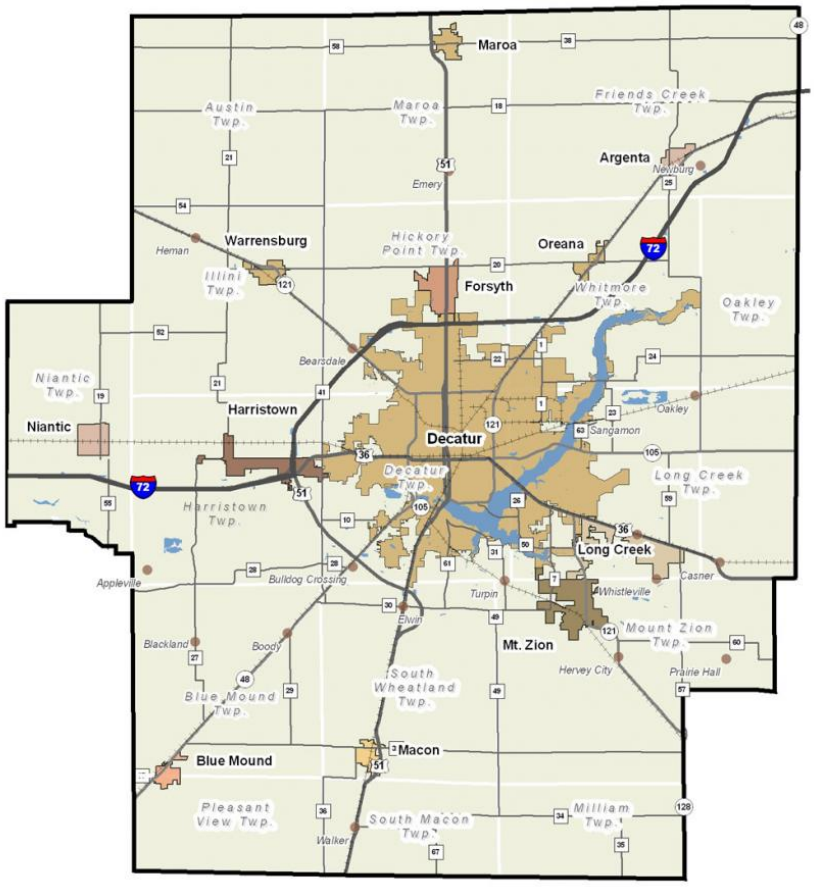
MACON COUNTY

CARE COORDINATION



Solicitation Response to the

Illinois Department of Healthcare and Family Services

Innovations Project / 2013 – 24-002

June 2012

Macon County Care Coordination

A Proposal in Response to the
Illinois Department of Healthcare and Family Services'
Innovations Project/2013-24-002
June, 2012

Table of Contents

Care Coordination Proposal
From

Macon County Care Coordination

3.2.1 Governance Structure, Scope of Collaboration, and Leadership

3.2.1.1 Please provide the name of the Care Coordination Entity (CCE) or Managed Care Community Network (MCCN).

Macon County Care Coordination
132 S. Water Street, Suite 604
Decatur, Il. 62523

3.2.1.2 CCE-Only. Who are the collaborators including but not limited to PCPs, hospitals, mental health Providers, and substance abuse Providers? Please submit articles of incorporation and by-laws. Using the format found in Attachment E (Table 1), list each collaborator and its relationship with care the CCE. The Department has the right to request agreements, contracts, letters of intent, etc.

Please see Attachment E (Table 1) for a listing of collaborators and their relationships with Macon County Care Coordination.

Core Collaborators include:

Macon County Mental Health Board (unit of local government)	Administrative Services
Community Health Improvement Clinic (federally qualified health center)	Primary Care Provider
Decatur Memorial Hospital	Inpatient Medical, Emergency Department
St. Mary's Hospital	Inpatient Medical, Psychiatric, Emergency Department and Long Term Care Services
Heritage Behavioral Health Center	Medicaid Mental Health and Substance Abuse Services
Macon County health Department (unit of County government)	Nursing Services

3.2.1.2.1 Who is the lead entity contracting with the State?

Macon County Care Coordination
Macon County Mental Health Board
132 S. Water St., Suite 604
Decatur, Il. 62523

3.2.1.2.2 Please explain your plans, if any, for advancing to full-risk capitation over time and applying to be a MCCN.

Macon County Care Coordination has considered a partial capitation model and would be open to discussion with DHFS about future development of this approach, based on the experience gained in operating a care coordination service under contract with DHFS.

3.2.1.3 MCCN-Only. Who are the MCCN founders or owners? Please submit articles of incorporation and by-laws. Attach a list of the entire network of contracted Providers in addition to the providers who are the founders or owners of the MCCN. Use the format found in Attachment E (Table 2). The Department has the right to request agreements, contracts, letters of intent, etc.

Not applicable.

3.2.1.4 Explain how your analysis of claims data leads you to believe the scope of your CCE collaboration/MCCN network (collaboration) is sufficient to effectively coordinate the care of and ensure access to care for the population you propose to serve. In discussing the scope of CCE collaborators/MCCN network of Providers (collaborators), indicate how the number of collaborators is sufficient and how the collaborators match the utilization patterns of the population you propose to serve.

The core collaborators requested via a Letter of Intent to DHFS Medicaid claims data for residents of Macon County. A summary of claims data is reflected below, indicating over $80 million dollars in Medicaid expense. A total of 14,001 individuals were provided Medicaid-covered services in 2010.

Table 1 All Medicaid Service Recipients in Macon County by Age Group

		Age Groups			
	Total	19-20	21 - 44	45 - 64	65+
# of Recipients:	14,011	989	8,065	3,230	1,727
% of Total	**100%**	**7%**	**58%**	**23%**	12**%**
Total Cost:	$80,499,126	$2,373,433	$27,068,740	S29,665,891	$21,341,062
% of Total	**100%**	**3%**	**34%**	**37%**	**27%**

Data was also requested from DFHS for two target populations: individuals with serious mental illness and seniors with chronic illnesses. Following is an analysis of key points discovered through analysis of claims data for each target population:

Data Analysis for Serious Mental Illness in Macon County

Analysis of the data provided by the Department of Healthcare and Family Services, Macon County residents with serious mental illness total 1547 individuals. Total cost of care for these individuals under the Medicaid program was $18,573,657 in 2010. The cost of care for these individuals was 23% of total cost of care for all Medicaid recipients in Macon County however the number of individuals with serious mental illness was only 11% of total Medicaid recipients receiving care.

Table 1 - SMI Target Population: Seriously Mentally Ill Adults (18+), Medicaid Service Recipients by Age Group

		Age Group > 18 +, SMI			
	Total	19-20	21-44	45-64	65+
# of Recipients:	1547	67	800	552	128
% of Total SMI	100%	4%	52%	36%	8%
% of County Total	23%	27%	26%	28%	12%
Total Cost:	$18,573,657	$645,409	$6,999,030	$8,302,905	42,626,313
% of > 18 +, SMI	100%	3%	38%	45%	14%
% of County Total	23%	27%	26%	28%	12%

Behavioral health conditions, such as substance abuse or mental health issues, often trigger the onset of chronic ailments such as obesity, hypertension, and diabetes. According to the Service Administration of Mental Health and Substance Abuse (SAMHSA), sixty-eight percent of individuals with a mental health disorder have one or more medical conditions. Of the nearly sixty percent of adults with a medical condition, about one-third have a co-occurring mental disorder. Those with co-occurring mental health disorders experience much poorer health outcomes.

Macon County claims data indicates that SMI individuals were found to have co-morbid conditions at a high rate. Of the total of 1547 individuals with SMI, 829 individuals have one of four most prevalent co-morbid conditions, including: 236 suffering from chronic obstructive pulmonary disease (COPD); 192, from hypertension; 261, from diabetes and 102, from congestive heart failure (CHF). A significant number of SMI individuals suffer from two or more of these conditions, including

87 with COPD and hypertension; 22 with COPD and CHF, 33 with COPD and diabetes; 74 with diabetes and hypertension; 29 with diabetes and CHF. Additionally, a number of SMI individuals suffer from three illnesses, including: 22 with COPD, diabetes and CHF; and, 36 with diabetes COPD and hypertension. Coordination of care for these individuals with co-morbid conditions will be a priority focus of the care coordination effort.

Table 2 - Seriously Mentally ill Individuals – By Diagnosis

Diagnosis	**Number of Individuals**	**Percent of Total**
All	1547	100%
Psychiatric		
Schizophrenia	522	31.5%
Bi-Polar, psychosis NOS, autism	270	16.4%
Bi-Polar, unspecified, depression, PSTD, ADD	795	48.6%
Substance Abuse		
Cocaine, opioids, amphetamine, combine	149	
Alcohol	92	5.6%
Cannabis, tobacco NOS	497	30%
Central Nervous System		
Epilepsy, Neuropathy	272	16.6%
Quadriplegia, anoxic brain damage	7	.4%
Sleep disorder, sleep apnea	359	21.9%
Cerebral palsy, MS, paraplegia	33	2%
Headache, fatigue, pain	217	
Gastro-Intestinal		
Ostomies, liver transplant	14	.9%
Chronic liver disease, cirrhosis	62	3.8%
Esophageal reflux, bleeding, pancreatitis	343	21.1%
Pulmonary		
Respiratory failure	81	4.9%
COPD, asthma	436	26.75
Respirator dependence	12	.8%
Hypertension	388	23.2%
Renal		
Urinary incontinence, retention	72	4.3%
Urinary frequency, kidneys, bladder, urethra	22	1.4%
Chronic kidney disease	5	.3%
Skeletal		
Rheumatoid arthritis, lupus	95	5.9%
Diabetes		
Type 1 – uncomplicated	38	2.3%
Type 1 – renal or other complication	2	.1%
Type 2 – involvement with eyes, other	36	2.2%
Type 2 – uncomplicated	182	11%

Cerebrovascular		
Occlusions, hemorrhage	42	2.5%
TIA	45	2.7%
Eye		
Myopia, presbyopia	131	7.8%
Hematology		
Coagulopathy, thrombocytopenia	37	2.2%
Sickle cell, other anemia	20	1.2%
Cancer	27	1.5%
Cardiac		
Myocardial Infarction, ischemia, fibrillation	172	12%
Tachycardia, palpitation	86	5.2%
Graft, heart transplant	10	.7%
Developmental Disabilities		
Mild, Moderate	44	2.7%
Severe, Profound	6	.4%
AIDS	10	.7%
HIV	3	.1%
Skin		
Dermatitis, contusion	456	27.5%
Metabolic		
Malnutrition, high potassium	52	3.3%
Malnutrition, low potassium, gout	68	4.1%
Hyperlipid, hypothyroid, weight change	452	27.6%
Metabolic syndrome	6	.3%
Infectious		
Hepatitis, thrush, herpes	50	3%
MRSA, Septicemia	24	1.4%
Genital		
Ovarian cyst, enlarged prostate	131	8.2%

With serious mental illness also comes a pattern of increased use of inpatient medical and behavioral inpatient services. The following table highlights inpatient utilization for seriously mentally ill individuals in Macon County.

Table 2 – Hospitalizations for Target Population of SMI Individuals vs. Individual without SMI

	Individuals with SMI	Individuals with no SMI
Hospitalizations Per 1000	554 per 1000	178 per 1000
Hospitalizations	912	2326
Total Days of Care	5042	8500
Average Length of Stay	5.5 days	3.7 days

Hospitalizations for individuals with serious mental illness occur three times more frequently than for those without serious mental illness. Hospitalizations are approximately 50% longer than the length of stay for those without serious mental illness.

Table 3 – Emergency Department (E.D.) Visits for SMI Individuals vs. Individuals without SMI

	Individuals with SMI	Individuals with no SMI
E. D. Visits Per 1000	2,914	1256
Total E. D. visits	4,797	16,369

Emergency Department visits for individuals with serious mental illness occur approximately two and one –half times more frequently than for those without serious mental illness.

The following tables provide a focus on high risk and high service use seriously mentally ill individuals in Macon County. The data in these tables reflect those individuals with one or more chronic health conditions and at least one hospital stay. Seriously mentally ill (SMI) adults in Macon County (1547 individuals) constitute 11% of the total number of individuals receiving Medicaid supported medical services (14,011 individuals). Total cost for treatment of SMI individuals ($18,573,657), however, amounts to over 24% of total Medicaid spending ($81,355,014) for all Macon County Medicaid recipients receiving services. Cost per individual with SMI is $12,006 per year, over two and one-half times as high as the cost for those individuals without serious mental illness ($4,715)). Hospital inpatient days for SMI individuals total 3974 or 37% of all inpatient days. ED visits for SMI individuals total 1921 and comprise 23% of total ER visits. SMI individuals are using inpatient and ED services at a rate over two times as frequently as those Macon County residents without SMI.

Table 4 - SMI Target Population:

Subset A: Medicaid Service Recipients with One or More Chronic Health Conditions and at least one hospital stay

>18 +SMI + 1 or more chronic health conditions + at least one hospital stay						
# of Recipients:		403	12	165	174	52
		100%	3%	41%	43%	13%
	% of >18 + SMI	26%	18%	21%	32%	41%
	% of County Total	3%	1%	2%	5%	3%
Total Cost:		$7,811,211	$327,633	$2,708.645	$3,669,637	$1,105,306
		100%	4%	35%	47%	14%
	% of >18 + SMI	42%	4%	58%	58%	52%
	% of County Total	10%	14%	10%	12%	5%

Table 5 - SMI Target Population:

Subset A: Medicaid Service Recipients with One or More Chronic Health Conditions and at least one hospital stay, by Gender

Gender					
Female	238	5	99	95	52
	100%	2%	42%	40%	16%
% of Subset A:	59%	42%	60%	55%	56%
Male	165	7	66	79	39
% of Subset A:	100%	4%	40%	48%	8%

These tables provide a narrow focus on those individuals who are most at risk for significant health problems. These individuals have a serious mental illness and at least one other serious chronic health condition and had at least one hospitalization in 2010. They comprise the highest of the high risk individuals in the County with SMI. They also represent the starting point for involvement in care coordination. In an effort to improve health outcomes for these individuals and to reduce Medicaid program expense, a narrow focus on the most health- challenged individual provides the best opportunity for health improvement and cost containment.

Table 6: Inpatient Utilization For SMI with One or More Hospitalizations

NOTE: Hospitalizations\1,000 recipients not applicable as query required recipients with at least 1 hospital stay

Hospitalizations	
Recipients:	403
Events (# of Stays)	
Mental Health	278
Substance Abuse	22
Other	395
Sub-Total:	695
Units (# of Days)	
Mental Health	1,739
Substance Abuse	61
Other	2,174
Sub-Total:	3,974
Cost:	
Mental Health	$436,995
Substance Abuse	$21,262
Other	$1,975,006
Sub-Total:	$2,433,263

Table 7: Dual Verses Non-Dual Eligibility

Dual Eligibility		
Recipients	182	45%
Total Cost	$2,674,203	34%
Hospital Cost	197,438	3%
ER Cost	$18,700	0%
NON -Dual Eligible		
Recipients	221	55%
Total Cost	$5,137,018	66%
Hospital Cost	$2,235,824	29%
ER Cost	$182,622	2%

Table 7: Emergency Department Utilization

Emergency Room	
Recipients:	359
% of Subset A:	89%
Events:	1,921
Units (# of Days)	1,921
Cost	$201,322
ER Visits\1,000 Recipients	4,767

# of ER Visits divided by (# of recipients in Group 1A/1,000)

Table 8: Residential Service Utilization

Residential	
Recipients:	114
Integrated Care Facility - Private	36
Integrated Care Facility– Public	
Public Nursing Facility	1247
Subtotal	1,283
Units (# of Paid Procedures)	
Integrated Care Facility Private	700
Integrated Care Facility –Public	-
Nursing Facility	24,516
Subtotal:	25,216

Examining the top quartile of Medicaid spending for individuals with serious mental illness, total Medicaid spending is $13,388,004.70, or 72% of total Medicaid spending for individuals with serious mental illness. Average Medicaid cost for this set of individuals is $34,865 per year. Of the 1547 SMI individuals in Macon County, 865 received mental health Medicaid services. The average annual cost per recipient for those receiving mental health Medicaid services is $9,606. A total of 682 SMI individuals are not receiving mental health Medicaid services. This group has an average annual cost per recipient of $14,830, approximately.

These data points strongly suggest that engaging those individuals in the top quartile of Medicaid service expense and those individuals not currently receiving mental health Medicaid services in care coordination is central to Medicaid cost containment and improved health outcomes for these groups. A focus on these two groups of individuals and their inpatient and Emergency Department utilization will be the primary aim of the care coordination effort. Macon County Care Coordination estimates that savings in Medicaid spending can be achieved through care coordination efforts focused on the two above described groups of seriously mentally ill individuals. This savings is anticipated to be beyond cost-neutrality of Medicaid service delivery and care coordination expense. As discussed elsewhere in this proposal, any shared savings that may accrue to Macon County Care Coordination would be re-invested in services for this target population through purchase of service contracting from the Lead Entity, the Macon County Mental Health Board, to service providers in the community. Service needs and services to be purchased through this shared savings amount would be

determined based on core collaborator recommendations for closing service gaps in the local service system.

The core collaborators for Macon County Care Coordination provide the treatment settings that will be necessary for involvement in care coordination efforts aimed at engaging both SMI individuals currently receiving behavioral health treatment and those not currently in treatment. The core collaborators' involvement is essential to the coordination of care for those SMI individuals with co-morbid conditions. The community hospitals (Decatur Memorial Hospital and St. Mary's Hospital), provide the only inpatient and Emergency Department services in the community. The FQHC (Community Health Improvement Center) serves as the outpatient primary care provider for the community's Medicaid and indigent populations. The certified mental health and substance abuse service provider (Heritage Behavioral Health Center) is the key provider for Medicaid mental health and substance abuse treatment.

Data Analysis for Seniors with Chronic Illness in Macon County

Seniors with chronic health conditions constitute 11.8% (1,758 individuals) of the total number of individuals receiving medical services paid by Medicaid (14,681 individuals). The senior population of Macon County includes 18,166 individuals age 65 or older, 16.4% of the total Macon County population. Macon County's elderly population is proportionately larger that the state average of 12.5%. Total Medicaid spending for Macon County Seniors in 2010 was $21,341,062, with a cost per recipient of $12,357. Of that total spending, $14,341,062 or 67% was spent for nursing facility services. Home and community-based service (personal care, homemaker and other) services totaled an additional $3,718,958. Twenty seven percent of seniors used a total of 965 Emergency Department visits. Twenty one percent of seniors were hospitalized, involving 472 hospitalizations and 2,014 inpatient days of care.

Ninety seven percent of seniors receiving Medicaid services were dually-eligible for Medicare and Medicaid. It is understood that, for purposes of the Innovations Solicitation, anticipated savings in Medicare spending will not be considered in calculating savings achieved by care coordination efforts. Macon County Care Coordination has identified gaps in the service delivery system for seniors, at hospitalization, post hospitalization and subsequent nursing home placement. While savings may not be significant in focusing on Seniors who are hospitalized and considered for nursing home admission, Macon County Care Coordination believes that the savings achieved through care coordination for seriously mentally ill individuals will support an effort to focus on a small set of Seniors who have been hospitalized and who may be diverted from nursing home placement through a coordinated application of community-based and in-home services. It was the consensus of the core collaborators for this proposal that coordination of care for seniors is a systems development

need for this community and an effort that will prepare the community for anticipated system changes in the future.

3.2.1.5 Describe the governance structure of the CCE or MCCN, such as policies and mechanisms in place to share information and ensure compliance with the care coordination model described in your Proposal. Please attach the relevant articles of incorporation or by-laws that outline the governance structure as Attachment G.

Macon County Care Coordination is organized as a program of the Macon County Mental Health Board, partnering with key medical and behavioral health service providers in Macon County. The Core Collaborators elected to establish a program design with the lead entity, supported by a care coordination agreement signed by all core collaborators. In addition, the core collaborators, as network service providers, have agreed via Business Associate Agreements, to exchange electronic health information for the purpose of care coordination. In addition, the core collaborators have entered into Memorandum of Understanding agreements with Macon County Care Coordination to serve as providers of service for the Solicitation proposal's target populations. All network service providers will be asked to enter into a Memorandum of Understanding with Macon County Care Coordination for collaboration in service provision and in care coordination for enrolled individuals. These agreements are outlined as follows, to establish the care coordination program and to provide for the operation of the program and permit health information exchange. (Please see executed agreements in Attachment G):

A. Agreement for Care Coordination in Macon County

   Core Collaborators have established an agreement establishing Macon County Care Coordination as a program of the Lead Entity, formed for the purpose of care coordination between and among the six core collaborators for enrollees in care coordination. Included as part of the Agreement for Care Coordination in Macon County, is authority for each Core Collaborators to represent Macon County Care Coordination with potential service providers. This provision has been included so that negotiations and discussions with potential providers for the network can occur.

B. Memorandum of Understanding between the Care Coordination Entity, Macon County Care Coordination, and each service provider that is part of the initial Macon County Care Coordination network.

   This Memorandum of Understanding outlines the responsibilities of the Network Service Provider to Care Coordination Enrollees and to Macon County Care Coordination, as well as Macon County Care Coordination's responsibilities to Network Service Providers and Enrollees. Several

Memorandum of Agreement documents have been completed with network providers (see Attachment G). Additional agreements are to be put in place following the award of a Care Coordination contract from and prior to commencement of enrollment of individuals in the care coordination service.

C. Business Associate Agreement

Macon County Care Coordination has executed HIPPA-required Business Associate Agreements between Macon County Care Coordination and each of the core collaborators/service providers prior to the due date of this Solicitation response. Business Associate Agreements will be completed with network providers following contract award by DHFS and prior to the beginning of enrollment.

D. Letter of Support and Interest to Participate

Southern Illinois University Healthcare has provided a letter of support and interest to participate in care coordination efforts. The Healthcare Clinic's Director, Dr. John Bradley, is interested in the development of the medical home concept within the Family Practice as a pilot project over the next year.

St. Mary's Hospital has provided a letter of support and interest to participate in care coordination efforts. The Director of Behavioral Services has been actively involved in the development of this proposal. St. Mary's Hospital has offered the letter of support as an indication of its interest in care coordination and this proposal.

3.2.1.6 Describe additional resources available to the CCE or MCCN to assist in implementation or operation of your care coordination model (funds committed by collaborators, Federal Innovations grants, private grants, etc.).

The following describes the resources that each of the core collaborators is prepared to contribute to assist in implementation of Macon County Care Coordination.

The Macon County Mental Health Board (the Board):

The Board, as the lead organization for Macon County Care Coordination, has contributed to project start up. Board funds have been used, to date, to support the establishment of an initial health information exchange process through a web-based system with controlled and secure access and adaptation of a care coordination software package for use in starting and operating secure storage of centralized care coordination health information and management of care coordination functions.

In addition, the Board, as a local funder of mental health and substance abuse services, currently contracts with 21 community agencies and expends in excess of $2.8 million in the purchase of services locally. Several of these existing contracts are focused on the target populations of the seriously mentally ill, seniors with chronic health conditions and the children and families of these two target populations, as identified in this Solicitation response. The Board has, over time, designed contracts with providers that are targeted to close apparent gaps in the local service network and facilitate integration of services. A number of existing contracts have been designed with the intent of filling service system gaps.

The Board has also established a Local Funds Initiative through which three local Medicaid certified organizations (Heritage Behavioral Health Center, Webster Cantrell Hall and Youth Advocate Program) may provide Medicaid mental health services to Medicaid-eligible individuals, as defined in DHS/Division of Mental Health Rule 132. The Board has designed program contracts to maximize the use of local funds as matching funds for Medicaid mental health services. The Board is willing to commit local funds as matching funds for substance abuse services as well, if billing mechanisms can be established through DHFS and/or the DHE Division of Substance Abuse.

The Board contracts with local community agencies that may address the target populations, their children and their families include the following:

1. Services Related to Mental Health/Mental Illness
   a. Campion and Associates - Early Intervention

      Therapy is provided for children, ages 0-15, who are displaying maladaptive, emotional, and/or behavioral disorders. Services are also provided to children and adolescents who have been impacted by sexual abuse either as victims or perpetrators. Services are also made available to mothers suffering from post-partum depression.
   b. Catholic Charities - Counseling/Student Assistance Services

      These services provide counseling to individuals, couples and families who are experiencing a wide range of psychological and interpersonal problems. Services are also made available to mothers suffering from post-partum depression. Catholic Charities is also providing student assistance services to each of the Catholic schools in Macon County.
   c. Community Health Improvement Center - Mental Health Services

      This service is designed to provide treatment to children, adolescents, adults and older adults with mental health problem, mental illness or a behavioral problem. These services include counseling, assessment, case coordination and outreach. Services are provided by licensed Community Health Improvement Center staff on-site at the Health Improvement Center. This contract is paid through Board funding. Locating these services within the clinic improves client/patient access to services and allows for the possibility of screening a wider population of youth and adults.
   d. Dove, Inc. - Domestic Violence Program

Dove, Inc. provides a wide range of services that help victims of domestic violence make better lives for themselves and their dependent children. Depending upon need, women may stay at the shelter during the critical stages of moving from violent home environments. Other services include advocacy and counseling services, parenting skills training, and assistance for children.

e. Heritage Behavioral Health Center - Mental Health Medicaid and Non-Medicaid Services Provided In A Clinic Setting

This program is designed to integrate Heritage services within a clinic setting. These services are billed to Medicaid through the Mental Health Board's Local Payer Initiative. Mental health services are provided on-site at Community Health Improvement Center and on-site at the Macon County Health Department.

f. Macon County Child Advocacy Center - Case Management

The Macon County Child Advocacy Center seeks to decrease the trauma to child abuse victims often perpetuated by the investigative process. Case management services are used to help families regain maximum functioning, reduce long-term detrimental mental health effects and prevent substance abuse.

g. Macon County State's Attorney - Hidden Victims

This service offers individual and group counseling for any family member of a homicide victim.

h. Macon Resources, Inc. - Psychosocial Work

The psychosocial work program provides individualized services for mentally ill adults that require regular attendance and participation at an appropriate coping level for the individual. The program is aimed toward improving social adaptation and community integration of individuals by increasing recipient coping skills and targeted at the development of work-related skills and capabilities.

i. Macon Resources, Inc. - Supportive Employment

Macon Resources provides a peer job coach to train mentally ill individuals placed in community-based employment. The peer job coach provides job training, serves as a role model, utilizes positive reinforcement and encourages independence for the trainees.

j. Mental Health Association - Suicide Prevention

Comprehensive post-vention services that address school situations related to youth suicide and/or traumatic death are made available to schools in Macon County. Post-vention services include outreach-counseling services; intensive tracking procedures to identify and find suspected high-risk youth, support throughout the visitation and funeral services, and administrative consultation. Prevention education for youth, teachers and parents is also included.

k. Mental Health Association - Mental Health Council for Disaster Services

The Mental Health Association is responsible for coordination of the activities for Mental Health Council for Disaster Services (MHCDS). The MHCDS consists of representatives from a broad

spectrum social service and community organizations who are activated when an emergency is identified. Upon activation, the Council coordinates all mental health services to victims and emergency personnel impacted by the event.

l. Webster-Cantrell Hall - Adult Case Management

Case management services are designed to help eligible individuals handle aspects of their lives that may or may not necessarily be related to substance abuse but might impact whether the eligible individual remains in treatment, has successful treatment outcomes or maintains successful treatment outcomes. These services provide assessment, planning, coordination, monitoring and evaluation of options and resources to meet an individual's specific needs.

m. Webster-Cantrell Hall - Youth Services (Medicaid Mental Health Services)

Services are coordinated for eligible children and adolescents diagnosed with a mental disorder while indicating difficulty functioning within their family home and/or community setting. These services, as defined by DHS/DMH Rule 132, Medicaid Mental Health Services, include comprehensive case management and counseling. Related activities include assessments, development and implementation of individual and family Rehabilitation Service Plans, referrals to other needed services, assertive case management activities, ongoing therapy and 24-hour emergency response. Services are

n. Youth Advocate - Youth Services (Medicaid Mental Health Services)

Services are coordinated for eligible youth (and their families) with emotional and behavioral disorders. These services, as defined by DHS/DMH Rule 132, Medicaid Mental Health Services, include client centered consultation, Case Management, Mental health Case Management, Crisis Intervention, Mental Health Assessment, Therapy / Counseling, Treatment plan development, review and modification, and Transition Linkage & Aftercare

o. Youth Advocate Program - Family Advocate

This is an intensive service in which a caseworker and two family advocates provide comprehensive support, counseling and advocacy services to families whose children (ages 0-13) have been identified by the Department of Children and Family Services (DCFS) as abused or neglected.

2. Services Related to Substance Abuse

a. Boys and Girls Club of Decatur - Little League Team

By participating on the Little League baseball team, youth enjoy a positive activity that provides an alternative to substance abuse. Youth between the ages of 7 and 16 shall form a baseball team that competes within the Decatur Park District. Parents are encouraged to assist with the team by helping in the dugout, keeping score and assisting with post-game activities. Social events such as cookouts or other outings serve as positive activities that parents and their children can participate in together.

b. Boys and Girls Club of Decatur - Smart Moves

"Smart Moves" are prevention services that provide alternatives to youth (primarily 7-13 years of age) to promote a drug-free lifestyle. The program distributes materials emphasizing substance abuse prevention. Group meetings, special events including field trips, overnight activities at the Boys and Girls Club, and tutoring for students needing help with schoolwork are all provided.

c. Heritage Behavioral Health Center, Inc. - Deferred Prosecution - Treatment

Working in cooperation with the Macon County State's Attorney, this program offers a second chance to first time offenders facing drug charges or drug-related offenses. It gives offenders a chance to recognize their culpability and to make a decision to participate in drug treatment and other interventions that will facilitate rehabilitation. Drug assessments, drug testing, pretreatment education and drug treatment are provided.

d. Heritage Behavioral Health Center, Inc. - Substance Abuse Treatment

Heritage provides an array of treatment services that includes admission and discharge assessments and level I and II individual and group counseling. These services are targeted towards those individuals previously unable to access these services because they do not have insurance and are ineligible for Medicaid or State DASA funds. These funds may also be used for eligible individuals if all State DASA funds are expended.

e. Macon County State's Attorney - Deferred Prosecution – Case Management

Working in cooperation with Heritage Behavioral Health Center, Inc., this program offers a second chance to first time offenders facing drug charges or drug-related offenses. The case manager provides a linkage between the State's Attorney's office and Heritage coordinates services and tracks each participant's progress through the program.

f. Macon United Methodist Church - Meridian Hawk Hangout

This service provides Meridian Middle School students with opportunity to complete homework assignments and receive academic assistance after regular school hours. It provides incentives for academic achievement and recognizes academic excellence with awards and fun activities for the students.

3. Services Related to the Combined Disabilities of Mental Illness and Substance Abuse

a. Boys and Girls Club – Modified Case Management

This service provides assistance to youth who may be at-risk for substance abuse or behavioral problems. These youth are provided intensive one-on-one case management.

b. Camelot Supportive Housing, Inc. - Residential Services

Camelot Supportive Housing opened this apartment building in February, 2010. Board funding assists with expenses related to the operation and support of 12 tenants in this building. All of the tenants have a mental illness and/or disability. The staff associated with this facility work to create a culture of support within the building by ensuring that residents are linked with services, provide organized assistance with daily living needs and engage in building-wide

activities to create a sense of community. Staff further maintain an awareness of resident risk and make appropriate referrals for health, mental illness, substance abuse, legal assistance, etc. Seven of the twelve individuals currently living in this apartment building were residents of Decatur Manor, the IMD (Institution for mental Disease), immediately prior to moving to Camelot Apartments. All seven of these individuals have successfully lived in this supportive environment for approximately two years.

c. Catholic Charities - Eldercare Services

Guardianship Referral Services address the need for guardianship or guardianship alternatives. Community agencies, families, or individuals make referrals to this service. Guardianship Referral Services staff conduct assessments on individuals and counsel families about the needs and appropriateness of guardianship. The needs of individuals are met through the coordination of the guardianship process or referrals to appropriate resources.

d. Catholic Charities - Elderly Guardianship

This program provides “guardianship of person” for indigent elderly individuals referred by Guardianship Referral Services (GRS) who are mentally ill and/or developmentally disabled. Catholic Charities assumes legal responsibility for the care and safety of each referred individual. Upon death of the client, the agency facilitates burial planning.

e. Catholic Charities - Faith in Action (FIA)

Referrals for potential new care receivers come from families, concerned friends and neighbors, and various social service and health organizations that have cooperative working agreements with FIA. Service includes a thorough intake assessment, an explanation of FIA guidelines, and a needs assessment. The care receiver is encouraged to take an active part in identifying their unmet needs. A plan of care is then developed utilizing the Care Receiver Service Plan, and Environmental Safety Checklist. Yearly satisfaction surveys are conducted by mail or phone to ensure service goals are on target or need to be modified or discontinued.

f. Charles Street Supportive Housing, Inc. - Residential Services

Charles Street Supportive Housing opened in February, 2011. This funding is to assist with expenses related to the operations of the apartments. The apartment building is identical in design to Camelot Supportive Apartments. All of the tenants have a mental illness, physical and/or developmental disability. The staff associated with this facility work to create a culture of support within the building by ensuring that residents are linked with services, provide organized assistance with daily living needs and engage in building-wide activities to create a sense of community. Staff further maintain an awareness of resident risk and make appropriate referrals for health, mental illness, substance abuse, legal, etc.

g. Growing Strong Sexual Assault Center - Sexual Assault Counseling Supervision

Children and adolescents who are victims of sexual abuse most frequently have an immediate traumatic psychological reaction. The Illinois Coalition Against Sexual Assault and the Illinois

Criminal Justice Information Authority has determined that organizations providing these services must have a Master's level clinical professional to supervise other staff that work with this population. Board funds partially support this staff position.

h. Heritage Behavioral Health Center, Inc. - Crisis Stabilization Center

The Emergency Behavioral Services Center has 14 crisis residential beds located on-site at Heritage BHC. The Center, open 24 hours a day, provides a safe and therapeutic environment for those who are at risk of hospitalization due to an emotional or psychiatric crisis and for those individuals requiring sub-acute detoxification. The program also functions as a step-down setting for those individuals who are discharged from inpatient psychiatric settings but still require a brief period of stabilization prior to returning to their previous living environment.

i. Heritage Behavioral Health Center, Inc. - Law Enforcement Center Counseling

This service provides crisis intervention and follow-up counseling - as appropriate - to individuals in need who are, with or without prior mental health treatment history, inmates of the Macon County Jail. Services focus on suicide risk assessment and intervention to effectively reduce such risk, supportive counseling to facilitate adjustment to incarceration and goal-oriented counseling to reduce recidivism and foster reintegration into the community. Board funds provide for 2.0 FTE counseling staff positions.

j. Heritage Behavioral Health Center - Title XX – OASIS Services*

This Title XX grant from the Illinois Department of Human Services' Division of Mental Health, with matching dollars from the Mental Health Board provides funding for the Oasis drop-in center. Services include the integration of primary care and behavioral healthcare through nursing and case management services provided by CHIC on site at OASIS, development of peer mentoring services and the development of a peer advisory council whose members are drawn from current Oasis participants. Programming for these services is subcontracted to Heritage Behavioral Health Center. In addition the Oasis Center continues to provide much needed drop-in and outreach services for homeless individuals with a mental and/or substance abuse disorder.

k. Student Assistance Services - Various Settings in Macon County

Student assistance services are personal counseling services designed to provide early intervention, brief counseling, and referral for student and/or family problems. Counseling is done in school to provide all students equal access to services and eliminate barriers to agency-based counseling caused by transportation problems, conflicting schedules, agency stigma, lengthy delays between the onset of problem and beginning of treatment, inconsistent follow-through and financial limitations. School settings in which student assistance services are available include Decatur District #61, Futures Unlimited, Argenta-Oreana, Maroa-Forsyth, Mt. Zion, Warrensburg-Latham, Meridian and Macon-Piatt.

l. Woodford Homes, Inc. - Residential Management

Woodford Homes, Inc. is a not-for-profit corporation founded in 1974, led by a seven member Board of Directors. The corporation contracts with the Macon County Mental Health Board for administrative support. Woodford Homes supplies the facilities (homes and apartment buildings) and subcontracts with provider agencies for building management and supervision. The purpose of this Board funding is to assist Woodford with the administrative and management services necessary to accomplish their mission of building, fostering, maintaining and operating quality, affordable housing for low income persons with a mental disorder and those with a mental or physical disability providing safe, affordable and quality homes for disabled individuals.

m. Youth Advocate Program - Crisis Housing

Youth Advocate has leased a home from Woodford Homes containing six beds for young people between eight and eighteen years of age who are experiencing a personal or family crisis. This house is a safe setting in which the child and or family situation can be moved away from crisis and directed toward resolution of individual or family problems. Youth Advocate staff is present at all times. Residents enrolled in school are transported to their respective schools. Those residents not enrolled in school are provided tutoring and home school activities during school hours. Other activities during non-school hours include life skills training, group and individual therapy and organized recreation. Residents are also assigned chores relate to cooking and cleaning.

n. Youth Advocate Program - Crisis Intervention (Title XX)

Crisis Intervention provides services to youth under 18 and their families who are experiencing a crisis as a result of a runaway youth, locked out youth or youth beyond control of their parents. Youth Advocate Program provides 24 hour, seven days a week, coverage for cases referred by local police departments and DCFS State Central Registry. The program diverts youth from the child-welfare, court/police system, addresses family issues with the purpose of reunification, protects the youth in assessing crisis situations and services provided, and initiates additional community services where ever necessary. Services are provided at the police department after the youth has been taken into limited custody. Assessment of the situation, interviews with the parents/guardian and youth, and short-term crisis counseling are done at this initial contact. Placement outside the home can be negotiated at this contact, providing parent/child agreement can't be reached.

