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# The Money Follows the Person Demonstration The Illinois' Program

## Pathways



## To Community Living

Persons with Intellectual Disabilities  
Persons who are Elderly  
Persons with Physical Disabilities  
Persons with Mental Illness



## Table of Contents

<b><i>I. Introduction</i></b> .....	<b>4</b>
<b>A1. Introduction</b> .....	<b>5</b>
<b>A3. Benchmarks</b> .....	<b>10</b>
1. Benchmark 1 – Transition Targets.....	10
2. Benchmark 3 – Successful Community Reintegration.....	12
3. Benchmark 4 – Coordinated Process for Outreach/Marketing of MFP and LTSS.....	13
4. Benchmark 5 - Increase Affordable, Accessible and Supportive Housing Options.....	14
<b><i>II. Demonstration Policies and Procedures</i></b> .....	<b>16</b>
<b>B1. Demonstration Implementation Policies and Procedures</b> .....	<b>17</b>
1. Referral Sources.....	17
2. Elderly Recruitment and Enrollment.....	19
3. People with Physical Disabilities Recruitment and Enrollment.....	20
4. Persons with Mental Illness Recruitment and Enrollment.....	20
5. Persons with Intellectual Disabilities Recruitment and Enrollment.....	21
4. Enrollment and Disenrollment Policy – All MFP Populations.....	24
<b>B2. Informed Consent and Guardianship</b> .....	<b>25</b>
<b>B3. Project Education, Outreach and Implementation</b> .....	<b>27</b>
1. Transition Coordinator Training and Processes.....	27
2. Program Marketing and Outreach.....	27
3. Program Implementation by State Agency/Division.....	29
<b>B4. Stakeholder Involvement</b> .....	<b>32</b>
<b>B5. Benefits and Services</b> .....	<b>35</b>
1. Service Overview.....	37
<b>B6. Consumer Supports</b> .....	<b>38</b>
1. Consumer Supports – Elderly.....	38
2. Consumer Supports – Physical Disabilities.....	40
3. Consumer Supports – Mental Illness.....	42
4. Consumer Supports – Intellectual Disabilities.....	47
5. Supports Available to All MFP Participants.....	51
<b>B7. Self-Direction</b> .....	<b>53</b>
<b>B8. Quality</b> .....	<b>54</b>
1. Quality Management Plan.....	54
2. Proposed Modifications to Existing Quality Improvement Systems.....	55
3. Quality of Life (QOL) Interviews.....	57
<b>B9. Housing</b> .....	<b>59</b>
1. Strategies.....	59
2. MFP Participant Access to Qualified Housing Options.....	60

- B10. Continuity of Care Post Demonstration..... 63**
- B.11 – The Colbert V. Quinn Consent Decree..... 65**
  - 1. Background of Colbert V. Quinn..... 65
  - 2. Colbert Implementation Strategy & Coordination with MFP..... 66
  - 3. Colbert and MFP/Pathways Service Model..... 69
- III. Organization and Administration..... 71**
- C1. Staffing Plan ..... 72**
- C2. Billing and Reimbursement Procedures ..... 74**
  - 1. Persons Who are Elderly..... 74
  - 2. Persons with Disabilities..... 74
  - 3. Persons with Mental Illness ..... 76
  - 5. Money Follows the Person MMIS Changes ..... 77
  - 6. HFS Oversight ..... 78
- IV. Evaluation ..... 80**
- V. Final Budget..... 82**
  - 1. Annual Budget ..... 83
  - 2. Original MFP operational protocol budget planning documentation ..... 83

# I. Introduction

## A1. Introduction

Illinois is working to expand health benefits, services and supports to better align with the preferences of older adults and people with disabilities for independent community living. Through seven Medicaid HCBS waiver programs, well over 71,000 people received services in their communities in 2007. More than 30,000 additional individuals were served through parallel programs to the two largest waivers (Aging and Physical Disabilities), which are funded entirely through State General Revenue Funds (GRF) dollars without federal match. With federal, state and foundation funding, Illinois continues to explore innovative models, pilot new services for addition to the current array, and test interventions aimed at rapid reintegration from institutional care and incentives to reduce the institutional bed supply.

As described in the original proposal, MFP was developed in the context of state legislative mandates for rebalancing the LTC systems for older adults and persons with physical, psychiatric, and Intellectual disabilities. The Illinois MFP Rebalancing Demonstration builds on the momentum of the Older Adult Services Advisory Committee (OASAC) and the Disability Services Advisory Committee (DSAC), combining efforts and coordinating activities to achieve several critical system changes. State legislators incorporated strategies from the Illinois MFP proposal with objectives from the federal statute and crafted a framework for the Money Follows the Person Implementation Act (PA 095-0438), which was passed by General Assembly and signed by the Governor, effective January 2008. The MFP Implementation Act outlines goals and major objectives that Illinois will pursue from 2008 to 2011 and beyond:

*Per PA 095-0438 - To promote individual choice and control and increase utilization of home and community-based services through:*

- 1. Increased ability of the State Medicaid program to ensure continued provision of home and community-based long-term care services to eligible individuals who choose to transition from an institution to a community setting.*
- 2. Assessment and removal of barriers to community reintegration, including development of a comprehensive housing strategy.*
- 3. Expanded availability of consumer self-directed service options.*
- 4. Increased use of home and community-based long-term care services, rather than institutions or long-term care facilities, such that the percentage of the State long-term care budget expended for community-based services increases from its current 28.5% to at least 37% in the next 5 years.*
- 5. Creation and implementation of interagency agreements or budgetary mechanisms to allow for the flexible movement of allocated dollars from institutional budget appropriations to appropriations supporting home and community-based services or Medicaid State Plan options.*
- 6. Creation of an equitable, clinically sound and cost-effective system for identification and review of community transition candidates across all long-term*

*care systems; including improvement of prescreening, assessment for rapid reintegration and targeted review of longer stay residents, training and outreach education for providers and consumers on community alternatives across all long-term care systems.*

- 7. Development and implementation of data and information systems to track individuals across service systems and funding streams; support responsive eligibility determination; facilitate placement and care decisions; identify individuals with potential for transition; and drive planning for the development of community-based alternatives.*
- 8. Establishment of procedures that are at least comparable to those required under the qualified home and community-based program to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.*

The Demonstration provides a vehicle for coordinating the work of state agency partners through the MFP Implementation Act. Original and revised Benchmarks (in CY2012) selected for the Demonstration address several of objectives in the Act and in federal priorities. To carry out the program, state agency partners will work together through the MFP State Leadership Team, representing the Department of Healthcare and Family Services (HFS) as lead agency, along with the Department on Aging (DoA), the Department of Human Services (DHS), and the Illinois Housing Development Authority (IHDA). The State Leadership Team will provide ongoing state policy direction and oversight.

The State Implementation Team, including the MFP Project Director from HFS and key MFP coordinating staff from DoA, IHDA, HFS and the DHS Divisions of Rehabilitation Services (DRS), Mental Health (DMH) and Developmental Disabilities (DDD), will manage implementation activities. To implement the MFP Demonstration, HFS has established a new partnership with the University of Illinois at Chicago (UIC), including an initiative for Quality Improvement in Community Long Term Care (LTC) Services.

Stakeholder involvement was important in the design of the Operational Protocol and will be the key to the ongoing success of the Demonstration. The original MFP Stakeholder Advisory Committee includes members of OASAC, and DSAC, along with primary consumers, consumer advocates, and family members representing older adults and people with physical, Intellectual, and psychiatric disabilities who use LTC services. Illinois reconvened the stakeholder committee in CY 2012 to represent a broad array of program stakeholders and consumer groups. Illinois has been very fortunate to have the active participation of people who are or have been in long term care settings and people who rely on HCBS community services and supports. The range of ages and disabilities, as well as the range of their perspectives, make the discussion more vital and valuable. During implementation, Stakeholders will have important roles in monitoring MFP Benchmarks, in Quality Improvement, and in developing strategies and recommendations to meet the challenges of rebalancing.

The Illinois MFP Rebalancing Demonstration includes two main components. *MFP Transitions* includes four community transition projects targeting older adults and persons with physical, Intellectual, or psychiatric disabilities with institutional residence of at least six months. At least 3,576 individuals will be assisted in moving to the community from institutional settings through CY 2016. Illinois expects an even greater number of transitions given the federal program extension through CY 2020. The broader *Pathways to Community Living* includes several initiatives aimed at achieving measurable progress in rebalancing LTC systems through strategic state investment of enhanced federal matching funds.

Illinois opted to set a relatively large goal for MFP transitions in order to include the range of LTC populations within one coordinated effort and focus on system changes. One such focus is the effort to incorporate identification of potential candidates for transition as a standard practice in LTC systems. Another is utilizing new MFP requirements (risk assessment/mitigation and critical incident reporting) to model QI processes for expansion beyond MFP. Through the Demonstration, Illinois will work to address a number of challenges in rebalancing state LTC systems, including the following:

1. The scarcity of affordable housing;
2. a large NF population with serious mental illness that lacks any equivalent to the HCBS systems for Intellectual and physical disabilities
3. Incentives for capacity reduction in the private institutional sector
4. Preparing to meet heightened QM requirements in HCBS systems with 50 - 70 thousand service participants
5. Timely information for management and quality

Illinois will invest enhanced federal matching funds generated by MFP in system improvements and support for community transition including, but not limited to, those listed below.

1. MFP Quality Management and Improvement activities, such as protocol development to address high frequency risks and serious risks and root cause analyses of serious reported incidents.
2. IT improvements to expand on initial web-based MFP enrollment and tracking, such as interagency data sharing for approval and prior authorization capacities.
3. Advanced training and consultation for transition coordinators, in areas such as devising creative risk mitigation strategies for complex risks or unengaged consumers.
4. Outreach and review strategies for community transition beyond MFP, such as targeted outreach and recruitment with nursing facility residents with lengths of stay under six months;

5. Incentives for downsizing institutional capacity, such as enhancement of the current downsizing rate adjustment for ICF/MR / ICF/DD.
6. Consultation costs for development of an HCBS waiver for adults with mental illness.
7. Housing search website costs, such as addition of special features.
8. One-time transition costs for individuals beyond MFP
9. Expansion of community capacity through an increase in direct support workers and service provision and support capacity

Senate Bill 773, establishes the Money Follows the Person Budget Transfer Fund (MFPBTF) to allow funding to be moved between agencies and programs providing institutional and community-based services to eligible clients as required by Illinois' federally-approved Money Follows the Person Demonstration Project. The MFPBTF will receipt deposits from agencies via vouchers drawn against either institutional long-term care appropriations or community-based program appropriations as deemed necessary by the Money Follows the Person Project Director. Such deposits will fund service expenses under the MFP Demonstration Project as follows:

- (1) Community-based services for individuals meeting the appropriate level of care eligibility requirements in the Department of Human Services, the Department on Aging or the Department of Healthcare and Family Services to the extent the expenses to be reimbursed or paid are in excess of the amounts budgeted to those Departments each fiscal year for persons transitioning out of institutional long-term care settings under an MFP transition project;
- (2) Institutional long-term care services at the Department of Healthcare and Family Services to the extent that the expenses to be reimbursed or paid are for services in excess of the amount budgeted to the Department each fiscal year for persons who had or otherwise were expected to transition out of institutional long-term care settings under an MFP transition project. This provision acknowledges the reality of readmissions and unrealized reintegration from LTC institutional settings. However, it is not anticipated that significant dollars will flow in this direction. State funding for HCBS is appropriated to the budgets of waiver operating agencies up front.

Expenses reimbursed or paid on behalf of other agencies by the Department of Healthcare and Family Services will be pursuant to an interagency agreement and allowable under the MFP Demonstration Project.

The MFPBTF will receipt all federal financial participation revenue resulting from the fund's expenditures. It will also receipt any enhanced federal financial participation revenue resulting from MFP spending regardless of the state fund making the original expenditure. This requirement will allow the State to segregate the enhanced federal



match revenues in a single fund to support long-term care rebalancing efforts and other purposes detailed in the federally approved MFP Demonstration Project and Operational Protocol. The MFPBTF will be further authorized to fund administrative expenses necessary to implement and operate the MFP Demonstration Project.

### A3. Benchmarks

#### 1. Benchmark 1 – Transition Targets

##### Measurable: Increase in annual transition totals

Illinois will continue to increase the number of transitions on an annual basis. The projected number in each target group assisted in transitioning from an inpatient facility to a qualified residence will increase each year through 2016.

Division	2008	2009	2010	2011	2012	2013	2014	2015	2016	Total
Elderly	<u>0</u>	<u>12</u>	<u>55</u>	<u>75</u>	<u>60</u>	70	77	85	93	527
Persons with PD	<u>0</u>	<u>18</u>	<u>29</u>	<u>67</u>	<u>99</u>	82	90	99	109	593
Persons with MI	<u>0</u>	<u>27</u>	<u>100</u>	<u>95</u>	<u>54</u>	30	33	36	40	415
Persons with DD	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>79</u>	140	154	169	186	728
Colbert	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	<u>N/A</u>	285	475	285	75	1120
Totals	<u>0</u>	<u>57</u>	<u>184</u>	<u>237</u>	<u>292</u>	607	829	674	503	3383

- 2008-2012 are Actual Transitions. 2013-2016 are Projected Transitions.
- Illinois anticipates a significant increase in transitions due to the settlement of two Olmstead lawsuits – Ligas and Colbert. The transition numbers do not totally reflect these Olmstead transition numbers

**Benchmark II – Increase in Qualified HCBS Expenditures**

<u>Waiver</u>	<u>FY2006 CMS64</u>	<u>FY2007 CMS64</u>	<u>FY2008 CMS64</u>	<u>FY2009 CMS64</u>	<u>FY2010 CMS64</u>	<u>FY2011 CMS64</u>	<u>FY2012* CMS64 (through 3/2012)</u>	<u>FY2013 Forecast</u>	<u>FY2014 Forecast</u>	<u>FY2015 Forecast</u>	<u>FY2016 Forecast</u>
<u>DD Waiver</u>	\$405,243,03 3	\$412,486,98 4	429,724,448	421,746,948	441,753,473	540,173,640	470,524,747	\$594,997,571	\$645,572,365	\$703,673,878	\$774,041,266
<u>Elderly Waiver</u>	\$119,427,69 9	\$168,817,10 9	182,342,747	142,685,929	235,742,832	264,486,060	237,736,806	\$297,980,127	\$323,308,438	\$352,406,197	\$387,646,817
<u>PD Waiver</u>	\$184,666,40 8	\$184,970,87 2	197,966,784	253,157,914	259,451,830	292,013,355	244,587,982	\$332,984,441	\$361,288,118	\$393,804,049	\$433,184,454
<u>SLF Waiver</u>	\$35,748,130	\$58,704,732	89,290,710	96,542,482	99,470,561	154,380,395	44,811,219	\$194,098,423	\$210,596,789	\$229,550,500	\$252,505,550
<u>SPA132 (New for 2012)</u>				260,286,577	261,156,388	241,667,862	187,604,652	\$270,918,084	\$293,946,121	\$320,401,272	\$352,441,399
<u>Totals</u>	\$745,085,27 0	\$824,979,69 7	\$899,324,68 9	1,174,419,8 50	1,297,575,0 84	1,492,721,3 12	1,580,353,8 75 (Forecast)	1,690,978,64 6	1,834,711,83 1	1,999,835,89 6	2,199,819,48 6
<u>% Increas e in HCBS</u>					10%	15%	6% (Forecast)	7%	8.5%	9%	10%

- \*Fiscal year 2012 figures include actual financial claims data through the third quarter. However, the total for fiscal year 2012 is an estimated amount determined by the 6% increase in community spending benchmark.
- It is anticipated that HCBS Waiver and State Plan MH services will increase due to the implementation of Colbert and Ligas class action lawsuits, however; the exact amount is not known at this time.

## 2. Benchmark 3 – Successful Community Reintegration

Illinois will increase the percentage of individuals that are sustained in the community post transition through the provision of quality, community based services and supports throughout the demonstration year.

### Measure: Increase in Successful Community Reintegration

University of Illinois at Chicago College of Nursing data demonstrates that for 2011 80% of individuals that transitioned to the community remained in the community for the 365 days post transition across DHS Divisions and the DOA. Illinois proposes to increase the percentage of individuals that are sustained in the community through 2016.

Year	2012	2013	2014	2015	2016
% of individuals who remain in the community for the entire MFP demo year	82%	83%	84%	85%	86%

### Measure: Decrease in MFP Disenrollment Rate

Illinois' MFP Disenrollment rate was 15% through 2011. Illinois proposes to decrease the disenrollment due to readmission to a long term institutional setting or a hospital.

Year	2012	2013	2014	2015	2016
% decrease in disenrollment rate	14.75%	14.50%	14.25%	14.00%	13.75%

### Measure: UIC College of Nursing Annual Report on Success in the Community

Beginning in Calendar Year 2012, the University of Illinois at Chicago College of Nursing will conduct an in-depth analysis of MFP participants that have lived in the community one year or longer and analyze trends and service mix in order to share this information with sister agencies and transition coordinators.

Year	2012	2013	2014	2015	2016
UIC CON Annual Report	1	1	1	1	1

### Measure: HFS will Conduct a Random Sample of Case Notes Post Critical Incidents to Ensure Compliance with the Risk Mitigation Plan to Inform Quality Improvement Discussions

Beginning in Calendar Year 2012, HFS will initiate random samples of Transition Coordinator case notes in the MFP web application to provide improved oversight, inform program directives, ensure compliance with follow-up strategies, and to ensure

individual's needs are being appropriately met in the community. HFS will discuss findings with sister agencies and Transition Coordinators to ensure program quality improvement.

Year	2012	2013	2014	2015	2016
<b>Quality Improvement Discussions Re: Findings from Random Samples</b>	5	12	12	12	12

### 3. Benchmark 4 – Coordinated Process for Outreach/Marketing of MFP and LTSS

Illinois will develop a coordinated process for the dissemination of outreach material on the availability of long term care services and supports. The MFP Demonstration was rebranded in Illinois in 2012 as “Pathways to Community Living”. MFP/Pathways outreach material will be widely distributed and accessible to consumers, stakeholders, including families/guardians, nursing home administrators and ICF/DD administrators, and advocates.

#### Measure: Increase in Marketing Material Distribution

In 2012, HFS will distribute MFP/Pathways outreach material to every nursing home and ICF/DD as well as key stakeholders, including Ombudsman, ADRC's, and Advocacy organizations. Additionally Outreach material will be made available on the MFP website ([www.mfp.illinois.gov](http://www.mfp.illinois.gov)). Outreach material will be provided to these stakeholders on an annual basis through 2016.

Year	2012	2013	2014	2015	2016
# of Consumers that receive material*	300	500	1000	1500	2000
# of Nursing Homes that receive material*	350	400	475	600	730
# of ICF/DDs	50	100			
# of Ombudsman Agencies	17	17	17	17	17
# of ADRCs	3	7	7	7	7
# of Centers for Independent Living	20	20	20	20	20
# of Case Coordination Units	44	44	44	44	44
# of Community Mental Health Centers	10	30	60	90	100

\*Goal numbers for providers represent the total number expected to be participating in MFP. Projected numbers for consumers could increase as the outreach for Colbert is initiated.

#### Measure: Increase in Utilization of MDS 3.0 Section Q Referrals

HFS will coordinate the dissemination of information related to the federal CMS changes to MDS 3.0 Section Q with the MFP/Pathways program. HFS will include information related to section Q on the MFP website including a list of Local Contact Agencies. Additionally, HFS will develop an online referral form for the MFP program and establish a link to the form on the MFP website ([www.mfp.illinois.gov](http://www.mfp.illinois.gov)). HFS will track section Q referrals that result in MFP transitions.

Year	2012	2013	2014	2015	2016
# of MDS Q referrals that result in an MFP transition	15	30	60	75	100

#### 4. Benchmark 5 - Increase Affordable, Accessible and Supportive Housing Options

Illinois will increase the coordination and collaboration amongst state agencies and MFP stakeholders to increase the supply of affordable and accessible and supportive housing options. The Illinois MFP Demonstration has formulated a comprehensive housing strategy in response to the scale of housing need and limited impact of single strategies. Two Housing Coordinators were hired in calendar year 2012 to build on the existing housing locator resource by developing referral networks and linkages and development of housing options. The Housing Coordinators, members of the MFP Implementation Team and members of the MFP Stakeholder Advisory Committee, will play active roles in providing assistance and advocacy for meeting these objectives and to monitor outcomes.

##### **Measure: Coordination with Public Housing Authorities and Associations**

Collaboration with Public Housing Authorities (PHAs) and Associations of Property Owners, Supportive Service providers and other member organizations is critical to the development of housing and linkages to housing for populations served under MFP. Recent Housing and Urban Development (HUD) guidance outlined the importance of providing preferences to individuals transitioning from Long Term Care Institutions. The addition of two Housing Coordinators in calendar year 2012 allows a focus on targeted collaboration and training with PHAs through meetings, surveys and presentations. Beginning in 2012, this benchmark will be tracked by the number of PHAs and above referenced Associations involved in collaboration with MFP or trained on MFP through the housing coordinators.

Calendar Year	2008	2009	2010	2011	2012	2013	2014	2015	2016
Number of PHAs and Associations trained on MFP	10	20	30	40	40	45	50	55	60

##### **Measure: Increase in Units on the Housing Locator Website**

The state has developed a housing search website with detailed information on vacancies, accessibility, income requirements, rental assistance, services etc. for consumers. IHDA, HFS, DOA and DHS are providing joint funding for the website ([www.ilhousingsearch.org](http://www.ilhousingsearch.org)) which is administered by Social Serve.com. The 2007 baseline is zero (0). The availability of the website will be publicized through other information and referral sources such as CCU's, CIL's, CMHC's, and PAS agencies to ensure that individuals and families interested in obtaining affordable and accessible housing will be able to search the site.

Calendar Year	2008	2009	2010	2011	2012	2013	2014	2015	2016
# of units on website	1000	2000	3000	4000	4250	4500	4750	5000	5250

##### **Measure: Increase in Transition Coordinators Utilizing Case Worker Portal**

The state housing locator website includes a specialized portal allowing enhanced access to Transition Coordinators. This portal is known as the Case Worker Portal and allows advanced housing searches by disability populations, service availability and accessibility accommodations among other factors.

<b>Calendar Year</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
% increase in the # of Transition Coordinators utilizing the Case Worker Portal	15%	20%	25%	30%	35%

**Measure: Increase in Interagency Communication Regarding Housing Issues via Bi-Monthly Conference Calls**

HFS, along with the Governor’s Office Statewide Housing Coordinator, IHDA, DHS and DOA will maintain regular communication to ensure that a comprehensive housing plan is established for meeting the increased demand for housing resulting from the Illinois specific Olmstead class action lawsuits and the MFP program.

<b>Calendar Year</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
# of Conference Calls	6	6	6	6	6

**Measure: Increased Availability of Rental Subsidies for MFP Participants**

In addition to these measures Illinois will increase the availability of rental subsidies for MFP participants through a combination of current and potential rental subsidy resources including State of Illinois Bridge Subsidies, Housing Choice Vouchers issued pursuant to current or future administrative plan preferences, 25 Non-Elderly Disabled (NED) Housing Vouchers, and the prospective Section 811 Project Rental Assistance funding opportunity.

<b>Calendar Year</b>	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>	<b>2016</b>
# of Rental Subsidies Utilized by MFP Participants	75	150	250	300	350

## **II. Demonstration Policies and Procedures**



## **B1. Demonstration Implementation Policies and Procedures**

### **Participant Recruitment and Enrollment - Elderly, Physical Disabilities, and Mental Illness Transitioning from Nursing Facilities**

#### **1. Referral Sources**

Referrals from multiple sources will be accepted, including, self-referrals, family and friends, NF staff, and ombudsmen. The assessment, recruitment and enrollment processes for these referrals will be the same as for those resulting from targeted outreach. Illinois' MFP website went live in 2012 ([www.mfp.illinois.gov](http://www.mfp.illinois.gov)), which includes an electronic referral form that can be filled out and directly sent to HFS staff. The MFP web referral form allows a central tool for stakeholders and the general public to be referred to the program. HFS will follow the same process for these referrals, and forward them to partner agencies for assessment and follow up.

HFS will forward identifying information for current residents to DoA, DRS or DMH as appropriate as well as the two managed care vendors that are serving as care coordinators for the Colbert Class members in Cook County, Illinois. The state agencies, in turn, will refer potential names for contact by their respective providers of outreach and review. Nursing facilities and residents will be contacted for initial MFP assessment, possible MFP recruitment, and enrollment of individuals with interest and potential for transition. The process used by each agency is described below. Referrals from other sources will also be accepted, including, residents themselves, NF staff, and ombudsmen. The assessment, recruitment and enrollment processes for these referrals will be the same as for those resulting from targeted outreach.

Medicaid eligibility for potential MFP participants will be confirmed through the HFS recipient database in PACIS (Public Aid Client Information System). Confirmation of participant eligibility under the MFP criteria of 90 day LOS in a qualified institutional setting will also be checked through HFS information systems. It will be the responsibility of the Transition Coordinators in each of the systems to document confirmation of eligibility under both criteria.

As noted earlier, Illinois is working to develop an equitable, clinically sound and cost effective system for identification and review of community transition candidates on an ongoing basis. The proposed MFP recruitment approach is the initial step in a strategy to maximize the utility of routinely collected data in triggering review for community transition, not only for longer stay residents in MFP, but also for diversion and rapid reintegration from institutional care. Approaches to the process and staffing of transition review at these three different points will also be explored during the Demonstration.

One major challenge in rebalancing is altering the default expectation of permanent nursing facility stay, which still pervades the thinking among NF management and staff, as well many long stay residents. Centers for Independent Living and Area Agencies on

Aging programs have reported having difficulty gaining entry to facilities and access to residents in current NF transition initiatives. Nursing facilities have expressed some legitimate concerns about current approaches as well.

A more formal referral for transition review coming from state agencies changes the dynamic and context of interaction. Contracted providers of outreach, who have been furnished with names for contact, are seen as performing the activity on behalf of state agencies with their direction and training. . HFS has issued several provider notices to Nursing Home administrators and staff in regards to MFP. In addition to engaging the industry as stakeholders in MFP, HFS plans to issue a future Provider Notice that will address the MFP recruitment process, identify community agencies designated to conduct outreach, outline appropriate mutual expectations, and emphasize cooperation for the benefit of residents. Provider Notices are familiar in Medicaid, and HFS has positive experience with this approach in rolling out Resident Review as a component of MH PASRR. Access to facilities and potential MFP participants will not be a problem. Nursing Home administrator and staff program guidance material was part of the marketing initiative Illinois completed in calendar 2011-2012 which will help to increase communication with nursing home staff.

Several initiatives HFS is in the process of implementing are also expected to improve the overall referral process. ADRC supplemental funding has allowed qualified engagement specialists to follow a no-wrong door approach to engage and refer potential MFP consumers regardless of populations/diagnosis. Additionally, Illinois has used rebalancing funds to support the expansion of the division of mental health outside of Cook County in 2012. This will allow individuals with serious mental illness residing outside of Cook County to access the MFP program.

### **MDS 3.0 Section Q Referrals**

HFS currently utilizes the MFP online web referral form to receive MDS 3.0 Q referrals from Nursing Home administrators and staff. The web referral has a box that is marked if the referral is related to MDS 3.0 Q. HFS plans to release a provider notice to inform providers of Illinois' MDS 3.0 Section Q processes and expectations

One goal of the ADRC project allowed through Federal CMS supplemental funding is to explore best practices and make recommendations for MDS 3.0 Q referrals and procedures. Using this evidence and MFP experiences, HFS and the MFP partner agencies will continue to explore mechanisms to track these referrals.

### **RUGS Methodology**

The final referral approach is similar to work in Arkansas and described in a paper by James, Wiley & Fries (2007). Illinois has a contract with Fries and his colleagues, under which data on individuals served in DoA, DRS, and DMH transition initiatives is being matched with data from the MDS, RUGS and the HFS data warehouse for analysis.

Group profiles from this analysis will be used to identify similar profiles among individuals currently residing in NFs. The resulting names provide a pool of residents for each the three transition projects with good potential for successful community reintegration.

The MDS and RUGS based methodology is focused on recognizing the differences in resource utilization among residents. The RUGS classification system uses information from the MDS assessment to classify nursing home residents into a group that represents relative care resource requirements. RUGS groups form a hierarchy from the greatest to the least resources used. The low RUGS groups include Reduced Physical Function (PA1, PA2) and Behavioral Symptoms and Cognitive Performance (BA1, BA2). The Reduced Physical Function category includes residents whose needs are primarily for support with general supervision and also ADLs such as eating, bed mobility, transferring and toileting. The Behavioral Symptoms and Cognitive Performance category includes residents who receive assistance with the same ADLs and also have behavioral or cognitive performance symptoms.

The rationale for an initial lower RUG score groupings is to identify those individuals that may require fewer home and community-based resources and assist them in community transition. However, based on the experience of the MFP program most nursing home residents have complex health histories and co-morbidities. This includes those that are identified using the methodology of Dr. Fries who have lower RUG scores. Participants possess multiple health and social conditions. This source of identification is intended as a starting point, and is not intended to exclude individuals with more complex classifications from potential participation in the MFP program.

## **2. Elderly Recruitment and Enrollment**

The Department on Aging contracts with 56 public and not-for-profit social service agencies designated as Case Coordination Units (CCUs) to serve as entry points to long-term care, including HCBS. The CCU case managers are trained and certified by the DoA to conduct assessments, develop care plans, act as advocates, and provide linkage to services for seniors. DoA will send referrals for MFP outreach to its CCUs, which will have dedicated Transition Coordinators to work with MFP candidates and participants.

CCU staff will contact residents in the nursing home. After an informal assessment of interest and fit with MFP program, potential candidates will be screened for eligibility using the Determination of Need tool (DON). Individuals whose DON scores qualify them for waiver services and have potential to be supported using CCP services within waiver service cost maximums will be actively recruited for MFP Transitions. Residents who are interested in discussing transition will receive information on MFP, including the transition planning process, services available, benefits and risks, and their rights and responsibilities in the program. At this point, individuals will also receive detailed explanation and written information regarding processes for reporting abuse, neglect,

and exploitation under the Elder Abuse Act and information on the Service Improvement Program for reporting complaints and problems with service.

Individuals who choose to proceed toward transition (or their appointed guardians) will review the MFP Informed Consent in detail with assistance from CCU staff and choose whether to sign it. If the consent is signed, the DoA will be informed and the person will be enrolled in MFP. The CCU Transition Coordinator will then begin planning for community reintegration using the Comprehensive Case Management Assessment.

### **3. People with Physical Disabilities Recruitment and Enrollment**

DRS contracts with 23 Centers for Independent Living (CILs) for operation of the Community Reintegration Program (CRP) to provide outreach and assistance to people with physical disabilities in leaving nursing homes. The CRP will provide outreach and recruitment for potential MFP participants who have physical disabilities. The CILs have experience and expertise in providing assistance with the complex activities of transition from institutional care to the community. Assessments are conducted by CRP staff with extensive consultation from DRS Home Services Program (HSP) central office staff.

DRS will send referrals to the CILs, which will contact residents and conduct an initial screening assessment, including collection of basic information, interview, review of community supports, and a preliminary DON assessment. If the initial assessment information, as reviewed with DRS, staff indicates eligibility and potential for community transition, recruitment for MFP will be pursued with interested individuals. CRP staff will provide information on the range of services available, benefits and risks, rights and responsibilities of the MFP program. There will also be extensive discussion how to report and receive assistance in the event of abuse, neglect, or exploitation. Brochures on Reporting Abuse and Neglect of Adults with Disabilities to the DHS OIG and on the

Adults with Disabilities Domestic Abuse Program will be furnished to the individual and family members or other supporters the individual has chosen to involve.

If the person (or guardian) chooses to participate in MFP, CRP staff will go through the Informed Consent and ensure the individual understands its provisions. If the person chooses to sign the Consent, CRP staff will advise DRS and complete the enrollment. CRP staff will begin working with the individual to determine preferences, needs, and resources to support a safe plan for transition and services in the community.

### **4. Persons with Mental Illness Recruitment and Enrollment**

DMH will send the names of individuals referred for targeted outreach to certified community mental agencies with contractual responsibility for MH PASRR. The MH PAS agency for the area where the nursing facility resident is located will conduct a review, utilizing the LOCUS 2000 (see Appendix B) and other assessment components. Individuals whose transition potential is confirmed in the Resident Review will be referred to designated MFP Transition Coordinators, if interested in transition and the

MFP program. Transition Coordinators will be Qualified Mental Health Professionals (QMHPs).

The TC will contact the individual at the nursing facility and provide information on MFP Transitions, including services available, benefits and risks, rights and responsibilities. If the person is interested in receiving services through MFP, the Coordinator will go through the MFP Informed Consent and ensure the individual understands its content. Information on how to report abuse, neglect, or exploitation will be presented to the individual and family or other supporters, including two brochures published the DHS OIG on Reporting Abuse and Neglect of Adults with Disabilities and on the Adults with Disabilities Domestic Abuse Program. If the individual chooses to participate in MFP and signs the consent, the Coordinator will inform DMH and enrollment will be completed. The TC will assist the participant in convening a person-centered transition planning process. The participant will choose the people to be involved in the process.

## **5. Persons with Intellectual Disabilities Recruitment and Enrollment**

MFP participants will be identified for possible entry into the DD MFP demonstration through five sources:

- 1) Identified from the Illinois Prioritization of Urgency of Need for Services (PUNS) database based on the individual's own expression of need for new, different, or additional DD service. Individuals or their guardians may initiate requests to update the person's PUNS database record anytime they believe the individual's needs have changed.
- 2) Identified because they reside in a private ICF/MR downsizing or closing
- 3) Identified because they are living in State Operated Developmental Centers or one that is closing.
- 4) Identified through the implementation of the *Ligas v. Quinn* Consent Decree
- 5) Identified through a MFP website or similar referral

These individuals will be assessed and will be enrolled for potential transition specifically under the MFP Demonstration if they have a preference for a residential setting qualified under the MFP Demonstration requirements and have potential accessibility to chosen formal and informal supports, and to back-up systems addressing identified risks. MFP transitions constitute a relatively small segment of planned DD community transitions.

### **Transition related to PUNS selection for available funds.**

During the ISC/PAS agency Intake interview, individuals with Intellectual disabilities are enrolled in the Illinois PUNS database if they have a need for new, different, or additional services available through the state Intellectual disabilities service system at the time of the interview or expect to have such a need within the next five years. This

database is the State's central record of individuals seeking services and the urgency of their need for services. The ISC/PAS agency is responsible for updating each individual's PUNS database record at least annually or whenever the individual's needs change significantly. Individuals or their guardians may initiate requests to update the person's PUNS database record anytime they believe the individual's needs have changed. In this way, individuals and their guardian self-refer their desire to seek a community living setting, whether an MFP qualified resident or not. ISC/PAS agency accepts referrals of individuals who may be eligible for or who are seeking DD services from community and state agencies, advocate organizations, and other sources.

The DD Division maintains the PUNS database, which is a central record of the 5-year service outlook for individuals with Intellectual disabilities. The PUNS database will be used to identify "potential" transition candidates who are seeking to move to a community living arrangement. This is one component in the triaging of potential MFP transition candidates based on other factors such, but not limited to, MFP qualifying stay in an institutional setting, assessment of individual transition risks, accessibility to formal and informal supports and back-up systems in the community of the individual's choice, and the availability and suitability to the individual of MFP qualified residences in the community of the individual's choice.

In early 2008, the Division sent letters to all individuals residing in state-operated developmental centers and private ICF/MR facilities and their guardians to encourage them to contact the ISC/PAS agency serving their area and complete a PUNS form if they have currently or expect to have within the next five years a need for a new, additional or different Intellectual disabilities service or support, including, but not limited to, seeking to move to another living arrangement in the community of their choice.

As Waiver capacity becomes available through vacancies or new funding, individuals are selected from this PUNS database for service authorizations. A portion of the individuals selected will be from among those currently residing in private ICF/MRs. In these instances, bed capacity is not being removed as individuals transition; however, this activity will complement the activity for the two following groups and further rebalancing overall.

### **Transitions related to voluntary downsizing/closure of private ICF/MRs.**

Currently, Illinois has a special rate methodology for facilities that voluntarily enter into a downsizing or closure agreement. The methodology attempts to address fixed cost issues during the downsizing or closure period. A major component of the MFP Demonstration an DD Division initiative to enhance and expand the application of this special rate methodology to encourage additional providers to participate.

Upon approval of the Operational Protocol, two activities will occur: 1) the Division of Developmental Disabilities will convene a workgroup of providers and other interested parties to examine alternative strategies and methodologies to give incentives for downsizing and closure and 2) the Division will inform all private ICF/MR providers of

this new opportunity and ask for voluntary participation. As agreements are finalized, individuals residing in the facilities will be informed by both the facilities and the State of downsizing or closure plans. Individuals will then be informed of all options open to them and assisted with transition activities.

### **Transition from State Operated Developmental Centers (SODCs)**

Staff from Illinois' nine SODCs, monitored by staff within the Division's Central Office, are identifying individuals within three tier categories. Individuals in the first two tiers are considered potential candidates for the MFP project.

1. Tier 1 - individuals who are interested in pursuing/transitioning to community-based support services; whose guardian, if applicable, is agreeable; and who has relatively few identified barriers to transitioning.
2. Tier 2 - individuals who have not at this time transitioned to community-based support services due to medical or behavioral issues as identified barriers.
3. Tier 3 - individuals whose legal guardian has refused to explore alternative services for their family member/ward.

Transition Coordinators are determined based on the current living arrangements of potential transition candidates. For transition candidates living in SODCs, staff from the Division's newly formed Bureau of Transition Services will serve as transition facilitators. These staff will work with the individual, his/her guardian, local transition support teams comprised of Division Network staff, SODC staff and other health care, behavioral and social service professionals conversant with the individual's situation and preferences to facilitate and coordinate transition risk assessments, community service packages, 24-hour back-up plans, incident mitigation strategies, moving arrangements and ongoing monitoring of individuals transitioned from private ICF/MR facilities.

For transition candidates living in private ICF/MR facilities agreeing to downsize, Division Network staff will coordinate the identification of potential transition candidates and confirmation, with the input of the guardian if necessary, of their current interest in moving and their community living preferences. In addition, ISSA is involved to assure individuals' choices are made and to facilitate the movement to the community setting. For those still interested in moving, the Community Support Team (CST) at the CILA preferred by the potential transition candidate and/or his/her guardian will serve as the transition facilitator. The CILAs are required to form an interdisciplinary team, called the CST, to comprehensively address the needs of individuals residing in CILAs. The CST is comprised of a QMRP, the individual, his/her guardian or parent (unless the individual is his/her own guardian and chooses not to have his/her parent involved, or if the individual has a guardian and the guardian chooses not to involve the individual's parent), providers of services to the individual from outside the licensed CILA provider agency (such as developmental training provider, supported employment employer), and other persons providing direct services in the community.

#### **4. Enrollment and Disenrollment Policy – All MFP Populations**

All individuals who enroll in the MFP program are required to complete an Informed Consent (please see section B2 for further detail) and also to complete an enrollment form (Form C) in the MFP web case management application. The Transition Coordinator responsible for the case is also required to enter this and other relevant information (i.e. case notes) into the MFP web case management application.

During the demonstration year persons who are discharged from an institution and subsequently readmitted for less than 30 days will continue to qualify for MFP services. The 365 day MFP demonstration period will be placed on hold during the readmission period, and continue upon discharge. If the readmission exceeds 30 days, the individual must be dis-enrolled from the MFP program via the completion of the Form D Disenrollment form. The individual may be re-enrolled upon discharge and a move back to a qualified community setting following a reassessment and service plan review, which analyzes the reason for readmission and identifies any unmet needs or risks that require further mitigation to ensure stability in the community. Persons who are re-enrolled will be offered the remainder of full year of MFP demonstration services.

Upon disenrollment from the MFP program, individuals will no longer receive critical incident or mortality reviews from Illinois' MFP quality assurance vendor. Quality assurance processes will be administered by the respective Home and Community Based waiver administering agency as appropriate.



## **B2. Informed Consent and Guardianship**

### **Stakeholder Participation**

The informed consent procedures that Illinois will utilize in the MFP project were developed with collaboration and input from the Stakeholder Committee. This broad-based group contained consumers representing the four populations addressed by the program, family members, service providers, advocates and state agency representatives.

A subgroup of the original Stakeholder Committee focused broadly on issues related to risks, rights and responsibilities under the MFP demonstration program. A statement of guiding principles is attached as an Appendix to this proposal. One of the major guiding principles included in this statement states that *“Participants and guardians will be provided with complete information throughout the MFP process so that they can make informed choices; and all parties involved in the transition should be provided with the information they need to assist the informed decisions throughout the process.”*

### **Informed Consent Policy**

Illinois revised the informed consent form in March 2012 to better explain participation in MFP and address stakeholder concerns and lessons learned. Please see the attached document for Illinois’ Informed Consent document.

All MFP participants will be required to sign the Informed Consent form prior to MFP enrollment and participation. Topics covered by the informed consent form include:

- General information about the program, including purpose, voluntary nature and impact on the participant’s Medicaid eligibility status.
- Benefits of participating in the program.
- Information about services available to the participant at the conclusion of the demonstration year.
- Responsibilities of the participant while enrolled in the program.
- Confidentiality of MFP participant information.
- The participant’s ability to withdraw from the program.
- Specific contact information for reporting incidents of abuse, neglect, theft or financial exploitation.
- Specific contact information for reporting complaints or appealing decisions regarding the type or delivery of services.
- Specific contact information for complex questions regarding benefits or services.
- The option to formally decline participation in the program.

In the case of MFP participants that dis-enroll before transitioning from a qualified institutional setting, a new and updated informed consent will be required to be signed and on file. The most recent date of informed consent will be the official enrollment date

into the program. This practice will assure the participant has a full understanding of the program and enable informed decisions.

### **Guardian Involvement**

For MFP, each program will identify the guardian, discuss the MFP program with the guardian and establish the frequency of contact and involvement of the guardian in the transition process. This will include whether or not they will want to be notified by mail, email, and telephone or be present in person for transition activities. Guardian information and preferences will be documented for each enrollment in the MFP web application.

Illinois law presumes that an adult eighteen years of age or older is capable of handling his or her own affairs. A guardian may be appointed to serve as a substitute decision maker if a person's disability is due to 1) mental deterioration, 2) physical incapacity, 3) mental illness or 4) intellectual disability and the disability prevents the person from making or communicating responsible decisions about his or her personal affairs. A guardian for a person who is eighteen years or older must be appointed by the Circuit Court.

For individuals with Intellectual Disabilities, The ISC/PAS agency will assess each individual's situation with regard to guardianship, e.g., whether the individual has a guardian, whether the individual does or does not need a guardian, whether the individual has been referred for guardianship determination. A standard, statewide form (DDPAS-8) is used to document this assessment and any actions taken. The form is available upon request. If a guardian is in place or is appointed as a result of this activity, he or she will be involved in all transition activities.

If a nursing facility resident is in need of guardianship, but one has not been appointed, Illinois law requires that the nursing facility notify the Office of the State Guardian. The Office of State Guardian is considered the guardian of last resort under Illinois law. Based on the resident's circumstances, the Office of State Guardian may elect to petition the Court for guardianship or work to identify family members or friends who are able to serve in this role. In order to avoid conflict of interest, Illinois law prohibits any agency that is providing residential services to the person with disabilities from serving as the resident's guardian.

## **B3. Project Education, Outreach and Implementation**

### **1. Transition Coordinator Training and Processes**

The project will provide extensive training to MFP Transition Coordinators and Case Managers. Input from partner agencies on the outline in Appendix B.7 is being used by the MFP State Implementation Team to prioritize training topics and identify those for which cross-training is desirable and those, which require a more agency-specific approach.

A comprehensive training webinar series and manual was developed in collaboration with the state agencies by Illinois' Quality Assurance vendor, the University of Illinois at Chicago (UIC) College of Nursing. Required components consist of Initial Transition Coordinator Training, Documentation and Web Application Training and Training on Administration of the Quality of Life instrument. Please see Appendix for TC Training Manual. Additionally, a Transition Coordinator manual (see Ver. 2.0 Appendix J) was created that outlines the detailed processes and procedures of the MFP program, care management requirements, and use of the web based case management system.

The initial training provided by UIC is required for all new transition coordinators. Ongoing training is also provided via phone, webinar, and in person meetings. Implementation activities were not delayed since transition coordination and case management was already provided by the agencies that will provide services in MFP. The Quality Section includes a brief description of training content and methods that have been developed by the UIC College of Nursing to be provided over the implementation period. The UIC Department of Disability and Human Development is also a partner in the Demonstration providing assistance in management of the program, consultation, and other support. UIC has also been an effective partner in several systems change grants.

In addition, HFS, UIC, and state agencies partners collaborated beginning in 2012 to implement monthly webinar trainings for MFP transition coordinators to improve quality outcomes and best practices in transition coordination work.

### **2. Program Marketing and Outreach**

Illinois choose to rebrand MFP under the broader "Pathways to Community Living" initiative in calendar year 2012. The Pathways to Community Living Initiative encompasses broad long term care rebalancing and includes Long Term Care Community Services and Supports, the MFP program and also several *Olmstead* lawsuits (*Colbert, Ligas, Williams*). Rationale behind the initiative included recommendations made by the University of Illinois College Of Nursing, a desire to enhance communication, and a desire to increase referrals. The rebranding project

included the development of a new logo for the Illinois MFP Demonstration (see O.P. cover), and also the development of the following material:

- Participant Packet – for consumers
- Program tri-fold brochure
- Consumer Frequently Asked Questions (FAQ)
- General Fact Sheet
- Legislative Fact Sheet
- Nursing Home Staff and Administrators Program Guidance
- Program Referral Form
- Program Web Site – [www.mfp.illinois.gov](http://www.mfp.illinois.gov)

Spanish versions of all material were also produced and are available to program consumers and stakeholders. Please see the attached appendix for Illinois' program marketing material.

Illinois' program website includes a variety of information and tools that will enhance MFP. In addition to general information for consumers, family/friends, providers, and stakeholders the website includes several consumer testimonials, an electronic referral form and email registration capabilities to receive programmatic updates and news. The website also links to federal MFP information, state agency partners, the Illinois Housing Locator website, and the hard copy marketing material. The MFP implementation team will continue to strategize on ways to best utilize the website and to increase stakeholder education, involvement, and program visibility.

All MFP outreach and marketing materials will be submitted to the CMS Project Officer for approval prior to any distribution or use in the MFP Demonstration. The Illinois Department of Healthcare and Family Services, along with the Departments on Aging, and the Human Services Divisions of Developmental Disabilities, Rehabilitation Services and Mental Health continue to consider other strategies to get the word out to consumer and caregiver publics.

Outreach to the professional community and the public was completed in the initial years of MFP through presentations at conferences and workshops, as exemplified by the chart of presentations included in the Stakeholder Section. Presentations to statewide professional and industry associations, consumer groups and advocacy organizations have continued. Outreach to local affiliates of state organizations and other local groups will proceed as well.

In the early implementation period of MFP, the identification and recruitment strategy for targeted outreach and numbers that were projected for transition in the first year made large scale public outreach less of a necessity. However, there was outreach and meetings with the LTC industry and with ombudsman to explain the identification strategy. The new marketing material and website will be utilized to conduct broader outreach and education to a variety of stakeholder groups. HFS Provider Notices will continue to be sent out periodically to nursing homes and ICF/DDs to provide program

guidance and resolve any questions. Illinois will also employ Industry, association, and advocacy organization newsletters and web pages to convey the message of MFP, as well as welcome referrals from outside targeted outreach activities and describe the process for making referrals.

In an effort to enhance communication with stakeholders, HFS developed a newsletter to highlight success stories – successful transitions and to alert stakeholders to changes in the Program. See Appendices to review newsletter.

### **Marketing and Outreach in Cook County**

Implementation of the *Colbert v. Quinn* consent decree requires increased coordination with the MFP program to avoid confusion between the programs. Illinois' expects 95% of Colbert class members to qualify for the MFP program. As a result, nursing homes in Cook County and ombudsman have been advised to use the MFP online referral form in order to route the referrals through HFS and onto the managed care vendors for follow-up.

As described in section B11, Aging and Disability Centers and Networks will conduct outreach and engagement of Colbert class members along with Ombudsman through the Illinois Department on Aging.

Illinois will develop marketing material for utilization in the Cook County area which will be utilized in place of existing MFP marketing material:

- Consumer Outreach Video
- *Colbert v. Quinn* Fact Sheet
- Program Website – [www.pathways.illinois.gov](http://www.pathways.illinois.gov) (linked to [www.mfp.illinois.gov](http://www.mfp.illinois.gov))
- Signage to be placed in Nursing Homes

### **3. Program Implementation by State Agency/Division**

#### **DHS Division of Mental Health (DMH) MFP Implementation Timeline**

(See Appendix C for Service Area Maps for Mental Health)

DMH is currently fully involved in MFP in Region 1, North (Chicago north and north suburban Cook County). Illinois began utilizing rebalancing funds in 2012 to expand DMH involvement outside of Cook County and further downstate to Peoria and Springfield, Illinois

Since Metro Chicago has the largest NF populations with serious mental illness, DMH designed the roll out of its MFP Transitions program to start in those areas and expand statewide at a pace that will assure effective implementation across the state.

