

Supportive Housing Providers Association

Moving Individuals with Mental Illness out of the Institutional Setting of Nursing Homes (including IMDs) and into the Community-based Option of Supportive Housing:

A Plan to Rebalance and Change the Illinois System for Serving Individuals with Mental Illness

Executive Summary

The Supportive Housing Providers Association (SHPA) recommendations are summarized in this basic direction:

Fully fund the cost of supportive housing—housing plus appropriate services—to accommodate all individuals with mental illness currently in nursing homes who are capable of living in the community and desiring to do so.

These specific recommendations describe this direction:

- **Fund both services and rental subsidy.**
- Fund sufficient supportive housing units and create policy to **prevent additional individuals with mental illness from entering nursing homes.**
- **Fully fund a flexible mix of services**, including mental health, physical health, case management, substance abuse treatment and management, supported employment, and everyday living skills. The mental health services should include a wide range of options, including ACT and CST options (with more flexibility than these models currently allow), as well as other flexible service options as dictated by the individual's needs and desires. The available options should also include the current DMH supported and supervised models. A small but important subset of these services, such as supported employment, will not be Medicaid billable and will require a mechanism to fund these services.
- **Create a multi-year plan for moving individuals to the community, from IMDs first and then from regular nursing homes.** Involve state agency staff, residents, and supportive housing providers (community mental health providers and providers of supportive housing to the general homeless population) in creating the plan. Make the plan one comprehensive and inclusive piece, rather than piecemeal. The plan must not include discharging individuals into homelessness.
- To fund this plan, it will be necessary to transfer resources from the Illinois Department of Healthcare and Family Services which funds the IMDs to the Illinois Department of Human Service to fund the community-based solution of supportive housing. Further, the Medicaid reimbursement that will be available to the state for individuals with mental illness moved to the community should be placed into a Mental Health Community Integration Trust Fund to fund this plan.

Supportive Housing Providers Association

- For a percentage of the supportive housing, **access sources of capital funding**, federal, state capital funding, city of Chicago, and other local funding to rehab or newly construct integrated (affordable or market units for the general population mixed with supportive housing units) and small single site supportive housing.

Initiate the plan:

- Move 500 or more individuals from IMDs to the community in the first year.
- Use what has already learned been learned from the Division of Mental Health (DMH) Money Follows the Person demonstration program and the DMH Permanent Supportive Housing Bridge Subsidy program. Also incorporate everything that is learned in the first year.
- Move 900 people a year for four years. Move at least 3,600 to 4,000 individuals to the community from IMDs and regular nursing homes. Then review what is left to be done.
- Make assessments based on clinical judgment, not rigid criteria. A task force that includes providers should be convened to determine assessment tools and methodology.
- Create more ease in the way in which these services are billed. Per diem billing is preferred because it will allow providers more flexible service delivery to meet individual needs and will cut billing costs significantly.

These recommendations will give many individuals with mental illness lives of dignity and purpose, will protect elderly individuals in nursing homes, and will save the state money.

Supportive Housing Providers Association

The Current Situation

Context

The Illinois issue of housing individuals with mental illness in nursing homes has a long history. In 1998, the Chicago Tribune featured a series of articles “Warehousing the Mentally Ill in Nursing Homes.” Some nursing homes sent “bed brokers” to homeless shelters looking for potential clients. Because Medicaid would support only homes where at least 50 percent of the patients were physically disabled, health problems were often invented for patients. One woman with a long history of mental illness received a diagnosis of “cranial dermatitis”— dandruff. In 1999 the U.S. Supreme Court decided the landmark decision of *Olmstead v. L.C. Ex Rel. Zimring*, giving rights to persons with disabilities (seniors, the physically disabled, the developmentally disabled, and persons with mental illness) to live in the least restrictive setting that is appropriate to their desires, needs, and capacity. This decision was based on the Americans with Disabilities Act of 1990 in which Congress identified the segregation of people with disabilities as a severe form of discrimination. The U.S. Supreme Court under the *Olmstead* Decision held that a state can meet its obligations if it has a “comprehensive, effectively working plan for placing qualified persons with mental disabilities in less restrictive settings, and a waiting list that moved at a reasonable pace not controlled by the State’s endeavors to keep its institutions fully populated”. To date the State has not developed a comprehensive plan for implementing *Olmstead*.