Community Health Improvement Clinic

The Community Health Improvement Center (CHIC) is a federally qualified health center that provides Primary outpatient medical care to Macon and its surrounding counties. CHIC will serve as the Medical Home for enrollees in care coordination. CHIC has offered to make office space available at reasonable rent cost for Care Coordination service operation and has pledged open access to the

Chief Operating Officer and Chief Financial Officer. CHIC advises that the following services will be made available to enrollees in care coordination:

1. Primary care (outpatient healthcare for children and adults).

   CHIC currently has CHIC currently has two primary care physicians (Dr. Dana Ray -Family Practice and Dr. Michael Bell - Family Practice), one Physician's Assistant (Ayaz Ahamed - Adult Practice - Adult Practice) and three Family Nurse Practitioners (Debra Oestreich; Jessica Sullivan and Amanda Shills). Aside from the two (2) one evening per week "free clinics" in Champaign there are no other organizations or private providers in the community or the area who provide health care services to the uninsured either free or on a sliding scale basis. The CHIC Board of Directors recently approved planning to place medical services at Heritage Behavioral Health Center. CHIC provides primary care services five days per week, four evenings per week and makes physician services available after hours via on-call service.
2. Pediatric Primary Care on-site at the Macon County Health Dept.
3. Mental/Behavioral Health Counseling

   CHIC, working collaboratively with the Macon County Mental Health Board and Heritage Behavioral Health Center, added .8 FTE counseling services in the main CHIC clinic site in Decatur. In an effort to decrease inappropriate utilization of Emergency Department services in Macon County, all patients utilizing this care were contacted and interviewed as to the reason why they did so and what barriers, if any, they experienced in accessing care at the Center. As a result the ability to obtain same day or early evening appointments is now highlighted in the reception area. There has also been significant improvement in depression screening compliance, as staff and provider education regarding the need to assess for depression in the mothers of children less than 1 year of age was completed.
4. HIV/AIDS Confidential Testing
5. Preventative Health Screenings
6. Dietician Services
7. Diabetic Eye Exams For Uninsured Patients (off site)
8. Dental Services by referral for pediatric patients and adults (emergency care only)
9. The Macon County Health Department Dental Clinic provides dental care to both children and adults who are Macon county residents and are currently on the medical card for the state of Illinois. The Health Department also partners with various civic organizations that will sometimes pay for emergency dental procedures in special circumstances. In addition, Community Health Improvement Center opened a dental clinic at its Champaign site in October 2011. This service capacity is open to Champaign and Macon County residents. Data from October through December, 2011 indicated: 395 users and 766 recorded encounters. The Clinic is staffed with 1 FTE Dentist and .8 FTE hygienists.
10. Laboratory Services

Decatur Memorial Hospital

Decatur Memorial Hospital, a not-for-profit organization, is a multi-facility medical complex with 30 satellite offices offering the latest in healthcare diagnostic and treatment modalities Decatur Memorial Hospital is a licensed and fully accredited 280-bed facility, employs approximately 2500 staff and offers a wide range of general and specialized diagnostic, surgical and treatment services. In 2011, DMH was named one of the nation's 100 Top Hospitals by Thomson Reuters. DMH offers a full range of comprehensive acute inpatient, surgical and outpatient, care including specialized centers of excellence such as the Cancer Care Institute, the Heart and Lung Institute, the ENTA Allergy, Head and Neck Institute, the Family Birth Center, the Women's Health and Breast Center, the Clinical Research Center. With almost 300 physicians representing a large variety of medical and surgical professions, DMH's care extends throughout Macon County and into neighboring Dewitt and Moultrie counties.

Decatur Memorial Hospital is licensed by the State of Illinois Department of Public Health. It is also licensed by the Nuclear Regulatory Commission to perform radioactive medical procedures. DMH is affiliated with the University of Illinois College of Medicine's School of Basic Medical Science and Clinical Medicine and with Southern Illinois University School of Medicine's Family Practice Residency Program. DMH is a member of the American Hospital Association, the Illinois Hospital & Health Care Association, Voluntary Hospitals of America, Inc. and VHA Mid-America. DMH Nursing Care Administration is affiliated with Millikin University's School of Nursing, Richland Community College, Parkland College, Decatur School District #61 Vocational Center, LakeLand College School of Nursing and Illinois Wesleyan University School of Nursing. The Nurse Anesthetist Program is accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools.

The DMH Cancer Care Institute is accredited by the American College of Surgeons Commission on Cancer and affiliated with the Association of Community Cancer Centers. DMH Oncology Research is an approved Community Clinical Oncology Program (CCOP) funded by the National Cancer Institute. DMH Center for Screening Mammography is accredited by the American College of Radiology and approved by the Federal Food & Drug Administration. DMH Radiation Therapy department is accredited by the American Board of Radiology and the American College of Radiology; the department is accredited in physics by the American Board of Radiology and in dosimetry by the American Association of Medical Dosimetrists. The Radiation Therapy department is affiliated with Southern Illinois University-Carbondale, which is approved by the Joint Review Committee on Education in Radiologic Technology and the Committee on Allied Health.

Specialized services include: the Arthur Medical Center, Births at DMH, the Bone and Joint Center, the Brain & Stroke Center, the Breast Center, the Cancer Care Institute, Carelink - Personal Emergency Response, the Center for Minimally Invasive Surgery, the Center for Sight, the Central Illinois Orthopedic Center, the Central Illinois Surgery Center of DMH, Chaplaincy Services, the Clinic at Wal-Mart, Corporate Health, Dialysis Inpatient Services, the Emergency Care Center, ENTA Allergy, Head &

Neck Institute, Express Care, the Family Birth Center, the Family Lodge, the Forsyth Imaging Center, the Forsyth Professional Center, the Heart & Lung Institute, Home Health Services, Hospice, the Kenwood Medical Center, Medical Equipment, the Medical Home Program, the Millennium Pain Center, the Nurse Anesthesia Program, Occupational Medicine, the Parish Nursing Program, Pastoral Services, Pharmacy Services, Psychological Services, Physical Therapy - Kenwood, Physical Therapy - East Gate, Physician Plaza Pharmacy, PrimeTime Services, Radiation Oncology, Radiology, Radiology, Interventional, Rehabilitation Services, Physical, Occupational & Speech Therapy, Senior Health and Wellness Center, SHORE, the Sleep Center, South Shores Imaging Center, South Shores Medical Center, the Spirit of Women Program, Sports Enhancement Center/Physical Therapy, Sports Medicine/Physical Therapy, the Sullivan Medical Center, the Thyroid Surgical Institute, the Vascular Center, Volunteer Services, Wal-Mart Clinics, the Wellness Center, and the Women's Health & Breast Center

In addition, for this care coordination effort, Decatur Memorial Hospital's Home Health program has agreed to expand post hospitalization transition services for Medicaid eligible Seniors without cost.

St. Mary's Hospital

St. Mary's offers a full range of patient services from birth to wellness to end-of-life care. Primary services include comprehensive inpatient medical/surgical, obstetric (Level II Nurseries), cardiology, neurology, sleep, behavioral health, orthopedic, pediatric, intensive care, skilled care and the Advanced Rehabilitation Center for intensive rehabilitation following brain injury or trauma. Outpatient services include extensive diagnostic and therapeutic care, ambulatory surgery, radiation oncology, emergency services and outpatient Behavioral Health and Substance Abuse services. Additional community services include an internal medicine physician network, extensive health screenings and community education programs. Specific services offered through the hospital include:

- Behavioral Health:

  The Behavioral Health Service is a recovery-based program that offers acute inpatient services including assessment, stabilization and referral to community resources. Inpatient behavioral health care is offered for seniors, adults, adolescents and children dealing with psychiatric conditions and concerns such as: anxiety disorders; attention deficit (hyperactivity) disorder (ADD/ADHD); mood disorders including major depression and bipolar disorder; emotional and behavioral disturbances; dementia; family/relationship counseling; medical detoxification; and, psychotic disorders, such as schizophrenia

- Cancer Care

  The Cancer Care Center provides not just medical care but also supportive services like massage therapy and spiritual care. Services include radiation as well as chemotherapy treatment, including treatment of almost any type of cancer regardless of diagnosis or stage; TomoTherapy Hi-Art radiation treatment, offering high level of accuracy and minimal side effects typically

associated with previous radiation therapy methods. The Center is led by specialists from The Cancer Care Specialists of Central Illinois. The Center also offers unique support services, like Mind-body Massage Program, individualized dietary consultations and spiritual care, and direction to local support groups.

Prairie Cardiovascular

- Prairie Heart Institute of Illinois

  The Prairie Heart Institute provides the full spectrum of Prairie cardiovascular care, including a cardiac catheterization lab, interventional cardiology procedures, electrophysiology procedures, a vascular lab where diagnostic and interventional procedures are performed in the same room, cardiovascular rehabilitation. All services are offered through a cardiac care team
- Community Health Education

  St. Mary's offers community health education opportunities such as health fairs, screenings, and presentations by healthcare professionals.
- Laboratory Services

  The St. Mary's Hospital laboratory is accredited by the College of American Pathologists and the Joint Commission for Accreditation of Healthcare Organizations. The laboratory is associated with Mayo Medical Laboratories and St. John's Hospital.
- Lifeline

  St. Mary's Hospital Lifeline Response System is a service that offers elderly, disabled, or medically fragile persons access to medical services, 24 hours per day. Subscribers wear a lightweight, waterproof button, which links to a communicator.
- Maternal Care
- Neuro-Ortho

  St. Mary's Neurology and Orthopedic Medicine include neurosurgery, orthopedics and podiatry, Shoreline Joint Center and Pain Medicine Center.
- Occupational Health and Wellness

  St. Mary's Occupational Health & Wellness offers health care for workers of Central Illinois.
- Pain Medicine Center

  The Pain Medicine Center of Central Illinois provides services for debilitating pain.
- Radiology

  Radiology services at St. Mary's include; Bone Density Scanning, Computed Tomography (or CT), Digital Mammography, Interventional Radiology, Magnetic Resonance Imaging (or MRI), Nuclear Medicine, Ultrasound and X-ray/Fluoroscopy. St. Mary's Hospital Mammography Departments, both on the Decatur campus and at the Field-Wright location in Sullivan, IL are accredited by the American College of Radiology (ACR). The Ultrasound department is also accredited by the ACR and by the Inter-societal Commission on Accreditation of Vascular

Laboratories for vascular examinations. The Nuclear Cardiology program is accredited with the Inter-societal Commission for the Accreditation of Nuclear Laboratories.

- Advanced Rehabilitation Center

  The Advanced Rehabilitation Center provides services for people suffering from severe arthritis, strokes, head or spinal cord injuries, major traumas, major joint replacements, severe burns, amputations and severe fractures of the hip or leg. Patients are typically referred to the ARC by their physicians when their recovery plans includes at least two types of therapy (physical, occupational or speech) along with inpatient care for a medical issue. In addition, patients must be healthy enough to participate in three hours of therapy a day. The ARC is accredited by CARF, the Commission on Accreditation for Rehabilitation Facilities
- Shoreline Joint Center

  Shoreline Joint Center provides patient education about the treatment process, services from orthopedic specialists and orthopedic nurses, a recovery program and Spiritual Care.
- Sleep Medicine Center

  The Sleep Center provides diagnosis of a patient's sleep disorders and provides treatment options. The Sleep Medicine Center recently received a 5-year accreditation from the American Academy of Sleep Medicine (AASM). Staff are board certified physicians and registered polysomnographic technologists.
- Spiritual Care and Mission Integration

  St. Mary's Hospital was founded over 130 years ago, as part of The Hospital Sisters Health System. St. Mary’s is Decatur’s only faith-based hospital, with professionally-trained chaplains available 24 hours per day. Also available are the SHARE Support Group, offered to support parents who have experienced the death of a baby during pregnancy, at birth or in early infancy and a Hospital Chapel, where Mass is offered.
- Stroke Care

  St. Mary's is a Joint Commission-designated advanced Primary Stroke Center, St. Mary's offers 24 hour care, collaborative case and CT Scan imaging review, interventional and surgical care, Dietician consultation, Neuropsychology and Family and spiritual counseling, if requested. The Stroke Center is coupled with the Advanced Rehabilitation Center. A monthly Stroke Support Group is also offered.
- Surgery

  St. Mary’s offer minimally invasive surgery in a broad range of surgical specialty and support services after surgery.
- Urology

  Lakeshore Urology specializes in the diagnosis and treatment of all male urinary, genital and reproductive conditions as well as all urinary diseases among females.
- Vascular

The St. Mary's Vascular Lab provides basic angiography procedures and necessary interventional procedures in the same room.

Heritage Behavioral Health Center

Heritage is the community's behavioral health treatment center. Established in 1955, it is a Medicaid certified mental health and substance abuse treatment center. Its services address three broad areas:

1. Prevention – This set of services provides education and support aimed at empowering individuals of all ages, families, neighborhoods, churches and other organizations to develop and sustain a drug-free lifestyle. Heritage's Prevention Service Team provides services to youth who may be at risk of experiencing the adverse impact of alcohol, tobacco, or other drug use who resides in Macon County. Additionally, selected neighborhoods and schools in Decatur have been targeted for special concentrated activities. The Prevention team uses evidence based curricula including: "Creating Lasting Family Connections", "All Stars", "Project Northland" and "Why Try?". One to one consultation and education is provided as well as to groups. Prevention staff may refer youth and families to Mental Health and Substance Abuse Treatment Services when appropriate
2. Addiction Services

   Clients have opportunities to participate in a wide variety of services oriented toward minimizing the impairments of their mental illness, chemical dependency, and/or emotional disturbance and optimizing their recovery efforts including but not limited to the following: counseling and therapy services; skill-building; self-management of behavioral symptoms and medication; independent community living; inter-personal relations and social-skills; relapse prevention; and motivation toward recovery. Programs offered include the following:

   a. Crisis Stabilization/Detoxification Services: These services provide short-term individual and/or group counseling to help clients develop more effective coping skills in dealing with mental/emotional issues with the long term goal of decreasing their need for future behavioral health services. Crisis Stabilization offers a 24-hour safe, therapeutic environment for those who are in a serious emotional, psychiatric or substance abuse crisis with the intent of preventing placement in a more intensive level of care and/or by assisting clients in stepping down from a more intensive level of care who may not be quite ready to return to their own home. Detoxification services assist addicted clients to safely withdrawal from alcohol and other drugs and to assist individuals in regaining stability and prepare for ongoing treatment. In addition to the administration of medications by licensed medical personnel for the treatment of mental disorders and/or detoxification, the program also offers individual and group counseling and supportive services to assist in the stabilization process.

b. Substance Abuse Level I/Outpatient Services: The target population for this service includes adults who meet ASAM PPC-2R criteria for Level I Outpatient Treatment (up to 8 hours of treatment per week). The purpose of this service is to assist those with addiction problems to become drug free and to become as successful and productive as possible in whatever role(s) they fill, i.e. parent, employee, significant other, etc. The program has an emphasis on the development/enhancement of life skills essential to the person's recovery while helping clients develop insight and knowledge about addiction and the effects it has on them, those they care about, and the society in which they live. Treatment consists of treatment planning, on-going assessment and treatment plan review, psycho-educational and therapy groups, individual counseling, and the development of an aftercare/continued recovery plan.

c. Substance Abuse Level II/Outpatient Services: The purpose of this service is to assist those with addiction problems to become drug free and to become as successful and productive as possible in whatever role(s) they fill, i.e. parent, employee, significant other, etc. The program has an emphasis on the development/enhancement of life skills essential to the person's recovery while helping clients develop insight and knowledge about addiction and the effects it has on them, those they care about, and the society in which they live. Treatment consists of treatment planning, on-going assessment and treatment plan review, psycho-educational and therapy groups, individual counseling, and the development of an aftercare/continued recovery plan.

d. Substance abuse level III Residential Treatment Services: The target population for this services includes adults 18 years or older who meet ASAM PPC 2-R criteria for this level of care who require a 24 hour supervised and supportive environment to continue the addiction recovery process. This level of care is intended to help addicts with drug and/or alcohol dependence to regain the emotional and functional stability which has been lost as a result of their addiction and to prepare them for outpatient (level I and II) services by developing and enhancing basic life skills as well as substance refusal skills. The program provides a 24 hour structured therapeutic environment for consumers at the greatest risk of relapse if they do not continue the treatment process within a 24 hour supervised environment. A minimum of 25 hours of treatment (a combination of individual and group counseling) is required per week. The predominant form of treatment is group counseling with limited individual counseling; treatment planning; ongoing assessment and treatment plan review; aftercare/continued recovery plan development planning, and discharge planning when appropriate.

e. Adolescent Substance Abuse/Outpatient Services: The target population for this service includes adolescents aged 12-17 years old who meet diagnostic criteria for ASAM PPC-2R Level I of outpatient care. Eighteen to twenty year olds may be admitted to the

program if the developmental assessment indicates adolescent treatment is more appropriate. Eleven year olds may be admitted with permission of DASA on a case-to-case basis. Clients can receive services for a period of 3 months without parental consent or notification. The purpose of this service is to assess, identify and treat adolescents with serious or emerging substance abuse problems. Beginning with a thorough bio-psychosocial assessment the program provides individualized intervention services including: assessment, treatment planning, group and individual therapy, family counseling, anger management/aggression reduction and didactic (i.e. education and life skills) groups and case management. The goal is to help clients eliminate drug-using behaviors and develop the necessary supports to maintain a drug-free life style. Services include assessment, individualized treatment planning, group and individual therapy, family counseling, and case management.

f. Methadone Maintenance Services: The target population for this service is adults addicted to opiates. The purpose of this service is to assist the client in achieving abstinence from opioid addiction, increase personal independence, restore functioning and maximize integration into the community. Services include Opioid Maintenance Therapy (OMT) which uses Methadone provided in a clinic setting by nursing and medical staff to reduce and/or eliminate symptoms of opiate withdrawal. Individual and Group Counseling is provided to support the recovery and well-being, and enhance the quality of life of the persons and families served. Therapeutic services focus on the development of new meaning and purpose as individuals and families recover from the problems and concerns associated with opiate addiction.

g. HIV Services Target Population: All clients receiving substance treatment services at Heritage. Purpose/Goal: To provide counseling and education to decrease clients' risk of contracting and spreading HIV. Services/Modalities: Individual counseling and education are provided to help clients identify their high risk behaviors which may lead to HIV infection and how to protect themselves. When appropriate, confidential HIV testing is provided.

3. Mental Health Services

Mental illnesses are diseases that can happen to anyone at any time. Based on the individualized treatment plan, individuals receive services, which are specifically designed to be innovative, aggressively client-centered and team-oriented. The continuum of Heritage services offers clients the opportunity to participate in a range of services, which will better meet their diverse personal recovery needs. Clients have opportunities to participate in a wide variety of services oriented toward minimizing the impairments of their mental illness, chemical dependency, and/or emotional disturbance and optimizing their recovery efforts including but not limited to the following: counseling and therapy services; skill-building; self-management of behavioral

symptoms and medication; independent community living; interpersonal relations and social-skills; relapse prevention; and motivation toward recovery.

a. Adult Outpatient service includes short-term individual and/or group counseling to help clients develop more effective coping skills in dealing with mental/emotional issues with the long term goal of decreasing their need for future behavioral health services. Additionally, the program provides crisis intervention services during regular business hours as well as screening and referral of persons for admission to the state regional psychiatric hospital (McFarland). The program's PAS Agent screens persons referred for long-term care placement.

b. Child & Adolescent Outpatient Service provides age specific assessment, individual, group and family treatment to reduce the emotional and/or behavioral difficulties experienced by youth, as well as strengthening identified deficits by providing therapy and case management services to clients and their families.

c. Screening Assessment & Support Services (SASS) provides screening and assessment of children to determine the need for psychiatric hospitalization and to deflect when appropriate; to provide ongoing monitoring of youth admitted to a state funded facility to ensure timely discharge planning, linkage, and aftercare; and to assure or provide appropriate mental health services to youth deflected from a state operated facility to sustain the youth in his/her home.

d. System of Care (S.O.C.) deflect DCFS wards or intact families from being placed in more restrictive settings and attempts to maintain them in their current placements whenever possible and to develop and identify strengths and then utilize them in the treatment process.

e. Psychiatric & Nursing Services provide assessment, evaluation, treatment planning, medication administration, training, education, and monitoring to consumers in all services at Heritage requiring psychiatric and nursing intervention. Services ensure that clients are receiving a full array of psychiatric, social and medical services appropriate to needs identified. Nursing Services are provided in a medication clinic where clients receive medications, daily medications administration, injections, medication monitoring and training, and assessment. Medical and nursing services are also provided around the clock in the Crisis/Detoxification/ Residential Rehabilitation Unit in the form of assessments on all newly admitted clients, medication administration, and close medical monitoring, observation, and on-going evaluation

f. Community Support Services provide linkage, coordination, support and advocacy to clients who have multiple service needs and attempt to strengthen clients' individual abilities to maintain stability in the least restrictive environment. Community Support Services include community linkage and referral, and assistance with crisis intervention

and stabilization. Services also include support, advocacy, and problem solving resolution. These services assist clients in maintaining self-sufficiency, community living, and enhancement of social support networks to assist the client to maintain self-sufficiency as well as community living.

g. Individual Placement Services (IPS) provides individuals with a severe and persistent mental illness with the opportunity to seek and obtain gainful employment in spite of their mental illness through the use of the Evidence Based Supported Employment Model as developed by Drake University. The model strongly supports the tenants of the Recovery Model and the importance of clients accepting responsibility for the treatment of their illness, self-efficacy, as well as employment in a job they choose whether full or part-time regardless of staff perceptions as to their ability to maintain gainful employment. Employment Specialist services including: Vocational Engagement/Assessment, Job Finding Supports, Job Retention Supports, and Job Leaving/Termination Supports. Additionally, persons participating in this program will also receive Case Management and Community Support Services. Case Management services include community linkage and referral and assistance with crisis intervention and stabilization. Services also include support, advocacy, and problem solving resolution. These services assist clients in maintaining self-sufficiency, community living, and enhancement of social support networks.

h. Hospital Liaison The purpose of the Hospital Liaison is to serve as a resource to Heritage staff in the hospitalization process and assist as needed in facilitating psychiatric admissions and subsequent discharge for the individual. The goal of this service is to effect the shortest possible length of stay and to speed the return of the consumer to the community in the least restrictive setting possible.

j. Jail Liaison serves as a liaison between Heritage consumers confined in the jail and their assigned Heritage service provider to ensure continuity of care, both while the consumer is confined and upon discharge from the jail. The Jail Liaison also determines the mental health needs of Heritage clients and those referred by jail staff and ensures linkage to needed services for those who are not Heritage open clients. In addition, the Jail Liaison provides crisis intervention for inmates who are experiencing destabilizing emotional difficulties. Services include individual counseling and some group counseling (as determined by the liaison) to assist inmates with mental health problems adjust and function better within the jail setting; client centered consultation with Heritage staff as well as jail corrections and medical staff to coordinate the care of mentally ill consumers residing at the jail; coordination and discharge planning to ensure continuity of care for consumers/inmates being released from the jail.

k. Senior Support Services provide age specific mental health and substance abuse treatment services to senior citizens, age 62 or older, who have developed a late onset of emotional, behavioral, and/or substance use difficulties with the intent of helping them remain as productive and independent as possible. Services include age specific assessment, individual and group therapy, as well as case management services both in the office and in the community.

k. Drop –In Center: Oasis Day Center is designed to alleviate homelessness in Decatur and Macon County and to provide homeless individuals with an opportunity to meet their basic needs while linking them to services in the community. Oasis targets homeless adults as well as those who suffer from multiple diagnoses, such as substance abuse and mental illness. Oasis also provides linkage to social service agencies for clothing, food, emergency shelter, housing, mental health and/or addictions treatment, employment related services, educational opportunities, energy assistance, veterans services, medical/dental services.

l. Residential Services – Heritage offers several housing settings, including: Orchard Street Group Home, a ten-bed supervised residential setting; West Main Group Home, a supported living residence; an 18-unit Supportive Independent Living Complex, Heritage Grove; a 34-unit Supportive Independent Living Complex, Heritage Fields; and, Harbor Place, operated in partnership with Dove, Inc., a local social service organization.

Macon County Health Department

The Health Department provides the following services and will make them available to the Care Coordination target populations:

1. Dental Clinic – This clinic provides dental care to children who are Macon county residents and are currently Medicaid eligible. The Clinic partners with CHIC and various civic organizations for emergency dental services.
2. Emergency preparedness – This set of services includes family preparedness, and family disaster planning; livestock disaster preparedness; pet emergency preparedness; and, special needs preparedness.
3. Environmental Health Service: This set of services includes inspection services for Body Art, Food Safety, Septic systems, Tanning establishments, Wells, Childhood Lead Poisoning Investigations, Nuisance Inspections, Public Swimming Pool and Spa Inspections,
4. Starting point - Starting Point is the Aging and Disability Resource Center (ADRC) at the Macon County Health Department. This unit serves seniors and persons with physical disabilities in Macon County, helping residents stay in their homes living independently as long as possible. Services include:

a. Care-giver Advisory Service - the purpose of the program is to inform caregivers of available services, to assist caregivers in accessing services, to provide emotional support through individual counseling and support groups, and to provide training and education to assist caregivers in making decisions and solving problems relating to their caregiving roles. The Service includes, a Caregiver Support Group; Powerful Tools for Caregivers program, a six week course designed to provide caregivers with "tools" to care for themselves so they can better care for loved ones; "Take Charge of Your Health: Live Well, Be Well" classes, a program to teach people with chronic health conditions and their caregivers skills to develop a healthier life style and manage symptoms of chronic illnesses; and, a bi-monthly newsletter for caregivers and a quarterly newsletter for kinship caregivers.
b. Choices For Care - This program offers consultations and assessments to provide information on in-home services for persons considering nursing home placement or discharge from a nursing home. Information Specialist offer free consultations to provide information, resources, and improved access to long term care support services to eligible clients. Anyone age 60 and older or over the age of 18 with a physical disability and their families are eligible for this program. Information provided includes: Housing options; In-home care services; Assistance with completing applications for Circuit Breaker, Medicaid, Low Income Subsidy; and, Assistance with Medicare Part D.
c. Community Care Program **-** Residents age 60 and older may qualify for CCP services based on eligibility determined by a care coordinator through a functional assessment and asset guidelines. Services include: Home Care Aide (personal care, laundry, housework, transportation, meal preparation, and/or supervision, as deemed appropriate and necessary); Emergency Home Response; Adult Day Care; Senior Companion
d. Money Management - This program offers money management services to help low-income senior citizens who have difficulty budgeting, paying routine bills, and keeping track of financial matters, promoting independent living for individuals who are at risk of losing independence due to inability to manage financial affairs.
e. Respite Care - This program provides services to relieve a caregiver when caring for a senior. Eligible clients must be age 60 and older, live in Macon County, and have a caregiver residing with them. Services provided under respite include: household help (laundry, housework, transportation, meal preparation, and/or supervision, as deemed appropriate and necessary); companion services; temporary nursing home stay; Adult Day Care; home health care
f. SHIP/Medicaid – This services include: Senior Health Insurance Program (SHIP)/Medicare, trained volunteer counselors who provide one-on-one counseling services on Medicare and other insurances issues to Medicare beneficiaries and their families; and, Take Charge of

Your Health: Live Well, Be Well, a self-management program that teaches participants to prevent and/or manage symptoms of chronic conditions. Classes are open to anyone with an interest in improving their own health, and especially geared toward those with chronic conditions and/or their caregiver(s).

5. Nursing Services – this set of service includes: foreign travel immunizations; Tuberculosis screening and referral; Sexually /transmitted Disease Clinic, with confidential testing and counseling; Communicable disease investigation; Medication management through home visits by registered nurses; and, an Immunization Clinic for children and adults.
6. Family Services – this set of services includes: screening for developmental assessment; pre and post-partum depression assessment; Family Case Management, supportive services for pregnant and parenting low income adults; Targeted Pre-Natal Case Management; Women, Infants, Children Special Supplemental Nutrition program
7. Lab Services – this includes a certified clinical laboratory services.
8. Health Promotion – the Office of Health Promotion and Public Relations promotes healthy lifestyle behaviors, addresses public health policy, manages several healthy living grants, provide information to the public in community outreach events and speaking engagements, and serve as a community resource for health issues and county health statistics. Other areas of concentration include product safety and recall.
9. Care Force One is Macon County's mobile health trailer, and is the only trailer of its type in the nation. Unlike other mobile units designed for a single purpose, Care Force One can be configured to accommodate school physicals, immunizations, health screenings, mental health assessments, finger printing, voter registration, and basic community information and resources.

3.2.1.7 What financial management mechanisms do you expect to have in place at the time of implementation to manage the CCE or MCCN including any subcontracting arrangement?

Financial and administrative management of care coordination functions will be provided by the Macon County Mental Health Board, in its role as the Lead organization for the Collaboration. The Mental Health Board, as a unit of local government, has extensive experience in financial and administrative management of contracts with the State, with local service providers and other entities. It is anticipated that financial management of Care Coordination will include budgeting, payroll and expenses management for care coordinators, vouchering for per-member/per-month care coordination, financial and program reporting requirements for the Department of Healthcare and Family Services. The Mental Health Board has well established procedures for budget development and management, accounting, vouchering, payment for services provided, accounts receivable and payable, payroll management, contracting and sub-contracting, contract management and financial,

service and program reporting. All financial operations of the Mental Health Board are subject to audit on an annual basis. All financial and administrative functions of the Mental Health Board are considered as public information and open for review upon request.

Subcontracts with the core collaborators of Macon County Care Coordination for work space, supplies equipment, etc. for care coordination staff to be located on site at core collaborator offices will be established upon contract award from DHFS. The board will also establish and manage any subcontracting arrangements with providers for service provision incentives.

Administrative functions will also include office functions, management of work space lease arrangements for care coordinators to be located with core collaborators, management of the web-based electronic health information system and management of care coordination functions.

3.2.1.8 Describe your plan for consumer input into the operations and management of the program.

Macon County Care Coordination will establish an Enrollee Advisory Council to serve in a formal advisory capacity to the Care Coordination program. Enrollees will be offered an opportunity to serve as members of an advisory group upon enrollment. Twelve individuals will be solicited from the ranks of Enrollees to serve on this Advisory Council. The Council will be staffed by the Care Coordination Director and will be introduced as a bi-monthly process in which the policies and operation of the care coordination program will be considered. These meetings will be scheduled as lunchtime meetings. Lunch and transportation assistance will be offered to Enrollee Advisory Council members. Frequency of advisory council meetings will be at the discretion of the Council, but at least quarterly.

In addition to the input from the advisory council process, Care Coordinators will be expected to encourage Enrollees to provide input on an ongoing basis for quality improvement and will be offered the opportunity through a formal annual survey process to provide feedback to the Care Coordination program on their satisfaction with services and recommendations for improvement in services.

3.2.1.9 Describe the experience of your collaborators in serving the needs and coordinating the care of the population you propose to serve.

Macon County Mental Health Board:

The Mental Health Board is a specialized unit of government charged with administering the county mental health tax levy. The Board purchases mental health, substance abuse and developmental disabilities services which are made available to Macon County citizens. Additionally, the Board serves a planning function in which community needs are assessed. Finally, the Board administers State and Federal funds and has a contract with the State to manage a children's early intervention program.

The Board annually administers local tax dollars and state and federal contracts of approximately $4 million. The Board contracts with 22 local agencies for the provision of services to youth, adults and seniors across the disability groups of developmental disabilities, mental illness and substance abuse. The Board's staff has been involved in multiple collaborative efforts over the Board's 40 plus year history, providing the seed funding for new programs, supporting existing programs, designing and re-designing programs to create a network of care and to further integrate services locally. The Board served as the impetus for developing a care coordination program.

The Board also provides financial support and staffing for care management for approximately 100 individuals who live in seven supportive housing and group home settings in Macon County. The Board created Woodford Homes, Inc. (Woodford Homes) in 1975 to serve as a provider of supported homes for disabled individuals. Supported living, as a concept, permits the disabled adult to live independently in their own home rather than in an institutional environment. Support may include independent living skills building, medication management assistance, coordination of services, illness self-management, identification and use of natural supports, and use of community resources. Woodford Homes has successfully provided these services to disabled individuals for over 37 years. In 2009, the board created two additional not-for-profit entities to hold two 12-unit supported apartment buildings, had the buildings constructed and provided housing for an additional 24 individuals with mental and/or physical disabilities. Eight of these were individuals who had previously lived in Decatur Manor, the community's Institution for Mental Disease.

Community Health Improvement Center:

The Community Health Improvement Center (CHIC) is a federally qualified health center that provides primary outpatient medical care to Macon and its surrounding counties. CHIC has served as primary care provider for individuals with serious mental illness and seniors with chronic illness since its inception in 1972. CHIC initiated outpatient mental health counseling services in the early 1990's and has maintained a full-time or near-full-time staff counselor position since that time. A licensed Master's Degree social worker currently holds this position and maintains a full case load. CHIC established a strategic partnership with the Heritage Behavioral Health Center approximately five years ago which has led to the advanced development of an integrated primary and behavioral health service offering. Heritage Behavioral Health Center counseling staff maintain and office and a caseload at the CHIC main clinic building, accepting referrals directly from CHIC primary care providers. CHIC provides primary care services on-site at two Heritage Behavioral Health Center settings – the Heritage main clinic office and the Heritage drop-in center for homeless and seriously mentally ill individuals. CHIC's chief executive officer has served as a professional trainer on topics related to successful

integration of primary and behavioral health services for audiences of mental health center executive directors. CHIC's primary care providers are actively involved in service delivery and program planning for services to seriously mentally ill persons.

CHIC is also a long standing member of the Decatur Health Coalition which includes, as member agencies, St. Mary's Hospital, Decatur Memorial Hospital, Decatur Community Partnership, Decatur Weed & Seed and the Macon County Health Department. In addition, CHIC is actively involved in the local United Way-sponsored Human Service Agency Consortium and has worked closely with other human service agencies in the community for coordination of care for pediatric to geriatric patient care.