### **Illinois Department on Aging (DOA) MPF Implementation**

(See original Operational Protocol Appendix C for Service Area Maps for Aging)

The Planning and Service Areas (PSAs) and counties in which the Money Follows the Person program will be offered in the **first year** of implementation are as follows:

- **PSA 1 - Northwestern Illinois Area Agency on Aging:** Joe Davies, Stephenson, Winnebago, Boone, Carroll, Ogle, Whiteside, Lee, DeKalb
- **PSA 3 – Western Illinois Area Agency on Aging:** Rock Island, Henry, Bureau, LaSalle, Putnam, Knox, Warren, Henderson, Mercer, McDonough
- **PSA 6 – West Central Illinois Area Agency on Aging:** Hancock, Schuyler, Adams, Brown, Pike Calhoun
- **PSA 11 – Egyptian Area Agency on Aging:** Perry, Franklin, Jackson, Williamson, Saline, Gallatin, Union, Johnson, Pope, Hardin, Alexander, Pulaski, Massac
- **PSA 12 – Chicago Department on Aging:** City of Chicago
- **PSA 13 – Age Options:** Suburban Cook County

The Planning and Service Areas (PSAs) and counties in which the Money Follows the Person program will be ADDED in the **second year** of implementation are as follows:

- **PSA 5 – East Central Illinois Area Agency on Aging:** Champaign, Clark, Coles, Cumberland, DeWitt, Douglas, Edgar, Ford, Iroquois, Livingston, Macon, McLean, Moultrie, Piatt, Shelby, Vermillion
- **PSA 8 – Area Agency on Aging of Southwestern Illinois:** Bond, Clinton, Madison, Monroe, Randolph, St.Clair, Washington

The Planning and Service Areas (PSAs) and counties in which the Money Follows the Person program will be ADDED in the **third year** of implementation are as follows:

- **PSA 2 – Northeastern Illinois Area Agency on Aging:** DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will
- **PSA 4 – Central Illinois Area Agency on Aging:** Fulton, Marshall, Peoria, Stark, Tazewell, Woodford
- **PSA 7 – Area Agency on Aging for Lincolnland:** Cass, Christian, Green, Jersey, Logan, Macoupin, Mason, Menard, Montgomery, Morgan, Sangamon, Scott
- **PSA 9 – Midland Area Agency on Aging:** Clay, Effingham, Fayette, Jefferson, Marion
- **PSA 10 – Southeastern Illinois Area Agency on Aging:** Crawford, Edwards, Hamilton, Jasper, Lawrence, Richland, Wabash, Wayne, White

Aging has a number of demonstration programs in place that are planned to be enhancements to the aging waiver in years following renewal. These enhanced services will be available to MFP participants once approved for all waiver participants. Year 1 sites represent one of those demonstration programs. DoA has a limited nursing home transition program in place. For Year 1, these sites will be expanded to include the entire geographic area shown in the chart. Currently a nursing home transition program exists in portions of these areas (e.g. the current program existing on the north side of Chicago will be expanded to the whole city and the program existing in suburban Cook County will be expanded to include all of Cook County). Programs are more successful when implemented statewide in phases, building on strengths and allowing the opportunity for staff to build relationships with facilities.

### **DHS Division of Rehabilitation Services MFP Implementation**

The DHS Division of Rehabilitation Services is fully involved in MFP statewide.

### **DHS Division of Developmental Disabilities MFP Implementation**

The DHS Division of Developmental Disabilities became involved in the MFP program in Calendar year 2012 with the closure of Jacksonville Developmental Center, a State Operated Developmental Center (SODC) in Jacksonville, Illinois. Other SODC closures are planned and DDD expects to become fully involved in MFP statewide in 2013. HFS and DDD are collaborating heavily on the ongoing closure of the Murray Developmental Center in CY 2013.



## **B4. Stakeholder Involvement**

Stakeholder involvement in the Illinois MFP Rebalancing Demonstration has evolved from the original approach to the current structure of the MFP Stakeholder Advisory Committee. Illinois proposed that stakeholder input for MFP would be obtained primarily through the two legislatively mandated bodies charged with changing systems for older adults and for people with disabilities. The Older Adult Services Advisory Committee (OASAC) and the Disability Services Advisory Committee (DSAC) both focus on redirecting service delivery away from institutional dominance toward community-oriented models emphasizing individual choice and control. MFP Project staff met with and made presentations to OASAC and DSAC during the OP development process. The development of the OP was informed by the work of OASAC subcommittees: Finance, Services Expansion, Nursing Home Conversion, Coordinated Point of Entry, and Workforce and Family Care-giving. DSAC also had an impact through recommendations from disability subgroups, including subgroups addressing persons with mental illness, persons with physical disabilities and persons with Intellectual disabilities, as well as proposals that applied to all disability groups.

During proposal review, consumers advocated for a much larger presence than they felt existed on either of these advisory committees. The structure for MFP stakeholder input was redesigned to retain the focus on integrating OASAC and DSAC activity, but greatly increase the representation of consumers and consumer advocates, with over 20 consumers on the Advisory Committee and many others participating in workgroups. The MFP Consumer Subcommittee was formed with recommendations for membership from the MFP partner agencies. HFS offered support to consumers for participation in the MFP Stakeholder Advisory Group, including reimbursement for transportation, uncovered personal assistant services, and lost wages, and will continue this offer of support during the implementation phase.

A core group representing the main constituencies from the membership of OASAC and of DSAC was identified and combined with the Consumer Subcommittee to form the MFP Stakeholder Advisory Committee. This committee was Co-Chaired by OASAC and DSAC consumer members.

The full Stakeholder Advisory Committee met six times during the development of the operational protocol. Each Transition Project has its own Service Design Workgroup and there were very active Housing and Quality Management Workgroups as well. Housing is a very large focus of the project because it is a significant barrier to community reintegration. The Quality Management Workgroup focused on the Risk Assessment and Mitigation requirements of MFP and the presence of different disabilities, ages, and consumer, family and advocate stakeholders made for a rich and lively discussion of the issues involved. The interaction of differing perspectives and the interest of members resulted in the decision to keep a QI Committee in operation through the Demonstration to assist in the development of a strong program that



balances respect for rights and autonomy with the importance of addressing modifiable risks and engaging the consumer in the process.

DRS Home Services Community Reintegration and Money Follows the Person Programs are built on policies, procedures and forms that have been interactively developed with the Centers for Independent Living (CILs). In particular, the MFP Peer Training Program will undergo continued development and scrutiny jointly with the CILs for the duration of the project. This will be required for both formal module development and modification activities as well as for ongoing tweaking of modules as necessary to address the unique needs of each training group.

DMH has assembled a planning group to advise the MFP Demonstration work design. The membership includes: primary and secondary consumers, long term care providers, community mental health providers, advocacy agencies, other stakeholders and interested parties. DMH will continue to meet with the program design workgroup through the operational protocol period. Additional meetings will be convened as the HFS and DMH examine waiver opportunities in year one of the MFP grant. The group's feedback has been and will continue to be used to inform various service components of the MFP Transition Demonstration for persons with mental illness.

The DD Division involved Intellectual disability stakeholders and consumers in its service design for the OP. Individuals were drawn from DSAC members, recommendations by the Illinois Council on Developmental Disabilities (ICDD) and other Intellectual disabilities advocate organizations. Stakeholders and individuals with Intellectual disabilities who receive Intellectual disability services and Division staff will continue to lend support to the development, implementation, refinement or evaluation of procedures throughout the demonstration period.

The DD planning advisory group met to review the proposed plan and to provide guidance in refining that plan. The DD planning group included individuals receiving Intellectual disability services, family members, guardians and advocates, ICDD, Illinois Voices, Illinois Association of Rehabilitation Facilities (IARF), and Health and Disability Advocates.

The MFP stakeholder committees (see Ver. 2.0 Appendix C) was re-convened in February 29, 2012 and will meet at least three times annually with an emphasis on consumer feedback, program improvement, and enhanced communication. Guiding objectives of the broad group include:

- Obtain general program feedback
- Achieve consistent program improvement
- Develop new ideas and best practices
- Enhance communication with stakeholders and partners
- Invite public participation

As the demonstration unfolds the stakeholder committee may be called upon to form workgroups and focus on specific areas of program improvement, to research refinements to the operational protocol that include:

- Identifying, preparing and supporting individuals interested in transition
- Developing the specific types of services and supports in the community that are most needed by individuals transitioned
- Expanding the number of qualified residential settings for transitioned individuals

## **B5. Benefits and Services**

### **Overview**

Qualified HCBS Services for Illinois MFP participants are approved Medicaid waiver services and State Plan services. MFP participants will be enrolled in existing programs immediately upon transition. At or after renewal of the Aging waiver, additional services may be added to the DoA Community Care Program. Personal care services for the elderly are provided under Homemaker Services. Homemaker Services include: assistance with activities of daily living including personal care, as well as other tasks such as laundry, shopping and cleaning. This information can be found in the MFP Array of Services chart as an appendix.

Originally, three of the four transition projects included Community Transition Services as a Qualified Demonstration Service. Illinois will fully utilize these services beginning in calendar year 2012 as a Qualified Demonstration Service. The DHS Division of Developmental Disabilities will begin to provide Community Transition Services in this manner. Assistance with the one-time costs of establishing a residence will reduce a substantial barrier to community reintegration. Nevertheless, the general scarcity of affordable housing, along with the limited range of MFP qualified options, might be a factor in the length of time required to accomplish transition for some participants. Illinois has made housing a main focus of MFP and is pursuing a comprehensive strategy to increase access to available housing and to increase affordable housing stock.

Transition coordination and case management services have been addressed in MFP with acknowledgement of new CMS case management regulations, as well as the renewal dates of waivers involved in MFP. For the elderly and people with physical disabilities, waivers will be renewed in 2009. Until waiver renewal, current administrative claiming of case management will continue. At renewal, case management services will be added to these waivers. In MFP, transition assessment and coordination required before the 60 days prior to discharge, for which case management can be claimed, is being covered as a Qualified Service. DMH must comply with the new rules immediately, so that case management will be claimed for MFP as TCM for the allowable 60 days prior to discharge and the transition assessment and coordination activities required prior that will be claimed as a Qualified MFP service.

### **MFP Demonstration Services to be added (CY2013)**

With the implementation of the Colbert V. Quinn Consent Decree, a new Demonstration Services will be offered to class members and those that enroll in the MFP/Pathways to Community Living Program including Peer Support.

## **Peer Support**

Peer Support will include trained and qualified individuals as certified peer counselors by providing training to consumers wishing to become a Certified Peer Counselor. The Certified Peer Counselor will work with their peers with a variety of issues ranging from adjustment to living in the community, adjustment to health and disability, coping with serious emotional disturbances and helping the participant navigate the array of issues to living in the community. These Certified Peer Counselors provide the service known as Peer Support.

With Peer Support, Certified Peer Counselors draw upon their experiences to help their peers find hope and make progress. Certified peer counselors are especially equipped to provide support, encouragement, and resources to participants because they have been in a similar situation and understand what it feels like. They assist participants with identifying goals and taking specific steps to achieve them- steps such as building up social support networks, managing internal and external stress, and navigating service delivery systems.

Peer support includes face-to-face interactions that are designed to promote ongoing engagement of persons addressing residual problems and promoting the individual's strengths and abilities with respect to socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer support also includes communication and coordination with services providers and others in support of the participant.

## **1. Service Overview**<sup>1</sup>

### **Elderly /Older Adults**

#### **Qualified HCBS**

- Community Care Program / Aging HCBS Waiver Services
- Supportive Living Program Waiver

#### **Qualified Demonstration**

- Community Transition Services
- Home Modification
- Assistive Technology
- Peer Support

### **Persons with Physical Disabilities**

#### **Qualified HCBS**

- Home Services Program / Disability HCBS Waiver / AIDS/TBI Waiver

#### **Qualified Demonstration**

- Community Transition Services
- Peer Community Training Services
- Peer Support

### **Persons with Mental Illness**

#### **Qualified State Plan**

- Assertive Community Treatment
- Community Support Team and Individual
- Psychosocial Rehabilitation Services
- Targeted Case Management

#### **Qualified Demonstration**

- Community Transition Services
- Intensive Peer Community Support Individual
- Peer Support

### **Persons with Intellectual Disabilities**

#### **Qualified HCBS**

- DDD HCBS Waiver Services

#### **Qualified Demonstration**

- Community Transition Services
- Peer Support

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<sup>1</sup> Further detail available in attached MFP Service Crosswalk

## **B6. Consumer Supports**

### **1. Consumer Supports – Elderly**

The Department on Aging (DoA) contracts with 56 public and not-for-profit social service agencies that it designates as Case Coordination Units (CCUs). The CCUs serve as entry points to long-term care, including home and community-based services, and employ case managers who are trained and certified by the DoA to conduct assessments, develop care plans, act as advocates and provide linkages to services for all Illinois' seniors age 60 and older. Although the MFP will be phased in across the state as indicated in state maps under Appendices 1 and 2, the processes for eligibility and supports will be quite similar as to those offered under the HCBS waiver for persons who are elderly. Each CCU will have a designated case manager solely devoted to activities involved in this project. This case manager will be responsible for:

- Utilizing the Comprehensive Case Management Assessment tool to assess eligibility for the Money Follows the Person project.
- Coordinating the MFP participant's transition to the community.
- Utilizing professional judgment in evaluating the MFP participant's ability to sustain themselves in the community.
- Developing a comprehensive transition Plan of Care (POC) that identifies the services needed to meet the health, cognitive, social and financial needs of the MFP participant in the community, as well as identify health and safety risks. The plan will include a projection of the anticipated costs for both one-time transitional service costs and ongoing service costs. The case manager may utilize a multi-disciplinary team to develop the POC.
- Obtaining authorization from the MFP participant's primary physician for reintegration back into the community.
- Ensuring that monthly face-to-face visits are conducted with the MFP participant for the first six months.
- Additional monitoring will be available to ensure the successful transition of the MFP participant back into the community. Monitoring may be completed by other participating entities with DoA approval. If monitoring is conducted by other entities, the documentation of the monitoring must be maintained by the designated MFP case manager in the MFP participant's file at the CCU.
- Maintaining the complete MFP participant file housed at the CCU/CMU. MFP participant files must be available for DoA and HFS review at any time.
- Retaining a copy of receipts for all merchandise, supplies, services and other items purchased with grant funds in the MFP participant's file.

## **Risk Assessments**

- In addition to the MFP Risk Inventory, risk factors (e.g. caregivers, falls) are addressed throughout the domains of the CCC assessment tool. Case managers are trained to discuss potential risks with the client and work together to develop a plan of care that will minimize or eliminate the risk.
- The plan of care will include numbers for emergency, transportation numbers, pharmacy, medical equipment and supply, 24 hour Nurse Line, abuse and neglect reporting, case manager and other numbers as determined by the plan and risk inventory.

## **24-hour back-up**

- Developing an emergency back-up system individualized to the participant. Each participant will be instructed in how to contact the statewide toll-free 800 Senior HelpLine available 24/7. This resource responds to reports of abuse and neglect, service disruptions, complaints or problems and other inquiries made by or on behalf of waiver and MFP initiative participants.
- DoA will track calls to the Senior HelpLine to identify what critical back-up is needed for MFP participants. This information will be used to identify gaps in services. See Service Improvement chart below.

## **Abuse, Neglect and Exploitation**

The DoA Office of Elder Rights administers the Elder Abuse, Neglect and Financial Exploitation Program (ANE), which responds to alleged abuse, neglect or financial exploitation of persons 60 years of age and older who reside in the community. The program provides investigation, intervention and follow-up services to victims. The Illinois Elder Abuse and Neglect Program was implemented statewide in Illinois April 1, 1991. It is locally coordinated through 43 provider agencies designated by the Area Agencies on Aging (AAA) and DoA. Contracts and training are separate from DoA contractual agreements for CCU services and CCP training. However, many of the CCUs are also designated Elder Abuse Provider Agencies. The Elder Abuse Agencies conduct investigations and work with older adults in resolving abusive situations.

Persons can report suspected abuse, neglect or exploitation to DoA by utilizing the Elder Abuse Hotline number at 1-866-800-1409, available 24 hours a day, seven days a week, or to the Senior HelpLine number, 1-800-252-8966, during regular business hours. After-hour and weekend calls are automatically transferred to the Elder Abuse Hotline number.

The Illinois Elder Abuse and Neglect Act (320 ILCS 20/1) requires “personnel of the Illinois Department on Aging and its subsidiary Area Agencies on Aging and provider agencies” to be mandated reporters in cases where the senior is unable to self-report.

DoA policy specifically states that if a direct service worker witnesses or identifies a case of possible abuse or neglect, they are mandated to personally report the allegations to the designated Elder Abuse Provider Agency or to DoA's Hotline numbers. DoA's Office of Elder Rights maintains a tracking system of ANE investigations and statistical reports are generated annually.

### **Service Improvement Program (SIP) Reporting**

DoA also maintains a SIP, which responds to reports of service disruptions, complaints or problems, and other inquiries made by or on behalf of the client. Clients, authorized representatives or family members can contact the service provider, CCU, AAA or the statewide toll-free "800" Senior HelpLine number to file a report. Upon receipt, complaint reports are logged and validated, and the Senior HelpLine seeks resolution immediately, with assistance, as needed, by DoA QI staff

## **2. Consumer Supports – Physical Disabilities**

The 23 Centers for Independent Living (CILs) will provide Transition Coordination/Case Management service to participants with physical disabilities. The CILs have significant experience in disabilities and community living. The case managers will provide the following services, all of which require the active involvement of the participants:

- Contacting and conducting a brief initial assessment of individuals referred as potential candidates for transition to the community;
- Completing the Case Manager/Participant agreement which defines the role of the potential participant as "director" of planning and the case manager as facilitator;
- Administering a preliminary Determination of Need eligibility assessment;
- Developing a draft, preliminary post-transition Plan of Care, including a draft risk assessment and mitigation plan;
- Interviewing and assessing the participant regarding family and other supports and preferences regarding type and location of housing, including potential for living with others;
- Completing the budget assessment form to determine if the participant's financial resources can support the preferred housing arrangement;
- Reviewing assessments with central state staff to obtain required approvals of eligibility;
- Developing the draft pre-transition Plan of Care, including paid and unpaid services, the post-transition risk assessment and mitigation plan, and the post-transition 24 hour back up plan;
- Securing approval from participant's physician regarding the safety of proposed post-transition Plan of Care;



- Working with the participant to implement pre-transition service plan;
- Administering post-transition Determination of Need (subject to approval by central state staff) after housing is secured;
- Developing formal, post-transition Plan of Care after housing has been secured (subject to approval by central state staff);
- Submitting copies of receipts for all merchandise, supplies, and services for reimbursement under Community Transition Services to central office state staff and maintain copies of these receipts as part of the MFP participant file.
- Conducting face-to-face and/or telephone contacts with participant's chosen method of contact, noted on the service plan: a minimum of weekly for first eight weeks after transition; biweekly in the third month; and monthly thereafter for the next nine months;
- Reviewing the Plan of Care with participant one month post transition to ensure that it is appropriate and amend as needed;
- Providing necessary supports to participant to promote success in transition;
- Re-determining waiver eligibility at least annually using the DON
- Providing reports as required on the service plan, noting frequency and type of participant contacts, with a minimum of quarterly contacts;
- Maintaining a complete MFP participant file from pre-transition forward and transmit copies of all documents to the central state staff.

### **24-Hour Back-up**

- The CIL will be responsible for developing an emergency back-up plan that includes telephone numbers for the case manager, hospital, doctor, transportation numbers, pharmacy, medical equipment and supply, 24-hour Nurse Line, abuse and neglect reporting numbers and other numbers and entering into the MFP web case management application as determined by the plan and risk inventory.
- DRS will make special on-call arrangements with a nursing agency on contract with DRS to provide back-up services for individuals that experience a breakdown in direct service delivery systems. The emergency number will also be on the individual's service plan.
- DRS will track calls made to the nursing agency to identify the numbers and types of calls, to identify need for changes in individual service plans as well as the need to make system changes that may also assist participants in HCBS waivers.

### **Abuse, Neglect and Exploitation**

All complaints of abuse, neglect and financial exploitation are reported to the DHS Office of Inspector General (OIG) at 1-800-368-1463 (voice and TTY). Abuse or neglect of an elderly person (60 years and older) is reported to the Elder Abuse Hotline at 1-866-800-1409. The CILS and case managers are mandated reporters and are trained to report suspected abuse or neglect to the appropriate authority.

All substantiated abuse and neglect cases on persons with disabilities are referred to DRS to develop safe plans of care. All substantiated abused and neglect MFP cases will be tracked and analyzed by DRS. This will include a review of the risk identification and service planning for risk mitigation to determine if there were system breakdowns. Analysis will be shared in quarterly QI meetings with HFS to identify methods to prevent and better identify risk and risk mitigation plans.

### **Unusual Incident Reporting (See Appendix B)**

All complaints, incidents, abuse and neglect are reported to the DRS central office. Case management staffs are assigned to the cases. Staff will assist with reporting and remain involved in the case to ensure the customer is safe from harm and that an adequate plan of care is in place. DRS has established a database for abuse, neglect, incidents, and complaints. DRS works with each case until there is satisfactory resolution. Additionally, incidents will be reported as a critical incident to meet MFP quality reporting requirements in the MFP web case management application.

MFP participants will be provided with the OIG “Adults with Disabilities Domestic Abuse Program” pamphlet at initial enrollment and at each reassessment. This helps the customers to understand how to self-report abuse or neglect.

Case managers are required to contact customers at least monthly to check the health, safety and welfare of the customer and follow-up on any identified issues. At that time the case managers also review the services received and determine if any additional services are needed. DRS will analyze the data specific to MFP participants and share analysis in quarterly meetings with HFS where system improvements will be discussed.

### **3. Consumer Supports – Mental Illness**

The Mental Health MFP program is not operated under a Home and Community-Based Services (HCBS) waiver, but under the mental health services provided under the state plan and overseen by the Department of Human Services, Division of Mental Health (DHS-DMH). The DHS-DMH will designate transition coordinators as the initial contact and constant partner in the transition process. Activities broadly include:

- After explaining the program and securing the participant’s informed consent, the TC will assist the consumer in convening a participant-centered planning process involving individuals chosen by the consumer, and guardian if appointed. The Transition Plan developed through this process will address participant strengths,

preferences, needs, skills and risks. TC conducts the comprehensive risk assessment, engages the participant in developing strategies and back-up plans to mitigate significant risks, monitors and updates plans and strategies. The TC has primary responsibility for identifying and accessing the resources, treatment, services and supports, formal and informal, which are assessed as necessary for successful transition to the community. This includes emergency back-up plans and developing an individualized plan based on risk mitigation that would include contacts for crisis, case management, pharmacy, transportation, medical equipment and supplies, 24 hour nurse line and other emergency numbers as identified through the risk inventory and mitigation process as described below.

- The TC assists in coordinating pre-discharge activities and facilitates linkage with housing, income support, transportation, and other supportive services. The TC accesses MFP Community Transition Services to cover one-time costs of establishing a household, with as much consumer involvement and direction of those purchases and arrangements as possible, and maintain records and receipts. The TC provides primary support during the move and in the first days and weeks after transition. During the MFP Demonstration year, the TC will follow up and support the participant with frequency of contact based on need and risk, monitor the quality service delivery based on the plan of care, track and follow up on any reportable incidents. The TC will conduct annual MFP Quality of Life Surveys after the close of the individual's Demonstration service year until the project ends.

**Specific TC Tasks include:**

- Interviewing the resident for his/her interest and preferences for transition.
- Reviewing (with resident) available community living options and services.
- Identify the receiving community mental health center, based on consumer choice and availability of needed service package and initiate linkage and engagement.
- Facilitating pre-discharge planning, coordinating appropriate activities by nursing facility, the Community Mental Health Center (CMHC), health care providers and the resident.
- Preparing a written budget for the resident, identifying the need for and authorization of MFP Transitional Supplemental dollars.
- Scheduling meeting between the consumer and the identified housing entity to: identify the resident's housing transition options/desires and necessary documentation to accessing financial supports. The Public Supported Housing entity will work with the consumer to conduct housing search.
- Initiating paper work to transfer management of benefits/entitlements from the LTC facility to the consumer or representative payee

- Developing a written transition plan, including a time line for relocation, crisis plan and assisting consumer identify elements in personal recovery plan. Engage consumer in their transition plan.
- Individuals will have available outpatient mental health services from a vendor of choice. This service array may include Assertive Community Treatment, Community Support (including Individual, Group or Team), Psychosocial Rehabilitation Services, Psychiatric Services (medication administration and monitoring), and all other pertinent mental health services based on medical necessity.
- On a quarterly basis, the Transition Coordinator completing and forwarding to the DMH Central Office a quality improvement status report using the Quality Improvement Checklist. The checklist will include information on: financial support, life safety, back-up systems, transportation, risk assessment, critical incidents, efficacy of mental health treatment plan, linkage with necessary medical services.
- If needed services or supports are not being provided, communicating those findings to the responsible CMHC provider and initiate a service plan amendment. The TC will report to DMH Central Office significant disparities in the service plan and service provision.
- The TC will conduct monthly face-to-face meetings for the first three months following transition, then quarterly for remainder of the first year and semi-annually through the grant period.
- After transition to the community the TC will remain involved monitoring the efficacy of the transition plan and consumer satisfaction. The TC will report progress as well as adverse outcomes and critical incidents in a quarterly community reintegration report.

## **24-Hour Back-up System**

Access to 24-hour emergency services will be incorporated into the participant's service plan and each individual will have a 24 hour back up plan included in the MFP web based case management application. Each consumer will develop a wellness / crisis intervention plan. The plan will incorporate consumer decision-making skills and personal strengths and identify preferred self-management approaches and interventions. During the move, each participant will receive a crisis information packet with detailed information of chosen crisis response options and back-up plans. The packet will include:

### **Individualized Crisis Plan:**

This plan is specific to and developed by the individual consumer with assistance from the TC, case manager or other chosen supporters. The plan should spell out action steps the consumer can take to cope with difficult situations, minimize triggers, and alleviate stressors. The plan should indicate what to do if next if coping strategies are ineffective.

### **24-hour access numbers for primary case managers:**

The on-call telephone contact number for the case manager or designated team member is available for individuals assigned to Community Support Teams. The case manager will work with the consumer to address the crisis situation over the phone, contact the consumer the next working day to assess the nature/severity of the crisis, and determine what action should be taken. A face-to-face visit is made if the situation warrants. Participants assigned to Assertive Community Treatment Teams will have 24-hour, year round, face-to-face crisis response from the ACT Team. If assessment of caller and situation indicates the need for immediate medical/psychiatric intervention, the case manager will access Emergency Response from 911.

### **Disease Management**

The HFS Disease Management (DM) program will be included in the transition planning and provide follow-up services to participants in the community. DM staff will complete an individualized profile on the MFP participants. These profiles will give HFS and DMH critical information on the health status of the individuals including pharmaceutical and other health care needs.

### **24 Hour Nurse Help Line**

The availability of a 1-800 Nurse Help Line will be explained to participants. The number will connect consumers with a live contact to provide limited crisis intervention and referral.

## **Emergency Room contact information:**

Information and direction to the closest hospital Emergency Department, in proximity to the participant's/consumer's residence, will be \_\_\_\_\_. The case manager will work with the participant/consumer in developing a plan to identify when it is appropriate to access Emergency Department services and 911 for medical intervention and when to access a physician for routine medical follow-up.

## **Abuse, Neglect and Exploitation**

All complaints of abuse, neglect and financial exploitation are reported to the DHS Office of Inspector General (OIG) at 1-800-368-1463 (voice and TTY). If necessary, cases will also be reported as critical incidents via the MFP web case management application per program quality requirements. Abuse or neglect of an elderly person (60 years and older) is reported to the Elder Abuse Hotline at 1-866-800-1409. Central office DMH staff will develop individual plans for all substantiated abuse and neglect cases. See the next section for tracking and follow-up.

## **Unusual Incident Reporting**

All participants in MFP, their family members, formal and in formal care givers will have information about reporting complaints, critical incidents and/or allegations of abuse/neglect/exploitation. Any critical incidents will be reported in the MFP web case management application per program quality requirements.

Incidents affecting the safety and well-being of participants, including incidents related to risk identified in the participants ISP, and complaints about the quality of care provided to the participant will be reported directly to the TC for follow-up.

All allegations of abuse, neglect, and exploitation shall be reported directly to the DHS/OIG as indicated under Abuse and Neglect reporting above. The OIG will forward those complaints within 48 hours to DMH CO. The DMH CO will notify the TC and other relevant providers. If necessary a safety plan will be completed immediately.

The TC will use the Quality Index document as the vehicle to report and monitor the status and actions of all complaints, critical incidents, a/n/e allegations.

The TC will forward a copy of the quality Checklist on a quarterly basis for the first year and semi-annually thereafter. The checklist will include the results of actions taken by providers in response to OIG investigations or incident reports and complaints received. On a semi-annual basis, the DMH CO will compile and report to the QI Committee, the outcome or actions taken in response to each report type and any proposed modifications needed to improve the system.

#### **4. Consumer Supports – Intellectual Disabilities**

All Waiver participants, and subsequently MFP participants, receive Individual Service and Support Advocacy (ISSA) services from independent entities under contract with the Department of Human Services (DHS), Division of Developmental Disabilities (DD). ISSA agencies provide collaborative assistance to both individuals and providers in order to enhance the delivery and effectiveness of service provision. When an individual is enrolled in the Waiver or MFP, DHS notifies the ISSA provider to initiate contact with the new participant and begin providing ISSA services. ISSAs are Qualified Mental Retardation Professional (QMRP) staff. Their responsibilities include:

- Annual re-determinations of level of care, participation in the support planning process, approval of all participant support plans, advocacy on behalf of the participant and family, visits with the participant at least four times per year to ensure health and welfare and that needs are being met, and alerting DHS about issues that require additional monitoring and technical assistance. This administrative service is required for all DD Waiver participants.
- Case Management is provided by QMRPs who are employees of direct service providers. These internal case managers are responsible for developing the individual support plan as part of a planning team that includes the individual, the ISSA and other necessary and optional participants. They are also responsible for day-to-day oversight and implementation of the support plan. In participant-directed home-based supports, the internal case management is also called Service Facilitation and is defined in Appendix C-3 of the Illinois Adult DD HCBS Waiver. In day and residential habilitation programs, case management is an integral part of the habilitation service.

When individuals are enrolled in the Waiver, they provide their consent and that of their guardian based on full disclosure of information about the rights, requirements and responsibilities embodied in the DD service delivery system, IDHS notifies the ISSA provider to initiate contact with the new Waiver participant and begin providing ISSA services. ISSAs are Qualified Mental Retardation Professional (QMRP) staff. Their responsibilities include annual redeterminations of level of care, participation in the support planning process, approval of all participant support plans, advocacy on behalf of the participant and family, visits with the participant at least four times per year to ensure health and welfare and that needs are being met, and alerting IDHS about issues that require additional monitoring and technical assistance. This administrative service is required for all Waiver participants

In addition all Waiver participants receive direct case management services from QMRPs who are employees of direct service providers. These internal case managers are responsible for developing the individual support plan as part of a planning team that includes the individual, the ISSA and other necessary and optional participants. They are also responsible for day-to-day oversight and implementation of the support



plan. In participant-directed home-based supports, the internal case management is also called Service Facilitation and is defined in Appendix C-3 of the Illinois Adult HCBS Waiver. In day and residential habilitation programs, case management is an integral part of the habilitation service.

## **Abuse, Neglect and Exploitation**

All individuals and guardians will receive two brochures published by the DHS Office of the Inspector General, "Reporting Abuse and Neglect of Adults with Disabilities", and "Adults with Disabilities Domestic Abuse Program". The brochures include a 24-hour a day, 365 days a year, toll-free telephone number (1-800-368-1463, voice and TTY) for reporting abuse, neglect or financial exploitation of an adult with a disability. All staff of programs operated, licensed or funded by DHS for mental health or intellectual disabilities services are required to report all allegations of abuse, neglect, financial exploitation or certain deaths to the DHS Office of the Inspector General.

## **Types of Incidents Reported**

Types of incidents reported are: alleged physical abuse, sexual abuse, mental injury, neglect and financial exploitation, and deaths of individuals receiving services in programs operated, licensed or funded by DHS for intellectual disability services and individuals with mental or physical disabilities impairing their ability to seek help who reside in private homes, unlicensed residential settings and board and care homes. Anyone may report allegations to the DHS Office of the Inspector General (OIG), however, all persons employed by community agencies serving individuals with intellectual disabilities, state-operated facilities or DHS are, by law, "mandated reporters" and must report allegations of physical abuse, sexual abuse, mental injury, neglect and financial exploitation, and deaths even if there is neither first-hand information nor a belief that the allegations are true. Mandated reporters are prohibited from "screening" allegations to decide whether they should be reported.

## **24 Hour Reporting Toll-free Hotline -1-800-368-1463 (voice and TTY)**

The Intellectual Disabilities service system is the solid planning that goes into the individual transition planning and the identification of an individual's need for 24-hour support and the development of services and supports to ensure this in the CILA program. Partly this is addressed by the ongoing review and monitoring of CILA providers by the Bureau of Accreditation, Licensure, and Certification and through the Bureau of Quality Management, to ensure standards and qualifications are being met and maintained. The provider is the first line for providing the service and supervision and for having adequate and qualified staff present. However, beyond this first-line are additional resources and services available to the individual and the provider including:

- The provider has made pre-arrangements for on-call or relief direct-service, personal service workers or agency Qualified Mental Retardation Professionals



(QMRP) as needed in the case of call-offs or other emergency or exigent circumstances

- The provider has made pre-arrangements for back-up medical and personal transportation service providers.
- All ISC/PAS agencies are required to be accessible by telephone for emergencies 24 hours a day, 7 days a week. Providers and individuals have access for emergent, non-health related situations
- Each CILA is funded for routine RN monitoring to be available and, when medications are administered by trained and authorized non-nursing personnel, RN supervision is also available to provide service and who can consult with physicians, pharmacists, or other health professionals as needed.
- Emergency Medical Services (EMS) is available by contacting 911
- Back-up plans for preventive maintenance of durable medical and other equipment and for emergency repairs or replacement for such equipment, including how and from where to secure equipment, including phone numbers, while repairs are being made.
- Plans to access and arrange for routine medical care and transportation by compiling a list of friends, relatives, churches, social service agencies and paid providers that will provide such transportation with advance notice.
- All individuals and guardians have access to a 24-hour a day, 365 days a year, toll-free telephone number (1-800-368-1463, voice and TTY) for reporting abuse, neglect or financial exploitation of an adult with a disability.

### **Timeline for Investigation of Incidents**

All allegations must be reported to the DHS OIG Hotline within 4 hours after initial discovery, even if community agency or state-operated facility policy requires reporting allegations through chain of command. The OIG contacts the complainant immediately but no later than within 3 working days. The investigation report must be submitted to the OIG within 60 days of the allegation unless there are extenuating circumstances (e.g., unavailability of witnesses or documents). The OIG determines whether to accept the findings or require additional documentation or investigation. The community agency or facility must submit a written response within 30 calendar days of receiving the OIG determination. At the same time, the OIG notifies the complainant, individual allegedly abused or neglected and/or his/her legal guardian and person alleged to have committed the offense. Requests for the OIG to clarify or reconsider its findings must be submitted within 15 working days of being notified of the findings.

### **Processes To Protect the Victim**

Providers of services funded by DHS must have a process for handling and reporting incidents of alleged abuse, neglect and death to the OIG. Providers must cooperate in OIG investigations and ensure that their staff is trained to recognize possible abuse and neglect, report alleged abuse or neglect, respond timely to allegations of abuse and neglect and take necessary action to protect the individual(s) from abuse or neglect during the investigation, prevent reoccurrences, eliminate problems identified and

implement any other administrative actions required by the OIG or DHS. Providers must ensure that all employees successfully complete DHS OIG approved 59 Ill. Admin. Code 50 training at the time of hire and participate in biennial refresher training.

### **Processes for Follow-Up and Monitoring of Individual Cases**

Individual Service and Support Advocacy (ISSA) agencies conduct a minimum of 4 visits per year: 1 visit to participate in the development or review of the Individual Service Plan (ISP); one visit to the individual's residence or developmental program; and one visit each to the individual's residence and developmental program if the individual participates in one. These visits are to assess whether program services are being provided in the interest of and to the satisfaction of the individual and to review the individual's health, safety, and well-being. The ISSA and Independent Service Coordination/Pre-Admission Screening (ISC/PAS) agencies are accessible 24-hours a day, 365 days a year for individuals in times of crisis. This requirement may be met through participation in a local network coverage plan. The OIG 24-hour hotline and ISSA and ISC/PAS agency 24-hour telephone accessibility can be used by the individual, guardian, CILA staff or anyone who is aware of an abuse and/or neglect situation or suspects such situations exist. In addition, nearly all DD MFP participants will be residing in 24-hour supervised living arrangements. Follow-up to such calls or situations by the OIG or ISSA or ISC/PAS agency staff or their emissaries are immediate to ensure the safety, welfare and well-being of the caller or the individuals subject to the suspected abuse and/or neglect.

The DHS Division of DD, through its Bureau of Quality Management, also reviews the appropriateness and timeliness of OIG training for its staff and on its OIG reporting process and follow-up activities during its periodic review of the operations and policy compliance of provider agencies. The DHS Division of DD, through its Bureau of Quality Management also offers training on Rule 50 reporting requirements. The OIG monitors the progress of its investigations and the timeliness of follow-up actions to its findings and recommendations.

### **Processes for Tracking Time from Referral to Investigation to Resolution**

The OIG maintains internal controls over the processing of complaints filed to ensure timeliness of the investigation and all follow-up activities. Community agencies and state-operated facilities also maintain internal controls over the processing of complaints and timeliness of all follow-up activities.

### **Processes for Analyzing Trends and Patterns, Report Receipt and Use**

The OIG maintains records of referrals, investigations, investigation reports and follow-up activities. The OIG prepares monthly summary reports that are provided to the DHS Secretary, Governor's Office, Quality Care Board, Director of the DHS Division of DD, Director of the DHS Division of Mental Health, Equip for Equality, the Illinois Protection and Advocacy Agency, OIG Leadership team and DHS General Counsel. The OIG

evaluates its data and evaluations of its Rule 50 Abuse and Neglect training to make revisions to its training course and to work with the DHS Division of DD through the Quality Management Committee to effect changes in Division policies, procedures and monitoring activities associated with abuse and neglect identification, reporting and follow-up activities. Equip for Equality also prepares quarterly reports for the OIG in connection with its National Demonstration Project to establish an Independent Abuse Investigations Unit. These reports record progress toward the project's goals and objectives in monitoring the conditions at selected ICF/MR facilities and state-operated developmental centers. Reports are shared with the DHS Associate Secretary for Programs, Directors of DD and Mental Health and DHS General Counsel for follow-up action where indicated.

### **Quality Improvements and System Changes**

The Division of DD reviews the OIG monthly summary reports and quarter for Equality quarterly reports to assess whether follow up action is warranted. The Division also reviews participant evaluations from its Abuse and Neglect training to work with the OIG to make necessary revisions or clarifications in future training. The interagency Quality Management Committee created and referenced in the Illinois HCBS Waiver for Adults with Intellectual Disabilities also reviews and considers information provided by the OIG during its quarterly meetings to determine whether changes in Division policies, procedures and monitoring activities are needed.

### **Monitoring Other Types of Incidents**

Certain types of critical or unusual incidents must be reported to the Department of Human Services. For example, all deaths occurring in CILA programs (or within 14 days of discharge from the program) must be reported to the Department's OIG. Medication errors must be reviewed by the provider's internal quality assurance protocol and summarized to the Department as part of quality assurance reports. The Division of Developmental Disabilities is currently working with the Department of Healthcare and Family Services to obtain access to data regarding hospitalizations, psychiatric admissions, doctor's visits, medications, etc., for review and analysis as part of on-going quality assurance activities.

## **5. Supports Available to All MFP Participants**

### **Transportation**

MFP participant's individual transportation needs will be assessed and identified on the plan of care. Information that should be included on the plan of care-follows: name of non-emergency transportation (NET) provider and contact information; back-up NET provider if designated provider is unavailable; level of transportation needed such as private vehicle, Medi-car, taxi cab, or non-emergency ambulance.

HFS will designate a liaison to trouble shoot individual problems, and will train transition coordinators on how to access medical transportation directly through the department's prior approval vendor.

HFS contracts with First Transit, Inc. to provide prior approval for non-emergency transportation services throughout Illinois. When requested, First Transit staff will provide a caller with the names and telephone numbers of transportation providers that have indicated a willingness to provide transportation services in the participant's geographic area and who are enrolled with HFS to provide transportation services at the level of service medically necessary for the participant.

Participants or their designated representative can request a prior approval for non-emergency transportation services by contacting First Transit, Inc. during regular business hours at 1-877-725-0569, TTY 1-877-204-1012, Monday - Friday 8:00 AM - 5:00 PM. Providers can request a prior approval for non-emergency transportation services by contacting First Transit, Inc. during regular business hours at 1-866-503-9040.

All non-emergency transportation requires prior approval. If it is not possible to obtain prior approval for non-emergency transportation, post-approval must be requested from the HFS or First Transit. Post-approval may be requested for items or services provided during HFS non-working hours or non-working hours of First Transit, or when a life threatening condition exists and there is not time to call for approval.

### **Illinois Nurse Helpline - 1-800-571-8419**

The Illinois Nurse Helpline provides back-up support to enrollees who cannot reach their physicians after-hours or on weekends as a means of minimizing unnecessary emergency department use and reconnecting enrollees to their Primary Care Physicians. The Illinois Nurse Helpline utilizes the McKesson Solutions' Care Enhance Nurse Advice Patient Assessment System. The web-based system is based on 455 clinical algorithms divided into five modules: adult, mental health, pediatrics, seniors, and women's health.

HFS Medical Program participants may contact the Illinois Nurse Helpline Monday-Friday, 6 p.m. to 7 a.m. (CST) and 24 hours per day on Saturday and Sunday. The 24 hour nurse line will be available to MFP participants after the demonstration period. HFS is working with the Nurse Helpline Vendor to develop a reporting system to case managers on calls made by MFP clients so that additional follow-up, tracking and analysis of calls can be made.

### **Durable Medical and Assistive Technology Liaison**

HFS will designate a liaison to work directly with case managers who are having difficulty assisting participants in accessing needed medical equipment, supplies and assistive technologies. Case managers will also be trained on what services are available through the Medicaid State Plan and how to access them.

## **B7. Self-Direction**

Illinois reviewed Appendix A in relation to DRS Home Services Program and determined that updates are required in the structure of training and support for self-direction and how it is made available to participants in order to meet the expectations of Appendix A. Illinois will continue to explore enhancements to self-direction initiatives.

The DRS Home Services Program (HSP) has been based on the independent living paradigm since its inception in 1979. Customers are active partners in all aspects of the program, including assessment, service planning and service delivery. All customers who are able to direct their own workers are encouraged to utilize individual rather than agency providers since this provides the greatest degree of customer control, direction and choice and allows customers to receive the most hours of service at the most flexible times. Approximately 85% of customers utilize the individual personal assistant service and 3% utilize individual home health providers including CNA's, LPNs and RNs. The remainders use homemaker and other services, although the homemaker service is also used as a stopgap until customers can find personal assistants. Customers may also always choose from available provider agencies.

Home Services customers recruit, interview, select, hire, supervise and fire their individual providers completely independently. Customers can use family, friends, and members of the church or others as personal assistants or individual home health providers. Customers are encouraged to do background checks on individual providers, but are not required to do so and receive the results of this check directly. It is then their choice as to whether or not they wish to hire. The state's 23 Centers for Independent Living work with customers to assist in managing individual providers. All service plans are required to have one or more back up providers identified.

The State serves as the fiscal agent for individual employees and withholds employee FICA and any other withholdings requested by the individual providers including income taxes, garnishments, etc. Individual providers are paid on twice monthly "payroll" based on twice monthly time sheets signed by both the customer and the individual provider. The State is also the co-employer for purposes of the labor agreement under which all personal assistants are covered. Currently, all personal assistants receive a fixed hourly wage, which has scheduled increases according to a five-year labor agreement. Personal assistants are also covered under state unemployment and may be covered by workers compensation. Customers cannot be held liable for either of these costs. Individual home health providers received negotiated hourly rates not to exceed the Medicaid rate.

The Department on Aging (DOA) and the DHS DD Division (DDD) are implementing consumer self-direction programs on a demonstration scale currently with plans to expand the availability of self-directed options.

## **B8. Quality**

### **1. Quality Management Plan**

Illinois will use the MFP Demonstration to build and enhance quality assurance and improvement systems across HCBS programs. The involvement of four distinct populations provides the opportunity for collaboration among a wide variety of stakeholders and service providers that will assist in developing an overarching approach to quality improvement and enrich the discussion of implementation strategies. The initiative will provide opportunities to share data between agencies through information technology expansions. IT development will proceed to web based systems and access to information for identifying, measuring and communicating performance measures. The increased capability for Quality Management will impact services to persons who transition, as well as those already supported by HCBS in the community. The quality improvement strategies modeled in the MFP Demonstration will also strengthen HFS administrative authority and capacity in its role as single state Medicaid agency.

#### **Current Quality Improvement Systems**

Currently, Illinois has nine home and community-based (HCBS) waivers that serve a broad mix of children and adults including programs for persons with Intellectual disabilities, physical disabilities, brain injury, HIV/AIDS and the elderly. Over 70,000 Medicaid eligible are served in the waivers with approximately 20,000 more served in state funded programs. HFS, the Medicaid agency delegates the day to day operations of seven of the nine waivers to other agencies including DHS-DRS, DHS-DDD, DoA and the division of Specialized Care for Children for medically fragile children. HFS enters into interagency agreements with each agency outlining the individual and mutual responsibilities including quality improvement activities. Each program has separate billing and payment systems. For waivers operated by other agencies, the operating agency pays providers, maintains utilization review and day-to-day monitoring responsibilities. Claims pass through the Medicaid Management Information System (MMIS) that include edits specific to procedure codes, modifiers and units of payment. Additional edits prevent claiming for individuals in more than one waiver. Systems do not talk and do not lend themselves easily to tracking and sharing performance indicators in regularly generated reports.

Original Operational Protocol Appendix H has been approved for the persons with Intellectual disabilities waiver, the plan has been expanded to specifically address risk and back-up systems in the DD system. The waivers for persons with physical disabilities and the elderly are operating under the old waiver formats and quality improvement strategies have been outlined following the federal HCBS waiver quality improvement requirements. The transition program for persons with mental illness is not a waiver in the initial year of the grant; a quality improvement strategy has been outlined in the HCBS waiver format for the MFP Qualified state plan services. When an

HCBS waiver for persons with mental illness is submitted, a new appendix will be completed. Six of the Illinois waivers are operating under approved Appendix Hs. Exceptions include the HIV/AIDS, due for renewal in October 2008, and the Physical Disabilities and Aging programs, both due for renewals in October 2009. The MFP Quality Improvement strategies that follow will allow Illinois to test strategies and model processes with the MFP population and explore ways to expand the methodologies to the much larger waiver populations.

HFS procured a Quality Improvement Organization (QIO) vendor to complete an analysis of the quality assurance systems in seven of the waivers. The reviews were based on federal requirements and identified strengths, gaps and recommendations. Two children's waivers were approved after the contract was procured and were not included in the assessment. Illinois will take this opportunity to apply what was learned from the analyses in the MFP quality improvement program. A major recommendation was to develop capability for interface between IT systems, which is critical for tracking and measuring outcomes and moving QM systems forward. The smaller numbers and varied populations in the MFP initiative provide opportunities to test program and system enhancements.

## **2. Proposed Modifications to Existing Quality Improvement Systems**

### **Information Technology (I.T.) Enhancements**

HFS will build on the initial phases of the MFP Enrollment Database. HFS IT staff will conduct assessments of requirements with each partner agency to identify what is measured, what needs to be measured and how to share the data through a web based system. Based on analysis of the assessments, HFS will submit an MFP Advanced Planning Document (APD) to support the system changes needed to fulfill the requirements. Combined with other monitoring activities, IT expansion will provide access to valuable data for tracking a broader array of performance indicators.

### **Risk Assessment and Mitigation**

Illinois will pursue a multi-faceted quality initiative on risk identification and planning across the programs. The State Implementation Team and the Quality Workgroup both had extensive meetings focusing on risk and responsibility issues. Not everyone among stakeholders or agency staff supported federal requirements for risk assessment and mitigation plans. Some viewed the requirement itself as an unnecessary barrier to transition. Others insisted that risk should be a major barrier to transition. There were also more nuanced views expressed. Debate was lively and thought-provoking, with implications for Illinois' approach to risk.

Designing an effective system for risk assessment and mitigation will require strategies to address, not only acquisition of knowledge and skills among transition coordinators and service providers, but also ways to address personal perspectives (e.g. political,



ethical) and their influence on practice. Illinois is fortunate to have one of the authors of an excellent book on ethical issues in community care as Co-chair of the Stakeholder Advisory Committee. She has agreed to work with the other author on an orientation to ethical and value issues in community care for Transition Coordinators and Stakeholders. System rebalancing should result in larger and more complex HCBS populations, increasing the need for effective and creative risk mitigation and for targeting resources in the larger HCBS systems. Illinois will use MFP to test approaches and develop model processes with potential to drive ongoing quality improvement in risk management systems.

An inventory of potential risk areas and interview questions was developed, reviewed, and approved. The MFP Participant Risk Inventory and User's Guide are contained in original operational protocol Appendix B. Although the MFP State Implementation Team, with the exception of Intellectual Disabilities, opted for creation of a common comprehensive risk inventory, it is important to explore how it works in the field. Moving to web-based systems opens up the option of common assessment dimensions with drop down options to capture detail important to one system and not the others. It will also be important to assess how risk assessments are utilized in the field by transition coordinators who may hold strong and disparate positions on risk issues of the sort encountered in the workgroup.

Currently, the MFP program utilizes a web based case management system that includes a comprehensive risk assessment and mitigation planning tool. Illinois will continue to explore system improvements and expansion and utilize lessons learned through the MFP program to date.

### **Alternatives for 24/7 Back-Up Systems**

The third challenge, developing reliable multi-level back-up systems, is closely linked with risk identification and mitigation. MFP participants will have access to a nurse helpline that can provide guidance on handling medical and health issues on off hours and weekends. However, Illinois plans to study different approaches to providing 24/7 assistance if other back-up systems fail. We will start with a case-by-case approach and look at agreements with home health agencies to provide back-up when providers do not show-up and the person's health is at risk without the assistance. The 24-hour back-up arrangements are described for each program under Consumer Supports.

Additionally, Illinois' web based case management system includes a 24 hour back up form to ensure quality oversight and ensure program quality requirements are met.

### **Incident Reporting**

The fourth challenge is to create an incident reporting system that will operate in real time as much as possible and generate data for interface with other quality indicators such as health data and quality of life interviews. Efforts will be made to utilize data to promptly and efficiently manage information to make informed assessments, such as



the effectiveness of plans addressing specific risks, and to make timely changes where needed. Analysis of the incident report data will improve identification of gaps in service systems indicate resources necessary to ensure successful transition and stability in the community. Incident reporting is also discussed under Consumer Supports.

Lastly, the Quality Committee will continue to meet on a regular basis to discuss aggregate performance indicators and system changes. The interagency approach will bring experts together at one table to share experiences, successes and challenges, strategies and ideas that will improve transitions and community living. Having partners with a broad array of expertise will also assist in solving unusual problems that cut across all agencies.

