DHS/DMH
Level Of Care Utilization System (LOCUS)
Pilot Project Report
July 31, 2006

I. **CONTEXT**: As part of the Department of Human Services/Division of Mental Health's Fee-for-service System Restructuring Initiative (SRI), the Services Work Group's Residential Subgroup agreed that a residential placement decision support tool would assist the community providers in determining the medical necessity and appropriate level of care for consumers referred to DHS/DMH supervised and crisis residential programs. During the same time period DHS/DMH issued a Request for Service Proposal (RFP) for the Pre-Admission Screening/Mental Health (PAS/MH) program in metro-Chicago requiring the use of the LOCUS in determining a consumer's appropriateness for nursing facility level of care.

The Residential Subgroup specifically recommended the following:

- A nationally validated tool should be required as part of the initial placement determination and periodically at the time of re-evaluation
- The tool should function as a "decision support tool"
- A single tool should be used state-wide
- After an extensive review of seven tools, the LOCUS was the tool recommended.

The Division of Mental Health adopted the above recommendations and conducted a large-scale pilot of this tool.

II. **OBJECTIVES**: The objectives of the pilot were:

- Inform statewide training and rollout
- Initiate development of a core of LOCUS expertise in provider community
- Gather data to inform crosswalk of LOCUS levels of care to Illinois' levels
- Gather data to inform continued efforts of Residential Subgroup

III. **PROCESS**: DHS/DMH asked agencies with 24 hour supervised, crisis residential, and PAS/MH services to volunteer to be part of the pilot. Twenty-nine (29) agencies agreed, representing the three services in various parts of the state (urban/rural) and serving culturally diverse populations. Training was conducted by Mary Thornton (Mary Thornton & Associates, Inc.) under contract with Parker Dennison & Associates, Ltd. and occurred on April 3 and 4, 2006. Participants then established procedures for the implementation and trained staff during the month of April. The Pilot ran from May 1st through June 30th. Agencies agreed to the following terms of the pilot:

- Complete a LOCUS for all new referrals to 24 hour supervised and crisis residential programs, all PAS/MH screenings, and 20% or 25 existing residential clients (whichever is greater)
- Complete and submit data to DHS/DMH on the LOCUS Data Collection Form (Attachment 1)
- Participate in two teleconferences

IV. **RESULTS**: (Please refer to attachment 2 - 6 for complete details.)
- A total of 795 LOCUS Data Collection Forms were submitted to DHS/DMH.
- Of these, 48% were completed by Mental Health Professionals (MHP), 35% by Qualified Mental Health Professionals (QMHP), and 16% by Licensed Practioners of the Healing Arts (LPHA).
- Seventy-two percent (72%) were completed on consumers currently residing in supervised or crisis residential programs.
- The average amount of time to gather/review assessment data was 37 minutes. (Highest agency average 110 minutes, lowest agency average 11 minutes.)
- The average amount of time to score the LOCUS was 22 minutes. (Highest agency average 51 minutes, lowest agency average 5 minutes.)
- Attachment #5 shows the Level of Care indicated via the completed LOCUS vs. the clinical assessor and the actual placement of the individual. It is important to note that the LOCUS authors expect there to be a percentage of variance between LOCUS scored level of care and assessing clinicians (typically not greater than 10% of the time). The LOCUS authors see this as a decision support tool and that clinical judgment ultimately should be strongly considered if there is disagreement. This early data is typical for a pilot in that staff new to using LOCUS tend toward higher acuity scores (which LOCUS actually recommends if there is any ambiguity).

V. **AGENCY FEEDBACK**: Two teleconferences (mid-pilot and post-pilot) were held with the 29 agencies to obtain feedback on the use of the LOCUS, the effectiveness of training, and to elicit input into the statewide rollout of the tool. The majority of the participants expressed positive experiences with the tool stating that it was user-friendly and helpful in making level of care decisions and identifying treatment needs. A few participants commented that it was difficult to complete, was too time-consuming and took additional time to translate for Spanish-speaking consumers. Ideas for improved training included receiving the LOCUS manual prior to the actual training and to allow more time for the case studies and scoring.