Decatur Memorial Hospital:

Decatur Memorial Hospital's Home Health Service provides a Care Transitions program based on the Coleman Care Transitions Model, providing Coaching and medication reconciliation to over 200 patients at a time. Staff are able to access Clinical Documentation systems from the hospital and many of the physicians' offices allowing ability to coordinate post hospital care. Staff are trained in motivational interviewing techniques. Nurses completing Medication reconciliation have training in this area as well. Evidenced based tools such as 8P's assessment tool are being utilized to determine greatest risk for re-hospitalization and assisting in identifying patients who need post-hospital services. In addition the Hospital's Emergency Department has frequent encounters with individuals with serious mental illness and seniors with chronic illnesses.

Heritage Behavioral Health Center:

Heritage Behavioral Health Center, Inc. traces its origin back to March 1, 1956, then known as the Mental Health Clinic. In 1970, the Mental Health Clinic became the Decatur Mental Health Center and established an inter-locked relationship with the Alcoholism Advisory Council. In 1987, the Alcoholism Advisory Council was merged into Decatur Mental Health Center. The Center continued its steady growth and became the primary provider of community-based behavioral health care in Macon County. In 1998, Decatur Mental Health Center became Heritage Behavioral Health Center, Inc. Heritage currently provides comprehensive community-based services to treat the most serious behavioral disorders and links them closely with providers of inpatient care. The Center is a Medicaid-certified provider of mental health and substance abuse services. The Center provide services to over 4,000 people annually and also provides a wide variety of outreach, crisis intervention and prevention services based in our schools and in our community.

Macon County Health Department:

Macon County Health Department is an unit of county government with the mission of enhancing and ensuring quality of life for Macon County residents by offering evidenced based health, wellness and social service programs; encouraging treatment, education and linkage; promoting prevention; advancing independence, inclusion and sensitivity to individual differences; and, providing advocacy and collaboration for community resources. Service areas include Nursing, Dental, Environmental Health, Senior Services/Starting Point, Health promotion, Laboratory services and Emergency Response. "Starting Point" is the Aging and Disability Resource Center (ADRC) in Macon County. It is designed to provide information, referral, and assistance to individuals over the age of 60 and those that are under 60 with a disability and/or their caregivers. Starting Point is a Care Coordination Unit for the Illinois Department on Aging. Since 1996, Starting Point has coordinated services for seniors through a care coordination assessment and care planning process. Assessment helps determine the needs of the senior. Care Coordinators are then able to give options to the clients to choose from which would enable them to remain safely in their homes. These service coordinated are offered by a network of providers for homecare, adult day service, emergency home response service, senior companion, home health, churches, energy assistance, senior center, center for independent living, Department of Rehabilitative Services, medication management, money management, caregiver, and grandparents raising grandchildren. Starting Point assists in transition from hospital to home or nursing facility to home by providing this assessment prior to discharge so services can be arranged and ready when the senior returns home. Starting point also provides on-going follow up with all clients to ensure the services continue to be appropriate and coordinates other services when needed.

St. Mary's Hospital

St. Mary's Hospital is a not-for profit healthcare facility located in Macon County. The Sisters of St. Francis established St. Mary's in 1878, and moved the hospital to its current location on 21 acres overlooking Lake Decatur in 1961. St. Mary's Hospital is part of Hospital Sisters Health System (HSHS), an "AA" bond rated system compromised of thirteen hospitals, eight in Illinois and five in Wisconsin. The primary mission of HSHS is to provide the means whereby the Hospital Sisters of St. Francis continue the healing mission of the Roman Catholic Church. Today, St. Mary's is recognized as a national leader in patient and associate satisfaction, providing care for a primary service area of 6 counties (Macon, Shelby, Moultrie, DeWitt, Christian, Piatt) and over 300,000 residents. St. Mary's prides itself on remaining community-based and governed by a volunteer Board of Directors. The Hospital provides inpatient psychiatric services, with specialized inpatient psychiatric service units for children, adolescents, adults and seniors. In addition, the Hospital operates an intensive care psychiatric unit.

3.2.1.10 Give the background of the key leaders of your collaboration, the role they will play, and the vision they bring to your Proposal.

Dennis Crowley Executive Director
Macon County Mental Health Board
132 S. Water Street
Decatur, Illinois 62523

Dennis Crowley is the Executive Director of the Macon County Mental Health Board and has served in that capacity for approximately 26 years. Mr. Crowley holds a master's degree in psychology and has pursued PhD studies at the University of Indiana. In addition to his Mental Health Board leadership role, Mr. Crowley serves as the Administrator for three not-for-profit housing corporations that provide supported residential living for over 100 mentally, physically and developmentally disabled individuals. He has also served as an Associate Professor in Psychology for Millikin University and has worked with the University of Illinois-Chicago in a visiting Senior Research Associate role. Mr. Crowley's vision for the care coordination proposal will focus on the seriously mentally ill, identification of needs and delivery of treatment and support that permits the individual to make sustained recovery from illness and improved independence, health and self-sufficiency.

Michael Bach, Associate Director
Macon County Mental Health Board
132 S. Water Street, Suite 604
Decatur, Illinois 62523

Michael Bach is the Associate Director for the Macon County Mental Health Board and will serve as the Director for Macon County Care Coordination. Mr. Bach holds a Master's degree in counseling psychology from and has pursued Ph.D. at the University of Illinois. He has 38 years of experience in the field of mental health administration and treatment in both in inpatient and outpatient treatment settings, experience in state-level policy positions and in state-level trade association activities. In addition, he has worked with the University of Illinois-Chicago in a visiting Senior Research Associate role. Mr. Bach' s vision for the care coordination proposal is for improved health and illness self-management for those patients involved with the program through improved collaboration, information sharing, coordination of treatment services/supports and fiscal efficiency in service delivery.

Barbara Dunn, C.E.O.
Community Health Improvement Center
2905 N. Main St.
Decatur, Illinois 62526

Barbara Dunn is the Chief Executive Officer of the Community Health Improvement Center, a position she has held for the past twenty nine years. Ms. Dunn's organization serves as the medical home for this proposal's target populations. She has been active with the Illinois Primary

Health Care Association, having served formerly as the Association's Board Chairwoman and currently as the Chairwomen for the Association's Legislative Public Policy Committee. Ms. Dunn is a graduate of St. Mary's College in Notre Dame, Indiana and has pursued graduate work at the University of Illinois, Springfield. In addition, Ms. Dunn has been very interested in the integration of primary and behavioral healthcare for over twenty years, having installed an MSW counselor position within the organization in the early 1990's, supported financially by the Macon County Mental Health Board. She has attended several of the annual conferences offered by the National Council of Community Behavioral Health Centers and together with Ms. Knaebe, C.E.O. for Heritage Behavioral Health Center, has made presentations and facilitated discussions on integration of behavioral health and primary care at the Community Behavioral Healthcare Association of Illinois, the National Council for Behavioral Healthcare, Mental Health Centers of America and the Illinois Association of Community Mental Health Boards as well as presenting individually to advocacy groups. Ms. Dunn's vision for the care coordination program is to enable patients of the center to receive better Quality services through the exchange of information between and among involved service providers and to increase patient satisfaction with services.

Tanya Andricks, Director, Home Health Services
Decatur Memorial Hospital
2300 N. Edward St.
Decatur, Illinois 62526

Ms. Andricks is the Administrator and Director for Decatur Memorial's Home Heath, Hospice and Durable Medical Equipment services. . She holds a Bachelor's degree in Nursing from Millikin University and is pursuing a Masters' degree in health administration. Ms. Andricks has been with Decatur Memorial Hospital for approximately 20 years, serving previously as an Emergency Department nurse and then as Director of Maternal Child Nursing. She has eleven years of experience as the administrator of home health and hospice service. HCECP Home Care Executive Certification Obtained 2007. She is also CSSGB (Certified Six Sigma Green Belt) trained in LEAN Six Sigma and serves as Pillar Champion for the Hospital's Organization Strategic Planning team, responsible for oversight of the Service Pillar of the organization wide strategic plan. Ms. Andricks' vision for care coordination is the provision of seamless care from patient's perspective, efficiency and reduction in duplication of services from the payors' perspective and improved quality in service provision from the provider's perspective. She views care coordination as a win-win-win approach.

Diana Knaebe, President and C.E.O
Heritage Behavioral Health Center
151 N. Main St.
Decatur, Illinois 62523

Diana Knaebe has served as Heritage's President/CEO since 2002. She started working at Heritage in 1993 as Vice President of Client Services. Ms. Knaebe received her Master of Social Work from Western Michigan University in 1986. As President/CEO she is responsible for the overall operation of the organization, the efficient and effective use of its financial and physical resources, the management and direction of its staff, and ensures compliance with applicable accreditation standards and federal, state, and local laws. Ms. Knaebe believes in creating a working environment that nurtures the growth and professionalism of its staff. She also espouses recovery and resiliency principles and belief in wellness that promote optimal well-being, living, learning and achievement, not only within the organization, but also with the larger community.

Julie Aubert, B.S., CPHA and Executive Director
Macon County Health Department
1221 E. Condit
Decatur, Illinois 62523

Ms. Aubert serves as the Executive Director for the Macon County Health Department and has served as a member of the health Department staff for 17 years. Ms. Aubert's organization serves as a core collaborator for this proposal. She is certified by the Public Health Practitioner Certification Board, Inc., is a Fellow of the Mid-America Regional Public Health Leadership Institute, a member and past Secretary of the Illinois Public Health Association (IPHA), the Chair of the Human Resources Management Committee, a member of the Illinois Association of Public Health Administrators (IAPHA), a Board member of Decatur Community Partnership, a member of National Association of County and City Health Officials (NACCHO) and a member of Illinois Aging and Disability Resource Center Council. In addition, she serves on the following Macon County-based committees: Juvenile Justice, Teen Pregnancy Coalition, IPHA Annual Conference Planning Committee, United Way Allocations Committees, Richland Community College Healthcare Workforce Development Committee, and Illinois Community Care. Ms. Aubert's vision for this project it to enhance and ensure care coordination and provide an improved environment for seamless transition from acute and/or institutionalized care to community based living, while encouraging treatment, providing education and linkage, promoting prevention and advancing independence.

Susan Shafter, Director of Behavioral Services
St. Mary's Hospital
1800 E. Lake Shore Drive
Decatur, Illinois 62521

St. Mary's key leader in this initiative will be Susan Shafter RN, BSN, and the Director of the Hospital's Behavioral Health. Ms. Shafter's inpatient programs serve as the behavioral health inpatient treatment programs for seriously mentally ill individuals. Susan has over 34 years' experience at St. Mary's and in the community. Susan is responsible for the administration,

direction, planning, implementation, facilitation, and evaluation of patient care provided in the behavioral service line at St. Mary's. The Behavioral Health Department has over 90 employees and 54 inpatient beds with programs for children, adolescents, adults and seniors. The Behavioral Health Department also provides outpatient services for adolescents, adults and adults with substance abuse problems. Susan has also been a key member of the Behavioral Health community in Macon County and Illinois serving on the IHA Behavioral Health Constituency Section Steering committee, Macon County Disaster Mental Health Committee, DHS regional advisory council and past board member of Growing Strong Sexual Assault Center. Ms. Shafter's vision for the care coordination effort is a better coordinated system of healthcare for Macon County residents.

3.2.2 Populations / Geography

3.2.2.1 *Which Priority Populations do you propose to serve?*

The priority populations Macon County Care Coordination desires to serve include Seniors and Adults with Disabilities (including long-term care populations and those with Serious Mental illness) and dual-eligible (Medicare and Medicaid) individuals and children and family members of adult enrollees. Care Coordination services will be targeted to residents of Macon County.

3.2.2.1.1 How many of each Priority Population do you propose to serve?

Year 1	700 individuals, including: 650 seriously mentally ill individuals 50 Seniors with chronic health conditions
Year 2	1,000 individuals, including: 950 seriously mentally ill individuals 50 Seniors with chronic health conditions
Year 3	1,200 individuals, including: 1,100 mentally ill individuals 100 Seniors with chronic health conditions

3.2.2.1.2 *Within the Priority Populations listed in this Solicitation are there particular subsets you intend to target? Please clearly define your Target Population.*

Within the Priority population of Adults with Disabilities, we propose to work with target populations as follows:

A. Adults with Serious Mental illness. Individuals with the following diagnoses will be considered for enrollment in care coordination: schizophrenia (295.xx), schizophreniform disorder (295.4), schizo-affective disorder (295.7), delusional disorder (297.1), shared psychotic disorder (297.3), brief psychotic disorder (298.8), psychotic disorder (298.9), bipolar disorders (296.0x, 296.4x, 296.5x, 296.6x, 296.7, 296.80, 296.89, 296.90, cyclothymic disorder (301.13), major depression (296.2x, 296.3x), obsessive compulsive disorder (300.30), anorexia nervosa (307.1), and bulimia nervosa (307.51) and including:
    1. those individuals with a serious mental illness and a co-occurring substance abuse problem, and

2. those individuals who have co-morbid chronic health conditions, including: anemia, cardiovascular disorders, central nervous system disorders, diabetes, HIV, hypothyroid and other hormonal disorders, obesity, osteoporosis, pulmonary disorders, renal disorders.
3. In addition to the serious mental illness, the co-occurring chronic health condition and/or substance abuse problem, this target population will have a history of medical and/or psychiatric hospitalizations and a history of excessive emergency room use.

B. Seniors, sixty five (65) years of age or older with chronic health conditions, including: coronary artery disease, chronic obstructive pulmonary disease, congestive heart failure, diabetes, hypertension, obesity, substance abuse, mental illness**,** gastro esophageal reflux disease (GERD).

C. Medicaid recipients who meet the above criteria and who are also Medicare eligible.

D. Children and family members of adult enrollees.

It is recognized that the following individuals are not eligible for enrollment:

1) Spend-down populations;

2) Children under age 19 who are not in the family of an adult enrolled in Macon County Care Coordination or;

3) Clients in the Illinois Breast and Cervical Cancer program;

4) Clients in Health Benefits for Workers with Disabilities; and

5) Clients enrolled in partial benefit plans.

3.2.2.2 *Do you propose to serve non-Priority Populations in your area? If so, which ones and how many do you propose to serve?*

We do not propose to serve non-Priority populations.

3.2.2.3 *Which geographical area(s) do you propose to serve?*

Our proposal will serve Macon County Illinois Medicaid recipients meeting the criteria of the target populations described above. Macon County has a population of 110,768, down 3.4% from 2000. The County seat, Decatur, has a population of 76,122, down 7% from 2000. While the Macon County community is considered as an urban area under U.S. Census classification, it is actually a rural environment with a mid-sized city located at its center. Population distribution by race is as follows: American Indian/Alaskan Native, 226 individuals (.2% of total); Asian/Pacific Islander, 1,150 individuals (1.0% of total); Black, 18,027 individuals (16.3% of total); Hispanic, 2,072 individuals

(1.9% of total); White, 87,855 individuals (79.3% of total); Other, 1,438 individuals (1.2% of total). The seniors' population in Macon County is 18,166. (2010 Census Data).

Medicaid claims data supplied by the Department of Healthcare and Family Services for calendar year 2010 indicates that there were 1547 individuals with serious mental illness and 1727 seniors (age 65 or over) in Macon County who are receiving Medicaid-covered services. The disabled population in Macon County is estimated to be 20, 319, or 18.3% of the County's total population. http://www.aaag.com/county/macon-county-il-population-demographics.htm).

3.2.2.4 *Do you plan to phase-in enrollment? Provide an estimated timetable (as part of Attachment H, below) for phasing in enrollment including when you expect to meet the minimum requirement for Priority Populations.*

We plan to phase in enrollment in care coordination. Please see Attachment H for the estimated timetable for Enrollment Phase-In during Year 1 of the program. Incremental increases in enrollment will occur in Years 2 and 3 of the program as well.

3.2.2.5 *Provide a detailed draft implementation work plan as Attachment H, with an estimated timetable to begin enrollment no later than January 1, 2013, and include at least the following elements:*

3.2.2.5.1 *Projected dates for hiring staff, by position;*

3.2.2.5.2 *Projected dates for finalizing legal documents;*

3.2.2.5.3 *Projected dates of finalizing collaborator and network participation;*

3.2.2.5.4 *Projected dates (including important milestones) for implementation of electronic communication;*

3.2.2.5.5 *Projected dates of staff training;*

3.2.2.5.6 *Projected dates of development, Department approval, and public release of Marketing Materials;*

3.2.2.5.7 *Projected dates for opening enrollment to Priority Populations; and*

3.2.2.5.8 *Projected dates for opening enrollment to non-Priority Populations.*

Please see Attachment H for the proposed implementation plan, including the following categories of information.

3.2.3. Care Coordination Model

3.2.3.1 *Provide your definition and approach to care coordination, including your identification of any deficiencies in the health care market specific to your proposed population and geographical area and how your model will help overcome these deficiencies.*

Care coordination is a patient-centered approach to healthcare in which care provided to an identified population is coordinated across the spectrum of the healthcare system, focusing on improved health outcomes, enhanced patient access, patient safety and patient overall wellness. Care coordination includes the provision of or arrangement for a majority of care around the individual's needs, including a medical home with a primary care provider, clinic-based services, inpatient and outpatient services, mental health and substance abuse treatment services, diagnostic services, access to specialist services, rehabilitation services and long-term services and supports.

Care coordination target populations are individuals at high risk for poor health outcomes. Its functional orientation is on problem-solving. The context of care is bio-psycho-social rather than exclusively medical. It seeks to facilitate access to needed service for enrollees. Service access includes both covered (Medicaid, Medicare) and non-covered services. The nature of care coordination is to promote coordination and communication of social support and medical service across different organizations and providers. *Care Coordination and Medicaid Managed Care: Emerging Issues for States and Managed Care Organizations, June 2000. Margo Rosenbach and Cheryl Young.*

Coordination of care places special emphasis on managing the individual's transition(s) between levels of care and coordination between and among physical and mental health and substance abuse service providers. Care coordination engages the community's healthcare partners in promoting coordinated quality care across provider and community settings and provides for measurement of the delivery system's effectiveness and efficiency. Care coordination is interdisciplinary and includes relationship development, advocacy, outreach, socialization, service planning, resource coordination, problem solving, referral and linkage, evaluation and record keeping. It includes direct and personal contact with the enrolled individual. It includes oversight of a personal care program. *A Guide for Housing Authorities and Their Collaborators Co-published by the Milbank Memorial Fund and the Council of Large Public Housing Authorities, September 2006)*

The Macon County model of care coordination will emphasize reaching and care coordinating those complex enrollees at highest risk for poor health outcomes, in order to make greater strides in controlling costs and improving the quality of care and quality of life enrollees will experience.

The model will operate from the perspective of a patient-centered medical home, considering the major providers and organizations with which a patent/client's medical home must interact -medical specialists, mental health and substance abuse providers, community service agencies, and hospital and emergency facilities. Full activation of the model will include assuming shared accountability for the

enrollee's overall health care, providing patient/client support, building relationships and agreements among providers that lead to shared expectations for communication and care, and developing connectivity via electronic and other information pathways that will encourage timely and effective information flow between and among providers. Improving Chronic Illness Care, The MacColl Center for Health Care Innovation http://www.improvingchroniccare.org/index.php?p=Care_Coordination_Model&s=353.

Macon County's healthcare system faces challenges that are similar to the challenges faced by other communities' healthcare systems. We have weakness in our ability to proactively monitor the health conditions of our patients/clients. We have limited access to primary care providers for urgent care, with the hospital emergency departments serving in a default position for urgent care provision. We have experienced poor coordination among providers at times. We have also permitted discontinuity of service for patients/clients as they transition from one service to another. We have provided less than adequate guidance to our patients/clients for their illness self-management. We have, at times, provided unwanted care and less than needed support for families and care givers. *Managing High Risk Patients in ACOs, Chad Boult, MD, MPH, MBA., Professor, johns Hopkins University, 2012.*

In proposing a model of care coordination, we are striving to address these deficits and pursue the further development of our health care delivery system, focusing on the following goals:

- Information Continuity - the patients'/clients' clinically relevant information is available to all providers at the point of care and to patients through secure but accessible electronic health information medium.
- Care Coordination and Transitions - Patient/client care is coordinated among multiple providers, and transitions across care settings are actively managed.
- System Accountability - There is clear accountability for the total care of patients/clients.
- Peer Review and Teamwork for High-Value Care - Providers both within and across settings have accountability to each other, review each other's work, and collaborate to reliably deliver high-quality, high-value care.
- Easy Access to Appropriate Care - Patients/clients have easy access to appropriate care and information at all hours, there are multiple points of entry to the system, and providers are responsive to patients'/clients' needs.

Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives, Douglas McCarthy, Kimberly Mueller, and, Jennifer Wrenn Issues Research, Inc.

The development of this model has opened a broader understanding between and among the core collaborators, has initiated discussion about sharing of health information and has accented the need for closer collaboration in treatment planning and service delivery. The model, as planned, will bring the development of a centralized electronic information exchange vehicle for Enrollee healthcare information where care coordinators and providers of service can place treatment information accessible to all involved service providers and the enrollee. Care Coordinators will also have the ability, under this model, to access health information as a user of each of the two community's hospital information systems (Please see Section 3.2.4, Health Information Technology). Care Coordination will provide the opportunity

to share communication across treatment settings, will enhance capability to problem solve those situations in which service access is difficult for the enrollee and will offer the extra support that an enrollee may need to continue in the development of self-management of his/her illness.

The Macon County healthcare system enjoys an advantage that other communities may not have. The geography and population of the community require that we rely on each other as service providers. We are in a rural county with an urban population concentrated at the center of the County, the city of Decatur. About 80% of the population is concentrated in the city and almost all service providers are located there. As a community, we are approximately 50 miles away from other major service providers. Healthcare providers in the community recognize the need to communicate, collaborate and integrate services and operations. The core collaborators in this care coordination effort share a common mission of caring for underserved and vulnerable populations.

The Macon County Mental Health Board (the Board) will serve as the lead entity for this collaborative. The Board also serves as a funder of services and has existing contracts with over twenty local providers for mental health, substance abuse, developmental disabilities and specialized senior services. The Board has the ability to and has, historically, shaped these contracts to address gaps in care, incentivize collaboration and promote access to care and integration of services. For example, the Board has financially supported and encouraged the integration of medical and behavioral health care through contractual agreements with Community Health Improvement Center - the federally qualified health center, Heritage Behavioral Health Center - the community's mental health and substance abuse provider and the Macon County Health Department. The Board also provided financial supported for the integration of mental health treatment in the federally qualified health center, beginning in the early 1990's.

The core collaborating service providers in this care coordination project include both community hospitals, the federally qualified health center, the community mental health and substance abuse Medicaid treatment center and the community's Health Department. Each of these organizations is a key service provider for the target populations addressed through this care coordination proposal.

3.2.3.1.1 *If you are targeting Clients with SMI, please expressly indicate how your model design will meet the needs of that population and how it will interface with State-operated facilities.*

Macon County Care Coordination is targeting seriously mentally ill individuals. Heritage Behavioral Health Center, the community's Medicaid mental health and substance abuse service provider, St'. Mary's Hospital, provider of medical, psychiatric inpatient service and Emergency Department Services and Decatur Memorial Hospital, provider of medical inpatient and Emergency Department services, and Community Health Improvement Center, the community's federally qualified health center, primary care provider and Medical Home for this proposal, are core collaborators in this care coordination effort. Macon County Care Coordination has established written agreements with each of these organizations

for care coordination involvement, referral, and participation in Enrollee Care Plan development, treatment and information sharing.

Heritage has a wide array of services for mentally ill individuals, including: assessment; psychological evaluation; crisis outreach and residential services; case management services; supported and supervised residential services; psychotropic medication monitoring, administration and training; therapy/counseling and intensive outpatient services; community support individual, group and team services; client-centered consultation services; transition, linkage and aftercare services, including linkage for individuals discharged from the state hospital (McFarland Mental Health Center) and local psychiatric hospital units (St. Mary's Hospital adolescent, adult and geriatric psychiatric units). Heritage operates a large drop-in center near downtown Decatur for homeless and mentally ill individuals. Heritage also operates a health and wellness program for mentally ill individuals, supported through a federal demonstration program grant.

St Mary's Hospital operates three psychiatric inpatient units – for youth, adults and seniors. These psychiatric units work very closely with Heritage Behavioral Health Center and have a collaborative process for treatment planning, discharge, linkage and transition for patients. Heritage has an assigned hospital liaison for the St. Mary's Hospital psychiatric units.

Both St. Mary's and Decatur Memorial Hospital Emergency Departments work closely with Heritage. Crisis Intervention staff from Heritage are routinely dispatched the hospitals at the request of the two hospital Emergency Departments for assessment of patients/clients, referral and follow up care. This activity occurs on a 24 hour basis, 7 days a week. In addition, if a patient presents at either of the Emergency Departments and advises that he/she is a current client at Heritage, the assigned case manager or therapist, is dispatched, when possible, to the Emergency Department to assist the individual and the Emergency Department. Those patients who are admitted to inpatient psychiatric treatment at St. Mary's Hospital are referred to the Heritage hospital liaison staff that, together with the attending psychiatrist, meet with and work with the patient during the patient's stay on the unit, and assist in formulating a plan of care and discharge planning to the patient. On an as-needed basis, assigned case managers/therapists may go to the inpatient unit to assist inpatient staff with treatment.

The Care Coordination program has also solicited a Memorandum of Understanding with McFarland Mental Health Center, the regional state-operated mental hospital. The Care Coordination program has established a Memorandum of Understanding with Decatur Manor, the community's nursing facility specializing in intermediate care for mentally ill individuals. Some of their residents, class members of the Williams v. Quinn class action suit, are anticipated to be moving to locations in Decatur and Macon County in the coming years. Heritage Behavioral Health Center is in the process of contract discussion with the Department of Human Service's Division of Mental Health (DHS/DMH) to establish a Transition team to work with Decatur Manor residents as they are discharged from the IMD. The residents of Decatur Manor are included in Macon County Care Coordination's target population. The care coordination program anticipates working actively with Decatur Manor and Heritage in the successful

transition of those individuals discharged from Decatur Manor to independent and supported living arrangements.

3.2.3.2 *Provide a detailed description of your care coordination model and how it meets the needs of the population you propose to serve including:*

Macon County's model of care coordination is based on a review of other care coordination models implemented with Medicaid populations and populations similar to the State's desired priority and target populations. The design is grounded in review and analysis of Medicaid claims data provided by DHFS, the observations of the core collaborators involved in this care coordination proposal and consideration of our system's needs for improvement.

The Care Coordination program will consist of several activities, including: gathering of medical and/or behavioral health treatment service utilization information; gathering of medical and/or behavioral health treatment records; identification of involved providers; interview with the prospective enrollee and significant others; engagement of the individual in care coordination through signed agreement and authorization for release of health information; completion of an evidence-based needs assessment and risk assessment; risk stratification based on evidence-based assessment instruments and utilization history; identification of the enrollees' level of knowledge about his/her health condition(s); assessment of the individual's level of illness self-management; development, with the Enrollee and involved providers, of an integrated and individualized care plan; assignment to the appropriate intensity of care coordination; advising all involved treatment parties of the availability and electronic access to integrated health information and a care plan for the Enrollee; coaching, guidance and education to the Enrollee and family/significant others about the plan of care, the Enrollee's health condition(s) and medications; reconciliation of Enrollee medications, especially upon transition from treatment setting to treatment setting, with involvement of pharmacy services as needed; education on self-management techniques, including limit setting, dietary considerations, exercise, sleep needs; researching, finding and making referrals for needed community services and supports, including non-covered services and independent living needs like housing, food, utilities set up; development and review with the Enrollee and key providers of a "crisis plan" that may be used when symptoms are exacerbated or acute suffering occurs, in order to avoid Emergency Department visits and/or hospital admissions; evaluation, re-evaluation and identification of change in the individual's functioning or behavior; active identification of gaps in service and advocacy for bridging these gaps; re-evaluation of the Enrollee's care plan with other team members and participating in plan changes; active communication with involved providers, sharing information and helping providers to view their treatment of the individual as a part of a broader effort to help the individual; modification of the plan of care based on Enrollee change in functioning and/or newly identified problems; and, advocacy for continued improvement in the individual's independence in living arrangement and self-management of his/her illness.

Macon County Care Coordination proposes to operate the care coordination program through a team approach. The patient is at the center of this team, supported by friend, family or significant other and by a team of professionals. The team will be involved in collaborative planning for the patient, relationship development for improved communication and coordination of care and decision-making regarding services provided. Communication processes will include telephone, person-to person and electronic communication and exchange of information. The team, during the initial year of the proposed service, will include the patient and patient's friend/family; the primary care provider (providing the medical home); a Program director; a team leader (preferably an Advance Practice Nurse); a mental health specialist; a mental illness and substance abuse specialist; a social service specialist; and, three professional "Navigators" to assist the patient in navigating within a treatment organization or across treatment settings. Administrative support functions for financial management, information systems management and reporting will be provided by the lead entity for the collaboration, the Macon County Mental Health Board. Each Enrollee will be assigned one primary care coordination staff member on the team as the "go to" person, while the whole team's expertise is available for care planning and care coordination activities.

The primary care physician will provide patient evaluation and diagnosis, testing evaluation, medication prescription and review and referral for or conducting of specific medical procedures. The primary care physician may also be involved in illness education for the patient and/or family members supporting the patient's involvement in treatment by other providers. The primary care provider will also participate in health information sharing for the individual though the care coordination information exchange system. Information to be exchanged may include portions of the individual's medical record, including the physician's assessment, care plan and notes from office visits. The primary care provider will follow the patient through the course of his/her care.

The Care Coordination Director will be responsible for supervision of staff, ensuring the program meets its planned objectives, overseeing all required data and reporting issues and conducting regular Enrollee Forums, seeking feedback for program improvement. The Care Coordination Director will be assisted by an Administrative Assistant who will be responsible for data input for Enrollees, billing for services provided, operations purchasing, payables and receivables.

The Care Coordination Team Leader, an Advance Practice Nurse (APN) will work with the medical home and with specialist physicians, including psychiatric specialists for individuals with mental illness. In addition, the APN will be involved in patient and family/friends education, follow up within 48 hours of patient transition from inpatient to outpatient or outpatient to inpatient service settings, medication reconciliation and assistance in access to additional needed services. Transition monitoring and service coordination will include a review of information important to transition, including: the patient's diagnosis, health problems, the plan of care, any legal documents (authorization for release of information, guardianship orders, advance directives),the patient's "health passport" (a document that summarizes and highlights key information about the patient – See Attachment M), the discharge summary from the

discharging facility, any follow up appointments scheduled or in need of scheduling, any test results of pending results, the facility discharge instructions and recommended follow up services or supports recommended. Care Coordination staff will be responsible for securing and transitioning information to the receiving provider.

The mental health and substance abuse specialists will be actively involved in care for those patients with mental illness or a co-occurring substance abuse and mental illness. Heritage Behavioral Health Center has a comprehensive case management service for its clients. The Care Coordinators will work closely with the Care Coordination APN, the Heritage staff case management staff, the St. Mary's Hospital inpatient psychiatric staff upon patient and both hospitals' Emergency Departments during care transition and on an ongoing basis.

The Care Coordinator's responsibilities will include the development of the care plan for the individual, with the input and participation of the patient, the primary care provider, the patient's significant others and the service providers involved in the individual's treatment. The Care Coordinator will be responsible for building an integrated set of information for the patient, soliciting treatment information from treatment sources and managing the accuracy and currency of this information. The Care Coordinator will also be responsible for relationship development with involved service providers and the proactive monitoring of the patient's functioning status.

The Care Coordination Navigators will assist in gathering the patient's medical information, to be used for the information exchange process with all providers, will assist by providing information to the patient and/or family members/significant supporters for treatment and service options and support the patient and family in the care plan's implementation. The Navigator will also make, coordinate and follow up on referrals to service for the patient. This service referral and support may include medical and/or behavioral health services, but may also include arrangements to secure housing, food, household items, and other needed social services and supports. These activities will require close coordination with the Heritage Behavioral Health Center's case management staff. Heritage's service array is described later in this section of the proposal.

Assessment will include an in-person visit by the Care Coordinator. Assessment will include a review of medical history and current assessments of involved providers; review of service utilization; screening for health and well-being, including nutrition, sleep habits and pain level; assessment of cognitive, mental and behavioral functioning; assessment of the individual's self-management ability; review of current services accessed; consideration of potential additional service needs; and; discussion with current service providers.

Assessment information will be organized and posted electronically for availability by all involved service providers, subject to the Enrollees authorization for release of information. This assessment information will become the basis for development of the individual's care plan. The Enrollee will be asked to identify his/her preferences treatment goals and provided with best treatment options. The primary care physician and/or psychiatrist will provide direction for clinical protocols for disease management. The

Care Coordinator and involved service providers may make recommendations for additional services. The care plan is constructed by the Care Coordinator, reviewed with the Enrollee for approval and consent. It is then posted electronically for access by the medical home and involved service providers and is provided to the Enrollee in writing as a care plan with an attached "health passport". The health passport (see Attachment M) is a brightly colored and simplified document indicating key demographic and medical care information. Its purpose is to alert the healthcare provider of the basic information about the Enrollee that is important to note prior to beginning treatment. The Enrollee is also provided with a Care Coordination identification card (see Attachment M) that may be presented at any health provider's office in Macon County, identifying the individual as an enrollee in Macon County Care Coordination. The identification card is intended as a symbol of the individual's interest to work toward illness self-management. The health passport is an information vehicle that an Enrollee may use to assist in transition from one service provider to another, and is intended to serve as a reminder to service provider's that the Enrollee is being serviced by multiple providers.

Services will be provided at varying levels of intensity based on identified risk and need for services. Provision of services will reflect sensitivity to cultural, language, educational/literacy and accessibility needs. Care coordination service delivery and caseload management will be prioritized in a manner that addresses the immediacy of the participant's needs and identified risks. Care coordination will be offered at three levels, based on the Enrollee's service utilization history, health and behavioral risk assessments, and ongoing service and support needs:

1. Intensive care coordination:

   Intensive care coordination serves the individual at high risk for poor health outcomes. The objective for this level of care coordination is support for recovery and a sustained decrease in avoidable service utilization and problematic symptoms, along with sustained progress toward an improved quality of life and a reduction or moderation of risk factors. This level of service includes frequent and multiple contacts with the Enrollee and the Enrollee's medical home, service providers, family and significant others. It may also include resource-finding and problem solving around obstacles in access to care or needed services and supports. It also may include active direct involvement with the Enrollee to support participation in healthcare services. Activity, for example, may include accompanying the Enrollee to a medical appointment or finding and taking food supplies to the Enrollee.

   Individuals in this risk category include those considered to be Medicaid's highest-cost beneficiaries, with multiple physical health problems and significant socio-economic barriers to care *(Hamblin and Somers, 2011)*. This group includes:

   - individuals with a serious mental illness and who have a chronic health condition or utilization history of chronic heart failure (CHF), chronic obstructive pulmonary disorder (COPD) or coronary artery disease (CAD- including acute myocardial infarction and ischemic heart disease, Alzheimer's disease/dementia, arthritis, atrial

fibrillation, cancer (excluding skin cancer), chronic renal disease, acute myocardial infarction (AMI), depression, diabetes, osteoporosis, stroke/transient ischemic attack, sickle cell anemia.

- Individuals with a serious mental illness and one or more admissions for inpatient services or Emergency Department services for serious mental illness or for one of the chronic health conditions listed above, within the previous 12 month
- Individuals with a serious mental illness and/or with co-morbid medical condition, as listed above, with a utilization of Hospital Emergency Department services twice or more in the previous 12 months
- Individuals with a serious mental illness and prescribed five or more medications
- Individuals with a serious mental illness and a co-occurring substance abuse diagnosis who has used community mental health crisis unit services, or community substance abuse detoxification or residential rehabilitation services within the past 12 months
- Individuals with a serious mental illness and under 30 years of age.
- Individuals with a serious mental illness and discharged from a state-operated mental health facility
- Seniors admitted to inpatient services and assessed to be at risk for nursing home placement.