Illinois MFP program has partnered with the University of Illinois at Chicago College of Nursing to ensure quality processes throughout the transition and care planning process in MFP. Through this partnership and the use of the MFP web case management application, critical incidents are quickly reported and reviewed. This practice ensures quality care planning continues throughout the MFP 365 day period and continuing with the respective HCBS waiver.

### **Quality Improvement Process for Supplemental Demonstration Services**

Illinois will explore the additional of new supplemental services as part of the MFP program. Interagency planning has been initiated to implement new case management rules with renewals of the waivers. Illinois will use the review of potential Transition Coordination Supplemental Services to develop strategies for how to address the longer-term transition support issues through assessment strategies and coordination with Nursing Facility discharge planning responsibilities.

### **3. Quality of Life (QOL) Interviews**

Illinois will use Transition Coordinators to conduct the baseline QOL survey. UIC College of Nursing staff (Illinois' quality assurance vendor) will conduct the 11-month and 24-month follow up surveys. HFS will provide oversight, tracking, and monitoring of the process to ensure compliance, as well as input the survey data to the QOL database, submit the required monthly reports, and complete the quarterly data uploads.

HFS maintains communication with Mathematica liaison, stays current with all changes and procedures, addresses any relevant procedural problems, ensures Illinois compliance with Mathematica expectations, and is the contact for all Quality of Life questions. Additionally, HFS will monitor and ensure completion of QOL training by survey administrators as required.

### **System Modifications and Services and Readiness for Implementation**

Original MFP Operational Protocol appendices include a flow chart summarizes Quality Improvement Systems across all agencies. A combined chart of the quality improvement indicators for the six assurances in each program follows the flow chart. Implementation of some MFP quality requirements will initially be tracked manually by each program and reported to HFS in accord with quarterly reporting requirements, but we are anticipating that the web-based system will be ready for testing during SFY 2009. Each of the agencies is ready to implement initial quality improvement strategies as described in the original operational protocol appendices including Appendix C.6 by July 1, 2008 or when transitions begin.

## **B9. Housing**

Illinois recognizes that increasing the supply of affordable, accessible and supportive housing is critical to the success of MFP and to rebalancing the LTC system. The shortage of housing is a major barrier to community transition and increasing the supply will require a comprehensive approach with a range of strategies. Collaboration between housing and service sectors is also critical. The MFP Housing Strategy Group was formed, with leadership from IHDA, to foster this collaboration, identify housing strategies, and secure the long-term engagement stakeholders in the process. The strategies outlines below are described in detail in Appendix B 8.

In early 2012, Illinois hired a Statewide Housing Coordinator to serve in the Governor's Office with the goal of improving coordination of housing resources between human services agencies, the state housing finance agency, and local public housing agencies. In addition to this, the Housing Coordinator is charged with promoting housing in conjunction with the long term care rebalancing efforts of the state and the MFP/Pathways program, and will focus on the coordination of referrals for housing throughout the state.

### **1. Strategies**

#### Locating Accessible and Affordable Housing

- Housing Search Website – [www.ilhousingsearch.org](http://www.ilhousingsearch.org)
- Regional Housing Referral Networks
- Coordination with Public Housing Authorities
- MFP Transition Coordination Staff Training

#### Addressing Housing Shortages for MFP Participants

- Rental Housing Support Program (RHSP)
- Division of Mental Health Bridge Rental Subsidy Program
- Low-Income Housing Tax Credit (LIHTC) Program
- Supportive Housing Set-Aside
- Points for Targeting Supportive Housing Populations with incomes at or below 30% AMI or the Elderly
- Enhanced Accessibility for Mobility Impairments

#### Services and Housing System Collaboration

- Illinois Housing Task Force
- MFP Stakeholder Advisory Committee
- Older Adults Services Advisory Committee (OASAC)

#### Strategies for availability/ affordability/accessibility

- Increasing Supply of Supportive Housing
- Joint NOFA through IHDA and State Agencies
- Building Capacity for Supportive Housing Development

- Assistive Technology Demonstration Program
- Home Modification Program
- Homeownership Coalition for People with Disabilities

## **2. MFP Participant Access to Qualified Housing Options**

Transition Coordinators/Case Managers in each of the transition projects will assist MP participants in accessing the type of MFP-qualified residence which they prefer and which meets their needs. This information will be documented in the MFP participant's transition plan, as well as in the central MFP Enrollment Database. The Transition Coordinator/Case Managers will verify that any qualified residential options subject to State or local licensure are currently or will be fully licensed or certified by appropriate State or local entities before any MFP participants move in.

In addition to a Home, Apartment, or residential setting with no more than four unrelated individuals reside, a Supportive Living Facility (SLF) is a qualified residential setting in Illinois.

A SLF is a qualified residential setting in the Illinois MFP program for elderly individuals and individuals with physical disabilities. The Supportive Living Program was created by state legislation in 1996 and was approved as a qualified Home and Community Based Waiver by Federal CMS in 1997. Like other HCBS waivers, the purpose of the program is to help maintain the health and independence of participants by offering the necessary supports and services in a community setting.

The Supportive Living Program waiver services both the elderly age 65 and older, and also persons with physical disabilities ages 22-64 who are in need of assistance with activities of daily living but do not require skilled nursing facility care. SLFs must be a minimum of ten apartments and no more than 150. Each apartment is independent with a locked door and is required to have a living area, bedroom, kitchen, and private bathroom. Common areas are also required for dining and socialization.

The chart on the following page describes the types of MFP-qualified residences. The flexibility in these categories is intended to allow for policies and practices that support assisting the individual to move into situations that reflect the highest possible levels of personal choice and ownership.

The housing settings are each regulated in the following manner:

- Home owned by individual or family member : Owned homes not regulated; lease, if present, regulates leased setting
- Apartment Setting and SLF - Lease regulates rental housing; housing assisted by federal or state funds also regularly monitored for compliance with terms of funding by housing's source of funding; SLFs regulated via HFS certification;

Supportive Housing Providers Association developing Standards & Best Practices for Permanent Supportive Housing

- DHS enforces the CILA Licensure Act. The Mental Health and Developmental Disability Code protect the rights of persons participating in CILA programs.

## Types of Qualified Settings

MFP Residence	State Definitions of Housing Setting	Services Available	Cost Contribution
<b>Home</b>	A home which the individual owns, or a home owned by the individual's family member that is leased by the individual.	Mental Health State Plan Services or qualified PD, Elderly, or DD HCBS waiver services (see fact sheet link)	Medicaid Financial Eligibility criteria. Individuals pay cost of rent/utilities minus what is covered by subsidized housing – costs vary throughout the state.
<b>Apartment</b>	Permanent housing in the form of a home or apartment, with rights and responsibilities of tenancy afforded by a standard lease. Must have individual lease, lockable access & egress, & which includes living, sleeping, bathing, & cooking areas over which the individual or the individual's family has domain & control.	In the Permanent Supportive Housing model, services are available to tenants, but tenants are not required to engage in services as a condition of tenancy. Services may include Mental Health State Plan Services or qualified PD, Elderly, or DD HCBS waiver services (see fact sheet link below)	Individuals pay cost of rent/utilities minus what is covered by subsidized housing – costs vary throughout the state.
<b>Community based residential setting</b>	A home with services and supports routinely available on-site in which four or fewer unrelated individuals reside. This definition includes 4-bed or less Community Integrated Living Arrangements (CILAs) and shared living with chosen roommate. <sup>2</sup>	Mental Health State Plan Services or qualified PD, Elderly, or DD waiver services (see fact sheet link below)	Medicaid Financial Eligibility criteria. Individuals pay cost of rent/utilities minus what is covered by subsidized housing – costs vary throughout the state.
<b>Supportive Living Facility (SLF) – For DOA and DRS transitions</b>	Apartment style housing with a minimum of ten apartments and 150 maximum. Each apartment is independent with a locked door and is required to have a living area, bedroom, kitchen and a private bathroom. Common areas required for dining and socialization. Serves elderly ages 65 and over and also persons with physical disabilities age 22-64 who are in need of assistance with ADLs but do not require skilled nursing care.	Basic assisted living services are available, but active participation is not mandated: Nursing Assessment, Medication management, ADL Assistance (CNAs), Daily well being checks, 24 hour staff, 3 meals plus snacks, Laundry, housekeeping, maintenance, Social/health activities, Arrangements for medical appointments and transportation. Requires a signed lease, but a resident may move at any time with a 30 day notice. If a higher level of care is needed due to a change in condition, the 30 day notice is not required	Minimum income for Medicaid eligible residents - \$698. Resident is responsible for paying room and board charges and receives a \$90 monthly allowance. Food stamps may be received by the SLF to supplement board costs

Illinois Waiver Fact Sheets - <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx>

<sup>2</sup> A CILA participant also can remain living in the home of his/her natural family. In this case, the CILA program does not provide housing, but will provide other services to assist the individual in achieving independence in daily living and economic self sufficiency.

## **B10. Continuity of Care Post Demonstration**

### **Continuity of Care – Elderly**

MFP participants who are elderly will be enrolled in the Aging HCBS Section 1915 c Waiver to receive any HCBS services they require upon transition from the nursing facility. There are sufficient slots available to accommodate projected MFP participants. Demonstration services in the DoA service design are primarily one-time services to be used within the first 12 months of transition. At the end of the MFP Demonstration year, participants will continue to receive the same waiver services without interruption. The Department on Aging also has flexible state funds that can be used to address many issues outside the scope of the current waiver.

The DoA is in the process of renewing its HCBS waiver that expires September 30, 2009. The DoA is currently implementing and evaluating demonstration services that may be amended to the waiver in calendar year 2009 or later. Money Follows the Person participants will be able to access these services in Years 2, 3 and 4 of the project period, but they are not included in the Service Design at this time.

### **Continuity of Care - Physical Disabilities**

MFP participants who have physical disabilities will be enrolled in the Home Services Program HCBS Section 1915 c Waiver to receive any HCBS services they require upon transition from the nursing facility. There are sufficient slots available to accommodate projected MFP participants. At the end of the MFP Demonstration year, participants will continue to receive the same waiver services without interruption. The DHS Division of Rehabilitation Services also has some flexible state funding that can be used to address issues outside the scope of the current waiver. In addition to the Home Services Program HCBS 1915c waiver, individuals with physical disabilities may be enrolled in the Traumatic Brain Injury (TBI) waiver or the AIDS waiver if their needs can be better addressed by those options.

### **Continuity of Care - Mental Illness**

MFP participants with mental illness will receive Medicaid State Plan Services upon transition from the nursing facility. At the end of the MFP Demonstration year, there should be no disruption of services based on their exit from the Demonstration. Some intensive services require prior approval and periodic confirmation of medical necessity from the ASO under contract with the DHS Division of Mental Health. Should a participant's needs change either during or after the year of MFP enrollment requiring a more or less intense level of service, a well-planned transition to the appropriate level of service intensity would be facilitated by the ASO and the community service provider, with the same access to appeal available to all recipients of State Plan mental health services.

### **Continuity of Care – Intellectual Disabilities**

MFP participants with developmental disabilities will be enrolled in the DD HCBS Section 1915 c Waiver to receive any HCBS services they require upon transition from the facility. There are sufficient slots available to accommodate projected MFP participants. At the end of the MFP Demonstration year, participants will continue to receive the same waiver services without interruption. There will not be any changes to their services due to the ending of the demonstration.



## **B.11 – The Colbert V. Quinn Consent Decree**

### **1. Background of Colbert V. Quinn**

On behalf of a class of Illinois residents with disabilities living in nursing facilities in Cook County, Illinois, *Colbert v. Quinn*, 07 C 4737, was filed on August 22, 2007, in the United States District Court for the Northern District of Illinois. The lawsuit sought declaratory and injunctive relief to remedy alleged violations of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. 12131-32, Section 504 of the Rehabilitation Act, 29 U.S.C. 794(a) and the Social Security Act, 42, U.S.C. 1396-1396v (SSA). This lawsuit represents one of three Olmstead lawsuits in Illinois and one of two that have the potential to include its Class Members as participants in Money Follows the Person Program. Illinois projects that close to 95% of the Colbert Class Members will be eligible to be counted as Money Follows the Person transitions.

Under the Colbert lawsuit, Plaintiffs alleged that they and members of the Class were being unnecessarily segregated and institutionalized in Nursing Facilities and forced to live with numerous other people with disabilities and in situations in violation of the ADA and the Rehabilitation Act. Plaintiffs further alleged that Defendants the Office of the Governor of the State of Illinois, the Illinois Department of Human Services (DHS), the Illinois Department of Public Health (DPH), the Illinois Department on Aging (IDoA) and the Illinois Department of Healthcare and Family Services (HFS), denied them the opportunity to live in appropriate community integrated settings where they could lead more independent and productive lives.

Plaintiffs sought injunctive relief requiring that Defendants (1) inform Class Plaintiffs as to their eligibility for Community-Based Services and their choice of such services; (2) provide comprehensive evaluations to determine the eligibility of Class Plaintiffs for Community-Based Services, both prior to and after admission to Nursing Facilities; and (3) provide, as appropriate, Class Plaintiffs with services and supports in the Community-Based Settings and refrain from providing services only in institutional settings.

The suit was settled, and on December 20, 2011, a Consent Decree was entered by the Court. On November 8, 2012, an Implementation Plan was filed jointly by the State of Illinois as the Defendants and the Plaintiffs. This Implementation Plan defines the strategies and mechanisms to implement the Decree and to meet the Court ordered benchmarks, timeframes and to provide Class Members the necessary supports and services to allow Class Members to live in the most integrated settings.

Class Members are all Medicaid-eligible adults with disabilities including persons who have a primary diagnosis of mental illness. A separate Olmstead lawsuit, *Ligas vs. Quinn* includes persons with intellectual disabilities and who are not likely to be residents of traditional nursing homes. There currently are between 16,000 and 17,000 Class Members residing in 186 long-term care facilities in Cook County, Illinois.

Simultaneous to the implementation of the Colbert Consent Decree, Illinois is in the process of meeting the requirements of Public Act 96-1501, which requires the enrollment of 50% of the State's Medicaid enrollees in risk-based care coordination by 2015. This expansion of managed care is anticipated to enroll approximately 40,000 Seniors and Persons with Disabilities (SPD) in managed care through an Integrated Care Program (ICP). This strategy was initiated in the spring of 2011 in Suburban Cook County, which covers Colbert Class Members and the collar counties surrounding Chicago.

## **2. Colbert Implementation Strategy & Coordination with MFP**

HFS, as lead agency for the implementation of the Colbert Consent Decree, utilized lessons learned from our experience in implementing MFP to inform the Colbert Implementation Plan. One of the lessons learned is that the MFP population has very complex needs that frequently cut across disability categories. As a result, our current MFP model with separate agencies providing transition coordination based on a primary diagnosis and/or age category does not fully address the needs of individuals that have on average four chronic health conditions, including depression, diabetes, chronic obstructive pulmonary disease and obesity. In addition, high percentages have been diagnosed with psychosis, bipolar disorder, and schizophrenia. The recommendation from our quality assurance activities is to implement a care coordination model to provide a holistic approach to serving this population – enhanced coordination across disciplines, including a multidisciplinary approach that incorporates a social worker and a nurse as members of a team.

An integrated care approach is consistent with the direction the Illinois legislature and Governor's office is pursuing with the passage of Public Act 96-1501 which requires that 50% of Medicaid clients be enrolled in care coordination programs by 2015. In Illinois, care coordination will be provided to most Medicaid clients by "managed care entities," a general term that will include Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs) and Managed Care Organizations (MCOs). Under this plan, the goal is to have about 2 million out of 3 million clients (or 66%) in care coordination by the 2015 deadline.

HFS is contracting on a fee for service basis with the Integrated Care Program (ICP) vendors to provide care coordination using an integrated multi-disciplinary approach. The Colbert Implementation Plan utilizes an array of MCE options, including: ICP vendors, Care Coordination Entities (CCEs), Managed Care Community Networks (MCCN), and the Medicare and Medicaid Realignment Dual Initiative to create an integrated multi-disciplinary delivery system realizing lessons learned in Illinois' MFP experience.

Integrated care coordination will also enable MFP participants and Colbert Class Members to engage with one person backed-up by a team of professionals. This one

Care Coordinator is responsible for the full range of care coordination from initial engagement, risk assessment and mitigation, in the role of transition coordinator, care plan development through monitoring its implementation. Integrated care coordination will allow for individual's primary healthcare, behavioral health care, and other disability service needs to be coordinated across disability categories and reduce additional outside entities from coming into the nursing home to assess for eligibility to current waiver services, particularly for those participants that have resided in the nursing home for one year or less. This Colbert implementation strategy and process is anticipated to avoid confusion and delays in addition to a lack of coordination.

### **Colbert and MFP/Pathways Process**

All Class Members who are eligible for MFP will be counted as MFP participants, but not all Class Members will be MFP eligible. Those Class Members not eligible for MFP is likely due to residency in the nursing home for less than 90 days or Class Members choose to reside in a non-MFP qualified setting.

The multi-disciplinary approach and use of qualified professionals is defined as a team consisting of:

1. A health care professional, who will be an Advanced Practice Nurse, a Registered Nurse, or a Licensed Practical Nurse with a minimum of two years prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities, who will focus on physical health issues;
2. A behavioral health specialist, who will be a Master level Clinical Social Worker with a minimum of two years prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities, who will focus on the mental health and social issues; and
3. A Care Coordinator, who will be a Bachelor level professional with a degree in a health or human service area, or a Masters degree in Social Work, and a minimum of two years of prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities.

### **Training and Oversight**

MCEs operating under the Colbert Consent Decree Implementation Plan for care coordination will be under contract with HFS. HFS, as the State Medicaid agency, will have oversight of the services provided by the MCEs. HFS will ensure training and oversight using existing MFP/Pathways to Community Living strategies as well as providing or employing others to ensure competency of professionals and assurances of quality. This represents a further modification for Colbert Class Members and MFP/Pathways to Community Living participants in Cook County, Illinois.

Once a Colbert class member enrolls in the MFP/Pathways program the goal is to utilize the resources, policies and procedures as identified in the MFP Operational Protocol. The MCEs will utilize their own critical incident management system as well as their risk mitigation strategies for MFP enrolled Colbert class members. HFS is requiring the MCEs to share data that is required by MFP for reporting purposes.

### **Outreach and Education**

Representatives of two Aging and Disability Resource Centers and Networks (ADRC/ADRN) will conduct Outreach to potential Class Members/MFP/Pathways to Community Living participants by conducting individual and small group meetings at the Nursing Facilities. This strategy expands on Illinois' funding already received through an existing federal CMS - MFP and ADRC grant where Engagement Specialists support MFP/Pathways by providing cross population outreach and engagement.

Additionally, Ombudsmen have been engaged by IDoA to assist in the identification of Class Members desiring to transition to the community regardless of type of disability under the Pathways to Community Living/Money Follows the Person program. It is anticipated that this coordinated approach of outreach, education and information dissemination will inform residents of Cook County Nursing Facilities of the MFP Program as well as the Colbert Consent Decree.

Outreach activities conducted by ADRC/ADRN and Ombudsman will be further supported through an information public website included at [www.mfp.illinois.gov](http://www.mfp.illinois.gov). The website will provide background information to potential consumers and stakeholders on Illinois' Long Term Care Rebalancing programs including the Colbert and MFP programs. A fact sheet, outreach video, and signage for Nursing Home placement will provide additional support.

### **Benchmarks and Rebalancing Fund Coordination**

All transitions under MFP enable the State of Illinois to receive an enhanced Federal match on the services provided to individuals for a one year period post transition. These additional dollars, under the MFP initiative, will be placed in the existing rebalancing fund that will be used for an expansion of home and Community-Based Services. Expansion of services will ultimately benefit all residents of Nursing Facilities including Class Members, transitioning to Community-Based Settings.

MFP transitions will be included in the benchmark number of transitions under the Decree where the MFP transition conforms with the benchmark requirements of the Consent Decree (and vice versa): the MFP qualified setting to which the Class Member is transitioned is a Community-Based Setting; the Class Member receives an Evaluation from a Qualified Professional; and the Class Member has a Service Plan. The Defendants also intend to count Class Members who are enrolled in MFP in the projected benchmark numbers of transitions under the MFP program.

Additional MFP/Pathways benchmarks will continue to be tracked and reported for Colbert class members who consent and enroll in the MFP/Pathways program.

### **3. Colbert and MFP/Pathways Service Model**

An addition to the current MFP/Pathways to Community Living array of home and community-based services includes the Colbert Service Model.

The Colbert Service Model will include:

#### **1. Outreach and Education Engagement Specialists**

Representatives of two Aging and Disability Resource Centers and Networks (ADRC/ADRN) will conduct Outreach to potential Class Members/MFP/Pathways to Community Living participants by conducting individual and small group meetings at the Nursing Facilities. The ADRC/ADRN will retain a total of two to three staff each, with the Chicago ADRN utilizing additional volunteers to conduct these Outreach and Educational sessions. This strategy expands on Illinois' funding already received through an existing federal CMS - MFP and ADRC grant where Engagement Specialists support MFP/Pathways by providing cross population outreach and engagement. In addition, the ADRC/ADRN will utilize Peer Support to assist with engaging Class Members. This Peer Support will be through the development of a Peer Registry. The literature and practice experience supports the inclusion of peers in helping to engage participants in the process by sharing personal experiences.

Use of Engagement Specialists at the ADRC/ADRN is a unique Colbert Consent Decree Implementation strategy that is currently in operation on behalf of MFP/Pathways to Community Living only as it relates to three ADRCs in Illinois under the ADRC/MFP grant.

#### **2. Housing Resource Coordination Specialists**

Housing Resource Coordination Specialists will work with realtors, landlords, housing developers and housing providers using resources of the regional and statewide housing coordinators in the Illinois Governor's Office and partially funded administratively through MFP. In addition, these Specialists will negotiate lease agreements and physically assist the Class Member/MFP Pathways to Community Living participants to visit identified properties and community surroundings to affirm these are desired community residencies. Once a property is identified, the Specialists will work with the professionals under contract to ensure accessibility if this is a Class Member need. Just prior to transition, the Specialists will assist the Class Member with the purchase of household items using resources under contract separately and administered by a fiscal agent.

MFP/Pathways to Community Living participants outside of Colbert Class Members have this similar activity performed by his/her transition coordinator as described elsewhere in this OP.

### 3. Home Accessibility Adaptation

Class Members/MFP/Pathways to Community Living participants that select an apartment in need of structural modifications are eligible to have this unit modified up to a one-time cost of \$5,000. This expenditure is usually incurred at the point of transition from the nursing home to community residency. Home Accessibility Adaptation Specialists will be retained to make recommendations for home modifications. The activities of these specialists will include schematic drawings of structural changes, working with consumers, private landlords and families, identifying and providing oversight to contractors and assuring that all modifications meet Housing and Urban Development standards.

MFP/Pathways to Community Living participants outside of Colbert Class Members have a similar benefit as described elsewhere in this OP.

### 4. Housing Assistance

The Fiscal Agent, under contract with one or more of the Defendants, will be a single independent entity responsible for working with all of the MCEs. These authorized funds may include a housing rental subsidy, rent for any temporary stay in a hospital or long-term care facility, and approved costs associated with the establishment of a household as defined in the Consent Decree and not to exceed \$4,000 for the lifetime of the Class Member.

### 5. Peer Support

Peer support has been identified as an integral service to individuals transitioning from institutional care to the community. Illinois provides different levels of peer support depending on the population and funding source. The Colbert class members and MFP enrollees will have access to peer support through the establishment of a peer registry that will be maintained and paid for by state General Revenue Funds by the two ADRC/ADRN's in Cook County. Peers will receive a small stipend for their activities along with money to cover their transportation when necessary.

HFS intends to expand the peer registry model statewide for MFP participants.

# **III. Organization and Administration**

## C1. Staffing Plan

**Note:** Detailed staffing plans for HFS, DoA, and the DHS Divisions of DRS, MH, and DD were included in the original Operational Protocol Appendix A .4.

The MFP partner agencies and divisions have each developed detailed staffing plans to identify staff handling all of the policy, regulatory, procedural, billing, claiming and reporting tasks required in carrying out the MFP Demonstration. Each partner agency has committed to providing significant support from executive leadership within the agency or organizational division. This level of commitment will “set the tone” for further conceptualization, policy development and implementation of MFP-related activities. Additionally, each partner agency or division will employ a project lead who will be responsible and accountable for planning, organizing and implementing all short-term and long-term project activities, as well as coordinating the activities of other staff assigned to the project. Each partner agency or division will dedicate staff knowledgeable in the areas of case management and pre-admission screening; quality management, fiscal management, including budgeting and rate-setting; program analysis and evaluation, and information technology to ensure the success of the project.

In addition, the Governor’s office employed a Statewide Housing Coordinator for Long Term Care Reform in CY2012, who will devote time to support of housing referral, linkages, and resource identification to the MFP program.

In carrying out the MFP Demonstration, Illinois has partnered with the University of Illinois at Champaign-Urban (U of I) and at Chicago (UIC) and has contracts with the entities below. Through these two contracts, Illinois may also obtain other expert assistance and consultation.

**UIC Department of Disability and Human Development** - Illinois originally had a contract in place through CY 2012 for the services of Paul Bennett as MFP Assistant Director, reporting to the MFP Project Director. Bennett has experience working with IDOA on federal RCSC grants and has produced a number of major reports, including an analysis of nursing facility pre-admission screening and review processes for the elderly. He also has extensive experience working for a CCU. Bennett's responsibilities will involve a wide variety of activities to assist in implementation, monitoring, and reporting for the Demonstration. In CY 2012, Bennett became an employee of HFS and began service as the Lead for implementing the *Colbert v. Quinn* Consent Decree – providing valuable coordination with the MFP Project Director and utilizing his previous experience working with the MFP program.

**University of Illinois College of Nursing (UIC-CON)** - Illinois contracts with the College of Nursing to provide extensive assistance with Quality Management and Improvement, including system design, development of initial and advanced training for Transition Coordinators and QM staff (including web-based training), case consultation to state agency staff and provider agencies on risk assessment/ mitigation and QI, quality field studies, and quality data analysis and report development. Primary contact is through Cheryl Schraeder PhD, RN, FAAN. Schraeder has extensive experience working with research and demonstration projects, developing practical community



health programs, and designing health care delivery approaches that effectively address issues related to disabilities, such as serious mental illness.

## **C2. Billing and Reimbursement Procedures**

HFS enters into interagency agreements with each of the programs outlining the responsibilities of each agency in implementation of HCBS waivers and state plan programs. The interagency agreement includes a program guide as an addendum. The guide is a living document that is updated as needed for new procedure codes or other claiming changes. It serves as a guide for claiming federal funds for the program. The guide includes an overview of the program, claiming description, description of services, rate methodologies, codes, units of service and a claims process flowchart. The following is a brief description of the payment and claiming process for each program.

### **1. Persons Who are Elderly**

Payment by DoA can be made only for covered services provided to individuals with a plan of care who are eligible on the date services are actually provided. It is the responsibility of the provider to verify an individual's eligibility prior to providing services, except where prohibited by law. HFS as the single state Medicaid agency, is, by Federal Regulations, "payer of last resort" and adjudicates claims for medical expenses only after all other sources have been exhausted.

All Case Coordination Units (CCU) and providers send bills to DoA's Division of General Services. The data for Medicaid claims are entered into a Vendor Request for Payment (VRFP) diskette, processed through edits and inserted in the Year to Date (YTD) File and Payment History SQL tables in the CCP system. The Division of General Services processes bills and sends to the Comptroller's office for payment. Medicaid bills are then identified and sent to HFS electronically for Federal Financial Participation (FFP) claiming.

The claim must be completed in accordance with billing procedures. To be eligible for federal reimbursement, the claim must be received by HFS in a timely manner to allow HFS to submit the claim for FFP no later than 24 months after the date the waiver service is provided. DoA claiming is based on the actual cost incurred as determined by the rate methodology for the services being claimed.

Direct DoA administrative costs applicable to the Medicaid program population served are eligible for federal matching funds. DoA shall maintain detailed records sufficient to meet the requirements of OMB Circular A-87 and document such compliance. All programmatic methodologies used to calculate the administrative claim must be incorporated into the aggregate DoA cost allocation plan and DoA must assure that claims for reimbursement of program costs are not duplicative of other DoA claims.

### **2. Persons with Disabilities**

Payment by IDHS-DRS can be made only for covered services provided to individuals with a plan of care who are eligible on the date services are actually provided. It is the responsibility of the provider to verify an individual's eligibility prior to providing services, except where prohibited by law. HFS, as the single state Medicaid agency, is, by federal

regulations, “payer of last resort” and adjudicates claims for medical expenses only after all other sources have been exhausted.

The claim must be completed in accordance with billing procedures developed by IDHS-DRS. To be eligible for reimbursement, a claim must be received by IDHS-DRS in a timely manner to allow HFS to submit the claim for FFP no later than 24 months after the date the medical services are provided. Each service filed is considered separately. The time limit applies to initial, resubmitted and adjusted expenditures.

IDHS-DRS pays the Medicaid waiver providers directly, and electronically submits claims to HFS. This is allowable because the provider enters into a three-party provider agreement, the HFS 1413A for agency and other licensed providers and the HFS 1413B for personal assistants. These agreements allow providers to voluntarily reassign payment to the operating waiver agency, rather than the Medicaid agency.

IDHS-DRS claiming is based on the actual cost incurred as determined by the rate methodology for the covered services being claimed. One of three actions may be taken by HFS on a claim for reimbursement. The claim may be approved, rejected, or suspended.

Reimbursement under this waiver will be claimed only for those customers who meet both programmatic waiver eligibility and financial eligibility for Medicaid. In order for the State to submit claims for FFP under this waiver, several computer matches are required.

- Each client is coded by IDHS-DRS for programmatic eligibility.
- Eligible clients who have expenditures for services covered under the waiver are matched against another IDHS-DRS internal computer data file to ensure a match of Social Security Number and to obtain additional information needed for the claim.
- Social Security Number then matches a computer file of dually matched clients and data against the HFS statewide Medicaid-eligibility file.
- Only expenditures incurred for a time period in which there is Medicaid eligibility and which are otherwise triple matched i.e., (1) the recipient, (2) the service, and (3) the provider are claimed. These records are available on the MMIS, IDHS-DRS computer system, and/or printouts HSP central office staff.
- To ensure the accuracy of all claims, IDHS-DRS utilizes computer program reports to edit for claim file integrity and correctness, for duplicate payments and claims, for correctness of programmatic eligibility codes, for mismatches based on incorrect social security numbers, and for other potential errors. The DRS central office maintains these records, provides monitoring based on them, and initiates indicated correction activities both for the purpose of the waiver claim and for the purpose of ensuring correct payments to service providers.
- Payment for services is made on a “purchase of services” basis (i.e., on a monthly basis, DRS authorizes, in advance, the service and amount of service to be

provided and provides documentation verifying that services were provided; and DRS approves and processes the bills). A combination authorization/voucher document is utilized in this payment process and constitutes a legal agreement between DRS and its service provider for short-term purchase of service. Services are authorized and voucher for no more than one calendar month. The State of Illinois Comptroller makes payments for services from IDHS-DRS obligations. IDHS-DRS submits the amount of expenditures made for Medicaid eligible customers to the Medicaid agency for submission for FFP.

The Operating Agency passes the detail expenditure data once a month via an electronic tape to HFS. HFS is the Medicaid Single State agency for the State of Illinois. The data is fed into the MMIS and is subject to edits to ensure the information provided is accurate and that the services/providers are eligible for federal match under Title XIX. Should any claims have inaccurate information those claims are rejected by the system and a file of the rejected claims is passed back to the Operating agency for their review. Claims that pass through the system without error filter down to the MARS reporting unit. The MARS unit is responsible for generating the reports to the Bureau of Federal Finance (BFF) who use the reports to claim Medicaid expenditure data quarterly on the CMS 64. MARS also has a series of edits and codes that are used to filter data to ensure accuracy and to determine to what program the expenditure should be reported.

Direct IDHS administrative costs applicable to the Medicaid Program population served are eligible for federal matching funds. IDHS shall maintain detailed records sufficient to meet the requirements of OMB Circular A-87 and document such compliance.

### **3. Persons with Mental Illness**

Payment made by HFS for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by HFS. Providers may only bill HFS after the service has been provided. When billing for services or materials, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided.

HFS will accept the medical claims submitted by DHS-DMH and process them through the HFS MMIS system. The MMIS contains edits to reject claims that conflict with other claims or reject claims that are duplicative.

DHS-DMH shall provide to HFS all documents and other necessary information to allow the HFS, as the Medicaid single State agency, to submit claims for payment and to monitor the program. Claims for administrative expenditures have been incurred prior to submittal to HFS are made in accordance with OMB Circular A-87.

#### **4. Persons with Intellectual Disabilities**

As specified in the interagency agreement with HFS, the Medicaid single state agency, IDHS is responsible for setting claiming rates, authorizing waiver services, contracting with waiver providers, and paying providers for waiver services delivered.

IDHS maintains at the central office level a computerized system that includes service plan authorization for each individual, payments to provider agencies, units of service delivered to each eligible individual, payment, and claiming rates per unit of service. The payment system contains edits to ensure that payments are made only when the individual is authorized for the program services delivered, via a plan of care that specifies the program services, the provider of the program services, and the amount of services authorized per state fiscal year. The payment system also contains edits to ensure that payments are made only to providers that have valid contracts for the services delivered and that payment is made at the correct payment rate.

Information from the IDHS computerized payment system then feeds into an IDHS computerized claiming system that contains edits to ensure that the individual has been determined to meet the level of care prior to the date of service. This IDHS claiming system also picks up the established claiming rate and compares it with the actual payment rate; the lower of the two is the amount claimed. Finally, the IDHS claiming system subtracts the spend-down obligation of each individual (available on a monthly extract from the HFS MMIS system) from the waiver claim.

The IDHS claiming data are transmitted to HFS via computer tape exchange. The waiver subsection of the MMIS matches the individual against the recipient eligibility file to ensure Medicaid eligibility on the date of service and matches the provider against the provider enrollment file to ensure that the provider is enrolled as a waiver provider with HFS. The waiver MMIS also includes edits to reject waiver claims that conflict with hospital, nursing home, hospice facility, or ICF/MR claims, or to reject waiver claims that are duplicative or are incompatible (such as two different residential services on the same date).

#### **5. Money Follows the Person MMIS Changes**

HFS is modifying the Medicaid Management Information System (MMIS) to include information and data specific to the Money Follows the Person (MFP) project. MFP participants will be identified with a special MFP indicator that is program specific and includes the status of the transition (pre-transition, demonstration, or post-demonstration).

For example, for participants being transitioned by the Department on Aging, the following indicators will apply: A0 is the current Aging Waiver code. The new MFP Aging codes would be:

- AT – MFP Aging Pre-Transition
- AD – MFP Aging Demonstration
- AP – MFP Aging Post Demonstration

The MFP indicators will be identified through the MFP web case management application enrollment and transition data by the MFP partner agencies. This data will then be coded appropriately by the HFS Enterprise Data Warehouse staff on a monthly basis and submitted to the Recipient Data Base. HFS will use the data to update the Recipient Data Base on the MMIS. The data will also be consistently accessible through the HFS Data Warehouse. An overview of the process is as follows:

1. Enrollment and transition data is collected in the MFP web case management application
2. Data feed is submitted weekly from the web case management application to the HFS Enterprise Data Warehouse, which runs edits and quality checks to ensure data integrity
3. Enterprise Data Warehouse staff submit monthly data into the MMIS Recipient Database, which runs additional edits and quality checks to ensure Medicaid eligibility and data integrity
4. MFP records receive appropriate coding to tag each record as MFP and ensure accurate claims data and enhanced match reporting
5. MFP records that do not pass edits and data checks are included in error reports that are then triaged by program staff

By using these indicators HFS will be able to identify all MFP participants and know the status of their transition. This will assist in tracking and trending data, by operating agency, and overall. The MFP indicators will also be used to edit against MFP services to assure that individuals only receive the services approved in the MFP demonstration. Additionally, the combination of the MFP indicator and the service code (HCPC) will determine the level of claiming (regular or enhanced).

## **6. HFS Oversight**

All claims for services provided under this demonstration will be processed through the department's approved Medicaid Management Information System (MMIS) using extant procedures and processes. They will be subject to the same standards and controls as are all other Medicaid services payments. MMIS has edits in place to verify that, on the date that the service was provided: (a) the recipient of the service was enrolled in the Medicaid program; (b) the provider of the services was certified to participate in the Illinois Medicaid program; and, (c) the service itself was covered under the Title XIX State plan, an approved waiver program, or the early, periodic, screening, diagnosis and treatment requirement of the *Social Security Act*.

Individuals participating in this demonstration will be identified in the MMIS with an indicator that identifies (a) which State agency is managing the services for the individual; (b) in which stage of the demonstration the individual is participating; and (c) the beginning and ending dates of that participation. This is an extant feature of the MMIS that is used by the department to track special subpopulations within the Medicaid program—including all waiver programs.

HFS has developed comprehensive oversight procedures that provide assurance that claims are coded and paid in accordance with approved reimbursement methodologies.

Department financial monitoring staff analyzes paid claims on a routine basis. Claims that appear not to have been paid appropriately are identified. All information relevant to the findings and remediation strategies are shared with the operating agency.

Department staff meets with the operating agency staff on a regular basis to discuss and review common monitoring topics and findings. Claims that are not appropriately paid are removed from the federal claim. Any suspected fraud is referred to the Office of the Inspector General.

# **IV. Evaluation**



**Illinois will not conduct an independent evaluation.**

# **V. Final Budget**

## 1. Annual Budget

Illinois will update the program budget annually in conjunction with federally required annual program reporting and supplemental budget documentation. This budget information will be updated annually with Federal CMS. This will include:

- MFP budget forms including the annual Worksheet for Proposed Budget
  - Transition projections
  - Services projections
  - Administrative projections
- SF 424 forms
- Budget Narrative
- MFP Maintenance of Effort Documentation

The Illinois General Assembly must approve budgets for the several Illinois agencies involved in the demonstration: Dept. of Human Services, Dept. on Aging, and the Dept. of Healthcare and Family Services.

## 2. Original MFP operational protocol budget planning documentation

**1. MFP Budget Form:** Utilizing the MFP Budget form provided in Appendix C (relocated to Appendix 20 in the Operational Protocol), include an annual budget divided into the categories described below. The MFP Budget Form is set up to have states fill in necessary information and then CMS can use the information to automatically calculate several indicators. The only cells that should be filled in by the States are those highlighted in yellow. Most of these cells represent total cost measures. This means that the number filled in should be the total costs of the service or administrative expense (not just the enhanced portion and not just the state or federal share).

Please see Appendix 20 for the MFP budget form & Appendix 21, the SF 424 forms.

- a. Enrollees: An unduplicated count of individuals the State proposes to transition under the demonstration. Please count the person in the year that he or she will physically transition.

**Illinois proposes to transition 3,457 individuals during this demonstration. This information is detailed in the MFP budget form located in Appendix 20.**

- b. Services: In each service costs section, provide costs estimates for the maximum number of participants in the demonstration project and their projected annual service costs.
  - i. “Qualified home and community-based program” services (eligible for enhanced FMAP);
  - ii. “Home and community-based demonstration” services (eligible for enhanced FMAP);
  - iii. “Supplemental demonstration” services (those eligible for regular FMAP).

**This information is located on the MFP budget for located in Appendix 20.**

- c. Administrative Budget: Please include projections for annual costs regarding the routine administration and monitoring activities directly related to the provision of services and benefits under the demonstration. Indicate any additional actions that are required to secure State funding (e.g., appropriation by the legislature, etc.), as well as costs associated with participation with the National Evaluation and Quality initiatives implemented by CMS.

Projections regarding the administrative budget are available in the MFP budget (Appendix 20) and further explanation is provided below (under #2, Budget Presentation and Narrative). The Illinois General Assembly must approve budgets for the several Illinois agencies involved in the demonstration: Dept. of Human Services, Dept. on Aging, and the Dept. of Healthcare and Family Services.

**The costs of the National Evaluation and Quality initiatives are detailed in the chart below:**

Year	Federal supports	Evaluation	
	Persons transitioning	Quality of Life Surveys (#)	Cost of surveys (\$100/per)
CY08	311	311	\$31,100
CY09	774	1085	\$108,500
CY10	1115	2200	\$220,000
CY11	1257	3457	\$345,700
Total cost:			\$705,300

- d. Evaluation Budget:

**Illinois does not plan to conduct a state-only evaluation.**

- 2. **Budget Presentation and Narrative:** Please provide a budget presentation and narrative that provides justification for Items E.1.c and E.1.d above. Please address the following items:

- a. Personnel –

	CY08	CY09	CY10	CY11
HFS Personnel:	\$ Amount	\$ Amount	\$ Amount	\$ Amount
Project Director (Senior Public Service Administrator)	\$96,000	\$98,880	\$101,846	\$104,900
Project Manager (Public Service Administrator)	\$72,000	\$74,160	\$76,385	\$78,677

Administrative Support (Office Coordinator)	\$41,000	\$42,230	\$43,497	\$44,802
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b. Fringe benefits

**Figures below estimate the fringe benefits costs for the three staff identified above.**

	CY08	CY09	CY10	CY11
	\$ Amount	\$ Amount	\$ Amount	\$ Amount
4. Fringe Benefits @ 25% of Salary	\$52,250	\$53,818	\$55,432	\$57,095

c. Contractual costs, including consultant contracts

Illinois anticipates utilizing several consultant contracts to accomplish the development of several tools and one to assist with oversight of the MFP program as follows:

- The development of improved assessment tools for transition candidates, primarily those transition candidates with mental illness, to assess cognitive skills; developing this tool and conducting training is estimated to cost \$75,000 in each of CY09, CY10 and CY11.
- Producing a person centered planning approach to transition and training workshops to implement the approach; these activities are estimated to cost \$75,000 in years CY09, CY10 and CY11.
- Contracting for a 24-hour nurse line to take telephone inquiries from MFP participants; this item is estimated to cost \$60,000 in CY08 and \$120,000 each year thereafter (CY09-CY11).
- Contract for UIC School of Nursing for technical support, training, QA field studies, and case specific consultation on risk assessment /mitigation, critical incident monitoring, quality indicators and improvement strategies; these costs are anticipated to be \$500,000 for CY08 and \$725,000 for each year CY09, CY10 and CY11.
- Obtaining expertise of Mr. Paul Bennett, an employee of the University of Illinois who possesses significant knowledge and expertise in long term care rebalancing strategies having served as the Illinois Systems Change Grant Project Director; Mr. Bennett will help with general management and oversight of the demonstration; the cost of acquiring his skills are estimated at \$75,000 in CY08, \$150,000 in CY09, CY10 and CY11.

d. Indirect charges, by federal regulation

e. Travel

Reimbursements for travel expenses of consumers participating in advisory group meetings are included at a cost of \$5,000 per year in CY08 and CY09, \$7,000 per year in CY10 and CY11.

The travel expenses of dedicated staff are estimated as follows:

	<b>CY08</b>	<b>CY09</b>	<b>CY10</b>	<b>CY11</b>
	<b>\$ Amount</b>	<b>\$ Amount</b>	<b>\$ Amount</b>	<b>\$ Amount</b>
Staff Travel (2 staff)	\$10,000	\$12,000	\$14,000	\$14,000

## Supplies

Expenses for the supplies of dedicated staff are estimated as follows:

	<b>CY08</b>	<b>CY09</b>	<b>CY10</b>	<b>CY11</b>
	<b>\$ Amount</b>	<b>\$ Amount</b>	<b>\$ Amount</b>	<b>\$ Amount</b>
Supplies (3 staff)	\$3,000	\$3,000	\$3,000	\$3,000

## f. Equipment

Expenses for the equipment of dedicated staff are estimated as follows:

	<b>CY08</b>	<b>CY09</b>	<b>CY10</b>	<b>CY11</b>
	<b>\$ Amount</b>	<b>\$ Amount</b>	<b>\$ Amount</b>	<b>\$ Amount</b>
Equipment (3 staff)	\$9,000	\$3,000	\$6,000	\$6,000

## g. Other costs

The development of MFP-specific Information Technology resources is estimated to cost \$100,000 in CY08, \$200,000 in CY09, \$150,000 in CY10 and \$150,000 in CY11.

In the first year of the demonstration, case management is included in the administrative budget. In years 2009, 2010 and 2011, case management is a qualified plan service if provided within sixty days prior to transition or a supplemental service if case management activity is more than sixty days but less than one hundred and eighty days before transition. The administrative budget for CY 2008 is, therefore, much higher than the subsequent years.

Case management services will include: ensuring eligibility for the program, determining each individual's goals and objectives; conducting a comprehensive assessment on each individual to develop a plan of care (including back-up plan and risk mitigation); working to locate housing,

planning for the move, and continued follow-up after the move to monitor transition, resolve issues and provide information/technical support to the MFP participant.

The administrative budget also includes Pre-Admission Screening and Annual Resident Reviews (PASARR screens) for persons with mental illness. These administrative costs are estimated at \$210,000 for the demonstration.

**Pathways to Community Living:  
Illinois' Money Follows the Person Demonstration Program  
Informed Consent**



**General Information**

I am applying for the Pathways to Community Living Program: Illinois' Money Follows the Person (MFP) Demonstration Program sponsored by the Federal Centers for Medicare and Medicaid Services (CMS). Pathways is a program designed to help persons like me move from a qualified institution (nursing home or ICF/DD) to a home in the community. My signature on this Informed Consent allows my transition coordinator to help me plan all services that would be needed to make certain a successful transition to the community. Transition to the community will be determined by my health, my willingness to participate in Pathways/MFP planning, and my ability to live safely in the community.

**Eligibility, Rights and Benefits of the Pathways to Community Living Program**

- I must meet all of the eligibility requirements including being eligible for Medicaid, must have lived in a qualified institution for at least 90 days and these 90 days can not include days paid for by another government program such as Medicare. Also, I must be receiving Medicaid benefits for at least one day before I move to the community. I also understand that participation in Pathways/MFP is voluntary.
- I understand that a benefit of Pathways/MFP participation includes the services of someone helping plan what programs and services I may need once living in the community. I understand that participation in Pathways/MFP is for 365 days beginning when I move to the community and that I will continue to receive services during and after the 365 days, as long as I continue to need them and meet eligibility requirements.
- I understand that a care plan must be designed to meet my needs once I move to the community. I am expected to help plan my services. This includes naming the things that I can do for myself, things where I may need help and learning what could happen if things do not go well. This is done to make sure I am safe and the information about me is true.
- As a participant in helping to plan my services, I have a responsibility to tell those helping plan my services with me if I have a complaint. I expect to be treated with respect and dignity by all persons involved with my service planning and all persons who provide me with services. I have a right to report any incidents of abuse, such as getting hurt or being neglected. Those helping me with my services also have a mandate or order to report abuse, neglect or exploitation.

**Housing**

- In order to participate in the Pathways/MFP program, I understand that when I move, I must live in what the Pathways/MFP program calls, a qualified residence. A qualified residence is either:
  - A house that I or a family member own(s) or rents(s)
  - An apartment with an individual lease, doors that lock and living, sleeping, bathing and cooking areas that I or my family member control; or
  - A residence in a community-based residential setting in which no more than four unrelated people reside.

I understand that, when I move to my new home in the community, a limited amount of funding is available to help me with expenses related to the move. These expenses may include such things as furniture and



household items. Funds may also be available to make accessibility modification(s) to my new home. These funds are used to buy items not covered by Medicaid or other governmental programs. Those persons helping me with my plans to move will help me obtain these funds.

**Information, Surveys, and Confidentiality**

- Information about me in this program will be used only for helping me with my services and studying the Pathways/MFP program. Certain information about my participation in Pathways/MFP will be provided to CMS, the Mathematica Policy Research, Inc., and the University of Illinois at Chicago, College of Nursing, who provides quality assurance, and case consultation. All of the information that is shared by me will be kept safe and protected by all state and federal laws.
- I have a responsibility to inform my Transition Coordinator how I am doing once I move. If there are problems with my services or if my health changes and I need medical assistance or need to go to a hospital, I need to tell my Transition Coordinator.
- As a Pathways/MFP participant, I understand that I will be asked to participate in answering surveys and interviews about my quality of life. Again, any information learned from these surveys and interview will be confidential and used only for evaluation purposes. I understand that participation in these surveys and interview is not required and that such participation will not affect my eligibility for the Pathways/MFP program.
- The nature and purposes of the services I look forward to receiving once living in the community have been explained to me. I also understand that when I move from my current place to live in the community, I may not necessarily be able to go back to the same place. I understand that if my circumstances change and I need to move back to an institutional setting, I will receive help.

**Reporting Abuse, Neglect and Exploitation**

- I have the right to report any incidents of abuse, such as getting hurt or being neglected.
- I understand that my transition coordinator or case manager is a mandated reporter. This means he/she must make a report of abuse or neglect if I am being hurt (abused) or not being cared for (neglected) or if someone is taking my money without my permission (financial exploitation).
- I can call the following person at any time to report these incidents:  
➤ \_\_\_\_\_ at \_\_\_\_\_

**Consent**

My signature below indicates I agree to the above, understand all of the conditions of the Pathways/MFP program, and wish to continue with the Pathways/MFP enrollment process.

Participant’s Signature (if appropriate): \_\_\_\_\_

Guardian’s signature: \_\_\_\_\_

Print name(s): \_\_\_\_\_

Witness’ signature (if possible): \_\_\_\_\_

Date: \_\_\_\_\_

*A copy of this Informed Consent is mine to keep*

<u>Money Follows the Person Presentations - Examples</u>			
<b>Groups/Audience</b>	<b>Date</b>	<b>Locations</b>	<b>Purpose</b>
MFP Training – Managed Care Vendors – Aetna & Centene	February 8, 2013	Chicago & Springfield	Lora McCurdy and Paul Bennett provided training to Aetna and Centene – managed care vendors responsible for implementation of Colbert and coordination with MFP.
MFP/DDD Training – Independent Case Manager & SODC Murray staff	January 31, 2013	Centralia, IL	Lora McCurdy, MFP Project Director, and HFS staff provided training to DDD staff that plan to provide transition coordination services for individuals transitioning from Murray – State Institution.
Regional State Ombudsman quarterly meeting	January 9, 2013	Springfield, IL	The Ombudsman quarterly meeting – discussed the status of the MFP program with emphasis on referral practices and improvement.
Governor’s Conference on Aging and Disability	December 13, 2012	Chicago, IL	Lora McCurdy, MFP Project Director, and Paul Bennett, Colbert Lead, presented on the coordination of MFP and the implementation of the Colbert Consent Decree.
Statewide PHA Housing Conference	September 27, 2012	Springfield, IL	With Statewide Housing Coordinator Dan Burke, presented overview of MFP program and Olmstead lawsuits in Illinois with emphasis on collaboration with PHAs to provide housing options to people with disabilities.
HSC Rebalancing Workgroup Meeting "Building Community Capacity - Best Practices	August 8, 2012	Springfield, IL	Lora McCurdy, MFP project director and MFP staff with UIC-CON (quality vendor) provided update on status of the MFP program and lessons learned to date
Illinois Department on Aging (IDOA) Quarterly MFP stakeholders conference call	June 26, 2012	Statewide Call	With Dan Burke, Statewide Housing Coordinator for Long Term Care Reform and Brady Hardin, Chicago Area Housing Coordinator for Long Term Care Reform, discussed MFP status and roles of housing coordinators and how they can assist MFP program
Statewide Center For Independent Living Meeting (CILs)	May 29, 2012	Springfield, IL	With DHS-Division of Rehab Services Director Kris Smith, presented on Supportive Living Facilities as a housing option and provided a status overview of the MFP program.