Existing Situation

In March of 2009, an Associated Press analysis showed Illinois ranking the highest among the states in the number of mentally ill adults under age 65 living in nursing homes. In 2008, according to the Associated Press analysis, 12,736 individuals with mental illness under 65 lived in Illinois nursing homes. Of these individuals with mental illness living in nursing homes, 5,063 live in nursing homes designated by the federal government as Institutions for Mental Diseases (IMDs). In IMDs, most of the residents are individuals with the primary diagnosis of mental illness. A list of IMDs supplied by the Illinois Department on Aging is attached (Attachment A). According to the Associated Press estimate, this leaves 7,673 individuals under 65 with mental illness living in regular nursing homes throughout the state. The total number of people living in nursing homes in Illinois is approximately 100,000¹.

Community care funding in Illinois has shrunk while institutional funding has expanded. In 1994, Illinois was allocating 92 percent of its Medicaid long-term care funds to institutional care and only 8 percent to home and community-based services (HCBS). In 2001, the distribution of Medicaid funds had not changed significantly: 86 percent to institutional care and 14 percent to HCBS². In the past 5 years, Illinois has increased spending for intermediate care for persons with mental illness while decreasing community alternatives to intermediate care. Community-based provider organizations were flat-funded for four years. Their funding was cut in FY 2009

¹ Illinois Department of Public Health Website

² U.S. Department of Health and Human Services, State Long-Term Care: Recent Developments and Policy Directions, Barbara Coleman, Wendy Fox-Grage and Donna Folkemer, National Conference of State Legislatures, July 2002.

Supportive Housing Providers Association

and again in this current year, FY 2010. Resources for community based options have shrunk by 15-20% over the past four to six years³, while nursing home providers received legislatively mandated annual increases.

Cost

According to the Illinois Department on Aging, nursing homes in Illinois cost on average \$117 per diem. IMDs are costing the state approximately \$160 million annually with no Medicaid reimbursement. Also, we are now spending taxpayer money to defend against lawsuits about institutionalization.

The Response

Access Living, the ACLU, Equip for Equality, Bazelon Center for Mental Health Law, and pro bono cooperating law firms filed three class action lawsuits charging Illinois with violating Olmstead:

1. ***Ligas v. Maram***, filed on behalf of 6,000 people with developmental disabilities who now live in large private facilities.
2. ***Colbert v. Quinn***, filed on behalf of 20,000 people with disabilities in nursing homes in Cook County.
3. ***Williams v. Blagojevich (Quinn)***, filed on behalf of 5,000 people with mental illness living in IMDs.

The Chicago Tribune has published a recent series of articles exposing the problems of housing people with mental illness in nursing homes. The Chicago Reporter in a recent issue revealed the devastating conditions in nursing homes with predominately African American residents. Governor Quinn created the Nursing Home Safety Task Force which held a series of public hearings and completed the final report of its recommendations to the Governor at the beginning of February 2010. A combined state Senate Public Health and Human Services Committees' Hearing was held on Nov. 5, 2009 regarding nursing home safety. The state is currently negotiating a settlement to the lawsuit filed on behalf of people living in IMDs.