2. Supportive care coordination

   Supportive care coordination services the individual at moderate risk for poor health outcomes. The objective for this level of care is the development of resiliency, in which the Enrollee begins to assume responsibility for illness management, taking steps to reduce the risk of future service utilization, decrease risk factors and increase those activities that protect the Enrollee's health. Services at this level of care coordination include special attention to the Enrollee's transition from one service setting to another, active engagement with the Enrollee's service providers to monitor the Enrollee's continuing involvement in treatment services, anticipating Enrollee challenges and helping to construct planning that will assist the Enrollee in overcoming these challenges. This level of care coordination also includes regular personal contact with the Enrollee.

   Individuals in this risk category include:

   - Individuals with a serious mental illness and/or a chronic health condition, as listed above,
   - Individuals with a serious mental illness and utilization of community mental health crisis unit residential services
   - Seniors remaining at home 6 months following hospitalization rather than admission to an intermediate care facility

3. Preventative care coordination.

Preventive care coordination serves the individual at low risk for poor health outcomes: Services at this level of care coordination include health education and illness self-management training for the Enrollee, referral to health and wellness activities and monitoring of the Enrollee's functioning. Individuals in this risk category include:

- Individuals with a serious mental illness and no utilization of inpatient services, hospital Emergency Department services, mental health crisis unit residential services and no substance abuse detoxification unit services within the past 24 months.

As the enrollee reaches a level of autonomy and takes on responsibility for his/her own health and well-being, including the management of personal health needs, care coordination has successfully achieved its goal. At this level of independence, the Enrollee may be considered for discharge from care coordination services. Special attention will be required to assure that the transition to follow up care is firmly established. (The Aetna Integrated Care management model: a managed Medicaid paradigm).

In the event that an Enrollee is hospitalized, the Care Coordinator will visit with the Enrollee within forty eight hours of admission, will repeat visit and will participate with the inpatient staff in the development of discharge planning and will coordinate follow up services or monitor the implementation of follow up service as established. For seriously mentally ill individuals, the Care Coordinator will work with the Heritage Behavioral Health Center Hospital Liaison and/or with the hospitals' social service staff and medical team. The Heritage Liaison typically sees the patient on a daily basis and makes arrangements for follow up care. The Care Coordinator will work in collaboration with the Inpatient liaison for implementation of post hospitalization transition services and follow up with the Enrollee after discharge, in support of participation in follow up appointments and treatment. The Care Coordinator will also, following either an Emergency Department visit or inpatient stay, review in person with the Enrollee the discharge instructions from inpatient or Emergency Department settings and assist the Enrollee in coordination of follow up services. This follow up will occur within 48 hours of the individual's discharge from inpatient or emergency services. As needed, the Care Coordinator will provide reminders to the Enrollee for follow treatment and may attend follow up medical appointments with the Enrollee.

For seniors, the Care Coordinator will work with the Health Department "Starting Point" nursing staff, the Decatur Memorial Hospital Home Health staff, the St. Mary's Home Health staff and the inpatient social service departments of the two hospitals immediately upon hospitalization. The Health Department staff will conduct a screening for potential nursing home placement and identify and engage community resources for the senior, in an effort to deflect from nursing home admission and maintain the senior in his/her home and with family and social service support. Decatur Memorial Hospital Home Health Services has volunteered to provide services for those dually covered (Medicare and Medicaid) individuals following hospitalization at DMH, using the Coleman Model of care coordination. Under this model, the patient is encouraged to take a more active role in their health care. Patients receive specific tools and skills that are reinforced by their "transition coach" who follows patients across settings for the

first four weeks after leaving the hospital and focuses on medication self-management and uses a patient-centered health record that helps guide patients through the care process. Follow up care is coordinated with the primary care provider and specialist for follow-up. The patient is helped to understand the "red flag" indicators of worsening condition and appropriate next steps. The senior is engaged prior to leaving the hospital. The follow up care includes one personal visit and three telephone calls. A follow up call is made within 24-48 hours after discharge. This call is followed by a home visit within 48-72 hours of discharge to complete a post-discharge assessment and initiate any community service referrals. Follow up calls are made weekly thereafter. The intent of the transition program is to help the Senior understand his/her medications, help in making follow up appointments, help in understanding when to call the doctor and help in putting together a personal health record that explains his/her needs to the primary care physician or other medical professionals. The Care Coordination APN will coordinate with Home Health staff, assist in securing community social services and supports and will continue with coordination activities upon the DMH Home Health staff completion of their programming.

Macon County's model will include the following essential elements of care coordination services as Hamblin and Summer described In "Introduction to Medicaid Care Management" in Comprehensive Care Coordination for Chronically Ill Adults (2012). These elements are as follows:

- Stratification and triage by risk and need

  Identification and rapid linkage to physical, behavioral or psycho-social services for high-risk/ high-need individuals is a key objective of initial stratification and triage activity with Enrollees, along with properly stratifying enrollees into intensive, supportive or preventive levels of care coordination service. Stratification efforts will use the review of Medicaid claims data, review of service utilization (including hospitalization, emergency department visits, diagnoses, medications, substance abuse service use) to identify individual Enrollee high medical expenditures, hospitalization or emergency department visit rates, and existing diagnoses. An evidence-based health and behavioral health risk screening will be conducted for the Enrollee by the Care Coordinator upon enrollment and will be used to identify individuals at high risk for poor health outcomes and to prioritize need for and level of care coordination services. Referrals from providers or specialists and the Enrollee's own self-identification may also be used as a triage tool.

  Priority for care coordination service delivery to Enrollees will also be based on safety concerns and immediate needs identified, severity of risk and need, the Enrollee's motivation to address risk/need, the ability to provide services that link to the Enrollee's risk and are likely to have a positive impact on outcomes, and the Enrollee's ability to access other community resources available to offset the risk/need.

  In addition to planned stratification and triage activities, Macon County Care Coordination is very interested to participate with DHFS as it seeks to develop a predictive modeling system which has the ability to predict future health outcomes based on past behaviors of Medicaid enrollees.
- Integration of Services

Integration of services is considered to be is the management and delivery of health services so that patients/clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system. For providers, integration means that separate technical services are provided, managed, and evaluated either together, or in a closely coordinated way. For the health care recipient, integration is the degree to which they have access to seamless and easy to navigate care. *Integrated Health Services – What and Why? World Health Organization, Technical Brief No.1, 2008.*

Enrollees at high risk for negative health outcomes generally have health care needs that require the services of multiple providers of care, potentially including primary care, specialist care, mental health and or substance abuse care, long term care and community supports (i.e., housing, transportation, utilities, independent activities of daily living, social activity, etc.). Review of target population data provided by DHFS clearly supports the need for integrated care. Given the obstacles to care that seriously mentally ill individuals and Seniors with chronic illness face, Macon County Care Coordination seeks to manage the care provided to an Enrollee through a collaborative approach to treatment; information sharing – interpersonally and electronically - with all parties involved in treatment; joint care plan development; joint ownership of treatment responsibility; and, adjustment in level and intensity of service in response to the individual's changing needs. Integration will be addressed through a number of activities.

1. The establishment of Macon County Care Coordination, involving the core collaborators in a unified effort for provision of medical and behavioral healthcare.
2. Establishment of written memorandum of understanding documents with providers as part of a network of care, outlining specific agreed-upon responsibilities and expectations for the delivery of and coordination of care for enrolled individuals.
3. Establishment of an electronic information sharing capability, with written agreement by network providers to share and use treatment information for care coordination purposes, established through a HIPAA-compliant Business Associate Agreement and authorized by Enrollees through specific release of information documents.
4. Agreement between and among core collaborators on quality and performance measures, providing a shared responsibility for evaluation of care.
5. Provision, through Macon County Care Coordination for management and operation of the care coordination information system and for provision of care coordination services.
6. Co-location of medical and behavioral health services (discussed in more detail in Section 3.2.3.14) between and among the five core collaborating service provider organizations.
7. Location of care coordination workstations at core collaborator service locations, in an effort to facilitate referral processes and information exchange.
8. Enhanced information sharing between and among core providers on program information, services, (including and admission and discharge criteria), referral procedures, designation of liaison staff at each core provider setting. These liaison staff will provide the primary

connection link for care coordinators for communication about program and organizational issues will serve as a bridge to assist the Care Coordinator and the Enrollee in navigating within the service organization and provide support for the Enrollee to move from one service or service setting to another with easy transition.

9. Development, for each Enrollee, of a care plan, involving the Enrollee and all key service providers, focusing on an agreed upon set of goals.
10. Pro-active detection of barriers to care and fragmentation of care by the Care Coordinator and problem-solving, with the help of service providers, to break down those barriers and work to close identified care fragmentation.

The key goal of all of the above activities is the establishment of an integrated system, defined by each individual's needs and provided within his/her family and cultural community. From the Enrollee's perspective, he/she is able to move from one level of care to another or from one service provider to another without breaking communication or treatment focus and maintaining a positive momentum toward illness self-management and improved health. *The Aetna Integrated Care Management model: a managed care Medicaid paradigm", Robert K. Atkins and Mark E. Douglas).*

- Designated Medical Home (Medical Home) and personalized care planning.

Macon County's model places the Medical Home as the central point in an Enrollee's care and a central point to facilitate integration of care. This Medical Home may be a primary care physician but may include a physician's assistant or an APN associated with the Medical Home. The medical home for an Enrollee may be located with medical staff of the Community Health Improvement Center, or with primary care physicians associated with Decatur Memorial Hospital or St. Mary's Hospital. Although not currently operating as a medical home, the SIU Healthcare Clinic has indicated an interest to develop the medical home concept as a pilot program over the next year, in association with Macon County Care Coordination.

The primary care medical home team is responsible for providing all preventive and primary care services to his or her assigned Enrollees and for partnering with the care coordination team and other providers that participate in the Enrollee's care. The intent of the medical home is the provision of continuous care for the individual rather than episodic care when a crisis occurs, a proactive rather than reactive approach to treatment and a focus on the individual's self-management of his/her illness. *Washington State's Medical Home Projects October 27, 2009*

If the Enrollee does not have a medical home, he/she will be provided with the opportunity to choose a location. Ideally, the enrollee should have opportunity to select a medical home that provides the best opportunity for the enrollee to develop and maintain a relationship with the primary care provider. While enrollment in care coordination is voluntary, the individual will be required to select or accept assignment to a medical home as a condition of care coordination enrollment. The default assignment will be with the federally qualified health center, Community Health Improvement Center.

The Medical Home is supported by a team-based approach to care coordination. The Care Coordination team, including medical home personnel, mental health and substance abuse specialists, social service agency personnel, care coordinators, inpatient hospital personnel and the Enrollee, work together to define care needs, develop, update, implement and adjust the Enrollee's plan of care. Personalized and integrated care planning addresses the individual's full range of needs, taking into account their health, personal, family, social, economic, educational, mental health, ethnic and cultural background and circumstances. It recognizes that there are other issues in addition to medical needs that can impact on a person's total health and well-being. It is a holistic process, seeing the person 'in the round' with a strong focus on helping people together with their care givers to achieve the outcomes they want for themselves, for example to live independently or return to work. The plan of care should include community and nonclinical services as well as healthcare services that respond to the individual's needs and preferences and contributes to achieving the individual's goals. This joint plan of care should include patient education and support for self-management and resources. Risk management and crisis and contingency planning are also integral to the process of care planning, in particular for people with complex health needs. National Quality Forum (NQF), *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report,* Washington, DC: NQF; 2010.

- Enrollee engagement strategies

All Care Coordination team members will participate in engaging and enrolling individuals from the identified target populations. As part of the enrollment consideration for Macon County Care Coordination, all potential Macon County Care Coordination enrollees not currently enrolled in IHC (including the long-term care population, those with serious mental illness, Seniors with chronic illness, Dual Eligible individuals and the children in the family of the prospective enrollee) will be referred to the Illinois Client Enrollment Broker for eligibility determination and enrollment and will be required to select a primary care provider from within the Macon County Care Coordination network of providers.

Macon County Care Coordination recognizes that there is a need to deal with existing socioeconomic barriers that impede access to care for the target populations. If an enrollee's basic needs are not being met, their health care and any medical conditions, including serious mental illness, will suffer. Care Coordinators may engage with triage personnel (mental health crisis workers, Emergency Department personnel, inpatient and long term care personnel) to assist the individual with referral to services for basic needs like housing and other basic needs while working to engage the individual in care coordination. As high risk individuals are identified and enrollment is proposed, care coordinators will begin initial assessment and triage for those individuals who have need for immediate care coordination activities.

For seriously mentally ill individuals:

The identification of high users of hospital emergency room services and inpatient services among the target populations will be a key part of initial engagement activities. It is anticipated that

elements of engagement in care coordination will include: 1) checking with partnering clinics and treatment settings where the individual appears to be established for primary care or other treatment, to cross-reference and assure the most updated contact information.; 2) scheduling work and initial person-to-person contacts so that these contacts can be made at different times of the day, including evenings and weekends; 3) using the spirit and method of motivational interviewing in interacting with these individuals; and 4) asking an individual from the clinic(s) where the individual is being treated to contact the individual and encourage participation, if he/she is reluctant to speak with the engagement specialist. *("King County Care Partners", Comprehensive Care Coordination for Chronically ill Adults, pgs. 339-348)*.

Engaging potential enrollees will include referral for enrollment in Care Coordination from current caseloads of five of the Core Collaborators, all of which are key Medicaid service providers within Macon County. Support by the individual's existing providers will help promote participation. *The Roles of Patient-Centered Medical Homes And Accountable Care Organizations in Coordinating Patient Care, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services AHRQ Publication No. 11-M005-EF, December 2010.*

Engagement of enrollees will also be requested through the Core Collaborators relationships through Memorandum of Understanding with local treatment and service organizations in Macon County, including; Decatur Manor – an Institution for Mental Disease; community social service providers, the Salvation Army, the Heritage Behavioral Health Center Oasis program for the homeless and both community hospitals. These team members will be asked to provide names of individuals who may benefit from care coordination and assist in educating these individuals o the benefits of the service. Additional service providers and referral sources will be identified and their participation sought as the care coordination program begins.

For Seniors:

Seniors will be identified upon hospitalization at one of the two local hospitals. Referrals will be generated by the Home Health Care staff of Decatur Memorial Hospital, the Social Service staff of St. Mary's Hospital and the Health Department's "Starting Point" program. As a result of care coordination planning activities, a newly developed process between Health Department personnel and the hospitals' social service personnel, seniors admitted to the hospital will simultaneously be referred to the Health Department for screening through their Starting Point services. Seniors identified as high risk for nursing home placement post-hospitalization will be prioritized for care coordination.

- Provider engagement strategies

  A review of Medicaid claims data has guided the focus of the care coordination planning. The key providers of service for the selected target populations of seriously mentally ill individuals and seniors are involved in the initial collaboration planning efforts. The community's two hospitals, the federally qualified health center, the mental health and substance abuse treatment center and the Health Department are the key providers of service in the community for the target populations. In

addition, the involvement of the Salvation Army and Decatur Manor were sought through Memorandum of Understanding. The Collaboration has reached out to the McFarland Mental Health Center, the state hospital for the central region of the state, and Catholic Charities, a specialized senior services provider, requesting that they each become a partner with the care coordination effort.

Additional provider involvement will be requested as care coordination efforts begin. It is recognized that consistent proactive effort with providers will be necessary to facilitate integration of services and to facilitate information sharing.

The Macon County Care Coordination's primary objective is to provide care coordination that will effectively assist our target populations in self- management of their mental illness and/or and health conditions, improving compliance with prescribed treatment protocols and medication regimens and increasing cost efficiency in the use of Medicaid funds. It is recognized that health improvement does not typically proceed in a direct path. Seriously mentally ill individuals often see their symptoms ebb and flow. Seniors experience set-backs in health condition and management. Maintaining a care plan and maintenance of the appropriate level of treatment and care support are important to recovery and sustaining improved health status. It's hard work for an individual to gain control over an illness that has gripped them and incapacitated them. The support of a team of health care providers who is pulling together to help the individual is critically important for the individual's health improvement and maintenance.

- Information exchange among all stakeholders

Just as patient-centeredness is an integral part of the program, so too is the ability to track care over time and across settings. Macon County Care Coordination will establish an electronic information exchange capability that will permit secure access to Enrollee health information from any point of service that has access to the internet. As explained in Section 3.2.4 of this Solicitation proposal, health care providers will access specially adapted care coordination software, Streamline Healthcare Solutions, through a web-host at the Macon County Mental Health Department's website, www.mcmhb.com. Access will be password protected and a second level of security will be further protected to permit access to health information for specific enrollees.

Care coordinators will be responsible for maintaining current and complete electronic health information for each assigned Enrollee expected to develop professional relationships with network providers. Care coordinators will provide system access training for healthcare providers in the community and advise them of the value of information exchange for improved healthcare for the Enrollee.

Merely having an electronic exchange capability is not enough to help in coordinating health care for the individual. The health information system itself must prove to be useful and providers must use it to achieve the goals of coordination and high quality of care.

To support increased formal use of the electronic information exchange process and to enhance communication between and among service providers, Care Coordinators will be asked to establish personal relationships with the healthcare and social service providers working to provide services to the Enrollee. These personal relationships will support the team effort for treatment and may be used to help providers become familiar with and see the value of electronic healthcare information exchange. Care Coordinators' responsiveness to the needs of the Enrollee and to requests for information or assistance from the provider will help make the information exchange process work more productively.

Care Coordinators will also work with providers for establishment of protocols for Enrollee/patient transition from treatment setting to treatment setting. Collaborative planning efforts for system improvement may include development of shared or standardized, evidence-based assessment instruments, standardization of the transition's information exchange and content of information to be transitioned.

- Performance measurement and accountability

Macon County Care Coordination plans to assess and evaluate the performance of a Care Coordination effort involving measurement of several keys areas of performance:

Access to services - does the patient/client have access to services? Does he/she have the ability to select a primary care provider? Is access to care culturally and linguistically appropriate? Does access to routine and urgent care during and after hours exist?

Identification and Tracking - Does the program collect demographic and clinical information about the programs' participants. Are patient risk factors identified? Are proactive and point in care reminders made to the participant?

Planning and managing care – Are patients/clients with high risk and complex needs (including medical and behavioral risk and need) identified? Is patient/client progress toward a goal assessed? Are barriers to treatment identified and addressed? Are patient medications reconciled as part of medical service and post hospitalization?

Self-management and support – Are patients/clients assessed for their self-management ability? Are they provided with a self-management plan? Are community services (including mental health and substance abuse services) and supports arranged or coordinated? Are they provided with health and wellness education?

Tracking and coordinating – Are patients/clients tracked for follow up appointments, referrals, tests and services at other providers?

Measuring and improving performance –Is patient utilization of services (i.e., hospitalizations, Emergency Department utilization) tracked? Is patient/client performance and experience data used for service improvement? National Quality Forum (NQF), *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report,* Washington, DC: NQF; 2010.

- Financial incentives aligned with quality care

Based upon review of Medicaid claims data and review of our own local service data and service patterns, Macon County Care Coordination proposes a combination fee per enrollee and shared savings model for the contract's first three years. The fee per enrollee model would include a stratified fee for the three identified levels of care coordination – intensive, supportive and preventative care coordination. All shared savings achieved through the operation of the program are to be reinvested in services to improve service access locally. Service supported through shared savings would be applied by Macon County Care Coordination, based on the experience gained through the care coordination effort and identified gaps in service identified, and made available through a fee-for-service contracting approach with local healthcare and social service providers.

Macon County Care Coordination is interested in accumulating experience in care coordination and would welcome the opportunity to discuss development of a capitated financial model with DHFS, after an accumulation of operating experience.

3.2.3.2.1 Services

Macon County Care Coordination intends to have the following services and providers for these services available in its network of care. All service providers identified are either core collaborators in this care coordination and/or have agreed to serve as network service providers for the care coordination target population. In some specific service categories, service shortages are noted and potential service providers have been identified for further network development.

- Primary Care Physicians:

Community Health Improvement Center (CHIC) provides primary care for its patients, employing a Medical Director, staff physician and Advance Practice Nurses. CHIC Adult Primary care providers include Dr. Dana Ray - Family Practice, Dr. Michael Bell - Family Practice, Ayaz Ahamed, Physician's Assistant-Adult Practice, Jessica Sullivan, Nurse Practitioner-Adult Practice, Debra Oestreich, Nurse Practitioner-Family Practice. CHIC's adult provider panel size is 4,561 patients. CHIC also provides a Primary Care Clinic, located at the Heritage Behavioral Health Center's main building and its drop-in center, the Oasis program located in downtown Decatur. In addition, CHIC operates as a clinic on-site at the Macon County Health Center.

As indicated earlier, SIU Healthcare Clinic is interested in establishing a pilot program through which the development of the medical home concept can be tested within the Clinic. Director Dr. John Bradley has expressed interest to develop this pilot project. The SIU Healthcare clinic was established in 1978 at the Southern Illinois University School of Medicine. SIU Healthcare is a group of nine faculty family physicians, four Physician Assistants, one

faculty Clinical Social Worker and fourteen resident physicians. Emphasis is placed on patient education and prevention of illness.

Two physicians in the community are in the process of establishing a new private practice. Dr. Pabalate, formerly employed by the Community Health Improvement Center, is establishing new practice with an associate, Dr. Konda. These two physicians are currently accepting Medicaid patients. Upon contract award from DHFS, Macon County Care Coordination will discuss the possibility of their becoming service providers within the Care Coordination network and their interest in implementing the medical home concept within their practice.

Decatur Memorial Hospital employs sixty eight physicians, including twenty one family practice physicians, eleven Hospitalists, and multiple specialists.

St. Mary's Hospital employs 7 Hospitalists and has multiple family practice physicians affiliated with the Hospital.

- Hospital Services:

For seriously mentally ill individuals, St. Mary's Hospital operates three psychiatric units (adolescent, adult and gero-psychiatric). Discharge, linkage and aftercare services are well-established between St. Mary's Hospital and Heritage Behavioral Health Center.

For Seniors - Decatur Memorial Hospital and St. Mary's Hospital provide inpatient services. A hospitalist will provide primary inpatient care coordination with the individual's primary care physician. Each hospital also provides social service discharge planning, referral and linkage services for individuals upon discharge.

- Long Term Care:

For seriously mentally ill individuals:

Decatur Manor, an Institution for Mental Disease, is located in Decatur, the Macon County seat. While residents of this facility are members of the recently-settled Williams class action suit, the facility has served as a long term care option for individuals with serious mental illness and is anticipated to do so for the immediate future.

For Seniors – Macon County currently has twelve nursing home facilities, providing both short-term and long-term care. The Macon County Health Department has close linkages with these facilities and serves as the "starting point" for an individual's entry into long term care and provides screening service for long-term care placement. In addition, both St. Mary's Hospital and Decatur Memorial Hospital offer a long term care setting.

Future network development may include service agreements with the community's intermediate and skilled care facilities. These facilities include: Aspen Ridge Care Center, Decatur Rehabilitation Health Care Center, Fair Havens Christian Home, Heartland of Decatur,

Heritage Health, Hickory point Christian Village, Imboden Creek living center, Lincoln rehabilitation, McKinley Court and Moweaqua Nursing Home. In addition, the community has eight assisted living and supportive living facilities, including: East Ridge of Decatur, Evergreen Place, Hickory Point Christian Village, Imboden Creek gardens, Keystone Meadows, Primrose, Tanglewood Village, and The Glenwood. It is recognized that Aspen Ridge and McKinley Court have the highest volume of Medicaid beneficiaries living in their facilities.

- Crises Care:

  Both of the community's hospitals are involved as Core Collaborators for this project and provide Emergency Department services. Heritage Behavioral Health Center provides crisis residential services and 24-hour outreach crisis services, including on-site services from Heritage provided at both Decatur Memorial Hospital and St. Mary's Hospital Emergency Departments. In addition, Heritage maintains staffing on site at the County Jail from 8 am until 9 am Monday through Friday (with on-call and on-site service in the evenings and weekends). Heritage also operates a detoxification unit and interacts frequently with both hospital emergency departments and local law enforcement.

- Transportation Providers:

  Network transportation providers include Decatur Memorial Hospital's Prime Time service, St. Mary's Lakeshore Connection and Catholic Charities Faith –In-Action service. The Decatur Public Transit system is also available to Enrollees. Additional providers that may be asked to become network providers are DMCOC Transportation and First Transit. The City of Decatur's taxi service has been intermittent. At times, the City of Decatur has stepped in to provide taxi service while the private provider was undergoing reorganization.

- Home Health Care:

  For seriously mentally ill individuals, Heritage provides outpatient services in the individual's home and in varying community settings. Outreach services are required under Heritage's contract with the Department of Human Service's Division of Mental Health. In addition, Decatur Memorial Home Health program provides in-home health care.

  For seniors - Decatur Memorial Hospital provides a significant amount of in-home health care services in the community. The Macon County Health Department operates the Medication Management Program, providing free services to seniors who are qualified based on income guidelines. In each of these services, registered nurses make home visits; work with physicians, clinics and pharmacies to support individuals with their medication management; and help improve their ability to live independently. The Health Department also has working relationships with a number of home health providers, including access to home delivered and

congregate meals for seniors through DMCOC Nutrition program (a social service agency) and Catholic Charities' Meals-On-Wheels. Finally, the Health Department accesses Sitter services through Hands Across America and The Woodridge Home.

Additional home health services may be sought for inclusion in the network of providers, including: Addus Health Care, Comfort Keepers, CHELP (a social service organization), Complete Care System, Community Care System, Help at Home and Precious Nurses, Addus Health Care, Advance Health Care, Alpha Care, Community Home Care, DMH Home Health and Hospice, Harbor Light Hospice, St. John's Home Health and Hospice, and Whitestar Home, Health Agency.

- Pharmacy

Multiple options are available for pharmacy services. Each of the two hospitals has a pharmacy located on campus. Heritage Behavioral Health Center has an affiliate pharmacy, Genoa Healthcare, co-located at its main building and is in advanced discussion with them about an expansion of their relationship to include medication management services. Community Health Improvement Center and Macon County Health Department have existing relationships with multiple local pharmacies. Historically, Dale's Southlake Pharmacy and Victory Pharmacy, located in downtown Decatur, have been very responsive to the needs of seriously mentally ill individuals and have delivery service as well.

Macon County Care Coordination has identified five pharmacies, Walgreen's, Rambo, CVS, Wal-Mart and The Medicine Shop, that provide the largest amount of pharmacy services to the target populations and will establish working relationships with those pharmacies, upon contract award from DHFS.

- Laboratory Services:

These services will be provided through existing agreements and relationships of the Core Collaborators. Lab services are located at each of the hospitals and available through the federally qualified health center.

- Work/Education Services:

For seriously mentally ill individuals: Evidence strongly suggests that when an individual from the serious mental illness target population is able to be involved in work activities, health outcomes and stability of a mental illness improves. Heritage Behavioral Health Center provides the evidence-based practice, Individual Placement Services, as part of its ongoing programming. In addition, Macon Resources, Inc. a network provider offers a work program (psycho-social rehabilitation) at their workshop and through job placement. Additional relationships with Richland Community College and the Decatur Public School District 61

G.E.D. program to facilitate responding to Enrollee interest in furthering their education may be developed.

- Medical Education/Preventive Health Education:

  Heritage Behavioral Health Center SAMHSA funding for prevention - education services for mentally ill individuals and has implemented a health and wellness program which combines a Primary Care Clinic, located at Heritage as a satellite of the Community Health Improvement Center with a health and wellness education program. This includes a variety of activities: exercise classes and smoking cessation, healthy cooking, planning and shopping, diabetes, hypertension and cardiovascular education classes. In addition, the Macon County Health Department operates the Office of Health Promotion and Public Relations which promotes healthy lifestyle behaviors and serves as a community resource for health issues. Decatur Memorial Hospital and St. Mary's Hospital offer health, education and wellness programs on wide range of topics.

- Rehabilitative Services:

  These may be psychiatric, substance abuse, medical and/ or physical rehabilitative services. These services are a part of current service offerings of the Core Collaborators.

- Housing and Other Basic Need Service

  For seriously mentally ill individuals: It is recognizes that an individual with serious mental illness and/or chronic health conditions cannot effectively deal with those conditions without adequate housing and their basic needs met. Each of the Core Collaborators has existing relationships with multiple local residential and housing service providers, including residential services for seriously mentally ill individuals. Heritage Behavioral Health Center provides mental illness and substance abuse residential services. Residential services for mentally ill individuals include supported and supervised residential settings, along with multiple apartment living settings. Substance abuse residential services include Level III residential/inpatient services. Heritage also provides halfway house settings and a non-medical detoxification unit.

  The Macon County Mental Health Board manages supportive housing services for over 100 disabled individuals, provided through three local not-for-profit residential service organizations - Woodford Homes, Inc., Camelot Supportive Housing, Inc. and Charles Street Supportive Housing, Inc. Both Heritage and the private housing corporations have ongoing working relationships with the Decatur Housing Authority, as well as close working relationships with the Salvation Army, a network provider.

  For Seniors: Multiple specialized living settings are present in this community. Five specialized apartment buildings, twelve nursing homes and eight assisted living settings

currently operate in Macon County. The Health department serves as the screening agent for nursing home placement.

- HIV Services:

  These services are available through the hospitals and the federally qualified health center.

- Psychiatric Services:

  The Macon County community has three psychiatrists: Dr. Rohi Patil; Dr. Choudary Kavuri; and Dr. Bhaskar Damera providing psychiatry services within the service network for seriously mentally ill individuals. They are very involved in the community's system of care. Dr. Damera is the Medical Director at Heritage Behavioral Health Center. Dr. Patil is the Medical Director for St. Mary's inpatient psychiatric services and the Medical Director for the IMD, Decatur Manor. Both Dr. Patil and Dr. Kavuri serve as part-time consulting psychiatrists with Heritage Behavioral Health Center. Dr. Kavuri has admitting privileges at St. Mary's Hospital and is a Board-certified child psychiatrist. Heritage, in addition, employs an Advance-Practice Nurse, Carol Woods, who assists Dr. Damera with psychiatric services for Heritage clients.

- Dental Services:

  Macon County Health Department is a provider of Medicaid –covered dental services for youth in Macon County. Community Heath Improvement Center manages the federally qualified health center located in Champaign, Illinois and refers youth with dental needs for treatment there. Heritage Behavioral Health Center has a referral agreement for dental services located in Taylorville, Illinois. A small subset of dentists has provided Medicaid-covered services for Macon County residents. Access to dental services is a concern for the community. Advocacy for and securing additional dental service access will be a priority for the care coordination team.

- Specialized Services for Seniors:

  The Macon County's Health Department provides community care programing, both on and off-site, including: comprehensive care coordination, medication management, money management, caregiver advisory services, nursing home pre-screening services, health information services, a chronic disease self-management program and serves as the senior health insurance program site for the community. In addition, The Macon County Health Department, as one of the core collaborator for Care Coordination in Macon County operates "Starting Point, the Aging and Disability Resource Center. Starting Point is the county's Aging and Disability Resource Center that helps local residents access long-term support systems such as housing, transportation, in-home services, health insurance, and Medicare. Along with

other senior agencies, Starting Point is a consumer-centered coordinated point of entry into the long-term care support systems that serve older persons and adults with disabilities and their families. The Health Department has the ability to coordinate emergency home response services through relationships with ADT Security Services, American Medical Alert Corp., GTL, Inc., Guardian Medical Monitoring, Inc., Lifeline Systems Company, the National Association for Healthcare Communications, HealthCom (Carelink) and Value Relationships, Inc. In addition, Catholic Charities, a network provider, offers elderly guardianship services, Faith-in Action services, professional counseling services, Individual, couple and family counseling , Eldercare Options, Elderly Guardianship, Faith in Action, Strong for Life Services, MedAssist service, Meals on Wheels, a Food Pantry and a Resale Store.

- Physician Specialty Services:

CHIC currently refers to the following for physician specialty services: Heritage Behavioral Health psychiatric services (Dr. Damera, Dr. Patil and Dr. Kavuri); St. Mary's Hospital (Cardiology, Prairie Cardiovascular, OB/GYNE, Vascular, Neurology, Nephrology/ Urology, Pulmonology, Rheumatology - Springfield Clinic, Orthopedics, Interventional Radiology, Pain Management; DMH (Cardiology, Pulmonology, OB/GYNE, ENTA, Orthopedics, Urology/Nephrology, Pain Management (Millenium Pain Clinic, Bloomington) Interventional Radiology, Podiatry, Infectious Disease, Hematology). CHIC has also referred patients to Cancer Care Specialists, St. John's Hospital (Springfield), Springfield Memorial -Springfield, Barnes Jewish Hospital - St. Louis, MO., Springfield Clinic (Gastroenterology, Neurology, Infectious Disease), SIU Springfield (Neurology, Gastroenterology, Orthopedic).

Decatur Memorial Hospital employs sixty physicians with forty seven specialists, including: eleven hospitalists; five cardiologists; one allergist; six general surgeons; five internal medicine physicians; one infectious disease specialist; three nephrologists; three neuro-surgeons; three occupational medicine specialists; four otolaryngologists; one pediatrics specialist; one plastic surgeon; one sports medicine specialist; and two urologists.

St. Mary's Hospital employs 7 Hospitalists and has a number of family practice physicians and specialists affiliated with the Hospital.

3.2.3.2.2 *How you will address and monitor transitions of care, including appropriate follow-up, from:*

3.2.3.2.2.1 *Inpatient to Outpatient (PCP, Mental Health Providers, and Substance Abuse Providers);*

Heritage has assigned a very capable Inpatient liaison staff to work on-site at St. Mary's Hospital psychiatric units and maintains the practice of daily or multiple times per week on-

site collaboration with the psychiatric unit staff and the Unit psychiatrist. Both Heritage mental health staff and substance abuse staff are present on the inpatient psychiatric unit at regular intervals. A Hospital liaison staff member has been assigned to St Mary's Hospital psychiatric unit to support the Heritage psychiatrist as he/she conducts rounds on the psychiatric unit and serves as the link between Heritage and St' Mary's staff for discharge planning, linkage and aftercare for the Enrollee upon discharge from the inpatient psychiatric unit. In addition, Heritage Behavioral Health Center has a long-standing relationship with the state hospital for this region of the State, the McFarland Mental Health Center and is under contractual obligation to the Department of Human Services' Division of Mental Health to provide linkage and aftercare services for individuals discharged from the state-operated hospital to the Macon County community. Care coordinators will participate in planning for Enrollee discharge from inpatient to outpatient services and/or monitor planned follow up scheduling. Follow up will include contact with the outpatient provider's office to confirm the Enrollee's participation in the follow up care and to determine and record the results of that follow up. If it is anticipated that the Enrollee may be reluctant or resistant to participate in follow up appointment, the Care Coordinator may engage the Enrollee and ask to accompany the Enrollee to the follow up visit or may encourage case management staff or a family member to assume this role. A practice of "firm linkage" will be required of Care Coordinators. This means that, while transition and follow up appointments are made, linkage is not considered "firm" unless the Enrollee has actually participated in the transition appointment.

3.2.3.2.2.2 *PCP to Mental Health Providers and Substance Abuse Providers, and vice versa;*

The Care Coordinator will interact with primary care provider representatives, either as a part of the Enrollee's visit with the primary care provider or through follow up with the primary care provider representatives to identify follow up care needs. Heritage Behavioral Health Center case management staff is actively engaged with clients of the Center and often attend primary care appointments with the individual. As coordinated with Heritage staff, the Care Coordinator may attend the appointment with the Enrollee or seek the assistance of a significant other to participate in the follow up appointment with the Enrollee. The Care Coordinator, if not in attendance with the Enrollee, will follow up with the provider and with the Enrollee to determine that the Enrollee did, in fact, attend and will identify recommended next steps. In the event that the Enrollee is not a current Heritage registered client, the Care Coordinator will encourage and assist the Enrollee in accessing services.