Illinois Department of Human Services State Operated Developmental Center Meeting	April 19, 2012	Springfield, IL	Provided background and statistical snapshot of MFP program to date with emphasis on work done to involve developmentally disabled population and DHS-DDD
Illinois Department on Aging (IDOA) Quarterly MFP stakeholders conference call	March 20, 2012	Statewide Call	With IDOA MFP lead John Eckert, provided update on MFP program and overview of new marketing material and website ( <a href="http://www.mfp.illinois.gov">www.mfp.illinois.gov</a> )
Medicaid Advisory Committee, Long Term Care Subcommittee, Springfield, Illinois	October 19, 2007 and ongoing (most recent December 14, 2012)	Springfield, IL	This Committee advises Healthcare and Family Services on issues related to the long term care program. It is comprised of Medicaid long term care provider representatives, advocates, Area Agencies on Aging and state agency staff.
Governor's Task Force on Affordable Housing, Springfield, Illinois	February 27, 2008	Springfield, IL	With Illinois Housing Development Authority staff person Tara Peele, provided overview of the MFP program to Governor-appointed Task Force. The audience consisted of approximately 50 members and state agency staff.
Nursing Home Administrators' Association, Springfield, Illinois	November 16, 2007	Springfield, IL	Provided information on the MFP demonstration award as part of overall Department presentation. The audience consisted of approximately 100 nursing facility administrators and executive staff.
Illinois Association of Housing Authority, Springfield, Illinois	September 21, 2007	Springfield, IL	In cooperation with other participating state agencies, provided MFP overview to the Illinois Association of Housing Authorities. Audience consisted of approximately 25 local Housing Authority Administrators.
Illinois Health Care Association-Regulatory Update, Peoria, Illinois	September 20, 2007	Peoria, IL	Provided information on the MFP demonstration award as part of overall Department presentation. The audience consisted of approximately 150 nursing facility administrators and staff.
Medicaid Advisory Committee, Springfield, Illinois	July 20, 2007	Springfield, IL	This Committee advises Healthcare and Family Services on all issues related to the Medicaid program. It is comprised of Medicaid provider representatives, advocates, state agency staff and consumers.
Governor's Conference on Aging, Chicago, Illinois	December 13, 2007 and April 2012	Chicago, IL	Initially with previous Project Manager Jean Summerfield and Department on Aging Planning Manager Shelly Ebbert, presented overview of the MFP program with emphasis was placed on aging services. Second presentation with Project Director Lora McCurdy and Colbert Implementation Lead Paul Bennett.

MFP – Pathways to Community Living Stakeholder Committee (re-formed February 2012)

**Members**

Adams, Christopher  
Alcala, Marian  
Baker, Lorrie (Lore)  
Bannister, Edward  
Cesal, Lisa  
Chawla, Erika  
Chambers, Cynthia  
Contarino, Cathy  
Erinson, Eliz  
Factor, Alan  
Farmer, Julie  
Ford, Ann  
Gambach, Jan  
Gorman, William  
Gunther, Willie (Wilhelmina)  
Hughes, Susan  
Irving, Terrance  
Jones, Cynthia  
Jones, Lucia  
Kenny, Vincent  
Klauer, Myrtle  
Lavin, John  
Laxton, Christopher  
Mercer, Lubertha  
Mitchell, Gloria  
Mitzen, Phyllis  
Niederer, Margaret  
Nirde, Fred  
Olszewski, Scott  
Paeth, Joy  
Patrick, Rahnee  
Paulauski, Tony  
Pick, Eli  
Pohlman, Greg  
Posner, Anne  
Price, Darrell  
Romano, Sheila  
Sajdak, Lucy

**Organizational Affiliate**

Consumer  
People First of Illinois  
IL Supportive Housing Providers Association  
Coalition of Citizens with Disabilities in IL - Bolingbrook Chapter  
Illinois Voices  
Heartland Health Alliance  
Heartland Health Alliance  
IMPACT CIL  
Consumer  
UIC Department of Disability and Human Development  
Alternatives for the Older Adult, Quad Cities Office  
Illinois Network of Centers for Independent Living (INCIL)  
Mental Health Centers of Central Illinois  
Statewide Independent Living Council of Illinois  
IL Assistive Technology Program  
UIC Institute for Health Research & Policy,  
Thresholds  
Counseling Center of Lakeview  
Northeastern IL AAA  
Consumer  
Illinois Council on Long-Term Care  
Age Options  
Life Services Network (LSN)  
Healthcare Consortium of Illinois (HCI)  
Consumer  
Health & Medicine Policy Research Group  
Citizen Action IL  
Human Services Center  
Consumer  
Area Agency on Aging of SW IL  
Access Living CIL and ADAPT  
Arc of IL  
Post Acute Innovations  
Chicago Lighthouse for People Who are Blind or Visually Impaired  
Age Options  
ADAPT and Access Living CIL  
IL Planning Council on Developmental Disability  
Growing Place Empowerment Org.

Salazar, Becky	Shawnee Alliance for Seniors
Sutton, Chris	Area Agency on Aging of SW IL
Thomas, Lora	National Alliance on Mental Illness (NAMI Illinois)
Thomas, Joanne	Central IL AAA
Vaughn, Bonnie	Southern IL CIL
Wooters, Jeri	Soyland Access CIL
Western, Bonnie	Consumer
Williams, Tenille	Thresholds
Yeoch, Keon	Area Agency on Aging of SW IL

**State of Illinois Members**

Baird, Mary  
Bennett, Paul  
Burson, Katherine  
Burke, Dan  
Cunningham, Kelly  
Eckert, John  
Harden, Brady  
Hoskin, Reta  
Housing Coordinator  
Johnson, Neyna  
McCurdy, Lora  
McGuire, Mary  
Mordka, Sam  
Pluta, Bill  
Reed, David  
Robinson, Nyle  
Schraeder, Cheryl  
Smith, Kris  
Vaughn, Peter

**Agency**

DHS DDD  
UIC  
DHS DMH  
Governor's Office - Housing Coordinator  
HFS  
IDOA  
Governor's Office - Housing Coordinator  
DHS DDD  
State of Illinois  
IDoA Ombudsman Program  
HFS  
HFS  
IHDA  
IHDA  
DHS DRS  
DHS DRS  
UIC College of Nursing  
DHS DRS  
HFS

# COLBERT CONSENT DECREE IMPLEMENTATION PLAN

November 8, 2012



Prepared by:

Illinois Department of Healthcare and Family Services  
in Partnership with

Office of the Governor  
Illinois Department of Aging  
Illinois Department of Human Services  
Illinois Department of Public Health

**Table of Contents**

1. Executive Summary ..... 4

    1.1. Background of the Consent Decree ..... 4

    1.2. Overriding Philosophy ..... 4

        1.2.1. Principles ..... 4

    1.3. Class Members ..... 5

2. Implementation Plan Development ..... 6

3. Cost Neutrality ..... 6

4. Outreach and Education ..... 6

    4.1. Aging and Disability Resource Centers and Networks ..... 6

    4.2. Peer Support Registry ..... 7

    4.4. Tracking Outcomes of Outreach and Education Activities ..... 8

5. Informational Materials and Methods for Class Member Self-identification ..... 8

    5.1. Illinois Pathways to Community Transition/Money Follows the Person (MFP) and On-Line Referral Form ..... 8

    5.2. Section Q Minimum Data Set (MDS) ..... 8

    5.3. Fact Sheet ..... 9

    5.4. Signage ..... 9

    5.5. Letters to the Guardians ..... 9

    5.6. Video ..... 9

6. Focused Approach to Class Member Identification Using Integrated Care Coordination ..... 9

    6.1. Focused Methodological Approach to Identification of Class Members ..... 10

    6.2. Class Members in Managed Care Entities (MCEs) ..... 11

    6.3. Analysis of Pathways to Community Living/Money Follows the Person Initiative ..... 11

    6.5. Process and Goals to Achieve Benchmarks ..... 12

7. Colbert Consent Decree in Relationship to Pathways to Community Living/Money Follows the Person (MFP) ..... 12

8. Illinois Client Enrollment Broker (ICEB) ..... 13

9. Evaluation of Class Members Not Yet Eligible for MCE Enrollment ..... 13

10. Evaluation Using an Integrated Managed Care Approach ..... 13

    10.1. Definition of the Qualified Professionals in the Multi-Disciplinary Team ..... 13

    10.2. Quality Components – Evaluation, Risk Assessment and Mitigation ..... 14

11. Successful Transition ..... 14

    11.1. Responsible Entity for Conducting the Evaluation and Development of the Service Plan of Care of Class Members ..... 14

    11.2. Initial Contact and Engagement ..... 14

    11.3. Multi-Disciplinary Teams of Qualified Professionals ..... 15

    11.4. Review of Nursing Home Medical Records ..... 15

    11.5. Face-to-Face Contact in the Initial Evaluation by a Care Coordinator ..... 15

12. Evaluation/Assessment, Services and Service Plan of Care ..... 15

    12.1. Evaluation, Assessment and Assessment Tools ..... 16

    12.2. Access to Medicaid Home and Community-Based Service Options ..... 16

    12.3. Access to Rule 132 – Medicaid Community Mental Health Services Program ..... 17

    12.4. Social History and Service Plan of Care ..... 17

    12.6. Pathways to Community Living/MFP Requirements ..... 19

        12.6.1. Risk Inventory and Mitigation Plan ..... 19

        12.6.2. 24-Hour Back-Up Planning ..... 19

        12.6.3. Quality of Life Survey ..... 20

    12.7. Care Coordination and Service Plan Conferences ..... 20

Colbert Consent Decree Implementation Plan – November 8, 2012

12.8.	Quality Assurance Resources Available through Pathways to Community Living/Money Follows the Person .....	20
13.	Class Member Finances .....	20
14.	Housing .....	21
14.6.	Identification of Housing .....	21
14.6.1.	State Housing Coordinators .....	21
14.6.2.	Care Coordinator Responsibilities for the Identification of Housing .....	21
14.6.3.	State-funded Internet On-Line Housing Locator .....	21
14.7.	Assessment and Guidelines for Home Modification .....	22
14.8.	Housing Assistance .....	22
14.9.	Identification of Long-term Rental Subsidy Supports .....	23
14.9.1.	Collaboration with Local Public Housing Authorities .....	23
14.10.	Guidelines for Costs Associated with Moving and the Establishment of Household .....	23
14.11.	Fiscal Agent .....	23
15.	Relationship of Colbert Implementation Plan with Various State Agencies .....	24
16.	Training and Supervision of Qualified Professionals .....	24
16.6.	Training Components .....	24
16.7.	Contractual Expectations of MCEs in Regards to Retention and Training .....	25
17.	Quality Assurance Activities and Actions to Comply with Obligations Under the Decree .....	25
17.1.	Monitoring of Outreach and Education .....	25
17.2.	Compliance, Communication and Reporting with MCEs .....	26
17.3.	Ensuring Cultural Competence of Qualified Professionals .....	26
17.4.	MCEs' Internal Quality Assurance Activities .....	26
17.5.	Ensuring Quality Performance and Network Adequacy .....	27
17.6.	Corrective Action Steps .....	27
18.	Information Systems .....	27
19.	Appeals .....	27
20.	Finances .....	28
21.	Appendices .....	29
21.1.	Chart Showing Current Breakdown of Class Members .....	29
21.2.	Timetable and Nursing Home Selection for Colbert Implementation Plan .....	30
21.3.	Colbert Housing Options – Summary for Transition Planning .....	32
21.4.	Survey - Waiver Services Necessary for a Successful Transition to Community-Based Settings	
	38	
21.5.	Acronyms and Abbreviations .....	39
22.	References .....	39



## 1. Executive Summary

### 1.1. Background of the Consent Decree

On behalf of a class of Illinois residents with disabilities living in nursing facilities in Cook County, Illinois, *Colbert v. Quinn*, 07 C 4737, was filed on August 22, 2007, in the United States District Court for the Northern District of Illinois. The lawsuit sought declaratory and injunctive relief to remedy alleged violations of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. 12131-32, Section 504 of the Rehabilitation Act, 29 U.S.C. 794(a) and the Social Security Act, 42, U.S.C. 1396-1396v (SSA). Plaintiffs alleged that they and members of the Class were being unnecessarily segregated and institutionalized in Nursing Facilities and forced to live with numerous other people with disabilities and in situations in violation of the ADA and the Rehabilitation Act. Plaintiffs further alleged that Defendants the Office of the Governor of the State of Illinois, the Illinois Department of Human Services (DHS), the Illinois Department of Public Health (DPH), the Illinois Department on Aging (IDoA) and the Illinois Department of Healthcare and Family Services (HFS), denied them the opportunity to live in appropriate community integrated settings where they could lead more independent and productive lives. Plaintiffs sought injunctive relief requiring that Defendants (1) inform Class Plaintiffs as to their eligibility for Community-Based Services and their choice of such services; (2) provide comprehensive evaluations to determine the eligibility of Class Plaintiffs for Community-Based Services, both prior to and after admission to Nursing Facilities; and (3) provide, as appropriate, Class Plaintiffs with services and supports in the Community-Based Settings and refrain from providing services only in institutional settings.

The suit was settled, and on December 20, 2011, a Consent Decree was entered by the Court. This Implementation Plan is required by the Consent Decree and defines the strategies and mechanisms to implement the Decree and to meet the Court ordered benchmarks and timeframes. The Consent Decree requires Defendants to provide Class Members the necessary supports and services to allow Class Members to live in the most integrated settings appropriate to their needs in Community-Based Settings. The Consent Decree also requires Defendants to promote the development of integrated settings that attempt to maximize individuals' independence, choice, opportunities to develop and use independent living skills, and to afford them the opportunity to live their lives similar to individuals without disabilities.

### 1.2. Overriding Philosophy

The Colbert Decree and the Consent Decrees in *Williams v. Quinn*, 05 C 4673 (N.D. Ill.), for persons who reside in Institutions for Persons with Mental Disease (IMDs), and *Ligas v. Hamos*, 05 C 4331 (N.D. Ill.), for persons who reside or who are at risk of residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), advance the efforts to balance the long-term care system in the State of Illinois.

#### 1.2.1. Principles

The Consent Decree's objectives are based on an individual's right to self-determination, informed choice and respect of that choice, person-centered planning, and the provision of the necessary services and supports to enable individuals to succeed in the community.

- Self-Determination is "the right of individuals to have full power over their own lives, regardless of presence of illness or disability. It encompasses concepts such as free will, civil and human rights, freedom of choice, independence, personal agency, self-direction and individual responsibility." (University of Illinois at Chicago (UIC) National Research Training Center on Psychiatric Disability.)

Colbert Consent Decree Implementation Plan – November 8, 2012

- Informed Choice requires the individual “to understand, or at least be able to understand, the information divulged, . . . [to] demonstrate a capacity for rational manipulation of information [and to] show that they not only understand the risks and benefits but also have weighed them in relation to their personal situation.” (Lidz and Meisel, 1982.) To ensure Informed Choice, counseling a Class Member, listening to his/her expressed needs and desires, eliciting his/her concerns and offering pertinent information is necessary and will be required. The Qualified Professionals should confirm the Class Member’s understanding of the available options and the expectations and consequences of a selection to affirm and document that an Informed Choice has been made.
- Person-Centered Planning is the “process designed to empower Class Members to make plans for their future according to their needs and desires, with the support of their legal guardians, family, friends, significant others or service providers as appropriate.” For Class Members with Mental Illness, Person-Centered means a process based on a model of recovery.
- Care Coordination is the process and procedures to provide each Class Member with a single Care Coordinator (to the extent possible) throughout all stages—assessment, transition services and ongoing community supports and services—to enable the Class Member to build the necessary trusting relationship that facilitates transition to the community. Care Coordination is needed for all Class Members in the current fragmented healthcare environment in order to be able to attend to the complex health and behavioral health needs of Class Members in a holistic manner, and thereby produce better health outcomes.

The Qualified Professionals will be trained and expected to involve the Class Member, guardians, family, friends and/or his/her significant others, if applicable, in all aspects of Evaluation, care planning and transition. Class Members will be kept up-to-date to afford them the opportunity to make Informed Choices. The actions of the Qualified Professionals will be documented in Class Members’ case records.

The Centers for Medicare and Medicaid Services (Federal CMS) guidelines for Home and Community-Based Medicaid Waiver and Money Follows the Person programs mandate enhanced quality assurance measures. These standards focus on participant-centered desired outcomes and address the development of performance measures, risk assessment and mitigation plans, 24-hour back-up capacity, and monitoring of health and welfare when and if critical incidents occur. Illinois’ Medicaid waiver funded programs and services must comply with these Federal requirements. These quality assurance standards support a person’s independence and promote a person’s ability to live in the least restrictive environment.

Class Members’ medical and behavioral health status will determine the Service Plan of Care and the environment required to support his/her state of health and well-being. The Parties anticipate that some Class Members may choose to remain in a nursing home even with proactive engagement and discussion of options to live elsewhere. An individual’s choice, regardless of what that choice is, shall be respected. Class Members will be reEvaluated if needs and/or desires change.

### 1.3. Class Members

Class Members are all Medicaid-eligible adults with disabilities who are being, or may in the future be, unnecessarily confined to Nursing Facilities located in Cook County, Illinois, and who with appropriate supports and services may be able to live in a Community-Based Setting. Class Members include persons who have a primary diagnosis of mental illness but do not include persons with intellectual disabilities who are not likely to be residents of traditional nursing homes. There currently are between 16,000 and 17,000 Class Members residing in 186 long-term care facilities in Cook County, Illinois.

## **2. Implementation Plan Development**

HFS has taken the lead responsibility for creating this Implementation Plan. HFS has worked collaboratively with Defendants the Office of the Governor, the IDoA, DPH, DHS and its Divisions of Mental Health (DMH) and Rehabilitation Services (DRS). HFS has conducted listening sessions with counsel for Class Plaintiffs. Public comments were heard in a series of face-to-face feedback forums and on-line responses to an Internet posting from July 13, 2012, through August 14, 2012, on an initial draft Plan. This document takes into account all of these comments.

## **3. Cost Neutrality**

The Colbert Consent Decree requires the development of a Cost Neutral Plan 31 months after this Implementation Plan goes into effect. The Cost Neutral Plan must include a reasonable pace for transitioning all Class Members desiring to transition to Community-Based Settings at a cost the same or less in the aggregate to the State as if those Class Members had remained in the Nursing Facilities. This Cost Neutral Plan may not be implemented if the Defendants, Monitor and Counsel for Class Plaintiffs jointly determine, based on an analysis of the data and other information regarding the cost of moving the first 800 to 1,100 Class Members, that no remaining Class Member can be moved in a cost neutral manner. If the Parties cannot agree on a Cost Neutral Plan, the Parties may seek the remedies permitted in the Consent Decree. If a Cost Neutral Plan is agreed upon, then the Defendants shall develop a schedule to assess and transition the remaining Class Members. A workgroup comprised of the Court Monitor, representatives of HFS and counsel and experts for Class Plaintiffs is working on the issues relevant to the Cost Neutral Plan. This Cost Neutral Work Group will provide quarterly reports, starting on July 1, 2013.

## **4. Outreach and Education**

The Implementation Plan includes informing and educating Class Members, their families, significant others and guardians about the Colbert Consent Decree. Some Class Members may have not yet considered transition to the community. For some, their original placement in a Nursing Facility followed an acute care hospital stay and moving to a Nursing Facility was required or perceived as the most appropriate option. Frequently, the health and welfare of the Nursing Facility resident has improved or stabilized so that transition to community residency is now appropriate and desirable. In other situations, Class Members were admitted to a Nursing Facility, because he/she lacked an alternative community residence and linkage to Community-Based resources for his/her health needs. Whatever the reason, an understanding that there are home and Community-Based options may not have been presented or appreciated at the time of the Nursing Facility admission. This Implementation Plan includes a proactive integrated approach by trained professionals to discuss alternative home and Community-Based programs and services to meet the needs of the nursing home resident, with a goal of transition to a Community-Based Setting. These trained professionals will use a person-centered approach and have expertise working with adults with physical disabilities and mental illness of all ages. It is anticipated that through the various strategies as defined in Section 5, the Class Members will have an opportunity to self-identify beginning with the implementation of the Plan.

### **4.1. Aging and Disability Resource Centers and Networks**

The Aging and Disability Resource Center or Aging and Disability Resource Network (ADRC/ADRN) is a collaborative effort of the Federal Administration for Community Living and Federal CMS that were created in 2003. ADRCs currently operate in over 350 community sites across 54 States and Territories. The goal of an ADRC/ADRN is to streamline access to long-term care as a single one-stop and no wrong door entry using a coordinated system in a highly visible and trusted place where people of all ages,

Colbert Consent Decree Implementation Plan – November 8, 2012

incomes and disabilities can obtain information on the full range of long-term support options. ADRC/ADRN will use the person-centered approach described as Options Counseling to assist consumers in exploring the full range of available long-term support options including home and Community-Based care.

The ADRC established in October 2008 in suburban Cook County is AgeOptions, an Area Agency on Aging working in collaboration with Community-based providers representing an array of disability populations and one of the 350 community sites mentioned above. The Chicago Department of Family and Support Services (CDFSS) and the designated Area Agency on Aging for the City of Chicago, in collaboration with the Chicago Mayor's Office for Persons with Disabilities, is in process of developing an ADRN similar in concept to the ADRC. The ADRN is expected to form by the end of 2012. Both entities will be ready to perform Colbert Outreach and Education within 60 days of finalization of this Implementation Plan

Using the ADRC/ADRN for Outreach and Education builds upon an existing model of using cross-disability transition engagement specialists currently operational under a two year grant received by HFS from Federal CMS in the Fall of 2011. AgeOptions is one of the three sites in Illinois that is a recipient of this grant. Under this model, the Engagement Specialist speaks with Nursing Facility residents; develops professional relationships with Nursing Facility staff and convenes meetings with the stakeholder community. This Colbert Implementation Plan will extend and expand the existing model to the ADRN in Chicago.

Specific to the Consent Decree, representatives of the two ADRC/ADRN will conduct Outreach to Class Members by conducting individual and small group meetings at the Nursing Facilities. The ADRC/ADRN will retain a total of two to three staff each, with the ADRN utilizing additional volunteers to conduct these Outreach and Educational sessions. AgeOptions will incorporate their current Engagement Specialist to support Colbert Class Member Outreach. In addition, the ADRC/ADRN will utilize Peer Support, as described in Section 4.2 to assist with engaging Class Members.

The ADRC/ADRN representatives will receive training to have a person-centered approach, and an expertise working and communicating with adults with physical disabilities and mental illness of all ages for their role in Outreach and Education. The training will include detailed information about the array of home and Community-Based options as alternatives to Nursing Facility care, an understanding of the strategies in the Colbert Implementation Plan and rights of Nursing Facility residents. The ADRC/ADRN representatives will enter into contract with HFS to implement the Outreach and Education portions of the Colbert Implementation Plan. HFS will inform the Nursing Facilities of the ADRC/ADRN role and expectations, the scope of their work and the start of these activities beginning in Fall 2012. The ADRC/ADRN actions are independent of the MCE schedules. However, they will initially use the same agreed upon schedule and expand their Outreach and Education activities to include up to 75 Nursing Facilities by the end of the first year. The ADRC/ADRN will utilize the Fact Sheet and Video in their individual and group sessions.

#### 4.2. Peer Support Registry

The ADRC/ADRN will develop, in partnership with the Defendants, a registry of peers of persons who have successfully transitioned to community residency. Staff of Community-Based agencies that have experience transitioning persons from a Nursing Facility to community residency also have a unique opportunity to further help identify peers of current nursing home residents to be participants in this peer support registry. The peers may be helpful to overcome Class Members' anxiety about moving and can be highly motivating by helping to answer Class Members' questions. Peers who agree to participate will

Colbert Consent Decree Implementation Plan – November 8, 2012

receive training on peer support, implementation requirements and expectations. The peers will also receive a small stipend for their efforts and assistance with transportation.

#### 4.3. Ombudsmen

Ombudsmen have been engaged by IDoA to assist in the identification of Class Members desiring to transition to the community regardless of type of disability-under the Pathways to Community Living/Money Follows the Person program. It is anticipated that this further strategy of outreach, education and information dissemination will continue to residents of Cook County Nursing Facilities.

#### 4.4. Tracking Outcomes of Outreach and Education Activities

Class Members who self-identify through the Outreach and Education activities will either complete or be assisted in completing a self-referral by the representatives of the ADRC/ADRN on-line MFP referral form, which is available at <http://www.mfp.illinois.gov> as described in Section 5.1. Class Members who self-identify through engagement by an Ombudsman will either complete or be assisted in completing an on-line MFP referral form completed by the Ombudsmen. Regardless of the strategy, Class Members who self-identify will be reported to the Qualified Professionals performing the assessment and care planning activities for Evaluation. These actions will allow each Class Member to be tracked through the process from outreach and self-identification to Evaluation. Tracking, particularly from the Outreach and Education activities will provide data regarding the effectiveness of the Outreach and Education forums and conversations.

### **5. Informational Materials and Methods for Class Member Self-identification**

All Class Members are entitled to request an Evaluation conducted by Qualified Professionals. Class Members already enrolled in a MCE will be encouraged by managed care staff to discuss community transition as part of their overall wellness plan.

#### 5.1. Illinois Pathways to Community Transition/Money Follows the Person (MFP) and On-Line Referral Form

Pathways to Community Transition/MFP has an on-line referral form at <http://www.mfp.illinois.gov>. This on-line referral form allows individuals, families, significant others, guardians and Nursing Facility staff to self-identify or identify a Class Member for potential transition. HFS receives the referral and sends the referral to the Local Contact Agency (LCA) (Defined in Section 21.4) for follow-up. The Care Coordination entities for this Implementation Plan will be the LCA. HFS will track the self-referrals-to ensure that a follow-up interaction has occurred with each of the Class Members.

#### 5.2. Section Q Minimum Data Set (MDS)

The MDS 3.0 is a federally-required clinical assessment instrument used in nursing facilities to assess all Medicare/Medicaid residents. The tool assesses the Nursing Facility resident across multiple health domains, assists in the determination of health issues and drives the development of the resident's Plan of Care.

In 2010, the MDS instrument was substantially revised to require a more person-centered planning approach, with active participation of the Nursing Facility resident expected. Nursing Facility residents who indicate an interest in returning to the community will be referred to a LCA for follow-up. HFS will regularly monitor Nursing Facility compliance with referral requirements.

Colbert Consent Decree Implementation Plan – November 8, 2012

**5.3. Fact Sheet**

The Defendants will create a Fact Sheet to describe the key processes defined in this Implementation Plan, options available on how a Class Member can self-identify, what to expect in the Evaluation, development of the Service Plan of Care and transition to community residency. The Defendants will use the existing MFP brochure for MFP options.

**5.4. Signage**

Defendants will produce signage with the relevant terms of the Colbert Consent Decree. Defendants will require Nursing Facilities to post the signage.

**5.5. Letters to the Guardians**

Class Members may have court-appointed guardians. Class Members with appointed guardians, while not independently able to choose community residency, shall have the same rights as any other Class Member. Consequently, a letter from the Director of HFS or designee will be sent to the Office of the State Guardian, the Cook County Public Guardian and to appointed guardians to the extent the guardianship information is available, informing them about the Consent Decree and the processes defined in the Implementation Plan to reach Class Members.

In an effort to inform all guardians, beginning in the Fall of 2012, HFS staff will meet with each case worker of the Office of State Guardian and review their wards with the goal of identifying those who are likely to be candidates for transition. The names of the individuals initially identified will be shared with the Managed Care Entities (MCEs) for assessment. Once consent to participate has been given by the guardian, the Care Coordinator from the MCE will work closely with the guardian and the Class Member.

For those Class Members with a guardian, but not one from the Office of the State Guardian, beginning in the Fall of 2012, HFS will request that Nursing Facilities (subject to the Colbert Consent Decree) provide a list of all current Nursing Facility Class Member residents who have guardians and the name, address and contact information for all guardians. Guardians will be sent the above described letter. Once contact has been made, the Care Coordinator will be in contact with these guardians to discuss community re-integration of the Class Member.

**5.6. Video**

By January 31, 2013, HFS will develop a video for use at educational sessions and initial face-to-face pre-assessment meetings concerning transition to community living. The video will make every effort to include testimonials from former nursing home residents who have successfully transitioned to community residency and describe what to expect during the pre-assessment, assessment, care planning and transition phases.

**6. Focused Approach to Class Member Identification Using Integrated Care Coordination**

The Defendants will use MCEs to create integrated delivery systems to enable Class Members to access services in a coordinated and effective manner. Class Members will be identified using two parallel approaches. The first and primary approach is through participation in a MCE. Various methodologies to identify Class Members for transition are defined in this section. The second approach to identify Class Members for transition is self-identification. Once a Class Member is identified, by either strategy, a multi-disciplinary, integrated Care Coordination approach by Qualified Professionals will address all Class Members.

6.1. Focused Methodological Approach to Identification of Class Members

As shown in the Appendix Section 21.2 of this Plan, Defendants will select 1,175 Class Members for evaluation. These Class Members will be current enrollees in the Integrated Care Program (ICP) in suburban Cook County and will be selected from approximately 31 Nursing Facilities. From this selection, it is anticipated that 117 Class Members will be identified for transition to the community. Resource Utilization Groups (RUG), which categorizes Nursing Facility residents based on assessments of their clinical status and daily living needs data, will be used. HFS will select Class Members for transition from a variety of disability groups and ages in an effort to obtain a representative sample. From this group, at least the agreed upon number of Class Members as referenced in Appendix Section 21.2, will be identified to move to Community-Based Settings during the first year of implementation (Year 1). The process of Evaluating Class Members in these facilities and other facilities will be ongoing throughout the time period of the Consent Decree.

Also as shown in the Appendix Section 21.2 of this Plan, Care Coordination services through the contracted ICP vendors will be provided to Class Members who self-refer for transition under the Consent Decree and who are not already enrolled in one of the ICP Plans. Class Members who are also Medicare and Medicaid eligible (dual eligibles) will be able to participate in the Evaluation process. Defendants project that approximately 30 individuals who self-refer will be identified to move to Community-Based Settings in Year 1. The self-referral process will be reviewed near the end of Year 1 to determine whether it should be extended for a longer period of time. Class Members who are seen by one of the ICP vendors and are not enrolled in a managed care plan will be asked to sign an Informed Consent document authorizing the Qualified Professionals from the ICP to access his/her medical records.

By March 1, 2013, HFS will contract with the ICP vendors to serve nearly 2,000 Class Members in up to 30 additional Nursing Facilities in the City of Chicago. Each ICP vendor will be assigned approximately 15 Nursing Facilities. From this selection, it is anticipated that 153 individuals will be identified for transition to the community. This expanded selection of Nursing Facilities will cover Medicare/Medicaid dual eligible Class Members residing in Nursing Facilities in Suburban Cook County and Medicaid (non-dual eligible) Class Members residing in Chicago Nursing Facilities.

These strategies should result in at least 300 Class Members moving to Community-Based Settings during Year 1 as required by the Consent Decree. In Year 2, up to an additional 72 Nursing Facilities across Cook County will be selected. This selection will bring the total targeted number to 133 Nursing Facilities. By this time, Care Coordination will be provided through one of the MCEs to the extent necessary Federal approvals are obtained — the ICP, Care Coordination Entity (CCE), Managed Care Community Network (MCCN), or the Medicare/Medicaid Alignment Initiative. HFS will continue to contract for Care Coordination beyond Year 1 to the extent sufficient MCEs have not obtained Federal approval. At least 500 Class Members will move to Community-Based Settings for a total of 800 by the end Year 2.

As more MCEs become available, Class Members who have already transitioned to Community-Based Settings will be able to choose from among the MCE options in Cook County, including a CCE, MCCN or the Medicare and Medicaid Alignment Initiative for the dual eligible population.

Eighteen months following finalization of this Implementation Plan, a total of at least 2,000 Class Members then residing in a Nursing Facility will have received an Evaluation. By the end of the first half of Year 3, all 186 nursing homes in Cook County will be targeted, and the MCEs will be providing care coordination services. An additional 3,000 Class Members will receive Evaluations and an additional 300 Class Members, for a total of 1,100 Class Members, will have moved to Community-Based Settings.

6.2. Class Members in Managed Care Entities (MCEs)

State law requires at least 50% of Medicaid recipients to be enrolled in some form of Care Coordination by January 1, 2015. Care Coordination for all Seniors and Persons with Disabilities in Cook County, including Colbert Class Members, may be offered through a number of different MCEs. A MCE, may include: (1) either of the two managed care organizations on contract through the ICP currently operating in suburban Cook County and collar counties, (2) a new CCE being developed through the HFS Care Coordinations Innovations Project and covering the City of Chicago, (3) a new or existing Managed Care Community Network (MCCN) covering the City of Chicago, or (4) an entity on contract through the Federal Medicare and Medicaid Alignment Initiative, covering dual eligible Medicare-Medicaid clients in the City of Chicago and Cook County suburbs. MCEs selected for this Initiative will also be available to serve Medicaid only Seniors and Persons with Disabilities in Cook County.

All MCEs who have enrolled Seniors and Persons with Disabilities who will benefit from long-term care services, including Class Members, will be required to coordinate a service package consisting of healthcare services and Long-term Services and Supports (LTSS). All Medicaid clients who are Seniors and Persons with Disabilities who desire long-term care services, including Class Members, will be required to enroll in an MCE for LTSS.

At the present time, HFS anticipates that ICP healthcare services will be expanded to offer a service package of LTSS for its 40,000 members – including Class Members who reside in nursing facilities in the Cook County suburbs. The CCEs and MCCNs currently bidding through the HFS Care Coordination Innovations Project are expected to be under contract during Year 1 of implementation. The Medicare and Medicaid Alignment Initiative is expected to be ready for enrollment in late 2013 based upon approval from CMS. For dually eligible persons who are receiving LTSS services, HFS will require managed care enrollment in a Medicaid LTSS service package but will not require enrollment in a medical service package as Federal policy prohibits mandatory enrollment in Medicare managed care.

All of the Class Members will have a choice of at least two MCEs throughout Cook County on a phased-in basis, as various MCEs become available. As described above, initial contact will begin with currently enrolled ICP Class Members. As managed care options become available for the remaining Class Members, the Illinois Client Enrollment Broker (see Section 8) will begin the process of enrollment by explaining the choice of two or more MCEs and will make a referral to the appropriate MCE selected.

6.3. Analysis of Pathways to Community Living/Money Follows the Person Initiative

At the time of drafting this Implementation Plan, over 600 MFP participants have transitioned from Nursing Facilities to community living. At the end of 2011, 80% of the participants were still living in the community. HFS will examine the transition characteristics of these individuals to determine if a specific Illinois profile can be developed to help identify potential Class Members for successful transition and use the information learned to develop a focused selection and approach for those enrolled in a MCE.

6.4. MDS and RUG Groupings

The use of MDS 3.0 and Resource Utilization Groups (RUG) data clusters is one strategy to help identify Class Members in a systematic way. Group profiles from this analysis will be used to identify similar profiles among individuals currently residing in Cook County Nursing Facilities. Initial lower RUG score groupings will be used because this classification system uses information from the MDS assessment to classify Nursing Facility residents into a group that represents relative care resource requirements. Based on what the Defendants have learned from the MFP Initiative, Nursing Facility residents who have lower RUG scores are nonetheless likely to present with complex health histories and comorbidities.



6.5. Process and Goals to Achieve Benchmarks

Appendix Section 21.1 contains a chart that shows the breakdown of the current Class Members by age, presence or lack of a diagnosis of Serious Mental Illness (SMI), and the number of Class Members that are dual eligibles. The data is based on the MDS. Defendants are aware that a mix of Class Member characteristics is critical for Cost Neutral Plan data analysis. This mix will be accomplished through a review of Class Members by State of Illinois staff as Class Members are evaluated, and as they are encouraged to self-identify. A systematic tracking of their characteristics will be completed to ensure the transitions reflect the necessary complexity and diversity of population.

**7. Colbert Consent Decree in Relationship to Pathways to Community Living/Money Follows the Person (MFP)**

All Class Members who are eligible for MFP will be counted as MFP participants, but not all Class Members will be MFP eligible. To be eligible for MFP, a person must be a Nursing Facility resident for a period of 90 days or more, none of those days can be for the sole purpose of short-term rehabilitation, none of those days can be paid by other government sources such as Medicare, the participant must be a Medicaid recipient for at least one day prior to transition to community residency, and the participant must consent to the program. In addition, a participant of MFP must choose one of the following community settings: (1) a home owned or leased by the individual or a family member of the individual; (2) an apartment with an individual lease, secure access and living, sleeping, bathing and cooking areas over which the individual or his/her family has control; or (3) a community-based residential setting with no more than four unrelated individuals. In Illinois, a Supportive Living Facility (SLF) qualifies under #2 above. If a Class Member chooses a setting other than the three defined MFP options, he/she cannot be counted as an MFP transition.

The Consent Decree offers benefits to Class Members that are not part of the current MFP program. For example, a Class Member who has lived in a Nursing Facility for six months or more may be eligible for housing assistance under the Decree. Under MFP, a housing bridge subsidy is provided only to qualifying participants being transitioned by the Illinois Division of Mental Health, and MFP requires only a 90 day nursing home stay to qualify for this benefit.

The quality oversight and requirements defined in the MFP Operational Protocol will be beneficial to all Class Members regardless of whether they are eligible for MFP. The MFP Risk Inventory, Risk Mitigation Plan and 24-hour Back-up Plan provide tools to better ensure a successful transition. They consider how the needs of the Class Member will be safely met through pre and post transition planning by addressing and asking the participant and Care Coordinator to identify the Class Member's health, activities of daily living and social requirements. The 24-Hour Back-up Plan will help a Class Member identify alternative community resources in the event the primary supports break down or an unforeseen health crisis emerges.

All transitions under MFP enable the State of Illinois to receive an enhanced Federal match on the services provided to individuals for a one year period post transition. These additional dollars, under the MFP initiative, will be placed in a rebalancing fund that will be used for an expansion of home and Community-Based Services. Expansion of services will ultimately benefit all residents of Nursing Facilities including Class Members, transitioning to Community-Based Settings.

MFP transitions will be included in the benchmark number of transitions under the Decree where the MFP transition conforms with the benchmark requirements of the Consent Decree: the MFP qualified setting to which the Class Member is transitioned is a Community-Based Setting; the Class Member receives an Evaluation from a Qualified Professional; and the Class Member has a Service Plan. The Defendants

Colbert Consent Decree Implementation Plan – November 8, 2012

also intend to count Class Members who are enrolled in MFP in the projected benchmark numbers of transitions under the MFP program.

**8. Illinois Client Enrollment Broker (ICEB)**

As MCOs become available, each Class Member who is not yet enrolled in an MCE will be contacted by an Illinois Client Enrollment Broker (ICEB). The ICEB will be under contract with HFS to discuss options available to the Class Member to ensure he/she has an opportunity to make an informed choice regarding the managed care entity options. By enrolling in a MCE, the Class Member gives the MCE access to his/her medical records. Whatever option is chosen, the Class Member will be linked with a Primary Care Physician (PCP) and other allied health and mental health providers, as well as home and Community-Based Services in their network. Networks are to include current Medicaid Waiver programs, State Plan services and other governmental and non-governmental program resources.

**9. Evaluation of Class Members Not Yet Eligible for MCE Enrollment**

The timetable for Nursing Facility selection and Class Member identification represents a phasing-in of MCEs. In order that all Class Members have the opportunity for an evaluation prior to his/her enrollment in a MCE, HFS will contract with the ICP vendors to provide care coordination using an integrated approach. This strategy is to be in-place as noted in the chart in the Appendix Section 21.2.

**10. Evaluation Using an Integrated Managed Care Approach**

Every Class Member is a potential candidate for community transition. The Qualified Professionals charged with Evaluation will use a person-centered approach in all stages of Care Coordination, including the development of the Service Plan of Care. A Service Plan of Care must reflect the concept that a person should not be isolated in an institution or in the community. Some Class Members may suffer from a dementia where community residency may place them or others at risk of harm. Persons with a Severe Mental Illness may lack the capacity to perform tasks associated with community living such as shopping, cooking and medication management. While it would appear that these skills could be learned, Class Members must have the capacity and motivation to learn even under a framework of a person-centered approach. Evaluators will work with these Class Members to identify all possible resources in an effort to transition to less restrictive environments. Class Members will have planned reEvaluations except otherwise described in the Consent Decree.

**10.1. Definition of the Qualified Professionals in the Multi-Disciplinary Team**

All MCEs will retain a Care Coordination and management system consisting of a multi-disciplinary team which will constitute the Qualified Professionals described in the Consent Decree. The Qualified Professionals will ensure that Class Members' needs are addressed in a holistic fashion. The multi-disciplinary team will consist of Qualified Professionals holding the credentials required by each of their respective professions and disciplines. These members of the multi-disciplinary team are the Qualified Professionals. The team consists of:

- A health care professional, who will be an Advanced Practice Nurse, a Registered Nurse, or a Licensed Practical Nurse with a minimum of two years prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities, who will focus on physical health issues;
- A behavioral health specialist, who will be a Master level Clinical Social Worker with a minimum of two years prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities, who will focus on the mental health and social issues; and

Colbert Consent Decree Implementation Plan – November 8, 2012

- A Care Coordinator, who will be a Bachelor level professional with a degree in a health or human service area, or a Masters degree in Social Work, and a minimum of two years of prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities.

These credentials are intended to ensure that the Qualified Professionals will possess the requisite skills in conducting Evaluations as described in the Consent Decree, assessments and interviews. Additional training, as set forth in Section 16 of the Implementation Plan, will be required to ensure team members are aware of community resources and benefits available to Class Members.

10.2. Quality Components – Evaluation, Risk Assessment and Mitigation

As part of the Evaluation, all possibilities and conditions, as well as the individual's strengths will be explored and addressed. Assessment instruments are only tools to further define and clarify. The Class Member's physical and mental health, including cognitive abilities, will ultimately determine who can transition. Transition decisions will depend on changes to the individual's physical and mental health. Where physical and/or mental health status may appear to place the individual at too much of a risk at the time of initial Evaluation (except where a medical doctor has diagnosed a medical condition that is unlikely to improve), a reEvaluation will take place to determine if improvement has occurred that would allow the individual to transition.

**11. Successful Transition**

The goal of this Implementation Plan is to provide Class Members with the resources they need in order to succeed in the community after they transition. A transition will not be viewed as successful if the Class Member is readmitted to a Nursing Facility or some other institutional setting in a short period of time. Class Members are likely to have complex needs and may have health conditions that are complicated. Class Members transitioned to Community-Based Settings are to maintain a relationship with their managed care professionals. Strong Care Coordination, at all phases of the process, is critical.

11.1. Responsible Entity for Conducting the Evaluation and Development of the Service Plan of Care of Class Members

In an effort to reduce redundancy and eliminate role confusion, all aspects of the process, from initial contact and engagement, Evaluation, development of Service Plan of Care and implementation of the Service Plan of Care will be the responsibility of the Qualified Professionals. These Qualified Professionals will be well-trained in available community resources and possess a multi-disciplinary skill set. The lead Qualified Professional assigned to and developing the long-term relationship with the Class Member, representing the MCE, will be called the Care Coordinator.

As required by Medicaid policies and procedures, an eligibility determination for a Medicaid waiver or State Plan mental health service may be involved. These frequently require the involvement of an organization such as a Care Coordination Unit (CCU) visiting a Class Member or conducting a review to determine eligibility. Even when these organizations are used, the Care Coordinator will be responsible for interfacing with providers and coordinating care and assistance for Class Members.

11.2. Initial Contact and Engagement

In addition to the ability to work effectively with Class Members, family members, significant others, friends, guardians and nursing home staff (including nurses, doctors, discharge planners and advocates), the Care Coordinators must be good listeners. Class Members will be encouraged to share life goals with

Colbert Consent Decree Implementation Plan – November 8, 2012

Care Coordinators as one of the means to begin to identify interest in community transition and begin the informal process of assessing the strengths and risks of the Class Member.

11.3. Multi-Disciplinary Teams of Qualified Professionals

The MCEs will initially conduct outreach and Evaluation by the Qualified Professionals. These teams will visit Nursing Facility residents, initiate engagement of the Class Members, and make contact with each Class Member regardless of age or status of disability.

11.4. Review of Nursing Home Medical Records

At the initial Nursing Facility visit and prior to a face-to-face conversation with a Class Member, the Care Coordinator and team will review the Nursing Facility medical records and begin to evaluate the Class Member's strengths and needs relative to planning for community transition. This review will determine whether a face-to-face meeting with the Class Member should take place. An example of a reason not to conduct a face-to-face preassessment is advanced dementia or current care for the end-stage of an illness.

If a Class Member's medical record indicates a significant mental illness, his/her last Resident Review and scores on the LOCUS (Level of Care Utilization System) will be reviewed. If a Resident Review has not occurred recently, either a member of the Qualified Professional team or another professional that is skilled at administering the LOCUS will administer the tool. A time frame will be established to review Class Members who are determined to meet the criteria identified for a follow-up assessment.

11.5. Face-to-Face Contact in the Initial Evaluation by a Care Coordinator

Class Members who have resided in an institutional setting for an extended period of time may not have considered returning to community residency. The Care Coordinator will meet the Class Member to engage him/her in a conversation to consider transition to the community.

The meetings will have several objectives:

- To learn where the Class Member hopes to be in the short-term and long-term;
- To learn why the Class Member is a nursing home resident;
- To understand what strengths and needs the Class Member may possess; and
- To begin a conversation regarding transition to community residency.

Class Members may need to talk with significant others or guardians in the community regarding transition to community residency. In addition, the conversation may lead the Care Coordinator to determine that transition to the community residency is premature, for example, due to preparation for a future surgery. In this instance, the Care Coordinator would document this outcome and plan for a future follow-up visit.

**12. Evaluation/Assessment, Services and Service Plan of Care**

Assessment and Evaluation involves speaking with the Class Member and those who he/she identifies as persons who should be involved in transition planning and in the development of a Service Plan of Care. The process not only involves the administration of assessment instruments, but also requires obtaining clarifications on current treatment protocols. While Nursing Facility medical records and discussions with Nursing Facility personnel can be valuable to create a comprehensive picture of the Class Member, further medical evaluations and consultations may be necessary.

Colbert Consent Decree Implementation Plan – November 8, 2012

As a result of an Evaluation and Assessment, the Qualified Professionals and Class Member will develop a Service Plan of Care to help meet the Class Member's identified needs. The Evaluation and assessment will provide a picture of what a person needs to be successful in the community. Needs will not be defined as a particular service; rather services will be identified that meet the Class Member's needs. The Qualified Professionals will evaluate all areas necessary to transition a Class Member successfully, including physical and behavioral health, nutrition, ability to perform activities of daily living and instrumental activities of daily living, social, recreational and spiritual, finances, informal supports, environment and housing requirements. The services necessary to meet the Class Member's needs will be contained in the Service Plan of Care and, subject to Section 12.5, will be those resources existing in the State's current service taxonomy for which the Class Member is eligible and which will meet the Class Member's needs.

#### 12.1. Evaluation, Assessment and Assessment Tools

No single tool has been identified to assess or Evaluate a Class Member. A statewide effort is currently underway by the Defendants to identify such a resource that would assess cross-disability. Current tools may include the Illinois Determination of Need (DON), the Comprehensive Assessment Instrument used by IDoA, the MDS Home Care, the LOCUS and tools that the MCEs may select. Additional tools will include those designed to assess mental health and substance abuse. No one tool gives the Qualified Professionals a definitive picture of the Class Member. Putting the assessments together from an array of instruments, one-on-one conversations with the Class Member and his/her support system, and consultations with other professionals should provide enough information to give the Class Member the ability to make decisions for a successful Service Plan of Care.

#### 12.2. Access to Medicaid Home and Community-Based Service Options

HFS is exploring options with the Federal CMS to enhance the benefits under the Pathways to Community Living/MFP initiative. The enhanced benefits may include demonstration services for a population for the first year post transition to community residency for those that qualify for MFP. Subject to Federal CMS approval a Class Member will be eligible for participation in an enhanced MFP program and make use of its benefits.

If a Class Member does not consent to participation in MFP, eligibility for other HCBS programs will be determined. The Qualified Professionals will use current standards to determine eligibility for HCBS waiver services. While the linkage with the actual providers of services is the responsibility of the Qualified Professionals, the eligibility determination for the HCBS waiver services is conducted according to the policies, procedures and rules of State agencies and as applicable by the Federal CMS.

The majority of Class Members may qualify and benefit from the array of HCBS options based upon his/her need. For example, persons who have physical disabilities between the ages of 18 to 59 may qualify for the Persons with Disabilities Waiver and/or State Plan services. Persons over the age of 60 may qualify for the Community Care Program under the Illinois Department on Aging and State Plan services. Persons 22 years of age and over may qualify for the Supportive Living Facility Waiver. Persons with SMI may qualify for various State plan services. There are a number of other waiver options depending upon meeting established criteria such as diagnosis of a brain injury or HIV/AIDS. Subject to Federal approval, Class Members may also have an enhanced MFP set of services.

To be eligible for waiver services, no new eligibility determination will be conducted for Class Members unless the last eligibility determination is more than one year old. A Service Plan of Care that utilizes the current eligibility determination will be used to establish waiver services. If the Class Member has not

Colbert Consent Decree Implementation Plan – November 8, 2012

received an eligibility determination for Nursing Facility or Community-Based Waiver Services in more than one year, the authorized entities will be called in to conduct the assessment of eligibility.