The Community-Based Supportive Housing Continuum of Care Solution

Introduction

Supportive housing is the core of a community-based continuum of care solution for individuals with mental illness currently living in nursing homes. The vast majority of the individuals with mental illness currently living in nursing homes can be successfully housed in community integrated supportive housing, thereby saving the state money, increasing the federal return, and improving the results for individuals with mental illness. Supportive housing has been proven to be effective for individuals with serious mental illness. Providing supportive services to people in housing is effective in achieving residential stability, improving mental health and recovery

³ National Alliance on Mental Illness Website

Supportive Housing Providers Association

from substance abuse, and reducing the costs of homelessness to the community⁴. The recently completed Study of Supportive Housing in Illinois demonstrated the cost savings of supportive housing across five state funding systems⁵ (Attachment B), and other studies nationally have shown similar cost savings⁶. The mental health services provided to individuals living in supportive housing are Medicaid billable. Supportive housing also leverages federal funding for operational subsidy and capital funding for new construction or rehabilitation.

Supportive Housing Defined

Supportive housing is a combination of affordable, permanent rental housing and supportive services, appropriate to the needs and choice of residents, either on-site or closely integrated with the housing. Typically the tenant pays no more than 30% of their income for rent. The supportive housing tenant has a standard lease or operates under a payee arrangement. Just like any other tenant there are no limits on length of stay as long as the supportive housing resident abides by the terms of the lease or agreement. The community-based mental health service provider works closely with the tenant and the landlord to insure lease compliance and to intercede as necessary. Through voluntary services tenants are supported in their efforts to recover, to achieve their individualized goals, and to maximize their ability to live independently. Many individuals are then able to move to other housing settings, if affordable housing is available. Services include mental health services, which will be described in detail below; medical and wellness services; substance use management, treatment and recovery; vocational and employment services; and coordinated support (case management).

Transition

The first year of transferring individuals from nursing homes to supportive housing should be considered a demonstration year. During this first year, one or several community mental health providers selected through an RFP process could move 500 individuals from IMDs. What is learned from this demonstration year should then inform the plan for moving additional persons with mental illness, the mix of service levels needed, and the cost of these services. Experience gained from the Division of Mental Health's portion of the Money Follows the Person (MFP) demonstration, the Division of Mental Health (DMH) Permanent Supportive Housing Bridge Subsidy program, and other similar demonstration programs should be used as the base from which to begin this process.

Assessments

The transition process will begin in the nursing home with assessments. Assessments should be robust, fast, and flexible. They should be based on clinical judgment, not rigid, standardized

⁴Culhane et al., 2001; Lipton et al., 2000; Tsemberis and Eisenberg, 2000; Rosenheck et al., 1998; Shern et al., 1997; Goldfinger and Schutt, 1996; Hurlburt et al., 1996.

⁵ The Social Impact Research Center of Heartland Alliance, *Supportive Housing in Illinois: A Wise Investment*. 2009.

⁶Culhane et al., 2002; Houghton, 2001.

Supportive Housing Providers Association

criteria. All assessments should be approached from the standpoint of determining what services will make it possible for this person to live in a more community integrated setting.

Only if it is not feasible to serve someone in the community, should a less integrated setting be considered. Some individuals may choose to live with families, friends, or market rate housing with appropriate services. A task force that includes community mental health providers of supportive housing providers should be convened to determine assessment tools and methodology.

Enough assessments should be done annually to allow for the transfer of a minimum of 900 individuals from nursing homes to community supportive housing settings per year for at least four years. Provided that adequate service funding is made available, providers could agree to take the individuals referred to them. Residents should have choice in the location to which they move. Clear rules with significant deterrents must be in place to prevent nursing homes from obstructing this assessment process. Individuals should be re-assessed at least annually. Collaboration between all agencies in a community or area to plan and implement this effort will make this workable. Agencies in mid-sized cities and more rural areas have strong motivation to serve individuals from their areas, to transfer them from nursing homes, and to keep them out of nursing homes.

Supportive Housing and the Continuum of Care

In this section the current supportive housing supply and other existing IDHS-service funded housing are described. These important resources, usually filled to capacity, keep many individuals from having to live in nursing homes. If services to these existing units are cut in this budget (FY 2010) or the next (FY 2011), many individuals will regress in their recovery and return to state-operated mental health facilities, nursing homes, prisons, or homelessness, at high cost to the state and to themselves. The supportive housing units currently in the pipeline will then be listed. Finally, we will outline the additional supportive housing units needed. Much of this is all ready part of the state's Comprehensive Housing Plan, described in the Supportive Housing Working Group Final Report (Attachment C) accepted by the Illinois Housing Task Force in August 2008.