The transition from primary care provider to mental health and/or substance abuse provider is facilitated by the co-location of services between the Community Health Improvement Center, Heritage Behavioral Health Center and the Macon County Health

Department. Representatives of these organizations coordinate these co-location functions and meet on a regular, bi-monthly basis to review programming functions and to provide for trouble-shooting, problem resolution, and closing of identified treatment gaps. The Care Coordination Team Leader will participate in this regular discussion for purposes of care coordination. The transition from mental health provider to substance abuse provider in this community is unique in that the same organization, Heritage behavioral Health Center, provides both sets of services. Heritage has its own internal quality assurance programming to monitor effective transition from one service to another, however, the Care Coordinator will maintain a monitoring and quality assurance role in ensuring that successful transition has occurred. This will be accomplished in the same manner that transition from primary care provider to mental health or substance abuse provider, through follow up with the provider to determine that the Enrollee did, in fact, attend and to learn recommended next steps. Enrollees will be encouraged to participate in service.

3.2.3.2.2.3 *Outpatient (PCP and Mental Health Providers and Substance Abuse Providers) to Inpatient*.

Upon admission for psychiatric inpatient services, Heritage Behavioral Health Center's Hospital liaison meets with the individual and participates in treatment planning care with inpatient staff. The Inpatient liaison, working together with the inpatient psychiatric staff and psychiatrist, serves as the connecting rod through the individual's course of inpatient treatment, assisting in planning, facilitating discharge planning for the individual and making necessary referrals for the individual's aftercare. During hospitalization, the individual's assigned mental health case manager may also visit the individual at the hospital and assist in planning for discharge. The Care Coordinator's role in this process will be to see the patient within 48 hours of admission, participate with inpatient staff and other involved parties in discharge planning, monitoring of the transition activities, requesting information from the inpatient liaison and following up with the individual and the assigned case manager upon discharge, to ensure that transition from inpatient treatment to outpatient follow up with the primary care provider, and/or psychiatrist and assigned case manager has been achieved. This monitoring may also include ensuring that any referrals for social services in addition to mental health treatment are achieved. The Care Coordinator may facilitate appropriate referrals or contacts, coordinating with the Inpatient Liaison or assigned case manager. Follow up contact with the Enrollee and assigned Heritage case management staff will occur within 72 hours of discharge from inpatient psychiatric treatment. For those not currently registered Heritage clients, the Care Coordinator will encourage the individual to engage in treatment services and facilitate referral and initiation of services.

Upon admission to impatient services for medical treatment, Care Coordination staff will be alerted by the Hospital's patient registration process for all patients enrolled in care coordination and advance-registered with the hospital. A part of enrollment in care coordination is completion of advance enrollment at each of the hospitals. The Care Coordinator will be responsible for visiting the Enrollee within 48 hours of admission, participating in discharge planning and providing follow up with the Enrollee within 48 hours following discharge. The Care Coordinator will review with the Enrollee the discharge plans, provide for medication reconciliation, if needed, and provide assistance in making arrangements for follow up care, including – if needed- accompanying the Enrollee to the follow up visit.

3.2.3.3 Provide a comprehensive statement of your proposed three-year staffing plan to demonstrate adequate support of your care coordination model. Include organizational charts and detailed job descriptions for key staff.

The Year 1 Care Coordination team includes a care coordination director and seven care coordinators, led by a Team leader, preferably an Advanced Practice Nurse who reports to the care coordination director employed by the Lead Entity, the Macon County Mental Health Board. The staffing plan in Year 1 of the program includes the director, the Team leader, two mental health/substance abuse specialists, a social service specialist, three professional Navigators and an Administrative Assistant. All care coordination staff will be involved in outreach and enrollment. Care coordination assignments will be established according to Enrollee-specific needs and Care Coordination staff specialization and skill set. Care coordination caseloads will average 100 individuals however caseloads may vary among Care Coordinators based on the required level of care coordination per Enrollee. Intensive Care Coordination requires a higher level of activity per Enrollee. A Care Coordinator with a higher number of Enrollees requiring intensive care coordination may have a lower total case load.

Year 2 of the program will add two additional staff, a mental health specialist and a Navigator. This additional staffing will permit expansion of enrollment to 1000 individuals and maintain the average care coordination caseload of 100.

Year 3 of the program will add an additional two staff, a mental health/substance abuse specialist and a Navigator. This additional staffing will permit expansion of enrollment to 1200 individuals and maintain the average caseload of 100.

A full-time program director will provide the focus and concentration to the program's effort to achieve cost savings and improved health outcomes for enrollees. The employment of an Advance-Practice nurse will provide the guidance and training capability for other team members in the integration of primary and behavioral health issues for enrollees. The addition of mental

health, mental health/substance abuse and social service specialists will provide the experience and understanding that will be necessary for engagement of the proposed target populations and ongoing monitoring of functioning. The Navigators will serve in the role of monitoring enrollee function, and assisting the Enrollee in participation in healthcare appointments, tests and activities. All care coordination staff will provide outreach services and all will assist in enrollee health education and independent living skills support. Each Care Coordinators will be assigned to serve as the primary liaison for interrelationship development with collaborating organizations and other service providers.

Care Coordination Director
Job Description

Position Title: Care Coordination Director

Responsibility: Under the direction of the Executive Director, provides direction, management and supervision of the Care Coordination Program

Position Requirements:

1. Master's Degree in a Mental Health related field with at least 5 years of experience working with seriously mentally ill individuals, and individuals with co-occurring disorders of mental ill ness and substance abuse.
2. Experience in project management, staff supervision.
3. Knowledge of data analysis, quality improvement processes
4. Valid Illinois driver's License, reliable transportation and evidence of insurability.
5. Proficient in use of computer and familiarity with Internet.

Duties:

1. Assures that team is meeting overall program goals;
2. Recruits, hires and supervises the care coordination Team staff;
3. Coordinates training activities for Team members;
4. Monitors outcome reporting, identifies any deliverables non -compliance and develops response plans for improvement;
5. Manages program enrollments and disenrollment, monitors and tracks per member per month system;
6. Coordinates care coordination software application training and use, including Enrollee record review for completeness and timeliness;
7. Participates in the review of any high risk cases with Team members;
8. Participates in the review of any critical incidents with Team members and/or with service providers;
9. Represents the Care Coordination program to other organizations, service providers, community groups;
10. Meets routinely with the core collaborators to provide program performance information, review program functioning, develop and/or reinforce practice and protocol for program operation, solicit input for program improvement;
11. Coordinates system problem-solving, especially for high risk, high service use and high cost treatment and care transition issues.
12. Coordinates regular consumer advisory forums seeking feedback on program effectiveness and suggestions for program improvement.

Care Coordination Team Lead
Job Description

Position title: Care Coordination Team Lead

Responsibility:
With supervision from the Care Coordination Director, provides leadership in the implementation of Care Coordination activities for individuals with serious mental illness and/or individuals with significant health concerns. Provides care coordination for assigned individuals; services as the liaison to the Medical Home; provides professional nurse-consultation services to the Care Coordination Team. This position is a full-time equivalent position.

Position Requirements:

1. Master's Degree Registered Nurse or Bachelor's Degree Registered Nurse with 5 years of experience.
2. Leadership, advocacy, communication, education and counseling, and resource research skills.
3. Experience in psychiatric and geriatric nursing preferred.
4. Valid Illinois driver's License, reliable transportation and evidence of insurability.
5. Proficient in use of computer and familiarity with Internet.
6. Successful completion of a background check

Duties:

1. Serve as liaison to the Medical Home.
2. Develops and maintains working relationships with primary and specialty care providers, including inpatient facilities.
3. Take a lead role in integrating medication administration and disease management into clients overall treatment plan
4. Provide feedback to Team members and gives direction to staff regarding health and behavioral issues
5. Leads in the development of wellness and prevention initiatives; health education groups
6. Provide on-going training to Care Coordination staff in the recognition and management of chronic medical conditions.
7. Provides care coordination services for enrollees, including
    - Outreach and rapport development with the prospective Enrollee and enrollment;
    - Assessment, with the Enrollee, his/her strengths, resources, needs and risks;
    - Developing care plans based on Enrollee goals with the Enrollee and care team;
    - Facilitate planning/problem solving with the Enrollee and significant others;
    - Provide information, education and encouragement needed to inform and/or motivate the Enrollee to take steps necessary to change situations placing him/her at risk;
    - Coordinating the development of, documentation of and monitoring of care plans;
    - Managing and tracking goal attainment, assessments, lab results, and referrals made by the primary care provider – to ensure timely transmission of information;
    - Coordinating and maintaining critical information sharing among the care team and Enrollee; Collaborate with other providers to assure continuity and coordination of care;
    - Promoting self-sufficiency and healthy outcomes (through encouragement and motivation, reinforcement of health care regimen, anticipatory guidance, supporting home safety, promoting continuation in health care, managing behavior concerns);
    - Advocating on behalf of the Enrollee, including communicating to providers their strengths, needs and feelings.\Ensuring that Enrollees are meaningfully informed about their care options
    - Reviewing high risk cases with team, and;
    - Participating in critical incident reviews
    - Care transition management for the Enrollee, from within and across treatment settings.

Care Coordination – Mental Health Specialist

Position title: Care Coordination – Mental Health Specialist

Responsibility:
With supervision from the Care Coordination Director, provides care coordination for individuals with serious mental illness and/or individuals with significant health concerns.

Position Requirements:

1. Masters' Degree in psychology or a related field and two years of experience working in community mental health with seriously mentally ill individuals or Bachelor's degree in psychology or a related field and 5 years' experience working in community mental health with seriously mentally ill individuals.
2. Core philosophy or values consistent with a client/patient-centered approach to care.
3. Culturally effective capabilities demonstrating a sensitivity and responsiveness to varying cultural characteristics and beliefs.
4. Valid Illinois driver's License, reliable transportation and evidence of insurability.
5. Proficient in use of computer and familiarity with Internet.
6. Successful completion of a background check

Duties:

1. Serves as a specialist for services to seriously mentally ill individuals and as a consultant resource for the Team;
2. Serves as liaison to the behavioral health service providers;
3. Provides care coordination services for enrollees, including
    - Outreach and rapport development with the prospective Enrollee and enrollment
    - Assessment, with the Enrollee, his/her strengths, resources, needs and risks
    - Developing care plans based on Enrollee goals with the Enrollee and care team;
    - Facilitate planning/problem solving with the Enrollee and significant others;
    - Provide information, education and encouragement needed to inform and/or motivate the Enrollee to take steps necessary to change situations placing him/her at risk;
    - Coordinating the development of, documentation of and monitoring of care plans;
    - Managing and tracking goal attainment, assessments, lab results, and referrals made by the primary care provider – to ensure timely transmission of information;
    - Coordinating and maintaining critical information sharing among the care team and Enrollee; Collaborate with other providers to assure continuity and coordination of care, and
    - Promoting self-sufficiency and healthy outcomes (through encouragement and motivation, reinforcement of health care regimen, anticipatory guidance, supporting home safety, promoting continuation in health care, managing behavior concerns);
    - Advocating on behalf of the Enrollee, including communicating to providers their strengths, needs and feelings.\Ensuring that Enrollees are meaningfully informed about their care options
    - Reviewing high risk cases with team
    - Participating in critical incident reviews
    - Care transition management for the Enrollee, from within and across treatment settings.

Care Coordination – Mental Health and Substance Abuse Specialist

Position title: Care Coordination – Mental Health and Substance Abuse Specialist

Responsibility:
With supervision from the Care Coordination Director, provides care coordination for individuals with serious mental illness, individuals with co-occurring disorders of mental illness and substance abuse and/or individuals with significant health concerns.

Position Requirements:

1. Master's degree in psychology or a related field and 5 years' experience working in community substance abuse treatment and mental health treatment and with a specialization in mental illness/substance abuse (MISA) service delivery.
2. Core philosophy or values consistent with a client/patient-centered approach to care.
3. Culturally effective capabilities demonstrating a sensitivity and responsiveness to varying cultural characteristics and beliefs.
4. Valid Illinois driver's License, reliable transportation and evidence of insurability.
5. Proficient in use of computer and familiarity with Internet.
6. Successful completion of a background check

Duties:

1. Serves as a specialist for services to seriously mentally ill individuals with co-occurring substance abuse disorders and as a consultant resource for the Team;
2. Serves as liaison to the behavioral health service providers;
3. Provides care coordination services for enrollees, including
    - Outreach and rapport development with the prospective Enrollee and enrollment
    - Assessment, with the Enrollee, his/her strengths, resources, needs and risks
    - Developing care plans based on Enrollee goals with the Enrollee and care team;
    - Facilitating planning/problem solving with the Enrollee and significant others;
    - Providing information, education and encouragement needed to inform and/or motivate the Enrollee to take steps necessary to change situations placing him/her at risk;
    - Coordinating the development of, documentation of and monitoring of care plans;
    - Managing and tracking goal attainment, assessments, lab results, and referrals made by the primary care provider – to ensure timely transmission of information;
    - Coordinating and maintaining critical information sharing among the care team and Enrollee; Collaborate with other providers to assure continuity and coordination of care, and
    - Promoting self-sufficiency and healthy outcomes (through encouragement and motivation, reinforcement of health care regimen, anticipatory guidance, supporting home safety, promoting continuation in health care, managing behavior concerns);
    - Advocating on behalf of the Enrollee, including communicating to providers their strengths, needs and feelings. Ensuring that Enrollees are meaningfully informed about their care options
    - Reviewing high risk cases with team
    - Participating in critical incident reviews

Care Coordination – Social Services Specialist

Position title: Care Coordination – Social Services Specialist

Responsibility:
With supervision from the Care Coordination Director, provides care coordination for seniors with chronic illnesses, individuals with serious mental illness, individuals with co-occurring disorders of mental illness and substance abuse and/or individuals with significant health concerns.

Position Requirements:

1. Master's degree in social work, social services or a related field and 5 years' experience working in community substance abuse treatment and mental health treatment and with a specialization in service delivery for senior citizens and seriously mentally ill individuals.
2. Core philosophy or values consistent with a client/patient-centered approach to care.
3. Culturally effective capabilities demonstrating a sensitivity and responsiveness to varying cultural characteristics and beliefs.
4. Valid Illinois driver's License, reliable transportation and evidence of insurability.
5. Proficient in use of computer and familiarity with Internet.
6. Successful completion of a background check

Duties:

4. Serves as a specialist for services to senior citizens and to seriously mentally ill individuals and as a consultant resource for the Team;
5. Serves as liaison to the behavioral health service providers;
6. Provides care coordination services for enrollees, including
    - Outreach and rapport development with the prospective Enrollee and enrollment
    - Assessment, with the Enrollee, his/her strengths, resources, needs and risks
    - Developing care plans based on Enrollee goals with the Enrollee and care team;
    - Facilitating planning/problem solving with the Enrollee and significant others;
    - Providing information, education and encouragement needed to inform and/or motivate the Enrollee to take steps necessary to change situations placing him/her at risk;
    - Coordinating the development of, documentation of and monitoring of care plans;
    - Managing and tracking goal attainment, assessments, lab results, and referrals made by the primary care provider – to ensure timely transmission of information;
    - Coordinating and maintaining critical information sharing among the care team and Enrollee; Collaborate with other providers to assure continuity and coordination of care, and
    - Promoting self-sufficiency and healthy outcomes (through encouragement and motivation, reinforcement of health care regimen, anticipatory guidance, supporting home safety, promoting continuation in health care, managing behavior concerns);
    - Advocating on behalf of the Enrollee, including communicating to providers their strengths, needs and feelings. Ensuring that Enrollees are meaningfully informed about their care options
    - Reviewing high risk cases with team
    - Participating in critical incident reviews

Care Coordination Navigator
Job Description

Position title: Care Coordination Navigator

Responsibility:
With supervision from the Care Coordination Director, provides Care Coordination activities for individuals with serious mental illness and/or individuals with significant health concerns, focusing on Enrollee navigation within the local healthcare system. This position is a full-time equivalent position.

Position Requirements:

1. Bachelor's degree in Social Service preferred, or relevant experience in working with seriously mentally ill individuals lieu of a college degree.
2. Willingness to work with high risk individuals with serious mentally illness and/or significant health concerns
3. Valid Illinois driver's License, reliable transportation and evidence of insurability.
4. Proficient in use of computer and familiarity with Internet.
5. Successful completion of a background check

Duties:

1. Establishes working relationships with social service providers in the community (including those providing Medicaid and non-Medicaid covered services), including referral processes, linkage arrangements, resources available and coordination of resources.
2. Provide practical assistance to clients to improve their ability to cope within the community within the least restrictive setting possible (e.g. assistance with transportation, budgeting, locating housing, and/or identifying vocational training opportunities);
3. Provide outreach to consumers who do not keep important follow-up appointments.
7. Serves as liaison to the behavioral health service providers;
8. Provides care coordination services for enrollees, including:
    - Outreach and rapport development with the prospective Enrollee and enrollment
    - Assessment, with the Enrollee, his/her strengths, resources, needs and risks
    - Developing care plans based on Enrollee goals with the Enrollee and care team;
    - Facilitating planning/problem solving with the Enrollee and significant others;
    - Providing information, education and encouragement needed to inform and/or motivate the Enrollee to take steps necessary to change situations placing him/her at risk;
    - Coordinating the development of, documentation of and monitoring of care plans;
    - Managing and tracking goal attainment, assessments, lab results, and referrals made by the primary care provider – to ensure timely transmission of information;
    - Coordinating and maintaining critical information sharing among the care team and Enrollee; Collaborate with other providers to assure continuity and coordination of care, and
    - Promoting self-sufficiency and healthy outcomes (through encouragement and motivation, reinforcement of health care regimen, anticipatory guidance, supporting home safety, promoting continuation in health care, managing behavior concerns);
    - Advocating on behalf of the Enrollee, including communicating to providers their strengths, needs and feelings. Ensuring that Enrollees are meaningfully informed about their care options
    - Reviewing high risk cases with team
    - Participating in critical incident reviews.

Administrative Assistant

Job Description

Position title: Administrative Assis**tant**

Responsibility:
With supervision from the Care Coordination Director, provides Care Coordination activities for individuals with serious mental illness and/or individuals with significant health concerns, focusing on Enrollee navigation within the local healthcare system. This position is a full-time equivalent position.

Position Requirements:

1. HS Diploma, AS – Office or Business Curriculum
2. Proficient with Microsoft Office including Word, Excel, and Outlook.
3. Good telephone skills, business writing skills, organizational skills and ability to plan and coordinate meetings.
4. Experience with Microsoft Publisher, Microsoft Access, Adobe Acrobat, Peachtree Accounting, and inventory and records management.
5. Ability to schedule and prioritize workload, work with minimal supervision, analyze and organize general office functions in an efficient and orderly manner, analyze specific tasks, assess for process improvement, and make recommendations for change, adapt and respond to changing environmental conditions.

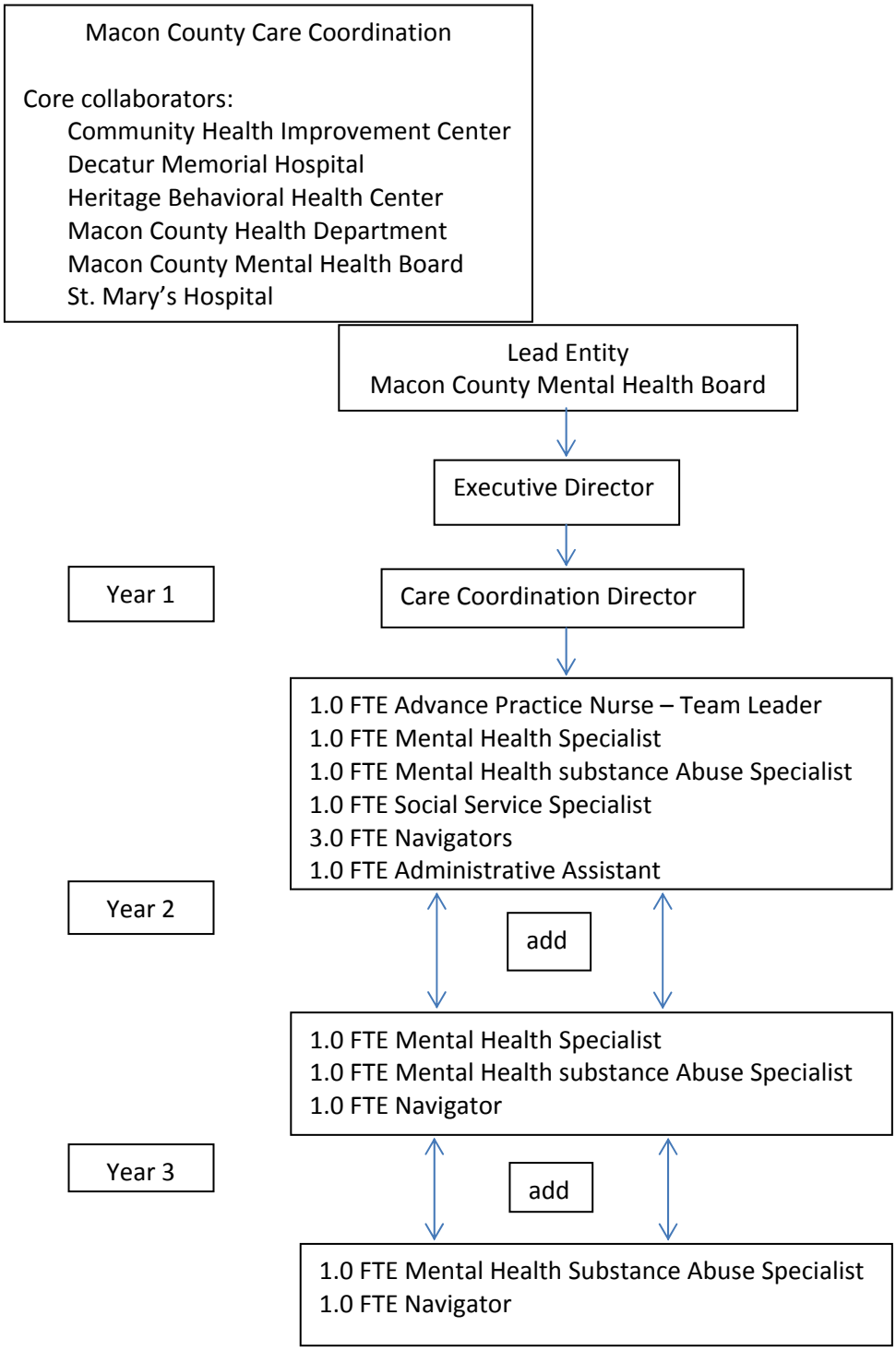
Duties:

1. Providing direct clerical support to the Director of Care Coordination and members of the Care Coordination team.
2. Managing the office phones.
3. Opening, routing, and processing incoming and outgoing mail.
4. Conducting inventories for office supplies and processing orders. Shopping for supplies at Sam's Club, Wal-Mart, etc.
5. Updating and circulating office lists and databases.
6. Care Coordination database entry.
7. Agency Address, Phone, E-mail listing.
8. Other mailing lists as needed.
9. Maintaining performance of office equipment
    - Keeping machines filled with paper
    - Taking monthly readings on machines
    - Placing calls for maintenance and supplies as needed.
    - Changing daily backup tape for computer network.
    - Updating automatic phone directory.
10. Keeping shared workspace in neat and orderly condition including cabinets and storage spaces
11. Assisting with accounting and reporting tasks
    - Managing petty cash, credit card receipts, staff scheduling
    - Contract performance reports

1. Conducting bi-annual inventories
2. Maintaining shared office files and maintaining system of record retention and storage.
3. Other support assistance as needed.

Macon County Care Coordination

Organizational Chart
June, 2012



3.2.3.4 Describe your expanded medical home functionality within your PCP network, including minimum hours of operation after hours availability, minimum appointment standards, and access standards.

The Community Health Improvement Center has expanded its medical home functionality through the establishment of clinic locations at the Heritage Behavioral Health Center's main building location, at the Heritage Oasis Center (a drop –in program for homeless and mentally ill individuals) and at the Macon County Health Department.

CHIC is open four evenings a week in addition to its daily hours of operation, beginning at 8:00 am each weekday morning. Physicians are available on a 24 hour per day basis via an answering service. CHIC continues to accept new patients. The clinic reserves a portion of daily available appointment times for same day appointments and for referrals from St. Mary's and Decatur Memorial Hospitals for both current and new patients. The Clinic is located in a well-traveled and well-lite location in Decatur, easily accessible via public transit. The Clinic has ample and free parking immediately next to the clinic building. The clinic itself is a one-story building and is handicap-accessible.

The Center is currently working to achieve PCMH status. The Center will submit a letter of intent to HRSA in August, 2012 and subsequently will apply to NCQA during the next 6 to 12 months for designation as a Primary Care Medical Home. Ultimately, CHIC plans to seek accreditation by AAACH as an Ambulatory Care Center.

3.2.3.5 Describe your proposed Provider to Enrollee ratios, including your plan to monitor and maintain ratios, for:

3.2.3.5.1 PCP to Enrollees;

By the end of the Proposal period, the Program expects to have 1200 persons enrolled in Care Coordination. The proposed Provider to Enrollee ratio is: 1:1800 for physicians

1:900 for mid-level providers

Panel size for each primary care provider for the care coordination program is as follows:

Provider	Year 1	Year 2	Year 3
Dr. Bell, MD	175	250	300
Dr. Ray, MD	175	250	300
Ayaz Ahamed - Physician's Assistant, Adult Practice	90	125	150
Jessica Sullivan - Family Nurse Practitioner, Adult Practice	90	125	150
Debra Oestreich - Family Nurse Practitioner, Adult Practice	85	125	150
Amanda Shils - Family Nurse Practitioner, Adult Practice	85	125	150

CHIC monitors its active patient roster and patient-to-physician ratio on a quarterly basis. CHIC has agreed to provide Macon County Care Coordination with quarterly reporting of provider to Enrollee ratios primary care provider.

3.2.3.5.2 Mental Health Provider to Enrollees;

Heritage Behavioral Health Center is the community mental health Medicaid service provider for the community. The planned Enrollee to provider ratio will vary according to services provided, as follows:

MI Adult Outpatient:	1:40
Case Management:	1:40
Intensive Case Management:	1:12

In addition, Heritage provides seven crisis unit beds, with 24 hour staffing, including nursing supervision. Heritage operates two group homes for the seriously mentally ill; the Orchard Street and West Main Group Homes with 10 and 8 beds, respectively. The Antioch Safe Haven facility/program has 7 beds and serves individuals who were homeless and provides them a lease without regard to their ability to pay. This model tolerates individuals who may be actively using drugs and/or alcohol (but not on the premises) and provides 24 hour staffing aimed at assisting the resident to gain employment, treatment services, and eventually to obtain their own home or apartment. Heritage has 3 permanent supportive housing sites (Heritage Fields, Heritage Grove, and Macon Street Apartments). Resident managers live at Heritage Fields and Heritage Grove and are available for facility emergencies. Clients are assigned case managers to assist with daily living skills, etc. Clay Street Apartments serves chronically homeless individuals with a mental illness and/or substance use disorder. The group homes and Clay Street also serves veterans. Heritage's Housing programs served 168 individuals in FY 11. Heritage also works closely with the Macon County Mental Health Board/Woodford Homes with two permanent supportive housing projects, Charles Street and Camelot Apartments, serving individuals with serious mental illness. Woodford Homes provides supportive housing for 108 individuals in seven separate facilities.

Heritage's information system has the ability to identify caseloads per staff member and total caseloads per program and for the organization. Heritage administration has shared this level of information on an ongoing basis and will provide this information for care coordination program management.

3.2.3.5.3 Substance Abuse Provider to Enrollees; and

Heritage Behavioral Health Center is the community substance abuse Medicaid service provider for the community. The planned Enrollee to provider ratio will vary according to services provided, as follows:

SA Outpatient : 1:40

SA Intensive Outpatient : 1:40

In addition, Heritage provides 7 detoxification unit beds, one half-way house bed and 16 residential rehabilitation beds.

Similarly, for substance abuse services, Heritage's information system has the ability to identify caseloads per staff member and total caseloads per program and for the organization. Heritage administration has shared this level of information on an ongoing basis and will provide this information for care coordination program management.

3.2.3.5.4 Specialist to Enrollees, if applicable.

Heritage Behavioral Health Center reports that it's specialty psychiatry ratio is 1:1155.

Dr. Damera (Heritage Behavioral Health Center Medical Director currently has 842 patients

Carol Wood (APN at Heritage) currently has 215 patients

Dr. Kavuri (consulting psychiatrist for Heritage) currently has 487 patients.

Dr. Patil (consulting psychiatrist at Heritage) currently has 418 patients. Dr. Patil is also the Medicaid Director for inpatient behavioral health services at St. Mary's Hospital and consulting psychiatrist for Decatur Manor, the intermediate care facility (Institution for Mental Disease).

3.2.3.6 Provide a detailed three-year budget as Attachment I that includes:

3.2.3.6.1 Revenue sources (projected care coordination or capitation reimbursement revenue and other revenue sources); and

3.2.3.6.2 Costs (operations, staffing, health information technology, performance incentive payments, estimates of reimbursement distribution among collaborators, and other costs).

Please see Attachment I for the three year budget outline.

3.2.3.7 To the extent that your model includes Dual Eligibles, describe your plan to address the specific needs of dually eligible populations.

The dually eligible person is generally considered the most disabled and most expensive population served by publicly funded healthcare programs. They often fall into a fragmented care delivery system that leads to episodic rather than coordinated care. Information about their care and

their needs can be scattered among providers and facilities facing two different payment systems and sets of program rules.

It is recognized that DHFS is not in a position to consider cost savings related to Medicare service delivery. Macon County Care Coordination has elected to include the dually eligible (Medicare and Medicaid) individual as part of the two identified target populations and believes that care coordination can help in improvements in access to services, improve individual health outcomes and, in total, reduce expense to the publicly-funded health system.

3.2.3.7.1 If your model to serve Dual Eligibles meets the requirements outlined in Federal CMS' Managed FFS model, describe:

3.2.3.7.1.1 How you will promote seamless integration and access to all services in the Medicare and Medicaid programs, based on the Enrollee's needs, through coordination across both programs; and

For the individual with Medicare and Medicaid coverage, Medicare becomes the primary payor, with Medicaid as the secondary payor. Dually eligible individuals tend to have disproportionately low incomes and tend to have greater medical needs, functional limitations and cognitive limitations than other beneficiaries. They are more likely to live in nursing home settings, more likely to have multiple inpatient stays and more likely to use Emergency Department services. A key to the integration of and access to services for dually eligible individuals is, as with Medicaid-only beneficiaries, the establishment of a medical home, and individualized care plan and support for that individual and the individual's medical home though a care coordination approach. Coverage and payment policies affect how beneficiaries receive their care and, so, influence access to care as well as the quality and cost of the care. Care Coordination staff will receive training in both Medicare and for Medicaid programs, in order to develop an understanding of current coverage for services and payment policies for dual eligible.

3.2.3.7.1.2 How you will assure access to all necessary care:

As with those Enrollees who are Medicaid-only beneficiaries, Care Coordinators will advocate for services for the individual, make referral for services as guided by the individual's care plan and follow up on the individual's care received. Referral and follow up protocols established by the Care Coordination program will be followed for all Enrollees, regardless of payor source.

3.2.3.7.1.2.1 Is provided in a culturally and linguistically appropriate manner;

As with Medicaid-only beneficiaries, services will be provided in a culturally sensitive manner, responsive to the individual and the individuals' family. If need exists for special assistance for translation services, the Care Coordinator will coordinate translation services through the Care Coordination team leader.

3.2.3.7.1.2.2 Includes caregivers, when appropriate;

Caregiver involvement will be sought, based on agreement by or request of the Enrollee. The Care Coordinator's work includes bringing the maximum amount of support to the Enrollee in his/her effort to improve illness self-management and health improvement.

3.2.3.7.1.2.3 Is provided in the appropriate care setting including the home and community;

Care coordination is provided in the least restrictive environment possible for the individual, and focused on prevention of institutionalization. Services currently provided by the Core Collaborators include home visiting and involvement with family and significant others. Care Coordination care planning will include the involvement of the individual's family, based on their desire for involvement. Heritage Behavioral Health Center has a contractual requirement with the Department of Human Services' Division of Mental Health for the provision of home-based and off-site services. The Health Department is well integrated with the system of care for seniors in the community and provides a significant amount of home-based care, as does the Decatur Memorial Hospital's Home Health Service. In addition, the local Department of Rehabilitation Services supports home-based services and may be a resource for Enrollees.

3.2.3.7.1.2.4 Is person-centered; and
3.2.3.7.1.2.5 Encourages consumer-direction.

Macon County Care Coordination's Care Planning process is based on the involvement of the individual in the design and consent to an individual plan of care. The Enrollee's care plan is developed for the Enrollee, with the help of the professionals surrounding the Enrollee and the Enrollee's medical home. The care plan is developed with the Enrollee, focused on the Enrollee's improved health and on the Enrollee's improved ability to self-manage his/her illness. The protocol for care planning and involvement of the Enrollee will be followed for all Enrollees, regardless of payor source.

3.2.3.8 *Describe how you will maintain a profile for each Enrollee that includes:*

3.2.3.8.1 *Demographics;*

3.2.3.8.2 *PCP;*

3.2.3.8.3 *Results of risk assessment, if applicable; and*

3.2.3.8.4 *Care management assignment, if applicable.*

Macon County Care Coordination will maintain Enrollee information through the use of its electronic health information system. Access to relevant clinical information in a timely manner is the key to identifying care needs, anticipating future health risks, insuring positive health outcomes and avoiding negative health outcomes. Health information technology is viewed as an essential tool for care coordination. Information to be made available through Macon County care Coordination's electronic health information exchange system and for care coordination functions, as developed, will include the following:

1. key socio-demographic information about the enrollee;
2. results of screening, assessment and risk assessment;
3. service utilization (hospital admissions, emergency room visits, outpatient visits);
4. primary care provider location;
5. care coordination assignment;
6. diagnoses
7. the enrollee's individual's Care Plan, including: care needs, goals and action steps;
8. case notes;
9. medications;
10. laboratory requirements and laboratory results data;
11. current primary and other healthcare provider contact information;
12. care coordination monitoring notes;
13. Scanned legal documents (Power of Attorney, Guardianship, Authorizations for Release).

Each Collaborator, service provider and the Enrollee will have secure access to an Enrollee's profile and Care Plan information. As individuals are enrolled, Care Coordination staff will complete consent for care coordination and necessary authorization for release of information forms, enter key demographic information about the Enrollee and solicit input from active service providers of all current assessment information. A Care Coordinator will be assigned by the Team Leader, according to the Enrollee's specific needs. The assigned Care Coordinator and supporting team members will review DHFS – Provided service utilization data and summarize this information in the Enrollee's profile. The assigned Care Coordinator will be responsible for conducting an initial risk assessment and coordination of the care planning. Included in this process will be the Enrollee, significant others

as identified by the Enrollee, and representatives from the Enrollee's medical home and current providers of service to the Enrollee. The Care Coordinator will be responsible for documentation of planning. Active service providers will be requested to provide, electronically, their assessment reports, case notes, treatment plans, lab reports (if any), and a listing of and updating of current medications, with appropriate authorization for release of information by the Enrollee. The Care Coordinator will be responsible for maintaining a current roster of the primary care provider and all service providers, including contact information for each, maintaining profile information for each Enrollee and securing all necessary signed release of information documents necessary for health information exchange.

3.2.3.9 *Submit a sample Enrollee profile as Attachment J.*

Please see Attachment J for a sample Enrollee profile. The profile is presented as a series of input screens from the Macon County Care Coordination adaptation of the Streamline Healthcare Solutions software that the Care Coordination program plans to use in implementing the program.

3.2.3.10 *If you are proposing to operate as a health home and serve Clients eligible under Section 2703 of the ACA, describe:*

Macon County Care Coordination is not proposing to operate as a health home.