The current tool used in Illinois to access waiver services for persons with physical disabilities beginning at age 18 is the DON. The DON “score is derived from the Mini-Mental State Examination (MMSE), six activities of daily living (ADLs), nine instrumental activities of daily living (IADLs) including the ability to perform routine health and special health tasks and the ability to recognize and respond to danger when left alone. Each ADL, IADL and special factor is rated by level of impairment (0-3) and unmet need (0-3). Scores for each area are totaled and weighted toward people with moderate or severe dementia. The process is designed to target services to people with high levels of impairment who may have informal supports, and to people with lower levels of impairment without informal supports.” (Mollica and Reinhard (2005), p. 2-3.)

The entities responsible for eligibility determination for the waiver services will determine eligibility in a timely manner. The Care Coordinator working with the Class Member will also ensure that a timely eligibility determination is made.

#### 12.3. Access to Rule 132 – Medicaid Community Mental Health Services Program

The Care Coordinator will collaborate with the community mental health provider to determine eligibility for the Rule 132 – Medicaid Community Mental Health Services Program. The Division of Mental Health uses the LOCUS tool. The LOCUS determines the level of care needs across six domains. The Care Coordinator will identify and collaborate with mental health service providers in their networks to determine and further establish a comprehensive Service Plan. The strength of the cross-discipline integrated approach is the ability of the professionals to coordinate the Service Plan of Care and develop an integrated Service Plan of Care.

#### 12.4. Social History and Service Plan of Care

All conversations with Class Members are opportunities to learn something relevant to the development of the Service Plan of Care. In addition to the various assessment tools that are used, a social history will be created as a cohesive narrative for each Class Member. A social history to explore the Class Member’s past and future goals and aspirations will be useful for linkages to home and community-based resources, including mental health services, necessary for success in the community.

The last section of the Social History will be the Service Plan of Care. This section will present what services are to be arranged for and on behalf of the Class Member. This Service Plan of Care is expected to address those needs that were identified in the Evaluation and Assessment.

#### 12.5 Data Gathering of Waiver Services Necessary for a Successful Transition to Community-Based Settings

Counsel for Class Plaintiffs and Counsel for Defendants have a disagreement over whether “Community-Based Services,” as defined in the Consent Decree, include any and all services under any Illinois Medicaid Waiver<sup>1</sup> or only those services available under the particular Illinois Medicaid Waiver (Waiver) for which the individual Class Member is currently eligible. Although the Parties are agreeing to collect

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<sup>1</sup> For purposes of the data gathering set forth in this section only, “any Illinois Medicaid Waiver” does not include the following waivers: Children and Young Adults with Developmental Disabilities-Support Waiver; Children and Young Adults with Developmental Disabilities-Residential Waiver; Waiver for Children that are Technology Dependent/Medically Fragile; or the Waiver for Adults with Developmental Disabilities.

Colbert Consent Decree Implementation Plan – November 8, 2012

and analyze certain data, as described herein, the Parties also disagree regarding the focus of the data analysis – *i.e.*, whether the focus of the data analysis is limited to the extent to which Class Members' ineligibility for services beyond the particular Waiver for which they are eligible is a barrier to successful transition to a Community-Based Setting or otherwise. Counsel for the Parties have agreed to defer Court resolution of this disagreement over the definition of "Community-Based Services," pending the completion of the data gathering and the Parties' analysis of the data described in this section.

Data will be gathered during the year following the first Evaluation on Class Members who fall into two categories: (A) Class Members who would need, in the opinion of the Qualified Professionals, one or more Waiver services not available under the particular Waiver for which the Class Member is currently eligible in order to transition successfully to a Community-Based Setting; and (B) Class Members who are eligible for a particular Waiver but who, in order to transition successfully, would need one of the eligible services in a quantity greater than the Waiver permits or a service that is not included within a service definition. The services described for categories (A) and (B) are collectively referred to as "Transition Necessary Services."<sup>2</sup> Transition Necessary Services are services vital to the Class Member's health or safety post-transition and, if they are unavailable, prevent the Class Member from transitioning to a Community-Based Setting.

As part of the Evaluation of those Class Members in categories (A) and (B), the Qualified Professionals will gather data and complete a survey as set forth below:

1. Evaluate, determine and document a Class Member's needs to transition without regard to the Class Member's eligibility for any Waiver.
2. Determine either (a) those needs can be met by the services available under an applicable Waiver for which the Class Member is eligible and that the Class Member is able to transition successfully; or (b) those needs cannot be met because the Class Member falls in either category (A) or (B) above, and Transition Necessary Services are unavailable, and thus the Class Member cannot transition to a Community-Based Setting.
3. If the Class Member is determined able to transition to a Community-Based Setting, the Qualified Professionals will develop one Service Plan of Care with those services available to the Class Member under an applicable Waiver for which the Class Member is eligible. The Qualified Professionals will not be required to develop any alternative Service Plan of Care for any transitioning Class Member. If the Class Member is determined unable to transition to a Community-Based Setting, the Qualified Professional will complete a survey (See Appendix 21.4) that includes a checklist of Transition Necessary Services.
4. The data gathered will not include data regarding:
  - Any Class Member or Guardian who has declined to take part in the Evaluation.

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<sup>2</sup> For illustrative purposes, an example for category (A) would be a Class Member who is eligible for the Aging Waiver but would need the personal assistant service provided under the Disability Waiver in order to transition successfully. An example for category (B) would be a Class Member who is eligible for the Disability Waiver but would need more hours per day of the personal assistant service that are permitted under the Disability Waiver program as implemented by Defendants' rules and policies and as approved by the federal government in order to transition successfully. A second example for category (B) would be a Class Member who is eligible for the Aging Waiver and the adult day service under the Aging Waiver but would need a service component (*e.g.*, personal assistant service) that is not included in the definition of adult day service.

Colbert Consent Decree Implementation Plan – November 8, 2012

- Any Class Member identified in Section 10.2 of this Implementation Plan as one whose physical or mental health status places him/her at too much risk to transition even if all Waiver services were available at the time of the Evaluation.
5. The data gathered will include data regarding any Class Member who participated in an Evaluation and was offered a Community-Based Setting, but declined to transition. For such Class Members, the Qualified Professionals shall complete the survey indicating the reasons stated by the Class Member and/or Guardian for declining to transition.

The data will be made available to the Defendants, the Court Monitor and Counsel for the Class Plaintiffs no later than 90 days following the first Evaluation and quarterly thereafter. The collection of data will cease 12 months following the first Evaluation, unless the Parties and the Court Monitor agree that the collection of data will continue for an additional period of time. Counsel for the Class Plaintiffs and Defendants and the Court Monitor may each conduct their own analysis of the data. Each party shall be responsible for the costs of their analyses, which costs shall not be included for purposes of the development of a Cost Neutral Plan. The Court Monitor, Counsel for the Class Plaintiffs and Counsel for Defendants shall discuss what actions, if any, should be taken on this disagreement. Unless the Parties agree otherwise, no sooner than 120 days after the completion of data collection, the Parties may take whatever actions they deem appropriate on the disagreement set forth in this section and in the Consent Decree.

#### 12.6. Pathways to Community Living/MFP Requirements

The goal is to utilize the resources, policies and procedures identified in the MFP Operational Protocol for Class Members under the Consent Decree. Care Coordinators working on behalf of Class Members who meet Pathways to Community Living/MFP requirements are required to fulfill the requirements of MFP. These requirements include the completion of a Risk Inventory, a Risk Mitigation Plan, a 24-Hour Back-up Plan and the Quality of Life Survey.

##### 12.6.1. Risk Inventory and Mitigation Plan

MFP has developed an Inventory of Risk document. The Inventory of Risks and the Risk Mitigation Plan further define elements for successful transition and are additional tools in the development of a holistic evaluation of the Class Member. The Inventory of Risk document re-frames needs identified in the Evaluation into identified risks. The Risk Mitigation Plan subsequently identifies specific strategies, tasks and services that should reduce each risk. For example, a Class Member that has difficulty preparing meals or may have a history of non-compliance to a prescribed diet could have a notable nutritional risk. Risks will emerge from the review of all face-to-face meetings and assessment tools. The risks will be documented in the MFP Risk Inventory and will be linked with mitigation strategies through the computer software program. These strategies define actions that the Care Coordinator, working in conjunction with the Class Member, should address in a Service Plan of Care.

##### 12.6.2. 24-Hour Back-Up Planning

MFP requires the completion of a 24-hour Back-up Plan. The development of this 24-Hour Back-up Plan, prepared in conjunction with the Care Coordinator, Class Member, his/her identified significant others and guardian, if applicable, is expected to be a valuable resource once the Class Member resides in the community. This document is one of the critical pieces and tools in sustaining a successful transition. The best intended plans often experience unanticipated challenges. Persons who agreed to provide assistance to Class Members may fail to live up to expectations. In addition, the Class Members may have physical and/or mental health issues that require emergency or alternative assistance. A 24-hour



Colbert Consent Decree Implementation Plan – November 8, 2012

Back-up Plan is not synonymous with calling 911. While reaching out to emergency services may be required, alternative resources should be put into action if plans fail to meet expectations.

#### 12.6.3. Quality of Life Survey

The Pathways to Community Living/MFP requires the administration of the MFP Quality of Life Survey to measure the individual who is transitioning and his/her perceptions relating to quality of life in seven domains. These domains are living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction and health status. The survey is to be administered to all participants at three points in time, just prior to transition, about 11 months after transition and about 24 months after transition.

#### 12.7. Care Coordination and Service Plan Conferences

Care Coordinators and service providers within their networks are to work collaboratively to ensure that all of the Class Members' needs are addressed. A minimum of one care conference will take place prior to transition to community residency. The care conference will include the Class Member and any significant others he/she chooses, the Care Coordinator, the guardian, if applicable, and other professionals affiliated with the MCE, home and community-based service providers and mental health providers. HFS staff will participate from time-to-time in these care transition conferences to ensure all processes and identifiable needs are being adequately addressed. The other participants in this care conference may include Nursing Facility staff knowledgeable about the care and care giving that is presently being provided in the Nursing Facility on behalf of the Class Member.

#### 12.8. Quality Assurance Resources Available through Pathways to Community Living/Money Follows the Person

The Pathways to Community Living/MFP Initiative has as part of its Operational Protocol a quality assurance team led by a nurse who reviews the service plan of care. This quality assurance activity takes place via a conference call and is an additional assurance that all medical needs are sufficiently addressed. This conference, prior to discharge, will further ensure quality to the plan development by the MCE and fulfill the expectations set-forth in the MFP Operational Protocols.

### **13. Class Member Finances**

A comprehensive assessment of each Class Member will include understanding his/her finances. A Class Member may require income to transition successfully into a Community-Based Setting, such as a private residence or permanent supportive housing. Depending upon the unit in which the Class Member seeks to live, he/she may need to meet income eligibility requirements for any Federal or State housing assistance program.

Class Members may receive income from many sources and will be required to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, including, but not limited to, Veterans' compensation and pensions, benefits from the Old Age, Survivors, and Disability Insurance program (OASDI) of the Social Security Administration (which includes common Social Security retirement benefits, survivor benefits, and Social Security Disability Insurance (SSDI) benefits), railroad retirement benefits, unemployment compensation, and/or income from Supplemental Security Income benefits (SSI). The Care Coordinator will link the Class Member to resources and/or legal advocates for the applicable population to assist with the applications for any sources of income and for any appeals of eligibility denials for such income. Each Class Member's financial picture should be

reviewed as early as possible in order to avoid delays in transitioning to the community due to a lack of necessary income.

#### **14. Housing**

The Consent Decree states that Class Members should transition to Community-Based Settings that promote “independence in daily living and ability to interact with persons without disabilities to the fullest extent possible.” These settings include “a private residence, a Supportive Living Facility, Permanent Supportive Housing, or other appropriate supported or supervised residential settings that are specifically chosen by the Class Member.” Class Member preferences, availability and type of setting will be factors for the Class Member to consider when making his/her choice.

##### **14.6. Identification of Housing**

###### **14.6.1. State Housing Coordinators**

The Governor’s Office currently employs two Housing Coordinators to identify means of enhancing housing opportunities for special needs populations including Class Members. One Housing Coordinator is focused on housing opportunities in Cook County and the other Housing Coordinator has State-wide Housing responsibilities. The Housing Coordinators are to expand networking opportunities, partnerships and relationships thereby facilitating the expansion of housing resources including PSH, access for Pathways to Community Living/MFP, housing opportunities for Class Members of the Consent Decrees and management of the referral flow to IHDA’s Low Income Housing Tax Credit Units. A portion of IHDA’s Low Income Housing Tax Credit units are targeted to persons with disabilities and referred through a State referral network that includes, but is not limited to, Class Members of the Consent Decrees.

###### **14.6.2. Care Coordinator Responsibilities for the Identification of Housing**

The Care Coordinator will work in conjunction with the Housing Coordinators and the Class Members to identify housing. The Care Coordinator will work with each Class Member to determine the best options. The Housing Coordinators will help in identifying the properties that meet these options.

Care Coordinators will work with each Class Member to explore all options including family, guardians, friends, significant others, newspaper advertisements and options identified through an on-line State funded housing search inventory. The Illinois Housing Search web based search engine is an available resource that contains thousands of units landlords have available to rent in the private market place. This website contains a caseworker portal that allows Care Coordinators to search a subset of housing options wherein landlords have expressed a specific willingness to rent apartments to persons with disabilities. Class Members, as part of their goal to be independent and invested in the transition, need to be active participants in the housing search.

###### **14.6.3. State-funded Internet On-Line Housing Locator**

The primary on-line State funded housing search inventory is the Illinois Housing Locator, [www.ILHousingSearch.org](http://www.ILHousingSearch.org). Class Members and Care Coordinators can access this site which lists housing by location, features, vacancy, and other criteria. Care Coordinators will have secure access to a web portal that enables them to search for housing options that may be targeted to populations represented by the various Consent Decrees and the Pathways to Community Living/Money Follows the Person initiative. This option further advances the ability to access additional and more detailed housing information relevant to the populations whom they service. Once a unit or housing option is located, the

Colbert Consent Decree Implementation Plan – November 8, 2012

Care Coordinators will assist in making arrangements for the Class Member to visit the property. A factor in the decision to choose the property may relate to assuring accessibility.

14.7. Assessment and Guidelines for Home Modification

Housing units that appear to require home modification to meet the needs of the Class Member will be referred to an assistive technology program and/or any other available programs. The Assistive Technology program will be under contract with one or more of the Defendants and will work with the MCEs to provide:

- An onsite assessment and production of a field sketch, specifications and scaled drawings of what needs to be done;
- Bid Solicitation, review contractor's proposal and review with Care Coordinator; and
- Project Management of selected contractor and authorize payment to contractor

The goal of the modification is for the Class Member to perform independently his/her ADLs, have a decreased need for assistance from another individual in the completion of his/her ADLs, prevent an anticipated increase in service costs, or improve the safety of the Class Member during the completion of his/her ADLs.

The modifications are limited as follows:

- Will be granted if there are no other public resources that will provide the modification;
- Will be reviewed after determination of private resources (the availability of private resources is not a barrier to eligibility for housing modification); and
- Home accessibility adaptation costs, including but not limited to the cost for home evaluation, purchase of all modifications and assistive equipment purchases, rentals and repairs does not exceed \$5,000 in accordance with the terms of the Consent Decree.

14.8. Housing Assistance

The Consent Decree states that following a review of the finances of a Class Member, financial assistance for housing may be required. The Consent Decree also establishes specific limitations to access financial assistance. The specific criteria can be found on pages 7-9 of the Consent Decree. The housing assistance is calculated by the difference of the actual or Fair Market Rent less any government funded housing subsidy and 30% of the Class Member's income. Class Members are to seek alternative arrangements or financing that may include accessing Section 8 HUD Vouchers or other public or privately supported housing programs.

At the point of transition and the development of the Service Plan of Care, the Care Coordinator will arrange for a home inspection by an identified home inspection agent. This agent has responsibilities separate from those previously described as relating to accessibility and home modification. All identified properties where the future Class Member tenant requires financial assistance to help pay rent must be inspected in order that it meet the United States Housing and Urban Development (HUD) approved Housing Quality Standards. Based upon the inspection, properties may require corrective actions for needed repairs. These repairs will be subject to the establishment of a timeline for the completion. The correction of deficiencies will require re-inspection before a property can be occupied and its future tenant is eligible for the State-funded housing subsidy.

Colbert Consent Decree Implementation Plan – November 8, 2012

The Care Coordinator will work in collaboration with the Fiscal Agent, (described in Section 14.6) and has the responsibility for the monthly disbursement of housing subsidy funds. The establishment of the exact subsidy amount is formula-based.

#### 14.9. Identification of Long-term Rental Subsidy Supports

The various rental subsidy support programs are listed in Section 21.3 of this Implementation Plan. The State has made and will continue to make efforts to increase access to and availability of rental assistance to Class Members.

##### 14.9.1. Collaboration with Local Public Housing Authorities

The Housing Coordinators and IHDA are working with local Public Housing Authorities to increase the availability of access by Class Members to their rental assistance programs and units. This collaboration is developing methodologies within the context of existing HUD policy guidance for both tenant-based assistance and project-based units. Examples include enhancing the availability of Housing Choice Vouchers for the elderly and persons with disabilities, as well as obtaining access for Class Members to vacant public housing units that exist within certain public housing authorities in the State.

#### 14.10. Guidelines for Costs Associated with Moving and the Establishment of Household

Financial resources are available to provide a Class Member with the necessary items and services to transition to community residency. One-time transition costs fall under five broad categories as defined on page 12 of the Consent Decree. On page 13 of the Consent Decree, there are defined costs that may not be counted as expenses associated with moving and the establishment of a household. The Care Coordinator will coordinate the needs of a transitioning Class Member and make the necessary arrangements to secure these items. These transition costs may not exceed \$4,000.

#### 14.11. Fiscal Agent

The Fiscal Agent, under contract with one or more of the Defendants, will be a single independent entity responsible for working with all of the MCEs. These authorized funds may include a housing rental subsidy, rent for any temporary stay in a hospital or long-term care facility, and approved costs associated with the establishment of a household as defined in the Consent Decree and not to exceed \$4,000 for the lifetime of the Class Member.

Housing units that are selected and meet the needs of the Class Member will be referred to the Fiscal Agent to handle all aspects of the Housing Assistance Benefits that are identified under the Service Plan of Care. The specific services of the Fiscal Agent include:

- Coordinate with HFS and the MCEs regarding the Assistive Technology Assessments and Home Modifications to secure landlord resources;
- Conduct site visits to ensure HUD Quality Standards inspection are met in every case and document inspections annually thereafter;
- Process housing assistance;
- Coordinate with the Care Coordinator regarding the enrollment process for permanent rental subsidies with HUD or the Illinois Housing Development Authority for Class Members in the Housing Assistance program;

Colbert Consent Decree Implementation Plan – November 8, 2012

- Inform and work with the Qualified Professionals of Class Members receiving Housing Assistance on housing stabilization skills;
- Assist, as needed, with terminations of Class Member lease agreements in the event of failure on the part of the landlord to comply with provisions in the Class Member's individual lease agreements and/or a decision on the Class Member to move to another residence in the community because of acceptance into another rental subsidy option or in the event of reinstitutionalization in a long-term care facility; and
- Manage a system of payment of expenses regarding moving and setting-up the household.

## **15. Relationship of Colbert Implementation Plan with Various State Agencies**

Many of the programs and services that Class Members will receive once transitioned to community residency are part of the various Medicaid waivers and State Plan services. As Illinois moves and advances the inclusion of these programs and services to a managed care environment, the Defendants are engaged in an on-going process of redefining the relationships of the service providers to current and future MCEs. Many of these same service providers may be members of the networks organized by the MCEs, having the same, modified or new roles. Class Members will be part of this transformation to care coordination and managed care. Through established monthly meetings addressing long-term care reform and other on-going discussions among the Defendants, processes are in place for ongoing collaboration in relationship to the Implementation Plan.

## **16. Training and Supervision of Qualified Professionals**

MCEs contracted by HFS for the Consent Decree will be required to have procedures in place for retaining, training and supervising their respective staffs. Evidence of such protocols will be required under the terms of their contracts. HFS has required and will continue to require all of the MCEs to have quality assurance procedures in place to show that they are able to demonstrate adherence to various Federal rules and laws related to managed care.

With recognition of a changing environment for service provision, delivery and a new model of care coordination bringing medical and non-medical resources together using an integrated care approach, education will be beneficial. MCEs will be required to provide a plan for on-going training of its staff and encourage their staff to attend State and local conferences and workshops. Also, Defendants will periodically provide training specific to the MCEs to insure a well-informed staff working with each Class Member.

### **16.6. Training Components**

The MCEs will provide a training program. This training will be provided by academics, practitioners and professional staff from the MCEs and HFS and its sister Defendant agencies. Members of the Qualified Professionals, because of previous clinical training, experience and acquired degrees and certifications, may not need to participate in certain topics of the training. Qualified Professional members may provide some of the training. In addition, all MCEs will be required to submit a training schedule annually beginning with the implementation of this Plan and at the beginning of Year 2 and Year 3 of the Implementation Plan. At a minimum, the training for all members of the multi-disciplinary integrative teams will include all topics that are identified in the list below.

Colbert Consent Decree Implementation Plan – November 8, 2012

Training will include:

- Background to the Consent Decree;
- The Holistic Approach to care coordination using a Multi-Disciplinary Integrative Approach;
- Building Positive Relations with Nursing Facilities;
- Engagement of a Class Member Regarding the Consideration of Community Transition;
- Multicultural Competence;
- Philosophical Approaches to Meeting the Needs of Various Populations with Disabilities;
- Social Work Methods of Person Centered Practice, Strengths Perspective, Person in Environment;
- Health and Disease Management;
- Physical and Behavioral Health Management and Treatment Options;
- Motivational Interviewing;
- Substance Abuse Management and Treatment Options;
- Nutrition;
- Caregiver Supports;
- Safety in Relationship to One's Environment;
- Evaluation and Assessment Processes;
- Assessment Tools, Expectations of Evaluation and Assessment and the Development of the Service Plan of Care and Budget Plan;
- Training on all MFP forms:
- Financial Assistance and Insurance Programs – OASDI, SSDI, SSI:
- Medical Assistance Benefits:
- Long-term Services and Supports (LTSS); Waiver options;
- Rule 132 Mental Health;
- Older Americans Act Programs;
- Legal Issues that include POAs and Guardianships;
- Informal Supports;
- Housing Resources; and
- Professional Ethics.

#### 16.7. Contractual Expectations of MCEs in Regards to Retention and Training

All MCEs are required to meet expectations set forth in contracts between the individual MCE and HFS. These contracts require that MCEs, at the request of HFS, secure documentation of compliance that Qualified Professional members meet or exceed the definitions of a Qualified Professional as stated in Section 10 of this Implementation Plan.

### **17. Quality Assurance Activities and Actions to Comply with Obligations Under the Decree**

Quality Assurance activities are designed to ensure that services, supports, processes and successful maintenance in all phases of implementation and stages of care coordination beginning with Evaluation through transition to community residency, meet appropriate standards of quality.

#### 17.1. Monitoring of Outreach and Education

Defendants will monitor the activities of providers engaged in Outreach and Education. In addition, Defendants will report, document and affirm the value of these Outreach and Education activities. While it is expected that those provider entities will provide Outreach and Education in a professional and

Colbert Consent Decree Implementation Plan – November 8, 2012

quality manner, State agencies will measure the effectiveness by tracking the number of transitions attributed to the Outreach and Education activities. Currently, there are processes in place that record the number of referrals generated by ADRC/ADRN. The on-line self-referral system for Pathways to Community Living/MFP will record all self-referrals. Class Members and the providers will be instructed to use these current systems so that effectiveness is measured.

17.2. Compliance, Communication and Reporting with MCEs

The lead Colbert staff person from HFS will be meeting and speaking with the identified and assigned staff from each of the MCEs on a regular and consistent basis. A schedule of these meetings will be developed beginning in the Year 1 and continuing through the full implementation of this Plan. The lead Colbert staff person from HFS will periodically attend Qualified Professionals meetings of preassessment, evaluation and care planning sessions of Class Members through the pre and post-transition process to ensure that MCEs are in compliance with expectations and to hear the progress and issues that emerge. Most of the pretransition sessions will take place at the Nursing Facilities and involve Class Members. The lead Colbert staff person from HFS will also make on-site visits and observe the Qualified Professionals in operation and also shadow the Care Coordinators on occasion to ensure that the needs of Class Members are being adequately addressed and that professionalism and quality are the hallmark of all Colbert related activities.

MCEs will provide weekly progress reports. These reports will include success stories, problems encountered, service planning needs and nursing home relations. Statistical data will report the number of contacts and the outcomes of initial reviews, number of persons engaged in transition planning, and the number of Class Members who have successfully transitioned. In addition, MCEs will need to provide a status report of how Class Members are doing post transition. For Class Members who are enrolled in the MFP Initiative, MCEs are required to adhere to all MFP Operational Protocols and procedures.

17.3. Ensuring Cultural Competence of Qualified Professionals

In addition to assuring that Qualified Professionals are trained and sensitive to working with Class Members of different ethnicities and cultures, MCEs will provide appropriate language translators for Class Members whose primary language is not English and ensure the ability to communicate with Class Members with special needs. MCEs will have various assistive technologies available to conduct Evaluations and to assess, develop and implement a Service Plan of Care.

17.4. MCEs' Internal Quality Assurance Activities

Internal processes for monitoring the quality of all activities will be required by all MCE contracts. The MCEs will incorporate accepted practice guidelines that are based on valid and reliable clinical evidence and consider the needs of their enrollees. As the contractors develop the work of assessment, pre and post transition planning and care coordination, they will be provided a written description of a Quality Assurance Plan (QAP) that includes medical and nonmedical related services, care coordination, care management, disease management and behavioral health services. This QAP must include: goals and objectives, scope, methodology, activities, provider review, a focus on outcomes, processes of quality assessment and improvement and consumer input. A more detailed description of these requirements will be found in the contracts with these entities. The contract will give HFS oversight authority over these QAP measures. A uniform method of reporting outcomes will be developed with each contract entity. HFS staff will also be making on-site visits to the nursing homes as assessment activities are performed, and randomly participate in pretransition and post-care coordination conferences.

Colbert Consent Decree Implementation Plan – November 8, 2012

17.5. Ensuring Quality Performance and Network Adequacy

The Defendants plan to have their own multi-disciplinary team representing HFS, DRS, DMH and IDoA to serve as an Oversight Committee. This committee will conduct random sample reviews of individual Class Member's Service Plans of Care to affirm that Class Members' needs are being adequately addressed. The knowledge and experience of State staff serving on this Oversight Committee will be valuable in assuring that MCEs are utilizing all available LTSS, in addition to medical treatment protocols. This Oversight Committee will also conduct random samples and reviews of all other contracted providers engaged in this Implementation Plan. This Oversight Committee will also allow the Defendants to review reports from the MCEs and address service and program gaps and capacity issues that may emerge. The Oversight Committee will affirm that individual Class Member's rights are respected and the key philosophical principles identified in the Consent Decree and Implementation Plan occur in all activities.

17.6. Corrective Action Steps

In the event HFS believes corrective actions need to be taken, written notification will be provided to that entity. The entity will be required to develop and implement a corrective action plan in accordance with the terms their contract.

**18. Information Systems**

During the drafting of this Implementation Plan, HFS has begun to explore what options are available to build upon existing IT systems. There are no current plans to develop another IT system specifically for the Consent Decree.

While the IT system issues are being identified, a system to provide information pertaining to the following will be required of the MCEs. This information includes: (1) File Review/Screening; (2) Initial Face-to-Face; (3) Assessment(s); (4) Social History and Service Plan of Care including housing; (5) Referrals to Community Resources; (6) Referral for Fiscal Agent and Information regarding Class Member finances and Home Inspection; (7) Referral Form for Home Modifications; and (8) Study of Services. In addition, regardless of whether a person is enrolled in MFP, the Care Coordinator will complete the MFP Risk Inventory, Risk Mitigation Plan, and a 24-Hour Back-up Plan as these are current and future requirements of all Medicaid waiver programs.

The system will provide information to track all Class Members as they progress from a medical record file review and screening to transition to community residency. The use of this information will enable the Defendants to report accurately the status of Class Members and provide data on the progression in reaching the Consent Decree benchmarks.

**19. Appeals**

The Consent Decree provides that Class Members have the right to appeal disputed decisions through the Defendants' existing fair hearing processes and may also avail themselves of any informal review or appeal process that currently exists. The appeal process will be outlined in a fact sheet (and include contact information) to be given to each Class Member. This fact sheet will explain rights, responsibilities and expectations of a participant who initially agrees to explore transition to community residency under the terms of the Consent Decree. This fact sheet will be given to the Class Member and reviewed by the Care Coordinator upon a verbal affirmation made by the Class Member that he/she wishes to pursue transition to community residency.



## 20. Finances

Each year of the Consent Decree, the Defendants will prepare and submit to the Governor's Office of Management and Budget (GOMB) budget proposals for inclusion in the Governor's Introduced Budget. These proposals will describe the programmatic purpose, amount of funding, and appropriation authority, if necessary, to ensure that provisions of the Decree are carried out. Elsewhere in this Implementation Plan, the specific tasks, timetables and goals necessary to carry out the provisions of the Decree are set forth. These comprehensive proposals will be coordinated across all Defendant agencies and will strive to ensure that funding for purposes, timetables and goals associated with the Decree are justified and included in the Introduced Budget. Based on the Implementation Plan, the known resource needs include:

- Court Monitor Compensation and Reimbursement
- Outreach/Education
  - ADRC/ADRN Contracts
  - Peer Registry
  - Tracking Outcomes of Outreach and Education Activities
  - Informational Materials
  - Methods for Class Member Self-Identification
- Implementation
  - MCE Evaluation and Transition Coordination Contracts
    - Includes services of Qualified Professionals for Evaluation, Service Plan of Care development and implementation, utilization of assessment tools, meeting requirements of Community-Based Services such as the quality assurance MFP requirements, identifying housing and on-going care coordination in the community.
    - Training of Qualified Professionals (may be included as part of fee paid to MCE)
  - Enhanced rates paid to MCEs for transitions and Care Coordination in fully capitated models.
- Illinois Client Enrollment Broker Contract
- Community-Based Services (after first year of implementation, may be included as part of MCE fee)
- Quality Assurance Activities and Actions
- Home Accessibility Adaptation Costs (including project management, development and review of specifications for modification and contractor fees)
- Housing
  - Housing assistance
  - Transition Costs
  - Fiscal Agent
- Administrative costs specific to the Implementation Plan
- Information/IT Services specific to the Implementation Plan

**21. Appendices**

21.1. Chart Showing Current Breakdown of Class Members

Chart shows the breakdown of current Class Members by age and whether or not there is a diagnosis of a Serious Mental Illness (SMI). Data also shows how many of the Class Members enrolled in Medicaid are also enrolled in Medicare as indicated by the term “Dual.”

< 60	< 60	60 – 64	60 – 64	65 +	65 +	Total	
SMI	No SMI	SMI	No SMI	SMI	No SMI	Medicaid	Dual
3225	1691	928	836	2803	7983	17466	14094

Colbert Consent Decree Implementation Plan – November 8, 2012

21.2. Timetable and Nursing Home Selection for Colbert Implementation Plan

## Timetable and Nursing Home Selection for Colbert Implementation Plan

Year	Target Date to Begin Process	Strategy using Qualified Professionals	Target # of nursing homes for each year	Quarter in which Initial Review and Evaluation process begins and becomes ongoing	Target # of Class Members for Initial Review and Evaluation	Anticipated # of Class Members Choosing Community Residency
Year 1/First Quarter	01/15/2013+	Integrated Care Program in Suburban Cook County -- Seniors and Persons with Disabilities (SPD) Medicaid clients only	Up to 31 NHs * ** Will serve their own members	Year 1/First Quarter	1175	117
Year 1/First Quarter	01/01/2013	Year 1 Transition Plan: Care Coordination services contracted with ICP vendors, for persons who self-identify (not already in ICP Plans -- Duals in Suburban Cook; any SPD in Chicago)		First Quarter/Year 1; Process will be evaluated if needed to continue in Year 2	Unknown	30
Year 1/ Second Quarter	03/01/2013+	Year 1 Transition Plan: Care Coordination services contracted with ICP vendors to cover residents who are Duals in Suburban Cook or any SPD in NHs in Chicago	Up to 30 additional NHs for a total of 61 NHs * ** Each vendor to be assigned 1/2 half of NHs	Year 1/ Second Quarter	1530	153
Year 1/ Second Quarter	05/05/2013	Within 180 days following the finalization of the Implementation Plan, at least 500 Class members residing in a Nursing Facility shall receive an Evaluation by Qualified Professionals.				
Year 1/Third Quarter	10/01/2013+	Year 1 Transition Plan: As Class Members are ready to transition to community, they will have full array of MCE options across Cook County, including CCEs, MCCN, Medicare and Medicaid Alignment Initiative for Duals				

## Colbert Consent Decree Implementation Plan – November 8, 2012

Year 1/ Fourth Quarter	First Year Benchmark of Transitions – November 5, 2013			Year 1/ Fourth Quarter		300
Year 2	11/05/2013+	Choice of full complement of MCEs providing all needs	Up to an additional 72 NHs for a total of 133 NHs ***	Year 2/ First Quarter	5000	500
Year 2	05/05/2014	A total of at least 2,000 Class Members then residing in a Nursing Facility shall have received an Evaluation		Year 2/ Second Quarter		
Year 2/ Fourth Quarter	Second Year Benchmark of Transitions – November 5, 2014			Year 2/ Fourth Quarter		800
Year 3 (2 yrs. & 5 mos.)	02/20/2015+	Choice of full complement of MCEs providing all needs	All 185 NHs in Cook Co.	Year 3/ Second Quarter	3000	300
Year 3 (2 yrs. & 5 mos.)	End of Third Year Benchmark of Transitions – May 5, 2015			Year 3/ Second Quarter		1100

+ Dates in this table as they relate to the future availability of MCE options are tentative and conditioned on Federal approval. HFS will continue to contract for Care Coordination services beyond Year 1 of the Implementation Plan as necessary until MCEs are approved by the Federal government and become available.

\* More nursing homes will be targeted if necessary to reach required benchmark by end of year.

\*\* Demographics of Class Members may be found in separate charts.

\*\*\* Additional nursing homes to be determined.

Colbert Consent Decree Implementation Plan – November 8, 2012

21.3. Colbert Housing Options – Summary for Transition Planning

<b>HOUSING PROGRAM OPTIONS (INFORMATION)</b>	<b>Program Description</b>	<b>Funding Source</b>	<b>Number of Units</b>	<b>Notes</b>
State Administered Housing Finance Programs				
1. IHDA Tax Credit Targeting Program (LIHTC Targeting Program)	Participating Developers set aside 10%-20% of units for PSH at rents that do not exceed payment of 30% of adjusted household income for households with extremely low incomes at or below 30% of HUD Area Median Income. Supportive services providers refer consumers to the State Lead Referral Agent for referral and processing of rental applications by the property manager, as available.	IHDA Low Income Housing Tax Credit Program	575 units developed since 2008. Approximately 175 units added annually. Units in program are available for 30 years on turnover basis after being made initially available at project opening for a 90 day marketing period	1. Because rents are already established at a lower level for 30%of AMI households (Average \$400 in Chicago for 1 BR), cost of rental subsidy is low relative to subsidy levels at HUD Fair Market Rent of \$853 for 1BR. Successful placement of class members in targeted units with Bridge Subsidy or other rental assistance will increase the number of units that can be provided with the available resources
2. Build Illinois Bond Program	Provides Capital Grants for new construction/rehab of PSH	Governor's Office Allocation to IHDA	\$17 million allocated to finance 122 units under Demonstration Program in 2011; \$40 million in additional bond proceeds to be provided as part of a PSH Request for Applications, which were due on 9/24/12	1. Includes HomeFirst Illinois/Access Living Initiative, Thresholds scattered site initiative, and other PSH Initiatives; 2. With 2012 funding round PSH is receiving 54% of \$130 million in total commitment of Build Illinois Bonds for Affordable Housing under the State Capital Authorization

Colbert Consent Decree Implementation Plan – November 8, 2012

<b>HOUSING PROGRAM OPTIONS (INFORMATION)</b>	<b>Program Description</b>	<b>Funding Source</b>	<b>Number of Units</b>	<b>Notes</b>
State Administered Rental Assistance Programs				
3. Rental Housing Support Program (RHSP)/(LTOS)	State of Illinois provides rental subsidy to allow extremely low income tenants to pay 30% of income in rent	Mortgage document filing fee at County Recorder of Deeds. IHDA Receives \$9 of every \$10 per recorded document to fund RHSP	\$10 million in funding announced in 2012, which will provide for the availability of approximately 150 units for persons with disabilities	<ol style="list-style-type: none"> <li>1. Original RHSP Authorizing Statute precludes preference for persons with disabilities</li> <li>2. Illinois Legislature adopted, and Governor just signed P.A. 97-0892 which allows IHDA and its Local Administering Agencies to grant a preference for persons with disabilities under the RHSP. IHDA just announced the availability of RHSP dollars for a new round of Long Term Operating Support (LTOS), with applications due on 10/24/2012. Recipients must be at 30% AMI, with 50% targeted at 15% of AMI or below.</li> </ol>
4. Bridge Subsidy Program("BSP")	Provides rental subsidy to allow extremely low income tenants to pay 30% of income in rent	IDHS – Division of Mental Health receives funding from Hospital Lockbox and GRF per Governor’s FY 13 Budget	700 units currently subsidized under BSP; program is expanding to provide housing subsidy for Williams and Colbert class members	<ol style="list-style-type: none"> <li>1. Current BSP administered for the State by Catholic Charities for persons with Mental Illness</li> <li>2. Program model can be replicated for Colbert Class</li> <li>3. Program has reputation for efficiency and excellent administration/payment cycles and inspection protocol</li> <li>4. Out of 700 Bridge Subsidies to date only five evictions</li> <li>5. Transition Coordinators experienced in use of BSP to house persons with disabilities; State Housing Coordinators and Divisions are working to expand the supply of landlords accepting BSP</li> <li>6. Caseworker Portal on Illinois Housing Search housing search engine provides supportive service providers with access to database of landlords who have expressed a specific preference to house persons with disabilities</li> </ol>

## Colbert Consent Decree Implementation Plan – November 8, 2012

<b>HOUSING PROGRAM OPTIONS (INFORMATION)</b>	<b>Program Description</b>	<b>Funding Source</b>	<b>Number of Units</b>	<b>Notes</b>
5. HUD Section 811 Project Rental Assistance Program	Allows State agencies to competitively apply to HUD for rental assistance for a 20 year term to allocate to non elderly disabled households with preferences for members of Olmstead classes; Authorized by Frank Melville Act to reform Section 811 as a community integrated program	HUD, to be administered by IHDA, if funded.	Maximum of \$12 million per state; maximum for Illinois approximately 825 units	<ol style="list-style-type: none"> <li>1. State of Illinois application submitted by August 7, 2012 deadline</li> <li>2. NOFA grants scoring preferences to States that have entered Consent Decrees to address the Olmstead case</li> <li>3. NOFA Grants scoring preference to States that obtain commitments from PHA's for Housing Choice Vouchers or public housing units as leverage to increase the supply of assisted housing for persons with disabilities;</li> <li>4. Must be under 62 to initially qualify for assistance but participants may age in place under the program beyond the age of 62 and so applications demonstrating strong programs for independent elderly households will be highly competitive; Illinois application met all of these criteria; HUD to announce grant awards by late 2012.</li> </ol>
6. Public Housing Authority (PHA) Programs	Includes: <ul style="list-style-type: none"> <li>- Project basing of Housing Choice Vouchers</li> <li>- Public Housing units</li> <li>- Housing Choice Vouchers</li> </ul>			
7. PHA Units and Housing Choice Vouchers	Tenants pay 30% of Income; PHA Pays difference in rent up to HUD Fair Market Rent or an "exception rent" if justified by market conditions	HUD via Public Housing Authorities	TBD	<ol style="list-style-type: none"> <li>1. CHA willing to match names of class members with waiting list to determine who is eligible for a voucher preference under CHA Administrative Plan; CHA has executed Protective Orders and the State is preparing class lists in format to protect privacy of class members and will submit to CHA shortly for list comparisons ;</li> <li>2. State in ongoing discussions with CHA regarding additional Voucher commitments consistent with HUD notices, and commitment of Project Based Rental Assistance("PRA") under State preference in CHA Administrative Plan;</li> <li>3. State in ongoing discussions with Housing</li> </ol>

Colbert Consent Decree Implementation Plan – November 8, 2012

<b>HOUSING PROGRAM OPTIONS (INFORMATION)</b>	<b>Program Description</b>	<b>Funding Source</b>	<b>Number of Units</b>	<b>Notes</b>
				<p>Authority of Cook County to negotiate a Demonstration Program for an allocation of Housing Choice Vouchers and public housing units for Money Follows the Person and Consent Decree Class Members;</p> <p>4. State has received list from HUD of hard unit vacancies in public housing authorities in State if Illinois and is following up with each PHA with vacancies to determine if units that are vacant may be viable opportunities for MFP Participants and Consent Decree Class members;</p> <p>5. IHDA has received a commitment of 50 Housing Choice Vouchers and 30 Public Housing Units from Rockford Housing Authority for Consent Decree members and MFP enrollees (as part of State's HUD Section 811 application).</p>
<p>8. Public Housing Authority Waiting List Preferences for Housing Choice Voucher Program for MFP enrollees</p>	<p>Provides rental subsidy to allow tenants to pay 30% of income in rent</p>	<p>HUD PIH Notice 12-31 issued June 29, 2012 encompasses a wide variety of HUD policy to encourage PHA's to prioritize rental resources for Olmstead class members, including specific guidance that PHA's may establish "Olmstead" waiting lists separate and distinct from their existing waiting lists</p>	<p>TBD</p>	<p>1. PHA's have authority to grant preference on waiting lists to MFP Enrollees and Olmstead class members;</p> <p>2. See paragraph 2 above for further detail on State actions in this area;</p> <p>3. State invited to present on Consent Decrees and housing needs to Illinois Association of Housing Authorities in September, 2012;</p> <p>4. HUD has offered to reach out to PHAs to encourage their participation in Olmstead compliance initiatives</p> <p>5. State also speaking to Illinois Chapter of NAHRO at its Annual Meeting on August 16, 2012, where HUD Regional Administrator Antonio Riley will encourage Olmstead initiatives.</p>



Colbert Consent Decree Implementation Plan – November 8, 2012

<b>HOUSING PROGRAM OPTIONS (INFORMATION)</b>	<b>Program Description</b>	<b>Funding Source</b>	<b>Number of Units</b>	<b>Notes</b>
9. Non Elderly Disabled (NED) Housing Choice Vouchers	Provides Rental Subsidy to allow tenants to pay 30% of Income in Rent and PHA pays difference up to Fair Market Rent	HUD awards competitively to PHAs	Under NED 1 Illinois has 445 NED 1 Vouchers allocated to 6 PHA's that are in place and can be utilized for non-elderly disabled households on voucher turnover; Under NED 2 Illinois received 25 NED 2 Vouchers; 15 to the Oak Park PHA and 10 to the Springfield PHA that are currently in lease up	Must express support to HUD/Congress for continued and increased annual allocations of NED Vouchers. No new NED vouchers proposed for FY13.

Colbert Consent Decree Implementation Plan – November 8, 2012

<p>10. Project Based Rental Assistance Program(PRA)</p>	<p>Provides 15 year Rental Subsidy contract for up to 25% of units for PSH in a market project or 100% PSH for developments that serve a 100% PSH tenant population</p>	<p>PHA Award to Developers on rolling application basis. This program is specific to CHA and Cook County Housing Authority</p>	<p>CHA has 2500-3000 PRA units for both PSH and non PSH developments; Housing Authority of Cook County has approximately 260 PRA units</p>	<p>CHA providing PRA in support of Home First Illinois acquisition of accessible units with proceeds from Build Illinois Bond Program; for Thresholds scattered site initiative and for the Diplomat Hotel under IHDA PSH Demonstration Program; State in dialogue with PHA's regarding set aside of percentage of PRA units for MFP enrollees or Consent Decree Class members</p>
<p>City of Chicago Programs</p>				
<p>11. City of Chicago Low Income Housing Trust Fund (CLIHTF)</p>	<p>Provides rental subsidy to allow extremely low income tenants to pay 30% of income in rent</p>	<p>City receives \$10 per recorded document in City of Chicago</p>	<p>TBD Based on Next Funding Round and \$\$ available per funding source</p>	<p>Need for Discussion with City on Availability of funding for PSH; meeting scheduled with City of Chicago Department of Housing and Economic Development in August, 2012.</p>

Colbert Consent Decree Implementation Plan – November 8, 2012

21.4. Survey - Waiver Services Necessary for a Successful Transition to Community-Based Settings

Survey of Transition Necessary Services						
RIN#:	Date of Birth:		DON Score (if administered):			
Circle outcome of initial Contact &/or Evaluation of Class Member	Class Member refused to consider transition	Guardian refused to consider transition	Evaluated & determined ineligible based on Section 10.2	Evaluated & declined transition	Evaluated, found eligible & waiver issue identified ( <i>complete section(s) below</i> )	
Circle the Illinois Waiver for which the Class Member is eligible:					Aging	Disability
Zip Code for Nursing Home:					HIV/AIDS	TBI
Zip Code for Community in which the Class Member desires to live						
	Waiver Service needs	Gaps in Waiver Service: Class Member would need one or more of these services in a quantity greater than the Waiver for which the Class Member is currently eligible permits or as defined in order to successfully transition ( <i>Check each applicable service</i> )				
Waiver Service	Class Member would need one or more of these services under a Waiver for which he/she is NOT currently eligible in order to successfully transition ( <i>Check each applicable service</i> )	Hours of Waiver Service		Waiver Service Definition		
		Class Member is eligible for the Waiver, but the hours of service were determined to be a barrier to transition ( <i>Complete for only those services that are provided on an hourly basis</i> )		Class Member is eligible for the Waiver service but, because of the scope of the service definition, the service definition is the barrier to transition ( <i>Indicate all that are applicable</i> )		
		Based upon eligibility, the Class Member qualified for the following number of total hours for this service	Based upon need, the following number of hours for this service is a necessity to transition	Check if "Yes"	Write in the specific task(s) that, if included in the definition, the Class Member would have been able to transition	
Adult day service (TBI, Disability, Aging, HIV/AIDS)						
Adult day service transportation (TBI, Disability, Aging)						
Behavioral/cognitive services (TBI) Day habilitation (TBI)						
Environmental modifications (TBI, Disability)						
Home delivered meals (TBI, Disability)						
Home health aide (TBI, Disability, HIV/AIDS)						
Homemaker (TBI, Disability, Aging, HIV/AIDS)						
Nursing (TBI, Disability, HIV/AIDS)						
Occupational therapy (TBI, Disability, HIV/AIDS)						
Personal assistant (TBI, Disability, HIV/AIDS)						
Personal emergency response system (TBI, Disability, Aging, HIV/AIDS)						
Physical therapy (Disability, HIV/AIDS)						
Respite care (TBI, Disability, HIV/AIDS)						
Specialized medical equipment and supplies (TBI, Disability, HIV/AIDS)						
Speech therapy (TBI, Disability, HIV/AIDS)						
Supported employment (TBI)						
Supported Living Facility (SLF)						
Transportation for employment (HIV/AIDS)						
Comments:						

## 21.5. Acronyms and Abbreviations

Coordinated Care Entity (CCE): A CCE is a collaboration of providers and community agencies, governed by a lead entity that receives a care coordination payment in order to provide care coordination services for its enrollees.

Integrated Care Program (ICP): The program under which HFS contracted with HMOs to provide the full spectrum of Medicaid covered services through a risk-based integrated care delivery system to seniors and adults with disabilities who are eligible for Medicaid but are not eligible for Medicare.

Illinois Client Enrollment Broker (ICEB): The entity contracted by HFS to conduct enrollment activities for potential enrollees, including providing impartial education on health care delivery choices, ICPs, CCEs, MCCNs and all other managed care entities (MCE) that may become available, providing enrollment materials assisting with the selection of a PCP and CCE or MCCN, and processing request to change CCEs or MCCNs.

Local Contact Agency (LCA): The entity is a Community-Based agency, according to Federal CMS expectations, that responds to Nursing Facility referrals by providing information to residents about available Community-Based long-term care supports and services, works with Nursing Facility staff to engage the resident in their discharge and transition plan and works collaboratively to arrange for all of the necessary Community-Based long-term care services.

Managed Care Community Network (MCCN): A MCCN is an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with HFS exclusively to persons participating in programs administered by HFS.

Managed Care Entity (MCE): MCE is the term referring to any number of options that is currently or planned to be offered to a Medicaid beneficiary in Illinois. MCEs include Integrated Care Program (ICPs), Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), and the Medicare and Medicaid Alignment Initiative, including the care coordination provided by these organizations. All Colbert Class Members will either currently be in a MCE or be enrolled in a MCE.

## 22. References

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Mollica, R. & Reinhard, S. (2005). *Community Living Exchange, Establishing Nursing Home Level of Care: How States Vary*, New Brunswick, NJ: Rutgers Center for State Health Policy.

UIC National Research and Training Center on Psychiatric Disability and the UIC NRTC Self-Determination Knowledge Development Workgroup. (2002) Self-Determination Framework for People with Psychiatric disabilities. Chicago, IL: Author. Retrieved on June 14, 2012 from: <http://www.psych.uic.edu/uicnrtc/sdframework.pdf>.

