Total Admission from catchment area	1523
FY 11 Total Admissions	1905
FY 11 Total Bed days	24,706
Average Length of Stay	11.6
Average daily census (ADC)	68
Occupancy rate	90%
30-day readmission rate	11.7%
% of discharges with SA as the primary diagnosis	23.6%
% of discharges with SA as the secondary diagnosis	60%
% of admissions by gender, Male	70%
Authorized psychiatric inpatient beds in catchment area*	312
Staffed psychiatric inpatient beds in catchment area*	296
Average occupancy rates for inpatient beds in catchment area*	53%

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\* IDPH data from Annual Hospital inventories CY2010; not all beds as authorized are used at hospitals for inpatient adult services. DMH is currently working with the Illinois Hospital Association to update these figures to 2012.

Appendix B

**ILLINOIS DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MENTAL HEALTH  
MENTAL HEALTH REBALANCING ADVISORY WORKGROUP**

Co-Chairs: Mark Doyle  
Governor's Office

Lorrie Jones  
Division of Mental Health

Hospital Engagement	Service Models & Innovation	Community Education & Support	Service Financing and Payment Methodology	Systems Performance & Outcomes Assessment	Messaging Media & Legislative Liaison
Co-Chairs	Co-Chairs	Co-Chairs	Co-Chairs	Co-Chairs	Co-Chairs
MaryLynn Clark	Joe Troiani	John Shustitzky	Ben Stortz	Sue Pickett	Janet Stover
Dr. Swaminathan	Lori Baker	Lora Thomas	Lynn O'Shea	Mary Smith	Pat Knepler
Mark Heyrman	Dan Wasmer	Gustavo Espinosa	Rick Nance		Debra Ferguson
Mike Pelletier	Jackie Manker		Shawn Cole		
Dennis Beedle	Rick Nance				

State Staff