3.2.3.11 *What is your approach to discharge planning and ensuring Enrollees receive appropriate follow-up services?*

Discharge of an Enrollee will occur under only three circumstances:

1. If the Enrollee expires;
2. If the Enrollee, after diligent effort, is not able to be located. Diligent effort includes at least three attempts to contact the Enrollee in person at his/her last known address, contact with the Medical Home and with each of the last known service providers, seeking new contact information or information about the Enrollee.
3. If the Enrollee reaches autonomy in health care self-management. The criteria for autonomy will be determined on an individual basis and with the Enrollee's input and agreement.

If the Enrollee reaches a level of autonomy in healthcare self-management, he/she will be provided with a discharge plan that includes instruction for continuation in self-management, contact information for the care coordinator, for use if additional information is needed, a contact list of all recent and current service providers and a final review of prescribed medications. Discharged

Enrollees will be offered the opportunity for re-enrollment if the need exists. In addition, the discharged individual will be informed that a representative of the care coordination team will follow up in 90 days with a phone call or visit, to check on their continuing self-management.

3.2.3.12 *How will your model of care decrease hospital readmission rates?*

Readmissions to the hospital may occur because of behavioral choices, such as non-compliance with dietary recommendations or medication regime. Readmissions may occur as a result of an adverse event that occurred following the initial hospitalization or as a result of a lack of social support, follow-up care, understanding of discharge instructions, or communication following discharge. These may be considered avoidable readmissions that occur as a result of a breakdown in the system of care. Individuals with multiple chronic health conditions and/or serious mental illness are at high risk for readmissions. Engaging providers and patients at each point along the system of care in efforts to improve communication, coordination, and discharge planning is essential to decreasing inappropriate and costly hospital readmissions.

The transition from the inpatient to the outpatient setting is a critical point in which there is a real opportunity to prevent readmissions. For example, the provision of care by hospitalists has the potential to create discontinuities in care, both at the time of admission and at discharge. Hospitalists may be unfamiliar with a patient's health and social history and, once a patient is discharged to the outpatient setting, the primary care physician may be unfamiliar with the rationale behind care provided in the inpatient setting. While the hospitalist may try to contact primary care provider to discuss care and discharge plans, it is often difficult to communicate directly with community-based providers. And, additionally, the current payment system does not allow payment to both a hospitalist and primary care physician on the same day for evaluation and management of the same clinical condition if the physicians are in the same medical group and specialty. Care Coordination can serve as a bridge for communication through relationship development with the Hospitalist and with outpatient care providers and follow up to ensure that communication between inpatient and outpatient settings has been transmitted. The Hospitalist is considered as a part of team-based care, and the Care Coordinator provides an assist in transmitting information across the transition from inpatient service to outpatient service.

The posting of the discharge plan and related treatment information in the central electronic health information exchange and advisement to all treatment partners that this central repository exists and is accessible serves as another important communication vehicle. Maintenance of this information in a constantly current status provides value to those providing treatment for the Enrollee. All treatment partners are able to see what treatment has been provided in other settings and how their treatment offering may fit in with and complement other treatment services.

Although patients may receive inpatient discharge plans from a nurse or social worker, they may not fully understand follow-up care instructions or have the ability to appropriately self-manage their care. Oftentimes, patients do not visit their primary care physician in a timely manner following discharge. Follow up calls or visits provided by the Care Coordinator may help to ensure that patients are receiving appropriate follow-up care. Care Coordinators may provide or advocate for answers to any outstanding questions that the patient may have. Care Coordinators may also support the Enrollee's efforts to get to his/her follow up appointment by providing reminders, helping with transportation, or accompanying the Enrollee to the appointment. The care coordinator's role in this situation is to conduct a patient assessment within 24 to 48 hours after discharge, reconcile patient medications, ensure prescriptions are re-filled as needed and ensure follow-up care with the primary care physician or ancillary services within 4 to 7 days. Additional activities may include supporting timely follow up care; reinforcing compliance with dietary, medication or other regimes; contingency planning for crises; communicating with outpatient treatment sites; providing additional support; making treatment information available to all involved parties; anticipating problems and pursuing problem solving. Reducing hospital re-admissions, Jenny Minott, Nov. 2008, Academy Health at www.academyhealth.org.

An additional strategy for avoiding re-admission may include development of a crisis plan for the Enrollee, listing appropriate numbers to call when certain symptoms are presented, reviewing it with the Enrollee, in person, and posting it on the Enrollee's refrigerator. For those Enrollee's identified as high risk for re-admission, another strategy is the front-loading of follow up visits by the Care Coordinator and/or the individual's mental health case manager or home health nurse, to provide the extra support that may be needed in the days/weeks following the hospitalization.

3.2.3.13 *Describe the process for identifying mental health and substance abuse issues among primary care patients and ensuring the delivery of appropriate mental health and substance abuse care.*

The Community Health improvement Center, as medical home, employs a depression screening as part of patient evaluation and routinely screen for mental health and/or substance abuse issues. In addition, the primary care staff has access to and referral capability through on-site mental health counseling staff and has used this process on an ongoing basis. In addition, Heritage Behavioral Health Center has counseling staff on-site at the Community health Improvement Center and receives referrals directly from the primary care provider. All individuals referred by Heritage Behavioral Health Center have undergone a comprehensive mental health and/or substance abuse assessment prior to referral to the primary care provider.

3.2.3.13.1 *Describe how you will educate PCPs in your CCE or MCCN about the importance of screening for mental health and substance abuse issues and the use of evidence-based practices in the treatment of Enrollees with SMI and substance abuse disorders.*

The Community Health Improvement Center has been highly invested in collaboration with the behavioral health service providers in the community and has incorporated mental health and substance abuse screening as part of its assessment procedures. The Macon County Mental Health Board has supported funding of mental health counseling services at the Community health Improvement Center since the early 1990's .An ongoing formal set of interaction between the Center and Heritage Behavioral Health Center has resulted in a high level of information exchange. The two organizations have invested significant energy to develop and evidence-based integration of services. The Care Coordination program will build upon this existing relationship and provide additional support to the medical Home and reinforce the importance of screening for mental health and substance abuse issues.

In addition to the enhanced screening and treatment processes that has developed between Community Health Improvement Center and Heritage Behavioral Health Center, the Southern Illinois University School of Medicine's Healthcare Clinic employs a licensed clinical social worker who serves as an instructor for physicians of the Practice and provides treatment services upon referral from Practice physicians. This clinical position has been part of SIU family Practice for over 20 years.

3.2.3.14 *Please describe your plans, if any, to co-locate physical health and mental health or substance abuse services.*

The Community Health Improvement Center (CHIC) co-locates APN nursing staff at Heritage Behavioral Health Center for health screenings and work with the Heritage psychiatrists. CHIC also co-locates APN nursing staff at the Macon County Health Department for health screening and consultations. Heritage Behavioral Health Center co-locates mental health counselors at CHIC and at the Macon County Health Department for assessment, referral and counseling.

Two of the Core Collaborators, Community health Improvement Center and Heritage Behavioral Health Center have been engaged over the past three years in an effort to integrate primary and behavioral health care. These organizations are using a conceptual model for integration called the "four quadrant model", a nationally recognized approach to service integration. The model is advanced by the National Council for Community Behavioral Healthcare and was initially developed by state mental health and substance abuse directors (National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors) with the support of the Substance Abuse and Mental Health Services Administration. Within this model, the

Community Health Improvement Center serves as the medical home for patients. Heritage Behavioral Health Center serves as the behavioral health home for clients. The majority of these clients have the Community Health Improvement Center's physicians as their medical home. The tenets of this model are as follows:

- communication exists when each clinician caring for the patient shares needed clinical information about the patient to other clinicians also treating the patient;
- collaboration is multidimensional, requiring a shared understanding of goals and roles, effective communication, and shared decision making;
- care coordination is the outcome of effective collaboration and corresponds to clinical integration;
- clinical integration is the extent to which patient care services are coordinated across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients. (Report to Congress on the Prevention and Treatment of Co-occurring Substance Abuse Disorders and mental Disorders, SAMHSA, 2002)

Through a SAMHSA grant, Heritage is integrating primary and behavioral healthcare with a team of two nurse care managers, one non-nurse care manager, a health and wellness coach and a Project Director. With a goal of 250 enrollees, 180 clients are currently served. A physician assistant, who is a contracted employee from the Federally Qualified Health Center (Community Health Improvement Center), is co-located at Heritage 20 hours per week. Heritage also has a counselor located at CHIC and at the Macon County Health Department, both supported with funds from the Macon County Mental Health Board).

Likewise, Community Health Improvement Center has primary care providers co-located at two Core Collaborator locations (Macon County Health Department and Heritage Behavioral Health Center). Procedures have been established among these three organizations for accessing, on a limited basis, healthcare information from each respective organization's clinical records, based on appropriately completed releases of information. Although this information exchange is not currently occurring electronically, the protocols for this exchange have been under discussion for the past year.

In addition, Heritage has an MSW Inpatient Liaison on the psychiatric inpatient unit at St. Mary's Hospital on a daily basis, providing case consultation, treatment planning, discharge planning and linkage to outpatient mental health and/or substance abuse services. Heritage also provides on-site services to individuals in the Emergency Departments of both St. Mary's Hospital and Decatur Memorial Hospital, at the request of the Emergency Departments. This availability exists 24 hours a day, 7 days a week. Service includes assessment, consultation and referral, as needed.

Further co-location is planned as the care coordination model is implemented, in which care coordination staff will be provided work locations adjacent to each of the hospitals' Emergency Departments. This will permit them to access each of the hospital's internal medical information data, retrieve medical information about care coordination enrollees and will facilitate interaction with Emergency Department staff. Similarly, care coordination staff will be provided work space at

Heritage Behavioral Health Center, the Health Department and the Community Health Improvement Center, to facilitate communication. Co-location will be facilitated through contractual arrangement for space usage between the core collaborator/provider and Macon County Care Coordination.

3.2.3.15 *Describe the process for emergency department data utilization review and identification of Enrollees with high utilization.*

Each Enrollee's electronic health information gathered by Care Coordinators will include utilization history. Emergency department utilization is a key part of this required data set. Each Enrollee's profile will include a review of Medicaid claims data and recording of all ongoing utilization of services. Those individuals identified as high users of emergency department services will be prioritized for engagement and enrollment. Through agreement with the community hospitals, all Enrollees, upon enrollment with Macon County Care Coordination, will be pre-registered at both of the community's hospitals and associated with the care coordination program. Through this electronic registration and association by program, utilization reports will be auto-generated by each hospital's information system on a daily basis and notice of these reports' availability forwarded to the Care Coordinator's e-mail. The Care Coordinator will have the ability to log in to each hospital's information system on a daily basis to access these reports. In addition, regular management reports will be provided to the core collaborators from the care coordination information exchange system (See Section 3.2.4, Health Information Technology), indicating utilization and utilization patterns.

3.2.3.16 *Explain the strategies to address high emergency department utilization that you will implement.*

Emergency Department use continues to be a significant cost to the healthcare system, regardless of insured status, constituting approximately 50% of all hospital visits nationally. Medicaid beneficiaries, who would be uninsured without the public program, were much more likely to use the ER in a 12-month period and to have had multiple visits than the uninsured and privately insured. (*Uninsured don't use ER more than insured, but Medicaid patients do. May 20, 2010, Lisa Scott Centers for Disease Control and Prevention (CDC), May 2010).*

Emergency departments are challenged by staffing issues and, at times, availability of primary care and specialty consultant services. Emergency Department use for non-emergent care is very costly. The patient "dis-incentive" of increased co-pays has not seemed to significantly impact and deter the use of the Emergency Department. Diversion efforts have not had significant impact on reduction of and/or more appropriate use of Emergency Departments. Strategies discussed most often in literature and research on the issue of Emergency Department over-utilization encourage the increased use of electronic health information exchange to provide data critical to improved

healthcare, the increased implementation of the medical home concept, capacity building for primary care and partnering between and among healthcare providers. *Community Health Integrated Partnership, Emergency Department Over-Utilization A New Paradigm? May 27, 2009, Salliann Alborn, www.chipmd.org.*

Macon County Care Coordination seeks to address Emergency Department utilization issue at our two local hospitals though the expanded implementation of the medical home concept, the further development of a healthcare/behavioral healthcare partnership of local collaborators, the establishment of an electronic health information exchange system that will permit health information exchange for enrollees and increased focus on communication between and among the Enrollee's service providers with a care plan that coordinates service provider treatment efforts.

Current practice includes on-site intervention at each of the two hospital Emergency Departments by Heritage Behavioral Health Crisis Service staff for psychiatric crises. The Crisis staff meets with the patient, assist the ED staff with recommendations and facilitate next day follow up by behavioral health treatment staff. Both hospitals provide electronic notice of a patient's treatment in the Emergency Department to the patient's primary care physician, if identified.

Health care partners need 24 hour turn-around notification of Emergency Department utilization, provided to the patient's medical home and care coordination program. The ability of Care Coordinators to access a daily utilization report as described above will indicate hospital services used by Enrollees at either of the hospitals. As protocols with the hospital partners become established, the Care Coordinators will become able to identify a specific cohort of enrollees who have high Emergency Department utilization, can reach out to them and/or can advise those providers in the network who are or recently have provided services to these individuals and offer opportunities to engage with those patients. A practice of next-day follow up with the Enrollee by the service provider and the care coordinator will be important in shaping the Enrollee's approach to managing health crises. Encouraging the Enrollee to use the services of the medical home and/or current service providers prior to development of a crisis and the development with the Enrollee of a "crisis plan" for future difficult times are additional tools for response to Emergency Department use.

Moving away from over-utilization or inappropriate use of Emergency Department services and toward preventative healthcare measures will require behavior modification on the part of patients as well as providers. The patient will need education on how to better manage urgent health situations, to learn to pay attention to warning signs of health problems and to be more pro-active in health management in order to avert Emergency Department service need. A closer relationship with the primary care provider and the Enrollees care coordination team can help with this change in behavior process. The providers will need timely information on service utilization, the ability to exchange information about all current services offered and opportunity to learn about best practices for the individual Enrollee. The core collaborators in the Macon County system of health care providers will seek an improved partnership for healthcare delivery, involving the two hospitals, Heritage Behavioral Health Center, the Community health Improvement Center, the Health Department and social service

organizations of the community. *Reducing Avoidable ER Visits Jackie Huck, Community Health Network of Washington, 2011.*

3.2.3.17 *Describe strategies you will employ to promote wellness and encourage access to and utilization of preventive care.*

Promoting wellness for an individual with serious illness requires a consistent, caring and encouraging approach to care and support. Care Coordinators will strive, through the application of motivational interviewing skills to encourage and reinforce positive efforts by enrollees to begin assuming responsibility for self-care and illness self-management. In addition, through communication with and exchange of information with service providers, Care Coordinators will encourage providers to reinforce enrollees in their efforts at positive self-management of their illness(s). Enrollees will be provided information about positive activities that promote wellness, including health education activities and social /recreational activities. Care coordinators will also advocate for inclusion of enrollees in structured events provided by the community's social serve and other organizations. In addition, Enrollees will be offered the opportunity to earn small reinforcers for participation in regularly scheduled primary care and behavioral health care appointments and annual physical exams. Case Coordinators will offer to accompany enrollees to annual physical exams and/or preventative screenings.

3.2.3.18 *Describe how you will educate PCPs on their responsibilities for compliance with the American Disabilities Act.*

The Care Coordination program will be working most frequently with primary care providers in the federally qualified health setting, Community Health Improvement Center. The Center is required to comply with the Americans with Disabilities Act. Similarly, the SIU School of Medicine's Healthcare Clinic, as it begins its pilot medical home design, is required to comply with the Americans with Disabilities Act.

3.2.3.19 *Describe the strategies that you will utilize to address Potential Enrollees who are very mobile, difficult to locate, homeless, or difficult to engage.*

The Care Coordination program has established a working relationship with the community's Salvation Army, as a network provider of services. The Salvation Army provides emergency shelter for homeless individuals, among other services. In addition, working relationships exist with other homeless shelters in the community. The core collaborators have been long-standing members of the community's Homeless Council, an organization chaired by DOVE, Inc. Heritage Behavioral Health

Center operates a drop-in center for homeless individuals, which is anticipated to serve as a referral source for prospective. Heritage Behavioral Health Center and both hospital Emergency departments have a well-established relationship with the City Police Department. Care Coordination staff will be expected to engage in outreach activities, during the day, evening and weekend and to use any existing individual, social service or other relationships in an effort to engage homeless and difficult to engage individuals.

3.2.3.20 *Describe methods you will employ to ensure your care coordination model takes into account the culture of and the specific needs of the population you propose to serve.*

A goal of care coordination is to maximize access to and benefit from programs, services and activities offered by providers to Enrollees, including those individuals who may experience limited English proficiency; those who are deaf or hard of hearing and prefer to use sign language; and/or, those who demonstrate unique individual differences along the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs or other ideologies. Staff recruitment and selection will reflect the diversity of the Macon County population and the demographic composition of our target populations. Staff will be provided with education and training in culturally and linguistically appropriate interaction and service delivery. Training activities will include dissemination of information on workshops, classes, on-line learning and literature about diversity issues; organization of workshops and seminars about diversity issues; cultivation of a work environment in which individuals can be respected as individuals regardless of beliefs, customs and backgrounds; review and analysis of data for personnel transactions and presented complaints to ensure that personnel decisions do not violate equity and fairness principles; promotion of awareness of and celebration of the cultural diversity of our staff, and clients (e.g., observance of religious holidays, culturally significant days and activities).

3.2.3.20.1 *Describe how you will supply interpretive services for all key oral contacts and ensure that written materials can be easily understood by the various populations.*

When an Enrollee demonstrates a special language need or limited English proficiency, making it difficult to benefit from a Provider's services without some type of assistance, care coordination staff will obtain appropriate resources, or make a referral to a provider, to obtain translator/interpreter, and/or other services (e.g., is deaf, blind, has cognitive impairments, etc.). Staff shall refer identified language assistance needs to their Team Leader. The Leader shall respond by securing needed specialized services. Bilingual/translation services shall be arranged through contract. Cost varies depending on language services required. Services may be

contracted for provision on-site at the Provider's offices. Services are available through Richland Community College, Millikin University, University of Illinois and private contractors. Core Collaborator staff include those with language skills in several languages, including sign language skills. Staff will be trained in resource availability and referral processes. Staff members will be trained to summarize/paraphrase in ways that do not cause embarrassment to clients with literacy deficits.

Written materials will be tested with comprehension-sensitive word processing software, targeting comprehension at a ninth grade reading level. Written materials presented in languages other than English will be reviewed by consulting Interpreter staff to ensure comprehension capability.

3.2.3.20.2 *Describe alternative methods of communication and how Enrollees will access these methods.*

Enrollees who have special communication needs will access alternate methods of communication through involved service providers or through referral by Care Coordinators for specific communication services or aids. Heritage Behavioral Health Center has the ability to access translator services through the Department of Human Services. Macon Resources, a network provider, has access to communication boards, as needed. The Care Coordinator will be responsible for researching services for identified communication needs and securing or advocating for access to those services for the Enrollee.

3.2.3.21 *Describe any incentives you will allow PCPs and other Providers to use to encourage healthy behaviors and patient engagement in preventive care.*

Consistent with care planning for the individual Enrollee, the PCP and other providers will be allowed to use any incentives that are available through their own resources. Care Coordinators will advise providers if there are incentives being made available through the care coordination program, permitting the service provider to reinforce efforts by the Enrollee to earn those incentives. Service providers may also establish conditions, as part of their program planning with the Enrollee, for earning incentives or reinforcers. Care Coordination staff will support service providers in this programming.

3.2.3.22 *To the extent your model includes care coordinators, provide proposed care coordinator to Enrollee ratios and describe:*

Three levels of care coordination will be provided. Care Coordinator to Enrollee ratios will be based on Enrollee health risk and intensity of care coordination activity.

- Intensive Care Coordination: The Care Coordination to Enrollee ratio will be 1:80.
  Intensive care coordination serves individuals at high risk for poor health outcomes. This level of service includes frequent and multiple contacts with the Enrollee and the Enrollee's medical home, service providers, family and significant others. It also includes resource-finding and problem solving around obstacles in access to care or needed services and supports. Specifically, it may include in-person visits within 24 hours of hospitalization and/or Emergency Department visit, active participation in hospital discharge planning, post-hospital visit medication reconciliation, in person support at approximately 72 hours post hospitalization and/or Emergency Department visit, at least weekly follow along 4 weeks post hospitalization. Patient education may include identification of "red flag" indicators for health problems and use if crisis planning. It may include accompanying the Enrollee to follow up medical appointments finding and taking food supplies to the Enrollee or assisting in meeting other needs of the Enrollee during service transition. Care Coordination will also include regular dialogue with service providers working with the individual, comparing findings on the Enrollee's functioning, collaborative planning to anticipate problem areas or obstacle to treatment and advisement to the Medical home and other providers of high-risk concerns.
- Supportive Care Coordination: The Care Coordination to Enrollee ratio will be 1:120.
  Supportive care coordination includes regular weekly or bi-weekly contact with the Enrollee to monitor functioning, support and reinforce adherence to care plan, identification of potential obstacles to progress in treatment, responsiveness to Enrollee expressed needs, problem-solving with the Enrollee, advisement to service providers of Enrollee functioning. Health education may include discussion of "red flag" indicators, crisis plan use, symptom recognition, health and wellness practices and medication management. Health education may also include invitation or referral to health and wellness activities and responsiveness to Enrollee requests concerning health issues.
- Preventative Care Coordination: The Care Coordination to Enrollee ration will be 1:180.
  Preventative Care Coordination includes at least monthly interaction with the Enrollee for assessment of functioning, health and wellness discussion, invitation or referral to health and wellness activities, health education materials presentation, responsiveness to Enrollee requests concerning health issues.

3.2.3.22.1 *How caseloads will differ depending on the needs of the Enrollees they are assigned;*

Enrollees will be assigned based on their primary identified needs. Those individuals with high-risk medical issues will be assigned to the Team Advance Practice Nurse. Seriously mentally ill

individuals will be assigned to Care Coordinators with expertise in mental illness. Those individuals with co-occurring disorders of serious mental illness and substance abuse will be assigned to the Care Coordinator with experience and training in co-occurring disorder treatment. Those individuals whose needs are identified as involving multiple social service provider services will be assigned to the Care Coordinator with social service training and experience. Care Coordination Navigators will assist the Care Coordinators and Enrollees in coordination activities and will provide supportive and preventative care coordination activities. While caseloads may differ over time, care coordination activities will be similar across staff positions.

3.2.3.22.2 *The qualifications of care coordinators and whether they vary depending on the Enrollee assigned;*

Qualifications for care coordinators will vary depending on the set of Enrollees assigned to the Care Coordinator and Care Coordination team responsibilities. The Care Coordination Team will include the following staff, with qualifications as described:

Team Leader: This individual will be an Advance-Practice Nurse with experience working with seriously mentally ill individuals and knowledge of psycho-active medication administration, monitoring and training.

Mental Health Specialist: Two individuals will serve in this role. These individual will have a Master's degree in mental health or a related field, preferably be llicensed as a Clinical Professional Counselor with at least 5 years of experience working with seriously mentally ill individuals, working knowledge of Medicaid mental health services, working knowledge of Medicaid substance abuse services and experience in treating individuals with co-occurring disorders of mental illness and substance abuse.

Social Service Specialist: This individual will be a Master's degree Social Worker, with at least 5 years' experience working with seriously mentally ill individuals and, preferably, experience working with geriatric patients.

Navigators: Three individuals will serve in the role of Navigator. Two of these individuals will have a Bachelor's degree in the field of social service and at least 2 years of experience working with seriously mentally ill individuals or an Associate's degree and at least 4 years of experience working with seriously mentally ill individuals. One of these individuals will have a Bachelor's degree and at least two years of experience working with geriatric patients or an Associate's degree and at least 4 years working with geriatric patients.

Administrative Assistant: This individual will provide support to the program director and the Care Coordination Team.

All Care Coordination staff will be required to have a valid Illinois driver's license and auto insurance. All staff will be required to submit to a criminal records and identity background check, verifications (I9, employment, education, references and OIG exclusions) and driving record.

3.2.3.22.3 *The duties of your care coordinators; and*

Care Coordinator Responsibilities include:

- Establishing rapport and developing a relationship with the prospective Enrollee (starting with initial contact);
- Identifying, evaluating and assessing, in collaboration with the Enrollee, his/her strengths, resources, needs and priorities;
- Conducting health risk and behavioral health assessments;
- Developing care plans based on Enrollee goals and in conjunction with the Enrollee and care team;
- Facilitate planning/problem solving with the Enrollee and significant others;
- Provide information, education and encouragement needed to inform and/or motivate the Enrollee to take steps necessary to change situations placing him/her at risk;
- Monitoring care plans;
- Managing and tracking goal attainment, assessments, lab results, and referrals made by the primary care provider – to ensure timely transmission of information;
- Coordinating and maintaining critical information sharing among the care team and Enrollee; Collaborate with other providers to assure continuity and coordination of care, and
- Promoting self-sufficiency and healthy outcomes (through encouragement and motivation, reinforcement of health care regimen, anticipatory guidance, supporting home safety, promoting continuation in health care, managing behavior concerns);
- Advocating on behalf of the Enrollee, including communicating to providers their strengths, needs and feelings.
- Ensuring that Enrollees are meaningfully informed about their care options.

Care Team Responsibilities include:

- Supporting the medical home to coordinate care across the Macon County health care system including managing transitions between levels of care;
- Outreach and enrollment
- Involvement in development and implementation of care plans for Enrollees;
- Assisting in early identification, documentation, and communication of changes in health status of Enrollees;
- Providing self-management training;

- Ensuring behavioral health, social, and functional needs of the Enrollee are met;
- Identifying and making use of community resources and services not covered by Medicaid;
- Providing Enrollee health education; and
- Assuring integration of services across settings and with the medical home, including Medicaid-covered services and social services and supports not covered by Medicaid.
- Communicating with all involved parties.

3.2.3.22.4 *The training programs care coordinators may receive regarding cultural competency.*

Training activities will include dissemination of information on workshops, classes, on-line learning and literature about diversity issues; participation in workshops and seminars, as available, about diversity issues; cultivation of a work environment in which individuals can be respected as individuals regardless of beliefs, customs and backgrounds; promotion of awareness of and celebration of the cultural diversity of the staff, and Enrollees (e.g., observance of religious holidays, culturally significant days and activities).

3.2.3.23 *To the extent your care coordination model includes any of the following services, describe how you will facilitate the delivery of appropriate health care and coordinate care between medical homes and:*

3.2.3.23.1 *Specialist services;*

Specialists have been identified through a review of Medicaid claims data. Each of the physicians who have previously provided Medicaid-covered services are affiliated with and/or have privileges at one or both of the two core collaborator hospitals in the community. Each of these physicians has offices located in Decatur, most in close proximity to one of the two hospitals. Primary care physicians routinely make referral for specialist services, depending on the patient's needs. The primary care physicians located within the community and specifically, the physicians affiliated with Community Health Improvement Center, make referral for specialty services, as needed, for their patients in an outpatient setting.

The following are specialists currently providing services in the community.

Cardiology: Dr. Manohar Kola, Dr. Lius Cacerus, Dr. Tansel Turgut, DR. John Waters, Dr. Jyothinagaram Madhu, DR, Nidal Aker.

Gastroenterology: Dr. Tawhid Gazi, and Dr. Victor Eloy.

Infectious Disease: Dr. Venkat Minnaganti

Internal Medicine: Dr. Perdekamp Grosse, Dr. James Wade, Dr. Ahmad Ahmad, Dr. George Duncan, Dr. Worlali Nutakor, DR. Theodore Addai, Dr. Hma Atluri, Dr. Velma Ajay,

Dr. Sudakar Sheth, Dr. Khaled Nazzal, Dr. Ahmed Elrakhawy, Dr. Jatoi Naeemuddin, Dr. Mohammad Hasnain, Dr. Dhirendra Patil and Dr. John Newlin.

Nephrology: Dr. Mohammed Dawood and Dr. Muhammad Qureshi

Neurology: Dr. Douglas Dove, Dr. Zaheer Ahmed, Dr. Tony Collins and Dr. Allen Devleschoward

Neurology Surgery: Dr. Tom Fulbright, Dr, Oliver Dold and Dr. Robert Kraus

Obstetric-Gynecology: Dr. Jeffrey Pfeiffer, Dr. Tony Amiewalan, Dr. Roy Tsuda, Dr. Adel Hanna, Dr. Derin Rominger, Dr. Gretchen Byrkit, Dr. Angela Anderson, Dr. Evelyn Odunsi, Dr. Vidya Morisetty, Dr. Trevor Lineberry,

Oncology: Dr. Dolorus Estrada, Dr. Perry Guaglianone, Dr. Mario Velsco, Dr. Benjamin Esparaz, Dr. Phillip Dy and Dr. Justin Floyd

Ophthalmology: Dr. Marcus Deranian, Dr. Gary Gillham, Dr. Phillip Alward and Dr. Sushant Sinha

Orthopedic Surgery: Marshall Brustein, Dr. Jeff Smith, Dr. Ken Tuan, Dr. John Britt, Dr. John Kefalas, Dr. Ed Raycraft, Dr. Tyler Jones and Dr. Steve Huss

Otolaryngology: Dr. Steve Sobel, Dr. Bethany Gibson and Dr. Azhar Aslam

Otorhinolaryngology; Dr. Steve Chadwick and Dr. Terry Woods

Pathology: Dr. David Johnson, Dr. Sue Strayer, Dr. Alan Frigy

Pediatric Surgery; Dr. Martin Okpalike

Pediatrics: Dr. Samir Patel, Dr. Solfia Saulog, Dr. Ben Brooks, Dr. Christina Branham, Dr. Mayra Arzon, Dr. Mourad Alatour and Dr. Irfan Ali

Physical Medicine and Rehabilitation: Dr. Wendell Beckman

Psychiatry: Dr. Chourary Kavuri, Dr. Rohi Patil and Dr. Doug Ellis

Pulmonary Disease: Dr. Jon Arnold and Dr. Carol Chen

Radiation Oncology: Dr. Michael Bruin

Radioogy: Dr. Bob Dodenhoff, Dr. Gene Forry, Dr. Howard Wiarda

Radiology Diagnosis: Dr. Jeff Boorstein, Dr. John Locke, Dr. Mark Muscato and Dr. Deol Baljit

Radiology Therapeutic: Dr. Mary Anne Depaz

General Surgery: Dr. Steve Weber, Dr. Albert Gilamn, Dr. Doug Maibenco, Dr. Dwain Rogers, Dr. Tim Bailey, Dr. Scott Sherwood, Dr. Jeff Trachtenberg, Dr. Manuel Duron and Dr. George Liu

Following are primary care physicians and Advance Practice Nurses currently providing services to seriously mentally ill clients of Heritage Behavioral Health Center:. Amanda Shills, APN; Dr. Anthony McCormick; Ayaz Ahamed (CHIC); Colleen Bowles (CHIC); Deb Destreich (CHIC); Dr. Bock; Dr. Buckner (CHIC); Dr. Cavanaugh; Dr. Chandra (CHIC); Dr. Duncan; Dr. Gill (SIU); Dr. Hebertson; Dr. Jatoi; Dr. Kamath (SIU); Dr. Kaur (SIU); Dr. Kirkwood (SIU); Dr. Koli; Dr. Konda; Dr. Kumar (SIU); Dr. Leiser (CHIC); Dr. Muneses; Dr. Newlin; Dr. Pabalate (SIU); Dr. Ramdass (SIU); Dr. Ray (CHIC); Dr. Thomson (CHIC); Dr. Yockey (CHIC); Jamie Forsythe, APN (CHIC); Jessica Sullivan, APN (CHIC); Lisa Smith, APN (CHIC); Michael Bell (CHIC); Phil Shills APN

(CHIC). Dr. Pabalate is no longer employed by CHIC but is in private practice with Dr. Konda. These two doctors are developing their practice and currently take Medicaid patients.

The primary care physicians typically make the referrals for specialist services. Heritage typically provides follow-up for registered clients and ensures the clients get to those specialist appointments. Care Coordination staff will work with Heritage nursing staff, focusing on high-risk Enrollees, as additional support for the Enrollee's follow up for specialty services. The following specialists are currently providing services to Heritage clients:

Surgeons:

Dr. Peter Birk (most often)

Dr. Brian Telle (one patient referred there)

Pulmonology:

Dr. Jon Arnold and Dr. Carol Chen

Gynecology:

Dr. Trevor Linberry

Cardiology:

Prairie Cardiovascular: Dr. Caceres and Dr. Kola

Urology:

Dr. Canham

Dentist: (located in Taylorville, Illinois

Podiatrist:

Dr. Jason Anderson

Heritage staff report that three specialty areas are difficult to access. These include Dermatologists, Neurologists and Dentists. This information will be used by the Care Coordination team in an effort to advocate for expanded access to service in these specialty areas. The Care Coordinators role in accessing specialty services includes advocacy for the Enrollee for specialty care services, assisting in planning for and arranging services and follow up with the Enrollee after specialty consultations, encouraging the Enrollee to pursue specialist recommendations. Advocacy for service provides an additional voice in support of the Enrollee, making the case for needed additional services that the Enrollee may not be able to express or may express without success.

3.2.3.23.2 *Dental services;*

The Community Health Improvement Center has dental services for adults available through its affiliate office in Champaign, Illinois on an emergency basis. The clinic works with the Community Health Improvement Center, Parkland College's dental hygiene clinic and local dental offices. The Macon County Health Department has on-site, scheduled dental services for children. The Health

Department and Community Health Improvement Center are core collaborators for care coordination and will assign liaison staff to work with the Care Coordination team for access to dental care.

In addition, the following dentists in the community have provided dental services to Medicaid eligible individuals, according to 2010 Medicaid claims data and may be asked by Macon County Care Coordination for inclusion in the network of providers for Enrollees: Dr. Paul Pladziewicz, Dr. Howard Stone, Dr. Lee Bennett, Dr. Aaron Parsons, Dr. Cliff Brown, Dr. Khin Laij, Dr. Mark Brunk, Dr. William Wall, Dr. Katherine Faber, Dr. Michael Lask, Dr. Lindsey Ingle, Dr. Kelly Clark, Dr. Richard Brown, Dr. Phil Jones, Dr. Bruce Wintersteen, Dr. Paul Miller, Dr. Kathy Eaton, Dr. David Trost, Dr. Susan Goldstein, Dr. Ken Webb, Dr. Ryan Johnson, Dr. Susan Maurer, Dr. Bradly Bush, Dr. Lily Laij, Dr. Brian Hastings, Dr. Jonh Ferry, Dr. Todd Johnson, Dr. Howard Crystal, Dr. Mathew Bell, Dr. Thomas Fonner (oral surgeon), Dr. Ibrahim Massoud, Dr. Denise Flynn (Orthodontist), Dr. Ajay Joshi.

3.2.3.23.3 *Existing HCBS Waiver case management services; and*

Macon County Health Department and St. Mary's Hospital are currently providing HCBS waiver services for the elderly, supported by the Department of Aging. Catholic Charities and C.H.E.L.P. currently provides HCBS waiver services supported by the Department of Human Services' Division of Rehabilitation Services. Although this care coordination proposal will focus on seriously mentally ill individuals and seniors with chronic health conditions, it is anticipated that an individual enrolled with Macon County Care Coordination may be involved in programming with C.H.E.L.P., Catholic Charities and/or St. Mary's Hospital. These social service and healthcare providers are involved with the core collaborators in service provision on an ongoing basis and have been approached to serve as network service providers. Existing referral mechanisms are in place between and among each of these organizations and with all of the core collaborators.

3.2.3.23.4 *Other community agencies and services.*

The Care Coordinators will have access to a comprehensive listing of local community agencies and services and will be expected to familiarize themselves with these offerings. This listing of services is maintained through the Mental Health Board's office. (See Attachment L, Community Resources) Service resources are organized by category of need (i.e., housing, food, etc. Because Macon County is somewhat a self-contained community, community agencies and their staff interact over time and develop working relationships that facilitate access to services. Care Coordinators will be expected to research treatment and service options on a case-by-case basis, make connections for Enrollees where opportunity exists and advocate for service when

obstacles are encountered. Community agency providers engaged in service with the Enrollee will be asked to participate in the care coordination network of providers and in care coordination activities.