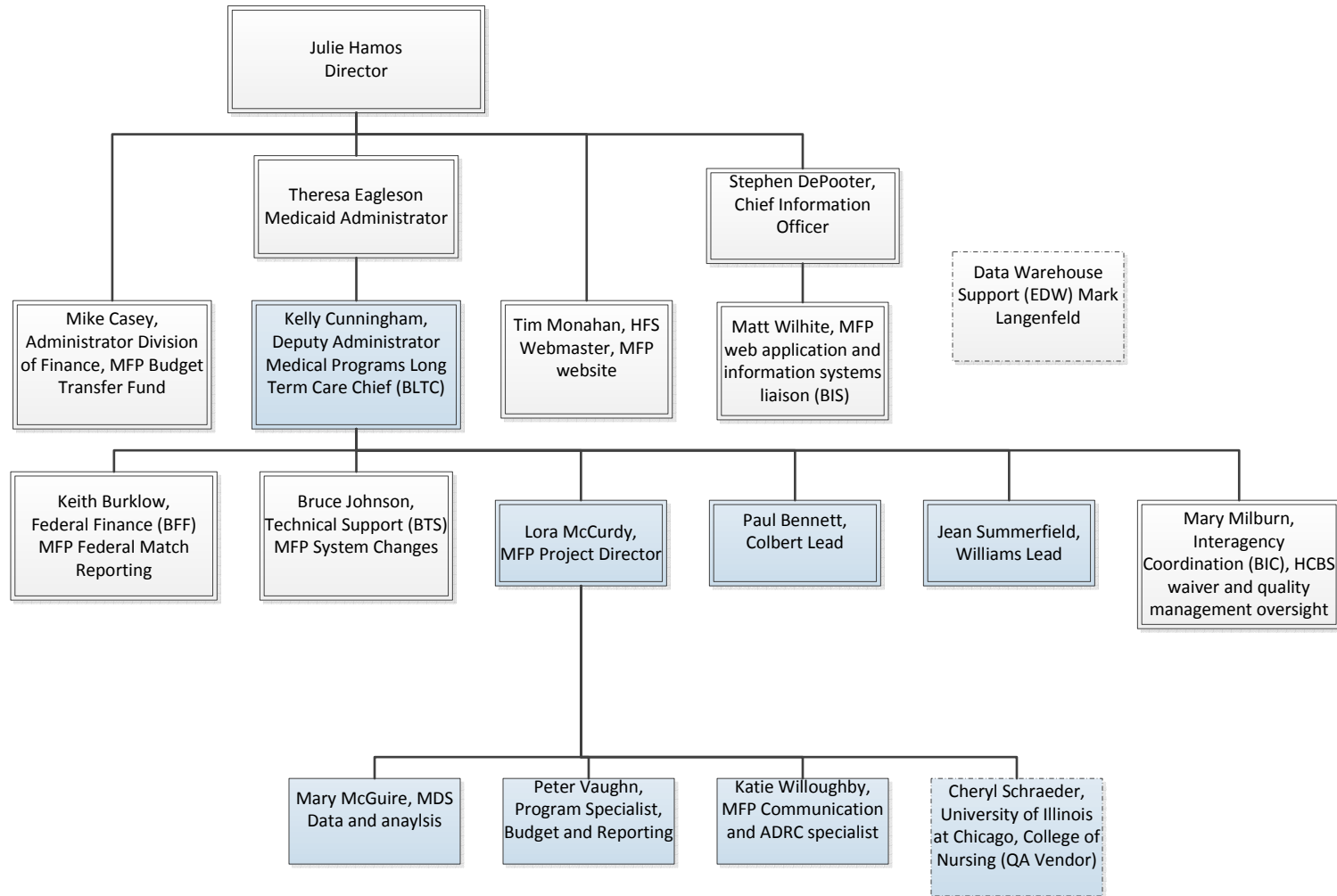
## Organizational Charts

### Pathways to Community Living - MFP Program Partners

Healthcare and Family Services (HFS)  
 Department of Human Services (DHS)  
     Division of Developmental Disabilities (DDD)  
     Division of Mental Health (DMH)  
     Division of Rehabilitation Services (DRS)  
 Department on Aging (DoA)

DHS Leadership – DDD, DMH, DRS  
 Michelle Saddler, Secretary

<b>DDD</b>	<b>DMH</b>	<b>DRS</b>	<b>IDoA</b>
<b>Leadership</b>	<b>Leadership</b>	<b>Leadership</b>	<b>Leadership</b>
Kevin Casey, Director	Lorrie Jones, Ph. D Director	David Hanson, Director	John Holton Director
<b>Systems Rebalancing</b>	<b>Systems Rebalancing</b>	<b>Systems Rebalancing</b>	<b>Systems Rebalancing</b>
Reta Hoskin Associate Director	Brenda Hampton Acting Assoc. Director	Nyle Robinson Manager, CRP	Sandra Alexander Division Manager
<b>Project Manager</b>	<b>Project Manager</b>	<b>Project Manager</b>	<b>Project Manager</b>
Mary Spriggs-Ploessl Community Director	Katherine Burson, Division Lead	Robert Kilbury, Division Lead	John Eckert, Agency Lead
<b>Information Technology</b>	<b>Information Technology</b>	<b>Information Technology</b>	<b>Information Technology</b>
To Be Identified – Interim contact Mary Baird and Mary Spriggs- Ploessl	Mary Smith, Ph.D. Strategic Planning, Evaluation and Service System Analysis	Sarah Colburn, MFP IT Lead	Jim Buckles, MFP IT Lead
<b>Fiscal Analysis</b>	<b>Fiscal Analysis</b>	<b>Fiscal Analysis</b>	<b>Fiscal Analysis</b>
HFS Consolidates Global MFP Budget annually	HFS Consolidates Global MFP Budget annually	HFS Consolidates Global MFP Budget annually	HFS Consolidates Global MFP Budget annually
<b>Quality Management</b>	<b>Quality Management</b>	<b>Quality Management</b>	<b>Quality Management</b>
UIC- College of Nursing	UIC- College of Nursing	UIC- College of Nursing	UIC- College of Nursing
	<b>Pre-Admission Screening Coordinator</b>		
	Katherine Burson, Division Lead		
	<b>Housing Coordinator</b>		
	Dan Burke, Housing Coordinator		



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201 South Grand Avenue East  
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**Telephone:** (217) 782-1200  
**TTY:** (800) 526-5812

## **CARE COORDINATION ROLL-OUT PLAN**

January 2013-January 2015

Illinois Medicaid is presenting our 2-year draft plan for meeting the state law requirement to move at least 50% of our Medicaid clients into care coordination by January 1, 2015. Under this plan, the goal is to have about 2 million out of 3 million clients (or 66%) in care coordination by the 2015 deadline.

In Illinois, “care coordination” will be provided by three types of “managed care entities”: traditional insurance-based Health Maintenance Organizations (HMO) accepting full-risk capitated payments; Managed Care Community Networks (MCCN), which are provider-organized entities accepting full-risk capitated payments; and Care Coordination Entities (CCE) which are provider-organized networks providing care coordination, for risk- and performance-based fees, but with medical and other services paid on a fee-for-service basis. An initial group of 6 CCEs and MCCNs recently have been awarded contracts under HFS’ Care Coordination Innovations Project; this program is expected to grow, based on interest and capacity by provider networks. In addition, a solicitation soon will be extended to CCEs and MCCNs for care coordination for children with complex health needs.

The roll-out plan contemplates continuing enrollment into care coordination for different Medicaid populations, at various stages and in different geographies, as per the attached chart. The major roll-out plan has already begun with a focus on Seniors and Persons with Disabilities (SPDs), who comprise 16% of the Medicaid population but incur 55% of Medicaid costs. Accordingly, Illinois Medicaid is focusing on this population first, to provide more coordinated, effective health care to the clients who have the most complex health and behavioral health needs. These SPDs in the Medicaid Program will be enrolled with a managed care entity for the “medical service package”, which includes medical and behavioral health services. In addition, those who need long-term care will also be enrolled with the same managed care entity for the “long-term supports and services” (LTSS) service package; this package may include care in a nursing facility or in the home, with assistance from the “home- and community-based waiver” providers.

Some of the SPD population includes people who are on both Medicare and Medicaid (“dual eligibles”); we expect the federal government to partner with Illinois Medicaid to provide better coordination of services under the unique demonstration called the “Medicare-Medicaid Alignment Initiative”. Medicare will continue to pay for the “medical service package” and Illinois Medicaid will continue pay for the “LTSS” service package, for those who need it; with a coordinated rate setting process that accounts for savings expected from enhanced care coordination by a managed care entity and better care.

In January 2014, Illinois Medicaid will expand the care coordination program to the other populations we serve: children, their parents, and newly-eligible Medicaid enrollees under the Affordable Care Act (e.g. adults with no dependent children). It is expected that care coordination for these populations will be provided by some or all of the current managed care entities on contract with the state, as well as others who are likely to apply (including MCOs, CCEs and MCCNs). The traditional managed care organizations serving Illinois Medicaid clients are also likely to offer private health insurance on the Illinois Health Insurance Exchange, thereby providing continuity of care, as clients go on or off Medicaid.

Draft, November 29, 2012

## CARE COORDINATION ROLL-OUT PLAN: JANUARY 2013 - JANUARY 2015

Focus of Plan	Population	# of Clients	Geography	Beginning Date
Integrated Care Program: adding "Phase II" LTSS - by Centene/Aetna ("Phase III" for Persons with Developmental Disabilities approx. 1 year later)	SPD-Medicaid	36,000	Collar counties	Feb-13
Care coordination for SPD adults, by provider-organized Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCN) - initially 5 CCEs, 1 MCCN	SPD-Medicaid and Duals; family members	16,000+	4 in Chicago area; 2 downstate - 6,000 initially (growth based on capacity)	Apr-13
Care coordination for SPD adults in additional regions - by variety of managed care entities	SPD-Medicaid	19,000	Central IL, Rockford, Quad Cities	Apr-13
		7,000	Metro East	Jul-13
		69,000	Chicago	Jan-14
Care coordination for children with complex health needs - by CCEs and MCCNs	Children	5,000+	Statewide (growth based on capacity)	Jul-13
Medicare-Medicaid Alignment Initiative - by MCOs	SPD-Duals	136,000	Chicago region/Central Illinois	Oct-13
Care coordination for children/family and caregivers	Children/families	1,476,000	Chicago region, central IL, Rockford, Quad Cities, Metro East	Jan-14
Care coordination for "New Medicaid" clients under Affordable Care Act	Adults 19-64	237,000	Chicago region, central IL, Rockford, Quad Cities, Metro East	Jan-14
Clients in fee-for-service as of 1/1/15 (rural counties/Duals opting out, etc.)	various	1,000,000+		

**TOTAL MEDICAID ENROLLMENT AS OF JANUARY, 2015**

**3,000,000+**

SPD = Seniors and Persons with Disabilities; LTSS = long-term supports and services



## Illinois' Pathways to Community Living Program:

*We Help Individuals Living in Nursing Homes or Long Term Care Facilities Move Back to the Community.*

### Our Mission

**To promote individual choice and control and increase the use of home and community based services.**



### Services and Supports

Pathways transition coordinators help you with the whole process:

- They give one on one support
- They help with your move
- They follow up with you for one year after you move
- They work with you to create a care plan with the supports and services you need

Pathways has financial support to help you with your move. We also have housing support to help you find the right place for you to live.

## Pathways to Community Living Partner Agencies:



For more information, contact your local care coordinator at:



Publication of the Illinois Money Follows the Person Demonstration Program. Funding provided by the Federal Centers for Medicare and Medicaid Services

In Partnership with the Illinois Department on Aging, Illinois Department of Human Services – Division of Developmental Disabilities, Division of Rehabilitative Services, and Division of Mental Health, Illinois Housing Development Authority, The University of Illinois at Chicago, U.S. Centers for Medicare and Medicaid Services, Centers for Independent Living, Community Mental Health Centers, Care Coordination Units, and service providers for the elderly, people with developmental disabilities, and people with mental health conditions statewide.

The Illinois Department of Healthcare and Family Services does not discriminate in admission to programs or treatment of employment in programs or activities in compliance with appropriate state and federal statutes.



## Pathways



## To Community Living

## *The Illinois Money Follows the Person Demonstration*

Email us at:  
[hfs.webmaster@Illinois.Gov](mailto:hfs.webmaster@Illinois.Gov)

Visit us on the Web:  
[www.MFP.Illinois.Gov](http://www.MFP.Illinois.Gov)

## Pathways



## To Community Living

### ***What Is It?***

Our goal is to help interested people living in a long-term care facility move to an apartment or house in the community, and to make sure they receive quality care after they move.

Illinois' Pathways to Community Living is part of a national project, called Money Follows the Person, and is administered by the Centers for Medicare and Medicaid Services.

### ***How Does It Work?***

We have trained individuals, called Transition Coordinators, to help you. They will meet with you one on one. They will help decide if you are eligible for this program. They will help you before, during, and after you move.

### ***Contact Us***

If you want more information, or if you have questions, please contact us. If you want to make a referral for yourself or someone else, we can help.

**Website – [www.MFP.Illinois.Gov](http://www.MFP.Illinois.Gov)**

**Email – [HFS.MFP@illinois.Gov](mailto:HFS.MFP@illinois.Gov)**

You can also talk to your local care coordinator. That contact information is on the back of this brochure.

# ***Success Stories***

***Since 2008, Pathways to Community Living has helped hundreds of people move from nursing homes back to the community.***

***We want to share some of their success stories with you!***

## **Success in the Community**

The Pathways program and the Shawnee Alliance for Seniors helped one couple move back to their own home. He has dementia, she is blind, and they spent a lot of time in nursing homes. Pathways provided financial help to make home improvements and accessibility updates they needed to live at home. This couple has done very well. They feel a great deal of comfort living back in their own home.



## **Scott Chose Community Living**

Scott was 40 years old and he lived in a nursing home. That changed one year ago. Illinois' Pathways to Community Living program and the Chicago area Heartland Alliance helped Scott move into his own apartment in Rogers Park.

*"Now I am doing very well. I try not to take anything for granted," Scott says. "I don't look at it as a place I have arrived at. I see it as a starting point. I feel like I have found a sanctuary where I can really think about what I want to do."*

## **Mary & Brian's Success Story**

Mary and I were the life of the facility," Brian says. Mary has a brain injury and Brian was in an accident that left him paralyzed. They were living in a nursing home where they met and fell in love. Soon after their engagement, a Pathways transition coordinator from the FITE Center in Elgin helped them move into their own apartment.

*"It works out nice," Mary says. "I am his legs, he is my memory."*



### ***Pathways to Community Living - Consumer FAQs***

### ***Illinois' Money Follows the Person Demonstration***

#### ***What is it?***

Pathways to Community Living is a federal program that lasts until September 30, 2016. It is focused on increasing the use of Home and Community based services. Home and Community based services are services that you can get at home instead of in a long term care facility.

The program is nationally known as the Money Follows the Person Program. The Federal Centers for Medicare and Medicaid Services are in charge. In Illinois, four state agencies help with the program. These are the Department of Healthcare and Family Services, the Department of Human Services, the Department on Aging, and the Illinois Housing Development Authority.

#### ***What Are the Goals?***

Pathways to Community Living helps people like you move out of a nursing facility. Also, the program provides services and supports to help people succeed in community living and be happy there. There are three goals that support this mission.

- To make it easier for interested people to receive long term care services in community settings
- To increase the ability of the state to provide home and community based services for individuals who move to the community
- To make sure that home and community based services are continuously improving

#### ***What Does the Program Mean For Me?***

Pathways to Community Living gives you choices about where you can live, and the services and supports to help you succeed in the community. It is all about giving you more control over your life. If you are in a nursing facility or an intermediate care facility for the developmentally disabled (ICF/DD) and want to move to the community, this program may be just for you. You control the process!

#### ***How Does it Work?***

If you choose to participate in the program, a Transition Coordinator will help to determine if you are eligible. They will also help to make a transition and care plan that includes services and supports to help you in the community. The Transition Coordinator is there to help you!

#### ***How Do I Know If I Am Eligible?***

Pathways to Community Living is available to many people! This includes elderly individuals over age 60, individuals with physical disabilities, individuals with mental illness, and individuals with intellectual and developmental disabilities. First, you just have to be interested in the program! There are a few other requirements that have to be met.

- You must be living in a nursing facility or ICF/DD, and have lived there for at least 90 days
- You must be receiving or be eligible for Medicaid
- You must be interested in moving to the community and able to do so safely
- You must choose to enroll in the program and move to a qualified community setting

## ***What Services Are Provided?***

Your Transition Coordinator will go over in detail what services you may receive in the community. Services offered through Pathways to Community Living include:

- Support with your move into the community including one on one assistance and financial support
- Guidance and support from a qualified Transition Coordinator who will follow up for 365 days with you
- A care plan with services to meet your needs
- Housing Support that includes help finding a home, help with transition costs, and home improvements

## ***What Housing Choices Do I Have?***

There are several housing options that you can choose from through Pathways to Community Living. Once your eligibility is determined, a Transition Coordinator will go over your housing options in detail.

- Home owned or leased by you or a family member
- Apartment with individual lease, secure access, as well as living, sleeping, bathing and cooking areas over which you or your family has control – including Supportive Living Facilities for individuals over 65
- Community-based residential setting a maximum of four unrelated people



***For more information, including how to make a referral, please visit us on the web at:***  
**[www.MFP.Illinois.Gov](http://www.MFP.Illinois.Gov)**



# ***Pathways to Community Living - Fact Sheet*** ***Illinois' Money Follows the Person Demonstration***

## ***Background***

- The Pathways to Community Living Program is a Federal Demonstration Project authorized by the Deficit Reduction Act of 2005. The program is nationally known as the Money Follows the Person Demonstration.
- The program is part of a larger effort resulting from the U.S. Supreme Court Olmstead decision in 1999. The Olmstead decision required states to take action to ensure that individuals with disabilities in need of long term care had access to services in the least restrictive and most integrated setting.
- The program seeks to increase the use of community services and rebalance the state's long term care systems by providing appropriate, person-centered services for individuals interested in transitioning from nursing facilities to qualified home and community based settings.
- In Illinois, the program is overseen by the Department of Healthcare and Family Services, in partnership with the Department of Human Services, the Department on Aging, and the Illinois Housing Development Authority.

## ***Program Components and Benefits***

- Transition coordinators work with each individual to determine eligibility and ability to live in the community, and follow up for 365 days after transition as an added community support.
- Assistance is provided in locating eligible housing that is affordable and accessible and with the actual move, including moving costs.
- An individual care plan is developed with consumers to determine necessary services and supports to meet each individual's needs. This also helps consumers to safely live in a community setting.

## ***Consumer Eligibility Requirements***

- **Targeted Population** – Illinois has chosen to target four populations of individuals - individuals over age 60, individuals with physical disabilities, individuals with serious mental illness, or individuals with intellectual/developmental disabilities who live in a nursing home or long term care facility.
- **Eligibility** – Currently reside in a nursing facility or Intermediate Care Facility for the Developmentally Disabled for at least 90 days, currently be receiving Medicaid or be eligible for it, able to be safely supported in the community, and move to a qualified housing setting.
- **Must be Interested in Moving to Qualified Community Housing** – Housing includes a home owned or leased by the individual or family, an apartment with individual lease, a community setting with no more than four unrelated individuals, or a Supportive Living Program facility may be a housing option for individuals age 65 and older.

## ***Who Can Make a Referral?***

- Anyone can make a referral, which will lead to an assessment and eligibility determination for the program.



***For more information, including how to make a referral, please visit us on the web at:***  
**[www.MFP.Illinois.Gov](http://www.MFP.Illinois.Gov)**





### Pathways to Community Living - Legislative Fact Sheet

### Illinois' Money Follows the Person Demonstration

#### **Background**

The Pathways to Community Living Program is a long term care rebalancing initiative authorized by the Deficit Reduction Act of 2005 and administered by the Federal Centers for Medicare and Medicaid Services. The program is not a grant, it is a federal demonstration project nationally known as the Money Follows the Person Demonstration (MFP). It began in 2007 with an award to 30 states and was recently extended through September 2016 by the Affordable Care Act (section 2403) with an award to an additional 13 states.

Illinois chose to rebrand MFP "Pathways to Community Living" to better represent the true meaning of the program. The program is directed by the Department of Healthcare and Family Services, in cooperation with the Department of Human Services, the Department on Aging, and the Illinois Housing Development Authority. The state agencies each contract with community providers who are responsible for assessing individuals in nursing facilities and assisting them with transitioning to the community.

#### **What is the Goal of Pathways?**

The program seeks to increase the use of community services and rebalance the state's long term care systems by providing appropriate, person-centered services for individuals interested in transitioning from nursing facilities to qualified home and community based settings.

#### **Programmatic Objectives**

Initial funds were made available by the federal Centers for Medicare and Medicaid Services in 2007. After the ACA extension through 2016 an additional \$450 million was nationally appropriated for each fiscal year 2012-2016. However, funding is contingent on actual individuals transitioned to the community. Illinois receives one year of enhanced federal match on qualified Home and Community Based Waiver Services and state plan mental health services to individuals who transition through the program. This enhanced match must then be reinvested into strengthening Illinois' long term care system.

#### **Program Components and Benefits**

- Transition coordinators work with qualified individuals to determine eligibility and ability to live in the community, and follow up for 365 days as an added community support.
- Assistance is provided in locating eligible housing and with the actual move, including transition costs.
- An individual plan is developed with consumers to determine necessary services and supports.

#### **Consumer Eligibility Requirements**

- **Targeted Population** – Illinois has chosen to target four populations of individuals - those over age 60, with physical disabilities, with serious mental illness, or with intellectual/developmental disabilities.
- **Eligibility** – Individuals must reside in a nursing facility for at least 90 days, be eligible for Medicaid, be able to be safely served in the community, and move to a qualified housing setting.



**For more information, including how to make a referral, please visit us on the web at:  
[www.MFP.Illinois.Gov](http://www.MFP.Illinois.Gov)**



## ***Pathways to Community Living - Program Guidance***

### ***For Nursing Home Staff and Administrators***

### ***Illinois' Money Follows the Person Demonstration***

#### ***Background***

The Pathways to Community Living Program (Pathways) is Illinois' Money Follows the Person (MFP) Rebalancing Demonstration. The program began in 2007 with a funding award to 30 states including Illinois, and was recently extended by the Affordable Care Act through September 30, 2016 with an award to an additional 13 states. In Illinois, the program is directed by the Illinois Department of Healthcare and Family Services. The program provides assistance to states to rebalance their long term care systems and assist individuals living in nursing facilities to transition to the community.

#### ***What is the Program Philosophy and Objectives?***

The Pathways program is focused on objectives that enable individuals to receive, access, and choose appropriate services in the settings of their choice. It is critical that the individual and those that he/she designates are completely involved and direct the process. This includes agreement to participate in Pathways, and to adhere to a plan of care and potential risks. All plans, including risk identification and the establishment of services, programs, and strategies to mitigate risks are to be person centered and driven.

#### ***The federal program has four key objectives:***

- Increase the use of home and community-based services and supports, rather than institutional long term care services.
- Eliminate barriers that prevent or restrict the flexible use of Medicaid funds to enable individuals to receive support for appropriate and necessary long term services in the setting of their choice.
- Increase the ability of the state Medicaid program to assure continued provision of home and community based long term care services to eligible individuals who chose to transition from an institution to a community setting
- Ensure that a strategy and procedures are in place to provide quality assurance for eligible individuals receiving Medicaid home and community based long term care services and ensure quality improvement.

#### ***Who is Involved in Illinois?***

This initiative is a statewide effort to implement the Illinois General Assembly's charge to promote a balance between home and community based services and institutional long term care. This is often referred to as long term care rebalancing. Partners in the Illinois program include the Illinois Department of Healthcare and Family Services as the lead agency for the program, in collaboration with the Department of Human Services, the Department on Aging, and Illinois Housing Development Authority. There are many other stakeholders involved with Pathways in addition to these state agencies. These include private agencies such as Centers for Independent Living, Community Mental Health Centers and Case Coordination Units, and also the University of Illinois at Chicago College of Nursing.

Illinois has been transitioning individuals through the Pathways program since 2008. As a result, you may already be familiar with transition coordinators and program representatives visiting your facilities. Across Illinois, transition coordinators from Centers for Independent Living, Case Coordination Units, and Mental Health providers are under contract with the state and are responsible for the implementation of this program. Transition coordinators will visit your facility and work to identify and assess individuals who are interested and eligible for the program. To date, the primary referral source for potential candidates has been MDS data through the lead state agency for the program, the Illinois Department of Healthcare and Family Services.

## **Who is Involved in Illinois?** (continued)

Another significant referral source is nursing home staff. Future outreach initiatives are expected to increase awareness, and you may be asked about Pathways. It is expected that these individuals be referred to the appropriate transition coordinator or local program in your community. Once a referral is made, a transition coordinator will visit the resident and complete an assessment. This includes informing the resident and his/her designee what options are available, and affirming he/she is a good candidate for the program. This process will often take time, and will involve your support and expertise as a long term care professional.

## **Who is Eligible?**

Individuals who have been residing in a nursing home for a minimum of 90 days and are currently enrolled in Medicaid qualify for the Pathways program. Participants must also be interested in moving to the community and are asked to play an active role in the process.

## **What is a Qualified Community Setting?**

There are several community settings that an individual can move to through the Pathways program. These include homes or apartments owned or leased by the individual or a family member, a community based setting with no more than four unrelated individuals, or a supportive living facility for some individuals. A transition coordinator will work with interested residents to determine appropriate and eligible housing.



## **What is Your Responsibility as a Nursing Home Professional?**

The Pathways/MFP program considers nursing home administrators and staff as key partners in the continued implementation of the program. It is expected that the staffs of long term care facilities will welcome and cooperate with transition coordinators. Pathways representatives will be asking for assistance as they interview residents and assist in the development of transition plans. They have a legislative charge and authority to perform these duties.

Not everyone who is referred will be a candidate for transition. Living in the community requires both formal and informal supports, resources, and a desire to make it work. Long term care facilities will continue to have a role in providing medical and non-medical care to persons with physical and mental challenges. The Pathways program is focused on assisting those who are able to successfully live in the community.



**For more information, including how to make a referral, please visit us on the web at:**  
**[www.MFP.Illinois.Gov](http://www.MFP.Illinois.Gov)**



# Pathways to Community Living: Illinois' Money Follows the Person



## Referral/Self-Referral Form

To Community Living

If you are interested in learning more about this program for yourself or for another individual, please fill out this form and a program representative will contact you. Eligibility and participation in the program will be determined after an initial face-to-face meeting. This referral form is only a first step in that process.

- Is this referral for you?             YES             NO (If yes, please go to Section B)
- Is this referral for someone else?     YES             NO (If yes, please complete Sections A and B)
- Is this an MDS 3.0, Section Q Referral?     YES             NO

### Section A (To be completed if you are referring someone else)

Your Name: \_\_\_\_\_

Your Organization: \_\_\_\_\_

Your Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Your Phone : \_\_\_\_\_

Your Email: \_\_\_\_\_

What is your relationship to the individual you are referring to this program?

Guardian or Legal Representative

Nursing Facility or ICF/DD Staff

Family Member or Friend

Other

If other, please explain: \_\_\_\_\_

Additional Relationship Information: \_\_\_\_\_

Does the individual know you are making this referral on their behalf?     YES             NO

If you are making a referral for someone else, by completing this form you agree to be contacted by a representative of one of the participating state agencies in the program.

## Section B (This section must be completed for all referrals)

Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone : \_\_\_\_\_

Email: \_\_\_\_\_

Residence (Name of nursing facility or ICF/DD): \_\_\_\_\_

Which of the following best describes the individual being referred (please check all that apply):

- Individual over age 60
- Individual with physical disability
- Individual with serious mental illness
- Individual with intellectual or developmental disability

Which of the following applies to the individual being referred (please check all that apply):

- Currently receiving Medicaid or is eligible to receive Medicaid.
- Interested in moving into a community setting.
- Currently residing in nursing facility or ICF/DD.

What is the length of time the individual being referred has resided in a nursing facility or ICF/DD: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



***For more information, please visit us on the web at [www.MFP.Illinois.Gov](http://www.MFP.Illinois.Gov)***

**Mailing address: 201 S. Grand Ave. E, Bureau of Long Term Care, MFP, Springfield, Illinois 62703**

**MFP Online Documentation**

Presented by UIC-College of  
Nursing

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**MFP ONLINE Documentation Processes**

- Most Forms are completed online in the MFP Online Documentation System (aka 'web app'): <https://mfp.nursing.uic.edu/default.aspx>
  - Quality of Life Survey and Informed consent are not online and must be faxed to UIC College of Nursing as soon as completed (217) 586-6059.
- If you are experiencing difficulty accessing the online forms, difficulties completing the online forms, or errors, contact your UIC pod leader.
- **Please notify your UIC pod leader and State Staff via phone or email of upcoming transitions so a case review conference can be scheduled prior to transition. Allow 2-3 weeks. Forms A, B, Informed Consent, F, G, H&I, J, K, L and Quality of Life survey must all be completed prior to transition and prior to case review.**

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**Brief Description and Process Overview**

- This presentation provides a brief overview of the purpose of each piece of documentation and when each is completed during the transition process.

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Pre-Transition

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**New Participant/First Contact  
(Form A)**

- Completed the first time you discuss MFP with a referral (face-to-face)
- Completed for ALL PERSONS who have been screened or received a brief face-to-face assessment

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**Form A: HFS Required Data**

- Date of the First Face-to-Face Contact:
- Participant's full legal name
- Current Facility name and address
- TC Name and Agency
- MFP Program
- **AT LEAST Date of Birth is required**
  - RIN#: RIN is the candidate's 9-digit Medicaid number.
  - Social Security #: Enter the MFP candidate's social security #.
- Referral source (multiple choice) (where did they learn about this potential participant)
- Outcome of the referral (multiple choice)

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## Updating First Contact Referral Outcome

- If at the time of First Contact the potential participant is Considering Enrollment but *changes their mind or their situation changes prior* to signing the informed consent, the TC should go back into the Form A and change the referral outcome from “Considering MFP” to an outcome that best describes their current situation.
- Do not complete a disenrollment form unless the participant has enrolled by signing the informed consent and Form B was completed.

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## Referral List Updates

- If you find out from the nursing staff that the referrals on your list are deceased or have transitioned to another facility contact:
  - *IDoA*: email Kelly Cunningham, Kelly.Cunningham@Illinois.gov, and cc: John Eckert and Mindy Bristle ([mbristle@uic.edu](mailto:mbristle@uic.edu)) with referral's name and date of birth.
  - *DRS*: email Kelly Cunningham and cc: David Reed, Department Representative, and Mindy Bristle with referral's name and date of birth.
- Do not complete First Contact Documentation (Form A) if the referral is deceased or transitioned to another facility.

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## Informed Consent Requirements

- To be completed if participant wishes to enroll.
- Two original copies to be signed by participant (or proxy) and TC
- One for participant
- One for TC's file
- Page 2 is faxed to UIC at 217-586-6059
- Not an online form

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## Participant Enrollment (Form B)

- Records all persons that have agreed to be enrolled in MFP and efforts will be made to transition
- Include a recipient ID# if possible – if No RIN at enrollment write a note to explain why.
  - It is the MFP Transition Coordinator's responsibility to verify Medicaid eligibility for at least one day prior to transition
- Should include assessment information that determines the Level of Care (LOC, DON score of at least 29). Recommended to do a new level of care assessment the same day you complete Form A or B.

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## MFP Enrollment, continued

- **\*\*A participant is enrolled if, and only if the participant has agreed by signing the *Informed Consent* document.**
- Form B is completed once informed consent is signed.
- The date of the participant's signature on the Informed Consent is the date of enrollment on Form B
- You do not have to wait to complete this form – as soon as someone is "Considering" begin working on the pre-transition documentation

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## Participation Face Sheet (Form F)

- Required to be completed before transition
- Records major diagnoses, sensory needs/impairments, recent hospitalizations
- Add information as needed both pre- and post-transition

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## Medication Chart (Form G)

- Required to be completed before transition
- Add/Update information as needed both pre- and post-transition
- Must have prescriptions ready for when participant transitions
- UIC clinical staff, pharmacists, nursing facility staff can assist when needed
- Client gets a copy of his/her medication chart

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## Risk Assessment and Mitigation Strategies (Forms H and I)

- Required to be completed prior to transition and must be operational on first day of transition
- Identifies risks and strategies to address risks
- Once completed, review the Risk Assessment with participant and their support to confirm risks and approve selected mitigation strategies

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## Mitigation Plan (Form J)

- Required to be completed before transition after *Risk Assessment and Mitigation Strategies* have been completed
- Discuss Mitigation Plan with participant and their support.
- Evaluate effectiveness of strategies/tasks during follow-up visits
- The Mitigation Plan should include everything the TC will be doing to structure a safe transition:
  - Tasks/services to complete each mitigation strategy
  - Agency/individual who will complete each task
  - The date each task/service is to begin or be performed
  - Planned follow-up dates for monitoring
- Client gets a copy

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### 24 Hour Back-Up Plan (Form K)

- Required to be completed prior to transition and must be operational on first day of transition
- Backup providers should be identified for all critical services.
- Participant should be educated on how to use the back-up plan in different scenarios.
- Client gets a copy

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### Personal Resource List (Form L)

- Required to be completed prior to transition
- Includes contact information for local resources, medical providers, etc.
- Client gets a copy

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### Quality of Life Survey

- Must be completed prior to transition and faxed to UIC.
- Complete one week to 30 days **prior to transition**
- If participant refuses, contact Mary McGuire at [Mary.McGuire@illinois.gov](mailto:Mary.McGuire@illinois.gov) for more information.
- Note
  - Second QOL Survey: To be conducted by the UIC College of Nursing (about 1 yr. post-transition)
  - Third QOL Survey To be conducted at "Second Follow-Up" (about 2 yrs. Post-transition) by the UIC College of Nursing

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## MFP STAFFING/Case Review

- **IMPORTANT:** Notify your State Staff (if required) and UIC pod leader by phone or email of upcoming transitions so that a case review conference can be scheduled. Allow 2-3 weeks prior to transition
- Forms A, B, Informed Consent, F, G, H&I, J, K, L must all be completed prior to transition and prior to case review.
- Quality of Life survey must be completed prior to transition and faxed to UIC.

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## Online Notes

- Transition coordinators should use the online notes feature to document contacts with participant before and after transition.
- If there are changes to the mitigation plan or forms (new risks, new/changed medications, new/changed medical providers or support, etc.), then transition coordinators should update the appropriate forms.

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## Transition

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## Transition (Form C)

- To be complete on the day of transition or within 2 business days post-transition
- Do not project a date of transition
- Starts a 365 day clock of eligibility
- Records date of transition
- Records housing information, new address and appropriate waiver and demonstration services.

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## Post-Transition

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## Critical Incident Report (Form M)

- Notify UIC of critical incidents as soon as you learn of them (e.g., hospitalizations, serious injuries requiring medical attention, Emergency room visits, etc).
- Incident Review teleconference between UIC and agency staff is scheduled within seven days of notification of incident
- Submit online Form M as soon as possible
- Discuss incident details with your supervisor and supervisor completes internal review on Form M.
- UIC completes external review on Form M after incident review teleconference.

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### Post-Transition Update (Form E)

- Is completed
  - when a new assessment is completed that requires a change in the *Mitigation Plan* or
  - when there is a change in address
  - when there is a change in waiver or demonstration services
  - when there are calls for emergency back up- if a TC finds that a participant had to use their back-up plan for transportation services, record this on Form E.

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### Update Existing Information

- Transition coordinators should review and edit (as needed) online forms after each follow up contact with transitioned clients and after critical incidents to ensure that forms remain current and accurate.
- Transition coordinators should use the “Notes” feature to record the follow-up contacts with their clients.

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### Disenrollment/Withdrawal (Form D)

- Occurs anytime a participant is no longer enrolled
- **Occurs only if Informed Consent has been signed and Enrollment FORM B has been completed**

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## Questions?

- If you have additional questions about forms and MFP processes consult your UIC pod leader. If you don't know who your pod leader is call UIC staff at 217-586-6039.

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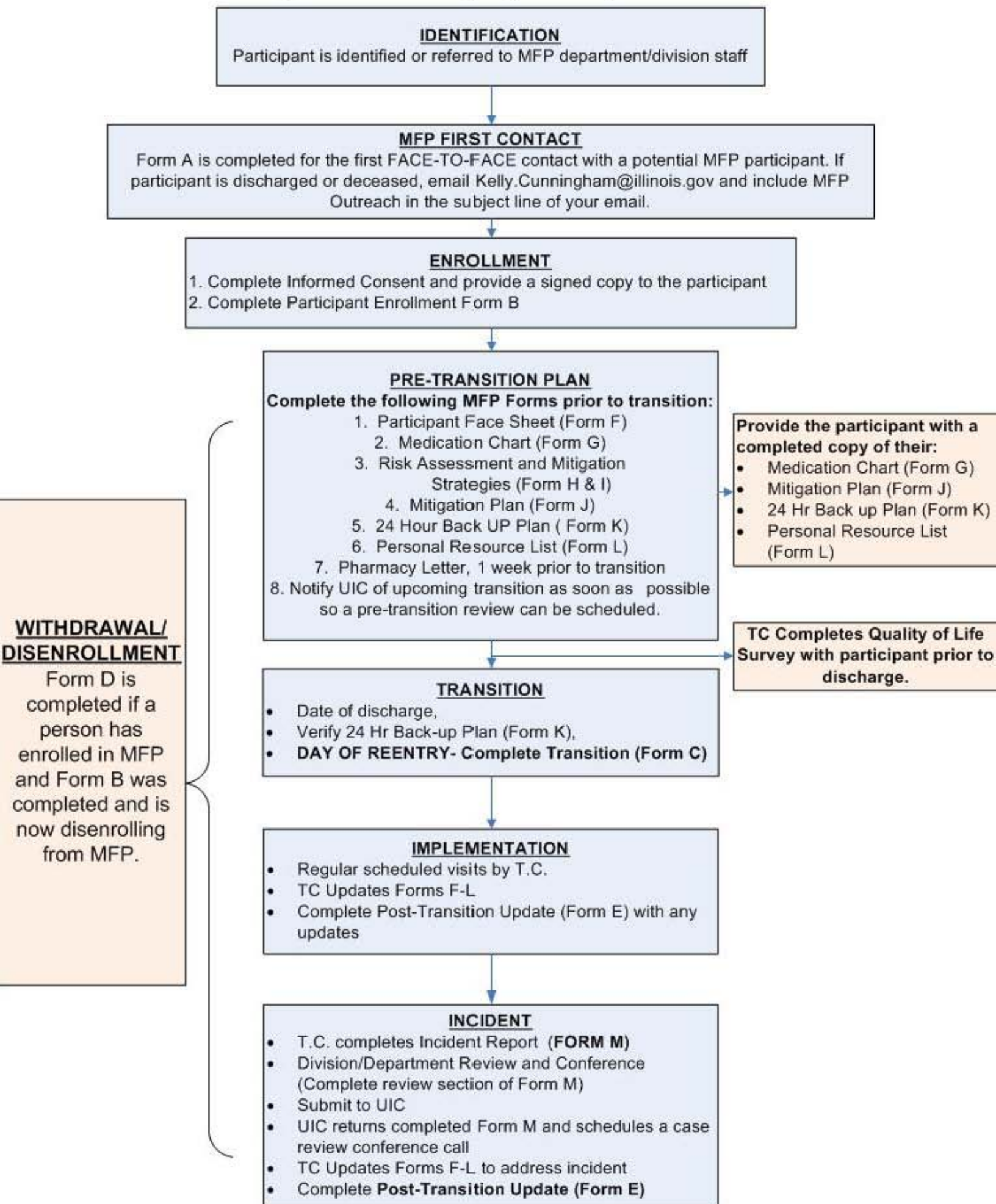
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# Money Follows the Person (MFP) Form Completion Flow Sheet



Note: This flow does not include agency/division/department forms.

Revised 11/30/2009



When working with technology, sometimes errors will occur. In some cases you get a yellow and red error message in other cases it appears that their form disappears. Here is what to do in these cases. Additional Questions? Contact your UIC pod leader.

### **Dealing with Error Messages**

Important: If you are working in Form J – Print it before you upload it.

If you receive an **error message** after submitting a form:

1. Right click on the screen and select “Back.” This should take you back to the form you were working on.
2. Print the form you had been working on so the data you entered is not lost. Right click and select “Print”
3. Attempt to submit the form again
4. If you receive the error screen again, please Copy and paste the text of the error into Microsoft Word and email it as an attachment along with the First name and Last Initial of the participant (e.g., Sue H) and what form you were working on when the error occurred (e.g., Form G) to your UIC pod leader.
5. Refresh/reload the browser (press F5 key) to confirm that the form was not submitted.
6. If the form was not submitted as entered, fax the hard copy you printed to UIC (217-586-6059). UIC will work with tech department to determine what caused the issue and UIC will complete the data entry so TC does not have to do duplicate work. In some cases, IT staff may need to contact the TC directly to work through the issue.

### **Dealing with “Time-Outs” or “Forms Disappear”**

Some users have reported that you were “kicked out” of the system or their forms disappear and they are sent back to a log-in screen so they lose their work when they attempt to upload their form. Happens most often in Form J.

### **What is happening:**

The MFP forms are completed in pop-up screens. In some cases you may be spending 30 minutes or more in a pop – up, especially Form J – Mitigation Plan. We believe that your computer “thinks” you are inactive, even though you aren’t. This is very frustrating because you may lose your work. Form J can be saved and completed later – we recommend doing this every 25 minutes or so.

### **What can you do to prevent this:**

1. Always print your completed Form J **BEFORE** you upload it. (Right click on your screen and select “Print”)
2. Also you can use ALT + Tab keys to go back and forth between the pop-up form and the main screen or just go back to the main screen periodically (every 20-30 minutes) and hit refresh (press F5 key). This will make sure your computer does not think you are idle.
3. If you do lose your form after you upload – you will have a printed form that you can fax to UIC. We will then enter your form for you ASAP.

# Example Error

## Server Error in '/' Application.

*Line 1: Incorrect syntax near '='.*

**Description:** An unhandled exception occurred during the execution of the current web request. Please review the stack trace for more information about the error and where it originated in the code.

**Exception Details:** System.Data.OleDb.OleDbException: Line 1: Incorrect syntax near '='.

### Source Error:

```
Line 157: End If
Line 158: Dim QuestionAnswer, CheckedYes, CheckedNo, QuesAns
Line 159: QuestionAnswer = "" & Sql.ReadField("SELECT ISNULL(QuestionNo, '')
AS QuestionNo FROM FormHDetail WHERE Question = " & row("Ques") & " AND FormHID
= " & FormHIDFirst)
Line 160: Dm.Write("<tr>")
Line 161: DM.Write("<td class='pad bold moderate' width='80%' >" &
row("Ques") & ". " & row("Question") & "</td>")
```

**Source File:** E:\IHC\cPatientFormH.aspx **Line:** 159

### Stack Trace:

```
[OleDbException (0x80040e14): Line 1: Incorrect syntax near '='.]
System.Data.OleDb.OleDbDataReader.ProcessResults(OleDbHResult hr) +1044506
System.Data.OleDb.OleDbDataReader.NextResult() +421
System.Data.OleDb.OleDbCommand.ExecuteReaderInternal(CommandBehavior
behavior, String method) +235
System.Data.OleDb.OleDbCommand.ExecuteScalar() +116
LibraryDM.Sql.ExecuteNonQuery(OleDbConnection connection, String commandText,
OleDbTransaction& commandTransaction) +73
LibraryDM.Sql.ReadField(String commandText) +62
ASP.cpatientformh_aspx.ListQuestion(DataRow row, String sort, String output)
in E:\IHC\cPatientFormH.aspx: 159
LibraryDM.List.RenderRecords(DataTable listData, HtmlTextWriter
outputStream) +347
LibraryDM.List.SingleList(String query, String whereQuery, String
havingQuery, String orderQuery, HtmlTextWriter outputStream) +1882
LibraryDM.List.Render(HtmlTextWriter outputStream) +8009
System.Web.UI.Control.RenderControlInternal(HtmlTextWriter writer,
ControlAdapter adapter) +27
System.Web.UI.Control.RenderControl(HtmlTextWriter writer, ControlAdapter
adapter) +99
System.Web.UI.Control.RenderControl(HtmlTextWriter writer) +25
ASP.cpatientformh_aspx.__RenderInputForm(HtmlTextWriter __w, Control
parameterContainer) in E:\IHC\cPatientFormH.aspx: 298
System.Web.UI.Control.RenderChildInternal(HtmlTextWriter writer,
ICollection children) +256
System.Web.UI.Control.RenderChild(HtmlTextWriter writer) +19
System.Web.UI.HtmlControls.HtmlForm.RenderChild(HtmlTextWriter writer)
+163
System.Web.UI.HtmlControls.HtmlContainerControl.Render(HtmlTextWriter
writer) +32
System.Web.UI.HtmlControls.HtmlForm.Render(HtmlTextWriter output) +51
```

# **MONEY FOLLOWS THE PERSON PATHWAYS TO COMMUNITY LIVING**



MFP/Pathways to Community Living Transition Coordinator Process  
(Care Coordination/Management)

September, 2012

*Prepared by*

The University of Illinois at Chicago  
College of Nursing  
Institute for Health Care Innovation



## Contents

Orientation and Training.....	3
Identification (Pre-Screens).....	3
First Contact .....	4
Enrollment.....	5
Assessment.....	5
Pre-Transition and Pre-Transition Planning .....	8
Day of Transition .....	12
First Week Following Transition.....	13
30-Day Post-Transition Follow-Up Call.....	14
On-going Implementation (365 days post-transition) .....	15
Roles.....	16
High –Risk Management .....	18
Medication Management.....	19
Self-Management.....	20
Transitional Care .....	20
Critical Incidents and Critical Incident Call.....	21
30 Day Post-Critical Incident Call: .....	22
Withdrawal/Disenrollment .....	23
Mortality Review Process.....	23
Appendices .....	24

## Orientation and Training

Identified transition coordinators (TCs) for MFP/Pathways are required to review MFP/Pathways related materials and complete training sessions. MFP/Pathways related materials include brochures and marketing material. TC training is divided into three sessions with additional Division/Department training and includes:

1. Initial TC Training – 3 sections
  - a. The first presentation includes an overview of MFP/Pathways and covers the program's objectives, participating divisions, participant eligibility, how to disenroll and re-enroll prior to transition, what occurs after completion of the 365 days, an explanation of what a qualified community setting is, the role of UIC in quality assurance, and federal CMS requirements
  - b. The second presentation covers the care management processes regarding the goals of care management, the roles of the TC, and step by step information for: outreach, enrollment, assessment, identifying risks, mitigation planning, follow-up and monitoring, and evaluation. This presentation also covers the development and completion of the 24-hour back-up plan and documentation; how to formulate notes and document in a descriptive and detailed way regarding the participant and their plan of care
  - c. The third presentation is on the critical incident (CI) process. This presentation defines critical incidents, how to report them, and how to adjust the risk inventory and mitigation plan to address any new risks and prevent future CIs of the same nature.
2. MFP Documentation Training – The second training covers documentation and the on-line care management system (WebApp). Using a simulated case study, TCs are taken through the WebApp and each form (A-M) is completed. This training is conducted through webinar and teleconference.
3. Quality of Life surveys - This teleconference covers the federally mandated Quality of Life survey (QOL). This call explains the purpose of the QOL survey and when it should be completed.
4. MFP partner Divisions/Departments may have additional TC training requirements that must be completed prior to the TC becoming active.

Once individuals have completed all three initial training sessions they complete a TC survey that provides information about their education, training and experience in care management. TCs may be required to participate in ongoing training sessions held by UIC or HFS in order to remain current and up-to-date on MFP requirements and processes.

## Identification (Pre-Screens)

Participants are primarily identified and referred to the TCs and designated staff through the following mechanisms:

1. A referral list of potential participants is generated by HFS and sent out to each agency.
2. Local or Regional Ombudsmen.
3. Self-referrals from participants and families.
4. Nursing home staff or provider staff.

## Transition Coordinator (Care Coordination/Management) Process

5. The MFP/Pathways online referral form that nursing facilities, program stakeholders, the public, and others can use to refer potential candidates. Nursing facilities can use this route to refer people identified after completion of the MDS Section Q.
6. Facility closures.
7. Other agencies.

Prior to initial contact with the potential participant, TCs review specific information, speak with nursing facility staff, and review records to determine if the potential participant is a good candidate for MFP/Pathways enrollment. The TCs also determine if the potential participant has any guardians, obtains the guardian contact information, and engages with the guardian(s). If the TC learns that the participant has been discharged or is deceased, they will communicate this to Lora McCurdy at [Lora.McCurdy@illinois.gov](mailto:Lora.McCurdy@illinois.gov) and the Division/Department leads via email and include "MFP Outreach" in the subject line of the e-mail.

### First Contact

The TC arranges to meet the potential participant, and guardian(s) if applicable. During this meeting, the TC reviews the MFP/Pathways materials with them, including the informed consent, and conducts a pre-assessment to determine level of care (LOC) needs. It may take more than one contact before a potential participant and/or guardian feels ready to make a decision regarding participation in the MFP/Pathways program. The participant and/or guardian may wish to review documents and/or speak with family members or other providers prior to making a decision to participate. If the potential participant and/or guardian wants time to review the information or are not interested at this time, the TC should leave the MFP/Pathways materials with them and provide them with the TC/agency contact information for future inquiries about MFP/Pathways. If the potential participant and/or the guardian are unsure about the program, leave the MFP/Pathways material with them and schedule a follow-up meeting to answer any further questions they might have.

After the first contact, the TC will complete Form A – "MFP First Contact" and document the encounter with the participant in the case "notes" section of the on-line care management system (WebApp) case notes. Be as descriptive as possible. Describe who the potential participant is and any known history. Include any legal information, i.e., living will and/or guardian information. All contacts with the potential participant and/or guardian should be documented with a descriptive note in the case "notes" of the WebApp.

#### Example Case Note following Initial Contact:

*Mrs. Paula Johnson is a 60 year-old Caucasian female who appears alert and oriented. She has no legal documents in place and does not have a guardian. Paula was admitted into Oak Nut nursing facility on June 26, 2009, after being involved in a MVA (motor vehicle accident) which resulted in a spinal cord injury. She has paralysis from the waist down and uses a wheel chair for mobility. Paula is unable to transfer from bed to chair. Paula has a history of diabetes (which she developed post-MVA and has never self-managed), HTN, and hyperlipidemia. She is divorced and has two adult children. Her son lives within an hour of her and visits on occasion, her daughter lives in another state and rarely comes to visit. She has a sister who lives 4 hours away and who is her emergency contact. Her sister has not visited for over a year. If Paula enrolls in MFP she will need an apartment that is wheelchair accessible. MFP brochure, pamphlet and informed consent were reviewed with Paula and given to her. At this time, Paula is unsure if she wants to transition to the community. She was informed of the housing options including supportive living facilities (SLF). She would like to take some time and think about it. TC will return to see Paula in one month (July 16<sup>th</sup>) in the afternoon. Paula was provided with contact information, including name and phone number if she has any questions. Form A-First Contact Form completed.*

## Enrollment

Once the potential participant and/or guardian agrees to participate in MFP/Pathways the 2 copies of the informed consent must be signed by the participant and guardians (if applicable), and witnessed. If the potential participant has more than one guardian the TC should determine which guardian(s) must sign the document and have that guardian sign it. One copy of the signed informed consent is left with the participant and/or guardian. A copy of the signature pages must be faxed (217-586-6059) or scanned and e-mailed to mbristle@uic.edu to UIC's Mahomet office. After the encounter, the TC must complete Form B – "MFP Participant Enrollment Form" and document the encounter in the case "notes" of the WebApp, being as descriptive as possible. The enrollment date on Form B is the date that the Informed Consent was signed by the participant and/or guardian(s).

