4. Narrative

a. Statement of need:

The 2006 Illinois population is 12,831,970. The enrolled Medicaid and SCHIP population totals 2,091,179, including the All Kids and Family Care programs.

In fiscal year 2006 (July 1, 2005 - June 30, 2006), 2,091,179 Medicaid and SCHIP clients made 1,133,617 visits to Emergency rooms that did not result in admission to the hospital. Illinois Medicaid clients made 54.2 ER visits/100 that did not result in hospital admission and 73.3 total ER visits as compared to an average national rate of 81.0 in 2003. Of the Illinois Medicaid visits, the top ten diagnoses were as follows:

Diagnoses Group	Total
Symptoms	291,980
Acute respiratory infections	161,973
Chronic obstructive pulmonary disease and allied conditions	103,387
Neurotic disorders, personality disorders, & other non-psychotic mental disorders	99,138
Diseases of the ear and mastoid process	85,943
Hypertensive disease	59,340
Sprains and strains of joints and adjacent muscles	53,530
Contusion with intact skin surface	51,715
Other diseases of urinary system	50,631
Other diseases due to viruses and Chlamydia	43,885

The category of "symptoms" includes the following diagnoses types:

General symptoms
Symptoms involving nervous and musculoskeletal systems
Symptoms involving skin and other integumentary tissue
Symptoms concerning nutrition, metabolism, and development
Symptoms involving head and neck
Symptoms involving cardiovascular system
Symptoms involving respiratory system and other chest symptoms
Symptoms involving digestive system
Symptoms involving urinary system
Other symptoms involving abdomen and pelvis

In addition, a large variety of non-emergent needs are currently addressed by emergency rooms for individuals with behavioral health needs. A partial list of these includes:

Urgent med management	Acute grief reaction	Non-suicidal self-harm
Intoxication	Panic attack	Inadequate clinical coverage
Family crises responding to intensive family crisis intervention	Acute social issues (homelessness, lack of food, etc.)	Toxicology screens prior to re-entry to residential treatment after addiction relapse.
Intensive crisis consultation to residential program staff in situations of behavioral crisis	Expedition of crisis therapy or crisis residential stay	Programs' attempts to discharge & circumvent 30-day notice rules

The majority of visits were made by clients living in the city of Chicago and Cook County and the surrounding collar counties which includes DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry and Will. Clients from Winnebago, St Clair, Madison, Peoria, Sangamon, Macon, Champaign, Rock Island, La Salle, Tazewell, Vermilion, McLean, Adams, and Jefferson make up a significant portion of visits such that 82% of all visits were made by clients living in these 23 out of 102 Illinois counties. The aforementioned counties are a mix of urban and rural and are distributed throughout the State. HFS plans to use this data to guide selection of pilot sites for the ERD project.

After much discussion with health care providers, the Illinois Department of Healthcare and Family Services (HFS) introduced in June and July 2006 two special programs to improve access to and quality of medical care for its clients. The first, a primary care case management program, is called "Illinois Health Connect". The basic tenet of the program is to assure that each person receiving benefits through

HFS has a "medical home". The medical home concept, strongly supported by medical professional organizations, including the American Academy of Pediatrics, greatly improves continuity of care and results in improved access to preventive care services. The medical home, also known as the primary care provider, is responsible for not only provision of primary care and preventive services, but also coordinating specialty care referrals. Automated Health Systems (AHS) administers the program for HFS. HFS chose Community Health Centers (CHC) to begin implementation of this program on a voluntary basis as a way to quickly get the program up and running throughout the state while certain operational aspects were still being implemented.

The second program, Your Healthcare Plus ™, is a disease management program focusing on clients with chronic conditions including asthma, diabetes, heart disease, chronic obstructive pulmonary disease, mental illness and those persons identified as high frequency users of emergency room care. HFS contracted with McKesson Health Solutions to administer the program and coordinate with medical homes under the Illinois Health Connect program.

The programs were implemented over the past year and a majority of clients have been enrolled in a medical home as indicated in the chart below.

Region	Number of Medical Homes*	Panel Size	Eligible Client Count	Clients Enrolled in IHC	Clients Enrolled in MCO	Clients with a Medical Home	% of Eligibles Enrolled
Cook	2,287	2,745,583	866,707	582,315	146,429	728,744	84%
Collar	1,075	671,747	282,910	245,500	0	245,500	87%
Northwest	617	441,702	190,315	151,479	0	151,479	80%
Central	253	387,487	175,781	11,326	0	11,326	6%

Southern	184	446,182	175,302	17,706	10,013	27,719	16%
IA	19	27,910	NA	NA	NA	NA	NA
IN	12	13,500	NA	NA	NA	NA	NA
MO	4	14,775	NA	NA	NA	NA	NA
WI	18	1,895	NA	NA	NA	NA	NA
Totals	**4,469**	**4,750,781**	**1,691,015**	**1,008,326**	**156,442**	**1,164,768**	**69%**

* CHC/Rural Health Clincic/Encounter Rate Clinic Sites are counted as 1 Medical Home