VI. **RECOMMENDATIONS**: The Pilot recommended several implementation ideas including:

- Though the LOCUS will not be mandatory for the designated programs until formal adoption of the Rule revisions, the training and roll out should occur as soon as possible this fall to allow continued use by those already trained and to give more time for providers to develop proficiency.
- DHS/DMH should look at which other tools the LOCUS should replace. This step should be concluded prior to the LOCUS becoming mandatory.
- Training should be targeted to supervisors, include more 'train-the-trainer' elements, allow more time for case studies, and be offered in multiple locations across the state.
- LOCUS administration and scoring needs to be clearly billable, expressly for scoring using clinical records (i.e., not only face to face).

VII. **NEXT STEPS**: Based on the recommendations of the Pilot, the following is planned:

- LOCUS training will be offered in four locations across the state in October, 2006. One location will be offered in South Illinois, one in mid-state, and two in the Chicago area.
- DHS/DMH will review the use of existing required tools and issue clarification regarding which tools the LOCUS will replace.
- Training curriculum will be modified to allow more training time to provide additional opportunity for train the trainer and case studies.
- DHS/DMH has reached agreement with the Interdepartmental Medicaid Group that LOCUS will be a billable activity. Rather than bill for a unit of time, the billing code will be for the 'event' of the LOCUS and be a flat rate. This will avoid the issue of face to face versus record review scoring by focusing the reimbursement on the product (a completed LOCUS). Actual scoring time data and credential mix from the Pilot will be factored into the rate setting process.

Attachment 1.

Completed LOCUS Data Collection Form

Please complete one Data Collection Form for each LOCUS completed during the pilot. Completed forms can be faxed to a confidential fax at 312-276-4761 (Attn: Jackie Manker) or e-mailed to LOCUS@dhs.state.il.us.

PROVIDER AGENCY NAME:	
ASSESSING STAFF INFORMATION	
Assessing Staff Name:	
Assessing Staff Credential:	□ MHP □ QMHP □ LPHA
NATURE OF ASSESSMENT	
Type of Assessment (check one)	□ PAS/MH □ Residential (New Referral) □ Crisis Residential □ Current Residential Placement - Admit Date: __/__/____ □ Other (Explain:)
Location of Assessment (check all that apply)	□ Agency office □ Agency residential site □ Consumer's residence (other than agency owned) □ Hospital (Gen. Med Unit) □ State Psych. Hospital □ ER/ED □ Community Psychiatric Unit □ Nursing facility □ Other community site
Information Source for LOCUS (check all that apply)	□ Client Interview □ Review of clinical records □ Family informant interview □ Other informant interview □ Other:
Referral Source (check one)	□ Mental Health Center □ Family □ Self/Consumer □ Hospital (Gen. Med Unit) □ State Psych. Hospital □ ER/ED □ Community Psychiatric Unit □ Social Service Agency □ Nursing Facility □ Currently enrolled 24 Hr Supervised Residential □ Other
Total Time to Gather/Review Assessment Data	Minutes
Total Time to Score LOCUS After Assessment Data Gathered/Reviewed	Minutes
CONSUMER INFORMATION	
Agency Generated ID # (Do NOT use RIN)	
Sex	□ Male □ Female
Age	Years
Ethnicity/Hispanic Origin (DHSCRS p. 5-7) (check one)	□ Not of Hispanic Origin □ Mexican/Mexican American □ Puerto Rican □ Cuban □ Central/South American □ Other Hispanic □ Unknown □ Not Classified
Race (DHSCRS p. 5-6) (check one)	□ White □ Black/African American □ Asian □ American Indian/Alaskan Native □ Native Hawaiian or Other Pacific Islander □ Unknown

Living Arrangement Prior to Admission ('Residential Arrangement' – DHSCRS p. 5-18) (check one)	□ Homeless □ Private residence/supervised □ Private residence/unsupervised □ 24 Hr Supervised Residential □ Supported Residential □ State-Operated Facility □ Jail or correctional facility □ Other institutional setting □ Nursing facility □ Other □ Unknown	
Global Assessment of Functioning (GAF)	Highest Last Year:	Current:
DSM Diagnosis (Code for Axis I, II, and/or III Diagnosis in rank order of primacy)	**Diagnosis (Code)**	**Rank**
		1
		2
		3

LOCUS SCORE

Domain Score

Risk of Harm

Functional Status

Co-morbidity

Recovery Environment – Environmental Stressors

Recovery Environment – Environmental Support

Recovery and Treatment History

Acceptance and Engagement

COMPOSITE SCORE

LOCUS RECOMMENDED LEVEL OF CARE
□Level I □Level II □Level III
□Level IV □Level V □Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (according with services crosswalk)
□Level I □Level II □Level III
□Level IV □Level V □Level VI