Current Supportive Housing Supply

There are approximately 7,500 existing units of supportive housing in Illinois. These units are in single site locations or are scattered site supportive housing located in market rate rental buildings. Of the scattered-site units, at least 375 units are part of the DMH Bridge Subsidy Permanent Supportive Housing program. Also, 43 of the scattered site units are from the DMH Money Follows the Person demonstration project. In addition, there are 3,911 units of supervised (staffed 24 hours and usually group homes) and supportive residential housing (staffed 12 hours and usually efficiency or one-bedroom apartments). These units are in single site locations with 16 or fewer units each.

Most of these existing units are funded through two state budget line items: one called Supportive Housing Services in the IDHS general revenue budget at \$3.382.8 million and the other, Supportive MI Housing, in the Mental HealthTrust Fund for \$17.965 million. Both line

Supportive Housing Providers Association

items need to be protected from cuts in order to move forward, instead of backward, in transitioning individuals with mental illness from nursing homes. Some supportive housing is developed with HUD Homeless funding. The requirements of this funding allow an institutional stay of up to 90 days with a history of previous homelessness. Supportive housing with this type of funding is very valuable and able to keep individuals out of nursing homes that would otherwise end up there after hospital, jail, or prison stays, or in housing people who have been in nursing homes for three months or less.

Supportive Housing in the Pipeline

There are 769 units ready to open in FY 2010 and FY 2011 with federal funding already committed for capital and rental subsidy, needing only \$3.6 million in state service funding to be operational. In addition to these units, DMH estimates that a total of 700 Bridge Subsidy units and 150 MFP units will open in FY 2010. In FY 2012, there are 476 units scheduled to open that have their federal funding lined up, needing only 1.9 million in state service funding. In addition, approximately 132 MFP units will open in FY 2011, 130 units in FY 2012 and 130 units in FY 2013.

Additional Supportive Housing Units Needed

If the Associated Press is correct that 12,736 individuals with mental illness live in nursing homes in Illinois, and excluding the 2,572 units currently in the pipeline, an estimated 6,500 to 8,500 more units of supportive housing are needed to house all the individuals with mental illness in nursing homes who could be successfully housed in supportive housing. The majority of the new units should be scattered site rental units located in existing market rate rental buildings. A small percentage of the new units could be new construction or rehabilitation housing containing a mix of affordable or market rate units with supportive housing units or small single site supportive housing projects.

Moreover, to keep nursing homes from filling up again with mentally ill individuals, additional supportive housing will need to be available. It is difficult to estimate the number of mentally ill individuals who currently enter nursing homes annually. However, it seems reasonable to estimate that at least 2,000 additional units will be needed to accommodate new people needing this affordable housing with support. Combining an estimated 10% annual turnover rate in existing supportive housing with these additional units, may be enough to alleviate the need for additional individuals with mental illness to be funneled into nursing homes.

HUD Housing Quality Standards are currently used to inspect units for the Bridge Subsidy program and the MFP demonstration. These standards seem reasonable, but inspections must be carried out in a timely fashion.

Some providers have found that a few clients, who can live in their own apartments, may also benefit from temporarily having a more supported situation, i.e., a group home, living with another person in an apartment, a crisis residential program, or other arrangement, when they are functioning poorly. Also, for some individuals it may be necessary to provide an initial more supported living environment, such as supervised or supported residential housing.

Supportive Housing Providers Association

Services

A flexible mix of services, including mental health, physical health, case management, substance abuse treatment and management, supported employment, and everyday living skills should be fully funded and available to be used as needed and desired by each individual. The mental health services should include a wide range of options, including, but not limited to, ACT and CST options (with more flexibility than these models currently allow), as well as other flexible service options as dictated by the individual's needs and desires. The available options should also include the current DMH supported and supervised models. An important subset of these services will not be Medicaid billable, such as supported employment.