A strong component of the 4,469 medical homes is the 287 community health center (CHC) sites serving Illinois citizens across the state. CHCs are private, not-for-profit, community-based organizations providing primary and preventive care to underserved populations regardless of their ability to pay. Illinois CHCs employ 671 full-time equivalent primary care physicians, nurse practitioners and physician assistants. Primary care providers include family practice, internal medicine, pediatrics and obstetrics/gynecology. By requirement, all CHCs serve medically underserved areas or populations [42 USC, section 254(b)]. While CHCs may appear to the casual observer as a "medical group" they are in fact much more complex. Dedicated to serving medically underserved populations they routinely provide whole person care, generally employing social workers, case managers and others to ensure that patients have broad access to medical care and needed social services. CHCs are important providers in their individual communities and have strong relationships with hospitals and other providers in the community. Most Illinois CHCs provide behavioral health care and oral health care as an integrated component of primary health care, respecting the whole person philosophy. Preventive dental care is provided by 86.1% of CHCs and 77.8% provide restorative services. Mental Health treatment and counseling is provided by 80.6% of CHCs and 44.4% of CHCs provide substance abuse services. However, the need to enhance these services to provide the

most innovative, effective and responsive services to individuals in crisis is acknowledged.

The ERD model that HFS proposes will link CHCs, community hospitals and behavioral health providers in an effort to assure that beneficiaries receive needed care in the most appropriate setting. Using a grant proposal process, HFS will select one CHC/Hospital/behavioral health provider pairing in Chicago and one in a rural area.

The selected pairings will agree to develop a new CHC site either on hospital premises or in very close proximity to the hospital emergency room department. The CHC will be accessible during the hours when the largest volume of ambulatory care sensitive cases is seen in that particular emergency room. For example, if most inappropriate ER visits are made weekdays between 6:00 p.m. and midnight and 3:00 p.m. to 9:00 p.m. Sunday evenings that is when the CHC site would be open and available for care. HFS recognizes that peak hours will vary by community and hours will be determined by the pairing based on hours of greatest need. The behavioral health emergency room diversion services would be available 24 hours per day, seven days per week.

After appropriate triage, the hospital ER would offer patients who do not need an ER level of service an option to obtain immediate health care during open hours at the CHC or at the behavioral health center for immediate crisis assessment 24/7. Clients will have a choice as to whether to be diverted: no additional co-payments will be charged if they choose to receive the service in the ER. For non behavioral health

services, if the CHC were not open, the hospital would provide the service and provide Illinois Health Connect literature, encouraging the patient to use his/her medical home for follow-up and ongoing care.

Given that many ER visits are made for mental health diagnoses, HFS will give particular preference to CHC/hospital pairings that demonstrate a partnership with a behavioral health provider to integrate behavioral health services. The Division of Mental Health within the Illinois Department of Human Services has been exploring the use of innovative "Peer Supported" behavioral health crisis intervention models for individuals who need intensive support, medication monitoring, and highly complex treatment planning but whose situations are not life-threatening and are not in need of ED care. We will look for the inclusion of these methods in selecting sites. More specifically, proposals that demonstrate plans to include some or all of the following behavioral health components will be given strong preference:

1) Co-location of urgent medical and psychiatric care to address mental health clients with medical co-morbidities who need differential diagnosis to ensure medical illnesses are not treated psychiatrically or vice versa;
2) Short-term peer-supported crisis residential treatment in more relaxing, less restrictive environments than ED's where clients can receive clinician and peer provided crisis intervention as well as psychiatric evaluation treatment and care supervision; and
3) Enhanced short-term medically monitored detoxification services involving an overnight or longer non-hospital stay including integrated mental illness and substance abuse services and complex discharge planning.

b. Project justification

HFS will select two CHC/hospital/behavioral health provider pairings in disparate areas of the State to pilot the ERD model. In each case, a new CHC site will be developed in collaboration with a hospital ER and either be co-located or located in close proximity so as to promote access. Selection will be based in part on the volume of inappropriate ER use and a high incidence of failure to use available primary and preventive services in the community. HFS will evaluate the availability of after hours care in the existing primary care network. HFS believes that due to the increasing prevalence of working families in government sponsored health insurance programs, the evolution of primary care to provide after hours access is the next step in ensuring greater access and use of medical homes. Incorporating the criterion of failure to use primary care will not only facilitate on the spot diversions, but will also reduce the number of clients who show up at the ER due to the increased access through establishment of a new primary care medical home site. Selection will also be based in part on the inclusion of a partnership with a behavioral health provider to incorporate behavioral health components in the application.

The HFS ERD model takes advantage of the tradition and excellence of CHCs in providing primary health care and the expertise of hospitals in triaging patients and identifying appropriateness of care. The CHC imperative of service to medically underserved areas and populations assures HFS that the neediest communities will benefit from the ERD model. The ERD project is a strong value added program given the existence of the Illinois Health Connect program, and the CHCs participation as

medical homes. Once seen at the ER/CHC site, the CHC will provide additional education about the appropriate use of the ER and the value of the medical home model and will offer to become the client's medical home through the Illinois Health Connect program. If the client chooses to remain with their current primary care provider the CHC will direct them to establish a relationship with that primary care provider so the client will be more likely to seek future care through their medical home.