Reason for deviation:
Explain:

DISPOSITION	
Placement Post Assessment ('Residential Arrangement' – DHSCRS p. 5-18) (check one)	□ Homeless □ Private residence/supervised □ Private residence/unsupervised □ 24 Hr Supervised Residential □ Supported Residential □ Crisis Residential □ State-Operated Facility □ Jail or correctional facility □ Nursing facility □ Other institutional setting □ Other □ Unknown

Attachment 2

Complete Count of LOCUS Assessment Data

Total LOCUS Assessments	795	
MHP	385	48.43%
QMHP	280	35.22%
LPHA	126	15.85%

Type of Assessment		
PAS / MH	74	9.32%
Residential (New Referral)	35	4.41%
Crisis Residential	111	13.98%
Current Residential Placement	568	71.54%
ACT	2	0.25%
Other	4	0.50%
Total Count	794	

Information Sorce for LOCUS		
Client Interview	465	38.02%
Review of clinical records	613	50.12%
Family informant interview	24	1.96%
Other informant interview	90	7.36%
Other	31	2.53%
Total Count	1223	

AvgOfTotal Time to Gather / Review Assessment Data

37.3770

AvgOfTotal Time to Score LOCUS After Asssessment

21.5322

Male	487
Female	304
Avg Of Age:	42.7370

Ethnicity / Hispanic Origin		
Not of Hispanic Origin	749	95.17%
Mexican / Mexican American:	21	2.67%
Puerto Rican	7	0.89%
Cuban	1	0.13%
Central / South American	1	0.13%
Other Hispanic	2	0.25%
Unknown	3	0.38%
Not Classified	3	0.38%
Total Count	787	

Location of Assessment		
Agency Office	347	41.86%
Agency Residential Site	358	43.18%
Consumer's Residence	10	1.21%
Hospital (Gen Med Unit)	10	1.21%
State Psych Hospital	3	0.36%
ER / ED	31	3.74%
Community Psychiatric Unit	52	6.27%
Nursing Facility	6	0.72%
Other Community Site	12	1.45%
Total Count	829	

Referral Source		
Mental Health Center	154	20.00%
Family	37	4.81%
Self / Consumer	19	2.47%
Hospital (Fen Med Unit)	25	3.25%
State Psych Hospital	97	12.60%
ER / ED	76	9.87%
Community Psychiatric Unit	74	9.61%
Social service Agency	25	3.25%
Nursing Facility	25	3.25%
Currrently enrolled 24 Hr	177	22.99%
Other	61	7.92%
Total Count	770	

Race		
White	571	72.74%
Black / African American	197	25.1%
Asian	8	1.02%
American Indian / Alaskan Native	1	0.13%
Native Hawaiian or Other	1	0.13%
Unknown	7	0.89%
Total Count	785	

Complete Count of LOCUS Assessment Data

Submitted

Living Arrangement Prior to Admission to Current Living Situation

Homeless	122	15.93%
Private residence / supervised	76	9.92%
Private residence / unsupervised	221	28.85%
24 Hr Supervised Residential	96	12.53%
Supported Residential	50	6.53%
State - Opperated Facility	99	12.92%
Jail or correctional facility	7	0.91%
Other institutional setting	10	1.31%
Nursing facility	61	7.96%
Other	17	2.22%
Unknown	7	0.91%
Total Count	766	

Locus Recommended Level of Care

Level I	14	1.78%
Level II	49	6.23%
Level III	102	12.98%
Level IV	154	19.59%
Level V	399	50.76%
Level VI	68	8.65%

Assessor Recommended Level of Care

Level I	10	1.28%
Level II	34	4.34%
Level III	76	9.71%
Level IV	129	16.48%
Level V	490	62.58%
Level VI	44	5.62%

Avg Of Highest GAF Score Last Year	46.62426
Avg Of Current GAF Score	44.11848

Average Domain Scores

AvgOfRisk of Harm	2.907
AvgOfFunctional Status	3.316
AvgOfCo-morbidity	2.793
AvgOfRecovery Environment/Stress	3.332
AvgOfRecovery Environment/ Support	2.996
AvgOfRecovery and Treatment History	3.301
AvgOfAcceptance and Engagement	3.094
AvgOfCOMPOSITE SCORE	21.71

Placement Post Assessment

Homeless	3	0.39%
Private residence / supervised	21	2.72%
Private residence / unsupervised	24	3.11%
24 Hr Supervised Residential	484	62.78%
Supported Residential	72	9.34%
State - Operated Facility	2	0.26%
Jail or correctional facility	1	0.13%
Nursing facility	49	6.36%
Other institutional setting	0	0.00%
Other	5	0.65%
Unknown	13	1.69%
Total Count	771	

Attachment 3.