3.2.3.24 *To the extent your care coordination model includes medication management, describe your approach to monitoring prescription drug usage including selected standards, models, and algorithms.*

The focus of medication management is on the elimination (or reduction of risk) of adverse medication/medical outcomes based upon drug interactions, poly-pharmacy, and lack of coordination between multiple physicians who are prescribing. The Care Coordination program nursing staff will provide medication reconciliation for the Enrollee at the point of transition of care, from inpatient tor outpatient care, post-physician visit involving medication changes or other transitions, as indicated. Medication management will also include education for the Enrollee for self-management. Information for the Enrollee will include explanation of the medication's mechanism of action, what the Enrollee should expect as a benefit from the medication, the side effects that may occur, any adverse effects that may occur, how to handle a missed or late dosage and any specific activities that the Enrollee should consider as part of self-management of his/her medications. The Care Coordinator may also help the Enrollee in devising a personal system for medication management, including a home storage system and a method for reminders for proper dosage, aimed at increasing medication adherence. The Care Coordinator may also assist in communication with the pharmacy for timely medication refills. Coordination of these support activities with the Enrollee's case manager at either Heritage Behavioral Health Center or the Health Department will support medication management, decrease risk of adverse reactions from drug interaction, poly-pharmacy or inadequate communication across providers.

Heritage Behavioral Health Center, through its onsite Genoa Pharmacy Service, is in discussion for the use of CMT's ProAct Analytics ä software. CMT's ProAct Analytics ä provides abstraction, aggregation, analysis, and interpretation of data, both prospectively and retrospectively, to aid clinical and financial risk analysis and management of a population. CMT integrates behavioral pharmacy and services data, and medical services and pharmacy data and analyzes this information in respect to proportional financial risk, including adherence markers, gaps in care, medical-behavioral co-morbid conditions that are associated with elevated cost burden, and chemical dependency or underlying addiction or substance dependency concerns. CMT also offers clinical guidance regarding cost and quality improvement opportunities. Heritages interest is in reducing unnecessary behavioral health inpatient days, reducing behavioral health inpatient readmission rates, and improving rates of engagement in outpatient post discharge treatment.

3.2.3.25 *To the extent your plan includes Enrollee health education plans, explain your plans and submit sample materials.*

Heritage has implemented the curriculum for Whole Health, Wellness and Resiliency program for seriously mentally ill individuals. Currently it is staff led, but The Center plans to gradually turn this responsibility over to clients with support from staff. Weekly groups are currently scheduled, are well received and well attended. Wellness activities continue to be added to the curriculum including, this year, smoking cessation, diabetic education classes, and trauma sensitive yoga. Heritage's Health and Wellness coach has become certified in yoga, trauma sensitive yoga, smoking cessation, personal training, and zumba. Currently being held are six weekly exercise classes, 2 cooking classes, 1 nutrition education class and 2 yoga classes using trauma sensitive yoga techniques, 2 water exercise classes at the YMCA in the therapy pool, a smoking cessation and a diabetic education class each week. In addition, the health and wellness coach holds 1:1 exercise classes for 2 clients each week who are too obese to attend or who wish not to attend with other consumers. Three clients who were immobile are now mobile and able to attend exercise group classes. Curricula in use include the Lilly Curriculum for Team Solutions and Solutions for Wellness, an adaption to the In-Shape program, and a smoking cessation program, "Learning About Healthy Living and You," by Jill Williams M.D. It is a collaborative curriculum by New Jersey Division of Mental Health Services, Robert Wood Johnson, University of Behavioral Health Care, New Jersey, and the School of Public Health at the University of New Jersey.

Each of the Core Collaborators provides disease-specific education classes. The hospitals have extensive offering in each major disease category, as do the Community Health Improvement Center and the Health Department. In addition to individual discussion with Enrollees and use of the core collaborators' education materials, the Care Coordination staff will access existing health education classes and activities for Enrollees.

3.2.3.26 *Describe your plan for monitoring quality of care provided to your Enrollees and providing ongoing feedback to affiliated Providers on their performance.*

The purpose of monitoring and evaluating chronically ill patients is to improve care effectiveness which has the potential to reduce their overall health care costs (Cesta and Tahan, 2003). The goal of care coordination is to empower the Enrollee to practice self-monitoring of his/her own health and to assess the quality of care received, requesting additional assistance as needed. Monitoring of the chronically ill individual's condition(s) is a complex process, involving disease-specific testing and skilled observation and diagnosis by professionals. The best case for monitoring is the paring of professional monitoring with the self-monitoring that the individual has learned to perform for

himself/herself. Monitoring can provide the advisement to the healthcare provider for adjustment in treatment planning and implementation.

It is recognized that self-monitoring is a difficult task for the chronically ill individual. For those individuals at high risk for poor health outcomes, the Care Coordinator, in coordination with the individual's case manager, if applicable, will assist in scheduling, coordination of on-going primary care visits. The continuing objective is to provide information to the Enrollee that will strengthen their ability to self-monitor and self-manage their illness.

The Care Coordination program plans to provide quarterly reporting to the core collaborators on program performance and quality of care information. Quality of care monitoring is a feature of the Streamline Healthcare Solutions software. Core Collaborators will have access and will be provided with program's performance on quality measures, number of Enrollees, hospitalizations, Emergency Department visits, transition activities –including timely follow up visits completed and medication reconciliations completed.

3.2.3.27 *Propose at least one Quality Measure to be used as a pay-for-performance measure. CCEs must propose at least one Quality Measure for each financial reimbursement method requested (See Section 3.1.6.1.1). The proposed measure should be related to your proposed care coordination model, not already included in Attachment A, and best demonstrate successful care coordination. See Section 3.4 Payment Terms and Conditions for more details.*

Macon County Care Coordination proposes, as a pay-for-performance measure:

A. For the serious mental illness target population:

#	Category	Quality Measure
4	Behavioral Health Support: 1) Follow up in 7 days	Follow-up after hospitalization for Mental Illness

B. For Seniors with Chronic Health Issues:

#	Category	Quality Measure
5	Care Coordination Influenza Immunization Rate	Enrollees who received at least one influenza immunization annually.

3.2.3.28 *Describe the experience of the collaborators using data to track utilization and to monitor Quality Measures.*

Community Health improvement Center

CHIC has an active QI/QA and risk management plan. Committees meet monthly at each site; meetings are attended by the Medical and Finance Directors. Changes are made using the Plan, Do, Study, and Act (PDSA) performance improvement model. CHIC currently reviews evaluative measures in the clinical areas of diabetes control, controlled hypertension, PAP documentation, child immunizations, depression screening, dental services utilization, pre-natal health services utilization, perinatal health, weight assessment and counseling for youth, adult weight screening and follow up, tobacco use and cessation and asthma pharmacological therapy. CHIC also conducts an annual patient satisfaction survey.

Decatur Memorial Hospital

Decatur Memorial Hospital utilizes six sigma methodologies throughout the organization. All key quality measures are tracked using control charts to determine trends and alignment with predetermined goals for the measure.

Heritage Behavioral Health Center

Heritage Behavioral Health Center has a strong Information System that utilizes state-of-the-art systems, software, and standards in collecting, storing, and reporting client data. An Information Management Council oversees the planning, design, implementation and evaluation of Heritage's systems to manage and process information, including an electronic clinical record (ECR) and integrated electronic billing system. The ECR was the first behavioral health center to ever be awarded the Nicholas E. Davies Award of Excellence for computer based patient record system in FY 2001 and remained the only behavioral health center with this distinction until 2006. Heritage has an excellent track record of collecting and reporting on process measures for various State and Federal grants and is committed to the improvement of operations and use of team-based decision-making. Heritage has established a variety of cross-functional teams, referred to as Councils, charged with gathering information, analyzing data, and making recommendations to improve its operations. These Councils report to and are coordinated by the Leadership Council. The Leadership Council also establishes time-limited cross-functional teams to study identified performance issues that need improvement. Heritage utilizes the Plan, Do, Study, and Act (PDSA) performance improvement model. This model helps us decide whether to adopt, adapt or abandon a process. Quarterly, Heritage's Utilization Review (UR) team conducts audits on a sampling of records to evaluate medical necessity for services. Quarterly reports are presented to Clinical, Corporate Integrity and Leadership Councils, which make recommendations for improvement of identified problem areas (ex: additional staff training or modifications in our processes).

UM activities include monitoring the service delivery system to help ensure that available resources are utilized in the most efficient manner possible. To this end, Clinical Council monitors the following items quarterly:

1. Number of individuals accessing treatment
2. Wait time from assessment to first visit
3. Utilization of high cost treatment: Crisis Stabilization, Detoxification, and Residential Rehabilitation number of admissions, length of stay, number of clients leaving against medical advice, and recidivism rate
4. Psychiatric hospital & state operated facility trends ; number of admissions, length of stay, and recidivism rates
5. Over/under utilization rates (ex: filled bed days, caseload size).

Utilization Review (UR) is that process whereby a sampled set of client records are audited to determine whether each client has been properly assessed to need services and that the client has received the right services, in the right amounts, by the right staff, for however long it is clinically necessary to receive these services and no longer.

Each Heritage program and/or level of care has written admission, continuing stay, discharge, and exclusion criteria, which define the information necessary to determine an individual's eligibility for entry into a program, service, and/or level of care. Heritage accepts individuals into programs and services based on these admission/exclusion criteria, as well as clinical assessment data, and according to established procedures and guidelines.

UR audits focus on the following items, looking for medical necessity and the "Golden Thread" that connects all three documents:

1. The Mental Health Assessment to assure:
    a. the client's diagnosis is supported by the DSM-IV-TR criteria
    b. that the client's signs and symptoms result in functional impairments
    c. they meet admission criteria to the program they were referred
2. The Treatment Plan to assure:
    a. care provision
    b. the client's problems and functional impairments identified in the assessment are addressed
    c. that the recommended amount, frequency and duration of interventions appear to be required to address the client's needs; neither too much nor too little given the client's level of functioning
    d. that the Treatment Plan is revised if the client needs more or less intensive services or at changes in level of
3. The Progress Notes to assure:
    a. interventions are listed on the treatment plan and linked to the
    b. appropriate objective being addressed
    c. treatment recommendations are being implemented
    d. the client's response to treatment and their progress or lack

e. document the need for continued services

Heritage recognizes that certain items can have serious compliance consequences. For example they do not bill for services delivered if they do not have a current Treatment Plan. To increase compliance with documentation requirements, Heritage runs100% audits on the following items quarterly:

a. Number of clients with no current Treatment Plan
b. Number of mentally ill clients with no annual Mental Health Assessment
c. Number of MI clients not seen in 90 days
d. Number of SA clients not seen in 30 days
e. Substance Abuse Level of Care service parameters

Roles and Responsibilities

The Leadership Council oversees the Utilization Management process and empowers Clinical Council and Corporate Integrity Council to address the processes that take place throughout the organization. Leadership Council appoints the Coordinator of Utilization Management who is the Director of Professional Development & Contracts Management.

A. The Utilization Management Coordinator's responsibilities include, but are not limited to:

1. Revising the Utilization Review audit tool to reflect changes in funder requirements and regulations governing the provision of services and risk areas identified by OIG.
2. Training staff conducting UR audits.
3. Randomly select charts to be audited.
4. Quarterly preparing aggregated UR and UM data and reporting findings to Clinical Council, Leadership Council, and CIC.
5. Quarterly, reporting UR findings to Leadership Council. Indicators billing below established thresholds will be presented along with a plan for improvement.
6. Annually, review UR policies and procedures and make recommended changes to Clinical and Corporate Integrity Councils.

B. The Clinical Council's responsibilities include, but are not limited to:

1. Monitoring and prioritizing UM Plan activities.
2. Developing, and annually reviewing Utilization Management Criteria for each Heritage program including the adequacy and appropriateness of admission, continuing care, exclusionary, discharge criteria, and length of stay norms.
3. Identifying criteria to evaluate medical necessity.
4. Establishing and reviewing thresholds of under and over utilization of programs/services.
5. Throughout the year, identifying the need for any revisions or refinement in the composition or operating procedures of the Utilization Review team, the need for any improvement in the Utilization Review process, or data collection mechanisms.
6. Establishing thresholds for indicators tracked through UR audits.

7. Reviewing quarterly UR findings for trends. Making plans of corrections for all indicators falling below our threshold.
8. Evaluating UM data to identify trends, what seems to be working and what needs improvement. For the latter, developing a Plan-Do-Check-Act plan for improvement.
9. Annually, reviewing and revising the UM Plan.

C. The Corporate Integrity Council's responsibilities include, but are not limited to:

1. Keeping Clinical Council apprised of OIG compliance and/or risk areas.
2. Reviewing quarterly UR and UM audits for trends, focusing on areas of risk.
3. A subcommittee of CIC is responsible for reviewing UR and UM findings and make recommendations for actions to be taken (ex: do we broaden an audit, go further back, self-disclose).

D. The Leadership Council's responsibilities include, but are not limited to:

1. Reviewing quarterly UR and UM reports that focus on indicators falling below established thresholds.
2. Based on UR and UM findings, approving performance improvement initiatives.
3. Annually review/approve the UM Plan and UR procedures.

In addition, Heritage Behavioral Health Center and the Community Health Improvement Center (CHIC) have been involved in a SAMHSA funded Primary and Behavioral Healthcare Integration grant awarded to Heritage in October 2010 to further integrate behavioral health and primary care. Through this grant, Heritage's wellness program tracks data on connections to primary care providers of all consumers served by the team (research database). Data is reviewed to make sure all consumers served in the program have been connected (or an attempt has been made to connect the consumer) to a medical provider. Data from this database and the EHR is collected and analyzed on a variety of other factors, including services received and health outcomes.

Heritage regular utilizes data to drive and determine course of treatment both at the individual client level as well as within groupings of clients based on a variety of factors such as, diagnosis, functioning level, expected versus actual service deliver.

Macon County Health Department

The Health Department's Office of Health Promotion and Public Relations is responsible for the completion of the state's required IPLAN (Illinois Project for Local Assessment of Needs) for health department certification in identifying and prioritizing health concerns for Macon County. The IPLAN is completed every 5 years in planning for the next 5 years and has been completed and approved for the 2011-2016 timeframe. In addition, every year, the Health Department publishes an annual report with detailed information about the Health Department's programs, services, and client numbers

Macon County Mental Health Board

The Mental Health Board, as a local funder of services, requires submission of demographic and treatment data from all providers under contract. Using this information, the Mental Health Board publishes, annually a demographics and service report. As part of the contractual agreement for service provision, providers also undergo a monthly or quarterly on-site record review and audit. Submission of service data and documentation is a condition for payment. The Board also contracts with three local agencies providing services as Medicaid certified providers. These providers submit Medicaid claims through the Board-operated Solutions billing system. This billing information is reviewed and forwarded to the Department of Healthcare and Family services for final edit and payment. In addition, The Board conducts monitoring site visits at each funded agency on a quarterly basis, reviewing documentation for compliance with contract requirements and verifying client eligibility for services.

St. Mary's Hospital

St. Mary's has a Quality Management Plan, which is an integrated, coordinated, and systematic program to identify opportunities to improve care, detect potential problems, prevent or resolve problems, and monitor effectiveness of actions taken. The Performance Improvement and Quality Committee correlates all quality information and looks for trends and methods of integration and for information of house-wide benefit to both internal and external customers. Among the duties of this committee are: To evaluate on a continual basis the clinical performance of the Medical Staff and individual appointees through reports provided by committees, patient care areas, and service line chairpersons; To provide oversight of the hospital's systems for process improvement, including clinical outcomes, evidence-based medicine, resource utilization, and patient safety; To provide oversight of the hospital's compliance with regulatory and accreditation standards pertaining to the Medical Staff. All these functions are highly data-driven.

3.2.3.29 *Describe how you will improve access to care.*

Access to care involves both service availability and willingness to seek care. The individual who has apprehensions about seeking care will postpone or avoid seeking health care. For the seriously mentally ill individual, this may involve a fear that seeking help will potentially result in restriction of rights or loss of freedom. Their illness may also impair their ability to make decisions regarding the need for health care. Likewise, for the senior, apprehension about seeking healthcare may be based in a fear of loss of independence. To address this apprehension or fear on the part of the individual, building of a trusting relationship between the individual and the healthcare provider or facilitator is an important first step. Along with trust building is the important skill of motivational interviewing, encouraging the individual to take action and seek treatment services and

providing education to the individual about the potential positive impact of treatment and beginning discussion about a plan of care for improved health.

Education for providers about the inter-relatedness of health and behavioral health is an important aid for improving access to healthcare, especially for the seriously mentally ill individual. As the medical community becomes more familiar with the physical health concerns experienced by seriously mentally ill individuals, the more clear it has become that it is necessary to view the individual in a more holistic manner and recognize the need for a more integrated approach to treatment. Part of the Care Coordinator's role is education for both the Enrollee and the provider on the importance of combining the efforts of primary and behavioral healthcare in an effort to improve the individual's health status and to move the individual to more proactive self-management of his/her illness.

3.2.3.30 Enrollee Care Plan. *Enrollee care plans are required for Priority Populations. To the extent your care coordination model includes Enrollee care plans for non-Priority Populations, please answer the following questions for those populations also.*

3.2.3.30.1 *Describe your approach to Enrollee care plan development, including:*

3.2.3.30.1.1 *The populations for which you will develop a care plan;*

3.2.3.30.1.2 *How each Enrollee's needs, goals, and preferences are identified and addressed;*

3.2.3.30.1.3 *Who develops and completes the Enrollee care plan and the process for collaboration; and*

3.2.3.30.1.4 *Your approach, if any, to risk stratification and how it relates to Enrollee care plan development.*

A single comprehensive person-centered care plan will be developed for each Enrollee. Those individuals assessed to be at highest risk will be prioritized for care planning and coordination of care.

The Care Plan is based on the needs and preferences identified through an evidence-based health risk and behavioral health assessment process and will include:

- a listing of Enrollee's primary care provider and medical home,
- the assigned care coordinator and any specialty providers;
- a summary of the Enrollee's health history; the Enrollee's goals;
- the actions, including interventions to be implemented;
- progress noting the Enrollee's successes;
- any barriers or obstacles existing or anticipated;
- timeframes for completing planned care actions;

- the status of the Enrollee's goals; crisis plans for Enrollees with behavioral health conditions;
- any determinations of need for community resources and non-covered services; and
- any negotiated risk identification and documentation.

In addition to serving as a guide for care provision, the Care Plan will be used to facilitate monitoring of an Enrollee's progress toward the Enrollee's goals and evolving service needs.

Enrollees will be encouraged to participate in their own Care Plan development, including the selection of providers and services to receive or not receive. In addition, the Enrollee's primary care provider, the Enrollee's family and/or care giver and other providers of care will be requested to participate, according to the Enrollee's agreement. The Care Coordinator will assume responsibility for coordinating this planning process and for the writing of the care plan, providing the opportunity for the Enrollee to confirm agreement with the care plan, dissemination of the Care Plan to the Enrollee and all providers and family or significant others, as requested by the Enrollee and posting of the Care Plan on the Care Coordination electronic health information exchange platform. This process recognizes that it may not be possible to bring all parties physically together for the planning process. The Care Coordinator will play the role of communicator, negotiator and organizer for bringing the input of multiple treatment providers together to form a single set of goals and interventions for the Enrollee. This plan will serve as the ongoing framework to guide integrated care, identifying the Enrollees needs, goals and preferences for care and treatment.

Those Enrollees receiving preventative care coordination services will receive a monthly visit or telephone call from the assigned Care Coordinator, for monitoring and to respond to any questions the Enrollee may have. In addition, individuals requiring preventative care coordination will be provided with disease-specific educational information and monitoring of functioning.

3.2.3.30.2 *Provide a sample Enrollee care plan as Attachment K.*

See Attachment K for a sample Enrollee Care Plan, indicating the components of the Enrollee Care Plan. The Care Plan format is detailed in the Streamline Healthcare Solutions software (See also Section 3.2.4, Health information Technology).

3.2.3.30.3 *Describe how the Enrollee care plan will be made available to Providers and Enrollees.*

The Enrollee's Care Plan will be provided to the Enrollee in writing and reviewed with the Enrollee by the assigned Care Coordinator. The Enrollee's Care Plan will be made available to involved service providers through a web-hosted access point located at the Macon County Mental Health Board website. (See Section 3.2.4 Health information Technology). Providers will be granted

secure access based upon their involvement in the Enrollee's Care Plan and with the Enrollee's consent to release and make this information available to the Provider. The Enrollee may review his/her care plan through secure access to the Macon County Care Coordination website as well. In those situations in which the service provider is unable to access the Enrollee's care plan electronically or is hesitant to use the electronic information exchange process, the Care Coordinator may hand-carry a hard copy of the Enrollee's care plan to the service provider and encourage the use of electronic access to the Enrollee's health information.

3.2.3.30.4 *Describe your strategies to enhance Enrollee compliance with Enrollee care plans.*

The best method for enhancing the Enrollee's compliance with or adherence to the Care Plan is the development of an understanding with the Enrollee that the Care Plan belongs to him/her. The Care Coordinator's and the service provider's relationship with the individual is key to the development of the trust that will be needed to permit the Enrollee to engage more completely in his/her treatment goals. In addition, the more education the Enrollee receives and connects with in order to understand his/her illness, its symptoms and red flags, the better the engagement in the process of health improvement and the better the adherence to the Care Plan. In an effort to encourage the Enrollee toward adherence, the Care Coordinators will be trained in rapport development, relationship development and motivational interviewing. In addition, the Care Coordinator will be trained to take advantage of existing relationships the Enrollee has formed. If a service provider's case manager has a close relationship with the Enrollee, the Care Coordinator should enlist the case manager's aid in motivating the Enrollee. Similarly, if a family member or significant other has the Enrollee's trust, this relationship becomes important to helping the Enrollee.

In addition, as indicated in Section 3.2.3.17, Care Coordinators will encourage providers to reinforce enrollees in their efforts at positive self-management of their illness(s). Enrollees will be offered the opportunity to earn small reinforcers for participation in regularly scheduled primary care and behavioral health care appointments and annual physical exams. Case Coordinators will offer to accompany enrollees to annual physical exams and/or preventative screenings.

A difficult though important strategy for enhancing adherence to care planning is the use of the moment of crisis, in which the Enrollee is motivated for change because of the difficulty of the health crisis. This moment of crisis can serve as a teaching and learning moment for the Enrollee and can have an impact on the Enrollee's understanding of his/her illness and the importance of learning self-management of the illness.

3.2.3.30.5 *Describe how you will coordinate Enrollee care plan development and implementation with Enrollee care plans and case coordinators serving Enrollees in HCBS Waivers.*

Providers of HCBS Waiver services will be advised by Care Coordination staff of an individual's enrollment in the care coordination program and will be asked to participate in the integration of planning for the individual. Waiver service providers will also be asked to participate as a network provider for the Care coordination program and will be offered the opportunity for access to the care coordination electronic information exchange process. Providers will be briefed on the activities of the care coordination program for the individual, other service provider involvements and the existing goals identified in the Enrollee's current care plan.

3.2.3.30.6 *Many of the Enrollees may already be enrolled in IHC and may have an Enrollee care plan with the Enrollee's PCP. Describe how you will incorporate these existing Enrollee care plans into the development of new Enrollee care plans.*

For those Enrollees already enrolled in IHC and with existing care plans, the care coordinator will seek consent from the Enrollee to discuss the care plan with the Enrollee's primary care provider, request the primary care provider's participation in a new Enrollee Care Plan, and will seek the involvement of other service providers in the development of the new plan. Existing care plans will be used as a starting point for development of a new care plan.

Analysis of the data provided by DHFS for 2010 indicates that, of the 1646 adults with serious mental illness, 735 were enrolled with Illinois Health Connect IHC), 644 were dually eligible for Medicare and Medicaid and 177 were in a long term care setting, Decatur Manor. Ninety seven percent of seniors were identified as dually eligible for Medicare and Medicaid. Macon County Care Coordination will accept individuals for enrollment who are not excluded from participation in IHC and who are part of the target populations of serious mental illness and/or seniors with chronic health conditions. As indicated earlier, Macon County Care Coordination does not plan to serve non-priority populations.

With the consent of the Enrollee, the Care Coordinator will seek information from the Enrollee's primary care provider, advise the provider of the Enrollee's participation in the Care Coordination program, offer additional information to the provider of the Enrollee's involvement with other service providers and invite the provider to participate in an expanded care plan development process that will include the care planning that is currently in place through the primary care provider.

3.2.3.31 Outreach

3.2.3.31.1 *Describe your plan for outreach to engage the population you propose to serve.*

All Care Coordination team members will be involved in outreach activities. Several outreach strategies will be used to engage the target populations.

- Staff of the core collaborators will be asked to refer those individuals on their current caseloads who may benefit from care coordination services. Care Coordination staff will make presentations to core collaborator staff groups, explaining the care coordination service.
- Care coordination staff will research individual potential enrollee locations/addresses and seek face-to-face interactions to meet the prospective enrollee, begin relationship development and offer care coordination services. Outreach to these individuals will occur at various times during the day, evening and weekend hours.
- Care coordinators will seek out staff of community providers, asking those staff who may have an existing relationship with the prospective enrollee to provide an introduction to the program concept to the prospective enrollee and propose a meeting between the individual and a Care Coordinator.
- Care Coordination staff may request assistance from Peer Mentoring staff employed by Heritage Behavioral Health Center to use their interactions with individuals who frequent the Oasis drop-in center and the Heritage "Living Room" program setting as a place to discuss care coordination and engagement in mental health services.
- Care Coordination staff will engage in some basic detective work, tracking down the hard-to-find prospective enrollees, identifying family, significant others who may be willing to help in discussion with the prospective enrollee about care coordination and scheduling a set of interactions with the individual to begin the engagement process.

It is recognized that outreach and engagement may be one of the more challenging aspects of care coordination, therefore a planned and methodical approach with repeated attempts in some cases, must be used. Staff will be trained in motivational interviewing techniques and will work to develop relationships with more difficult to engage individuals over time.

3.2.3.31.2 *Describe your staffing plan for outreach.*

As indicated above, all Care Coordination staff will be involved in outreach activities. Schedules will be varied to include evening and weekend outreach activities, in an effort to reach the potential Enrollee. Care Coordination staff will have the ability to meet potential enrollees on-site at provider locations, at the Enrollees home or at neutral sites in the community.

Staff of the core collaborating organizations will also be asked to serve in an outreach role, advising prospective enrollees as they are encountered of the care coordination

program and making connections between the individual and care coordinators. Peer mentoring staff of Heritage Behavioral Health Center will also be asked to serve in an outreach role for care coordination. Peer Mentors are individuals who are mental health care consumers well on their way to successful recovery who are employed by Heritage Behavioral Health Center, where they have been and are receiving mental health care, in order to help those with a similar diagnosis improve their level of functioning.

3.2.3.31.3 *Describe the outreach process in your PCP offices.*

Primary care provider offices will be provided with an overview of the Care Coordination program at their clinic location by Care Coordination staff. The primary care provider offices and all service providers will be provided, via program brochure, with a description of the Care Coordination program, containing an abbreviated listing of care coordination functions and protocols. In addition, all providers involved in the local network of providers will have access to web-based training information on care coordination and a full description of the Care Coordination program.

The Community Health improvement Center, by positioning Advance practice nurses part-time at Heritage Behavioral Health Center' main building, Heritage's drop in center for homeless and mentally ill individuals and at the Health Department, currently provides significant outreach activity. Administrative staff of these organizations have regular bi-monthly program development meetings .Care Coordination Director participate in regularly scheduled meetings, as part of an ongoing effort for further integration of primary and behavioral healthcare in Macon County.

3.2.3.31.4 *Describe how you will ensure that written materials can be easily understood by various populations, including ensuring the accuracy of translated materials.*

Approximately ninety seven percent of the Macon County population is either of Caucasian or African-American heritage. Of the population in the community five years of age or older (103.844 individuals), 3,123 or 3% of Macon County residents speak English "less than very well" *(U.S. Census, 2010*). Within this community, the Hispanic population is slightly less than two percent. The Asian population is approximately one percent. Program marketing materials will be developed and published in English and will be developed to address an audience with an approximate ninth-grade reading level equivalence, using Micro-Soft reading level-sensitive software. An initial group of prospective Enrollees from each of the target populations will be asked to review the proposed materials and provide feedback on comprehension and clarity.

A translated version will be created in Spanish and made available on an as-needed basis. Interpreter services for Spanish and other languages will be made available on an as-needed basis through service referral. Options for consultation and translation services exist through Richland Community College and the University of Illinois Linguistics Department in Champaign, Illinois. In addition, the core collaborators have existing staff with secondary language skills in several languages.

3.2.3.31.5 Describe alternative methods of communication you will offer and how Enrollees will access these methods.

Additional alternate methods of communication will include:

1. Direct face-to-face method with Care Coordination staff or Core Collaborator staff, on-site at the individual's home or in an agreed upon meeting setting. If interpreter services are required, the care coordination staff will coordinate through the Care Coordination team leader for consultant translator services.
2. Written marketing materials (brochures, contact cards, introductory letters) made available through the intake and treatment processes of core collaborator service providers and other network providers. Written materials will include a program description and telephone, office and e-mail access information.
3. Posted materials at network provider offices.
4. Access via internet to the program's website. Information available will include general program information, health education information and secure-access, password-protected Enrollee Care Plan and Health Care Information.

3.2.4 Health Information Technology (HIT)

3.2.4.1 *Describe the technology capacity among the collaborators (CCE collaborators/MCCN network) at the time of submission, including:*

3.2.4.1.1 *PCP communication capabilities to support their role in care coordination;*

Community Health Improvement Center (CHIC)

In 2009 CHIC implemented the NextGen Practice Management System; and, in February, 2012 began implementation of their electronic health record (HER) system. The Dental Clinic in Champaign associated with CHIC uses QSI software (the dental component of NextGen). Illinois Primary Health Care Association hosts the system. CHIC is one of the planned nineteen (19)

members of the Illinois Health Center Controlled Network. This Network group meets monthly to discuss issues and is seriously studying possible migration to a new host.

Implementation and overall system usage proved to be extraordinary challenging. Initial slowness of the system was frustrating to providers and support staff. There was, initially, insufficient training available for support staff and lack of understating of what must be accomplished in terms of changing work flow processes. In the Champaign offices associated with CHIC, because of a "quirk" in their scheduling methodology, it became necessary to bring all providers "up" essentially simultaneously. The system's "bugs" are being worked out over time.

With upgrades to the system, the hiring of a trainer experienced in instructing providers as well as support staff in the use of EHR technology and the presence at all sites of some enthusiastic providers, the Center has a considerably better outlook for use of the EHR and development of skills and ongoing training to insure success. By the end of 2013 that CHIC will have made successful progress toward Meaningful Use expectations. As the Center moves toward complete use of EHR, policies are being formulated to address timeliness of documentation and tracking of outside referrals to assure adequate follow-up is in place.

All of CHIC's primary care providers currently use NextGen for documentation and e-prescribing.

3*.2.4.1.2* *Mental Health and Substance Abuse Provider communication capabilities to support their role in care coordination;*

Heritage Behavioral Health Center

Heritage has been developing an electronic record for approximately fifteen years. Heritage uses The Echo Group's Clinician's Desktop (CDT) electronic health record, Version 8.13, certified under the Drummond Group's Electronic Health Records Office of the National Coordinator Authorized Testing and Certification Body program. This version adds the client's assessment, treatment plan, services documentation and assessment tools, permitting measurement of progress.

The Echo Group software, Version 8.2, captures Heritage client demographic information, bio-psychosocial assessments, treatment plans, progress notes and billing documentation. Heritage was awarded Primary and Behavioral Health Care Initiative (PBHCI) supplemental funding through SAMHSA for Federal Fiscal year 12-13, to expand the electronic clinical record which will enable Heritage staff and the physician assistant (PA) to gather and share needed information between the partnering agencies about the PBHCI clients.

Upon grading to Echo Clinician's Desktop version 8.13 Heritage can begin using the features available allowing for easier navigation, better security and the ability to share

information. Currently, the system is not interoperable with our primary care partner, an FQHC, the Community Health Improvement Center (CHIC), who is in the early stages of implementing their electronic health record, NextGen. With this upgrade, Heritage will be integrating some of their data along with information about labs and medications.

Heritage plans to use the PBHCI grant as a springboard for transforming its service delivery to become more fully integrated. The HIT grant will enable Heritage to expand staff access to electronic data on consumers' medications and doctors' orders. Currently, only nurses, physician's assistants, and psychiatrists have access to such data, but with the HIT grant, all clinical staff will obtain access to medical data in the EHR. This supplemental grant is being used to support the following goals: Partnering with a compatible e-prescribing platform creating a current list of medications in our clinical record. By the end of this 1 year grant supplement, at least 40% of prescriptions will be submitted electronically for Heritage clients; Enhancing and developing a certified electronic health record system to achieve Stage 1 EHR Meaningful Use Specifications will be accomplished by installing the 8.13 version of Echo's Clinician's Desktop that is certified for meaningful use; Becoming capable of sharing a continuity care record between our primary care partner, CHIC, and Heritage; Incorporating information from the primary care visit into our clinical record, preferably through a Clinical Care Report; Electronically incorporating lab and test results into our clinical record so that the staff treating the client could see tests results; Establishing methods for extracting data from the clinical record and importing it into the clinical registry; Continued participation in the development and implementation of the central Illinois Health Information Exchange to achieve improved health outcomes for patients.

As noted above, Heritage currently transports CHIC records for needed treatment information by the physician assistant. Portions of the CHIC records are scanned, the Physician Assistant (PA) dictated reports, and test results including labs, into our electronic health record. Heritage staff consult on a daily basis with CHIC staff and other providers (ex: laboratory or diagnostic tests completed at local hospitals), have telephone communication with the PA during off hours, when needed, make frequent phone calls with consumers to discuss treatment issues, remind them of appointments as well as health and wellness activities, and make or confirm appointments with specialists and/or to schedule various diagnostic tests. Client referrals to the PBHCI program occur daily, mainly from case managers and the assessment team. PBHCI staff attend other Heritage staff team meetings to explain the program, discuss referral criteria, and address questions.

In addition, Heritage currently has a business associate agreement with St. Mary's Hospital, permitting their Hospital Liaison staff to access St. Mary's Meditech system for registered clients of Heritage. This information exchange facilitates inpatient treatment planning, transition from inpatient to outpatient services and follow-up post hospitalization.

The inclusion of other healthcare treatment disciplines in information exchange for improved healthcare is a desired positive development.

St. Mary's Hospital

St. Mary's Hospital uses the Meditech Electronic Medical Record system and has agreed to add Macon County Care Coordination to IT system as a business associate. All individuals who are enrolled in Macon County Care Coordination will be pre-registered with St. Mary's Hospital, associating registration with Macon County Care Coordination, permitting auto-generated and custom-designed reporting via daily e-mail notification to care coordination staff. Staff would then be required to log-into Meditech and retrieve their report of Enrollee use of Hospital services.

Macon County Mental Health Board - Lead Entity

The Board currently operates using a local area network for intra-office communications and e-mail for communication with individuals and organizations outside of the Board office. The Board also manages a website that serves as a portal for agencies under contract with the Board for service delivery, providing them the ability to submit service vouchers and service documentation via this on-line system. In addition, the Board is part-owner of Solutions, Inc., an organization of collaborating Mental Health Boards from several communities that has developed a billing software for Medicaid certified mental health service providers. There are currently three Medicaid-certified agencies in Macon County providing Medicaid mental health services and billing for services through the Solutions software. The Board provides the matching funds for these Medicaid mental health services and uses the Solutions software to provide billing to the Department of Healthcare and Family Services under a Local Government Funds Initiative contract with the Department. The Board also hosts the Healthcare Solutions Care Coordination software and is providing a portion of the funds necessary to adapt this software for use by Macon County Care Coordination. The Board's website will serve as the secure portal for service providers to access the software application, upload and download Enrollee health information and will serve as the central repository for health information for Enrollees in care coordination program. The reader(s) of this proposal may view this website at www.mcmhb.com.