Example Case Note following Enrollment:

July 16, 2012: One month follow-up visit made to Paula at Oak Nut nursing facility. She is alert and in good spirits today. She has read and re-read the MFP material previously left with her and would like to enroll in MFP and be considered for transition into the community. She reports her son and ex-husband are supportive and will assist as much as they can. Paula reported she understands the purpose of the program and the informed consent. Paula signed the informed consent and a copy was made and given to her and *a copy of the signature pages* was faxed to UIC. Form B was also completed.

## Assessment

After a potential participant is enrolled into MFP/Pathways the TC should contact UIC for a copy of the Medicaid claims data. The claims information is shared with the TC to assist them in identifying diagnoses, issues, and patterns of healthcare utilization (i.e., LTC admits, hospitalizations, ED visits) in the participant's history.

The TC obtains a copy of the nursing facility's medical management plan for the participant. This documentation is useful as a basis for completing a comprehensive assessment and completing required documents, the MFP risk inventory and strategies (Form H & I) and mitigation plan (Form J).

The TC completes their agency-specific assessment or comprehensive assessment of the participant. The information needed to complete the assessment can be obtained from: the participant, nursing home chart, nursing home staff, family members, friends, guardian, and other service providers (physical therapy, social worker). Areas to include in the assessment are: demographics; the participant's goals, strengths, preferences; cognition/comprehension; medical, psychiatric and developmental disability history; substance use/abuse history; social history; functional ability; safety issues (both environmental and behavioral), including harm to self or others; issues with nutrition, sleep, pain, or incontinence; and self-management ability and skills.

- Demographics: name and address; Medicaid number (RIN); race; ethnicity; primary language; caregiver or emergency contact information; education; religion; employment history; criminal history; previous living arrangements, and attempts at community living.
  - Legal documents or issues: Presence of any legal documents including a living will; power of attorney (POA); guardianship; and court ordered treatments.
  - Finances/Economic issues: Current income sources and amounts; outstanding non-paid bills; Medicaid eligibility both prior to and after transition (participant must retain Medicaid eligibility to stay in MFP after transition); and Medicare eligibility.
- Goals, strengths, preferences: are to be identified and prioritized by participant.
- Cognition/comprehension: MMSE score and/or Mini-Cog; and presence of dementia or other diagnoses (i.e. brain injury, hepatic encephalopathy, substance use) that affect cognition/comprehension and judgment.

## Transition Coordinator (Care Coordination/Management) Process

- Medical/Physical history: Diagnoses and status of control; accidents and previous surgeries that affect participant's functional ability, or which requires self-management activities (i.e., colon resection with resultant colostomy); history of falls, history of wounds; etc.
- Psychiatric history: Diagnoses and status of control; affect on the participant's day to day functioning; history of self-neglect; history of non-compliance, etc.
- Developmental disability history: Diagnoses and status; affects on participant's day to day functioning.
- Substance use/abuse history: History of substance use including type, frequency, amount, and duration; current or recent substance use including type, frequency, amount, and duration.
- Utilization history: Previous nursing facility admissions and discharges, reason for discharge (especially if discharged to home and transition was unsuccessful), previous and recent hospitalizations and emergency department visits and reasons. Some of this information is available on the Medicaid claims document.
- Medications: Current allergies and medications including name, dosage, route, frequency, side effects, whether or not laboratory monitoring is needed, and participant's history of self-administering and current ability to self-administer medications (including injections, inhalations, and other therapies). Include prescription, non-prescription (over-the-counter), vitamins, herbal supplements; drops, creams, or lotions.
- Social history: Presence of family/significant other/friends and their involvement; interaction, commitment, and ability to interact with other individuals. Presence of family/significant other/friends as caregivers and/or caregivers are needed.
- Functional ability: Abilities and limitations in performing activities of daily living and instrumental activities of daily living. If assistance to complete activities is needed, identify the type and extent of the assistance. Also identify what medical equipment (DME) and supplies are being used and what will be needed after transition.
- Safety issues, environmental: Complete a home safety assessment, neighborhood safety assessment, and a falls risk assessment.
- Safety issue, behavioral: Identify recent, previous, or history of self-harm and harm to others. Complete or order a suicide risk or self-harm mini assessment, if needed. Obtain as many details as possible about the previous incident(s). Identify any history or current risks related to abuse, neglect or exploitation.
- Lifestyle: Identify issues with nutrition, sleep, pain, incontinence. Complete additional mini assessments as needed to identify issues with quality of life related activities.
- Self-management ability and skills: Identify ability or inability, willingness or unwillingness to engage in development and implementation of plan of care. Identify educational needs, barriers to self-management activities, and the participant's historical and current performance of self-management activities.

After the comprehensive summary has been completed, the TC documents a summary of the assessment information in the case 'notes' of the WebApp, being as descriptive as possible. Include the pertinent information in each area, paying special attention to risks and/or unresolved issues.

The following is an example a post-assessment case 'note' following the above outline.

August 5, 2012:

Demographics:

Mrs. Paula Johnson is a 60 year-old Caucasian female, 5'2" and 235 pounds, with a BMI of 43, which is considered morbid obesity. She was admitted to Oak Nut nursing facility 3 years ago after an accident that resulted in a spinal fracture and cord injury at T 4-5. Her primary language is English and she can read and write. She is of the Catholic faith and does like to attend mass at least once a week. She is not in need of a guardian and her emergency contact person is her sister who lives 4 hours away. She is divorced and was a victim of domestic violence. She does not have any legal documents in place (no POA or living will). Paula has a 9<sup>th</sup> grade education and has worked in dry-

clears off and on in the past. She was arrested once for stealing and was placed on probation for 2 years afterwards. This happened about 25 years ago and she has not been in legal trouble since. She had a bank account in the past but had difficulty remembering to pay her bills. Her current income is SSDI at \$652.85 a month. She is a Medicaid recipient and has no idea if she would qualify for Medicare. She had lived independently in the community before her accident.

Participant's Goals, Strengths, Likes and Dislikes:

Paula would like to live independently again but she is unsure she is able to because of her health conditions. Prior to her accident she was not managing her diabetes or other medical conditions. She agrees that she will need to learn to manage her diabetes, including giving herself insulin injections and checking her blood sugar twice a day, as she has never done this before.

Cognition/Comprehension:

Her MMSE score is 26. She notes she is forgetful at times.

Diagnoses:

- diabetes type 2 with insulin,
- T 4-5 spinal cord injury,
- coronary artery disease (CAD) with previous myocardial infarction (MI),
- hypertension (HTN),
- depression,
- anxiety,
- bipolar disorder,
- morbid obesity,
- constipation, and
- occasional UTI.

Substance Use:

She has in the past drunk alcohol, which she describes as a social activity when she would get together with friends. She reports that her drinking did not have a negative effect on relationships, employment or social activities.

Utilization:

In the last 12 months Paula has been in the ED x2 for UTI and the hospital x 1 after falling out of her wheelchair trying to go to the bathroom. This is her only admission to a nursing facility.

Medications:

*Allergies:*

- penicillin and abilify

*Medications:*

- Lisinopril 10 mg for blood pressure,
- HCTZ 25 mg daily for hypertension,
- Metformin 1000 mg BID for diabetes,
- Lantus 20 units every evening,
- Atenolol 50 mg BID for CAD,
- Nitroglycerin 0.6 mg sublingual for chest pain,
- Baclofen 10 mg TID for muscle spasms,
- Seroquel 200 mg at bedtime for bipolar,
- Trazadone 100 mg at bedtime for sleep,
- Docusate sodium 100 mg capsule BID for constipation prevention,
- Milk of magnesia 30 mg at bedtime for constipation, and
- Ducolax suppositories if no BM for 2 days

She thinks she can learn to take her medications as prescribed but is not sure about the insulin injection and checking her blood sugar twice a day.

Social:

Paula speaks to her ex-husband regularly. They got divorced after she was admitted to the nursing facility, and she believes it has been a contributor to her depression. Other than her husband, she has one sister who lives 4 hours away who she never sees. She also has 2 adult children and 4 grandchildren. Her daughter lives in Texas and her son lives within an hour of the nursing facility. She believes her ex-husband would check on her and assist her on occasion. A concern regarding this relationship is Paula reported that when they were married he drank a lot and would come home drunk and “smack” her around.

Functional:

Paula has limitations in ability and movement. She uses a wheelchair for mobility. She is paralyzed from the waist down and will require a bariatric wheelchair with cushion, shower grab bars, shower chair, lift chair, Hoyer lift, and bariatric hospital bed with a trapeze to assist with turning herself at night. She has not been able to transfer from bed to chair on her own. She will need diabetes and incontinence supplies.

Safety Issues, Environmental:

Since no apartment has been identified for Paula, a home safety assessment/environmental/neighborhood assessment cannot be completed. She is a fall risk because of her mobility, transfer impairments, and history of falls. Her apartment will need to be wheelchair accessible.

Safety Issues, Behavioral:

The nursing home reports that Paula gets depressed and refuses to get out of bed sometimes. She yells at the staff to leave her alone and will throw items at them. She has not engaged in any drinking activity since she has been in the nursing home, but they acknowledge she has no opportunity to get any alcohol.

Lifestyle:

Paula is incontinent of bowel and bladder. She does not like to follow her diet (diabetic/cardiac). She has trouble sleeping and takes Trazodone medication at bedtime, which helps. She does not participate in exercise class and does not care to lose weight.

Self-Management Ability:

Paula has never checked her own blood sugar, blood pressure, or given herself insulin injections. She believes she can learn to manage her diabetes if she has someone help her with the “daily tasks.”

## **Pre-Transition and Pre-Transition Planning**

See the MFP/Pathways “Transition Checklist” (Appendix A) for tasks that are required to be completed prior to transition. Be sure to complete the document and “note” what was completed (yes), what was not completed (no), what was not applicable (N/A), and the date. Once the document is completed fax to UIC at 217-586-6059. The document will be attached to the participant’s WebApp file.

Federal CMS mandates that all MFP demonstrations develop forms and processes to capture risk identification, mitigation planning and management; a 24-hour back up plan; and reporting, tracking, and analysis of critical incidents.

In addition to their agency-specific comprehensive assessments, for MFP/Pathways participants, TCs will also complete:

## Transition Coordinator (Care Coordination/Management) Process

- Form F: Participant Face Sheet: includes an overview of the participant’s reason for admission into the nursing facility, diagnoses, impairments, recent hospitalizations, and current list of providers.
- Form G: Medication Chart: includes the participant’s medication and food allergies, all prescription and over the counter medications. Be sure to include any vitamins, herbs, supplements, drops or creams the participant is currently using.
- Form H, I & J: Risk Inventory and Mitigation Plan: identified risks and strategies to develop a comprehensive, individualized plan of care (mitigation plan) that facilitates a safe, sustainable transition to community-living
- Form K: 24 Hour Back-Up Plan: lists the primary and backup service providers for the participant/caregiver after transition. It also has space for participant specific action plans, including self-management activities, symptoms to monitor, and who to call if they experience abnormal or unexpected symptoms that could indicate worsening of their condition. See Appendix B.

Provide the participant with copies of these completed MFP documents: Form G – Medications, Form J – Mitigation Plan, and Form K – 24-hour Back-up Plan.

A Quality of Life survey also has to be completed prior to transition. Once the Quality of Life survey is completed, fax it to the Mahomet UIC office at 217-586-6059. This should be completed within 30 days prior to the transition, but no later than one week beforehand.

Be sure to document the completion of the forms and all participant-specific encounters in the case ‘notes’ section of the WebApp and be as descriptive as possible.

After compiling all the assessment information and completing all of the pre-transition planning documents notify the appropriate UIC staff contact that the participant is ready for a case review. A case review document will be completed by the UIC staff contact for the TCs agency and will be provided to the TC and the Division/Department MFP lead. This will include a summary and evaluation of the participant’s Medicaid claims history and the assessment documents completed by the TC. It will also include a discussion of the participant’s **risk status and risk category** (see below). A case review teleconference is conducted to discuss the participant’s case and identify any additional risks and mitigation strategies. The case review conference is to be held prior to transition. If more than 60 days has lapsed since the case review and the participant has not transitioned, an additional case review conference should be conducted. An action plan will be developed during the case review call(s) and documented in WebApp case notes by the UIC. The final pre-transition case review document will be attached to the participant’s WebApp file. The status of the action plan will be monitored during a 30 day post-transition conference call.

### *Risk Status & Risk Categories:*

Through review processes (mortality and re-institutionalization), common criteria have been identified and the presence of these criteria put the participant at *high-risk* for either re-institutionalization or mortality:

Mortality high-risk	Re-institutionalization high-risk
<ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic pain</li> <li><input type="checkbox"/> Obesity (BMI <math>\geq</math> 30)</li> <li><input type="checkbox"/> Alzheimer’s disease/Dementia</li> <li><input type="checkbox"/> COPD</li> <li><input type="checkbox"/> Lack of peer support</li> <li><input type="checkbox"/> History of falls</li> <li><input type="checkbox"/> <math>\geq</math> 2 ADL limitations</li> <li><input type="checkbox"/> Advanced age &gt; 65</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Any pre-transition medication risk (non-adherence, poly-pharmacy)</li> <li><input type="checkbox"/> Needs Additional Supports to live in the community*</li> <li><input type="checkbox"/> Pre-transition ED visit/hospitalization within 12 months prior to transition</li> <li><input type="checkbox"/> Any post-transition hospitalization</li> </ul> <p>Reduced Risk: living in a supported living facility (SLF)</p>



## Transition Coordinator (Care Coordination/Management) Process

Emergency Department visit in the first few days after transition are also significant but not as significant as these criteria.

Other criteria identified in the literature that put the participant at *high-risk* for either re-institutionalization or mortality:

- Suicide ideation or previous suicide attempt
- CHF (congestive heart failure)
- Active cancer
- Isolation

The following chart includes lists of characteristics, a recommended visit schedule and recommended provider follow-up for persons who are high, moderate or low risk of re-institutionalization and/or death after transition to the community. These categories were developed from the criteria identified above. The presence of one of the independent risk criteria automatically puts the participant in that category. For example, a diagnosis of COPD automatically places the participant in the high-risk category, and the presence of morbid obesity automatically places the person at moderate risk.

Also note the visit schedule may change based upon the participant's status, and the participant may move from one category to another depending upon a change in their health status and conditions. A hospitalization or ED visit will automatically move the participant into the high-risk category and required increased face-to-face visits.

	<b>High Risk</b>	<b>Moderate Risk</b>
<b>Risk Level Criteria</b>	<p><b>Any one of these criteria:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic obstructive pulmonary disease (COPD)</li> <li><input type="checkbox"/> Presence of wounds</li> <li><input type="checkbox"/> Suicide ideation or previous suicide attempt</li> <li><input type="checkbox"/> Any ED visit/hospitalization in the 12 months prior to transition</li> </ul> <p><b>2 or more of these:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Morbid obesity: BMI <math>\geq</math> 35</li> <li><input type="checkbox"/> Alzheimer's/Dementia</li> <li><input type="checkbox"/> Congestive heart failure (CHF)</li> <li><input type="checkbox"/> 5 or more Major physical/ mental health conditions*</li> <li><input type="checkbox"/> 2 or more ADL/IADL limitations**</li> <li><input type="checkbox"/> Isolation</li> <li><input type="checkbox"/> Needs additional support to live in the community***</li> </ul> <p><b>3 or more of these:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Medication risk****</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Chronic pain</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Active cancer</li> <li><input type="checkbox"/> History of falls</li> <li><input type="checkbox"/> History of alcohol or substance use/abuse</li> </ul>	<p><b>Any one of these criteria:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Morbid obesity: BMI <math>\geq</math> 35</li> <li><input type="checkbox"/> Alzheimer's/Dementia</li> <li><input type="checkbox"/> Congestive heart failure (CHF)</li> <li><input type="checkbox"/> Medication risk****</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Chronic pain</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Active cancer</li> <li><input type="checkbox"/> History of falls</li> <li><input type="checkbox"/> Isolation</li> <li><input type="checkbox"/> History of alcohol or substance use/abuse</li> <li><input type="checkbox"/> 5 or more Major physical/ mental health conditions*</li> <li><input type="checkbox"/> 2 or more ADL/IADL limitations**</li> <li><input type="checkbox"/> Needs additional support to live in the community***</li> </ul>
<b>Recommended minimal TC Visit schedule</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> TC present on the day of transition</li> <li><input type="checkbox"/> 2 face-to-face visits a week for the first month</li> <li><input type="checkbox"/> A phone call to participant the day after transition</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> TC present on the day of transition</li> <li><input type="checkbox"/> 2 face-to-face visits the first week post-transition</li> <li><input type="checkbox"/> A phone call to participant the day after transition</li> </ul>

## Transition Coordinator (Care Coordination/Management) Process

	<ul style="list-style-type: none"> <li>□ 1 face-to-face visit a week for the next 2 months</li> <li>□ 2 face-to-face visits the following next 7 months alternating with phone contacts the opposite weeks</li> <li>□ After transferring back home after an ED visit or hospitalization visits return to 2 face-to-face visits a week for at least the first month</li> <li>□ Visit schedule can be adjusted as needed based upon participant status/mitigation plan</li> </ul>	<ul style="list-style-type: none"> <li>□ 1 face-to-face visit a week for the following 6 weeks</li> <li>□ 1 face-to-face visit in the remaining months with weekly phone calls</li> <li>□ An ED visit or hospitalization results in the participant becoming high-risk. TC visits become 2 face-to-face a week for at least the first month</li> <li>□ Visit schedule can be adjusted as needed based upon participant status/mitigation plan</li> </ul>
<b>Recommended Provider follow-up visits</b>	<ul style="list-style-type: none"> <li>□ Determine which providers participant will need to engage with after transition and have appointment scheduled prior to transition to occur as soon as possible after transition, preferably in the first week.</li> </ul>	<ul style="list-style-type: none"> <li>□ Determine which providers participant will need to engage with after transition and have appointment scheduled prior to transition to occur within the first 30 days.</li> </ul>

**Definitions:**

**\*Major Physical/Mental health conditions:** CAD (ischemic heart disease or previous MI), CHF, Diabetes, Alzheimer's disease, Atrial Fibrillation, chronic kidney disease, depression, bipolar disorder, schizophrenia, psychosis, alcohol dependence, drug dependence

**\*\*ADL/IADL:** needs assistance with ambulation, needs assistance with finances, needs assistance with toileting, needs assistance with transferring, has a history of falls, needs assistance with meals, has other ADL/IADL risks, needs assistive or adaptive devices in the home, and requires a special diet.

**\*\*\*Additional Supports to Live in the Community:** needs assistance to avoid harmful activities, lack of natural support, lack of peer support system, at risk of financial exploitation, at risk of social isolation, needs support to be in the community, history of suicide attempts/threats, and needs support to be in the home alone.

**\*\*\*\*Medication Related Risks:** takes seizure medication, needs assistance taking or monitoring medications, taking 9 or more medications, at risk of non-adherence to medications, and taking 2 or more psychotropic drugs.

### Paula's Risk Determination

*Paula has the following diagnoses/conditions.*

- *Diabetes type 2 with insulin,*
- *T 4-5 spinal cord injury,*
- *Coronary artery disease (CAD) with previous myocardial infarction (MI),*
- *Hypertension (HTN),*
- *Depression,*
- *Anxiety,*
- *Bipolar disorder,*
- *Morbid obesity,*

**Functional:** *Paula has limitations in ability and movement which result in ADL and IADL limitations. She is paralyzed from the waist down. She uses a wheelchair for mobility. She will require a bariatric wheelchair with cushion, shower grab bars, shower chair, lift chair, Hoyer lift, and bariatric hospital bed with a trapeze to assist with turning herself at night. She has not been able to transfer from bed to chair on her own. She will need diabetes and incontinence supplies.*

**Utilization:** *In the last 12 months Paula has been in the ED x2 for UTI and the hospital x 1 after falling out of her wheelchair trying to go to the bathroom. This is the only time she has been in a nursing facility.*

Per our chart above, Paula is automatically at *high-risk* due to her utilization pattern of any ED visit or hospitalization in the last 12 months. If Paula had not had a positive utilization history she would still be high-risk due to morbid obesity and ADL/IADL limitations.

Paula's initial contact schedule will be a home visits twice a week after transition with phone contacts as needed.

*Low-Risk Recommendations* for participants not meeting either the high-risk or moderate risk criteria:

- ❖ Visit schedule: 1 face-to-face visit a week for the first month post-transition; a phone call to participant the day after transition.
- ❖ Provider visits: Determine which providers participant will need to engage with after transition and have appointment scheduled with PCP and psychiatrist prior to transition to occur within the first 30 days.

Example of a pre-transition note and action plan:

*Case review staffing September 19, 2012:*

Paula is a 60-year-old female who has significant co-morbid medical conditions. She was admitted to the nursing facility following a motor vehicle accident and has paraplegia. She uses a manual wheelchair to get around and is unable to transfer by herself. She is incontinent of urine and bowel. She has a complex medication regimen. Paula has limited family involvement in her care and will need assistance to re-integrate into the community. She likes to spend time outside whenever possible. Paula is determined to be high-risk based upon her recent hospitalization/ED visits.

- ✓ Assess for dehydration secondary to diuretics and laxatives: increase in heart rate, decrease in alertness, dry tongue or mucous membranes, decreased urination, dizziness, and thirst.
- ✓ Assess for signs of edema that is beginning to affect the lungs: weight gain will be an early sign followed by productive cough, shortness of breath, trouble breathing when lying flat.
- ✓ Arrange for staff to accompany Paula to all provider appointments and ensure that changed or new information gets relayed to all professional and paraprofessionals engaged in her care.
- ✓ Arrange for staff training on safe use of Hoyer lift and transferring Paula.
- ✓ Coordinate home care nursing for diabetes education and management.
- ✓ Coordinate evaluation and follow-up with a psychiatrist and a community mental health center.
- ✓ Coach and evaluate the staff on proper use of mechanical lift and all DME.
- ✓ Develop and implement a caregiver staffing level and schedule to support recommended level of coverage.
- ✓ Develop a plan for review and update of Paula's medication list after every medical appointment.
- ✓ Monitor that Paula has adequate amounts of medical supplies to meet her needs: diabetes supplies, attends/disposable briefs, ted hose.
- ✓ Monitor Paula is checking her blood sugar twice a day and reporting to her provider. Increase in blood sugar levels may be a sign of early infection or may signal a need for a medication adjustment.
- ✓ Monitor/promote Paula's engagement in activities for structuring her free time. Assist her to identify local support groups and activities of interest.

Additionally, TCs should complete a follow-up note that describes the status of each of the action plan items. If they were unable to implement an action plan item, they should describe why.

## Day of Transition

On the day of transition the TC or an MFP/Pathways-trained representative of the TC should accompany the participant to their new home or visit the participant in their new home to ensure that all required items are present: furniture, utilities are in working order, any needed DME and/or medical supplies, EHRS, etc. Ensure that the participant has his/her medications from the nursing facility, including any injectable, refrigerated, sprayed or inhaled medications, and pain medications. Determine how many days of medications are available and discuss the plan for obtaining refills.

Verify the information on the 24-Hour Back-Up Plan is complete and accurate. Discuss what the participant/family/caregivers should do if the participant needs backup services/ supports, or if the participant's wellness status changes. Ensure that the participant has a functioning telephone and/or

## Transition Coordinator (Care Coordination/Management) Process

EHR to contact backup providers or emergency services. Provide the participant/caregiver with the TC's contact information and a copy of the following completed documents: Medication chart – Form G, Mitigation Plan – Form J, and 24-hour Back-up Plan – Form K. Once the participant is transitioned the TC will complete the Transition Form – Form C within 48 hours of transition. This starts the participant's 365 days of post-transition eligibility in the MFP/Pathways program.

Obtain signed release of information forms from the participant for the community providers he/she will be seeing (i.e., primary care provider, mental health worker or psychiatrist, home health care staff).

The TC will document a transition day case 'note' in the WebApp note to include: the date of transition, who was present at transition, the status of all required items (grocery, furniture, medications, DME, medical equipment supplies), that all utilities were on and in working condition, that the EHR/PERS (an emergency response system) was installed and the participant understands how and is able to use the device, if the participant was satisfied, if the participant has any additional needs, what caregiver coverage is provided during first days of transition, that the Transition form (Form C) was completed, and the date and type of the next follow-up visit.

### Example Transition Day Case Note:

Day of Transition October 15, 2012:

Paula moved into her new home today. The nursing facility provided a wheelchair accessible van for her and all of her belongings went with her. TC arrived at Paula's apartment at the same time she did. Paula's son and ex-husband were also present and are assisting her with getting settled in. She has an apartment on the third floor that is accessible to her via an elevator and the apartment is wheelchair accessible. Paula is able to navigate through her apartment from one room to the other and her *shower grab bars, shower chair, lift chair, Hoyer lift, and bariatric hospital bed with a trapeze and diabetes and incontinence supplies are all present and in good working order.* The telephone company came out the same day and connected her telephone and her lifeline was installed. Paula has the lifeline around her neck and understands how to use it. Paula has enough food for the first week and then she will go shopping with her son when he comes to visit. *The nursing home gave Paula the remaining medication which will be enough for the rest of this month. Paula's first appointment with her community PCP is next week the 23<sup>rd</sup> at 2 pm.* The son plans on attending the first visit with her and that is when he will take her to get more groceries and whatever else she may need. He reports that with the help of the caregiver they will be able to get her into his minivan. Paula said she was excited and happy to be out of the nursing home. TC made a plan with Paula to call her tomorrow to see how her first night went and to return on the 19<sup>th</sup> for another home visit.

## First Week Following Transition

The TC contacts the participant within a day or two of transition to monitor the following:

- Discuss relevant action items from the case review and strategies from the mitigation plan. Make any needed updates to the mitigation plan and 24-Hour Back-Up Plan.
- Determine if the participant has all necessary DME, adequate medical supplies and that utilities and appliances are in working order.
- Determine if there has been any change in the participant's wellbeing, including:
  - the status of chronic illnesses,
  - level of pain,
  - emotional well-being, and
  - sleep patterns.
- Determine if there have been any critical incidents such as falls, use of EHR or ED visits.
- Monitor that participant has all medications and that they are being taken as prescribed.

## Transition Coordinator (Care Coordination/Management) Process

- Discuss the community appointments that are scheduled or that should be scheduled, including primary care provider, psychiatrist, specialty care, and therapy services. If possible, arrange to accompany the participant to their first provider visits, or have someone else accompany them.
- Determine and discuss issues with ADLs and IADLs.
- Determine if there have been any environmental safety issues and if so, how were they addressed.
- Determine if there are any issues with income or finances.
- Discuss professional or paraprofessional in-home services being received (e.g., homecare nursing, personal assistants, homecare aides) and if there are any related issues. Determine what services they are providing and if the services are meeting the needs of the participant.
- Determine and discuss plans for social engagement.
- Discuss follow-up plan, including next contact date and type and what will be accomplished or discussed during that visit.

Document this and all contacts made with the participant/family/caregiver(s) and/or guardian in the WebApp case notes. Include the topics above and be as descriptive as possible. Summarize how the participant is managing during this first week at home.

### 30-Day Post-Transition Follow-Up Call

The UIC staff contact will schedule a 30 day post-transition follow-up call with the TC and the Division/Department MFP lead for an update on the participant's first month in the community and specific questions will be directed at the identified action plan items from the pre-transition case review. This is a time to discuss any new or unforeseen issues/risks and brainstorm how to mitigate them.

1. Overview of participant status for the first month in the community. Items to discuss on the 30 day follow-up call include the following introductory areas:
  - Status of provider visits, if they have occurred, or when they are to occur, if any changes in the participant's care was made, if anyone accompanied the participant to the visits;
  - Medications, is the participant taking their medications, do they need refills and how they are obtaining those refills;
  - Is the participant spending time socializing or participating in community activities and if not, what is being done to prevent social-isolation or loneliness;
  - Environmental issues;
  - DME or medical supply issues;
  - Service provider issues; and
  - The participant's safety and satisfaction with the new home.
2. Implement the action plan. Participant specific areas to discuss on the 30 day follow-up will be determined by participant risks/action plan.  
Paula's action plan from case review staffing call prior to transition will need to be addressed in the 30-day follow-up call:

- |   |
|---|
| <ul style="list-style-type: none"><li>✓ Assess for dehydration secondary to diuretics and laxatives: increase in heart rate, decrease in alertness, dry tongue or mucous membranes, decreased urination, dizziness, and thirst.</li><li>✓ Assess for signs of edema that is beginning to affect the lungs: weight gain will be an early sign followed by productive cough, shortness of breath, trouble breathing when lying flat</li><li>✓ Assess skin for signs of redness or change and if any occur contact PCP same day.</li><li>✓ Arrange for staff to accompany Paula to all provider appointments and ensure that changed or new information gets relayed to all professional and paraprofessionals engaged in her care.</li><li>✓ Arrange for staff training on safe use of Hoyer lift and transferring Paula.</li></ul> |
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## Transition Coordinator (Care Coordination/Management) Process

- ✓ Coordinate home care nursing for diabetes education and management.
- ✓ Coordinate evaluation and follow-up with a psychiatrist and a community mental health center.
- ✓ Coach and evaluate the staff on proper use of mechanical lift and all DME.
- ✓ Develop and implement a caregiver staffing level and schedule to support recommended level of coverage.
- ✓ Develop a plan for review and update of Paula's medication list after every medical appointment.
- ✓ Monitor that Paula has adequate amounts of medical supplies to meet her needs: diabetes supplies, attends/disposable briefs, ted hose.
- ✓ Monitor Paula is checking her blood sugar twice a day and reporting to her provider. Increase in blood sugar levels may be a sign of early infection or may signal a need for a medication adjustment.
- ✓ Monitor/promote Paula's engagement in activities for structuring her free time. Assist her to identify local support groups and activities of interest.

### Example 30-Day Follow-Up Case Note:

November 12, 2012:

Paula has done well her first month in the community. She has seen her PCP and provided him with the results of her blood sugar. Her ex-husband has accompanied her to her visits and writes in the communication notebook any changes or instructions from the PCP including medication changes. She has also been to the community mental health center and seen the psychiatrist. Her next appointment was scheduled for one-month. Her home care nurse has been seeing her regularly for diabetes education and management. The nurse indicates that Paula is not having any problems with dehydration or edema. The DME provider that delivered the Hoyer lift instructed Paula's caregivers on how to safely transfer her and she has not had any falls or troubles with transferring. Paula has all of the necessary medical supplies and a monthly delivery of supplies has been arranged. Paula has learned to check and record her own blood sugar. Her 24-hour back-up plan indicates who she should call if the results change or become too high or too low (details were written in the communication notebook by the homecare nurse). The nurse has also requested that Paula be transferred from her wheelchair into her bed in the afternoon for a rest period and to provide relief of pressure on the skin. Caregivers are monitoring her skin on a daily basis for redness or changes and will notify her PCP immediately if any occur. Paula's caregiver schedule is posted on her refrigerator alongside her 24-hour back-up plan. Paula has looked into a diabetes support group but has not yet attended one. She reports that is on her list of activities for this next month.

## On-going Implementation (365 days post-transition)

### *Process*

The implementation phase of the process is based upon information gathered during the comprehensive assessment and interventions and strategies outlined in the mitigation plan. Integrated into the mitigation plan are proactive monitoring activities. For proactive monitoring to occur, the patient is contacted at predetermined intervals for further assessment, teaching and monitoring of self-management skills, and coordination of care. Participants are encouraged to contact the TC between scheduled contacts when they have questions or need guidance in addressing changes in their condition. Participants and their caregivers/family are asked to report any change in their status or condition, a hospitalization, or emergency room visit.

A monitoring schedule is established for each participant and their caregiver based on the participant's risk status. Monitoring contacts occur via telephone or face-to-face in the patient's home, clinical office, hospital, or another agreed-to site. During each encounter, the participant will update the TC on current health issues and changes in health status or medications, and results of their self-management activities, such as daily weights, blood sugar monitoring, diet, and exercise/activity level. Teaching/coaching by the TC is included to increase the participant's ability to self-manage and



## Transition Coordinator (Care Coordination/Management) Process

problem solve. Not only does the participant need to know how to monitor their condition, they need to know how to evaluate indicators of change and develop an action plan to address the changes.

Assist and support the participant's efforts to develop a social support system in the community. Connect or link the participant to needed services and/or providers to ensure continued health and safety in the community. Respond timely to any issues that arise to prevent critical incidents.

Monitoring activities are incorporated into the participant's mitigation plan. Specific information to be monitored is reflective of the mitigation plan content and addresses any new identified patient needs. The overall status of the mitigation plan is evaluated during the patient/family monitoring process. Consistent, proactive monitoring allows the TC to obtain information that might signal significant decline in health status. This consistent monitoring enables early intervention, possibly preventing a downward spiral in the participant's health or functional status. At the completion of the monitoring call or visit, the next monitoring date is set and agreed upon. Document in case 'notes' how the participant is doing, evaluate the effectiveness of the current mitigation plan, and identify any new needs or risks.

Continue to monitor the identified risks, action plans, and mitigation plan. Review with the participant any provider visits they have had and update the medication list, mitigation plan and 24-hour back-up plan as needed. Provide the participant with the updated version of these documents and discard the outdated versions.

Develop a means for ongoing communication between any professional and paraprofessional persons involved in the participant's care. A 'communication book' (kept in the participant's home) that participant, caregivers and in-home service providers can all read and write in is a good way to keep everyone up-to-date on the participant's status and current plan of care.

If there are any changes in the participant's demographics (e.g., name change, address change) complete Form E –Post-Transition Update. Document every contact with and about the participant in the case 'notes' in the WebApp. Be as descriptive as possible. The minimum required number and type of visits should be outlined in each department/division's policy.

The UIC staff contact will sporadically review each transitioned participant's case 'notes' and will email or call the TC with questions if the case 'notes' in the WebApp are unavailable or unclear regarding how the participant is managing in the community. The goal is to ensure a safe and sustainable transition. The UIC APN staff contact is available to the TC for periodic case reviews, 30 day follow up conference calls, critical incident conference calls, and case updates as needed. TCs can contact the UIC staff contact with any questions or concerns.

### Roles

Comprehensive care management works best with a team approach and includes a number of various roles. Each member of the MFP/Pathways care management 'team' has activities specific to their role on the team. Although other caregivers are not listed in the following table, their roles are significant to a successful team, and the TC can assist with determining how formal and informal caregivers can best support the care management team.

<b>Roles &amp; Activities</b>	<b>Primary Care Provider/ Psychiatrist</b>	<b>Participant</b>	<b>Transition Coordinator</b>
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## Transition Coordinator (Care Coordination/Management) Process

Roles & Activities	Primary Care Provider/ Psychiatrist	Participant	Transition Coordinator
Assessor	<ul style="list-style-type: none"> <li>Diagnose and evaluate participant and perform specified procedures.</li> <li>Interpret test results with the participant/family.</li> <li>Assist participants in synthesizing information regarding health status and recommendations for care.</li> </ul>	<ul style="list-style-type: none"> <li>Provide accurate information to the transition coordinator, primary care provider, and other health/community providers.</li> <li>Alert the team to changes in their life situation or health status.</li> <li>Prioritize health problems</li> </ul>	<ul style="list-style-type: none"> <li>Completes and documents assessments and care plans</li> <li>Integrate objective and subjective data from medical records, face-to-face visits, primary care provider reports, staff comments, family and participant reports, and health and community provider reports into assessment and care plan</li> </ul>
Planner	<ul style="list-style-type: none"> <li>Develop medical plan of care interventions with input from the health care team.</li> </ul>	<ul style="list-style-type: none"> <li>Identify goals and assist TC in personalizing and prioritizing plan recommendations.</li> </ul>	<ul style="list-style-type: none"> <li>Develop and document plan of care with participant/family</li> </ul>
Implementer	<ul style="list-style-type: none"> <li>Reinforce recommendations from guidelines/protocols.</li> <li>Reinforce recommendations for transition coordinator/service provider.</li> </ul>	<ul style="list-style-type: none"> <li>Responsible for follow-through on agreed upon action in order to manage plan of care.</li> </ul>	<ul style="list-style-type: none"> <li>Support participant/family in implementing plan of care by assisting with identification of barriers to implementation and problem solving.</li> </ul>
Evaluate and Monitor	<ul style="list-style-type: none"> <li>Evaluate health status and follow through on plan of care.</li> </ul>	<ul style="list-style-type: none"> <li>Alert team to difficulties following the plan of care and change in health status or new needs/problems.</li> </ul>	<ul style="list-style-type: none"> <li>Monitor proactively participants on a regular basis and document</li> <li>Evaluate and document participant progress</li> <li>Re-assess participants at each contact and document in 'notes'</li> <li>Adjust plan of care based on change in status, information from team members and participant preferences and revise Mitigation Plan (Form J).</li> </ul>
Educator/ Coach	<ul style="list-style-type: none"> <li>Provide basis for prescribed treatments and recommendations/introductory teaching.</li> <li>Determine type of health promotion activities needed</li> </ul>	<ul style="list-style-type: none"> <li>Responsible for personal health and make appropriate lifestyle changes.</li> <li>Complete self-management activities and adhere to recommended care protocols.</li> </ul>	<ul style="list-style-type: none"> <li>Teach/coach participant/family about disease processes, medications and evidence based self-management strategies.</li> <li>Reinforce positive steps when implementing self-management strategies. Document your actions</li> <li>Reinforce reason and need for health promotion activities</li> </ul>
Facilitator (Medication management)	<ul style="list-style-type: none"> <li>Review and prescribe appropriate medications</li> </ul>	<ul style="list-style-type: none"> <li>Take medications as prescribed</li> <li>Report any suspected complications from medications: not effective, side effects, adverse events</li> </ul>	<ul style="list-style-type: none"> <li>Complete medication reconciliation and revise Form G as needed</li> <li>Provide accurate information to providers during transitions in care</li> </ul>
Transitional Care Manager	<ul style="list-style-type: none"> <li>Notify TC of known participant hospitalization or ED visits</li> </ul>	<ul style="list-style-type: none"> <li>Notify TC of ED or hospital visits</li> <li>Provide accurate information to providers</li> </ul>	<ul style="list-style-type: none"> <li>Responsible for follow-through post acute care visit (i.e. short-term rehab or nursing facility stay).</li> </ul>
Referral Provider	<ul style="list-style-type: none"> <li>Refer as appropriate to health providers.</li> </ul>	<ul style="list-style-type: none"> <li>Utilize correct level of service with assistance from team.</li> </ul>	<ul style="list-style-type: none"> <li>Refer to appropriate disease specific organizations, self-help groups, and other community services.</li> </ul>
Coordinator	<ul style="list-style-type: none"> <li>Coordinate care (primary through tertiary) in a variety of settings.</li> </ul>	<ul style="list-style-type: none"> <li>Alert team to use of health/community services, any recommendations, or issues encountered.</li> </ul>	<ul style="list-style-type: none"> <li>Coordinate longitudinal health care and community services.</li> </ul>
Communicator	<ul style="list-style-type: none"> <li>Communicate effectively with team members using multiple formats.</li> </ul>	<ul style="list-style-type: none"> <li>Communicate effectively with team members.</li> </ul>	<ul style="list-style-type: none"> <li>Serve as a conduit for continual communication among team members using multiple formats. Document all communications</li> </ul>
Collaborator	<ul style="list-style-type: none"> <li>Collaborate with numerous other professionals regarding the</li> </ul>	<ul style="list-style-type: none"> <li>Collaborate effectively with team and other healthcare</li> </ul>	<ul style="list-style-type: none"> <li>Collaborate with numerous other professionals regarding the</li> </ul>



## Transition Coordinator (Care Coordination/Management) Process

Roles & Activities	Primary Care Provider/ Psychiatrist	Participant	Transition Coordinator
	participant's needs	professionals	participant's needs
Advocate	<ul style="list-style-type: none"> <li>Advocate for participant services.</li> </ul>	<ul style="list-style-type: none"> <li>Express viewpoint concerning needs, problems, and services.</li> </ul>	<ul style="list-style-type: none"> <li>Advocate for the participant/family needs and services.</li> </ul>
Utilization Manager	<ul style="list-style-type: none"> <li>Ensure cost-effective utilization of services</li> </ul>	<ul style="list-style-type: none"> <li>Notify care team of previous services utilized</li> <li>Notify care team of any hospital or ED visits</li> <li>Appropriate use of services when needed</li> </ul>	<ul style="list-style-type: none"> <li>Obtain participant's past utilization of services and look for patterns</li> <li>Ensure future cost-effective utilization of services</li> </ul>
Negotiator	<ul style="list-style-type: none"> <li>Identify needed services</li> <li>Provide information and recommendations to team and payor source</li> </ul>	<ul style="list-style-type: none"> <li>Identify needs</li> <li>Identify gaps in care</li> <li>Provide information to team and payor source</li> <li>Negotiate with payor source for needed services</li> </ul>	<ul style="list-style-type: none"> <li>Negotiate with payor source for services needed</li> <li>Negotiate with healthcare system to ensure needed tests/services are received</li> </ul>
Risk Manager	<ul style="list-style-type: none"> <li>Identify areas of risks in the participant/families care and area of services</li> </ul>	<ul style="list-style-type: none"> <li>Identify and prioritize areas of risks in care and area of services</li> </ul>	<ul style="list-style-type: none"> <li>Identify areas of risks in the participant/families care and area of services and document</li> </ul>
Quality Manager	<ul style="list-style-type: none"> <li>Ensure participant safety</li> <li>Improve quality of care provided</li> <li>Take part in evaluation of care management activities</li> </ul>	<ul style="list-style-type: none"> <li>Identify and prioritize safety needs</li> <li>Identify areas of needed improvement in quality of care</li> <li>Take part in evaluation of care management activities</li> </ul>	<ul style="list-style-type: none"> <li>Ensure participant safety</li> <li>Improve quality of care provided</li> <li>Take part in evaluation of care management activities</li> </ul>

### High –Risk Management

Management of *high-risk* participants requires a greater frequency of contacts and continuity of care. When participants with high-risk criteria are transitioned consider their ability to self-manage their conditions. Participants are moving from a living environment where someone checks on them multiple times a day and assists them with management of their conditions to an environment where they may be alone for a large part of the day and be required to manage their own conditions. The participant needs to be able to engage in self management activities upon day of transition and every day thereafter. Self-management activities may include: medication management, including injections, drops, creams or lotions; peak flow monitoring; oxygen use; wound care and; identification of decreasing or abnormal results; blood sugar checking and identification of abnormal results; daily weights; management of diet and/or exercise; avoidance of irritants; monitoring for red flags or symptoms that indicate their condition is worsening or they are developing an acute infection or illness and the ability to problem-solve or take appropriate action.

*High-risk* participants are likely to have a number of professional and paraprofessional people involved in their care. It is essential that the TC communicate with all of these people to coordinate the participant's care and document these communications. The TC is accountable to ensure that the participant's care is meeting their needs and their risks are being mitigated.

	High Risk	Moderate Risk
<b>Recommended minimal TC Visit schedule</b>	<ul style="list-style-type: none"> <li><input type="checkbox"/> TC present on the day of transition</li> <li><input type="checkbox"/> 2 face-to-face visits a week for the first month</li> <li><input type="checkbox"/> A phone call to participant the day after transition</li> <li><input type="checkbox"/> 1 face-to-face visit a week for the next 2 months</li> <li><input type="checkbox"/> 2 face-to-face visits the following next 7 months alternating with phone contacts the opposite weeks</li> <li><input type="checkbox"/> After transferring back home after an</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> TC present on the day of transition</li> <li><input type="checkbox"/> 2 face-to-face visits the first week post-transition</li> <li><input type="checkbox"/> A phone call to participant the day after transition</li> <li><input type="checkbox"/> 1 face-to-face visit a week for the following 6 weeks</li> <li><input type="checkbox"/> 1 face-to-face visit in the remaining months with weekly phone calls</li> <li><input type="checkbox"/> An ED visit or hospitalization results in the participant becoming high-risk.</li> </ul>

## Transition Coordinator (Care Coordination/Management) Process

	<p>ED visit or hospitalization visits return to 2 face-to-face visits a week for at least the first month</p> <ul style="list-style-type: none"> <li>□ Visit schedule can be adjusted as needed based upon participant status/mitigation plan</li> </ul>	<p>TC visits become 2 face-to-face a week for at least the first month</p> <ul style="list-style-type: none"> <li>□ Visit schedule can be adjusted as needed based upon participant status/mitigation plan</li> </ul>
<b>Recommended Provider follow-up visits</b>	<ul style="list-style-type: none"> <li>□ Participant will need ongoing follow-up and monitoring by her providers. Discuss with providers or have participant discuss with providers the needed follow-up schedule and document for all to see.</li> <li>□ Provider visits will range from monthly to quarterly.</li> <li>□ Post-ED visit or hospitalization a provider visits is usually within 7 days</li> </ul>	<ul style="list-style-type: none"> <li>□ Participant will need ongoing follow-up and monitoring by her providers. Discuss with providers or have participant discuss with providers the needed follow-up schedule and document for all to see.</li> <li>□ Post-ED visit or hospitalization participant should be considered high-risk and provider and TC contacts stepped-up</li> </ul>

### Medication Management

Appropriate medication management is of utmost importance for participants to be successful. In the nursing facility this activity is completely managed for them. Without a thorough medication assessment and medication management plan the participant is unlikely to succeed at community living.

When determining if a participant can manage their own medication regime and what type of assistance they will need ask the following questions:

- Do you have a complete list of all your medications including name, dosage, frequency, and purpose?
- Do you take your medications exactly as you are ordered to?
- Do you understand the purpose of all of your medications?
- Do you think the medications are doing what they are supposed to?
- Do you think you are experiencing any side effects or problems secondary to your medications?
- Do you understand and take medications that are prescribed on an “as needed” basis?
- Have you ever stopped taking your medications or not taken them as prescribed? Why?
- Do you have any cultural or religious beliefs that affect how you take your medications (i.e. fasting)?
- Are you experiencing any sensory or functional changes that might interfere with proper taking of your medications (vision, swallowing, mobility-can they open child proof lids)?
- What type of Medication Assistance is needed?
  - Reminding to take medications
  - Opening medication container
  - Pouring medication from the bottle
  - Preparing the injection syringe
  - Handing the medication to the participant
  - Guiding the participants hand to their mouth
  - Injecting the medication
  - Inhaling the medication
  - Taking eye drops

## Transition Coordinator (Care Coordination/Management) Process

- Supervision while the participant takes the medication
- Understand how often to take “as needed” medication
- Instructing on what to do if medication dose is missed
- Assistance with finding payment for medication
- Assistance in getting to the doctor or pharmacy
- Assistance in getting medication refills from the provider and/or pharmacy
- Other: \_\_\_\_\_

### Self-Management

To determine a participant’s ability to self-manage there are several areas that can be assessed.

- ✓ Assess the participant’s/family’s/caregiver’s level of education/literacy, learning styles, and readiness for change as needed.
- ✓ Assess the participant’s functional ability or ability to perform self-management tasks.
- ✓ Assess the participant’s current self-management strategies which can be completed by observing self-management behaviors.
- ✓ Assess the participant’s/family’s/caregiver’s ability to problem solve.
- ✓ Identify areas where participant/family/caregiver education and additional self-management strategies are needed.
- ✓ Ensure the participant/family/caregiver receives education in areas identified.
- ✓ Develop with the participant/family/caregiver additional self-management activities using participant driven action plans.
- ✓ Follow-up with the participant/family/caregiver to ensure their knowledge base has increased and their level of self-management skills has improved.

Once these areas have been assessed, determine the participant’s ability and willingness to perform self-management activities and document. Some participants may be willing to monitor their own blood sugar and give themselves insulin injections, but due to a chronic condition they may not have the functional ability. Other participants may want to adhere to their treatment plan but for various reasons they may not remember what they are supposed to do.

### Transitional Care

Transitional care is designed to assist patients in smooth transitions from one location or level of care to another. Participants with chronic conditions often move from one care setting to another due to changes in their health status. Initially the participant is transitioning from a nursing facility to independent living. In the future the participant may be transitioning from a hospital or ED or temporary rehabilitative facility back to their community home. At these times, participants need closer follow-up. When participants move from one level of care to another, the specifics of their care plan do not always transfer with them.

An interruption in the continuity of care during transition can be confusing to participants/families and can result in unintentional non-adherence to the treatment regimen, adverse outcomes, and can lead to unnecessary re-hospitalization. The TC shares and documents information with the treatment team about any outpatient health care or community agencies providing care or services to the participant, what services are being provided, and any relevant information about the participant’s living situation that may affect treatment and discharge planning.

Ideally, the TC visits the participant in the hospital or other institutional setting and determines what follow-up community care will be needed. The TC also discusses the participant’s discharge plans and needs with the facility discharge planner.

## Transition Coordinator (Care Coordination/Management) Process

The goal of transitional care is to provide participants with a seamless transition that does not result in duplication of services or loss of care. The TC will follow the participant through the care system. The primary focus will be on maintaining continuity of care, enhancing participant and caregiver self-management activities, and prevention of complications and re-hospitalization.

*Recommended follow-up* for transitional care is initial visit within 24-72 hours after discharge then biweekly home visits with or without additional phone contact, and then weekly home visits for at least an additional 4 weeks. The TC will document the participant's progress during this transitional period.

### Critical Incidents and Critical Incident Call

In the event that the participant experiences a critical incident the TC is required to complete Form M – Critical Incident Report- as soon as possible once the TC is notified that the event occurred. TCs and agency supervisors review the critical incident and complete the internal review section of Form M. TCs contact the UIC APN staff within 24 hours of learning of the critical incident. The UIC APN staff contact will complete a critical incident summary document and work with the TC to schedule a critical incident conference call to occur within the next 48 - 72 hours. During the call the TC updates all parties on the details and events involved in the critical incident, what happened as a result of the critical incident, and the current status of the participant. The TC, UIC APN staff contact, and other individuals on the call will identify new risks, brainstorm ways of preventing future critical incidents, and develop an action plan to mitigate the current risks.