More will be known about the range of the level of services needed after the first demonstration year. It is important that the flexibility to work as needed with each individual be built into the service delivery system. Services should not be mandated at levels higher than necessary, nor should they be limited for individuals requiring very high intensity services.

Actual services provided could include, but not be limited to, the following:

- Assessment
- Transition planning and support
- Engagement, motivational interviewing, and retention
- Service planning for high risk behaviors
- Specialized training and support of jail/prison involved persons
- Integrated dual disorders treatment
- Individualized placement and support (supported employment)
- Wellness management and recovery services
- Case management
- Crisis management
- Psychiatric services: prescribing and medication monitoring and support
- Social: recreation activities and development of natural sources for this
- Representative payee services
- Life skills training: money management, transportation, health care, personal hygiene, housekeeping, laundry, shopping, food preparation, and use of community services
- Apartment finding and landlord relationships

The connection to primary healthcare resources is of paramount importance. Partnerships with Federally Qualified Healthcare Centers, Rural Health Clinics, and hospitals should be strongly encouraged.

Funding Required for Supportive Housing

Two or three types of funding are required for supportive housing. Single site or scattered site supportive housing requires funding for operating or rental subsidy. Single site supportive housing, either newly constructed or rehabbed, requires operating or rental subsidy and it requires capital funding for acquisition, rehabilitation, and construction. All types of supportive housing require funding for services.

Supportive Housing Providers Association

Cost of Services

The cost of the services will depend on the results of the demonstration year and on the mix of individuals living in IMDs and other nursing homes. Obviously, the greater the degree of acuity, the greater the cost. Most of the service costs incurred, but not all, will be Medicaid billable. Services should be billable on a per diem basis rather than per hour, drastically reducing the cost and the risk incurred by providers to bill for services. Billing for services needs to be done in way that allows providers to do what it takes to succeed with each individual, to be flexible, and to be paid for non-Medicaid eligible services as well as Medicaid eligible services.

Cost of Rental/Operating Subsidy

With DMH's Bridge Subsidy program, the average rent per unit per month has been \$719 for efficiency and one bedroom apartments. The average subsidy paid by the state has been \$580 per unit per month with the tenant paying \$120 per month out of their income. This is consistent with the estimates of the Illinois Housing Task Force Supportive Housing Working Group report, which estimates the rent of an efficiency apartment at a statewide average of \$600 per month and a one-bedroom apartment at \$900 per month.

Capital Costs

This same report estimates the capital costs for new construction and rehab at \$125,000 per efficiency unit. An estimated average cost of \$1,000 will be required to bring each scattered site rental unit up to inspection standards.

Moving Costs

The moving costs allocated under the MFP are approximately \$2,000 per person, covering the cost a security deposit, utility connection, and household items.

Funding Recommendations

- In order to go forward, and not backward, in the amount of supportive housing available for this transition, **keep current state funding for existing supportive housing services intact.**
- To fund this plan, it will be necessary to transfer resources from the Illinois Department of Healthcare and Family Services which funds the IMDs to the Illinois Department of Human Service to fund the community-based solution of supportive housing. Further, the Medicaid reimbursement that will be available to the state for individuals with mental illness moved to the community should be placed into a Mental Health Community Integration Trust Fund to fund this plan.
- **Apply for the same enhanced Medicaid reimbursement rate** that the MFP project is currently receiving for the whole of this project.
- **Ask for a special set aside at the federal level to fund this mass transition** of individuals from nursing homes to the community.
- **Use the current set aside in the state capital budget for affordable housing** toward capital costs for supportive housing construction.

Supportive Housing Providers Association

- **Access federal sources for capital and subsidy**, including the 1,000 housing vouchers set aside for individuals transitioning from institutions.