CHCs will also survey clients who already have a primary care provider when they show up in the ER for a non-emergent condition to try to ascertain why they did not seek care through their medical home. HFS will then use this information to further understand the issue and, if possible, enhance the Illinois Health Connect program and educational outreach.

CHCs have particular expertise in treating patients with asthma, diabetes, hypertension and cardiovascular disease as well as behavioral health and oral health maladies. Studies have overwhelmingly shown that health disparities exist in these diseases for the underserved population. Given that many of the common ER diagnoses noted above fall into these categories of ambulatory sensitive conditions and CHCs' current focus on health disparities, CHCs are particularly well suited to partner with hospitals in treating persons with these and other non-emergent conditions.

In addition, improving connections between primary and psychiatric care puts in place systemic underpinnings to more thorough and accurate differential diagnostic evaluations to avoid unrecognized medical illnesses masquerading as psychiatric ones or vice versa. Possible provision of short-term detoxification services will also enhance links between mental illness, substance abuse and primary medical care. Finally, co-location of urgent medical and behavioral health care will provide consumers with clear and direct relationships to expedite the establishment of a primary care home.

c. Project Goals and Outcomes

The goals and outcomes of the ERD are as follows:

1. Develop criteria and an application process to solicit CHC/hospital pairings for the ERD project. Outcome: CHC/Hospital ERD applications received within 6 months of grant award.
2. Select two CHC/Hospital/behavioral health provider pairings, one in Chicago and one in a rural area. Outcome: Two new CHC primary care sites developed in close proximity to hospital ER within 18 months of grant funding.
3. Each CHC/Hospital location will strive to change client behavior through education on the benefits of a medical home and provide assistance in choosing or changing their primary care provider. Outcome: Clients educated and visiting medical homes for non-emergent care.
4. Give preference to CHC/hospital pairings in partnership with a behavioral health provider to integrate behavioral health components that may include co-location of urgent care, crisis residential care and integrated dual diagnosis detoxification

services. Outcome: Demonstrate the effectiveness of this type of partnership for future expansions.

d. Estimate of Impact to Beneficiaries

51% of HFS clients reside in Chicago; nearly **68**% live in the Cook and the surrounding "collar" counties. The remainder of clients are dispersed across the state. The ERD project will impact clients across the state.

Elements of criteria for choosing CHC/Hospital/behavioral health provider pairings will include greatest population impact, current lack of primary care access, ability and expertise in provision of behavioral health services amongst others to be determined during the initial planning stages. While it is not possible to measure potential outcomes in raw numbers prior to project selection, HFS intends to select projects for maximum client benefit.

e. Description of Sustainability

The program will be administered in the form of a grant to the two pilot CHC/hospital/behavioral health pairings. Grant funds will be used for initial planning, build-out, equipping and start-up of the new sites. Since they are under the auspices of CHCs they will apply to the Federal government, Department of Human Services, Health Resources Services Administration (DHS/HRSA) to become bona fide CHC sites. This application process is known as a change in scope of practice and is a routine method of site and service expansion in the CHC program. Once approved they will take advantage of CHC encounter rate reimbursement from HFS and

Medicare under federal guidelines while continuing to bill fee for service to those otherwise insured or self-pay. The delivery sites will then also be able to take advantage of other CHC grant funding opportunities. Thus the sites will become self-sufficient.

For the behavioral health components, including peer supported crisis services, medication monitoring, detoxification monitoring, and intensive treatment planning, sustainability will be accomplished through fee-for-service billing and reimbursement directly to the behavioral health providers (i.e., the CHC/Hospital partner). Medicaid reimbursement to behavioral health providers will be directed by 59 Illinois Administrative Code 132.

f. Evaluation Plan

HFS will monitor the goals and outcomes of the project to ensure timely progress of development. Once fully operational, CHC/hospital pairings will be expected to evaluate success in ER diversion and make periodic reports to HFS. The pairings will be encouraged to discuss best practices amongst the two grantees and share such with HFS at regular intervals.

g. Description of project readiness

There are 44 CHCs serving Illinois Medicaid and SCHIP clients throughout the State adept at expanding services and capacity to care for the underserved and about 200 community hospitals across the State. In addition, there are more than 150 behavioral health providers within Illinois. Given that CHCs, community hospitals and

behavioral health providers already have established relationships as federal regulations require all CHC sites to have hospital admitting privileges or formal arrangement to admit, and behavioral health providers funded by the State are required to serve the individuals with the greatest need and with the fewest resources, HFS believes that once an application is released, response will be rapid. HFS has an established working relationship with the Illinois Primary Health Care Association (IPHCA), the trade association for the CHCs, the Illinois Hospital Association (IHA), Community Behavioral Healthcare Association (CBHA), and the state mental health and substance abuse authorities. IPHCA has agreed to work with HFS in soliciting CHC/hospital and behavioral health center applications.