Following critical incidents, the TC reviews and updates WebApp forms F-K and enters case "notes". UIC completes the Critical Incident External Review Section of Form M – Critical Incident form. UIC will document the agreed upon action plan in the case 'notes' of the on-line care management system (WebApp). The TC addresses items in the action plan and then documents the items, how it was or why it was not implemented, and the outcome.

#### *Example Critical Incident and Critical Incident Case Note:*

##### *Critical Incident:*

About three months after transition Paula's caregiver called the ambulance and Paula was taken to the ED for elevated blood sugars and confusion. It was determined that she had a UTI. The ED physician started Paula on an antibiotic and sent her home.

The TC notified their UIC contact and a critical incident call occurred. During the call the critical incident, events that led up to the critical incident, and Paula's current status were discussed. An action plan was developed.

##### *Critical Incident Case Note:*

On January 20, 2013, this TC was notified by Paula's caregiver that on January 18, 2013, he called an ambulance to take Paula to the ED. For the last 2-3 days Paula had not been herself and on that day she was saying odd things, such as a the wall clock looking like a face that was watching her and her blood sugars had been over 300.

A critical incident call occurred on January 22, 2013. Present on the call were: TC, TC supervisor, Department/Division lead, UIC contact.

Summary since CI occurred: Paula returned home from the ED and has been taking her antibiotic as prescribed. Since home she has had a decreased appetite and eaten less and her blood sugars are between 110-150. The ED physician did not adjust any of Paula's other medication. Her discharge instructions were to see her PCP if her blood sugars stayed over 150. Since they are under 150 Paula does not want to make a special trip to the physician's office. She has her regular appointment in about 3 weeks.

After discussion of the case the following action plan was agreed upon:

- ✓ Monitor Paula's fluid intake. She will need adequate fluid to help eradicate the current UTI and prevent future ones from occurring.
- ✓ Monitor Paula's urine for changes that may signal a worsening of her UTI or a new one: dark urine, odorous urine, orange colored urine which could be a sign of blood in the urine, decreased urination frequency.
- ✓ Monitor Paula's blood sugar results; if they start to go up again schedule an appointment with her primary care provider. An elevation of blood sugar for no other apparent reason may be a sign of worsening or returning UTI.
- ✓ Ensure Paula completes the course of antibiotics as prescribed.
- ✓ Ensure Paula keeps her appointment with her PCP in three weeks.
- ✓ Educate/Coach Paula on the importance of notifying her PCP immediately with any changes in her blood sugar either too high or too low.
- ✓ Increase frequency of home visits to twice a week until Paula sees her PCP.

### 30 Day Post-Critical Incident Call:

There will be a 30-day post critical incident call scheduled to occur 30-days after the initial critical incident call to review how the participant is doing and the progress on the previous action plan. Items for the call include: an update on how the participant has done in the last 30 days; have the items in the action plan been addressed, and if so what was the outcome, or if not, what was the reason they were not addressed (participant refused, not needed, etc.); any new or unforeseen issues/risks and strategies to prevent further critical incidents from occurring.

During the 30-days between calls the TC follows the participant closely with bi-weekly contacts and documents in the on-line case 'notes' in the care management system (WebApp).

#### *Example 30 Day Post-Critical Incident Call Case Note:*

##### Previous agreed upon action plan:

- ✓ Monitor Paula's fluid intake. She will need adequate fluid to help eradicate the current UTI and prevent future ones from occurring.
- ✓ Monitor Paula's urine for changes that may signal a worsening of her UTI or a new one: dark urine, odorous urine, orange colored urine which could be a sign of blood in the urine, decreased urination frequency.
- ✓ Monitor Paula's blood sugar results if they start to go up again schedule an appointment with her primary care provider. An elevation if blood sugar for no other apparent reason may be a sign of worsening or returning UTI.
- ✓ Ensure Paula completes the course of antibiotics as prescribed.
- ✓ Ensure Paula keeps her appointment with her PCP in three weeks.
- ✓ Educate/Coach Paula on the importance of notifying her PCP immediately with any changes in her blood sugar either too high or too low.
- ✓ Increase frequency of home visits to twice week till Paula sees her PCP.

##### Current Update:

TC saw Paula twice a week for two weeks and then only once a week the week she went to see her PCP. Paula has completed all of her antibiotic and the provider rechecked her urine and told her the UTI was resolved. Paula is trying to drink more water and she and her caregiver are alert to the fact that they need to notify Paula's PCP if the color or smell of her urine changes. She is checking her blood sugar twice a day and it is now under 130. Paula and her caregiver are aware they need to call her PCP if her blood sugar goes up again. At this time Paula reports that she feels well and is happy and satisfied with her home and living out in the community. She is trying to get out more but thinks

the weather may affect her leaving her home if it gets too cold. Her daughter is coming home to visit next month and she is excited about seeing her. Paula will call this TC with any concerns or changes in her health and TC plans on visiting her in 2 weeks.

## Withdrawal/Disenrollment

Participants who have enrolled in MFP/Pathways (completed Form B-Enrollment Form) and have not yet completed 365 days in the community, and a disenrollment is to occur, the TC completes Form D – Disenrollment Form. Prior to completing Form D ensure that any other required forms are completed and/or updated and all case notes are entered. Once Form D is completed and entered-- the chart is locked and no additional information can be added to the participant's file without calling UIC and having them delete Form D to re-activate the chart.

If the participant completes the 365 days in the community no Form D – Disenrollment Form is needed. In the event the participant dies, do not complete the form D until notified by the UIC APN staff contact or mortality reporting team to do so.

## Mortality Review Process

In the event of a death of an MFP enrolled participant UIC will conduct a mortality review. The mortality review is to identify areas to learn from and assist with future transitions. The process for MFP mortality cases is different from the typical 'Critical Incident Review' process. When a MFP participant death has occurred, there will NOT be a critical incident call in the usual manner. Instead, there will be an in-person or over-the-phone interview that will take the place of the usual 'Critical Incident Review' call. UIC will do this same mortality interview/process with all agencies, departments and divisions when a MFP participant passes away in the community.

A mortality interview questionnaire will be used during the interview to gather additional information. Prior to the interview, the interview questionnaire will be e-mailed to TCs participating in the interview and their supervisor and division/department leads. This will provide an opportunity for the TCs/Supervisors to review the interview questions and gather the necessary information and documents in order to respond to the questions regarding this MFP participant.

In addition, UIC will request additional documents to be faxed to the Mahomet office at 217-586-6059:

- Records from primary care and other providers and the hospital if the death occurred in the hospital;
- Death certificate and/or cause of death from the hospital;
- History of service plans, agency assessments, additional notes, DONs, CCC, etc.

The TC will also complete a critical incident form (Form M) and update all agency case "Notes" in the electronic WebApp system. Lastly, the TC completes the disenrollment form (Form D) for the participant after receiving notification from the UIC staff contact.



## Appendices

Appendix A


### MFP Transition Checklist

Participant's Name: \_\_\_\_\_ RIN # \_\_\_\_\_


Planned Date of Discharge: \_\_\_\_\_

A comprehensive mitigation plan, completed medication list, and completed 24-hour back-up plan must be in place prior to transition.

#### Personal Identification and Changing Address

	Task	Yes	No	N/A	Date
	Obtain birth certificate and state ID				
	Change address with post office				
	Change address with voter registration				
	Change address on state ID and/or drivers license				
	Change address with social security				
	Change address with the Dept. of Human Services local office (formerly public aid)				
	Change address with Medicaid				
	Notify nursing facility of new address				


#### Caregiver Services

	Task	Yes	No	N/A	Date
	Determine which tasks participant/consumer will require assistance with:  <u>Tasks:</u> Bathing, Grooming, Housekeeping, Laundry, Meal Preparation, Shopping, Scheduling Appointments, Telephone use, Medication Management				
	Determine service hours/month: _____/Hours per month				
	Determine who will provide these services and develop a schedule				
	Determine level of family/friend support				

Transition Coordinator (Care Coordination/Management) Process

	Assist the participant in hiring a Personal Assistant (DRS) or obtaining a homemaker/caregiver and/or home care services				
	Hire primary PA and list them on 24 Hour Back-Up Plan (Form K) and Personal Resource List (Form L).				
	Hire secondary PA and list on 24 Hour Back-Up Plan (Form K) and Personal Resource List (Form L).				
	Create PA/caregiver schedule including tasks and hours/days present throughout the week.				
	Arrange for caregiver(s) to spend the first couple of nights with participant in the community after transition (if applicable).				
	List all identified caregivers on the 24 Hour Back-Up Plan (Form K) and the Personal Resource List (Form L).				
	Identify Back-Up PAs and list them on 24 Hour Back-Up Plan (Form K) and Personal Resource List (Form L).				
	Request PA Management Training provided if needed				
	Arrange Homemaker Services and list on 24 Hour Back-Up Plan (Form K) and Personal Resource List (Form L).				
	Arrange other Home Services needed and list them on 24 Hour Back-Up Plan (Form K) and Personal Resource List (Form L).				
	Review 24 Hour Back-Up Plan (Form K) and Personal Resource List (Form L) with PA and caregiver(s).				
	List Support Persons and Groups on the 24 Hour Back-Up Plan (Form K) and Personal Resource List (Form L), where appropriate.				

**Environment/Housing**


	Task	Yes	No	N/A	Date
	Acquire Housing Application				
	Complete housing applications for rental assistance (if needed)				
	Submit housing accommodations letter (if housing becomes available and services still need to be arranged)				



Transition Coordinator (Care Coordination/Management) Process

for participant to safely transition)				
Have housing lease (if needed) signed by client and landlord				
Determine if home modifications are necessary (ex: grab bars, rails, ramp, etc.) Obtain approval. Secure bids. Complete				
Obtain telephone service. Verify functionality. Obtain an ENHR/PERS service. Verify functionality. Discuss with the participant the need to maintain these after transition				
Collaborate with participant on furniture, household needs—purchase these. Deliver these to participant’s post-transition home				
Schedule/verify moving date				
Schedule moving van or other assistance with moving if needed				
Activate natural gas/electricity				
Activate water service				
Arrange installation of Life line/ emergency response system and have it activated				
Activate television service and pay cable deposit (as needed)				
Create emergency evacuation plan. Review plan with participant and caregiver(s)				
Arrange for physical therapy home safety assessment. Obtain order from nursing facility physician				
Purchase groceries so they are available on move in day				

**Finances**

	<b>Task</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Date</b>
	Confirm what income is available, how much it will be and when first amount will be available				
	Request budgeting and money management training as needed				
	Identify bank and list on Personal Resource List (Form L)				


Transition Coordinator (Care Coordination/Management) Process

	Make necessary arrangements for account/services completed				
	Identify representative payee (if needed) and list them on 24 hour Back-up plan (Form K) and personal Resource List (Form L)				
	Arrange education on paying rent/bills				
	Notify SSA, bank, etc of change of address				
	Transfer Medicaid (Medicaid Eligibility Card - formerly public aid) to new county of residence				
	Sign up for LINK Card				
	Transfer SSI or SSDI payments to new address— <ul style="list-style-type: none"> <li>○ Communicate new bank account information if payments are made electronically, to Social Security.</li> <li>○ Complete the same procedures for retirement payments from social security</li> </ul>				

**IMPORTANT NOTE:**

If a person notifies SSA that they have returned to the community prior to the 22nd day of the month or cut-off date, his or her SSI will be reinstated on the first of the following month. If SSA is notified after the cut-off, the person will get their \$30 on the first of the month and a subsequent check making up the difference will come later in the month with full benefits beginning the first of the next month.

**Providers**

	Task	Yes	No	N/A	Date
	Locate Primary Care Provider in community and verify that services/care will be provided. Obtain name/location/contact information. Obtain the first appointment <b>prior to Nursing Home discharge or within 1-2 days of discharge</b> . Educate the participant on the need to attend the first and all subsequent appointments. Determine transportation.				
	Identify accessible Therapy Services (if needed) <ul style="list-style-type: none"> <li>• Schedule intake appointment if not previously scheduled and arrange transportation to services.</li> </ul>				
	Locate psychiatric care provider in the community (if needed) and verify that services/care will be provided to the participant. Obtain name/location/contact information. Schedule the first appointment as soon as possible after				

Transition Coordinator (Care Coordination/Management) Process

	Nursing Home discharge. Educate the participant on the need to attend the first and all subsequent appointments. Determine transportation.				
	Locate Specialists: Psychiatry, Cardiology, Oncology, Podiatry, etc. <ul style="list-style-type: none"> <li>Obtain name/location/contact information/date/time. Educate the participant. Determine transportation.</li> </ul>				
	Identify specialty Clinics: Wound Care Center, Heart Failure Clinic, HIV Clinic, Dialysis Center, etc.				
	Arrange Support Services: Mental Health Services, Substance Abuse Support, Palliative Care, etc.				
	Obtain a prescription for Home Health services (RN, PT/OT) from the NH physician. Initiate the referral. Determine the date/time of first home visit. Educate the participant on the Home Health agency name/contact information/first home visit. Educate the participant on the need to cooperate with ongoing home care services.				
	Locate support groups in the community and provide this information to the participant if he/she demonstrates abstinence from substance abuse prior to transition. Locate accessible Substance abuse services (if needed). <ul style="list-style-type: none"> <li>Schedule intake appointment if not previously scheduled and transportation to services arranged.</li> </ul>				
	Arrange for nursing facility physician to order a neuropsychological evaluation on MFP participant if he/she has multiple mental health and/or neurological disorders.				
	Arrange for nursing facility physician to order a neuropsychological evaluation on MFP participant if he/she has multiple mental health and/or neurological disorders.				
<b>Medication/Pharmacy</b>					
	<b>Task</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Date</b>
	Obtain current list of medications from nursing home: prescription and over-the-counter. Update Form G.				

Transition Coordinator (Care Coordination/Management) Process




<p>Schedule II Medications: Obtain written (active/valid) prescription. Determine pharmacy that will fill the prescription. Determine the plan for which provider will write a new prescription <b>each month</b>, including how this prescription will be obtained by the participant and delivered to the pharmacy and picked up at the pharmacy.</p>				
<p>Complete MFP Medication List (Form G), provide a copy, and review with participant and circle of support.</p>				
<p>Determine needed medical supplies: home blood pressure monitor, scale, glucose meter, and supplies, syringes and supplies, sharps container, Home Oxygen and portable oxygen, Home nebulizer machine, Home CPAP machine, Incontinence pads; etc.</p> <ul style="list-style-type: none"> <li>• Order and ensure availability on move in day</li> </ul>				
<p>Collaborate with the NH to have the prescriptions written ahead of time</p>				
<p>Obtain remaining medications from nursing home that participant is entitled to (show long-term care provider letter, if needed).</p>				
<p>Locate a pharmacy to fill the prescriptions on an ongoing basis. Deliver the prescriptions prior to NH discharge. Obtain prescription medications and purchase over-the-counter medications prior to NH discharge.</p>				
<p>Determine if the pharmacy will deliver or if the participant will need to pick up medication</p>				
<p>Determine if pharmacy will fill pill organizers on a monthly basis</p>				
<p>List Pharmacy (and available second pharmacy) on the 24 Hour Back Up Plan (Form K) and MFP Personal Resource List (Form L).</p>				
<p>Request Medication Management education if needed.</p>				
<p>Ensure that a sufficient initial supply of medications is available so participant does not go without medications while waiting for new scripts. To assure everything will be in place on day of discharge you must initiate a letter to the pharmacy with the date of planned discharge approximately 5-7 days <b>PRIOR</b> to planned discharge date.</p>				

Transition Coordinator (Care Coordination/Management) Process


	<p>See "Provider Notice" and "cover letter". (Note: The "Provider Notice" will inform the pharmacy of the MFP program and advises that the 'Refill Too Soon' approval requests will be granted to MFP participants upon entering the community. There will be a standard cover letter that will be faxed to the pharmacist with the provider notice. The 5-7 day period is needed to lift the hold and to assure everything will be in place on the day of discharge.) <u>Back-up plan</u>: What should they do if pharmacy will not dispense?</p>				
	<p>Assist participant with organizing medications in new residence.</p>				
	<p>Arrange for home health nursing services for medication and disease management. Obtain a prescription for home health nursing services from nursing facility physician.</p>				

**DME/Medical Supplies**


	Task	Yes	No	N/A	Date
	<p>Locate a home medical supply company to obtain needed supplies, including refills as appropriate. Educate the participant. Collaborate with the participant in developing a system to obtain additional supplies as needed. Provide the participant with the supplier's name and contact information.</p>				
	<p>Verify that the participant currently owns DME and is using it appropriately..</p>				
	<p>Determine needed DME (an Emergency Home Response System-EHRS (required); wheelchair and "Roho" cushion; Walker; Cane; Over-lay mattress for the bed; Hospital bed; Commode; Grab bars; Shower chair/bench; Hoyer lift; etc.)</p>				
	<p>Obtain delivery and verify functionality and safety of DME. Verify the participant knows how to use.</p>				
	<p>Obtain delivery and verify functionality and safety of DME. Verify the participant knows how to use.</p>				

**Transportation**


Transition Coordinator (Care Coordination/Management) Process

	Task	Yes	No	N/A	Date
	Determine options for the participant after transition.				
	Determine how the participant will be transported from the NH to the home in the community.				
	Determine how the participant will be transported from the NH to the home in the community.				
	Obtain a "Disabled Person Identification Card" for public transportation				
	Confirm transportation is available (Access, First Transit, Bus application, etc.)				
	List transportation providers on 24 Hour Back-up Plan (Form K) and Personal Resource List (Form L)				



**Medical Diagnoses and Illnesses**

	Task	Yes	No	N/A	Date
	Obtain medical physician <b>clearance/approval</b> for transition.				
	Obtain psychiatric clearance/approval for transition.				
	Recommend no hospitalizations/ER visits at least 6 months prior to transition.				
	Collaborate with the NH staff to initiate education on illnesses, medications, illness management, etc.				

**Advance Directives/POA/Guardian**

	Task	Yes	No	N/A	Date
	Assess for the presence of a guardian. Obtain documentation. Include the guarding on all decisions regarding transition.				
	Assess for the presence of Advance Directives: Power of Attorney for Health Care; Power of Attorney for Finances/Property; Living Will; Do Not Resuscitate order. Obtain copies.				
Discuss with the participant if he/she would like to create a Power of Attorney for Health Care. Collaborate with the family and the NH Social Worker on initiating and developing this document.					

Transition Coordinator (Care Coordination/Management) Process

	Discuss with the participant if he/she would like to create a Power of Attorney for Health Care. Collaborate with the family and the NH Social Worker on initiating and developing this document.				
<b>MFP Process and Documentation</b>					
	<b>Task</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Date</b>
	Complete the Quality of Life survey- before the participant leaves the NH.				
	Email UIC to alert to a potential transition. Complete all MFP Forms “paperwork.” Allow UIC at least 2 weeks to review the claims and paperwork and to develop the Case Review guide.				
	Complete 24 Hour Back Up Plan (Form K)				
	Complete Personal Resource List (Form L)				
	Complete Risk Inventory and Mitigation Strategies (Form H&I)				
	Complete Mitigation Plan (Form J)				
	Complete Medication Chart (Form G)				
	Provide participant with a copy of all MFP forms				
	Provide the participant with a copy of POA and out-of-hospital DNR form (if applicable)				
	Provide the participant with a copy of POA and out-of-hospital DNR form (if applicable)				
<b>Discharge</b>					
	<b>Task</b>	<b>Yes</b>	<b>No</b>	<b>N/A</b>	<b>Date</b>
	<ul style="list-style-type: none"> <li>Complete Discharge paperwork</li> </ul>				
	<ul style="list-style-type: none"> <li>Obtain Discharge card (if needed)</li> </ul>				

Transition Coordinator (Care Coordination/Management) Process

MFP 24 HOUR BACK-UP PLAN – Form K

\*\*Place near all telephones and on the refrigerator\*\*

Appendix B:

Date Created: \_\_\_\_\_ Participant Name: \_\_\_\_\_ Participant Phone: \_\_\_\_\_

RIN#: \_\_\_\_\_ Emergency Contact Name: \_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_

<p><b>EMERGENCY</b> IF, There is... A Medical Emergency Life support Equipment Failure Serious Injury/Accident Call 911</p> <p><b>IN CASE OF A FIRE,</b> follow these individualized instructions...</p> <p><b>Non-emergent numbers:</b></p> <p>Local Fire Dept #:</p> <p>Local Police Dept #:</p> <p><b>IN CASE OF A TORNADO,</b> follow these individualized instructions:</p>	<p><b>CAREGIVERS</b> IF, regular caregiver does not show, call back up in this order...</p> <table border="1"> <tr> <th>Name</th> <th>Phone</th> </tr> <tr> <td>1</td> <td></td> </tr> <tr> <td>2</td> <td></td> </tr> <tr> <td>3</td> <td></td> </tr> </table>		Name	Phone	1		2		3		<p><b>TRANSPORTATION</b> For Medicaid funded (NON- emergency) call contracted provider: Name:  Phone:  If they cannot be reached call back up transportation at: Name:  Phone:</p> <p><b>MEALS and FOOD</b> Delivered by:  Phone:  IF not delivered as usual, call:  Name:  Phone:</p> <p><b>REPORT ABUSE, NEGLECT, EXPLOITATION TO:</b></p>	<p><b>MY ACTION PLAN</b></p> <p>Blood sugar too high or low call: Name:  Phone:</p> <hr/> <p>Blood pressure too high or low call: Name:  Phone:</p> <hr/> <p>I feel depressed or lonely call: Name:  Phone:</p> <hr/> <p>24-Hour crisis Name:  Phone:</p> <hr/> <p>Asthma symptoms to call for: Short of breath with activity Yellow sputum Name:  Phone:</p> <hr/> <p>Additional participant – specific information:</p>
	Name	Phone										
	1											
	2											
	3											
	<p><b>SPECIAL MEDICAL EQUIPMENT</b> Emergency Home Response Equipment Hotline #:</p> <p>Local Special Equipment Dealer #:</p> <p><b>Case Manager Agency &amp; Phone:</b></p>	<p><b>PREFERRED PHARMACY</b> Name:  Phone:</p> <hr/> <p><b>HFS 24 HOUR Helpline #:</b></p>										
	<p><b>OTHER CRITICAL NUMBERS</b></p> <table border="1"> <tr> <th>Name/Agency</th> <th>Phone:</th> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td></td> </tr> </table>		Name/Agency	Phone:								
	Name/Agency	Phone:										
1	<p>MFP Transition Coordinator (TC) Name:  Phone:</p>	2	<p>If MFP TC can't be reached, call Community Case Mng Name:  Phone:</p>	3	<p>If they can't be reached call Name:  Phone:</p>	<p><b>Senior Helpline:</b> 8:30 a.m.- 5:00 p.m. 1-800-252-8966 1-800-206-1327 –TTY) <b>24-hour Elder Abuse Hotline:</b> 1-866-800-1409 –Voice/TTY</p>						



Appendix C:

**Transition Coordinator Resource Web Sites**

- [www.mfp.illinois.gov](http://www.mfp.illinois.gov), MFP program website for consumers and stakeholders
  - Contains consumer based information and links to MFP marketing and outreach material
- <https://mfp.nursing.uic.edu/mfpweb/> , Transition Coordinator website
  - Contains Transition Coordinator specific information on eligibility, housing, training, forms and processes, critical incidents, Quality of Life surveys, educational material and other resources
- <http://www.ilhousingsearch.org/index.html> , Housing Search Website
- <http://www.mathematica-mpr.com/Health/moneyfollowsperson.asp>, Mathematica (national evaluation vendor) reports on MFP
- <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Money-Follows-the-Person.html> , Federal Center for Medicare and Medicaid Services MFP website

Appendix D:

## **Transition Coordinator Talking Points**

### **Pathways to Community Living - Illinois' Money Follows the Person Program**

#### **Transition Coordinator and Engagement Specialist Talking Points**

The Pathways to Community Living Program seeks to increase the use of community services and rebalance the state's long term care systems by providing appropriate, person-centered services for individuals interested in transitioning from institutions to qualified home and community based settings.

The process of supporting an individual to transition and begin building a community based life is a critical component of Long Term Care Rebalancing and a meaningful experience. Transition efforts like Pathways to Community Living allow Illinois residents to move into their own homes and become part of their local communities. Transition Coordinators, Transition Engagement Specialists, and Ombudsman should be prepared to explain Pathways to Community Living to a variety of stakeholders while in the field.

Pathways to Community Living marketing and outreach material (available at [www.mfp.illinois.gov](http://www.mfp.illinois.gov)) are tools that may be utilized to explain the program to potential consumers. Individuals may also be directed to the program website for additional information – [www.mfp.illinois.gov](http://www.mfp.illinois.gov). These brief talking points were developed to assist Transition staff in explaining the program to interested and/or potentially unreceptive nursing home staff. Three topical areas are covered – a background on MFP, a background of the Illinois Program, and authorizing legislation. Thank you for being a part of this effort!

#### **Talking Points Contents**

- 1. Program Background**
- 2. Illinois Context**
- 3. HIPPA Issues – Right to Access Records of Long Term Care Facility Residents**
- 4. Authority and Related Legislation**
- 5. Pathways to Community Living Program Timeline**

#### **1. Program Background**

- According to the U.S. Supreme court decision *Olmstead v. L.C.* (1999), providers have an obligation to serve residents in the most integrated setting of their choice and states are required to develop plans to ensure that individuals with disabilities in need of long term care had access to services in the least restrictive and most integrated setting
- There are numerous national and state “rebalancing” initiatives that support the *Olmstead* decision, including the Money Follows the Person (MFP) Demonstration Grant awarded to Illinois in 2008. The program was extended through 2016 by the Affordable Care Act and 43 states are currently participating in the program.
- “Rebalancing” means to Increase the availability and appropriate use of home and community based services for long term care eligible individuals traditionally served in institutional settings, such as nursing homes, state facilities, or Intermediate Care Facilities for the Developmentally Disabled. Rebalancing continues to be a Congressional, Federal, and State priority.

#### **2. Illinois Context**

- Illinois' Demonstration is called Pathways to Community Living. Illinois has transitioned hundreds of individuals through the program since 2009 – over 500 through March 2012.

- The program is administered under the authority of the Federal Centers for Medicare and Medicaid (CMS) Services by the Illinois Department of Healthcare and Family Services. Several partner agencies participate as well:
  1. The Illinois Department on Aging;
  2. Three Divisions of the Illinois Department of Human Services – the Division of Developmental Disabilities, the Division of Mental Health, and the Division of Rehabilitation Services;
  3. The Illinois Housing Development Authority.
- I am a trained transition coordinator/transition engagement specialist/Ombudsman. The State of Illinois partner agencies have contracted with Case Coordination Units (CCU), Centers for Independent Living (CIL), Mental Health Centers (MHC), and Bureau of Transitional Services (BTS) to provide information to nursing home residents, their families, and staff about available community choices and to provide transition services to nursing home residents who want to live in the community.
- To accomplish the goals of MFP and implement the Pathways to Community Living Program, CCU, CIL, BTS, and MHC transition coordinators and transition engagement specialists must advise, engage, and assess nursing home and Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) residents and provide resources to help them transition into the community
- As you know, nursing home staff must engage residents in discharge planning activities. Resources available under the Pathways to Community Living can help to transition some residents who face barriers to discharge.
- Many residents will not be able to transition to other settings and by no means do we want to encourage raising resident's hopes and expectations falsely, but the Pathways to Community Living team will explore community care options/supports and conduct appropriate care planning to determine if transition back to the community is possible.
- Close collaboration between nursing facility staff Pathways to Community Living staff is needed to evaluate the resident's medical needs, finances and available community transition resources.
- We see Nursing Homes as partners in the Pathway to Community Living Program. Only by working together in partnership can we ensure that individuals in need of long term care services and supports receive them in the most appropriate and least restrictive settings.

### **3. HIPPA Issues – Right to Access Records of Long Term Care Facility Residents**

- IL Department of Healthcare and Family Services Official Provider Release (dated 4/26/2010) directs nursing home administrators and facility staff to “facilitate access of residents, staff caregivers, and records as required for both Ombudsman and Transition Coordinators working with potential MFP candidates.”
- Federal legislation requires a nursing home to provide reasonable access to any resident by any entity or individual that provides health, social, legal or other services to the resident [42 CFR 483.10(j)(2)].

### **4. Authority and Related Legislation**

- Federal law states that, a resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the home. A home must protect and promote the rights of residents [42 CFR 483.10]. More specifically, a nursing home must provide reasonable access to any resident by any entity or individual that provides health, social, legal or other services to the resident [42 CFR 483.10(j)(2)].

- The Money Follows the Person Demonstration is authorized by the Federal Deficit Reduction Act of 2005, the program began in 2007 with an award to 30 states and was recently extended through September 2016 by the Affordable Care Act (section 2403) with an award to an additional 13 states.
- The State of Illinois Money Follows the Person Implementation Act, which amended the Disability Services Act of 2003 (Public Act 095-0438, 20-ILCS-2407) promotes the civil rights of persons with disabilities by providing community based services for those persons when they are determined appropriate and desired.
- According to the U.S. Supreme court decision *Olmstead v. L.C.* (1999), providers have an obligation to serve residents in the most integrated setting of their choice and required states to develop plans to ensure that individuals with disabilities in need of long term care had access to services in the least restrictive and most integrated setting.
- According to *Olmstead* and the Americans with Disabilities Act of 1990 (ADA), individuals have a right to receive care in the least restrictive and most integrated setting and government have a responsibility to enforce and support these choices.



To Community Living

Risk Screen: Complete upon enrollment of participant into MFP/Pathways program to determine participant's risk of re-institutionalization or mortality after transition.

Participant Name: \_\_\_\_\_ RIN#: \_\_\_\_\_ Date \_\_\_\_\_

Transition Coordinator Name: \_\_\_\_\_ Agency Name: \_\_\_\_\_

**Determining Risk Status:**

**1. Does participant have any one of the following criteria/conditions? Check all that apply.**

- Chronic Obstructive Pulmonary Disease (COPD)       Wounds
- Suicide ideation or previous suicide attempt       Any ED visit/hospitalization in the last 12 months.

If any of the above boxes are checked, **STOP** participant is in high-risk category.

**2. Does participant have 2 or more of these co-occurring criteria/conditions? Check all that apply.**

- Morbid obesity: BMI  $\geq$ 35       Alzheimer's/Dementia
- Congestive Heart Failure (CHF)       5 or more Major physical/mental health conditions\*
- Isolation       Needs additional support to live in the community\*\*

If any 2 of the above boxes are checked, **STOP** participant is in high-risk category.

**3. Does participant have 3 or more of these co-occurring criteria/conditions? Check all that apply.**

- Medication risk\*\*\*\*       Diabetes       Chronic pain       Anxiety
- Active Cancer       History of falls       History of alcohol/substance use/abuse

If any 3 of the above boxes are checked, **STOP** participant is in high-risk category.

**4. Does participant have any one of the following criteria/conditions? Check all that apply.**

- Morbid obesity: BMI  $\geq$ 35       Alzheimer's/Dementia       Congestive Heart Failure (CHF)
- Medication risk\*\*\*\*       Diabetes       Chronic pain       Anxiety
- Active Cancer       History of falls       Isolation
- History of alcohol/substance chronic use or abuse       2 or more ADL/IADL limitations
- 5 or more Major physical/mental health conditions\*
- Needs additional support to live in the community\*\*

If any of the above boxes are checked, **STOP** participant is in moderate-risk category.

**Definitions:**

\*Major Physical/Mental health conditions: CAD (ischemic heart disease or previous MI), CHF, Diabetes, Alzheimer's disease, Atrial Fibrillation, chronic kidney disease, depression, bipolar disorder, schizophrenia, psychosis, alcohol dependence, drug dependence

\*\*ADL/IADL: needs assistance with ambulation, needs assistance with finances, needs assistance with toileting, needs assistance with transferring, has a history of falls, needs assistance with meals, has other ADL/IADL risks, needs assistive or adaptive devices in the home, or requires a special diet.

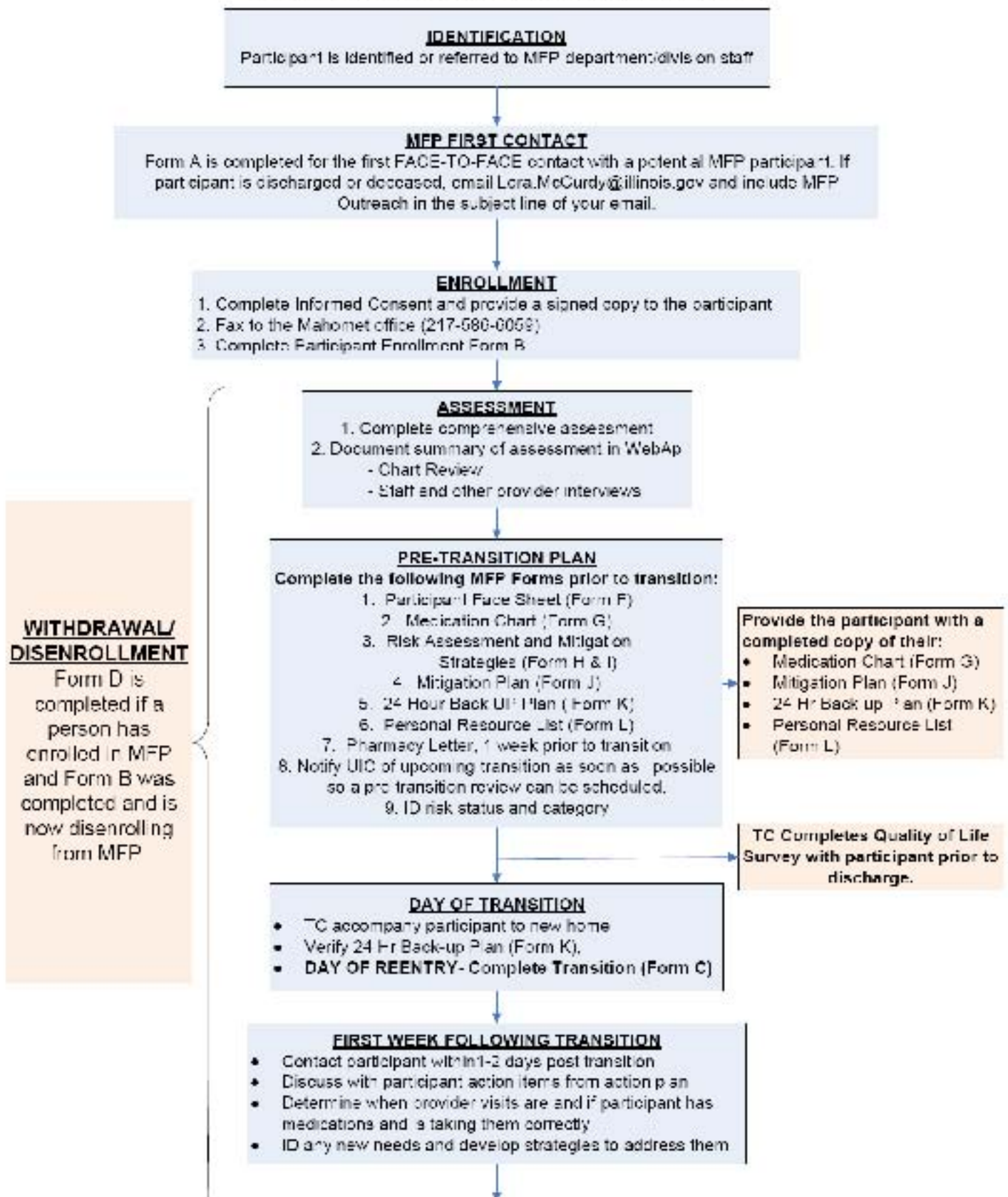
\*\*\*Additional Supports to Live in the Community: needs assistance to avoid harmful activities, lack of natural support, lack of peer support system, at risk of financial exploitation, at risk of social isolation, needs support to be in the community, history of suicide attempts/threats, or needs support to be in the home alone.

\*\*\*\*Medication Related Risks: takes seizure medication, needs assistance taking or monitoring medications, taking 9 or more medications, at risk of non-adherence to medications, or taking 2 or more psychotropic drugs.

Appendix F:

MFP Process Flow – Need to add 30 day follow-up

**Money Follows the Person (MFP) Form Completion Flow Sheet**



Note: This flow does not include agency/division/department forms.

**30 DAY POST-TRANSITION FOLLOW UP CALL**

- Review and summarize how participant has managed this first month.
- Address action items
- ID any new risks and update mitigation plan



**IMPLEMENTATION**

- Regular scheduled visits by T.C. per risk category
- TC Updates Forms F-L
- Complete Post-Transition Update (Form E) with any updates
- Monitor medication management
- Coach self management
- Transitional care as needed



**CRITICAL INCIDENT REPORTING AND CALL**

- T.C. completes Incident Report (FORM M)
- Division/Department Review and Conference (Complete review section of Form M)
- Submit to UIC
- UIC returns completed Form M and schedules a case review conference call where action plan developed
- TC Updates Forms F-L to address incident
- Complete Post-Transition Update (Form E)



**30 DAY POST-CRITICAL INCIDENT CALL**

- Summarize how participant has managed
- Review and address action items
- ID any new risks and update mitigation plan



**MORTALITY REVIEW PROCESS**

- TC notifies UIC of death
- UIC schedules mortality interview
- TC completes Form M (Critical Incident)
- After review process is completed, TC completes Form D (Disenrollment)



December 2012

## **MFP/Pathways Exceeds 700 Transitions**

As of December 13, 2012 the MFP/Pathways Program has transitioned 702 individuals since transitions were initiated in February, 2009. HFS would like to thank the 300 plus Transition Coordinators for their dedication and on-going support to MFP participants as they transition to the community. Additionally, we would like to recognize the University of Illinois, College of Nursing, for their focus on the provision of quality services and supports to enable MFP participants to be sustained in the community and we would like to thank our sister agencies for their support, collaboration, and their continued focus on improving the MFP/Pathways Program.

HFS anticipates the number of MFP transitions to substantially increase over the next several years due to the implementation of the Colbert and Ligas Consent Decrees and the closure of state facilities.

## **UIC Re-institutionalization Report Presented at November 7 Stakeholder Meeting**

As HFS is constantly striving to improve the quality of the MFP/Pathways Program, one of the goals of HFS is to collect and analyze data in order to implement revisions as a result of what we are learning from the program data. An important tool in analyzing the success of the Pathways program is the number of individuals who are re-institutionalized after transitioning into the community. (As of December 2011, the re-institutionalization rate for Illinois was 11%.) Cheryl Schrader, Director of Policy and Practice Initiatives at the UIC College of Nursing, reviewed the MFP/Pathways 2009-2011 Re-institutionalization report at the Stakeholder Meeting held on November 7th. Analysis of the various causes and contributors to re-institutionalization has prompted MFP to incorporate a more intensive case management approach for individuals who are assessed as having characteristics that are associated with a higher risk of re-institutionalization. These characteristics include: Advanced age; male gender; medical co-morbidity; SMI co-morbidity (including a history of alcohol and/or drug abuse or dependence; poly-pharmacy issues; social isolation and/or lack of family and peer support; functional disability (ADL/IADL limitations); and, multiple hospitalizations.

## **Money Follows the Person/Pathways forms Inter-agency Mortality Workgroup:**

The MFP/Pathways Program recently formed a Mortality Review Workgroup to review the mortalities that have occurred for individuals enrolled in MFP. The University of Illinois at Chicago (UIC), College of Nursing, conducted an in-depth analysis of the 20 individuals that had passed away after transitioning to community under the MFP Program since the inception of the program in 2009. Through the end of 2011, MFP transitioned 478 individuals with 20 mortalities which equates to an all-cause mortality rate of 4%. The majority of these mortalities occurred due to natural causes, however; it is the intent of HFS and its sister agencies to learn from these mortalities and make improvements to the MFP Program based on a more in-depth analysis of the mortalities.



December 2012

In its analysis of the 20 mortalities, UIC identified six characteristics that place individuals for higher risk of mortality post transition, including: chronic pain; morbid obesity; Alzheimer’s disease/dementia; COPD; lack of peer support system; and a history of falls. The workgroup plans to develop a system to identify individuals with these characteristics as “high risk” prior to transition in order to ensure that the Transition Coordinators are aware that certain individuals are deemed at higher risk for mortality due to these characteristics and subsequently to ensure that the care plan is adequate to address the health/safety for these individuals.

### **Money Follows the Person Revised Benchmarks:**

Establishing transition goals and annual increases in community service expenditures are two of the minimum/standard MFP benchmarks required by Federal CMS. In 2012, benchmarks developed specifically for the Illinois Pathways Programs were revised to include:

- Increase in Annual transitions by 15% every year (2012 – 2016)
- Increase in the percentage of participants remaining in the community (2011 = 80%)
- Decrease in the MFP Disenrollment rate due to readmissions at LTC facilities
- HFS to conduct a random review of case notes after critical incidents in order to ensure compliance with established risk mitigation plans to better inform quality improvement decision
- Increase in affordable, assessable and supportive housing
- Establishment of monthly quality webinars targeted at Transition Coordinators (TCs)

### **Housing News:**

Several initiatives have been established in conjunction with the defined benchmark of increasing access to affordable housing. These measures include:

- Increasing coordination with Public Housing Authorities and Associations
- Increasing units on the housing locator website <http://ilhousingsearch.org>
- Increasing the number of TCs utilizing the case worker portal featured on the housing locator website
- Increasing interagency communication regarding housing issues via bi-monthly conference calls
- Increasing the availability of rental subsidies for MFP participants

### **MFP success story!**

Read how agencies in suburban Chicago are collaborating in order to provide adequate housing for disabled individuals enrolled in MFP.

December 2012

**Organizations collaborate to provide accessible housing for the disabled**

By Deb Quantock McCarey

*(Originally published in Wednesday Journal of Oak Park-River Forest on Dec. 4, 2012. Reprinted with permission)*

Marc Lucas lost everything in his life when he became a quadriplegic after a car crash in 2004. For eight years, Lucas, 27, lived at the Berkshire Nursing and Rehab Center in Forest Park hoping to get out.

November 1st, he says, was his independence day, as that is when Lucas moved into one of two newly created wheelchair-accessible apartments of the Oak Park Residence Corporation's multi-unit building at 901 Pleasant Street.

As a participant in the Money Follows the Person Demonstration Program, which is administered by the Illinois Department of Healthcare and Family Services, and thanks to a recent collaboration with the Oak Park Housing Authority and the Progress Center for Independent Living in Forest Park, Lucas is a rent-paying tenant.

"[The Progress Center] asked me if I wanted to come back out into the community, and said we can offer you this. I said, 'Yeah, I'm ready,'" recalls Lucas. "It was time to get out of the nursing home. It was not the place for me."

Medicaid has helped fund his transition from an institutional facility to the vintage two-bedroom apartment in Oak Park. He also has a nonelderly disabled voucher via the Oak Park Housing Authority. Three years ago, in a nationwide HUD initiative, the federal agency was awarded a special allocation of 15 housing vouchers for use in helping transition individuals out of nursing homes and back into the community, says Ed Solan, executive director of Oak Park Residence Corporation.

"We knew we had the units in our Pleasant Street building that could appropriately be retrofitted and rehabbed into rentals for persons with disabilities who use a wheelchair, and Mr. Lucas is a beneficiary of one of these HUD vouchers," says Solan.

The housing initiative, adds Dan Burke, who is Gov. Pat Quinn's statewide housing coordinator for long-term care reform, is specifically targeted to a population of individuals who are below age 61, and who are disabled and living in a nursing institution. To qualify for the program, the person must be willing and capable of moving out and into a community-based setting.

The cost of an individual with a disability to reside in an institutional setting can end up in the range of \$50,000 to \$75,000 per year, whereas the cost of funding an individual in a community-based setting is about \$25,000 to \$30,000, according to Horacio Esparza, executive director of the Progress Center for Independent Living.

As part of that cost a governmental subsidy covers approximately \$7,500. To this sum the tenant will pitch in an additional \$2,500 from his/her social security disability check, or just over \$200 a month in rent.

"These individuals do have skin in the game, in terms of paying something out of their very small check for their housing," Burke says.

December 2012

### **The accessibility makeover**

The renovation work began on the two rental units more than a year ago when the resident corporation tapped Oak Park architect Frank Heitzman to design the new space with a budget of about \$70,000, says Solan.

"A roll-in shower is a difficult thing to do because you have to fit an accessible bathroom into a very small apartment unit," says Heitzman.

"Bathrooms that are accessible with a roll-in shower tend to take up a lot of space, because you have to make the whole bathroom, in a sense, a shower."

Likewise in the kitchen, Heitzman had to be aware of the type of appliances to install as well as the height of the cabinets and countertop. Everything needed to be wheelchair-friendly.

"We also provided the tenant with an electronic [entry pad], where instead of using a key, he can swipe this FOB pad against the receiver and open up an iron gate, which is locked and hard to open, and the doors," says Heitzman. "In case of emergencies, we also put in an uninterruptable power supply just for that opener, which was kind of unique, and something that isn't done that often."

On deck for the Oak Park Resident Corporation, adds Solan, is locating 13 additional local property owners who are able and willing to join in on this type of accessible housing.

"Our goal and role in this project is to provide assistance and support for the transition process," Burke says, "because under the Money Follows the Person Demonstration Program there are a series of protocols and follow-ups with the service agency (Progress Center) to ensure that the person is receiving appropriate care in the community, so we do have an ongoing role. We are interested in Oak Park's success, under this program, because it mirrors what the state of Illinois is undertaking at a more global level to achieve as many transitions from long-term care facilities to the community as possible."

### **The state of this state**

Mandating this effort, adds Burke, are two landmark court decisions. First, in 1999, in rejecting the state of Georgia's appeal to enforce institutionalization of individuals with disabilities, the Supreme Court affirmed the right of individuals with disabilities to live in their community.

"That was the opening of the door in this area, the 1999 U.S Supreme Court decision, and it spurred a number of lawsuits in the State of Illinois in the following decade," Solan explains. "The most important of which is what is called the Colbert Decision, where a group of individuals with disabilities sued then Governor (Rod) Blagojevich, in the name of the State of Illinois and won a consent decree which said the state had to discontinue the practice of placing people in nursing homes if they didn't want to be there, and if they didn't have to be there."

Recently, adds Burke, under the principles of the decision made in Georgia, the court approved an implementation plan in the case of Colbert v. Quinn that requires the state of Illinois to offer community housing opportunities, with support services, to residents receiving Medicaid in 185 nursing homes in Cook County.

They have agreed to achieve 1,100 of these transitions over the next 30 months, according to Burke.

December 2012

Meanwhile, on Pleasant Street, Marc Lucas has a new neighbor, and Solan is hoping that soon 13 more mobility impaired individuals will be moving out of a local nursing home and into one of his collaboration's newly identified wheelchair accessible rental units in Oak Park.

"Mr. Lucas, he needs more assistance than the new consumer we are moving now, who is more independent," says Esparza, who is blind and oversees the Progress Center's offices in Forest Park and Blue Island. "Nursing homes for a person with a disability are the worst option.

"We firmly believe that people with disabilities have the right to live in the community, make their own choices like anyone else, and, 'we' have the right to succeed and to fail.

"We have a list of people we are working with; Marc is not the only one. We have people we have already moved out, and others behind him on the list."

<http://www.oakpark.com/News/Articles/12-4-2012/Organizations-collaborate-to-provide-accessible-housing-for-the-disabled/>

### Training for Transition Coordinators:

HFS encourages all TCs to participate in a 12 part series of Quality Assurance webinars. The focus of these webinars will be on improving the quality of services people receive after they have transitioned into the community, in order to ensure that individuals are not re-institutionalized after moving out of a long term care facility. It is the hope of HFS, in collaboration with UIC, that these "Quality" webinars will provide the tools needed by the TCs to ensure this important benchmark is met. Webinars are held on a monthly basis from 9:30 – 11:30am, and each month will feature a different topic.

The following is a tentative schedule of TC "Quality" training webinars for 2013: January 17; February 21; March 21; April 18; May 16; June 20; July 18; August 15; September 9; October 17; and November 28.

Additionally, in response to program guidance provided by Mathematica, HFS will begin hosting refresher webinars for TCs administering the Quality of Life (QoL) survey, which is a federal requirement for MFP participants. All TCs who were previously trained to administer this survey will be asked to attend one refresher training session in 2013. TCs are welcome to attend one of the quarterly QoL trainings scheduled for new TCs, to be held on: January 16 (9-10AM); April 16 (9-10AM); July 16 (9-10AM); and October 15 (9-10AM). Pre-registration is required. HFS will also schedule additional trainings at other times for anyone unable to attend on these dates. If you have any questions regarding the Quality of Life Survey, please contact Mary McGuire at HFS ([Mary.McGuire@illinois.gov](mailto:Mary.McGuire@illinois.gov)).

### MFP Referral Process

HFS is in the process of revising the method in which MFP referrals are currently handled in an effort to streamline these referrals and increase efficiency for all agencies and individuals involved with MFP. Once these procedures are finalized, information regarding the referral process will be distributed.

December 2012

### **Colbert Consent Decree – Update:**

The Colbert Implementation plan was filed in court on November 8, 2012. The finalized version of the plan can be accessed on the MFP program website at <http://mfp.illinois.gov/colbert.html>.

### **Outreach & Marketing Update:**

The new marketing and outreach material developed for the MFP/Pathways to Community Living program is available on the program website ([www.mfp.illinois.gov](http://www.mfp.illinois.gov))! Spanish versions of the material are also available on the website. Additionally, HFS has hard copies available for distribution upon request. If you are interested in attaining printed copies, please contact Lora McCurdy at [lora.mccurdy@illinois.gov](mailto:lora.mccurdy@illinois.gov).

### **Future Meetings:**

HFS recently released the calendar of MFP Implementation and Stakeholder meetings for 2013:

#### **MFP Stakeholder Committee Meetings**

- March 26, 2013 10:00 AM – 12:00 PM
- July 10, 2013 10:00 AM – 12:00 PM
- November 19, 2013 10:00 AM – 12:00 PM

We would like to encourage greater consumer participation in the committee meetings. If you would like to refer an individual or know someone who would like to participate, please let us know! You may email that information to Pathways to Community Living Staff by clicking the “contact us” link on the program website - [www.mfp.illinois.gov](http://www.mfp.illinois.gov).

Happy Holidays,

Lora McCurdy  
Pathways to Community Living/MFP Project Director  
Illinois Department of Healthcare and Family Services