Decatur Memorial Hospital:

Decatur Memorial Hospital currently uses Healthcare Business Infomatics (HBI), a McKesson-designed system and has the ability to permit healthcare business associates to access HBI. In a process very similar to that which is used at St, Mary's Hospital, Macon County Care Coordination can be added to HBI as a business associate, with care

coordination enrollees pre-registered with DMH. Registration with association to Macon County Care Coordination will permit the auto-generated and custom-designed reporting via daily e-mail notification to care coordination staff. Staff would then be required to log-in to HBI and retrieve their report of Enrollee use of Hospital services.

Macon County Health Department

The Health Department does not currently use an electronic health record system. They are in the development stage for system design. All staff have computer and internet access and will have the ability to access the care coordination information exchange system via the internet and communicate about Enrollee health status in a secure electronic environment.

3.2.4.1.4 *Indicate which collaborating or network Providers have registered for Electronic Health Records Payment Incentive Program payments with either the State or federal government*.

The following core collaborators have registered for electronic health Records Payment Incentive Program:

- Decatur Memorial Hospital
- St. Mary's Hospital
- Community Health Improvement Center

3.2.4.2 *What is the expected HIT functionality of the collaborators 12 months after Contract Execution and how will this capacity support your care coordination model?*

Macon County Care Coordination's goal at the 12 month mark of care coordination operation is the implementation and active use of a web-based clinical information exchange platform, using an adaptation of the Streamline Healthcare Solutions care coordination software. This design will enable sharing of patient-specific clinical information across partnering organizations for the care and treatment of individuals enrolled in care coordination. The software adaptation will provide a standardized electronic, information exchange system that is accessible from all points of care.The modified Streamline Healthcare Solutions software package will be hosted by the Macon County Mental Health Board's website and will provide secure access for the Enrollee and for all service providers, according to the Enrollee's formal authorization for release of information. The initial adaptation cost is being shared by three care coordination entities, the Macon County Care Coordination program and two other CCEs. The intent of this adaptation is not to create an electronic health record, but instead, to develop a health information exchange platform and process.

The Macon County Mental Health Board is supporting Macon County's adaptation and development costs. This software adaptation process is anticipated to have the behavioral health

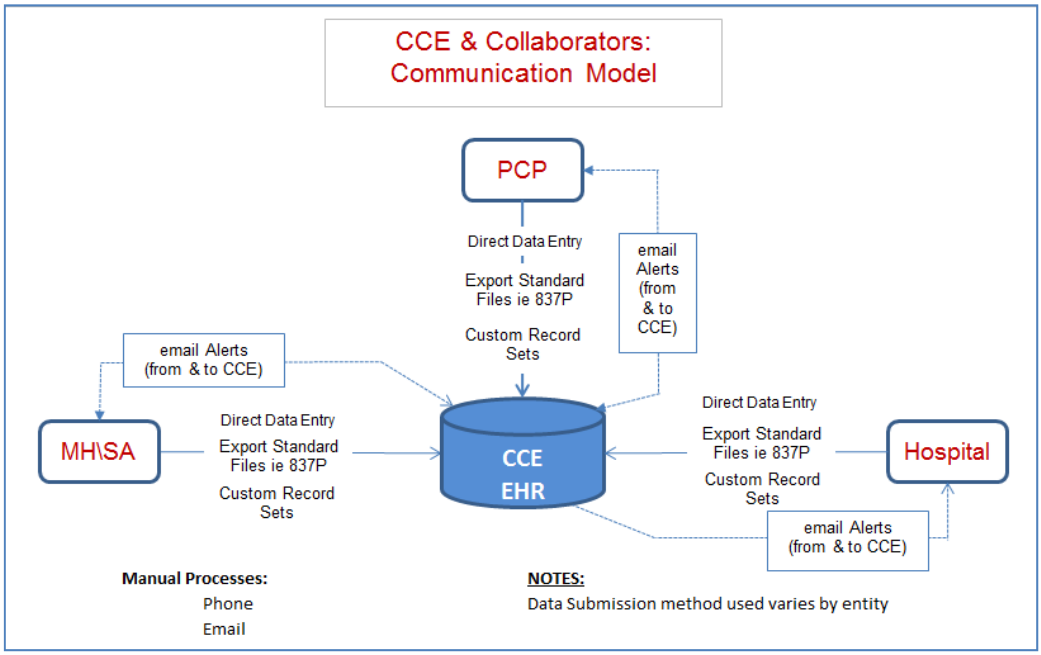
component in place by September, 2012 and the medical component in place by December, 2012. Customization of the software will occur over the first year of implementation, permitting modifications that allow for the uniqueness of the Macon County Care Coordination program's setting and activities. The software information exchange vehicle will permit the Enrollee's plan of care and all additional health information to be accessible to the Enrollee, the Enrollee's designees, the medical home and all authorized service providers. This will permit the medical home and all providers to work from the same plan of care, and share responsibility for their contributions to the plan of care and for achieving the Enrollee's goals. Information exchange capabilities, secure messaging and advisement of treatment adjustments for the Enrollee will be included as part of the adaptation. *National Quality Forum (NQF), Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report, Washington, DC: NQF; 2010.*

Macon County Care Coordination and its collaborators represent a broad range of technology capacity, ranging from fully integrated electronic health record systems to custom systems supported substantially by manual processes. In order to bridge this disparity of systems (or technology) capabilities and provide the vehicle of coordinated communications, Macon County Care Coordination determined that it needed to implement a common database and communication systems and processes. Two particular and complimentary web-based solutions have been identified:

1. Electronic Health Record system ("EHR System"), and
2. Custom Information and Communication Exchange Repository ("Repository"). EHR+ System:

This browser-based application has achieved ONC-ATCB Complete EHR certification. In summary, its suite of applications includes the following:

- Electronic Health Record (EHR): HIPAA compliant electronic health record for clinicians, supervisors, case managers, doctors and nurses
- Practice Management (PM): Registration, scheduling, billing, accounts receivable, scanning and administration for providers.
- Managed Care (MCO): Provider contracting, authorizations, claims adjudication for managed care organizations.
- Medication (Rx): Integrated electronic prescribing for providers.



The emphasis of these applications has been on behavioral health. However, primary care functionality is being and will be integrated into this EHR system by the end of 2012. This integration meets the requirements of linking the various CCE collaborator types together. The interoperability of the EHR System is reflected in its flexibility of providing access and data entry capability through direct data entry (DDE) and\or through the importing of standard record formats (i.e. 837Ps) as well as custom records uploads via flat text files(i.e. in .csv format). Email alerts will also be generated by the System to advise Collaborators of upcoming, key milestones or events.

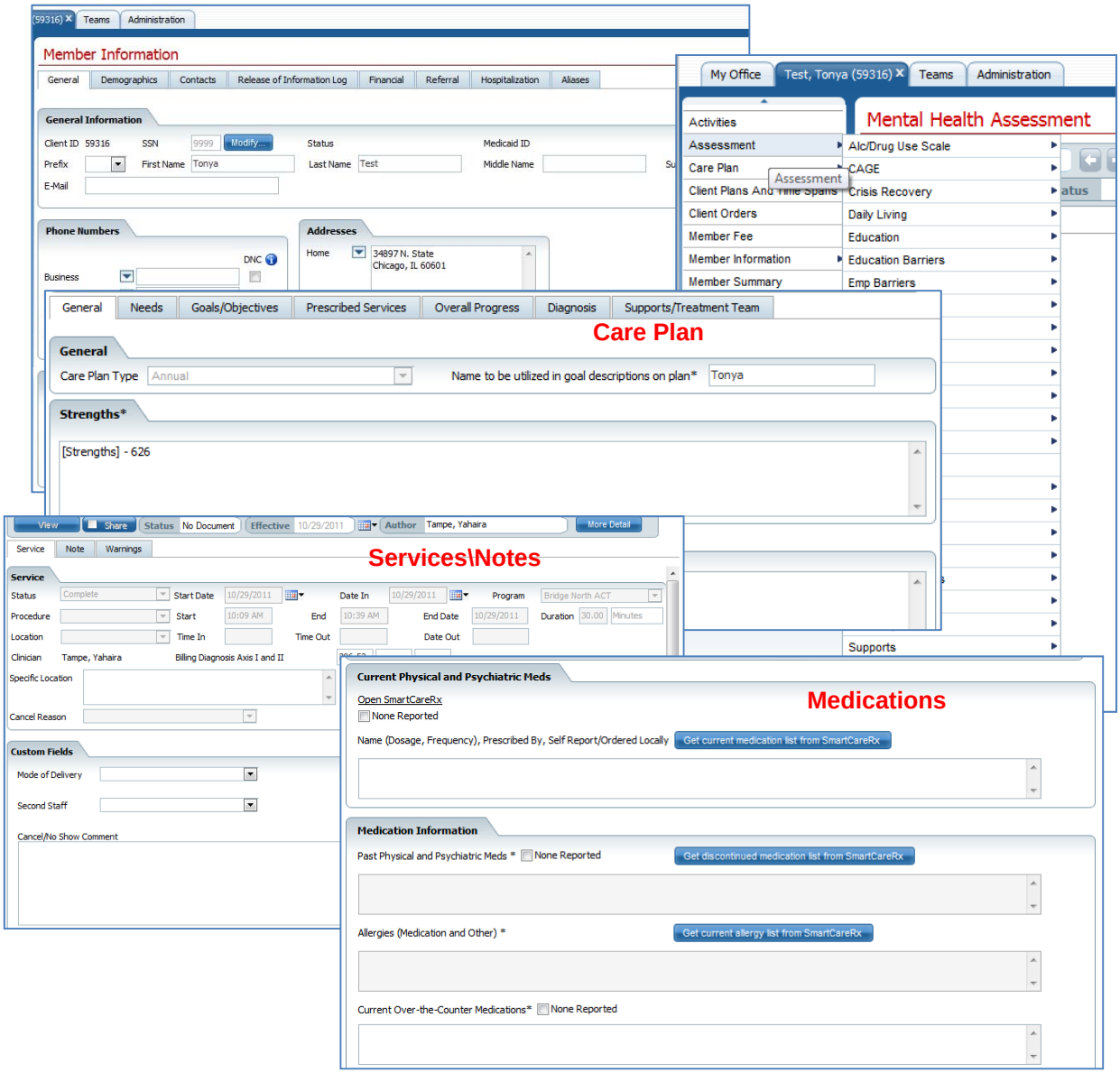
As part of the software adaptation, Macon County Care Coordination desires an information exchange for care coordination that includes the following:

1. key demographic information about the enrollee,
2. results of initial health screening and risk assessment,
3. service utilization (hospital admissions, emergency room visits, outpatient visits)
4. care coordination assignment,
5. the Enrollee's individual's Care Plan,
6. case notes,
7. medications,
8. laboratory requirements and laboratory results data,
9. current primary and other healthcare provider contact information.

The EHR System will have the ability to collect at a minimum the following data areas:

- Enrollment\De-Enrollment: Import of EDI270 from Illinois Client Enrollment Broker.
- Demographics

- Screening, Assessments & Risk Assessments
- Care Plans
- Services/Notes
- Medications



Repository:

In addition to the System described above, Macon County Care Coordination will be providing a secure, web-based system which will serve as a common repository for both the Care Coordination program and its collaborators for the exchange of related documents as well as well as communication on key issues. File sharing and the exchange of communication can be set at a one to one level (Macon County Care Coordination to a single collaborator) or at a one to many (Macon County Care Coordination to network of collaborators)

Functionalities for quality measurement and practice improvement will be incorporated in the software adaptation and will include Enrollee and service tracking capabilities necessary to establish and generate reporting that focuses on the following quality measures:

a. Required Pay-For-Performance Measures
   1. Emergency department visits per 1000 enrollees.
   2. General hospital inpatient utilization admits per 1,000 enrollees.
   3. Ambulatory care follow up visit with assigned PCP within 14 days of inpatient discharge.
   4. Inpatient hospital 30 day readmission. Mental health readmission reported separately.
   5. Proposed Measure

      A. For the serious mental illness target population:

#	Category	Quality Measure
4	Behavioral Health Support: 1) Follow up in 7 days	Follow-up after hospitalization for Mental Illness

      B. For Seniors with Chronic Health Issues:

#	Category	Quality Measure
5	Care Coordination Influenza Immunization Rate	Enrollees who received at least one influenza immunization annually.

b. Shared Savings - Pay for Performance Measures:

1. Enrollee who had an annual ambulatory or preventative care visit with the Enrollee's assigned PCP, or
2. Medication Review of All Enrollees taking 5 or More Prescription Medications with Documented Plan for Reducing Medications when Appropriate
3. Follow-up with a Provider within 30 days after an initial behavioral health diagnosis.
4. Proposed Measure

A. For the serious mental illness target population:

#	Category	Quality Measure
4	Behavioral Health Support: 2) Follow up in 7 days	Follow-up after hospitalization for Mental Illness

B. For Seniors with Chronic Health Issues:

#	Category	Quality Measure
5	Care Coordination Influenza Immunization Rate	Enrollees who received at least one influenza immunization annually.

3.2.4.2.1 *Describe your connection to and support of: 1) PCPs, 2) Hospitals, and 3) Mental Health and Substance Abuse Providers; and*

All of the core collaborators' professional and administrative staff and service sites and the providers in the service network engaged via Memorandum of Understanding and completion of the Business Associate Agreement, will have the ability to access the Care Coordination programming via the internet. E-mail communication has been the standard between and among these collaborators however, secure messaging will be the standard means of communication regarding care coordination enrollees, via a web-based care coordination software, Streamline Healthcare Solutions This software, has been adapted for use by Macon County Care Coordination and is hosted at the Macon County Mental Health Board's website. Streamline software and information exchange capability will be managed by the Macon County Mental Health Board's experienced systems consultants. Training to all providers in the network on access to, use of and uploading of data to the software application will be provided by the Mental Health Board's consultants. In addition, a user manual will be constructed, to be retained by all service providers at their point of service and point of data exchange. Care Coordination staff will be assigned as liaisons to each service provider, to serve as a contact point for system use issues and solution development. The assigned care coordination staff will also monitor the

information accumulated per Enrollee for exchange with other providers and assist and/or prompt providers to upload, post or review information.

1. PCP

   Community Health Improvement Center serves as the primary care provider and has the ability to interface electronically with a Care Coordination information exchange system via log-in through the Macon County mental Health Board web-host. This log-in procedure has been used by CHIC for the past two years in accessing the Mental Health Board's electronic vouchering system. CHIC staff are familiar with uploading information and documentation to this system. CHIC has a login user name and password permitting access to the Board's website. CHIC Medical Home and supporting staff, as part of an individual's care coordination team, will be provided electronic access to the care coordination application. Access to specific Enrollee's health information will be secured and accessible only according to access privileges provided by care coordination staff, based on the Enrollee's written, signed and electronically posted authorization for release of information to CHIC personnel. CHIC primary care providers and their supporting staff will be provided with a login user name and password permitting access to the application as release of information is authorized for release by the Enrollee. CHIC personnel will also be offered training in system use, trouble-shooting options and system use documentation.

   Physicians affiliated with St. Mary's Hospital and Decatur Memorial Hospital may serve as primary care providers for Enrollees. Care Coordination staff will need to reach out on an individual basis to each physician, in the interest of the Enrollee, to establish a working relationship and develop a process for health information exchange. It is anticipated that relationship development at the physician's office nursing staff level will be the starting point for this relationship. Educating nursing staff about the design, intent and process of care coordination program will be an important first step. Accompanying the Enrollee to physician office visits may also be an important first step in relationship development.

2. Hospitals

   Each of the two community Hospitals (Decatur Memorial Hospital and St. Mary's Hospital) will be provided with a log-in user name and password permitting access to the Mental Health Board's website and access to the Streamline Healthcare Solutions care coordination software. Both Hospitals' personnel, including Emergency Department staff, will also be offered training in system use, trouble-shooting options and system documentation entry and uploading. Hospital primary care providers and treatment staff, as part of an Enrollee's care coordination team, will be provided electronic access to the care coordination application. Access to specific Enrollee's health information will be secured and accessible only according to access privileges provided by care coordination staff, based on the

Enrollee's written, signed and electronically posted authorization for release of information to Hospital personnel.

St. Mary's Hospital uses the Meditech Electronic Medical Record system and has agreed to provide Care Coordination staff access to their patient record system. Care Coordination staff, upon starting work, will each make a request to the Hospital for access to the Hospital's electronic record system, sign a confidentiality agreement with the Hospital and then be assigned an access password and Meditech account for Care Coordination. St. Mary's Hospital will then provide instructions for accessing the gateway for entry into Meditech. This process is currently in use, providing the Heritage Behavioral Health Center's Hospital Liaison staff access to Meditech for patients hospitalized at St. Mary's who are registered clients of Heritage Behavioral Health Center. As part of enrollment in care coordination, the individual will be registered by care coordination staff in the St. Mary's Meditech EMR and associated with the care coordination program. This association will actuate notifications to care coordination staff of enrollee use of Hospital services on a same day or next day basis. Care Coordination staff will have the ability to request notification via e-mail about care coordination enrollee use of Hospital services, including inpatient, Emergency Department, lab services, etc.

Decatur Memorial Hospital uses Healthcare Business Infomatics (HBI) software and has also agreed to provide Care Coordination staff access to the Hospital's electronic record system for Care Coordination Enrollees. Access will be provided after the Care Coordination program signs a confidentiality agreement with the Hospital and is then assigned an access password and HBI account for Care Coordination. Decatur Memorial Hospital will then provide instructions for accessing the gateway for entry into HBI. As part of enrollment in care coordination, the individual will be pre-registered in the HBI-EMR and associated with the care coordination program. This electronic association will actuate notifications to care coordination staff of Enrollee use of Hospital services on a same day or next day basis, in a manner very similar to the notifications provided from St. Mary's Hospital. Care Coordination staff will have the ability to request notification via e-mail about care coordination enrollee use of Hospital services, including inpatient, Emergency Department, lab services, etc.

3. Mental Health and Substance Abuse Provider

Heritage Behavioral Health Center currently has the ability to interface electronically with the Care Coordination information exchange system via log-in through the Macon County Mental Health Board web-host site. This log-in procedure has been used by Heritage for the past two years in accessing the Mental Health Board's website and uploading information and documentation to the electronic vouchering process. Heritage has a login user name and password permitting access to the Board's website.

Heritage staff, as part of an individual's care coordination team, will be provided electronic access to the care coordination application via the Board's website. Access to information on specific an Enrollee's health information will be secured and accessible only according to access privileges provided by Care Coordination staff, based on the Enrollee's written, signed and electronically posted authorization for release of information to Heritage personnel. Access coding per Enrollee will be provided to Heritage service provider staff as the individual is enrolled and as release of information is authorized.

4. Macon County Health Department

   The Health Department staff, as indicated earlier, have computer and internet access and have the ability to access the care coordination software via the web-host at www.mcmhb.com, will have the ability to upload and download clinical information, access shared care coordination health information for enrollees and participate in secure messaging.

3.2.4.2.2 *Describe how you will address issues of privacy and confidentiality.*

The following is an outline of considerations Macon County Care Coordination will address concerning issues of privacy and confidentiality:

System:

- User ID and password-based Authentication
- Function-level security groups that feature on\off selection
- Program-level security which restricts user access based on organization, program, location etc.
- Encrypts data during authentication
- Change password dialog allows user to change password if needed more frequently than required
- Application requires user to change initial password when logging in for the first time
- Requires password change every to be determined interval
- Locks user out for specified period after a pre-determined number of unsuccessful login attempts.
- Provider restrictions by patient
- Audit trail: Log user log-on\log off of system
- Providers assigned to a Security group for application access.
- Providers cannot change authorization data.

Process:

- Client release of information before setting up Authorizations
- System administrator role clearly defined in assignment of providers\clinicians to clients.
- Define levels of access:
  - Individual Role
  - Care Coordinator Supervisor
  - Care Coordinator
  - Provider Organization
  - Provider

Macon County Care Coordination will comply with all HIPAA compliance obligations and provide procedures consistent with the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and 45 CFR Part 164 subparts A and E, for protected health information (PHI), as defined in 45 CFR section 164.501. Macon County Care Coordination will use or disclose PHI only for the following purposes:

1. to perform the functions, activities, or services for, or on behalf of, the Department of Healthcare and Family Services (DHFS) as specified in a Care Coordination Contract between DHFS and Macon County Care Coordination.
2. to manage and administer or to carry out the legal responsibilities of Macon County Care Coordination.
3. to disclose PHI for the management and administration of Macon County Care Coordination, provided that the disclosures are required by law, or Macon County Care Coordination obtains written assurances from the organization/person to whom the PHI is disclosed that the PHI will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed.
4. to use PHI to provide data aggregation services to the Department of Healthcare and Family Services, as permitted by 45 CFR section 164.504(e)(2)(i)(B).
5. to use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR section 164.502(j)(1).

In addition, Macon County Care Coordination will:

1. not use or further disclose PHI other than as permitted or required by the Contract between the Department of Healthcare and Family Services and Macon County Care Coordination, or as required by law;
2. use and disclose an Individual's PHI by limiting disclosures as required by HIPAA.

3. refrain from exchanging any PHI with any entity of which Macon County Care Coordination knows of a pattern of activity or practice that constitutes a material breach or violation of HIPAA;
4. use safeguards of secure and password protected web-based access to PHI by care coordination staff and health service providers, in order to prevent use or disclosure of PHI other than as provided for by contract between DHFS and Macon County Care Coordination and by agreement between Macon County Care Coordination and network service providers; in addition, Macon County Care Coordination will provide for secure, locked storage of any paper records related to an individual's PHI;
5. mitigate, to the extent practicable, any harmful effect that is known to Macon County Care Coordination of a use or disclosure of PHI by Macon County Care Coordination which is in violation of the requirements of the contract between DHFS and Macon County Care Coordination;
6. report to DHFS any use or disclosure of PHI not provided for by the contract of which Macon County Care Coordination becomes aware;
7. ensure that any health service providers, including any sub-contractors, to whom Macon County Care Coordination provides PHI received from DHFS or created or received by Macon County Care Coordination on behalf of DHFS, agree to the same restrictions and conditions that apply through the contract between DHFS and Macon County Care Coordination with respect to such PHI;
8. provide access to a designated set of PHI to DHFS and work to incorporate any amendments to this designated set of PHI, at the request of DHFS; This access and incorporation of any prescribed amendments will be provided with the required 15 day period;
9. make Macon County Care Coordination's internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from DHFS or created or received by Macon County Care Coordination on behalf of DHFS available to the DHFS and to the Secretary of Health and Human Services for purposes of determining the DHFS' compliance with the Privacy Rule;
10. document disclosures of PHI and information related to disclosures of PHI as would be required for DHFS to respond to a request by an individual for an accounting of disclosures of PHI;PHI will be made available to DHFS within the required 10 day period;
11. provide to DHFS, upon request, information collected as a part of the contract between DHFS and Macon County Care Coordination, to permit the DHFS to respond to a request by an individual for an accounting of disclosures of PHI. This information will be made available to DHFS within the required 15 day period; and,

12. return or destroy all PHI received from DHFS or created or received by Macon County Care Coordination on behalf of DHFS that Macon County Care Coordination still maintains in any form, and to retain no copies of the PHI, upon termination of the contract between DHFS and Macon County Care Coordination, for any reason.

In the event that Macon County Care Coordination discovers a breach of unsecured PHI, Macon County Care Coordination take the following measures within 10 calendar days after first becoming aware of the incident:

1. notify the DHFS of any incident involving the acquisition, access, use or disclosure of unsecured PHI in a manner not permitted under 45 C.F.R. part E. This notice will be provided even if Macon County Care Coordination has not conclusively determined within that time that the incident constitutes a Breach as defined by HIPAA, unless instructed otherwise by law enforcement;
2. include the names of the Individuals whose unsecured PHI has been the subject of a Breach;
3. complete and submit a Breach Notice form to DHFS;
4. provide the Breach notification to the affected individuals;
5. assume all costs for providing Breach notification, unless DHFS agrees to assume any costs; and,
6. indemnify DHFS for costs associated with any incident involving the acquisition, access, use or disclosure of unsecured PHI in a manner not permitted under 45 C.F.R. part E.

Consistent with P.A. 0 97-0515, recently signed legislation designed to enhance the ability of providers to integrate mental, developmental disability and physical healthcare services for consumers covered by Medicaid, SCHIP and other programs, each potential enrollee will be asked to authorize release of healthcare information to each involved healthcare providers. Enrollees will be asked, as part of initial enrollment processes, to sign a release of information forms permitting disclosure of medical and/or behavioral health information from each provider to Macon County Care Coordination and to Network providers involved in their care. Failure to authorize release of information may prohibit enrollment.

It is understood that the Department of Healthcare and family Services is currently working on a standardized release of information format that addresses the change in law identified in P.A. 097-0515 and that this format may be available for use by care coordination entities.

In addition, all Enrollee health information will be stored securely and accessible only with authorization specific to each provider and to each Enrollee for whom consent for release of information has been secured. Care Coordination staff will assume responsibility for maintaining current access permissions for providers. Only Care Coordination staff will have access to all Enrollee data, as authorized by the individual Enrollee upon consent for involvement in the care coordination program.

All service providers will be asked and required to complete the Business Associate Agreement (see Attachment G, Business Associate Agreement), prior to being granted permission to access the electronic information exchange system used by Macon County Care Coordination. DHF will be notified of any identified breach in information security.

3.2.4.3 *Describe any resources you plan to provide to collaborators in the area of HIT.*

Macon County Care Coordination has joined with a consortium of two other care coordination entities and has contracted with Streamline Healthcare Solutions for the adaptation of a care coordination software package that will permit the exchange of and storage of health information for Enrollees in care coordination. Macon County Care Coordination has elected to use a privately developed software package to permit secure messaging and information exchange rather than using the ILHIE (Illinois Office of Health Information Technology) Direct Secure Messaging. Based on individual provider requirements, Care Coordination staff will have access to ILHIE and may use this communication vehicle for communication with service providers while all parties become acquainted with the use of Streamline Healthcare Solutions system.

The Streamline Healthcare Solutions adaptation will be accessible to all providers of service with internet access and proper authorization. The software will permit uploading of data and information from each provider. Initially, it is anticipated that care coordinators will assume primary responsibility for ensuring that all important health information is incorporated in the information exchange system for use by service provider partners. Streamline Healthcare Solutions consultants will provide the following:

- Project management in integrating the various collaborators into the systems and addressing the impact of change to the collaborators.
- Training of collaborators' personnel in use of the aforementioned systems, offered where applicable.
- On-going 'help desk' to address issues with use of the systems.

3.3.1 Financial Model

3.3.1 CCE Reimbursement

3.3.1.1 Which of the three reimbursement options is the CCE selecting? Note: CCEs may select more than one option (See Section 3.1.6.1.1).

Care Coordination Fee: an administrative Per Member Per Month (PMPM) fee for each population type in its care coordination model. See Section 3.1.4.3.1 Pay-for-Performance and Section 3.4 Payment Terms and Conditions for more details.

Shared Savings: A CCE will be eligible to receive shared savings payments. Shared savings calculations will compare the projected cost of care with care coordination to baselines developed by the State and Federal CMS. The CCE will be eligible for up to 50 percent of savings annually (the remaining savings will go to federal and State governments) and will propose how its shared savings will be distributed among its collaborators. See Section 3.1.4.3.1 Pay-for-Performance and Section 3.4 Payment Terms and Conditions for more details.

Interagency Payment Flexibility Proposal: A CCE may choose and is encouraged to develop new, innovative payment methodologies as long as the model facilitates care coordination among a diverse set of Providers and incentivizes more efficient practice. These models may include combining payment streams from multiple State agencies and new methods for paying for currently reimbursed services such as bundled payments and payments for episodes of care. A CCE may also propose regulatory flexibility to enable better coordination of care.

Macon County Care coordination has selected two reimbursement options, as follows:

Care Coordination Fee: A three-tiered fee schedule, based on the level of care coordination service required by the Enrollee. The fee schedule shall be used for both target populations: individuals with serious mental illness and seniors with chronic health conditions. The three tiers of care coordination offered include:

- Intensive
  Intensive care coordination serves the individual at high risk for poor health outcomes. The objective for this level of care coordination is support for recovery and a sustained decrease in avoidable service utilization and problematic symptoms, along with sustained progress toward an improved quality of life and a reduction or moderation of risk factors. This level of service includes frequent and multiple contacts with the Enrollee and the Enrollee's medical home, service providers, family and significant others. It may also include resource-finding and problem solving around obstacles in access to care or needed services and supports. It also may include active direct involvement with the Enrollee to support participation in healthcare services.
- Supportive
  Supportive care coordination services the individual at moderate risk for poor health outcomes. The objective for this level of care is the development of resiliency, in which the Enrollee begins to assume responsibility for illness management, taking steps to reduce the risk of future service utilization, decrease risk factors and increase those activities that protect the Enrollee's health. Services at this level of care coordination include special attention to the Enrollee's transition from one service setting to another, active engagement with the Enrollee's service providers to monitor the Enrollee's continuing involvement in treatment services, anticipating Enrollee challenges and helping to construct planning that will assist the Enrollee in overcoming these challenges. This level of care coordination also includes regular personal contact with the Enrollee.
- Preventative

Preventive care coordination serves the individual at low risk for poor health outcomes: Services at this level of care coordination include health education and illness self-management training for the Enrollee, referral to health and wellness activities and monitoring of the Enrollee's functioning.

Shared Savings

Any and all shared savings received by Macon County Care Coordination will be reinvested in the purchase of services for the two proposed target populations, seriously mental ill individuals and seniors with chronic illness. The Macon County Mental Health Board, as the Lead Entity for the care coordination proposal, has extensive experience in purchase of service contracting and uses the DHFS Medicaid reimbursement rate as the payment rate in contracting for services that are comparable to Illinois mental health and substance abuse Medicaid services. Shared savings amounts will be incorporated into the Mental Health Board's contracting procedures. Local network providers will be approached will be invited to contract with the Mental Health Board for services supported through shared savings. Specific services to be contracted will be identified by consensus of the core collaborators about identified service gaps in the local system and identified providers.

3.3.1.2 *If proposing a Care Coordination Fee, propose an administrative PMPM by population type for each of the first three years of the Contract, following the template provided in Attachment F.*

Please see Attachment F.

3.3.1.3 *If proposing another interagency payment flexibility methodology, describe the proposed payment structure including amounts and how often the CCE would be paid.*

Macon County Care Coordination is not proposing an interagency payment flexibility methodology.

3.3.1.4 *With respect to Department data, indicate the population definition number(s) and version number that you relied upon for preparing this Proposal.*

Population # 18. No version number was noted.

3.3.1.5 *Describe any data (other than data received from the Department) that you relied upon.*

Macon County Care Coordination used the combined observations of the core collaborator leadership in appraising community service need and, in addition, compared finding from DHFS data analysis with another collaborating group that one of the core collaborators, Heritage Behavioral Health Center, has been working with on a separate Care Coordination Entity proposal.

3.3.1.6 *Describe in detail how you expect your care coordination model to result in cost neutrality – to reduce costs by at least as much as the care coordination fees you expect to receive over three years.*

Medicaid cost savings are achievable only by concentrating care coordination services on high-risk, high cost seriously mentally ill individuals. As identified earlier in this proposal, SMI individuals in Macon Count y comprise 11% of all Medicaid service recipients in the County, however, total cost for treatment of SMI individuals ($18,573,657) amounts to over 24% of total Medicaid spending ($81,355,014) for all County Medicaid recipients receiving services. Cost per individual with SMI is $12,006 per year, over two and one-half times as high as the cost for those individuals without serious mental illness ($4,715)). Hospital inpatient days for SMI individuals total 3974 or 37% of all inpatient days. Emergency Department visits for SMI individuals total 1921, or 23% of total ER visits. SMI individuals are using inpatient and Emergency Department services at a rate over two times as frequently as those Macon County residents without SMI.

The top quartile of Medicaid spending for individuals with serious mental illness, total Medicaid spending is $13,388,004.70, or 72% of total Medicaid spending for individuals with serious mental illness. Average Medicaid cost for this set of individuals is $34,865 per year. Of the total cost for treatment of individuals with serious mental illness, $5,378,296 is spent for congregate care and is not included as part of potential cost savings.

The focus for cost savings involving individuals with serious mental illness is on inpatient medical and psychiatric treatment and emergency department service utilization. Seriously mentally ill individuals accumulated 912 hospitalizations in 2010, 5042 patient days of care, an average length of stay of 5.5 days and hospitalization rate of 554 per 1000 recipients, over three times the hospitalization rate for non-seriously mentally ill individuals. Total cost for inpatient care for seriously mentally ill individuals was $3,438,674, including $2,812,333 for inpatient medical care and $626,341 for inpatient behavioral health care. Emergency department visits by seriously mentally ill individuals totaled 4,792 visits, 69% of total emergency department visits by all Macon County Medicaid recipients and a utilization rate of 2914 visits per 1000 recipients. Total cost for emergency department services in 2010 was $489,609. The pool of expense from which potential savings is projected, the combined total of inpatient and Emergency Department expenses, is $3,928,283.

As cited previously, of the 1547 SMI individuals in Macon County, 865 received mental health Medicaid services through the Medicaid mental health services program while an additional 682 SMI individuals did not. Recognizing that many with serious mental illness struggle both physically and mentally and are sometimes difficult to engage in treatment, the care coordination program will prioritize outreach to those difficult to engage, those with serious mental illness and co-morbid medical conditions and those individuals with patterns of high inpatient and emergency department services. Projected savings from care coordination programming is as follows:

Year	Potential Savings Pool (Inpatient and E.D. Expense)	Enrollment penetration rate (N = 1547)	Projected Savings Rate	Projected Savings Per Year after Care Coordination Expense
1	$3,928,283	39%	20%	$111,372
2	$3,928,283	58%	25%	$175,566
3	$3,928,283	70%	30%	$251,788
Projected 3 Year Total Savings				**$538,726**

3.3.1.7 *How do we plan to distribute the payment(s) among collaborators?*

Per member per month reimbursement will be used exclusively to support care coordination services. The core collaborators have not requested nor do they anticipate payment for service provided, other than fee-for-service payments for Medicaid-covered services, as services are provided to Medicaid-eligible individuals. As described earlier in this proposal, any shared savings that would accrue to Macon County Care Coordination would be re-invested in services for the target populations through purchase of service contracting from the Lead Entity, the Macon County Mental Health Board by service providers in the community. Service needs and services to be purchased through this shared savings amount will be determined based on identified need, as recommended by the core collaborators involved in this proposal and as approved by the Macon County Mental Health Board of Directors.

3.3.1.8 *What percentage of payment(s), if any, do we plan to put into a reserve pool?*

Five percent.

3.3.1.9 *Please list all case management fees collaborators receive other than IHC fees, such as case management fees paid in HCBS Waivers. The State will not pay twice for the same care coordination services.*

Macon County Health Department and St. Mary's Hospital are currently providing HCBS waiver services for the elderly, supported by the Department of Aging.

3.3.1.10 *Do we plan to request an advance on the care coordination fee to assist in the development of the CCE infrastructure prior to implementation?*

3.3.1.10.1 *What percentage or amount are we requesting?*

3.3.1.10.2 *Describe the intended use of the fee advance.*

3.3.1.10.3 *Propose a repayment schedule.*

Macon County Care Coordination is requesting an advance of $309,379, which is the difference between first year operating costs for the program, $673,869, and projected first year PMPM payments, $364,490. This advance will be used to support first year operations.

Repayment is proposed as follows:

Year	Repayment Amount	Monthly Repayment Amount
1		
2	$ 203,069	$ 16,922
3	$ 106,310	$ 8,859
Total	$ 309,379	