Locus Completion Times

PROVIDER AGENCY NAME	Avg Of Total Time to Gather/Review Assessment Data	Avg Of Total Time to Score LOCUS After Assessment Data Gathered
Association for Individual Development	59.218	21.612
Association House of Chicago	75	30
Bobby Wright	36.136	19.545
Bridgeway	26.875	23.906
Chestnut Health Systems	45.347	26.527
Coles County	36.875	27.8125
Community Counseling Center	15	15
Community Mental Health Council	43.518	14.259
Cornerstone	16.363	15
Ecker Center	26.351	16.216
Family Counseling Center	46.875	36.875
Habilitative Systems	18.333	16.666
HRDI	30.857	50.571
Human Service Center	30.967	13.419
Human Support Services	17.8	10.04
Lutheran Social Services	22.5	24.583
Mental Health Center of Champaign	110.72	22.534
MHCCI	24.236	14.236
MHCWI	27.142	13.333
North Central	42.972	14.583
Pilsen Little Village CMHC	40.5	16.5
Robert Young	21	27.541
Sinnissippi	36.279	20.348
SIRSS	12.631	12.631
Southeastern IL Counseling	11.1875	21.0625
Stepping Stones	36.538	18.653
Thresholds	43.431	40.295
Victor Neumann	29.375	10.833
Victor Nuemann	30	15
Will County	50.384	17.692

Attachment 4.

Provider Assessment Type Count

29 Agencies Participating

PROVIDER AGENCY	*PAS/MH*	*ACT*	*Residential (NR)*	*Crisis Res*	*Current Res*	*Other*	*# Assessments*
Association for Individual Development	8	0	0	0	24	0	32
Association House of Chicago	0	0	2	0	2	0	4
Bobby Wright	0	0	0	0	22	0	22
Bridgeway	1	0	0	0	31	0	32
Chestnut Health Systems	27	0	0	18	27	0	72
Coles County	0	0	4	0	11	1	16
Community Counseling Center	0	0	0	0	12	0	12
Community Mental Health Council	0	0	2	0	25	0	27
Cornerstone	0	0	1	0	10	0	11
Ecker Center	0	0	4	17	16	0	37
Family Counseling Center	0	0	0	0	8	0	8
Habilitative Systems	0	0	2	0	10	0	12
HRDI	0	0	0	0	35	0	35
Human Service Center	0	2	3	1	25	1	32
Human Support Services	0	0	0	0	25	0	25
Lutheran Social Services	0	0	0	0	24	0	24
Mental Health Center of Champaign County	0	0	1	40	3	0	44

PROVIDER AGENCY	*PAS/MH*	*ACT*	*Residential (NR)*	*Crisis Res*	*Current Res*	*Other*	*# Assessments*
MHCCI	0	0	9	35	28	0	72
MHCWI	0	0	2	0	18	0	21
North Central	11	0	2	0	24	0	37
Pilsen Little Village CMHC	0	0	2	0	8	0	10
Robert Young	0	0	0	0	24	0	24
Sinnissippi	9	0	0	0	34	0	43
SIRSS	0	0	0	0	19	0	19
Southeastern IL Counseling	0	0	0	0	16	0	16
Stepping Stones	0	0	0	0	26	0	26
Thresholds	5	0	1	0	36	2	44
Victor Neumann	0	0	0	0	24	0	24
Victor Nuemann	0	0	0	0	1	0	1
Will County	13	0	0	0	0	0	13

Attachment 5.