Policy Recommendations

- Revise the assessment process of individuals currently in nursing homes. Use flexible and clinically competent judgment to ensure that individuals are placed in the most integrated setting appropriate to their needs.
- Develop policy and procedure for educating individuals with mental illness living in nursing homes about the differences between nursing homes and supportive housing.
- Formulate policies that prevent additional individuals with mental illness from being diverted to nursing homes.
 - Revise the PASRR screening process to prevent nursing home admissions of people with mental illness who could be served in a more integrated setting. All assessments should be approached from the standpoint of determining what services will make it possible for this person to live in a more community integrated setting.
 - Insure adequate funding for community mental health services to prevent individuals with mental illness from having to go to hospitals.
 - Provide state funding for supportive housing that will prevent individuals from entering nursing homes.
 - Fund services (\$3.6 million) for the 769 new units of supportive housing ready to open in FY 2011. This service funding will leverage over \$21 million worth of mostly federal funding for capital and rental subsidy, plus approximately \$1 million in Medicaid reimbursement. This federal funding is committed to these projects with the caveat that it will be matched by funding for services.
 - Fund \$2.5 million from the Illinois Department of Corrections for 100 new units of supportive housing for individuals with mental illness leaving prison and jail.
 - Fund the services for the 446 new units scheduled to open in FY 2012, now estimated at \$1.9 million.
 - Train hospital social workers about alternative placements to nursing homes, e.g. supportive housing, as soon as these alternatives are available.

Capacity Building for DMH and Community Mental Health Providers, Engaging and Training Providers

Capacity Building for DMH

This complex undertaking with great potential to benefit Illinois citizens and save state money requires strong state leadership. DMH will need to be supported as it undertakes this effort so that it can serve as the clinical, administrative, and fiscal authority for this project. Additional

Supportive Housing Providers Association

staff with appropriate background and concentration of authority will be required. It will not work to have this endeavor spread over several state departments. Assistance from a consultant will be helpful to initiate this program.

Capacity Building for Providers

Providers for this project should be selected based on a RFP process with providers competing on the basis of quality and added value rather than price. The state could spec and price the contract requirement and ask providers to offer their best proposal within the limits of the specifications and price. Providers should also be selected based on their capacity and expertise in the following areas, considering geographic coverage and cultural competency:

- Assessment of high risk consumers
- Engagement and retention expertise
- Expertise in motivational and state-wide interventions
- Service planning for high risk behaviors
- Flexible Assertive Community Treatment team services and higher intensity community support team services with focus on recovery and community integration
- Integrated dual disorders treatment
- Individual placement and support (Supported Employment)
- Wellness management and recovery services
- Psychiatric services including prescribing and medication monitoring and support
- Representative payee services
- Medical case management & supportive services (education, monitoring, etc)
- Apartment finding
- Transition planning & support
- Specialized training for support of jail/prison involved people
- Peer support & education
- Cognitive behavioral treatment
- 24 hours a day, 365 days year continuous operations
- Robust information management capacity
- Strong recovery orientation as measured by a standardized assessment
- Strong program evaluation and quality management processes

Providers selected should then participate in a series of training sessions and ongoing support mechanisms covering these same areas. A lead training group should be selected by the state through an RFP process and could include the Corporation for Supportive Housing, the University of Illinois at Chicago, providers, or other entities.

Safety Planning

Planning in this area should be based on the results of the demonstration year and other examples of providers working successfully with individuals with mental illness who have a wide range of needs. Attention should also be given to providers working well with landlords in housing individuals with mental illness.

Supportive Housing Providers Association

System Outcomes

System outcomes should include: housing stability, ability to perform daily living tasks, integration into the community, connection with family, increased independence, employment, and progress on other goals that individuals set for themselves. However, evaluation of system performance should be primarily based on process measures (assessment of recovery orientation, quality process, fidelity measures, etc.), rather than outcomes to avoid the pull to serve those easiest to serve.