LOCUS Scored Levels vs Assessors Recommended Levels

LOCUS LEVELS OF CARE	LOCUS Recommend	Assessor Recommendation	Placement Post Assessment
Level I Recovery Maintenance & Health Maintenance	14 (1%)	10 (2%)	
Level II Low Intensity Community Based Services	49 (6%)	34 (4%)	
Level III High Intensity Community Based Services	102 (13%)	76 (9%)	
Level IV Medically Monitored Non-Residential Services	154 (20%)	129 (16%)	Supported 72 (9%)
Level V Medically Monitored Residential Services	399 (51%)	490 (63%)	Supervised/NF 533 (69%)
Level VI Medically Manged Residential Services	68 (9%)	44 (6%)	SOH ** 2 (1%)
			** did not collect data on admissions to private psy hospitals

LOCUS: LEVEL OF CARE CHARACTERISTICS

LOC Characteristics	I. Recovery Maintenance and Health Mainten. *(Usually a step down LOC)*	II. Low Intensity Community Based Services	III. High Intensity Community Based Services	IV. Medically Monitored Non-Residential Services	V. Medically Monitored Residential Services	VI. Medically Managed Residential Services
Client Living situation	Independent with minimal support	Independent with minimal support	Independent OR with support	Independent or with support	Residential setting, community-based. Some Board and Care and LT Resi also.	Traditionally hospital but could be in free-standing facilities.
Recovery History	Achieved significant recovery from past episodes	Clients generally need on-going support.	Intensive support and treatment needed.	Intensive support and treatment needed.	Acute and chronic situations depending on client.	Acute situations primarily.
Supervision and Contact Needed	Minimal for both	Do not require intensive management	Daily not required but usually several times per week	At least several times per week by a multi-disciplinary team.	24 supervision	24 hour monitoring and supervision.
Other	Some community or home-based services.	Traditionally clinic but can do community – based.	Traditionally clinic but can do community – based.	Facility or community: services are partial hospital or ACT	In some cases, intensive supportive housing may meet criteria	
I. Care Environment	Access can be monitored; egress not controlled.	Access can be monitored; egress not controlled.	Access can be monitored; egress not controlled.	Services may need to be mobile depending on client needs.	Adequate and safe living space. Usually no seclusion/ restraint but may manage egress. Food services/food prep avail.	Secure care; locked environment avail.; seclusion/restraint avail; Can do involuntary care.
II. Clinical Services	Up to 2 hrs/mo and not < 1 hr/3 months Med manage at least q 1-4 months Med use can be managed Ind or Grp supportive therapy	Up to 3 hours/wk and not < 1 hr q 2 wks Med manage about 1 x q 8 weeks Med use can be managed Ind, grp and family (I,G,F) therapies.	Tx (I,G, F)available at least 3 days/wk and 2-3 hrs/day. Med manage about q 2 wks Med use monitored/not administered. No skilled nursing needed. I,G, F and rehabilitative services and therapies	Services available most of day, 7 days/wk. Med manage avail. daily/ contacts usually at designated intervals. 24 hr by remote. Nursing available > 40hr/wk. Physical assess avail and accessed. Intensive Tx (I,G,F) 5 days/wk. Rehab services integrated. Meds monitored usually not administered.	Access to care: psych = 24 hours/day; psych contacts daily avail but s/be wkly; on-site nursing if doing med administration; on-site Tx (I,G, F) plus rehab and educational services either on or off-site.	Treatment available 24/7 on site or in close proximity. Psychiatric or medical contact daily. TX daily and pharmacological management.
III. Supportive Services	Yes	CM not usually required, may need help accessing certain services. Assist w/ coordination with support services.	CM and outreach available and integrated. Assist w/ coordination with supports. Ed and voc coordination. Facilitation of social, recreational.	CM integrated with mobile or on-site teams. ADL maintenance along with other coordination and supports, transport, systems management. Ed and voc coordination. Facilitation of social, recreational.	Supervision of ADL or may be custodial care. Staff facilitate social and recreational; staff coordinate interface w/ rehab and educational services if provided off-site	Total care available; client encouraged to do what they can.
IV. Crisis Stabilization and Prevention*	Basic see *	Basic see *	Mobile services, day care and child enrichment programs added to basic.	Mobile services, day care and child enrichment programs added to basic.	Services s/be directed to return to lower LOC in community. Develop transition plan, coord. w/ community resources and family.	Designed to reduce stress related to resuming normal community place. Develop transition plan

*** Includes at least access to 24/7 availability of crisis evals, brief interventions, and respite; vocational and educational and empowerment services. And, all basic services must be available as well: prevention programs that are population based and crisis management and evaluation services.**